The Massachusetts Child Psychiatry Access Program
The First 15 Years: Lessons Learned

Barry Sarvet, MD
Professor and Chair, Dept of Psychiatry
University of MA Medical School-Baystate
Statewide Medical Director, MCPAP

Outline

- Overall Program Description
- Start-up Considerations
  - Staffing
  - Enrollment of practices
  - Training
- Building engaged relationships with PCPs
- Program evaluation considerations
  - Measuring engagement
  - PCP satisfaction
  - Service quality
  - Clinical evaluation: peer review
  - Outcomes
- Future Directions
1. Define and Support the role of Pediatric PCPs in addressing mental health needs of children and adolescents in the primary care setting
2. Connect Primary Care Practices to the pediatric healthcare system
3. Improve the quality of mental health service delivery in the primary care setting

CPAPs are systems of relationships
3 Teams/7 Sites

- Each Team operates call center
- Face-to-Face evals conducted at site most convenient for Family

MCPAP Structure – 3 teams (1,500,000 youth)

Each team:
- 2 FTE child psychiatrist
- 1 FTE behavioral health clinician
- 1 FTE resource & referral specialist
- 1 FTE program coordinator
MCPAP Services

- Telephone Consultation
- Face to Face Assessment
- Resource and Referral
- Training and Education
Telephone Consultation

Telephone consultation is the primary currency of this relationship and the “engine” of a CPAP.

Telephone consultation is derived from a time-honored tradition of “curbside consultation”.

Face-to-Face Assessment

Reasons may include:

- Diagnostic Question
- Medication Question
- Second Opinion
- Reassurance to PCP
- Bridging

Followed by a consult letter within 48 Hours.
Criteria for F2F encounters

- Can’t answer question on the telephone
  - Or
  - PCP really wants it
    - And
    - Agreement that PCP can/will be managing the patient
      - Or
      - Second Opinion Consult

Resource and Referral

Community services can include:
- Psychiatry
- Psychotherapy
- Child home and wraparound services
- Neuropsychological testing
- Other services such as support groups, group therapy, social skills groups, parent education, early intervention, etc.

MCPAP contracts for statewide database of resources.
3-legged stool of MCPAP

Training and Education

On-site at practices, via webinar, videoconference, newsletter:
- Screening and toolkits – SUD (S2BI)
- Clinical topics (brown bag lunch)
- Resources and mental health system
- Clinical guidelines and Clinical Pearls
- Practice transformation, BH integration
- Case rounds – learning collaborative
- Monthly clinical conversations (webinar) between expert and PCP
Additional MCPAP Services

Provided by Central Administration:

www.mcpap.org

Straus J, Ravech R, Sarvet B, Health Affairs, 2014
MCPAP Results: PCP Knowledge

PCPs reported comfort treating:

- ADHD – 77%
- Depression – 68%
- Anxiety – 67%
- SUD – 15%
  (SIM grant support to increase SUD competence.)
Getting started: Enrollment vs. Grand Opening

**Enrollment allows:**
1. Framing expectations
2. Initiating a longitudinal relationship
3. Samples of informal consultation
4. Gradual ramp up—allowing you to work out the kinks

**Grand opening allows:**
1. Faster ramp up
2. Conserves resources

Marketing the program

- Press releases
- Grand Rounds, AAP chapter meetings
- Public service announcements/Direct to consumer marketing
- Presentations to community mental health providers
Recruitment of CAPs
Suitable child psychiatrists for the program are:
- Flexible
- Practical
- Confident
- Gregarious
- Creative

Recruitment of CAPs
Less suitable child psychiatrists for the program are:
- Perfectionistic
- Ponderous
- Risk-averse
- Socially avoidant
Concerns of prospective psychiatrists

<table>
<thead>
<tr>
<th>Concern</th>
<th>How to address</th>
</tr>
</thead>
<tbody>
<tr>
<td>My clinic is already full</td>
<td>Differentiate clearly from outpatient clinic</td>
</tr>
<tr>
<td>Patients expecting longitudinal relationship after F2F</td>
<td>No prescription pads (ever), Careful patient education</td>
</tr>
<tr>
<td>Malpractice liability for PCP error</td>
<td>Provider education</td>
</tr>
<tr>
<td>Inadequate time</td>
<td>Structured schedules, Protected time</td>
</tr>
</tbody>
</table>

Training

- **CAPs: Focus on Telephone Consultation Skills**
- **Care navigation and administrative staff: Keeping the trains running on time**
  - Customer service orientation
  - Ensuring that phones are answered during hours of operation
  - Ensuring that CAP schedules are built correctly
  - Data systems are operational
  - Reliable follow up to phone consults
    - Scheduling F2F evals
    - Providing support for referrals
    - Circling back to PCP when plans can’t be implemented
Telephone Consultation

Telephone consultation is the primary currency of this relationship and the “engine” of a CPAP.

Telephone consultation is derived from a time-honored tradition of “curbside consultation”.

Telephone consultation as educational encounter

— a teachable moment
— identifying learning need vs giving the answer
— “the bite-size chunk”
— avoiding use of psych jargon
— finding the right level of depth
— not pushing them past their “edge”
— emphasize the PCP’s agency, avoid dictating or directing treatment
Telephone consultation as relationship-building activity

— notion that every phone conversation is an opportunity for developing and enhancing a personal collegial relationship
— collegial attitude (not talking down to the PCP)
— positivity
— building trust
— expressing appreciation for their use of the CPAP
— encouraging follow-up
— promote CPAP functions (handoff to care coordination)
— making collaborative overture
— checking at the end of the call that the PCP has a clear sense of what to do next

Telephone consultation as opportunity to promote practice-level change

— promoting measurement-based care (could be touched upon in every call)
— promoting systematic screening
— promoting strength-based and family driven care
— promoting use of registries
— promoting practice-level care coordination
Engagement

May be the most important driver of the overall performance of program

Call volume works well as an indicator of engagement, may be even better than satisfaction surveys

Need regular data to evaluate engagement by team, region

Measuring engagement

Call volume and frequency, changes over time
  • By individual provider
  • By practice
  • By network

Presence/absence of embedded resources for care coordination

Presence/absence of adjacent child psychiatry resources

Variability by hub
PCP Engagement Factors

- Perceived usefulness of encounters
- Customization: to practice variables
- Quality of relationships with: CAPs, Coordinator, Referral specialist
- Efficiency of process
  - Trust: in clinical judgment of consultant
  - in reliability of program to follow through
- Patient/Parent satisfaction

Utility of encounters

**Practical:**
- vs scholarly/academic

**Clear next step:** make sure to negotiate this. What you think is realistic may not actually be realistic
Customization

to PCP

- Wide range of skill, confidence

- May need to see more patients for F2F consults from less experienced/nervous PCPs

- May need to have lower threshold for specialist referral

Customization

to Practice

- Presence/Absence of embedded therapist

- Role of medical assistant, referral coordinator, case manager

- Practice workflow/communication policies and preferences
Customization

To Network/ACO

- What quality measures related to behavioral health are they focused on?
- Network policies and practice guidelines
- What kind of population health resources do they have

Quality of Relationship

Friendliness and positivity

Building trust: reliability, consistency

Important for program staff (not just CAPs)

Continuity features
Efficiency of encounter

No telephone tag

Avoid long-winded explanations

Ask PCP how much time they have before going deep

Don’t collect data from PCP that’s not absolutely necessary for the service

For clinical researchers: be careful about recruiting subjects from your telephone consultation work

Trust

- Reduce variability in recommendations about common questions
  - Practice guidelines come in handy for this.
  - Need to negotiate these with members of your CAP team.

- Fulfill promises:
  - Have systems to ensure follow-through on post-consult action steps: setting up F2Fs, providing resource navigation
  - Feedback loops for PCPs around scheduling F2F and making referrals
Parent/Patient satisfaction

PCPs are happy when their patients are pleased with the service. (Makes PCP look good 😊)

Focus on customer service issues around resource navigation, scheduling and delivery of F2F consults
Program Evaluation Domains

1. Utilization (ie Engagement)
2. PCP Experience
3. Service Quality: Patients, Primary care staff
4. Clinical Quality
5. Outcomes

Engagement

Measure telephone consultation encounter volumes
- By Provider, Practice, Hub
- Outreach to low-utilizing practices

Longitudinal relationships/Shared care
- Follow up consultation rates
PCP Experience (survey methodology)
Can measure annually and/or post-encounter
Measure:
1. Overall satisfaction
2. Usefulness
3. Personalized
4. Experience of support
5. Development of confidence
6. Self-assessment of skills for particular diagnoses

Service quality
1. Patient (parent) experience surveys:
   Effectiveness of resource navigation, completed initial appointments for referrals
2. Response time for telephone consultation
3. Wait times for F2F evals
Clinical quality

- Peer review of telephone consultations (recording of telephone consults)
- Peer review of face-to-face consultation (record review)
- Assess fidelity to practice guidelines, rapport with PCP, best practices for telephone consultation

Outcome Assessment

Beyond the scope of most programs to assess clinical outcomes

Program would either:
- Require PCPs to measure and report
- Conduct follow up PCP medical record reviews
- Directly assess patients and/or administer patient/parent reported outcome measures

With appropriate funding and resources, outcome assessment would be quite valuable.
Limitations and Challenge of CPAP Model

- Push vs. Pull
- Inadequacy of surrounding specialty care system
- Pediatric Factors
  - Variability in pediatrician motivation
  - Variability in PCP practice readiness
- Geographic vs network model
- Perceived competition with integrated and collaborative care models

Future innovation of CPAP model to support CoCM

**CPAP-enabled CoCM**

- Systematic Screening
- Embedded child/family therapist devoting portion of time to:
  - Consultation/brief intervention/care coordination and “warm hand-offs”
  - Measurement-based care for a selected diagnosis
- CAP provides weekly case review with therapist focused on MBC group
- CPAP runs in the background to support the educational needs of the PCPs and to provide consultation for patients with ambiguous or complex diagnostic pictures
Sustainability Factors

- First and Foremost: Quality of relationships with pediatricians
- Becoming a part of mental health and public health infrastructure
  - Examples in MA: Enablement and support for MA Children’s Behavioral Health Initiative
  - MCPAP role in implementing universal screening, MCPAP for Moms, collaboration with crisis teams, collaboration with community mental health)
- Relationship with health systems and networks (ACOs)
  - Visibility and collaboration with stakeholder coalitions, MCAAP, consumer advocacy groups
- Public awareness