



3.a.i. INTEGRATION OF PRIMARY CARE AND BEHAVIORAL HEALTH



PROJECT GOALS

- ▶ Identify patients in need of behavioral health services and better access to these services.
- ▶ Integrate services for depression, substance abuse, and other psychosocial services for primary care practices.
- ▶ Reduce potentially preventable emergency department visits and hospitalizations for behavioral health diagnoses.
- ▶ Promote better health through collaboration among the Primary Care Physician (PCP), the patient, the behavioral health care manager, and treating behavioral health providers.

OVERVIEW

The National Institute of Mental Health (NIMH) estimated in a 2008 report that 26.2% of Americans ages 18 and older – about one in four adults – suffer from a diagnosable mental disorder in a given year and three-quarters have begun by age 24. Unfortunately, evidence also shows that the mental health system fails to reach a significant number of people with mental illness, and those it does reach often drop out or get insufficient, uncoordinated care.¹

More than 70% of visits to PCPs are related to psychosocial issues. PCPs, in fact, treat 60% of those with depression in the United States.² One-quarter of adults experience a mental illness in a given year, and more than half do not receive treatment, according to the National Alliance on Mental Illness.³

The integration of mental health and substance use disorder management into medical practice and implementation of an evidence-based clinical decision support system is a critical feature of Element 3E of the Patient Centered Medical Home.⁴

THREE MODELS

SOMOS providers participate in three models. All models require documentation in the EHR and should be available for all treating professionals.

MODEL 1: Integration of Behavioral Health Providers in Medical Clinics

OMH- and OASAS-licensed network clinics will have behavioral health provider staff co-located within the same facility. PCPs or extenders who screen patients meeting the threshold for targeted disorders (depression and/or substance/alcohol disorders) will perform a “warm handoff” to the behavioral health co-located provider.

Model 1 practices include SOMOS contracted Patient Centered Medical Homes that have on-site behavioral health providers, Federally Qualified Health Centers, or MediSys clinics in which a clinical social worker or mental health counselor is on-site.

MODEL 2: Integration of Medical Providers in Behavioral Health Clinics

Licensed OMH/OASAS clinics will have a PCP or extender on site at least 16 hours per week. The medical provider is expected to engage in annual medical screenings for behavioral health clinic patients, and/or coordinate medical care with the patient’s provider if outside the behavioral health clinic. The medical provider is also available to the staff at the behavioral health clinic to consult on patients’ medical issues.

SOMOS Model 2 practices include affiliated hospitals. MediSys behavioral health clinics have integrated primary care providers (including PCPs, nurse practitioners, and physician assistants working closely with a PCP) who perform preventive care screenings for those individuals with mental health disorders, such as schizophrenia,

bipolar disorder, and depressive disorders, and/or with alcohol and substance abuse disorders. The role of the primary care provider in Model 2 practices is to perform all screening in accordance with age-appropriate guidelines per the U.S. Preventive Services Task Force (USPSTF) A and B recommendations.⁵ These include the age-appropriate behavioral health screens (mental health screening at a SUD site) and/or SUD screening at a Mental Health site. In addition, primary care providers at the Model 2 sites will provide annual wellness visits, timely visits for minor, acute, and common chronic illness, including hypertension, diabetes, and obesity. Referral to SOMOS specialists will also be arranged as needed. All services and communication will be documented in the shared medical record.

MODEL 3 (IMPACT MODEL): Integration of Behavioral Health and Primary Care in Free-Standing Ambulatory Practices

Collaborative care is the cornerstone of this model and functions in two main ways:

1. The patient's PCP works with an in-practice or off-site **behavioral health care manager** (warm handoff or virtual warm handoff) to develop and implement a treatment plan (medications and/or brief, evidence-based counseling or more intensive treatment).
2. The in-practice or off-site care manager and primary care provider collaborate with an affiliated **consulting psychiatrist** for medication management and/or to amend treatment plans if patients do not improve. The collaborating psychiatrist consults with the PCP and/or mental health case manager on the care of patients who do not respond to treatment as expected or who have more severe or complex behavioral health conditions or for other support needed.

ROLE OF THE CARE MANAGER

- Reviews medical information coming from the PCP, including test scores for PHQ and other screening assessments (e.g., AUDITC, DAST, CAGE, CRAFFT).
- Contacts patient (unless this is done in the PCP office) to make introductions and discuss support services the care manager can provide.
- Upon patient approval, engages in support services, either face-to-face or telephonically. Support services include, but are not be limited to: making referrals to behavioral health professionals, including substance use professional counseling;

asking if patient wants to discuss psychotropic medication change with a psychiatrist; engaging in triage activities with PCP and/or medical specialties; and providing triage support to other community-based organizations as needed.

- Reviews the psychotropic therapy prescribed by the patient's primary care provider and stresses the importance of adherence, reporting side effects, and other barriers (e.g., financial) to obtaining and taking medication.
- Monitors depression symptoms using PHQ-9 for treatment response within 6-8 weeks of starting the care management process.
- Monitors adherence to SUD treatment.
- Completes a relapse prevention plan with patients who have improved.
- Discharges patients who have reached goals with suggestions that care management is available in the future.
- Engages patients in a Health Home if they desire and meet criteria.

EHR documentation is required to demonstrate a successful collaborative care system.

STEPPED CARE

- Treatment is adjusted and based on the AIMS Impact evidence-based model and clinical outcomes
- The aim is for a 50% reduction in symptoms within 6-8 weeks.
- If the patient has not significantly improved within 6-8 weeks, an altered plan is implemented. The change can be an increase in medication dosage, a different medication, the addition of psychotherapy, referral to an appropriate rehabilitation program, a combination of medication and psychotherapy, or other treatments suggested by the team psychiatrist.

The **first step** of behavioral care involves basic educational efforts, such as sharing information and referral to self-help groups.

The **second level** "steps up" the care to involve clinicians who provide psycho-educational interventions and make follow-up phone calls.

The **third level** involves more highly trained behavioral health care professionals who use specific practice algorithms. If a patient does not respond to these progressions of care (or if specialized treatment is needed), the patient is referred to the specialty mental health system.

The **final level** occurs when referral to specialty care is necessary. The primary care team will work collaboratively with the mental health provider.

- At times, the patient's care can be transitioned back (or stepped down) fully to primary care after adequate specialty mental health treatment/intervention has been provided.

EXPECTATION FOR ALL MODELS

All patients age 12 years or older will be screened annually for depression and substance use disorder.¹ In SOMOS' smaller offices, PCPs or their medical assistants will screen for depression with the PHQ2 and will use a validated screening tool for alcohol and substance abuse, and document the results in the medical record. In larger offices, a designated care manager can perform the screening. Evidence indicates that patients are twice as likely to attend the visit with a mental health professional if introduced by the PCP.

The PHQ shall be re-administered at patient follow-up visit following the initial diagnosis and implementation of treatment for a chronic illness (e.g., diabetes, cancer, asthma, cardiovascular disease).

The Screening, Brief Intervention, and Referral to Treatment (SBIRT) approach¹ will be used for screening and delivery of early intervention and treatment to people with substance use disorders, as well as those at risk of developing these disorders. Screening tools include the AUDIT-C, DAST, CRAFFT and T-ACE screens. For patients meeting the clinical threshold, the PCP will counsel the patient on the deleterious effects of continuing misuse (Brief Intervention) and

ask if the patient would like a referral to the Behavioral Health Care Manager. If the screening and clinical interview for either depression or alcohol/substance or both by the PCP indicates an urgent need, the PCP or designated care manager will counsel the patient that an immediate referral is recommended and provide a warm handoff to an available provider system in the SOMOS network. If the need is non-urgent, the patient will be counseled that the designated care manager will make contact to begin the supportive process, follow the patient's treatment course, and make appropriate referrals to network behavioral health practitioners for mental health or substance use.

All screenings will be incorporated into the EMR and available via the integrated platforms established, and on the website.

ENGAGEMENT MEASURES

- The number and percent of patients 12 years of age and older with annual screening with PHQ2/9.
- The % of those screened who reach threshold.
- The number and percent of adult patients screened with AUDIT C and DAST or another validated SUD tool.
- The number and percent of adolescents with documented alcohol and drug screening with the CRAFFT.
- All screenings, including clinical notes summarizing the intervention and outcome, will be incorporated into the EMR and available via the integrated platforms established, and on the website.

SCREENING TESTS: FOR DEPRESSION

Interpreting the PHQ 9⁶

Scores Diagnosis	Total Score	Action
Minimal Depression	1-4	Score suggests the patient may not need depression treatment
Mild Depression	5-9	Physician uses clinical judgment about treatment, based on patient's duration of symptoms and functional impairment
Moderate Depression	10-14	
Moderately Severe Depression	15-19	Warrants treatment for depression, using antidepressants, psychotherapy and/or combination of treatment
Severe Depression	20-27	

SCREENING TESTS: FOR ALCOHOL AND SUBSTANCE ABUSE

SOMOS PCPs will perform evidence-based screening at an initial visit (or as soon as feasible) and at least annually after that. Screening results will be incorporated into the EMR.

All screenings will be incorporated into the EMR and available via the integrated platforms established and on the website.

Alcohol Abuse Screening for Adults (18 and over)

- Primary Care providers shall employ the AUDIT-C screening tool for all adults (the first three questions of the AUDIT tool). If the AUDIT-C score is 3 or higher for women or 4 or higher for men,⁷ the full AUDIT is then done. A positive result on the AUDIT is a score greater than 7 and reflects the severity of alcohol misuse.
- For patients with AUDIT-C scores 4-7 and no prior alcohol treatment, the provider should offer a brief intervention:
 1. Express concern about the patient's drinking, if drinking above recommended limits.
 2. Provide feedback linking the patient's drinking to his/her health concerns, noting that patient is drinking above recommended limits, and
 3. Offer explicit advice to stay below recommended limits.

- Patients with more severe problems due to drinking should be referred to a Mental Health specialist partner, as well as to community-based organizations and services, or city and/or state programs (e.g., AA). Patients who do not accept referral should also be offered intervention.
- Providers should obtain more information on specific symptoms due to drinking. Questions #4-10 of the full AUDIT can be used as a brief assessment, and patients should be referred to a mental health specialist partner.

Other Substance Use Disorder (SUD) Screening Test for Adults

For adults who answer yes to question #1 of the DAST ("Have you used drugs other than those required for medical reasons?"), screening with the full DAST-10 (Drug Abuse Screening Test) Questionnaire will be used. All SOMOS primary care providers will employ the DAST-10 at least annually (unless previously diagnosed with SUD) for all adults age 18 years and older when negative and more often if possible or if patients exhibit high-risk drug use behaviors involving cannabis (e.g., marijuana, hash), solvents, tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD), or narcotics (e.g., heroin). Results will be recorded in the Electronic Health Record.

Suggested Action related to the DAST-10 Score⁸

DAST-10 Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No problems reported	None at this time
1-2	Low level	Monitor, reassess at a later date
3-5	Moderate level	Further investigation
6-8	Substantial level	Intensive assessment
9-10	Severe level	Intensive assessment

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Alcohol and Drug Abuse Screening for Adolescents (12 and over)

The CRAFFT Screening Interview⁹ is a behavioral health screening tool designed for children under the age of 21. Recommended by the American Academy of Pediatrics' Committee on Substance Abuse for use with adolescents, the screening tool consists of a series of six questions intended to identify adolescents who may have simultaneous risky alcohol and other drug use disorders.¹⁰

If the adolescent answers “No” to all three Part A opening questions, the provider only needs to ask the adolescent the CAR question in Part B. If the adolescent answers “Yes” to any one or more of the three opening questions, the provider asks all six CRAFFT questions. It is a short, effective tool meant to assess whether a longer conversation about the context of use, frequency, and other risks and consequences of alcohol and other drug use is warranted. Results of the screening and follow-up will be documented in the EHR.

/REFERENCES

¹<http://www.milbank.org/uploads/documents/10430EvolvingCare/EvolvingCare.pdf>

²<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3670434/>

³ <http://medicaleconomics.modernmedicine.com/medical-economics/content/tags/affordable-care-act/integrating-primary-care-and-mental-health-key-im?page=full>

⁴https://www.integration.samhsa.gov/integrated-care-models/7_29_15_NCOA_BH_and_PCMH_FINAL.pdf

⁵<https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/>

⁶<http://archinte.jamanetwork.com/article.aspx?articleid=208954>

⁷Skinner, H. A. (1982). The Drug Abuse Screening Test. *Addictive Behavior*, 7(4),363–371.

⁸http://www.integration.samhsa.gov/clinical-practice/sbirt/CRAFFT_Screening_interview.pdf

CRAFFT is a mnemonic acronym of first letters of key words in the 6 screening questions. Have you ever ridden in a **CAR** driven by someone (including yourself) who was “high” or had been using alcohol or drugs? Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in? Do you ever use alcohol or drugs while you are by yourself, or **ALONE**? Do you ever **FORGET** things you did while using alcohol or drugs? Do your family or **FRIENDS** ever tell you that you should cut down on your drinking or drug use? Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?

⁹<http://www.integration.samhsa.gov/clinical-practice/sbirt/screening>

Other resources for staff training on integrating behavioral and primary health care: <https://www.thinkinglink.com/channel/622854013355819009/slideshow>