PRIMARY CARE/BEHAVIORAL HEALTH INTEGRATION

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OBJECTIVES:

TO REVIEW OUR EXPERIENCE WITH PC/BEHAVIORAL HEALTH INTEGRATION

- PATIENT BENEFITS
- PROGRAM AND PRACTICE BENEFITS
- CHALLENGES

1. WHY COLLABORATION?
2. MODELS OF COLLABORATION
3. OUR EXPERIENCE

COLLABORATION- WHY?

CURRENT HEALTHCARE CLIMATE

- LIMITED ACCESS FOR PATIENTS WITH ID/DD WITH BEHAVIORAL HEALTH NEEDS
- GENERAL LACK OF PSYCHIATRIC PROVIDERS- APPROXIMATELY 15,000 VACANT POSITIONS FOR PSYCHIATRIC PROVIDERS NATIONWIDE
- SHORTAGE OF PRIMARY CARE PROVIDERS EXPECTED TO BE 21000 TO 50,000 BY 2032
- OVERALL LACK OF EXPERTISE IN THE DD MENTAL HEALTH FIELD

MODELS OF COLLABORATION

- IMBEDDED Social Work/Psychology in PRIMARY CARE
- IMPACT MODEL- PC Provider/Psychiatry (Nurse Manager TBA)
- Team Care Consultation

WHAT WE DO-PRIMARY CARE

- PHQ2/9 Everyone and often
- “Warm Hand-off for positive Screens
  - Frees PCP from trying to be a therapist, allows medical focus
  - Increases the likelihood of engagement at the moment of distress
  - Already in a safe, familiar setting, trust is established readily
- Discussion between PCP provider and Psychology/Social worker provider
  - Initiation of Medical management and therapy, allows prompt adjustments and recognition of change in status

PRIMARY CARE /PSYCHIATRY COLLABORATION-MODIFIED IMPACT

- Patient who do not respond to initial intervention-
  - “curb side consult”
- Two-Way Street- PC Accepted transfer for patients on stable regimens
  - Freed Psychiatrists to see more acute and complex patients
  - Collaboration and discussion for patients that destabilized or non-responder to initial therapy
  - Psychiatrists can refer to PC
    - for evaluation of acute medical issues or needed medical workup,
    - medication side effect management,
    - routine screening for diabetes and hyperlipidemia for patients on anti-psychotics.

PRIMARY CARE /PSYCHIATRY COLLABORATION-MODIFIED IMPACT

- SUPPORTS PC WITH PSYCHIATRIC KNOWLEDGE AND GUIDANCE FOR LESS COMPLEX OR STABLE INDIVIDUALS,\
- INCREASES KNOWLEDGE BASE AND COMFORT OF MANAGEMENT FOR PCPS.
- SUPPORTS PSYCHIATRY PROVIDERS WITH MEDICAL BACKUP
- MAKES BEST USE OF SCARCE PSYCHIATRIC AND PRIMARY CARE RESOURCES
- IMPROVES ACCESS FOR PATIENTS BY USING THE "RIGHT RESOURCE"
- INCREASES AWARENESS OF MEDICATION SIDE EFFECTS AND INTERACTIONS AND ALLOWS JOINT DECISION MAKING IN MEDICATION CHANGE.
- PSCYHOLOGY PROVIDES THE COUNSELING PIECE WHICH UNBURDENS PC AND PSCYHAITRY AND PROVIDES NEEDED RESOURCES FOR PATIENTS

PATIENT BENEFITS

- For patients/caregivers who may be reluctant to be seen by a behavioral health professional, the process is made easier.
  - Patient Is seen in the Primary Care area they are familiar with.
- The “warm hand-off”: when Primary Care refers a patient, they are either seen immediately or get a call directly from the psychologist, and an appointment is scheduled. No red tape.
- The integration of care improves the quality of care and the sharing of critical information- a benefit to the patient.
- Multi-disciplinary insight
- Counseling and Medical management share observations and identify focus.
- Improves access to psychiatric care when appropriate.

CHALLENGES

- Limited time and cost of social worker- finding the balance between availability and reimbursement
- **A Surprise-** Resistance/Comfort on the part of Residential Staff and Nursing regarding Primary Care ability to treat and monitor Mental Health issues.
- Provider comfort and expertise.
- PHQ 9 is not a validated tool in patients that have ID/DD but has, in my opinion, value as historical information. Dependence on outside reporters.
- Culture change- We like our silos! We are not used to sharing information.

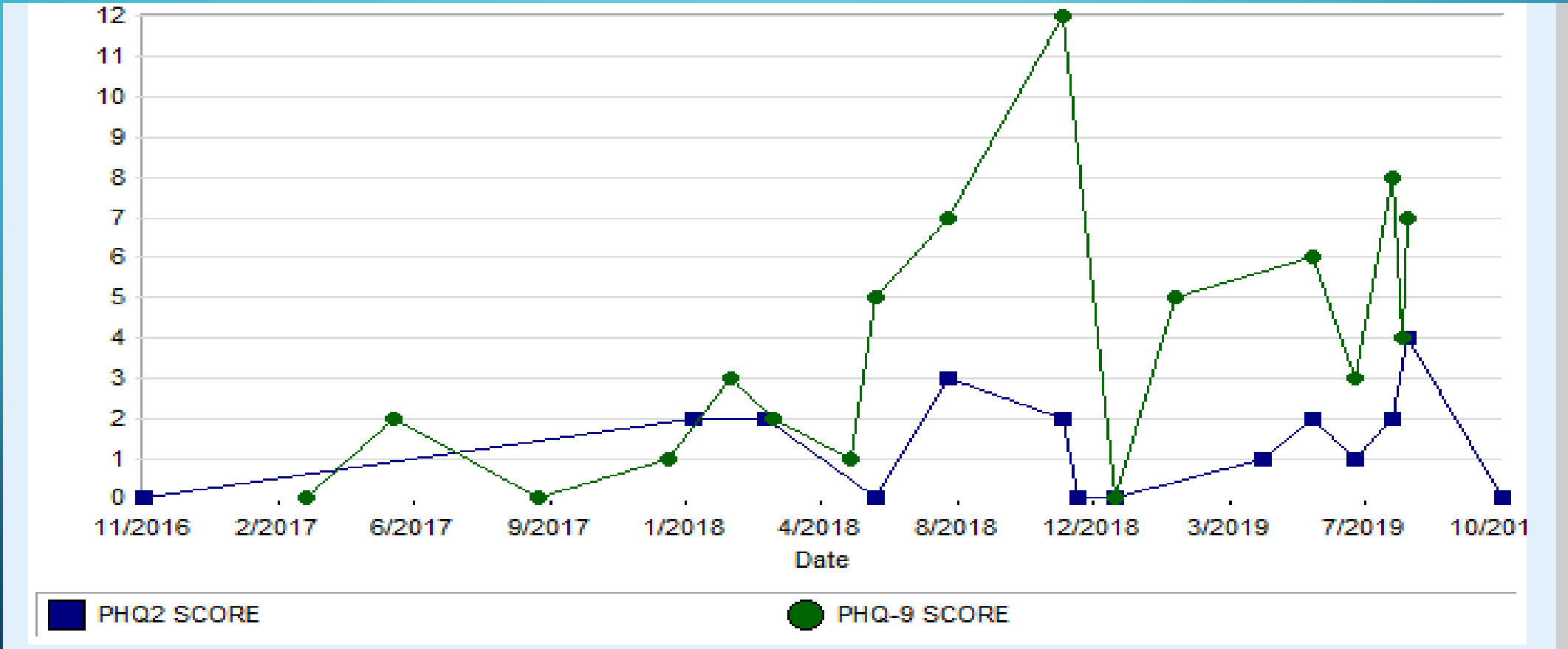
CASE STUDY AR

- AR is a 45 year old with congenital deafness, mild intellectual disability, seizure disorder, cerebral palsy, hypertension, and hyperlipidemia.
- She is a long term patient in Primary Care and Social Work in Center Health Care. She was previously seen by a Psychiatric provider and had been stable on Lexapro 20 mg for long term.
- Psychiatric provider was no longer available and her care was transferred to Primary care. Remained stable until 2018.

AR CONTINUED

- In Feb 2019, House staff and behaviorist noted increased stress at day program and increased tearfulness at on. Her PHQ was 3 at that time. She was referred to counseling at CHC
- April 2018 Increased isolation and low motivation noted. Medication changed to duloxetine in primary care. With improvement of symptoms
- Significant flare of symptoms of depression in December of 2018 when medication was decreased because of side effect of elevated blood pressue
- Increased to intermediate dosing with improvement.
- Flare in July related to loss of meaningful employment in day program related to defunding.
- Social work, in the loop and counseling continued throughout.

CASE STUDY AR PHQ2 AND 9 SCORES



PROFESSIONAL BENEFITS – PSYCHOLOGIST PERSPECTIVE

- Integration involves co-location; Psychologist is based for 4 hours a week in the Primary Care area.
- The cases can be complex, involving interactions between behavioral health and medical issues- working together facilitates quality care.
- Proximity leads to quality rapport and mutual support on cases.
- Providers are naturally inclined to cross-refer when we know and trust each other

ADVERSE CHILDHOOD EXPERIENCES (ACES)

- ACES in childhood result in a wide range of health risks, including significant risk of early morbidity.

Adverse Experience Categories in General Population	
Psychological (by parents)	11%
Physical (by parents)	11%
Sexual (anyone)	22%
Household Dysfunction	
Substance Abuse in family	26%
Mental Illness in family	19%
Domestic Violence	13%
Imprisoned Household Member	3%
Loss of parent	23%

ACE Score	*Prevalence*
0	**48%**
1	**25%**
2	**13%**
3	**7%**
4	**7%**

THE RISKS OF ACES FOR PEOPLE WITH IDD ARE 3-4X HIGHER THAN THE GENERAL POPULATION

- To address this, we have added the ACE questionnaire to our templates in behavioral health.
- Primary Care staff have been trained about ACES by the Psychologist
- http://www.acesconnection.com/blog/a-trauma-informed-toolkit-for-providers-in-the-field-of-intellectual-disabilities OR- just Google "Marcal, Toolkit, and Blog"

CASE STUDY- CARE FOR THE FAMILY IN PRIMARY CARE

- _____ is a man with a mild Autism Spectrum Disorder, mental health difficulties and a history of dangerous behavior.
- He is focused on self-improvement, and continues to work very well with this psychologist toward that end.
- He has a fiance now who resides in a rural area.
- As far as this writer knows the relationship is a healthy one. Her family is reportedly lacking resources and has some mental health problems as well.
- His grandmother, who is medically frail, sees Dr Kansas. On one visit, she expressed her fear of dying and leaving her family vulnerable.

CASE DISCUSSION-

- 30 year old with Autism, anxiety, depression and mild IDD seen by psychologist in our outpatient service for many years.
  - Hx of dangerous behavior, stable for 10+ years.
  - Household has multiple stressors: Multiple relatives with a range of difficulties- including grandparent with dementia and the cousin of patient who also has a developmental disability.
  - Grandmother, main family support, aging with chronic illness, who has no IDD, is seen in our Primary Care office. + PHQ9 Screen, expressed distress and fear of dying.
  - " Warm hand-off" occurred.
  - This lead to a family meeting in which we could accomplish a good deal of problem solving and boundary setting, and advocacy for the person with the IDD.

TEAM CARE COLLABORATION

- Funded by Patients residence
- 1-2 hour multi-disciplinary review which includes:
  - Director of Psychological Services
  - Primary Care
  - Psychiatry
  - Social Worker/Psychology
  - Residential Team
  - Behaviorist

CASE STUDY- KS

- Ks is a 45 year old male with Autism Spectrum Disorder, Bipolar affective Disorder with Psychosis, Personality Disorder, History of Childhood Abuse, Obstructive Sleep Apnea, hypothyroidism, History of Leukopenia 9 low white count)
- Attends Center Primary Care, Psychiatry Psychology, Center Day Program and Center Residence.
- Ongoing aggressiveness toward others- sometimes requiring the recruitment of law enforcement, frequent expression of suicidal ideation and frequent ED visits.
- Medication regime include :
  - Depakote
  - Risperidal, Loxapine and Olanzapine
  - Clonidine
  - Benzotropine
  - Lorazepam

THANK YOU

Questions?