PRIMARY CARE MODERNIZATION

Behavioral Health Integration

CORE CAPABILITY

A team-based approach to prevention, early identification and promotion of developmental, socio-emotional, and mental health for children and families within the pediatric medical home and community.

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HOW CARE WILL IMPROVE

PATIENTS AND FAMILIES CAN...

- Connect with a behavioral health clinician right away at your primary care visit
- Have a care team that understands how stress and trauma impact your child's development and health later in life
- Meet with a care coordinator to connect you to community-based supports and additional behavioral health and developmental services
- Get coaching on managing your child's behaviors
- Access the behavioral health clinician through video visits
- Get help communicating with your child's school or childcare center about development and behavior
- Have a single point of contact to coordinate all of your child's providers

PEDIATRIC CARE TEAMS CAN...

- Expand capacity to provide behavioral health screenings, brief interventions, and medication management
- Improve early identification and treatment of behavioral health and developmental issues, and ability to provide trauma informed care
- Coordinate with schools and childcare centers and facilitate access to behavioral health and related community services
- Better address the preventive and medical care needs of children with serious behavioral health conditions
- Access psychiatric consultation to support prescribing and management of behavioral health and health behaviors
- Access behavioral health care information on your EHR

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Andre is in sixth grade and having trouble concentrating in school. His teacher says he is disruptive in class and doing poorly on assignments. Andre's parents have noticed he is more active than his peers and distractible at home.

Andre and his mom Marie go to the pediatrician's office for an annual check-up. The PCP sends his mom home with the Vanderbilt ADHD Diagnostic Rating Scale to complete and return. With permission, the PCP sends the scale to Andre's teacher.

The practice's care coordinator follows up with Marie and Andre's school to get the completed scales and gives them to Andre's PCP at their weekly meeting. The PCP has an eConsult with a child psychiatrist about whether medication is indicated.

At a follow up visit, Andre's PCP introduces Andre and Marie to the psychologist at the office to determine if counseling is needed. The care coordinator reaches out to Andre's school regularly to keep the care team informed about his progress.

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WE WANT TO HEAR FROM YOU!
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HOW

Care Team and Network Requirements

- Dedicated behavioral health clinician (BHC) on-site or via telemedicine
- Dedicated care coordinator with expertise in coordinating access to services in support of BH and SDOH needs of children and parents, and who coordinates across all service systems (e.g., schools, Title V, child welfare)
- Administer universal screenings to assess developmental and socio-emotional health; behavioral health and health behaviors; and social and environmental factors
- Provide brief interventions for behavioral health and health behaviors and promote trauma-informed care
- Provide referrals to and coordinate with community BH specialists, higher level BH services and supports, developmental services and community resources (e.g., housing)
- Train primary care teams and BHCs in core competencies, effective teaming and cultural sensitivity
- Establish arrangements with community-based child psychiatrist or psychiatric APRN for telephonic and eConsults, such as through Access Mental Health CT
- Develop and track outcome measures assessing effectiveness of the practice in addressing BH needs; including health equity and disparities

Health Information Technology Requirements

- Access to common EHR platform for medical and behavioral health care
- EHR configuration or complementary platform to support telemedicine and eConsult
- EHR configuration and protocols to ensure capture of all interactions between patient/family and care team members, including nonoffice-based care
- EHR configuration to support outcomes measurement and performance accountability
- Referral management platform with interoperability to confirm visits with BH specialists and community-based organizations
- Bi-directional communication solution to support coordination with BH specialists and community care settings (e.g. school health centers)
- Consent and confidentiality management solution

MEASURING IMPACT

✓ Patient Experience

- Improved patient/family experience with respect to timely care, communication, coordination, access to BH care, and provider support
- Single point of contact for services received at practice and community settings
- Less time off work or school for parents and children

★ Quality

- Earlier identification and intervention for behavioral health and developmental conditions
- Improved behavioral health outcomes (e.g., remission of disruptive behavior disorders)
- Improved school outcomes (e.g., school readiness, attendance)
- Improved family functioning (e.g. reduced exposure to adverse childhood events)
- Reduced risk of developing chronic conditions in adulthood

$ Cost

- Lower out of pocket costs for patients and families when treated in primary care
- Reduced ED and hospital utilization

Access

- Easier access to BH services and reduced wait time for treatment
- Assistance connecting to community-based BH specialty services and community supports

IMPROVING HEALTH EQUITY

Children and families who have BH needs face obstacles accessing care. Childhood BH conditions that go untreated can negatively impact health in adulthood. BH integration will:

✓ **Improve access for families** who, for reasons related to culture, stigma or SDOH barriers, may not access behavioral health treatment in other settings.

✓ **Expand connections with culturally appropriate community services** to address BH and SDOH needs for children and their parents.

✓ **Use care coordinators and medical interpreters** to improve communication between primary and behavioral health providers.

LEARN MORE!
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PEDIATRIC BEHAVIORAL HEALTH INTEGRATION

ALL PEDIATRIC PRIMARY CARE PROVIDERS TEAM-BASED CARE

Child & Family

Standard screening for behavioral health and social determinants

Dedicated pediatric behavioral health clinician (LCSW or APRN)

- Available on-site or via telemedicine
- Performs brief screenings and assessments, brief treatment services and care team consultation
- Conducts phone consultations through Access Mental Health CT

eConsult arrangement with community-based psychiatrist or advance practice registered nurse (APRN)

Team-based, biopsychosocial approach to care, health promotion, and prevention

Medication management

Practice team training

PRACTICE-BASED CARE COORDINATOR WITH BEHAVIORAL HEALTH EXPERTISE

- Supports referrals and patient navigation to community-based care
- Community resources to support behavioral care
- Works with the primary care team and with behavioral health specialist
- Avoids duplication of care coordination services

HEALTH NEIGHBORHOOD

Connects patients via established relationships with pediatric behavioral health clinics, psychologists/APRNs/LCSW to provide extended therapy, counseling, and extensive evaluation

Connects to community-based organizations, schools, and child care

Bidirectional communication among primary care team, community-based behavioral health specialist and community support organizations. Access to Electronic Health Record and systematic outcomes tracking.