Behavioral Health Integration for Chronic Disease Management of Depression and Diabetes

Final Report Out Webinar
August 23, 2017

Today’s Moderators

Madhana Pandian
Associate

Deann Jepson, M.S.
Co-facilitator
To participate

Use the chat box to communicate with other attendees

Use the question box to send a question directly to the presenters.

Disclaimer: The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA), or the U.S. Department of Health and Human Services (HHS).
Enhancing Diabetes Management Services with BHPs
Gaston Family Health Services
Jeffrey Ellison, PhD

The Problem

- Prevalence of Diabetes
  - United States - 9.4% of adults have diabetes
  - North Carolina - 10.9% of adults have diabetes
  - Our Communities - 13.5% of adults have diabetes
  - GFHS Patients - 21% of adults have diabetes
The Plan

- GFHS serves 50,000 patients per year across 5 counties and 15 sites
  - In 2016 GFHS had 1.5 FTE of diabetes educators working across 2 sites
  - Currently GFHS has 95% in behavioral health coverage across its 15 clinics
  - By 2018 we aim to have basic diabetes education services easily accessible in all of the regions that we serve
  - By doing this we hope to decrease the burden (e.g., health, social, economic, ED utilization, etc.) of unmanaged diabetes on the communities that we serve
- Goals/Objectives
  - Train Behavioral Health Providers (BHPs) in diabetes management protocols
  - Ensure that BHPs trained in diabetes management protocols are accessible to patients in all GFHS primary care clinics
  - Develop a program staffed by BHPs to systematically identify and provide education, motivation, and support services to patients with uncontrolled and unmanaged diabetes

The Result

- 7 behavioral health providers and 1 pharmacist completed the AADE diabetes level 1 training
- 4 of these behavioral health providers will be eligible to complete CDE examination and credentialing process within next six months
- Now there is at least 1 provider located in each GFHS region that can provide at least basic diabetes education services
- A diabetes and chronic condition management committee has been convened to assist in the development of the new diabetes programming
- A “Lead Diabetes Educator” has been hired to continue to guide program development and expansion
The Rear-View Mirror

- In the beginning nursing and medical staff were skeptical that BHP ability and background were not sufficient to meet patient’s needs
- Following BHP training and engagement, medical providers and patients have welcome behavioral health involvement with diabetes education and management
- Organizational and cultural change takes time

The Road Ahead

- Develop a department/program specifically focused on diabetes and chronic disease management
- Develop systematic policies and metrics for referral, follow-up, and monitoring of patients with diabetes
- Develop a tiered diabetes intervention programming (mirroring SBIRT protocols) including brief interventions, group interventions, intensive one-on-one interventions, and ongoing monitoring through care management services
Questions?

BEHAVIORAL HEALTH AND PHARMACY COLLABORATION IN PRIMARY CARE

IHA

Kristyn Spangler, MSW – Program Manager
Sarah Fraley, MSW – Behavioral Health Care Manager
Kelly Hect, PharmD – Ambulatory Pharmacist

Ann Arbor, Michigan
August 23, 2017
Behavioral Health and Pharmacy will jointly treat patients with comorbid depression and uncontrolled diabetes

- Knowledge
  - Training Plan for social workers
  - Pre/post test
  - Deadline 07/31/2017

- Workflow
  - Identify potential shared patients
    - EMR reporting
    - Case finding
  - Plan shared services
  - Deadline 08/31/2017

Video learning for diabetes; EMR and humans for patient identification

- Coach shared video modules

- EMR comorbidity report
- Social Worker and Pharmacists brainstorm

Out of the 2,644 patients who have depression, 474 (18%) also have comorbid diabetes.
Social Workers increased knowledge of diabetes; patient sharing workflows tested

- Pre and post testing
- PDSA cycles for workflow

Next adventure: outcome data!

- Analyze outcomes
  - EMR for reporting
  - PHQ9
  - HgA1c
- More PDSA with stakeholders
- Lower threshold for participation?
Ken achieved improvements with shared services

- Pt with 20 meds, up to 3x/day
- Multiple comorbidities
- PHQ24
- Sugars trending up

- Pharmacy for med changes
  - Class X and Class D
  - Cost
  - Regimen
  - Efficacy

- Behavioral Health for depression and anxiety
  - Behavioral Activation
  - Self management
  - Motivational Interviewing for compliance

Questions?
Incorporating Depression Management into Diabetes Care

NORTHCOUNTRY HealthCare

Leads: Reneé Nelson  Jennifer Nosker  Rock Todd
Assisting: Raquel Sanchez  Marilyn McNabb  William Smith

WORK PLAN

GOAL

- Develop a diabetes and depression referral program aimed at connecting a behaviorist with a newly diagnosed patient with diabetes to evaluate mood and compliance.
- Pilot program at one NCHC clinic.

STEPS TAKEN

- Identified populations to target
  - Expanded target from just newly diagnosed individuals to include patients with A1C of ≥9.0%; added Moderate/Severe Depression and Diabetes Diagnosis.
  - Expanded to two pilot locations.
- Identified a screening tool
  - Problem Areas in Diabetes (PAID)
- Trained staff and medical providers
  - Multiple/repeated f/u reminders (individual, group, email).
  - Ran reports, flagged charts
LESONS LEARNED

BARRIERS
• Limited identification of patients:
  - Reports, flags, PCP/MA memory
  - Flags only work if the Patient has a scheduled appointment
  - Multiple DM Dx, one Dx per report
• Current automatic referral to health coach in Kingman; now adding BHC
• Timing
  - Training/schedules
  - Vacations, maternity leave, staff shortages, overwhelm
• Implementation/buy-in/adjustment takes time; i.e., SBIRT (3-5yrs)
• Organization / Buy in from CMD, BHCs, MAs, PCPs, Patients.
• A1C (3 months)

SUCCESSES
• New Reports Expected in Fall
• Buy-in is essential
  - 4 Providers/MAs out of 10
• Warm-handoffs best
  - Was able to reach both newly dx and A1c over 9.0
  - No response to telephone outreach
  - 50% response to take home/return PAIDs (2 offered)
• Positive patient response
  - PAID/PHQ9 combination

RESULTS

• Not Yet Able to Run a Report for Newly Diagnosed, all DM Dxs together
• Reports run by location:
  - A1c ≥ 9.0% (highest was 15.8)
  - PHQ9 of Moderate to Severe Depression and DM Dxs
• Charts/Flagged Requesting BHC Notification and Warm Handoff (PAID)
  - 3 Patients on both reports in Kingman
  - 2 patients on both reports in Kingman
  - Same patient on the PHQ9/DM report had not been seen in 4 years; declined telephone FBI
• Very few patients referred:
  - 2 Patients referred in Kingman. All Negative for depression.
  - 2 of 6 Patients seen in Lake Havasu.
  - 5 Patients referred in Kingman.
  - 4 Patients referred in Lake Havasu.
  - 1 Patient (with depression) referred in Kingman.
• 2 Patients referred in Lake Havasu.
• 1 Patient referred in Kingman.
• Very few patients referred.

<table>
<thead>
<tr>
<th>Category</th>
<th>Report Identified/Chart Flagged: Lake Havasu City</th>
<th>Report Identified/Chart Flagged: Kingman</th>
<th>PCP/MA Referred: Lake Havasu City</th>
<th>PCP/MA Referred: Kingman</th>
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<td>A1c ≥ 9.0%</td>
<td>147</td>
<td>61</td>
<td>11</td>
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<td>Newly Dx</td>
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<td>PHQ9 &gt;14 / DM Dx</td>
<td>118</td>
<td>48</td>
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<tr>
<td>Seen</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td>6</td>
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PLAN OF ACTION

- Increase focused training with MAs
  - Review flags, notify providers, notify BHC. Same process as SBIRT.

- Increase focused training with PCPs
  - Need to identify/diagnose depression w/ DM.
  - How PAID can help.

- Training Health Coaches for BHC referrals/PAID completion

- Reminders / Review with PCPs
  - Ask for warm handoffs for flagged/ newly identified patients.
  - (Already get referrals for positive PHQ9)

- Run reports once new ones available; flag charts.

- Continue to refer to 2-hour DM education class, BHC services, ZMHCS, outside resources.

- Avoid Complacency
  - One time training does little. Reminders / Retraining are the life blood of the program.
  - If you implement incentives for referrals for MAs, PCPs, and Patients.
  - INCENTIVES WORK.

- Continue to Re-evaluate

BUT DID WE MAKE A DIFFERENCE?

Making a difference starts with an idea, a problem being identified.

- Depression is being overlooked/untreated in individuals with diabetes despite high occurrence rates and negative outcomes of not treating both.

It starts with planting the seed of knowledge and finding ways to nurture it. We've done these.

- Administrators, BHCs, PCPs, MAs, Health Coaches, Patients

Next, possible solutions are identified and steps are taken to begin to make a change.

- Our providers are becoming more aware and our patients are beginning to receive more complete care.

Now it is time to nurture our newly planted seed so that it can grow and prosper. We can no longer ignore the elephant in the room, but instead use this newly planted seed and acknowledge the elephant’s existence so that it too can receive the care it needs.

- Reminders, more training, new reports, re-evaluation of progress, etc.

Diabetes and Depression go hand in hand. It’s part of the natural process for any chronic disease. One can not get better if the other one is ignored.
Questions?

Jennifer MacLeamy, Psy.D.
Director of Behavioral Health

Tiffany Jimenez, RN, MSN,
Director of Quality
AIM Statement

• Improve care for patients with diabetes and ability to self-manage by increasing the percentage of diabetic patients who have seen a BH provider in the last year from 16% to 25% by December 2017
  – We serve ~1900 patients with diabetes
  – A1c control rate = 75% of patients with A1c <9 in last year
  – 41% of our patients with diabetes have depression
  – 16% of our patients had a PHQ-9 in the past 12 months
  – PDSA: How can we screen for depression in a meaningful way?

Primary Change Interventions

• Multidisciplinary team to address Diabetes/Depression needs:
  • patient advisor
  • PCP
  • MAs (PC and BH)
  • BH provider
  • Quality Director
  • BH Director
  • EHR trainer
  • Informatics
  • Clinic currently undergoing full BH integration into PC teams
  • Training for all BH providers in Diabetes
  • Poster in exam rooms for Chronic Illness and Depression
  • PDSAs for depression screening with in primary care team, conjoint with BH warm handoffs
PDSA Findings

- Variations among MA staff re: screener delivery.
- Scripting and coaching enabled a more meaningful, better received intervention.
- Increased warm handoffs to BH.
- Patients did not mind screeners
- PHQ scores did not correlate with warm handoff acceptance
- Eye contact was crucial
- Patient advisory: screeners & teamwork are appreciated
Data/Informatics

Diabetic patients who have seen Behavioral Health in the last 1 year increased from 16% to 18%!

Warm Hand-Offs (Orange) have increased from average of 150/mo to 350/mo!

Behavioral Health in the last 1 year increased from 16% to 18%!

Questions?
Let’s Discuss!

Please type your questions/discussion points in the chat box!

Questions?
Thank you for joining us today. Please take a moment to provide your feedback by completing the survey at the end of today’s webinar.

If you have additional questions/comments, please send them to:
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