April 24, 2013

Testimony to HHS Committee Re LD 716

My name is Sandra Fritsch, and I come to you today wearing many hats;

- First as a citizen of the state of Maine, I am mindful of fiscal responsibility and sensitive of the need to promote the health and welfare of our youngest citizens
- Second, but of equal importance, as a mother of 12 & 14 yo children
- Third, I serve as the residency training director for the only child and adolescent psychiatry fellowship program in the state of Maine. In this role, I have a mission to ensure we are producing the best child and adolescent psychiatrists in the country who will hopefully remain in Maine
- Fourth, I am a practicing outpatient child and adolescent psychiatrist treating children and adolescents covered by all insurances including MaineCare
- Fifth, I am the physician leader of the grant funded Child Psychiatry Access Program-a program to support and work with pediatric primary care clinicians to provide education and consultation so that the primary care clinicians may care for behavioral/mental health problems in childhood and adolescence
- And finally as the president of the Maine Council of Child & Adolescent Psychiatry, the state chapter of the American Academy of Child & Adolescent Psychiatry. The Maine Council represents over 90% of the practicing child psychiatrists in this state.

In all of my many roles/identities, I care passionately about the health and welfare of the youth in the State of Maine and I also care greatly about the fiscal health and welfare of the state of Maine. And in each of my roles, I wish to voice my opposition of LD 716 and respectfully ask the HHS to reconsider LD 716.

Our health care system is broken, but LD 716 will not provide the solution for problems it is intended to address. I have had the opportunity to meet with Rep Malaby and I believe our goals are the same; to ensure that the youth in Maine receive appropriate evaluation and care for medical and mental health concerns, evaluations and treatments that are founded on principles of evidence-based medicine and are fiscally viable.

I too, am disturbed by the notion that any aberrant disruptive behavior can be fixed by a medication, a belief –or hope-that seems to be increasing due to a number of reasons, including direct to consumer marketing. I am concerned that youth in Maine on MaineCare may be being diagnosed and treated for conditions at rates that extend beyond the expected.

I am, however, disturbed by the effort to address this potential problem before there is a clear understanding as to why this is happening, and whether there are regional differences in the state. I know there are many areas in the state that do not have direct access to a child and adolescent psychiatrist, nor to consultation services, nor to educational support services. To obtain specialty services, patients in rural Maine may have lengthy waits (up to a year sometimes) or have to travel large distances for care; it is not unusual for families to have to travel 2 to 3 hours or more to one of the psychiatric hospitals in order to see a child psychiatrist. Thus care becomes the responsibility of primary care providers; family medicine physicians, pediatricians, nurse practioners, and physician assistants; providers who have received limited to no training about child mental health conditions.

Legislating how people care for children will not overcome these fundamental deficits, rather this legislation may increase stigma and decrease the motivation for our already beleaguered primary care clinicians treat children with behavioral health concerns.

As a parent and a practicing child and adolescent psychiatrist, I do not take making the diagnosis and the treatment of ADHD lightly. The assessment must include input from more than one setting (for a child this should include at least the home and school), use of validated objective scales to monitor the response to treatment, and the need to rule out other confounding conditions such as learning disabilities, receptive language challenges, distractibility due to anxiety or PTSD, distractibility due to hunger, or even just the immature brain with developing frontal lobes. That being said, a child has two major jobs in life: 1) to be a student and 2) to have peer relationships. The under treatment of ADHD can lead to poor functioning in both of those domains which can escalate to poor self-esteem, and eventual school failure or drop out. There is enormous evidence to show the increased rates of dangerous behaviors in adolescents and young adults with untreated ADD.

From my second role, and on a personal level, I have a 14-year old son who was born "challenged" with some oxygen deprivation. He has struggled throughout his life with poor judgment, impulsivity, some odd responses to situations, and has required some extra supports in the school setting. I was fortunate to know how to access services, supports and evaluations for him since he began to struggle in the first grade. My son's father was adamantly opposed to any treatment (medication or otherwise), so my son was placed on a school 504 plan for support around impulsive and disruptive behaviors, occupational therapy needs, and supportive behavioral plans. Despite the supports, he struggled. Finally, the summer before 7th grade, he received a full neuropsychological battery of testing that showed evidence of academic decline and supported the diagnosis of ADHD. I told his father he had no choice and would support any recommended treatments. In December of his 7th grade year, he started a trial of a stimulant medication and received full supports academically on an Individualized Education Plan (IEP). Modern technology allows me to monitor my child's progress in school daily, and I witnessed a remarkable academic transformation, from failing classes to receiving commendations within days of beginning a trial of a stimulant medication. He went from seeking negative attention, needing to be the class clown, and on a downward spiral to recognizing he could be successful, and recognizing that he is smart. He then went on to seek academic success. I wish I had advocated more strongly for him earlier in his schooling as he clearly earned a negative reputation with some teachers and parents of some of his classmates despite behavioral plans and other supports provided by the school.

I am also testifying as the physician leader of the Child Psychiatry Access Program, also called CPAP. I am providing a description of the program for you in your testimony packet. CPAP began in 2009 with funding from a three year grant from the Maine Health Access Foundation and has continued with funding by private philanthropy support (although this money is almost gone). The goal of CPAP is to assist pediatric primary care providers have the support, develop the skills and sense of efficacy to screen, evaluate, and treat uncomplicated behavioral and mental health conditions in the primary care office. We provide assistance in finding community resources, provide telephone consultation with a child psychiatrist within 45 minutes per provider request and we provide regular, continuous education for the providers. We will also do face-to-face consultations. The first educational session focuses on mental health screening tools; general screening tools and condition-specific

screening tools. We do not mandate screening tools the provider should utilize as each specialty has developed its own guidelines and preferences. A discussion occurs during every telephone consultation about evaluation tools and the results of the screening tools. In the first year of the practice's participation, a session always occurs on stimulant medications and treatment of ADHD. It is striking how much of what is discussed is novel for the provider. As an aside, many pediatricians had limited training and education around treatment of childhood disruptive behaviors during their residency and there is no requirement in either medical school or pediatric residency for education or experience in child psychiatry. And for the family medicine physicians, exposure and support in residency for child psychiatric conditions is even less, yet a large proportion of children and adolescents in the state of Maine have family practice physicians, nurse practioners, and physician assistants directing their care. An essential role of CPAP is to help educate and support primary care providers treating children and adolescents evaluate and treat behavioral and mental health concerns in the primary care office. Currently we work with practices in Brunswick, Bath, Westbrook, Yarmouth, Portland and Norway; practices that care for roughly 38,000 children and adolescents. The providers are all committed to providing the very best care they can for the children they treat, yet are often hampered by state requirements of prior authorizations, novel initiatives for a number of different conditions, and the frustration of not being able to find the care for their patients they are seeking. They are often pressured by schools, therapists, and families to prescribe medications when behavioral or education services are needed. Through CPAP, we help the providers decipher the possible routes to pursue and strategies to best support getting their patients' needs met. I know the Maine Medical Association has started an academic detailing program to help educate clinicians around some conditions and treatments such as: " Antipsychotics, A Weighty Matter: Antipsychotic Medications for Children and Youth", "Atypical Antipsychotic Augmentation in Major Depressive Disorder", "Chronic Pain", " Atrial Fibrillation", and that is wonderful. But the academic detailing program is limited to one meeting and provides no ongoing support or resources.

I am also testifying today in my two other roles, that of the director of the child and adolescent psychiatry residency program and as the president of the Maine Council of Child and Adolescent Psychiatry. In both roles I am committed to ensuring the graduates of our training program have the skills, knowledge and attitudes to practice evidence-informed medicine, are prepared to collaborate with primary care providers, share treatment cases, and support the primary care clinician as they care for children and adolescents with mental health needs. We are also attempting to teach our residents the principles of practice and quality improvement as well as patient safety.

Concerns raised by Rep Malaby and sought to be addressed by LD 716 should not be a legislative concern, but rather viewed as a quality improvement project. I believe we need to discover the true extent of the problem, whether there regional or provider specific differences, and assess the availability of supportive, adjunctive treatments. Then can we take an educated and informed approach to develop an intervention to improve identification and treatment of children in Maine with ADHD, and see if we can we both improve the health and lower the costs to the State.

Thank you for listening to my testimony.

The Child Psychiatry Access Program (CPAP) began in 2009 with funding from the Maine Health Access Foundation (MEHAF) through a three year grant and has continued with funding from a private foundation. The program was developed, to better meet the mental and behavioral health needs of children, teens, and their families in Maine through collaboration between child and adolescent psychiatry and pediatric and family medicine practices. This was in response to the needs of a state with a severe shortage of child and adolescent mental health providers (child and adolescent psychiatrists, psychologists, social workers/psychotherapists, and others) and severe maldistribution of such personnel, with most concentrated in the Greater Portland area and few in less densely populated regions. The geographical distances between many patients and providers in a rural state add the barrier of the time and costs involved in families traveling to obtain services, further limiting access to care.

The primary activity of the Child Psychiatry Access Program (CPAP) is to provide clinical support to pediatric Patient Centered Medical Homes and pediatric primary care providers, to enable those practices to meet the behavioral health needs of their patients. CPAP is modeled after the first such program in the country, the Massachusetts Child Psychiatry Access Program (www.mcpap.org). Massachusetts has the highest density of child and adolescent psychiatrists in the country, yet children in Massachusetts were not having their mental health and behavioral health needs met. The Massachusetts Child Psychiatry Access Program (MCPAP) was developed in response to the shortage of child and adolescent mental health providers. Since the successful advent of MCPAP, a number of similar programs throughout the country, in response to the national shortage of child and adolescent mental health providers, have been developed. States that have developed similar programs include New York, Illinois, Minnesota, Washington, and Wyoming, and a national organization has been developed, the National Network of Child Psychiatry Access Programs (www.NNCPAP.org). Funding for these programs have included direct state support (AK, AR, MA, NY, WA, MN, IL, and others), grant support (MI, NJ, OH, ME, and others), and the state of Delaware has support from commercial insurance carriers .

CPAP was developed to assist primary care providers find available resources for the patients they treat, and to help the providers increase their own sense of efficacy for screening, assessment and treatment of behavioral health conditions in the office. The program has the following core components:

1) A Clinical Care Coordinator (CCC) to help primary care providers (physicians, NP's, PA's) find access to services for their patients needing mental/behavioral health services
2) Telephone consultation by a Child and Adolescent Psychiatrist within 45 minutes of request by the primary care provider in order to gain support around care in the primary care office
3) Direct, regular, quarterly ongoing education; "Lunch and Learns" around issues such as: screening tools, treatment of ADHD, "what is therapy", treating anxiety in the primary care setting, atypical antipsychotic medications; monitoring and evidence for use, etc.
4) Face to face consultation with the child/family by coming to the Maine Medical Center Child and Adolescent Psychiatry Clinic

The experience of CPAP over the four years since its inception has resulted in some important modifications to meet the needs of Maine. A fundamental core component is the emphasis on continuing education of the primary care practices, both through scheduled "Lunch and Learn" sessions and by deliberately incorporating an educational component into each contact regarding a specific case or clinical problem. This training and education format results in a steady increase in the competence and comfort of the primary care provider in meeting the behavioral health needs of its patients.

The effectiveness of the program is based on several factors: 1) the relationships that develop through the educational programs which build trust and increase the sense of efficacy of the provider, 2) adhering to specific principles and fidelity, and 3) a single point of contact (phone number) for the providers to call - which is seen by the practices as one of the most important components.

Education of the primary care providers is a key element of CPAP, delivered through the "Lunch and Learn" format. We bring providers together from all practices in the region (for example we may have 16 providers from 4 different pediatric practices attend in Brunswick) and include a formal presentation followed by time to apply the principles to specific cases. From the materials developed for the Lunch and Learns, each provider also receives an electronic "toolkit" of the materials. Topics created and presented to date are noted in the table below:

Lunch & Learning Sessions By Year			
Year One	**Year Two**	**Year Three**	**Year Four**
Formal signing up the practice	Fundamentals of Antidepressant Medications	Encopresis & Enuresis	Aggression: Do we have a fighting chance?
Mental Health Screening Tools	Crisis and Chaos in the PCP Setting	ODD, "Just Say Yes"	Unexplained Physical Complaints
Basics for ADHD, Medications and Treatments	Treatment of Anxiety in Primary Care	Natural Therapies for Mental Health Issues and Sleep	Suicide and Self-Injurious Behaviors
What is Therapy? What are the Systems of Care in Maine?	Depression and Suicide and the Role of the PCP	Substance Abuse	Antipsychotic Medications & Children

Future topics to be developed include: "Behavioral and Mental Health Concerns in 0 to 5 Ages", "Postpartum Concerns", "What is "testing"? The ABC's of Individual Educational Program (IEP) testing."
"Mindfulness for the Practioner and for the Patient", and others to be determined by the practitioners.

CPAP sites

~ Number of practicing CAP

State of Maine; largely rural, and geographically large, roughly equivalent to Austria