Incorporating Behavioral Health into the Primary Care Practice

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Objectives

► Identify which screening tools are practical to use in primary care
► Learn how to interpret screening results
► Identify successful workflows to accomplish screening
► Learn accurate coding for reimbursement
Actual Situation

• Physicians screen fewer than half of their patients for alcohol use disorders

• Roughly two-thirds of those with a behavioral health disorder do not get behavioral health treatment

• Depression is identified in fewer than half of primary care patients
Primary Care is the ‘De Facto’ Mental Health System

National Comorbidity Survey Replication
Provision of Behavioral Health Care: Setting of Service

- No Treatment: 59%
- 41% Receiving Care
- General Medical: 56%
- Mental Health Professional: 44%

The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. (B recommendation)

USPSTF

Adults aged 18 years or older

Screen for alcohol misuse and provide brief behavioral counseling interventions to persons engaged in risky or hazardous drinking.

Grade: B

Potential Solutions For Primary Care Clinic Adoption of Screening

- Keep the primary screening as brief as possible
- Use non-judgmental approach and allow the “patient to lead.”
- Make sure clinical processes are modified to reduce redundant assessments and make the information actionable for the clinician.
- Provide clinical pathways, protocols, and referral resources to improve behavioral health access and support.
Depression Screening
Patient Health Questionnaire
(PHQ-2/PHQ-9)

► Most commonly used and recommended primary care screening tool to identify depression
► Can be administered in person, by telephone, or self-administered
► Provides validated assessment of symptom severity
► Proven effective in geriatric populations
► If PHQ-2 is positive – complete PHQ-9

http://www.phqscreeners.com/sites/g/files/g10016261/f/201412/PHQ-9_English.pdf
### PHQ-9

**Patient Health Questionnaire-9 (PHQ-9)**

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "x" to indicate your answer)

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

For office coding: __ + ___ + ___ + ___ + ___

= Total Score: ___

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- [ ] Not difficult at all
- [ ] Somewhat difficult
- [ ] Very difficult
- [ ] Extremely difficult

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.
Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.

Scoring of the PHQ9

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1; More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

<table>
<thead>
<tr>
<th>Total Score</th>
<th>Depression Severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-4</td>
<td>Minimal depression</td>
</tr>
<tr>
<td>5-9</td>
<td>Mild depression</td>
</tr>
<tr>
<td>10-14</td>
<td>Moderate depression</td>
</tr>
<tr>
<td>15-19</td>
<td>Moderately severe depression</td>
</tr>
<tr>
<td>20-27</td>
<td>Severe depression</td>
</tr>
</tbody>
</table>
Scoring PHQ-2

The Patient Health Questionnaire-2 (PHQ-2)

Patient Name ________________________________________________  Date of Visit _______________________

Over the past 2 weeks, how often have you been bothered by any of the following problems?

<table>
<thead>
<tr>
<th>Problem</th>
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<tr>
<td>2. Feeling down, depressed or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

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### Major Depressive Disorder (7% prevalence)

<table>
<thead>
<tr>
<th>PHQ-2 Score</th>
<th>Sensitivity</th>
<th>Specificity</th>
<th>Positive Predictive Value (PPV*)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>97.6</td>
<td>59.2</td>
<td>15.4</td>
</tr>
<tr>
<td>2</td>
<td>92.7</td>
<td>73.7</td>
<td>21.1</td>
</tr>
<tr>
<td>3</td>
<td>82.9</td>
<td>90.0</td>
<td>38.4</td>
</tr>
</tbody>
</table>

### Any Depressive Disorder (18% prevalence)

<table>
<thead>
<tr>
<th>PHQ-2 Score</th>
<th>Sensitivity</th>
<th>Specificity</th>
<th>Positive Predictive Value (PPV*)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>90.6</td>
<td>65.4</td>
<td>36.9</td>
</tr>
<tr>
<td>2</td>
<td>82.1</td>
<td>80.4</td>
<td>48.3</td>
</tr>
<tr>
<td>3</td>
<td>62.3</td>
<td>95.4</td>
<td>75.0</td>
</tr>
</tbody>
</table>

Depression Screening Considerations

- **Frequency**: Annually with staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment and follow-up.

- **Staffing**: Clinical staff (e.g., nurse, physician assistant) must be available to advise physician of screening results and to facilitate and coordinate referrals to mental health treatment.
Additional Depression Screening Tests for Adults in Primary Care

- The Geriatric Depression Scale
- Hamilton Depression Rating Scale (HAM-D)
- Beck Depression Inventory (BDI)
- Zung Self-Rating Depression Scale (SDS)
- Center for Epidemiological Studies Depression Scale (CES-D)
- Cornell Scale for Depression in Dementia (CSDD)

Alcohol Use Screening
AUDIT/AUDIT-C

► Alcohol Use Disorders Identification Test (AUDIT) is a 10-item questionnaire that screens for hazardous or harmful alcohol consumption

  - AUDIT-C is modified, validated 3-question screen for hazardous or harmful drinking; Can be incorporated into general health history questionnaires

► Correctly classifies 95% of people into either alcoholics or non-alcoholics

► Brief and Simple: Popular in primary care

Add up the points associated with the answer to each question.

A total score of **eight or more** indicates harmful drinking behavior.

AUDIT-C Questionnaire

Patient Name ________________________________ Date of Visit ________________

1. **How often do you have a drink containing alcohol?**
   - [ ] a. Never
   - [ ] b. Monthly or less
   - [ ] c. 2-4 times a month
   - [ ] d. 2-3 times a week
   - [ ] e. 4 or more times a week

2. **How many standard drinks containing alcohol do you have on a typical day?**
   - [ ] a. 1 or 2
   - [ ] b. 3 or 4
   - [ ] c. 5 or 6
   - [ ] d. 7 to 9
   - [ ] e. 10 or more

3. **How often do you have six or more drinks on one occasion?**
   - [ ] a. Never
   - [ ] b. Less than monthly
   - [ ] c. Monthly
   - [ ] d. Weekly
   - [ ] e. Daily or almost daily

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**Scoring**

The AUDIT-C is scored on a scale of 0-12.

Each AUDIT-C question has 5 answer choices. Points allotted are:

* a = 0 points, b = 1 point, c = 2 points, d = 3 points, e = 4 points

**In men,** a score of 4 or more is considered positive, optimal for identifying hazardous drinking or active alcohol use disorders.

**In women,** a score of 3 or more is considered positive (same as above).

However, when the points are all from Question #1 alone (#2 & #3 are zero), it can be assumed that the patient is drinking below recommended limits and it is suggested that the provider review the patient's alcohol intake over the past few months to confirm accuracy.

Generally, the higher the score, the more likely it is that the patient’s drinking is affecting his or her safety.
CAGE Questionnaire

- Have you ever felt you should Cut down on your drinking?
- Have people Annoyed you by criticizing your drinking?
- Have you ever felt bad or Guilty about your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (Eye opener)?

Scoring:

Item responses on the CAGE are scored 0 or 1, with a higher score an indication of alcohol problems. A total score of 2 or greater is considered clinically significant.

Developed by Dr. John Ewing, founding Director of the Bowles Center for Alcohol Studies, University of North Carolina at Capel Hill, CAGE is an internationally used assessment instrument for identifying alcoholics.
Additional Alcohol Misuse Screening Tests for Adults in Primary Care

- SMAST (Short Michigan Alcohol Screening Test)
  - SMAST-G (Geriatric Version)
- T-ACE (Tolerance – Annoyed, Cut down, Eye-opener)
- TWEAK (Tolerance, Worried, Eye-opener, Amnesia, K/Cut down)

Medicare Billing: Depression Screening

G0444 (Depression Screen – 15 minutes)

► Places of Service: Primary care office, outpatient hospital, independent clinic, FQHC (federally qualified health center) state and local health clinic and RHC (Rural health clinic)

► Rates: $18.30 (Atlanta); $17.07 (GA); $17.38 (NC)

► Is covered whether the screening is positive or negative

► No diagnosis code is required

► Is covered as Medicare telehealth service (HPSA)

https://www.cms.gov/Medicare/Prevention/PreventionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html


Medicare Billing: Depression Screening

► G0402 - IPPE/Welcome to Medicare visit
   – depression screening is included - i.e. procedure is bundled into the IPPE and therefore, not separately billable

► May be separately reported when provided in addition to G0438 (Initial AWV) and G0439 (Subsequent AWV).

https://www.cms.gov/Medicare/Prevention/PreventionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html
Medicare Billing: Alcohol Misuse Screening

G0442: (Alcohol Misuse Screen, 15 Minutes)

- **Eligible Providers (EPs):** General practice, family practice, internal medicine, obstetrics/gynecology, pediatric medicine, geriatric medicine, certified nurse midwife, nurse practitioner, certified clinical nurse specialist, physician assistant

- **Places of Service (POS):** Physician’s office, outpatient hospital, independent clinic, state or local public health clinic

- **Rates:** $18.30 (Atlanta); $17.07 (GA); $17.38 (NC)

https://www.cms.gov/Medicare/Prevention/PreventionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html
Alcohol Misuse Screening Considerations

- **Frequency**: Annually
- **Intervention**: For those that screen positive, CMS will cover up to 4, brief, face-to-face behavioral counseling interventions annually for Medicare beneficiaries, including pregnant women
  - **G0443** (Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes)
    - Same EP and POS rules as G0442
    - Rates: $26.12 (Atlanta); $25.13 (GA); $25.26 (NC)
GA Medicaid

► Initial preventive visit
  – CPT 99385-99387; $75.38
  – Both screens included

► Annual preventive visit
  – CPT 99395-99397; $75.38
  – Both screens included

* Depression and Alcohol Misuse screenings are not separately reimbursable
Billing For Depression Screening (NC Medicaid)

Current “Health Risk Assessment” Code
- 99420
- Reimbursement is $7.90
- For Beneficiaries 20 and under, it needs to be billed with an “EP” modifier when used at a well-visit.

“Social / Emotional Screening” Code
- 96127
- Can be used to screen for Depression, Anxiety, ADHD
- Reimbursement is $4.25
- For Beneficiaries 20 and under, it needs to be billed with an “EP” modifier when used at a well-visit.
- 99420 will continue to be active, but 96127 should be used for Depression Screening when activated.

https://dma.ncdhhs.gov/physician-services-cpthpcs
► Alcohol Misuse Screening and Intervention
  – CPT 99408 (15-30 mins): $29.81
  – CPT 99409 (30+ mins): $58.60

https://dma.ncdhhs.gov/document/physician-services-cpthcpcs
Free Technical Assistance

► Education on screening tools, treatment and referral processes
► Workflow analysis to improve screening efficiency
► Designing process and linkages to referral programs
► Quality improvement technical assistance
► Training in quality improvement methodologies
► Education on best practices, shared successes and lessons learned
Contact Information

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MAKING HEALTH CARE BETTER