Basics of an Effective IBH Clinician as a Partner in the Medical Home

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DISCLOSURE

- No disclosures to report

LEARNING OBJECTIVES

- 1.Physician or practice will exhibit an understanding of IBH as a subspecialty as a clinical mental health provider and how to identify the most effective integrated behavioral health clinician for your practice.

- 2.Physician or practice will be able to identify the steps of training or enhancing an existing IBH clinician to maximize effectiveness and efficiency in joint visit.

- 3.Physician or practice will be able to analyze and adjust their current model of integrated behavioral health to create more optimal productivity and functionality with their embedded clinicians in joint care.

IBH as Subspecialty

LMFT/LSCW/LPC'S ARE NOT TAUGHT THIS MODEL IN GRADUATE SCHOOL

THIS IS LEARNED OVER TIME AND TAKES A CERTAIN TYPE OF CLINICIAN WHO IS BENT TOWARD MORE COLLABORATIVE WORK

THERE IS A LEARNING CURVE WHEN INTRODUCING AN EMBEDDED CLINICIAN INTO YOUR PRACTICE

Typical Outpatient Behavioral Health	Integrated Behavioral Health
Professional Model: Bx Health as a specialty service for referral and consultation **Clinical focus**: mental health care • Diagnosis • Treatment plan • Treatment impacting daily functioning and requires outpatient work Sessions generally 45-60 minutes	**Professional model**: Mental health services an integrated aspect of medical care. Subspecialty. MH clinician as a member of the care team. **Clinical focus**: medical and psychological care intertwined (bio-psycho-social model of care) • Psychosocial aspects of care for any illness or complaint (comorbidity, somatic sxs, psychophysiological sx, complex cases, systemic disruption, chronic illness • Evaluation and referral are foundational • Coordination with specialty MH care, schools, social services, other providers Generally 15-30 minutes (sometimes shorter sometimes longer)
Often 60 minute visit blocks/often no same-day scheduling	Often 30 minute visit blocks/25%-50% of schedule is for same-day scheduling
Status is “active” or “discharged”	Revolving door care/no formal “close”
Clinician generally work independently	Multi-disciplinary/collaborate team working interdependently
Mostly focused on psychological health	Focused on relationship between psychological and physical health in collaboration with PCP
Care is episodic/ Frequent visits for a few months to a couple of years	Care is episodic/frequent visits at times for a month or two/infrequent over years/access care today for life
Patient view:	Patient view:

• The PCP may ask patient to accept a MH referral to a MH clinician in a MH clinic	coordination and automatic info sharing between clinician and PCP • Seen as medical home and often is the start of a formal referral • PCP introduces clinician as part of medical team
Operational systems: • Separate MH clinic/office • Separate scheduling, billing, EMR • Traditional MH clinic professional culture	**Operational systems:** • Medical clinic space within physician office and exam room visits • Shared EMR, joint billing • Traditional medical clinic professional culture
PCP expectations:*** • PCP receives brief updates from treating clinician per the patient's discretion • Practices are independent of one another	**PCP expectations:***** • Communicate consistently about patient on an informal/formal basis. Notes are shared in EMR. • All patient health needs are treated for all patients by a team, who function effectively together • IBHC will offer developmental education, brief behavioral interventions, systemic analysis, conceptualizing diagnostic information, making appropriate referrals, coping skills, psychoeducation

dapted from Interprofessional Primary Care Institute; Spear & Net Fishers AND Patterson, Peak, Heinrich, schoff, & Scherger (2002). Center of Excellence for Integrated Health Solutuions; Substance Abuse and Mental ealth Services Administration; National Council for Behavioral Health

Outpatient Therapy	Co-located Clinic
	•
• Treatment timeline is open-ended	• Short-term 6 session treatment model to ensure broader availability to a larger number of patients
• Longer term modalities used, aka TF-CBT, EMDR	• Modalities are more solution focused and narrowly targeted, i.e., CBT/DBT/brief SF
• In-depth treatment	• Primary/secondary prevention
• Assessment done by MH provider	• Assessment done by IBH provider in order to prevent bottleneck with referrals and limited clinicians
• Clinical focus can include long term tx of any DSM-VI-TR dx	• Tx for broad range of dx, however, clinician will conceptualize goals according to limited sessions and target behaviors rather than treat broad range
	What providers can expect: There is not necessarily certain dx that are appropriate for CLC; however, the IBHC will conceptualize case with several factors in mind including attachment, cost/benefit for shorter term care (often times will need a long-term clinician).

ELEMENTS OF AN IBH CLINICIAN

- Networking capabilities to maximize referral sources
- -Training in a collaborative model
- -Strong interpersonal skills
- -Flexibility to adapt to clinical setting
- -Ability to build relationships with physicians, MA’s, nurses, staff
- -Able to conceptualize cases quickly and develop interventions in the moment
- -Ability to understand family dynamics
- -Identify nuances to a clinical care practice versus private practice

EXPECTATIONS OF IBHC

-Case conceptualization
-Decision for clinical direction
-Training in many modalities to meet wide range of patient needs
-Administer screening tools
-Have knowledge of referral sources including more intensive services (IOP, RTF)
-Daily huddles
-Culturally adapted methods of care
-Communication with the entire care team
-Knowledge of local resources that are clinical - social services/community agencies

IBH CORE COMPETENCIES CITATION

- Benjamin F. Miller, PsyD, Emma C. Gilchrist, MPH, Kaile M. Ross, MA, Shale L. Wong, MD, MSPH, Alexander Blount, EdD, C.J. Peek, PhD. Core Competencies for Behavioral Health Providers Working in Primary Care. Prepared from the Colorado Consensus Conference. February 2016. Miller, Gilchrist, Ross, and Wong of the Eugene S. Farley, Jr. Health Policy Center, University of Colorado School of Medicine organized and led this project. Blount of Antioch University New England and University of Massachusetts served as consultant for behavioral health competencies and training. Peek of the University of Minnesota served as consultant to facilitate the consensus process and help synthesize the resulting content.

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WHAT DOES COMPETENCY MEAN

Competence as a licensed BH provider working in an embedded PCP setting refers to *knowledge*, *skills*, and *attitudes*—and their **interconnectedness**—that allow an individual to perform the tasks and roles in that setting (adapted from Kaslow, Dunn, & Smith, 2008).

1. IDENTIFY AND ASSESS BEHAVIORAL HEALTH NEEDS AS PART OF A PRIMARY CARE TEAM

BH providers apply knowledge of cognitive, emotional, biological, behavioral, and social aspects of health, MH, and medical conditions across the lifespan; and incorporate their clinical observations into an overall, team-based primary care assessment that may include identifying, screening, assessing, and diagnosing.

2. ENGAGE AND ACTIVATE PATIENTS IN THEIR CARE

BH providers engage patients in their care, helping them understand how their BH factors affect their health and illness, and how the BH aspects can be integrated in a team-based care plan.

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3. WORK AS A PRIMARY CARE TEAM MEMBER TO CREATE AND IMPLEMENT CARE PLANS THAT ADDRESS BEHAVIORAL HEALTH FACTORS

BH providers work as members of the primary care team to collaboratively create and implement care plans that address BH factors in primary care practice. These factors may include mental illness, substance use disorders, and physical health problems requiring psychosocial interventions.

Quick note on releases: Behavioral health may be included in care and all charts are shared between PCP and BH

4. HELP OBSERVE AND IMPROVE CARE TEAM FUNCTION AND RELATIONSHIPS

BH providers help the primary care team monitor and improve care team function and collaborative relationships. By knowing their own and others' roles, they help the team pool knowledge and experience to inform treatment, engage in shared decision-making with each other and with patients, and share responsibility for care and outcomes.

5. COMMUNICATE EFFECTIVELY WITH OTHER PROVIDERS, STAFF, AND PATIENTS

BH providers in primary care communicate effectively with providers, patients, and the primary care team with a willingness to initiate patient or family contact outside routine face-to-face clinical work. BH providers communicate in ways that build patient understanding, satisfaction, and the ability to participate in care.

6. PROVIDE EFFICIENT AND EFFECTIVE CARE DELIVERY THAT MEETS THE NEEDS OF THE POPULATION OF THE PRIMARY CARE SETTING

BH providers in primary care use their available time and effort on behalf of the practice population, setting prioritized agendas (with roles and goals) with patients and the team, managing brief and longer patient encounters effectively, and identifying areas for immediate and future work with appropriate follow-up care for which BH availability is maintained.

7. PROVIDE CULTURALLY RESPONSIVE, WHOLE-PERSON AND FAMILY-ORIENTED CARE

BH providers in primary care employ the biopsychosocial model – approaching healthcare from biological, psychological, social, spiritual, and cultural aspects of whole-person care, including patient and family beliefs, values, culture, and preferences.

8. UNDERSTAND, VALUE, AND ADAPT TO THE DIVERSE PROFESSIONAL CULTURES OF AN INTEGRATED CARE TEAM

BH providers act in ways consistent with the collaborative culture and mission of primary care with an attitude of flexibility. BH providers adapt their work style to meet patient needs while building confidence and comfort in working in primary care culture, with providers, and medical situations.

The Coalition assisted in completion of a strategic plan on workforce development for the federally funded Center for Integrated Health Solutions (CIHS). Under the CIHS umbrella and with funding from the Substance Abuse Mental Health Services Administration and the Health Resources and Services Administration, The Annapolis Coalition developed the Core Competencies for Integrated Behavioral Health and Primary Care. These were developed from a comprehensive review of the literature and the recommendations from a panel of 50 experts on behavioral health and integration.

Hoge, M.A., Morris, J.A., Laraia, M., Pomerantz, A., & Farley, T. Core Competencies for Integrated Behavioral Health and Primary Care. Washington, DC: SAMHSA-HRSA Center for Integrated Health Solutions, 2014.

TABLE 1. SPECIFIC COMPETENCIES BY CATEGORY

I. INTERPERSONAL COMMUNICATION

The ability to establish rapport quickly and to communicate effectively with consumers of healthcare, their family members and other providers.

Examples include: active listening; conveying information in a jargon-free, non-judgmental manner; using terminology common to the setting in which care is delivered; and adapting to the preferred mode of communication of the consumers and families served.

II. COLLABORATION & TEAMWORK

The ability to function effectively as a member of an interprofessional team that includes behavioral health and primary care providers, consumers and family members.

Examples include: understanding and valuing the roles and responsibilities of other team members, expressing professional opinions and resolving differences of opinion quickly, providing and seeking consultation, and fostering shared decision-making.

III. SCREENING & ASSESSMENT

The ability to conduct brief, evidence-based and developmentally appropriate screening and to conduct or arrange for more detailed assessments when indicated.

Examples include screening and assessment for: risky, harmful or dependent use of substances; cognitive impairment; mental health problems; behaviors that compromise health; harm to self or others; and abuse, neglect, and domestic violence.

IV. CARE PLANNING & CARE COORDINATION

The ability to create and implement integrated care plans, ensuring access to an array of linked services, and the exchange of information among consumers, family members, and providers.

Examples include: assisting in the development of care plans, whole health, and wellness recovery plans; matching the type and intensity of services to consumers' needs; providing patient navigation services; and implementing disease management programs.

V. INTERVENTION

The ability to provide a range of brief, focused prevention, treatment and recovery services, as well as longer-term treatment and support for consumers with persistent illnesses.

Examples include: motivational interventions, health promotion and wellness services, health education, crisis intervention, brief treatments for mental health and substance use problems, and medication assisted treatments.

VI. CULTURAL COMPETENCE & ADAPTATION

The ability to provide services that are relevant to the culture of the consumer and their family.

Examples include: identifying and addressing disparities in healthcare access and quality, adapting services to language preferences and cultural norms, and promoting diversity among the providers working in interprofessional teams.

I. INTERPERSONAL COMMUNICATION

COMMUNICATING IN THE JOINT VISIT

- 1. Ability of a BH to be able to *rapidly* develop rapport with a wide range of individuals along with the PCP is crucial.
- 2. Listening actively and effectively is key to making the patient and family feel thoroughly heard and understood. Primary problems need to be grasped **quickly** and a framework begins to develop about patient needs, preferences which are then **reflected** back to the family.
- 3. Utilizing psychoeducation in a non-judgemental way that is tailored to the patient/family members in the room can be key in helping create a simple understanding of holistic and helpful concepts.
- 4. Explain to the patient/family the roles and responsibilities of each team member and how they will work together to provide services. This will include the PCP, the BH, referral sources, the case manager or other care roles within your office.

CONT'D

- 5. Avoid using terminology that is too clinical or confusing for the patient including acronyms or getting in the weeds.
- **BE BRIGHT, BE BRIEF, BE GONE**
- 6. Use an interpreter wherever needed
- 7. Adapt your language based on family capacities
- 8. Provide visual/tangible resources/health/psycho- education materials that are appropriate for the family and give them something to bridge the information presened verbally.
- 9. Recognize and manage personal biases related to healthcare consumers, families, health conditions and healthcare delivery.

Collaboration and Team-Work

NOTES

- Assertiveness is important in the room to make the visit as effective and efficient as possible.
- Pick 1-2 topics and have the family back if needed to address less acute concerns
- Present a united front: be attuned to and respect/ respond to the leadership displayed by other providers in or out of room - important to defer to others in clinical leadership on the particular case
- Be practical in your approaches and practice flexibility /adaptability if mid-intervention you realize it does not fit or meet the needs of the family. Be aware of an avoid rigidity.
- Connect the patient and family to others in the moment through the “warm hand off.”

SCREENING & ASSESSMENT

COMMONLY USED

BASC

Behavioral assessment system for children

Conners

LEmail option

SCARED/PHQ-9/Vanderbilts

Immediate results and used by both PCP and IBH

CARE PLANNING & CARE COORDINATION

INTERVENTION

CULTURAL COMPETENCE & ADAPTATION

SYSTEMS ORIENTED PRACTICE

PRACTICE-BASED LEARNING & QUALITY IMPROVEMENT

IBH CORE COMPETENCIES

- Our Mission
- The Team
- New Products and Services
- Competitive Analysis
- Competitors
- Size of Market
- Our Numbers
- Path to Integration

Types of IBH models (citation included)

THE PRACTICE INNOVATION PROGRAM AT THE UNIVERSITY OF COLORADO ANSCHUTZ MEDICAL CAMPUS, PRACTICE INNOVATION PROGRAM AT CU

STEPHANIE B. GOLD, MD; EMMA GILCHRIST, MPH; STEPHANIE KIRCHNER, RD, MSPH; BAHROZE RAZEEN, PHD(C); LARRY A. GREEN, MD; W. PERRY DICKINSON, MD. THE BUILDING BLOCKS OF BEHAVIORAL HEALTH INTEGRATION. THE EUGENE S. FARLEY, JR. HEALTH POLICY CENTER & THE PRACTICE INNOVATION PROGRAM AT THE UNIVERSITY OF COLORADO ANSCHUTZ MEDICAL CAMPUS. JUNE 2022

MODELS

The Collaborative Care Model:

Includes consultation with a psychiatrist, proactive outreach and population management by a behavioral health care manager, and a measurement-guided care plan. The demonstrated effectiveness of the Collaborative Care Model has led to a focus on this model in policy efforts to integrate care. While it is an important approach, it does not reflect the entire breadth of ways integrated behavioral health can and will be implemented in primary care practice.

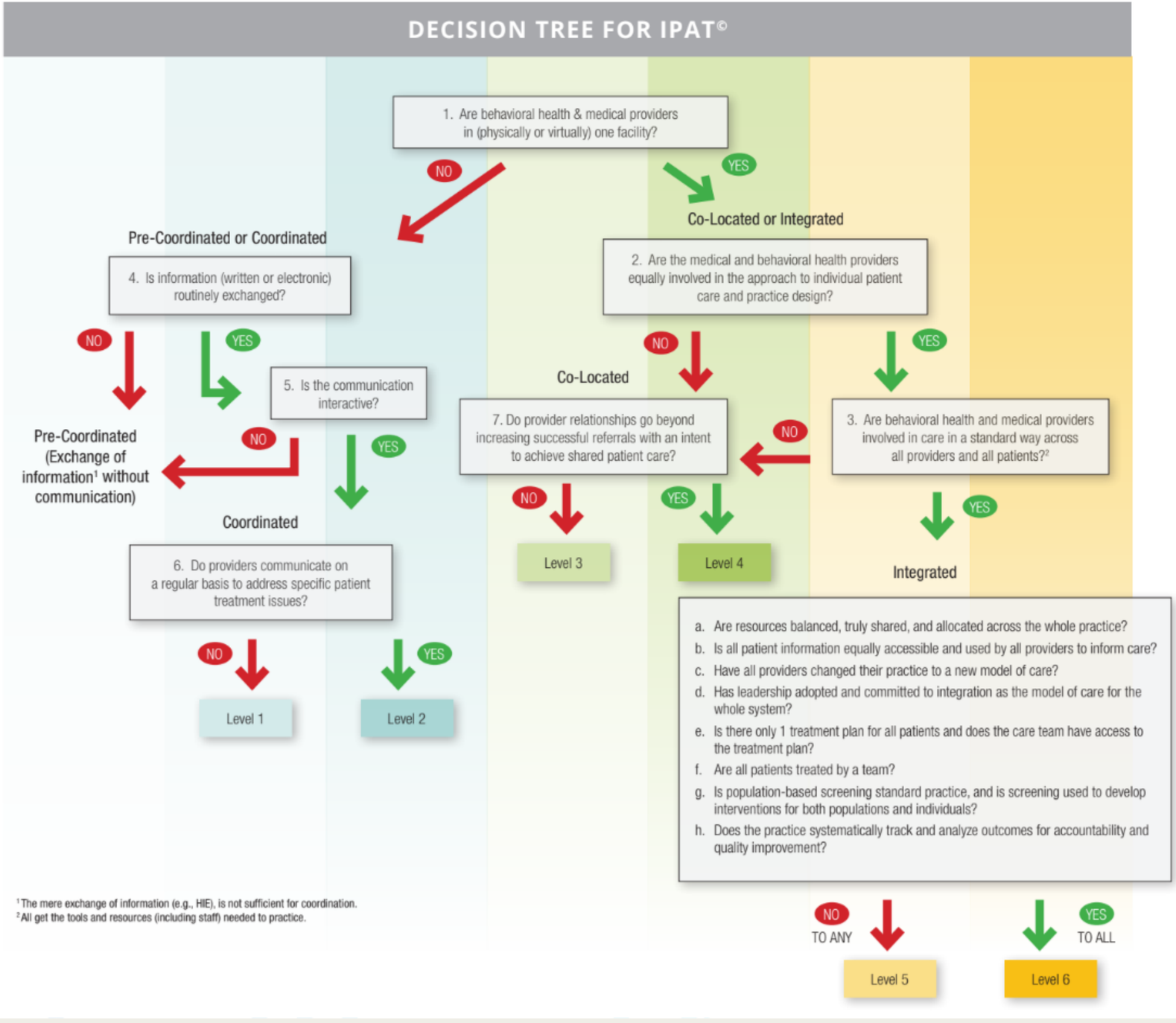
The Primary Care Behavioral Health model:

Incorporates a behavioral health clinician into the primary care team who works as a generalist in providing accessible services for behavioral health problems and biopsychosocially influenced health conditions. Other models of behavioral health integration include integration into specialty care settings and integration of primary care into a behavioral health clinic.

EXISTING FRAMEWORKS OF BEHAVIORAL HEALTH INTEGRATION: COMPONENTS AND LIMITATIONS

Integrated Practice Assessment Tool (IPAT)13

Includes 6 levels organized into 3 categories (Coordinated, Co-located, and Integrated). Level 1 is minimal collaboration and Level 6 is full collaboration in a transformed practice.


DECISION TREE FOR IPAT©
1. Are behavioral health & medical providers in (physically or virtually) one facility?
NO
YES
Pre-Coordinated or Coordinated
Co-Located or Integrated
4. Is information (written or electronic) routinely exchanged?
2. Are the medical and behavioral health providers equally involved in the approach to individual patient care and practice design?
NO
YES
NO
YES
5. Is the communication interactive?
Co-Located
7. Do provider relationships go beyond increasing successful referrals with an intent to achieve shared patient care?
3. Are behavioral health and medical providers involved in care in a standard way across all providers and all patients?[2]
Pre-Coordinated (Exchange of information[1] without communication)
NO
YES
NO
YES
NO
YES
Coordinated
NO
YES
Level 3
Level 4
Integrated
6. Do providers communicate on a regular basis to address specific patient treatment issues?
a. Are resources balanced, truly shared, and allocated across the whole practice?
b. Is all patient information equally accessible and used by all providers to inform care?
c. Have all providers changed their practice to a new model of care?
d. Has leadership adopted and committed to integration as the model of care for the whole system?
e. Is there only 1 treatment plan for all patients and does the care team have access to the treatment plan?
f. Are all patients treated by a team?
g. Is population-based screening standard practice, and is screening used to develop interventions for both populations and individuals?
h. Does the practice systematically track and analyze outcomes for accountability and quality improvement?
NO
YES
NO TO ANY
YES TO ALL
Level 1
Level 2
Level 5
Level 6
[1] The mere exchange of information (e.g., HIE), is not sufficient for coordination.
[2] All get the tools and resources (including staff) needed to practice.

Practice/Location:_____Date:_____

Current Level of Integration: (Circle one)

Pre-Coordinated	LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some Systems Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/Merged Integrated Practice

Assessment Team Completing IPAT: (Names/Position at Practice)

Name:_____Position :_____

Name:_____Position :_____

Name:_____Position :_____

Name:_____Position :_____

Notes/Comments:

_____

_____

_____

_____

_____

_____

COMPREHENSIVE HEALTHCARE INTEGRATION FRAMEWORK (NAT'L COUNCIL FOR MENTAL WELLBEING)

Eight Domains of Integration

Screening, Referral, and Follow-up

Prevention and Treatment of Common Conditions

Continuing Care Management

Self-Management Support

Multi-Disciplinary Teamwork

Systematic Measurement and Quality Improvement

Linkage with Community and Social Services

Sustainability

NATIONAL COUNCIL for Mental Wellbeing

ALTITUDE'S APPROACH

1.
evidence-based

There are foundational expectations established to enable an infrastructure to build from

2.
sustainability

We leverage grants/funding along with billable hours to make our program sustainable

3.
dynamic

Our framework is every changing and dynamic versus static in its approach

4.
infrastructure

There are foundational expectations established to enable an infrastructure to build from

SCHEDULING CONCEPT

1 year
in operation

IBHC’s are scheduled in a staggered form in order to maximize availability per needed throughout day

180k
subscribers

20 minute joint visit availability

3 million
raised

Can be filled with billable case management if not scheduled by a provider

7
employees

60 minute CLC visits

SCHEDULING

- IBHC’s are scheduled in a staggered form in order to maximize availability per needed throughout day
- 20 minute joint visit availability
- Can be filled with billable case management if not scheduled by a provider
- 60 minute CLC visits

EXPECTATIONS OF IBH COORDINATOR

-Being aware of additional funding sources including grants
-Staying up to date on latest billing practices, coding standards, changes in state ethic requirements
-Networking with knowledge of reliable referral sources who accept patient’s insurance and have reasonable availability
-Tracks CLC referrals of self and team members and gathers data on levels of completion
-Practice provides crisis resources and referrals as indicated

TEAM BASED CARE

- Practice has clearly defined roles, responsibilities, and workflows related to behavioral health services.
- Practice incorporates behavioral health training into onboarding and ongoing professional development efforts, including for primary care providers and all clinic staff

WARM HAND OFFS

DAY IN THE LIFE

- ⬤9:00am: Check schedule and huddle with physicians for the day's patients.
- ⬤9:10am: Meet with Dr. Lopez for an IBH appt to follow up on an IEP meeting for a teenager with significant behavioral issues.
- ⬤9:25am: 60 minute therapy session with 3-year-old and her mother,who is beginning to exhibit Autism Spectrum behaviors. Make referrals to provide scaffolding for the family system.
- ⬤10:25am: Return messages about one middle schooler and one first grade both needing therapy; refer middle schooler for group and first grader to private practice clinician.
- ⬤10:35am: Called in by Dr. Murphy to see an 8th grader with suicidal thoughts. Spend 30 minutes assessing, the risk is acute enough to call the state hotline who sends mobile crisis. Coordinate care with provider and make patient comfortable until crisis arrives. Pt meets admission criteria.
- ⬤11:00am: 60 minute session with a recently graduated 19-year-old struggling with identity versus role confusion which has led to daily marijuana use. This patienthas stomach issues that have been medically ruled out with labs and exam and are largely deemed psychosomatic. Utilize EMDR to help with nervous system regulation and to help with marijuan cravings. Ask the physician to join the appointment to discuss adding a PRN anxiety medication in addition to her SSRI. Physician decides on Hydroxyzine. Collaborate with the physician to help the client utilize medication and coping skills in tandem.
- ⬤12:00pm: Warm hand off for a child who met ADHD criteria on Vanderbilts for executive functioning clinic.

DAY IN THE LIFE CONT'D

- ⬤1:00 pm: 60 minute family therapy session to help parents navigate behaviors of an adopted child who is exhibiting attachment issues. Discuss referral to a new group at Altitude that uses modality of Circles of Security to help with parent training, support, attachment analysis and a protocol to help orient family toward healing.
- ⬤2:00 pm: IBH appt with Dr. Willy to discuss a 6-year-old patient with sleep issues. Work on sleeping plan together and will follow up in 2 weeks.
- ⬤2:20pm: 60 minute session with 6th grader who is struggling with transition into middle school. Worked on adaptive coping techniques.
- ⬤3:20pm: IBH appt with Dr. Joy to follow up on Vanderbilts assessments for a complex 5th grader. Referred for further testing at Behavioral Health and Wellness to gather more information to inform treatment planning.
- ⬤3:40pm: 60 minute session with 5-year-old struggling with transition to and from parent's home who are recently divorced. Worked on utilizing transitional objects and helping parents understand inherent stressors of divorce.
- ⬤4:40 pm: Return phone calls from 2 parents following up on last session's content and help with homework for the patients to complete before the next session.

Co-Located Clinic

-IBHC’S AIM TO SEE PATIENTS FOR 6 SESSIONS FOR BRIEF SOLUTION FOCUSED THERAPY

-TREATMENT CAN BE ELONGATED PER THE THERAPIST’S CLINICAL JUDGEMENT

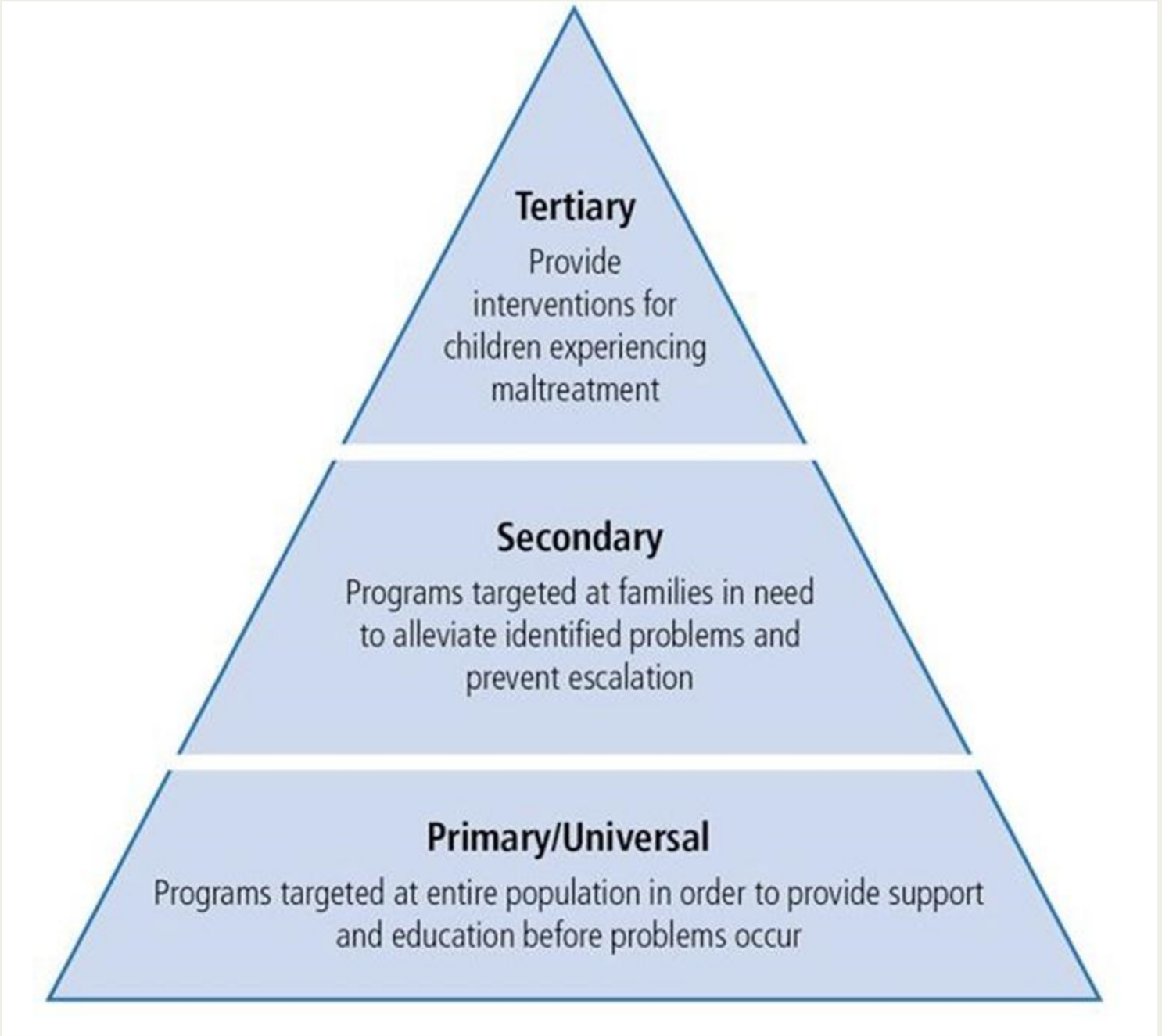
-MEDICAID: AFTER 6 SESSIONS, COVERAGE IS TURNED OVER THE RAE

-PRIVATE PAY: CO-PAYS OR PAY AT TIME OF SERVICE

Prevention Model

FOR THOSE PATIENTS IDENTIFIED FOR 6 SESSIONS BRIEF MODEL, PREVENTION SYMPTOMS MAY BE TARGETED RATHER THAN A “TRAUMA DEEP-DIVE.”

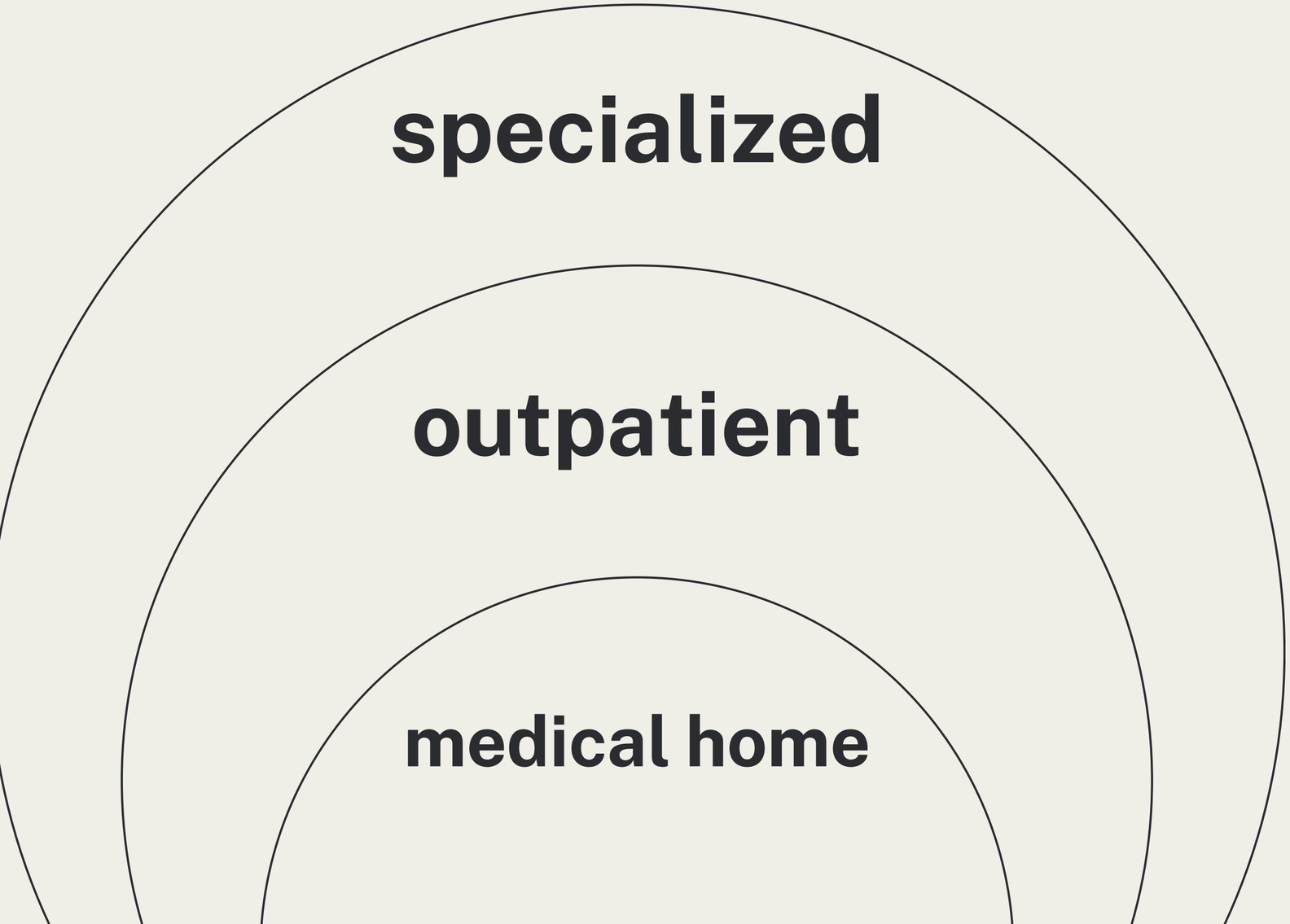
APPROPRIATE USE OF SCREENERS, BASC, CONNERS, PHQ-9, SCARED, Y-BOCS ETC


Tertiary
Provide interventions for children experiencing maltreatment
Secondary
Programs targeted at families in need to alleviate identified problems and prevent escalation
Primary/Universal
Programs targeted at entire population in order to provide support and education before problems occur

WORKFLOW

- Physician determines if a joint BH visit is appropriate
- BH joint visit is scheduled
- IBHC determines if patient is appropriate for co-located model or if a referral is needed
- If referred out, source is identified and referral is formally sent by practice

REFERRALS TO MAXIMIZE CARE



Executive functioning resources

ABA

Neuropsychological testing

Evaluation for IEP, 504 plans
Medication management

Other specialized services not available in the CLC clinic

APA RESEARCH

- PCBH improves the patient/family experience of care (satisfaction with care)
- •Patient preference for PCBH services (Ogbeide et al., 2018)
- •Improves access to mental health care (Hodgkinson et al., 2017; Pomerantz et al., 2010)
- •Increases engagement and linkage to specialty mental health treatment when needed (Bohnert et al., 2016; Brawer et al., 2010; Wray et al., 2012; Zanjani et al., 2008)
- •Increases antidepressant adherence (Szymanski et al., 2013)
- •Reduces wait time for mental health services (Pomerantz et al., 2008; Pomerantz et al., 2010) and no-show rates (Pomerantz et al., 2010)
- •Improves relationship between patient and provider (Corso et al., 2012)

PEDIATRIC IBH SPECIFICALLY

- •Integrated behavioral health services in pediatric primary care offers a wide continuum of services ranging from prevention and health promotion activities (e.g., pregnancy-related depression, developmental and Healthy Steps consultations) to interventions around mental health concerns (e.g., mental health and psychopharmacology consultations; Talmi et al., 2016).
- •Pediatric integrated care provides population-level care to more children, removes barriers to obtaining care and increases access to quality evidence-based treatments (Njoroge et al., 2016).
- •PCBH services with pediatric patients are associated with savings in terms of medical cost-offset with one study finding a total monthly savings of $9,424 in reduced health care charges over the period after a behavioral health visit as compared to the period prior across patients who completed an episode of care (Dopp et al., 2018).

IMPROVING OUTCOMES

- PCBH improves patient outcomes (improves population health; Reiter & Bauman, 2016)
- •Increases provider adherence to treatment guidelines and appropriate antidepressant prescribing (Brawer et al., 2010; Serrano & Monden, 2011)
- •Decreases in level of patient distress found two years post integrated primary care intervention (Cigrang et al., 2007)
- •Improvements in outcomes regardless of presentation severity (Bryan et al., 2012; Cigrang et al., 2007)
- •Targeted interventions associated with broad improvements in symptom reduction, functioning, and well-being (Bridges et al., 2014, 2015; Bryan et al., 2009, 2012; Cigrang et al., 2007, 2011; Corso et al., 2012; Davis et al., 2008; Gomez et al., 2014; Goodie et al., 2009; McFeature & Pierce, 2012; Ray-Sannerud et al., 2012; Sadock et al., 2014; Wilfong et al., 2021)

Thank you!

QUESTIONS?