MARYLAND BEHAVIORAL HEALTH INTEGRATION IN PEDIATRIC PRIMARY CARE

BHIPP
Maryland Behavioral Health Integration in Pediatric Primary Care

Sign Up Form

Today's Date:

Provider Name:

Practice Name:

Practice Website:

Address:

_____

Street Address/P.O. Box Suite No

_____

City County State Zip Code

Phone 1: Work Cell Home Pager

Phone 2: Work Cell Home Pager

Email:

Fax:

Alternative contact person & phone:

Provider type: MD DO NP PA SW Other:_____

Years in practice:

Years in practice at current site:

Please circle your primary specialty: Family practice Pediatrics Internal medicine Other: _____

What is your personal weekly patient volume (caseload):	<25	25-50	51-75	76-100	101+
What percent of your patients are 0-5 years old?	0%	1-25%	26-50%	51-75%	76-100%
What percent of your patients are 6-18 years old?	0%	1-25%	26-50%	51-75%	76-100%
What percent of your patients are 19-24 years old?	0%	1-25%	26-50%	51-75%	76-100%
What percent of your patients are 25 or more years old?	0%	1-25%	26-50%	51-75%	76-100%

Except for the basic curriculum for your degree and residency (or other required post-degree training), have you had any specialized training related to child mental health topics (e.g., psychopharmacology, child development)? Y / N
If yes, please describe: _____

Gender: Male Female Other

Do you consider yourself Hispanic or Latino? Y / N

What do you consider to be your racial identity? African American Alaska Native American Indian Asian Caucasian Native Hawaiian/Pacific Islander Other: _____

Are services at your practice offered in a language other than English (other than through a translator)? Y / N
If yes, please indicate:_____

Is your practice certified as a Patient-Centered Medical Home? Y / N

Is your practice affiliated with a health system (e.g., a hospital or health network)? Y / N

Do you practice in a school? Y / N

Are mental health services available on-site at your practice? Y / N
If yes, please indicate type of providers that provide mental health services (circle all that apply):
Psychiatrist Psychologist Counselor Social Worker/Case Manager Telepsychiatrist
PCP at this practice Other: _____

Please indicate the number of Primary Care Providers (physicians, nurse practitioners) at your practice: 1 2-5 6+

Please indicate the number of staff at your practice: 1-5 6-10 11-15 16+

What insurances do you accept? Uninsured Sliding Scale Public (Medicaid/MCHIP) Privately Insured

Please fax completed forms to: 855-632-4477

For internal use: Entered on (MM/DD/YYYY) by (Initials) Checked on (MM/DD/YYYY) by (Initials)

Which BHIPP services interest you? Telephone consultation Continuing education Resource identification

Tele-psychiatry Tele-counseling Care coordination Social work co-location

How did you hear about us (please check all that apply)?

☐ Mailing ☐ BHIPP Networking Event ☐ Colleague/professional network

☐ Presentation at my practice ☐ Web search ☐ Conference/professional meeting

☐ Drop-in visit to my practice ☐ Email ☐ Other_____

☐ BHIPP Training

Description of Program

Goals & Scope

This consultation program has been developed to offer a resource to primary care providers for children and youth related to identification and treatment for behavioral health concerns. The goal of the BHIPP program is to support your capacity, as the primary care provider, to give basic mental health care to your patient. In keeping with this aim the following are not covered/provided by the consultation team: forensic/custody issues, emergency psychiatric assessment or care, direct clinical care to your patient, direct contact with the parent/guardian, reporting abuse or neglect to Child Protective Services, or direct hospital admissions. We hope that you find the guidance you receive through our phone consultation helpful. Please remember that while BHIPP consultants are available to provide general recommendations based on the information you provide, you maintain responsibility for decisions around care of your patient(s).

Privacy

BHIPP is made possible through funding from the Maryland Department of Health, Behavioral Health Administration and partnerships among the University of Maryland School of Medicine, Johns Hopkins University School of Medicine, Salisbury University and Morgan State University. Therefore, the names of participating providers may be shared with state officials. Occasionally, other stakeholders are interested in learning who is participating in BHIPP.

____Please initial here if you prefer to **opt out** of being included in such lists.

Procedures

After each phone consultation, BHIPP will send you a summary of the specific recommendations discussed. The summary may include: psychoeducational information to share with parents, clinical guidelines for pediatrician use in the delivery of care, and/or community based resource information to support linkage to needed care. As part of the program's continuing quality assurance, we will ask you to provide feedback about your experience.

Summary of consultation procedure:

Call the central phone line, 855-MD-BHIPP (855-632-4477)

1. The Behavioral Health Clinician (BHC) will receive your request, obtain intake information, and address general questions. If additional expertise is necessary, the BHC will arrange for a consultant to contact you by phone within 1 business day.
2. A written summary of the recommendations will be provided for your records.

I have read and agree to utilize the BHIPP pediatric consultation service as described above.

Provider Signature Date

BHIPP is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of award U4CMC32913-01-00. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government.