Integrating Behavioral Health Care in a Primary Care Practice Transcript

>> Sorry about the delay. Thank you for working through that. This is Kristen Palcisco. I'm calling from Cleveland, Ohio. We are here to discuss depression screening and primary care. I worked on implementing depression screening and primary care when I served at MetroHealth between 2011 and 2013. We not only began routinely doing depression screening but we built the PHQ into the electronic medical record here at Metro, which is epic. The mental health system is an integrated health system with an acute care hospital—housing a level one adult trauma and burn center. We have more than 25 locations throughout Cuyahoga County and several more have opened even in the last year or two.

>> Some quick facts about depression that some of you may already be aware of. The lifetime prevalence is 10–24 percent in women and 5–12 percent in men. 19 million Americans are diagnosed each year with 151 million people affected worldwide. And one of the kickers is that this is the second leading cause of—are projected to be the second leading cause of disability by the year 2020. Depressive disorders are two fold, more prevalent in patients that have chronic nations like diabetes, coronary artery disease, HIV and stroke. And I will add heart failure. Depression is associated with it double the risk—increasing risk of type two diabetes and associated with a 64 percent increase in risk of coronary artery disease. Generally speaking, untreated symptoms of depression exacerbate chronic illness. So this is really something that primary care should be in tune to and working with, in order to manage the patient's overall health.

>> A little bit of background. When I was the informatics fellow here I was working with better health, greater Cleveland. Which I think the name has changed. But at that time, it was a nonprofit house with an MetroHealth which was deporting—reporting screening. Beginning in 2012 but full reporting began in 2014. And so some of the other reasons for working on the project were based in meaningful use and Medicare which covered annual depression screening for adults and a primary care setting. I am on slide four and moving to slide five.

>> What we know about Ohio. A million and a half Medicare fee-for-service beneficiaries and provider practices across Ohio. And CMS data indicates only 1.89 percent were screened for depression. For providers, this is approximately over $56 million of lost revenue. Not a small number.

>> So for those of you not familiar with the patient health questionnaire, there are two components. First is the PHQ-2— which are the first two questions of the full nine question screening. And it is generally a yes or no question. This inquiry about the frequency of depressed mood and a lack of interest or pleasure. Over the last two weeks only. The PHQ-2 is the first step in screening and is not for diagnosis purposes or monitoring. Patients that screened positive, answering yes to either of the first questions, should be evaluated further with the full PHQ-9 to determine whether they meet criteria for depressive disorder diagnosis. There are many different kinds—the PHQ-9 touches on physical aspects like emotional and physical symptoms. I am on slide six and moving to slide seven.

>> And primary care does primary care providers are basically the frontline for many patients, for accessing healthcare. A lot of patients will come into primary care and speak with their provider as does not only a medical provider but also almost like the only counsel they receive or social support. Only 30-50 percent of patients with depression are recognized by primary care providers. And only 50 percent of patients with actual depression receive treatment. A lot of people who are not recognized and not treated, also have chronic conditions.

>> This is current. Who are we screening X at the time when we implemented this, who were we screening quickly built into the system—an annual screening for all patients that were considered adults. For ages 18 and older who are seen in primary care and who did not have a current diagnosis of depression. Not only did they not have a current diagnosis of depression, but something called a problem on electronic medical records— if they didn't have any depression diagnosis, that would also allow them to be part of the criteria. At the time, that was the ICD-9 diagnosis. Now we are on to ICD-10. We successfully implement it this at Broadway family practice in December of 2012 and West park clinic in March of 2013. So those are two different sites for MetroHealth. Broadway family practice is where I was practicing at the time. And we did a pilot there. So we could gather data.

>> Actually, I will go back to slide eight and talk about screening. I know one of the main issues and concerns for people—especially people at MetroHealth, was, how many patients will we uncover and what are we supposed to do with them? Part of what we did to alleviate some of that anxiety was, we actually went from site to site and we did a training similar to what we are going over today. We walked them through the roles, the background, the purpose and the different pieces that were part of the screening process. And we went not only from site to site but we held training for people based on their role—whether ban—which is people at the front desk checking and, the medical assistance, the nurses and providers. And as we worked with the different members who were involved in workflow, we started to realize that there were major concerns for time. Particularly with the providers, there was a lot of anxiety about how many patients they would have to see, how much time this would take because the PHQ asks very sensitive questions and of course that could take an entire 20 minutes. And so when we piloted this at Broadway, we did it with that practice alone and it was a family practice. And we were able to report on some—report on the numbers. As it turned out, I think we have this in one of the future slides. It was a very small number of patients that would have been screened weekly. It came out to 1.8, or 1.2. And with that, we added on some training for the providers so they could feel comfortable managing basic depression and primary care. And we will get to that a little bit later.

>> What happens in the workflow process? We discussed the population. An annual screening of adult patients without a diagnosis of depression. To be done in all outpatient primary care clinics. And we were holding off on specialties at the time. We have something called a pre-visit summary. It is a screen you can access by the front desk personnel. It shows all the information that can be printed out onto the patient's paperwork when they first arrive and when they check it. Basically, it would automatically print when the patient is checked in and be handed to them. The patient would be given a clipboard and a pencil. They would sit in the waiting room and they would complete the PHQ-2 and directions to go on to complete the full PHQ-9 if the screen is positive. The directions also indicate that if you did not answer yes to one of the first two questions, that you do not need to continue. At that point, when they were brought back, a MTA or registered nurse, non-physician, would enter the PHQ-9 data into the PHQ tab into the calculator. So they would check the vitals. They would not ask any questions or discuss any part of the PHQ. They would just take the paperwork and enter the data. For positive screens, one of the things we built into epic was a best practice alert which would be for the provider when they entered the exam room. So the provider did not have to ask questions. The provider did not have to enter data. When they log in, this would immediately pop up. And for negative screens -- the screenings would repeat -- it would automatically come out in the summary.

>> On slide 10, you can see an example of the PHQ-9—and asked, how often have you been bothered by the following problems -- it starts off with little interest or pleasure in doing things which is what we were discussing. Feeling down, depressed or hopeless. So the first two questions, you would ask—answer yes or no. Trouble falling or staying asleep or sleeping too much. Feeling tired or having little energy. Appetite changes which could be a decrease or an increase. Different extremes and appetite. For self-esteem, feeling badly about yourself like you are a failure, like you have let yourself or someone else down. Trouble with concentration, moving or speaking slowly that other people have noticed or the opposite, being fidgety or restless. A lot more than usual. Question nine—this was another major concern by providers. It asked if you have thoughts that you are better off

dead or of hurting yourself. As research showed -- at the time of asking the question, number one does not cause people to become suicidal. But it helps people to feel cared about and opens up the possibility of discussion.

>> Slide 11 shows the pilot results. In one month, we had 137 alerts triggered at Broadway family practice. That meant that there were, in some form or another, 137 positive screens. The number of PHQ-2's and PHQ-9's completed—there were 653 PHQ's completed and one had a blank score. Most likely an error. The diagnoses given as a result of completing them, 26 depression diagnoses new to the problem list. You can see how many scores were positive. Only 26 were diagnosed with depression, a new diagnosis of depression. The average was 13.7 positive PHQ-9 per provider for a nine-week period which averaged out to 1.5 positive PHQ-9 per week per provider. So this is not an overwhelming number. So in making the diagnosis, the average 1.8 diagnoses of depression per divider over a period of nine weeks, which is .2 per week per provider. So not a huge number. This data was really helpful in alleviating anxiety. The next slide, slide 12 was—I think that is where we had intended to bring in my workflow diagram, which was a little too large to include here. We can potentially send that out. It is the little diagram that shows the process we discussed and what the possible outcomes are and choices to make at different points.

>> For the workflow, for the PSR, which is the front desk personnel, we would have the patient check in the PHQ—Prince on the pre-visit screening questions. We also have a medication list that printed with the pre-visit summary and that was part of the usual workflow. So the PSR handed us the patient and was asked please answer the questions on these forms. We also had the PHQ—we had printed versions of the PHQ in other languages. At each site, we would have a staff of printed PHQ's for the language is most commonly spoken—for patient populations in that area.

>> Slide 14, you can see the pre-visit summary and how it was placed or how it was worked into the other questions and information available there. MTA and a nurse. When the patient was called back, they should have reviewed medications, the general screening questions which have since been taken off the summary. And then the PHQ. The responses were entered in the same place as epic in the navigator. And we added a new PHQ tab in the current navigator. And the MTA was simply to ask the patient, did you answer all the questions? If the patient had not, that was an opportunity to hand them a pencil and paper and ask them to complete this. And doing that without discussing the questions themselves. And that could take quite a long time. Slide 16, you can see the PHQ-9 navigator that we built into epic. So the PHQ-9—and I think we have gone through different versions of this. One of the original versions was—you would answer yes or no. It was a score from 0–3. For the rest of the questions, it would be, how often. For the providers—when they went to the exam room and logged into the medical record, and alert was fired for positive screening. And we asked all the providers to add the diagnosis that was made to the problem list. Then we built best practice alert smart sets. So this was a list of diagnoses to choose from, medication and I believe also we had referrals. Is a large component of what we did was bring in support for mental health support? So we had behavioral health and psychiatry located on-site. We also encouraged everybody to reach out to social work. So if on that date someone was feeling suicidal, that they could have a same-day appointment with a social worker that could further evaluate depression and the urgency.

>> So on the SmartSet, there were diagnoses—there still is antidepressant medication to choose from. First-line agents—referral options. And after the visit summary and charting notes you can include. With the after visit summary when it is printed and given to the patient, if they score positive for depression, there would be a little blurb in there that you were screened for depression and you had a score of mild depression. And we recommend that you do this. And I believe it gives emergency contact numbers and case something was to go very wrong or get worse.

>> On slide 20, you can see an example of the best practice alert. This one says your patient completed a PHQ-9 depression screening today. They are scoring moderate depression. And you may accept the SmartSet for referral

information or two, if the SmartSet is not accepted, please choose your reasons. Review the following algorithm for a score of depression. Treatment options include patient education and oppression, follow-up was recommended to be by clinician discretion and to repeat the PHQ-9 if the clinician feels it is needed. And so the treatment algorithm was developed by myself and doctor Tony Johnson who was a vice chair at the time of psychiatry at MetroHealth. And it was based on the studies that were done on the PHQ-9. There was mild, moderate, moderate to severe and severe depression. The next slide, 21, shows the sample best practice alert message does the last one was for moderate depression. This one is for severe depression. And you can see how the recommendations differ. Next is the PHQ data, where the PHQ data was stored. We have what is called a doc flowsheet. So the information could be referred to and could also be gathered as part of the data collection.

>> Slide 23 shows depression treatment algorithm that I just referred to. So a score of 5–9 was mild depression. 10–14 is moderate. 15–20 is moderate to severe. A score of greater than 20 would be considered severe depression. That is the point in which you really want to consider antidepressant therapy. So we did some education. We built education for the providers on how exactly to go about that. Most of the providers we talked toward hesitant to manage depression and primary care.

>> Next, the after visit summary—I think I referred to that before. This is typically what it would say on the summary that was handed to the patient for their visit that day. Letting them know that they completed a screening and they should follow the plan of care that was instructed by the provider. And some emergency numbers and casings were to get worse.

>> The evidence-based resources were based on the impact and MacArthur model. I would encourage you to go to these websites because there is a lot. Quite an abundance of information and recommendations on how to manage depression and primary care. And that was the foundation for a lot of the information we used here and integrated into our approach.

>> Next on slide 26, you can see—you should be able to see a couple of websites. This is where we pulled the PHQ does the PHQ questionnaires in different languages. I think it was 20 different languages.

>> Next, the educational component. Dr. Johnson and I created three webinars on depression education. I haven't checked. But I don't believe this is the updated website. And if it is not, we could potentially send out either the webinars or the updated link. This is. I apologize. So I encourage you to visit. And we did three different webinars. We covered medication management. We covered suicidal ideation.

>> Following that, we went live and epic after the pilot with Broadway. We ended up going live and all of the ambulatory clinics in 2013. For a while, we left out main campus internal medicine. Because we had to work out some kinks. With those have been live now for a while and working very well.

>> The PCMH and NCQA conducts depression screenings for adults and adolescents using a standardized tool.

>> At this point, if anybody has any questions, feel free to ask. My contact information is listed. My e-mail is Kpalcisco@MetroHealth.org. And I am happy to answer any questions by e-mail as well.

>> Thank you for your time.

>> Thank you. We have several questions that have been entered into the chat. I will pop them in so everybody can see them because they were sent privately. The first one is, how is the PHQ entered?

>> A great question. We just went over that a little bit. There are basically these little tabs and buttons that you would click on, on a computer. That data was stored and what is called the doc flowsheet. So a separate area with an epic where the data would go. And it can always be pulled out through the team. We could ask for a report showing the data. But we did not scan those there were a lot of questions—a lot of discussion about this. That we did not scan the actual paper into the electronic medical record.

>> Next question. Is there a message or spiel that repent—that receptionists share before giving the PHQ to patients?

>> Yesterday basically hand them the pencil and do something to write on. They ask them to please fully complete any questions on the paperwork. I will say that this was also a piece that we have been looking at and have talked about revising. Sometimes patients don't read well and sometimes, the paperwork gets lost. And there is always a concern and they feel like maybe it is in private enough to complete in the waiting room. That has not always been the case. Sometimes it is just some kind of error like they forget to fill it out and they don't realize it was there and they are called back too soon. As a provider myself, depending on what was going on with my patient, I would go through the full PHQ-9 which can take it while. Depending on who the patient is and what their concerns are, it might be worth it. But that is not common at all.

>> Next question. What if another language was needed or if the patient could not see or read?

>> If the patient could not see or read, we would ask the—MTA would ask if they want assistance in going over it and they could ask the questions. I think I have only—I don't have the data for that. I have only heard of that happening once or twice. And—I'm sorry, what was the other part of the question?

>> What if the patient could not see or read—so they were disabled in some way.

>> I think we answer that. I thought there was another piece to that.

>> Next question. What is keeping a broader acceptance—the need to screen by all primary care clinics.

>> Say that again please.

>> What is keeping a broader acceptance of the need to screen by all primary care clinics?

>> I think what they are asking is—how can we do that? Keeping a broader acceptance. For one thing, it is part of a culture change -- at least for us here. And also financial incentives. I think—which is not something—for the institution, there is some financial incentive—I think, for meaningful use. At least for MetroHealth, there was. Also, for—at least for the clinics themselves, it was part of us going into the clinic and doing the education and helping them see the importance. And the fact that it wouldn't take too much of their time and effort to do so. And emphasizing the need to treat the whole person. If we just separate all the components, we would all be working and specialty care. Primary care providers are well aligned to be treating the whole person. And I think should be focusing on that.

>> Fantastic. We have two minutes before the hour is up. So I want to give people what you have time to type in questions. Do us a favor and type it into the chat. You will notice at the top right-hand corner of the screen, there are some icons there. One that lists participants and one that is for chat. I want you to click on the chat. When you send it, send it to all participants. Private messages are fine but we will end up copying and putting it into the chat as well. We would like to hear you. So we welcome that. Any other comments that you would want to jump in and make it, Bonnie, considering there are implications here with adopting these methods that would help

people—help them participate in the quality payment program? Should be a time for the agency—payment program service center.

>> That would be great. Depression and alcohol screening both would be—even though it is difficult to wrap your arms around at first, as support staff for a provider and office, it really is something that is challenging in the beginning. Sooner than later, it becomes routine. And they can't remember when they did not ask those questions. Support staff as well as providers were very hesitant at first. When we started to roll this out—it I would say in a couple of weeks, they were pretty much use to it. From a workflow perspective and working that into the average routine.

>> Fantastic.

>> One last question. What outcome measures have you tracked? Do you think the effort is a successful?

>> For a while, we were tracking things like, how many of the scores fell within a certain range, how many antidepressant medications were prescribed and what they were and how many referrals were made—not only made but followed through on, to either psychiatry, behavioral health or social work. To be very honest, we don't have any updated information with us today. We were using it to go back and do more education with the providers. So we were also looking at how many of the providers were accepting the SmartSet. And who had alerts fired for them. And so for some of the providers, we could use that data to go back and say, is there a way we can help you or is there—is there a challenge you are having with the process? Is there something you are not understanding—so we could go back to the sites and do more education with people. We had to do that a few times.

>> A late breaking question. We have an integrated primary care and behavioral health and our practices—the NH works closely with social workers and case management—we want to give a shout out to the person that provided the comment. We thank you. Let me see if there is another. No question. Just a comment.

>> To our Speaker, Kristen Palcisco, thank you for your insight. As we close the webinar, I will ask everyone to take a few moments to answer the survey. You will be directed there when you close the browser. If you want to take the survey later, you will be receiving an e-mail that contains a link for you to do so. Will also have a Lincoln the same thank you e-mail that will take you right back to our website where you can download the slides and the recording of today's event. I know we had a lot of technical issues. So we want to thank you for your patience. If there are any late questions coming here on out, we will follow up. Thank you so much.

>> Thank you.

>> [Event Concluded].

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