

Outreach and Engagement of High Risk Primary Care Populations: Addressing Suicidality via an Integrated Behavioral Health Community Care Team Model

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Objective

The focus of this presentation is to answer the following question:

What engagement, assessment, and outreach activities can be utilized with suicidal populations in primary care?

Scope of Problem

Suicide in Primary Care Populations

- Research has shown that on average 45% of all people who commit suicide visited their primary care doctor within 1 month of completion, a percentage that can be even higher depending up on age and gender.¹
- In suicidal populations the rate of contact with primary care providers is higher relative to contact with mental health providers.¹
- More older adults ages 55 and up have contact with primary care providers within 1 month of suicide as compared to younger populations.¹
- Physicians do not consistently ask their patients about suicidality.²



Comorbidity of Medical Illness and Mental Illness

- People with serious mental illness (SMI) are more likely to experience comorbid medical conditions than people in the general population, including higher rates of diabetes, lung diseases, and liver problems.³
- Patients with SMI, including schizophrenia, bipolar disorder, and other psychotic disorders who also have co-occurring substance abuse issues are at risk for multiple comorbid medical problems, including heart disease, asthma, gastrointestinal disorders, skin infections, and acute respiratory disorders.⁴

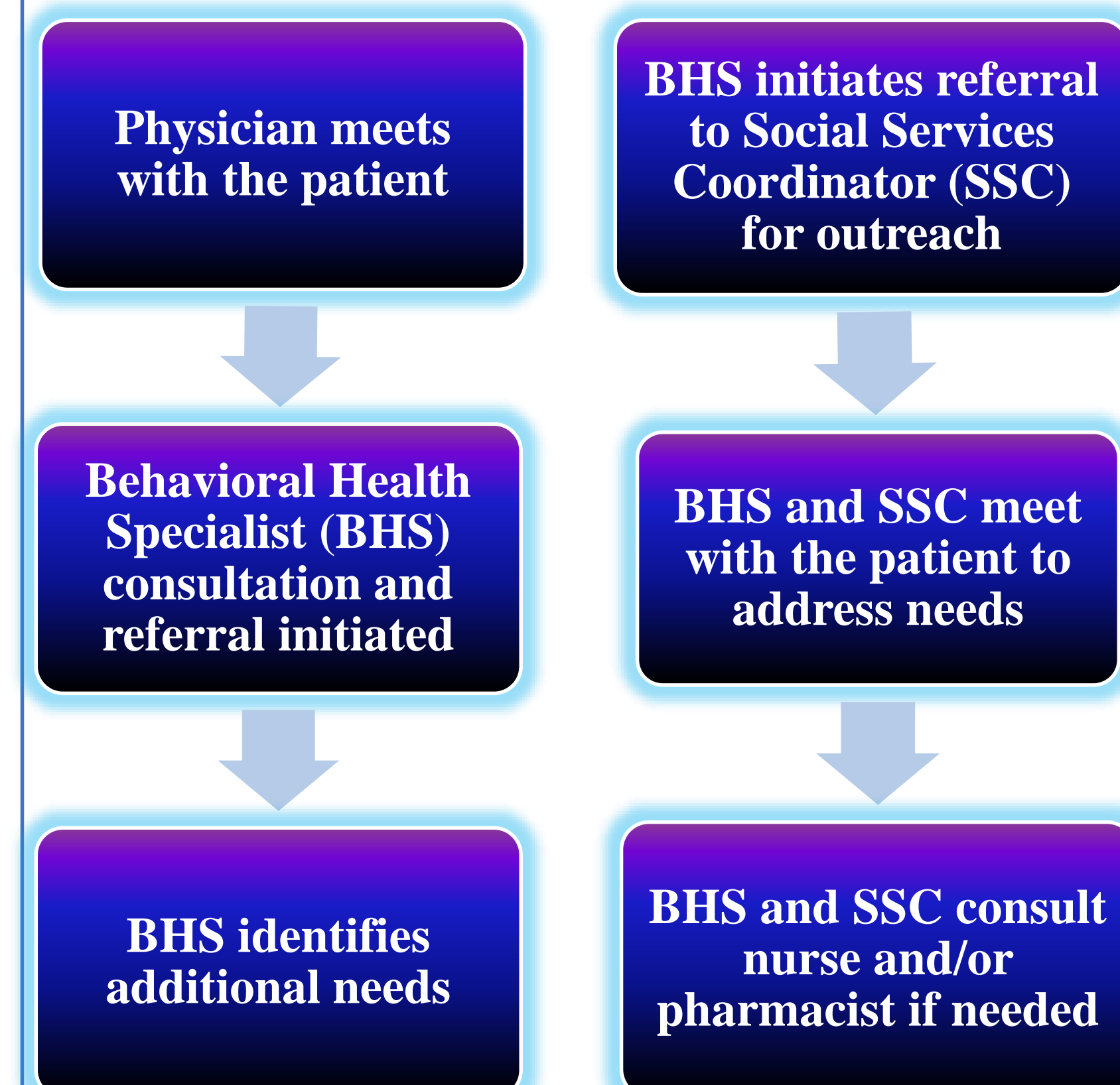
Effectiveness of Collaborative Care Models

- Strong evidence exists in favor of team based models to treat mental health issues in primary care.⁵
- Effective strategies in team based models include providing population based care, treatment planning, clinical management, self-management support, consultations, and continued follow up.⁶

Community Care Team Model at LVHN

- The Population Health Department provides comprehensive, integrated care coordination in primary and specialty care practices in the community by addressing the physical, socioeconomic and psychosocial needs of high risk patients.
- The Community Care Team (CCT) model at LVHN was implemented as a way to address these multiple needs, and was based upon work done in North Carolina⁷ as well as the Vermont Blueprint for Health.⁸

Sample Multidisciplinary Referral Process



Engagement, Assessment, and Outreach Activities with Suicidal Patients in Primary Care

Initial Engagement

- Introduction to team based concept and additional services that are available to the patient, including explanation of BHS role and introduction of the BHS to the patient within the medical visit (the “warm hand off”).

Evidence Based Screening

- In-person consultation and assessment of suicidality completed by BHS in real time utilizing evidence based screening tools including the PHQ-9 and/or the C-SSRS (Columbia Suicide Severity Rating Scale).

Appropriate Referral and Case Management

- Referral to appropriate level of care and other team members to address multiple psychosocial needs; may provide brief therapeutic interventions in house until appropriate level of care can be secured.
- Interface with community mental health services to coordinate appropriate treatment for patient and expand patient’s treatment team beyond PCP office setting.

Regular Follow up

- Follow up via phone by BHS and other team members who work together to provide continuous support and monitoring as well as an ongoing treatment plan with the patient.

Implications

Policy Development and Funding Needs

- The development of more integrated, team based models across major healthcare networks is needed.
- More innovative reimbursement strategies outside the fee for service model, such as billing for group visits and consultations, are essential to sustaining integrated models of care.⁹
- More research assessing organizational readiness for change in adopting a new model that involves learning new skills and changing established processes.¹⁰

Outcomes Data

- Need for specific processes to measure mental health outcomes that are tied to data from the hospital electronic medical record (EMR) including examination of patient hospital and emergency room visits, specialty care, and no show rates to assess treatment engagement.
- Preliminary LVHN internal program evaluation data reveals information on the facilitators and barriers of the behavioral health integration program implementation process at the individual, practice based and system wide levels.

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