Talking Points

Improving Mental Health Services in Primary Care:
Reducing Administrative and Financial Barriers to Access and Collaboration

American Academy of Pediatrics

Facts

- Almost 1 in 5 children in the US meet diagnostic criteria for a mental health (MH) or substance abuse (SA) disorder with impaired functioning, yet only 20% to 25% receive needed services.
- With the implementation of the federal mental health parity law, many more children may be seeking mental health treatment. Shortages of children's mental health professionals will make the coordination of care between pediatricians and child and adolescent psychiatrists even more necessary.
- The primary care setting provides opportunities for early identification and intervention, counseling, guidance, care coordination, and chronic illness management.
- Enhanced access to out-patient mental health services has been shown to substantially reduce psychiatric hospitalizations, offsetting (or, in some studies, *more* than offsetting) any increase in out-patient costs.

Principles

- Families and children need access to mental health screening and assessment and a full array of evidence-based and evidence-informed therapeutic services to appropriately address mental health conditions ideally within the child's medical home.
- Primary care clinicians and the medical home must be recognized as a portal of entry to the specialty mental health system and ongoing source of care and coordination for children and adolescents in the mental health specialty system.
- Primary care clinicians and families must have continuous access to consultation and collaboration with child and adolescent psychiatrists and with other members of the mental health services system who are equipped to provide support to family members of all ages.
- Payment for assessment and treatment of mental health problems must be adequate and comparable with payment for services addressing other medical illnesses.

Recommendations

1. ***Support integrated models of care within the family and-patient centered medical home***
   Allow for integrated care, including consultation and colocation, through economically viable models recognizing the shortage of mental health professionals with pediatric expertise in many regions of the country and, specifically, of child and adolescent psychiatrists nationwide.
2. ***Eliminate mental health carve-out models***
   Mental health carve-outs provide a significant barrier to access to mental health care for many children and this suggests a subtle form of discrimination against children with identified mental health conditions. Only through consistent and universal parity of mental health codes with physical health codes among all third-party payers will this aspect of limited access be addressed.
3. ***Expand and align provider network***
   Allow primary care clinicians to provide and authorize services for common mental health conditions of childhood and adolescence. Restructure mental health plans to include primary care clinicians in mental health networks and ensure coordination of mental health specialty care with the primary care clinician through ongoing communication, exchange of information, and co-management.
4. ***Pay primary care clinicians for the mental health services they provide***
   Pay primary care clinicians appropriately for the assessment and engagement process preceding a definitive diagnosis, as well as the use of standardized tools, by paying for mental health screening at routine medical visits and paying for the administration, scoring, and interpretation of standardized mental health–assessment instruments. Remove disincentives for appropriate and accurate diagnostic coding by allowing primary care clinicians to be paid for services on reported mental health diagnostic codes.
5. ***Provide payment for non-face to face care, team-delivered care and team meetings***
   Recognize circumstances such as treatment-planning and treatment-team meetings, in which the most appropriate service delivery does not include the patient or, at times, even family members. In these situations, there should be payment for primary care clinicians, child and adolescent psychiatrists, and other mental health professionals for time spent in consultation. Support payment for non–face-to-face aspects of care, such as communication with community providers including early education and child care professionals, teachers, social workers, therapists, and case managers, and other nonclinical aspects of caring for children with mental health problems (eg, care-plan oversight, health-risk assessment). There should also be financial support for coordination.