OneCare Vermont
Network Success Story

INTEGRATING BEHAVIORAL HEALTH INTO PRIMARY CARE IN VERMONT

Patient Centered Medical Homes (PCMH) throughout Vermont provide timely, comprehensive and collaborative care to Vermonters. According to the American Psychiatric Association (APA) "the integration of behavioral health and general medical services has been shown to improve patient outcomes, save money, and reduce stigma related to mental health." Six practices in the St. Albans Health Service Area (HSA) participated in a year-long learning collaborative to integrate behavioral health and substance use screenings, services, and personnel into primary care. The learning collaborative leveraged the expertise, relationships, and resources of primary care practices, the local hospital and Federally Qualified Health Center (FQHC), the Designated Agency (DA), Blueprint, and OneCare.

https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/get-trained/about-collaborative-care

ST. ALBANS HEALTH SERVICE AREA

KEY DRIVERS

- Co-hiring agreements and collaboration between the DA and the hospital, FQHC, Blueprint, Primary Care (private and hospital owned), Women's Health, and Pediatrics.
- Motivated, engaged and expert staff who support the integration of behavioral health and substance use screening, interventions and personnel in the medical home.
- Office processes and flow (e.g., visit planner, rooming plan, panel management, and the use of screening tools) to support patient identification, screening and follow-up.
- Training for providers and office staff concerning effective 'scripts' to use for screening and follow-up.
- Coding for positive behavioral health or substance use screenings, warm-hand-offs and follow-up.
- EHR optimization to support the recording, reporting and panel management for positive behavioral health or substance use screenings, warm-hand-offs and follow-up.

ACTIONS TAKEN

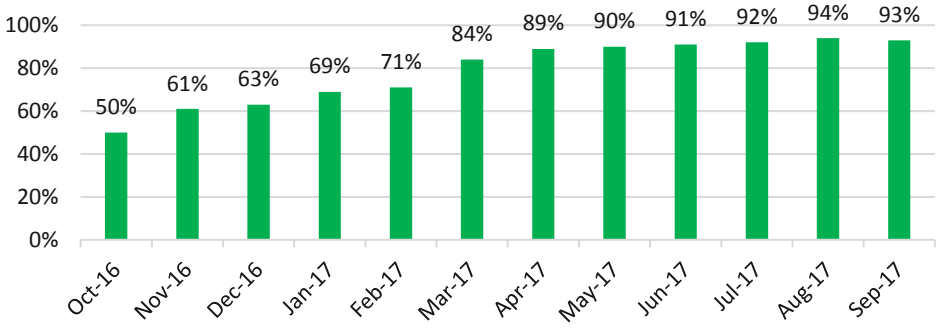
- Identified and integrated screening tools into workflow and EHR (PHQ2 & PHQ9 Depression Screening and the DAST-10 Drug Abuse Screening Test).
- Created scheduling, tracking and processes for warm hand-offs, referrals and follow-up appointments with integrated behavioral health staff for positive screens.
- Developed and implemented a follow up plan and/or referral to treatment process for patients with a positive PHQ2 or PHQ9.
- All six FQHC practices conducted chart audits to track changes in PHQ9, attendance for depression follow-up appointments, and the number of patients who were offered medication therapy, education, in-house referral for therapy, engagement with self-management and the patient's response to treatment plan.

OUTCOMES at the FQHC - NORTHERN TIER HEALTH CENTER (NOTCH)

- Achieved a 43% increase in universal depression screening rates
- Met their screening rate target of 80%
- Transformed practice workflow

Depression Screening (PHQ2 & PHQ9) Rates at NOTCH Practices

(The NOTCH is an FQHC with 6 practice locations in the HSA)



LESSONS LEARNED

- Working with Designated Agencies through shared hiring and aims improves access to screening and care for patients, and strengthens relationships and collaboration among providers and practices.
- The use of quality improvement strategies to identify and integrate coding, tracking and reporting for screenings, warm hand-offs, referrals and follow-ups is essential to successful integration.
- Support and engagement from practice leaders, provider champions and quality improvement leaders strengthens clinical and administrative staff engagement and adoption of integration.

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