How to get your EHR to match reality for UDS measures on depression

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SAMHSA-HRSA CENTER for INTEGRATED HEALTH SOLUTIONS

Moderators:

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Roara Michael, Associate, CIHS

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Learning Objectives

• Tips and guidance to improve electronic health record workflows, data entry and reports for depression screening and follow-up interventions

• Key lessons learned from one provider on how changing utilization of the EHR improved outcomes

• Practical strategies for sharing data with the team to improve benchmarking and quality
Today’s Speakers

Adrian Bishop
Director, eHealth and Organizational Development, Advocates for Human Potential

Ellen Radis, MMHS
Senior Program Manager, Advocates for Human Potential

Belinda J. Stiles, MA, LISW-S
Behavioral Health Manager, Five Rivers Health Centers
How to Get Your EHR to Match Reality for UDS Measures on Depression

Adrian Bishop and Ellen Radis,
Advocates for Human Potential
Agenda

- Electronic Health Data – The Big Picture
- Depression Screening Data Life Cycle – Data Definition, EHRs and Clinical Workflow
- Five Rivers Health Center – Improving Depression Screening
- Depression Screening Data Life Cycle – Data Capture and Data Validation
- Uniform Data System – Depression Screening Measure
  - Current Reporting
  - UDS Review Strategies
  - Validating your Data
- Depression Screening Data Life Cycle – Substantive Use
- Resources and Questions
Health Integration
Bi-Directional Opportunity

“Just as screening and evaluation for behavioral health disorders is appropriate in primary care settings, screening and evaluation for general health problems should be available to individuals in behavioral health settings.”

Linda Rosenberg, CEO NCBH
Health Integration
Bi-Directional Opportunity

“Integrated primary care is a service that combines medical and behavioral health services to more fully address the spectrum of problems that patients bring to their primary medical care providers. It allows patients to feel that, for almost any problem, they have come to the right place.”

Alexander Blount
The Center for Integrated Primary Care
University of Massachusetts Medical School
Electronic Health Data

The Big Picture
Electronic Health Data – The Big Picture
The Clinical Perspective

- Patient Education and Self Management
- Health Maintenance
- Integrated Care Management
- Orders and Referrals
- Disease Management

PATIENT

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Electronic Health Data – The Big Picture
The Systems Perspective

- Reimbursement
- Stakeholder Reporting
- Disease Registries
- Data Warehouses
- Health Information Exchange
Why is Electronic Health data important?

- Manage patient’s health
- Prevention
- Chronic Disease Management
  - Integration across services
  - Manage Public Health
- Health threats to individuals and communities
- Provide informed health choices
- Manage Population Health
- Provides claims data and other financial information

Maximizes Efficiency Quality and Safety
UDS Depression Screening

UDS Depression Screening Rates - 2014 - 2016

- 2014: 38.80%
- 2015: 50.60%
- 2016: ?

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Hypertension
An Example of the power of data!

![Graph showing percentage of hypertension and controlled hypertension from 1999 to 2014.](integration.samhsa.gov)
Depression Screening Data Life Cycle

- Data Definition
- EHR
- Clinical Workflow
- Substantive Use
- Data Validation
- Data Capture
Depression Screening Data Life Cycle

Data Definition

- EHR
- Clinical Workflow
- Data Capture
- Data Validation
- Substantive Use
- Data Definition
Data Definition and Reporting

- Data must be defined if it is going to be useable
  - Must be in the correct form
  - Must be in the correct place within the EHR
  - Must be attributable (Patient, provider, location, date etc.)

- Reports must be defined
  - Attribute
  - Numerator
  - Denominator
  - Exclusions
Data Definition and Reporting

- All EHRs have multiple reporting capabilities
  - Certified reports – Primarily CMS electronic Clinical Quality Measures (eCQMs)
  - Other vendor developed reports – e.g. Million Hearts, UDS
  - Capability to “write” customized reports
  - Reporting capability of EHR may be supported by data warehouses and other reporting tools.

- EHR must be regarded as the Data Source of Truth
**eCQMs – electronic Clinical Quality Measures**

Use data from electronic health records (EHR) and/or health information technology systems to measure health care quality.

- Currently 64 eCQMs for Eligible Providers (Clinicians)
- The (e) means Electronically Specified
- Part of ONC EHR Certification criteria – means that the reported data for a measure should be consistent regardless of vendor.
- Annual Updates as needed
- Where possible, 2016 UDS Clinical Quality Measures have been aligned with the CMS eCQMs.
- CMS eCQM Library

eCQM CMS2v5

- Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
  - UDS Table 6B Section M, line 21

- Universe / Denominator
  - The number of patients ages 12 years and older with at least one medical visit during the measurement period

- Numerator
  - The number of patients screened for clinical depression on the date of the visit using an age-appropriate standardized tool and, if screened positive for depression, for whom a follow-up plan is documented on the date of the positive screen

- Exclusions
  - Patients who are already participating in ongoing treatment for depression. Also excluded are patients with an active diagnosis for depression or bipolar disorder
eCQM CMS2v5

- **Universe / Denominator**: The number of patients ages 12 years and older with at least one medical visit during the measurement period.

- **Numerator**: The number of patients screened for clinical depression on the date of the visit using an age-appropriate standardized tool and, if screened positive for depression, for whom a follow-up plan is documented on the date of the positive screen.

- **Exclusions**: Patients who are already participating in ongoing treatment for depression. Also excluded are patients with an active diagnosis for depression or bipolar disorder.
How to find the Screening for Clinical Depression and Follow-Up Measure Specifications?

<table>
<thead>
<tr>
<th>Table 6B Reference</th>
<th>Previous Measure Description</th>
<th>2016 Measure Description</th>
<th>e-CQM</th>
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</thead>
<tbody>
<tr>
<td>Section C, Line 10</td>
<td>Childhood Immunizations</td>
<td>Childhood Immunization Status (CIS)</td>
<td>CMS117v4</td>
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<tr>
<td>Section D, Line 11</td>
<td>Cervical Cancer Screening</td>
<td>Cervical Cancer Screening</td>
<td>CMS124v4</td>
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<tr>
<td>Section E, Line 12</td>
<td>Weight Assessment and Counseling for Children and Adolescents</td>
<td>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents</td>
<td>CMS155v4</td>
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<tr>
<td>Section F, Line 13</td>
<td>Adult Weight Screening and Follow-up</td>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up</td>
<td>CMS69v4</td>
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<td>Section G, Line 14a</td>
<td>Tobacco Use Screening and Cessation Intervention</td>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</td>
<td>CMS138v4</td>
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<tr>
<td>Section H, Line 16</td>
<td>Asthma Pharmacologic Therapy</td>
<td>Use of Appropriate Medications for Asthma</td>
<td>CMS126v4</td>
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<tr>
<td>Section I, Line 17</td>
<td>Coronary Artery Disease (CAD): Lipid Therapy</td>
<td>Coronary Artery Disease (CAD): Lipid Therapy</td>
<td>No e-CQM</td>
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<tr>
<td>Section J, Line 18</td>
<td>Ischemic Vascular Disease: Use of Aspirin or Another Antithrombotic</td>
<td>Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic</td>
<td>CMS164v4</td>
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<td>Section K, Line 19</td>
<td>Colorectal Cancer Screening</td>
<td>Colorectal Cancer Screening</td>
<td>CMS130v4</td>
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<td>Section L, Line 20</td>
<td>HIV Linkage to Care</td>
<td>HIV Linkage to Care</td>
<td>No e-CQM</td>
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<td>Section M, Line 21</td>
<td>Depression Screening and Follow-up</td>
<td>Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan</td>
<td>CMS2v5.0</td>
</tr>
<tr>
<td>Section N, Line 22</td>
<td>Dental Sealants for Children</td>
<td>Dental Sealants for Children between 6-9 Years</td>
<td>CMS277v0 (Draft e-CQM)</td>
</tr>
</tbody>
</table>

https://ecqi.healthit.gov/ep/ecqms-2016-reporting-period
Data Definition – CMS2v5

CMS Measure ID: CMS2v5
Version: 5
NQF Number: 0418

Measure Description: Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.

Initial Patient Population: All patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period.

Denominator Statement: Equals Initial Population

Denominator Exclusions: Patients with an active diagnosis for Depression or a diagnosis of Bipolar Disorder

Numerator Statement: Patients screened for clinical depression on the date of the encounter using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the positive screen

Numerator Exclusions: Not Applicable

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Data Definition – CMS2v5

Specifications

- CMS2v5_3.html
- CMS2v5_3.xml
- CMS2v5_SimpleXML_3.xml
- EP_CMS2v5_NQF0418_Depression_Screening_3.zip
- CMS2v5TRNs05012015_3.xlsx

Measure Steward: Centers for Medicare & Medicaid Services
Documented follow-up for a positive depression screening must include one or more of the following:

- **Additional evaluation for depression**
- Suicide Risk Assessment
- Referral to a practitioner who is qualified to diagnose and treat depression
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression
## CMS 2v5 – Follow-Up Plan

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90407005</td>
<td>Evaluation of psychiatric state of patient (procedure)</td>
</tr>
<tr>
<td>79094001</td>
<td>Initial psychiatric interview with mental status and evaluation (procedure)</td>
</tr>
<tr>
<td>45392008</td>
<td>Psychologic evaluation or test procedure (procedure)</td>
</tr>
<tr>
<td>428151000124107</td>
<td>Standardized adult depression screening tool completed (situation)</td>
</tr>
<tr>
<td>38756009</td>
<td>Psychiatric evaluation of patient for criminal responsibility with report (procedure)</td>
</tr>
<tr>
<td>370803007</td>
<td>Evaluation of psychosocial impact on plan of care (procedure)</td>
</tr>
<tr>
<td>165190001</td>
<td>Psychiatric evaluation for rehabilitation (procedure)</td>
</tr>
<tr>
<td>165171009</td>
<td>Initial psychiatric evaluation (procedure)</td>
</tr>
<tr>
<td>10997001</td>
<td>Psychiatric evaluation of patient for testamentary capacity with report (procedure)</td>
</tr>
<tr>
<td>10197000</td>
<td>Psychiatric interview and evaluation (procedure)</td>
</tr>
</tbody>
</table>
Why do we need to ‘Drill Down’ into the Depression Measure?

- The specifics of the measure provide a road map to understanding how to configure your EHR and developing the workflows that are:
  - Customized to your setting
  - Support the development of protocols and best practices that align with these workflows.
  - Generate data for reporting
  - Generate data to support quality improvement

- Applies to all measures
Depression Screening Data Life-Cycle

Data Definition

Substantive Use

Clinical Workflow

Data Validation

Data Capture

EHR

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What is a Certified EHR?

A certified EHR must:

- Meet the certification criteria defined by CMS and ONC including:
  - Store data in defined structured format(s)
  - Meet the defined functionality and security requirements
  - Able to share data with other EHRs securely
  - Able to report data (including eCQMs)

- Be certified as CEHRT (certified electronic health record technology) by ONC – ONC CHPL [https://chpl.healthit.gov/#/search](https://chpl.healthit.gov/#/search) (Complete EHR and Modular Certifications)

- Meet the requirements of CMS EHR incentive programs (Meaningful Use)

- Over 90% of the FQHCs are on CEHRT.
What is an Integrated EHR?

- Master patient index (Unique patient identifier)
- Common Practice Management across programs
  - Demographics
  - Race / Ethnicity / SOGI
  - Scheduling
  - Insurances
  - Check-in / Check-out
  - Revenue Cycle Management
- Share clinical data (within the limits of HIPAA and CFR42 Part 2) between programs
- Share Care Plans across programs
- Support the precept ‘One Patient’
Depression Screening Data Life Cycle

EHR

- Keep up to date with upgrades and patches
- Formally manage by an EHR team that includes:
  - IT
  - Clinical leadership
  - Operations
  - Finance / billing
  - Quality Improvement
  - Data Analysts
  - Team is responsible for functionality, security and quality improvement

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Depression Screening Data Life Cycle
Clinical Workflow

- Clinical workflows – all processes that contribute to the delivery of services
- The alignment of workflows an EHR configuration
- One of the main roles of your EHR Team
- Clinical workflows need to be developed collaboratively across functions and with the input of all stakeholders if all need are to be met:
  - Front Desk
  - Primary Care Providers
  - Care Coordinator
  - Behavioral Health
  - Medical Assistant
  - Nursing
  - Referral Coordinator

Workflow stakeholders includes everyone who inputs or extracts data in the EHR as part of a patient visit or as a result of the visit
Improving Behavioral Health Screening at Five Rivers Health Center

Five Rivers Health Center
UDS Depression Screening Rate

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>45.74%</td>
</tr>
<tr>
<td>2016</td>
<td>96.05%</td>
</tr>
</tbody>
</table>

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CIHS Levels of Behavioral Health Integration

- **Coordinated**: Behavioral services by referral at separate location with formalized information exchange.
- **Co-Located**: By referral at medical care location
- **Integrated**: Part of the “medical” treatment at medical care location

### Table 1. Six Levels of Collaboration/Integration (Core Descriptions)

<table>
<thead>
<tr>
<th>Coordinated</th>
<th>Co-Located</th>
<th>Integrated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key Element: Communication</td>
<td>Key Element: Physical Proximity</td>
<td>Key Element: Practice Change</td>
</tr>
<tr>
<td>Level 1: Minimal Collaboration</td>
<td>Level 2: Basic Collaboration at a Distance</td>
<td>Level 5: Close Collaboration Approaching an Integrated Practice</td>
</tr>
<tr>
<td>Level 3: Basic Collaboration Onsite</td>
<td>Level 4: Close Collaboration Onsite with Some System Integration</td>
<td>Level 6: Full Collaboration in a Transformed/Merged Integrated Practice</td>
</tr>
</tbody>
</table>

Behavioral health, primary care and other healthcare providers work:
Overview

- 20,000+ patients per year
- Family Practice, Center for Women’s Health/ Pediatrics, Medical Surgical, Homeless Clinic, Dental, Pharmacy.
- Medical staff is comprised Nurse Practitioners, Physician Assistant, Dietitian, OB’s, Midwives, Psychiatrist, and residents from Wright State University’s school of medicine and Pharmacy students from various schools.
- Behavioral Health staff is comprised of Social Workers, Professional Counselors, Chemical Dependency Counselors and Case Managers.
Integration Work Flow

- Evidence based screening tools; PHQ-9, AUDIT/DAST, Post-Partum screen
  - The PHQ-2 is built into the intake template for the MA’s rooming the patient. If the PHQ-2 is positive it automatically triggers the PHQ-9. If the PHQ-9 is positive the medical provider and behavioral health provider are notified.
  - The post-partum screen is built into the system.
  - The AUDIT/DAST are smart phrases built into the behavioral health notes.
  - The face sheet of the chart is where information on “completed” screens are posted.
Integration Work Flow

- Morning Huddles (all/team specific) powered by the EHR schedule and review of patient chart.
  - The MA’s review the patient schedule for the next day to identify chronic medical conditions, mental health/substance abuse history, medication refills, specific behavioral concerns.
  - BH (BHC/CM/SA/PWHCM) specific huddle is a review of the next day patient list and identifying who needs follow up and planning for introductions to new patients.
  - BH huddles with specialty teams like, Healthy Start - Community Health Workers
Communication

- Our behavioral health department is newly formed and in 2017 our goal is to provide quarterly department team meetings and conduct bi-weekly site specific meetings.

- These meetings will consist of a review of the data measures and how we are doing quarterly and discussion on ways to improve those measures.

- These meetings also consist of training to attempt the overall data measures supporting diabetes, hypertension etc.
UDS Depression Measure Improvement

Depression Screening Rate increased from 45% – 96% between 2015 and 2016

- Better understanding of the data definition and workflow:
  - We determined that the “Follow-Up Plan” in the initial visit.
  - Patients who scored positive on the PHQ-2 were automatically screened with the full PHQ-9.
    - The screening tools are a part of the intake template in our EHR and can not be skipped.
  - If the PHQ-9 was positive the MA/Nurse, who roomed the patient would inform the medical provider and the behavioral health provider of positive screen.
UDS Depression Measure Improvement

Depression Screening Rate increased from 45% – 96% between 2015 and 2016

- The MA/Nurse rooming the patient makes the patient aware of their score and the supportive services available at the health center, calling the behavioral health providers by name.
  - “Rebecca, our behavioral health provider will be in to have more discussion with you regarding your score.” Discussion amongst all providers happens on the medical floor and a plan of action is created.

- Discussion amongst all providers happens on the medical floor and a plan of action is created.

- Patient’s who screened positive are viewed as priority and often, do not leave that appointment without an intervention from the medical provider and/or the behavioral health provider.

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UDS Depression Measure Improvement

Depression Screening Compliance Rate increased from 45% – 96% between 2015 and 2016

- Interventions include:
  - Medication from the medical provider
  - Brief intervention regarding coping skills from the behavioral health provider
  - Support with scheduling an appointment at a community mental health agency with the case manager.

- Cover sheet of the patient’s chart indicates that a PHQ-9 was conducted and that an intervention was provided. It also includes patient diagnosis and a snippet of the last visit note.

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Depression Screening Data Life Cycle

Data Capture

- The correct person putting the correct data in the correct form in the correct place!

- Data capture linked very closely with Clinical Workflows:
  - Must operate consistently:
    - Staff changes or absences
    - Busy / not busy
  - Often defined by documented protocol
  - Must not “expand” until burdensome
  - Exceptions must be formally managed

Good data is CONSISTENT data!

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Data validation is the process of ensuring that an EHR operates on clean and correct data.

It is a constant process.

Data can be verified by:

- Data audits to ensure that data is accurate and consistent
- Understanding trends and identifying “outliers”
- Comparing data from multiple sources
- Confirming by manually sampling
- Comparing data to state and national benchmarks
- Formal corrective action taken when data is found to be problematic

Key reports (e.g. UDS) should be run regularly so that it is time to submit data is known to be accurate.
Three Outcomes of Data Validation

- **Numerator Issues**
  - Report not finding evidence of Compliance in charts

- **Denominator/Universe Issues**
  - Report including patients that should not be in the universe; wrong time frame, missing exclusions

- **Clinical Issues**
  - Indicated service is not being provided or outcome not being achieved
Data Validation – The Path Forward

- **Numerator Issues**
  - Workflow
  - Structured data
  - EHR report programming

- **Denominator/Universe Issues**
  - Structured data
  - EHR report programming

- **Clinical Issues**
  - Policy Protocols
  - Clinical decision-making
  - Referral data
  - Training
UDS – Depression Screening Measure
### 2015 UDS Screening Clinical Measure Results

<table>
<thead>
<tr>
<th>UDS Screening Measure</th>
<th>National Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorectal Cancer Screening</td>
<td>38.35%</td>
</tr>
<tr>
<td>Depression Screening and Follow-up</td>
<td>50.61%</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>56.03%</td>
</tr>
<tr>
<td>Weight Assessment and Counseling for Children and Adolescent</td>
<td>57.89%</td>
</tr>
<tr>
<td>Adult Weight Screening and Follow-up</td>
<td>59.41%</td>
</tr>
<tr>
<td>Tobacco Use Screening and Cessation Intervention</td>
<td>82.83%</td>
</tr>
</tbody>
</table>
# 2015 UDS Screening Clinical Measure Results

<table>
<thead>
<tr>
<th>Health Center Descriptor</th>
<th># of Health Centers</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>621</td>
<td>51.52%</td>
</tr>
<tr>
<td>Rural</td>
<td>754</td>
<td>49.82%</td>
</tr>
<tr>
<td>&lt; 25% Homeless</td>
<td>1283</td>
<td>50.62%</td>
</tr>
<tr>
<td>&gt; 25% Homeless</td>
<td>92</td>
<td>50.00%</td>
</tr>
<tr>
<td>&lt; 25% Agricultural Workers</td>
<td>1338</td>
<td>50.64%</td>
</tr>
<tr>
<td>&gt; 25% Agricultural Workers</td>
<td>37</td>
<td>49.69%</td>
</tr>
</tbody>
</table>
### 2015 UDS Depression Screening Measure Results

<table>
<thead>
<tr>
<th>Health Center Descriptor</th>
<th># of Health Centers</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 5,000 patients</td>
<td>363</td>
<td>48.25%</td>
</tr>
<tr>
<td>5,000 – 9,999 patients</td>
<td>281</td>
<td>49.22%</td>
</tr>
<tr>
<td>10,000 – 19,999 patients</td>
<td>355</td>
<td>50.50%</td>
</tr>
<tr>
<td>20,000 – 49,000 patients</td>
<td>286</td>
<td>49.17%</td>
</tr>
<tr>
<td>&gt; 50,000 patients</td>
<td>90</td>
<td>53.30%</td>
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</tbody>
</table>
### Screening for Clinical Depression and Follow-up Plan, Line 21

- **Universe (Denominator), Columns A and B:** Patients aged 12 years and older with at least one medical visit during the measurement period
  - Born on or before December 31, 2003
  - Had at least one medical visit during the measurement year

<table>
<thead>
<tr>
<th>Line</th>
<th>Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan</th>
<th>Total Patients Aged 12 and Older (a)</th>
<th>Charts Sampled or EHR Total (b)</th>
<th>Number of Patients Screened for Depression and Follow-Up Plan Documented as Appropriate (c)</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>MEASURE: Percentage of patients aged 12 and older who were (1) screened for depression with a standardized tool, and if screening was positive (2) had a follow-up plan documented.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Screening for Clinical Depression and Follow-up Plan, Line 21

Universe (Denominator), Exclusions:

- Patients who refuse to participate or who are in urgent or emergent situations
- Patients whose functional capacity or motivation to improve impacts the accuracy of results
- Patients with an active diagnosis for depression or a diagnosis of bipolar disorder
- Patients who are in ongoing treatment for depression
Screening for Clinical Depression and Follow-up Plan, Line 21

Numerator, Column C:
- Patients screened for clinical depression on the date of the visit using an age-appropriate standardized tool and, if screened positive for depression, a follow-up plan is documented on the date of the positive screen

Include patients with screening test results:
- That were negative
- That were positive and had a follow-up plan documented
UDS Review – Common Report Issues (edits)

- ‘Universe (denominator) in Question’
  - Are you including all medical patients over 12 from all of your sites?
  - Have all the patients included had at least one medical visit during the measurement period?
  - Are you excluding patients with current diagnosis of depression?
  - Are you excluding patients currently in treatment for depression?
UDS Review – Common Report Issues (edits)

● ‘Compliance Rate Questioned’
  – Are you counting only positive depression screenings? (which would result in a lower compliance rate)
  – 100% Compliance rate?
  – Is your workflow mapping properly – is the right data getting to the right place
  – Have you validated your data?
Validating Your Data

Validating your Data Audit Tool
http://www.hiteqcenter.org/Resources/HealthITEnabledQl/ValidatingDataAccuracy/tabid/141/Default.aspx

Potential Data Issues:

- **Report Missing Values**
  - *Example:* report not picking up patients from all sites/report not pulling follow-up data

- **Timing**
  - *Example:* report not pulling data from correct time frame

- **Non-Compliant Value**
  - *Example:* report pulling values such as when patient refused depression screening and is counted as compliant
Validating Your Data

Validating your Data Audit Tool

Potential Data Issues:

- Documentation in the wrong location
  - *Example: Follow-up provided, but documented in free text*

- Documentation in invalid form
  - *Example: Follow-up provided, but documented as free text instead of a check-box*

- No Service Provided
  - *Example: Report is not pulling when screening and follow-up was provided or report is correct and no service provided*
Validating Your Data

Validating your Data Audit Tool

Potential Data Issues:

● Exclusion Issue
  – *Example: report is pulling patients with a diagnosis of depression or currently in treatment for depression.*

● Service Incomplete
  – *Example: report is pulling only screening information and not picking up follow-up provided.*
The data you are collecting, reporting and using is important and meaningful.

- Manage patient’s health and behavioral health
- Identify prevention needs of healthy patients
- Support management of patients with chronic conditions
- Supports integration of primary care and behavioral health services
- Supports improvement activities
- Also supports Public Health and Population Health activities
CIHS Resources

- Screening Tools

- Health Information Technology
  - http://www.integration.samhsa.gov/operations-administration/hit

- Workflow
  - http://www.integration.samhsa.gov/operations-administration/workflow

- Confidentiality
  - Http://www.integration.samhsa.gov/operations-administration/confidentiality

- Integrated Care Models
Health IT Enabled Quality Improvement

EHR Selection and Implementation

Health Information Exchange

QI/HIT Workforce Development

Value-Based Payment

Privacy and Security

Electronic Patient Engagement

Population Health Management

http://www.hiteqcenter.org/
Q & A
CIHS Tools and Resources

Visit [www.integration.samhsa.gov](http://www.integration.samhsa.gov) or e-mail [integration@thenationalcouncil.org](mailto:integration@thenationalcouncil.org)
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.