HRSA
Maternal & Child Health

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Implementation Toolkit

for Pediatric Mental Health Care Access (PMHCA) programs and Screening and Treatment for Maternal Health and Substance Use Disorder (MMHSUD) programs

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“We hope that this toolkit is helpful and help us all create care systems in which the professionals caring for children and perinatal individuals have the support and resources they need to deliver evidence-based and equitable mental health care.”

—Nancy Byatt, DO, MS, MBA. DFAPA, FACLP, Executive Director, Lifeline for Families Center, and Lifeline for Moms Program

“As President of the National Network of Child Psychiatry Access Programs, thanks for using this toolkit. We look forward to the time when primary care clinicians for children, and perinatal clinicians, can all call an access program to achieve equitable access to behavioral health care.”

—John Straus, MD, FAAP

Background

The first child psychiatry access program (CPAP), the Massachusetts Child Psychiatry Access Program (MCPAP), began in 2004 to support pediatric primary care providers who address behavioral health concerns presenting in the primary care setting. MCPAP was developed to solve the problem of lack of access to pediatric mental healthcare, especially child psychiatry. Due to workforce shortage challenges, primary care providers could not find pediatric mental healthcare for their patients. MCPAP supports the pediatric primary care providers in 1) assessing and treating mild to moderate mental health concerns presenting in the primary care setting, and 2) finding resources to address mental healthcare needs. MCPAP does this through numerous different platforms including consultation, training and education, and resource and referrals. A core component of all CPAPs is the "warm line" or peer-to-peer consultation model with timely access to a child and adolescent psychiatrist to support the primary care provider. Due to the success of MCPAP in increasing access to pediatric mental healthcare and workforce shortages across the United States, other states began similar programs. Building on the success of MCPAP, MCPAP for Moms was initiated to help perinatal providers detect, assess, and treat mental health and substance use concerns. Similar to expansion across the country after MCPAP demonstrated success, other states began to implement Perinatal Psychiatry Access Programs (PPAPs) modeled on MCPAP for Moms. The benefits provided by these and other programs across the United States led to Sec 10002 of the 21st Century Cures Act, which called for the development of pediatric mental health care access grants to support the development of Pediatric Mental Health Care Access (PMHCA) programs and Screening and Treatment for Maternal Mental Health and Substance Use Disorder (MMHSUD) programs.

This "implementation toolkit" has been developed to guide new PMHCA and MMHSUD grantees with implementation strategies and tools.

Initial Steps

Grantees have learned they are funded, and funding will commence on a specific date. It is essential to determine who will actually "own" the grant. For example, will the jurisdiction be conducted through a state agency, a different state entity, state university, state behavioral health program, or Tribal government? The official grantee will need to gain an understanding of the decision-making structure of the funded organization, reporting lines of the organization, and the "rules" with respect to public facing "products" developed by the PMHCA or MMHSUD program.

> "As the HRSA Team Lead for the Pediatric Mental Health Care Access program, thanks for using this toolkit. Regardless of what stage of the journey you're in with program implementation, this toolkit has been built with your program in mind. Our hope is that you will use it to increase the reach of your programs to pediatric primary care providers. We are striving for a day where there is increased access to better behavioral health care for all kids who need it."
>
> —Madhavi M. Reddy, MSPH

Shortly after funding notification, a planning and implementation team must be established and will need administrative support from the grantee agency. It is vital/crucial for this team to include clinical care providers (pediatric primary care providers for PMHCA, providers serving pregnant and postpartum individuals for MMHSUD, family medicine and school-based health centers). If possible, providers practicing in both rural and urban settings. Clinical care providers will help to inform the planning and implementation team of the

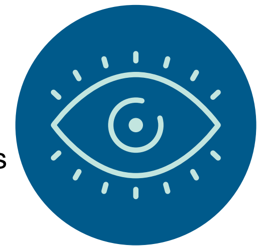
realities of the workflow and demands faced in community-based clinical settings. These clinical care providers can also serve as champions with implementation and growth of the program. Early in the planning phase, members of the planning and implementation team need to have or gain an understanding of the need for and value of these relationships. Successful PMHCA and MMHSUD programs incorporate relationship building as a core tenet. Relationships need to be established or nurtured with professional regional organizations such as American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Obstetricians and Gynecologists (ACOG), and School-Based Health Alliances. During the application writing, were there advisors involved that could continue as part of the planning committee?

For membership in the planning process, consider including institutions with child psychiatry departments for PMHCA and perinatal psychiatry for MMHSUD.

As the planning and implementation team is established, each team member will need to understand the proposed model and key components, the outcomes being sought, and initial ideas with respect to workflows/algorithms. Consider obtaining consultation from an established PMHCA or MMHSUD program. For MMHSUD programs, the Lifeline for Moms Program is available to help you find other programs to consult with or can provide consultation. Programs can also consider joining the National Network of Child Access Programs (NNCPAP) (www.nncpap.org) or the National Network of Perinatal Psychiatry Access Programs (www.umassmed.edu/lifeline4moms/Access-Programs/). Their websites have helpful information and newly funded programs may learn from programs that may share similarities (urban/rural splits, approaches to Medicaid, cultural and equity factors, Tribal Nation, etc.) Technical support is also available from your HRSA project officer and the HRSA MCHB TA Innovation Center.

> “We’ve learned so much from implementing Pediatric Mental Health Care Access programs over the past five years; Dr. Fritsch has synthesized the essence of those lessons learned so that all pediatric primary care clinicians can have access to this practice- and life-saving intervention.”
>
> —David Keller MD, FAAP (pediatrician)

Developing Vision for Program and Early Implementation Procedures



There are several critical questions to answer when developing a vision for a PMHCA or MMHSUD program. Below are questions that are critical to answer while developing a vision for implementation:

- What was/is the “vision” for the implemented program?
- What is the potential child or perinatal population being served?
- Based on the size of the youth or perinatal population being served, should there be a single operational site for administrative and clinical services inclusive of regional, cultural, urban, and rural differences, or should the program be developed as a “multihub” program established based on population, geographic, or cultural differences?
- If multihub, what entity is going to coordinate the hubs, collect data, set policies and procedures, and coordinate financing?
- If the program’s jurisdiction does not have enough psychiatry resources or population to support a full team, should the program partner with another jurisdiction?

Questions to consider while operationalizing the vision include:

- What will be the service components being offered, with the consultation line being an essential component and what additional core service components will be offered (resource and referral, perinatal/youth/family direct consultation, types of educational services)?
- How will the consultation line be constructed (telephone line or e-consult platform)?
- Real time vs. asynchronous response?
- How will resources be identified and offered, with supports through a clinical care coordinator or virtual electronic resources, even potential utilizing search algorithms?
- Will the program be offering formal education products for enrolled providers and any platforms for educational products?
- Is there also a local CPAP or Perinatal Psychiatry Access Program (which may also be funded by HRSA) program that could be partnered with to be more efficient in terms of staffing/administration/education?

Visioning also includes a strategy for marketing and branding. Questions to consider for branding include:

- What will the name of the program be? Will there be a logo?
- Will there be website offerings and supports, and if so, will this be a unique URL or a link to the grantee organization?
- Part of considerations during this visioning include what will be permitted from the grantee organization, but also what will engage participants the most.
- How is the grantee organization viewed by potential participants? In some areas, state agencies and university systems are viewed by community providers as controlling and forcing undesired changes, and in other areas the grantee organizations are highly regarded by community providers and patients.
- Who are the main child psychiatry or perinatal psychiatry academic potential partners?
- How will the program develop and nurture these relationships such that all potential organizations and individuals feel mutually valued and respected?

As the vision for the program is being developed by the planning and implementation team, developing a financial plan should occur simultaneously (See Appendix C-6). This plan should include anticipated full cost of program for when it is fully operational, the program startup funding sources (HRSA + other possible funding sources), plans for sustainability, and economic justification. HRSA money should only be considered “startup” funding, with sustainability work occurring even in the initiation phase of the program.

As the planning and implementation team begin their work, defining and assigning the organization and persons accountable for components of executing the workplan is critical.

An early operational detail is determining your telephone needs. Questions for that include:

- Will the program have a central number if multihub, or a unique number for each hub? If multihub, should the program consider a web-based phone system to facilitate call triage.
- Can the program obtain an easily remembered number?

Developing the Core Team

To move towards implementation, the core team needs to include a clinical team, data management team, evaluation team, and a team that focuses on communication and marketing strategies. Pediatric/family medicine/obstetric/school-based health center liaisons/champions also need to be developed. In addition, if there will be geographic hubs, the functioning spaces for operations will need to be determined.

Currently operating PMHCA and MMHSUD programs typically have the following functioning teams or team members (See Appendix C-1):

- Program manager
- Medical director
- Care coordinators/navigators
- Consulting child and adolescent psychiatrists or perinatal psychiatrists
- Consulting behavioral health specialists (integrated clinician-masters or PhD prepared)
- Data manager
- Evaluation team
- Grantee Administrative Support

Other factors to consider when developing the core clinical team include the need for communication expertise inclusive of branding, promotional materials, marketing (outreach) plan and materials, and website development.

The data manager and core team will need to determine what data will be collected (see below) and what IT platform will be used. Data management must be HIPAA compliant, portable (used in multiple settings by multiple individuals), and if possible, provide dashboards that are easy to use and provide meaningful data. The data management system should serve to not only allow input of your required data but support efficient operations such as assigning and tracking calls so that nothing is lost. Additionally, the system should keep track of your clinical advice so when a provider calls again about the same patient, your advice is consistent and knowledgeable about that patient. Some programs are using their software to provide secure connections with providers to enter requests and allow e-consults. Your software can also support follow up and a include a secure platform to build measurement-based care with connections to families and providers. The data management system could be constructed from internal software such as REDCap or Microsoft Access or utilizing commercial products from companies such as Trayt™ or Salesforce™. This toolbox does not promote use of one data management tool over another if it supports all the needs of your program and fits your budget.

As the core team is being recruited, training core team members is also part of the onboarding process. For onboarding and training of your PMHCA or MMHSUD team consider a site visit to an established program to learn about their onboarding processes. Some tips with respect to team member training include the following:

Medical Director

- Core functions include oversight to model development and fidelity measures, input on all educational activities, and interfacing with key primary care provider stakeholder groups.
- Will also recruit consultants for team, and train/onboard new consultants.

Program Manager

- Core functions include hiring and supervising clinical care coordinator(s)/navigator(s), ensuring fidelity to the model, fiscal oversight, and oversight of reporting requirements (monthly, quarterly, annual, etc.)
- Will also help with program development and ensure fidelity to the program components.

Clinical Care Coordinator/Navigator (CCC or CCN)/ Resource and Referral Specialist

- Interview and hiring process should include ensuring a core understanding of customer service ("always answer the phone in welcoming way"), commitment to ensuring accurate data, and some awareness of behavioral health needs of youth treated in primary care in order to achieve appropriate triaging.
- Needs to be core part of team; support engagement materials ("one pager"), process of practice enrollments, able to connect with practice managers.
- Would be helpful to observe a functioning CCC either in current site or another PMHCA or MMHSUD site.
- In the early phases of the program, consider a strategy of using a "Secret Shopper" for assessing the CCCs contact with primary care or obstetric providers for satisfaction and learning opportunities for effectiveness of new CCC/CCN.
- Develop and revise the coverage schedule of the child or perinatal psychiatrists.
- Participate as part of the quality assurance data management team.

Child and Adolescent or Perinatal Psychiatry Consultant(s)

- In considering attributes of your child and adolescent or perinatal psychiatric consultant(s), some core characteristics that are essential include: recognizing that each point of contact is an educational opportunity, has motivational interviewing skills to meet each primary or perinatal care consultant at their stage of knowledge and comfort, ability to "coach" the primary care or perinatal care providers, and understands and will participate in timely documentation for clinical continuity and quality improvement.
- Consider partnership with an organization that has child and adolescent and perinatal psychiatric providers to support recruitment.
- Plan for a Formal Orientation to Providing Peer to Peer Consultations (See Appendix A) including:
  - Overview of the program/core essentials conducted by program director
  - Training of peer-to-peer consultations: Mock calls with pediatrician or obstetrician following scripted cases (see Appendix B)
  - Data entry training
- Overview of other components of the role including practice enrollments, formal educational opportunities, and resources and materials development

Data Manager

- Must have familiarity of data collection, data management, and fidelity tracking
- Ensuring data management tools appropriate to the data needing to be collected
- Skills to provide training on the data management tool

Evaluation Team

- Must have familiarity in qualitative and quantitative methodology
- Reviews core evaluation components and meets with funders to ensure appropriate data metrics being collected to sustain program
- Notifies team of outcomes, timely trends, and guides towards new initiatives

Grantee Administrative Support

- Appropriate institutional leadership involvement
- Human resource support (institutional policy for job descriptions, salary, and hiring)
- Financial and accounting support
- Space, IT, supplies, other operational support

Advisory Committee

Your Advisory Committee can provide key supports towards implementation, growth, and work on sustainability. Members of your Advisory Committee could include:

- Key state pediatric or maternal and child health agency stakeholders such as the equivalent of a state behavioral/mental health office, early childhood, Medicaid agency, public health, Title V office, Tribal organization, and state education agency.
- Parent/lived experience groups
- Providers (pediatricians, family physicians, child psychiatry centers, pediatric academic centers, school-based health centers, emergency departments groups interested in BH/PH integration, obstetric providers and other groups interested in integrated primary care/obstetric and mental health care)
- Regional chapters of national organizations such as AAP, CAFP, AACAP, ACOG, AAFP, APA
- Insurers (commercial and Medicaid)
- Legislators
- Diversity, equity, and inclusion expertise

Quarterly meetings with the Advisory Committee could happen in person or virtually (post pandemic times have led to greater comfort with virtual meetings). If in person, "breaking bread together" can be a way to engage and connect. If virtually, starting each meeting with an introduction and fun "ice breaker" can support team member engagement. Below is a potential sample Advisory Committee agenda:

- Introduction and Ice Breaker
- "Hot Topics," Current Trends Happening with Behavioral Health, Current Topical Issues Affecting Committee Members
- Current Program Development: What has been accomplished since last meeting?
- Recruiting/Enrolling Practices: Gaining support for program growth from committee members
  - Specific practices that have utilized program but not enrolled in program-are there members who can reach those practices
  - Upcoming regional training opportunities being conducted by committee members from regional professional organizations (annual meetings, etc.) that program could present at and/or have a promotional booth
- Sustainability (new grant or legislative opportunities)

Work Plan/Project Management Considerations

Work plans are a component of the HRSA funded PMHCA and MMHSUD programs. These plans can be utilized as a project management tool, or the initial work plan written as part of the grant could be transferred/converted into a project management software system to guide the planning and implementation team. This functional document can serve as an indicator of progress (See Appendix C-5 for sample Excel work plan template and example from Colorado). Software programs such as Gantt charts or Smartsheets can also be utilized.

This project management tool should be reflective of the work needed to be accomplished for implementation, who is responsible (and reporting on progress), and percentage of completion. The project management tool should be reviewed at regularly scheduled grant meetings. When core milestones are completed, this should be celebrated and "shouted out."

Developing and Conducting a Needs Assessment

A "Needs Assessment" is an initial step to gaining an understanding of the perceived needs of the practices and providers intended for enrollment in either the PMHCA or MMHSUD program. The needs assessment should be crafted to inform your program of gaps and needs for behavioral health care for the defined population. (See Appendix C-2).

Know your denominator: It is imperative to know the practices operating in the program's catchment area that could be engaged in the PMHCA or MMHSUD program. The number of practices that could be engaged in the denominator and the number that have been engaged or enrolled is the numerator. Knowing and tracking this information can help programs track their engagement. This will also help programs to have an accurate database for email contact with providers considered for eventual enrollment in your program. Strategies to obtain a database of primary care providers can include reaching out to the state medical licensing board, asking regional professional organizations for their listservs (this is unlikely secondary to privacy stipulations) or asking regional professional organizations to post a link to the Needs Assessment in regular newsletters with a "closing date" also posted for the survey. Other state agencies that may be able to provide email contacts for providers may include the state medical society, the state public health department, or other agencies with access to that information. Your Advisory Committee members may be able to help construct the contact list as well. Many programs find that the best way is to use Google, town by town, to find pediatric and obstetric providers. For MMHSUD programs, request list of practices from birthing facilities.

Partnerships with Functioning PMHCAs and MMHSUDs

Wheels do not need to be reinvented. You will have a project officer helping support the development of your PMHCA or MMHSUD who is also the project officer for fully implemented PMHCAs and MMHSUDs. The project officer often has programs in the same geographic region or with programs with similar demographics of rural, urban, cultural, ethnic, or Tribal compositions. A consulting partnership with a functioning program can be helpful to guide your planning and implementation. NNCPAP and the National Network of Perinatal Psychiatry Access Programs and the Lifeline for Moms Program are available to help you find other programs to consult with or to provide consultation. Plan to join each network's listserv to hear about and ask for solutions to your questions.

Determining Core Program Components and Data Metrics (required and additional)

What will be the core components of your PMHCA or MMHSUD program? Defining the core components at the outset will also help determine your potential data points to capture. Questions to answer to define the core program components can include:

- Will your program offer an asynchronous electronic peer-to-peer consultations or a real time warm line or both? For the warm line, will there be a benchmark response guarantee call back time (within 30 minutes or at the primary care providers' time request)?
- What other consultations will your program offer? Patient/family consultations? Support on resource identification for the primary care provider? Face-to-face or telehealth consultations between the program provider and patients?
- What will your outreach efforts include? Marketing materials such as videos? Visits to practices? Offer to join a practice meeting to describe the program? Doctor to doctor contacts always work best. (See Appendix C-3.)
- Will your program offer a formal practice enrollment (recommended)? What will be included at the formal practice enrollment? Education about the program? Other formal education? Review of the participation agreement form? A "presurvey" to measure current state of access to care, use of screening tools, other metrics which then can later be paired with a follow up survey? A pragmatic "how to use the program?"
- Will your program offer formal training of new team members and subsequent monitoring for interrater reliability?
- How will your program develop a resource database? Will you ensure the resources are current and accepting referrals? Where will the database be stored? Will participating providers have access to the resource database independent of a call to the CCC/CCN? Will you just provide resources to practices or will you contact families to navigate finding a resource? If you contact families, will you follow up to see if the referral was successful?
- Will your program offer formal education to enrolled providers? Through what formats will those trainings occur? In-person large CME events? Webinars? Virtual trainings through programs such as Project ECHO or The REACH Institute? Offer Maintenance of Certification opportunities? Less formal lunch and learn formats? Presentations at summits and annual meetings of regional professional organizations?
- Will your program be developing a website and, on the website, offer other resources, such as a list screening tools or validated rating scales to provide measurement-based care, and additional clinical materials?
- Develop own clinical care supports and guidebooks or link to already existing one? (See Appendix C-4.)
- Another consideration is how to support the moral distress of the primary care providers, will your program offer supports to the primary care providers? Self-care initiatives? Informal virtual support gatherings?

Once the essential program offerings are determined, then data tracking and monitoring points can be developed keeping in mind HRSA data requirements, including:

- Practice enrollment metrics
- Encounters: peer-to-peer consultations (and the data tracking from each consultation), referral resource consultations, face-to-face patient consultations
- Annual utilization by provider and by practices
- Potential pre- and post-provider surveys to guide care
- Participation in educational activities, who and from what demographics (zip code, rural, urban, Tribal)

- Evaluation of effectiveness of the learning activities
- Plan for advanced trainings such as PMHCAs including perinatal and caregiver screening and concerns, early childhood socioemotional development, substance use concerns, eating disorder concerns, etc. For MMHSUDs, Autism spectrum disorders, substance use concerns, parental self-efficacy, wellness in the postpartum period, etc. This may require the addition of specialized consultants to the team.

Assessment & Screening

One of the core utilities of standardized approaches to screening at yearly well-child and perinatal visits is earlier identification and treatment. With early identification and treatment, there is the potential for prevention of co-morbidities and to enhance positive development. When programs screen regularly, positive screens drive the need for consultation and model for families that the practice is available to help with behavioral health issues, which also drives the need for consultation. As your program is being planned and then implemented, it is important to define your expectations and recommendations with respect to screening tools for both perinatal and primary care providers. Considerations include:

- Determine the screening policies, requirements, and supported billing codes in your jurisdiction. This will vary from state to state and territories.
- Know if any of the practices you are enrolling have "screening" as a Key performance indicator (KPI) to help support (can be an incentive to enroll if practices are receiving support)

Review current resources already available including AAP's Bright Futures or CoPPCAP's Screening Tools and Colorado Care Guide on Assessment & Screening, and MCPAP's "Screening & Toolkits". For MMHSUD program resources available include:

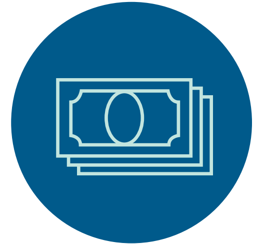
- Treatment and Management of Mental Health Conditions During Pregnancy and Postpartum | ACOG

Implementation "Pragmatics" Checklist

- ☐ Core team hired and trained?
- ☐ Has workflow algorithm been developed for program operations?
- ☐ Phone number, point of contact been determined? Ways to transfer phone when others covering?
- ☐ Coverage plans for expected (PTO) and unexpected absences?
- ☐ Do team members have the technology needed to run the program?
- ☐ Is there an outreach plan? And marketing materials developed?
- ☐ What will be the formal enrollment process?
- ☐ Is there a regular cadence to "grant meetings" (weekly recommended)?
- ☐ Does your work plan have achievable deadlines?
- ☐ Are there other state initiatives that the program can support such as socioemotional screenings at well-child visits or depression screening during obstetric visits?
- ☐ Have you contacted your regional professional organizations (AAP, AAFP, SBHCs, ACOG) for support and promotion of your program?
- ☐ Have you contacted your local child/perinatal/family/mental health advocacy organizations?
- ☐ What do you want to capture for outcomes and to share with others?
- ☐ Remember "every point of contact is an educational opportunity."
- ☐ Remember to bring a sense of fun and celebration to the work.
- ☐ Remember to capture testimonials to share with potential funders and others.

- Screening and Diagnosis of Mental Health Conditions During Pregnancy and Postpartum | ACOG
- Perinatal Mental Health Conditions | AIM (saferbirth.org)
- Guide for Integrating Mental Health Care into Obstetric Practice | ACOG

Payment and Financing



Each state and jurisdiction may have different opportunities with respect to billing and payments. This can continually evolve, and each team needs an awareness of potential new opportunities. On the provider side, the move to "time-based billing" allows for the provider to upcode their billing if receiving a PMHCA or MMHSUD consultation on the same day the patient is seen. Current billing codes for peer-to-peer consultation to the primary care provider without seeing the patient are now becoming available from insurers, and if they are available, reimburse the primary care provider for the time spent doing the consult when the consult is not on the same day.

Appendices:

Appendix A: Training of PMHCA or MMHSUD Psychiatric Consultants

Sample Schedule and Content

Schedule

1. Introductions, ice breaker
2. Discussion of PMHCA or MMHSUD program, goals and components of the program: Project Director or Medical Director conducting
3. Overview and discussion of cultural differences between:
    a. Pediatric primary care and child psychiatry or obstetric and perinatal psychiatry, and also training in the differences in each type of callers for PMHCA or MMHSUDs — all have different levels of expertise and cultures within their discipline — calls need to be tailored for type of caller and responsive to differing needs of caller
    b. Differences between academic medicine and community practicing providers regarding productivity, fiscal challenges, provider moral distress
    c. Likely differences between urban and rural practices (Advice may be different based on extent of community resources.)
4. Key/fundamental principles of:
    a. Every point of contact is an educational opportunity.
    b. Identifying where the caller is at with respect to experience and comfort and meet them at their current knowledge and skill level
    c. Make sure they know that you have their back and are there to help.
    d. Make education accessible.
    e. Management of our own anxiety since not seeing patient and complexity of patients treated in community settings
    f. How motivational interviewing fundamentals may be helpful in this model
    g. During the call, the calling provider's needs (and concerns) matter, and we need to help them develop self-efficacy and skills in managing mental health.

8. Current status: list of practices, what happens to enroll practices, schedule ahead for others to join
9. Overview of the data collection; patient encounter forms
10. Adult learning, experiential learning: practicing calls
11. Coverage schedule, needs, wants
12. Wrap up; feedback from participants

Appendix B: Active Learning Vignettes

(describe role playing as teaching method)

Setting the scenes:

PMHCA

Practicing pediatricians or peer consultants can be utilized as the pediatric primary care "calling customers."

CCC/N will present what he or she has learned so far and the patient encounter he or she has completed to date with the CAP who is doing the phone consultation.

Potential Practice Scenarios for the peer-to-peer phone consultation including:

1. Pediatric provider calling because their 11 yo patient was admitted to psychiatric inpatient unit, heard about admission when 13 yo sib was in for WCC, provider knows family, has treated family members for > 15 years and has valuable information to give. Why didn't someone call me?
2. 16 yo, practice just started screening with PHQ-A and teen screened with a 20, OMG that is in the moderate to severe range, but no SI and "what do I do" (nervous Nelly, but wanting help and support provider)
3. Provider in more rural area, taking care of kiddo with autism, did well for irritability and explosions with risperidone at 0.5 mg bid, but now with weight gain and gynecomastia, too far to travel, willing to handle the case if you can provide help, what next

Seeking 1x only consultations:

1. Calling because parents of 7 yo came into office after their child had been to see a child psychiatrist at another facility. The child psychiatrist diagnosed their child with attention-deficit/hyperactivity disorder (ADHD) and "rejection-sensitive" dysphoria disorder. Pediatrician has taken time to learn to feel comfortable with treating common ADHD and anxiety and in all the trainings and courses has never heard of "rejection-sensitive dysphoria disorder. The CAP had recommended a stimulant and guanfacine ER, the pediatrician is comfortable with that medication combination, but would like a 1x only consultation for diagnostic clarity.
2. 9 yo with anxiety, will be getting therapy, need a face-to-face consult for what to do about medication (hopefully CAP will put the brakes on and help you start something without being seen).
3. Complex kid, 11-year-old, just discharged from residential without resources planned, on Adderall, Abilify, Zoloft, and lamotrigine. Goal here would be for the CAP to say, will co-manage with you on the phone but really need to help you get resources, having the face-to-face may delay getting resources in place.
4. Calling wanting a 1x consultation for diagnostic clarification; has been seeing integrated clinician in the office, 6 yo with h/o ADHD and disruptive behaviors, some benefit with stimulant, but now seems sad, nervous, not sure of therapist is a good fit, please see and give some guidance.
5. Calling for a 1x consultation/2nd opinion as parents won't follow treatment suggestions for their very anxious and depressed appearing 14 yo daughter, PCP willing to follow whatever you recommend.

Perinatal

Case 1

22 yo G3P2 at 20 weeks GA presents reporting symptoms of depression. EPDS not done. Bipolar disorder screen not done. The provider tells you, “I want you guys to call her and get her services.” Additional history includes that the patient has been on an SSRI before, which worked well. The patient has no psychiatric treatment or therapy in place. You ask the provider some clinical questions (e.g., EPDS score), and the provider says, “I don’t know, I do not pretend to be a psychiatrist, nor do I feel comfortable treating these patients. They need to be seen by a specialist. I just want you to call her and get her services.”

Case 2

25 yo G2P1 at 15 weeks GA with 17 on EPDS, history of bipolar disorder, several psychiatric hospitalizations, was recently on an inpatient psychiatry unit, was started on lamotrigine and discharged without any outpatient psychiatry follow-up and has no one to prescribe her psychiatric medications. The provider reports, “I am calling to get her hooked into the psych system.” Additional history includes that the patient has been on several psychiatric meds in the past, is not currently suicidal, has had therapy previously, but does not have a therapist currently.

Case 3

35 yo G1P1 at 6 weeks postpartum with EPDS of 14. You call the practice, and the RN says the provider is too busy to talk and is on L and D today. She asks for a psychiatry referral. You explain the process of your Access Program, and the RN gives you the provider’s pager. You page the Ob, and she calls back and says (sounding irritated), “I am doing a circ, let’s make this quick, what information do you need from me to get her in?”

Case 4

30 yo F G4P3 at 25 weeks GA presents with EPDS of 19. The patient declined therapy and medication treatment 6 weeks ago. The provider reports she tried to educate patient yet the patient “refused treatment.” She also reports that the patient calls a lot and “bothers the nurses.” The provider reports that the patient is worried about the pregnancy and appears anxious yet does not want help. You glean that there is character pathology. The provider reports, “I have no idea what to do, she is driving us crazy.”

Appendix C: Active Resource Links

1—Sample Job Descriptions

https://public.3.basecamp.com/p/D49AH8otCR9e19xUc6BXeH7o/vault

2—Needs Assessments

https://public.3.basecamp.com/p/bSVL7q9AmLfrmVK5F9KuuDJc/vault

3—Marketing Materials

One-Pagers

https://public.3.basecamp.com/p/Xf66z1YXNwkuGu8o4ALiy5uu/vault

Videos

- Virginia Mental Health Access Program (VMAP): https://www.youtube.com/watch?v=s5TM3sLmCWA
- Mississippi Child Access to Mental Health and Psychiatry (CHAMP): https://vimeo.com/471021728
- Michigan Clinical Consultation and Care (MC3): https://www.mivideo.it.umich.edu/media/1_8ykrucq0
- Delaware Child Psychiatry Access Program (DCPAP): https://drive.google.com/file/d/1I8naMWFztp5BIus1ITojFkyxU3yTN6bp/view
- Texas CPAN (Child Psychiatry Access Network): https://www.youtube.com/watch?v=DIPgAhkY8dk

4—Care Guides/Guidebooks

https://public.3.basecamp.com/p/8g5gx55DKCHeYgJcuULH37Lp/vault

5—Workplan

Template and Colorado Sample

https://public.3.basecamp.com/p/1muMzXFmAbvTivnv247f4fxa/vault

6—Sample Financial Plan

https://public.3.basecamp.com/p/1tGFDzgRdouL7NLZ7t8TG39v/vault

7—HRSA Performance Measures

https://mchb.hrsa.gov/sites/default/files/mchb/data-research/omb-0915-0298-dgis-measures-exp-08312025.pdf