



# Behavioral Health Integration into Adult Primary Care Model Guideline

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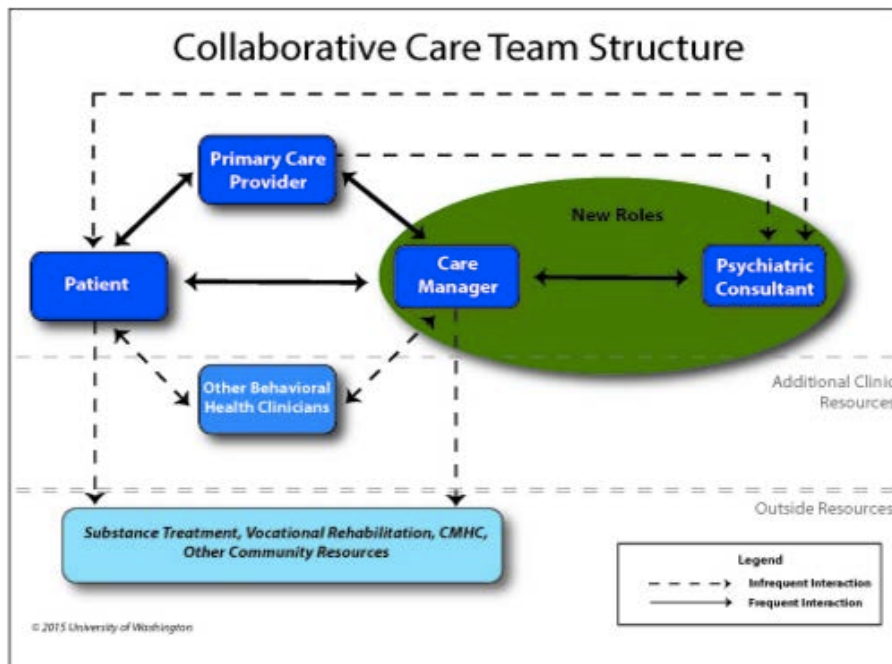
## EXECUTIVE SUMMARY:

Mental and substance use disorders are common in the primary care setting, and frequently co-exist with and worsen the outcomes of chronic diseases. Behavioral health disorders are undertreated due to inadequate recognition, a shortage of behavioral health clinicians, stigma, and challenges navigating complex healthcare systems. Integrating behavioral health care into primary care provides a holistic care approach that reduces fragmentation, destigmatizes behavioral health disorders, lowers care costs, increases patient<sup>2</sup> and provider satisfaction, and improves both behavioral<sup>2,3</sup> and physical health outcomes. One model of integrated care, the Collaborative Care Model, follows the principles of Wagner's Chronic Care Model and has been extensively studied and widely adopted.

### Essential Elements of the Collaborative Care Model:

#### 1. Team-Driven Care

*A multidisciplinary group of healthcare delivery professionals providing care in a coordinated fashion and empowered to work at the top of their professional training.*



(Source: University of Washington's AIMS Center<sup>4</sup>)

The three main members of the team are:

- **Primary Care Provider (PCP):** oversees the overall patient care plan and is the ultimate decision-maker for the clinical team.
- **Care Manager:** the lynchpin linking the team members to the patient and to each other. CMs work to keep patients engaged in their care, assess treatment adherence and side effects, explore treatment preferences, facilitate referrals outside primary care, and collect clinical outcome metrics. Ideally, the CM would have mental health training, be able to provide brief counseling, and be hired specifically for this role (termed "behavioral health clinician" at DHMC Lebanon). Alternatively, existing clinic personnel could be trained for this role.
- **Consulting Psychiatrist:** reviews the CM's caseload at routine intervals, provides consultation and feedback to PCPs (through "curbside" or e-consults (initial consults from primary care) and other EHR

communication), and may evaluate and/or co-manage patients directly (through on-site care or off-site telemedicine).

Other members of the primary care based team can be added depending on the needs of the clinic- psychologists, social workers, licensed alcohol and drug counselors, and community health workers. Medical assistants can be involved in screening and self-management support.

## 2. Population-Focused Care

*The Collaborative Care team is responsible for the provision of care and health outcomes of a defined population of patients.* This may include the use of registries and aggregated data to highlight resource allocation, trends in care delivery, and outcome monitoring. A population-based approach is proactive, reaching out to patients rather than waiting for them to self-identify in an office, and links patients to other clinical or community-based resources as necessary. “Stepped care”, where service intensity is titrated to the degree of patient complexity and response to treatment, is an essential component of population-based care- ensuring that limited specialty resources are applied where they are most needed.

## 3. Measurement-Guided Care

*The team uses systematic, disease-specific, patient-reported outcome measures (e.g., symptom rating scales) to drive clinical decision-making and track treatment response.* Use of measurement based care (MBC, treat to target) using the principles below has been shown to improve treatment outcomes by identifying non-responders through proactive longitudinal follow-up and reducing clinical inertia. In addition, the use of MBC is increasingly required by health plans and accreditation agencies.

### Six components of effective measurement:

- a. Measurement alone is not enough; outcomes must be incorporated into the clinical encounter.
- b. Patient-reported outcomes are more accurate than clinician-reported outcomes.
- c. Measures must be collected frequently to accurately assess the most recent clinical state.
- d. Measures must be tightly correlated to the illness state and are typically diagnosis-specific.
- e. Instruments must be reliable and sensitive to change.
- f. Methods must be relatively simple to implement and low cost.

## 4. Evidence-Based Care

*The team adapts scientifically proven treatments within an individual clinical context to achieve improved health outcomes.* Evidence-based care is most effective when treatment algorithms are standardized and levels of treatment intensification are commonly accepted among practitioners as a standard of care. This “stepped care” approach (see appendix 3) allows for a more rapid application of a treatment intensity framework for individual patients and facilitates the caseload review process and population management. Clinical decision supports, such as treatment guidelines and educational materials for patients, clinicians and CMs, are essential to this work.

## 5. Accountability and Quality Improvement

Successful implementation and ongoing maintenance of an integrated care program requires many new system processes to achieve each of the previously outlined four core elements of the model. From the outset, programs should have a plan for periodically monitoring their success in achieving desired outcome measures as well as monitoring fidelity to the clinical model using process measures. In a constantly changing environment of care, a structured and continuous quality improvement strategy is critical for initial and ongoing success.

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## D-H GUIDELINE ENDORSEMENT STATEMENT

### Scope:

This guideline is intended to support primary care clinicians and behavioral health clinicians embedded in primary care in their efforts to optimally identify, assess, triage and manage adult patients with behavioral health issues in a Collaborative Care Model in the ambulatory setting and to clarify D-H clinical standards for this work.

### Definitions:

**BH-** Behavioral Health (includes mental health and substance use disorders)

**CCM-** Collaborative Care Model

**CM-** Care Manager (i.e. MSW, RN, Behavioral health clinician)

**EHR-** electronic health record

**SUD-** substance use disorder

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## RECOMMENDATIONS FOR D-H IMPLEMENTATION

Specific recommendations in the CCM associated with clinically significant outcomes improvement:

- Regularly scheduled CM supervision by a psychiatrist (i.e., weekly patient caseload review) was significantly correlated with improved outcomes.<sup>5</sup>
- CMs with mental health experience generate better clinical outcomes than CMs from other disciplines.<sup>5-7</sup>
- Physical co-location of the mental health team, while effective, is not critical to the effectiveness of the model.<sup>8,9</sup>

### Potential Benefits:

- Improved recognition and management of BH disorders
- Improved access to BH services
- Reduced fragmentation of care
- Improved patient and clinician satisfaction
- Improved patient outcomes- both behavioral health and physical health

### Potential Harms:

- Added care team time burden of screening lower risk sub-populations and downstream assessment and intervention
- Expanding accountable team risks imperfect hand offs and dropped care components if coordination is not tight

### Costs Considerations

Main costs are personnel: the new roles of care manager/mental health clinician and the consulting or embedded psychiatrist. There will also be costs of training MAs for screening and training nurses without mental health care experience. Implementation studies of behavioral health integration have shown improved quality and reduced costs through decreased healthcare utilization. Four-year analysis of the IMPACT study demonstrated that \$1 spent on collaborative care saved \$6.50 in overall health care costs.<sup>10</sup> Intermountain found sites integrating BH into primary care had overall costs of \$115 per patient per year less than usual care sites, compared to the cost of \$10 per patient per year to implement the program.<sup>11</sup> Effective

January 2017, PCPs can bill Medicare for the services of the behavioral health care manager (with specialized training) and consulting psychiatrist working together in the collaborative care model.<sup>12</sup>

## Implementation Tools

### 1. Clinician Dissemination:

- a. Clinical practice guidelines for the assessment and management of Depression, Anxiety, Unhealthy alcohol and substance use, and Medication Assisted Therapy of Opioid Use Disorder in Primary Care.
- b. Updating existing Preventive Care clinical practice guideline with recommendations for behavioral health screening tools, including frequency and score cut-offs
- c. A primary care clinician “Behavioral Health Playbook” that synthesizes the roles, tasks, workflows and treatment algorithms for the four behavioral health conditions, above.

### 2. Clinical Support:

- a. A “one stop” website to support clinicians in addressing behavioral health issues

### 3. Patient Education and Resources:

- a. D-H internet web-page that summarizes information, self-management support, self-help groups, counseling resources, etc. for all behavioral health disorders

### 4. Behavioral Health Clinician/Case Manager/Nurse-supported Behavioral Health Care:

- a. Care pathways
- b. Training for nurses without mental health care delivery experience

### 5. eDH (EHR) Tools:

- a. Build a behavioral health screening questionnaire in eDH (initial single question screens for depression, alcohol, and SUD triggering more detailed instruments (see appendix 1)
- b. Best practice advisories to alert clinicians to positive screens and offer guidance.
- c. Smartsets offering decision support, ordering efficiency, and patient information and resources

### 6. Clinical Performance Measures (see condition specific guidelines for condition specific outcomes):

- a. Process Measures: percent of patients with new diagnoses of depression, anxiety or SUD enrolled in collaborative care; percent of patients enrolled in collaborative care who are successfully contacted within 4 weeks of enrollment; patient satisfaction, clinician satisfaction, clinician confidence.

## Qualifying Statements

Pathways & Guidelines: Clinical Practice Guideline and pathways are designed to assist clinicians by providing a framework for the evaluation and treatment of patients. This Clinical Practice Guideline outlines the preferred approach for most patients. It is not intended to replace a clinician’s judgment or to establish a protocol for all patients. It is understood that some patients will not fit the clinical condition contemplated by a guideline and that a guideline will rarely establish the only appropriate approach to a problem.

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## APPENDIX 1: Screening Instruments

### Initial Screening Instruments

Condition	Initial Screening Instrument	Frequency
<b>Depression</b>	PHQ-2 <sup>13</sup>	If not done in previous 3 months
<b>Substance Use Disorder</b>	<i>In the past year have you used an illegal drug or used a prescription medication for non-medical reasons?</i> <sup>14</sup>	Once annually (expert opinion)
<b>Alcohol Use Disorder</b>	<i>In the past year have you had 5 (4 for women) or more drinks in a day?</i> <sup>15</sup>	Once annually (expert opinion)

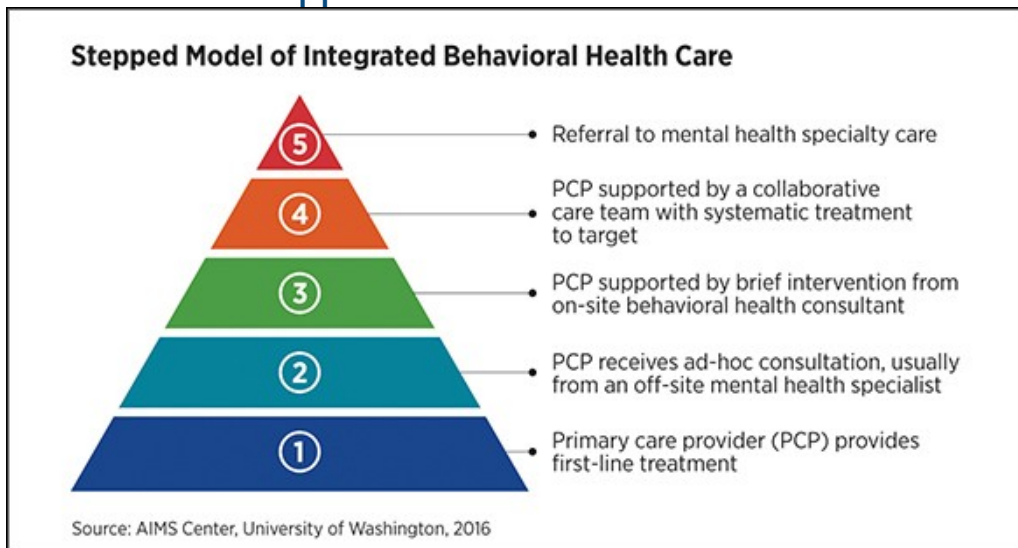
### Secondary Screening Instruments

Condition	Secondary Screening Instrument
<b>Depression</b>	PHQ-2 score $\geq 3$ triggers PHQ-9
<b>Substance Use Disorder</b>	“Yes” triggers DAST-10 <sup>16,17</sup>
<b>Alcohol Use Disorder</b>	“Yes” triggers AUDIT <sup>18</sup>

## APPENDIX 2: Tasks of Collaborative Care

Prepare System	<p><b>Provide System Level Supports for Care</b></p> <ul style="list-style-type: none"> <li>• Establish a Program Vision</li> <li>• Define Population Targeted by Collaborative Care</li> <li>• Choose Tracking Method/Registry</li> <li>• Train Team Members</li> <li>• Provide System Level Supports for Care</li> </ul>
Patient Care	<p><b>Identify and Engage Patients</b></p> <ul style="list-style-type: none"> <li>• Identify People Who Need Help</li> <li>• Screen for Behavioral Health Problems Using Valid Measures</li> <li>• Engage Patient in Integrated Care Program</li> </ul>
	<p><b>Establish Diagnosis</b></p> <ul style="list-style-type: none"> <li>• Perform Behavioral Health Assessment</li> <li>• Identify &amp; Treat Coexisting Medical Conditions</li> <li>• Diagnose Behavioral Health Disorders</li> <li>• Patient Education about Symptoms &amp; Diagnosis</li> </ul>
	<p><b>Initiate Treatment</b></p> <ul style="list-style-type: none"> <li>• Patient Education about Recommended Treatment</li> <li>• Develop &amp; Update Behavioral Health Treatment Plan</li> <li>• Brief Counseling, Behavioral Activation</li> <li>• Prescribe Psychotropic Medications – as indicated</li> <li>• Evidence-based Psychotherapy (e.g., PST, CBT, IPT) – as indicated</li> <li>• Facilitate Referral to Specialty Care or Social Services – as indicated</li> </ul>
	<p><b>Follow-Up Care and Treat to Target</b></p> <ul style="list-style-type: none"> <li>• Track Treatment Engagement &amp; Adherence using Registry</li> <li>• Reach out to Patients who are Non-adherent or Disengaged</li> <li>• Track Patients' Symptoms with Valid Outcome Measures (e.g., PHQ-9)</li> <li>• Track Medication Side Effects &amp; Concerns</li> <li>• Track Outcome of Referrals &amp; Other Treatments</li> <li>• Assess Need for Changes in Treatment</li> <li>• Provide Caseload-Focused Psychiatric Consultation Focused on Non-responding Patients</li> <li>• Adjust Treatment if Patients are Not Responding</li> <li>• Facilitate Changes in Treatment Plan</li> <li>• Provide In-Person or Telehealth Psychiatric Assessment of Challenging Patients</li> </ul>
	<p><b>Complete Treatment and Provide Relapse Prevention</b></p> <ul style="list-style-type: none"> <li>• Assess for Completion of Goals</li> <li>• Create &amp; Support Relapse Prevention Plan</li> <li>• Communicate Plan to Team</li> </ul>
Ongoing System Supports	<p><b>Provide System Level Supports for Care</b></p> <ul style="list-style-type: none"> <li>• Provide Administrative Support for Program (e.g., Scheduling, Resources)</li> <li>• Coordinate Communication Among Team Members/Providers</li> <li>• Engage in Continuous Quality Improvement Efforts, Focusing on Patient Panels (Entire Population Served)</li> </ul>

## APPENDIX 3: Stepped Care Model<sup>19</sup>





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