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Integrated Behavioral Health Medical Management

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Abstract

The general purpose of this article is to inform our peers about the integration of Behavioral Health Care into Medical Management in a Patient Center Medical Home.

1. The specific purpose of this report is to provide details of the work flow we have planned and implemented to accomplish this objective; with the hope that others in a variety of settings will attempt to customize this model to meet their patient needs and facilitate the work of their staff in order to enhance the quality of integrated care.

2. It is important to have a behavioral management plan because it introduces both structure and acts as a tool to monitor the many facets of a patient's care that may be affected by the use of controlled substances. In order to provide the highest level of care each provider must be aware of current happenings as well as all practicing within the same guidelines. This will help to ensure that each patient is receiving the highest level of care with the least invasive and potentially dangerous measures.

3. With this goal in mind, perhaps one of the simplest ways to ensure this is to show the utmost respect for each patient and what they are currently struggling with. This must be recognized and delivered by each part of the healthcare team that interacts with the patient. This includes but is not limited to the receptionist, medical assistant, nurse, medical doctor, therapist, and psychiatrist.

Keywords: Behavioral health; Impairments; Mental illness

Introduction

I am a Medical assistant [NF] who had been working alongside of Dr. Manohar during the summer months 2014; during this time, we have discovered a unique model of care for the patients we serve. Below you will find this work flow that has been followed to ensure each patient receives comprehensive and integrated care that we are proud of. We have found that by following these steps we are improving patient care, compliance, and adherence. As outlined by Psychiatry.org/integratedcare's website, integrated care is defined as: care from a team of primary care and behavioral health clinicians, working together with patients and families, providing patient-centered care. The above website later goes onto explain that 77.5 million people in America have a diagnosed mental disorder or substance abuse disorder each year; but only 38% of these adults and 20% of these children receive the needed treatment. "In 2014, expenditures on mental health and substance abuse treatment are projected to reach an astonishing $239 billion". "Long-term analysis has demonstrated that $1 spent on one model of integrated care saves $6.50 in health care costs". This adds up to an estimated $26-48 billion savings.

One of our concerns regarding nursing and overall medical care is the treatment of woman in the 25-55 year age group that present with pain and are prescribed opioids. This is important to us because there are reports stating that 29-39% of woman in this age group have filled an opioid prescription in a pharmacy between the years of 2008-2012. (Washington post (2015), New York times (2015), CBS News (2015), Modern Healthcare (2015), and Milwaukie Journals Sentential (2015). These sources discuss the risks of prescribing opioids within this age group.

Throughout this document, the words "opioid" and "narcotic" are used interchangeably, and both are included in the term "controlled substance." A "controlled substance" is any medication regulated by the Controlled Substance Act (CSA) (See Appendix 1). This policy applies to all long term use of Scheduled drugs that may be prescribed and have high abuse potential (II, III, IV and V); According to Community Health Centers policy and procedures.

Our policies for the use of controlled substances for the treatment of pain are in compliance with Joint Commission as well as the Statement of the Connecticut Medical Board on the Use of Controlled Substances; that was drafted by one of the authors. We also follow the guidelines set forth by PSAP and their guidelines of Pain Management in Patients with Substance-Use Disorders. This outlines the guidelines of treatment to manage withdrawal, prevent relapse, provide effective analgesic, effective treatment of opioid dependence, treatment of co-occurring psychiatric and medical disorders, and effectively treat anxiety.

What is Our Model for Integrated Behavioral Health Medical Management?

We want to present the information on this evolutionary and innovative model in a conversational Q and A format.

The below workflow was designed and implemented in the environment of a Patient Centered Medical Home by a Psychiatrist and

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Medical Assistant working as a team. Since all of our patients have a medical provider within the health center, the implementation of this design we communicated closely with primary and mental health providers before and after or time with each patient to determine when and if certain interventions should be made; these may include: EKG, pill counts, frequency of the UTox, liver function test (LFT), and other bloodwork. It should be noted that a pregnancy could and will be done by the psychiatrist before the start of and controlled or psychotropic medication. The two authors are able to look at past medical records to determine if there are any health risks such as renal, hepatic, or metabolic abnormalities. We are also able to determine if levels of Depakote, Lithium, or Depakote were obtained and if these are at a therapeutic level and then to create a call back if these need to be repeated via the patients PCP. There are several occasions we are able to link with a therapist and primary care to discuss the outstanding health issues and any pending labs that may need to be addressed. Both of the authors have responded to the PCP or therapists request to follow-up with lab results. This has also been very effective in increasing the patient's compliance. One important area that we work closely with primary care providers is potential drug-drug interaction and adverse reactions of prescribed drugs within the circumstances of their current health profile.

With each patient receiving care across the disciplines, it increases the encounters a care provider has the opportunity to observe a potential adverse reaction(s) to treatments or a decline in the patient's conditions; thus leading to an intervention more frequently and effectively.

4. We would like to remind the reader that this all stems from a larger policy regarding behavioral health and was further tuned to create a workable and effective flow. We would encourage the reader to research the guidelines within their facility and add upon that to provide the highest level of care to each patient in order for the patient to enhance their ability to manage their illness, reduce the impairments that can lead to future accomplishments of social, education, vocational, and health goals.

In our treatment model we refer to use the phrase co-occurring disorder or co-morbidity opposed to dual diagnosis because a individual will commonly have more than two disorders that are being treated concurrently. The patient centered home models offers the opportunity to effectively address all of the health concerns concurrently. These terms are use when an individual has a mental illness simultaneously with substance abuse or another medical condition; this can include hypertension, and diabetes. We think it is important to identify and treat these co-occurring disorders congruently because:

Co-occurring disorders are very common in a health center population.

Greatly shortens life expectancy. For example, persons with severe and persistent mental illness has a shortened life expectancy by 25 years.

Severely interferes with compliance with care plan and compliance with medication regimen with worsening prognosis.

Therefore there are sharp increases in complications, relapses, hospitalizations, and disability resulting in extremely high, per-capital cost of treatment without corresponding added benefit.

SAMHSA has Proposed a Continuum Comprises of Nine Domains which Include

- Health Homes
- Prevention and Wellness Services
- Engagement Services
- Outpatient and Medication Assisted Treatment
- Community Supports and Recovery Services
- Intensive Support Services
- Other Living Supports
- Out of Home Residential Services

Acute intensive services

The integrated treatment in the PCFMH supports the efforts of the authors and others in the Treatment Teams in the CHC have the capacity to identify the needs of persons with Severe and Persistent mental illness, to make referrals and support the efforts of patients and their community based care givers including hospitals and specialist to achieve their rehabilitation goals during the recovery process.

How Do you Prepare for Each Patient Visit?

Each evening the MA goes through the next day's schedule and determines what is needed for each visit; i.e. Blood work if the patient is on Depakote, Tegretol, or Lithium, A UDS or SDS, and finally if they are due for a new Medication Agreement.

A Urine Drug Screen (UDS) is a drug screening we use that test for 10 controlled substances. These include:

- Amphetamines
- Methamphetamines
- Barbiturates
- Benzodiazepines
- Marijuana
- Cocaine
- Opiates
- Phencyclidine
- Methadone
- Propoxyphene

If this were to be contested by the patient or provider we would then request either a random serum drug screen or that a gas chromatography/mass spectrometry (GC MS) be run on the urine sample. A serum drug level may also be requested if the sample is obviously tampered with; i.e. diluted in color or below or above the bodies average temperature of 98.6 degrees Fahrenheit.

Natalena puts into the virtual yellow "stickies" [in the HER of each patient]what we should be doing with tomorrow's patients by way of signing contracts (med agreements) and ordering different types of tests, doing med reconciliation with their bags of meds and doing pill counts. So the next day there is as smooth a work flow as possible without damaging the therapeutic alliance with me or the therapist or CHC.

The next morning, the MA and prescriber will huddle to go through what has been determined as outstanding for each patient. Two eyes are always better than one!

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We also contact PCP'S in CHC who are prescribing controlled meds to find out if we should perform an UDS during my visit or should we let them handle it.

We also coordinate with therapists and PCPs in the whole site to facilitate tests for CBC. LFTs. TSH, UA's (for Lithium) which we order for BH patients on their meds mentioned above. With more people becoming aware of this TX integration effort there is an augmentation of the commitment to work on the review of the needs for testing and renewing the Medication agreements etc. Some PCPs have mentioned this benefit of the BH Integrated TX initiative.

We have to huddle also about the patients who need to be advised not to take the AM doses of meds because we need to test for the levels of lithium or Tegretol or Depakote the next day. These levels plus the results of BMP, LFT and CBC will inform me better if:

1. An additional med if necessary can be used relatively safely
2. If the doses of these drugs need titration up or down.

The next morning, the MA and prescriber will huddle to go through what has been determined as outstanding for each patient. Two eyes are always better than one!

What Do you Ask of the Patient?

Yearly UDS, more if clinically indicated.

Yearly "Controlled Medication Agreements" must be signed by the patient and Physician.

In regards to the UDS, we will obtain a SDS from the lab located on the lower level of the facility. When the patient has completed said test they may then return to retrieve their Rx for the controlled medication.

What is your Role as the MA in this Integrative BH Medical Management Model?

For patients currently on controlled medication the prescriber and the MA will complete random pill counts throughout the year. The patient is called the morning of the appointment and requested to bring in all medications in their bottles. This is done with short notice to keep any illegal activity to a minimum.

Patients are also handled in the best manner possible by all staff involved; this is to avoid they client feeling as though they are being judged or suspected of anything less than what is expected and outlined in the contracts.

With new strict regulations about confirming controlled substance prescriptions sent by fax we have to call each pharmacy with each script and or make arrangements to print it on blue paper and hand to patients in the session or by leaving it on II floor dispensary for them to pick it up.

What Do you Do when a Patient will not Submit a Urine Sample?

For those people 6, who are unable to provide a urine sample when requested, we have to order blood tests. We do this also when people report the urine container fell into the toilet as it was being flushed and the sample is gone or those who hand over a cold or completely water like sample.

Do you Do Anything during the Interim Interval between the UDS Tests and Yearly Contracts?

Between the UDS, SDS, and pill counts we are already seeing the benefits. Patients are sharing this with other prescribers and peers. We believe this is helping the adherence to the safest standards in regards to controlled substances.

We are breaking new ground by doing the routine medication agreement and urine drug screen and med reconciliation and identifying real confusion and compliance issues. We never expected all the developments enumerated. Patients and other staff members have responded favorably. For the most part almost always patients don't feel we are like entomologists pinning the bugs they wish to study on a board with pins. They get over their misgivings during the visit with Natalena and me.

Future directions: To de determined by data collection and analysis. I wonder if IT can identify the occurrence of out of range results and improvements over time. It is important for Natalena and me to determine if all this is for naught or is it adding value to the treatment process and ultimately benefiting patients by the sentinel effect and the Hawthorne phenomenon.

Perhaps one of the greatest accomplishments of this project was the integration and collaboration between providers across the board. Not only did we work closely with the medical and behavioral providers within CHC to facilitate testing they had ordered or on medications otherwise prescribed by them. As well as with providers within the community, i.e. sleep lab, IOP (intensive outpatient services, etc.)

In the future the practice of including a patient's support network should become routine. If family members are educated they can be a vital link in breaking the cycle of stigma that is often associated with mental illness as a whole. With family, patient, and their healthcare workers working as one, there is a higher chance of successful treatment.

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