2012 National TA Center Webinar Series

We will begin our webinar on Thursday at 1 PM (ET)

Call-in Number: 1-800-832-0736       Conference Room: 2884179

TA Call Website:
http://gucchdtacenter.georgetown.edu/resources/2011calls.html
Integrating Behavioral Health Services with Primary Care

*We will begin our webinar on *Thursday at 1 PM (ET)*

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Please call: **202-687-0308** or email **mn344@georgetown.edu** if you need any assistance during the call.
Pennsylvania Medical Home Initiative

A statewide quality improvement initiative for children and youth with special health care needs

Renee Turchi, MD, MPH
Medical Director, EPIC IC

Molly Gatto, MHA
Program Director, EPIC IC

Emily Kane
Program Assistant

Mental Health Integration
What is a Medical Home?

A medical home is not a building, a house, or a hospital...

...it is an approach to health care that emphasizes the partnership between pediatric clinicians and families

-Pediatrics, Policy Statement 2002
Medical Home Care Components

- The American Academy of Pediatrics, with support from the Maternal and Child Health Bureau, has defined 9 core elements of the medical home:
  - Family-centered
  - Comprehensive
  - Continuous
  - Coordinated
  - Compassionate
  - Community-based
  - Culturally-competent
  - Accessible
  - Environment of trust and mutual responsibility

-Pediatrics 2002
Joint Statement Core Principles

- Personal Physician
- Physician-directed medical practice
- Whole person orientation
- Care coordination across multiple systems
- Quality and safety
- Enhanced access
- Appropriate payment for services

AAP, AAFP, ACP, AOA, March 2007
EPIC-IC Medical Home Initiative

- EPIC-IC’s mission is to enhance the quality of life of CYSHCN through recognition and support of families as the central caregiver for their children, effective community-based coordination, enhanced communication and primary health care.
Who are Children and Youth with Special Health Care Needs (CYSHCN)?

Children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.

(Maternal and Child Health Bureau ’95)
How do practices participate?

- Quality improvement teleconferences
- Fall & Spring Conferences (networking opportunities)
- Education
  - Identification of CYSHCN
  - Parent Partner recruitment and utilization
  - Coding
  - Time Management
  - “Hot topics” like transition, cultural competency, family-centered care, obesity, etc.
  - Quality improvement cycles
Medical Home and Mental Health

- Challenges:
  - Primary care practices (PCP’s) see kids with behavioral health diagnoses and have few supportive resources available to them
  - There is a lack of communication between the physical health and behavioral health providers to coordinate care
  - PCP’s are often not aware of the BH providers in their communities
Medical Home and Mental Health

- Positives
  - Medical home registries help identify children and youth with BH conditions
  - Model allows for the integration of screening tools during well exams
  - GLS grant helps the practice identify and create a linkage to BH providers in their communities as well as identify supports for both the youth and the PCP’s
Pennsylvania Medical Home Initiative

A Medical Home is not a building, a house, or a hospital...

...it is an approach to health care that emphasizes the partnership between pediatric clinicians and families, providing care for children and youth with special health care needs (CYSHCN) that is:

- accessible
- continuous
- comprehensive
- family-centered
- coordinated
- compassionate, and
- culturally-effective

Educating Practices in Community-Integrated Care

Find us on Facebook

Medical Home Video

Start here to make your practice a Medical Home
The Pennsylvania Physical Health/Behavioral Health Learning Community Vision:

“To advance commonwealth wide efforts to improve the provider focused planning, policy development, communications, and practice enhancing collaboration and coordination of care between behavioral health providers and primary care providers serving Pennsylvania residents of all ages.”
Our Learning Community is a Collaboration

- Pennsylvania Community Providers Association
- Pennsylvania Chapter of the American Academy of Pediatrics
- Pennsylvania Academy of Family Physicians
- Pennsylvania Association of Community Health Centers
- Pennsylvania Psychiatric Society
- Pennsylvania Psychiatric Leadership Council
- Pennsylvania Coalition of Nurse Practitioners
- PA Psychological Association
Thank you!

Please keep building.
Everyone deserves a medical home.
The Pennsylvania Model for Youth Suicide Prevention in Primary Care: Overview, Barriers, Solutions, Outcomes and Next Steps

The Pennsylvania Garrett Lee Smith Grant Team
State Level Involvement

- The Children’s Bureau, within the Department of Public Welfare, has strong commitment to youth suicide prevention:
  - State Plan
  - Statewide Student Assistance Programs in all Schools
  - Saw need for connection between the medical community and the behavioral health community
  - Partnered with Children’s Hospital of Pennsylvania and Jefferson Medical College
SAMSHA Garrett Lee Smith Grant

- Enlisted the Pennsylvania Chapters of professional organizations representing Pediatricians, Family Physicians, Nurse Practitioners, and Federally Qualified Health Centers.

- Serve as advisory board, provide awareness and training, and help recruit and support practices.
Why Screen For Suicide in Primary Care?

- 70% of adolescents seen once a year by a PCP
- Many at-risk subpopulations (e.g. HIV, chronic illness, family planning)
- 16% of adolescents in the last year were depressed, and 5% were at risk for suicide
- Over 70% of adolescents report a willingness to talk with a primary care physician about emotional distress
- 7-15% of adolescent attempters contacted a health provider in the month previous to an attempt and 20-25% in the previous year
Screening Barriers

- Over 200 screening tools have been developed, however...
  - Most focus on a single domain (e.g., depression)
  - Most focus on psychiatric symptoms while PCPs think more in terms of risk behaviors
  - Most are paper-pencil administration and require hand scoring
  - Very few map on to formal diagnostic categories
  - Few screening tools (less than five) have psychometric support
Multiple Barriers to Implementation

- Provider Barriers
  - Lack of training, lack of time, lack of tools

- Organizational Barriers
  - Access to MH services, insurance

- MH Barriers
  - Long waiting lists, staff turnover

- Family and Patient Barriers
  - Low priority, treatment refusal or reluctance
Conclusion......

- Primary care is an excellent context for early identification, prevention, and intervention for behavioral health problems.
- While screening tools are a good start, overcoming barriers to implementation requires provider education, psychometrically sounds screening tools, and bridging the medical-behavioral health service gap.
Youth Suicide Prevention in Primary Care (ages 14-24)

Office of Mental Health and Substance Abuse Services
Pennsylvania Department of Public Welfare

Funded by SAMHSA through the Garrett Lee Smith Memorial Act
# Youth Suicides (15 to 24 years old), by Pennsylvania County, 1990-2005

Data source: Pennsylvania Department of Health

- Less than 50 Youth Suicides
- 50+ Youth Suicides
Project Team

Project Director
Stan Mrozowski (OMHSAS)

Project Co-Director
Shaye Erhard (OMHSAS)

Project Director
Guy Diamond (CHOP)

Evaluation Unit
Tita Atte (CHOP)

Training Unit
Matt Wintersteen Director
(Jefferson)
Paula McCommons (U Pitt)
Kim Poling (U. Pitt)
David Brent (U. Pitt)
Virginia Biddle (Jefferson)

MH County Directors
Working with MH/MR directors as the starting point in ten counties across Pennsylvania.

Public & Private Healthcare & Insurance Entities:
Community Care
Behavioral Health (Judy Dogin)
Access Plus (Physical Health Medical Assistance)
PA Community Providers Association (Connell O’Brien)
PA Council on Children, Youth and Families Services (Pam Bennett)

Steering Committee

Professional Organizations
Suzanne Yungahas (PA Chapter of the American Academy of Pediatrics)
Angie Halaja-Henriques (PA Academy of Family Physicians)
Susan Schrand (PA Coalition of Nurse Practitioners)
Cheryl Bumgardner (PA Association of Community Health Centers)

Key Statewide Monitoring Committee Members
Carol Thornton (Public Health)
Lonnie Barnes (Substance Abuse)
Mynra Delgado (Education & Cultural Competence)
Doris Arena (Transition Specialist)
Arlene Prentice & Melissa Valentine (Juvenile Justice)
Darlene Black & Becky Stephens (Child Welfare)
Vick Zittle (Child Death Review)
State-Level Stakeholders

**Project Director**
Stan Mrozowski (OMHSAS)

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**Project Director**
Guy Diamond (CHOP)

**Evaluation Unit**
Tita Atte (CHOP)

**Training Unit**
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Paula McCommons (U Pitt)
Kim Poling (U. Pitt)
David Brent (U. Pitt)

**County Task Forces**

**County MH/MR Directors**

**Public & Private Healthcare & Insurance Entities:**
Community Care
Behavioral Health
Access Plus (Physical Health Medical Assistance)
PA Community Providers Association
PA Council on Children, Youth and Families Services

**Steering Committee**

**Professional Organizations**
PA Chapter of the American Academy of Pediatrics
PA Academy of Family Physicians
PA Coalition of Nurse Practitioners
PA Association of Community Health Centers

**Key Statewide Monitoring Committee Members**
Public Health
Substance Abuse
Education & Cultural Competence
Transition Specialist
Juvenile Justice
Child Welfare
Child Death Review
Academic Partners

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(CHOP/U. Penn)

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County Task Forces
County MH/MR Directors

Public & Private Healthcare & Insurance Entities:
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Behavioral Health
Access Plus (Physical Health Medical Assistance)
PA Community Providers Association
PA Council on Children, Youth and Families Services

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PA Coalition of Nurse Practitioners
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Substance Abuse
Education & Cultural Competence
Transition Specialist
Juvenile Justice
Child Welfare
Child Death Review
Who Will Help with Sustainability?

Project Director
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Child Welfare
Child Death Review
Five Central Aims

# 1: Create state and local stake holder groups

# 2: Increase coordination between medical and behavioral health services

# 3: Provide youth suicide “gatekeeper” training

# 4: Introduce empirically supported therapies to local behavioral health providers

# 5: Provide web-based screening tool
Aim # 1: Stakeholder Involvement

Stakeholder Involvement

State-Level

Community-Level
State Level Stakeholders

State Agencies:
- Dept. of Welfare
- Dept. of Health

Medical Associations:
- PA Chapter of the American Academy of Pediatrics
- PA Association of Family Physicians
- PA Coalition of Nurse Practitioner
- PA Association of Community Health Centers

Behavioral Health:
- Pennsylvania Community Providers Associations

Payers:
- Access Plus, Community Care
State Level Strategies

- State survey (N= 667) of PCPs regarding behavioral health needs and challenges (Diamond et al, 2011)
- Produced a series of training webinars
- Presentations at numerous state medical and behavioral health meetings
- Bi-monthly call with Pennsylvania Office of Medical Assistance to explore sustainability
- Participated in Start-up of the Pennsylvania Physical Health/Behavioral Health Learning Community
- Sponsored a state suicide prevention conference
County Suicide Prevention Task Forces

- Hosted four regional suicide prevention task force meetings
  - Over 35 counties represented by 137 participants

- Needs assessment, resource development, increased communication

- Activated their interest in the YSP-PC project
Aim # 2: Coordination of Behavioral Health & Medical Services

Stakeholder Involvement
State-Level
Community-Level

Coordination of Medical and Behavioral Health Services
State Survey Results (N=667 PCPs)

- Most practices do not have an on-site mental health (MH) worker

- 45% reported that they cannot quickly get MH appointments for suicidal patients and encounter long waiting lists for non-urgent patients

- Only 24% reported that the MH provider always or often let them know if a patient attends services
Other Challenges

- PCPs cannot get reimbursed for identifying and treating BH problems
  - Nearly 50% report submitting a medical diagnosis in order to provide reimbursable behavioral health services
- Limited relationships with MH providers
- Overly restricted interpretation of HIPAA prohibits exchange of information
- PCPs have a poor understanding of available resources
Models of Collaborative Care

- **Coordinated**
  - Routine screening for behavioral health problems in primary care
  - Referral relationship between BH and PCP
  - Routine exchange of information

- **Collocated**
  - BH services provided on site of the medical office.
  - Enhanced communication between providers
  - Consultation to increase skills of both groups
  - Significant reduction of no-shows for behavioral health treatment

- **Integrated**
  - BH and PCP share the same facility
  - One treatment plan with both medical and behavioral health components
  - BH and PCP work as a team with each family.
Coordination of Services

- Screen and refer patients, but also improve the relationship and exchange of information between PCPs and behavioral health providers and agencies
Liaison/Navigator Role: Within Practices

- Collaboration with County MH/MR Directors.
  - Funded part time liaison/navigator between PCPs and the behavioral health community.
- Identified interested PC practices to participate in the project
- Educated PCPs on how to access services
- Created support material for accessing behavioral health services (phone numbers, office posters, wallet cards)
- Offered educational services about suicide and behavioral health assessment
- Invited local MH providers to a meeting at the medical practice.
Primary Mechanisms of Success

- Relationship development
- Behavioral health community reaching out to PCPs
- PCPs screening enough patients to make it financially viable for the behavioral health providers to consider collocating services.
Aim # 3: PCP Gatekeeper Training

- Stakeholder Involvement
  - State-Level
  - Community-Level

- Coordination of Medical and Behavioral Health Services

- Training
  - PCPs
  - Behavioral Health Providers
Why Training?

- PCPs get very little training on suicide and mental health
  - Less than 50% of PCPs feel competent in diagnosing depression
- Physician education increases PCPs feelings of capability and competency which leads to increased identification rates of high risk youth
- Physician education is one of only two suicide prevention strategies shown to reduce the suicide rate (Mann et al., 2005)
Recognizing and Responding to Suicide Risk in Primary Care (RRSR-PC-Y)

- Developed by the American Association of Suicidology
- Covers material pertinent to PCPs
- Designed as a 90-minute presentation
- Includes lecture, video demonstrations of techniques, and printed resources

Information about RRSR-PC available at www.suicidology.org
Content of RRSR-PC-Y

- Suicide risk assessment
- Triage decision making
- Crisis Response Planning
- Interventions for Primary Care
- Documentation
Suicide Prevention Toolkit for Rural Primary Care
Suicide Prevention Resource Center (SPRC)

Information available at www.sprc.org
The Toolkit is available in 2 forms:
- Hard copy, spiral bound ordered through WICHE
- Electronic copy (www.sprc.org)

Includes 6 sections:
- Getting started
- Educating clinicians and office staff
- Developing mental health partnerships
- Patient management tools
- Patient education tools
- Resources

New content on billing for services in PC setting
Online Training
Developed by Virginia Biddle, PhD, CRNP, RN

- Geared to primary care providers, including nurse practitioners, physician assistants, as well as school nurses, nurse midwives, and other clinicians

- Program focuses on the assessment of background and subjective risk factors using the well known HEADSS (Home, Education, Activities, Drug use and abuse, Sexual behavior, and Suicidality) interview

- Pretest and post-test including videotaped vignettes
Online Training

- Specific topics include the following:
  - Importance of suicide risk assessment
  - Prevalence/epidemiology of suicide
  - National efforts for suicide prevention
  - Reasons why suicide becomes an option
  - Performing an adolescent assessment (background and subjective factors)
  - Levels of suicide risk
  - Referral
  - Treatment
  - Assessment tools
  - Family assessment
Online Training

- Available on website of National Association of Pediatric Nurse Practitioners

- Continuing education available for nurses and nurse practitioners

- Also available on www.payspi.org
  - Click on News & Events
  - Under “Adolescent Suicide Risk Assessment”
Aim #4: Training Behavioral Health Providers

- Stakeholder Involvement
  - State-Level
  - Community-Level

- Coordination of Medical and Behavioral Health Services

- Training
  - PCPs
  - Behavioral Health Providers
Behavioral Health Trainings

- Provided training and supervision empirically supported treatments for youth suicide
  - Cognitive behavioral therapy (Brent, 2011)
  - Attachment based family therapy (Diamond et al, 2010)
- Crisis management training (Wintersteenen, 2012)
- Suicide Risk and intervention training, SPRC
- Co-occurring training with the Bureau of Drug & Alcohol Programs
Continued Barriers

- Little time for additional supervision and training
- Unclear level of support coming from agency administrators and directors
- No mandate to learn new skills
- High staff turn over
- Bottom line: Agenda was too ambitious for this grant. Focused now on
  - Safety Planning Training
  - Crisis Management Training
  - Working with GLBT patients
Aim # 5: Web-based Screening

Stakeholder Involvement
  State-Level
  Community-Level

Coordination of Medical and Behavioral Health Services

Training PCPs Behavioral Health Providers

Screening
Why is Screening Helpful?

- Standardizes screening questions across patients and providers
- Adolescents or more likely to report psychosocial problems
- Facilitates patient-doctor conversations
- Increases early detection of risk behaviors
- Patients are more likely to receive care after being screened
Why Web-Based Screening?

- Greater dissemination and accessibility
- Instant scoring of results, automated skip outs, preferred by adolescents
- Interface with electronic medical records
- Track patient status over time
- Aggregates data for reports within a practice, treatment system, our county
- Supports quality assurance projects and license renewal
Behavioral Health Screen – Primary Care (BHS-PC)

- Screens for risk behavior and psychiatric symptoms
- Covers areas recommended by the American Academy of Pediatrics as best practice guidelines for a well-visit interview
- Takes 9 - 15 minutes
- Generates summary report and follow-up recommendations in real time
- Strong psychometric properties
Key Domains of BHS-PC

- Medical
- School
- Family
- Safety
- Substance Use
- Sexuality
- Nutrition and Eating
- Anxiety
- Depression
- Suicide and Self-Harm
- Psychosis
- Trauma
- Independence
Sample Patient Screen

Behavioral Health Screen

Welcome bhstest6 | preferences | log off | Not bhstest6?

Have you ever, in your whole life, even once, used alcohol?

☐ Yes
☐ No

I can't answer because...

< Previous  > SAVE where I am and I will return later  Next >

Version: 1.0.7

©2009 Medical Decision Logic Inc. All rights reserved.
Sample Report for PC provider

Patient Name: ___________ DOB: ______
MRN: ___________ Date: ______

BEHAVIORAL HEALTH SCREENING RESULTS
CONFIDENTIAL

INSTRUCTIONS
Review report before meeting with the patient. Review results with patient and follow standard care procedures, including referral, if necessary. Place results report in medical chart.

CRITICAL ITEMS

SCALES (All scales are 0 – 4, 0 = no risk and 4 = highest risk)

<table>
<thead>
<tr>
<th>Scale</th>
<th>Score</th>
<th>Clinical Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td></td>
<td></td>
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<tr>
<td>Anxiety</td>
<td></td>
<td></td>
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<tr>
<td>Suicide - Lifetime</td>
<td></td>
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<tr>
<td>Suicide - Current</td>
<td></td>
<td></td>
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<tr>
<td>Traumatic Distress</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating Disorder</td>
<td></td>
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<tr>
<td>Substance Abuse</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

RISK BEHAVIORS

PATIENT STRENGTHS
Implementation Challenges

- Consent
- Confidentiality
- Technology
- Workflow
Progress & Outcomes

Stakeholder Involvement
State-Level
Community-Level

Coordination of Medical and Behavioral Health Services

Training PCPs Behavioral Health Providers

Screening

Evaluate Outcome and Report Back to Stakeholders
Screening Progress

- Approached 17 practices, 11 participated
- Based on data from last September, 1200 youth had been screened
- 187 (15.5%) endorsed having thoughts of killing themselves at some point in their life
- 54 (4.5%) had current ideation (function of indicated screening)
- Of those identified at risk for suicide:
  - 8% were already in treatment
  - 21% refused services
  - 44% accepted their referral and went to services
### Other Behavioral Health Concerns

<table>
<thead>
<tr>
<th></th>
<th>Total # Screened</th>
<th>Suicide</th>
<th>Depression</th>
<th>Anxiety</th>
<th>Trauma</th>
<th>Eating Disorder</th>
<th>Substance Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>1,042</td>
<td>169 (16.2%)</td>
<td>223 (21.4%)</td>
<td>343 (32.9%)</td>
<td>240 (23.0%)</td>
<td>29 (2.8%)</td>
<td>39 (3.7%)</td>
</tr>
</tbody>
</table>

- 303 youth (28.4% of sample) met the clinical cut-off for at least one behavioral health concern other than suicide
Patient satisfaction with the BHS-PC was also very high. Only 16.6% of youth reported that they felt uncomfortable answering the screening questions while 90.2% felt that it was a good idea for their medical provider to ask these types of questions.
Patient and Provider satisfaction

Patient
1. 94% of patients reported feeling comfortable answering the questions.
2. 90.2% felt medical providers should ask these questions.

Provider
1. 96% reported satisfaction with the training programs.
2. 91% reported satisfaction with the screening tool
3. 70% report improved relations with MH providers and greater access to MH services.
Sustainability

1. Find practices that are more project-ready and willing to integrate innovative models into their practice (e.g., medical home practices)

2. Build a comprehensive web-site with our multiple resources

3. The more the PCP screens, the more cases there will be for behavioral health assessments and treatment; therefore, creating a viable business plan

4. Continue to lobby for PCP reimbursement for screening
Summary and Main Findings

- Systems change model is needed

- Picking a screening tool is easy; getting PCPs to use it is much harder

- Need a point person to help implement changes and screening

- PCPs will continue to be reluctant to screen unless:
  - Reimbursement for screening
  - Increased availability of behavioral health referral sources
The Pennsylvania Model for Youth Suicide Prevention in Primary Care (YSP-PC)

- Stakeholder Involvement
  - State-Level
  - Community-Level

- Coordination of Medical and Behavioral Health Services

- Training
  - PCPs
  - Behavioral Health Providers

- Screening

Referral to a Better Prepared Behavioral Health System

Evaluate Outcome and Report Back to Stakeholders
Integrating Behavioral Health Services into Primary Care: Youth Suicide Awareness & Prevention

Dr. Linda Thomas-Hemak
Board Certified IM/Peds
The Wright Center for Primary Care Mid-Valley Practice
Who Are We?

• The Wright Center for Primary Care Mid-Valley
  ■ Academic Safety Net Provider located outside Scranton, Northeastern Pa

• Patient Population approx 6,000 patients
  ■ Approximately 950 ages 14-24

• NCQA Level 3 PCMH, certified in 2011

• All eligible providers EMR MU certified

• Beginning to integrate mental health services this July

• Behavioral health screens completed in clinic since starting in June 2010: 808

• Positive screens at MVP: 140
How We Do It?

- Education and Staff Buy In
- PDSA Style Implementation in June 2010
- MA, role specific, EMR Health Maintenance Alert to encourage every patient aged 14-24 to complete a straightforward questionnaire on a droid tablet pre-visit.
- Process compliance report cards and exception reports
- Positive screens explored in the provider visit and referred to community Mental Health agencies.
- High risk cases construct a crisis response plan.
- High risk referred to our care manager for follow-up and directly navigated to services by The Advocacy Alliance.
Why We Do It?

- Behavioral health (prevention, treatment, recovery supports) viewed as a social problem rather than a public health issue.
- Too many missed opportunities to save lives in primary care settings.
- Each year, 150,000 youth aged 10-24 receive medical care for self-inflicted injuries, 30x the number who die by suicide.
- 9.3% of girls and 4.6% of boys in grades 9-12 report attempting suicide in last 12 months.
- Higher rates of suicide in NEPA
- Rural demographics
Why We Do It?

- Continued challenges with our effective referral tracking so backup from larger system of care reassuring.
- Better, solution oriented care delivery
- Better than town hall reactions to tragedy.
To Learn More...

- Guy Diamond: diamondg@email.chop.edu
  Overall project and BHS

- Matthew Wintersteen: matthew.wintersteen@jefferson.edu
  Overall project and Training
Contact information

- PA Learning Community
  - Connell O’Bien: connell@paproviders.org

- PA Chapter of the American Academy of Pediatrics: Medical Home Program
  - Molly Gatto: MGatto@paaap.org

- PA Department of Public Welfare
  - Stan Mrozowski, smrozowski@pa.gov

- MDLogic (for info on the BHS)
  - Allen Y. Tien, MD, MHS, allen@mdlogix.com
IMPORTANT LINKS

**EVALUATION FORM:**
https://www4.georgetown.edu/uis/keybridge/keyform/form.cfm?FormID=4410

**TA CALL WEBSITE:**
http://gucchdtacenter.georgetown.edu/resources/2012calls.html

**DATA MATTERS:**  http://www.gucchdgeorgetown.net/data/
Next National TA Center Webinar

Outcomes Measurement and Outcome Management for Children and Youth Behavioral Health Services

June 21st from 1:00-2:30pm ET

Register on our webinar website:

http://gucchdtacenter.georgetown.edu/resources/2012calls.html