3.a.i Integration of Primary Care and Behavioral Health: Model 2

Project goal

Immediate: Integrate Primary Care Services into Suffolk County OMH and OASAS licensed facilities.

Long-term: Improve screening rates and access to chronic disease management/primary care services among residents enrolled in Suffolk County OMH and OASAS licensed facilities.

Deliverables to include diabetes monitoring for people with diabetes and schizophrenia (HbA1c and LDL-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**) Providing space and scheduling resources to the co-located PCP to ensure patients can be readily seen for physical health services. **2**) Providing OMH/OASAS patients with access to an annual physical/well visit (at a minimum) and address in a timely manner physical health concerns (i.e. sick visits) when indicated. **3**) Screening all OMH/OASAS clinic patients seen by the PCP for chronic conditions: i.e. hypertension/blood pressure, diabetes/A1c and height-weight/BMI. **4**) Documenting all screening/lab results for both clinical and reporting purposes in the EHR. **5**) Working collaboratively with the PCP to ensure referrals to external pre-identified specialists are made for laboratory tests/treatment when indicated. **6**) Working with the PCP to ensure the full scope of primary care services is available to patients at the OMH/OASAS clinic site. **7**) Arranging for shared documentation to ensure communication about the patient is easily accessible and documented for reporting purposes.

Patient Engagement Metric

The number of patients receiving primary care services at a Behavioral Health site (Mental Health or Substance Abuse Site) from a Primary Care Provider (PCP, NP, PA working closely with PCP).

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.

(continued on reverse)

Suffolk Care Collaborative

Office of Population Health - 1383-8 Veterans Memorial Highway, Hauppauge NY 11788
Tel: (631) 638-2227 | Fax: (631) 638-1009 | suffolkcare.org

REV. 04052018

Integration of Primary Care and Behavioral Health: Model 2

Clinical Metrics (continued)

- **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: Applicable physical health preventative screening tools.

References/Guidelines

1. "Integrating Primary Care into Behavioral Health Setting: What works for Individuals with Serious Mental Illness." Martha A. Gerrity, MD, MPH, PhD
2. http://www.integration.samhsa.gov/integrated-care-models/primary-care-in-behavioral-health