collaborate
with mental health providers
Children’s mental health needs are addressed by a variety of providers and caregivers who work in a range of diverse and loosely organized public and private settings. Approximately 21% of US children and adolescents are served by this “de facto mental health service system” each year. This patchwork of providers and services is typically categorized into 4 components: (1) specialty mental health (eg, psychiatrists, psychiatric nurses, psychologists, and social workers), (2) primary care (eg, pediatricians, family physicians, and nurse practitioners), (3) human services (eg, social services and school-based counseling services), and (4) voluntary support networks (eg, self-help groups). In turn, these providers work within public and private service delivery systems.

A quality children’s mental health service delivery system relies on the ability of providers to collaborate, coordinate services and activities, and share health information related to the treatment of a patient. In the absence of this integration, services can become fragmented and duplicated, and children’s access to care can be compromised. Several factors can impact the provision of children’s mental health care. At the minimum, it is important for primary care clinicians to be able to communicate and share health information with mental health professionals regarding the treatment of children with mental health problems. However, differences in practice culture between provider groups, lack of knowledge about professions, differences in use of terminology, and federal and state laws and policies can hinder effective communication and collaboration between providers.

Numerous federal and state laws protect the privacy of health care information, creating significant barriers for collaborative practices between primary care clinicians and mental health professionals. Recent federal privacy rules permit a health care provider to disclose protected health information about an individual, without his or her authorization, to another health care provider for that provider’s treatment of the individual. However, state privacy laws (eg, informed consent laws) may place further protections on health privacy. (See Tools and Resources in this section, Overview of Confidentiality Statutes and Children’s Mental Health, for more information.)

What Does This Mean for American Academy of Pediatrics Chapters? Chapters may want to engage the range of mental health professionals who provide mental health services in dialogue and efforts to improve the children’s mental health system. At the minimum, conversations with the various state organizations representing mental health professionals can illuminate issues related to better integration of primary care and mental health systems, and specific mechanisms for improving communication and information sharing at the practice level. Informational meetings with mental health professional organizations are an important overall “starting point” to identifying and better understanding the opportunities and challenges to effective collaboration, and in determining mutual concerns and interests in improving the children’s mental health system. Some mental health organizations may not even know of the primary care’s interest in working together. Finally, with regards to information sharing between providers, chapters may want to first understand the federal and state laws and policies.
that impact information sharing between providers. (See Tools and Resources in this section, Overview of Confidentiality Statutes and Children’s Mental Health, for more information.)

**Chapter Strategies**

Chapters may want to identify and consider a range of strategies for collaborating with mental health professionals. Key strategies include the following:

- **Initiate a dialogue with the leaders of the state organizations of social workers, psychologists, psychiatrists, school psychologists, school counselors, family physicians, and other providers who serve children by convening a meeting to discuss mental health services for children.** Such a dialogue can bring together all stakeholders in children’s mental health who typically do not work together, share the same professional culture, or even know each other. Additionally, this dialogue can be the basis for building a coalition to educate policy makers about the need for system changes. (See Internet Resource List for Child and Adolescent Mental Health in the Additional Resources section for further information.)

- **Identify the key provider barriers to providing comprehensive and integrated children’s mental health services.** Issues to consider and address include (1) universally accepted guidelines for information sharing that work within confidentiality laws and consistent reporting forms and (2) standards for certification of non-physician therapy providers. (See Tools and Resources in this section, Template Referral and Feedback Form for Referrals Between Primary Care Clinicians and Mental Health Professionals, for a sample referral form.)

- **Consult with multiple sources to obtain information about state-specific privacy laws and rules related to sharing of health information, including a minor’s consent for services.** Provide a synopsis of federal and state privacy laws to chapter members. (See Tools and Resources in this section, Overview of Confidentiality Statutes and Children’s Mental Health, for general information on federal and state confidentiality statutes related to sharing of health information.)

- **Identify the key barriers to the sharing of health information between primary care clinicians and mental health professionals.** In doing so, determine whether these barriers are the result of state law, informed consent laws and policies, and/or the culture of mental health practice in the state and/or community.

- **Identify mechanisms for improving communication among and between primary care clinicians and mental health professionals who serve children with mental health needs.** Improved communications between primary care physicians and mental health professionals could help alleviate one of the problems created when managed care carves out behavioral health care services, as is the case in some states. Chapters that have established “pediatric councils” to engage with private insurers can consider enhancing communication between mental health professionals and primary care clinicians as part of their agenda. (See Tools and Resources in this section, Working to Improve Mental Health Services: The North Carolina Advocacy Effort, for an example of one state’s advocacy efforts to improve children’s mental health services.)
References

Resources for Further Information


The Health Privacy Project, Institute for Health Care Research and Policy, Georgetown University provides health care stakeholders with information and tools related to greater protection of health information through research studies, policy analyses, Congressional testimony, extensive work with the media, and a Web site. Available at: http://www.healthprivacy.org/ Accessed January 8, 2007


strategies to collaborate with mental health professionals
tools and resources

strategies for system change in children’s mental health: a chapter action kit

Overview of Confidentiality Statutes and Children’s Mental Health
This policy brief provides an overview of federal and state confidentiality statutes and related issues regarding sharing of health information between primary care clinicians and mental health professionals.

Physician Referral and Feedback Form Template
This tool is a sample referral and feedback form that primary care clinicians can adapt for use with mental health professionals.

Working to Improve Mental Health Services: The North Carolina Advocacy Effort
Reprinted with permission from Pediatrics. This article discusses the efforts of the North Carolina chapter of the American Academy of Pediatrics to organize an advocacy initiative designed to improve children’s mental health services in the state.
Numerous federal and state laws protect the privacy of health care information. In particular, at least 3 types of laws affect the ability of pediatricians and mental health professionals (e.g., psychiatrists and psychologists) to share information about a patient in their care. These laws are (1) federal medical privacy rules issued under the federal Health Insurance Portability and Accountability Act (HIPAA), (2) state privacy laws, and (3) state minor consent laws. In addition, there are specific federal confidentiality rules that govern facilities deemed to be federal alcohol and drug abuse treatment programs.

Confidentiality statutes are complex, subject to federal and/or state oversight and jurisdiction, and typically vary by state depending on the law. It is beyond the scope of this Chapter Action Kit to provide an in-depth analysis of these statutes. However, general information, chapter strategies for obtaining state-specific information about the laws, and resources for further information are outlined below.

Health Insurance Portability and Accountability Act Privacy Rules

In 1996, Congress passed HIPAA to establish national standards to protect the privacy of health care data, and to promote more standardization and efficiency in the health care industry. The HIPAA Privacy Rules, which are enforced by the US Department of Health and Human Services, Office for Civil Rights, took effect on April 14, 2003, and represent a uniform, federal floor of privacy protections for consumers.1

The HIPAA Privacy Rules limit the ways that health plans, pharmacies, hospitals, doctors, and other health care providers can use patients’ medical information (e.g., information that is in medical records, communicated orally, or on computers). They are designed to govern disclosure of patient protected health information while protecting patient rights. With regard to sharing of health information between providers, the HIPAA Privacy Rule permits a health care provider to disclose protected health information about an individual, without their authorization, to another health care provider for that provider’s treatment of the individual. Indeed, consulting with another health care provider about a patient is within the HIPAA Privacy Rule’s definition of “treatment” and, therefore, is permissible.2

State Privacy Laws

In addition to these federal rules, many states have enacted state privacy laws (informed consent laws) that place further protections on health privacy. The HIPAA standards do not affect state privacy laws that may be more restrictive regarding privacy protections. Any state law providing additional protections would continue to apply.2

Health Insurance Portability and Accountability Act and Minor Consent

While the HIPAA rules permit sharing information between providers, there are unique considerations for minors who have legally consented to care. In general, HIPAA allows a parent to have access to the medical records for his or her minor child, when the access is not inconsistent with State or other law. Three exceptions to the HIPAA Privacy Rule are as follows:
1. When a minor has consented for the care and the consent of the parent is not required by state or other applicable law
2. When a minor obtains care at the direction of a court
3. When a parent agrees that a health care provider and minor may have a confidential relationship

In the case of consenting minors, parents do not necessarily have the right to access the minor’s health information and whether they can do so is dependent on state laws. Health care and mental health professionals need to examine state laws to determine whether they specifically address the confidentiality of a minor’s health information and, if not, professionals can typically determine whether or not to grant access. The next section provides an overview of key considerations regarding state minor consent laws.

Health Insurance Portability and Accountability Act and Federal Substance Abuse Confidentiality Requirements
Federal confidentiality regulations for substance abuse treatment programs (42 CFR Part 2 or Part 2) establish confidentiality requirements for patient records that are part of any federally assisted alcohol and drug abuse treatment program. Overall, Part 2 confidentiality requirements parallel the HIPAA Privacy Rule requirements in many areas. However, the “general rules” established by Part 2 and the Privacy Rule regarding use and disclosure of patient health information are very different. In general, federally subsidized substance abuse treatment programs must abide by Part 2 and cannot disclose information without written consent. This is more restrictive than the HIPAA Privacy Rule, which, as previously mentioned, permits disclosure of health information for treatment, payment, and health care operations without prior written authorization.

Furthermore, with regard to disclosure of health information of a minor, the HIPAA Privacy Rule defers to other applicable state and federal laws. In this case, Part 2 requires that a minor always sign the consent form for a program to release health information, even to his or her parent or legal guardian. (For further information, see The Confidentiality of Alcohol and Drug Abuse Patient Records Regulation and the HIPAA Privacy Rule: Implications for Alcohol and Substance Abuse Programs listed in the references at the end of this section.)

State Minor Consent Laws
State minor consent laws govern whether minors can give their own consent for health care (eg, care obtained without the consent of a parent or guardian). Every state has enacted these laws, which fall into 2 overall categories: (1) laws that are based on the status of the minor—minors who are emancipated, living apart from parents, married, pregnant, and/or parenting, and (2) laws that are based on the type of care that is sought (eg, emergency, family planning, drug/alcohol, and mental health). With regard to mental health services, at least 31 states have enacted laws that allow minors to consent for mental health services but with limitations (eg, age of minor, type of care, health professionals who are covered, and number of visits), depending on the state. Nearly all states have enacted some type of law that allows minors to consent for care related to drug and alcohol use.
Examples of State Minor Consent Laws for Mental Health Services

- In California, a minor 12 years or older may consent for outpatient mental health treatment or counseling if the minor, according to the attending professional, is mature enough to participate in the outpatient mental health treatment or counseling and the minor either would present a danger of serious physical or mental harm to self or others without the treatment, or is the alleged victim of incest or child abuse.

- In Illinois, any minor 12 years or older (eg, younger than 17 years) may request and receive counseling services or psychotherapy on an outpatient basis without parental consent. These services are limited to 5 sessions with a session not lasting more than 45 minutes.

- In North Carolina, any minor may consent to a physician for medical health services for prevention, diagnosis, and treatment of emotional disturbance.

Conclusion

The sharing of health information is complicated and subject to state and federal laws, rules, and regulations. Chapters may want to consult with multiple sources to obtain information about the privacy laws and rules specific to their state. These sources include the following:

- **State Minor Consent and Privacy Laws.** State mental health agencies and associations will have information on the privacy and confidentiality laws and rules that apply for mental health services in their state. State-by-state resource lists and contacts in state mental health agencies, state protection and advocacy agencies, and state mental health associations are available on the Web site of the Substance Abuse and Mental Health Services Administration (SAMHSA) at: [http://mentalhealth.samhsa.gov/publications/Publications_browse.asp?ID=185&Topic=State%20F Territory%20Resources](http://mentalhealth.samhsa.gov/publications/Publications_browse.asp?ID=185&Topic=State%20F Territory%20Resources).


- **HIPAA Privacy Rules.** Further information about the HIPAA Privacy Rules is available from the HHS Office for Civil Rights, SAMHSA, and other federal agencies (see Resources for Further Information).

In addition, chapters may want to determine whether barriers to the sharing of information between primary care clinicians and mental health professionals are the result of state law, informed consent laws and policies, and/or the culture of mental health practice. The American Psychiatric Association clearly supports the sharing of information between physicians when it is related to a patient’s treatment. Chapters could meet with mental health professional groups to explore these issues further and to determine strategies for improving information sharing as it relates to children’s mental health care. (See Strategies to Collaborate With Mental Health Professionals in this Chapter Action Kit for related chapter strategies.)

For more information on state consent and confidentiality laws, please contact the American Academy of Pediatrics Division of State Government Affairs at 800/433-9016, ext 7799, or stgov@aap.org.
References

Resources for Further Information

The Health Privacy Project, Institute for Health Care Research and Policy, Georgetown University provides health care stakeholders with information and tools related to greater protection of health information through research studies, policy analyses, congressional testimony, extensive work with the media, and a Web site. Available at: [http://www.healthprivacy.org/](http://www.healthprivacy.org/) Accessed March 2, 2007


physician referral and feedback form template

strategies for system change in children’s mental health: a chapter action kit

Date: ________________  ( ) Initial  ( ) Follow Up

Referring Physician Name: ___________________________________________________________________

Address: ________________________________________________________________________________
(Street/PO Box)  City  State  Zip

Fax: (____) ___________________________ Phone: (____) __________________

Patient’s Name: _______________________________________________________________________
DOB: ________________________________________________________________________________

Parent’s Name: __________________ Address: __________________ Phone: ________________

Date(s) Patient Seen: __________________________________________________________________

Reason for Referral: _____________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Any Specific Questions or Requests: _______________________________________________________________________
_____________________________________________________________________________________

__________________________________________
Physician Signature

Thank you for evaluating this patient. To facilitate communication and treatment, please mail or fax this completed form to the physician listed above. This is not a request for copies of psychotherapy notes, which require a signed consent to release. Thank you for your collaboration.

☐ Patient did not make appointment
☐ Patient made an appointment but did not keep appointment
☐ Patient not seen within 60 days
Initial Diagnoses:
1. __________________________________________________________________
2. __________________________________________________________________
3. __________________________________________________________________

Recommendations:
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Medications Prescribed:
_____________________________________________________________________

Follow-up Planned:

- Medication management
- Individual therapy
- Family therapy
- Medical lab requests
- Referral for additional diagnostic testing
- Return to your care for medication management
- Recommend follow-up in _____ weeks
- Other ________________________

Name (type or print) _______________________________________________________________________________
Signature _______________________________________________________________________________________

Add Disclaimer Statement Per Your Institution Here:
_______________________________________________________________________________________________
SPECIAL ARTICLE

Working to Improve Mental Health Services: The North Carolina Advocacy Effort

Jane Meschan Foy, MD*; Marian F. Earls, MD‡; and David A. Horowitz, MD§

ABSTRACT. Poor reimbursement of pediatricians for behavioral and developmental services and the disarray of children’s mental health services in the state led leaders of the North Carolina chapter of the American Academy of Pediatrics to organize an advocacy effort with the following objectives: 1) to articulate pediatricians’ perspective on the current crisis in delivering and coordinating children’s behavioral health services; 2) to represent the collective voice of both academic and community pediatricians in dialogue with mental health providers, Medicaid leaders, and the health and mental health segments of state government; 3) to build consensus about an achievable plan of action to address pediatricians’ reimbursement and systems issues; 4) to develop a full and appropriate role for pediatricians as providers and, potentially, coordinators of behavioral health care; and 5) to facilitate implementation of Medicaid changes, as a first step in carrying out this plan. This article describes the 24-month process that achieved these objectives. Pediatrics. 2002;110:1232–1237; mental health, advocacy, Medicaid.

ABBREVIATIONS. NC, North Carolina; MH, mental health; AAP, American Academy of Pediatrics; SCHIP, State Children’s Health Insurance Program; SHP, state health plan; DMA, Division of Medical Assistance.

NORTH CAROLINA’S SETTING AS DESCRIBED IN DECEMBER 1998

In North Carolina (NC), as in many other states, mental health (MH) services are in disarray. Inadequate reimbursement has undermined the capacity of virtually every source of MH care, with the end result being that children of all income levels have limited access to behavioral health services. Many communities have no child psychiatrists and an inadequate number of MH providers trained and credentialed to care for children. Medicaid’s low reimbursement for office visits, requirement of a definitive diagnosis, and lack of reimbursement for the many nonface-to-face aspects of delivering behavioral health services have contributed significantly to many providers’ reluctance or inability to serve publicly insured children. Table 1, an excerpt from the position paper developed as a tool in NC’s advocacy effort, provides an example. Disparate deductibles, co-payments, and caps for MH services in private health plans have created access barriers for privately insured children as well.

Primary care pediatricians, faced with these barriers and with the estimated 30% of children who require MH intervention, frequently experience pressure to prescribe psychiatric medications and deliver services for which they feel inadequately trained. Some have attempted to expand their expertise and involve themselves in these new areas. Others, already frustrated by inadequate compensation for the many behavioral services they provide in the context of comprehensive pediatric care, refer children with behavioral problems through available channels, knowing that only 21% of children with MH problems receive MH services; 70% to 80% of these through the meager resources of public schools, where MH professionals are focused primarily on testing and attendance issues.

In NC, as elsewhere in the country, there is an artificial schism between behavioral health systems and medical systems of care. Poor coordination and poor integration of MH services with children’s pediatric care further diminish accessibility and quality of the care that is provided in both the public and private sectors. Inadequately funded public MH facilities experience high turnover of staff and difficulty with recruitment; those MH professionals who are on staff usually are anonymous to community pediatricians. Because NC Medicaid does not allow social workers and psychologists to bill Medicaid unless they are employed or credentialed by a state-funded, state-administered MH program, collegial relationships between pediatricians and Medicaid MH providers are virtually nonexistent in most communities. In many private health plans, families self-refer children for behavioral services; here also there are often inadequate or absent procedures for communication between MH providers and primary care physicians, who often do not have access to the list of behavioral health providers. Reimbursement for MH services is frequently allowed only to MH providers, eliminating any financial incentive for primary care physicians to share in the care of children with MH conditions.

For all these reasons, pediatricians are frequently
unaware of medications prescribed by MH providers and of therapeutic efforts important to the ongoing management of a child’s emotional and family problems. An additional factor contributing to poor coordination is the paucity of care coordination programs in NC for children with behavioral problems and mental illness: the state-funded Child Services Coordination Program serves children with developmental and medical problems from birth to age 5; neither the Child Services Coordination Program nor the state-supported Developmental Evaluation Centers serve school-aged children. Low ratios of school nurses in the state—1:2451 statewide, 1:5000 or more in some areas—prevent most nurses from playing a role in coordination. Public school psychologists and guidance counselors, who deliver the majority of MH services to youth, function virtually outside the health care system.

Compounding these reimbursement and coordination issues in NC, as elsewhere, are the problems arising from the compartmentalized training of MH and medical professionals and the separate administrative structures that perpetuate this compartmentalization. As a result, MH professionals and community pediatricians typically do not work in the same buildings, utilize the same terminology or diagnostic approach, attend the same educational programs, use the same forms or reimbursement codes, or sit at the same tables to address their concerns. At the level of state government, 2 separate systems, functioning largely in parallel and funded by separate streams, oversee medical programs in 1 building, MH programs in another. This separation posed significant challenges for the process of addressing NC’s problems.

NC’s ASSETS

NC has an active chapter of the American Academy of Pediatrics (AAP) and 5 academic pediatric programs whose chairs are closely involved in the chapter’s educational and advocacy efforts. The chapter has a long history of effective collaboration with state government, enhanced by the tenure of David Bruton, MD, a community pediatrician from Pinehurst, North Carolina, who served as secretary of the Department of Health and Human Services from 1997–2001. The primary setting for the chapter’s collaboration has been an open forum, convened 3 times yearly by the chapter, which brings together pediatricians, child advocates, and representatives of state government to update each other on important developments affecting the health of children and to address mutual concerns. The former Director of Medicaid, Richard Perruzzi, was among the attendees. Secretary Bruton and Mr. Perruzzi worked closely with chapter leaders in developing a non-Medicaid State Children’s Health Insurance Program (SCHIP) built around the State Health Plan (SHP) for state employees. The SHP experience in MH coverage had been especially positive: in 1992, NC introduced into the SHP full coverage parity of MH and non-MH conditions, a single insurance deductible, full freedom of choice of MH providers, and only moderate management of generous benefits through a contract with Value Behavioral Health. With MH parity in place, by 1998 NC had seen the following changes:

- MH payments as a percentage of total health payments decreased from 6.4% to 3.1%.
- MH hospital days decreased by 70%.
- Actual per member/per month cost for MH benefits (including administrative overhead) went from $5.43 in fiscal year 1990 to $4.11 in fiscal year 1998.
- Actual utilization patterns remained constant and modest: 6% to 7% of enrollees sought outpatient services per year; half went for only 3 to 4 sessions, three-fourths completed treatment within 11 to 13 sessions; utilization >26 visits remained constant and low (0.40%–0.75%).

Although MH parity did not increase overall costs, and although it brought about a marked reduction in inpatient MH days (an outcome also documented by Sturm, who studied insurance plans that offered parity in behavioral health spending limits), these data were insufficient to persuade state legislators to pass MH parity legislation on multiple annual attempts. However, the SHP experience was sufficient to open dialogue that could not have otherwise occurred in NC’s fiscally conservative political climate.

THE PROCESS

1) Articulating Pediatricians’ Perspective: The Position Paper

A critical first step was bringing together pediatricians to form a task force of NC’s AAP chapter. Key members felt passionate about the MH issue, had expertise and experience, and were already involved in chapter leadership: a community pediatrician who chairs the chapter’s Mental Health Committee and is the parent of a child with special developmental needs; an academic developmentalist from the chapter’s Committee on Disabilities; a developmental pediatrician who serves as medical director of a community health program for low-income children in

TABLE 1. Excerpt from the NC Pediatric Society Position Paper

<table>
<thead>
<tr>
<th>Current Procedural Terminology</th>
<th>Medicaid to Pediatrician in Private Practice</th>
<th>Private Plan 1</th>
<th>Private Plan 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code 99205, comprehensive, new patient</td>
<td>$114.21</td>
<td>$128.00</td>
<td>$148.50</td>
</tr>
</tbody>
</table>

The pediatrician spent 120 minutes evaluating a hyperkinetic 7-year old, implementing and coordinating therapy for attention-deficit/hyperactivity disorder, writing reports, and following up by telephone. If this had been an established patient instead of a new patient, the Medicaid reimbursement would have been lower still.
an urban county, former chair of the local Board of Mental Health, Developmental Disabilities, and Substance Abuse, and Chair of the chapter’s School Health Committee; and an adolescent specialist in combined community and academic practice, former chair of the chapter’s Committee on Adolescence. The chair of the group, which was named the Task Force on Mental Health Care Access and Reimbursement, is an academic generalist, formerly in private and public health settings, involved in developing school-based health services and serving as NC’s AAP chapter president.

As the group began meeting to discuss the problem, anecdotal experiences and discussion about our sources of frustration dominated the discussion. It became evident that, to move forward, we needed to find expression for the angst, educate each other about unfamiliar aspects of the issues, and prepare to speak in one, understandable voice to fellow child advocates and policymakers. We settled on the idea of writing a position paper, which went through many iterations and served to focus our efforts during our first few months. This document appears on the Web site of the NC chapter of the AAP, which is available at: www.ncpeds.org.

2) Including Other Stakeholders: Consensus Plan

Having reached consensus on the position paper, we began expanding our Task Force to include other MH advocates, including the executive directors of the state’s organizations for social workers, psychologists, and psychiatrists and the president of the state’s Council of Child and Adolescent Psychiatrists. These individuals brought with them their experience in lobbying the state legislature and state government on MH issues, linkage to other advocacy groups such as the Alliance for the Mentally Ill, and their own expressions of anger and frustration, which the Task Force processed and discussed over several meetings. With their input, the Task Force developed a plan of action, which served mutual goals; this plan became a second chapter of the position paper, which is available at: www.ncpeds.org.

3) Working With Medicaid

With this document complete, we made the decision to approach Medicaid leadership. The group’s optimism was greatly increased by a surprise legislative response to years of chapter advocacy, facilitated by Secretary Bruton, to increase Medicaid rates to parity with Medicare, effective January 1, 1999, and to allow clients 1 year of Medicaid eligibility, rather than month-to-month. Although these measures were not specific to MH and did not solve other problems, such as the absence of reimbursement for nonface-to-face activities and barriers to collaboration with Medicaid MH providers, they were enormously helpful to the cause and signaled a mood of receptiveness to physician concerns.

The Task Force approached the Director of Medicaid, and he agreed to meet with the group about its access and reimbursement concerns. We decided to locate the meeting in his conference room at the Division of Medical Assistance (DMA) building and have met there regularly since, frequently involving other members of the DMA staff and consulting with them about wording of new regulations resulting from our negotiations, as well as unrelated topics such as preventive dental programs, for which they needed our advice and support. We soon pulled in other members of state government, leaders from the Department of Mental Health, Developmental Disabilities and Substance Abuse Services, who had not previously interacted with our pediatric leadership, and began to address MH systems issues, as well as reimbursement. These new relationships continue to be of great value to the chapter.

4) Outcomes

Advocacy is not science; consequently, outcomes cannot be attributed tidily to any 1 factor in the complex environment of that period. Generations of chapter leaders gave this advocacy effort their legacy of credibility and effective relationships with state government. Secretary Bruton’s powerful position and supportive posture toward the Task Force undoubtedly helped to get Medicaid leaders to the table and to facilitate progress. Other MH advocacy groups worked in parallel with the Task Force, invigorated by the support of pediatricians. To these ingredients the Task Force added focus, persistence, a consensus voice, a framework for negotiation, and access to the clinical expertise of pediatricians motivated to participate in a change effort.

Results came about laboriously. Several contentious issues required discussions by telephone or in small groups outside Task Force meetings. Occasionally, impacted groups (eg, physicians in local area MH programs) requested a hearing of their concerns, which we all heard first by Task Force representatives, then considered and addressed by the Task Force as a whole. Meticulous notes of meetings (an essential component of an advocacy effort) recorded agreements and reminded the group of unfinished business. Snags sometimes required data-gathering, outside expertise, and special visitors to Task Force meetings, occasionally including Secretary Bruton himself or other members of the Department of Health and Human Services staff. Periodically, the Task Force revised the position paper to clarify a point and then recirculated it to Secretary Bruton and other government leaders.

The following Medicaid changes resulted from this collaborative effort:

- Reimbursement for up to 6 visits to a MH/substance abuse provider without assigning a diagnosis and up to 26 unmanaged visits in a calendar year for Medicaid recipients up to age 21.6 DMA confirmed on October 12, 2001 that this policy also applies to physicians performing behavioral assessment and treatment.

We anticipate that the steps in bold print will facilitate pediatricians’ collegial relationships with, employment of, and/or co-location with MH professionals. We believe that these changes will, in turn, improve access to MH services for Medicaid-enrolled children and increase the likelihood that these services will be provided within or coordinated with a child’s medical home.
MH visits annually for children under the age of 21.\textsuperscript{7} MH providers are educated to communicate at regular intervals with the primary care provider.

- Expansion of “incident to” rules,\textsuperscript{6} allowing physicians employing licensed clinical social workers, and clinical nurse specialists with psychiatric certification to bill for the services of these MH professionals if the physician provides on-site supervision.\textsuperscript{8}

- Expansion of “incident to” rules,\textsuperscript{6} allowing health departments who employ licensed clinical social workers, licensed psychologists, and advanced practice nurses to bill for their services in school-based health centers, if a physician provides supervision by phone or beeper.\textsuperscript{9}

- "Direct Medicaid enrollment of independently practicing licensed clinical social workers, licensed psychologists, and advanced practice nurses allowing them to bill for services delivered in their offices.\textsuperscript{10,11,12}

An additional provision allowing independently enrolled MH professionals to bill for services delivered in school sites.\textsuperscript{13}

We were not successful in achieving Medicaid reimbursement for nonface-to-face services. Nor were we successful in achieving an enhanced fee for services performed by pediatricians with subspecialty training. Both these approaches created troubling complications for DMA outside the realm of pediatrics. Although we were successful in enabling new categories of MH professionals to deliver services in school sites without on-site physician supervision, we were unsuccessful in expanding this opportunity to those employed by private physicians or universities.

We should add that some of these changes created new challenges for NC’s area MH programs. For the first time, they must compete for physician referrals of low-income patients. A positive outcome has been their heightened interest in streamlining their own referral processes and enhancing communication with referring physicians. A negative outcome has been the growing phenomenon of split therapy, a name they have given to the circumstance that develops when a nonphysician community MH professional delivers a portion of a patient’s therapy and a physician without an established relationship with that professional is expected to deliver the other (eg, emergency hospitalization or psychopharmacologic therapy). The latter problem appears amenable to relationship-building among the concerned parties and may prove an additional incentive to collaboration.

5) Educating Our Membership

To bring the membership of our chapter along in the process and to expand pediatricians’ capacity to deliver and coordinate behavioral and MH services, we planned educational sessions around the topics our Task Force identified as most critical, including developmental and behavioral health screening, psychopharmacology, and coding for MH services and special needs health care. The session on coding received the highest evaluation of any offering. Future offerings will focus on expansion of other MH skills important to primary care pediatricians: use of the Diagnostic and Statistical Manual for Primary Care, family assessment, management of attention-deficit/hyperactivity disorder and depression, collaboration with schools and other community agencies, referral to MH professionals, and behavioral therapy.

We met with the leadership of our NC area health education centers to plan regional grand rounds on MH topics. NC’s Council of Child and Adolescent Psychiatrists is participating in this effort. The Northwest Area Health Education Center, which serves 17 counties, has undertaken a project to assist selected communities in organizing systems of care for children with attention problems. This effort will be patterned after a successful model in Guilford County, which developed a community protocol for the assessment of children with classroom inattention and behavior problems; established roles for school personnel, public health nurses, primary physicians, and MH agencies in the assessment and management of these children; created communication forms and procedures for each step of these processes; and implemented an educational plan for introducing these new procedures to physicians and school personnel.

The next phase of our educational effort will be workshops for pediatricians on collaboration with MH providers, explaining new reimbursement opportunities. We will be distributing the names of newly enrolled MH providers (>400 statewide as of this writing), information about their training and scope of practice, and recommended referral procedures. A new brochure under development by NC’s representatives on the AAP’s Committee on Psychosocial Aspects of Child and Family Health will facilitate this process.

6) Other Advocacy Efforts

The chapter joined with our colleagues in social work, psychology, and psychiatry for yet another failed effort to pass legislation requiring parity of MH benefits in insurance plans. Our chapter’s resolution to address MH parity specifically in the AAP’s Universal Health Insurance proposal was passed by the 2000 AAP Annual Chapter Forum. Our chapter’s resolution to provide assistance to chapters on MH issues was adopted by the 2001 Annual Chapter Forum.

Private insurers lag well behind in improving MH benefits. The chapter formed a group, the Managed Care Solutions Committee, to move the chapter’s advocacy efforts into the private sector. Medical directors of NC’s major managed care organizations meet to discuss an agenda that is jointly developed by our chapter leadership and a health maintenance organization medical director, who is also a pediatrician. Modest first steps in relation to MH include
an agreement to share behavioral health provider lists with pediatricians and attention-deficit/hyperactivity disorder coding guidelines specific to each of the plans.

Perhaps the Task Force’s most long-lasting accomplishment will be the inclusion of pediatricians on state government committees and MH planning groups that previously did not include any primary care physicians.

NEXT STEPS

There is much left to do. Evaluation of NC’s progress toward improving access to MH services for Medicaid-enrolled children will be a challenge. Medicaid has only claims data. In these data, MH services delivered by employed MH professionals under new “incident to” policies are so far indistinguishable from those delivered by their supervising physicians. On the other hand, we will be able to track the number and type of services delivered by newly enrolled independent providers and the total number of MH services delivered. Individual providers will be able to analyze their changes in reimbursement. Other measures will require a separate evaluation effort.

We remain hopeful that improvements in Medicaid will place pressure on private insurers if and when we achieve a buy-in option for children who are financially ineligible for Medicaid and SCHIP. If, as we suspect from experience in the SHP, improved MH benefits in Medicaid and SCHIP do not have adverse cost implications, there may be incentives for expanding private MH benefits, even without the buy-in option.

LESSONS LEARNED ABOUT WORKING WITH STATE GOVERNMENT

The following principles drawn from NC’s experience may be helpful to pediatricians in their advocacy efforts:

1. Advocates must take advantage of political opportunities that present themselves. One such opportunity is a sympathetic person in a key government role; this might be a physician, a parent, or grandparent of a child with mental illness, or a child advocate. Full advantage is gained only if pediatricians with the requisite clinical expertise position themselves to be accessible and well-organized during this person’s period of empowerment, with clearly articulated consensus positions on important policy areas.

2. State government administrators often view subspecialty care, especially that which is delivered at academic centers, as exotic and expensive. There may also be an adversarial relationship between the governmental agency and the medical center. Efforts by academic pediatricians to lobby state government on their own behalf appear self-serving and suffer from this baggage. Academic pediatricians will benefit from joining with community pediatricians in their AAP state chapter to approach Medicaid and other state agencies. The community pediatrician can speak to the value of subspecialty services in the care of their patients. This reframes the academicians’ problems in terms of access to care for children in need, rather than survival of tertiary hospital infrastructure (a cause that few government officials will find appealing).

3. Personal relationships with state government leaders are at the heart of successful negotiations. These grow over time. Many AAP state chapters have developed these relationships over a long period, adding to their value as partners in any advocacy effort. Parents and grandparents of patients may also have relationships with administrators or with legislators, as well as passion and experience to bring to an advocacy effort.

4. State government leaders weary of listening to splinter perspectives of various advocacy groups. All advocates are best served by participating in a coalition, which agrees on a common agenda. If there are issues outside this common agenda—especially if they are in conflict with the common agenda—there should be advance understanding by all partners in the coalition. One partner’s end run around a process and agenda developed by a coalition is very destructive to trust and credibility.

5. A government official will have little sympathy for enhancing physicians’ income, especially because it probably far exceeds his own. The fundamental issue when seeking increased reimbursement should always be access. The AAP Members Only Channel provides links to a number of documents that make the case for the association between access and reimbursement (available at: www.aap.org/moc/medlegal2.CFM).

6. Child advocates must seek out opportunities to understand the perspective of state government administrators and, when possible, to assist them with their problems. Frequently, these opportunities enable advocates to address their own concerns in an unexpected way. In the present economic environment, opportunities for cost-saving are particularly powerful. The state DMA will likely have a medical director—possibly a pediatrician—who is a good initial contact. By linking DMA to pediatricians with expertise in the management of complex and expensive conditions, advocates can assist Medicaid in reducing cost and improving quality, while laying the groundwork for a productive problem-solving relationship.

7. Child advocates must pursue strategies that are compatible with the political and economic environment. Administrators of state government agencies serve political leaders. They are looking for opportunities to align themselves with their constituents’ interests.

8. Specific strategies most beneficial in negotiating with Medicaid will necessarily vary from state to state. The following section suggests some approaches that may yield results.

APPROACHES TO MEDICAID

The exact approach a state uses to negotiate with Medicaid will depend on the particular shortcom-
ings of that Medicaid program. Examples might include the following:

- Codes reimbursed by Medicare but not Medicaid
- Absence of reimbursement for visits not resulting in a diagnostic code (ie, screening, testing, multivisit assessment)
- Absence of reimbursement for nonface-to-face services (telephone consultation, record review, parent or school conferences, etc)
- Restrictions built into the “incident to” policy (supervision requirements, failure to reimburse categories of MH professionals)
- Impediments to reimbursement for MH services delivered on school premises
- Failure to recognize advanced credentials of physicians (ie, no enhanced fee for a more complex service delivered by a more highly trained professional)
- Failure to reimburse categories of MH professionals and MH professionals in certain employment arrangements
- Monopolies of state MH programs
- Managed care policies excluding the primary care physician from referral/management decisions
- Monthly renewal of Medicaid eligibility (as opposed to yearly)
- Across-the-board inadequacies in reimbursement

The negotiation process involves exploring the feasibility of each of these strategies with Medicaid leaders. Some will have more appeal than others, depending on that Medicaid agency’s history and political climate. Child advocates dealing with tight state budgets must fight the perception that increasing access will balloon costs. NC’s experience with its SHP (see above) and the experience of other plans that provide MH parity® contradict this perception: total expenditures for MH care have, at most, modestly increased with parity; furthermore, plans with parity have experienced the very positive outcome of decreased inpatient days. There are undoubtedly other needed MH care reforms, such as those that build the capacity of neglected systems, that will be financially costly; advocates for these changes must build their case around the human and economic costs of untreated behavioral problems.

REFERENCES

4. Data on the Mental Health Benefit. Prepared by the North Carolina Psychological Association from data supplied by the North Carolina State Health Plan Office. April 1999
5. Sturm R. How expensive is unlimited mental health coverage under managed care? JAMA. 1997;278:1533–1537
8. Incident to policy for licensed clinical social workers and clinical nurse specialists. NC Medicaid Bulletin. August 2000:14
9. Supervision of services performed in health departments. NC Medicaid Bulletin September 2000:21
11. Outpatient mental health services for children birth through 20 years of age. NC Medicaid Bulletin. February 2001:2

WORKING TEENAGERS

“American teenagers are an atypically industrious lot. In most developed countries, teenagers work only if the family needs income. Yet the American teens most likely to work have historically been white, and (perhaps most surprisingly of all) had a family income above $40,000 a year. By contrast, poor inner-city kids have been much less likely to hold jobs. A new report by the Center for Labor Market Studies at Northeastern University in Boston points out that this has been the toughest summer-job market for teenagers in 37 years.”

The Economist. August 24, 2002

Noted by JFL, MD