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Overall the document represents a great deal of consideration and effort, and is a reasonable outline for moving forward. I would like to suggest some specifics, which may reinforce the goals and strategies of the plan:

- There must be a multistakeholder commitment to mutual funding, not just mutual coordinating. The same way professional providers must have skin in the game, each stakeholder must too. By having each stakeholder committed to help fund access to value-based care, better coordination and availability will both be supported and carefully monitored.
- Multistakeholder funding also brings in better access to the full range of non-profit organizations in the community systems of care, access to which can be coordinated by the same behavioral health care coordinators and other patient care navigators who help to tie the mental health and substance abuse treatment teams to the primary care teams in the integrated care settings.
- There must be a significant increase in the proportion of overall healthcare funding that goes to support comprehensive primary care. Comprehensive primary care includes access to mental health and substance abuse assessment and primary care consultation, training of primary care professionals, case review, professional to professional consultation, and integrated treatment team planning in comprehensive primary care and integrated care settings. Overall proportions increasing from 5% to 10% are being recommended by other state plans.
- Substance abuse care must include access to community systems of care, including recovery house and job programs and fellowship groups following detox, acute care, and residential programs for there to be longer term successful recovery. Fellowship with others in recovery must extend beyond 12 step meetings, and encompass daily life.
- Access to direct primary care and comprehensive primary care and preventive care can be incentivized by removing these services from deductibles and even from copay payments for care.
- At AACAP Healthcare Access and Economics Committee we have met with the National Alliance of Healthcare Purchaser Coalitions, representing 45,000,000 lives and they are strongly encouraging insurers to begin opening the collaborative care codes to reimbursement over the next 1-2 years by the commercial and Medicaid insurers. If these codes are reasonably reimbursed, this will help to incentivize the mental health professionals to increase the portion of their practice devoted to collaborative and integrated care.
- We found that the major factor among child and adolescent psychiatrists in working with insurers is the prior authorization process, trumping all other concerns. We continue to need to support Delaware's new law on streamlining and making this process transparent, and moving this to the Medicaid markets as well.
- Screening tools, reasonable outcome benchmarks for mental health, and registries regarding such things as antipsychotic use in children will be needed to increase value based care delivery.
- To make it possible for professionals to have time with their patients in traditional settings and with their teams in integrated care settings, we must continue to look at system investment in such practice supports/tools as care coordinators for small practices, technicians (about $12-18 per hour) to assist in E H R data entry, ACO provision of child psychiatry consultants to those practices who do not wish to arrange and fund through collaborative care payments directly, but prefer, as many do, to let the ACO do the funding for the consultant for a fee from the

primary care practice. This fee must be accounted for in the value-based or capitated payment to the practice or in the amount of reimbursement the primary care practice expects to recover through the use of the collaborative care codes.

- There must be a recommitment by state agencies that at budget time, they will be judged not only on whether they have managed their own budgets wisely, but whether they have cost shifted to other agencies. PBH, for instance, has cut its services significantly, leading to more Emergency Department visits. These visits are very expensive, but come from the Medicaid, not the PBH budget.
- Telemedicine is a helpful tool to better access integrated teams, schools, and patients at home. However, in some places, professionals are quitting direct care practice, signing up to do telemedicine practice, and then seeing similar patients. This later form of practice actually creates more distance and does not increase the overall professional availability.
- We must support training and recruitment. I mentor residents in the Delaware Psychiatric Center program, many of whom have then entered child and adolescent psychiatry fellowships in New York and elsewhere. We need to continue to seek ways to recruit and incentivize return of our own trainees back to service in Delaware.

Thank you for allowing me to share some of these boots-on-the-ground thoughts. A roadmap will only be as good as the roads they describe and the cars that will actually drive on them …

Respectfully submitted,
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