Warm Hand-Off Approach

In the integrated behavioral health model, the behavioral health clinician collaborates with the primary care provider for the medical and/or behavioral health condition of each client It is the medical provider's responsibility to assess the client's needs or barriers to treatment in the medical visit. Some of the issues patients may present with include but are not limited to:

- Depression, mood disorder, bipolar disorder
- Stress and anxiety
- Irritability
- Inability to concentrate or focus
- Sexual dysfunction or loss of interest in sexual activity
- Weight gain or loss
- Multiple and/or recurrent vague symptoms
- Chronic pain or fatigue
- Strange thoughts
- Social isolation and withdrawal
- Substance Use
- Impaired Functioning

The provider usually has enormous influence on how the clients will perceive and respond to the offer of behavioral care. It is recommended that the provider make a direct **"warm hand-off" (WHO)**. With a warm hand-off, the primary care provider directly introduces the client to the behavioral health provider at the time of the client's medical visit. The warm hand-off establishes an initial face-to-face contact between the client and the behavioral clinician, and confers the trust and rapport the client has developed with the provider to the behavioral clinician.

It is also the responsibility of the primary care provider to communicate with the clinician and remain fully informed of the client's progress via charting and discussion, and make final decisions regarding the client's overall treatment, with consideration given to recommendations made by the clinician.

Culturally Competent Services

SJWCFC believes that it is essential that all aspects of wellness promotion and mental health and substance use disorder prevention and treatment be reflective of the diversity of the communities being served, and that we strive to become and remain culturally and linguistically competent. A culturally and linguistically competent system incorporates skills, attitudes, and policies to ensure that it effectively addresses the cultural and communication needs of consumers and families with diverse economic and social resources and capacities, and diverse

values, beliefs, and sexual orientations, in addition to backgrounds that vary by race, ethnicity, religion, and language.

IBH Program Procedures

Accessing IBH Services

Medical providers can make an IBH referral via a Warm Hand-off or the EMR system. They can also refer patients to support groups as needed.

Patients may also schedule an appointment with IBH by calling the Call Center or scheduling with an IBH Care Manager.

Based on our host of pioneering programs designed to support a healthy and empowered community, the following care team members can also communicate any specific needs by patients to the primary care provider:

- Care Managers
- Health educators
- Patient care coordinators
- Dentists
- Nurses
- Clinical Manager
- Physician's Assistant
- Behavioral Health staff
- Substance abuse counselors

Warm Hand-Offs

If a provider believes that a patient would benefit from IBH services, or the patient requests IBH services, the provider can make a referral for a same-day Warm Hand-off (WHO).

If a patient presents with a crisis, the care manager or a behavioral health clinician may be available to make an assessment.

If a patient is a possible danger to self or others, the IBH Care Manager or clinician will assess the patient in the examination room and should not be walked to IBH unless/until deemed safe by clinician.

If, after being assessed, the patient is deemed to be at-risk of hurting self or others, and ACCESS or 911 is called, the Care Manager may need to reschedule some of the clinician's appointments so that the patient may remain in the clinician's office while waiting for the ACCESS team or law enforcement/paramedics to arrive. Our goal is to ensure we treat as many

patients as possible, therefore the number of appointments rescheduled may vary based on the severity of the case and other patient/clinic needs.

If there is no IBH Care Manager on-site, the clinician will work with the medical staff to allow the patient to remain in an examination room and/or work with front staff or an IBH Care Manager to reschedule patients as needed to allow the patient to remain in clinician's office while waiting for the ACCESS team or law enforcement/ paramedics to arrive.

In non-emergency situations:
If there is an IBH Care Manager on-site, the patient should be walked over to IBH. If there is no IBH Care Manager on-site, the IBH clinician will meet with the patient in the medical provider's examination room and may walk the patient back to an IBH office.

If Behavioral Health Services are not available at a specific SJWCFC clinic location, a referral to Behavioral Health Services can be submitted by the medical provider via EMR. The program will respond to the referral within 48 hours. Alternately, the patient may be directed to a clinic that does offer Behavioral Health Services and/or to a LA County Department of Mental Health facility.

Scheduling

Appointments may be scheduled by the Call Center, Care Manager, and the Behavioral Health Clinician.

When patients with scheduled appointments do not show to their appointments, Behavioral Health clinicians will accommodate same day referrals from primary care providers and focus on ensuring that Behavioral Health supports the goals of the program.

Scheduling Interpretive Services

If a patient requires interpretative services (e.g., ASL), the Care Manager will call the patient's insurance company to schedule an interpreter for the patient's scheduled appointment.

Referral to Outside Agencies

Based on the assessment of the primary care provider and the behavioral health clinician, when patients require specialty care, patients will be referred to appropriate sources (such as Kedren, LAC-USC, UCLA-Harbor, DMH) for specific, additional, or more intensive support services.

Patients who require more frequent or intensive services can be referred to any Tier 1 agency, usually a DMH facility. Referrals for higher level of care are made on a case-by-case basis. Clinicians are encouraged to consult with supervisors during individual or group supervision or

in peer consultation to make this determination. Clinicians and medical providers are also encouraged to discuss these cases at the Multidisciplinary Team Meetings.

The following descriptions of Tier 1, 2, and 3 patients are provided below to assist clinicians in determining the appropriate level of care:

Tier 1 patients

"Individuals with serious and persistent mental illness (SPMI); high risk and high need for intensive mental health and rehabilitation interventions AND/OR the need for long-term Services and supports; probability of significant deterioration in an important area of life functioning AND typically requires intensive intervention to maintain stability in the community, prevent decompensation and/or need for a higher level of care (e.g., psychiatric hospitalization)."

Tier 2 patients

"Individuals seen in a primary care setting who may benefit from and are willing to engage in an early intervention via short-term, time-limited treatment; are moderate- to low-risk and have a need for mental health interventions; AND/OR Individuals experiencing a recent crisis or are struggling with symptoms indicative of a mental illness who have not sought mental health treatment in the past; have not been diagnosed with SPMI, are not at imminent risk of hospitalization or, in most cases, immediate medication evaluation and services. The assessment should determine if these individuals may be experiencing the onset of a serious psychiatric illness.

Diagnosis that is amenable to short-term treatment using the Mental Health Integration Program. In general, these will be individuals with depression and anxiety diagnoses; AND difficulty functioning in one or more essential roles; AND expectation that short-term, early intervention will ameliorate symptoms or life problem."

Tier 3 patients

"Individuals seen in primary care settings who receive and desire only medication management and are not interested in participating in any psycho-therapeutic interventions. May include individuals previously served in the mental health system who no longer need on-going recovery support for a serious mental illness; minimal supports to maintain the client's stability and functioning."

Appropriateness of Care

If at least one of the factors below is present, the patient is most likely a good candidate to be referred to a Tier 1 agency:

- Patient has lengthy history of significant mental health issues
- Patient is emotionally unstable/labile
- Patient comes into appointments/sessions in crisis on multiple occasions
- Patient requires weekly sessions
- Patient has, or is suspected to have, Axis II issues that interfere with treatment
- Patient has dual diagnosis

Other factors to consider:

- Severity/intensity/frequency of suicidal ideation
    - Is it difficult for patient to manage or control suicidal thoughts? Are suicidal thoughts persistent throughout the day?
- Lethality of past suicide attempts
    - Did patient make actual attempt? Did others know about attempt? How was patient found?
- Recency of last suicide attempt
    - Was last suicide attempt within last 6 months?
- Frequency/intensity of any auditory or visual hallucinations
    - Is it difficult for patient to manage or control AH and VH? Does patient follow through on AH (e.g., being told to hurt self or others)

Substance Abuse

Substance abuse, also known as drug abuse, is a patterned use of a drug in which the user consumes the substance in amounts or with methods which are harmful to themselves or others, and is a form of a substance-related disorder. The solution lies in integrated care, as integrating substance abuse care in mental health and primary care services produces the best outcomes and proves to be the most effective approach to caring for people with multiple healthcare needs.

Substance Abuse Care consists of outpatient behavioral counseling (individual and group), care management, psychiatric care, evaluation and treatment of co-occurring disorders, and/or linkage to appropriate care for detoxification and/or Medication Assisted Treatment (for opioid, tobacco, or alcohol addiction).

For patients with severe substance abuse, the substance abuse counselor and/or care manager will link the patient to appropriate care. A patient or provider can also contact the Alcohol and Drug Program Administration, a division of the County of Los Angeles Department of Public Health, at 800/564-6600 for services and/or Los Angeles County Department of Public Health, Substance Abuse Prevention and Control.

For a provider list, please refer to http://publichealth.lacounty.gov/sapc/provider.htm

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