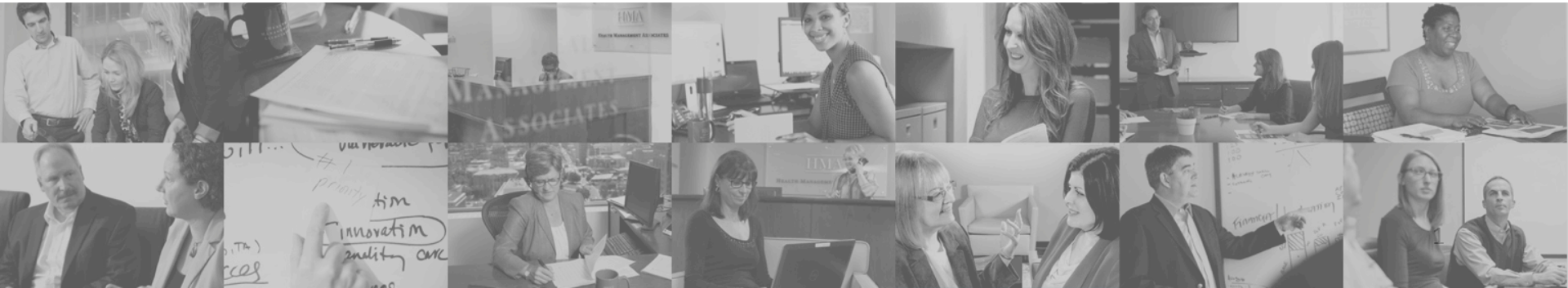
HEALTH MANAGEMENT ASSOCIATES

Lori Raney, MD
Principal

Screening and Measurement-Based Care

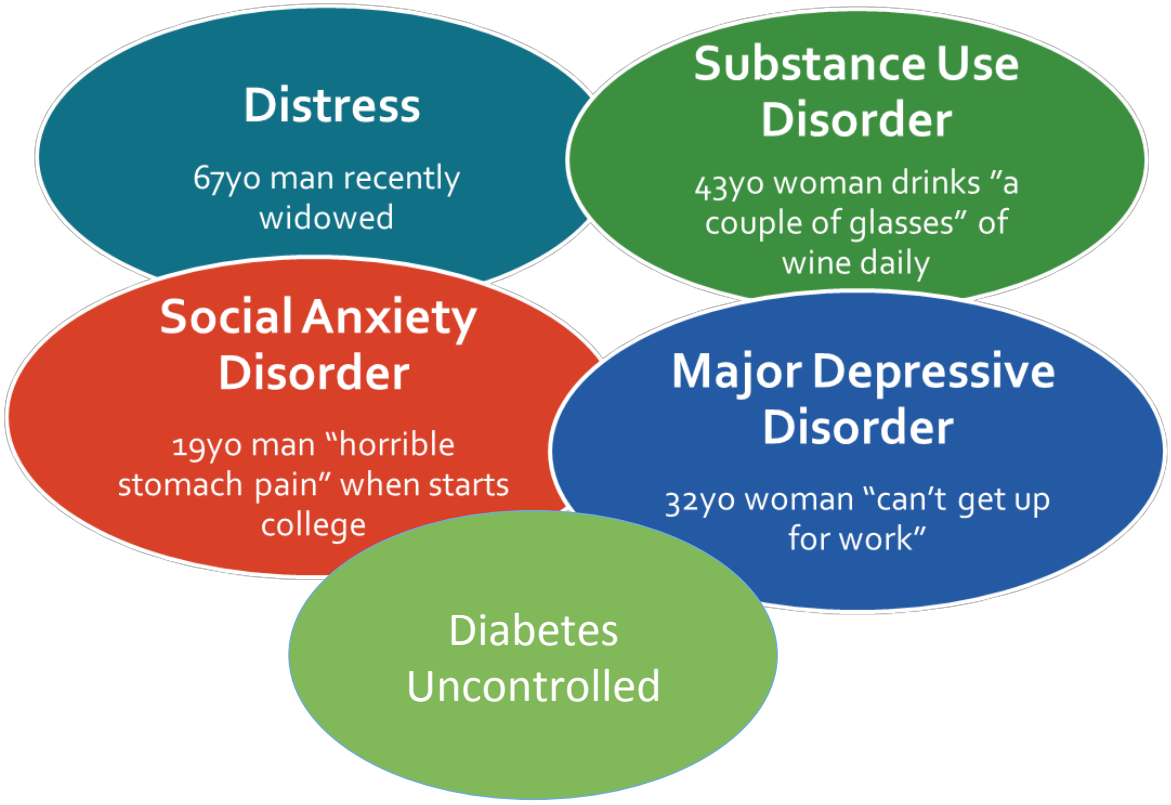
Considerations for Deepening & Strengthening Integrated Behavioral Health



AGENDA

- Review of effective integrated care principles
- Review of validated screening tools: adults and pediatrics
- Process of measurement-based care
- Using a registry to track results
- Tracking individual patient response
- Tracking practice performance on process and outcomes measures
- Workflow Considerations

Behavioral Health Presentations in PC



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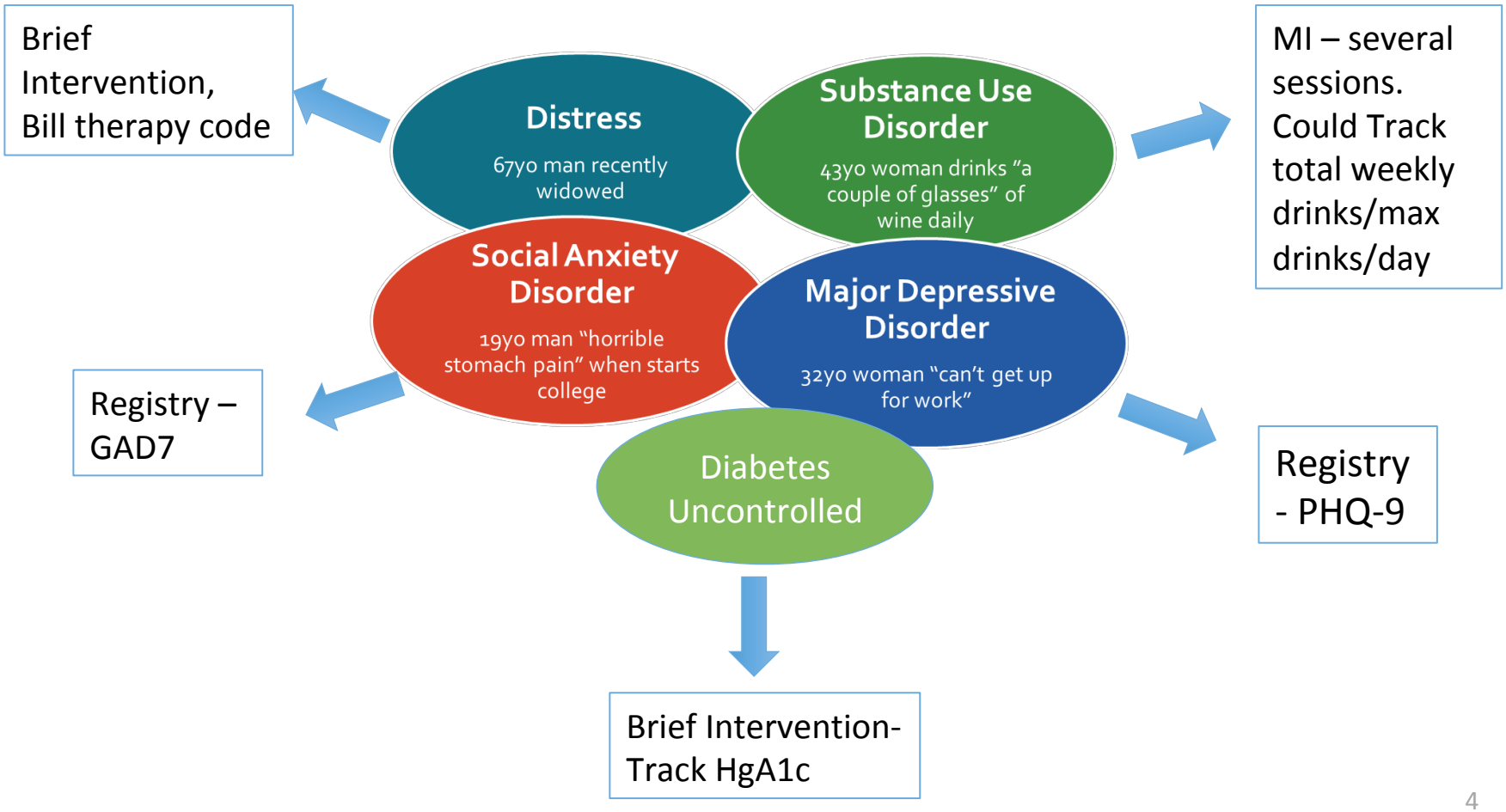


Recipe for Success

Ingredients TEMP

- Team that consists at a minimum of a PCP, BHP and psychiatric consultant
- Evidence-based behavioral and pharmacologic interventions
- Measuring care continuously to reach defined targets
- Population is tracked in registry, reviewed, used for quality improvement
- Accountability for outcomes on individual and population level

Process of Care Tasks

- ***2*** or more contacts per month by BHP
- Track with registry
- Measure response to treatment and adjust
- Caseload review with psychiatric consultant

Secret Sauce *Whitebird Brand*

- Strong leadership support
- A strong PCP champion and PCP buy-in
- Well-defined and implemented BHP/Care manager role
- An engaged psychiatric provider
- Operating costs are not a barrier

Raney L: Integrated Care: A Guide for Effective Implementation APPI, 2017

Effective Integrated Care

Operationalizes the principles of the chronic care model to improve access to evidence based mental health treatments for primary care patients.

Integrated Care is:

- **T**eam-based effective collaboration and Patient-centered
- **E**vidence-based and practice-tested care
- **M**easurement-based care, treat to target
- **P**opulation-based care – registry, systematic screen

- **A**ccountable care

WORKFLOW: SCREEN, TREAT, TRACK, FEEDBACK

- Screen – where and by who?
- Diagnose – PCP or licensed BHP
- Start treatment – PCP and BHP
- Measure treatment response – who does repeat measures?
- Track outcomes – who manages the registry
- Adjust treatment if needed – PCP and BHP
- Feedback results to team – integrated care lead or other

A Tipping Point for Measurement-Based Care

John C. Fortney, Ph.D., Jürgen Unützer, M.D., M.P.H., Glenda Wrenn, M.D., M.S.H.P., Jeffrey M. Pyne, M.D., G. Richard Smith, M.D., Michael Schoenbaum, Ph.D., Henry T. Harbin, M.D.

Objective: Measurement-based care involves the systematic administration of symptom rating scales and use of the results to drive clinical decision making at the level of the individual patient. This literature review examined the theoretical and empirical support for measurement-based care.

Methods: Articles were identified through search strategies in PubMed and Google Scholar. Additional citations in the references of retrieved articles were identified, and experts assembled for a focus group conducted by the Kennedy Forum were consulted.

Results: Fifty-one relevant articles were reviewed. There are numerous brief structured symptom rating scales that have strong psychometric properties. Virtually all randomized controlled trials with frequent and timely feedback of patient-reported symptoms to the provider during the medication management and psychotherapy encounters significantly improved outcomes. Ineffective approaches included one-time screening, assessing symptoms infrequently, and feeding back outcomes to providers outside the context of the clinical encounter. In addition to the empirical evidence about efficacy, there is mounting evidence from large-scale pragmatic trials and clinical demonstration projects that measurement-based care is feasible to implement on a large scale and is highly acceptable to patients and providers.

Conclusions: In addition to the primary gains of measurement-based care for individual patients, there are also potential secondary and tertiary gains to be made when individual patient data are aggregated. Specifically, aggregated symptom rating scale data can be used for professional development at the provider level and for quality improvement at the clinic level and to inform payers about the value of mental health services delivered at the health care system level.

Psychiatric Services 2016; 00:1–10; doi: 10.1176/appi.ps.201500439

https://www.thekennedyforum.org/a-national-call-for-measurement-based-care
https://www.thekennedyforum.org/a-supplement-to-our-measurement-based-care-issue-brief

PROCESS OF MEASUREMENT-BASE CARE

- Systematic administration of symptom rating scales – use huddle or registry
- Measurement Based Care is NOT a substitute for clinical judgement
- Use of the results to drive clinical decision making at the patient level – overcome clinical inertia
- Patient rated scales are equivalent to clinician rated scales

INEFFECTIVE APPROACHES

- One-time screening
- Assessing symptoms infrequently
- Feeding back outcomes outside the context of the clinical encounter

SOURCE: Fortney et al Psych Serv Sept 2016

SCREENING: USE VALIDATED TOOLS

Mood Disorders

- **PHQ-9 Depression**
- MDQ: Bipolar Disorder
- CIDI: Bipolar Disorder
- EPDS: Postnatal Depression

Anxiety Disorders

- **GAD-7: Anxiety**
- PCL-C: PTSD
- **SCARED**
- Mini Social Phobia: Social Phobia

Psychotic Disorders

- Brief Psychiatric Rating Scale
- Positive and Negative Syndrome Scale

Substance Use Disorders

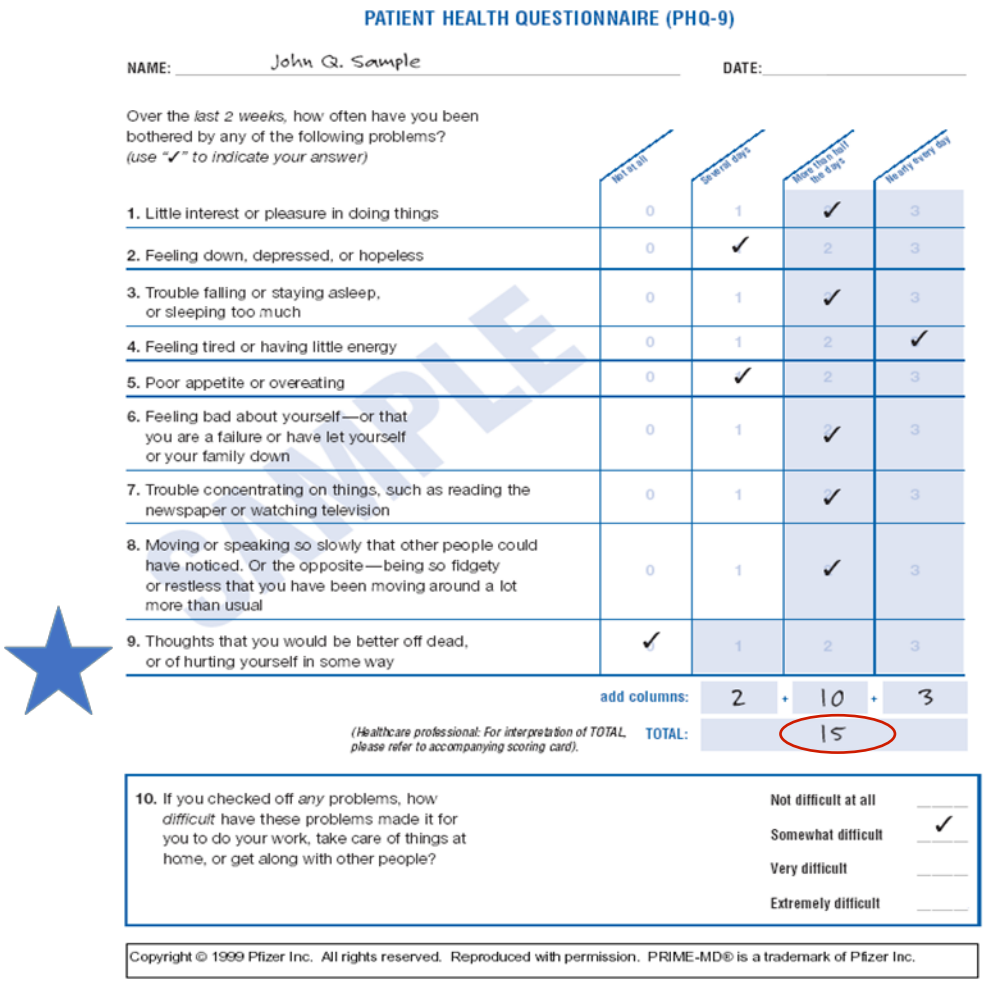
- **AUDIT-C**
- CAGE-AID
- DAST
- CRAFFT
- Alcohol Screening and BI for Youth

PHQ-2

Over the last 2 weeks, how many days have you been bothered by any of the following problems?	Not at All	Several Days	More than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

Scoring:
O-2 – negative score
3 or more – positive and give PHQ-9

VALIDATED SCREENING AND MEASUREMENT TOOLS



PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: John Q. Sample DATE:

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	✓	3
2. Feeling down, depressed, or hopeless	0	✓	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	✓	3
4. Feeling tired or having little energy	0	1	2	✓
5. Poor appetite or overeating	0	✓	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	✓	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	✓	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	✓	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	✓	1	2	3
add columns:		2	+ 10	+ 3
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:			15	

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all
- Somewhat difficult ✓
- Very difficult
- Extremely difficult

PHQ 9 > 9

- < 5 – none/ remission
- 5 - mild
- 10 - moderate
- 15- moderate severe
- 20 - severe

GAD-7

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =	Score ≥ 10 indicates possible diagnosis			

CHILD AND ADOLESCENT

- PHQ-A – Depression
- Vanderbilt – ADHD
- SCARED

NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3

BHPs/Care Managers

Who are the BHPs/CMs?

- Typically MSW, LCSW, MA, RN, PhD, PsyD, paraprofessionals
- Brief intervention skills, generalists

What makes a good BHP/CM?

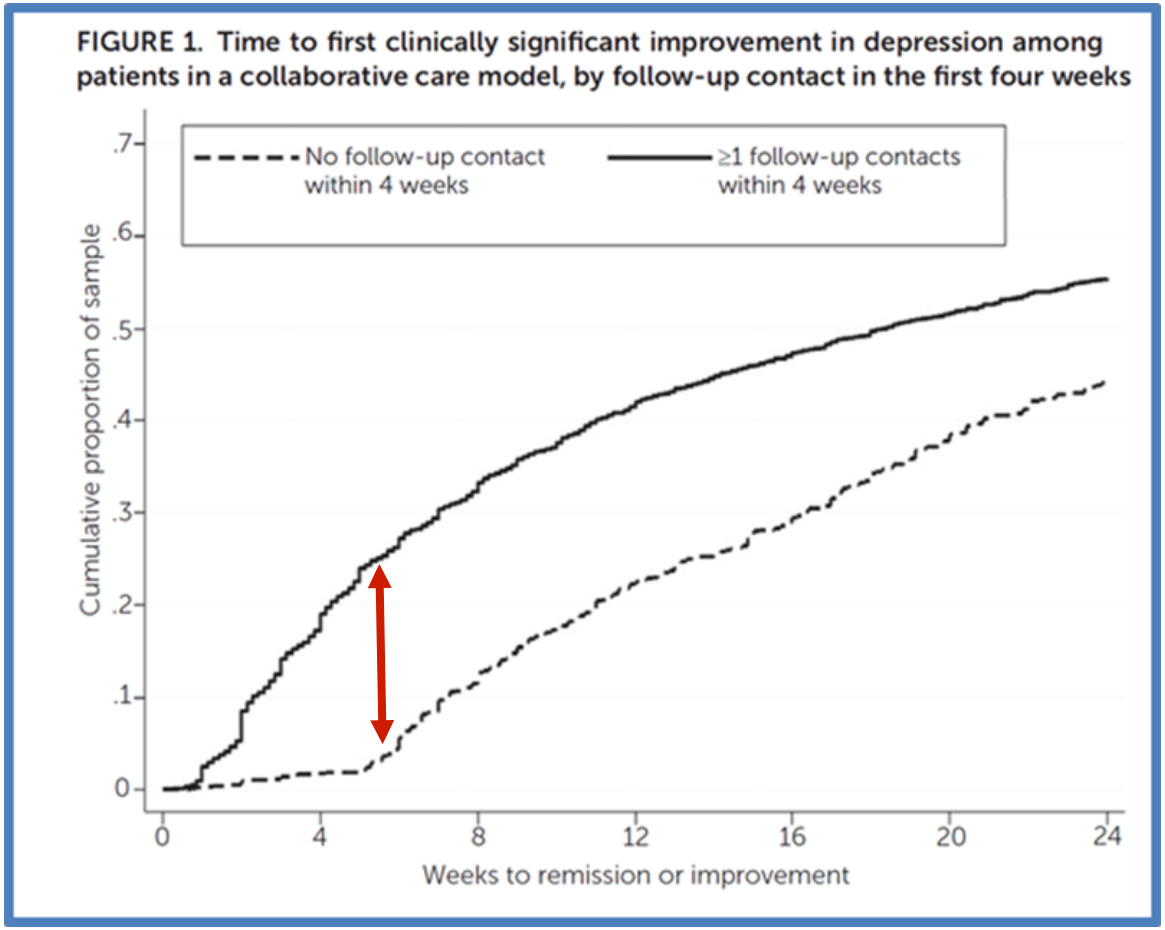
- Organization
- Persistence- tenacity
- Creativity and flexibility
- Enthusiasm for learning
- Strong patient advocate
- Willingness to be interrupted
- Ability to work in a team

CAUTION:
Traditional Approach to therapy
Not willing to be interrupted
Timid, insecure about skills

Evidence-based Brief Interventions

- Motivational Interviewing
- Distress Tolerance Skills
- Behavioral Activation
- Problem Solving Therapy

Frequent, Persistent Follow-up



Bao et al: Psych Serv 2015

WHAT IS A REGISTRY?

- Systematic collection of a clearly defined set of health and demographic **data** for patients with specific health characteristics
- Held in a central **database** for a predefined purpose
- Medical registries can serve **different purposes**—for instance, as a tool to monitor and improve quality of care including risk stratification, or as a resource for epidemiological research.

J Am Med Inform Assoc. 2002 Nov-Dec; 9(6): 600–611

HOW CAN A REGISTRY HELP?

- Keep track of all clients so no one “falls through the cracks”
  - Up-to-date client contact information
  - Referral for services
- Tells us who needs additional attention
  - High risk individuals in need of immediate attention
  - Clients who are not following up
  - Clients who are not improving
  - Reminders for clinicians & managers
  - Customized caseload reports
- Facilitates communication, specialty consultation, and care coordination
- Helps to stratify risk
  - Concentrate resources where needed most
- Choose the initiative most likely to have significant impact and use to focus educational efforts

MEASUREMENT AND TRACKING RESPONSE TO TREATMENT

			Treatment Status				PHQ-9				GAD-7				Psychiatric Consultation	
			! ndicates that the most recent contact was over 2 months (60 days) ago				✓ Indicates that the last available PHQ-9 score is at target (less than 5 or 50% decrease from initial score) ! Indicates that the last available PHQ-9 score is more than 30 days old				✓ Indicates that the last available GAD-7 score is at target (less than 10 or 50% decrease from initial score) ! Indicates that the last available GAD-7 score is more than 30 days old					
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View	Active	Nancy Fake	2/4/2016	2/4/2016	0	4	.	No Score			.	No Score				
View	RP	John Doe	9/15/2015	3/6/2016	10	25	20	✓ 2	✓ -90%	3/6/2016	14	✓ 3	✓ -79%	3/6/2016		2/20/2016

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PSYCHIATRIC REVIEW, SAFETY FLAGS

			Treatment Status				PHQ-9				GAD-7				Psychiatric Consultation	
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MEASURING CHANGE

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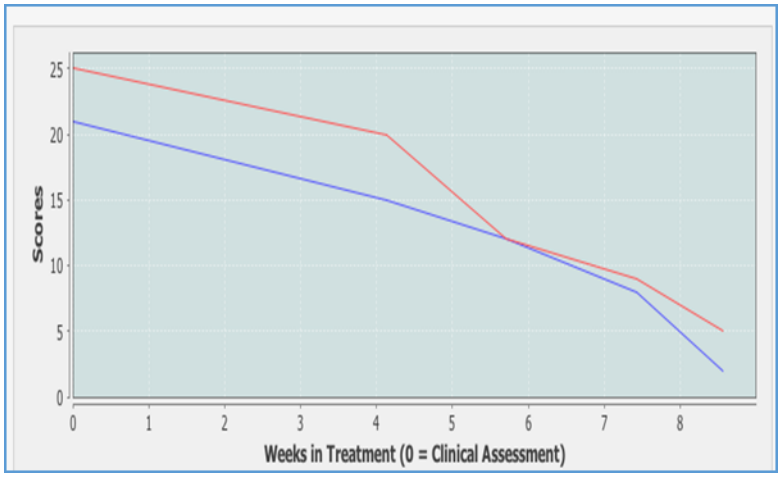
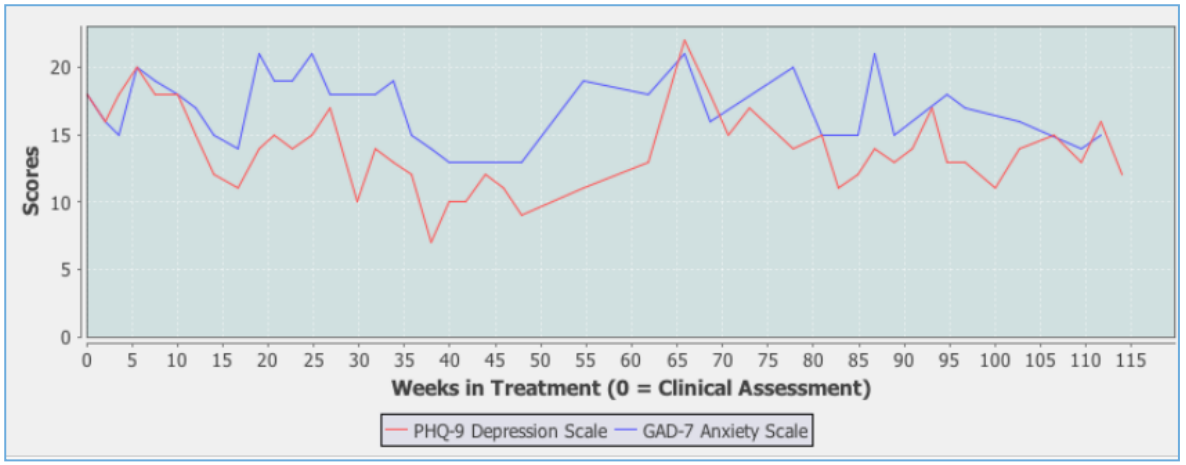
Two crucial data points:
50% reduction PHQ-9
Remission (PHQ 9 < 5)

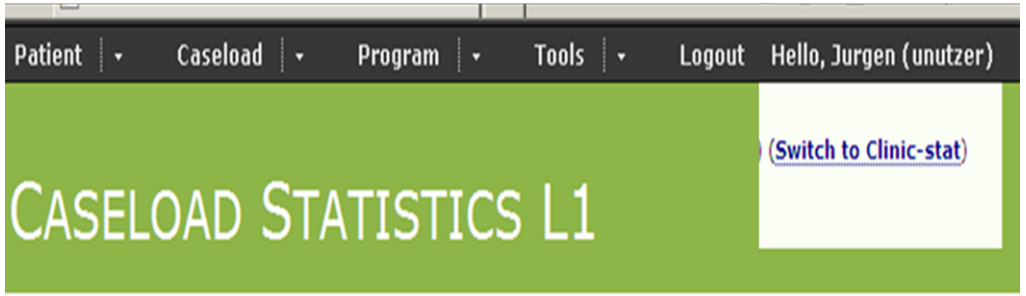
SHARE RESULTS WITH PATIENTS AND STAFF





AGGREGATE DATA

- Professional development at the provider level – MACRA, MIPS
- Quality improvement at the clinic level
- Inform reimbursement at the payer level



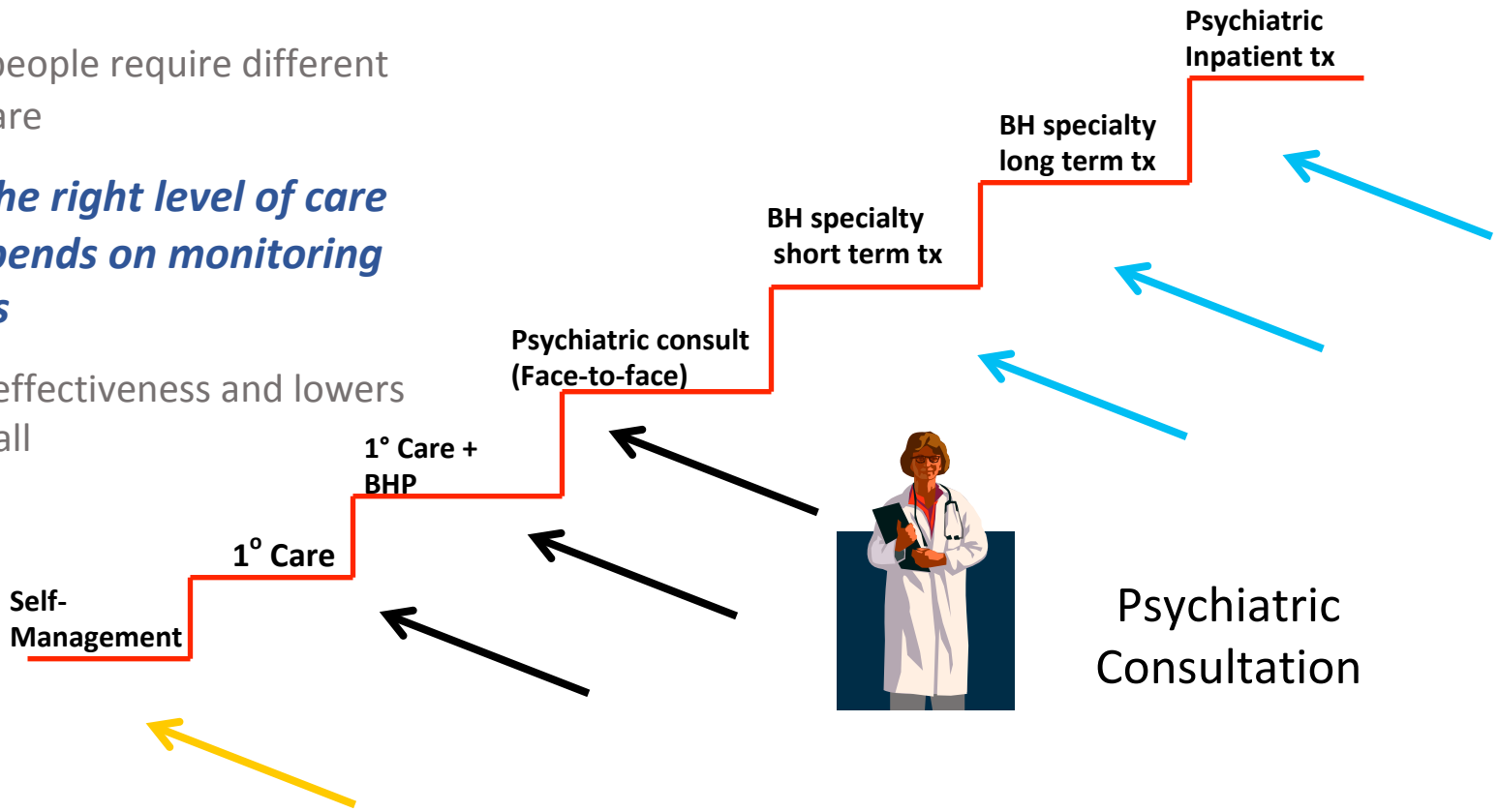
CO	# OF P.	CLINICAL ASSESSMENT			FOLLOW UP				50% IMPROVED AFTER > 10 WKS	
		#	MEAN PHQ	MEAN GAD	# OF P.	MEAN #	MEAN # CLINIC	MEAN # PHONE	PHQ	GAD
LCSW	70	68 (97%)	15.1 (n=61)	12.8 (n=52)	62 (91%)	6.7	5.5 (82%)	1.2 (18%)	19 (49%) (n=39)	16 (41%) (n=39)
LCSW	86	86 (100%)	15.9 (n=86)	14.2 (n=84)	79 (92%)	12.4	6.4 (52%)	6.0 (48%)	34 (68%) (n=50)	28 (56%) (n=50)
All	156	154 (99%)	15.6 (n=147)	13.6 (n=136)	141 (92%)	9.9	6.0 (61%)	3.9 (39%)	53 (60%) (n=89)	44 (49%) (n=89)

C/C = Continued Care Pla

SOURCE: Fortney et al Psych Serv Sept 2016

STEPPED CARE APPROACH

- Uses limited resources to their greatest effect on a population basis
- Different people require different levels of care
- ***Finding the right level of care often depends on monitoring outcomes***
- Increases effectiveness and lowers costs overall



SOURCE: Van Korff et al 2000

WHO NEEDS REFERRAL TO A HIGHER LEVEL OF CARE?

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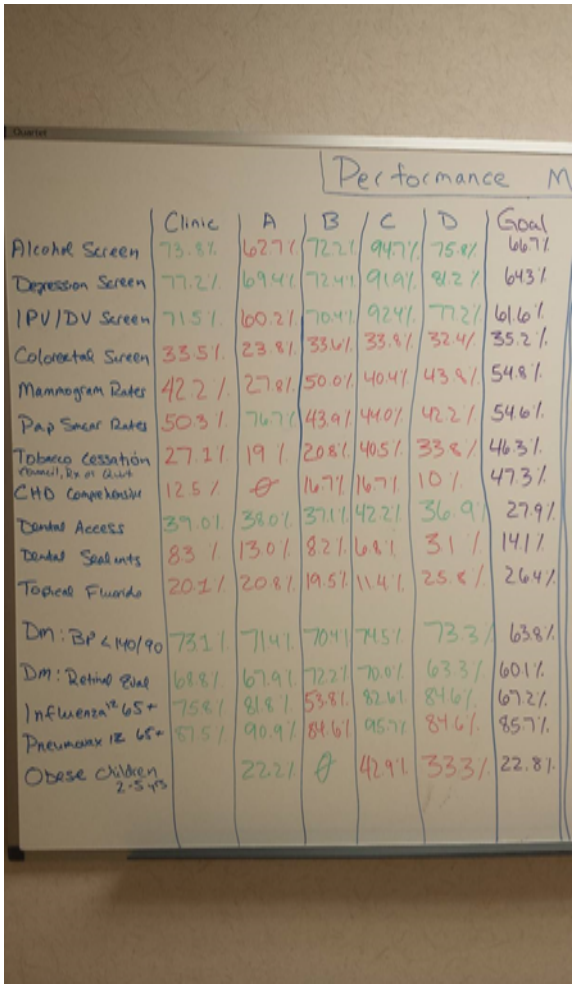
PERFORMANCE MEASURES



- **Process Metrics**
  - Percent of patients screened for depression – NQF 712
  - Percent with follow-up with care manager within 2 weeks
  - Percent not improving that received case review and psychiatric recommendations
  - Percent treatment plan changed based on advice
  - Percent not improving referred to specialty BHP
- **Outcome Metrics**
  - Percent with 50% reduction PHQ-9 – NQF 184 and 185
  - Percent reaching remission (PHQ-9 < 5) – NQF 710 and 711
- **Satisfaction** – patient and provider
- **Functional** –work, school, homelessness
- **Utilization/Cost**
  - ED visits, 30 day readmits, med/surg/ICU, overall cost

OTHER METRICS

- Anxiety
  - 50% reduction in GAD-7
  - Remission in anxiety GAD-7 < 5
- Depression and chronic medical conditions
  - % with depression and 2 or more chronic conditions who had improvements in HbA1c/DBP/Lipids, etc
- Alcohol use
  - % of patients with AUD who reduced intake to NIAAA safe drinking limits
  - % of patients with AUD who are abstinent
- ADHD
  - % of patients with reduction in score of items 1-18

Effective Implementation: 9 Factors

Table 1. Factors Considered Important for Implementation of DIAMOND

Ranking	Implementation Factor	Definition
1	Operating costs of DIAMOND not seen as a barrier	The clinic has adequate coverage or other financial resources for most patients to be able to afford the extra operational costs.
2	Engaged psychiatrist	The consulting psychiatrist is responsive to the care manager and to all patients, especially those not improving.
3	Primary care provider (PCP) "buy-in"	Most clinicians in the clinic support the program and refer patients to it.
4	Strong care manager	The care manager is seen as the right person for this job and works well in the clinic setting.
5	Warm handoff	Referrals from clinicians to the care manager are usually conducted face-to-face rather than through indirect means.
6	Strong top leadership support	Clinic and medical group leaders are committed and support the care model.
7	Strong PCP champion	There is a PCP in the clinic who actively promotes and supports the project.
8	Care manager role well defined and implemented	The care manager job description is well defined, with appropriate time, support, and a dedicated space.
9	Care manager on-site and accessible	The care manager is present and visible in the clinic and is available for referrals and patient care problems.

DIAMOND indicates Depression Improvement Across Minnesota—Offering a New Direction.

Whitebird, Jaeckels Kamp et al. Am J Manag Care. 2014;20(9):699-707

Registry Review Exercise

Review the registry below and consider these questions:
1. Who is not improving and needs psychiatric consultation?
2. Who is not engaging in care and needs outreach by the behavioral care manager?
3. Who is ready for relapse prevention?

Today's date 2/07/2017

	Clinical Assessment			# of Sessions	Weeks in Tx	Last Follow-Up Contact			Psych. Note
	Date	PHQ-9	GAD-7			Date	PHQ-9	GAD-7	
1	8/29/16	16	11	15	25	1/8/17	12	11	11/14/16
2	1/9/17	5	4	5	6	2/11/17	2	1	
3	1/16/17	16	20	1	5				
4	8/1/16	27		4	29	12/10/16	24		
5	10/19/15	11	19	14	70	11/11/16	14	17	6/24/16
6	12/5/16	10	10	3	11	2/4/17	2	1	
7	8/29/16	12	10	11	25	2/6/17	12	8	11/21/16
8	8/15/16	15	15	4	27	1/2/17	7		1/9/17
9	5/30/16	24	21	10	38	2/6/17	21	19	11/21/16
10	10/10/16	12	8	28	19	2/4/17	3	2	9/4/16

WORKFLOW CONSIDERATIONS WITH MBC

- How will you perform these tasks?
- Who does what?
- How is it reported?
- What will you do it not improving?

CONTACT ME

LORI RANEY, MD

Principal

lraney@healthmanagement.com

HMA

Gap Assessment Exercise

- Review and discuss the Implementation Checklist in your small groups - 15 mins
- Review and complete the gap assessment and discuss as a team – 30 mins
- Share with the larger group
  - What gaps did you find?
  - What solutions have you thought of to address these?

Effective Integrated Care Gap Analysis Team Exercise

Key Component	Score 0 = not at all in place 5 = fully in place	If you scored low in this category- what are the barriers to having this element in place?	Strengths/Opportunities-
1.Team-based approach to care			
Clinic has a defined team(s) with clear roles.			
Behavioral health staff member is a regular member of the clinical care team.			
The team has created and trained on processes and workflows for hand-offs and communications from one team member to another.			
PCPs and BHP meet with regularly with consulting psychiatrist/psych NP			
2. Evidence-based care			
The care team understands the evidence for screening for BH conditions in the primary care setting.			
Providers have reviewed and applied the evidence-based guidelines on depression diagnosis and treatment.			
The model of "stepped care" is the approach. The team understands this approach and it is used for systematic			