

**Summary and Proceedings of the
Minnesota Society of Child and Adolescent
Psychiatry**

**Children's Mental Health
Leadership Summit**

Friday, April 20, 2007

Hosted by:

**L. Read Sulik, MD, President, MSCAP
Tim Gibbs, MD, Secretary/Treasurer, MSCAP
Steve Sutherland, MD, President-Elect, MSCAP**

**Black Bear Crossings
Como Park
St. Paul, Minnesota**

Greetings,

This report contains the summary and the transcribed proceedings of the Children's Mental Health Leadership Summit held by the Minnesota Society of Child and Adolescent Psychiatry on April 20, 2007. The purpose of this Summit was to bring child and adolescent psychiatrists from around the state of Minnesota together with primary care physicians, children's mental health professionals, child and family advocates, and key leaders in state government, health systems and health plans. Our goal was to discuss the current practice issues faced by child and adolescent psychiatrists in Minnesota and also listen to the issues experienced by other professionals as we try to meet the needs of the children and adolescents of Minnesota.

The Summit included many invited stakeholders involved in the field of children's mental health in Minnesota and also several special guests. Dr. Tom Anders, President of the American Academy of Child and Adolescent Psychiatry joined us from Santa Barbara, California and Dr. David Fassler, Assembly Chair of the American Academy of Child and Adolescent Psychiatry joined us from Burlington, Vermont. Cal Ludeman, Commissioner of the Minnesota Department of Human Services, Lori Swanson, Minnesota Attorney General, and Mike Hatch, the immediate past Minnesota Attorney General spoke during the Summit proceedings. Dr. Timothy Gibbs who is the current Secretary / Treasure of MSCAP and Dr. Steve Sutherland who is the President-Elect of MSCAP joined me in hosting this summit.

There are many reasons why this type of a meeting is significant. Access to care for children and adolescents with mental health needs continues to be a critical issue. There is a dearth of child and adolescent psychiatrists in Minnesota and especially in all areas outside of the Twin Cities. Improved collaboration between child and adolescent psychiatrists and other children's mental health specialists, and primary care providers is another critical need. We need better collaboration with schools and with social services. We also need to be more involved with our children's mental health advocacy groups and also with our state and federal government. Improved standards of care based on evidence and cultural competence continues to be another area of needed improvement. Of course the economics of providing children's mental health care continues to be the area that is brought up by providers and by payors alike. The ultimate question is "Can we work together better to improve access to care, quality of care at reduced overall cost and ultimately improve the lives of the children and adolescents who are suffering with mental illnesses or mental health problems?"

We came together at the Summit in April to discuss these access to care issues, standards of care issues and economics of care issues and identify specific actions that could be taken to lead to change for the better so that the children and adolescents of Minnesota can have access to top quality mental health care in a collaborative system of care. I believe that Minnesota has a unique culture of collaboration amongst individuals and agencies that allows this type of consensus building on behalf of children to occur. Much

work has been done already to examine the mental health care system in Minnesota and propose changes to improve the quality and efficiency of care. This previous work has helped facilitate relationships and open the door for new relationships to be made in efforts to collaborate better with one another. I hope you will agree with my belief that the efforts to bring people together and establish relationships are what lead to ultimate change in thinking and in practice. Therefore, if nothing else was to come of this Summit this past Spring, then the process that occurred there may have been beneficial to all of us who participated. However, the charge committed to by all of us who hosted this meeting was that we would not stop with the process alone but move to implement the changes that have been suggested throughout the day.

Participants had an opportunity to share their own concerns and experiences and dialogue over the current pressing issues. These points were listed and participants selected top priorities needing immediate action by assigning votes to their selected priorities. The priorities were categorized into 9 areas and then the participants self-selected which of the nine areas they wished to contribute ideas towards. Each of the nine groups presented a list of suggested action steps and then presented this to the list at the end of the meeting.

This report includes the dialogue that ensued through out the day and provides the identified action steps suggested by each group assigned to one of the nine areas of priorities. I encourage you to read not only the suggested actions but the entire meeting proceedings in order to experience the great energy and enthusiasm that was shared. I hope that you will find this report as a guide to improve an understanding of the framework of our children's mental health systems of care that still must be improved. The Minnesota Society of Child and Adolescent Psychiatry members will continue to work with many others in our state to implement the suggested changes.

Finally, in the spirit of full disclosure to any outside potential financial influences, I would like to emphasize that this meeting was conducted with no outside funding and all the costs of holding this meeting and producing this report were paid from the dues of the Minnesota Society of Child and Adolescent Psychiatry members.

With warmest regards,

*L. Read Sulik, MD, FAAP
President
Minnesota Society of Child and Adolescent Psychiatry
July 2005 to June 2007*

PROCEEDINGS

L. Read Sulik, MD
President
Minnesota Society of Child And Adolescent Psychiatry

Read Sulik: We're going to go ahead and get started. There are a couple of little background announcements I am going to make before I give a 3-5 minute opening.

First of all, you notice there are microphones at your tables. The purpose of that is we intend to have an awful lot of dialog at this meeting. Portions of today's meeting include comments are coming from the tables, so please use your microphones so all of us can hear each other well. Linda Vukelich who is the Executive Director of the Minnesota Psychiatric Society has been working with me to help put together this meeting today. She and I will use the recording from today's meeting to create the summary report that we intend to distribute to each of you.

I am Read Sulik. I am the Medical Director of Child and Adolescent Psychiatry at St. Cloud Hospital / CentraCare Health System in St. Cloud. I am also the President of the Minnesota Society of Child and Adolescent Psychiatry which is the Minnesota Chapter of the American Academy of Adolescent Psychiatry. I wanted to take just a few minutes to summarize the purpose of why we are doing this today and then I'm going to lead to some introductions and we will move into the day's agenda.

Special Thanks to . . .

- Linda Vukelich
– Executive Director, MPS
- Tom Anders, MD
– President, AACAP
- David Fassler, MD
– Assembly Chair, AACAP
- All of you!

I want to provide a special thanks to Linda. As I said, Linda and I have been discussing this meeting since last year around this time. She has put an enormous amount of work in getting everything you see here organized and arranged for us. So, big thank you to Linda (clap). As a child and adolescent psychiatry society hosting this meeting we have two really great special guests here. To my left, Dr. Tom Anders, is currently our President of the American Academy of Child and Adolescent Psychiatry and to his left, Dr. David Fassler is the Assembly Chair of the American Academy of Child and Adolescent Psychiatry. More importantly, these two individuals are really not only significant leaders within our organization but are leaders at the national level regarding advocacy issues in children's mental health. It is an incredible pleasure to have them here and they are here to help us create some momentum to solve some of our current issues that we experience here.

As a final thank you, I want to thank all of you for coming and attending today. I know that some of you are here briefly and need to leave early and if you notice, there are places at your table for people who couldn't be here in the morning but will be joining us as the day goes along.

I have to point who all is here, because this is really a nice representation of essentially, bringing the choir together, so to speak. We have a wonderful representation of what I consider to be key and significant stakeholders in the state of Minnesota regarding mental health issues. At each table there is an adolescent psychiatrist (hopefully 2 or more). You will notice that we don't have family physicians here. They happen to be at their annual meeting unfortunately, so missed getting

Who is Here Today?

- Child and Adolescent Psychiatrists
- Pediatricians
- Advanced Practice Nurses
- Mental Health Professionals – Psychologists, Social Workers
- Health Plans
- Representatives for Federal Elected Officials
- State Elected Officials and Representatives of State Elected Officials
- State Agencies
 - Department of Human Services
 - Department of Health
 - Department of Education
 - Department of Corrections
 - Department of Commerce
- County Social Services
- Advocacy Groups
- Health System and/or Clinic Administration

representation from family practice to join us today. We have many advocates here and representatives from our state government and state departments of human services, department of health, department of education, department of commerce and department of corrections. We have representatives of our elected officials at the state and federal level and we have many advocacy groups represented here. We also have leaders and administrators of clinics, some health systems and health plan leaders here. So we have a really wonderful assortment of people. Most of you around the table have been at meetings with those at other tables many different times. One thing I was sharing with Dr. Fassler and Dr. Anders is I do think we have something unique here in Minnesota, when we do come together to really think through and problem solve, particularly for children, it seems that this is the natural response. It is almost an automatic, “Well of course I can come”. So I think we are a culture here really committed to making some changes for kids.

Why?

- As child and adolescent psychiatrists we need to address the . . .
 - Rising acuity and mental health needs of the children and youth of Minnesota
 - Improve access to care
 - Outpatient
 - Inpatient
 - Alternative models of care
 - Prevention
 - Improve coordination of care
 - Improve standards of care
 - Approach to complexity
 - Approach to new models of care – Integrated Care / Collaborative Care
 - Approach to monitoring
 - Improve economics of care
 - Improve the way that child and adolescent psychiatrists are utilized in the systems of care for children and adolescents

So, why are we here? Last year, we got a group of child psychiatrists in the state together. We had 28 child psychiatrists sitting in this room. You probably didn't even know there were 28 child psychiatrists in the state of Minnesota (laugh) much less gathered all in one room. So the security was quite high (laugh) because one small mishap could have taken out the entire work force (laugh), but we really came together because we're struggling. We are having a

lot of issues living up to the mission we have to serve the youth and children of Minnesota. Multiple things came forward in that discussion and dialog and what emerged was the goal to try to bring people together with us as a “think out loud group” to address some of our own practice issues. However, we are trained listeners as well and have an opportunity to hear from you about what we can do differently.

Some of the things we came up with as child and adolescent psychiatrists:

1. We need to address the rising acuity and the increasing mental health needs of the children of Minnesota.
2. We need to improve access to care. This is a huge issue not only in outpatient but inpatient beds. We need to promote models of care that are an alternative to inpatient beds.
3. We need to be much more actively involved as child psychiatrists in thinking about prevention in our state.
4. We need to be improving coordination of care with all of you and all of our other key stakeholders and team members in the care of children.
5. We need to be improving our own standards of care, coming together with some understanding of common approaches of the complexity of children's needs, common approaches in new models of care including integrative models of care that involve bringing mental health and primary careworkers together.
6. We need to adjust economic care issues. This always comes up at these kinds of dialogs. We need to improve the way that child and adolescent psychiatrists are utilized in this state in the most effective manner. We realize that not only is there a shortage nationally of child and adolescent psychiatrists, we are far below even the national mean in Minnesota when it comes to the number of child psychiatrists in this state.

So in other words HELP! That's why you all are here to think out loud with us.

<p>MSCAP Leadership Summit 2007</p>
<ul style="list-style-type: none">• Discussion will focus on<ul style="list-style-type: none">– Access to Care Issues– Standard of Care Issues– Economics of Care Issues• Identify Priority Issues• Identify Action Steps for next year to address issues

Throughout today we are going to discuss topics and issues you all will raise under these three categories:

1. Access to Care Issues
2. Standards of Care Issues
3. Economic Care Issues

We are going to identify priorities. The most important ones that need our immediate attention and then this afternoon we are going

to work together to come up with specific action steps to immediately start addressing them. The outcome of this meeting will not be to suggest that "we have another meeting." We need to come to some specific responses and actions.

Now this is just a quick agenda today so you know what we're about to do. You don't have this in front of you because it has been a secret up until this moment (laugh). Our Minnesota Department of Human Services Commissioner, Cal Ludeman, is going to make a few comments right after me. Then we are going to do introductions from all of you here at the tables. You can all just say a brief word about who you are and where you're from and what you're doing. Try to keep that as brief as possible as there are close

Meeting Agenda

- 9:00 Welcome and Introduction of Agenda – Read Sulik
 - Meeting Background, Purpose and Agenda
 - Welcome Greetings
 - Introductions
- 9:45 Workforce Shortage – Dr. Tom Anders
- 10:15 Commentaries
 - Dr. David Fassler
 - Dr. Tim Gibbs
 - Dr. Steve Sutherland
- 10:30 Open Discussion of Issues
 - Access to Care
 - Standards of Care
 - Economics of Care
- 12:00 Lunch and Vote Selection of Priorities
- 12:30 Summary of Findings and Table Assignments
- 1:50 Sharing of Table Assignments
- 2:30 Final Discussion and Clarification of Action Steps
- 3:00 Adjourn

to 70 some people here and if we take 5 minutes each that takes up the day. Then we're going to spend about 30 minutes for Dr. Anders to present us the national perspective in issues of child psychiatry that we are confronted with primarily as a whole work force shortage issue. We are going to have commentary not only from Dr. Fassler but also from Dr. Gibbs who is our immediate past president of the Minnesota Society of Child and Adolescent Psychiatry and our current Secretary and Treasure (raise your hand in case

people don't know you) and also Dr. Steve Sutherland who is the up and coming president for the Minnesota Society of Child and Adolescent Psychiatry and will serve the next 2-year term.

Following Dr. Gibb's comments we are going to have a 90-minute period where we will have some raised issues from all of you. At lunch we are going to ask you to vote with the stickers you have inside your packets. We are counting on each of you to help us prioritize what we are going to focus on following this meeting so your votes are critical. We are then going to assign each table one of the prioritized issues and come up with some suggestions not only for child psychiatry, but for all of us to address immediately. Then we are going to wrap up with what the directions are we have come up with.

I would now like to turn this over to Commissioner Ludeman. Cal is the Commissioner for the Department of Human Services, prior to that, he was the chair of the Governor's Health Cabinet. One thing I have certainly witnessed in the last several years since I first met Cal is that I see him all over the place and you probably all do as well.

Cal Ludeman
Commissioner
Minnesota Department Of Human Services

Commissioner Ludeman: Thank you very much Read. I really appreciate that. I remember specifically the day I met Read Sulik and you're lucky to have him as a president of your organization. As you know, this man speaks with a certain amount of energy, intelligence and will that is just embodied in him. So, he does get things done and we appreciate that in any environment he operates in. We do work in a lot of orbits, as you know, in this world. These tables are round; they tend to bounce and bump and intersect with others. That is how the Department of Human Services is only a part of what can be done about children's mental health. Glenace Edwall is here, many of you

know her. She is the division director and well-versed and extremely professional in coordinating our policy relative to children's mental health.

Welcome to the folks who are not from Minnesota to Minnesota. Everyday is like this. (laugh) If you are in an elevator you will notice Minnesotans are so nice and in need of affirmation and confirmation about where we live; people will say "Isn't this a nice day?" (laugh) and you need to answer that question. You have to confirm with them that "Yes indeed, it is a nice day." Sometimes we simply can't believe it. (laugh) You are on the shores of a beautiful park, one of the premiere parks of Minnesota, Como Park.

What we talk about is many challenges. I don't want to slow the meeting down, dry it down. You're going to have the right energies at these tables to talk about it. We have helped and participated at this department with other tables of conversation. The most significant one that I'm going to review with you is the Governor's Health Initiative. I am passionate about it. We have a strong foothold in both the house and the senate bills. The Governor feels as equally strong about it. It is important you know not anybody in life dare spend all their time and all their attention with their head turned toward the state capitol and Washington, DC. Much of the work you have to do is not about that. But yet, when we get to rate reimbursements and payment reforms and many of these things, the fact of the matter is sometimes policies and funding arrangements have to be changed to allow the right people to get to the right place at the right time. To save lives, to improve health, and certainly even against the backdrop of what happened at Virginia Tech, informs us all about where we're actually deficient in many areas. Many of you work in an area that the world doesn't know about until they absolutely have to when they or a family member enter this system. That is when they learn about it and they learn about the deficiencies. It's our responsibility as professionals and as a state agency to fill that void and provide the right services. Treatment of children with mental health disorders requires extra effort. I'm not a professional here to preach to you about this, but lots of stakeholders have to get involved, not only the child but the families themselves, schools, other physicians and sometimes other parts of the public system, like our social services that is administered in Minnesota at the county level.

In 2005, the legislature did add two new features to the benefit for all of the publicly funded health care programs that were important in this area, the psychiatric care coordination between psychiatrist and primary care physician without the patient in attendance is actually allowable. So that was important and also relates to some of the events and readings of what was involved in last week's issues (at Virginia Tech). The legislature also approved providing mental health services through interactive video. We have a state of the art facility at the Department of Human Services and it is used every day for consultations through interactive video capacity. In 2006, the Governor introduced his mental health initiative. Some of it got passed, certain portions of it. The most significant at that time was to address the shortage of psychiatrists in Minnesota. We actually have a live-time census of how many psychiatrists (in particular, child psychiatrists) work in Minnesota, because we don't have enough of them anywhere in the market place. With the help of some federal match to the rate, there was a significant

increase in the rates of 23.7%. Additional funding was appropriated to extend mental health crisis intervention services. Read knows a lot about these kinds of issues.

The 3 primary components of the mental health initiative is the establishment of a common set of mental health benefits in all of Minnesota's publically funded health care programs. When you go to benefit conversations they can go on for centuries and so that we could even find some agreement on whatever it is (not letting "completely perfect" get in the way of the "good") and have a common benefit set is a standard platform from which we can now work from and improve.

Integration of mental health treatment into primary care and the mainstream of health care delivery. This has been talked about I think in psychiatry and the mental health community for years and years and years. This is important and needs to happen and it will happen in Minnesota.

The third component of the proposal is to further invest in developing and supporting mental health infrastructure to better respond to those in need of care. We have proposed 46 million dollars to shore up school based mental health services for uninsured and under insured children. We are proposing another 28 million dollars to extend mental health crisis services for children and adults. The children's emergency assessment system in the St. Cloud area where Read works is going to be duplicated and funded throughout other parts of the state. We have called for an investment of more than \$300,000 to monitor and track availability of mental health services to create a system for measuring outcome. There is also in the components (as talked about - Read had it on his slide and in many slides relative to healthcare reform efforts even for physical and mental health), the idea of care coordination.

You should know, I'm still Chairman of the Governor's Health Cabinet. We've talked about this a lot (care condition) because there is where change in medicine, the change in the practice of healthcare itself, is going to occur. There are actually many, many competing elements coming into this field trying to say "we'll do that." We'll be the care coordinator, whether it be the management vendor of a health plan itself, or a provider community, a medical system, everyone wants now to discover and compete for this care coordination. There is probably a range of quality ideas of how care coordination has to happen in the best way so that the consumer, the patient, the client is able to find this kind of care delivery system available to them that actually works toward better outcome. Without that, we're disjointed and we're expensive and we're not even communicating with each other.

This is a tough environment to accomplish in Minnesota, which has the toughest privacy requirements in the nation. And so, we'll overcome those issues from a system viewpoint in how we can make consultations available. Will patients and families have to give up something in this regard? If we do it carefully they really won't, but we have to be able to communicate it and allow it to happen and then we also have to find a way to pay for care coordination. The Governor is anxious to say oftentimes 'What is measured improves and what gets paid for gets done'. We're not pretending that we can just ask for it or insist on

it. We do know that for the most part the system and the dollars have to flow to get this accomplished. So, care coordination is going to be a major topic of conversation. In this regard the Governor's Mental Health Initiative is going to be transformational, not just in the mental health area because it is now integrating mental health with regular health care. Its delivery will force care coordination in and of itself in such a way that we will discover chronic disease management for diabetes and cardiovascular care can be incorporated in very much the same way. So we think this is a bigger deal than it even looks on paper. I just wanted you to know that.

We also have 7.5 million dollars in new funding to address the needs of other specialty populations. In the department itself of course we deliver very deep end services. Many psychiatrists work for the State of Minnesota and Department of Human Services. We have the Security State Hospital at St. Peter, which has reached an all time high census last week in our sex offender treatment program, which is expanding every day, part of it at Moose Lake with a new facility to be built, as well as at St. Peter. We also have Anoka Regional Treatment Center and soon, ten behavioral health hospitals spread out throughout the state. These are the deep end services. Most of what we can do from the positive side, the preventive side, and the real help side is hopefully not delivered at the Department of Human Services, but within the marketplace. That is what we would like to encourage and actually help finance.

Read, I don't want to take any more of the day. I think most of the action that is going to happen is here. But I do want to say that one of the relationships we built at another table of conversation was the Minnesota Healthcare Action Group. They are an important member at this table and other tables in this environment. I inherited my part of that as a co-chairman from my predecessor, Kevin Goodno, who I give much credit for helping keep that organization alive and to other members whose force of will also made this happen. This is not actually a lobby group, it's a developed group with many advocates and professionals, health plan people, and many of the people at this table, forcing themselves to talk about this in such a way to develop something like the Governor's Mental Health Initiative. With that help, the force is with us and I think it will pass and the Governor will be anxious to sign it.

Read, that's my story for the day and thank you for the invitation. (clap).

Read Sulik: You know Cal, I just want to make sure that I'm summarizing one thing that you have emphasized is that a priority for the Department of Human Services and perhaps the Governor is care coordination. I think it is a great take home message and something folks keep bringing up and talking about so it is an outstanding point that you emphasized. Thank you for mentioning you are the Chair of the Mental Health Action Group. Glenace asked me to make sure that I mention that you are the Chair of MMHAG because it is so important and I forgot to do that, so you just saved me. (laugh).

INTRODUCTION OF PARTICIPANTS

Read Sulik: I would like to ask now that you each as quickly as you can say who you are and where you're from so we get a good feel for who is sitting at the tables with us. We've introduced ourselves up at the front table so how about if we start with Table 1.

David Cline, Child and Adolescent Psychiatrist, Private Practice, Abbot Northwestern and Consultant for a Children's Residential Treatment Center.

Heather Renner, with Congressman Jim Ramstad's office. He's in Washington and couldn't be here today.

Ernie Swihart, Behavioral Pediatrics, SW Pediatrics of MN

Amy Burt, pediatrician, Park Nicollet

Barb Peterson, advanced practice nurse, Children's

Regina Driscoll, clinic administrator, Children's

Chris Bray, Minnesota Department of Corrections. I'm currently working on an initiative related to juveniles and addressing their mental health needs.

Deborah Saxhaug, Executive Director for the Minnesota Association for Children's Mental Health

Mike Runyan, Administrative Manager for State Operated Services Child and Adolescent Behavioral Health Services

Steve Setterberg, Child and Adolescent Psychiatrist with Prairie St. John Hospital in Fargo and our partial hospitals in the Twin Cities

Gulshan Singh, Child/Adol Psychiatrist and Pediatric Psychiatrist, Wilmar RTC

Ann Schwanke, Clinic Administrator for Blue Stem Center in Rochester

Matt Eastwood, Director of Behavioral Health at BCBS

Cari Michaels, Coordinator for the University of Minnesota's Center of Excellence for Children's Mental Health. Our purpose is to create bridges between research and clinical practice in children's mental health.

Candy Kragthorpe, Director of the newly formed Minnesota Association for Infant and Early Childhood Mental Health

Linda Norlander, MN Dept. of Health, Office of Rural Health and Primary Care

Dr. Paul Renner, Child and Adolescent Psychiatrist for 4 different rural mental health centers Faribault, Albert Lea, New Ulm and St. Peter

Vicky Thrasher-Cronin, Advocate with Ready for K

Will Dikel, Child and Adolescent Psychiatrist. I consult around the state and nationally around issues related to child psychiatry as it relates to educational systems, social services, corrections, public health and mental health systems.

Amy Berg, General Pediatrician, Park Nicollet

Suzy Peterson, Child and Adolescent Psychiatrist at Fairview Riverside and also in private practice

Joann Hoffman Jecha, Pediatrician at Southlake Pediatrics

Marybeth Lardizabal, Child and Adolescent Psychiatrist at United Hospital in St. Paul

Frances Go, Child and Adolescent Psychiatrist at United Hospital in St. Paul

Peg Hayes, I'm the Director of Clinical Services, Wilder Child Guidance Clinic.

Mark Kruppe, CEO of HSI, a nonprofit, private community mental health center in the east metro area

Mark Kerekes, Child and Adolescent Psychiatrist in Fridley w/ BHSI

Carol Woolverton, Assist Commissioner at MN Dept of Health and Dept of Health's Rep. to the Mental Health Action Group

Donna Ahrens, Sr. Editor at MN Physician Publishing

Muhammad Waqar Azeem, Child and Adolescent Psychiatrist and Medical Director, State Operated Services, Child and Adolescent Behavioral Health Services.

Tom Converse, Child and Adolescent Psychiatrist in private practice in Golden Valley/Maplewood and I also consult at Social Services in Minneapolis

Kathy Carter, I am with the early head start program in Ramsey County which is for children ages birth to 3, pregnant woman and their families. We do a lot of prevention and early intervention kinds of work. I also manage the Beginnings Home Therapy Program which is part of a larger McKnight funded initiative in Ramsey County to work at developing a continuum of services for children birth – 5.

Pam Johnson, Director of the Child and Family Division at HSI in Washington County.

John Scanlan, Psychiatrist, Medical Director at Blue Cross Blue Shield and advocate for tele-psychiatry and integrating behavior health and primary care.

Bob Perzacki, Child/Adol Psychiatrist, HSI in Oakdale

Carrie Borchardt, Child and Adolescent Psychiatrist, Children's Hospital of Minnesota

Jeremy Olson, Health Care Reporter, St. Paul Pioneer Press

Nancy Collins, Child and Adolescent Psychiatrist, Park Nicollet. One of the things I do there is supervise a clinical nurse specialist who has prescribing privileges. I supervise her, She has exactly the case load as I do.

Mark Anderson, Barbara Steiner Foundation. We work with our partners in the criminal justice system to improve the response to folks with mental illness in that system.

Judd Rainey, Developmental and Behavioral Pediatrician at the Alexander Center for Child Development and Behavior at Park Nicollet Clinic, and child abuse consultant at Corner House in Minneapolis.

Cindy Shevlin-Woodcock, Interagency /Mental Health Specialist with the Minnesota Department of Education, Special Education Policy Division

Glenace Edwall, Director of Children's Mental Health Division at the Minnesota Department of Human Services and a Child Clinical Psychologist by training

Francis Gull, Child and Adolescent Psychiatrist at United Hospital in St. Paul

Jon Jensen, Child and Adolescent Psychiatrist, Director of residency training in child and adol psychiatry at the University of Minnesota

Theresa Lau, Child and Adolescent Psychiatrist at St Cloud Hospital / CentraCare Health System in St. Cloud.

Nimi Singh, Division Head of Adolescent Health and Medicine in the Department of Pediatrics at the University of Minnesota. My area of focus and interest is really improving and expanding prevention and early intervention, so really, approaching mental health from the primary care prospective.

Susan Jenkins, Child and Adolescent Psychiatrist in Rochester, MN out of Blue Stem Center. We are sort of unique. I employ a staff of about 12 other professionals including a developmental pediatrician.

Kim Oberstar-McPhatter, I'm a pediatric nurse practitioner working in child psychiatry at Children's Hospital in St. Paul.

Karen Lloyd, Health Partners Health Plan. I am the leader of behavior health strategy focused on quality improvement and also satisfaction improvement to our members

Larry Daily, I do building maintenance here (laugh), no actually I'm temporarily retired after 30+ years as a Child and Adolescent Psychiatrist at Hennepin County Medical Center.

Ghita Worcester, I'm responsible for public affairs at UCARE MN

Mark Kuppe, Human Services Inc. (HSI) chief operating officer

Peg Hayes, clinic administrator, Wilder

Candy Kragthorpe, I'm with the Minnesota Association for Infant and Early Childhood Mental Health.

Sue Abderholden, Executive Director of Minnesota National Alliance of Mental Illness (NAMI). Right now the chicken little of children's mental health. I'm really concerned that anti-children's mental health will become a platform of the Republican Party so please see my newest action alert.

Constance James, CEO of the Red Lake Hospital

David Einzig, Child and Adolescent Psychiatrist at Children's Hospital in St Paul and also I do some General Pediatrics.

Sanjiv Kumra, Child and Adolescent Psychiatrist and Division Head of Child and Adolescent Psychiatry at the University of Minnesota

Jeff Schiff, pediatrician, past president of the Minnesota Chapter of the American Academy of Pediatrics

Read Sulik: Tom, I'm going to ask you go ahead and we'll move toward your talk and take a little bit of time to discuss some of the broader issues we have as child psychiatrists at the national level that certainly apply to us here in Minnesota regarding our shortage. I'm sure this will be a nice launching pad to our discussion of issues as we go on.

**Tom Anders, MD,
President
American Academy Of Child And Adolescent Psychiatry**

Tom Anders: Well it is really a great honor and privilege for me to be here. I really think you all should be very proud of what Read, Tim and Steve and the rest of the group have pulled together here. It is really unique and unusual and in my experience I haven't seen this kind of constituency pulled together, a constituency that will result in an action plan. As the commissioner said, coordinated care seems to me to be one of the big needs identified to improve the mental health care of our children.

These are familiar statistics and yet only about 20% of those children in need get services and only a fraction of them are treated or evaluated by child psychiatrists.

MAGNITUDE OF THE PROBLEM-3

- The population of children and adolescents under age 18 is projected to grow by more than 40 percent in the next 50 years from the current 70 million to more than 100 million by 2050 (U.S. Bureau of the Census, 1999).

4

Currently there are about 7,000 of us practicing in the United States. Not all of those people practice full-time as child psychiatrists, so the FTE's are actually less than that. In 1980, Geminac (Graduation Education Council) recommended that there be 8,000 to 10,000 psychiatrists by 1990.

MAGNITUDE OF THE PROBLEM

- About 20 percent of U.S. children and adolescents (15 million), ages 9 to 17, have diagnosable psychiatric disorders
Methodologic Research for Multisite Epidemiologic Surveys of Mental Disorders in Child and Adolescent Populations (MECA), 1996; the Surgeon General, 1999
- About 10% meet the definition of "serious emotional disturbance;" ~5% have "extreme functional impairment."
The Center for Mental Health Services (1998)

2

The population is growing. There is going to be more children and adolescents and there is not going to be enough child psychiatrists in the future.

SUPPLY OF CHILD AND ADOLESCENT PSYCHIATRISTS

- There are currently about 7,000 child and adolescent psychiatrists practicing in the U.S. (AMA, 2006).
- In 1980, GMENAC* recommended that the number of child and adolescent psychiatrists be increased to 8,000 - 10,000 by 1990 in order to meet the projected needs for treatment of child mental disorders.
*Graduate Medical Education National Advisory Council (forerunner of COGME)

5

SUPPLY OF CHILD AND ADOLESCENT PSYCHIATRISTS-2

- In 1990, COGME reported that the nation would need more than 30,000 child and adolescent psychiatrists by 2000, based on increasing rates of child mental illnesses and managed care staffing models.

6

We didn't make it by 1990 obviously with only 7,000 now. In 1990 the successor of Geminac reported that there ought to be 30,000 child and adolescent psychiatrists by the year 2000, so we are really very far behind what has been projected as the need.

Beyond that there is a severe maldistribution of child psychiatrists, where we practice. The areas most affected are rural areas and areas in which there is low SES children living. This ratio of child and adolescent psychiatrists per 100,000 really varies around the country from 3.1/100,000 in Alaska to 21.3 in Massachusetts. I don't know what it is in Minnesota - the number of child psychiatrists. Do you know Read?

SUPPLY OF CHILD AND ADOLESCENT PSYCHIATRISTS-3

- There is a severe maldistribution of child psychiatric services in the U.S., with children in rural areas and areas of low SES having significantly reduced access.
- The ratio of child and adolescent psychiatrists per 100,000 youth ranges from 3.1 in Alaska to 21.3 in Massachusetts with an average of 8.7 (Thomas & Holzer, 2006)

7

Read Sulik: Minnesota is in the bottom 30th percentile of number of child and adolescent psychiatrists per 100,000 people. I believe the article in the Journal of the American Academy of Child and Adolescent Psychiatry in 2006 stated that there were 4.2 child and adolescent psychiatrists per 100,000 in Minnesota.

Tom Anders: So you're down in the bottom, yeah. What are some of the reasons behind this?

RECRUITMENT PROBLEMS

- The number of child and adolescent psychiatry residents has not increased, 712 in 1990, 718 in 2000.
- The number of child and adolescent psychiatry training programs decreased by 5 to 114 in the same period.
- These numbers are increasing slightly: 723, 742, 766 in 2004-6 and 3 new programs opening (ACGME, 2006).

8

Between that decade 1990 to 2000 the number of people in training in child psychiatry remained constant. We lost 5 child psychiatry training programs in the country. But in the last couple of years and that is what I want to get to, the initiative of the American Academy of Child Psychiatry has begun and three new programs have opened.

The numbers of people in the program have gradually been increasing again so that in 2006 there was 756 people in training. So something positive, although small may be happening for child psychiatry. We have a lot of IMGs (International Medical Graduates) in child and adolescent psychiatry training. It has increased from 20% to 34.8%. Since 9/11 international medical graduates are more and more being asked to go back to their home country and so this is going to reduce our work force as time goes on. We are not filling the places we have available. 756 residents filled 882 slots so there are a number of slots that are funded and available but not being filled.

RECRUITMENT PROBLEMS-2

- The proportion of IMG's in child and adolescent psychiatry residency programs has substantially increased from about 20 percent in 1990 to 34.8 percent (AMA, 2006).
- A recommendation to enforce return to the home country after training post 9/11 will likely further reduce the future workforce (COGME, 1999) .

9

RECRUITMENT PROBLEMS-4

- About 20 percent of U.S. medical schools do not sponsor child and adolescent psychiatry residency programs
- 30 percent of U.S. medical students have minimal or no clinical exposure to child and adolescent psychiatry

11

Here's one of the problems, that some 20% of the US medical schools don't have any adolescent and child psychiatry residency programs and worse than that is almost 1/3 of medical students get no exposure to child psychiatry during their 4 years of medical training.

Why are medical students not choosing child psychiatry as a career? It is a long training program. The average debt burden that medical students now graduate with is over \$100,000 and the loan repayment programs start immediately upon graduation so the number of years required for training increase that debt burden. Many residents are now married and there is a need to support family. There have been national pressures for medical students to pursue careers in primary care. When a bright medical student tells their faculty, their supervisor of internal medicine they want to go into psychiatry the internist say, "What do you want to do that for? Why don't you want to be a doctor?" So there is stigma still toward our profession although I think it is being reduced.

RECRUITMENT PROBLEMS-5

- Factors that discourage medical students from choosing a career in child and adolescent psychiatry
 - Increasing educational debt and loan repayment
 - Need to support a family
 - Pressures to pursue a primary care career
 - Professional stigma toward a career in psychiatry
 - The long training period
 - Reimbursement and regulatory problems in the managed care era

12

Of course as you all well know, the reimbursement and regulatory problems in managed care area have made it very cumbersome to pursue a career in child and adolescent psychiatry. Training grants have dried up. Basically the NIH helped us out for a long time but since 2001 there has been no money for training and state and federal budgetary constraints have also negatively impacted reimbursement by teaching hospitals especially

SO,

- A consensus concerned with an oversupply of specialists has failed to recognize the well documented critical shortage of child and adolescent psychiatrists
- Child psychiatry becomes marginalized as a profession that cannot provide needed services
- Undersupply results in children receiving inadequate care from health and mental health professionals who lack the necessary training.

14

indirect GME funding. So, a consensus concerned with an over supply of specialists have failed to recognize the well documented shortage of child and adolescent psychiatrists. We have been marginalized as a profession because we aren't there to provide the needed services at the times children are in need. So, basically the problem is this under supply results in children who are receiving inadequate care from health and mental health professionals who lack the necessary training.

In 2002 the Council of American Academy of Children and Adolescent Psychiatry selected the work force crisis and the problems in access to care as the number one priority over the next 10 years for the academy to focus on. A strategic plan was created. A call to action - children need our help and that strategic plan covered three different areas. In summary, we needed to improve our attraction as a specialty.

- We need to develop data, develop an annual report card that would tell us which programs were successful in recruiting residents. What about those programs that did bring attention to medical students to join a residency program.
- We wanted to improve residency fellowship communication through a list serve website.
- We wanted to develop a mentoring program to impact education early in the medical school years.
- We wanted to improve our public relations image and the stigma associated with mental disorders.
- We wanted to increase the portals of entry.
- We thought the training was too long and we wanted to increase flexibility and diversity and how child psychiatrists are training.
- We wanted to increase our triple board programs. We wanted to have pediatricians be more interested in child and adolescent psychiatry and we wanted to promote integrated training.

One of the big problems is that medical students who expressed an interest in child psychiatry when they applied to a psychiatry residency - about 50% of those residents changed their mind during the course of general psychiatry training because they don't get to the children they wanted to take care of until much later. So there is an emphasis on developing integrated training, which exposure and experiences with children occur much earlier in the residency period.

The third arm of the strategic plan was

- to improve our congressional lobbying and our advocacy at the federal and state level.

So this is what the steering committee has on work force issues and what the academy has accomplished to date. We're about half way through the 10 year period that we set as our priority period. There is a user friendly website. ACAP.org has a place for medical students and for residents to learn about our profession, to see and hear what we are doing. One of my presidential initiatives was to develop with ACAP/ Harvard Mason Partnership for Medical Education. We have sent 21 faculty so far to Boston for an intensive 2 week course in being a teacher's teacher if you will. These individuals have each had to have projects which they take back to their medical schools focused on 1st and 2nd year medical students. The Harvard Mason Program is helping them to implement the projects. These 21 people have come to our annual meetings and held seminars to teach what they have learned to attendees at the annual meeting to make better medical educators of our faculty and better role models for our medical students.

We also have the Klingenstein 3rd Generation Foundation to fund medical student programs within medical schools. There were 6 programs funded 2 years ago and the foundation has just agreed to fund 6 more programs. We're hoping Minnesota will apply and this is a program that establishes mentors for 1st and 2nd year medical students. At UC Davis where I work we have one of these programs. We have 1st and 2nd year medical students shadowing clinicians in their practice in child psychiatry and during the summer they spend an intensive 6 week period working on one of our clinic inpatient units between their first and 2nd year. The number of students choosing psychiatry as a profession in our medical school has jumped from about 6% to over 10% in the last 3 years. These medical student interest groups and mentoring programs I think are very useful in eliciting interest in that profession.

We just learned 2-3 weeks ago that the ACGME (the accrediting body for residencies) have approved a new pediatric portal for training which means any board eligible or board certified pediatrician who would like to come into the field of child and adolescent psychiatry through 18 months of child and 18 months of adult training in a 3 year period of time integrated would be board eligible in child and adolescent and adult psychiatry. So ACAP is in the process with the ACGME of now mounting programs around the country which will have openings for pediatricians. When this was announced in the AAP (American Academy of Pediatrics) ACAP was flooded by interested pediatricians who wanted to pursue this track. We'll see what happens.

The other thing we have done is we have an executive leadership counsel now between the American Academy of Pediatrics and the American Academy of Child Psychiatry with executive committees of the two organizations. They are meeting once and sometimes twice a year to think through common issues. This pediatric portal emerged from one of those early meetings. We are also meeting bi-annually (twice a year) with the leadership of the family advocacy groups like NAMI, the Bipolar Foundation, Mental Health Association. We meet and work together collaboratively on legislative issues. In fact, later this week over 100 child and adolescent psychiatrists will be meeting in

Washington to lobby on the hill for several pieces of legislation that is being considered. We will be joined by members of these advocacy groups to visit our representatives. So we are getting very active in lobbying efforts.

The problem with the pediatric portal is that it is expensive. We figure that it is \$75,000 a year to support a resident. These programs are going to have to have two residents in each of the years so it is going to cost for a particular program over a 5 year period something like 1.8 million dollars and we are now working on how to get those positions funded.

PPPP COSTS OVER 5 YEARS \$75,000/Resident/Year				
	PG-4	PG-5	PG-6	TOTAL \$1.8m
1 ST YR	2	0	0	150,000
2 ND YR	2	2	0	300,000
3 RD YR	2	2	2	450,000
4 TH YR	2	2	2	450,000
5 TH YR	2	2	2	450,000

What's next? As I mentioned we are going to the capital next week. The Wellstone Mental Health Parity Bill is first and foremost on our agenda but the Workforce Crisis Relief Act has some very important components if we can get it passed. This seems to be a congress that is more receptive than any that we have had recently. We're hopeful that we can get both of these bills passed this year. The Work Force Crisis Relief Act among other things would incentivize medical students and all child mental health professionals, all mental health professionals to pursue training in child mental health. It will give loan

reimbursements, debt forgiveness and will provide increased funding for training institutions like hospitals or supportive residency training. We need to have things like this. Statewide initiatives, Read and I are going to Virginia next week to do something like this again. We need many more of these.

NEXT STEPS

- **FEDERAL LEGISLATION**
 - Wellstone MH Parity Bill
 - Workforce Crisis Relief Act
- **STATE-WIDE INITIATIVES AND CONFERENCES (LIKE THIS ONE)**
- **eAACAP**
- **PARTNERSHIPS AT THE LOCAL LEVEL**
 - Pediatrics/Family Medicine for Training
 - Family Advocacy Groups for Lobbying

You'll be hearing a lot about something called EACAP which my successor is president of the academy, Dr. Bob Hendren. Bob Hendren is pushing for....

let me back up a little. We will never, through all of the recruitment initiatives that we have and attraction initiatives that we have, we will never have enough child and adolescent psychiatrists to meet the need. So the American Academy of Child and Adolescent Psychiatrists needs to do more. We need to develop partnerships with our pediatric colleagues and with our primary care physicians and perhaps nurse practitioners. But EACAP is going to be a informational portal where we will be able to work with parents. We will be able to work with child psychiatrists and with other professional groups providing them with information that is timely and serves their needs. We are going to be an information conduit for our constituencies. Then we need to develop partnerships at the local level. We have done it at the national level. We have the

executive leadership at the Academy of Pediatrics and Child Psychiatry meeting. We have the executive leadership of the family advocacy groups meeting, but we need to do it at the local level, like here. The Academy has provided a grant program through the assembly and David may talk about that, where groups like this can come together and request funding for a particular initiative. I think that is my time. Thank you. (clap)

Read Sulik: David I'm going to ask you to comment now.

**David Fassler, M.D.,
Assembly Chair
American Academy Of Child And Adolescent Psychiatry**

David Fassler: I think I will start where Tom ended and Tom said it – we're never going to have enough child and adolescent psychiatrists to see all the kids that need to be seen and I think that is very true. While Tom was talking I jotted down three words. 1) Access 2) Triage and 3) Collaboration and those are at least my thoughts from what we have heard so far this morning about areas I suggest we spend some time focusing. Tom also talked about some of the national issues, but also said (I was happy to hear) that solutions are really local and different strategies will work in different areas.

Along those lines I was going to spend just a couple of minutes how we had a very similar meeting like this in Vermont about 7 or 8 years ago and it really came from parents. At the time we had a guy named Howard Dean who was governor who also happened to be a physician. He also had a habit of giving out his home phone number on the radio. I don't know if your governor does that, but (laugh)... so he got calls from parents who said, "I can't get my kid seen by a child/adolescent psychiatrist. What are you, Dr. Governor Dean, going to do about it?" And then we had a meeting exactly like this. It was really sponsored by child psychiatry, pediatrics and the state and corrections were there, social services; the same kind of representation. We tried to come up with a local strategy and there are a couple of lessons in it which is why I'll share some of the experience.

First, the pediatricians said the problem is there is such long waiting lists. What we really need is a quick way to get kids seen. So one of the things we did was the state agreed to fund special evaluations slots. We have two – the University of Vermont and we have Dartmouth which is on the boarder of New Hampshire. We created special slots that were funded through the state at a relatively high rate \$400 an evaluation and it was meant to be 1-2 visits and consultation with the pediatrician about this referral. What we found, was they weren't used very often. Many, if not most of the slots were going unused. Part of the problem was the people in the academic centers, often the psycho-pharm consultation may have been exactly accurate by the research, but in terms of understanding the larger systems issues, which was a large part of what people where really being asked. "What do I do at 4:00 on a Friday afternoon with a suicidal kid in my office as a pediatrician? I don't need to know which SSRI to use." So the next step we started putting mental health clinicians, masters level clinicians in the pediatrician's

offices who were connected to the mental health centers and funded through the mental health centers who could help with some of the triage work.

The third step was we got funding through Administrative Medicaid which none of us knew existed. Is anyone here from the health department? There is a stream of Medicaid which is separate from mental health. It comes through the health department that we could use to put child and adolescent psychiatrists in pediatric practices. Now we have 6, soon to be 8 child and adolescent child psychiatrists who are spending about a day a month working side by side working with pediatricians enhancing collaboration. The goal is not to see as many kids as we can see, but really to work side by side. The child psychiatrist gets paid directly at our usual fees regardless of how many kids are seen through this Administrative Medicaid and the pediatrician gets paid by billing the usual clinical services. So that has been actually a quite successful program for us.

The other thing we did, I heard someone mention telemedicine earlier. We got funding, (which amazed me) from the Department of Transportation for telemedicine. I'm saying, why would the Department of Transportation fund telemedicine? Vermont, like Minnesota, we have a lot of rural areas and telemedicine keeps people off the roads. They don't have to drive to Burlington. Same way they wouldn't have to drive to the places where the child psychiatrists are so we were able (through our delegation in Washington) to get grants through the Department of Transportation to really fund the infrastructure for quite sophisticated telemedicine.

So, those are some of the ways. Not everything worked. The first thing we tried didn't work so we needed to be flexible and it took time. This took 7 or 8 years to get all these pieces in place.

The other thing I wanted to mention was the importance of triage. We were talking last night and also Tom said we're never going to have enough child psychiatrists. I would also say that not all kids with mental health problem need to be seen by a child psychiatrist. We collectively need to do a better job. I think Read mentioned standards of care or guidelines. We could help figure out who are the kids that need to be seen. How can we better use our time as child and adolescent psychiatrists? We were talking last night about a program Read has with a masters level nurse who is kind of an interface who can do primary evaluation. Of the referrals from pediatrics to her, Read you said about 9% kids are ultimately referred to child and adolescent psychiatrists—same experience in Massachusetts. Massachusetts has done some interesting innovative things. Someone here from Blue Cross? Anyone here from managed care? So, Massachusetts managed care/managed Medicaid is funding over a million dollars a year for phone service where a child and adolescent psychiatrist are available by phone to pediatricians. Then back up face-to-face evaluation is done at specific times, fully funded by managed care plan. It was actually built into their contract as a requirement to enhance access to child and adolescent psychiatry. They have similar statistics. The majority of phone calls don't turn into referrals. It can be handled with triage on the phone.

One of the other sort of low hanging fruits I think about increasing the number of child and adolescent psychiatrists. I think if we increased 10%-15% we will feel like we are heading in a positive direction. But one of the thoughts I have is we need to have the amount of time that child and adolescent psychiatrists see kids vs. adults. So Read did a survey in the assembly. Most child and adolescent psychiatrists also see adult patients and many child and adolescent psychiatrists see primarily adult patient because it's easier and it pays better. You don't have all those pesky external systems. You don't have parents, you don't have schools, you don't have pediatricians. You can just see the patient and get paid. So we are, across the country developing different mechanisms and you have one of the best here. Your bill to provide reimbursement for consultations - one of the issues in child psychiatry. You call the pediatrician, you don't get paid. Now, in Minnesota you can actually bill at least Medicaid from what I understand and at least hopefully can expand that to other payers. Other states are looking at your legislation closely to see how it works. One of the things they did in Massachusetts is they convinced Blue Cross to raise the rates for child psychiatric services as a way to increase access. If we can increase the amount of time child psychiatry see child patients by 10%-15% we will have a similar impact on access. It is easier than recruiting all those new people into the field.

So, the last thing I want to talk about is collaboration and which you've heard a fair amount already. We've talked about collaboration with pediatrics. Clearly that is a direction for the future. Nationally, locally, certainly that is what we have been trying to do in Vermont. Collaboration with advocacy groups including the people who are here today. We wouldn't have gotten anywhere with our initiatives without working with NAMI, MHA, Federation of Families. One group that hasn't been mentioned and I wanted to at least bring up is our colleagues in general psychiatry. I'm starting to hear more and more about concerns, partly because there aren't enough child psychiatrists, that adult psychiatrists (I'm told I'm suppose to call general psychiatrists). Ginger says child psychiatrists are fully trained psychiatrists (laugh) ... but our colleagues in general psychiatry are doing more and more child and adolescent psychiatry. When I started practicing, adult psychiatrists were reluctant to see people under 18, 17, 16. Now where I am most adult psychiatrists will go down to 15, 14, 13. There are some adult psychiatrists who are seeing kids because they are the only ones around, particularly in rural parts of the state. I spoke last week to a woman in an academic setting who said the adult psychiatrists are now being told they have to back up the child services and child emergency services. They haven't had any training, they say. So I think we need to look at the national level and you may want to look at the local level about how we can work with our colleagues in general psychiatry and help give them more training, knowledge, back-up. We think easily about the pediatricians, but we also have to think about our colleagues in general psychiatry.

The last thing I want to mention was the Semfli Grant program which Tom referred to. This is sort of a specific suggestion that we do have grants that are called collaboration grants and they need to be co-sponsored by a psychiatry group, either an advocacy group or a chapter of the American Academy of Pediatrics so they are easy to obtain. It is a two page application. It is \$4,000 and it is really meant to help support gatherings/meetings

and some administrative assistance around collaboration and advocacy initiatives. So again, thank you Read. Thank all of you for inviting both of us back and for having this kind of meeting. I think this is exactly what we need to be doing both on the local and national level and I'd encourage us to be creative throughout the day and think out of the box. Be flexible and be persistent. (clap)

Tom Anders: I should have mentioned earlier when I was talking about the lobbying effort that is going to take place next Thursday at Capital Hill your own representative, Jim Ramstad is going to be honored and given an award by ACAP. So, I hope Read will be able to be there to present it to him. If he's not I will, but he is a terrific guy.

Tim Gibbs, MD
Secretary / Treasure
Minnesota Society of Child and Adolescent Psychiatry

Tim Gibbs: I just wanted to comment a little bit about the local view in Minneapolis and really this is going to be more the sort of corporate view from Allina. First of all the situation in Minnesota is that typically our group (MSCAP) has had about 100 child psychiatrists on our mailing list - that covers the state of Minnesota, a little bit of Wisconsin and a little bit into North and South Dakota. Actually over the last year there has been more recruiting efforts and our mailing list is up to 130. We really have improved in that area. About half of those child psychiatrists practice in the metro area. The shortage in the metro area is not quite as acute as in the rest of Minnesota. Minnesota's figures are about 20%-30% behind the national average and of course you saw the national figures are way behind what is needed.

In terms of coordination of care there are very few systems where we have child psychiatrists and pediatricians co-located in the Twin Cities area—none in the Allina system right now. Allina has a number of outpatient clinics called AMC (Allina Medical Clinics). They do have some psychology staffing, but very little psychiatric staffing. That is currently an area of effort. Allina in the local area is trying to get more coordination of care going in that area. Many of the large providers in the Twin Cities area are going to electronic medical records. Unfortunately they have all purchased different systems and the different systems don't talk to each other. So, although the electronic medical record is one conduit for increasing coordination of care, right now there are a lot of problems. I believe the state has offered some grant money to help with projects that allow these systems to talk to one another so we can get a portable electronic medical record to get better information back to the primary care colleagues who refer their patient for psychiatric care.

We are adding more advanced practice nurses who are doing prescribing under the supervision of a child psychiatrist. Dr. Collins mentioned working with one. I work with one. The University of Minnesota is actually changing that program so the nurses who will have prescribing privileges have to get doctorates in nursing in the next few years and additional training. But that is one way we are going to expand the availability of

providers. In Minnesota we haven't had much in the way of pressure getting prescribing privileged for psychologists.

In terms of recruitment: The corporate recruitment of new child psychiatrists is ok. I think we are fairly competitive. I think we get people to come and look at the programs. We often get people to sign on for a year or two. The retention is terrible. There is very little incentive for someone to stay and there is lots of pressure for people to move on and get hired somewhere else. There is lots of hiring incentives that go on, but I think we really need to work on more retention practices. In terms of recruiting at the University of Minnesota I am doing some mentoring of medical students. Dr. Kerekes and Dr. Cline are doing some. Dr. Cline has an actual program set up that is sort of run by the medical students and maybe he can talk in more detail about that later. Also, Dr. Wells at Mayo Clinic does quite a bit of mentoring of medical students and recruiting for child psychiatry.

Another issue in the metro area I want to talk about (there is a lot of talk and I'm sure we'll talk more this morning and this afternoon) about problems with payers and reimbursement. In working for a large system like Allina one of the problems is that the system as a whole will make deals with the payers about how much gets paid in what areas and there are aggregate deals that are made so we find we are having a hard time recruiting more child psychiatrists. They say well we don't get enough reimbursement to hire these people at this kind of wage and we say well you need to go back and make better deals with the payers. They say, well we did that and the payer said ok we'll give you a little more money for mental health but we're going to cut back on what we were paying for cardiology and it makes it very difficult for us to make our shortage known to people who are buying our product because they are buying at an aggregate and they don't see the value in changing that system.

One other thing I wanted to mention in the metro area is that a number of psychiatrists are opting out the insurance plans because of all the problems of payer relations. Will, I don't know if this number is exactly right, 3 out of the last 4 presidents of MPS are now doing cash only practices. Yeah, I think it is 3 out of 4. I know it is the last 2 for sure. So the problems are becoming so big people are just saying I just can't deal with insurance anymore. I'm just going to go into cash only practice. Now that makes access and a lot of things better for people who can pay for their care, but it really cuts out people who are uninsured or under insured. Thank you. (clap).

Steve Sutherland, MD
President-Elect
Minnesota Society of Child and Adolescent Psychiatry

Steve Sutherland: Thank you Tom, David and Read too. I am Steve Sutherland. I am in Duluth and based out of a community mental health center where we serve a 5 county area of the Arrowhead as far south as Moose Lake and as far north and east as Grand Marias, plus across the river into Wisconsin where our organization is essentially merged

or swallowed up somehow with the Douglas County, Superior Wisconsin Community Mental Health Center as well. We have in that system three child psychiatrists for a total of 2.3 FTE's of child psychiatry serving this 5 county area. In addition we have 2 advanced practice nurses that we have a collaborative practice agreement with that have child training and certifications specifically for child psychiatric advance practice nursing with our system as well. That is our group. I guess you could narrow the 2.3 FTE's down a little bit more since we each do some adult work too.

We are split off from the inpatient system there. We, like probably Rochester and St Cloud to some degree, have a combination of a couple of psychiatry systems, Duluth Clinic, Miller-Dwan System and the St. Luke System that doesn't do child psychiatry interestingly at all. We in the Community Mental Health Center do some crisis intervention services, the kind of things to attempt to keep people out of hospitals. That's how it is set up in Duluth. We also happen to be a destination for child psychiatry beds. As many of you well know from the Twin Cities, Miller-Dwan Hospital is one of the places when the beds are full in the Twin Cities that people go. For those of you familiar with some of the Minnesota statutes and how some of the systems that work or aren't working are ways we measure this. Duluth is well over the 30-mile range specified in the statutes for how close somebody needs to be hospitalized for acute care. Everybody is trying to do their best it seems and yet this is one of the areas that is glaringly out of compliance you might say with how our own leaders have tried to develop a system where the providers, payers, health care systems and government everybody tries to work together to get the system to work well. So maybe in Duluth we're an example of something that isn't working well in terms of that compliance.

We are probably under-using telemedicine right now. We're set up to do more. We are internal telemedicine when we try to do outreach services in Grand Marias and in that neck of the woods. We're not using it (telemedicine) as much as we could to other rural sites, for instance rural family practice clinics. There have been two temporarily successful or failed experiments whichever you prefer to call them in terms of integrated care in our region where there have been co-located psychiatrists including child psychiatry on family practice sites. But because of some of the technical difficulties of interacting with different systems, telemedicine among other problems David was outlining in terms of some of the payers and the way consultation has been reimbursed for those haven't been financially feasible to keep going. There aren't currently any child psychiatry co-located or integrated care models functioning in Duluth.

One good piece of news, Tom, on recruitment, is our family doctor when giving a physical to our 2 year old yesterday told us she wanted to train in child psychiatry, Now we need to get the American Academy of Family Practice portal going too. So we've got maybe one more that is only a few years away from training, you never know. (laugh). One other comment on that as far as recruitment. Interestingly looking at the training issue, we were starting to take medical students a few years back up in Duluth and exposing them to child psychiatry. Eventually there came a mandate from the Dean's Office from the University of Minnesota saying they were not going to allow externships or rotations at locations that did not have psychiatry residency programs. So we had a

willing community in Duluth of child psychiatry mentors that were willing to teach, but from a Dean's office perspective it became an unqualified location. So did any other location that didn't have child psychiatry residency programs that were part of the mix too. So, those are few things about Duluth, especially as they pertain to some of the discussion today. So, thanks.

Read Sulik: Actually, we've got one more person to turn the mic over to. Attorney General Lori Swanson is here along with her guest, our former Attorney General, Mike Hatch. I'm going to ask Lori to also share a few words. This is absolutely perfect timing as we launch then into some opportunity for the next hour and a half for some feedback and thoughts from all of you. So again, thank you for being here. (clap)

Lori Swanson, JD
Minnesota Attorney General

Attorney General Swanson: Good morning and thank you for having me. I appreciate the opportunity to be included today. You know, the Attorney General's office is involved in a lot of different issues. We get something like 700 phone calls a day, 250 letters a day from people all over Minnesota, all over, all walks of life have big problems and small problems, but they do have problems and one of the areas we hear a lot about from a lot of different perspectives is the area of mental health care.

We see it in some of the fraud cases we have, people who are a subject of anything from mortgage foreclosures to various scams—activities partly because they have mental illness problems so they end up being victimized and re-victimized over and over again. We see it in the law enforcement work. We in the Attorney General's office act as a law firm if you will, and represent county attorneys, especially the rural county attorneys on various cases and we see it there. Mental health care is an area I want to be very engaged in. I think it is a hugely important issue for our state. Former Attorney General Hatch and I had lunch not too long ago with a Ramsey County District Court Judge. We asked him how many kids were in juvenile court (he believed) because of untreated/undiagnosed mental illness and chemical dependency. He said 85% easy or more are there because they are not getting the treatment they need. They're not getting the kind of help they need.

We see it with capacity issues, the closure of various hospitals that used to have mental health beds in St. Paul, Mankato or other parts of the state. We have heard from judges who say they try to get kids the treatment they need but are literally shipping them to Duluth, Fargo or far away from their families. That is a tragedy because one of the things these kids need is a support system. If you're trying to get them the treatment they need only to ship them far away because we don't have the capacity then that is a huge problem as well. I think we have been very penny wise and pound foolish as a state when we look at the investments in mental health care, when we look at some of the programs we have had. When we had an era of budget cutting in this state that literally zeroed out

some of the programs that existed to intervene early in troubled young peoples lives, things like boot camp programs where you have kids who could go one way or the other way in life and we have zeroed out some of those programs which are cheap programs. We're talking 2 million dollar programs, it is really a spit in the ocean of a 31 billion dollar state budget, but yet leaders couldn't find the money for those kinds of programs and I think that is a travesty. Then of course we see the managed care abuses and issues as well in terms of mental health being different. If you go in with cancer or a broken arm people are going to get the kind of payments they need.

With mental health care it is a kind of disease that is harder to see and harder to recognize and that has lead to some abuses as well with regard to managed care and claim payments and so on and so forth. So it is an issue I want to be very engaged in. We have people in the office who are looking at it. What do you think are the problem areas? What can an Attorney General do? Basically we can enforce the laws, so we have somewhat limited authority, but what from your perspective can the Attorney General do. How can we address this issue? I think it is a critical issue that we are engaged in. We just ask that you write to me, call me, meet with me, tell me what is on your mind and how we can be helpful to finding a solution here when it comes to some of the abuses and the problems we see.

I'd be happy to take any questions if there are any as well or if anyone has any thoughts.

I've got to acknowledge Mike Hatch, the former Attorney General. He has done so much for kids and mental health care, so. .

(Comment from the audience regarding cyber-bullying).

Attorney General Swanson: You know it used to be when a lot of us grew up you'd have bullies, but the bullies would be in the cafeteria, the school playground and it would kind of limit the effect of the bullying because it would happen one-on-one. But with the invention of the Internet one of the things we are seeing is huge problems with regard to cyber-bullying. Kids being bullied, intimidated and harassed over the internet that not only defames and harasses them but really spreads throughout a whole school and whole community. I'm talking gay kids getting outed on the internet. In one case the parents of an Edina kid came to the office saying that a boy who is 14 took out a fake Internet account in her name, put up her picture, put up her cell phone number, said things about her being loose, sleeping with all the boys in the school, call for a good time and it literally just... well, the girls in mental health counseling because of it. So I proposed at the state level we have a law to address that kind of cyber-bullying and that school districts also adopt a cyber-bullying policy to try to shine attention on the problem. It is a real issue and it needs to be addressed and I'm pleased to say I think the law will pass. I think it will be on the statute books and hopefully we can call more attention to the issue and make sure it is not occurring as it is now.

Mike Hatch, JD
Former Minnesota Attorney General

Mike Hatch, Former Attorney General: When Attorney General Swanson was sworn in she had offered me a job there. Which is kind of her. One of the projects she put me to work on was that issue, so we have.

As a matter of fact I have interviewed at least a couple of people here about the issue of the hospital bed closings. The fact of the matter is, every hospital is great on heart care. They say “We’re the best hospital on heart care”. They all are. It’s like Lake Wobegone, they’re all above average (laugh). The problem is, you make more money on a heart patient. You make more money on surgery and those patients are pretty good. They’re lying there. They’re not causing any trouble. You can stick the antibiotics in them and ship them out when you’re done with them. The problem with mental health is, you know, they cause trouble. You have to have locked wards, they beat up the nurses, all sorts of things occur and so when you get down to the negotiation and health plans—guess what—nobody is negotiating with regard to mental health beds. We’re all going to be heart specialists and so you see hospital bed closings. You see them being shipped to Des Moines, Sioux Falls, Winnipeg. In fact Children’s Hospital there is some testimony who does not have a psychiatric unit so they have to ship these kids somewhere else. Over the year they indicate that 50% of the kids can’t go anywhere so they are held at Children’s even though they don’t have a psychiatric ward—50%. We’ve talked to psychiatrists who have called for a bed and you know if you rush over you might be able to find a bed, but if you’re not quick enough it’s not there. You know about the requirements, the anti-dumping laws and things like that, but you haul them into the hospital. They tell them to take your kid and bring him to Mayo, so they’re taking a psychotic kid down Hwy 52 or whatever it is, that’s really dangerous. It’s also by the way, probably a violation of the law. What do we do about this? That is one of the first orders of business that AG Swanson initiated and we can’t go public about it. I’m talking about it a little more than I should but she is on my back every week about where are you on that. I’m working on it. There are many theories with regard to this bed shortage and is there anything the Attorney General can do? Again, she can only enforce the statutes. She is not the legislature, she’s not an administrative agency, but there are a lot of theories going on now.

Comment from Audience: We have some school districts who do a marvelous job and some school districts ... you know, repeated correspondence where I say to the principal or special education coordinator this child has bipolar disorder. Please do an IEP evaluation and they respond, “I don’t understand. He’s just bad.” You know, parents are really at a loss because they have 4 other children going through the school and they don’t want to make an enemy of the administration.

Attorney General Swanson: They want the attention. They want the treatment but they don’t want to make waves so how do you get the attention over that. We’ve heard that from the school system as well.

David Cline: I would just like to take a moment to thank Mike Hatch for all of the things he did while he was Attorney General. (clap).

Attorney General Swanson: Well please do call, write. Call me. Call Mike. Let us know what is on your mind. You can do it on the record or off the record, but we really do want to hear what is on your mind. We do want to be very engaged in that issue and try to help bring about some of these reforms. We need your help. Thank you very much. (clap).

OPEN COMMENTS AND DISCUSSION FROM PARTICIPANTS

Read Sulik: I want to thank Attorney General Swanson and former Attorney General Mike Hatch for taking the time to come here this morning and share their thoughts and encouragement. It's a bit funny that even today collaborating together is a bit of a grassroots effort but it is. At the root of this meeting is the need to be working together which means being able to listen to one another's thoughts and needs. Attorney General Swanson I hope that we can continue to contact you and share some ideas that come out of this meeting. Throughout this morning we have heard repeatedly from Commissioner Ludeman, Dr. Anders and Attorney General Swanson that access to care is a critical issue in children's mental health. We will continue to need to look at ways of collaborating together and building integrative models of care in order to address this. As I open comments up from the tables please use the microphones. Dr. Sutherland is going to be writing key points raised during the discussion on the poster sheets over here to the right. Remember that we will rank these and vote on priorities over lunch.

Sue Jenkins: I have a number of proposals and I'll just run through these. In terms of coding reform; I was listening to your talk on recruitment Dr. Anders and thinking to myself, really I need to hear you talk about retention because as Read said, a lot of us are really overwhelmed. If you go to work every day and the work is very, very difficult and you get hammered by a number of oversight people who come in and tell you that you've violated this or that statute and they're going to fine you. Then you don't get paid enough to keep the lights on and the office doors open, you really start to wonder, why am I doing this?

So in terms of reimbursement I would like to propose

- We get an automatic ok for the use of 90802 - Interactive Evaluation Code for anybody under age 10 and that I not have to prove that I used a set of blocks when I interviewed the child.
- That we have a code that allows interview and treatment planning with the parents without the child present. I understand the new legislation might help with that.
- That there be a code that allows reimbursement for a telephone contact with parent in lieu of an office visit when the parents have to drive more than an hour one way to see us. I know to how to evaluate children, I'm very careful, but

sometimes you just need a follow up on the side effects and I need reimbursement for my time.

- I would like to have a code for a neuropsychiatric assessment because many of my children are both psychotic and developmentally delayed and they may have some other neurologic disorder. It's a very complex assessment and I'd like to be recognized for that.
- I'd like some acknowledgement that a routine child psychiatry assessment takes 90 minutes and not 60.

In terms of reducing cost, I'd like to reach a standard about what might be reasonably shared between agencies via email. Right now I get emails from social workers and everyone is very nervous about privacy and they will say 'the kid you saw last week and I were talking and' ... and I have to go, which kid would that be? Can you give me a hint? It would be very convenient to have some acknowledgement and some standard that we're at least allowed to use their initials and hometown or something.

Last year I think we went a long way as a group of psychiatrists saying if I'm hospitalizing a kid and you need information I'll get it to you within 24 hours. I would just like to reaffirm that when we're as harassed as we are that we expedite the records.

(comment from audience).

The standardized prior authorization form has saved us hours and hours. We have a statewide prior authorization form that is used for every insurance plan. I would like to see a standardized developmental history form that we could exchange and then I would know no matter where this kid was seen before I know where to look on your form for the information and I don't have to keep doing the history over and over again. It is not unusual for me to see a kid who has been evaluated six times, the parents did a 20 page intake form every time. I had one family come in last week who said, "We're not doing another one of these. Get it from last time." Well, Austin isn't going to send it you know.

I would like to see us get reimbursed for the rule 79 referrals and TEFRA reports. I calculated last year and sent one letter to DHS that I haven't heard back yet from St. Paul. I probably spent two full work weeks filling out rule 79's for counties. I have to get paid for that time.

I'm skeptical developing an office of care coordinators. As far as I can see it is another group of people who are going to be inefficient and ineffective at the stuff I have to do anyway. Every child psychiatry patient takes at least 30 minutes of unpaid time after the family leaves my office.

Jon Jenson, poor man, I'd love to hear from Jon whether those MA quality assurance things that I keep getting are actually doing any good, because they're upsetting to get and they're time consuming to follow up on. (Comment from audience). Well bless his heart, but I'd still like to know whether there is any use coming out of them.

I'd like to have my nurse be able to get reimbursed for patient education services she provides and I'd like to know she could be reimbursed for example, if she sat down and did the developmental history so I could use my time to do other things. Right now I am told invariably by insurance plans we can't do that.

And finally, I'd be concerned again about insurance rules. It seems like every time I've developed efficiency in my practice over the last 10 years, the next year the insurance rules change. So for example, the rule that says psychologists can't be reimbursed until they've been licensed and in practice for 5 years. The elimination of RNs being able to function, again we're careful about what we do, but if I start a kid on Ritalin and I want to follow up with the family in 2-3 weeks it doesn't take an advanced practice RN to tell me Dr. Jenkins could you step in here. I think it's fine they just need a refill prescription. I'd like to see some acknowledgement that we know how to do our jobs and we can reasonably supervise people and we deserve to get reimbursed for it.

Read Sulik: A really nice snapshot/overview of the life of an extraordinarily busy clinic where you practice in child and adolescent psychiatry. Nice highlights. Next, right here, go ahead. If you guys can unclip those microphones on your tables I think they will be easier to pass for now.

Sue Abderholden, NAMI: A lot of what you're going to talk about today is going to require legislation and I really want to lay it out. I kind of alluded to it before, but we have always enjoyed bipartisan support on mental health issues, because mental illness doesn't care what party you are from, it can hit you. But this year in particular, we have seen an increasing movement by the far right wing of the Republican Party to say in fact that mental illnesses really don't occur in children. It is a group called EdWatch. For those of you women who are old enough to remember the Eagle Forum...what they are really saying is that this is a way for the left to control their children. The problem is this is affecting all the Republicans in the House. They are voting as a block against things like mental health screening, which could provide early intervention and early identification, and always we're talking about parental opt in. We're not talking about sneaking behind your back and screen your kids. We're talking about parental opt in, not just opt out. The amendment that was voted on the floor of the House this week managed to get 7 Republicans out of 49 to not vote as a block. In the Finance Committee we had every Republican except 1 voting to eliminate funding for evidence based practice for children. The amendments that are going to go on the floor of the House this week are again trying to eliminate funding for evidence based practices for kids, but also the bed tracking system because somehow they've decided we're tracking people. Eliminate the outcome measurements because somehow they think we're going to share personal data on the Internet.

This really concerns me because if this becomes a Republican vs. Democrat issue I've been around lobbying long enough to know the tides turn all the time. We've had good leadership in terms of the President's New Freedom Commission, Congressman Ramstad, the Governor, the House Republicans is really an issue and we have tried to work with the Psychiatric Society, children's mental health providers to say we have got

to step up to the plate and let people know these are real illness and explain what is going on. But, I don't want you to just fling this off because the things you are going to want to change in the upcoming years are going to be impossible if we can't get it to be a bipartisan effort.

Read Sulik: As we are thinking through action steps we have to be thinking about how to corral the support of our state congressmen and representatives.

Sue Abderholden: Actually, your own representative is vocal against children's mental health.

Read: Okay, back here. Go ahead. Use the microphone

Amy Berg: I'm a pediatrician and I just want to tell a little story. I trained and worked in Miami before I moved here. What we knew was if it rained, people didn't come out. If it was sunny people didn't come out. They didn't bring children into our clinics. Through and through I'm a primary care person, so we developed a van that went to the schools to provide primary care to the children and it slowly became the mental health van at the schools. The families showed up for it. The kids loved it. The teachers loved it. All the collaboration could be done in one setting. If it was somebody who needed one of our psychiatric colleagues then we were happy to call them in, but typically at the schools we could do a lot of prevention. But I guess my plea is to bring it to where the children are. Bring it to the schools so we can do prevention. It worked really well with the teenagers. It worked great with the young children too. So I guess what I'm asking for as a primary care pediatrician if we could take mental health to the schools. It really works great.

Read Sulik: So Steve, as an access to care, the idea of access to mental health care within the school system. You know, we do have one model of a mobile wellness center. A mental health 37' air stream recreational vehicle converted to a mental health clinic in St. Cloud that we have going to all the school systems in St. Cloud. We are in our 4th year of doing this, trying to figure out how to make it work. We are bringing diagnostic assessments, educational resources, and interdisciplinary team evaluations to the school system. So we have one model of that in place. Ok, next comment.

Joann Hoffman Jecha: I'm a Pediatrician with Southlake Pediatrics, also a general pediatrician. Yesterday I think 40-50% of my day was spent with mental health. I think we do a lot of mental health. We're not fully trained perhaps but we can do a lot of basic mental health. What I see from my perspective is we need help with evaluation. We're talking a lot about psychiatrists, but if I could get more psychology help in that urgent level. I can get emergent access. We have relationships with a number of clinics if I have someone that is really in trouble I can get some help. Now, long term, that's a different issue. But that urgent care we need standards and systems of care to help us look through which drugs are ok for us to use now. What's the latest? You know, I can do a lot of different mental health things but I need more help when it gets complicated. I think if we could continue to work on primary care physicians being able to provide better services

with better evaluation help we could unburden the psychiatrist to do what we really need them to do.

Nimi Singh: I'm a pediatrician with Adolescent Medicine Health at the University. I just want to let the schools know that I recently (at yet another committee at the university - the Ambulatory Care Education Steering Committee which is based in the medical school) they're really looking to see what are the critical tools all medical students need to learn. Particularly those who end up in primary care so not only pediatricians but also the folks that end up going into family medicine and internal medicine. I would make a plea to this group that I would be happy to develop standards of care and tools to be taught at the medical school level. I'm also very much involved in pediatric education at the university where I would like to see all medical students leaving medical school with some clear understanding of how to evaluate and screen. Really be the first line screeners and treaters at a minimum of anxiety and depression and also be familiar with basics about psychopharmacology and at least know how to keep up with the literature. This is clearly the wave of the future when you look at the American Academy of Family Medicines report in 1997. They realized back then that they have to step up to the plate, but certainly it is showing up in pediatric clinics as well. It seems to me that family medicine and pediatrics are much more willing to pick up the gauntlet if you will, than the world of internal medicine. I think starting at the medical school level is critical and I realized I have this golden opportunity to be a really loud voice and this is really my area of academic and scholarly interests.

I'm sorry, I'm looking at you, but I'm thinking we need to collaborate and develop some tools, not only for Minnesota but boy wouldn't it be wonderful if we could really come up with something that was doable and something we could actually evaluate and disseminate widely.

Read Sulik: One word to what you said there, hoping that every medical student can leave medical school with mastery and ability to screen and assess for mental health problems in children and I'd also add the word promotion; to be able to promote mental health and wellness in kids. It is our responsibility to be teaching our trainees that as well.

Nimi: And Read if you'll allow me to counter again. Actually, I lied, that really is my area of focus (laugh). Those are such simple skills. I'm talking about very basic cognitive behavioral skills and stress management skills are very much along the lines of what is traditionally taught in developmental and behavioral fellowships, but some of that can really be honed into skills that can be implemented in a 20-minute office visit. So, you know I think these are skills all physicians and nurse practitioners should have as part of their armamentarium in addition to being able to take a good blood pressure and all the other things we think of as being standards of care. This whole idea of separating out mental health and physical health, I mean – yeah.

Read Sulik: Nimi, you probably are aware of the Academy of Pediatrics Mental Health Initiative and the Mental Health Coalition led by Jane Foy. They are creating a tool kit

for pediatricians to do just what you are suggesting only you're bringing it down to medical students which I think is really important. John, you've got your hand up.

John Scanlan: I hope the training programs will start to expose residents early on to this kind of practice vs. an office based 1 to 1 with a patient or family because there is a shortage of psychiatrists and child psychiatrists. If we continue to train them to do individual practices we aren't going to have a chance of meeting the need because they won't have the skills when they leave their residency.

Sue Jenkins: What happens is as a child psychiatrist you're often the only player in a department of psychiatry and it leads to an automatic inefficiency. So you know, in designing my practice it's not hard for me to keep 6 therapists busy. I'm doing what they need me to do which is evaluation, medication, and complex medical neuro management. If you're going to put child psychiatrists into a department of pediatrics then you've got to give them the freedom to hire the therapists and the back up personnel they need.

Paul Renner: I'm a Child Psychiatrist in rural areas. I want to bring up the issues that Dr. Borchardt mentioned about access in terms of kids who don't fit into a program or a program isn't available. Dr. Go's point about, well that's somewhat true at times we just can't accommodate that and Dr. Jenkins dealing with schools 'there is no problem here – they're just bad' and Mr. Hatch's point about cardiology having a big deal but there is a lot of technology invested in other medicine and to me one of the common (there are people who just don't want to deal with it) but instead of trying to find the bad guy – which I can always identify, it's that other person who won't meet my needs. There may be people who may actually be well intentioned in the schools...we would like to do this, we would like to have a program that does this. The technology that we lack is human technology. The cost of a lot of child care, yes we have a lot of development in psychopharmacology but what we are lacking I think a lot of in rural areas and schools is the human technology, technology in the sense of a tool and skills that people can apply. Because I too give recommendations to schools about difficult kids and they are some of them very difficult, very atypical. It may well be that they don't understand how to do that. How do we invest in that? The cost of inpatient hospitalization is because you need a lot of labor force and you need qualified, educated labor force. That doesn't change when the child leaves the hospital, at the school setting it's the same way and the home setting or an intermediate setting. So that we not just look at that they've got to do that, which is a role we need to play but try to find out what maybe the barriers for these other systems not doing that and not having the program and how can we partner with those people to say this a problem we can't solve individually and we can't find which ones to blame and is it parenting at home or is it this person or that and try to get all the stakeholders together and say what is the end point and I think I'd like emphasize it is the human technology, the skills, having therapists who are trained and we devote money to that in the specifics in evolving new types of training and therapy so we look at trying to involve these people who we see as maybe reconstitute opposite as to what is their barrier. If it is they don't believe in it then that's a separate issue. If it's we're overwhelmed too by this odd child we can't implement what you're doing let's see how we can partner with them.

Read Sulik: So Paul, I'm going to challenge you to identify the take home message from that comment for us, something to think about that could lead to an action step for us is what?

Paul Renner: I think, well, investment in training skills in human beings who provide care to children from the families, to the school centers, to outpatient offices.

Read Sulik: So under the category of standard of care, we have a standard also of training and improving the skill set of not just the children's mental health professional but also the professionals working with children.

Paul Renner: And the parallel will be I can prescribe a medication. I can accept prior authorization issues, which are a pain in the butt too, but that is going to be available. I can prescribe behavioral, psychological counseling type interventions and the truth is that is not on the shelf in many places and that is what maybe needs to be developed.

Read: Great, ok. Go ahead.

Gulshan Singh: I work at the Waverly Treatment Center and by the time we get those cases they have been to maybe 10-15 hospitals and a number of places. Two things I came across again and again is a number of these kids have been bullied and bullied and bullied so much in school that I am very concerned. Especially with what happened in Virginia. You talk to schools, you call the schools you spend so much time on it, they so "Oh, we didn't know about it, we didn't know about it" The other thing I need to know is we need to educate our principals and teachers. We talk about taking care of our kids, but unless they have the education, which I don't think they have in spite of my talking. I think we need to have a program where all elementary schools, all high school teachers and principals are educated about mental illness and what people look for. I have a son in Breck School and the principal there used to go at lunchtime to see how the kids were sitting, are they sitting alone? Then he would go down the hallways and look for wall huggers. Kids who had some problems or they were lonely and they would walk along the wall and he'd pick up those kids and bring them in and find out what is going on. I think if we can pick up those kinds of things we can prevent it. And what to do about the bullying that has been going on a lot comes more to the surface now especially when we have so many kids recently.

Read Sulik: Beautiful. Sue and then to Cindy who I'm going to call on to make a comment about that. Go ahead.

Sue Abderholden: We did pass a law actually a couple of years ago that all teachers as part of their continuing education requirements have to actually take a class on mental illness, early warning signs and we worked with the department on that curriculum. There are lots of groups here who do the training for teachers and we actually had one of the special ed directors from Bemidji who said it was one of the best things that happened because we are seeing an increasing number of teachers understanding this issue that

never understood it before. Now, there is more that needs to be done on the bullying etc, but just so folks know we were one of the first states in the country to actually pass that law.

Cindy Shevlin-Woodcock: Sue Aderholden of NAMI-MN has informed me that is sponsoring the “early Warning Signs” legislation in 15 other states. One of the things that happened when we started looking at the continuing ed re-licensure requirement is that teachers came forward and said, “ok we can find early signs – what do we do about it?”. Our schools are so terribly understaffed by student support staff .The MN Department of Education is aware that we need to have school trained support staff available in our schools. Minnesota falls to the very bottom of how many counselors we have, how many school social workers we have, how many school psychologists we have available to the general education population. We are pretty well staffed for special ed but we’re not so well staffed for our general ed students Then we run into the issue of being able to find the people. If we create jobs, how do we find people to fill them?

Read Sulik has been absolutely wonderful to work with in developing training to help our educators learn about ht early warning signs of children’s mental illness. MDE has developed 4 modules and trained local student support staff to deliver the training. The 1st module one is an awareness building video. We talk about anxiety, depression and attention and behavior disorders. Read does a beautiful job of talking about what is going on in the brain, why is the kid reacting like that and what are some simple things people can do and we stressed over and over again, empathy and relationship.

The 2nd module was developed to introduce simple interventions that can be used in the classroom and at home. This module was developed in response to people saying, “Okay, what do I do about it in my classroom?” What do I do in my classroom, in my school, in my community, in my work with kids, in dealing with kids with anxiety and depression?

The 3rd module is going through the approval process now. It has to do with the prevention model and how we’re looking at the framework of dealing with all kids and those targeted few kids that all the prevention stuff doesn’t work for. That 3rd tier of kids that needs the wrap-around services. Then part of that module is going to be on when you have a child with a disability and a diagnosed mental health disorder, how do you incorporate their special education program and their mental health needs all together. So we’re really working on the training piece.

The 4th module is going to be on resource mapping and is targeted at administrators. I certainly get much deeper questions from teachers now than I used to. I used to get questions like, “How do I get this kid out of here?” Now I get, “What can I do?” So, I think the tide is changing a little bit and people are really caring and compassionate about kids.

Read Sulik: Cindy, I’m just sitting here thinking. Thank you. I’m thinking that model you have developed for the public school system could be a perfect model to piggyback

on Nimi about how to create a curriculum for medical students. It really would be outstanding.

Cindy Shevlin-Woodcock: OK. That sounds really good

Read Sulik: A collaborative outcome.

Muhammad Waqar Azeem: I just mentioned before that I'm with Minnesota State Child and Adolescent Services. I was just wondering first, how many of you know that the state has inpatient beds, state run child and adolescent beds. About half of us know, ok. I just wanted to mention we have 50 inpatient child beds—29 in Willmar and 21 Brainerd. That's probably 25-30% of all the inpatient child beds in the state. We have about 7 child psychiatrists, part-time, full-time, contract basis and we served about 70 counties last year. I think there is not a tertiary care hospital which has not sent patients to us. So I thought I'd let everyone know about that.

We talk a lot about what we don't have, but I think as a Society we need to put some kind of directory on resources. What is our resources? We are talking about what we don't have, but we don't even know first where to start. I think with what we have. That's probably more important than not what we don't have, like inpatient, outpatient, partial hospitalizations, residential care, what is our resources in the state, so that is one recommendation.

Second is, as state-run child services, we bill the insurance companies and medical assistance and I think this is going to be on legislature and of course Glenace Edwall is going to play a part in that. Kids who don't have any insurance or don't have any resources to get some kind of funding from the state to get care in our system too.

Will Dikel: Susan Jenkins, I'm thinking that you are losing money on every patient, so you must be making it up in volume somehow. (laugh) I don't want to come here a year from now and hear the same list of all of these things. Every one of the things you mentioned need to be reimbursed. I'm trying to figure out how we cannot be here a year from now and hear you say the same list. What do we need to do is to say, "Look, if we're here to do the work we can't do the work unless the reimbursement is there".

I just want to make a mention about the issue of collaboration. It has come up before and I think it is a major issue. They say that "collaboration is an unnatural act committed between non-consenting adults", and those of you who have tried to do collaboration know what that means. I think there is multiple systems that these kids are in and the question is how much money is being spent *not* providing the services we heard about—for example, the Corrections system with all of these kids with unidentified problems.

You have the lack of dual diagnosis chemical and mental health treatment services. How many of you send kids to these dual programs? They're not out there, there are hardly any of them, and yet these kids have these problems.

If you look at each system, the question for this group I think is to identify what needs to be addressed. In the education system, the teachers are told what early signs of mental health disorders to identify in their students, but school psychologists will tell you in general that they're under a gag order to never recommend mental health evaluation or treatment because schools are the payers of last resort for what they recommend. I don't know how many of you have seen functional behavioral analysis done by school systems where a student with Bipolar Disorder has manic behaviors that are seen as a "function of their need to seek attention", for example.

We need to get the word out that what is being done in these different systems has to be done according to the reality of the kids' needs.

I would challenge this group to look at what needs to be addressed in the public health system in terms of early screening and diagnosis of kids. EPSDT is a mandate for Medicaid screening in Minnesota and around the country. Are these kids being screened and are their mental health problems being identified? The corrections system is screening kids for mental health and often it is finding they have already been diagnosed but they never received treatment.

The education system can co-locate services and do it right and the mental health and medical systems can work together. We need to identify the specifics of what needs to be done to be able to make the system work and then move forward to do it. I think we have the players here to do that and I think the question is, "What kind of specific issues need to be addressed and overcome in order to make collaboration actually possible?"

Read Sulik: Thanks Will. Ok, I pointed to this table first so we'll go Carrie and then Judd and then we'll go back here.

Carrie Borchardt: We are a very passionate group and we are a very smart group. We have a lot of ideas and as people have been saying because there is a shortage of us, most of us are overwhelmed and I think that one thing we have not done very well is to work with legislators and leaders to make changes and make happen the things we think need to happen. There was a small group of us who went and met with Mindy Griling recently about her bill and our concerns. I learned a lot of things at that meeting and came away thinking about the skills we don't have and the things we don't understand/know and the things we don't do that could make us more effective. So, I would like to see us all, or at least a group of us become better educated. More committed to understanding those things and working better with the legislature and the leaders in the state so we can have a larger impact.

Read Sulik: So I'm going to say that falls under, for me, standards of care. We have to have a standard practice in our state that there is ongoing communication and education to our legislative representatives to represent the needs of the children they serve. I think that is well said. Judd

Judd Rainey: I'd like to urge that whatever comes out of this, something that ought to be imposed on all the ideas here is also have cultural competence as a key component and that we judge what we do based on cultural competencies and cultural diversity as well. As I look around this room, I don't think it is a good representation of the face of Minnesota today. Minnesota is a richly diverse state. It is pluralistic culturally, as well as, religiously and our children are even more that way. So, children are even more diverse culturally than the rest of the population. I think that should be sort of a test we have for things we do and is superimposed on anything else that comes from the meeting.

Kim Oberstar-McPhatter: As I said earlier, I'm a pediatric nurse practitioner but I worked in psychiatry for 13 years. There have been a lot of barriers to practice for pediatric nurse practitioners as well, even though I was able to take my own path into psychiatry. The same issues you guys have with residency are the same issue the pediatric nurse practitioner is having in terms of training, so, also working with pediatric nurse practitioners to get more training in mental health.

Secondly, to me it seems there are so many barriers in families getting the help they need on the same day. What we have found at Children's is if we submit a bill from psychiatry and a psychologist submits a bill, one bill gets paid. We both don't get paid. Now I can go to Mayo and see an endocrinologist, a diabetic educator and a heart specialist if I wanted to and they would all get paid. So I think mental health is done a disservice because they assume because you've seen a psychiatrist you also don't need to see a therapist. We have families, some of which take three buses to get to us and it's a huge disservice.

The third thing, as a nurse practitioner I cannot write a letter because of the IDEA Act in 1970 that a child needs an IEP based upon diagnosis. One of the docs and I totally respect child and adolescent psychiatrists. I am not one and I never went to school, but as I'm seeing the patient it would be so much easier if I could write that letter. Instead, I have to go to one of them, explain the situation, explain the case and say we need school services and they have to sign the letter to get the IEP in place.

Read Sulik: Steve, if at any point you're not capturing the key points I need you to let us know.

Steve: That's why I'm counting on everyone else's notes here (laugh)

Read: Ok, Sue and then back here after Sue

Sue Jenkins: Steve, get ready. All right. As I'm sitting here things are triggering. Reimbursement for translators. One of my therapists is American Sign Language proficient. I loved seeing those children. It makes sense doesn't it that if you're born deaf there might be other things wrong with your brain, but we were going broke because Medicare pays less than we have to pay a translator. I would also like to see a training program for guardian ad litem.

Read Sulik: What about PCAs?

Sue Jenkins: Well them too. (laugh). But I'm thinking as a Society we might be able to put together a 6 or 8 hour day program for guardian ad litem where we explain child development in the course of divorce, explain medications. Yes, I do know about them more than you do. You know, just cover some basics. How to contact us, who to contact, social workers and what different roles people play. I'd love to see us recognize special education services that are doing excellent work. In my area we have two different alternative school settings who are just doing masterful work and I would really like as a society to give an annual award to school districts that are doing really excellent work.

And then my last thought when I read about evidenced based medicine I just get chills down my spine because we know that we have a vast shortage of data in child psychiatry. I just shudder that I'm going to be held to a very restricted group of medications because those are the ones we have studies for. We've developed a way of using each child as their own control and tracking over time to demonstrate effectiveness of treatment and I would like to see us look at some formats where we can talk back to...I mean I just know in the coming years I'm going to be on the phone to a managed care company and they say I'm not going to reimburse that medication because we don't have evidence and I'm going to say yes I do. It's individually controlled but I have evidence.

Read Sulik: So under standards of care, something I'm really big on right now is approach to monitoring and outcome based measures. I think it is really critical for us. Back here.

Candy Kragthorpe: I'm with the Minnesota Association for Infant and Early Childhood Mental Health. I'd like to ask your leadership in two of the areas up here. One is if you would consider a leadership role in promoting standards of care for infants and young children, particularly those focused on relationship-based care, looking at the parent or caregiver and the baby and young child. Recently in Minnesota, a stakeholder group has provided strong support for purchase of a professional endorsement program from the Michigan Association of Mental Health. We'd like your leadership and partnership in promoting this endorsement program. Under the access to care area we would also like to consider your leadership in building the capacity in Minnesota to provide care addressing infant and early childhood mental health, particularly serving as mentors and providers of reflective practice in this area.

Read Sulik: Outstanding. It's very exciting we have this new association and I think that as child psychiatrists one thing I want to advocate for is we really need child psychiatrists who are willing to see young children and think developmentally. Because in my area very often other people have been referred to me because they have seen a child psychiatrist or tried to get in to see a child psychiatrist who says I won't see anyone under 6. I think this an opportunity to improve all of our skill sets and comfort levels in thinking developmentally about the emotional issues and needs of young children as well.

How about, there is a hand back here...here is what I'm going to do, I'm going to call on Deborah and then Glenace I'm going to give you a little forewarning that I'm going to ask you to say a few words after Deborah. Ok, go ahead.

Suzy Peterson: I'm a newer child/adolescent psychiatrist. I did open my own private practice but also had to do a part-time job at Fairview to support my practice and to pay back my debts. \$100,000 is by no means the average debt people are coming out with in child and adolescent psychiatry. That is way under estimated.

I find it quite interesting every week we get checks into the clinic and I don't know how they come up with a reimbursement rate but it can vary from \$30, maybe \$90 if we are very lucky for a med check and you know a 90805 therapy and med check. I would love to know how they come up with those rates, it's just amazing and I'd like to comment too about the people who need the most care that often will come in taxis. The taxi driver will often get paid more than I do for the med check at a therapy appointment. That is just ludicrous. To try to attract people into this field with that type of reimbursement and system, good luck. We have too many loans; if you have a family on top of it I don't know how you could possibly management it. It's just unrealistic so we're not going to get more child psychiatrists with our reimbursement rates. Economics is so important for everybody and that is why ¾ of those in the Minnesota area are doing only pay for practice. I didn't want to do that because I have insurance myself and I feel if I go to something I expect them to take my insurance. I don't know if I'll be able to survive this way but I'm trying it.

Read Sulik: Excellent point, it really is. Ok, I'm going to ask Deborah then Glenace and then I'm going to give Matt, John and Karen a little forewarning I'm going to just ask you to make some comments. We are seeing a lot of progress in Minnesota with our work with the health plans. I think I've never been at any one of these meetings where John, Matt and Karen haven't been there. Scott Craven also from UBH was not able to be here today, but we've got some incredibly passionate advocates within the health plan leadership in this state so we want to keep taking advantage of moving things forward as we've really begun to. Go ahead Deborah.

Deborah Saxhaug: I'd like to speak to impacting the legislature and remind you that one call from a parent of a child you are working with is worth all of our calls. It makes a huge difference. If you take the time to encourage parents who have reached a road block or can't access a service to make phone calls or actually have them call an advocacy organization like mine, Minnesota Association for Children's Mental Health or NAMI we can help them through that process. It is important to remember they are very powerful.

Read Sulik: Great. You ready?

Glenace Edwall: Read can talk me into almost anything so....

Read Sulik: Everybody probably knows who Glenace is, but for those that may not, she is our Director of Children's Mental Health at the Department of Human Services and has

been one more of those people that is at every single table discussion and has never refused to come to this table when I have asked her to. So, go ahead.

Glenace Edwall: Has anyone here ever tried to say no to Read? (laugh) It's daunting. (laugh) I was just going to say that I'm really appreciative of being here and being able to hear all of these many things. It is sometimes a real challenge in my job to keep seeing the half of the glass that is full. But we have to see that as well. The first thing I want to say is I hear all of these things and I really do hope we can create a taxonomy and form an action plan around how to address in some priority way, the things that are most pressing in our system. We want very much to work with you in doing that.

I want to offer just one word of caution about the many things I've heard especially about coding and reimbursement. We live in a very challenging environment with regard to making changes in the Medicaid system. Many of the things that seem like good ideas to those in clinical practice are things that would be extraordinarily difficult to implement administratively right now. So we need to have not an alarmist, but nonetheless candid conversations about those things. I think it will help us in our priority setting. I'm glad to see our national leaders also echoing that.

Through the many things that have been said here today some of those glimmers of hope are really coming through to me. Many of you have heard us talk about a sort of overall strategic plan at DHS coming over the last 5 years. Our Children's Mental Health Task Force is focusing on early identification and early effective intervention, quality standards and trying to find ways to access care. All of those are really daunting tasks.

First of all I'm really grateful to MACMH and various other partners who have helped to create the Infant and Early Childhood Mental Health Association. It was part of our strategic planning as part of our ABC Grant, our work with CentraCare and Children's Hospitals to find better ways to make sure that in the places where kids are seen early that we are in fact screening, identifying and helping their families connect with services. We're very excited about that work. I'm also convinced that early identification is what we have to do if we are ever going to have an impact on those much larger system problems down the road. Someone said it very eloquently, that bed shortage is just the tip of the iceberg—it's not the problem. The problem is we're not picking up and dealing with problems early and effectively and coordinating care around those kids so they don't have to be continually moving from one crisis to another.

So for all of you who are doing that work on early identification I am tremendously grateful. I could talk for an hour about this and you don't want me to, but we're doing a number of things that many of you are helping us with. Things we are pretty excited about. We think we have an approach to evidenced base practice that is really unique in the country and is not being prescriptive but trying to use a heuristic system that can really be helpful to practitioners. I'm happy to talk much more about that. We're also trying for the first time to ask; What is actually happening for our kids when they get treatment? We are beginning to work with a number of sides from health plans, counties, and individual providers in piloting new outcome measurement tools so we can begin to

get a handle on getting better and then finance it. You've raised many very specific things about rates and codes and I appreciate those with all the provisos I've said at the beginning, but overall we really do understand the fundamental rate problem and it is why there was a plank in the governors platform last year about that, renewed again this year for a better range of providers and why the advocates bill had an even steeper rise in it. We recognize it, but I think all of us regardless of whatever budget we are constrained by and working within certainly understand the rate structure is one of the fundamental issues that must be addressed. The governor acknowledges that.

With regard to finance the other thing I want to also emphasize is a point Read just made which is MMHAG has been a really incredible experience for us because it is the first time I've ever seen a sustained effort of this sort where the players (including primarily the payers) have stayed at the table doggedly working at the problems. It must be invisible, I realize, to much of the state but to those of us who have been part of it we are very grateful for the full participation of a wide range of parties in trying to make solution so thank you all of you for doing that. Thank you for forums like this that provide more information back to all of us who are working in those spheres.

Read Sulik: If I could... I hear comments about MMHAG and like you said Glenace, they may not be able to see all the work that is continuing to be done. I know in our state (I've been here 7 ½ years now since moving back after completing my training) and in that 7 ½ years I can't tell you how many times I have been in rooms like this for meetings. What I continue to see happening is (though it may seem like there is an awful lot of these things that have to occur) relationships are being formed that clearly create the foundation that lead to some unbelievable potential for change. I think that is what is unique to us here in Minnesota. I keep trying to think back when people say how are you guys doing this? How are you getting health plans to come to meetings like this? Well, because the relationships are clearly there. They're all starting from all these other efforts that have already occurred.

All right, who did I say I was going to pick on next? Matt? John?

John Scanlan: I think Matt (laugh)

Read Sulik: Matt, alright. For those who don't know Matt. Matt is Director of Behavioral Health for BCBS and from a distance the health plans can seem somewhat ominous to us but what I can tell you is the health plan leaders I've come to know around the state really are trying to make a lot of change happen. Go ahead.

Matt Eastwood: Well a couple of things. First I want to thank you Read for inviting me and allowing me the opportunity to come and listen. One of the things we don't do (as a health plan) enough of...and I keep talking with executives about it is we need to act less like we have answers and more like we have questions. We need to be out here talking with folks and listening to you more than talking about what your struggles are and what the issues are and is there a role for us and what that role is. I do think that role goes beyond reimbursement. I think we have more to offer than that, although that is certainly

a piece of the pie for us. So I want to thank you for inviting me. I do want to say the next time you are going to invite the Attorney General you might want to warn me. There was a little bit of a damp moment as a blue cross guy for me. (laugh) And actually despite Blue Cross's history or what you believe it is with the Attorney General's office we have worked very closely with them for the last 5 years on a number of issues. It is not always discontented as it might appear.

Just a couple of other comments. I understand people's issues with evidenced based assessment or evidenced based care and why you could be concerned about that as a practitioner. I guess a person at a health plan who is partly responsible for helping set coverage policy, we'd like people to be going and the kind of work we'd like to see in a community. For us, I think it's not about coming to a narrowly defined way of how we want people to work. I think we would just like to reduce some of the variability. We see tremendous variability particularly in terms of assessment. I've been with the health plan for 4 years. I was a practitioner. I'm a psychologist and marriage and family therapist for nearly 20 years. I've supervised tons of people. I know how poor some of the assessment is that goes on by some of my colleagues. I'm not speaking about psychiatry in particular but some of my other colleagues in mental health. I think we need to do a better job of really assessing the issues kids have and doing that from an evidenced based prospective, not so much your particular orientation or piece of training.

Read Sulik: So from your perspective then, representing BCBS, what you need from us as providers is some coming together in our approaches and arriving at some standards of approaches to care, assessment and evaluation. I know we've been in conversations about that.

Matt Eastwood: Absolutely.

Question / comment from audience: Matt, I'm curious if you can give us sort of a peek into working discussions. Would you want to go in prepared for presenting models of care or new ideas that have come up while trying to implement some strategies for best practices? What can we do as mental health professionals to give you more of the evidence you need. I know there is tons of homework that could go into any one meeting like that, but if you can give us a window into that it would be helpful.

Matt Eastwood: Sure. What I can tell you about is the process we use for developing policy at Blue Cross. I have a person who spends full-time researching interventions and new technologies what the evidence says. We then have a group of practicing psychiatrists, psychologists and a doctorate level social worker who come in monthly and review the material with us, comment on it and make recommendations to us. Yes, there is evidence here to support this/no, there's not. It's still investigative and gives us an idea of where to go with it. That is a part of the process. For the 5 years the program has been in operation we have always acted on that and gone with the committee's recommendation. We are trying to use the information that is existing in literature using the recommendation so there is a local quality to it for Minnesota. What do clinicians here tell us works and then to build on that. Actually as a health plan and it is also in the

medical side we're just really beginning to think about how we get more of this information to clinicians because I'm not sure they all know it when there is some clear evidence for some things. Certainly with kids there is little we know and a lot we don't in terms of what research says. We have to be very careful about that. When we do know some things 1) How can we get that out to people? 2) How can we implement that? 3) How can we incent providers if they don't know this skill or technology to learn it, to use, to make it a part of their practice. I think we are just beginning to think about that.

I hear people looking more at prevention and prescreening. We're very interested in that. So you know as a whole it is certainly the medical side, the medical colleagues we hear talking. It is clearly the direction most health plans nationally are thinking about now – prevention and early intervention. Really moving or trying to intervene in the shallow end of the pool rather than simply at the point the person enters the hospital or needs a deeper end service.

I'm not sure to be honest with you, where you go with those things. We're just beginning to identify strategies for ourselves. We're certainly very open to input people have and collaboration and we're involved in a number of those.

Read Sulik: Ok. John do you have anything to piggyback with?

John: Yeah. Two comments. One in response to that question, I think Read coming to Blue Cross with a proposal for his program that came with data, what he had done over the past few years and the data to support it. He came with the support of his organization. So it wasn't just Read coming to us. He came representing CentraCare with his proposal so it carried a lot of weight with an insurance company.

I agree with you. We need to pay attention to the legislature. You also need to start getting involved with business coalitions. At Blue Cross over 60% of people who carry a Blue Cross card in Minnesota are on a self insured plan, administered by Blue Cross. The benefits are determined by the employer. Now, Blue Cross has a policy that when they sell or renew a contract it's a requirement that the salesperson tries and convince them to go for parity. But most of them do not agree with parity which gets into some other things. We have to fight about how mental health is seen. As a Blue Cross employee for example, we have full parity. There is no limit on mental health services or chemical dependency services as compared to medicine. It's the same benefit. That has been in place over 3 years. After 3 years now I've asked the question why do we have a mental health benefit defined if there is full parity? We don't have a cardiology benefit, why do we have a mental health benefit? After 3 years they are finally saying that makes sense. But it's surprisingly complicated to remove the language from the contract. It speaks to that bias even though as an organization they decided to go for full parity they still wanted to have that definition there and so long as we have that definition then we are different in mental health. I think we really have to fight. It's easy to limit mental health and we still have that fight with the employers. So, I think the more you can get to some of these big business coalitions and sell them the story of what we have to offer, the closer we will get to parity and away from some of these other rules.

Also pay attention to CMS. Medicare has set up a lot of standards for the insurance company including not seeing two providers in the same group on the same day. You can see the psychiatrist in one group and walk across the street and see the psychologist on the same day and they pay both, but they won't pay the same group. It makes no sense, but who said that Medicare has to make sense. So you have to follow what is going on in Medicare because it set a standard for the insurance industry. We have to remember that in regard to the RVUs how much we're paid in comparison to a cardiologist was established by physicians. That was an AMA imitative back when RVUs came in. So, as physicians our peers told us we should get paid less than a surgeon or some of these procedural interventionists. So, it's well to keep track what the MA is doing whether you are a member or not a member. So, those are a few things. I appreciate this meeting. I think we are out of the battle of the insurance company trying to do things to the practitioner. I think we are all trying to find better ways to provide services within the economic restraints we all face. Nobody wants to pay more for their health insurance personally.

Read Sulik: Excellent. Ok, I'm going to Karen first, and then we'll go to Mark and then I'm going to ask for comments from Ucare. But before Karen comments, because I do believe positive reinforcement is a really important thing. I just want to acknowledge the incredible scribing that Dr. Steve Sutherland is doing over here. (laugh – clap). You're being very quiet but incredibly diligent. We're noticing and appreciative.

Steve Sutherland: I tell my patient's families a true story about my kindergarten teacher who told me I was going to be a doctor and it was not a compliment (laugh)

Karen Lloyd: I'm on my 10th page of notes and I'm writing excessively like you as I think of things to do. I have been part of MMHAG. HealthPartners was the first plan to join up on the evidence child approaches that Glynnis is leading that really has us looking at us using standardized tools, outcomes, having research available to us for the psychotherapy. It doesn't extend to the medical. So, we don't have that yet but we've been really pleased to be doing that. Through MMHAG I've participated in a lot of these committees. I am the co-chair of the model benefit set. So, I've stepped forward when that was out there and my company supported me in saying we need to do this. We need to figure out what is the right way to build a model benefit set. Louise Brown was my co-chair on that. I see several people who actually worked on that.

Let's see, what else is going on at HealthPartners. Well I think that the access, standards of care and economics are how we see it also and we've been working. I've been there 9 years and every year I work on those issues. It may not seem like it to you but you do have champions within the health plan that help carry your messages. Matt, John, Ghita and I are those champions. We go to our administration. We also go to the business consortiums. So I am the person they pull out when we've got a group that wants to go with 30 or 60 outpatient visits for mental health per year; I've got a lot of data that shows this will not save money. This will probably cost you more money because as you restrict outpatient care what happens is primary care and so on goes up. Inpatient goes up. School

attendance or work attendance goes down. Productivity and learning goes down. So I can be pretty convincing and I've gotten some of them to take an unlimited even though they are self-insured. The good news is the biggest health insurers in the state or country self-insured employers get it. It's kind of the middle market, the employers with 100 employees that are still not understanding mental health. The big insurers that are self-insured hire consultants that tell them the same stuff I'm telling them. I would echo the statement that was made earlier as getting in there as a society.

Let's see, what else have we got here. Health Partners has sought a lot of NAMI for a lot of years. We have been the first funder at a couple fund raising events for NAMI and I'd like to see this community more involved in helping to support NAMI and NAMI teaching us how to work the legislature. It has been really incredibly successful. Not everything they are working on but they are persistent so they will work an issue for 3 or 4 sessions if they need to, to try and gain friends and influence the outcome. There are 2 fundraisers for NAMI that HealthPartners has started and continues to support. One is called Music For The Mind. I don't have the date and Sue left for another appointment but we have a new thing that Health Partners really wants to decrease stigma and increase awareness. It is the right thing to do. It is the moral thing to do, clinically appropriate and it is cost effective. There is the first NAMI Walk for the state of Minnesota on Saturday, September 29th. I'd like for this group to help us be champions for that. It's going to be a fun day. We'll have balloons, colored t-shirts, etc. We'll take mental health out of the closet and have a walk like every other condition has. It's going to be at Minnehaha Park at 1:00 p.m. on Saturday September 29th.

So, I really value coming to these kinds of things. I have a long list of things I'd like to see changed. In 9 years I've made progress but I'm sure we have 30 years more to make progress. Thanks.

Read Sulik: Karen, pick your top one thing you would like to see child psychiatrists do differently in the state of Minnesota from your perspective.

Karen Lloyd: Ok we've been working at HealthPartners Medical Group because child psychiatry within the group is very short and the pediatricians are having the same problems. We have difficulty in getting that collaborative thing to work. What would I like them to do? Can I think for a couple of minutes and come back to me?

Read Sulik: Sure, I'd like to point out that we keep talking about how short child psychiatry is in Minnesota and some of the child psychiatrists are actually tall. (laugh) Like Dr. Hintz. Many are about my height though. (laugh) Mark, you had a comment?

Mark Kerekes: Does anyone from the insurance companies, John and Matt, have numbers, the kind of stuff Karen was talking about in terms of taking somebody with ADHD, depression, teens for example or adults and tracking them and looking at those numbers, the savings you were talking about? Do we use those numbers when we talk to businesses when we sell the benefits of mental health? We often see in our journals and occupational psychiatry field etc. something like 44 billion they quote. That was about 10

years ago when they quoted that one. I'm not crunching these numbers but it seems pretty obvious we can focus better if your mood's better, you're sleeping better, you're not blowing up at home or the work place, you're not abusing substances, etc. You're going to function a whole lot better in a work place and that is going to benefit the company, community, etc. So, are we crunching those numbers and looking at those numbers and are we sharing those numbers in the best way we can? Back to what Will was saying, how can we support that process as child psychiatrists?

Read Sulik: So perhaps under the economics issue is being able to come up with the actual costs of untreated care and the impact on our businesses in the state who can be perhaps our greatest advocate. Dave, you have a thought?

David Einzig: Insurance companies tend to respond well to data. It might be interesting to pick some specific things that we know about like, if you treat adolescents with ADHD and treat their ADHD well you are going to reduce the risks of accidents. It is in the literature that you are going to reduce the ER visits. You are going to reduce car accidents and BlueCross or a health plan has the capacity to capture that kind of data and look at a pilot project on something like that.

Mark Kerekes: Barkley has long term data. You folks have been hearing about the Milwaukee study right? In the late 20's we're talking about higher rates of legal problems, higher rates of substance abuse problems, lower education status, etc, etc, etc, teen pregnancies, STD's and it goes on and on.

Read Sulik: Ghita, you want to...and then Connie I'm going to ask you to talk after her if you would.

Ghita Worcester: I was just thinking I was going to be sitting here listening so I've quickly been thinking about what might be of some value to you. For those of you who don't know who Ucare is we have about 130,000 members in Minnesota and they are all paid for by either the Federal Medicare program or Medicaid. I was really appreciative of Glenace's comments because although we are capitated, we have this pool of money when the state goes back and looks at what they are expecting of us. They are building it all off the state fee for service table which I think if we're going to talk about how we need to change payment rates the health plans can be a conduit in that conversation. We have to change the basic payment in part of the governor's legislation this year because if we were to, lets say, double how much is being paid for a particular service it has to come out of somewhere else or you have shown us by paying the additional money we are going to save money out of the whole. It is a pool of money that doesn't vary from health plan to health plan and is set by the state with targets. As Ucare we are pretty appreciative of Karen, Scott, Matt and John's work. With 130,000 members we think we're pretty big, the 4th largest plan in the state but we're pretty small in being able to influence anyone. We work with Fairview and the University of Minnesota psychiatrists to make sure our primary care physicians have access to mental health consultation through psychiatrists. 60% of our board are family physicians from the U of M Family Medicine Department so

obviously they understand the issues and push us very hard to make sure they have appropriate access.

I was appreciative earlier of the comment about cultural competency. 75,000 of our members are on the state public program. Over 20% don't have English as their first language and their cultural background is not understanding what we are talking about in our behavioral health systems here. Community University Health Care Center I see is one of those shining lights out there where they have done a lot on cultural competency for example with the Hmong population. We've had to step back and think about how we can support that differently because even when you're talking about the children if you haven't helped the parents understand what you are talking about you are not going to be very successful.

I think what really struck us recently and I know we are talking about children it was a program we run called Minnesota Disability Health Options. There are about 800 voluntary folks who are physically disabled, most dual eligible on the program and when we got into it we were thinking about the medical model of that program. 65% of the members that come in with a physical disability have significant behavioral issues. We really are trying to develop that coordinated model with the medical/behavioral together for that population which has not been able to access that in this community very well.

So, thank you for letting me listen. I don't have as many notes as Karen, but a lot.

Read Sulik: Thank you Ghita. I am going to ask my friend here Connie to get the microphone. Connie is the CEO of the Red Lake Hospital and was assigned there approximately two weeks after the shooting on March 21, 2005. I would like Connie to speak to us about the incredible degree of needs, mental health needs in particular, of the American Indian youth in Minnesota that we've got to keep bringing to tables like this to try to address in a more systematic way and take advantage of the resources that are here in our state. Connie has helped Linda Vukelich and myself develop a volunteer psychiatric outreach service to Red Lake Hospital every other weekend since June 2006. We have psychiatrists who are being flown up to the reservation by volunteer pilots to see children, adolescents and adults at a Saturday Psychiatry Clinic day at the Red Lake Hospital. Connie go ahead.

Connie James: Well like many of you I think we should have our own support group being friends of Read (laugh). I too thought I was going to be more of an observer than a participant but you know this is just fine too. As soon as I got here I realized it was not so, but I guess it is an appropriate venue to thank many of you in the room who have supported the Red Lake Hospital during the recovery phase. Many of you come every other weekend purely as volunteers to provide assessment services to the children and families of Red Lake Nation.

I have so valued Read and Dave and everyone who have come to provide a bridge into care. Once again we say bridge because that bridge has been so (I think) critical to the recovery efforts of the Red Lake Hospital. I think there are a lot of opportunities to work

from a public health perspective in a community that is relatively heterogonous. We know we can influence behaviors relatively quickly. Being the first managed care organization on the planet; we in the Indian Health Service have many valuable things to share with the greater medical population, as well as, I believe the federal government in terms of addressing and developing health and mental health programs. We work with tribal people and have that capacity in this country. Certainly when we talk about cultural competency and the intricacies of groups and subsets of populations the importance of professional relationships is to “bridge” medical intelligence. So how you do that? Minnesota has helped to define truly what is advocacy for Indian Country from the days of Hubert Humphrey and Roger Jourdain and the great era of health and human policy in the mid-70’s and that great era of support for special populations, and certainly the work of Senator Wellstone.

I look to all of you as true Minnesotans and what you believe.

I also, like a lot of you, am very analytical and very trained to look at problems. I think sometimes I have not acknowledged the strengths and positive things that I have seen. I have witnessed a lot so I think it is so critical that certain elements of technology and clinical practice be built in Indian communities. So much of what you all do has really been focused on this part of Minnesota. I’m not certain how many of you will be as familiar as we would hope with what is happening in the more rural Northern Minnesota communities and certainly bridging access which I believe is truly our greatest issue there.

I think for us with this very culturally based and family community model that care coordination is absolutely critical to us. It is what bridges essentially the time it takes to work through families who are dealing with very complicated issues. I certainly think any work that reflects the need for the ability (especially for the tribes) who are reimbursed for primary care case management; we continue to look for ways to really spread technology and spread medical intelligence are important. I can stand here and say I’m really easy to find and if there is any way I can participate in dialogue or link you with people in my universe even though I assume a lot of that work is being done.

Once again I appreciate being invited and thank you to all of you for your humanity and being good human beings.

Read Sulik: Thanks. I appreciate you making the trip all the way down here Connie. I think the take home message would be...I think we need to keep the needs of our youth in Indian Country in Minnesota on our radar screen and I guess that is one thing I will continue to try to do when I’m at the table as yet one more thing I’m trying to advocate for. It has been clearly an eye opening experience with the level of need and we need to keep bringing that level of awareness.

I’m going to do a time check. We are at the point where we are going to break for lunch. What I’m going to suggest we do is take a couple of minutes to organize this list. To start lunch I’ll end this morning’s session with one of my all time favorite quotes, which is

from Billy Holiday who said, “You gotta have something to eat and a little love in your life before you can hold still for any damn fool sermon on how to behave.” (laugh) So I’ve made a point to feed you all, anybody needing a hug, I’m Italian so I’m ok with that too (laugh). This will take some time to come through the line. We’re not leaving a lot of time for lunch because we’re going to keep moving forward, I’m going to ask you to come up, get lunch as quickly as you can and get back to your seats. Once we are organized we are going to try to have this ready to mill over by 12:30 to place your votes.

Can we just do a check on how we are going to do this? Inside your packet you should have a little strip of circles and you get that many votes, 1, 2, 3, 4, 5, 6. Basically as a way for us checking in with one another to prioritize what we consider are some key issues we think is really important. It doesn’t matter how many times you vote for one topic if you think it is that important or you can vote for six. Put your circle by the ones you think are really critical to you and who you represent. Then we are going to spend some time this afternoon presenting that ranking and try at each table to assign you all a task which is to leave here by the end of this day with some clear action steps about those particular topics.

Steve Sutherland: One thing, I was talking to Will Dikel earlier. One example of what we had hoped to see this afternoon we were talking about the geographic range of care statutes that exists in the state of Minnesota which we are all clearly guilty of being in non-compliance with from practitioners to health plans to government and there is this tangles web of legislation that says care needs to be provided within a 30 mile radius within a reasonable distance of where families are coming from. It applies of course to the mental health care of kids and so Will was talking about how we have these statues that say this. We have a lot of well-intentioned people, practitioners, well-intentioned legislatures, well-intentioned people in the Department of Human Services, all of the various groups that have somehow come to this stalemate where there is a lot of inertia and we still haven’t been able to fully comply with that statute. So that is an example of what we want to see going on in some of the work groups this afternoon is taking...we’ll try to identify some of the highest priorities and have specific tables working on specific action plans to for instance to untangle webs, come up with an action plan to help untangle webs sort of like that and that was one that Will Dikel had brought up earlier.

Read was there anything else before we send them off...ok

Question / comment from audience: Just a question. Can we get a list of all the attendees and contact information? Forgive me if somebody else already said that.

Read Sulik: Actually let me make a point of that. Before anybody leaves here today if you would please leave your email. I think we have your emails because I think everybody responded by email. Oh, perfect if you would just write your email on the back of your tent sign and drop it off at the desk we will make sure one of the first things we do is email the roster of everyone who has been in attendance. When Linda and I and the rest of us put together the summary from today from the recordings and our notes we will email that out to everybody as an immediate action step that will happen after this.

I'm usually the first one to get in line for lunch but I have something I have to do so somebody get this moving. We've got to move quickly and when we come back we will arrange for some votes up here.

SUMMARY OF OPEN DISCUSSION AND RESULTS OF VOTING OF PRIORITIES AND TABLE ASSIGNMENTS

David Fassler: Remember the goal between now and 2:00 is to come up with specific action plans on each of these topics. So be as concrete and specific as possible with steps and recommendations. We just collated all of the votes and tried to group some of the categories together but I think we included all of the things that had the most votes. So the first would be:

Summary of Findings

- Early Intervention / Prevention / Infant-Toddler Services
 - Table 1
- Cultural Competence / Addressing Needs of Diverse Populations
 - Table 2
- Collaboration with Primary Care
 - Table 3
- Legislative Issues and Collaboration with Advocacy Groups
 - Table 4
- Directory of Resources
 - Table 5
- Enhancing Collaboration Between Systems
 - Table 6
- Screening / Bullying / School-based Services
 - Table 7
- Evidenced-based Practice / Outcome Measures
 - Table 8
- Improving Reimbursement for Child and Adolescent Mental Health Services
 - Table 9

1. Looking at early intervention, prevention and infant, toddler services.
2. Looking a cultural competence and addressing the needs of diverse populations.
3. There was a lot of interest on the broad issues of collaboration with primary care including both training and consultation services.
4. Legislative issues including issues revolving around collaboration with the various family and advocacy groups.
5. There was a lot of interest in a specific directory of resources and that already sounds like a specific recommendation but maybe a group can help flesh that out. I have one suggestion I will bring that group on how to fund it— developing a directory of resources.
6. Looking at collaboration, coordination and communication between various systems and the longer the list stayed up the more systems people added, so

mental health, school, corrections, public health, emergency medicine, law enforcement, the courts, etc.

7. The whole issue of screening in schools, bullying and school based services and really looking at concrete specific recommendation about schools.
8. We combined evidenced based practice and looking at outcome measures and there was a specific comment that we should look both clinically and in terms of fiscal measures and outcome.
9. Improving reimbursement broadly for child and adolescent mental health services so the whole issue of coding and people getting reimbursed for the services that are actually being provided.

So that is a summary of the categories as consolidated in the table assignments and we have until 2:00. Then the plan would be to review specific steps and recommendations from each of these groups. So we can now separate into the group that looks most interesting to you. Yes, you can move. You're now allowed to move.

Read Sulik: And when you are at your tables somebody needs to be willing to stand up and summarize what you all have discussed at 2:00. I'm watching the exit doors. This is the point of meetings I usually split (laugh) so my eyes are on each and every one of you, just so you know.

I'm going to be a little bit of a ringleader. Table 8 – Evidence based practice outcome measures needs more people – calling table 8. Table 9 is – Improving reimbursement for child and adolescent mental health services. (Mark Jenkins you are in the way of the slide). Table 5 – Directory of resources. Table 4 – Legislative issues and collaboration with advocacy groups.

Ok so, we need to get us assigned to tables as well. Is that one I can assign you too? Why don't you start with that one so that would be a great place to start. Ok great.

Read Sulik: How about if I ask everybody to wrap up and then we will just quickly try to capture discussions. That's the warning. Tim, David, Tom, Steve I'll meet you up front and then we're going to have to figure out how to do this in a concerted way. I'm not worried about us recording notes on what you all tell us because it will be captured in the recording. At each table if you could take a second and identify who is going to speak for your table about what was reviewed.

PRESENTATION OF ACTION ITEMS

Read: We'll start with Table number 1 and we'll go down. Alright, there are 9 tables. I'm going to be somewhat of a taskmaster and cut you off at about 4 minutes to summarize, 5 minutes at the most to wrap up. That would be 45 minutes if we each spent 5 minutes at each table. We will definitely be leaving here by 3:00 sharp. David and Tom do need to leave at 2:45 to catch a plane and again, I just wanted to express thanks to both of you for making the trip out here and being with us. (clap). Ok table 1 – go ahead.

Early Intervention / Prevention / Infant-Toddler Services Table 1 Action Summary

Table 1: First I want to call everyone's attention to the fact that Tom is the infant mental health specialist. He was at our table. Ok, we have a lot of good concrete action steps for the society.

- Endorse multi-disciplinary application of the DC 0 – 3R (Diagnostic Criteria Zero to Three)
- Identify and collaborate with a partner organization to reach out and target pediatricians, both existing and pediatric residency programs to enhance their skills in working with infants and parents.
- Endorse screening for maternal depression and developmental and mental health screening of young children through the use of the ASQSE and Pediatric Symptom Checklist.
- Identify clinics that would expand upon the ABCD2 model and explore the feasibility of integrating screening programs with well child visits.
- Explore possibly pilot co-locating monthly in community clinics, child psychiatrists with other multi-disciplinary practitioners to provide mental health assessment and recommendations to providers of care to 3 and 4 year olds.
- Promote the infant mental health professional endorsement program to enhance the skills at all levels with people working with young children to address their mental health needs.

- We had this groundbreaking idea to promote an AARP model of low dues and high education services to new families. This would be funded with non-Pharma private funding.
- Promote more research in translation of research to practice.

Read Sulik: Any other comments from Table 1? Nicely done. So, that will be table 1’s recommendations. Do we have a sense of what the specific next action steps are that A) the child psychiatrists in the state need to do and B) the rest of us need to do to address what you just said?

Question / comment from audience: Are you asking me?

Read Sulik: I’m asking your table and all of us. In a minute or two if anyone has any specific thoughts. Tom, do you?

Tom Anders: The Minnesota Psychiatric and Child Psychiatric Associations need to vote on, and endorse, the DC0-3R manual for diagnosing infant, toddler, pre-school mental health problems. (clap). This will slap DSM V in the face, but you’ve got to be ready to do that.

Read Sulik: That is a great thought. That is an outstanding action step.

Question / comment from audience: How many organizations do we need?

Tom Anders: Well clearly the Child Psychiatry Group and hopefully the General Psychiatry Group. The next step would be to ask both the Minnesota Assembly reps to the Academy Assembly and to the APA Assembly to bring that action forward for discussion and a vote in those groups and then we can bring prospectively to the Council of the Academy and the Board of the APA.

Read Sulik: Great, thank you. Ok Table 2.

**Cultural Competence / Addressing Needs of Diverse Populations
Table 2 Action Summary**

Table 2: Our topic was cultural competency, addressing needs of diverse populations. Everybody knows all the different cultures and populations.... they settle in their own groups, don’t learn English and continue as in their original home. Then their children get in trouble and end up being the interpreters. Children are in essence parenting their parents. We also wanted to identify that diverse populations include some physical handicaps and it is not just culture. So we’ve identified that and there isn’t any one easy way of doing this. It would probably be more community efforts than it is just on us. What we would need is some connections with communities directly. Develop some

focus groups for two-way communications and development of forms. We don't know who would do that. We do know that the Minnesota Department of Health has a Community Health Agency for each community and that could be a resource to start to see what they have done in their community and go from there. I also know that in Rochester where we are from some of the social workers have parenting classes so we were thinking that someone could have American language and culture education type classes and maybe we work with those people in our communities to try to set something like this up.

Also, translators – this comes from the insurance side when we ask to get paid for translators somehow there needs to be a professional standard so that there is a consistent competency among the professionals that are doing the translation. That would help get more funding and set up the standards.

Read Sulik: Excellent. Action Steps? What would be some recommendations as a specific follow-up to those thoughts and ideas, not just you all, but the rest of the group any ideas about specific action steps to take? Go ahead.

Question / comment from audience: I have a question. Does insurance reimburse for translation now?

Karen Lloyd: PMAPs do, commercial doesn't

Question / comment from audience: (inaudible) . . . recommend that for the contacts we have . . .

Read: That wouldn't necessarily affect what the health plans choose to cover and not cover though right? Glenace, am I correct in that?

Glenace Edwall: I think there was a bill requiring...but I don't know what that included.

Read Sulik: So organizations can, I think, follow up with that.

David Fassler: From the legislative group I may also mention that the Academy now has a full-time State Legislative Coordinator whose name is Ramon. I don't remember Ramon's last name, maybe you do, Tom? But one specific step might be to contact Ramon and ask him to research what other states have done legislatively around reimbursement for translation services. There may be a model or language from another bill that has been successful elsewhere that you could adopt and modify.

Question / comment from audience: I was thinking there might be a concrete step to informally have cultural competence training as a Society.

Read Sulik: That is a tremendous idea and to also figure out how to do that. How to do it so that our membership and other mental health specialists in the state can access that in a meaningful way. Is Cindy still here? Cindy, you are. So this idea you talked to me

about a web path or web base learning tool. If we could pull that off in the Department of Education for teachers we can pull it off anywhere. If we can do that it might be a nice model to build on for providers regarding cultural issues as well.

Ok, any other comments or thoughts regarding action steps.

Question / comment from audience: Another thing just occurred to me that many of you may not have computers to go on the website. The second point I want to raise is Minnesota is becoming more diverse now, different minorities and the kids starting schools, I think it is important for us to educate the teachers, students and principals about the culture and then the other side as well. The parents need to be encouraged to learn the language (English) because in this country they have to learn it because if that communication is not there, what's happening is the kids become the parent and the parents are then becoming the kids. There is nobody there to really understand what is going on with this kid and then this kid becomes a teenager and gets into big trouble and comes to us...you can do one-by-one, but all of us have this problem that I couldn't get the parents to learn the language.

Question / comment from audience: I'd just like to add that we shouldn't emphasize translation services at the expense of cultural consultation. You can translate words and that is not the same in terms of pulling who in that community is capable of making decisions; Does a head shaking really mean yes?...it goes on and on and on obviously from culture to culture but I don't think we should just focus on translation.

Read Sulik: As a place to begin I'm going to suggest that the Minnesota Society of Child and Adolescent Psychiatry work with the American Academy of Pediatrics and the Minnesota Psychological Association to come up with some educational forum around mental health needs in diverse populations addressing cultural competency issues to improve the skill sets of all of us as providers as a place to start. Is that a logical action step? Ok great. Table 3

Collaboration with Primary Care Table 3 Action Summary

Table 3: We had a very rigorous and exciting discussion about working with the primary care system and we were very fortunate that we had not only child psychiatrists in this group but also primary care providers. A couple of things that came out of our group:

- One was the discussion of the real need for child psychiatry to be working with the primary care system because the primary care system is where the portal is. It is where people are going to go and the reality is we don't have enough child psychiatrists. So, we need to do the kind of work that will enhance the work of the primary care physicians. In order to do that we talked about the importance of collaboration. As we narrowed that down we talked about having a need for some

type of central organization that would help push and enhance the collaborative efforts. We weren't exactly sure what that organization would be but we had a couple of suggestions. For example, it's the children's physicians network that is already in place that could perhaps be enhanced and structured in such a way to really work throughout the state to help the collaboration between primary care and child psychiatry.

- We also talked about the importance of supporting models out there. We had some discussion on some of the models that are working right now. Where maybe child psychiatry is co-located in a family practice or pediatric setting. There are a bunch of other kinds of models out there and having the kind of funding that would support those pilots. If the pilots worked then how do we disseminate them so they work throughout the state? We talked too about the importance if we're going to enhance primary care relationship building between child care providers and child psychiatrists is very, very important. There are some communication needs. We talked about the importance of educating not only the family practice and pediatricians and how to communicate with a child psychiatrist but also educating child psychiatry in how to communicate with family practice.
- The other thing we talked about is engaging some other type of organization that is already in place and the name that came up was ICSI. They set up guidelines and have done some work in guidelines for depression in adults but have not done any in setting up guidelines for children psychiatry issues. So maybe engage ICSI in that kind of discussion.
- As everybody here was talking about Table 1 and Table 2 specific action plans one of the things that struck me was I thought is was very interesting the discussion we had about being able to communicate with each other. A pediatrician being able to communicate with the psychiatrist and the other way around and I thought a specific action step you might take might be developing some type of communication training, particularly in crafting that barrier between primary care and psychiatry.

Read Sulik: Nice summary. So there are several action steps that you mentioned.

The first would be perhaps exploring the Children's Physician Network as a structure that is already in place to expand on that structure to create a statewide organization that is the central resource for collaborative children's care in Minnesota.

Approach ICSI to be part of that initiative and look at using ICSI to develop more collaborative models that could be put into place. The burden of cost to those models be shared amongst all systems and health plans that are part of ICSY. Bring children's mental health issues to the forefront of ICSI because that is part of my argument with ICSI is that often...like the depression diamond project which is a great idea and great program, it is only for adult depression right now and it didn't broaden itself into thinking about children/adolescent depression and primary care.

Any other action steps anybody else wants to comment on for table 3? Ok nice, table 4.

Legislative Issues and Collaboration with Advocacy Groups

Table 4 Action Summary

Table 4: Our group had the topic of legislative issues and collaborating with other groups. We have the benefit of David Fassler and his experiences elsewhere which was really helpful to us. Our first action step:

- We learned that the Academy would fund someone to train us on working with the legislature, which I think would be a fabulous thing. Her name is Kristin Kroger or somebody who works with her. I think bring her in to one of our MSCAP meetings or a larger group to be trained so we can improve our knowledge and skills would be a really good way to start.

Read Sulik: Can I ask, would that be something that (and this is a question to David) Kristin could train us a group of children's mental health professionals and advocates working together for child psychiatrists.

David Fassler: I think she would be particularly happy to work with people from advocacy groups and family members I think that would be great.

Read Sulik: Great idea.

Table 4:

- It was also suggested we could apply for \$4,000 from the Assembly of the Academy for an advocacy and education grant to support the development of a program for this.
- We all thought it would be really helpful for our state to have a full-time child psychiatrist as the mental health director for the state. Other states have this and it is apparently very helpful and useful in supporting children's mental health needs in the state. That person would help direct policy at the state and I think real importantly be available to testify to the legislature and educate our legislators about children's mental health needs and policy needs. Which I think is just a huge problem for us. It's very hard as I have started to learn to be able to get away to go over...I work just a few blocks from the capital, but you find out a day or two ahead of time when they need you to meet with somebody to do something and it's hard to get there for most of us.

Read Sulik: I'm going to reframe that a little bit because I think there are multiple different ways that could be done. I think it is somehow making child and adolescent psychiatrists available for consultation, policy, because right now we are almost intangible and us being involved is almost impossible because of all the barriers because that system is not in place. So it could be a full-time medical director for child and adolescent services, however, an ongoing consultative role child psychiatrists can play can somehow have that availability. That is a great thought.

Table 4: Most of us have full-time jobs.

Read Sulik: Right, that's exactly it. We've got to get carved in somehow.

Table 4: And then, we spent a fair amount of time talking about having regular meetings with other mental health professionals and advocacy groups with one possibility being an annual meeting before the legislative session, maybe a couple of meetings a year. We discussed everybody's legislative ideas and priorities and then the group as a whole settles on a couple that they then work toward and get passed. As a part of that it is important to have a long term strategy and short term goals or steps that you take toward the things you want to accomplish. It is also very important to involve parents because parents tend to have voices that are best heard at the legislature.

Read Sulik: Great. Great thoughts. Thoughts/comments? Any other action steps for Table 4?

Question / comment from audience: Just one more thing. When we go to child training as a child fellow we don't get any training about legislation or advocacy or leadership. It would help to have a few courses during the training so we will be in a better spot than we are right now.

Read Sulik: Another great thought, it really is.

Question / comment from audience: On involving the parents, I think somebody mentioned that. I have a question and maybe this could be directed to the Academy or someone...are there ethical issues about asking a parents to do some general advocacy work in the context of the individual doctor/patient relationship.

Read Sulik: Well that's a nice question and I know that Sue is gone and Deborah is gone?

Question / comment from audience: I think there are and I wasn't suggesting to ask your own patients. I don't ask my own patient but I go to the advocacy organization. So I go to NAMI, I go to MHA or the Federation of Families and they find people who want to be spokes people. But you are right, I think you have to be very careful asking your own patients to...it's fine to leave literature in the waiting room, but if people want to get involved or people come to you and say I'm involved in this and think you should know about it that's fine, but I think for us given the relationship and the power differential, personally I think it is inappropriate for us to ask our patients.

Read Sulik: Actually the American Psychiatric Association does have a policy about psychiatrists not to have APA legislative information in their waiting room. But we could have NAMI and things like that for the advocacy groups. I think the key is that the advocacy groups need us to help them build their support system, membership and their

voices. I think referring patients to advocacy groups to become active is a great way we could begin that.

Question / comment from audience: I was going to say the same thing. I work a lot with families with children with autism and I frequently refer the families for the extra support they need to family advocacy groups like FEAT for example.

Read Sulik: Ok, table 5.

Directory of Resources Table 5 Action Summary

Table 5: We had directory of resources. The first thing we talked about is how do we get that set up and what funding would be available. We found out that there is a \$500 grant available to set up a directory (I believe we found that out through David) and also putting it on line so it could stay current. We would need somebody to manage it on a yearly basis to make sure the resources are current and having it available for primary care, psychiatrists and other providers. We talked about mainly doing it more like NAMI and include the link on the page, so not so much listing about every resource but doing it more in a link format. I know even St. Cloud has their assessment form, intake form on their website so it could be listing like that and then the link to bring you right to that website. Maybe work with First Call for Help to see what they have available and also United Way to see what they have already accessible. Also making sure Social Services and other treatment facilities statewide are listed. There were questions and Tim was maybe going to send out an email asking doctors who wanted to be included and they could list things like “not taking patients” if they are closed to patients right now. We talked about transition into adulthood, are there psychiatrists who are willing to pick up kids who are transitioning to adulthood. I guess the action plan is:

- To apply for the grant and working with our board in terms of setting up the website.

Read Sulik: I’m going to suggest corraling our advocacy groups on this because I think they have some incredible resources both NAMI and MACMA. Also, the Center of Excellence for Children’s Mental Health. Where is Cari? The University Center of Children’s Mental Health is another perfect option to address this...so those three...I think it would be very appropriate to come out of this meeting requesting this and us assisting with writing for some additional funding to support the development of that is an excellent idea.

Question / comment from audience: The other thing I talked about was going to the MN AAP because pediatricians could have easy access as well and the CNS groups and practitioner groups in the state.

Read Sulik: Ok, other thoughts or comments on actions related to Table 5? Table 6.

Enhancing Collaboration Between Systems Table 6 Action Summary

Table 6: The first thing we came up with was realizing that none of the discussions on any of the topics such as quality of care, best practices, etc., is meaningful unless people are actually being paid to do the service they are being asked...collaborating, etc. I would just take this time to mention that there are statutes and rules that mandate access to services including a rule that says HMOs will contract or employ sufficient numbers of qualified providers of mental health services. If we don't have enough people in the state to do it, if kids are being sent to Duluth or elsewhere because they can't be hospitalized, if people have to wait too long for evaluation with a child psychiatrist, that is against the law. It violates statutes regarding geographic and timely accessibility, and if the Department of Human Services is the mental health authority and if they are setting rates that are too low to provide the service, then the advocates are very concerned. The reason I bring this up is because I understand that the Mental Health Law Project is looking for examples of this to bring a class action law suit if necessary, and I don't want my tax dollars spent on defending such a suit. So the reason I bring this up around the collaboration issue is that I'm hoping people here with the HMOs, the State, etc that came to listen and then realized they are participating, I'm hoping the next step is to make a commitment before they leave that they are going to work raising these reimbursement rates. I recently consulted to an HMO and convinced them to raise their reimbursement for all mental health providers by 25% over the state's increase of 25%.

That being said, in order for collaboration to take place, and actually have the money to succeed, we would recommend the following:

- Require data analysis of public funding. It appears that mental health and/or chemical health problems are the key contributors or causes for people to be in so many of these systems, whether it is Corrections, Special Education EBD, Social Services, Child Protection, etc. If these are the major contributing factors (mental health or chemical health) one of the questions is, "Where is the money going?" "Where is all the public funding directed, especially for the individuals in systems other than the Mental Health system?"
- Secondly, we recommend screening and identification of individuals in these various systems who have mental health problem. For example, in Social services – are these parents who are neglecting their kids suffering from depression, chemical dependency, etc? Is Social Services screening for mental health disorders? There is a very high co-morbidity of mental health and chemical health disorders in these clients, especially in women. Special Education in the state mandates a mental health screen for children for an evaluation for EBD services, but the State needs to tell school professionals what to do once the screening is done if it identifies a mental health disorder in a student. There is no direction to

- school districts of what to do. The Corrections system has the same problems. We need to identify these people and assist in the provision of their treatment.
- Improve data gathering, analysis and communication within the systems. We need to have methods within data privacy where different systems can communicate effectively, and we need the technology to do this in a way that does not violate data practices statutes.
 - Co-location of services. There are many successful examples that we are seeing where social workers are working in police departments, where mental health professionals are working in doctor's offices, where there is school based mental health treatment in the schools. We have to push for the co-location because that is one of the best ways to collaborate, but we have to find ways to do it that are actually reimbursed, where people can be paid for same day services and where the services can be coordinated among the different systems.
 - Training. Who to train? Basically everybody. We need to educate lawyers, police, educators, medical professionals, social workers, judges, probation officers; they all need training about mental health. They all have individuals who have mental health disorders in their system and the lack of knowledge often results in very expensive services that are not effective.
 - We have to overcome disincentives. Mark Twain said, "I'm all for progress, I just can't stand change" The systems are doing things that need to be changed; we need to figure out how to do it. Each system has its own mission, vocabulary, history, agenda, hidden agenda, funding streams, and legal constraints; we have to understand what these are. If you want these systems to collaborate we have to be able to overcome the disincentives for change.
 - We have to address cultural issues. This has been discussed here today, and our group is very supportive of addressing this need.
 - We need to assure payment for collaboration. The question is, "If you have multiple fragmented systems, how do you get the systems to cooperate? One way to do it is to make sure they don't get paid until they actually cooperate. One way to do this is to have an integrated payment system whereby if these clients are in public systems, then the systems need to look at their overall costs regarding services to these individuals, and then to create a payment mechanism in such a way that there is an incentive rather than a disincentive to collaborate.
 - How about universal coverage of health insurance for all Minnesotans? Now, that would be a nice start. This would also overcome the disincentive for school districts to become the payer of last resort, which is a major problem of kids being identified, and services being provided.

So we're expecting all these to be resolved within the next 30 days (laugh). No, we expect that major progress can take place with these issues and we are hoping that the Academy can be helpful in this regard.

Read Sulik: Outstanding. What about now...all those are incredible ideas and very action oriented. The "who" comes to mind for me.

Table 6: You. (laugh)

Read Sulik: Besides me. (laugh)

Table 6: I would like to reiterate that before the folks leave the room that are involved in payment I would love to hear somebody make a statement...you know, you're all right and I'm going to go back to Blue Cross or Ucare or whomever and we're going to push for this to happen.

Read Sulik: I think we've got a really nice relationship with our health plans in Minnesota I think it continues to build and build. I think there is room to really bring those relationships to allow us at the table with the more senior leaders in the health plans to address some of these issues. So an action step here would be to take that list of very action oriented ideas and for us as the Minnesota Society of Child and Adolescent Psychiatry what is our role in trying to put several of these things to action right now. Ok, any other thoughts? Any other ideas for Will and Will's table?

Ok, we're doing great on time. Table 7.

Screening / Bullying / School-based Services
Table 7 Action Summary

Table 7: We were to discuss school-based prevention, screening and bullying was also on the list. We spent a fair amount of time talking about the political context and some of the things that were eluded to earlier about sort of Right Wing paranoia if you will about what are we trying to do to kids minds and this sort of thing and then I got educated on some of the systems that were involved so far in this issue. As we were trying to discuss what could this academy do to address the school screening issue, Cindy mentioned there is already a school social worker organization working on social and emotional development being embedded into the curriculum and I think I'll ask her to explain a bit more about that.

Cindy: The Minnesota School Social Workers Association is in the development of a legislative proposal promoting the adoption of standards for social and emotional development similar to reading and math and social studies standards that we have in our schools. Then it becomes embedded as work the school needs to do. There are several states that have pushed to have standards built into their schools curriculums such as, Illinois, Alaska and Hawaii. Standards for Social emotional development would concretizes the role that schools play in not only the academic development but also the social and emotional development of children.

Table 7: Thank you, so as a concrete step I think this organization should reach out and form a connection if we don't have it already with this Minnesota school social work group that is working on that.

The 2nd issue has to do with available resources in the school to do adequate triage when kids are identified. There is another group Cindy identified called the Student Services Coalition for Effective Education, which I'm not sure we have a connection with. Read do you know?...ok, it is a coalition of school psychologists, nurses, counselors, social workers and chemical health people that are already meeting to talk about adequate staffing levels in the school for social support and that sort of thing. So again, a lot of this is beyond the purview of our usual practice but we ought to at least have a dialog with them and I think we can be resources in advising on what is an appropriate triage, what is an appropriate screen. So concretely reaching out to those organizations and being sure we are in contact with them as legislation develops.

Read Sulik: So you've got contact with both these organizations. Can I ask that you set up a meeting with us and both of them at some point in the future as a place to begin and we'll distribute anybody who is interested in coming to those meeting as a place to start. I promised Will that the outcome would not be; let's have another meeting...we'll call it a gathering. (laugh). Table 8.

Evidenced-based Practice / Outcome Measures Table 8 Action Summary

Table 8: Karen was going to present and then she had to leave and she gave the mic to Cari who had to leave who gave the mic to me and I'm going to take it because I don't want Larry to have it (laugh). Our table was working evidence based practice and outcome measures. These are summarized by the group:

1. The Academy endorse the use of standardized system checklists at baseline and follow up. As an action item I would ask perhaps the Center for Excellence could make these available for free to clinicians on-line.
2. Adjust therapy and treatment if no progress is shown.
3. Evidenced base should apply to psychotherapies as well as medications.
4. Use functional status or impairment as a possible outcome measure. Cari's group, the Center for Excellence is involved in translating research to clinical practice. We talked about operationalizing the treatment plan for example, using real world outcomes like jail time, school absence, job lost or kept.
5. Recognition that clinicians are fearful that the use of evidenced based standards will limit our treatment options and we might be able to counter that by using patients as their own control.
6. Influence organizations that fund research studies by building stronger links between clinicians and researchers and also the funders.
7. Expand the definition of evidenced based practice to include general clinical skills such as communication between professionals or education of patients and parents as well as treatment options per say.
8. Educate members including teachers and parents on why it is important to cooperate with evidenced based initiatives.

Read Sulik: Outstanding. Ok, I think we've got some good action oriented steps there. Does anybody have any additional thoughts? Glenace first and then over here.

Glenace: (inaudible)...really good work on that (inaudible)...intense coordination

Question/ Comment from audience: One of the things from a general pediatrician standpoint was that when the Vanderbilt (which is the ADHD/ADD screening tool) became public domain we all started to use it because it was public domain, I really would encourage anybody who has any say to push toward some screening tools becoming public domain. It really enhances our ability to use them.

Read Sulik: Table 9

**Improving Reimbursement for
Child and Adolescent Mental Health Services
Table 9 Action Summary**

Table 9: I can start out and then Mark is going to add a few things too. Obviously we bit off a little more than we can chew in terms of reimbursement as an overarching topic but some of the thoughts leading to the action plan and the macro issues of what we started out today talking about which was Tom Anders talking about work force shortage and there is a macro issue of how can we convince clinics, health care systems to hire more people. We need to steal them from other states and give the other states access problems (laugh) or they'll need to work on this on their own, but it's an interesting strategy. In terms of right now all health care systems are operating under the assumption that providing child mental health is a money losing proposition as defined by the usual fee for service or other kind of health care economics running a health care system as opposed to say cardiology or other intervention based specialties. So part of this works toward convincing health care systems that they can afford to hire. I can speak from personal experience in Duluth as an underserved area including all the providers in the area, every single one of the providers in the Duluth area is skeptical about hiring more children's mental health providers because of that fear and that has been brought up before that retention is as much of an issue too. So those are some of the macro issues.

MMHAG is going to be a crucial organization as well as the other advocacy organizations in the state or groups. Because of it's having practitioners and legislatures, human services people in the same room, that's anything pertaining to issues affecting reimbursement some of the important meeting are going to take place at such a table. Another thing we discussed as an overarching concerns of the reimbursement issue is the anti-trust rules that apply. We all know or know somebody who knows anything about the economics of running (whether you are a profit or non-profit entity, small business or big health care group) we all negotiate our own contracts with each of the insurance providers and there are anti-trust considerations that limit us, for instance of being able as a group (say the Minnesota Society) of being able to negotiate what would be clear fee

schedules that would help our recruitment efforts. So we can't do something directly on a grand scale like that but we are all going to be responsible to understand the need to negotiate independently while using each other as a resource. For instance one of the steps on the action plan is: Do we need to present to health plans a set of...it was brought up earlier prior authorization problems, getting approval for service provision right from the outset. A lot of the problems have gone away thanks to the health plans seeing that it doesn't do any good to try and limit those kinds of things but there are still codes that don't go through when you try to bill them, especially when we're looking at the fact that if you can consider a standard child psychiatry eval to be 90 minutes vs an adult eval to be 60 minutes yet the same codes are used. There is small modifier there if you use for instance what some of you know as a 90802 code and interactive billing code as opposed to a standard psychiatric evaluation code but not enough to make up for the difference. There is not an automatic piece whether it is an evaluation or follow up to address the complexity that goes into some of the child psychiatry issues. So part of the going backwards to the action plan step, try to do away with any remaining issues with respect to coding, for instance to have consultation codes, evaluation and management codes, standard evaluation codes, interactive codes, all being able to be on the list of approved codes so that systems aren't left trying to get those approved separately wasting the efficiency.

Will had mentioned some good news about negotiating with a specific HMO. I know that BlueCross and medical assistance within the past year announced rate increases that try to go toward this. It's too early to tell what the impact has been including on the ability of systems to hire more people to provide the care. PMAP is another thing.

Again in terms of an action step a lot of work is probably going to be happening in MMHAG and affiliated organizations but parallel with universal health care idea in the state of Minnesota is going to be how to manage medical assistance populations efficiently and effectively. I know a mission dear to Glenace's heart and some of the how do we deal with paradoxes and for instance that we can see that sometimes our best payer is straight medical assistance and where we get the worst reimbursement is on the prepaid medical assistance plans and different paradoxes about that when it comes to essentially managing largely the same population. So the sound of this is more of a problem list than a action plan, but I think that there is a certain amount of homework that each of our systems is going to need to do on it's own. Then there is going to continue to be a need for work groups to discuss how are we going to go to MMHAG and represent there and other organizations. Mark you had some other things too.

Mark Kerekes: Way to go Steve. Nice job. You know what are we doing is the big question. What do we do day by day and how do we capture that. There is so much we do and I know you guys are all probably on roller-skates too. With all the schedules to do prescriptions, and the phone calls, card forms, IEP's, it's a lot besides just these codes. The codes - by the way, I had a nice opportunity to review some of this coding stuff for the meeting and just look at our initial eval. We have the 90801, the 90802, (I don't know if I've got these numbers right), you've the E&M 99205, 99245 consultation, various levels of those, you can code by the form with all the different stuff on it. You can do it

by the time which 50% of the time in counseling and/or coordination of care there is six different options for what we do. It's pretty confusing and in and of itself takes a lot of time away from the patients and I don't know why this isn't just a pure time kind of thing. I think the E&M gets closest to capturing that. Many of you have gone to the seminars and I know most of us probably have, take a good look at that and see what you're doing and try to get a line as best you can with what you are doing and capturing that. It's complicated by the federal level, it's complicated by the OCMS, the state level the AMA, the whole RVU issue and the individual payers will ultimately pay what they pay and it is variable depending on what contracts were negotiated. There are so many pieces here and you wonder why how many of the last MPS presidents have gone off into fee for service. Which is a problem...many good people are going off and saying enough of this. That is what is happening and how many people can fork out whatever the fee is for med check or evaluation when you have ADHD. The family may have ADHD or financial issues that don't allow them to do that. So some questions I have are, What do we have available to us? Is there anyway of standardizing or having universal codes for just basic ones, maybe they are already out there, I don't know. I hear a lot of people are doing 90801s the 90805, the bundled codes with therapy plus ENM or evaluation or management. What are the codes out there that are being used that not one has any confusion or disagreement about? What are some basic ones and I know there was quite a list there. It would be very helpful if we could do them. I don't know. We were just talking in our group how realistic...

Read Sulik: The American Academy of Pediatrics as part of their mental health task force has just done an exhaustive review of every potential code that can be used in the primary care setting or mental health setting for what we do and how to use those codes. That will be coming out in two different types of tool kits. There will be a mental health tool kit made available to all primary care providers or anybody else cares for it, but there is also a state council tool kit that will go out. The idea of those council tool kits is that it will reach organization to use in partnership with their local child and adolescent psychiatric organizations to use as an educational format for providers.

I think an action step that I would suggest is maybe we arrange a joint meeting when those tool kits are available to arrive at some training availability for how to be using these codes in a more efficient manner.

Mark Kerekes: Another one is on the AACAP website have you guys checked out the CPT module? There is one October 2006 that are about 45 pages long, but they update on a regular basis and they're careful to say that because it changes so often. It is really pretty good. It is one of the better things and the American Psychiatric Press has some things as well. So that's about it.

Read Sulik: I think we are at the point where we adjourn in about one minute or less and I just want to just sort of summarize what we are going to do. We've actually been very successful in capturing this day with the recording and we are going to have the meeting transcribed and from that transcription Linda and I will work together to collaborate this into a nice little report that will get distributed then with the summary action steps. We

are going to really move on this. Each of the table really came up with some very concrete specific things that I think we can move forward on very quickly. We can't solve it all within 30 days probably, but we'll get started. I think that this was really a great way to...I would say as a child and adolescent psychiatrist it feels incredibly reassuring when we can ask for some people to come to a room like this and help us think through these issues we are really struggling with and we've got to work together to make this work better here. I thank you again for coming and look forward to us all coming back together to speak not only about ongoing problems and concerns but about progress. Thank you.

Appendix 1: Summary of Suggested Action Items Table Discussions

1. Early Intervention / Prevention / Infant-Toddler Services
 - A. Endorse multi-disciplinary application of the DC 0 – 3R (Diagnostic Criteria Zero to Three) The Minnesota Psychiatric and Child Psychiatric Associations need to vote on, and endorse, the DC0-3R manual for diagnosing infant, toddler, pre-school mental health problems. The next step would be to ask both the Minnesota Assembly reps to the Academy Assembly and to the APA Assembly to bring that action forward for discussion and a vote in those groups and then we can bring prospectively to the Council of the Academy and the Board of the APA.
 - B. Identify and collaborate with a partner organization to reach out and target pediatricians, both existing and pediatric residency programs to enhance their skills in working with infants and parents.
 - C. Endorse screening for maternal depression and developmental and mental health screening of young children through the use of the ASQSE and Pediatric Symptom Checklist.
 - D. Identify clinics that would expand upon the ABCD2 model and explore the feasibility of integrating screening programs with well child visits.
 - E. Explore possibly pilot co-locating monthly in community clinics, child psychiatrists with other multi-disciplinary practitioners to provide mental health assessment and recommendations to providers of care to 3 and 4 year olds.
 - F. Promote the infant mental health professional endorsement program to enhance the skills at all levels with people working with young children to address their mental health needs.
 - G. We had this groundbreaking idea to promote an AARP model of low dues and high education services to new families. This would be funded with non-Pharma private funding.
 - H. Promote more research in translation of research to practice.
2. Cultural Competence / Addressing Needs of Diverse Populations—The Minnesota Society of Child and Adolescent Psychiatry work with the American Academy of Pediatrics and the Minnesota Psychological Association to come up with some educational forum around mental health needs in diverse populations addressing cultural competency issues to improve the skill sets of all of us as providers as a place to start.

3. Collaboration with Primary Care –
 - A. Explore the Children’s Physician Network as a structure that is already in place to expand on that structure to create a statewide organization that is the central resource for collaborative children’s care in Minnesota.
 - B. Approach ICSI to be part of that initiative and look at using ICSI to develop more collaborative models that could be put into place. The burden of cost to those models be shared amongst all systems and health plans that are part of ICSI.

4. Legislative Issues and Collaboration with Advocacy Groups\
 - A. Apply for \$4,000 from the Assembly of the Academy for an advocacy and education grant to support the development of a program for this.
 - B. We all thought it would be really helpful for our state to have a full-time child psychiatrist as the mental health director for the state. Other states have this and it is apparently very helpful and useful in supporting children’s mental health needs in the state. That person would help direct policy at the state and I think real importantly be available to testify to the legislature and educate our legislators about children’s mental health needs and policy needs.

5. Directory of Resources – There is a \$500 grant available to set up and put online so it could stay current, include the link on the page, so not so much listing about every resource but doing it more in a link format. The action step is to apply for the grant and work with our board in terms of setting up the website. The other thing I talked about was going to the MN AAP because pediatricians could have easy access as well and the CNS groups and practitioner groups in the state.

6. Enhancing Collaboration Between Systems
 - A. Require data analysis of public funding. It appears that mental health and/or chemical health problems are the key contributors or causes for people to be in so many of these systems, whether it is Corrections, Special Education EBD, Social Services, Child Protection, etc. If these are the major contributing factors (mental health or chemical health) one of the questions is, “Where is the money going?” “Where is all the public funding directed, especially for the individuals in systems other than the Mental Health system?”
 - B. Secondly, we recommend screening and identification of individuals in these various systems who have mental health problem. For example, in Social services – are these parents who are neglecting their kids suffering from depression, chemical dependency, etc? Is Social Services screening for mental health disorders? There is a very high co-morbidity of mental health and chemical health disorders in these clients, especially in women. Special Education in the state mandates a mental health screen for children for an evaluation for EBD services, but the State needs to tell school professionals what to do once the screening is done if it identifies a mental health disorder in a student. There is no direction to school districts of what to do. The Corrections system has the same problems. We need to identify these people and assist in the provision of their treatment.
 - C. Improve data gathering, analysis and communication within the systems. We need to have methods within data privacy where different systems can communicate

effectively, and we need the technology to do this in a way that does not violate data practices statutes.

- D. Co-location of services. There are many successful examples that we are seeing where social workers are working in police departments, where mental health professionals are working in doctor's offices, where there is school based mental health treatment in the schools. We have to push for the co-location because that is one of the best ways to collaborate, but we have to find ways to do it that are actually reimbursed, where people can be paid for same day services and where the services can be coordinated among the different systems.
 - E. Training. Who to train? Basically everybody. We need to educate lawyers, police, educators, medical professionals, social workers, judges, probation officers; they all need training about mental health. They all have individuals who have mental health disorders in their system and the lack of knowledge often results in very expensive services that are not effective.
 - F. We have to overcome disincentives. Mark Twain said, "I'm all for progress, I just can't stand change" The systems are doing things that need to be changed; we need to figure out how to do it. Each system has its own mission, vocabulary, history, agenda, hidden agenda, funding streams, and legal constraints; we have to understand what these are. If you want these systems to collaborate we have to be able to overcome the disincentives for change.
 - G. We have to address cultural issues. This has been discussed here today, and our group is very supportive of addressing this need.
 - H. We need to assure payment for collaboration. The question is, "If you have multiple fragmented systems, how do you get the systems to cooperate? One way to do it is to make sure they don't get paid until they actually cooperate. One way to do this is to have an integrated payment system whereby if these clients are in public systems, then the systems need to look at their overall costs regarding services to these individuals, and then to create a payment mechanism in such a way that there is an incentive rather than a disincentive to collaborate.
 - I. How about universal coverage of health insurance for all Minnesotans? Now, that would be a nice start. This would also overcome the disincentive for school districts to become the payer of last resort, which is a major problem of kids being identified, and services being provided.
7. Screening / Bullying / School-based Services
- A. Develop standards for social and emotional development similar to reading and math and social studies standards that we have in our schools. Then it becomes embedded as work the school needs to do. So it concretizes the role that schools play in not only the academic development but also the social and emotional development. This organization should reach out and form a connection if we don't have it already with the Minnesota school social work group that is working on that.
 - B. Resources must be available in the school to do adequate triage when kids are identified. There is another group Cindy identified called the Student Services Coalition, a coalition of school psychologists, nurses, counselors and chemical health people and social workers that are already meeting to talk about adequate

- staffing levels in the school for social support and that sort of thing. So again, a lot of this is beyond the purview of our usual practice but we ought to at least have a dialog with them and I think we can be resources in advising on what is an appropriate triage, what is an appropriate screen. So concretely reaching out to those organizations and being sure we are in contact with them as legislation develops.
- C. Table 7 participants will set up both meetings as a place to start.
8. Evidenced-based Practice / Outcome Measures
- A. The Academy endorse the use of standardized system checklists at baseline and follow up. As an action item I would ask perhaps the Center for Excellence could make these available for free to clinicians on-line.
 - B. Adjust therapy and treatment if no progress is shown.
 - C. Evidenced base should apply to psychotherapies as well as medications.
 - D. Use functional status or impairment as a possible outcome measure. Cari's group, the Center for Excellence is involved in translating research to clinical practice. We talked about operationalizing the treatment plan for example, using real world outcomes like jail time, school absence, job lost or kept.
 - E. Recognition that clinicians are fearful that the use of evidenced based standards will limit our treatment options and we might be able to counter that by using patients as their own control.
 - F. Influence organizations that fund research studies by building stronger links between clinicians and researchers and also the funders.
 - G. Expand the definition of evidenced based practice to include general clinical skills such as communication between professionals or education of patients and parents as well as treatment options per say.
 - H. Educate members including teachers and parents on why it is important to cooperate with evidenced based initiatives.
9. Improving Reimbursement for Child and Adolescent Mental Health Services
- Again in terms of an action step a lot of work is probably going to be happening in MMHAG and affiliated organizations but parallel with universal health care idea in the state of Minnesota is going to be how to manage medical assistance populations efficiently and effectively. I know a mission dear to Glenace's heart and some of the how do we deal with paradoxes and for instance that we can see that sometimes our best payer is straight medical assistance and where we get the worst reimbursement is on the prepaid medical assistance plans and different paradoxes about that when it comes to essentially managing largely the same population. So the sound of this is more of a problem list than a action plan, but I think that there is a certain amount of homework that each of our systems is going to need to do on it's own. Then there is going to continue to be a need for work groups to discuss how are we going to go to MMHAG and represent there and other organizations.

The American Academy of Pediatrics as part of their mental health task force has just done an exhaustive review of every potential code that can be used in the primary care setting or mental health setting for what we do and how to use those codes. That

will be coming out in two different types of tool kits. There will be a mental health tool kit made available to all primary care providers or anybody else cares for it, but there is also a state council tool kit that will go out. The idea of those council tool kits is that it will reach organization to use in partnership with their local child and adolescent psychiatric organizations to use as an educational format for providers.

I think an action step that I would suggest is maybe we arrange a joint meeting when those tool kits are available to arrive at some training availability for how to be using these codes in a more efficient manner.

Appendix 2: Attendee Information

Attendees

Sue Abderholden
Donna Ahrens
Tom Anders
Mark Anderson
Muhammad Waqar Azeem
Carrie Borchardt
Chris Bray
Amy Burt
Catherine Carter
David Cline
Nancy Collins
Tom Converse
Larry Dailey
Will Dikel
Regina Driscoll
Matthew Eastwood
Glenace Edwall
David Einzig
David Fassler
Tim Gibbs
Frances Go
Peg Hayes
Mike Hatch
JoAnne Hoffman Jecha
Connie James
Susan Jenkins
Jonathan Jensen
Pam Johnson
Mark Kerekes
Wes Kooistra
Candy Kragthorpe
Sanjiv Kumra
Mark Kuppe
MaryBeth Lardizabal
Theresa Lau
Karen Lloyd
Kim McPhatter
Cari Michaels
Linda Norlander
Jeremy Olson

Roberta Opheim
Robert Perzacki
Suzy Peterson
Barb Peterson
Judson Reaney
Heather Renner (for Congressman Jim Ramstad)
Paul Renner
Mike Runyan
Debra Saxhaug
John Scanlan
Jeffrey S. Schiff
Ann Schwanke
Stephen Setterberg
Cindy Shevlinwoodcock
Gulshan Singh
Nimi Singh
Read Sulik
Steve Sutherland
Lori Swanson
Ernie Swihart
Vicki Thrasher Cronin
Linda Vukelich
Carol Woolverton
Ghita Worcester