

Treating and Managing Behavioral Health Conditions

Primary Care Provider Toolkit



““ *Overwhelming evidence indicates that mental health problems are common but often go under-recognized in primary care settings, they compromise the quality and outcomes of treatment for physical health conditions, and appropriate mental health treatment can alleviate these impediments to well-being. National studies estimate that, during a 1-year period, up to 30 percent of the U.S. adult population meets criteria for one or more mental health problems.*””¹

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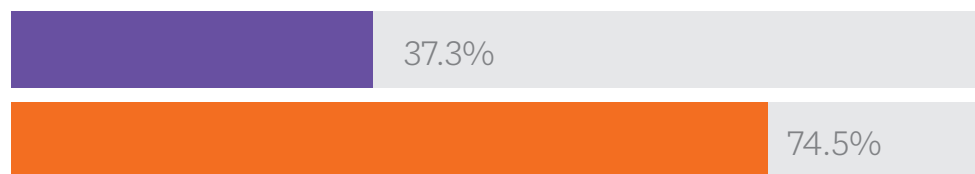
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Overview



Research indicates that in recent years the role of the primary care physician (PCP) has expanded such that PCPs are also becoming the primary psychiatric care physician (PPCP) for a considerable number of their patients.

From 1987 to 1997, the percentage of patients who received psychiatric medication from PCPs increased from 37.3 percent to 74.5 percent.²



The expanding role of primary care physicians is likely due to shortages of mental healthcare providers and the patients' reluctance to access prescribing behavioral health providers (BHPs), such as a psychiatrist, due to the stigma that society has assigned to this and/or higher copays often associated with seeing a specialist.

With the development of safer psychotropic medications, PCPs may feel more comfortable with treating psychiatric disorders. In the medical field, there is an increased awareness that psychiatric disorders are medical problems requiring medical treatment such as medication.

Finally, with easier public access to electronic information, patients have become more knowledgeable about psychiatric conditions and treatments and may be more willing to seek treatment.³

THE FACTS

- > Mood and anxiety disorders occur in about 20–25 percent of patients in mixed-income clinics
- > Among low-income clinics, as many as 50 percent of patients have mood and anxiety disorders.
- > Behavioral health conditions are the second-largest cause of disease burden and disability worldwide.
- > In patients who have chronic medical illnesses such as diabetes, arthritis, and chronic pain, mental health problems are two to three times more common.⁴
- > There is a growing body of evidence to suggest that treatment outcomes are worse for those with untreated or undertreated mental health disorders.

CHALLENGES

- > Many individuals suffering from mental health problems are being treated by their PCP, and the numbers are rapidly growing.

- > When mental illness is recognized in the primary care setting, it is not always adequately diagnosed, treated, followed, or monitored, as other medical conditions are often more clearly evident or more easily recognized.
- > Referrals from primary care to specialty mental health providers are often not completed.
- > Both medical and behavioral health conditions should be treated for optimal health.

THE GOOD NEWS!

PCPs can provide effective treatment for mild to moderate mental illnesses by following evidence-based protocols to identify and monitor conditions and coordinate with BHPs when indicated.

Patients prefer receiving treatment from their PCP for mild to moderate behavioral health conditions and are more willing to return for follow-up.



Behavioral Conditions Commonly Treated in the PCP Setting⁵



Anxiety

Anxiety disorders are one of the most common types of mental disorders.⁶



- > Usually develops in childhood and persists into adulthood
- > An estimated 40 million adults in the U.S., or 18 percent, have an anxiety disorder⁷
- > Excessive fear (emotional response to a real or perceived threat) or anxiety (anticipation of a future threat) that impacts daily functioning

TYPES OF ANXIETY DISORDERS INCLUDE:



Generalized Anxiety Disorder



Social Anxiety Disorder



Panic Disorder



Separation Anxiety Disorder



Elective Mutism

Generalized Anxiety Disorder: Excessive anxiety and worry (apprehensive expectation) occurring more days than not for at least six months about a number of events or activities.

Social Anxiety Disorder, Social Phobia, Agoraphobia and Specific Phobia: Fears in excess of real danger or threat that typically lead to avoidance of situations that may trigger those fears.

Separation Anxiety Disorder: Anxiety and fear atypical for one's age level over separation from people and places to which he/she has a strong attachment.

Panic Disorder: Symptoms include pounding heart; sweatiness; a feeling of weakness, faintness, or dizziness; numbness or tingling; or feeling flushed or chilled. There can be chest pain or smothering sensations, a sense of unreality, a fear of impending doom, or loss of control. The person may genuinely believe they are having a heart attack or stroke, losing their mind, or on the verge of death. There must be either persistent concern about the implications of the attack or a significant change in behavior as a result of it.

Elective Mutism: An unwillingness to speak in specific situations due to overwhelming anxiety.

TREATMENT FOR ANXIETY

In addition to maintaining good nutrition, getting routine exercise, active community involvement, and good sleep hygiene, various forms of counseling include:

- 1. Cognitive behavioral therapy (CBT)** - a form of therapy, well established and highly effective, that focuses on identifying, understanding, and changing thinking and behavior patterns.
- 2. Stress and relaxation techniques.**
- 3. Acceptance and commitment therapy (ACT)** uses strategies of acceptance and mindfulness to cope with unwanted thoughts and feelings.
- 4. Medication.** please refer to page 9 Medications used to treat anxiety and/or depression.

Treatment usually consists of a combination of pharmacotherapy and/or psychotherapy.⁸ It is important to remember that medications work differently in different people and need to be prescribed and monitored by appropriate medical personnel.





Depression⁹

Depression is another one of the most common behavioral health disorders in the US, yet, even the most severe cases are often treatable. A self-assessment score greater than 9 using the Physician Health Questionnaire-9 ([PHQ-9](http://www.phqscreeners.com/sites/g/files/g10016261/f/201412/PHQ-9_English.pdf)) would typically call for action. Treatment is most effective when it is started as early as possible and includes psychotherapy and medication for moderate to severe cases. Follow this link to view the PHQ-9: http://www.phqscreeners.com/sites/g/files/g10016261/f/201412/PHQ-9_English.pdf



Depression can happen at any age. Children with depression may present with symptoms of irritability rather than low mood. Risk factors include family history of depression, major stress or trauma, and specific physical illnesses and medications.

TYPES OF DEPRESSION INCLUDE:



Persistent Depressive Disorder



Perinatal Depression



Psychotic Depression



Seasonal Affective Disorder



Bipolar Disorder

Persistent depressive disorder (formerly known as dysthymia): Depressive mood that lasts at least two years in adults and one year in children and adolescents. Sometimes mixed with episodes of major depressive disorder (MDD) along with periods of less severe symptoms.

Perinatal depression: More than just the “baby blues,” which normally goes away two weeks after delivery. Women with perinatal depression have a full blown MDD with feelings of extreme sadness, anxiety, and exhaustion that interfere with caring for themselves or their babies.

Psychotic depression: This occurs when a person has both psychosis and severe depression. It typically requires referral to a psychiatrist.

Seasonal affective disorder (SAD): Onset occurs when there is less sunlight and generally lifts during spring and summer. Symptoms include increased sleep, weight gain, and social withdrawal. This disorder predictably returns each winter.

Bipolar disorder: Although this disorder is different from depression, people with bipolar disorder can experience extreme episodes of depression in addition to manic or hypomanic episodes.

TREATMENT FOR DEPRESSION:

- > **Cognitive behavioral therapy (CBT):** a form of therapy, well established and highly effective, that focusses on identifying, understanding, and changing thinking and behavior patterns.
- > **Acceptance and commitment therapy (ACT):** uses strategies of acceptance and mindfulness to cope with unwanted thoughts and feelings.
- > **Stress and relaxation techniques.**
- > **Medication.**
- > **Bright light therapy:** Also known as phototherapy, is now commonly prescribed for individuals experiencing SAD. ¹⁰

MEDICATIONS USED TO TREAT ANXIETY AND/OR DEPRESSION:

Medication Class	Medication Names
SSRI (Selective Serotonin Reuptake Inhibitors)	<ul style="list-style-type: none">> Citalopram (Celexa)> Escitalopram (Lexapro)> Fluoxetine (Prozac)> Paroxetine (Paxil)> Sertraline (Zoloft)> Fluvoxamine (Luvox)
Novel Serotonergic Agents	<ul style="list-style-type: none">> Viibryd, Trintellix
SNRIs (Serotonin-Norepinephrine Reuptake Inhibitors)	<ul style="list-style-type: none">> Venlafaxine (Effexor)> Duloxetine (Cymbalta)> Desvenlafaxine (Pristiq)
Dopamine Norepinephrine Reuptake Inhibitor	<ul style="list-style-type: none">> Bupropion (Wellbutrin, Forfivo, etc.)
Benzodiazepines	<ul style="list-style-type: none">> Alprazolam (Xanax)> Clonazepam (Klonopin)> Lorazepam (Ativan)
Tricyclic Antidepressants	<ul style="list-style-type: none">> Amitriptyline (Elavil)> Imipramine (Tofranil)> Nortriptyline (Pamelor)

Though all patients may experience thoughts of suicide with the initiation of treatment, children and young adults under the age of 25 are more likely to do so when taking antidepressants, especially during the first six weeks of treatment. It is important to monitor pediatric patients on antidepressants for this reason.



MEDICAL IMPLICATIONS

- > Screen for suicide, as appropriate - energy levels may improve before mood symptoms resolve, increasing the risk of suicide.
- > Provide ongoing close psychiatric follow-up.
- > Screen for metabolic syndrome given that antidepressant medications are associated with weight gain and metabolic abnormalities.
- > Discuss possible medication side effects with patient. (Per patient satisfaction surveys, members frequently say they were not told about side effects by prescribing provider.)



MEDICAL MANAGEMENT

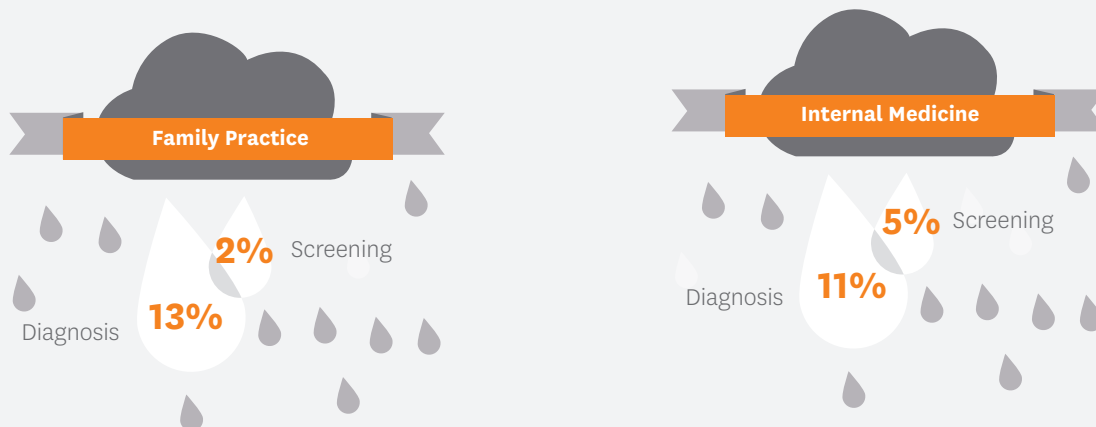
Emphasize the importance of staying on medication for at least six months, as recommended by the National Committee on Quality Assurance (NCQA). Depending upon the severity and frequency of the depressive episodes, many individuals may benefit from longer-term or lifetime treatment with antidepressants. The Health Net HEDIS team measures and reports two phases of medication adherence per NCQA:

- 1. Acute Phase.** Members who stay on medication for at least 12 weeks.
- 2. Continuation Phase.** Members who stay on medication for at least six months.

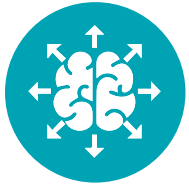
Frequent and regular follow-up is important when antidepressants are started or after any adjustments.

Analysis of National Ambulatory Medical Care Surveys reveals that despite the high prevalence of depression in primary care (10 to 12 percent), screening is extremely low at 2 to 4 percent (see the graphic below from the American Academy of Family Physicians).

Percentage of visits with depression diagnosis and screening



Cherry DK, et al. National ambulatory medical care survey: 2006 summary. *Adv Data.* 2008;(3):1-39.



Childhood Attention-Deficit/Hyperactivity Disorder (ADHD)¹¹

A persistent pattern of inattention that includes impulsivity and inappropriate, excessive motor activity preventing the ability to stay on task, complete tasks, and interact with other children. There is a high degree of inheritability for ADHD.



According to the Centers for Disease Control and Prevention, the prevalence of ADHD among children in 2011 was approximately 11 percent.¹²

THE AMERICAN ACADEMY OF PEDIATRICS HAS PUBLISHED GUIDELINES INCLUDING THE FOLLOWING BROAD ACTION STATEMENTS:¹³

1. The primary care clinician should initiate an evaluation for ADHD for any child 4 through 18 years of age who presents with academic or behavioral problems and symptoms of inattention, hyperactivity, or impulsivity (quality of evidence B/strong recommendation).
2. To make a diagnosis of ADHD, the primary care clinician should determine that current Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria have been met (including documentation of impairment in more than one major setting). Information should be obtained primarily from parents or guardians, teachers, and other school and mental health clinicians involved in the child's care. The primary care clinician should also rule out any alternative cause (quality of evidence B/strong recommendation).
3. In the evaluation of a child for ADHD, the primary care clinician should assess for other conditions that might coexist with ADHD, including emotional or behavioral (e.g., anxiety, depressive, oppositional defiant, and conduct disorders), developmental (e.g., learning and language disorders or other neurodevelopmental disorders), and physical conditions (e.g., tics, sleep apnea) (quality of evidence B/strong recommendation).
4. The primary care clinician should recognize ADHD as a chronic condition and therefore consider children and adolescents with ADHD as children and youth with special healthcare needs. Management of children and youth with special healthcare needs should follow the principles of the chronic care model and the medical home (quality of evidence B/strong recommendation).

TYPES OF ADHD INCLUDE:



Predominantly Hyperactive/Impulsive



Predominantly Inattentive



Combined Hyperactive/Inattentive

Predominantly hyperactive/impulsive: Hyperactivity may be defined by fidgeting or squirming, excessive talking, running about, or difficulty sitting still. Impulsive children may be impatient, blurt out answers to questions prematurely, have trouble waiting their turn, frequently interrupt conversations, or intrude on others' activities.

Predominantly inattentive: Children may have trouble paying close attention to details, make careless mistakes in schoolwork, be easily distracted, have difficulty following through on tasks (such as homework assignments), or quickly become bored with a task.

Combined hyperactive/ inattentive: Display behaviors of hyperactivity/ impulsiveness and inattentiveness.

TREATMENTS ADHD:

- > ADHD is most effectively treated with a combination of medication and counseling.
- > Prescription stimulants are the most widely used medications to treat ADHD. Seventy to eighty percent of children with ADHD show improved attention span, reduced impulsivity, and improved on-task behavior while taking stimulant medications.¹⁴
- > Provide practical assistance, like:
 - helping a child organize tasks or completing schoolwork (teaches a child how to monitor his or her own behavior).
 - helping a child control anger or think before acting.
- > Laying out clear rules, chore lists, and other structured routines to help a child control his or her behavior.

Symptoms vary depending on the type of ADHD disorder, but include:

- > Makes careless mistakes
- > Has difficulty sustaining attention
- > Does not appear to listen
- > Struggles to follow through on instructions
- > Has difficulty with organization
- > Is easily distracted
- > Is forgetful in daily activities
- > Fidgets with hands or feet or squirms in chair
- > Runs around or climbs excessively
- > Has difficulty engaging in activities quietly
- > Talks excessively
- > Interrupts or intrudes upon others

TREATMENTS FOR CHILDREN WITH ADHD:

For preschool-aged children (4–5 years of age), the primary care clinician should prescribe evidence-based parent and/or teacher-administered behavior therapy as the first line of treatment (quality of evidence A/strong recommendation) and may prescribe methylphenidate if the behavior interventions do not provide significant improvement and there is moderate-to-severe continuing disturbance in the child’s function. In areas where evidence-based behavioral treatments are not available, the clinician needs to weigh the risks of starting medication at an early age against the harm of delaying diagnosis and treatment (quality of evidence B/ recommendation).

For elementary school-aged children (6–11 years of age), the primary care clinician should prescribe U.S. Food and Drug Administration–approved medications for ADHD (quality of evidence A/strong recommendation) and/or evidence-based parent- and/

or teacher-administered behavior therapy as treatment for ADHD, preferably both (quality of evidence B/ strong recommendation). The evidence is particularly strong for stimulant medications and sufficient, but less strong for atomoxetine, extended-release guanfacine, and extended-release clonidine, in that order (quality of evidence A/strong recommendation). The school environment, program, or placement is an integral part of any treatment plan.

For adolescents (12–18 years of age), the primary care clinician should prescribe U.S. Food and Drug Administration–approved medications for ADHD with the assent of the adolescent (quality of evidence A/ strong recommendation) and may prescribe behavior therapy as treatment for ADHD (quality of evidence C/ recommendation), preferably both.

The primary care clinician should titrate doses of medication for ADHD to achieve maximum benefit with minimum adverse effects (quality of evidence B/strong recommendation).



MEDICATIONS FOR ADHD:

Medication Class	Medications	Medication Notes
Stimulants	<ul style="list-style-type: none"> > Amphetamines (Adderall, Adderall XR, Adzenys XR-ODT) > Dexmethylphenidate (Focalin, Focalin XR) > Lisdexamfetamine (Vyvanse) > Methylphenidate (Concerta, Daytrana, Ritalin) > Dexedrine, Dextrostat 	These medications are well tested and have been used for a long time, especially for children who have a hard time at school, work, or home.
Nonstimulants	<ul style="list-style-type: none"> > Atomoxetine (Strattera) > Clonidine hydrochloride ER (Kapvay) > Guanfacine (Intuniv) ER 	Increases the amount of norepinephrine in the brain and helps to lessen hyperactivity and impulsive behavior.
Antidepressants	<ul style="list-style-type: none"> > Venlafaxine (Effexor) > Duloxetine (Cymbalta) > Desvenlafaxine (Pristiq) 	May be prescribed for children and teens with mood issues.



MEDICAL IMPLICATIONS

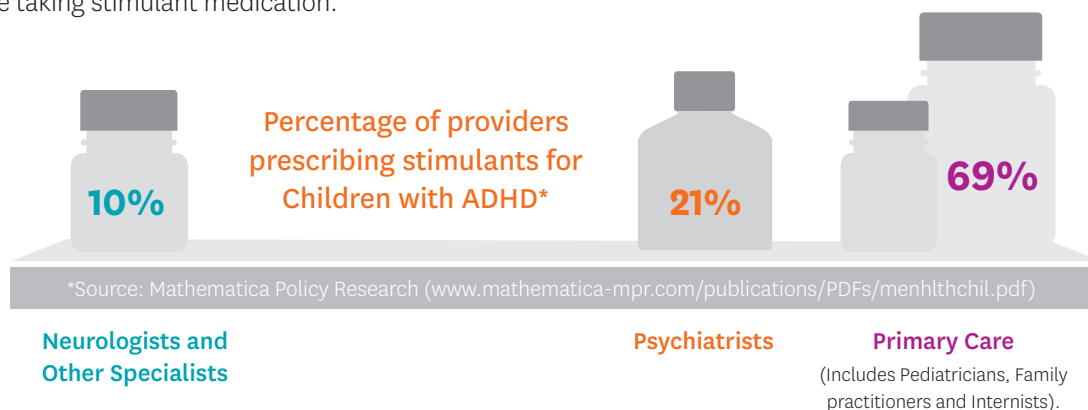
- > Assess for co-occurring conditions (e.g., oppositional defiant disorder, conduct disorder).
- > Many children who have mood or anxiety disorders may demonstrate symptoms that appear to be ADHD. These disorders should be ruled out or treated prior to diagnosing ADHD unless there is clear evidence of the presence of ADHD in the absence of these disorders.
- > Use the chronic care, care coordination model by encouraging family-school partnerships.



MEDICAL MANAGEMENT

The follow-up care for children and patients who are newly prescribed ADHD medication (ADD) a HEDIS measure consists of 2 phases of follow-up:

- > **Initiation Phase:** Please schedule a follow-up appointment within 30 days following prescription fill.
- > **Continuation and Maintenance Phase:** Please schedule at least two more appointments within nine months after the first follow-up appointment.
- > Height, weight, and cardiovascular status should be monitored especially in those taking stimulant medication.



Substance Use Disorders Commonly Treated in the PCP Setting

There are more deaths, illnesses, and disabilities from alcohol and other drug (AOD) use than from any other preventable health condition.¹⁵ Unfortunately, roughly 15 percent of individuals who suffer from AOD dependence receive treatment. [A CAGE-AID](#) self-assessment questionnaire (only four questions) often captures hazardous or harmful drinking in anyone willing to report it. The CAGE-AID self-assessment questionnaire can be found here: <https://www.mhn.com/static/pdfs/CAGE-AID.pdf>



Alcohol

OVERVIEW

Maximum recommended alcohol use:

- > Women – no more than three drinks on any day or seven drinks in a week.
- > Men – no more than four drinks on any day or fourteen drinks per week.



Binge drinking:

- > Is now the number one form of alcohol misuse resulting in a high blood level (0.08 or higher) within two hours after starting to drink.
- > Is more common among those over the age of 26 with annual incomes over \$75,000.¹⁶

Older adults (65+):

- > Are using and misusing alcohol at rates higher than previous generations.
- > Are more likely to have health problems that can be worsened by alcohol, including stroke, high blood pressure, memory loss, and mood disorders.
- > Are likely to be more sensitive to alcohol's effects and are more likely to experience drug interactions with alcohol. The guidelines for maximum alcohol intake are likely too lenient for this population.

Medical Implications:

Screen patients at least annually when your patient has experienced a major life change (death in the family, divorce, or serious illness), your patient displays personality changes, or whenever there is reason to suspect problematic alcohol or drug use. Another evaluation tool to consider is the [AUDIT](#) questionnaire. A copy of the AUDIT questionnaire can be found at: <https://www.drugabuse.gov/sites/default/files/files/AUDIT.pdf>

MEDICAL MANAGEMENT:

- > For patients who screen positive for AOD, use at a low to moderate risk level: Initiate brief interventions, as outlined in the SBIRT (screening, brief intervention, and referring to treatment) model to encourage patients to cut back or abstain from substance use. *
- > Naltrexone 50mg/day has been shown to be effective in reducing drinking episodes and amounts. Campral 666mg TID could be used for those who cannot manage severe drinking cravings. Topiramate has also demonstrated efficacy in reducing alcohol cravings. For patients who wish to abstain but drink impulsively, Antabuse 250mg/day uses an aversive mechanism that can prevent them from drinking; however, the combination of alcohol and Antabuse may cause extreme flushing, elevated blood pressure, or seizures.
- > Refer patient to behavioral health for specialized care when the condition is beyond your scope of practice.

* *The Screening Brief Intervention Referral to Treatment (SBIRT) for Substance Use Disorder PowerPoint is available on the Health Net provider portal. To access the portal, please register for your Health Net provider account or enter your login credentials and get access to features designed to help you streamline your practice. Once you register or log in to the provider portal, look for the tab, "Working with Health Net." Then look for the "Quality" tab within that section. The SBIRT PowerPoint is available within the "Behavioral Health Resources for Health Net Providers."*

Number of Americans Identifying use or dependence on Illicit Substances (SAMHSA 2011)

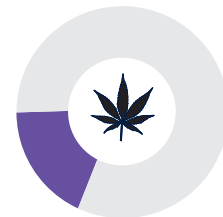
15.9 MILLION
heavy drinking



1.8 MILLION
pain relievers



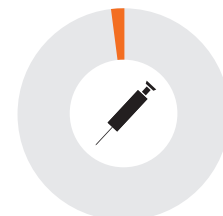
4.2 MILLION
marijuana



0.8 MILLION
cocaine



0.4 MILLION
heroin

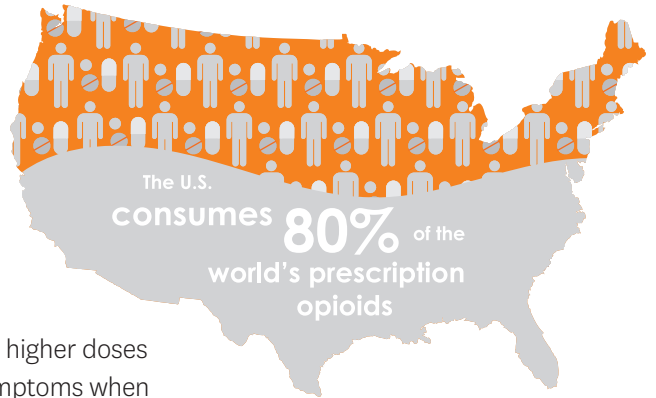




Opioid¹⁷

OVERVIEW

- > Primary care providers account for 50 percent of prescription opioids but report they have insufficient training in prescribing opioids. ¹⁸
- > Prescription drug (opioid) abuse and death is now higher than cocaine, heroin, hallucinogens, and inhalants combined.
- > The United States consumes 80 percent of the world's prescription opioids. (The US population comprises only 5 percent of the world population.)
- > Opioid prescriptions and opioid deaths have both quadrupled since 1999. More than half of all opioid overdose deaths are due to prescription opioids.
- > There is an increased risk for abuse among patients with a history of mental illness



THE ROAD TO OPIOID ABUSE

- > Opioid side effects include tolerability, requiring higher doses to reduce pain, and engendering withdrawal symptoms when medication is stopped.
- > Even when opioids are taken exactly as prescribed, some patients may still become addicted.
- > 80 percent of heroin users first abused prescription opioids before moving on to heroin.

TREATMENT IN A PCP SETTING

As a prescriber, you have the ability to identify, address, and reduce prescription opioid abuse in your practice:

- > Start by prescribing non-opioid pain relief whenever possible.
- > When dealing with chronic moderate to severe pain, when available and appropriate, it would be important to consult early with a pain management specialist; non-opioid medications that have been often used to dampen the pain or make it bearable include but are not limited to amitriptyline, gabapentin, duloxetine, venlafaxine, levomilnacipran, and/or pregabalin.
- > If opioids appear necessary, begin with the lowest effective dosage.
- > Consider using the five-question Opioid Risk Tool (ORT) before prescribing.
- > Check your state's PDMP (Prescription Drug Monitoring Program) to monitor your patient's prescribing activity.
- > Avoid benzodiazepines along with opioids if at all possible, as this combination has been associated with a significant increase in the risk of respiratory arrest.

For additional information and courses about evaluating the benefits of opioid therapies, opioid risk tools, managing patient pain, and several video clips about identification of opioid abusers, please go to: <http://www.searchandrescueusa.org/opioid-abuse-resources/>



MEDICAL IMPLICATIONS

- > Screen patients annually for substance use or when the patient experiences a life changing situation.
- > Patients with an SUD are 2–4 times more likely to have another mental illness.
- > Patients with an SUD are more vulnerable to diseases including cancer.
- > Patients diagnosed with an SUD need follow-up to monitor patient’s ability to cut back or abstain. This is a recommended NCQA best practice. Follow-up visits are tracked and reported by the Health Net HEDIS team.



MEDICAL MANAGEMENT

The complete Initiation and Engagement of Alcohol and other Drug Dependence Treatment (IET-AOD) HEDIS measure consists of 2 phases of treatment for Members who are newly diagnosed with a SUD diagnosis and who attend treatment during the following time frames:

- > Initiation of AOD Treatment: The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis
- > Engagement of AOD Treatment: The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

With over 100 million people suffering from pain, providers are faced with the challenge of mitigating patient risk versus pain management when prescribing opioids.



Serious Mental Illnesses Seen in the PCP Setting¹⁹

An SMI is defined by the National Institute of Mental Health as a serious mental impairment that substantially interferes with or limits one or more major life activities. However, a particular behavioral health condition may be mild to moderate for one person, but serious and disabling to another. Listed below are the more common SMI conditions that normally cause serious impairment and require evaluation, treatment, and follow-up by a BHP.

TYPES OF SMIS



Psychosis



Schizophrenia



Bipolar Disorder



Major Depression



Suicidal Behavior



Major Depression

A mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life.

Mental health disorders, particularly depression, are more prevalent in people with increasing number of physical disorders. Major depression is defined as having persistent and intense depressed mood most of the day for at least two weeks that severely impacts everyday life.

Key Features

Symptoms May Include:

- > Loss of interest or pleasure in activities
- > Trouble sleeping, tired, low energy
- > Feeling unworthy, empty, or having thoughts of death
- > Feeling sad, irritable, or anxious most days

May Be Triggered By:

- > Alcohol or drug use
- > Certain medical conditions
- > Medications including steroids



Psychosis

A symptom, not an illness, that can be caused by a medical condition

An episode of psychosis, when a person has a break from reality, often involves seeing, hearing, and believing things that aren't real. Psychosis is not an illness but rather a symptom of a mental illness.²⁰ A psychotic episode can be the result of a mental health disorder (bipolar disorder, schizophrenia, delusional disorder, severe depression, medication or substance abuse/withdrawal, etc.) or other physical illnesses such as Parkinson's disease, Huntington's disease, brain tumors, delirium, and dementia. Illness, substance use, trauma, or extreme stress can also result in psychosis. In frail, immunologically compromised people, a urinary tract infection could present with acute changes in mental status, including psychosis.



Key Features

Symptoms may include incoherent speech, disorganized behavior, and unpredictable anger and generally involve one or two of the following:

- > Hallucinations: Hearing, seeing, or sensing something that is not present
- > Delusions: A fixed belief in the existence of a situation, cause, or circumstance without evidence or despite evidence to the contrary. It may include grandiose or paranoid thinking or thoughts of reference



When working with patients having psychosis, ensure patient safety by having friends or family close by, minimize stress and stimulation, do not argue with psychotic thinking, and avoid confrontation.



Schizophrenia²¹

A serious brain illness

People with schizophrenia may hear voices that aren't there. They may believe other people are trying to hurt them. Sometimes they don't make sense when they talk. The disorder makes it hard for them to keep a job or take care of themselves. Onset is usually between ages 16 and 30, though we are increasingly seeing the onset of this disorder outside of this age range. Schizophrenia is strongly linked to a higher-than-normal chance of suicide and suicide attempts.²²

The cause is unknown and there is no cure, but medication and psychotherapy can help control symptoms.



Key Features

Symptoms may include incoherent speech, disorganized behavior, and unpredictable anger and generally involve one or two of the following:

- > Hallucinations, delusions, trouble organizing thoughts, and strange movements
- > Trouble using information, making decisions, and paying attention
- > “Negative” symptoms that make it difficult to show emotions and to function normally. A person may seem depressed and withdrawn



Bipolar Disorder²³

A disorder associated with episodes of mood swings ranging from depressive lows to manic highs.

People who have bipolar disorder experience periods of unusually intense emotions. Also noted are extreme changes in energy and unusual behavior. They may experience hallucinations or delusions. This disorder makes it hard for them to keep a job or take care of themselves. Episodes of bipolar disorder may cycle rarely or frequently. The episodes may be discretely manic or depressed or may have elements of both at the same time. One must rule out disease states and certain medications such as steroids, which can present with similar symptoms.





Key Features

Mania

- > Increased energy and activity
- > Feel “jumpy” or “wired”
- > Rapid speech
- > Elevated mood or irritability
- > Think they can do a lot of things at once

Depression

- > Low or sad mood
- > Loss of interest or pleasure
- > Disturbed sleep
- > Poor concentration
- > Eat too much or too little



Suicidal Behavior

The strongest predictor of suicide is one or more previous attempts; however, most people who die by suicide die on their first attempt. Up to 45 percent of individuals who die by suicide have visited their primary care physician within a month of their death.²⁴

For additional information on assessing and managing suicidal patients, please visit: http://www.magellanprovider.com/media/11750/prov_suic_tipsheet.pdf



Key Features

- > Hopelessness
- > Feeling trapped
- > Withdrawal from friends, family, society
- > Anxiety, agitation, unable to sleep
- > Sleeping all the time
- > Acting reckless or engaging in risky activities
- > Increased alcohol or drug use
- > Dramatic mood changes
- > No reason for living; no sense of purpose
- > Threatening or talking about death or wanting to hurt or kill oneself
- > Looking for ways to kill oneself by seeking access to firearms, available pills, etc.



Develop an office protocol for hospitalization if patient is at high risk for suicide.

COMMENTS ABOUT SUICIDE

The key to assess for risk of suicide is to ask directly about thoughts of suicide or ending one's life as part of the screening with a non-judgmental, non-condescending, matter-of-fact approach.

Sample questions:

- > “Have you ever thought things would be better if you were dead?”
- > “With this much stress (or hopelessness) in your life, have you thought of hurting yourself?”
- > Additional research suggests that up to 67 percent of those who attempt suicide receive medical attention as a result of their attempt.²⁵
- > Given these statistics, primary care has enormous potential to prevent suicides and connect people to much needed specialty care — especially when they collaborate or formally partner with behavioral healthcare providers.
- > Screen for diabetes if patient is on psychotropic medications and communicate results to BHP, if appropriate.

According to the Centers for Disease Control, a combination of individual, relationship, community, and societal factors contribute to the risk of suicide. Risk factors are those characteristics associated with suicide – they might not be direct causes.

RISK FACTORS for suicide may include:

- > Family history of suicide.
- > Family history of child maltreatment.
- > Previous suicide attempt(s).
- > History of mental disorders, particularly clinical depression.
- > History of alcohol and substance abuse.
- > Isolation, a feeling of being cut off from other people.
- > Barriers to accessing mental health treatment.
- > Loss (relational, social, work, or financial).
- > Physical illness.
- > Easy access to lethal methods.

Protective factors buffer individuals from suicidal thoughts and behavior. To date, protective factors have not been studied as extensively or rigorously as risk factors. Identifying and understanding protective factors are, however, equally as important as researching risk factors.

Some PROTECTIVE FACTORS for suicide may include:

- > Effective clinical care for mental, physical, and substance abuse disorders.
- > Easy access to a variety of clinical interventions and support for help seeking.
- > Family and community support (connectedness).
- > Support from ongoing medical and mental health care relationships.
- > Skills in problem solving, conflict resolution, and nonviolent ways of handling disputes.
- > Cultural and religious beliefs that discourage suicide and support instincts for self-preservation (U.S. Public Health Service 1999).



Treatment for Serious Mental Illness symptoms often includes prescribing antipsychotic medication, especially for:

- > Severe anxiety
- > Severe depression (with or without psychosis)
- > Schizophrenia
- > Bipolar disorder
- > Sometimes used for OCD, eating disorders, obsessive compulsive disorder (OCD), or behavioral dyscontrol as is sometimes seen in dementia or delirium.

First-Generation Antipsychotic Medications

- > Chlorpromazine hcl
- > Fluphenazine hcl
- > Fluphenazine decanoate
- > Fluphenazine enanthate
- > Haloperidol
- > Haloperidol decanoate
- > Haloperidol lactate
- > Loxapine hcl
- > Loxapine succinate
- > Molindone hcl
- > Perphenazine
- > Pimozide
- > Promazine hcl
- > Thioridazine hcl
- > Thiothixene
- > Thiothixene hcl
- > Trifluoperazine hcl
- > Triflupromazine hcl

Second-Generation Antipsychotic Medications

- > Aripiprazole
- > Clozapine
- > lloperidone
- > Olanzapine
- > Olanzapine pamoate
- > Paliperidone
- > Paliperidone palmitate
- > Quetiapine fumarate
- > Risperidone
- > Risperidone microspheres
- > Ziprasidone hcl
- > Ziprasidone mesylate
- > Thiothixene

Combinations

- > Olanzapine-fluoxetine hcl (symbyax)
- > Perphenazine-amitriptyline hcl (etrafon, triavil [various])



MEDICAL IMPLICATIONS

- > Patients taking psychotropic medications should be tested annually for metabolic syndrome (lipid profiles and glucose regulation along with waist circumference and BMI).
- > Evaluate patient for risk of suicide as appropriate.
- > Emphasize to patient that depression is treatable and emphasize the importance of staying on medication.
- > The American Diabetes Association and the American Psychiatric Association recommend obtaining baseline values for weight, waist circumference, blood pressure, fasting plasma glucose, and fasting plasma lipid profile. These indicators should be monitored at various intervals. The recommended schedule for monitoring parameters is outlined below.
- > Providers should then monitor these values using the following guidelines from the Center for Quality Assessment and Improvement of Mental Health.
- > Health Net encourages providers to inform prescribing physicians of members' diabetes status so they can adjust and monitor their medications more closely. (HN Provider Update 14-575, 11/2014.)
- > Screen for metabolic syndrome in patients taking second and third generation antipsychotics.

Metabolic monitoring parameters based on American Diabetes Association/American Psychiatric Association consensus guidelines

While antipsychotic medications are essential in managing specific psychiatric conditions, antipsychotics can increase a patient’s risk for diabetes, cardiovascular events, and metabolic syndrome in both children and adults.

Diabetes: There is an increased risk for weight gain and obesity, and particularly type 2 diabetes. This is common among patients with SMI, specifically those receiving treatment for schizophrenia or bipolar disorder. Evidence shows the prevalence of diabetes among patients with schizophrenia or bipolar disorder is two to three times higher than in the general population.²⁶

Metabolic Monitoring for Children and Adolescents: Antipsychotic medications can increase lipid levels and blood sugar levels in children leading to diabetes.

Cardiovascular events: Antipsychotic medications regulate a number of neurotransmitters in the brain and are often used to treat schizophrenia, bipolar disorder, and severe anxiety or depression. Patients taking these medications may be at an increased risk for cardiovascular events.²⁷ In fact, people with mental illnesses (both on and off of medication) have anywhere from two to five times greater risk of heart disease than the general population.

	Baseline			Annually		
Medical history	X			X		X
Weight (BMI)	X	X	X	X	X	X
Waist circumference	X			X		X
Blood pressure	X			X		X
Fasting glucose/hemoglobin A	X			X		X
Fasting lipids	X			X		X
Waist circumference	X			X		X

*Personal and family history of obesity, diabetes, hypertension, and cardiovascular disease.

MEDICAL MANAGEMENT

- > Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications (SSD). The percentage of members 18–64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.
- > Diabetes monitoring for people with diabetes and schizophrenia. The percentage of members 18–64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.

METABOLIC MONITORING FOR CHILDREN AND ADOLESCENTS ON PSYCHOTROPIC MEDICATIONS

Children who had at least two antipsychotic medications dispensed within a year should have the following tests within that same year:

- > At least one test for blood glucose or HbA1c.
- > At least one test for LDL-C or cholesterol tests.

Guidelines for Sharing Patient Information

Coordination of Care

PCPS ARE ENCOURAGED TO SHARE INFORMATION WITH BEHAVIORAL HEALTH PROVIDERS (BHPS) WHEN:

- > You refer a patient to a BHP.
- > You are prescribing psychotropic medications (share with a BHP when they are involved in the care of the patient).
- > A new patient reports a concurrent behavioral health condition, a substance use disorder, and/or a major mental illness or when there is a change in one of these in an established patient.
- > You learn that a BHP is prescribing psychotropic medications for your patient.
- > You terminate care with a patient about whom there had previously been communication with a BHP.

BHPS ARE ENCOURAGED TO SHARE INFORMATION WITH PCPS WHEN:

- > Your patient is prescribed psychotropic medications or a significant change is made to the regimen.
- > A BHP learns that a PCP is prescribing psychotropic medications.
- > A BHP terminates care with a patient about whom there had previously been communication with a PCP.

IMPORTANCE OF COMMUNICATING WITH BHPS IN ORDER TO:

- > Monitor vital signs including body mass index (BMI) and blood pressure.
- > Ensure both medical and behavioral health symptoms and illnesses are being addressed.
- > Avoid medication interactions from other medical conditions.
- > Ensure medical histories are complete and accurate, including lab tests with results.

GUIDELINES FOR THE EXCHANGE OF INFORMATION:

- > The Health Insurance Portability and Accountability Act (HIPAA) permits the exchange of general medical record information (excluding psychotherapy notes) for the purpose of treatment between physicians and specialists, without patient consent.
- > Behavioral health specialists must obtain an authorization from the member prior to the exchange of psychotherapy notes.
- > Session notes kept separate from the medical record that contain information related to a private, group, joint, or family counseling sessions and other general information about treatment do not require member consent.
- > Records regarding substance abuse require a written release of information.
- > Federal regulations under 42CF Part 2 restrict any use of the confidential information to criminally investigate or prosecute any alcohol or drug abuse patients.

Referring Patients to MHN Behavioral Health Services

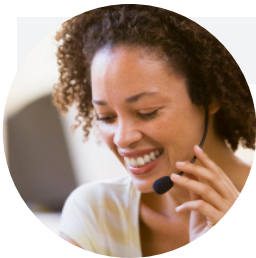
Please use “Coordination of Care between Medical and Behavioral Health Providers Form” when referring patients to MHN. A copy of this form is available for downloading and printing on the Health Net provider portal. To access the forms, please register for your Health Net provider account or enter your login credentials. Once you register or log in to the provider portal, look for the tab, “Working with Health Net.” Then look for the “Quality” tab within that section. The form is available within the “Behavioral Health Resources for Health Net Providers.

Please ensure to obtain the patient’s authorization prior to disclosing or requesting protected health information (PHI) from another healthcare provider. Please keep a copy of the patient’s authorization forms for your records



Refer Patients To MHN When:

- > Patient has a polysubstance use disorder.
- > Brief intervention appears to be insufficient treatment.
- > Patient has a comorbid psychiatric disorder.
- > Pharmacological treatments for addiction are needed and are beyond the scope of your practice.



MHN Customer Service Department

1 (888) 935-5966

- > A physician and/or staff can contact MHN Customer Service if, during medical evaluation, there is indication that a psychiatric or substance abuse problem is present.
- > This number also provides information about member eligibility, benefits, and general questions.



Online PCP Toolkits are available for:

ADHD – Attention Deficit Hyperactivity Disorder for Children, 6 – 12

AOD – Treatment for Alcohol and Other Drugs in the PCP Setting

SBIRT - For Screening and Brief Interventions in the PCP Setting

To access the online PCP toolkits, please register for your Health Net provider account or enter your login credentials. Once you log in to the provider portal, look for the tab, “Working with Health Net.” Then look for the “Quality” tab within that section. These toolkits are available within the “Behavioral Health Resources for Health Net Providers.”



MHN Direct Services Physician Help

To reach the MHN Service Team: Use the number on the back of the patient’s insurance ID card.

Summary of HEDIS 2017 Behavioral Health Measures

The Health Net HEDIS team calculates scores for the following measures, and they are published annually:

Depression Screening and Follow-Up for Adolescents and Adults (DSF) (This is a DHCS External Accountability Set (EAS) Performance Measure)

Depression Screening and Follow-up for Adolescents and Adults. The percentage of members 12 years of age and older who were screened for clinical depression using a standardized tool and, if screened positive, who received appropriate follow-up care.

Depression – antidepressant medication management (AMM)

- > The percentage of members that were prescribed and stayed on antidepressant medication for at least **three months**.
- > Of the patients who stayed on medication for three months, the percentage of those members who stayed on medication for **six months**.

Substance Use Disorder – Initiation and Engagement of Treatment for Alcohol and other Drugs (IET-AOD)

- > The percentage of members who had a follow-up appointment within **14 days** after a substance use disorder diagnosis.
- > The percentage of members who also had **two additional appointments** within 30 days following the initiation appointment.

Attention Deficit Disorder – follow-up care for children prescribed ADHD medication (ADD)

- > The percentage of children who have a follow-up visit with a prescribing provider within 30 days of starting medication.
- > The percentage of members who remained on medication for at least 210 days and had two more appointments within nine months of the initial visit.

Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (SSD)

This measure assesses the percentage of members 18–64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening during the measurement year.

Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)

This measure assesses the percentage of members 18–64 years of age with schizophrenia and diabetes, who had both an LDL-C test and an HbA1c test during the measurement year.

Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)

This measure assesses the percentage of members 18–64 years of age with schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year.

Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)

This measure assesses the percentage of members with schizophrenia who were 19–64 years of age during the measurement year and were dispensed and remained on an antipsychotic medication for at least 80 percent of the treatment period.

Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)

This measure assesses the percentage of members 0–17 years of age who filled two or more antipsychotic prescriptions and had metabolic monitoring.

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MHN is becoming Envolve PeopleCare™

MHN, Inc. is a leading health care company that provides comprehensive behavioral change solutions for individuals and organizations. We are now becoming part of the Envolve PeopleCare, part of the Envolve family of companies, focused on relentlessly improving health and life behaviors, one person at a time. With continued support by our parent company, Centene Corporation, the leading multi-line healthcare enterprise operating local health plans and offering a wide range of health insurance solutions to individuals across the country, we are poised to assist all of our members in the best manner possible.

Envolve® is a family of health solutions, working together to make healthcare simpler, more effective and more accessible for everyone. As an agent for change in healthcare, we're committed to transforming the health of the community, one person at a time.

Envolve represents one, integrated company with three main focus areas: Pharmacy Solutions, PeopleCare, and Benefit Options.



- Drug Benefit Management*
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We are here to help you with information regarding our clinical and operational resources and programs, all designed to support the treatment you provide our members and improve member outcomes.



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