CPCP Child Psychiatry Consultation Program

Year 1 Report

This report was written by the Department of Health Services and the Child Psychiatric Consultation Program (CPCP) Critical Planning Team as a means to share early results from CPCP: Year 1

Executive Summary

There is a recognized shortage in child and adolescent psychiatrists nationwide and across the state of Wisconsin. One intervention strategy to address this shortage was the creation of the Wisconsin Child Psychiatry Consultation Program (CPCP), funded by state General Purpose Revenue (GPR) funds. The CPCP offered this service to Primary Care Providers (PCPs) in the Northern Region and Milwaukee County. The CPCP increases PCPs' capacity to support the behavioral health needs of children and families by:

- Providing consultation to primary care providers regarding diagnosis and management options for children and adolescents with mental health problems
- Providing and ensuring a referral support system for these pediatric patients to other mental health professionals and community resources as identified and needed
- Providing education and training in mental health issues for primary care providers

This program was created through a contract with the Medical College of Wisconsin who implemented a model similar to that of Massachusetts Child Psychiatry Access Project (MCPAP) but with some notable differences. It is important to understand that this report shares preliminary data that is based on the short period of time in which the CPCP has been in existence. Data will continue to be collected and analyzed to guide the current model and process, but also used to guide potential changes that may be needed.

Key CPCP Highlights:

- In its first year, CPCP enrolled 72 clinics, including 278 providers, covering approximately 160,000 children and adolescents in the Northern Region and Milwaukee County. This equates to about half of the total child/adolescent population in the two regions.
- CPCP provided 328 PCP consultations. Thus far, 121 different providers (41% of those enrolled) have utilized the consultation service.
- The vast majority of consults related to medications and 86% of these were for medications that had previously been prescribed. This suggests providers are calling primarily for managing medications or their side effects.
- PCPs participated in educational sessions on topics such as attention-deficit/hyperactivity disorder (ADHD) and depression.
- Baseline survey data show variability in PCPs' confidence and ability to prescribe medications and provide mental health management for child patients. A follow-up, nine-month survey is being conducted.
- Satisfaction surveys (n = 20) suggested over 90% satisfaction with the length of time in which the CPCP responded to their call or email, the amount of time a CPCP staff member spent with them, and their encounters. Nearly all were satisfied with the educational lectures they attended.

A provider said…

"The CPCP has been a wonderful resource to me as a primary care provider. The ability to have direct access to psychiatrists has helped me to treat and give resources to children I normally wouldn't have been able to help. The program helps to reassure me that my treatment decisions are appropriate and it guides me when complex patients walk in the door that I normally would be uncomfortable treating on my own. Without the program, I would have many patients who would not have access to proper mental health treatment. It is truly a great program!"

Contents

Background

CAPs = Child and Adolescent Psychiatrists

PCPs = Primary Care Providers

There is a recognized national and state shortage of CAPs (2). In 2015, the Milwaukee County Outpatient Behavioral Health Capacity Study (completed by Human Services Research Institute) reported a six- to 12-month wait time for children to see a child psychiatrist, with wait times longer in rural areas that experienced more severe CAP shortages (1). According to a recent Wisconsin Area Health Education Center (AHEC) report, "The overall population to provider ratio for psychiatrists professionally active in Wisconsin was 7513:1 in 2012. There are significant disparities in distribution within Wisconsin; however, with the ratio ranging from well over 30,000:1 in rural areas to under 10,000 in metro and urban areas of the state" (3, p. 1). This shortage reflects a lack of general psychiatrists, but the shortage of CAPs is much worse. According to an AHEC report, there are 151 CAPs in Wisconsin and most practice in the most populated counties. In 2012, 48 out of Wisconsin's 72 counties, nearly 70%, did not have a practicing outpatient CAP. A lack of access resulting from the shortage of CAPs results in diagnosis and treatment delays, which have implications for both short- and long-term health outcomes for children, adolescents, and the overall community.

Limited numbers of CAPs in Wisconsin result in pediatric primary care clinicians increasingly caring for children with behavioral health challenges. It is estimated that as many as 50% of pediatric primary care visits are related to behavioral and emotional concerns (4). This reality is coupled with less than half of primary care clinicians self-reporting that they feel comfortable in their ability to treat children with behavioral health disorders (5).

Wisconsin's historical efforts to address CAP shortages and build primary care clinician capacity to address mental health concerns

Due to Wisconsin's lack of CAPs and the emergence of national models for child psychiatry consultation service for PCPs, stakeholders in Wisconsin embarked on efforts to create a child psychiatry consultation program. There have been collaborative efforts to bring primary care clinicians and CAPs together over many years. Three historical projects to highlight are: Ministry Health Care, Linking Actions for Unmet Needs in Children's Health initiative (Project LAUNCH), and the Medical College of Wisconsin's Kubly Project.

Ministry Health Care initiated a program in 2010 that allocated 1.0 FTE of child psychiatry time for child and adolescent psychiatry consultation to over 15 clinics, and over 65 primary care clinicians. This program met a critical need in the Northern Region; however, lack of adequate funding for the consultation service contributed to its closure in 2014.

Wisconsin Project LAUNCH, a grant-funded project that aimed to improve mental health consultation for underserved children, brought together a range of stakeholders, and performed a review of initiatives in other states. After several months of stakeholder meetings, a proposal

for an urban and rural pilot program was shared with the Wisconsin Assembly Speaker's Mental Health Task Force in the summer of 2013.

The Medical College of Wisconsin's (MCW) Department of Psychiatry and Behavioral Medicine, in partnership with MCW's Development Office, and with a generous donation from the Billie and Michael Kubly family, piloted a child psychiatry access project. The objective of the project was to improve mental health care for children by means of implementing a linkage intervention whereby pediatricians would have:

- Access to a CAP for general case consultation by phone or email Monday through Friday.
- Access to a mental health case manager for community mental health resource information.
- An informed curriculum developed by CAPs for pediatricians to help them better manage basic psychiatric issues in their patients.
- Second opinion clinic access for diagnostic and management dilemmas.

National efforts to build primary care providers' capacity to address child and adolescent mental health concerns

It is recognized that the current CAP workforce is not large enough to care for the children and adolescents who need mental health support. Consistently, PCPs report a lack of behavioral health training, resulting in lack of knowledge and confidence to address the mental health needs of their young patients.

One solution to address this shortage of CAPs is to provide PCPs with support and education necessary to recognize, diagnose, and treat child and youth social and emotional issues, as mental health concerns are often asked about during an encounter with a PCP. Several national models to address the CAP shortage have evolved. These models include PCP education and psychiatric consultation on child and adolescent mental health issues. The Massachusetts Child Psychiatry Access Project (MCPAP) is a nationally recognized program. The MCPAP began in 2002 and covers the state of Massachusetts through six regional teams, which are based in academic medical centers. MCPAP provides timely telephone-based psychiatric and clinical consultation and guidance to PCPs to support the treatment of children with mental health needs. MCPAP includes multiple methods of receiving consultation, and has a moderate emphasis on in-person psychiatric consultations. In addition, MCPAP took 8-10 years for consultation utilization to peak and plateau. More information about the MCPAP can be found at: https://www.mcpap.com/

Other states have also started similar child psychiatry access programs, such as Washington's Partnership Access Line for Kids, which is a tele-video consultation service for PCPs. These programs empower PCPs to provide timely and necessary behavioral health support for their patients.

Creation of a Wisconsin child psychiatry consultation program (CPCP)

Project LAUNCH, the success of the Charles E. Kubly Child Psychiatry Access Project, reports of the value to primary care clinicians of the Ministry Health Care Program, and the experience of several states inspired stakeholders and partners to work with legislators to develop a bill to create a State of Wisconsin Child Psychiatry Consultation Program (CPCP) by. State Representative Steineke authored the bill which appropriated State GPR funds for a CPCP and passed with nearly unanimous, bipartisan support. In April of 2014, Governor Walker signed Act 127 into law. Act 127 allocated $500,000 per year to the CPCP, which represented approximately half of the projected costs to adequately support one urban and one rural pilot as recommended.

In August of 2014, The Medical College of Wisconsin (MCW) applied through a Request for Application (RFA) process and received funds from the Department of Health Services (DHS) to develop and implement a CPCP in one or more of Wisconsin's Public Health Regions and or Milwaukee County. MCW, with support from Children's Hospital of Wisconsin, launched the CPCP in the Northern Region and Milwaukee County in December 2014.

Project leadership believed having a contrasting rural component would help inform MCW's current urban experience to better prepare for statewide expansion. The allocated GPR funds of $500,000 were split to cover both the Northern Region and Milwaukee County. A match of $250,000 was required for Year 1 and was met through a private donation. This match could be used for face-to-face consultation.

Goal of Wisconsin's CPCP

According to ACT 127, the CPCP exists to increase primary care clinicians' capacity to support behavioral health needs of children, adolescents, and their families in their care. The CPCP accomplishes this goal by providing:

- Support to PCPs to assist in the diagnosis and management of children and adolescents with mental health problems and to provide and ensure a referral support system for these pediatric patients.
- Triage–level assessment to determine the most appropriate response to each request, including appropriate referrals to other mental health professionals and community resources as identified and needed.
- Diagnostic and therapeutic feedback when medically appropriate.
- PCP education.

Wisconsin CPCP Overview

MCW utilized components of the MCPAP model to inform the design, development, and implementation of Wisconsin's CPCP in Year 1, which spanned from December 1, 2014 to December 31, 2015. The work included:

- Establishing two regional hubs – Northern Region and Milwaukee County.
- Recruiting health systems-clinics to participate.
- Enrolling pediatric and family medicine providers.
- Creating an evaluation structure to assess outcomes, track successes and areas for improvement, and identify opportunities to capitalize on lessons learned.
- Developing a shared data system to capture consultation encounter data.
- Developing a central triage call center in Milwaukee that determines which team member at which hub is best-positioned to answer a PCP's question.

The CPCP includes four core components. Each enrolled provider can:

1. Participate in ***educational sessions*** on mental health and psychiatric disorders and medication issues delivered by CPCP staff. Initially, educational sessions were provided in-person, but were then made available online for enrolled clinicians. Education for PCPs was viewed as critical to improving care providers' knowledge and efficacy in providing frontline mental health care to children and adolescents.
2. Request child ***psychiatric consultation*** by calling the CPCP telephone line or sending questions through a dedicated email address and expect to receive a response within 30 minutes for phone calls and a same-day response for emails. CPCP child psychiatrists, a psychologist, and intake coordinators are available by phone Monday through Friday, 8 AM to 5 PM, to answer questions and provide child psychiatric consultation to primary care clinicians regarding issues such as diagnosis, psychotropic medication management, and community resources or referral support.
3. ***Access additional educational sessions*** online and in person regarding assessment and treatment, including psychopharmacology.
4. Obtain assistance to ***connect children to other local mental health resources***.

In addition to the components listed above, enrolled and unenrolled PCPs received persistent, ongoing, and targeted outreach to:

- Ensure knowledge and understanding of the program.
- Enroll in the program.
- Receive education and assistance with referrals for mental health resources.
- Establish trust with CPCP team of experts available to offer assistance.

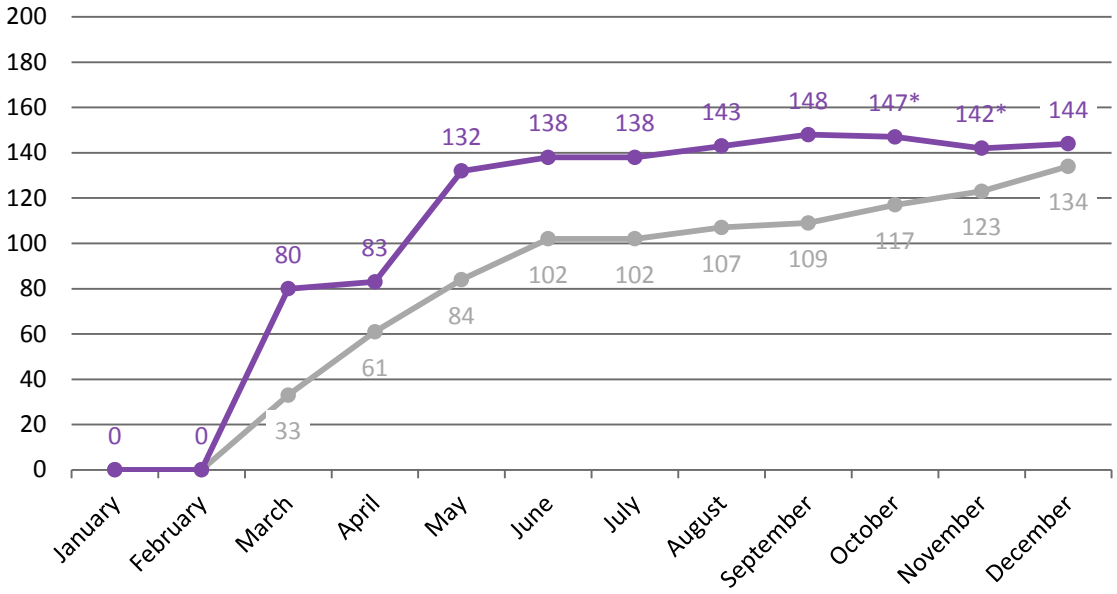
Wisconsin CPCP Outcomes

CPCP outcomes involve both infrastructure and service-related outcomes. Data come from tele-consultation encounter records, baseline surveys from enrolled providers, and satisfaction surveys.

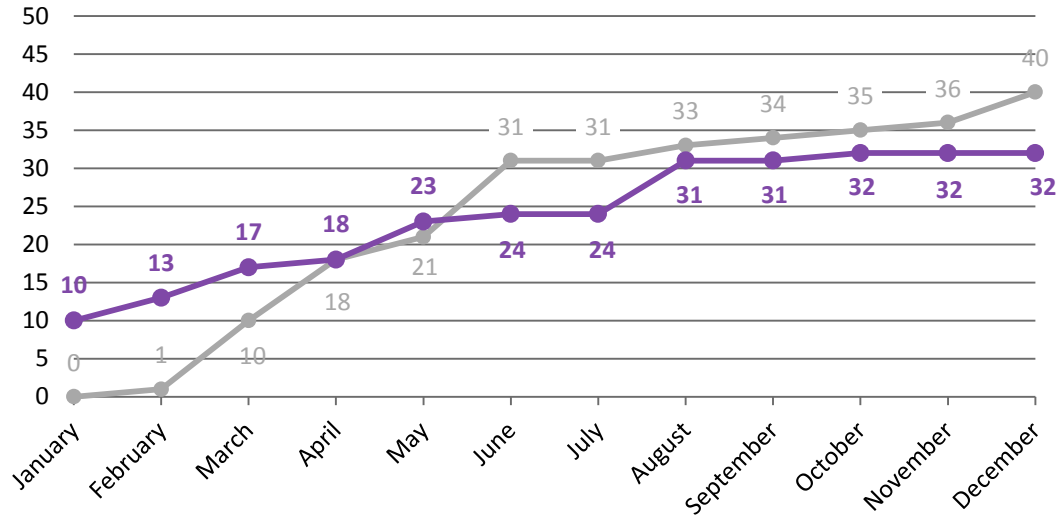
Who has been served and reached by the CPCP?

Between December 1, 2014, and December 31, 2015, CPCP enrolled ***72 clinics***, including ***278 providers***, covering approximately ***160,000 children and adolescents***. This is about half of the total child/adolescent population in the Northern Region and Milwaukee County.

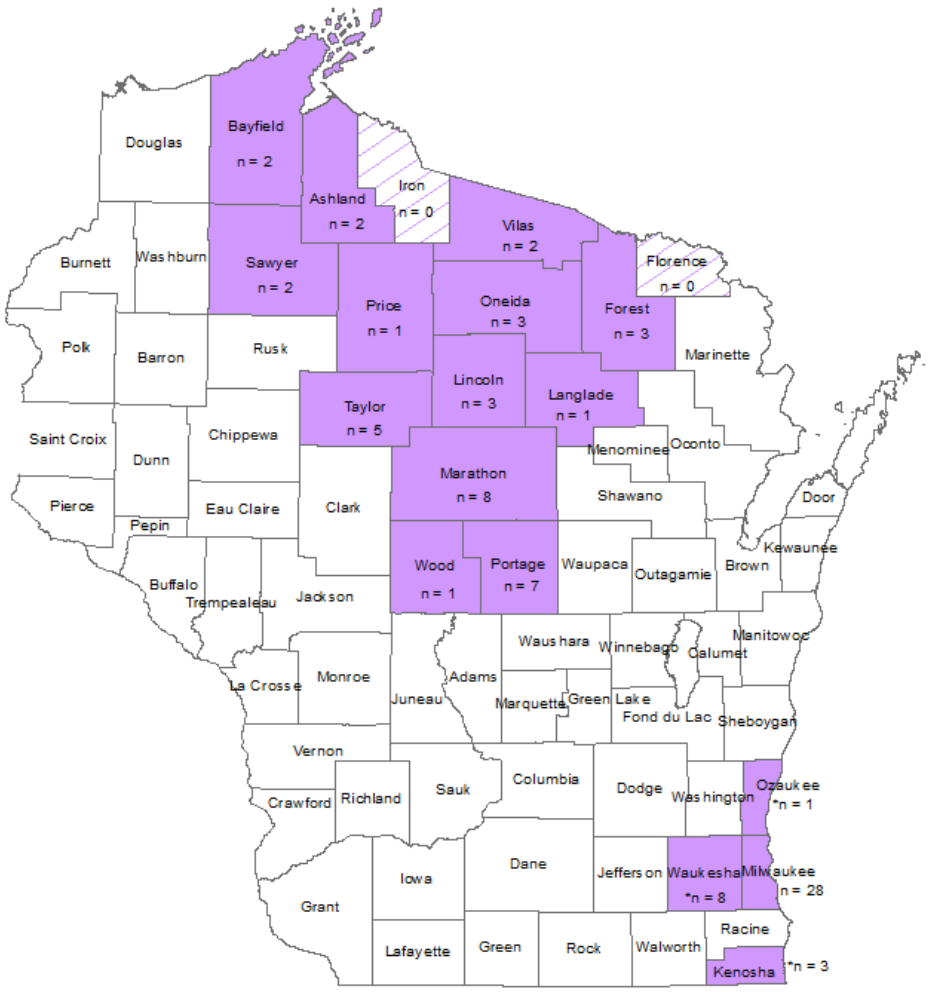
The total number of *providers* enrolled in CPCP increased in the **Northern** and **Milwaukee** regions over 2015. (*Some providers left their practice or retired.)



The total number of *clinics* enrolled in CPCP increased in the **Northern** and **Milwaukee** regions over 2015.



The CPCP has ***clinics enrolled throughout nearly the entire Northern Region*** and a ***large number of clinics in Milwaukee County****.



*Prior to receiving the state CPCP grant, the Medical College of Wisconsin (MCW) had a pilot project with philanthropic funding from the Kubly Family. During this pilot, the MCW enrolled Children's Medical Group Clinics serving Kenosha, Waukesha, and Ozaukee Counties.

What education did CPCP deliver to PCPs?

During the first year, CPCP provided ***61 face-to-face educational sessions*** that were also converted into online modules available to all enrolled providers.

The number of PCPs who received the primary educational sessions included:

- 118 for "Treatment of ADHD in children and adolescents."
- 98 for "Assessment and treatment of depression in children and adolescents."
- 98 for "Use of atypical antipsychotics in children and adolescents."

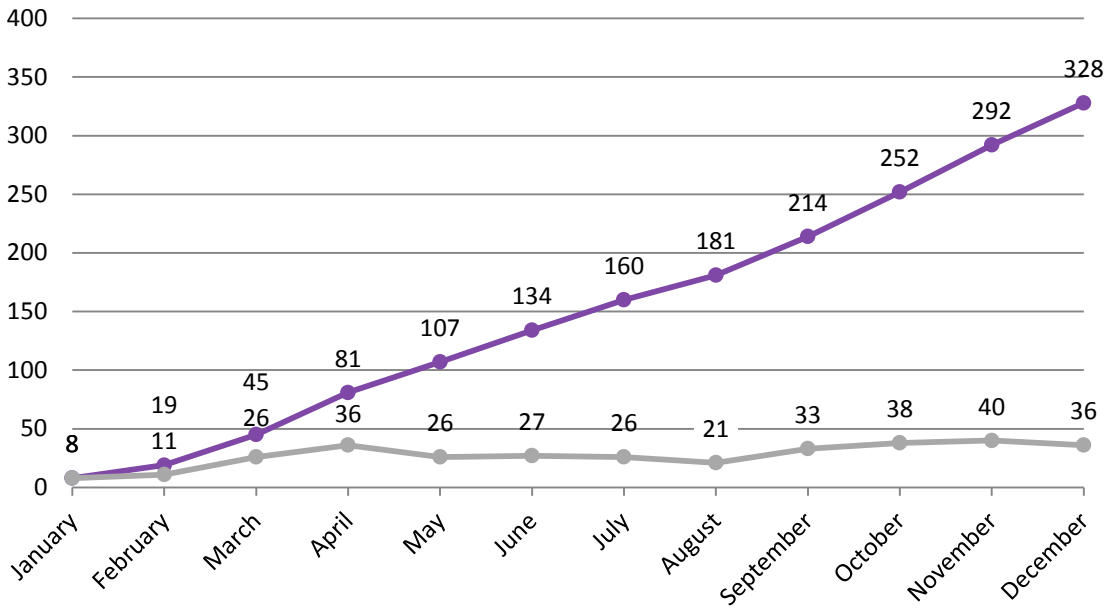
Other educational sessions that were available included:

- Trauma-informed care.
- Use of mental health rating scales for children and adolescents.

What type of psychiatric consultation did CPCP provide and what were the outcomes?

Over the first year, the CPCP provided ***328 PCP consultations via telephone or secure email*** (i.e., encounters). More than half of these calls originated from Milwaukee and Marathon counties (38% and 19%, respectively). Thus far, 121 different providers (41% of those enrolled) have utilized the consultation service, calling about approximately 275 children and adolescents with behavioral health needs in their practice.

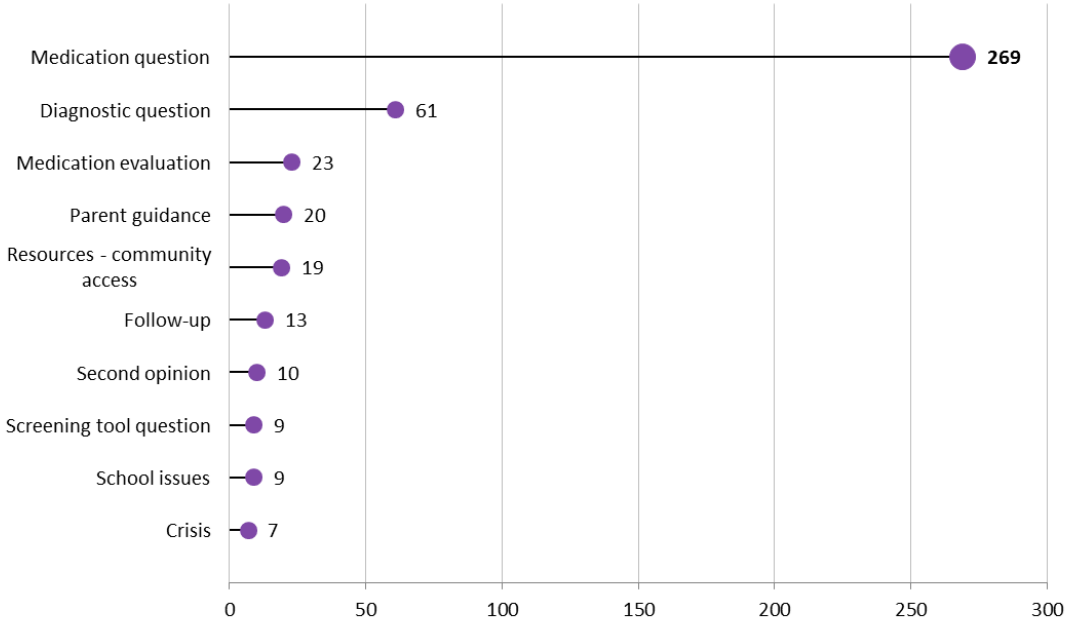
The number of CPCP consultations **remained steady** each month, but cumulatively **increased** over 2015.



Providers contacted the CPCP for numerous reasons. Overall, 77% of providers contacted the CPCP for one reason, but other providers (about 23%) contacted the CPCP for two to five different reasons. Nevertheless, this rate varied by region with a ***greater proportion of providers in the Northern Region contacting the CPCP for 2-5 reasons (36%) than in the Milwaukee area (18%)***. This may suggest that providers in the Northern region are serving children and adolescents with more unmet mental or behavioral health needs. On the other hand, it is possible that these providers have greater educational or consultation needs regarding mental and behavioral health.

Reasons for contacting the CPCP include numerous areas of need.

The primary reason providers contacted the CPCP was to have their **medication questions answered.** (multiple reasons were possible)

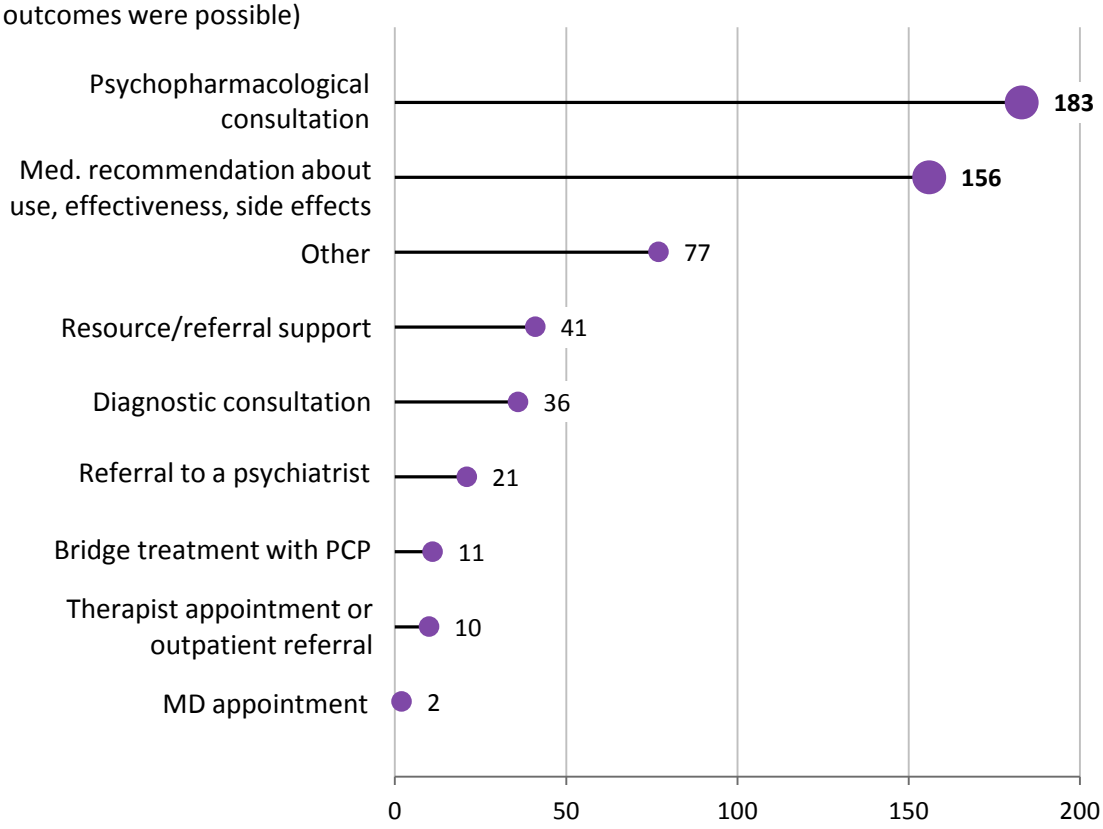


Of all of the encounters that involved medication questions, 86% were in reference to children and adolescents who were already taking medications for mental or behavioral health issues. This may suggest that providers are not necessarily calling for help in prescribing medication, but rather managing the use and/or side effects of medications.

A provider said:

"We are all familiar with the shortage of pediatric psychiatrists available to treat our patients. Mental health and behavioral problems continue to increase in our patients, however. Working with the CPCP allows for a preliminary plan to be put in place for the family while awaiting further evaluation by a psychiatrist if needed."

In response to PCPs' reasons for contacting CPCP, the **top services they received were psychopharmacological consultation and/or a medication recommendation**. (multiple outcomes were possible)



Have PCPs' mental health knowledge and self-efficacy in serving children with mental health issues improved?

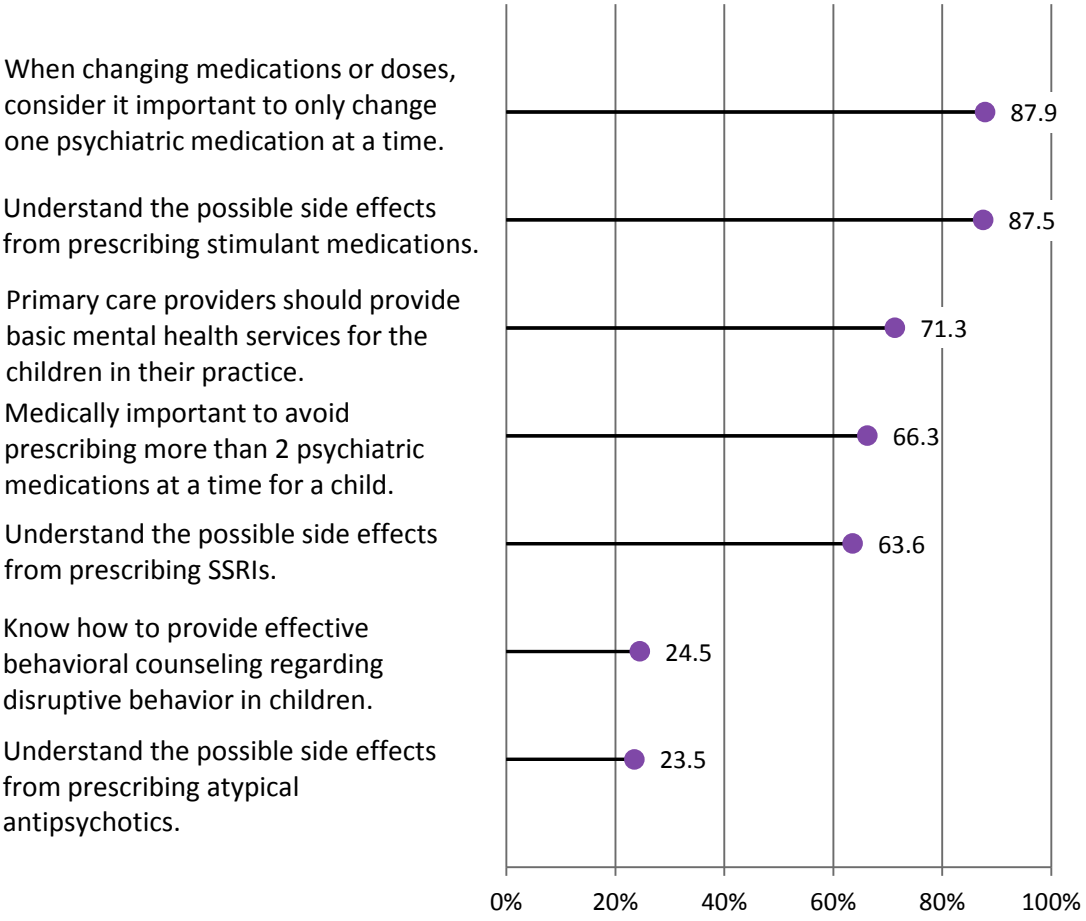
In order to assess the impact of the educational sessions on PCP knowledge about mental health and the consultation line's potential effect on confidence in addressing children's mental health, MCW asked enrolled clinicians to complete an initial survey at enrollment in CPCP (prior to completing educational sessions) and nine months after enrollment. Because many PCPs were not eligible to complete the nine-month survey at the time of writing this report, only baseline levels of PCPs' knowledge and self-efficacy are presented.

Based on results from the baseline survey, PCPs' confidence in their ability to provide mental health management for child patients depended on the condition. Nearly ***60% of PCPs indicated that they felt confident three-quarters to nearly all of the time in providing mental health management for children with ADHD*** at baseline. Yet, for ***child patients with depression or anxiety, PCPs' confidence in providing mental health management dropped to about 20%***.

Similar sorts of variability were seen in PCPs' confidence in appropriately prescribing medications to children and adolescents in their practice. About ***75% felt confident to very confident in their ability to appropriately prescribe stimulants, but only about 5% felt confident to very confident in their ability to appropriately prescribe antipsychotics***.

The baseline survey also inquired about PCPs' knowledge about different mental and behavioral health topics as well as their confidence in their clinical skill level in managing and treating several child mental health difficulties. Results are presented below.

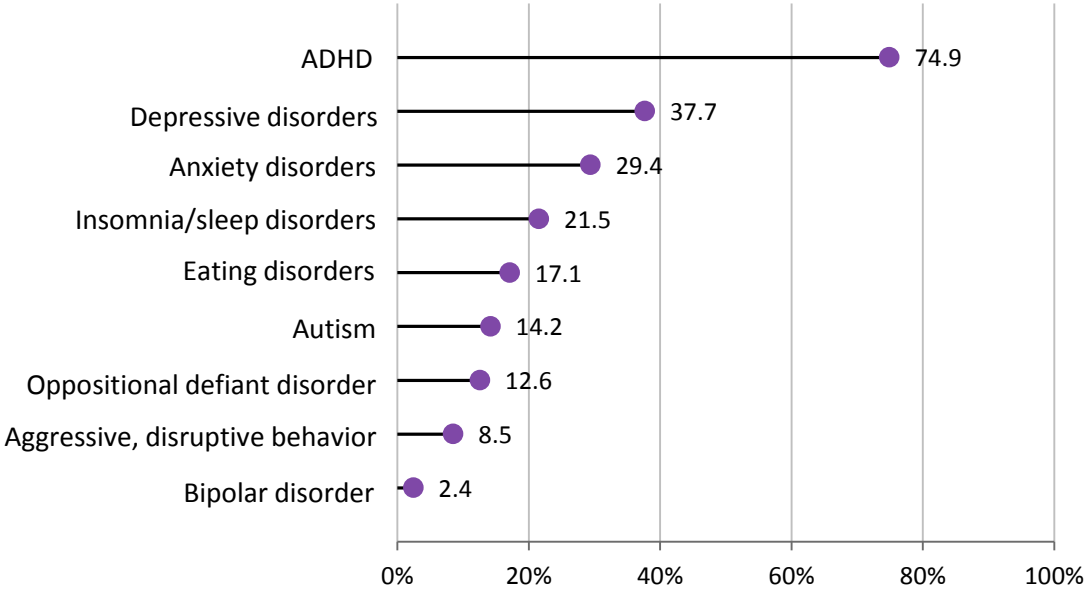
The percent of PCPs who **knew about different mental and behavioral health service topics varied widely at baseline,** as shown below.



A provider said:

"In circumstances where a family is doubtful of recommendations or is wanting more information regarding a mental health problem, seeking the opinion of a psychiatrist through the CPCP can serve as a second opinion. The suggestions the CPCP providers offer can serve to both improve the plan for the patient and create more 'buy-in' from the family regarding the plan."

The percent of PCPs who were **confident in their clinical skill level in the management and treatment of child mental health difficulties varied greatly** at baseline.



Are PCPs satisfied with the services provided by the CPCP?

MCW implemented satisfaction surveys with PCPs enrolled in CPCP to understand satisfaction with the education and consultation services provided by the program. ***Overall, the results indicate a high satisfaction with CPCP services.*** Out of all enrolled PCPs, 48 completed the satisfaction survey, representing about 19% of all PCPs served by CPCP. Those who completed the satisfaction survey are drawn from the same sample of those who completed the baseline enrollment survey. Among those in this group who attended or completed an educational session (n ranged from 25 to 30, depending on lecture topic), ***nearly all were satisfied with the various lectures they attended***. In addition, among PCPs who had an encounter with the consultation line and completed the satisfaction survey (n=20), over ***90% were satisfied with the length of time in which the CPCP responded*** to their call or email, ***the amount of time a CPCP member spent with them***, and the ***encounters regarding medications***.

What infrastructure was established in order to achieve the results?

In order to provide the educational and teleconsultation services, CPCP had to build a solid infrastructure. In addition, the Request for Application (RFA) required essential staff for the CPCP including a licensed child and adolescent psychiatrist in the State of Wisconsin, a licensed social worker, mental health therapist and/or a psychologist, and a care coordinator or a community support worker experienced in mental health services. MCW has built the current CPCP staffing structure to meet CPCP goals in the Northern Region and Milwaukee County:

- 3 part-time child psychiatrists
- 1 part-time child psychologist
- 2 full-time project/resource coordinators

- 1 part-time project manager
- 1 part-time project director/evaluator

CPCP also developed resources to support the educational sessions, referrals, and evaluation activities. Staff developed:

- 4 educational lecture series
- 1 mental health knowledge and efficacy survey
- 1 educational needs survey
- 2 regional mental health resource lists

Other important infrastructure components included time spent engaging and enrolling clinics, establishing a toll-free number, and intense outreach and promotion efforts including magnets, books, stickers, newsletters, emails, and stakeholder meetings. A CPCP website was also built that included information for the public about the program, how to become enrolled, and resources. (http://www.chw.org/medical-care/psychiatry-and-behavioral-medicine/for-medical-professionals/psych-consult-site/)

PCPs can log in to the website with their username and password to find the CPCP phone number, email address, and online educational modules. Currently, there are efforts to have all local public health departments in the Northern Region and Milwaukee County add a link to the CPCP website from their local county website.

Importantly, many of the infrastructure components are not duplicated across hubs. The educational modules and the evaluation processes are shared across the hubs. In addition, psychiatric resources are shared across hubs to maximize consultation efficiency, response times, and access for PCPs.

A Provider said…

"The CPCP has been a wonderful resource to me as a primary care provider. The ability to have direct access to psychiatrists has helped me to treat and give resources to children I normally wouldn't have been able to help. The program helps to reassure me that my treatment decisions are appropriate and it guides me when complex patients walk in the door that I normally would be uncomfortable treating on my own. Without the program, I would have many patients who would not have access to proper mental health treatment. It is truly a great program!"

Wisconsin CPCP Barriers and Lessons Learned

Several barriers were identified during the pilot phase through stakeholder meetings, individual interviews conducted with members of the CPCP team, anecdotes shared by PCPs, and general observations by CPCP team members. The most significant of these, along with the outcomes and lessons learned, are presented in the tables below.

Infrastructure challenges

Challenge	Outcome	Lessons Learned
1. Busy schedules of PCPs and clinic managers.	Missing baseline and satisfaction survey forms from PCPs and enrollment data from clinics.	Obtain necessary information during first call or meeting with clinic. Hire regional project coordinators prior to starting clinic enrollment period.
2. Staffing limitation with 1.2 psychiatry FTEs to address outreach, education, and consultation.	Lack of availability for face-to-face second opinions from psychiatric consultants in a timely fashion.	Need for other funding to hire additional psychiatric FTE staff or to provide face-to-face consultations.
3. PCPs outside of the Northern region and Milwaukee County have requested access to the CPCP.	Limited access to support other Wisconsin-based PCPs.	Additional funding would be required to expand to the other regions of Wisconsin.
4. Northern Region providers appeared to be less interested in face-to-face educational sessions.	Difficulty reaching PCPs in Northern Region with educational modules.	Educational modules should be made available online but may vary by regional preference.

Monitoring and data collection challenges

Challenge	Outcome	Lessons Learned
1. Clinics in Northern Region have difficulty reporting number of children and adolescents served possibly due to reduced access to electronic medical record systems.	Reduced ability to estimate current child and adolescent coverage by clinics in Northern Region.	Obtain information about patients served from PCPs during enrollment meeting.
2. Many PCPs work at multiple clinics.	Difficulty estimating reach and clinic coverage of CPCP	Obtain number of providers with patient load from clinic managers at first contact from CPCP administrative team.
3. Evaluation system does not include outcomes from children, adolescents, or families.	Difficulty evaluating CPCP beyond PCP education, self-efficacy, knowledge, and satisfaction.	Additional funding would be required to develop and implement a more comprehensive evaluation.

	Lack of understanding of CPCP impacts on individual child, adolescent, and family outcomes.	that includes data from children, adolescents, and families without violating Health Insurance Portability and Accountability Act (HIPPA).

Communication challenges

Challenge	Outcome	Lessons Learned
1. PCPs do not return enrollment forms.	PCPs attempt to use CPCP without proper paperwork completed.	Coordinators systematically and regularly track enrollment forms and offer immediate enrollment for providers at eligible clinics.
2. Community confusion about what CPCP is, who is eligible, and how to enroll in the program.	Lack of accurate knowledge about the program, where to find more information, and how to advocate for its continuation and expansion.	Creation of "CPCP Brief" document for diverse audiences. Regular stakeholder meetings remain important in funded and non-funded DHS regions. Collaboration with key stakeholders in each region to coordinate resources and messaging.

Wisconsin CPCP Conclusions

Infrastructure successes

One of the main successes of the CPCP in Year 1 was the rapidity with which the team was able to develop the infrastructure necessary to enroll clinics in the Milwaukee County and Northern Region. This was accomplished by hiring requisite program leadership and staff in both regions along with the creation of a phone line, email process, website, stakeholder meetings, and standardized communication tools. The creation and implementation of in person and online training also reflect the agility of the CPCP team to work together to fill a gap in education among PCPs in child and adolescent psychiatry in a method that is responsive to their learning needs. This work required multi-sector collaboration and flexibility over the granting period among all vested partners, a theme that resounded from many CPCP team members during discussions. These qualities have provided the current CPCP team a solid framework on which to build the structure to execute successfully the goals of the Year 1 CPCP in two regions of Wisconsin. ***It is important to remember that with the yearly GPR funds of $500,000, and a match of $250,000 by MCW, the MCW split these funds to cover both the Northern Region and Milwaukee County. Thus, each region was not funded at full-time staffing capacity.***

Service outcome successes

As evidenced by the results of Year 1 of the CPCP, the initial state funding allocated for this program supported only half the staff needed and met only half of the potential needs of children and their families with behavioral health needs and, provider education in Milwaukee County and the Northern Region of Wisconsin. The use of CPCP steadily increased over Year 1. PCP survey results indicate high satisfaction with the program. Approximately 100 PCPs also attended or viewed online each of the educational sessions that were offered.

Monitoring and data collection limitations

It is important to note that the Wisconsin CPCP has been operational for only about 12 months. This time span limited the breadth and scope of the evaluation activities, as there has not been sufficient time to do a comprehensive evaluation or adequately validate the overall success of the program during its infancy.

Continued work

Work continues as clinics in both Milwaukee County and Northern Region continue to enroll and complete educational modules. In addition, the CPCP team is collaborating with the Wisconsin Medical Home Project to offer Pediatric Behavioral Health Screening Training to enrolled providers and is participating in its shared resource group to enhance mental health resources across the state. Importantly, the team has sustained communication with the Child Psychiatry Access Programs through the National Network of Child Psychiatry Access Programs in order to learn how best to grow and expand the program in Wisconsin.

Future of the Wisconsin CPCP

The Massachusetts model will continue to guide Wisconsin's vision for CPCP. Expanding this program to serve all five public health regions in the state and Milwaukee County would require additional funding to: (1) hire adequate staff, and (2) support the infrastructure in the four added regions, which includes spreading to the rest of the counties in the Southeast Region, as well as fully covering and serving all practices in the Northern Region and Milwaukee County. Moreover, the number of hubs providing CPCP services would have to expand to include a hub in the Northeastern, Western, and Southern Regions, and spreading to all other counties in the Southeastern Region. **It is currently projected by MCW that it would take approximately $3.125 million (or $625,000 for each of five total hubs and Milwaukee County) annually to provide PCPs throughout the entire state of Wisconsin with CPCP* services.**

(* This cost is based upon current rates and salaries and is subject to change based upon market costs. CAP salaries are increasing across the country due to the shortage of providers.)

A parent said…

"My son's pediatrician told me of the CPCP services that she was enrolled in and how it worked. She said my son's treatment was outside the scope of her practice but that she could consult with psychiatrists through this program. I agreed and trusted her. It was a quick turnaround in which my son's pediatrician called me to discuss medication and treatment options. He is currently stable and doing great in school, and he is even excelling in math! I have more respect for my pediatrician for seeking out assistance and using CPCP because we all don't know everything and need help. As the saying goes: It takes a village to raise a child."

References

1. **State of Wisconsin Department of Health Services, Division of Mental Health and Substance Abuse Services**. Wisconsin Mental Health and Substance Abuse Needs Assessment. Madison: Abuse Services, 2014.

2. **The Henry J. Kaiser Family Foundation**. Mental Health Care Health Professional Shortage Areas (HPSAs). Mental Health Care Health Professional Shortage Areas (HPSAs). (Online) April 28, 2014. (Cited: February 20, 2016.) http://kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/.

3. **Wisconsin Area Health Education Center System**. Wisconsin AHEC Health Workforce Data Brief: Psychiatrists. Madison: Wisconsin AHEC, 2015.

4. Child and adolescent psychopharmacology: Approaches to recognition and management of childhood psychiatric disorders in pediatric primary care. **Cassidy, L. J., and Jellinek, M. S.** 1998, Pediatric Clinics of North America, Vol. 45, pp. 1037-1052.

5. Behavioral Health in the Pediatric Primary Care Setting: Needs, Barriers, and Implications for Psychologists. **Pidano, Anne E., Kimmelblatt, Craig A. and Neace, William P.** 2011, Psychological Services, Vol. 8, pp. 151-165.

Wisconsin
Department of Health Services

Division of Public Health

Publication Number: P-01444 -07/18/2016