



Using Multi-Condition Assessment to Optimize Management of Mental Health in Primary Care

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BACKGROUND

Primary care practitioners (PCPs) serve as the frontline of care for people with mental health and substance use disorders (MHSUDs).¹ They treat up to 70% of individuals with MHSUDs and write up to 65% of psychotropic prescriptions.² Patients are most likely to turn to their PCPs to address their mental or behavioral health issues, often because they already see them for other health needs.³ Yet, PCPs frequently report that they feel unprepared to diagnose or effectively treat these conditions.

PCPs also routinely encounter chronic medical conditions that are impacted by MHSUDs. About two-thirds of people with mental health disorders have a chronic medical condition,³ yet only 13% receive effective treatment in general medical settings.⁴ Not only are outcomes far less than optimal as a result, but overall costs are much higher. A recent financial analysis found that medical costs

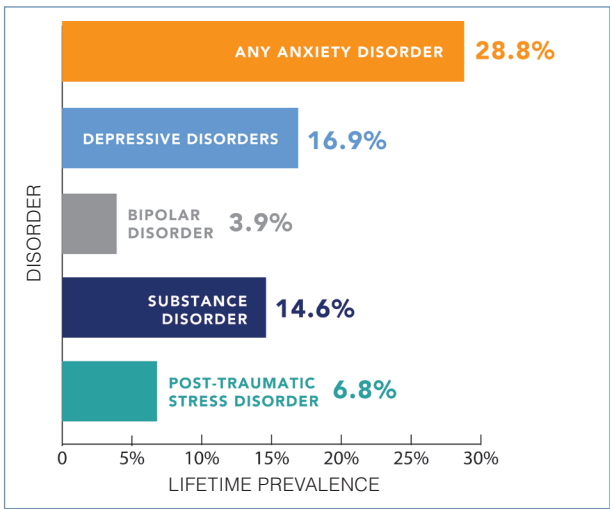
for 18 common chronic conditions are 2 to 3 times higher for those with comorbid behavioral health conditions, estimated at \$293 billion in the United States in 2012, with most of the increased cost attributed to worsening medical conditions.⁵ PCPs are better able to manage medical comorbidities and achieve improved outcomes if they address the mental health issues that interact with these other conditions and worsen outcomes.

DETECTING MENTAL HEALTH CONDITIONS

The 12-month prevalence of any psychiatric disorder in the United States has been shown to be 26%, with major depression affecting 6.7% of Americans during any year and 18% experiencing anxiety disorders.⁶ The variety and prevalence of mental health disorders over a lifetime can be seen in **FIGURE 1**.⁷

Currently, most mental health screening conducted in clinical settings only detects depression, resulting in low recognition of other lifetime diagnoses.⁸ Significantly, 60% of Americans with any mental health diagnosis have more than one diagnosis.⁷ Some authors have concluded that assessments capable of identifying multiple conditions would lead to better patient care and outcomes.⁹⁻¹⁰

FIGURE 1. Lifetime prevalence of mental health disorders⁷



FACULTY

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DISCLOSURES

Drs. Daviss, Hurowitz, and Culpepper are members in M-3 Information, LLC.

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The US Preventive Services Task Force recommends that positive depression screens “should lead to additional assessment that considers severity of depression and comorbid psychological problems, alternate diagnosis and medical conditions.”¹¹

WHAT IS THE MULTI-CONDITION M3 CHECKLIST?

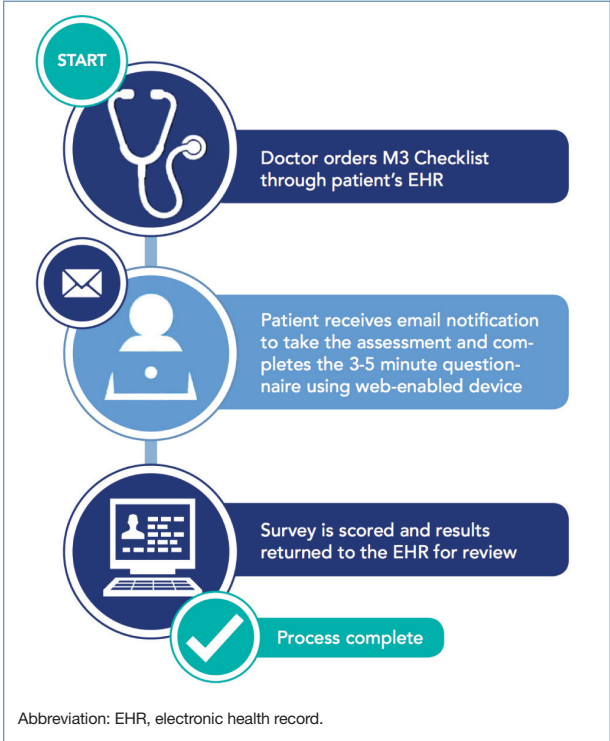
The M3 Checklist is a nationally-recognized, peer-reviewed, and clinically validated tool⁶ that compiles and evaluates a patient’s potential risk for mood and anxiety symptoms (FIGURE 2). More specifically, the M3 Checklist is a multi-condition assessment tool, measuring symptoms of depression, bipolar disorder, post-traumatic stress disorder (PTSD), and anxiety disorders in one 27-question, Web-based, patient-completed questionnaire. Clinicians can order it in the same way they do any LabCorp lab order. Prior to an appointment, patients are sent a secure link so they can complete the electronic assessment on their personal computer, tablet, or smartphone. The results are sent to the clinician’s electronic health record (EHR) as structured data.

The M3 Checklist creates a symptom profile that helps PCPs and other clinicians focus on appropriate treatments. Over time, repeat assessments can be used to track an individual longitudinally and monitor treatment effectiveness, and the data collected can be used for outcomes-based measures.

OFFICE PROCEDURE

Payers have recognized the value of assessment tools for some time, but they have been largely unsuccessful in spurring their adoption by clinicians. One obstacle has been the interruptions to clinical

FIGURE 3. Physician/patient data flow

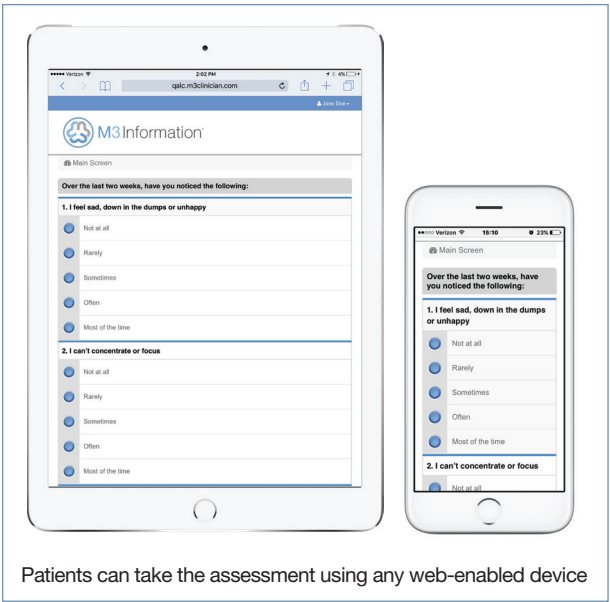


workflow caused by unwieldy, poorly-integrated instruments. Another has been the uncertainty of reimbursement for use of an assessment tool. As seen in FIGURES 3, 4A, and 4B, the M3 Checklist fits within the office workflow as easily as any lab order. Reimbursement is also addressed, as many providers find that the M3 Checklist is reimbursed under one of several commonly used behavioral health assessment codes.

In January 2017, new billing codes were created for behavioral health integration services for Medicare patients receiving collaborative care.¹² Other payors have begun to adopt these codes on their own schedule (e.g., Blue Cross & Blue Shield of Rhode Island in April 2017). The collaborative care model is defined as a team-based approach to mental health care, including the patient, PCP, care manager, and a psychiatrist in which patients are screened, diagnosed, treated to target, and progress is tracked on a regular basis. Integrating primary care and behavioral health has been shown to lead to improvements in mental and physical health and quality of life, and to a decrease in costs.³

Clinical quality measures (CQMs) are an important component of alternative payment models, and CQMs for behavioral health conditions have, to date, been rather limited. The M3 Checklist meets the requirements of more than a dozen accepted CQMs. As the trend towards greater acceptance of outcome measures and greater use of alternative payment models advances, the M3 Checklist will be positioned to help clinicians comply with the CQMs expected to be introduced in coming years.

FIGURE 2. M3 Checklist



1 M3 Score indicates the overall level of mental health symptom burden. Greater than 32 is flagged as High. It includes the **M3 Gateway**, which, when positive, indicates impairment in functional status and overall level of diagnosis risk. The Gateway is positive if any of the 5 Gateway questions (Q5 & Q24-27) are positive.

2 Diagnosis Risk A psychiatric diagnosis requires significant impairment in function, which is indicated by a positive Gateway.¹¹ A sufficient level of symptoms is also required to meet diagnostic criteria for any dimension. Generally, each Diagnosis Risk incorporates both requirements into its score.

3 The Gateway Questions address functional status, substance use, and thoughts of suicide. Suicide assessment is included to help determine risk when treating mood and anxiety disorders. Positive answers to these questions should be followed by additional inquiries to better understand the patient's response and to determine whether this is a change or there is need for further intervention.

4 Symptom Severity indicates the severity of symptoms for each of the 4 clinical conditions. These subscores are most sensitive to change over time, and their review should be combined with looking at the responses for each question.

FIGURE 4A. How to interpret the M3 checklist

LabCorp		M-3 Information LLC 155 Gibbs Street Suite 522 Rockville, MD 20850-0392		Phone: 301-444-4400	
Specimen Number 012-A34-5678-9	TEST	Patient ID	Control Number	Account Number 012345678	Account Phone Number 123-456-789
Patient Last Name DOE		Patient First Name JANE		Patient Middle Name	
Patient SS#		Patient Phone		Total Volume	
Age (Y/M/D) 47/03/17	Date of Birth 01/01/70	Sex N	Fasting	Additional Information PATIENT@EMAIL.COM	
Date and Time Collected 04/18/17 00:00		Date Entered 04/18/17		Date and Time Reported 04/18/17 15:25ET	
Physician Name		NPI		Physician ID	
M3 CHECKLIST					
TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
M3 CHECKLIST					
Assessment Date/Time 04/18/2017 03:03PM EDT					01
M3 Score	49	High		0-32	01
M3 Gateway	Positive-Med	High		Negative	01
DIAGNOSIS RISK					
Depression Dx Risk	Positive-Lo	High		Negative	01
Bipolar Diagnosis Risk	Positive-Hi	High		Negative	01
Anxiety Diagnosis Risk	Positive-Med	High		Negative	01
PTSD Diagnosis Risk	Positive-Hi	High		Negative	01
GATEWAY QUESTIONS					
Q5 Thoughts of suicide	Rarely	High		None	01
Q24 Impairs work school	Sometimes			No-Sometimes	01
Q25 Impairs friends family	Rarely			No-Sometimes	01
Q26 Led to using alcohol	None			No-Sometimes	01
Q27 Led to using drugs	None			None	01
SYMPTOM (Sx) SEVERITY					
M3 Depression Sx Subscore	14	High		0 - 12	01
Reference Range:					
None	Mild	Mod	Severe		
0-6	7-12	13-19	20-28		
M3 Bipolar Sx Subscore	12	High		0 - 7	01
Reference Range:					
None	Mild	Mod	Severe		
0-3	4-7	8-11	12-16		
M3 Anxiety Sx Subscore	20			0 - 21	01
Reference Range:					
None	Mild	Mod	Severe		
0-10	11-21	22-33	34-48		
M3 PTSD Sx Subscore	12	High		0 - 7	01
Reference Range:					
None	Mild	Mod	Severe		
0-3	4-7	8-11	12-16		
QUESTIONS					
Q1 Feel sad, unhappy	Often	High		None-Rarely	01
TESTING, VERBIAGE		TEST		012-A34-5678-9	
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FIGURE 4B. Optional audit-C: Alcohol risk

6 AUDIT-C		Positive	
AUDIT-C Total Score			
Points	0	1	2
	Never	Monthly or less	2-4x Monthly
		3-4 drinks	5-6 drinks
		7-9 drinks	10+ drinks
Q1: How often did you have a drink containing alcohol in the past year?			
Q2: How many drinks did you have on a typical day when you were drinking in the past year?			
Q3: How often did you have 6 or more drinks on one occasion during the past year?			

5 The 27 **Questions** and responses inform how the clinician focuses on further assessment after reviewing the report. Responses flagged as High on the right side of the bold line have the highest severity and can be targeted for more detailed review with the patient. Categorically, the questions track symptoms as follows:

- Depression: 1-7
- Anxiety: 8-19 (GAD 8-9; Panic 10-11; Social 12; OCD 17-19)
- PTSD: 13-16
- Bipolar: 20-23

6 AUDIT-C identifies people at high risk for Alcohol Use Disorder. A positive test is a total score of 3 or higher (some use 4 as the threshold for men) or any response to Q3 other than "Never."

TABLE. Use cases for M3 in primary and specialty care settings

Use Case	Logic	How Often to Administer
Annual physical	Routine screening, per USPSTF recommendations ^{11,14}	An estimated 43.6 million adults dealt with a mental disorder in 2014 ¹⁵
Monitoring those in therapy or receiving medication	Monitor progress to adjust treatment to improve outcomes	USPSTF suggests using clinical judgment in consideration of risk factors, comorbid conditions and life events to determine if additional screening is warranted ¹¹
Readmission reduction efforts	Mental illness may affect the chances of hospital readmissions	Depression and mental illness are responsible for up to 20% of rehospitalizations ¹⁶
Behavioral health/employee assistance	Decrease absenteeism and workplace impairment ^{17,18}	Depression results in almost 400 million disability days each year ¹⁷
Specialty settings	High rates of mental illness and physical illness comorbidity ^{19,20}	<ul style="list-style-type: none"> • OB/GYN (Post Partum)^{20,21} • Endocrine (Diabetes)²⁰ • Cardiology (IHD, Hypertension)²⁰ • Neurology (Stroke)²⁰

Abbreviation: TBI, traumatic brain injury.

CONCLUSION

Large numbers of Americans have mental health conditions that result in high costs to the health care system. Costs are even higher and outcomes worse when considering the interaction of unrecognized and/or untreated mental health conditions and many comorbid chronic health conditions. Most people with mental health conditions continue to receive care from PCPs, who also write most prescriptions for psychotropic medications. PCPs, however, are often ill-prepared to diagnose or treat mental health disorders. The M3 Checklist, available through LabCorp, is a concise and reliable patient-reported questionnaire that leads to an assessment of risk for 4 common mental health disorders with an option for screening of substance use. It fits efficiently into office workflow and can be applied through a variety of clinical use cases (see **TABLE**). Potentially reimbursable under commonly used billing codes, the M3 Checklist is also reliable as a tool to monitor treatment progress and outcomes. ●

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