3.a.i Integration of Primary Care and Behavioral Health: Model 3

Project goal

Immediate: Implement the IMPACT model at primary care sites.

Long-term: Improve identification and access to Behavioral Health Services in Suffolk County.

Deliverables to include diabetes monitoring for people with diabetes and schizophrenia (HbA1c and LCL-C), diabetes screening for people using antipsychotic medication; cardiovascular monitoring for people with CVD and schizophrenia (LDL-C); antidepressant medication management - acute and continuous phase treatment; adherence to antipsychotic medications for people with schizophrenia; initiation of alcohol and other drug dependence treatment (1 visit within 14 days) and engagement (initiation and 2 visits within 44 days); follow up care for children prescribed ADHD medication – initiation and continuation phase; screening for clinical depression and follow up; follow up after hospitalization for mental illness within 7 and 30 days; decrease potentially avoidable ED visits.

Interventions

Providers will be responsible for: 1) Utilizing the IMPACT approach to depression care management in the PCMH with fidelity to the model. (See Reference). 2) Collaborating with a Depression Care Manager for patients. 3) Establishing a working partnership/ agreement with a psychiatrist or Psychiatric Nurse Practitioner, clinic that employs a psychiatrist or with the local OMH Project TEACH/CAP-PC initiative. 4) Screening all patients once per year (at a minimum) as part of their regular visit, for depression and substance use with evidence based screening tools. 5) Documenting scores for both clinical and reporting purposes in the EHR. 6) Connecting patients with the Depression Care Manager to address needed referrals and follow-up for behavioral health concerns when the individual screens positive. 7) Arranging for regular communication between the Depression Care Manager, Psychiatrist and PCMH personnel per the IMPACT model to review patient cases. 8) Arranging for shared documentation among all parties to ensure communication about the patient is easily accessible and included in the EMR. 9) Ensuring the Depression Care Manager carries out “warm handoffs” and referrals to appropriate mental health and substance abuse resources/ providers for treatment when indicated.

Providers will integrate the following behavioral health screening tools into the workflow:

- Depression Screening Tool: - PHQ2 (First two questions of PHQ9) followed by the PHQ9 when a patient scores positive on the PHQ2 or PSC-Y/ PSC-17 for the pediatric population. PHQ2 positive result is defined as a score of 3 or higher. PHQ9 add score to determine severity.

- Depression Screening Tool: Perinatal Population - EPDS positive result is defined as a score of 9 or higher, indicating a need for additional assessment OR score 1 or higher on question 10 (suicidal ideation), indicating immediate need for follow-up and/ or referral to treatment.

- Substance Abuse Screening Tools: Adults age 18 or older - AUDIT C (First three questions of AUDIT) followed by the Full AUDIT when a patient scores positive on the AUDIT C. AUDIT-C positive score is 3 or higher for women and 4 or higher for men. A positive on the full AUDIT is greater than 7.

  DAST pre-screen (question 1 of DAST) followed by the Full DAST when a patient screens positive (‘yes’ to question 1) on the pre-screen. Full DAST add score to determine severity.

- Substance Abuse Screening Tools: Age 13-17 - Pre-Screen CRAFFT: Provider asks first 3 questions. If “No” response to all three pre-screen questions, the provider needs to ask the fourth question - the CAR question. If the adolescent answers “Yes” to any one or more of the three opening questions, the provider asks all six CRAFFT questions. CRAFFT Scoring: Each “yes” response in Part B scores 1 point. A total score of 2 or higher is a positive screen, indicating a need for additional assessment.

(continued on reverse)

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Patient Engagement Metric

The number of patients screened with PHQ2 or PHQ9 or PSC-Y/ PSC-17 for the pediatric population or EPDS for perinatal population; or number of patients screened using both Audit C and DAST; or number of patients (age 13-17) screened using the CRAFFT.

Clinical Metrics

- Screening for Clinical Depression and Follow-up - People 18 and older with an outpatient visit who were screened for clinical depression using a standardized depression tool, and if positive, with follow-up plan within 30 days.
- Adherence to Antipsychotic Medications for People with Schizophrenia – People age 19 to 64 with schizophrenia dispensed an antipsychotic medication during the measurement year and remained on the antipsychotic medication for at least 80% of their treatment period.
- Antidepressant Medication Management – Effective Acute Phase Treatment – People 18 and older diagnosed with depression and treated with an antidepressant medication who remained on antidepressant medication during the entire 12- week acute treatment phase.
- Antidepressant Medication Management – Effective Continuation Phase Treatment – People 18 and older diagnosed with depression and treated with an antidepressant medication who remained on antidepressant medication for at least six months.
- Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia – People age 18 to 64 with schizophrenia and cardiovascular disease who had an LDL-C test during the measurement year.
- Diabetes Monitoring for People with Diabetes and Schizophrenia People age 18 to 64 with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.
- Diabetes Screening for People with Schizophrenia or Bipolar Disease who are Using Antipsychotic Medication – People age 18 to 64 with schizophrenia or bipolar disorder, who were using an antipsychotic medication who had a glucose test or HbA1c test during the measurement year.
- Initiation of Alcohol and Other Drug Dependence Treatment (1 visit within 14 days) – People age 13 and older with a new episode of alcohol or other drug (AOD) dependence who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth, or medication assisted treatment (MAT) within 14 days of the index episode.
- Engagement of Alcohol and Other Drug Dependence Treatment (Initiation and 2 visits within 44 days) – People age 13 and older with a new episode of alcohol or other drug (AOD) dependence who initiated treatment and who had two or more additional services with a diagnosis of AOD dependence within 30 days of initiation visit.
- Follow-up after hospitalization for Mental Illness – within 7 days
- Follow-up after hospitalization for Mental Illness –within 30 days
- Follow-up care for Children Prescribed ADHD Medications - Initiation Phase – Children age 6 to 12 years, who were newly prescribed ADHD medication, who had one follow-up visit with a practitioner within 30 days after starting medication.
- Follow-up care for Children Prescribed ADHD Medications - Continuation Phase – Children age 6 to 12 years who were newly prescribed ADHD medication and remained on medication for 210 days who, in addition to the first follow-up visit in the initiation phase, has at least 2 follow-up visits in the 270 days after the initiation phase ended.
- Potentially Preventable Emergency Department Visits (for persons with Behavioral Health Diagnosis)

Tools to be employed: PHQ2 / 9; EPDS; AUDIT-C; AUDIT; DAST; CRAFFT

References/Guidelines

1. http://www.integration.samhsa.gov/integrated-care-models/list
2. http://aims.uw.edu/impact-improving-mood-promoting-access-collaborative-treatment/
3. https://aims.uw.edu/resource-library
4. https://projectteachny.org/