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Integration of Physical and Mental Health Care Delivery for Oregon's Children: Recommendations to the Oregon Health Authority

Oregon Children's Mental Health Task Force

A joint committee of the Oregon Pediatric Society and Oregon Council of Child and Adolescent Psychiatry

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EXECUTIVE SUMMARY:

PURPOSE:

Oregon's massive health system transformation initiative offers an extraordinary opportunity to bend the cost curve through a focus on health promotion, early intervention and integrated care. This is a paper prepared by the Oregon Children's Mental Health Task Force, a joint committee of the Oregon Pediatric Society and the Oregon Council of Child and Adolescent Psychiatry. It is intended to provide input for OHA and policy makers involved in health system transformation to specifically address children's mental health and the medical home. Likewise, this document provides guidance for the Addictions and Mental Health Division as they transform the system of services and supports administered through local Mental Health Authorities. After listing the *Key Principles*, we review the *Background of the Taskforce*, *Importance of the Effort*, *General Axioms* of an integration effort and elaboration of specific recommendations for each of the *Key Principles*. Our efforts are to provide guidance within the frame of

“The Triple Aim” to assure that health system transformation will substantively improve the health and mental health of our child population, in the context of a strengthened patient centered primary care home environment within a comprehensive system of care.

KEY PRINCIPALS:

A. HEALTH SYSTEM TRANSFORMATION SHOULD PROMOTE THE ARRAY OF ACTIVITIES THAT BUILD HEALTH, HEALTHY DEVELOPMENT AND RESILIENCE IN THE CHILD WITHIN THE CONTEXT OF FAMILY.

- 1. Support The Continuity Of The Medical Home.**
- 2. Ensure Child And Family Involvement In All System design and Implementation Processes**
- 3. Ensure An Environment of Cultural Competence And Diversity.**
- 4. Ensure that Transformation Activities are Trauma-Informed and Supportive of Strong Parent-Child Attachments**
- 5. Develop Policies That Support Screening Tools And Processes Within The Medical Home For Risk Identification, Developmental And Psychosocial Monitoring And MH Screening.**
- 6. Develop Policies That Support Financing And Expansion Of Proven Child Mental Health and Addictions Prevention Programs And Early Childhood MH Interventions.**

B. INTEGRATION OF MENTAL EMOTIONAL AND BEHAVIORAL (MEB) TREATMENT STRATEGIES REQUIRES STRENGTHENING OF THE CAPACITY OF THE MEDICAL HOME TO IDENTIFY AND TREAT THESE CONDITIONS.

- 1. Develop Policies That Support And Promote Integration And Collaboration Specifically For Children’s Primary Care And Child’s Mental Health Consistent Across CCOs.**
- 2. Implement Oregon Psychiatric Access Line for Kids (OPAL-K) As Children’s Mental Health *Decision Support* for Primary Care Providers.**
- 3. Ensure Other Ongoing Training Strategies for Primary Care Providers in Children’s Mental Health Competencies.**
- 4. Implement Health Care Finance Reforms Which Support Integration And Transparency Of Funding Streams.**
- 5. Implement Measures That Evaluate And Drive Critical Outcomes Across All Coordinated Care Organizations (CCO’s).**
- 6. Assure That The Training Of Our Future Healthcare Workforce In All Disciplines Includes Knowledge And Competences In Lifespan Health, Mental Health, And Care Coordination.**

C. INTEGRATION OF MEB TREATMENT STRATEGIES INTO THE MEDICAL HOME REQUIRES COORDINATION OF SERVICE WITH OREGON'S BROAD MENTAL HEALTH, ADDICTIONS, DEVELOPMENTAL HEALTH, SOCIAL AND EDUCATIONAL SERVICE ARRAY.

- 1. Assure That The Current System Of Mental Health Care And Addictions Treatment For Children And Adolescents Evolves In A Planful And Intentional Process, Coordinated With AMH System Of Care Transformation Activities (And In Line With HB 2144; Children's Wraparound Law).**
- 2. Health Care Information Must Follow The Child And Family Where Ever They Are.**
- 3. Care Coordination Activities For Children And Families Between Medical Homes, Community Services, Insurers, Agencies, And Programs Must Be Efficient, Accountable, Financed And Aligned.**
- 4. Assure that CCO and Transformation Outcomes Include Responsibility for Health Outcomes in the Educational, Correctional and Child Welfare Service Array.**

BACKGROUND of the TASKFORCE:

The Oregon's Children's Mental Health Taskforce began in 2007 as collaboration between **Oregon Pediatric Society (OPS)** and **Oregon Council of Child and Adolescent Psychiatry (OCCAP)** with the goal of integrating and improving mental health services for children within primary care. Our broad membership had expanded to include over 50 cross-system attendees to date with 25 making up the core team of high level leaders committed to this goal.

The Taskforce Charter created in the summer of 2009, states:

VISION: An integrated children's health system in Oregon that monitors social-emotional development, identifies risk and challenge, and provides effective and appropriate treatment to assure that all children, adolescents and their families achieve optimum health and development.

MISSION: To strengthen the collaboration between children's mental health systems and primary care providers through service delivery and policy changes that improve the quality of children's mental health care

VALUES

We believe.....

1. That all children deserve accessible quality healthcare
2. That an integrated children's health system is the essential provider of coordinated mental health care
3. That psychiatric illness in children is frequently under-recognized, insufficiently diagnosed, and often inappropriately or insufficiently treated
4. That early identification and treatment yields better outcomes for children and their families
5. That children and families are most effectively treated when providers of mental health and primary care collaborate
6. That collaboration and integration require sustainable financial models
7. That a child's developing total health occurs with a family's cultural tradition and requires careful honor, respect and attention

Basis of the taskforce recommendations:

The work of Oregon's Children's Mental Health Taskforce has built upon the local wisdom, guidance and experience and from national scientific knowledge and policy recommendations. The following source materials are noteworthy:

- National Research Council and Institute of Medicine report: *Preventing Mental, Emotional And Behavioral Disorders Among Young People* (2009).

- The American Academy of Pediatrics: *Addressing Mental Health Concerns in Primary Care; a clinician's toolkit* (2010).
- The American Academy of Child and Adolescent Psychiatry *Improving Mental Health Services in Primary Care: Reducing Administrative and Financial Barriers to Access and Collaboration* (2009).

This document represents integration of these comprehensive data driven sources and the perspective of Oregon leaders in the field of children's health and development.

IMPORTANCE OF THE EFFORT:

Most mental, emotional and behavioral (MEB) conditions emerge from forces in early childhood. These conditions represent the outcome of the complex interplay of biological, social and relational influences (eco-biodevelopmental model) that become embedded in the developing brain and body. Unfortunately, our country emphasizes expenditure of our limited resources in the management of these chronic conditions *late in life*. The cost of these interventions takes the form of an inverse pyramid; *early events have expanding impacts during the aging process both in positive and negative terms*. An emphasis on chronic disease strategies to intervene, manage and contain the impact of the adverse childhood experiences downstream results in massive expenditures in health care and incarceration. Furthermore, this emphasis aggravates the perpetuation of poverty, violence, chronic disease, lost opportunity, lost productivity and human suffering.

Fortunately we have emerging evidence that specific health promoting strategies can build health, mitigate risk, support healthy families and build more successful communities while decreasing the total health expenditure. These activities require intentional efforts to:

- Mitigate toxic risk effects on early brain development
- Support families to form secure attachment and strong parent-child relationships
- Assure safe, engaged communities around young families
- Education for all about building optimal physical, developmental and relational health

True prevention is far more than the avoidance of disease – it is building of health by the intentional reduction of the impact of toxic stress and adverse experiences in the early years. The pediatric medical home is rapidly transforming in its processes and mission to the future health of children. The expanded, integrated medical home is the first / best environment to engage with families, monitor early physical, developmental and relational health trajectories

The development of the new Patient Centered Primary Care Home (PCPCH) must assure that policies and processes support these activities of building health and monitoring trajectories. The integration of children's mental health services within the medical home is an essential component of this transformed system of care for children and families. *For this to be effective, improved capacity and competence of the PCPCH to identify deliver and coordinate this care depends on skill development, coordination of care and a robust and functional mental health and chemical dependency continuum of care.*

GENERAL AXIOMS OF INTEGRATION:

The health of the child's family is of paramount importance to the development of their child's health: Children are dependent upon their care-takers for their current and future health. As the number of family risk and trauma factors increase, (i.e. poverty, family drug use, parental depression, domestic violence) so does the child's risk for chronic disease, educational and social-emotional/mental health issues. These Adverse Childhood Experiences are the most basic cause of health risk behaviors, morbidity, disability, mortality and health costs. (Felitti, 2002)

Prevention requires a paradigm shift to "building health": For children's health promotion, we must move beyond the disease model to one that supports lifespan health and the building of healthy capacities. This requires special consideration of cumulative risk, biological/epigenetic susceptibility, social, relational and environmental drivers that will impact a child and family over time. Prevention efforts for health and mental health are best organized through strong medical homes with careful attention to the earliest attachment patterns of parent-infants and the broader social environment. The integration and linkage of health and mental health services that are comprehensive, continuous, family focused and accessible over time strengthen the engagement and alliance with families necessary to "assure a healthy future."

Mental health and physical health are inseparable: The bidirectional influence of physical and mental health is well established. 25 - 40 % of primary care visits involve MEB related issues. Likewise, a similar proportion of children with chronic illnesses and disabilities have mental health and behavioral disturbances which adversely impact disease management, outcomes, and cost. Comprehensive biopsychosocial analysis including careful attention to the social and relational determinants of health and disease requires close alignment of health and mental health services.

Mental, emotional, and behavioral disorders emerge from genetic susceptibility influenced by early toxic stress and weak social supports impacting brain development: Healthy brain development requires safe, secure, attuned and positive early relationships. Identifying risk, providing supports for families, focusing on early education and community engagement offers the greatest opportunity for future health.

Successful prevention is inherently interdisciplinary: Building health requires coordinated and integrated care in local communities with the expertise of family members, health care providers, educators, community workers and partnerships with business, vocational and political leaders.

Coordinated community-level systems are needed to support families and young people, especially with chronic conditions: Silos of funding for health care, social services, juvenile justice and education maintain artificial barriers to integrated care, cost-efficiency and future health/mental health outcomes. *Each system possesses its own coordination of care / care management principles and methods. This is an inefficient duplicative process that is confusing and ineffective for children and families.* Successful systems that link primary care and specialty service providers depend on the quality of the relationship of one coordinator with the family and with members of the care team.

Primary care providers will require expanded training to build the needed competencies in integrated care: Competencies will include: early identification of child and family risk; the use of standardized MH screening tools for youth; referral and care coordination with community services to management of developmental and social risk; treatment, coordination, and referral for mental health and chemical dependency services for youth; and others. Organized and strategic educational efforts are underway with START, webinars, learning communities, tool kits, QI initiatives and OPAL-K. (Oregon Psychiatric Access Line for Kids) Available, immediate and expert psychiatric consultation to the medical home is a key factor to the quality, success and emerging competency of the medical home to support children and families with mental health disorders and crises.

Cultural competence is critical to successful engagement with a diverse population: Health care disparities by race, ethnicity, culture, sexual orientation and socioeconomic status are substantial. Eliminating the associated barriers is not only an issue of social justice, but also essential to address the known poor health outcomes and massive costs of the chronic disease burden these marginalized populations. Cultural specific parenting, mental health and community building prevention activities should be supported as means of engagement to prevention activities.

Oregon's Health System Transformation should balance individual creativity of its regional organizations while utilizing over-arching, statewide core principles and care guidelines. Consistent overarching care principles, communication strategies, data sharing and coordination between communities/regions is critical to the success of this venture for Oregon. The overall health of the citizens of our state will require strategies of a shared vision that assures continuity for those who move from community to community within Oregon.

SPECIFIC RECOMMENDATIONS:

A. HEALTH SYSTEM TRANSFORMATION SHOULD PROMOTE THE ARRAY OF ACTIVITIES THAT BUILD HEALTH AND INFLUENCE HEALTHY DEVELOPMENT AND RESILIENCE IN THE CHILD IN THE CONTEXT OF FAMILY.

1. Support the Continuity of the Medical Home:

- a. Policies should support the importance of children maintaining continuity of care within their same medical home within their community.
- b. Insurance issues, Foster Home preferences, CCO or MHO contracting issues should not disrupt the medical home and the critical importance of this long term relationship.
- c. When changes in the medical home are unavoidable, a medical “passport” with medical, psychiatric and psychosocial information must follow the child.
- d. Create mechanisms to assure PCC capacity for screening, referral, feedback and coordination with all other care delivery systems.

2. Ensure Child And Family Involvement In All System design and Implementation Processes

- a. While the mental health system of care is embracing the importance of family involvement in strategic development, physical health settings are far less advanced in the continuum of family / consumer engagement.
- b. Family and transition age adults should participate in CCO leadership from the beginning.
- c. Family and transition age adults should participate in CCO quality assurance committees at the beginning of the process.
- d. Consent and assent to treatment procedures should be standardized for mental health care and coordination activities.
- e. The medical home environment should encourage and train transition age adults to advocate and participate in health care decisions.

- 3. Ensure an environment of Cultural competence and diversity:**
- a. CCOs should develop and monitor cultural competence and diversity training and implementation strategies.
 - b. In the adolescent population, issues of sexual orientation and gender identity are associated with high rates of victimization and suicide. The CCOs should ensure an environment where this population feels accepted and supported.

4. Ensure that Transformation Activities are Trauma Informed and Supportive of Strong Parent-Child Attachments

- a. Breaking the transgenerational transmission of trauma that drives costs and health/mental health morbidities requires practices and policies that identify trauma risk, engage families in treatment and recovery while providing support and protection for trauma exposed children and family members.
- b. Because of the importance of early relationships and parent-child attachment to buffer against toxic stress and its lifelong health impact, policies and practices must promote activities that support, strengthen, educate, treat and heal parent-child attachments and early childhood relationships.

5. Develop policies that support screening tools and processes within the Medical Home for risk identification, developmental and psychosocial monitoring and MH screening:

- a. Build the OHA policies in synergy and coordination with the screening and monitoring recommendations of the Governor's Early Learning Design Team's "Strawperson Proposal" (June 2011)
- b. Build OHA Policies that support specific medical home activities in implementing a broad array of standardized development and mental health screening tools, for example:
 - 1. Prenatal and post-natal parental mental health and depression screening
 - 2. Family violence and substance abuse screening
 - 3. Developmental screening and monitoring from 0-21 yrs of age
 - 4. Psychosocial and MH screening from 0-21 yrs of age
 - 5. School readiness screening
- c. CCO's should come to a consensus on accountability metrics

that include measures of screening rates or documentation of screening processes for each of the screening tool recommendations:

- d. Create policies and metrics that assure two-way communication between providers, agencies and systems and feedback within screening and referral processes.

6. Develop policies that support financing and expansion of proven child mental health and addictions prevention programs and early childhood mental health interventions:

For example:

- a. Positive Parenting programs (see reference)
- b. Collaborative Problem Solving strategies (see reference)
- c. Circle of Security Parenting and Group Interventions
- d. Child-Parent Psychotherapy (CPP)
- e. Other child and family education strategies for the management of anxiety, PTSD and depression.
- f. Early childhood mental health consultation
- g. Respite care, Wraparound and flex funds

B. INTEGRATION OF MEB TREATMENT STRATEGIES REQUIRES STRENGTHENING OF THE CAPACITY OF THE MEDICAL HOME TO IDENTIFY AND TREAT THESE CONDITIONS.

1. Develop policies that support and promote integration and collaboration specifically for children’s primary care and child’s mental health consistent across CCOs:

- a. As CCOs ascend in their role, transformation /incorporation of the roles and activities of MHOs should be an intentional process assuring systematic integration efforts for children.
- b. Consider methods of consistent training and certification for care coordinators whether they have expertise in wrap around, physical, mental, chemical dependency, developmental or educational systems.
- c. Develop mechanisms for electing the primary care coordinator for children and families with complex needs (families must play a key role in these decisions).
- d. When possible, collocation of physical and mental health providers should be encouraged and administrative barriers to such alliances removed. This should occur for mental health co-located within medical home as well as physical health providers co-located in the

mental health clinic.

- e. All children in mental health care should have communication and coordination of care with the medical home as a quality measure.

2. Implement OPAL-K as children's mental health

Decision Support for Primary Care Clinicians:

- a. The Oregon Psychiatric Access Line for Kids (OPAL K; a joint project of OCCAP, OPS and OHSU division of Child and Adolescent Psychiatry) should be implemented statewide to support primary care providers in their effort to manage mental health issues in the medical home environment. This project will support primary care clinician's effectiveness in addressing MEB conditions in a comprehensive way.
- b. Implementation of OPAL K will address concerns regarding HB 3114, the psychotropic prescribing in foster care bill.
- c. OPAL K will have evidence based treatment strategies available on the WEB.

3. Ensure other ongoing training strategies for primary care providers in children's mental health competencies:

- a. Support the continued expansion and success of START (Screening Tool and Referral Training for PCC) across the primary care sector as vehicle for training in mental health competencies
- b. START's current training modules for primary care include: early childhood developmental screening and maternal depression screening
- c. START training modules in development include: comprehensive developmental/autism screening and management, adolescent depression/suicide screening and monitoring, early childhood risk assessment and management.
- d. Trainings in identification intervention and referral of adolescent substance abuse

4. Implement Health Care Finance Reforms Which Support Integration and Transparency Of Funding Streams:

Financing and administrative policies should:

- a. Assure that all funds allocated for prevention and treatment of the pediatric age in health and mental health are so designated with transparency and clear metrics that are based upon penetration rates.
- b. Support payment to primary care providers for services for common mental health conditions of children and adolescents
- c. Support participation of mental health providers in primary care medical homes. Many insurance carriers or mental health carve out carriers will not approve credentialing and payment of new

mental health care providers, which then prohibits effective, full integration of services within the medical home.

- d. Support the principal of diagnostic parity (payment to primary care medical practitioners for mental health and autism diagnostic codes)

5. Implement Measures That Evaluate And Drive Critical Outcomes Across All CCOs

- a. Hospitalization and ER visits for mental health diagnoses
- b. Screenings in primary care
- c. Prevention classes
- d. Kindergarten readiness (Early Developmental Inventory)
- e. Psychotropic prescribing practices
- f. Emergency room visits
- g. Hospital and residential stays
- h. Satisfaction surveys
- i. Cultural competence
- j. Family involvement and engagement.
- k. Timeliness of record sharing
- l. START and MH Competence trainings

6. Assure That The Training Of Our Future Health Workforce Of All Disciplines * Includes Knowledge And Competences Of Lifespan Health, Mental Health, Coordinated Care And Care Coordination.

*For example:

- a. All licensed health care workers with medical, mental health and addictions training
- b. Social Service Workers
- c. Special Educators
- d. Peer workforce

C. INTEGRATION OF MEB TREATMENT STRATEGIES INTO THE MEDICAL HOME REQUIRES COORDINATION OF SERVICE WITH OREGONS BROAD MENTAL HEALTH, ADDICTIONS, DEVELOPMENTAL HEALTH, SOCIAL AND EDUCATIONAL SERVICE ARRAY.

1. Assure That The Current System Of Mental Health Care And Addictions Treatment For Children And Adolescents

**Evolves In A Planful And Intentional Process,
Coordinated With AMH System Of Care Transformation
Activity (And In Line With HB 2144; Children’s
Wraparound Law).**

- a. Oregon has an extensive range of children’s mental health and chemical dependency services and providers. Careful consideration of the functional, financial and collaborative aspects of the current system of care and how they will relate to the new structures must consider the continuum of care necessary for our population. Service provider contracting must occur in a timely fashion to prevent disruption of service array. Intensive level services (wrap around demonstration projects, , day treatment, residential treatment, hospital treatment, chemical dependency services....) are not created overnight. Their expertise is developed over years of program development, staff development, cultural development, community partnerships and family engagement. Inadvertent policy, contracting and funding disruptions that lead to program insolvency can not be undone and would create dangerous service gaps.
- b. Children and families with chronic MED conditions and long term provider relationships should not have care disruption due to contracting issues.
- c. Access to competent psychotherapy services prevents an over reliance on psychotropic medications in pediatric care. In addition, a number of significant studies highlight the effectiveness of combined (medication plus psychotherapy) approaches, for example: Depression (Treatment of Adolescents with Depression Study “TADS”) Attention Deficit Hyperactivity Disorder (Multimodal Treatment Study “MTA”) Anxiety (Child-Adolescent Anxiety Multimodal Study “CAAMS”) Obsessive Compulsive Disorder (Pediatric OCD Treatment Study “POTS”). Financial and contractual aspects of reform should encourage high quality psychotherapy services in the treatment continuum.

**2. Health Care Information Must Follow The Child And
Family Where Ever They Are:**

- a. Electronic Medical Record Standards: CCOs should utilize technology that will allow sharing of health care information across the state, communities and across disciplines.
- b. DHS records: any child in DHS custody or out-of-home care should have an up to date medical (including mental health and chemical dependence) record available at the time of medical care.
- c. A consistent standard for medical information release across all CCOs
- d. Transition age adults (18-25yrs - those at risk due to serious mental illness and or suicide potential) should have identified supportive adult who is participating in care and informed of risks (already in place for 14-18 age group)

- e. Children receiving mental health care outside of the medical home should have required initial and ongoing bidirectional communication between providers.

3. Care Coordination Activities For Children And Families Between Medical Homes, Community Services, Insurers, Agencies, And Programs Must Be Efficient, Accountable, Financed And Aligned.

- a. Financing structures for care coordination in medical homes must support payment for communication processes between medical home and mental health systems
- b. Care coordination in any mental health, early childhood, early education or social service systems must include coordination and communication with medical home

Any plan for coordination must consider methods of eliminating duplication of these services between systems, which are inefficient as well as confusing to the consumer.

5. Assure that CCO and Transformation Outcomes Include Responsibility for Health Outcomes in the Educational, Correctional and Child Welfare Service Array.

- a. Develop mechanisms of accountability and funding that remove barriers to identification and treatment of conditions in all settings, related to fear of primary financial responsibility for implementation by system partners.

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