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REPORT

Behavioral Health Integration in Pediatric Primary Care: Considerations and Opportunities for Policymakers, Planners, and Providers

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Message from the President

Nearly one in seven children aged 2 to 8 years in the United States has a mental, behavioral, or developmental disorder. Among children and adolescents aged 9 to 17 years, as many as one in five may have a diagnosable psychiatric disorder. Yet not a single state in the country has an adequate supply of child psychiatrists, and 43 states are considered to have a severe shortage.

Untended behavioral health conditions in children exert a toll on them and on society. It is estimated that 70% of children in the juvenile justice system have a mental health condition, and children with mental health issues have significantly lower family incomes as adults. Models exist, however, for treating many of these children effectively in primary care settings that offer integrated, family-centered care.

In this Milbank-sponsored report, Elizabeth Tobin Tyler, JD, MA, of Brown University, and Rachel L. Hulkower, JD, MSPH, and Jennifer W. Kaminski, PhD, of the Centers for Disease Control and Prevention, explore the prevalence of childhood behavioral health problems; describe the need for, barriers to, and models of behavioral health integration (BHI) in pediatrics; and offer BHI policy and implementation considerations for policymakers, planners, and providers. This paper was developed by Professor Tobin Tyler. It was reviewed by Milbank Memorial Fund staff and disseminated by the Fund.

The report is intended for anyone interested in improving the welfare of children in the health care system. It is the latest of several reports on BHI published by the Milbank Memorial Fund. Other reports have covered BHI for adults and BHI for people with serious and persistent mental illness. Policymakers and providers alike, confronting the evidence of underlying behavioral health conditions that drive much of health care utilization and other human services, continue to look for research-supported models of care that address those conditions in cost-effective settings.

The Fund hopes the information and evidence in this report—and the companion reports—is helpful for all who are working to improve the health of populations by improving the models of behavioral health care. Successfully implemented, these models will benefit patients, their families, and the communities in which they live and work.

Christopher F. Koller
President
Milbank Memorial Fund

The findings and conclusions in this article are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

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Introduction

Nearly one in seven US children aged 2 to 8 years has a mental, behavioral, or developmental disorder.¹ Among children and adolescents aged 9 to 17 years, as many as one in five may have a diagnosable psychiatric disorder.² A 2012 study estimated that treatment of mental disorders accounts for the most costly childhood medical expenditures, totaling \$13.9 billion that year, far more than other costly conditions, such as chronic obstructive pulmonary disease and asthma (\$8.3 billion), trauma-related disorders (\$7.8 billion), acute bronchitis and upper respiratory infections (\$3.2 billion), and infectious diseases (\$2.5 billion).³

Children's physical and behavioral health needs are distinct from those of adults, as they are heavily influenced by stages of development, as well as by family, social, and educational environments. Untreated or poorly managed childhood mental health disorders not only affect individual children and families but also have significant consequences for a range of systems, including health care, child welfare, juvenile justice, and public education.

Recent research points to the benefits of behavioral therapy for many common childhood mental health disorders, including attention-deficit/hyperactivity disorder (ADHD),⁴ autism,⁵ anxiety,⁶ depression,⁷ and disruptive behavior disorders.^{8,9} The American Academy of Child and Adolescent Psychiatry (AACAP) and the American Academy of Pediatrics (AAP) recommend behavior therapy as the first line of treatment before medication for young children with ADHD,^{10,11} although recent data suggest that fewer than 55% of those children receive any kind of psychological services.¹² With a shortage of pediatric psychiatrists and limited community pediatric behavioral health resources, many children and families who need these specialty services do not receive them. The fragmented health care system has made access and referral to appropriate behavioral health services difficult for families and primary care pediatricians, respectively.

Not surprisingly, pediatric primary care providers often identify and manage their patients' behavioral health problems. Because of its preventive and family-centered approach, pediatric primary care is well suited for early identification of developmental and behavioral health problems and assessment of child and family needs. Data from the National Survey of Children's Health showed that more than 90% of children nationwide had visited a primary care provider at least once in the previous year.¹

Researchers have demonstrated the critical importance of early childhood social-emotional development for lifelong productivity and success.¹³ Integration of behavioral health care with pediatric primary care offers a unique opportunity for early intervention on a population level to prevent behavioral health problems from interfering significantly with functioning in both childhood and adulthood. There are a growing number of examples of innovative models of behavioral health integration (BHI) in pediatric primary care practice. Pediatric

BHI has been described as “the approach and model of delivering care that comprehensively addresses the primary care, behavioral health, specialty care, and social support needs of children and youth with behavioral health issues in a manner that is continuous and family-centered.”¹⁴

Until recently, system and payment barriers have hindered BHI in pediatric primary care. While the AAP and the AACAP have been advocating for BHI for some time, the Patient Protection and Affordable Care Act of 2010 (ACA) has provided new opportunities for system integration and payment reforms that facilitate BHI. Preliminary research on pilot programs (described in detail below) suggests that BHI leads to improved behavioral health outcomes for children. With attention to the specific behavioral health needs of children and thoughtful planning and leveraging of children’s health funding streams, pediatric BHI can be implemented effectively.

This report begins by exploring the prevalence of childhood behavioral health problems. While substance abuse disorder is also an important component of behavioral health, particularly for adolescents, this brief focuses exclusively on mental health and developmental disorders in children. It then describes the need for, barriers to, and models of BHI in pediatrics and offers BHI policy and implementation considerations for policymakers, planners, and providers.

Prevalence of Childhood Mental Disorders

Estimates consistently indicate that 13% to 20% of US children have been diagnosed with a mental disorder.^{1,2} Data collected from 2005 to 2011 indicated that the most common mental disorders diagnosed among children aged 3 through 17 years were ADHD, behavioral or conduct problems, anxiety, depression, autism spectrum disorder, and Tourette syndrome, all of which are amenable to behavior therapy approaches.¹⁵ Timely and adequate treatment can promote lifelong health and development, whereas a lack of appropriate treatment could lead to worsening and compounding of the child’s difficulties in home, academic, and community settings.

Access to Treatment

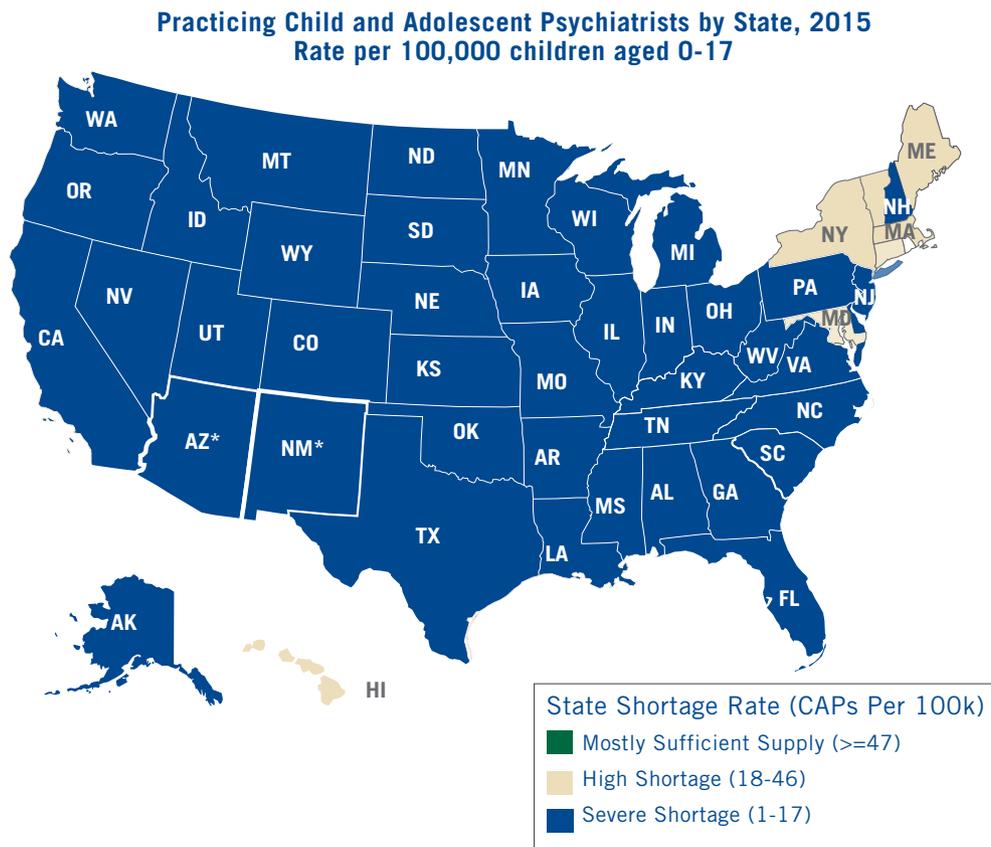
In 2012, the AACAP estimated that only 15% to 25% of children with psychiatric disorders received specialty care, and approximately three-quarters of children with mental health disorders were seen by their pediatric primary care physician.^{16,17} Primary care pediatricians diagnosed increasing percentages of children with mental health problems during the 25-year period from 1970 to 1996, from 6.8% of children aged 4 to 15 years in 1979 to 18.7% in 1996.¹⁸

Many factors influence the underutilization of mental health services by parents and children, including stigma, cost, cultural barriers, access to and regional distribution of providers, and a shortage of child and adolescent psychiatrists.¹⁹ Workforce shortages

in child and adolescent psychiatry are not projected to improve significantly in the near future.²⁰ One study estimated the need for 30,000 child and adolescent psychiatrists but found that only 6,300 were in practice.²¹ Figure 1 shows substantial shortages across the United States.

Significant shortages are projected for other behavioral health practitioners as well. A 2016 report by the US Department of Health and Human Services that estimated supply and demand for behavioral health practitioners from 2013 to 2025 predicted major shortages of practitioners by the year 2025.²² For example, the report estimates a shortage of 16,940 mental health and substance abuse social workers, 8,220 clinical counseling and school psychologists, and 13,740 school counselors. While some of these projections include practitioners for both adults and children, they portend substantial gaps in behavioral health services for children and adolescents. The shortage estimates are even higher considering a 20% unmet demand at baseline in 2013. In addition to encountering shortages, many families who seek specialty care encounter long waiting lists or discover that providers do not accept their insurance.²³

Figure 1.



Source: American Academy of Child & Adolescent Psychiatry, Workforce maps by state. https://www.aacap.org/aacap/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx. 2015.

The Role of Pediatric Primary Care Providers in Behavioral Health and the Need for BHI

With significant barriers to accessing specialty care, primary care pediatricians are often tasked with identifying and managing their patients' behavioral health needs. Not surprisingly, many primary care providers report the inability to find specialty services when they seek them for their patients.²⁴ They are also the primary prescribers of psychotropic medications.²⁵ Behavioral health issues comprise a significant part of pediatric primary care practice; as many as half of pediatric office visits involve behavioral health concerns.¹⁶

According to an AAP survey, nearly two-thirds of pediatricians report lack of training in treatment of children with mental health disorders, and 70% report lack of time to treat as a barrier to care.²⁶ Yet, integration of children's behavioral health fits squarely into the patient-centered medical home (PCMH) model, which originated in pediatrics and is becoming the model for adult primary care as well.²⁷ The AAP's *Bright Futures Guidelines*, which are designed to support primary care practices with evidence-based tools and resources across the spectrum of child development—infancy, early childhood, middle childhood, and adolescence—include detailed discussion of screening for and promotion of mental health.²⁸ In 2009, the AAP embraced the role of pediatric primary care in screening for and treating behavioral health problems in a policy statement (see Box 1). Further, a 2015 AAP report suggested changes in primary care practice and the health system to promote screening for children's behavioral and emotional problems, including “innovative collaborations,” such as colocation and integrated and consultative models.²⁹

Box 1. The American Academy of Pediatrics describes the following traits inherent in pediatric primary care supportive of developing competencies in behavioral health:

- “A longitudinal, trusting, and empowering therapeutic relationship with children and family members;
- The family-centeredness of the medical home;
- Unique opportunities to prevent future mental health problems through promoting healthy lifestyles, anticipatory guidance, and timely intervention for common behavioral, emotional, and social problems encountered in the typical course of infancy, childhood, and adolescence;
- Understanding of common social, emotional, and educational problems in the context of a child's development and environment;
- Experience working with specialists in the care of children with special health care needs and serving as coordinator and case manager through the medical home; and
- Familiarity with chronic care principles and practice-improvement methods.”

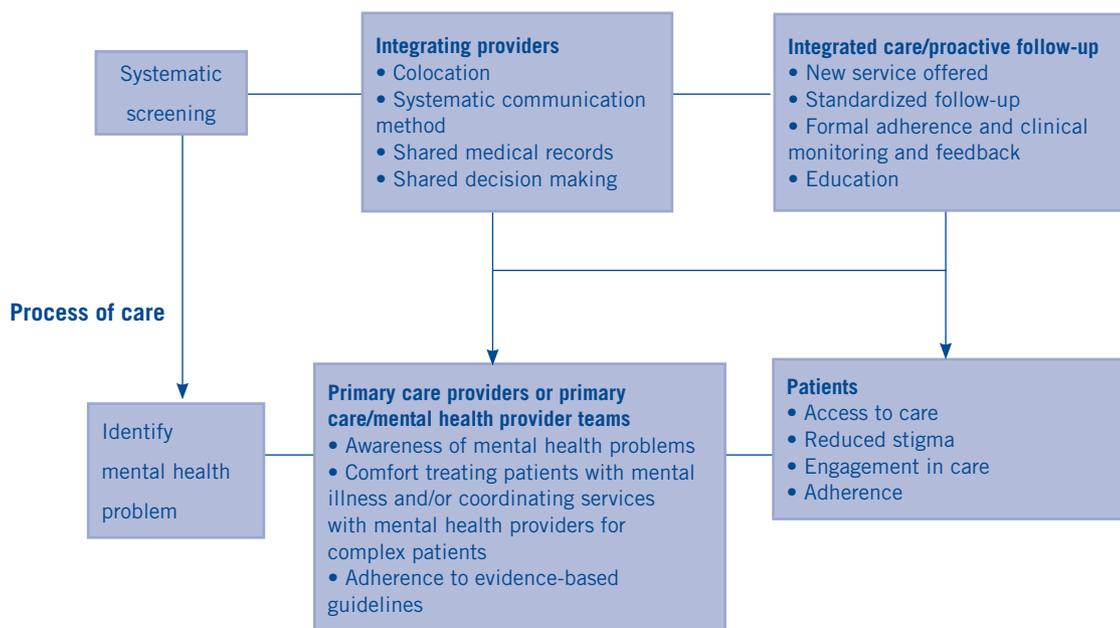
Source: Committee on Psychosocial Aspects of Child and Family Health and Task Force on Mental Health, American Academy of Pediatrics. Policy statement: The future of pediatrics: mental health competencies for pediatric primary care. *Pediatrics*. 2009;124(1):410-421.

The scarcity of specialty care available to pediatricians, children, and families is driving the movement toward innovations in behavioral health care delivery, including BHI in pediatric primary care. The PCMH model is also helping to expand the idea of the medical home as encompassing comprehensive, coordinated care, including behavioral health services. Figure 2 illustrates the characteristics of BHI and the process of care in the pediatric setting.

Figure 2.

Integration of Mental Health and Primary Care

Characteristics of Integrated models



Source: Butler M, Kane RL, McAlpine D, et al. Integration of mental health/substance abuse and primary care. No. 173. (Prepared by the Minnesota Evidence-based Practice Center under Contract No. 290-02-0009.) AHRQ Publication No. 09-E003. Rockville, MD: Agency for Healthcare Research and Quality; October 2008.

The Impact of Children’s Behavioral Health Needs on Health Care and Other Systems

While many of the BHI payment and delivery system reforms have focused on reducing expenditures for adults who incur high health care costs, pediatric behavioral health is also a significant cost driver. The Center for Health Care Strategies reports that “while children receiving behavioral health care represent less than 10 percent of the overall Medicaid child population, they account for an estimated 38 percent of all Medicaid child expenditures.”³⁰ Medicaid costs for children using behavioral health services are nearly five times as high as for children using only physical health services, averaging \$8,520 per child, compared with \$1,729 per child.³¹

As is true for childhood physical health, inadequately managed childhood behavioral health conditions contribute to worse health over the life course. In addition to the costs to the health care system, childhood mental health disorders have a substantial impact on other systems, including child welfare, juvenile justice, and education. The National Conference of State Legislatures reports, “Many of the two million children and adolescents arrested each year in the United States have a mental health disorder. As many as 70 percent of youth in the system are affected with a mental disorder, and one in five suffer from a mental illness so severe as to impair their ability to function as a young person and grow into a responsible adult.”³²

A study of children’s mental health service use across sectors in North Carolina described the education system as a “de facto system of care” for children who do not receive appropriate behavioral health care elsewhere: “More than three-fourths of children receiving mental health services were seen in the education sector, and for many this was the sole source of care.”³³

Untreated or poorly managed mental health disorders in children also affect long-term adult productivity. An economic analysis by the National Academy of Sciences found a 28% lower net family income by age 50 for individuals who had experienced mental health issues as a child and concluded that “effective treatments targeted to children that lower the risk of experiencing these psychological conditions or that mitigate adult psychological and economic consequences are likely to have long-lasting payoffs and to be very cost-effective.”³⁴

Because pediatric BHI offers an opportunity for upstream prevention, it has the potential to improve both short-term and long-term outcomes and reduce costs. While the evidence base regarding pediatric BHI is still accumulating, some studies are indicating important benefits.

Evidence of the Benefits of BHI in Pediatric Primary Care

Most research on BHI has focused on adult populations. A review of studies of the collaborative care model—a BHI approach in which primary care providers collaborate with care managers and psychiatric consultants to manage patients’ mental health problems and monitor patient progress—shows that it is more effective than usual care in treating depression and anxiety as well as bipolar disorder and schizophrenia. BHI in primary care settings has also been classified as a “Scientifically Supported” strategy to improve mental health by *What Works for Health*, a Robert Wood Johnson Foundation program that rates the effectiveness of various health improvement strategies.³⁵ In addition, long-term cost analyses show significant cost savings: \$1 spent on collaborative care saves \$6.50 on health care costs.³⁶

Preliminary studies of BHI models in the pediatric setting also suggest promising outcomes. A recent meta-analysis of randomized controlled trials to evaluate whether BHI for children and adolescents leads to improved behavioral health outcomes compared with usual primary care found that “the probability was 66% that a randomly selected youth would have a better outcome after receiving integrated medical-behavioral treatment than a randomly selected youth after receiving usual care.”³⁷

Models of Pediatric BHI through the Three Cs: Consultation, Care Coordination, and Colocation

Pediatric BHI differs from adult models of care in several ways. First, children see primary care providers much more frequently than adults, particularly in the early years. Well-child visits include screening for a range of developmental and psychosocial concerns in consultation with parents and caregivers.³⁸ Because of this early screening, pediatric BHI offers an opportunity not only to improve care for children and families but also to meet the triple aim of better care, better health, and lower costs.³⁹ Different models of BHI have been developed in recent years, from facilitating consultation by child and adolescent specialists to on-site care coordination to colocation of pediatric primary care and behavioral health services.

Consultation

Given the shortage of child and adolescent psychiatrists and other mental health professionals, some states have developed regional consultation models that allow primary care pediatricians to leverage scarce behavioral health resources. One of the most prominent models of consultation is the Massachusetts Child Psychiatry Access Project (MCPAP). When primary care pediatricians enroll in the program, they can access timely assistance for any patient with a behavioral health concern. After an initial phone consultation with a child psychiatrist, MCPAP might then provide an in-person clinical assessment, short-term therapy, or a facilitated connection to a community resource.²⁰ MCPAP has regional teams that each consist of child psychiatrists, licensed therapists, care coordinators, and appropriate administrative support.⁴⁰

Data from MCPAP indicate that 28% of initial consultations led to the child receiving a face-to-face consultation with a child psychiatrist or nurse. Pediatric primary care providers agreed to manage psychiatric follow-up care for 50% of patients involved in the MCPAP, which might indicate pediatric primary care provider confidence in managing behavioral health issues when supported by a specialty team. Provider surveys indicated that confidence in meeting the needs of children with behavioral health problems increased from 8% to 63% after implementation of MCPAP. Providers reporting that they successfully obtain consults in a timely manner grew from 8% to 80%.⁴¹

According to the National Network of Child Psychiatry Access Programs, the MCPAP model has been adapted in 28 states.⁴² In addition to the child psychiatry access project model, another version of the consultative model focuses on educating primary care providers about behavioral health issues and treatment through a consultation conference in which a child psychiatrist discusses specific cases and the reasoning behind certain treatment decisions.⁴³

Care Coordination

As mentioned above, the PCMH concept has its history in pediatrics, making BHI a logical extension of team-based care coordination within primary care. Care coordination is linked to system transformation efforts as a means of improving quality and efficiency and achieving cost reduction. There is a growing trend toward the use of care coordinators (sometimes referred to as navigators or care managers) who help address barriers to care and facilitate self-management.

As described earlier, a meta-analysis of studies on pediatric BHI found the strongest effect with collaborative care, a team-based approach in which primary care providers, care managers, and mental health specialists coordinate care.³⁷ A randomized controlled trial studying the use of a collaborative care model that included integration of on-site care managers into pediatric primary care to address behavioral problems related to ADHD and anxiety reported numerous benefits of BHI over usual treatment. BHI was associated with higher rates of treatment initiation and completion and improvement in behavior problems, parental stress, treatment response, and consumer satisfaction. Pediatricians reported greater perceived efficacy and skill in treatment of ADHD.⁴⁴ Another study using lay care coordinators to improve care access and treatment for low-income children with ADHD found improvement in symptoms among children in the treatment group.⁴⁵

Models of care coordination are also being piloted at the state level. In Wisconsin, through a partnership between the Department of Health Services and the Department of Children and Families, the Care4Kids program provides a medical home for children in the child welfare system. Providers participating in the Children's Community Health Plan network serve as Centers of Excellence for coordinating primary care with behavioral health and other social services through an individualized care plan based on the needs of the child. Care coordinators facilitate information sharing among providers, efficient coordination of services, and monitoring of service utilization.⁴⁶

Colocation

BHI that involves colocation generally means having behavioral health specialists on-site in a pediatric primary care practice to improve access, facilitate care coordination, and streamline billing.⁴⁷ The trend toward colocation of physical and behavioral health providers is most prevalent in community health centers.⁴⁸ But colocation of primary care and mental health providers is also being piloted in pediatric practices. For example, Community Care of North Carolina, a statewide Medicaid primary care case management program, has colo-

cated mental health professionals in pediatric primary care practices.¹⁹ Box 2 describes the role of behavioral health professionals on a primary care team.

Box 2. The role of behavioral health professionals on a primary care team might include

- Being part of the primary care team;
- Providing immediate triage/response to a positive screening;
- Conducting behavioral health screening or follow-up with secondary screenings or assessments;
- Providing services ranging from brief interventions to short-term or long-term therapy;
- Offering self-management counseling for children with chronic medical conditions and their families;
- Facilitating referrals to and communication with external behavioral health providers;
- Facilitating transitions across care settings and levels of care; and
- Communicating with teachers or other interested parties.

Source: SAMHSA-HRSA Center for Integrated Health Solutions. *Integrating Behavioral Health and Primary Care for Children and Youth*, July 2013.

Supporting Pediatric BHI through Payment Reforms

A key question for policymakers and planners interested in BHI is how to finance an integrated delivery system. Fee-for-service billing has been one of the primary roadblocks to innovation and investment in BHI. With the larger movement toward value-based payment reform, there are new opportunities for system integration.

Traditional fee-for-service billing practices have created barriers to BHI innovations in pediatric primary care by limiting or prohibiting reimbursement for behavioral health specialist consultation, care coordination, or physical and mental health services provided on the same day. Another obstacle to BHI has been mental health carve-outs, in which an insurer or managed care organization contracts separately for behavioral and physical health services and will only pay for behavioral health services provided by a specified behavioral health organization.⁴⁹ Although changes to fee-for-service payment structures could facilitate pediatric BHI, the most promising opportunities for BHI initiatives might occur through health care system and payment reform.

Opportunities for Pediatric BHI through Health Care Reform

Health system reforms have incentivized BHI in several ways. First, recognizing behavioral health treatment as an essential health benefit has reduced the stigma and isolation of behavioral health services. Second, the Mental Health Parity and Addiction Equity Act of 2008 has expanded coverage for behavioral health treatment. Third, the adoption of the PCMH model has encouraged the use of interdisciplinary health care teams. Fourth,

value-based payment reforms, such as accountable care organizations (ACOs) to coordinate care across providers and incentivize efficiency, have supported BHI. Fifth, Medicaid expansion in some states has helped drive BHI innovations by increasing the funding available to Medicaid managed care programs and community health centers to broaden and better integrate services.⁵⁰

Finally, Medicaid health homes provided for under Section 2703 of the ACA facilitate BHI. Like the medical home, which blends multiple funding sources to integrate and coordinate medical care, the health home encompasses behavioral health care for patients with multiple chronic conditions, including serious mental illness, using the Chronic Care Model.¹⁰ Although Section 2703 is typically used for adult populations, some states have used it to focus on children with special needs. For example, Rhode Island CEDARR Family Center Health Home offers health homes to children who have two chronic diseases, who have one chronic disease and are at risk for a second, or who have a serious mental illness.⁵¹ Maine is also implementing health homes for children under its State Health Care Innovation Plan.⁵²

Advancing BHI through Medicaid System Reform

New York State is advancing BHI through the Medicaid Delivery System Reform Incentive Payment (DSRIP) program. The Medicaid Redesign Team's Children's Health and Behavioral Health Subcommittee has built a multi-year plan to transition children's behavioral health into Medicaid managed care. The plan includes enrolling children with two or more chronic diseases or a qualifying condition into health homes; expanding the behavioral health services available under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits; and allowing for coverage of non-physician practitioner services, such as social work services.⁵³ Texas⁵⁴ and Massachusetts⁵⁵ are also using DSRIP to achieve BHI for adults and children through their Medicaid managed care programs.

In addition to state innovations in BHI through Medicaid managed care programs, multi-payer projects are providing new opportunities for BHI. For example, Colorado is building a state innovation model through a \$65 million federal grant to enable six payers to bolster BHI.⁵⁶

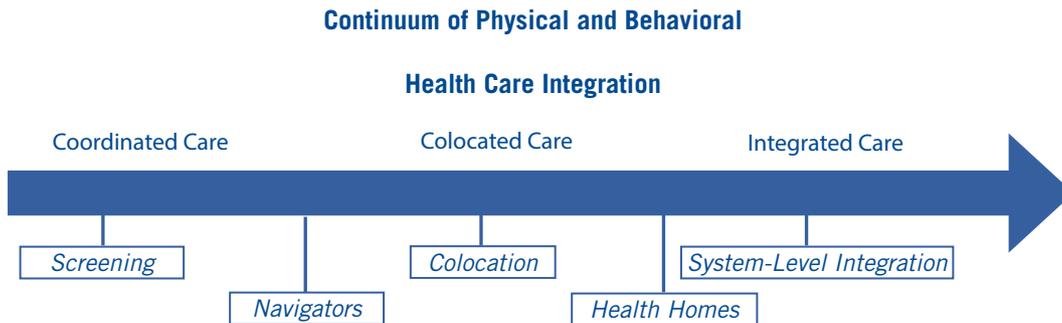
Actions States Can Take to Support Pediatric BHI

Below are policy and implementation strategies for consideration by policymakers, planners, and providers working toward pediatric BHI.

Develop a Strategic Plan to Transform Pediatric Primary Care Practices to Include BHI

As described above, there are different models of BHI representing various levels of integration of behavioral health services into pediatric primary care. Figure 3 depicts the continuum of integration in BHI. Reaching seamless integration requires many steps within the transformation of the pediatric primary care practice, as well as regulatory and payment structures that support system-level change.

Figure 3.



Source: Kaiser Family Foundation, *Integrating Physical and Behavioral Health Care: Promising Medicaid Models*, Issue Brief, Executive Summary. February 2014:3.

A number of tools are available to policymakers, planners, and providers that describe key goals and strategies for implementation of BHI. The United Hospital Fund created a framework to support planning and implementation of BHI.⁵⁷ The SAMHSA-HRSA Center for Integrated Health Solutions also published a guide for planners focused on pediatric BHI.¹⁴ Finally, the AACAP issued “A Guide to Building Collaborative Mental Health Partnerships in Pediatric Primary Care.”⁴⁷

As providers, planners, and policymakers undertake pediatric BHI, it will be important for them to build the evidence base for this practice through careful tracking of outcomes. States that can link data across systems—medical, behavioral health, child welfare, juvenile justice, and education—are especially well suited to evaluate the impact of pediatric BHI, not only on short-term and longer-term outcomes for children but also on other state systems.

Leverage and Direct Medicaid Funds toward Preventive BHI in Pediatric Primary Care

Medicaid now covers nearly half of all births and 44.1% of children from birth to age five years.^{58,59} Effective early childhood intervention can prevent short-term and long-term behavioral health problems, which are often costly.¹³ The EPSDT benefits under Medicaid cover prevention and early intervention, including screening, diagnosis, and treatment. States must provide comprehensive services that are “appropriate and medically necessary” to “correct and ameliorate health conditions,” including physical, developmental, and mental health problems, even if such services are not covered for adults.⁶⁰ This requires arranging for referrals and services for treatment of conditions identified through screening.

States can support pediatric primary care BHI by providing clear guidance through EPSDT programs regarding the following:

- How to bill for developmental and behavioral health screening and ensure that reimbursement is sufficient to incentivize appropriate follow-up referral and direct interventions
- How therapeutic developmental and behavioral services (including home visits, counseling, and social work) might meet the definition of “medically necessary” services under federal law, and mechanisms for billing for these services

Support Pediatric BHI through Managed Care Contracts and ACOs

Some states have designed programs for children with special health care needs as part of their Medicaid managed care programs and some are developing Medicaid ACOs. In managed care and ACO contracting, states can clarify administrative billing procedures for BHI as part of value-based payment structures, such as capitated payments. These can include the following:

- Development of billing codes for behavioral health services provided by primary care pediatricians, as well as for non-physician providers (e.g., care coordinators, social workers, and psychologists) who are employed in a primary care setting
- Allowing payment for non-face-to-face consultations with partnering behavioral health providers, such as child psychiatrists
- Allowing billing for medical and behavioral health visits in the same day
- Eliminating mental health carve-outs that do not support BHI

Develop Quality Measures for BHI in Pediatric Primary Care

The Children’s Health Insurance Program Reauthorization Act of 2009 called for the development of quality measures in Medicaid and the Children’s Health Insurance Program. Simultaneous efforts by the National Quality Forum led to the development of nine measures of the quality of children’s mental health care.⁶¹ These measures, however, do not explicitly include quality measurement for BHI in primary care. As states invest in and implement pediatric BHI, both process and outcome metrics will be important to assessing and informing the quality of patient and family care, sustainability, and the potential for health care cost reduction.

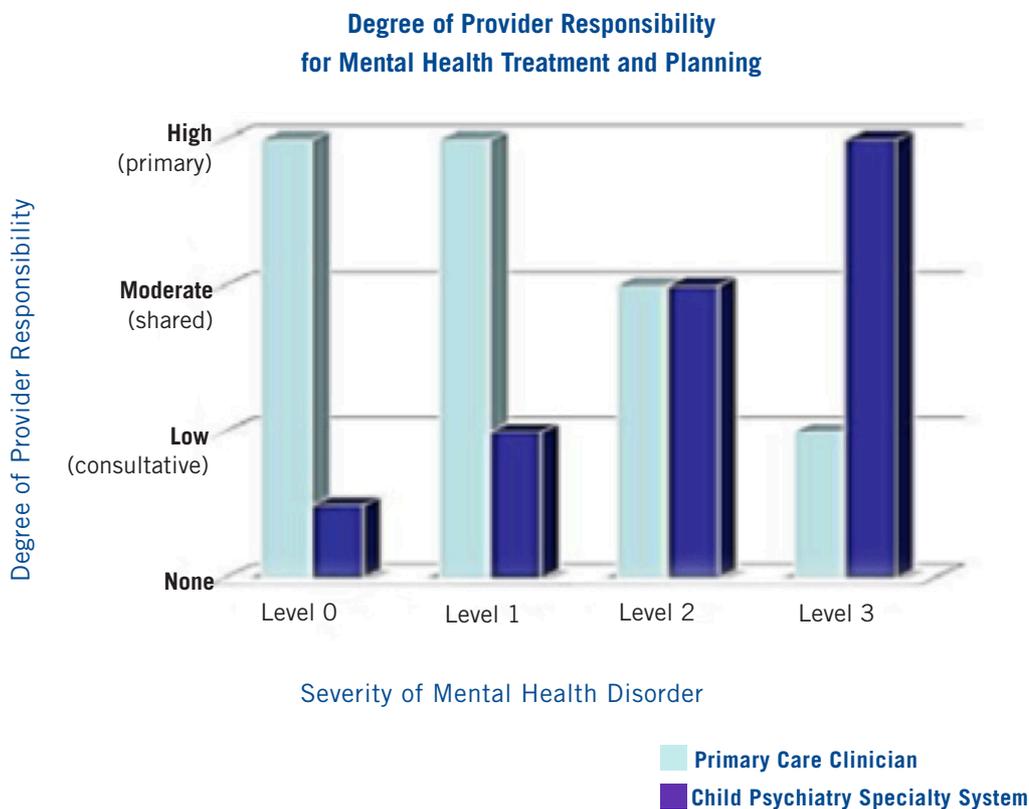
The Agency for Healthcare Research and Quality has developed “A Framework for Measuring Integration of Behavioral Health and Primary Care” that can guide policymakers, planners, and providers as they design and assess pediatric BHI initiatives.⁶²

Design BHI to Leverage Scarce Pediatric Behavioral Health Resources

BHI offers an opportunity to leverage scarce behavioral health resources and more efficiently match them to need. Early evidence suggests that leveraging behavioral health services through BHI—whether through educating and consulting with primary care pediatricians by child psychiatrists or implementing a behavioral health team and care coordination within primary care—can improve care access and outcomes for children with mental health problems.

Considering the level of intervention required by a behavioral health specialist (versus conditions that may be more easily managed by a primary care provider) is key to planning pediatric BHI. Although some mental health issues might be more easily managed by a primary care provider, others require specialty care from child psychiatrists and other behavioral health providers. Figure 4 illustrates how the need for specialty care increases by the mental health disorder's level of severity.

Figure 4.



Source: American Academy of Child & Adolescent Psychiatry. *Best Principles for Integration of Child Psychiatry into the Pediatric Health Home*, June 2012.

Conclusion

Given the prevalence of behavioral health disorders in children and adolescents and the unique opportunity presented in pediatric primary care for early intervention, BHI in pediatric primary care offers great promise for identifying and effectively treating children's behavioral health concerns. Health care delivery system reforms are supporting new mechanisms for designing and financing innovative approaches to BHI in pediatric primary care. Policymakers, planners, and providers can work together to use data and evidence-informed strategies that create sustainable programs to address the mental health needs of children and families.

Notes

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