SHARING THE SANDBOX: THE COLLABORATION BETWEEN INTEGRATED PRIMARY CARE & COUNTY CRISIS

September 30, 2016
Philip Robinson, LCSW; Stacy Braun, PhD; ABPP; Julie Kaprelian, PsyD; Stephanie Kohlbeck, PhD

AGENDA
- Overview on Integrated Primary Care
- Overview on County Crisis Service Role
- Integration (wraparound) of two systems
- Review of Interview guideline for two systems
- Recommendations for best practice

GOALS
- To enhance county partnership with primary care; promoting integrated medicine.
- To enhance the continuum of treatment options among community resources.
- To enable recovery, self-direction, and community based diversion through interventions with primary care.
GOALS

- To strengthen the quality of consultation between primary care and crisis programs.
- To enable accurate match of services to meet consumer's needs.

“Integrated primary care combines medical and behavioral health services to more fully address the spectrum of problems that patients bring to their primary medical care providers. It allows patients to feel that, for almost any problem, they have come to the right place.”

- Alexander Blount, Ed.D.
- Center for Integrated Primary Care

WHAT IS INTEGRATED PRIMARY CARE?

- Primary Care Behavioral Health is an integrated service model that embeds a behavioral health professional into the primary care setting
  - Referral source
  - Co-location
  - Integration
WHAT IS INTEGRATED PRIMARY CARE?

- Goal: Improve overall health of population
  - Behavioral health becomes a routine part of medical care
  - Population-based care
  - Co-management of patient with PCP

WHAT IS INTEGRATED PRIMARY CARE?

- Key Features:
  - Warm-handoffs
  - Curbside consultation
  - Brief assessments
  - Problem focused, functional and brief interventions

WHY IS IPC NEEDED IN PEDIATRICS?

- Nearly 1 in 10 children and adolescents are diagnosed with a mental health disorder that severely disrupts their functioning (Tynan, Woods & Carpenter, 2013)
- More than half of mental health care is provided in primary care (NAMI, 2011)
- Parents or PCPs raise behavioral or psychosocial concerns during 50-80% of all child health care visits (Mendows, et al., 2011)
WHY IS IPC NEEDED IN PEDIATRICS?

- 50% of all lifetime cases of mental illness begin by age 14 years with an average delay of 8-10 years from onset of symptoms to intervention
- 40-50% of pts receiving mental health treatment outside of primary care terminate services prematurely

PEDIATRICIANS & FAMILIES

- Pediatric offices are key child serving systems
- Pediatricians are a trusted source of information and expertise
- 79% of parents in a rural pediatric sample report seeking help for a psychosocial concern
  - 63% identified PCP as most common source of help, only 24% of parents sought out mental health professionals (Polaha, Dalton, & Allen, 2011)
- In past 25 yrs, rate of psychosocial problems identified by PCPs has increased from 7 to 18%

“Integration is in response to the fragmentation of health care. As individuals, we are not fragmented, we are a whole people. The current health care system does not recognize this. Integration is trying to fix a big problem, which is that we have two separate systems that take care of our health. Integration is a game changer for health care.”

- Benjamin Miller, PsyD
  University of Colorado School of Medicine
IPC WORKFLOW

PCP identifies patient with mental health concerns. PCP documents integrated services (IPC).

If pt agrees to meet, PCP completes a warm hand-off of pt to BHC.

If pt declines to meet, IPC documents suggestion of IPC services and pt declines.

Onsite warm hand-off:

- Page
- Knock on exam door
- Find BHC in resident dictation room

BHC sees pt and/or family for presenting concern.

If pt refuses to meet, PCP documents suggestion of IPC services and pt declines.

KEY

- BHC: Behavioral health consultants
- BH: Department of Behavioral Health
- BHV: Behavioral health visit
- EHR: Electronic health record
- ICV: Integrated care visit
- IPC: Integrated primary care
- PCP: Primary care provider

IPC WORKFLOW

Severity of concern reported determines level and type of follow-up offered.

Visit includes:

- Signed consent
- Brief assessment
- Brief intervention

Concerns identified that could be appropriately treated short-term; Offer follow-up in IPC.

Schedule BHV; identified problem to be treated in 3 - 5 brief visits (15-30 min).

Schedule ICV; typically less regular follow-up and just need to check-in when see PCP.

Pt/family declines follow-up appointment.

Concerns identified that warrant referral to higher level of care (e.g. Dept of BH, mental health provider in community).

Communicate plan to PCP; PCP or BHC completes referral as necessary.

No ongoing or only minor concerns identified; Psychoeducation provided; pt/family to implement strategies at home.

Contact PCP and/or BHC as needed for further questions or concerns; can schedule prn.

At conclusion of visit:

- Communicate with PCP
- Document to CMR
- Enter follow-up BHV/ICV appointment if applicable

Severity of concerns reported determine level and type of follow-up offered.

ROLE OF CRISIS SERVICES

- Assessment & Response
- Criteria for 51.15
- Medical Necessity for Crisis Services
- Linkage and follow up
INTEGRATION ON CONTINUUM OF CARE

- Where services live in relation to one another
- Shared objectives; safety, autonomy, growth
- Developmentally informed interventions
- Visualize and make happen
INTERVIEW GUIDELINE

- Understanding risk/need
- Eliciting relevant information
- Developmentally informed
- Attachment based
- Team oriented
- Consistent with other assessments