**NRHI SAN Behavioral Health Integration: Questions and Answers**

\*This document reflects questions asked during Behavioral Health Integration (BHI) learning Modules: Module 1: *Addressing Behavioral Health Issues in Primary Care*, Module 2: *Building Internal Capability,* Module 3: *Care Processes and Connections*, and Module 4: *Measuring and Improving Care for Depression*.

**BHI Clinical and Quality Experts included on the Q&A panel:**

Bruce Block MD, Pittsburgh Regional Health Improvement

Tina Frontera, Minnesota Community Measurement

Tani Hemmila, Institute for Clinical Systems Improvement

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**1. How have practices with limited staffing / resources capacity approached behavioral health integration?**

One option is to focus on one particular patient population as opposed to all patients, for example patients with uncontrolled diabetes, hypertension or COPD. These are patients with high likelihood for depression and the health plans offer payment incentives for improvement in their status.

Another option for getting started is to look at ways to improve the function of your care team: reduce waste (duplication of effort, re-work due to miscommunication, etc.) and delegation of tasks to underutilized office staff (visit pre-work, patient wrap-up, post-visit calls, etc.) These are activities that will enhance care for all patients, not just those with depression. And again, they are the key to achieving better PFP results.

If your practice cannot afford a full-time care manager you should look to share one with other practices, or hire a nurse part-time. Many of the health plans offer care management services that can be applied to your complex patients. Set up local meetings with behavioral health and social service agencies: they have outreach and care management services for eligible patients.

Screening does not require much time if you use patient waiting time in reception areas or the exam room for patients to complete the screen. A small rural health system was able to save 5.66 minutes per visit. As more patients start using your portal, screenings and surveys can be accomplished there.

As a primary care provider, meet with the mental health providers who are available to you and talk about how you can work together more effectively. Mental health providers will respect the fact that you are doing everything you can to identify and care for patients with mental health problems.

Many psychiatrists spend an inordinate amount of time refilling prescriptions for patients that could be taken care of more efficiently in the primary care setting. By developing relationships with mental health providers and using psychiatrists as consultants to support your care, you will need to refer fewer patients to them. Developing relationships with mental health providers can also help your practice to recruit more community psychiatrists in your region.

For additional information check out Module 2: *Building Internal Capability*

In Module 3: *Care Processes and Connections* we list new codes available which can be used to offset the cost of care management and behavioral health integration. You should also look at your E&M coding behavior to make sure you are getting credit for the extra time and breadth of care that comes with behavioral health integration.

**2. What are some team configurations / roles to better manage integration?**

Practices have successfully used RNs, LPNs, MAs, BSWs, MSWs, and peer specialists to take on roles in behavioral health screening and tracking. The key is clear role definition, on-going audit of outcomes and iterative improvement of skills and methods. In a family health center in Pittsburgh, one of the LPNs volunteered to track positive screens as her special care improvement project, the phlebotomist made monthly calls to patients with lapsed care, and the MAs performed depression screening as part of their rooming function. Regular team meetings were held to evaluate progress and solve new problems.

**3. When practices are thinking about how they are measuring their efforts, what are some ways practices can measure and report their behavioral health integration efforts?**

Patient success stories can be a great form of data and can also help garner initial engagement with physicians. Compare your outcomes with other practices using national benchmarks and health plan data. In a practice in Pittsburgh, they used the increase in number of patients with a depression diagnosis, number of visits with a depression code, and change in PHQ-9 scores. They also looked at co-morbidity outcomes such HbA1c, BPs, and LDLs.

Another method in Pittsburgh was to use quality circles to look at how patients were doing with chronic diseases, such as hypertension, COPD, etc. They used their EHR to identify patients with worrisome results who were not responding to repeated advice. In Pittsburgh they began to understand that these patients were not engaged in self-care. Depression and PTSD screening were positive in most of these patients. Changes in PHQ-9 and GAD-7 scores as well as chronic disease markers were correlated with increased use of behavioral and pharmacologic interventions.

In Module 2: *Building Internal Capability*, we list the clinical quality measures related to mental health and substance use care; reports for these measures are built into your EHR. Contact your EHR vendor for assistance in configuring and activating them.

**4. How can we measure collaboration and success with behavioral health agencies?**

We continue to face obstacles to transferring information between mental health and traditional medical care. The Transition of Care reports built into the EHR can be used to track and improve sharing of records. The behavioral health agency’s data can also be used to meet the reporting needs of the primary care practice.

The Suite of Depression Care measures discussed in Module 4: *Improving Care for Depression*, can be measured by both mental health practitioners or primary care practitioners and data can be received from both. If there is a mental health provider working with a primary care provider, the mental health provider can perform their care, communicate with the PCP and the PCP can then administer the PHQ-9 on a follow-up visit. You can measure the patient’s progress through this partnership and the mental health provider does not need to be the administering entity of the PHQ-9.

**5. Understanding that the Depression Care suite of measures focus on patients with a diagnosis – how can these measures impact a population health/screening improvement?**

Identifying and effectively treating depression improves engagement. Engagement is one of the biggest obstacles to achieving quality outcomes. There is no doubt that quality outcomes are an important effect of treating depression. Studies have shown that even the outcomes of cardiothoracic surgery improved by treating depression—the whole aspect of recovery and healing that is necessary for many treatments is markedly improved when people can overcome their depression.

For that reason, many practices have instituted regular depression screening to identify patients who do not have a depression diagnosis but did have complex health care needs. Initially in Pittsburgh it was decided that screening should be initiated by the physicians, but they performed screening only about 30% of the time. They then switched the responsibility to the MAs doing the rooming of patients. They were able to achieve and sustain a screening rate of over 95% for all visits to our residency-based Family Health Center. As a result, in Pittsburgh they nearly doubled the number of patients diagnosed with a major depression disorder in their practice. They then used the EHR to track these patients using the same measures discussed by the Minnesota Community Measurement.

New billing codes now support payment for annual depression screening and PQRS (soon to be MIPS-Quality) measures provide the means to review the performance of such screening using your built-in EHR reports.

**6. What specific action steps can folks supporting practices be thinking about to help practices do this work / what questions could they help practices consider?**

Go and talk to the practices. The clinical staff in practice will have some idea about impacts on their practice. Finding out what the practice is seeing as a problem in their practice/community is a good way to get the practice engaged, and a good place to start. [The Kennedy Forum resource](https://thekennedyforum-dot-org.s3.amazonaws.com/documents/KennedyForum-MeasurementBasedCare_2.pdf) is a nice way of outlining how this work is important to do nationwide. This resource will help knowing what questions to ask practices. Patients often visit pharmacies frequently, so having a community pharmacist as part of the care team can be helpful to understanding how a pharmacist might be engaged in understanding this work and helping move this forward.

It’s important to understand that these practices do care about the mental health of their patients but most had no residency training to support enhanced services. And many of us can still remember when our claims would be denied if we listed depression as the reason for the visit.

We cannot expect clinicians to diagnose disorders for which there are no care resources. Encourage resource lists and direct relationships with behavioral health and social service agencies. As a practice facilitator, you may be able to arrange meetings that bring together important members of the health care community.

**7. Have there been any developments for depression prevention incorporated into care planning?**

Many of the risk factors for depression could be identified by practice-based searches of the patients’ diagnosis codes, but, so far, few practices enter information about the social determinants of health (SDOH). Adler and Stead, *Patients in context—EHR Capture of social and behavioral determinants of health, N Engl J Med, N Engl J Med 2015; 372:698-701* offer some helpful suggestions from the Institute of Medicine.

Addressing SDOH in primary care settings requires integration efforts similar to those we have discussed with behavioral health issues. DeVoe et al, *Perspectives in Primary Care: A Conceptual Framework and Path for Integrating Social Determinants of Health into Primary Care Practice AnnFamMed vol. 14, no. 2, March/April 2016* outline this approach along with an excellent bibliography.

The interventions to influence SDOH require connections to social service and behavioral health agencies which we discussed briefly in module 3: Care Processes and Connections. Taylor et al. provided a very helpful review (<http://bluecrossfoundation.org/publication/leveraging-social-determinants-health-what-works>) of effective programs for common health problems, including for depression prevention.

**8. How do you know which screening tool to use for depression- the Patient Health Questionnaire (PHQ-9) or the Generalized Anxiety Disorder (GAD- 7), and how should PTNs work with practices to implement screening tools?**

Begin by sharing the importance of screening and the evidence that we know screening works. There are some capabilities that must be developed in preparation- for example quality improvement, care management, and understanding of mental health issues. It’s important that a practice has a relationship with a mental health agency prior to integrating behavioral health into practice.

When the practice has completed this groundwork, the best place to start is often depression. Tools for depression are well developed and from the clinician’s point of view this issue can feel most like other medical care that is practiced routinely. The PHQ-2 and PHQ-9 have been validated for assistance in diagnosis and for assessing progress of treatment. They can be self-administered, done over the phone, or in the office. In Pittsburgh, they use Medical Assistants to ask the 2 question screen then have them provide the patient with a clipboard and the PHQ-9 to fill out while waiting for the provider (if the PHQ-2 is positive). The GAD-7 is a screen for anxiety disorders, not depression. It also has been validated widely.

Some practices start by using the Screening, Brief Intervention and Referral to Treatment (SBIRT); for clients 18-30 years old, drug and alcohol screening may be the most important place to start. A lot of practices that start with depression choose not to start with universal screening, but instead focus on screening patients with chronic disease or complex patients. Screening complex patients can be the most cost effective.

For specific how to information: check out Module 2: *Building Internal Capability*

**9. What is some advice on engaging providers who might not see the benefit of integrating behavioral health?**

Don’t pose it as another project. Pose it as something that will provide physicians help in taking care of their patients. Connect behavioral health integration to the physician’s own ideals—these are patients that providers are already taking care of and may not be getting the outcomes they want. For instance, the screening techniques for depression identify many patients with primarily somatic complaints who have been refractory to purely physical interventions.

Beginning to provide care for behavioral health issues is going to enable providers to be more successful. It will also increase reimbursement by reducing unnecessary and costly care when shared savings becomes a reality.

For additional information check out Module 1: *Addressing Behavioral Health Issues in Primary Care*

**10. Shared perspective on experiences with practices in the field- Conversation with Bruce Block and Tani Hemmila- How do you get physicians to start screening for substance use / alcohol and treating mental health / chemical health needs in primary care and dealing with discomfort in addressing these issues in primary care practices?**

Start by educating providers about mental health and chemical health use, specifically the impact on health outcomes and the impact on emergency department use. The majority of emergency department readmissions are related to mental health / chemical health use.

To increase providers comfort level in screening, start by addressing the questions providers have about treating these patients.

In experience, once you get started with screening you may find things out about patients you have been working with for years that you didn’t know about.

In the Compass project, when focusing on depression treatment it was found that the frequency of care manager contact did have correlation with health outcomes. Patients with complex needs are often disengaged with the health system. Two important system issues were uncovered- 1) The regular system isn’t working for these complex patient patients; 2) Care managers were being encouraged to contact patients with depression just three times and were then encouraged to take the patients off their panels. It was quite clear that the phone calls were quite important and what really made a difference in outcomes for patients, so the system was changed.

In the Compass work, randomized controlled trials about collaborative care showed that having a care manager background did not correlate with outcomes. In Minnesota, there are many clinics who use Medical Assistants as coordinators. It’s important to find the right fit for your system, as well as the patient population. Someone who is oriented to community based care and chronic needs of patients is a good person to start with. It’s also important to support the staff who are taking on these new roles.

**11. When looking at addressing specific challenges to integrate behavioral health into primary care, what is some advice for working with providers who may believe that certain types of patients do or don’t have alcohol and / or substance abuse problems?**

A number of years ago a law in Florida required all prenatal patients to do drug testing—it was found that about 1 in 5 patients had evidence of consuming a substance. These patients did not fit into one category; they were across the board. That was a big surprise to everyone. We often underestimate what’s going on. The current opioid epidemic is a case in point. The [SBIRT programs](http://www.sbirttraining.com/) have been shown to work. They Identify people who need treatment, and identify people with rising risk. Addressing these people early on can produce positive health outcomes.

**Resources:**

Additional Behavioral Health Integration resources, include Behavioral Health Integration Module slide decks and recordings can be accessed through the [NRHI SAN online community](https://nrhisan.healthdoers.org/communities/community-home/librarydocuments?communitykey=a6b60c69-5d3b-4635-89bd-52582bca9d19&tab=librarydocuments).