How to ask a question during the webinar

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Today’s Objectives

• Health Center Program Impact
• Key Strategies
• Clarification on reporting for UDS
  What population needs to be screened? What screening tools do I use? What “counts” as a brief intervention, referral to treatment? How do I document and record?
• What “counts” as documentation?
• Identify barriers and challenges that CHCs might be facing in screening for depression and reporting results
• How to utilize the EHR to produce meaningful data

• Provide a vehicle for peer sharing via the CIHS BH Expansion listserv
• Generate discussion, clarification and questions
Primary Care: Key Strategies

- Increase access to primary health care services for underserved populations
- Modernize the primary health care safety net infrastructure and delivery system
- Promote a performance-driven and innovative organizational culture
- Improve health outcomes for patients
- Modernize the primary health care safety net infrastructure and delivery system

Primary Care Strategy: Modernize Infrastructure and Systems

Accomplishments:
- Modernized over 2,300 service delivery sites
- 96% of health centers have installed Electronic Health Records (EHR)
- 61% of health centers are Patient Centered Medical Home (PCMH) recognized

Program Goals:
- Increase % of health centers that report UDS data using an EHR
- Increase % of health centers reaching Stage 2 Meaningful Use Standards
- Increase % of health centers with PCMH at all sites
- Increase % of health centers with modernized facilities
Primary Care Strategy: Improve Health Outcomes

Accomplishments:
• $36 million in Quality Improvement Awards
• Over $100 million in Behavioral Health Integration Awards

Clinical outcomes in certain areas routinely:
• Surpass national averages; and
• Close the gap on disparities

Program Goals:
➢ Increase % of health centers exceeding Healthy People 2020 goals
➢ Increase % of health centers improving performance on quality measures
➢ Increase % of health centers that provide integrated care

February 15, 2015

In 2014 HRSA launched the new depression UDS measures and changes for CY 2014 data collection.

_BH Grantees are required to permit accurate UDS data analysis and submission on February 15, 2015._
UDS Depression Screening and Follow-Up Measure

PERFORMANCE MEASURE: The performance measure is percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented.

Health Center 2014 National Average = 38.8%

Table 6B: Depression Screening and Follow-up

Numerator: Number of patients aged 12 and older who were 1) screened for depression with a standardized tool and, if screened positive for depression, 2) had a follow-up plan documented

Denominator: Number of patients who were aged 12 or older at some point during the measurement year and who had at least one medical visit during the reporting year.

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

Patients who are already participating in on-going treatment for depression
Measure Alignment

<table>
<thead>
<tr>
<th>Metric</th>
<th>UDS</th>
<th>NQF 0418</th>
<th>CMS2v4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator</strong>:</td>
<td>Number of patients aged 12 and older who were 1) screened for depression with a standardized tool and, if screened positive for depression, 2) had a follow-up plan documented</td>
<td>Patient’s screening for clinical depression using an age appropriate standardized tool AND follow-up plan is documented</td>
<td>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</td>
</tr>
<tr>
<td><strong>Denominator</strong>:</td>
<td>Number of patients who were aged 12 or older at some point during the measurement year and who had at least one medical visit during the reporting year</td>
<td>All patients aged 12 years and older</td>
<td>All patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period.</td>
</tr>
</tbody>
</table>

Note: There are minor differences in exclusion criteria for each measure definition.

What population needs to be screened?

Screening of (medical) patients age 12 and older
What screening tools do I use?

A Standardized Depression Screening Tool

A normalized and validated depression screening tool developed for the patient population in which it is being utilized

Details

**Standardized Depression Screening Tool:** A normalized and validated depression screening tool developed for the patient population in which it is being utilized

**Examples of depression screening tools include but are not limited to:**

- **Adolescent Screening Tools (12-17 years):** Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory Primary Care Version (BDI-PC), Mood Feeling Questionnaire, Center for Epidemiologic Studies Depression Scale (CES-D) and PRIME MD-PHQ2

- **Adult Screening Tools (18 years and older):** Patient Health Questionnaire (PHQ9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (SDS), Cornell Scale Screening and PRIME MD-PHQ2
Follow-Up Plan

Proposed outline of treatment to be conducted as a result of positive clinical depression screening. Follow-up for a positive depression screening must include one (1) or more of the following:

- additional evaluation
- 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

What “counts” as a brief intervention, referral to treatment?

“and had a follow-up plan documented if screened positive”

- Sounds like SBIRT?
- We are probably doing this already?
- Looks different for different health centers, patients, and situations
How do I document and record?

• Utilizing the EHR

• V79.0 Screening performed 3725F

• Making it part of the daily workflow

• Who can administer the PHQ9?

Why is this important?

• Improve Quality of Care
• Requirements of the grant
• Outcomes support the work we do
• Data can help change behavior
• Improves quality of care – ex: med compliance – data to help patient’s choice, patient awareness of mood, data to help PCP with med management
An example of a successful roll out of a Depression Screening project at the First Choice Health Centers of Connecticut.

Plan Phase
Baseline Data: Compliance rate of less than 15% by 12/1/14 (*20.60% 2014)
Goal: 80% compliance rate
Identify assigned staff
Mobilize a multi-disciplinary work group
Homework: Answer 2 Questions

Do Phase
Committee structure & public agreements
Addressing the why
Develop an intervention
Pilot the intervention
Provide feedback
An example of a successful roll out of a Depression Screening project at the First Choice Health Centers of Connecticut.

Study Phase

<table>
<thead>
<tr>
<th>Week</th>
<th>Control GRP</th>
<th>Intervention GRP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Week 1</td>
<td>31.93</td>
<td>37.93</td>
</tr>
<tr>
<td>Week 2</td>
<td>31.81</td>
<td>45.71</td>
</tr>
<tr>
<td>Week 3</td>
<td>32.95</td>
<td>57.3</td>
</tr>
<tr>
<td>Week 4</td>
<td>35.19</td>
<td>61.35</td>
</tr>
</tbody>
</table>

Control GRP: Total Nu. of Eligible Pts: 1,972. Total Nu. Screened: 694

Intervention GRP: Total Nu. of Eligible Pts: 326. Total Nu. Screened: 200

Act Phase/Roll Out

- Parallel training of medical assistants and provider
- Weekly monitoring and sharing of data
- Coaching
- Seeking consumer representation
- Sharing results with our consumer base
Example of internal posting and sharing of weekly data at First Choice Health Centers Jan 1- Aug 1, 2015 (81.37%)

Depression Screening: One more reason why you can feel confident that First Choice is the Best Choice for all your health care needs.

In August 2014, First Choice Health Centers launched their behavior health services. In December 2014, medical and mental health providers and other staff at First Choice Health Centers united efforts to increase the screening of patients ages 12 and older for depression. This is important because untreated clinical depression can negatively impact health outcomes for people who have other chronic diseases such as diabetes, hypertension, asthma, and angina (CDC, 2012). Today, First Choice Health Centers has screened 80% of all eligible patients for depression and is on track to exceed the national benchmark in 2015. This is one more reason why you can feel confident that First Choice is your best choice for all your health care needs.

For more information about this performance improvement project please contact Ivette Santiago, Behavior Health Care Coordinator at (860) 528-1359 ext. 261 or at isantiago@firstchc.org
Questions, Comments, Clarification

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For More Information & Resources

Visit www.integration.samhsa.gov or e-mail 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.