Objective

This research poster describes an innovative program developed in Maine to address workforce shortages in pediatric primary care. The program, called the Child Psychiatry Access Project (CPAP), seeks to improve access to child mental health services by assisting primary care physicians in delivering mental health care to children and adolescents.

Background

The ability to address the mental and behavioral health care needs of children and adolescents in the United States is severely challenged due to a shortage of child mental health providers and inadequate training of primary care clinicians. Additionally, there is a severe maldistribution of child psychiatric services in the U.S., with children in rural areas and areas of low socioeconomic status having significantly reduced access. The ratio of child and adolescent psychiatrists per 100,000 youth ranges from 3.1 in Alaska to 21.1 in Massachusetts with an average of 8.7. The state of Maine is largely rural and child mental health resources beyond Cumberland County are extremely limited. It has been estimated that the prevalence of 18-12% of children and adolescents suffer emotional/mental health illness in Maine, of which 71.6% do not receive treatment. The recent increase of fuel costs and decline of the economy have further increased the burden to receive evaluation and treatment for mental health issues in a timely manner. The Maine Health Access Foundation (MEHAF) set a strategic mission to support the development of models to increase mental health delivery in primary care settings and funded the Child Psychiatry Access Project (CPAP). The CPAP was modeled on the highly successful Massachusetts Child Psychiatry Access Project (5,4) and additionally developed a formal Collaborative Office Round model with the providers involved. The goals of CPAP are to increase access to child mental health services by assisting primary care clinicians in finding resources, providing telephone and electronic (e-mail) consultation within 45 minutes of the request, providing direct face-to-face consultation for diagnostic or treatment cases, and enhancing the effectiveness of the primary care clinicians’ assessment and treatment of mental health conditions through an established educational series.

Methods:

CPAP is a grant-funded service providing 0.25 FTE child & adolescent psychiatrist (CAP) and 0.5 FTE clinical care coordinator (CCC). Practices enrolled were determined by previous established outpatient consultative relationships, “rural” and urban sites. In year one, all pediatric practices (4) in Brunswick (rural) were enrolled. In year two, pediatric practices in Westbrook and Yarmouth (urban), and Boothbay Harbor (rural), were enrolled. In year three the lone pediatric practice in Norway (very rural) was enrolled. At each first formal meeting, the parameters of the program were discussed, a formal “contract” was signed, and a baseline provider satisfaction survey was conducted. Once enrolled, primary care providers initiate contact with the CPAP, leading to a telephone consultation with the CAP or a formal consultation. The EMR provides the patient’s mental health care needs, and the information is used to facilitate this consultation. The collaborative office rounds (COR) are scheduled with each site. A survey was developed to assess the impact of tele-consultation and treatment for children with mental health issues, and the effectiveness of the “Lunch & Learns.” Further, data was collected from families coming for a face-to-face consultation including distance traveled, time away from work and school, level of comfort with the family receiving mental health treatment from the primary care clinician, and employer paid time off for medical visits.

Results

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

Conclusions

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

References