QI-6: 2022 Behavioral Health Screening

Co-Occurring Disorders Screening Program Description

Unidentified and consequently untreated coexisting mental health and substance abuse problems can create a myriad of problems that are often related to the highest treatment costs. U.S. Dept. of Health and Human Services (2002) reports that individuals with co-occurring mental health and substance abuse disorders have an increased risk of developing medical and legal problems or experiencing unemployment, incarceration, homelessness, poor relationships, and suicide. Hawkins (2009) report that individuals with co-occurring disorders are less likely to seek help and tend to have poorer outcomes when and if they do receive treatment. Mueser, et al (2006) report that as many as 40-60% of individuals presenting in mental health settings have a co-occurring substance use diagnosis, and 60-80% of individual presenting in a substance use treatment facility have a co-occurring mental illness diagnosis. Zhu & Wu (2018) found that individuals who had a co-occurring mental health disorder and were hospitalized for inpatient detoxification increased significantly from 43 percent in 2003 to almost 59 percent in 2011.

Access Behavioral Health's Co-Occurring disorders screening program is based on the Substance Abuse and Mental Health Services Administration (SAMHSA) TIP 42: Substance Abuse Treatment for Persons with Co-Occurring Disorders. The ABH Co-occurring Disorders Screening Program has been designed to make the PHQ-9 and the CAGE or CAGE Aid readily available to practitioners in order to screen for the existence of co-occurring substance use and mood disorders. The recommended assessments are straightforward and allow for both practitioner use and recipient self-screening to maximize identification of co-occurring disorders.

Eligible Members

Any ABH member who is at risk for a co-occurring substance related disorder and mood disorder who presents for assessment and/or treatment is eligible for the screening. ABH may also use data such as claims, treatment records, PCP or psychiatric referrals, diagnosis codes, care coordination, complex case management or member self-referral to identify members who may be eligible for the screening.

Frequency

The PHQ-9 and the CAGE/CAGE Aid are designed to be conducted primarily upon initial screening; however, due to the shifting nature of depression compounded by alcohol and/or other drug use, this screening program may be conducted at any time during the course of treatment. It may be conducted for diagnostic purposes, level of care needs, ongoing treatment/length of stay, and discharge readiness purposes.

Conditions

The co-occurring screening is indicated whenever substance related disorders and mood disorder symptoms are displayed by a member, when the practitioner suspects a co-occurring disorder is present, or as a matter of routine screening to determine diagnosis and treatment planning.

Practitioner Input

Practitioner input on ABH's Co-Occurring Screening Program is acquired through the Quality Management Committee's (QMC) Quality Subcommittee. Provider and practitioner input includes program design and implementation.

Promotion

ABH's Co-Occurring Screening Program is promoted to practitioners via the ABH website, where the tools may be accessed freely by both members and providers. ABH also provides an annual training to all network providers and practitioners and the Screening Program is also promoted at that time.

Metabolic Syndrome Screening Program Description

The Mayo Clinic defines metabolic syndrome as a cluster of conditions, including increased blood pressure, a high blood sugar level, excess body fat around the waist and abnormal cholesterol levels that occur together, increasing a person's risk of heart disease, stroke, and diabetes. Vancamfort, et al (2015) report that individuals diagnosed with a severe mental illness, including schizophrenia and related psychotic disorders, bipolar and major depressive disorder, experience a two-three times higher mortality rate than the general population. Sixty percent of this morality rate can be contributed to symptomology of metabolic syndrome. According to the Florida Medicaid Drug Therapy Management Program for Behavioral Health, as many as 63% of individuals diagnosed with schizophrenia and 49% of individuals diagnosed with bipolar disorder are at risk for developing metabolic syndrome. Therefore, behavioral health members on atypical antipsychotics should be routinely monitored for symptoms of metabolic syndrome. Access Behavioral Health has created this screening program for practitioners to use as a guide when serving members who are prescribed the below listed atypical antipsychotics.

Abilify	Risperdal
Clozaril	Saphris
Fanapt	Secuado
Geodon	Seroquel
Invega	Symbyax
Latuda	Vraylar
Rexulti	Zyprexa

Eligible Members

ABH utilizes a systematic approach when identifying members eligible for the program. Data sources include member claims data and provider record monitoring data. Eligible members are identified among members who have received medication management behavioral healthcare services. Any member who is consistently prescribed atypical antipsychotic medication is eligible for the program.

Frequency

Table 1: Guidelines for monitoring metabolic syndrome for children and adolescents on atypical antipsychotics

Parameter	Baseline	Week 4	Week 8	Week 12	Quarterly	Annually	Every 5 years
Personal/Family medical hx	√					√	
Weight (BMI)	√	√	√	√	√		
Waist circumference	√					√	
BP	√			√		√	
Fasting glucose or hemoglobin A1C	√			√		√	
Fasting lipid profile	√			√			√

*Medical history includes personal and family history of obesity, diabetes, hypertension, and cardiovascular disease. More frequent assessments may be warranted based on clinical status.
**In children and adolescents, waist circumference may be less informative than for adults due to changes in waist circumference with growth and development. Various studies have sought to develop waist circumference percentile norms based on age, sex, and ethnicity

Table 2: Guidelines for assessments at baseline and follow-up monitoring for Adults on atypical antipsychotics

Assessment	Baseline	Follow-up Assessments
Vital signs (blood pressure, pulse, weight, including calculation of body mass index)	√	Each visit
Lifestyle behaviors (smoking, diet, exercise, substance use, sleep)	√	Each visit
Personal/family history [hypertension, diabetes, cardiovascular disease, cerebrovascular disease (stroke), cancer, epilepsy, Parkinson's disease, thyroid disease]	√	As clinically indicated
Dental history	√	As clinically indicated
Sexual/reproductive function	√	At 3 months and 6 months thereafter

Table 3: Recommended laboratory monitoring for Adults taking atypical antipsychotics

Assessment	Baseline
Complete blood count with differential (CBS with diff)	As clinically indicated (e/g/ treatment with clozapine)
Complete metabolic panel (CMP)	As clinically indicated
Fasting lipid profile	All patients over 40 years at baseline and annually thereafter, or sooner as indicated (e.g., cardiac history, obesity, diabetes, hypertension)
RBC Folate	As clinically indicated
Hemoglobin A1c (HbA1c)	All patients over 40 years at baseline and annually thereafter, or sooner as indicated
Prolactin	As clinically indicated (e.g., amenorrhea/oligo menorrhea, poor sexual function, osteopenia/osteoporosis)
Thyroid stimulating hormone (TSH)	As clinically indicated
Urine Drug Screen	As clinically indicated
Vitamin B12	As clinically indicated
Vitamin D	As clinically indicated

Conditions

All patients on atypical medications should be screened as indicated in the tables above. Given the serious health risks, patients taking atypical antipsychotics should receive appropriate baseline screening and ongoing monitoring. Clinicians who prescribe atypical antipsychotics for patients with psychiatric illnesses should have the capability of determining a patient's height and weight (BMI) and waist circumference. These values should be recorded and tracked for the duration of treatment, Clinicians should also encourage patients to monitor and chart their own weight. It is particularly important to monitor any alteration in weight following a medication change. The patients' psychiatric illness should not discourage clinicians from addressing the metabolic complications for which these patients are at increased risk.

Practitioner Input

Practitioner input on ABH's Co-Occurring Screening Program is acquired through the Quality Management Committee's (QMC) Quality Subcommittee and consultation with network psychiatrists. Provider and practitioner input includes program design and implementation.

Promotion

ABH's Metabolic Screening Program is promoted to practitioners via the ABH website, where the tables may be accessed freely by both members and providers. More information is readily available at https://floridabhcenter.org. ABH also provides an annual training to all network providers and practitioners and the Screening Program is also promoted at that time.

References:

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