

# Workgroup I: Behavioral Health / ADHD

*The first session of the Arkansas Health Care Payment Improvement Initiative workgroup convened on November 7, 2011 to discuss Behavioral Health and specifically Attention Deficit Hyperactivity Disorder (ADHD). The discussion centered around opportunities to improve quality of care and patient experience in Arkansas.*

*The workgroup meeting was the first in a series of discussions, which will inform the design and implementation of a new payment model. Approximately 80 Arkansas family practice physicians, pediatricians, psychologists, psychiatrists, provider executives, patients, and family members attended in Little Rock as well as at videoconference locations in Fort Smith, Jonesboro, Texarkana, and Fayetteville.*

## **KEY COMPONENTS OF WORKGROUP 1 DISCUSSION**

- ADHD was chosen as the initial episode to be designed for the Behavioral Health category but all components of behavioral health (including substance abuse) will eventually be addressed by the health care payment improvement initiative.
- **Patient journey.** There was general agreement with the patient journey including the differences in treatment today for more complex cases (usually where a comorbid condition exists). The group also acknowledged two main paths: (1) PCP / Specialist and (2) Rehabilitative Services for Persons with Mental Illness (RSPMI). Specific modifications were made regarding where initial identification comes from, when PCP sign-off should occur, and how to incorporate parent training and psychiatric assessments.
- **Opportunities to improve quality of care, patient experience, and cost efficiency.** The group also generally agreed with the opportunities outlined but raised several important clarifications and additions
  - **Opportunity 1: Encourage accurate and specific diagnosis.** There was a desire to understand the underlying drivers for the high diagnosis rate in Arkansas. This could come from demographic or environmental factors contributing to greater numbers of children with ADHD but could also stem from misdiagnosing children who do not have ADHD or who have other conditions.
    - A proper ADHD assessment can take several hours but due to paperwork requirements and caseloads this can be difficult to do.

Components of an assessment should include: structured interviews, intelligence screening, a broad band instrument to assess co-morbidities, parental screening, and screening for learning disabilities.

- Factors driving overdiagnosis today include school demands (e.g., requirement to be receiving treatment before returning to school), short-term symptoms following traumatic experience, or if physicians find it easier to treat other conditions through an ADHD diagnosis.
- **Opportunity 2: Develop appropriate treatment for diagnosis and severity.** Parent education should be considered an integral component of any treatment plan. Mental health paraprofessional (MHPP) interventions should be evidence-based and related to the severity of symptoms and the dysfunction that the symptoms are creating at home or school. Access may not be sufficient in several areas (e.g., specialty consultation before moving to more intense treatment, appropriate resources for parents).
- **Opportunity 3: Increase measurement of outcomes against identified goals.** Few outcomes are currently measured. A mechanism needs to be built to compile and follow-up on outcome data, including tracking quality improvement.

**Additional areas to explore for subsequent workgroups included:**

- Further disaggregating and explaining paraprofessional spending, non-RSPMI physician services spending, demographic and geographic breakdown of patients, and geographic breakdown of providers.
- Determining if there are factors other than comorbid conditions make a case complex (i.e. environmental factors such as home or school environment and support available).
- Collecting information on spending from commercial payors and a breakdown on what is covered by Medicaid vs. Commercial, if differences exist.
- Identifying ways to work more closely with schools to align their incentives with desired outcomes (i.e. ensuring schools are accepting ADHD students and are being flexible with assessment timing given health care system capacity constraints)