ELEMENT III: Collaboration and Coordination of Mental and Physical Health Services

An Overview and Rationale

Collaboration and coordination with community mental health services, specialty mental health, and medical care is essential for improving primary care capacity to help families experiencing early childhood trauma and stress. The primary care provider (PCP) is the child's regular care provider, and children typically see their PCPs at least once a year. This gives PCPs a unique role in serving as coordinators of the child's overall care within and outside of the primary care setting. When PCPs identify the need for mental health specialty care for trauma-related issues, they can identify the best source of care for the child, introduce the child to the specialist, manage overall treatment, and monitor progress over time.

The idea that primary care can help provide and coordinate an array of services that meet a child and family's needs, help children and families understand and navigate systems of care, and follow progress over time, dates back several decades (See M*odels of Integrating Services, Families, and Communities* in Chapter 2). Though there are many possible models that PCPs might use to achieve these goals – medical homes, comprehensive clinics, collaborative or integrated care – evidence suggests that a necessary, and, in some cases, sufficient, ingredient is the ability of PCPs to form personal, trusting relationships with the specialists and organizations with whom they collaborate. The relationships among providers create the pathways across which information can flow safely and efficiently, so that services are most likely to meet patients' needs and preferences.

Goal 1: Develop partnerships with specialists providing trauma services

Goal 2: Provide coordinated, integrated care

DEVELOP PARTNERSHIPS WITH SPECIALISTS PROVIDING TRAUMA SERVICES

Goal 1: Develop Partnerships with Specialists Providing Trauma Services

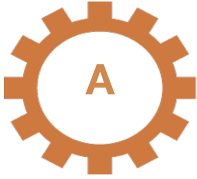
Why Is This Goal Important for Trauma-Informed Integrated Care?

Partnerships between primary care and specialists providing trauma services are good for patients and their families. Partnerships can make it easier to obtain needed care, as it is rare that any single provider can provide all that a family might need in terms of expertise or services. They also ensure that care is coordinated in ways that make sense for families. Partnerships are also good for providers and the organizations in which they work. Partnerships can improve quality of care, efficiency, reduce duplication of effort or services, and make work more satisfying and, ultimately, more successful.

To provide coordinated care, providers need to know what types of expertise and services best meet the different needs of their patients and their families. From the primary care perspective, that means understanding the community, school, or mental health services for which there is evidence of effectiveness (whether that is known formally from studies or from the recommendations of other families or from colleagues).
In addition, providers need to know that the necessary expertise, services, and providers exist in their community, and they need to know how to contact them, details of the services available, any relevant financial or insurance information, and the logistics of families receiving services (where they are located, hours of availability, etc.).

Partners need to establish mechanisms for transfer of information in both directions at the initiation of care, periodically during care, and when care ends. Ideally there are opportunities for actual discussions among providers that inform each of these decision points. The steps to identify partners, develop communication systems, build on existing relationships, and sustain relationships overtime are discussed below.

This goal includes three change concepts: A) identify potential partners and have introductory meeting; B) develop communication systems between collaborating providers; and C) sustain and strengthen partnerships over time.



IDENTIFY AND MEET WITH POTENTIAL PARTNERS

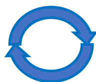
Change Concept A: Identify and Meet with Potential Partners

While there are many concrete ways in which partnerships might be structured, the intent remains mostly the same: two or more providers or organizations recognize that they have overlapping goals and offer complementary services – and thus in working together they can better serve their clients/patients as well as meet their own needs. Partners commit to the up-front effort of articulating their common goals, figuring out how to work together, and sustaining the efforts required in making the relationship work. Primary care providers have a role in initiating and supporting the ongoing shared care of a patient or family among different specialty providers (especially mental health or trauma-focused services).

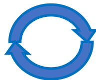
Partnerships can develop among individual providers or among organizations. Partnerships, both new and existing, must be built on the foundations of knowledge and trust.

Moving from Change Concept to Change Strategy

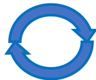
Below, you will see examples of change strategies that could be carried out to identify and meet with potential partners. Each of these possible strategies is detailed further – making them even more practical and specific –in the sample PDSAs that follow.



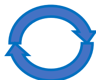
Identify Families' Needs



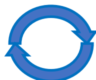
Identify Providers Of Services



Understand Access Issues



Provide Cross-education



Ensure Clarity About Expectations And Opportunities

Implementing Change Strategy through Small Tests of Change (PDSAs)

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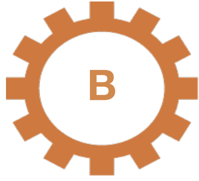
Families from different races and cultures may respond to engagement strategies in different ways. Talk with your family advocate, or a sample of caregivers from your community to get a sense of what strategies they find most engaging, supportive, and respectful.

Change Concept A. Identify Potential Partners and Have Introductory Meeting	
Possible Strategies	**Specific Ideas to Test**
Identify families' needs	→ Recognize the specific mental health and trauma needs of families and children that are not currently being met in the PCP visit.
Identify providers of services	→ Know local providers of those services that are needed, including services for caregivers.
Understand access issues	→ Recognize those issues that impact or impede families' abilities to access services, including linguistic and cultural needs.
Provide cross-education	→ Share information about themselves and their services as well as about the population being served with potential partners -- this can be in writing, in a face-to-face meeting, a "lunch and learn," etc.
Ensure clarity about expectations and opportunities	→ Be clear about what PCP wants/needs from partnership as well as the opportunities for partners.



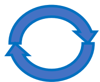
DEVELOP COMMUNICATION SYSTEMS BETWEEN COLLABORATING PROVIDERS

Change Concept B: Develop Communication Systems Between Collaborating Partners

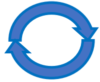
There are four key elements of partnership and coordinated care: 1) knowledge of partner's service; 2) cultivating trust in partner's clinical performance; 3) information sharing; and 4) collaborative delivery of care. The knowledge of a partner's services is the focus of the first strategy; the remaining three elements are connected to developing communication systems. From a practical perspective, partnerships between mental health/trauma specialty and primary care providers can develop into coordinated care plans that monitor and support patient care over time. Partnerships can allow for co-management between behavioral and medical providers who consider themselves a team and work as colleagues. In order to coordinate care in this way, partners must discuss how they will share information and collaborate to deliver care.

Moving from Change Concept to Change Strategy

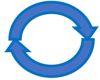
Below, you will see examples of change strategies that could be carried out to develop communication systems between collaborating providers. Each of these possible strategies is detailed further – making them even more practical and specific –in the sample PDSAs that follow



Develop Trust in Partner's Clinical Judgement



Share Information Openly



Provide Collaborative Delivery of Care

Implementing Change Strategy through Small Tests of Change (PDSAs)

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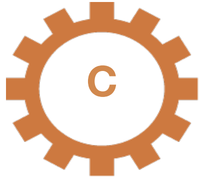
Change Concept B. Develop Communication Systems between Collaborating Providers	
Possible Strategies	**Specific Ideas to Test**
Cultivating trust in partner's clinical performance	→ Share decisions and rationales for decisions openly across partners. → Ensure that all partners are as transparent as possible about their clinical practice and work.
Share information openly	→ Agree on a mechanism to contact each other for advice and to share information about mutual patients (e.g. telephone calls, meetings, email, or text). Sharing patient information with the purpose of coordinating care is protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), permitting medical providers to share protected health information without an individual's authorization with another health provider treating the individual. (HIPAA Privacy Rule and Provider to Provider Communication see Appendix C.1). → Although it's not required, make sure patients know you are working in partnership and sharing information as part of your service.
Provide collaborative delivery of care	→ Consider various types of collaboration that promote true integration (shared information, decision-making, and co-management. For example, shared electronic medical records, joint visits, morning huddles to discuss patients, or in-office consultations.



SUSTAIN AND STRENGTHEN PARTNERSHIPS

Change Concept C: Sustain and Strengthen Partnerships

To sustain partnerships over time, it's important to keep in contact with partners and have regular meetings – either in person or by phone – to talk about shared patients as well as to address organizational issues that may arise.

Moving from Change Concept to Change Strategy

Below, you will see examples of change strategies that could be carried out to sustain and strengthen partnerships. Each of these possible strategies is detailed further – making them even more practical and specific –in the sample PDSAs that follow.

Implementing Change Strategy through Small Tests of Change (PDSAs)

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Change Concept C. Sustain and Strengthen Partnerships Over Time	
Possible Strategies	**Specific Ideas to Test**
Talk about shared patients	→ Have clearly established organizational ways of sharing information about patients. This requires more than a common EMR; it requires actual communication, either in person, via phone, or by email, in order to make joint decisions.
Review patient outcomes	→ Review patient outcomes jointly. → Include individual patient outcomes as well as population-level outcomes in the review. → Use these discussions to help strengthen partnerships as providers can see and evaluate the impact of their collaboration.
Identify organizational improvements	→ Include discussions about IT, EMRs, billing, reimbursement, service availability and access, staffing, etc. → Talk openly with one another about organizational strengths and challenges across organizations.
Conduct joint trainings	→ Continue to deepen trust and enhance their joint expertise by providing clinical training to one another in their own specialty areas.
Provide leadership and organizational support	→ Ensure leaders and the overall organizations to which the providers belong also partner. → Help leadership actively support the collaboration by understanding productivity and workload requirements, technology needs, staffing support, etc.

Assessing Your Progress

As you begin testing concrete strategies, you want to ensure that your changes are resulting in improvements. Below are some key questions to help you assess and reflect on how you are doing in each of the change concepts in this goal.

1	2	3	4	5
Serious Concerns/ Challenges				Very Strong, Positive

Change Concept A. Identify Potential Partners and Have Introductory Meeting

- ❑ What type of provider lists do you have for the full range of community, school, and specialty expertise and services that might be needed or that are recommended by treatment guidelines?
- ❑ What types of specific types of expertise or services are needed based on the unique needs of your patient population, including specific cultural or linguistic needs?
- ❑ What relationships do you already have with specialty providers or organizations?
- ❑ How can existing partnerships be expanded in some way, or used to understand how to build new partnerships?

Change Concept B. Develop Communication Systems between Collaborating Providers

- ❑ *How do you and your staff currently communicate with specialists with whom you hope to partner in ways that are as simple as possible?*
- ❑ *How do you and your partner document your communication in ways that are feasible, simple, helpful, and minimally intrusive?*
- ❑ *How are EMRs and other existing data systems used to support the communication and collaboration across partners?*
- ❑ *How is your open communication shared with families?*

Change Concept C. Sustain and Strengthen Partnerships Over Time

- ❑ *How do you keep in touch with existing partners about shared patients?*
- ❑ *How do you keep in touch with existing partners about shared patient population outcomes?*
- ❑ *How do you address and resolve challenges as they arise within the partnership?*
- ❑ How do the organizations' leadership support the partnerships?

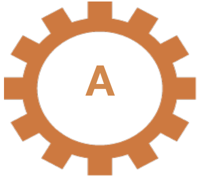
Goal 2. Provide Coordinated & Integrated Care

Why Is This Goal Important for Trauma-Informed Integrated Care?

When the primary care and mental health providers coordinate care across sites, it helps ensure the patient receives the type and quantity of care that is needed. Services are more efficient and effective when providers know what services families are already receiving, how much help they can absorb now, and how needs might be prioritized so that services can be sequenced in the most effective or acceptable way. Coordination of care may also reduce no-show rates and encourage patients to follow-up with specialists, while reducing duplication of services.

In order to provide coordinated, integrated care, mental and physical health providers must first have partnerships based on the foundations outlined in Goal 1: (1) knowledge of partner's service, (2) trust in partner's clinical judgment (3) systems to share information and, (4) collaborative delivery of care. Once these partnerships and communication systems are in place, coordinated and integrated care can be explained and delivered to patients and families following the strategies outlined below.

This goal includes five change concepts: A) improve processes for obtaining consent; B) improve process of making referrals; C) give reminders and follow-up calls; D) establish "family partners"; and E) determine funding and financing mechanisms to support coordination and integration.



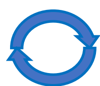
IMPROVE PROCESSES FOR OBTAINING CONSENT FOR EXCHANGE OF INFORMATION

Change Concept A: Improve Processes For Obtaining Consent For Exchange Of Information

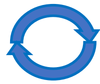
While HIPAA allows for the sharing of protected health information to coordinate care, some providers desire an additional consent form. Additionally, as you strive to engage families as authentic partners in their own care, it is good practice to let them know your plans to share their information. This can be especially important if they specific concerns related to culture, beliefs, or safety. *(Note: In situations where there is a concern for family violence, special care has to be taken that disclosures are not documented in a portion of a child's record to which a potentially violent partner may have access.)*

Moving from Change Concept to Change Strategy

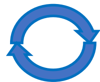
Below, you will see examples of change strategies that could be carried out to improve processes for obtaining consent for exchange of information. Each of these possible strategies is detailed further – making them even more practical and specific –in the sample PDSAs that follow.



Integrate Into Routine Paperwork



Explain Purpose of Sharing to Families



Ensure Consistency Across Providers

Implementing Change Strategy through Small Tests of Change (PDSAs)

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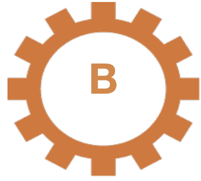
Change Concept A. Improve Processes for Obtaining Consent	
Possible Strategies	**Specific Ideas to Test**
Integrate into routine paperwork	→ If you are going to use a consent form, try to integrate it into your routine paperwork for new patients. → For existing patients, ask caregivers for permission right up-front.
Explain purpose of sharing to families	→ Take time to explain how the sharing of information will contribute to their families' care. → Understand and respect their reluctance, if they have any, especially based on possible cultural concerns. Most of the time when providers help families understand that the sharing of information is intended to provide them the best, most seamless care possible, families will value both the coordination of care and the transfer of information that they will not have to repeat.
Ensure consistency across providers	→ Understand Make sure that partners use the same – or at least consistent – consent forms and language around information sharing. Families may find it confusing if the language is different.



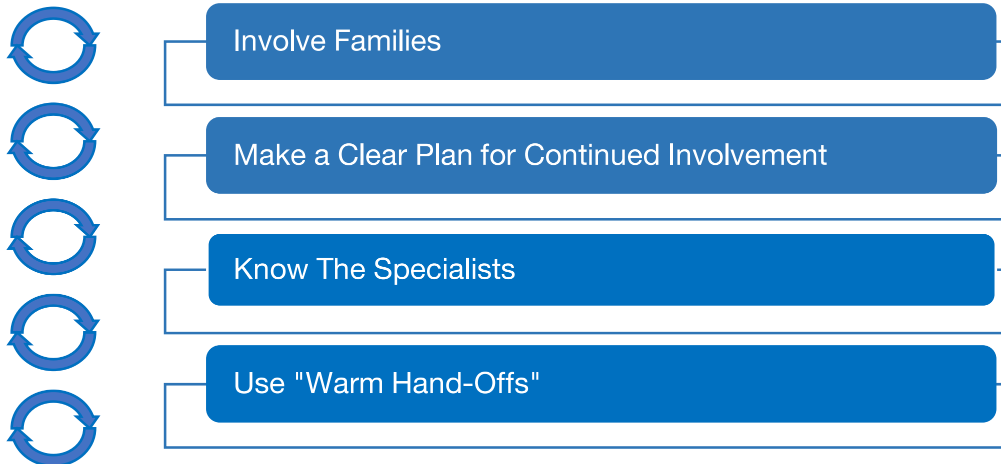
IMPROVE PROCESS OF MAKING REFERRALS

Change Concept B: Improve Process Of Making Referrals

Recognize that some patients/families may be reluctant to leave the primary care setting for new services. To address this issue it is important the primary care providers provide meaningful referrals by stating their plans to stay involved in the care. They should also “introduce” patients/families to the specialty care provides whenever possible.

Moving from Change Concept to Change Strategy

Below, you will see examples of change strategies that could be carried out to improve processes for improving the referral process. Each of these possible strategies is detailed further – making them even more practical and specific –in the sample PDSAs that follow.



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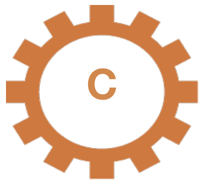
Change Concept B. Improve Process of Making Referrals	
Possible Strategies	**Specific Ideas to Test**
Involve families	→ Ask families for permission to offer advice. → Explore the pros and cons of involving specialty care. → Be willing to consider alternatives. → Explore barriers. → Rely on relationship with provider to further help coordinate care across members of the family. → Recognize when multiple family members, including caregivers, have needs and, to the extent possible, leverage the work in individual treatment of each member to inform the care of the family as a whole.
Make a clear plan for continued involvement	→ Facilitate the specialist's involvement by making a clear plan for staying involved in the family's care. → Clearly communicate this plan with the family.
Know the specialists	→ Cite a true personal relationship with the specialist. → Share in-depth knowledge of specialty treatment.
Use "warm handoffs"	→ Introduce the patient directly to the specialist to help the patient feel comfortable with the new provider. → Take the time for both providers and the family to be virtually or literally in one place. → Talk together about how everyone – including the family -- will work together going forward.



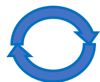
GIVE REMINDERS AND FOLLOW-UP CALLS

Change Concept C: Give Reminders And Follow-Up Calls

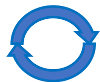
Understand and respect that there are many reasons patients don't follow up with specialty care. As part of this understanding, put into place systems for improving patient follow up and show rates at appointments with mental health specialists.

Moving from Change Concept to Change Strategy

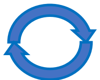
Below, you will see examples of change strategies that could be carried out to improve processes for reminders and follow-up calls. Each of these possible strategies is detailed further – making them even more practical and specific –in the sample PDSAs that follow.



Text Reminders



Ask For Updates



Make Follow-Up Calls

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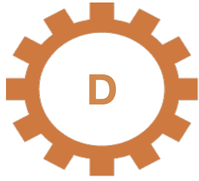
Change Concept C. Give Reminders and Follow-Up Calls	
Possible Strategies	**Specific Ideas to Test**
Text reminders	→ Include the provider name, location, date, time, contact information, and reason for visit to ensure the family remembers the importance of the appointment.
Ask for updates	→ Request text or phone updates from patients after their visits with specialists to help them put the visit into their own words.
Make follow up calls	→ After the day of the scheduled appointment with the specialist, call the patient to see if they showed up. → Ask the patient how it went. This can also help with planning next steps in the patient's care.



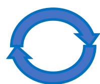
ESTABLISH FAMILY PARTNERS

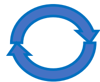
Change Concept D: Establish Family Partners

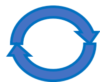
Some families may feel uncomfortable seeking mental health treatment and be apprehensive to voice their concerns to their primary care providers. A family navigator or "partner" from the community can help to bridge the gap between the patients and provider.

Moving from Change Concept to Change Strategy

Below, you will see examples of change strategies that could be carried out to establish family partners. Each of these possible strategies is detailed further – making them even more practical and specific –in the sample PDSAs that follow.


Text Reminders


Ask For Updates


Make Follow-Up Calls

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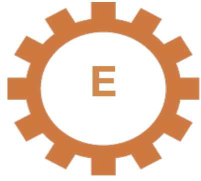
Change Concept D. Establish “Family Partners”	
Possible Strategies	**Specific Ideas to Test**
Welcome families to the clinic	→ Engage family advocates as “greeters” for other families who are new to the clinic or community to ease their transition.
Run or serve as site for support groups for families	→ Develop family advocates as leaders of support groups.
Provide peer mentors for families	→ Engage family advocates serve as one-to-one mentors (for tips on incorporating peer-to-peer support into your program see Appendix C.2).



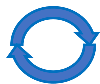
SECURE FUNDING TO SUPPORT COORDINATION & INTEGRATION

Change Concept E: Secure Funding To Support Coordination & Integration

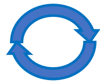
Primary care and mental health services have specific reimbursement limitations, often related to face-to-face visits with patients. To support coordinated and integrated care, however, funding and financing mechanisms need to be developed and identified to support those other activities that providers will be doing, such as peer consultation, care coordination, warm hand-offs, care management, and follow-up.

Moving from Change Concept to Change Strategy

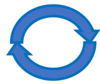
Below, you will see examples of change strategies that could be carried out to establish family partners. Each of these possible strategies is detailed further – making them even more practical and specific –in the sample PDSAs that follow.



Identify Possible Billing Codes



Create Dedicated Positions



Advocate for Improved Reimbursement Options

Implementing Change Strategy through Small Tests of Change (PDSAs)

We encourage you to use the strategies and small tests of change included in this toolkit as starting points: taking and adapting what might work for you, and adding to this list so that our collective work continues to grow. Below are more specifics about how you might consider testing and ultimately implementing these strategies in your own daily work.

Families from different races and cultures may respond to engagement strategies in different ways. Talk with your family advocate, or a sample of caregivers from your community to get a sense of what strategies they find most engaging, supportive, and respectful.

Change Concept E. Determine Funding and Financing Mechanisms to Support Coordination and Integration	
Possible Strategies	**Specific Ideas to Test**
Identify possible billing codes	→ Know the specific billing and reimbursement codes for your state. → Use existing resources, such as the helpful guides developed by the national American Academy of Pediatrics, for ideas on how various services and supports can be effectively billed. → Review and use these guides to support care reimbursement.
Create dedicated positions	→ Create specialized positions, such as care coordinators/navigators, peer consultants, cultural brokers, and care managers. → Base these positions on salary rather than fee-for-service or productivity requirements so they can attend fully to the needs of supporting coordinated, integrated care.
Advocate for improved reimbursement options	→ Invite leaders and other partners (including family partners) to serve as advocates in the policy realm. → Use stories and data of improved patient care. → Develop a case for overall cost-benefit savings.

Assessing Your Progress

As you begin testing concrete strategies, you want to ensure that your changes are resulting in improvements. Below are some key questions to help you assess and reflect on how you are doing in each of the change concepts in this goal.

1	2	3	4	5
Serious Concerns/ Challenges				Very Strong, Positive

Change Concept A. Improve Processes for Obtaining Consent

- ❑ What policies and mechanisms do you have in place for obtaining consent to share information?
- ❑ How readily is information received and incorporated into medical records?
- ❑ How is the rationale for consent communicated with families?

Change Concept B. Improve Process of Making Referrals

- ❑ How are families being prepared for and linked to specialists?
- ❑ How are primary care providers sharing information about specialists with families?
- ❑ How is care continuity being maintained when referrals are made?

Change Concept C. Give Reminders and Follow-Up Calls

- ❑ How are the outcomes of referrals being tracked?
- ❑ What is the current rate of successful linkages?
- ❑ What are the best ways to reach families and ensure follow through?

Change Concept D. Establish "Family Partners"

- ❑ How are family partners used to help families understand the need for specialty mental health services?
- ❑ How are family partners used to help engage families in accessing or receiving specialty mental health services?

Change Concept E. Determine Funding and Financing Mechanisms for Coordinated, Integrated Care

- ❑ What billing systems are in place to support coordinated, integrated care?
- ❑ What billing systems need to be added to support coordinated, integrated care?
- ❑ What positions have been or need to be created and funded to support coordinated, integrated care?

Element III. For More Information

Goal 1. Develop Partnerships with Specialists Providing Trauma Services

The resources listed below can be found in **Appendix C.1**

Developing Partnerships

1. Developing Effective Child Psychiatry Collaboration with Primary Care (Sarvet and Wegner, 2009)
   This article encourages collaboration between pediatricians and child psychiatrists, acknowledging both the benefits and the barriers. It also offers strategies for collaboration, including communication between services, structuring a psychiatric service to meet the referral needs of primary care, and an example of embedding collaboration within the region's healthcare system.
2. Confidentiality Laws Tip Sheet
3. HIPPA Privacy Rule

Select Links

- AAP Mental Health Initiatives (Available at: http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health
  Resources from the American Academy of Pediatricians focused on mental health efforts in a pediatric context.
- SAMHSA Integrated Care Models. (Available at: www.integration.samhsa.gov/integrated-care-models)
  General information and resources from SAMHSA regarding behavioral and primary healthcare integration.

Goal 2. Provide Coordinated, Integrated Care

The resources listed below can be found in **Appendix C.2**

Providing coordinated, integrated care

1. Enhancing Pediatric Mental Health Care- Strategies for Preparing a Primary Care Practice (Foy et al., 2014)
2. Integrating Behavioral Health and Primary Care Services- Opportunities and Challenges for State Mental Health Authorities
3. Integrating Child Psychiatry Into the Pediatric Medical Home (Keller and Sarvet, 2013)

A short article advocating for the integration of child psychiatry and pediatrics in a Patient-Centered Medical Home model, with a focus on consultation services and specialized care coordination.

4. Integration of Mental Health, Substance Use, and Primary Care Services (2011)
5. The Integration of Behavioral Health Interventions in Children's Health Care: Services, Science and Suggestions
6. Best Principles for Integration of Child Psychiatry into the Pediatric Health Home
7. Ten Key Principles for Successful Health Systems Integration (Suter et al., 2009)
   A review identifying ten principles of successful integration efforts, regardless of the integration model, population served, and healthcare context.

Peer to Peer Support

1. Tips for Incorporating Peer-to-Peer Support into Your Program
   A brief summary of the value of linking new clients with those who have been through treatment, different forms of peer-support and tips for implementation within a program.
   Available at: http://www.nctsn.org/nctsn_assets/pdfs/Pathways_PeertoPeerTipsheet.pdf