Wednesday, March 31, 2021; 12:00pm PT

California Quality Collaborative

Accelerating Integrated Care: Increase Depression Screening

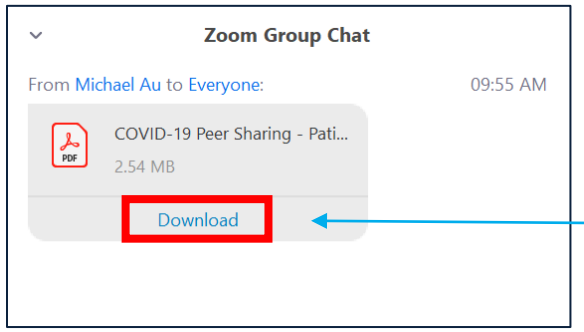
PBGH California Quality Collaborative

Tech Tips – Zoom Meetings

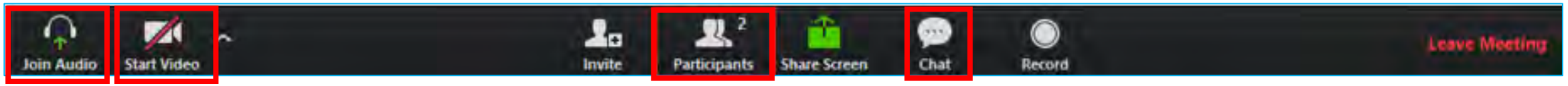
For polls, click the blue **submit button** to complete

Direct message Erika Lind if you have any technical issues

Recording & deck will be shared with attendees



Click Download in Chat for PDF of slide deck



Click to join or mute audio

All attendees have video off upon entry

Click to see who else has joined

Ask questions and insert comments

Poll: Who's in the (virtual) room?

From where are you dialing?

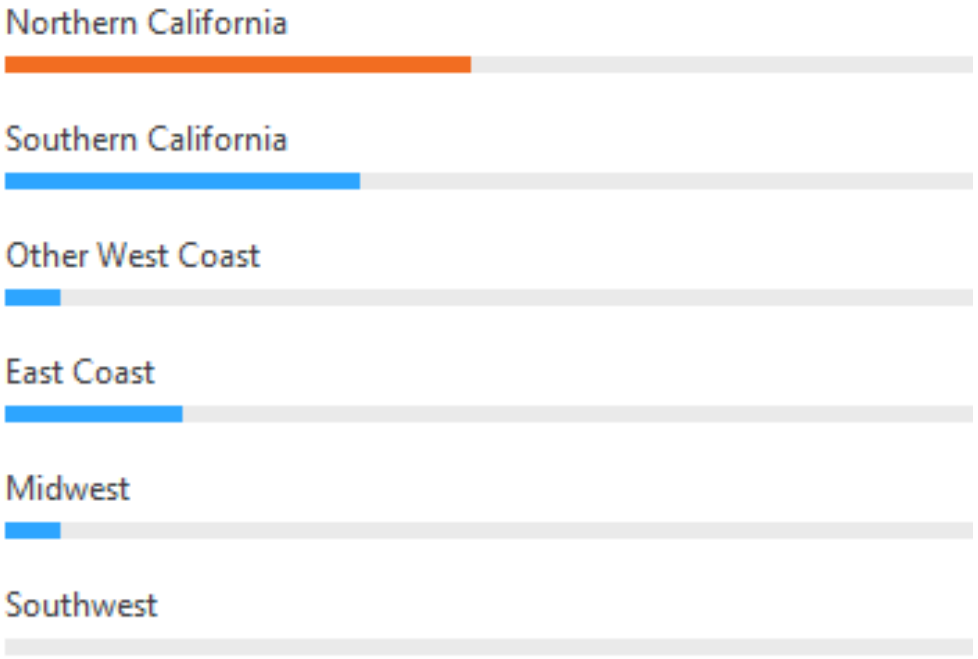
- Northern California
- Southern California
- Other West Coast
- East Coast
- Midwest
- Southwest

What type of organization do you represent?

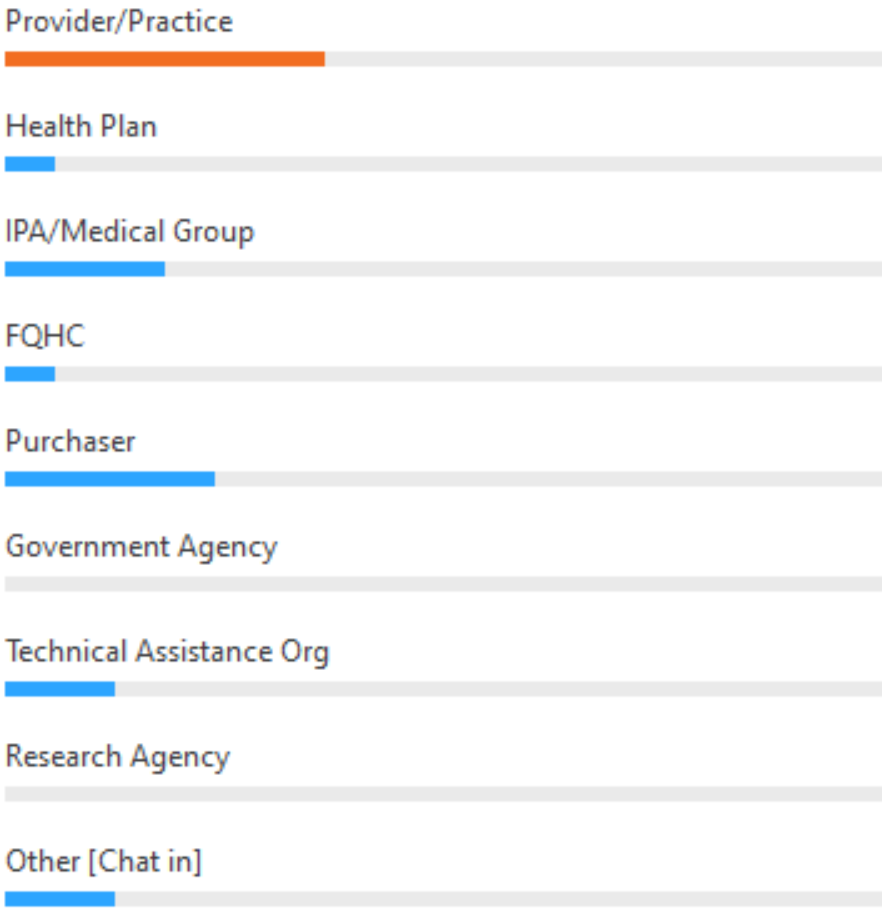
- Provider/Practice
- Health Plan
- IPA/Medical Group
- FQHC
- Purchaser
- Government Agency
- Technical Assistance Org
- Research Agency
- Other [Chat in]

Poll Results

1. From where are you dialing?



2. What type of organization do you represent?



About CQC

California Quality Collaborative (CQC) is a healthcare improvement program dedicated to advancing the quality and efficiency of the health care delivery system in California.

- Generates scalable and measurable improvement in the care delivery system important to patients, purchasers, providers, and health plans.
- Governed by a multi-stakeholder committee and administered by the Purchaser Business Group on Health.

Purchaser Business Group on Health

- Visit CQC's site for additional information and resources **pbgh.org/program/california-quality-collaborative/**
- Visit PBGH's homepage for additional information and resources **pbgh.org**

Today's Speakers

Rachel Brodie
Senior Director, Measurement and Accountability, PBGH

Valerie Kong
Senior Manager, Transparency, PBGH

Michelle Blackmore, PhD
Project Director at Montefiore Medical Center's Care Management Organization

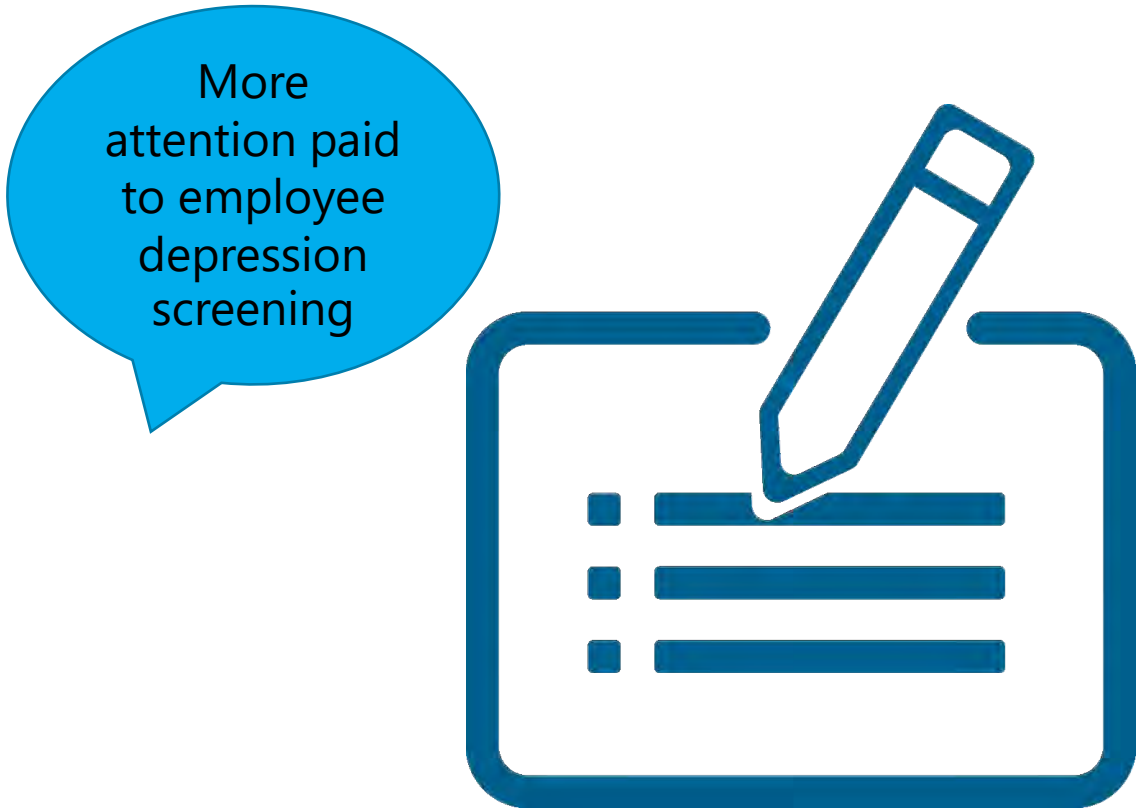
Jessica Jeffrey, MD
Child and Adolescent Psychiatrist at the UCLA Semel Institute for Neuroscience and Human Behavior

Clara Lin, MD
Internal Medicine-Pediatrics Physician, UCLA Health

Rachel Linonis
Director of Digital Solutions for the Nathanson Family Resilience Center and UCLA Division of Population Behavioral Health

Chat in

How has the pandemic changed the way your organization approaches depression screening?



Our Agenda

Today, we'll:

Review importance of depression screening for patients, providers and payers

Hear practical advice and lessons learned from leading health care organizations optimizing depression screening

Share challenges and questions related to depression screening at your organization

Identify a next step you can apply at your own organization

Why we must improve depression screening

CLINICAL

- Depression affects millions of Americans (e.g., high prevalence, lifetime incidence and costly)
- Depression often underdiagnosed in primary care settings
- Treating behavioral health is essential to whole person care / population health outcomes
- Access, cost and stigma pose significant barriers; undertreatment is also a challenge due to access to mental health providers

MENTAL HEALTH ENVIRONMENTAL TRIGGERS

- Mental health crisis exacerbated by public health emergency, disproportionally affecting underserved communities

POLICY/PAYMENT DRIVERS

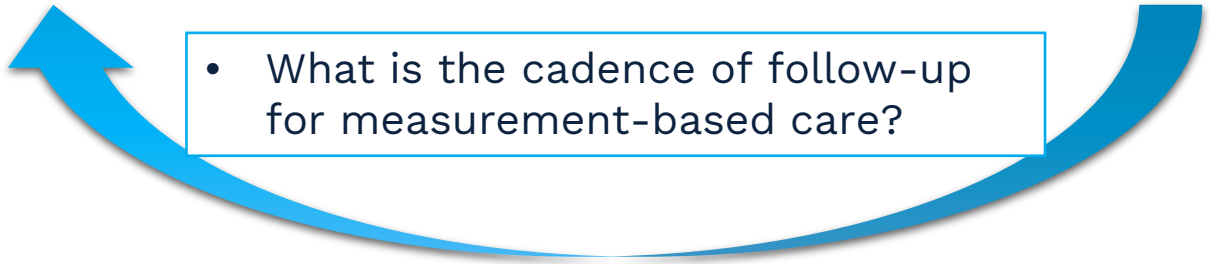
- Increasing demand for behavioral health measures, particularly PROMs, by payers and purchasers
- IHA-PBGH ACO Measure Set
- CQC-PBGH Advanced Primary Care Measure Set
- Covered California pilot with Advanced Primary Care measure set (planned for 2022)
- DHCS California Advancing & Innovating Medi-Cal (CalAIM)

PBGH's Depression Screening Work

- Collaboration with Integrated Healthcare Association to implement and test depression PROMs
- Supporting provider organizations to address practical challenges
  - April 2019: Workgroup of purchasers, plans and POs convened by IHA, PBGH & CQC
  - July 2019: National PHQ-9 Symposium
  - 2020: Four PHQ-9 Workgroup meetings
  - 2021: Developing PHQ-9 Toolkit
- Measurement-based care improves quality – **more effort, but clinically useful and meaningful measurement helps providers and improves outcomes**

Screening is the first step.

STEP	Provider identifies cadence for screening	Team implements screening workflow	Patient completes depression screening	Provider reviews results and makes referrals as needed	Patient begins treatment for behavioral health (if needed)
QUESTION	• How often does screening occur?	• What are front office, clinical and IT tools and workflows needed?	• What screening tool is used? • What modality is used for screening?	• How did you ensure high-risk cases are addressed timely? • If patient is high risk what are next steps?	• How can data sharing be improved between primary care and behavioral health? • Will treatment be in primary care collaborative care or behavioral health setting?

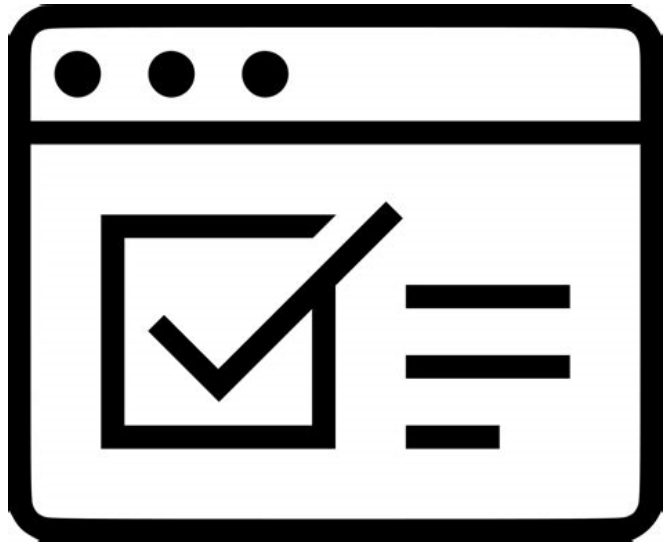


- What is the cadence of follow-up for measurement-based care?

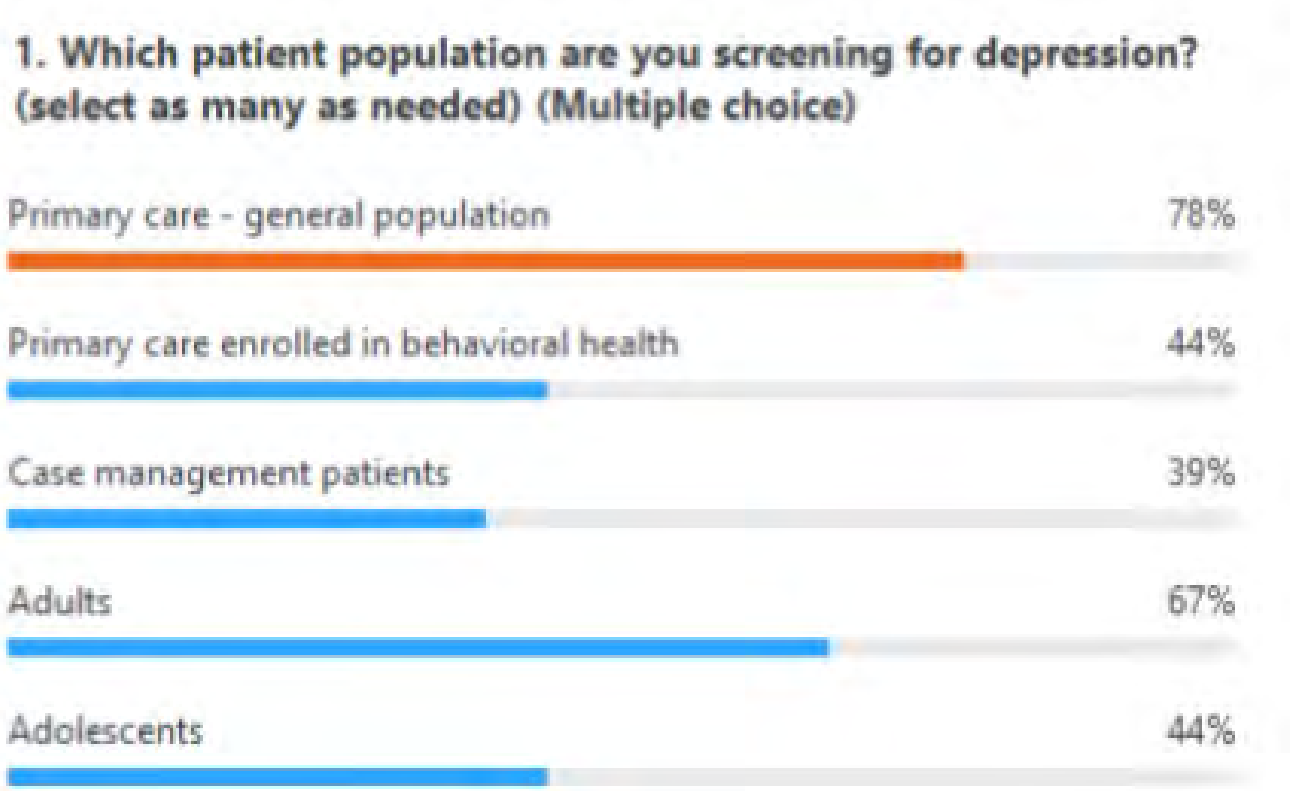
Poll

Which patient population are you screening for depression?
(select as many as needed)

- Primary care – general population
- Primary care enrolled in behavioral health
- Case management patients
- Adults
- Adolescents



Poll Results



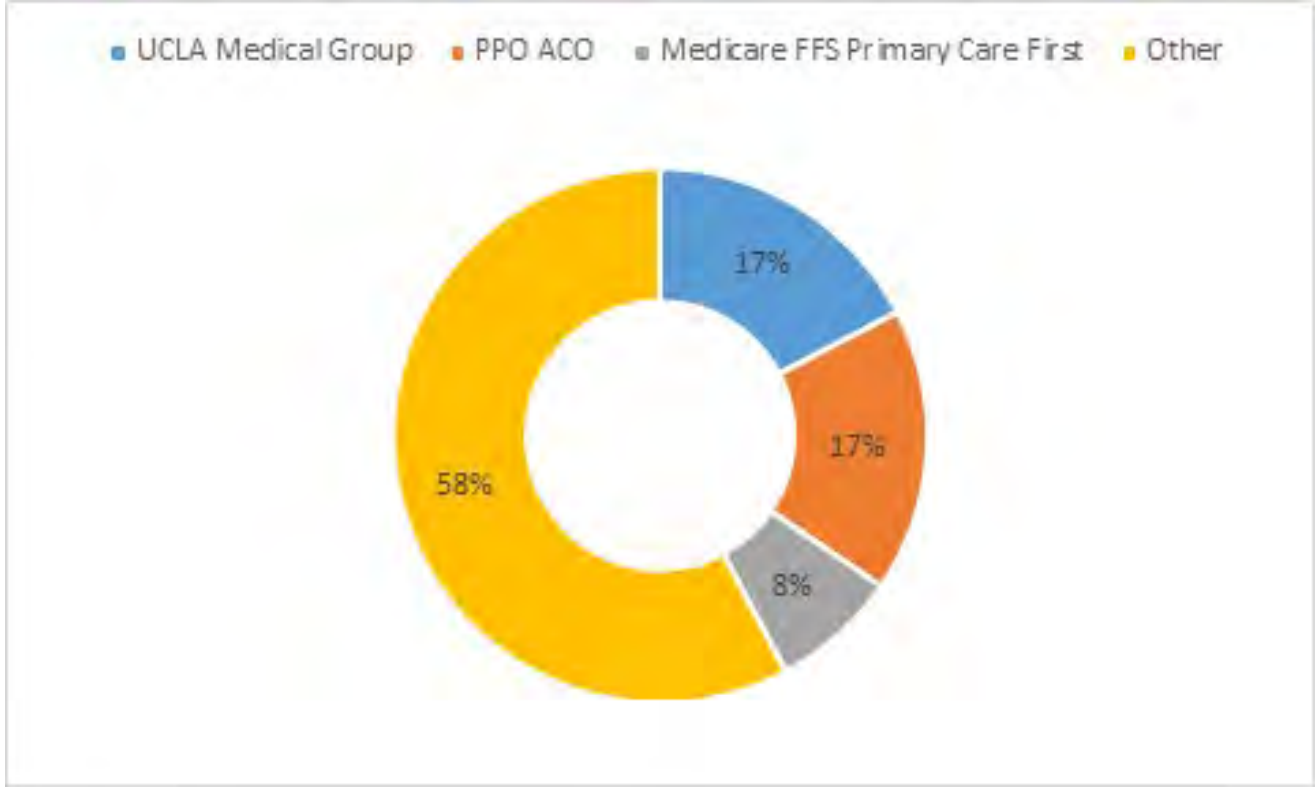
UCLA

Locations

- Primary Care
- Behavioral Health Associates
- Department of Psychiatry

Totals

- 22k+ BHC screenings administered from Jan 2019 – March 2021



Current ACO breakdown in 2021

UCLA Workflow Diagram: Pre-Pandemic

Workflow

When	Annually, and every 3 months if positive
Where	In clinic
1	Computer prompts rooming MA to give PHQ-2 or PHQ-9 (if previously positive)
2	Positive PHQ-2 or previous PHQ-9 >= 5 prompts 4 questionnaires
3	Doctor reviews results during office visit

Key Features

- Baseline completed using a tablet or rooming computer
- 4 questionnaires: PHQ-9, GAD-7, Audit-C, 1 item substance use screener; screens into DAST-10
- Scores recorded in EHR and viewable in real-time by physician via Flow Sheets & standard report in the encounter note
- Positive scores prompt PHQ-9 @ 3-month intervals
- Best practice advisory + C-SSRS triggered by positive Q9

UCLA Workflow Diagram: Modified

Workflow

When	Annually, and at 2-3 months if positive
Where	Remote/virtually checked in for visit, or in clinic
1	MA checks in patient in clinic or virtually
2	MA performs PHQ-2 if prompted
3	MA sends link via MyChart of 4 questionnaires, and Pt advised to complete on their devices
4	Doctor reviews results during office visit

Key Features

- Leverages virtual rooming process (but doesn't capture all patients)
- In-person visit will require patients to bring their own devices
- Survey can be completed outside of clinic as long as patient is virtually checked in
- Q9 considerations: Same day response, pre- and post-survey text, safety-net inbasket messages

UCLA Key Features & Challenges for Discussion

Strengths

- Leverages virtual rooming workflow
- Leverages existing workflow where a positive PHQ2 score triggers 4 additional surveys
- Leverages MyChart process which is familiar to patients and providers
- Q9 considerations: Same day response, pre- and post- survey text, safety-net inbasket messages

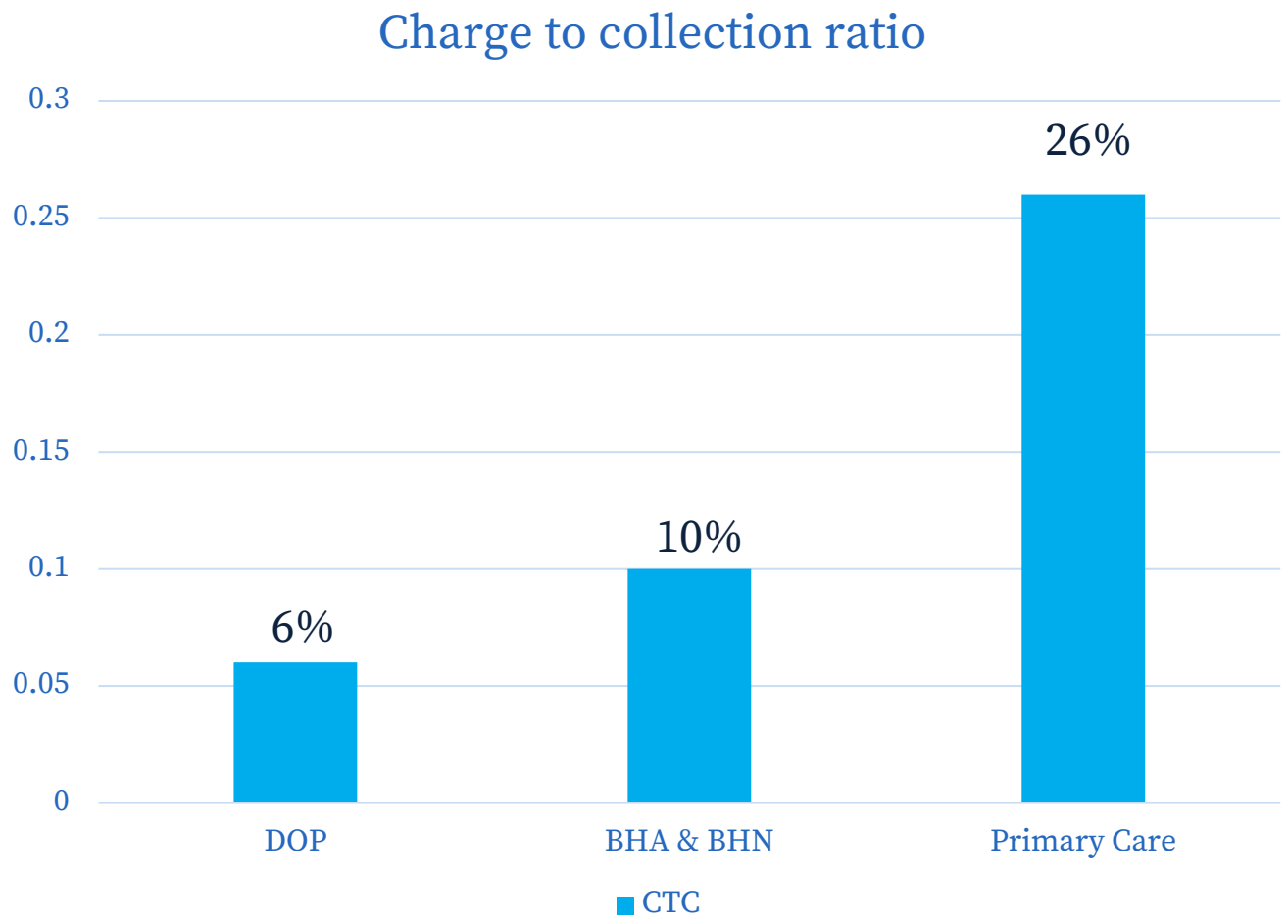
Remaining Challenges

- MyChart method does not capture all patients, particularly those at risk and/or less tech-savvy
- In considerations to expand timeframe of screening pre-visit
- Separate virtual and in-person workflows create constraints on clinic staff
- Risk that patient may not complete virtual visit after endorsing suicidality

UCLA - Coding

96127 Billing Code – Charge to collection ratio

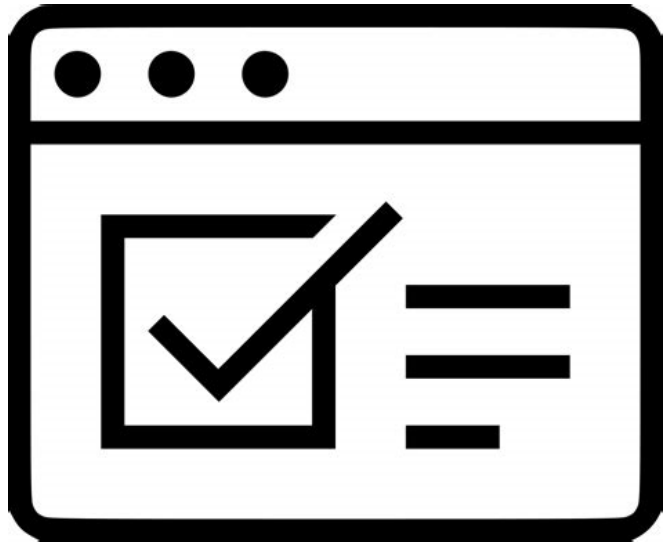
- We see larger reimbursements in Primary Care (but it may also take longer)
  - Need to do more analysis
- 65k+ charges dropped since Jan 2019 – Dec 2020



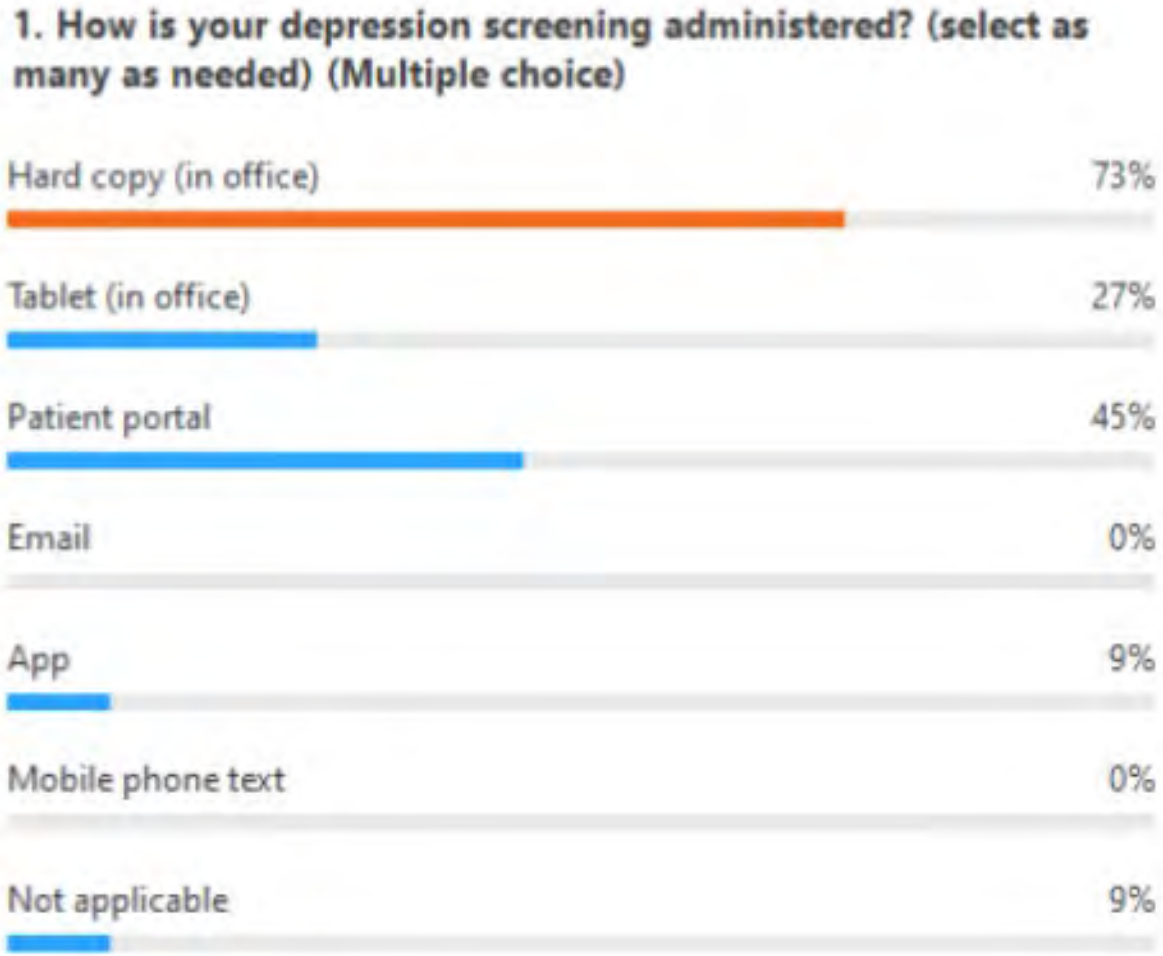
Poll

How is your depression screening administered?
(select as many as needed)

- Hard copy (in office)
- Tablet (in office)
- Patient portal
- Email
- App
- Mobile phone text
- Not applicable



Poll Results



Montefiore

General background

- Patient population
- When and where are screenings done?

Relevant Publications/Articles:

- Carleton K.E., Patel U.B., Stein D., Mou D., Mallow A, & Blackmore M.A. (2020). Enhancing the scalability of the collaborative care model for depression using mobile technology. *Translational Behavioral Medicine, 10,* 573-579.
- Blackmore M.A., Carleton K.E., Ricketts S.M., Patel U.B., Stein D, Mallow A, Deluca JP, & Chung H (2018). Comparison of collaborative care and colocation treatment for patients with clinically significant depression symptoms in primary care. *Psychiatric Services, 69,* 1184-1187.
- Ricketts S, Nguyen TNB, Narasimhan V. Screening for Depression in Pregnancy—There's an App for that! Ann Fam Med May/June 2019 vol. 17 no. 3 275. doi: 10.1370/afm.2388
- American Hospital Association. Members in Action: Improve Quality & Patient Outcomes. Published February 2019. Accessed from: https://www.aha.org/system/files/2019-02/value-initiative-case-study-montefiore-app-improves- outcomes.pdf
- Leavitt Partners. Leveraging Digital Technology to Improve Behavioral Health Integration with Primary Care. Case Study Brief. Published March 2018. Accessed from: https://www.accountablecarelc.org/sites/default/files/ACLC_CSB_Montefiore_Final_1.pdf

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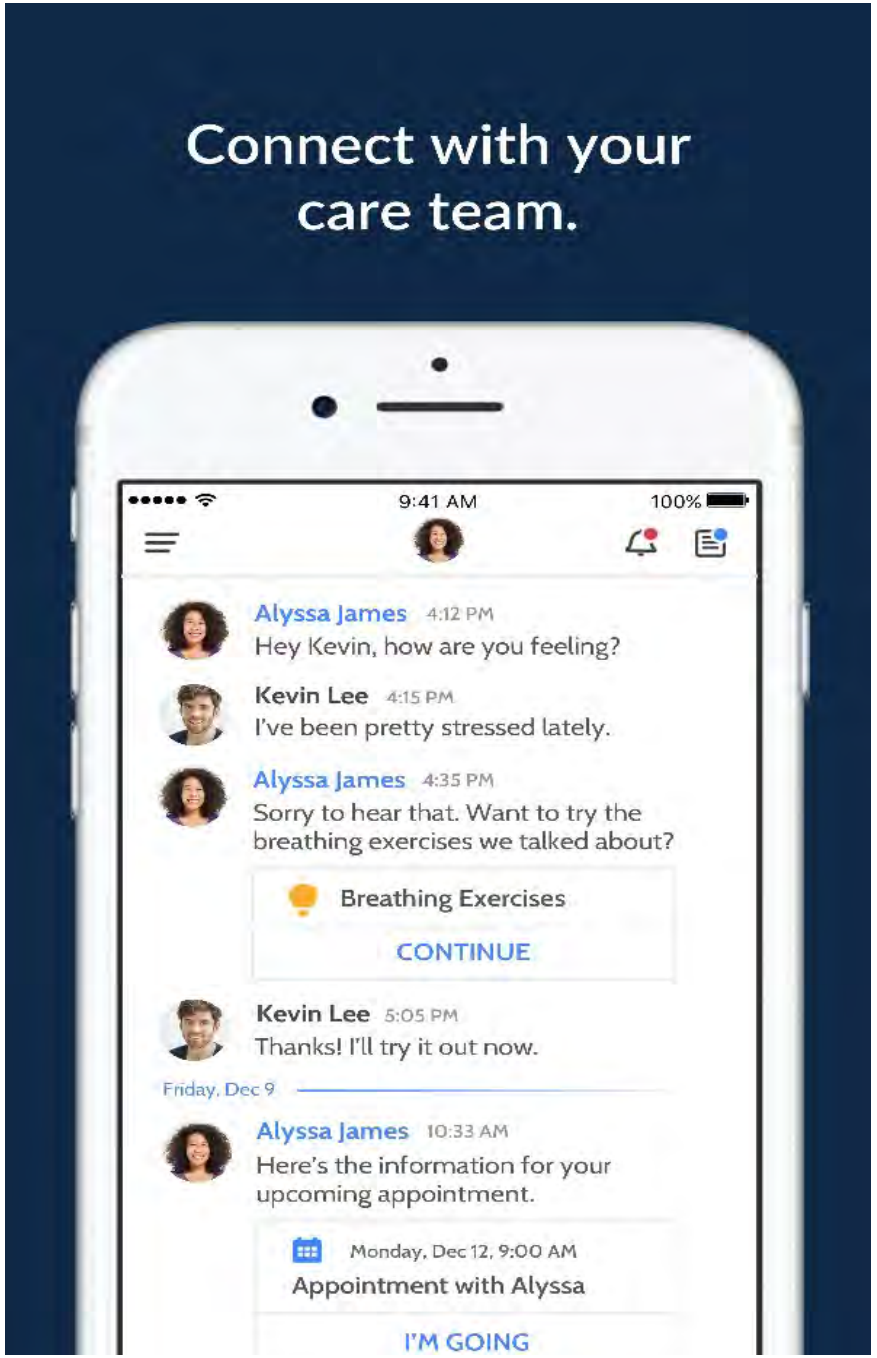
Benefits of Technology Use in Whole Person Health Care

1. **Extend identification & reach of behavioral health care**
   - Improve screening for & monitoring of behavioral health needs
   - Manage higher caseloads w/ less resources
   - Provide in b/w visit care at lower costs

2. Promote pt **self-monitoring & self-management**
   - Increase patient health knowledge & symptom monitoring
   - Promote treatment adherence
   - Transparency of data collection (shared visual representation of progress)

3. Enhance **quality** of care
   - Improve patient & provider communication & engagement
   - More timely identification of patients in need
   - Improve measurement-informed care & timely stepped care interventions

Smartphone App*: Features



*Valera Health

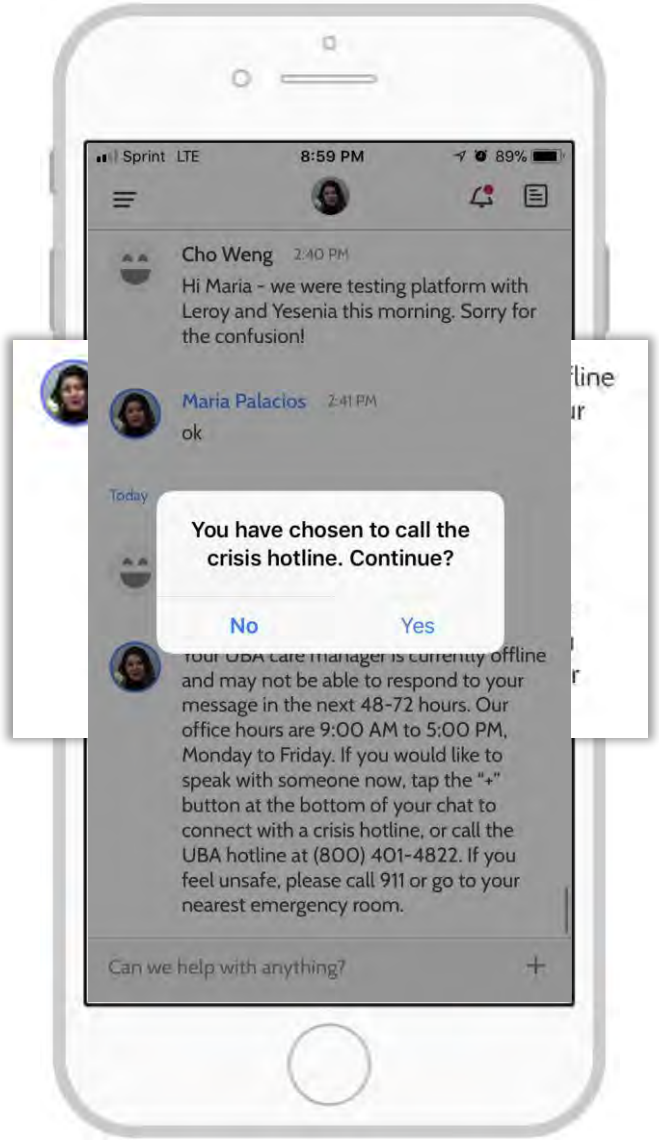
Off-Hours Messaging

Chat messages sent after office hours will receive an **automated response**.

Crisis resources can be accessed directly from the chat screen.

The text option connects patients to the **Crisis Text Line** service.

The crisis hotline connects to the **National Suicide Hotline** or can be configured to connect to **your on-call line**.



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Smartphone Pilot Data: Study Demographics

Enrollment & Engagement Data	
Enrolled	2,962
Engaged in the app	2,086 / 2,962 (70%)

Patient Characteristics	
Age	35.9 ± 12.4
Sex	
Female	87%
Male	13%
Race/Ethnicity	
Hispanic	44%
Non-Hispanic Black	29%
Non-Hispanic White	4%
Asian	1%
Other	9%
Unknown	13%

**Includes: Primary care settings, specialty behavioral health clinics, & Health Homes*

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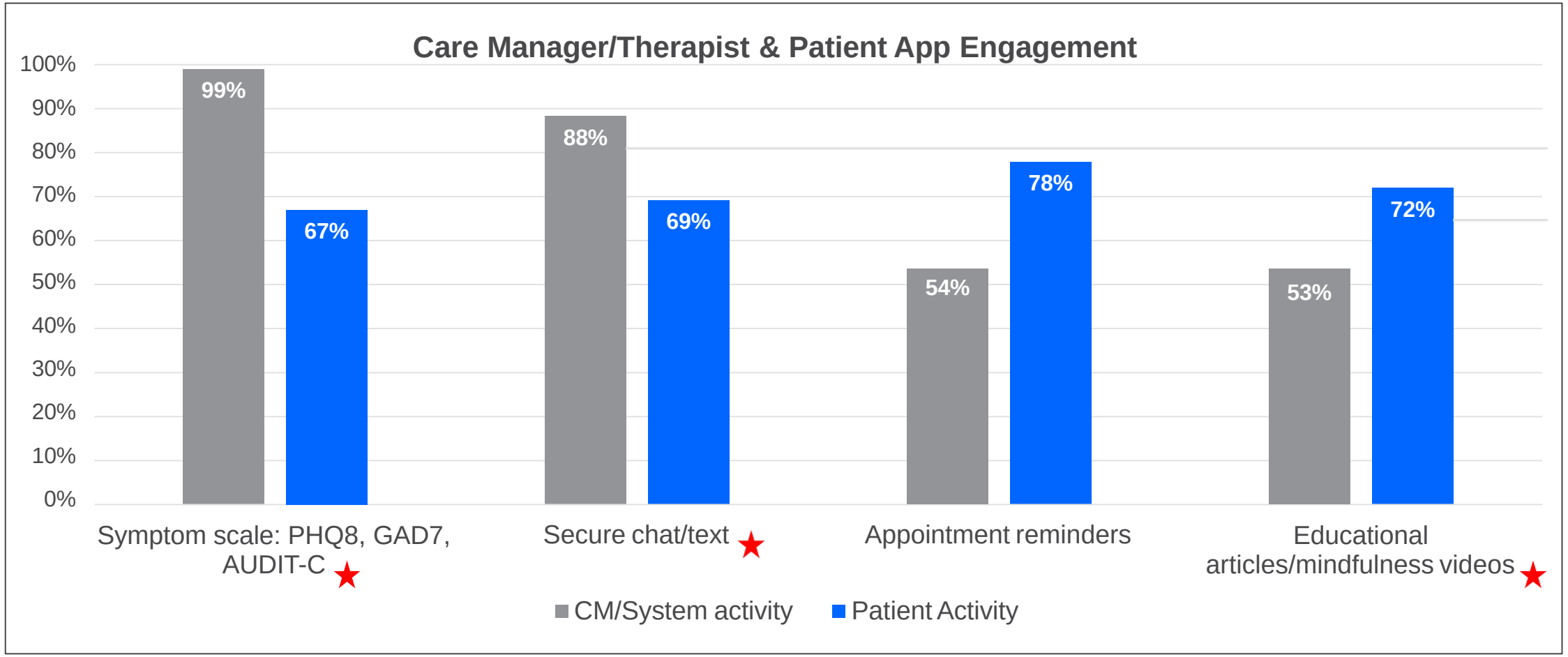
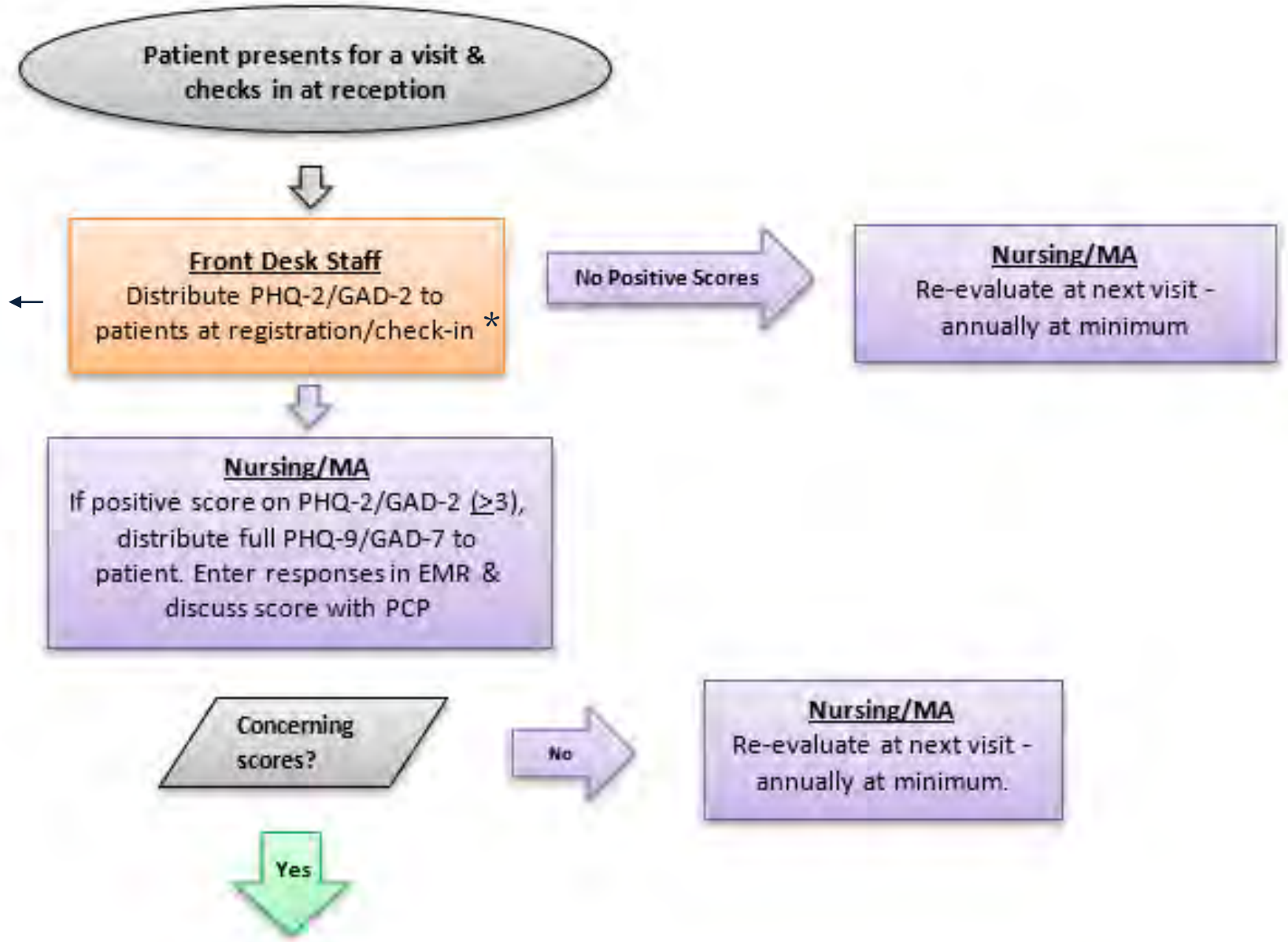
Smartphone Pilot Data: Engagement



★ - *Targets self-management, assertive follow-up, ongoing care management, & measurement-informed care domains on continuum-based framework*

Behavioral Health Screening: Example Workflow



*Coming Soon:
Initial screen can be completed prior to appt via MyChart app

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Triaging & Managing Patients Using Scale Scores

Depression or Anxiety: Positive Screen

PHQ-2 or GAD-2 ≥ 3

PHQ-9 or GAD-7 ≥ 10

PCP intervention

Score = 10-14 (moderate sx):

-Educate/brief psychoed, inform/handouts

-Consider psychopharm (e.g., SSRIs) &/or referral to counseling (PST, BA)

-Monitor/scale follow up 1-3 months *(scales via staff or auto send w/ app or MyChart)*

Score = 15-19 (mod-severe sx):

-Recommend psychopharm &/or referral to counseling

-Review w/ psychiatric consultant if resource avail

-Monitor/scale follow up in ≥1 month *(scales via staff, app or MyChart)*

Involve BH Team Support

Score = 20+ (severe)

-Accelerated review of case & institution of treatment

-Strongly recommend psychopharm &/or referral to specialty BH care

-Review w/ psychiatric consultant if resource avail

-Close monitoring/scale follow up 2-4 weeks *(scales via staff, app or MyChart)*

Talking Points for Behavioral Health Screeners

Question	**Why do I need to fill this out?**
Answer	**SCREENING** Your provider is interested in how you are feeling. It's like taking your blood pressure or temperature but it's focused on how you've been feeling over the past 2 weeks. We ask these questions for all of our patients because we care about how you're doing in all areas. **FOLLOW-UP** *(already in treatment)* Your provider wants to know how you are feeling so that we know if the treatment is working. It's important to measure regularly so that we can change the treatment it it's not working.

http://aims.uw.edu/resource-library/helping-clinic-staff-talk-patients-about-phq-9

App-Augmented Measurement-Informed Care: Take-Aways

App utility generalizable to diverse patient populations & settings

- Patients w/ mild/moderate depression & anxiety to individuals w/ SMI
- Socioeconomically vulnerable; racially/ethnically diverse
- Primary care settings, specialty behavioral health clinics, & Health Homes

Can maximize practice resources essential for timely engagement & care quality

- Aids in quality management of larger caseloads; improves patient access/more treated
- Allows innovative & flexible provision of health care services in b/w office visits
- Automates aspects of measurement-informed care

Improves patient engagement in behavioral health care

- Limit wait times; begin education & monitoring prior to first in person visit
- Improve patient self-management: easy access to health education materials, appt reminders/rescheduling, symptom monitoring scales
- Improve ease of communication w/ care team (text, call, video, etc)

Q & A

- **Rachel Brodie** Senior Director, Measurement and Accountability, PBGH
  - rbrodie@pbgh.org
- **Valerie Kong** Senior Manager, Transparency, PBGH
  - vkong@pbgh.org
- **Michelle Blackmore, PhD** Project Director at Montefiore Medical Center's Care Management Organization
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- **Jessica Jeffrey, MD** Child and Adolescent Psychiatrist at the UCLA Semel Institute for Neuroscience and Human Behavior
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- **Clara Lin, MD** Internal Medicine-Pediatrics Physician, UCLA Health
  - YCLin@mednet.ucla.edu
- **Rachel Linonis** Director of Digital Solutions for the Nathanson Family Resilience Center and UCLA Division of Population Behavioral Health
  - RLinonis@mednet.ucla.edu

Q & A

1. How are your organizations addressing equity issues?
2. How can organizations improve coding for both CPT/HCPCS and LOINC?

Takeaways & closing thoughts

1. Measurement of depression screening improves care
2. Virtual and hybrid office visits adapt well to capture depression screening
3. Technology is an effective tool for engaging hard-to-reach patients
4. ***What's yours? Add into chat….***

Depression screening can decrease health care costs and also increase efficiency (fewer other primary care visits for patients with comorbid conditions)

My takeaways were around how to implement behavioral health check-ups and how to do it virtually and in-person. Also the finance behind the screens and the difference in payment in primary and behavioral health. Thank you!

Great to see technology maximized for health care. Thank you.

Thank you Dr. Blackmore -- it's very inspiring to see that an external app can be utilized so seamlessly into a large health system to improve patient care and specifically depression screening!

Great presentations - really insightful!

Thank you!
Stay Connected to CQC

California Quality Collaborative

Webinar materials will be posted

www.pbgh.org/program/california-quality-collaborative

For questions, feedback, or to receive our newsletter, email us
cqcinfo@pbgh.org

California Quality Collaborative

Appendix

Screening glossary

- PHQ-9: Patient Health Questionnaire-9
  - PHQ-2: Contains first 2 questions of PHQ-9
  - PHQ-8: Contains first 8 questions of PHQ-9
- GAD-7: General Anxiety Disorder 7
- AUDIT-C: Alcohol Use Disorder Identification Test
- DAST-10: Drug Abuse Screening Test
- C-SSRS: Columbia Suicide Severity Rating Scale

Sample Education Material: Antidepressant Adherence

Week 0 (Enrollment)

Week 2

Week 4

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Sample Education Material: OB Project

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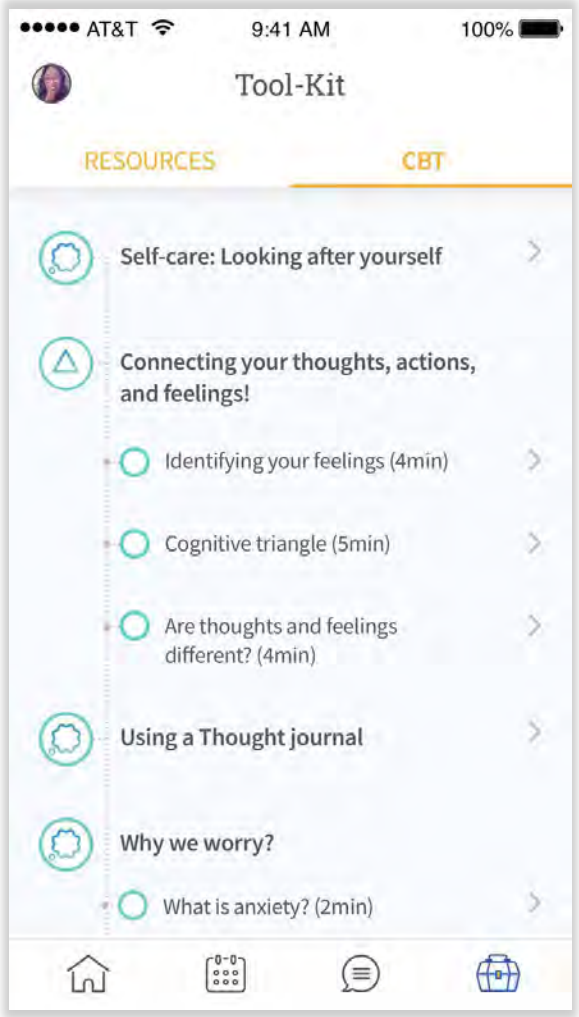
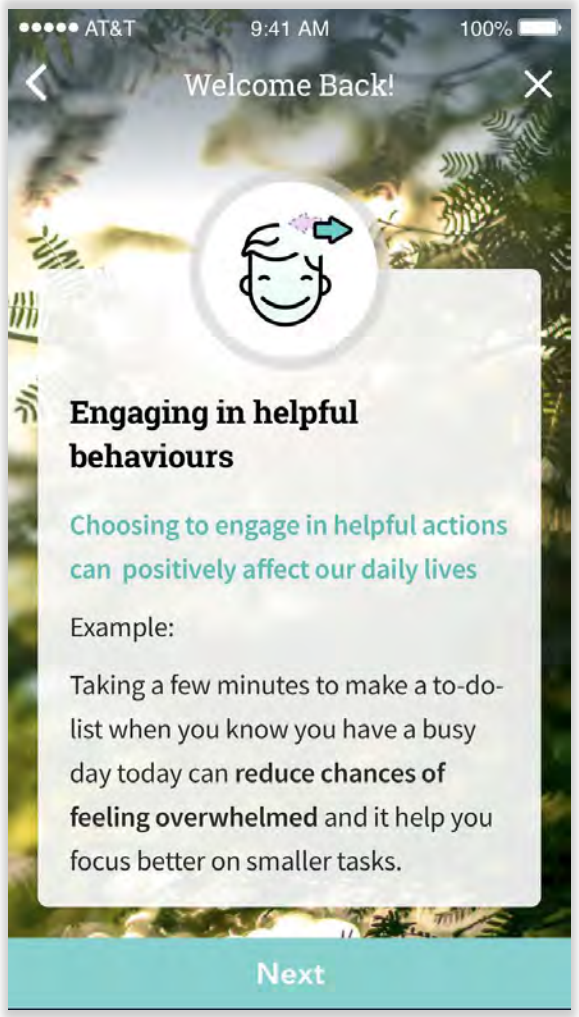
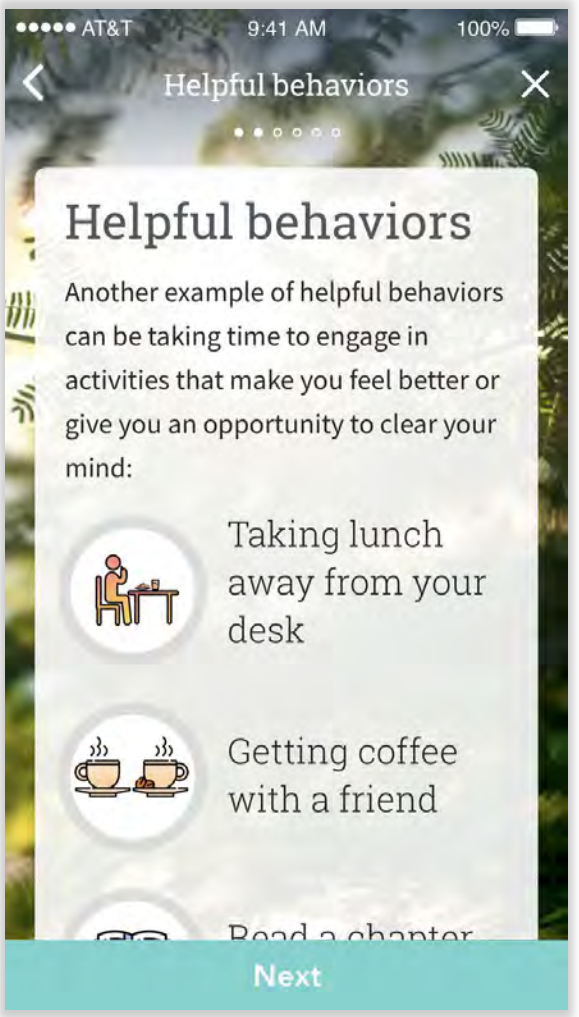
Sample Education Material: Cognitive Behavioral Strategies







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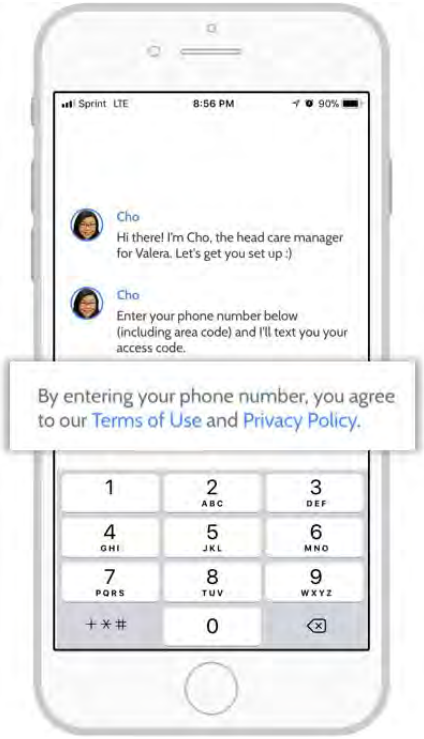
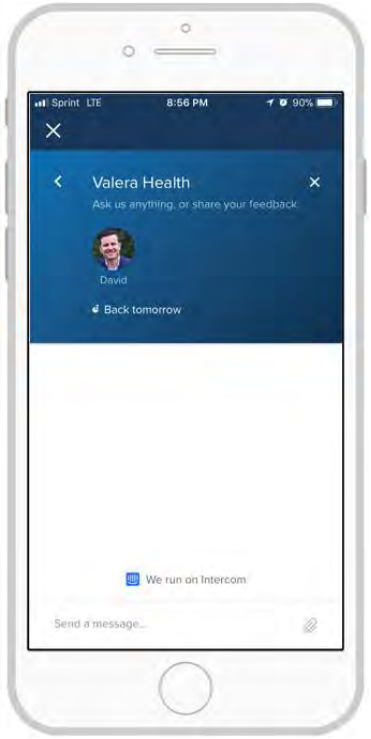
Privacy & Data

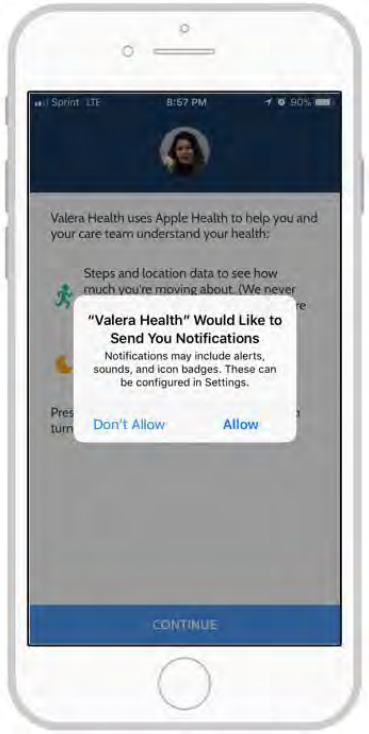
Valera's **Terms of Use** and **Privacy Policy** are presented at the start of onboarding.



Patients can review both documents and ask questions directly from the app before proceeding with login.



Data permissions requests are clearly explained. Patients can choose to allow or deny any of these permissions.



Patients may also set a **passcode** on their Valera app for added security.

Primary Care App Pilot: Appointment Data

Greater app engagement leads to ***less no show appts & more completed appts*** w/ the behavioral health team

-App-engaged patients compared to 1-to-1 matched cohort of non-app engaged patients

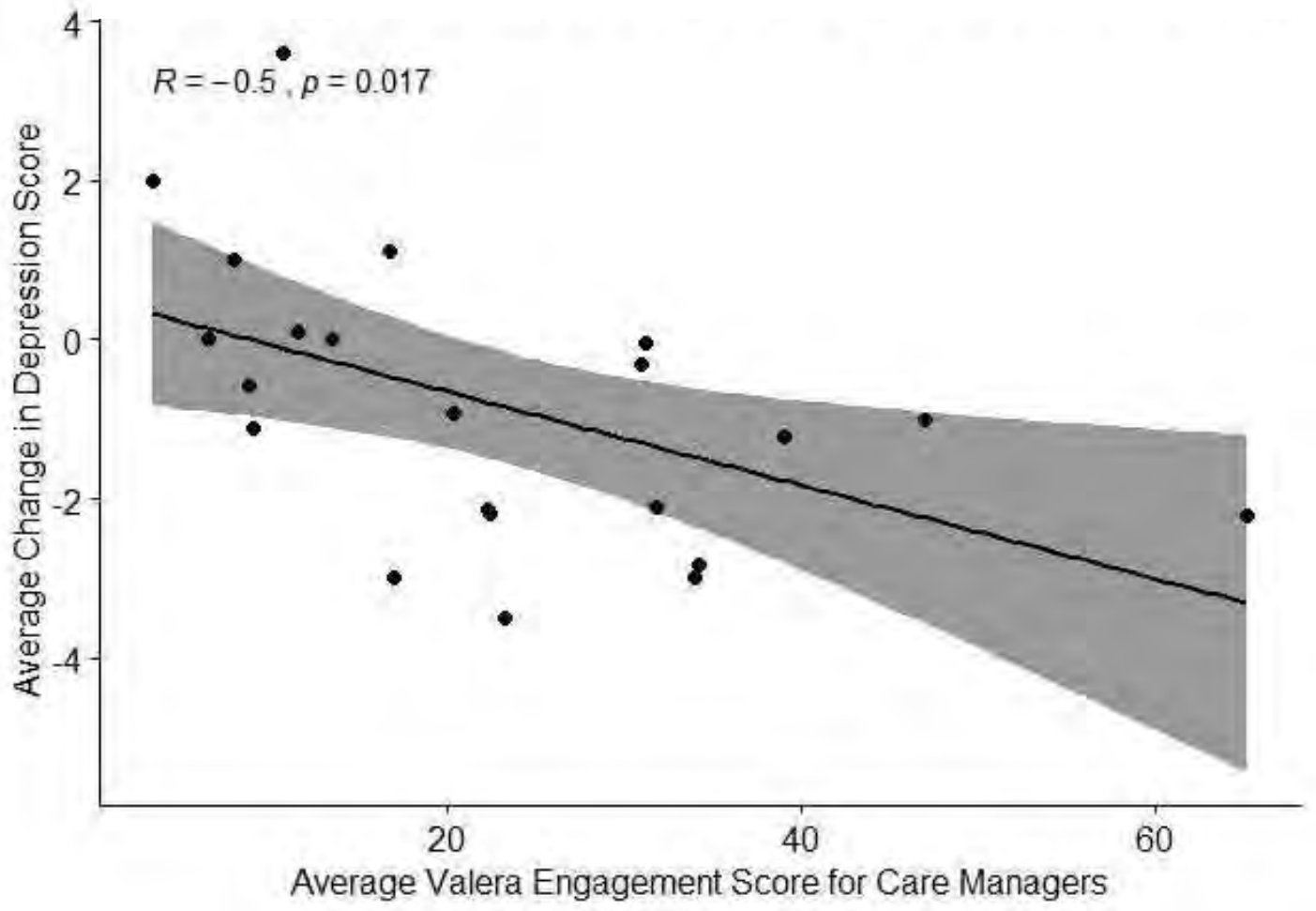
-Matched on: gender, insurance type, age w/i 3 yrs, & prior appt adherence

App Activity Level	Appointment Outcome	App Users	Non-App Matched Cohort	P-value
Used chat or appt feature	No-showed	*n* = 310 **(13%)**	*n* = 261 **(18%)**	*p* = 0.02
Top 24% engaged (13+ active responses)	1) Completed 2) No-showed	*1)* *n* = 103 **(59%)** *2)* *n* = 103 **(7%)**	*1)* *n* = 99 **(51%)** *2)* *n* = 99 **(18%)**	*1)* *p* = 0.02 *2)* *p* < 0.001

Primary Care App Pilot: Engagement & Clinical Outcomes

Care Managers who Use App More Have Patients that Achieve Better Clinical Outcomes

Each dot represents a care manager



OB-GYN Population Data

(*Note: patients are enrolled in ob-gyn clinic & typically not engaged in behavioral health care)

- App module developed for perinatal & prenatal women to screen for depression, substance use, & social determinants of health. Interposed short articles about pregnancy, fetal development, & wellness.
- Rate of positive screens for depressive symptoms concordant w/ prospective research; higher positive screen rate via app self-report than observed w/ on-site screenings throughout NYS.

Enrollment Data (Since April 2018)	
Enrolled in the app/approached to use the app	118/185 **(64%)**
Engaged in the app	88/118 **(75%)**

Primary Outcomes		
App Feature	**CM/System activity**	**Pt activity**
Symptom scale (PHQ8, GAD7, AUDIT-C)	88/88 **(100%)**	65/88 **(74%)**
Educational article/mindfulness video	88/88 **(100%)**	71/88 **(81%)**
Chat/text	84/88 **(95%)**	30/84 **(36%)**
Social determinants of health screen	83/88 **(94%)**	52/83 **(63%)**

Patient Satisfaction Data

Main Outcomes	
Patients satisfied w/ application & would recommend	262/353 **(74%)**
Found the app **“easy to use”**	305/353 **(86%)**
Would **continue using the app** past tx	291/353 **(82%)**
Felt **more connected** to care team	244/353 **(69%)**
Helped pts **work on their healthcare goals**	173/353 **(49%)**
Learned more about their health	146/353 **(41%)**

Monitoring Treatment Response Using Scale Scores

Medication Re-Evaluation after 4-6 Weeks of Treatment		
PHQ-9/GAD-7	**Treatment Response**	**Treatment Plan Examples**
No Response (PHQ-9/GAD-7 same or worse)	Inadequate	-Increase, switch, or augment medication dose -Informal or formal psychiatric evaluation -Refer/add or adjust psychotherapy
Partial Response (PHQ-9/GAD-7 < 5 pt change)	Possibly Inadequate	-Increase medication dose if not at maximum
Response (PHQ-9/GAD-7 $\geq$ 5 pt change)	Adequate	-Maintain medication dose for 4 weeks, & then reassess for further PHQ-9/GAD-7 reduction -If plateau at PHQ-9/GAD-7 $\geq$ 10, increase dose or augment w/ 2nd antidepressant (not both SSRI)

App Project: Publications

Translation Behavioral Medicine[1]

- Non-randomized convenience sample compared frequency of clinical contacts, depression/anxiety severity outcomes, pt & CM engagement, & appointment adherence, at Montefiore primary care sites employing the app
- App-augmented CoCM (*n* = 807) received more clinical contacts, improved treatment and appt compliance, and similar clinical outcomes compared to standard CoCM patients not using the app (*n* = 3,975)

Annals of Family Medicine Publication[2]

- App module developed for perinatal women to screen for depression, substance use, & social determinants of health. Interposed short articles about pregnancy, fetal development, & wellness
- 100+ women enrolled, rate of positive screens for depressive symptoms concordant w/ prospective research; higher positive screen rate via app self-report than observed w/ on-site screenings throughout NYS

LINK - AHA's Members in Action series (2019)[3]

- Series highlighted health systems implementing new value-based strategies to improve health care affordability
- Included detailed description of Montefiore CoCM & use of smartphone app
- Provided lessons learned & implementation suggestions for using technology to maximize workflow & staffing resources

APA Case Study (2018)[4]

- Case study on use of smartphone technology in CoCM program
- Results indicated more frequent & timely patient clinical contacts. Equivalent clinical improvement despite more severe patient population than total CoCM population.

1. Carleton K, Patel U, Stein D, Mou D, Mallow A, Blackmore M. Enhancing the scalability of the collaborative care model for depression using mobile technology. Translation Behavioral Medicine. Transl Behav Med. 2020;10(3):573-579
2. Ricketts S, Nguyen TNB, Narasimhan V. Screening for Depression in Pregnancy—There's an App for that! Ann Fam Med May/June 2019 vol. 17 no. 3 275. doi: 10.1370/afm.2388
3. American Hospital Association. Members in Action: Improve Quality & Patient Outcomes. Published February 2019. Accessed from: https://www.aha.org/system/files/2019-02/value-initiative-case-study-montefiore-app-improves-outcomes.pdf
4. Leavitt Partners. Leveraging Digital Technology to Improve Behavioral Health Integration with Primary Care. Case Study Brief. Published March 2018. Accessed from: https://www.accountablecarelc.org/sites/default/files/ACLC_CSB_Montefiore_Final_1.pdf

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