The Webinar will begin promptly at 12pm

Due to the number of participants, you will be automatically placed on mute as you join to ensure good quality sound. If you would like to comment or ask a question, please use the "chat feature"

Send your questions to the host via the chat window in the Zoom meeting.

Q+A will open at the end of the presentation.

Follow-up questions?

Contact

Samantha Di Paola
sdipaola@healthmanagement.com

BEHAVIORAL HEALTH CONSULTATION: HANDLING BEHAVIORAL HEALTH EMERGENCIES IN PRIMARY CARE

PRESENTED BY:
Marsha Johnson, MSW, LCSW
Suzanne Daub, LCSW

Tuesday, November 15, 2022
12:00pm – 1:00pm EST

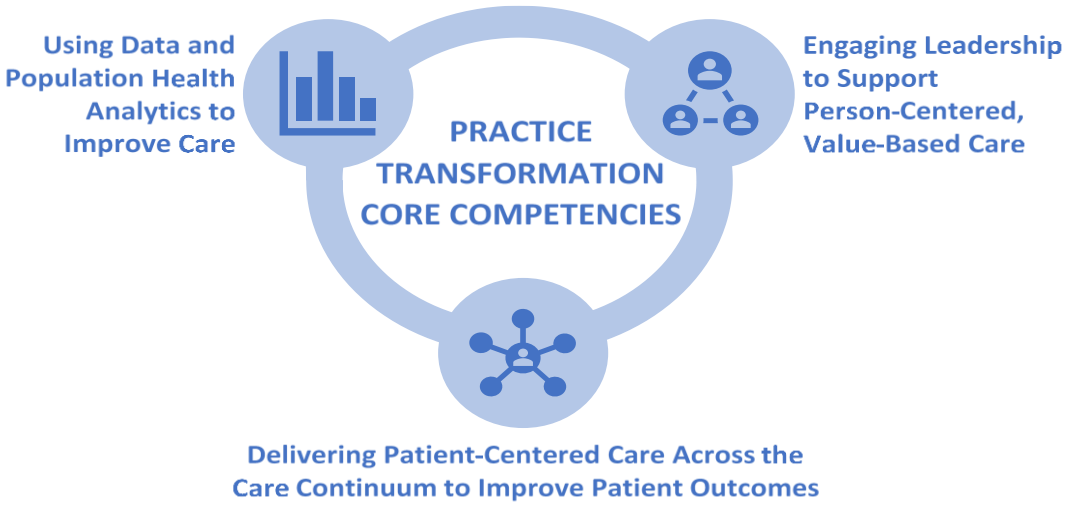
Integrated Care DC is managed by the DC Department of Health Care Finance (DHCF) in partnership with the DC Department of Behavioral Health (DBH). This project is supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $4,616,075.00 with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, or an endorsement by, CMS/HHS, or the U.S. Government.

WHAT IS INTEGRATED CARE DC?

- Integrated Care DC is a five-year program aimed to enhance Medicaid providers' capacity and core competencies to deliver whole person care for physical, behavioral health, SUD and social needs of beneficiaries.

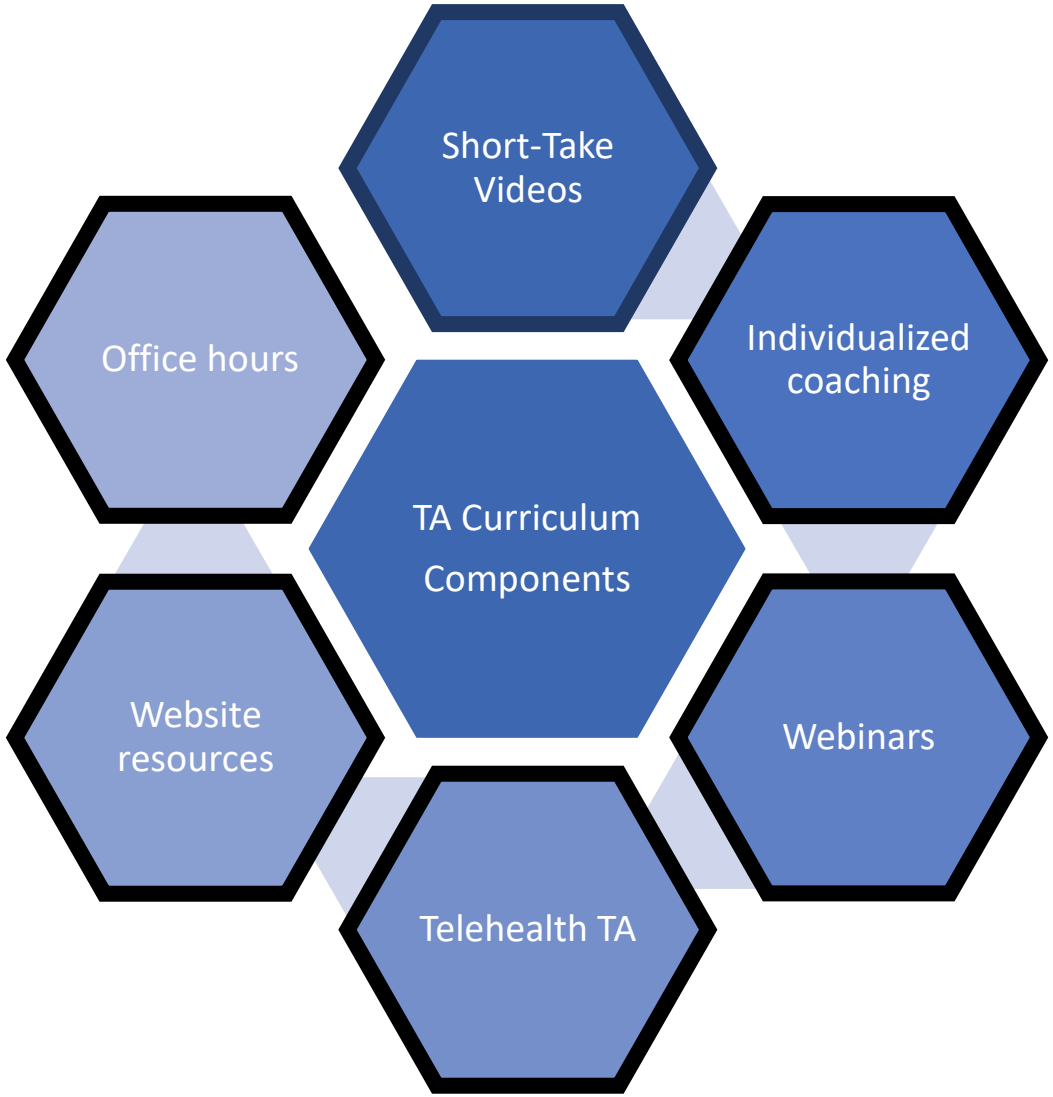
- Integrated Care DC is managed by the DC Department of Health Care Finance (DHCF) in partnership with the DC Department of Behavioral Health (DBH). Health Management Associates will provide the training and technical assistance.

The goal is to improve care and Medicaid beneficiary outcomes within three practice transformation core competencies:



INTEGRATED CARE DC TECHNICAL ASSISTANCE

- The program offers several components of coaching and training. Material is presented in various formats. The content is created and delivered by HMA subject matter experts with provider spotlights.
- All material is available on the project website: Integratedcaredc.com
- Educational credit is offered at no cost to attendees for select elements.



INTEGRATED CARE DC UPDATES

Are you receiving our Integrated Care DC Newsletters?

Check your inbox at the beginning of the month for the Monthly Newsletter and around the 15th for the Mid-Month Update.

Got ideas?

Take this short survey to share suggestions and requests for trainings.
https://www.integratedcaredc.com/survey/

PRESENTERS

Marsha Johnson, MSW, LCSW
TA Coach/SME
mjohnson@healthmanagement.com

Suzanne Daub, LCSW
TA Coach/SME
sdaub@healthmanagement.com

Faculty	**Elizabeth Wolff, MD, MPA** **CME Reviewer**	**Muriel Kramer, LCSW** **CE Reviewer**	**Marsha Johnson, MSW, LCSW** **Presenter**	**Suzanne Daub, LCSW** **Presenter**
Company	No financial disclosures	No financial disclosures	No financial disclosures	No financial disclosures
Nature of relationship	N/A	N/A	N/A	N/A

HMA discloses all relevant financial relationships with companies whose primary business is producing, marketing, selling, re-selling, or distributing health care products used by or on patients.

CONTINUING EDUCATION CREDITS

- Health Management Associates, #1780, is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved as ACE providers. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. Health Management Associates maintains responsibility for this course. ACE provider approval period: 09/22/2021 – 09/22/2025. Social workers completing this course receive 1.0 continuing education credits.

To earn CE credit, social workers must log in at the scheduled time, attend the entire course and complete an online course evaluation. To verify your attendance, please be sure to log in from an individual account and link your participant ID to your audio.

- The AAFP has reviewed Integrated Care DC Webinar Series and deemed it acceptable for AAFP credit. Term of approval is from 02/08/2022 to 02/07/2023. Physicians should claim only the credit commensurate with the extent of their participation in the activity. This session is approved for 1.0 Online Only, Live AAFP Prescribed credits.

- **If you would like to receive CE/CME credit, the online evaluation will need to be completed.** You will receive a link to the evaluation shortly after this webinar**.**

- Certificates of completion will be emailed within 10-12 business days of course completion.

AGENDA

Behavioral Health Consultation: Handling Behavioral Health Emergencies in Primary Care

- Welcome and Program Announcements
- Case Presentation
- Managing Behavioral Health Emergencies in Primary Care: System and Clinical Considerations
- Case discussion
- Closing Remarks/Q&A

OBJECTIVES

1. Define a behavioral health emergency in a primary care setting
2. Identify the goals of managing a behavioral health emergency in primary care
3. Identify evidence-based system level and clinical interventions
4. Collaborative learning

Image permitted by DC Department of Health Care Finance

ONGOING LEARNING TOGETHER

- We hear you
  - You enjoy the content
  - You enjoy learning from each other
  - You want more time

- Experiment with a new format
  - Start with a case
  - Have a mini best practice content presentation
  - Come back to the case and discuss and share ideas and questions

ONGOING LEARNING TOGETHER

For 2023: What are your top topics? Choose up to three

- PCBH Ethics
- Complex PTSD/Trauma
- Engaging families
- Pediatric: ADHD
- Grief
- Women's Health
- Pregnant and parenting people
- Domestic Violence
- New diagnosis of a chronic condition
- Getting unstuck when facing a difficult or confusing problem

BEHAVIORAL HEALTH CONSULTATION: HANDLING BEHAVIORAL HEALTH EMERGENCIES IN PRIMARY CARE

CASE PRESENTATION: BREAD FOR THE CITY
KRISTEN JONES, LICSW

Situation:

SB came into the clinic Wednesday without an appointment after missing scheduled appointments Monday and Tuesday. Ct was with her mother and three children. Client's mother stayed in the waiting room with the Ct's 5 y/o and three-month old sons. Ct and BHS met with Ct's three y/o son in the room.

Background:

SB is a 29 y/o single mother of three children under five, BHS met Ct once in July when she was referred to BH b/c she was 35 weeks pregnant and had not received any prenatal care. Ct continued to reach out to BHS through the pt. portal about crises related to basic needs. Ct has a hx of homlessness and was unstably unhoused, living with her cousin, who is in a housing program with SOME. In July, the Ct's cousin had been told SB had to leave or her cousin would be evicted. SB reported she is now staying with her mother, her sister, and her sister's family in her mother's apartment. Ct is unemployed and receives TANF.

Assessment:

On Wednesday, Ct cried throughout the meeting, discussed poor relationships, low mood, poor sleep, poor appetite, guilt, anxiety and feeling overwhelmed. Ct reported she had a breakdown last week and was willing to take medication and needed to get help. Ct's mother called, texted while we were meeting and then had the front desk message that SB needed to feed the baby. While Ct was walking out she reported that last week she was thinking about killing herself, with intent and plan to jump out of the third story window of their apartment. At that time BHS assessed Ct using C-SSRS and assessed for safety. BHS determined Ct was not an immediate threat to herself.

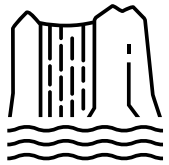
DEFINING BH EMERGENCY

- A behavioral health emergency is defined as an emergent situation in which the person needs assessment and treatment in a safe and therapeutic setting. The individual
  - Is a danger to themself or others
  - Exhibits acute onset of psychosis
  - Exhibits severe thought disorganization or
  - Exhibits significant clinical deterioration in a chronic behavioral condition rendering the person unmanageable and unable to cooperate in treatment

Source:
American Psychological Association Behavioral Emergencies: https://www.apa.org/pubs/videos/4310935
Mental Health Disorder Treatment Guidelines and Consumer Guides: https://www.psychguides.com/

BH EMERGENCIES IN PRIMARY CARE

- Thinking about the last three months, what kinds of BH emergencies have you seen at your health center?



BH EMERGENCIES IN PRIMARY CARE

- Common BH Emergencies seen in primary care settings
  - Suicidal/homicidal ideation/self harm
  - Child abuse/neglect
  - Domestic Violence
  - Psychosis
  - Severe panic/agitation
  - Receiving a diagnosis of a serious health issue (e.g., 4th stage cancer, HIV, HEP C)

- Which of these is the most common in your PCBH practice?

MANAGING BEHAVIORAL HEALTH EMERGENCIES IN PRIMARY CARE: SYSTEM AND CLINICAL CONSIDERATIONS

MANAGING EMERGENCIES: SYSTEM LEVEL

- POLL QUESTION: We have a written protocol for supporting BH emergencies as a team
  - Yes
  - No
- What are some of the key components of the policy?

- What works? What doesn't?

GOALS OF INTERVENTION

- Goals/principles
  - Immediate intervention will interrupt a prolonged crisis
  - Be active in helping, exploring and resolving
  - Limit goals, focus only on goals related to addressing the crisis
  - Build hope and expectations

THE LOGIC OF DE-ESCALATION

- If you take a LESS authoritative, LESS controlling, LESS confrontational approach, you actually will have MORE control
- You are trying to give the person a sense that he or she is in control
- Why? Because they are in a crisis, which by definition means the person is feeling out of control. The person's normal coping measures are not working at this time

THE ABCD MODEL OF CRISIS INTERVENTION

- **A**chieve Contact
- **B**oil Down the Problem
- **C**ope With the Problem
- **D**etermine the Meaning of the Event

Source:
Cheryl Regehr, C., Roberts, A. Bober, T., On the Brink of Disaster: *A Model for Reducing the Social and Psychological Impact.* Journal of Social Service Research , Volume 34, 2008 - Issue 3, 2008

SUICIDALITY: A COMMON BEHAVIORAL HEALTH EMERGENCY IN PRIMARY CARE

- People who die by suicide are more likely to have seen a PCP in the previous month before their death than any other health care provider.
- For a patient at risk for suicide, a visit with the PCP may be the only chance to access needed care.
- National health care improvement efforts (e.g., patient-centered medical homes) are providing new ways to integrate suicide prevention into primary care.

Source:
Ahmedani, B. K., Simon, G. E., Stewart, C., Beck, A., Waitzfelder, B. E., Rossom, R., . . . Solberg, L. I. (2014). Health care contacts in the year before suicide death. *Journal of General Internal Medicine*, *29*(6), 870–877

ZERO SUICIDE

- Zero Suicide is a system level response to assist healthcare providers in taking action
  - The best way to prevent suicide is to use a comprehensive approach that includes these key components:
    - Establish **protocols**
    - **Train all staff**
    - Create **agreements**
    - Ensure **continuity of care**
    - **Provide information** on the National Suicide Prevention Lifeline crisis line and services

https://zerosuicide.edc.org/

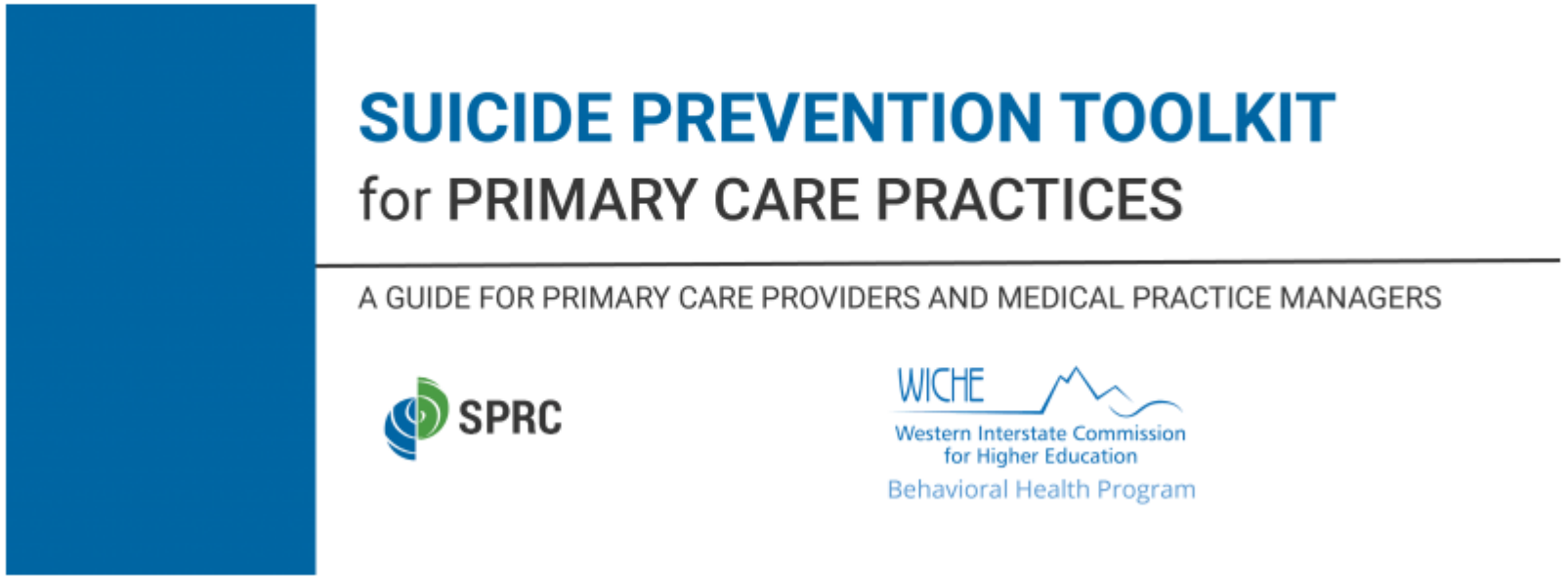
SEVEN CORE ELEMENTS OF ZERO SUICIDE

LEAD	• Lead system-wide culture change committed to reducing suicide
TRAIN	• Train a competent, confident, and caring workforce
IDENTIFY	• Identify individuals with suicide risk via comprehensive screening and assessment
ENGAGE	• Engage all individuals at-risk of suicide using a suicide care management plan
TREAT	• Treat suicidal thoughts and behaviors directly using evidence-based treatments
TRANSITION	• Transition individuals through care with warm hand-offs and supportive contacts
IMPROVE	• Improve policies and procedures through continuous quality improvement

SUICIDE PREVENTION RESOURCE CENTER

HMA INTEGRATED CARE DC

Suicide Prevention Toolkit for Primary Care Practices



Suicide Prevention Resource Center
About Suicide Effective Prevention Online Library Training News & Highlights Organizations

https://www.sprc.org/settings/primary-care/toolkit

EVIDENCE BASED SUICIDE SPECIFIC TREATMENTS

Intervention	Resource
Dialectical Behavior Therapy (DBT)	https://behavioraltech.org/resources/faqs/dialectical-behavior-therapy-dbt/
Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP, sometimes referred to as CT-SP)	https://beckinstitute.org/workshop/cbt-for-suicide-prevention/
Brief Cognitive Behavioral Therapy (BCBT)	Rudd, M.D. (2012). Brief cognitive behavioral therapy (BCBT) for suicidality in military populations. Military Psychology, 24(6), 592–603. Rudd, M.D., Bryan, C.J., Wertenberger, E.G., Peterson, A.L., et al. (2015)
Collaborative Assessment and Management of Suicidality (CAMS)	Comtois K.A., Jobes D.A., O'Connor S.S., Atkins D.C., et al. (2011). Collaborative assessment and management of suicidality (CAMS): Feasibility trial for next-day appointment services. Depress Anxiety, 28(11): 963-72.
Teachable Moment Brief Intervention (TMBI)	O'Connor, S.S., Mcclay, M.M., Choudhry, S., Shields, A.D., et al. (2020). Pilot randomized clinical trial of the Teachable Moment Brief Intervention for hospitalized suicide attempt survivors. Gen Hosp Psychiatry, 63, 111-118.

Source:
https://zerosuicide.edc.org/sites/default/files/2020-10/Treatments%20and%20Brief%20Interventions%20for%20Suicide-Specific%20Care.pdf

EVIDENCE BASED SUICIDE SPECIFIC TREATMENTS

Intervention	Resource
Motivational Interviewing to Address Suicidal Ideation (MI-SI)	Britton, P.C., Conner, K.R., Chapman, B.P., Maisto, S.A. (2020). Motivational Interviewing to Address Suicidal Ideation: A Randomized Controlled Trial in Veterans. Suicide Life Threat Behav, 50(1), 233-248.
Crisis Response Planning for Suicide (CRP)	Bryan, C.J., Mintz, J., Clemans, T., Leeson, B., Burch, T., WIliams, S., Maney, E., Rudd, M. (2017). Effective of crisis response planning vs. contracts for safety on suicide risk in U.S. Army Soldiers: A randomized clinical trial. Journal of Affective Disorders, 212.
Collaborative Safety Planning Intervention (SPI)	Stanley, B., Brown, G.K., Brenner, L.A., Galfalvy, H.C., et al. (2018). Comparison of the safety planning intervention with follow-up vs usual care of suicidal patients treated in the emergency department. JAMA, 75(9), 894-900.
Attempted Suicide Short Intervention Program (ASSIP)	Gysin-Maillart, A., Schwab, S., Soravia, L., Megert, M. Michel, K. (2016). A Novel Brief Therapy for Patients who Attempt Suicide: A 24-months follow-up randomized controlled study of the Attempted Suicide Short Intervention Program (ASSIP). PLOS Med, 13(3), e1001968.
Caring Contacts	Luxton, D.D., June, J.D. & Comtois, K.A. (2013). Can post discharge follow-up contacts prevent suicide and suicidal behavior? A review of the evidence. Crisis, 34(1), 32-41.

Source:
https://zerosuicide.edc.org/sites/default/files/2020-10/Treatments%20and%20Brief%20Interventions%20for%20Suicide-Specific%20Care.pdf

CASE DISCUSSION
WORKING AS A TEAM

CONTACT US

Marsha Johnson, MSW, LCSW
TA Coach/SME
mjohnson@healthmanagement.com

Suzanne Daub, LCSW
TA Coach/SME
sdaub@healthmanagement.com

REFERENCE LIST

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WRAP UP AND NEXT STEPS

- Please complete the online evaluation! **If you would like to receive CE or CME credit, the evaluation will need to be completed.** You will receive a link to the evaluation shortly after this webinar**.**
- The webinar recording will be available within a few days at: https://www.integratedcaredc.com/learning/
- Upcoming Webinar:
  - *PCBH Part 6: Allowing Data to Tell a Story: Relevant Metrics to Help Reflect the Infinite Values of Integrated Healthcare*, December 13, 12:00pm-1:00pm EST
- For more information about Integrated Care DC, please visit: https://www.integratedcaredc.com/