QDI Peer Learning Call

Screening for Depression and Follow-Up

8/26/20

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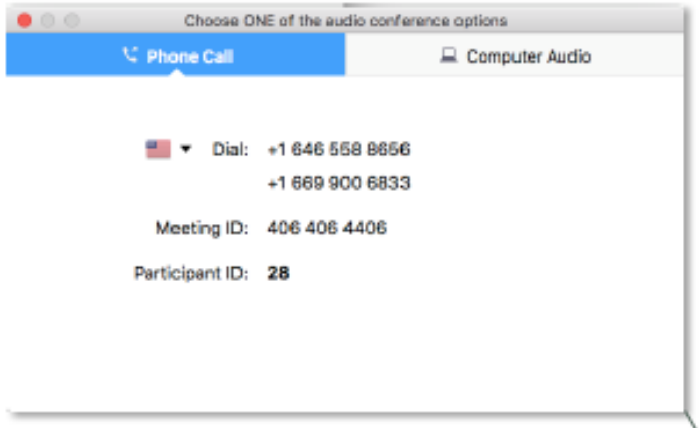
Zoom tips and tricks!

CHAT: Please jump in if you have something to share, but we also have this nifty chat function.

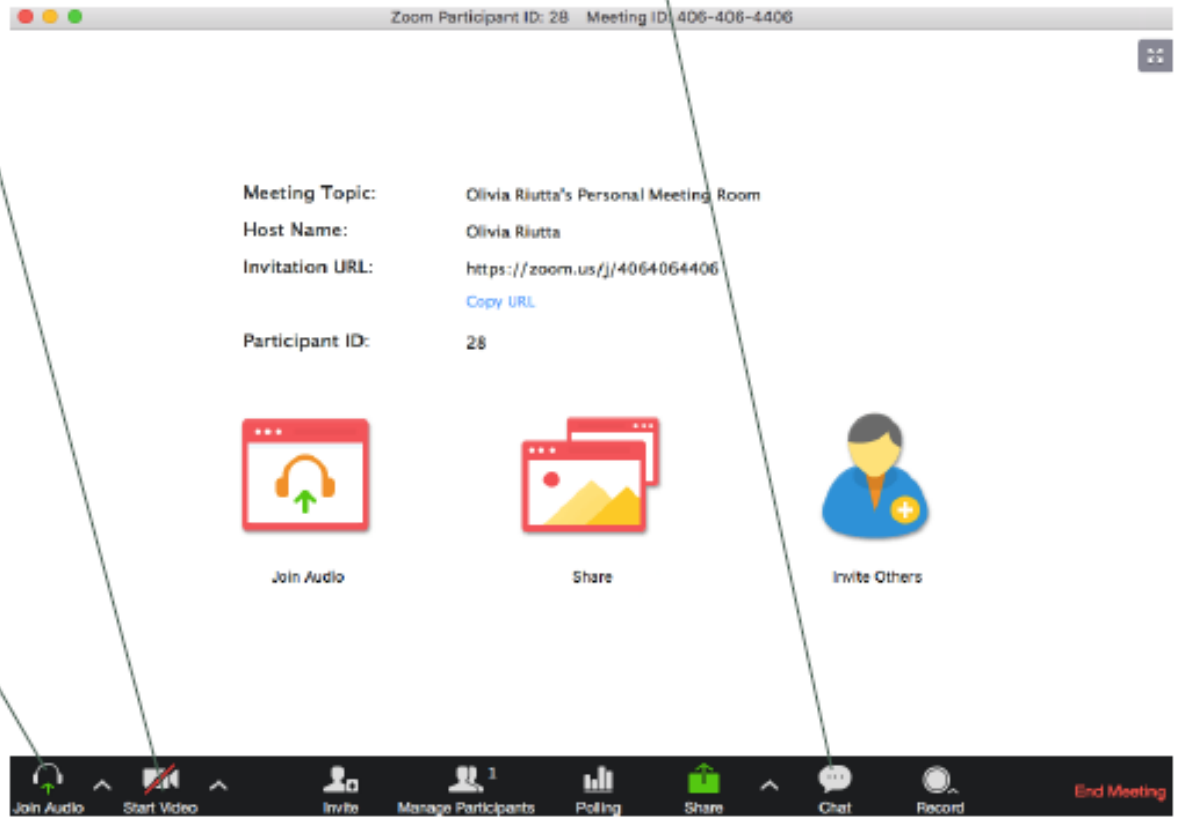


VIDEO: We want to see you!
If your camera isn't on, start your video by clicking here.

ATTENDANCE: If there are multiple attendees together on the call, please list the names and your location in the chat box

AUDIO: You can use your computer speakers or your phone for audio. The phone is generally better quality. If you click "Join Audio," this "Choose one…" box will pop up. If you dial in, just make sure you include your audio code.

MUTE/UNMUTE: *6 or click the mic on the bottom left of your screen.



Agenda

Data Review and Updates

FIT KIT Project

Screening for Depression and Follow-Up

Quality Awards

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July QDI Data Report

JANUARY 1, 2020- JULY 31, 2020

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Diabetes Management

Measure

Denominator: Patients 18-75 years of age with diabetes with a visit during the measurement period

Numerator: Patients whose most recent HbA1c level (performed during the measurement period) is >9.0%

UDS, Medicaid PCMH

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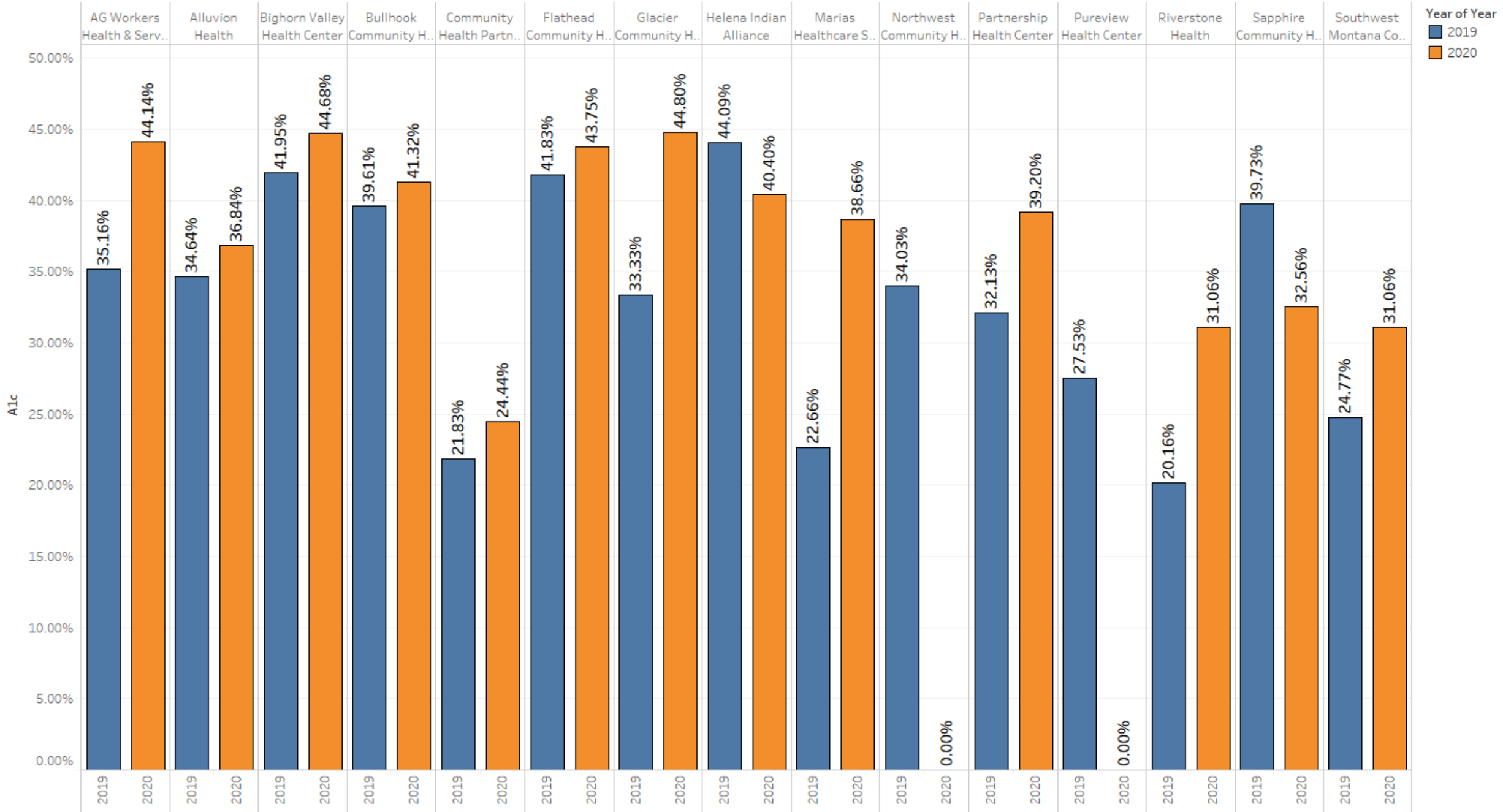
Diabetes Management

Diabetes Management (June 2019 vs June 2020)



Colorectal Cancer Screening

Measure

Denominator: Patients 50-75 years of age with a visit during the measurement period

Numerator: Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the following criteria:

-Fecal occult blood test (FOBT) during the measurement period

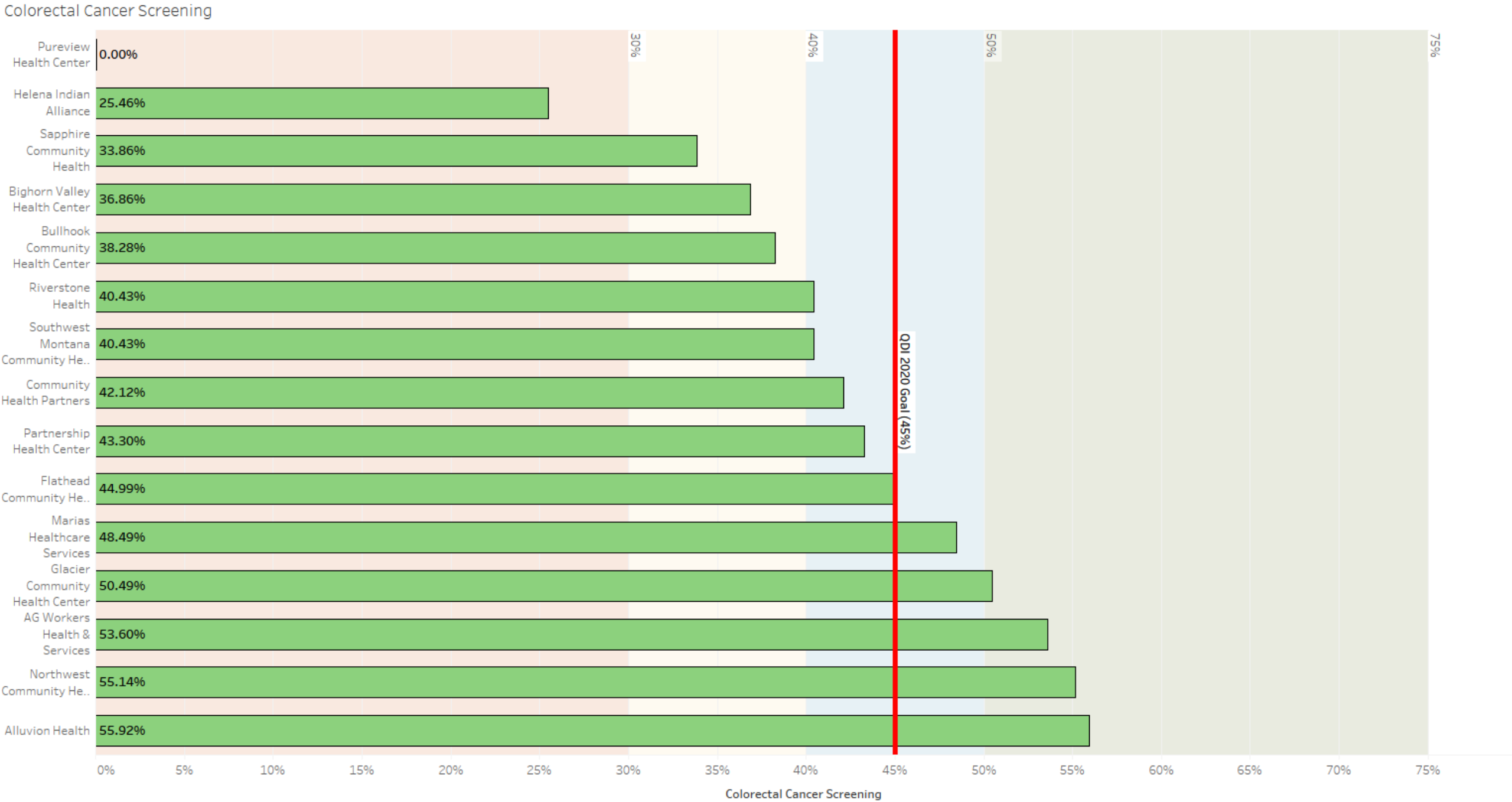
-- Flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period

-- Colonoscopy during the measurement period or the nine years prior to the measurement period

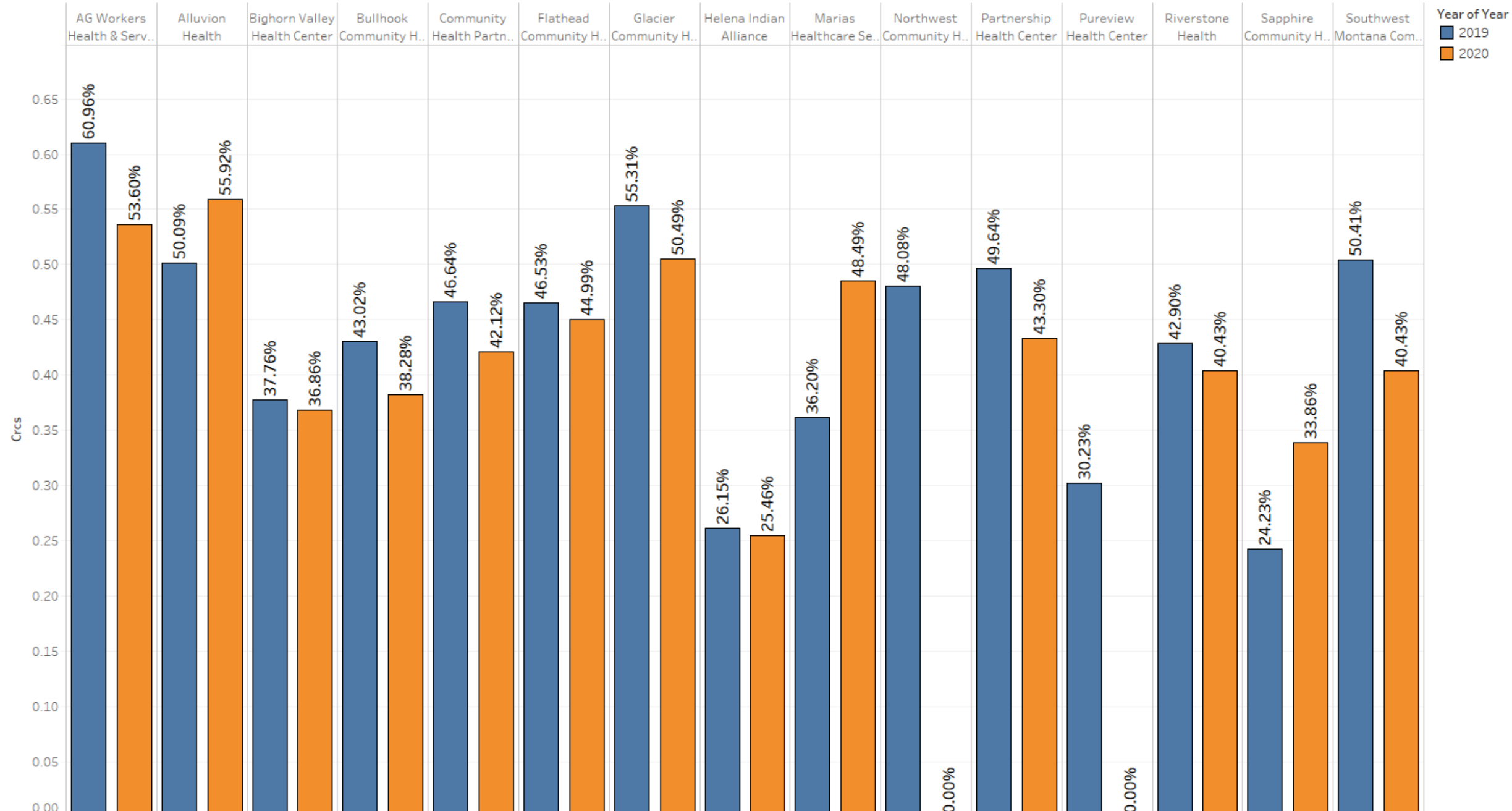
-- FIT-DNA during the measurement period or the two years prior to the measurement period

-- CT Colonography during the measurement period or the four years prior to the measurement period

UDS, Medicaid PCMH,


Colorectal Cancer Screening
Pureview Health Center
0.00%
Helena Indian Alliance
25.46%
Sapphire Community Health
33.86%
Bighorn Valley Health Center
36.86%
Bullhook Community Health Center
38.28%
Riverstone Health
40.43%
Southwest Montana Community He..
40.43%
Community Health Partners
42.12%
Partnership Health Center
43.30%
Flathead Community He..
44.99%
Marias Healthcare Services
48.49%
Glacier Community Health Center
50.49%
AG Workers Health & Services
53.60%
Northwest Community He..
55.14%
Alluvion Health
55.92%
30%
40%
50%
75%
QDI 2020 Goal (45%)
0%
5%
10%
15%
20%
25%
30%
35%
40%
45%
50%
55%
60%
65%
70%
75%
Colorectal Cancer Screening

Colorectal Cancer Screening (June 2019 vs June 2020)



Cervical Cancer Screening

Measure

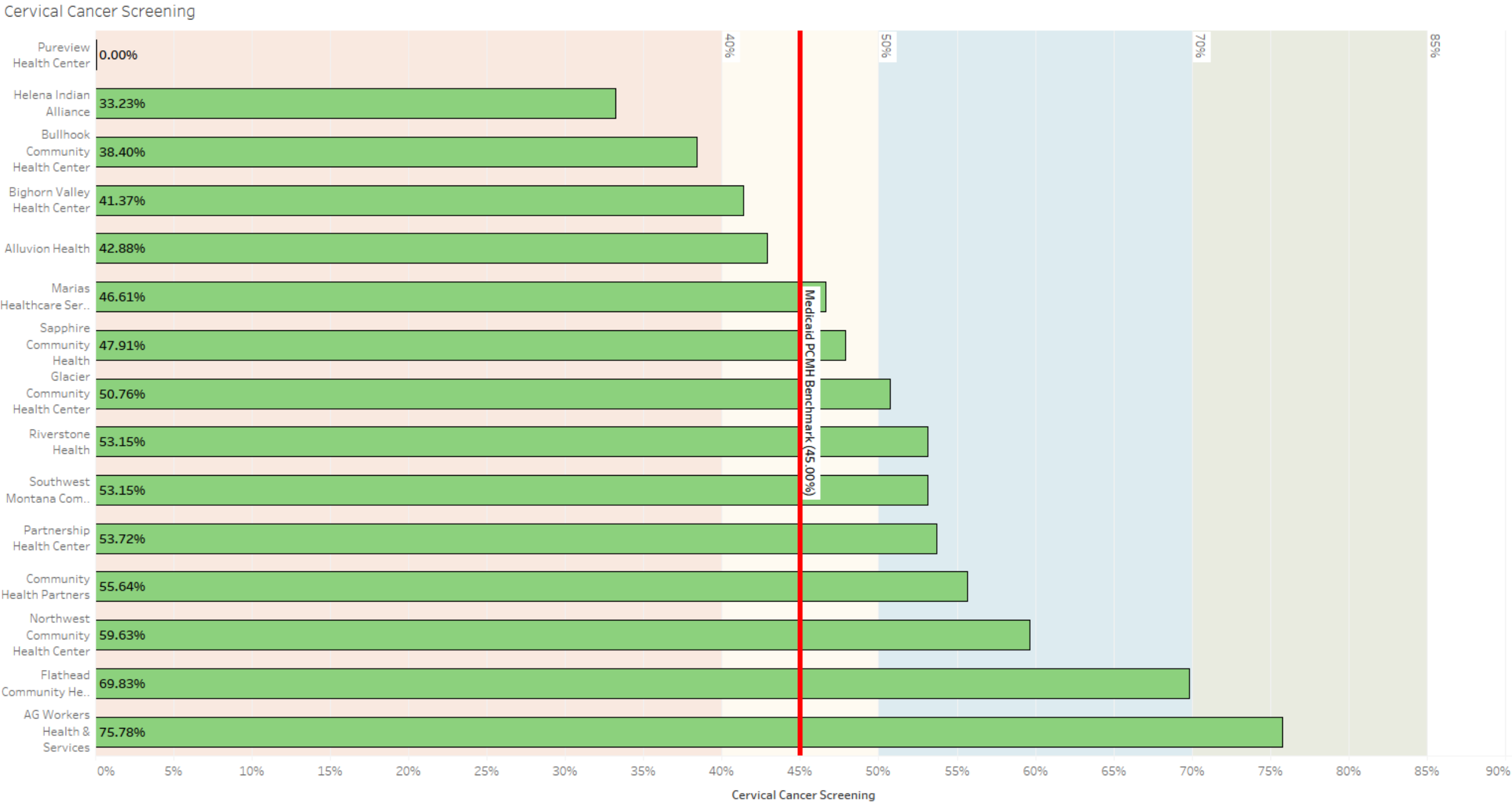
Denominator: Women 23-64 years of age with a visit during the measurement period

Numerator: Women with one or more screenings for cervical cancer. Appropriate screenings are defined by any one of the following criteria:

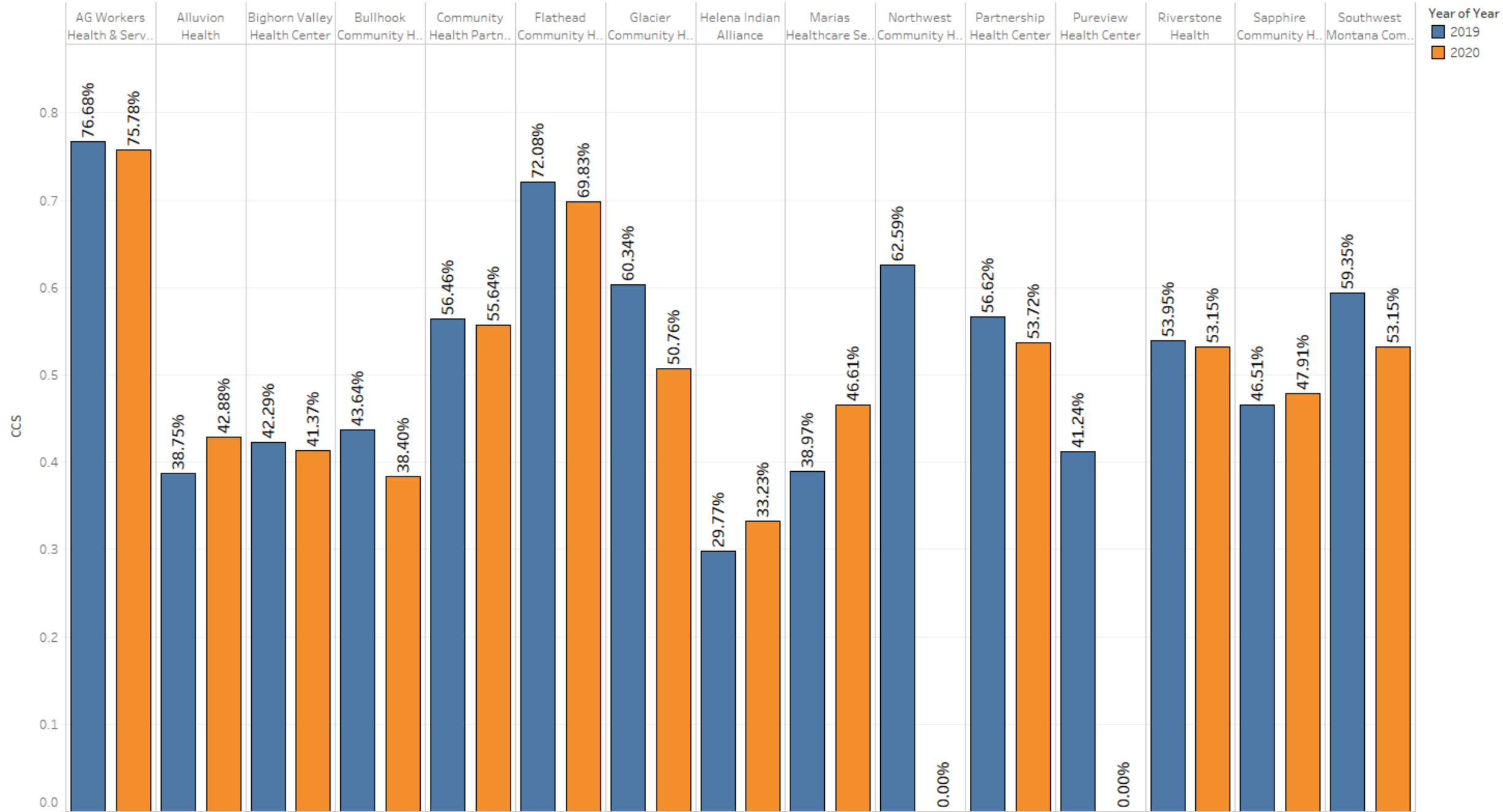
- Cervical cytology performed during the measurement period or the two years prior to the measurement period for women who are at least 21 years old at the time of the test

- Cervical cytology/human papillomavirus (HPV) co-testing performed during the measurement period or the four years prior to the measurement period for women who are at least 30 years old at the time of the test

UDS, Medicaid PCMH


Cervical Cancer Screening
Pureview Health Center
0.00%
Helena Indian Alliance
33.23%
Bullhook Community Health Center
38.40%
Bighorn Valley Health Center
41.37%
Alluvion Health
42.88%
Marias Healthcare Ser..
46.61%
Sapphire Community Health
47.91%
Glacier Community Health Center
50.76%
Riverstone Health
53.15%
Southwest Montana Com..
53.15%
Partnership Health Center
53.72%
Community Health Partners
55.64%
Northwest Community Health Center
59.63%
Flathead Community He..
69.83%
AG Workers Health & Services
75.78%
40%
50%
70%
85%
Medicaid PCMH Benchmark (45.00%)
0%
5%
10%
15%
20%
25%
30%
35%
40%
45%
50%
55%
60%
65%
70%
75%
80%
85%
90%
Cervical Cancer Screening

Cervical Cancer Screening (June 2019 vs June 2020)



Breast Cancer Screening

Measure:

Denominator: Women 51-74 years of age with a visit during the measurement period

Numerator: Women with one or more mammograms during the measurement period or the 15 months prior to the measurement period

Medicaid PCMH, UDS

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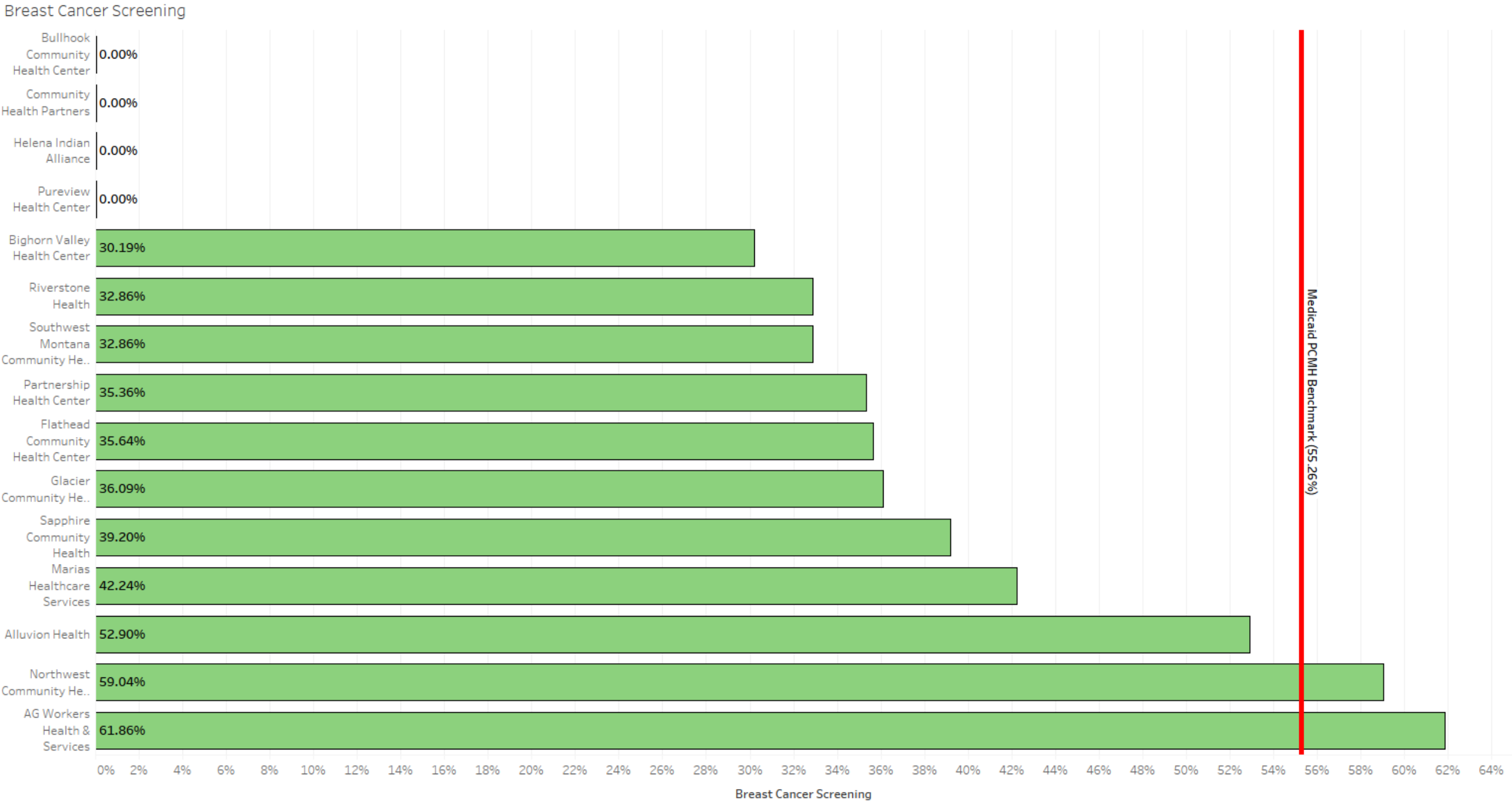
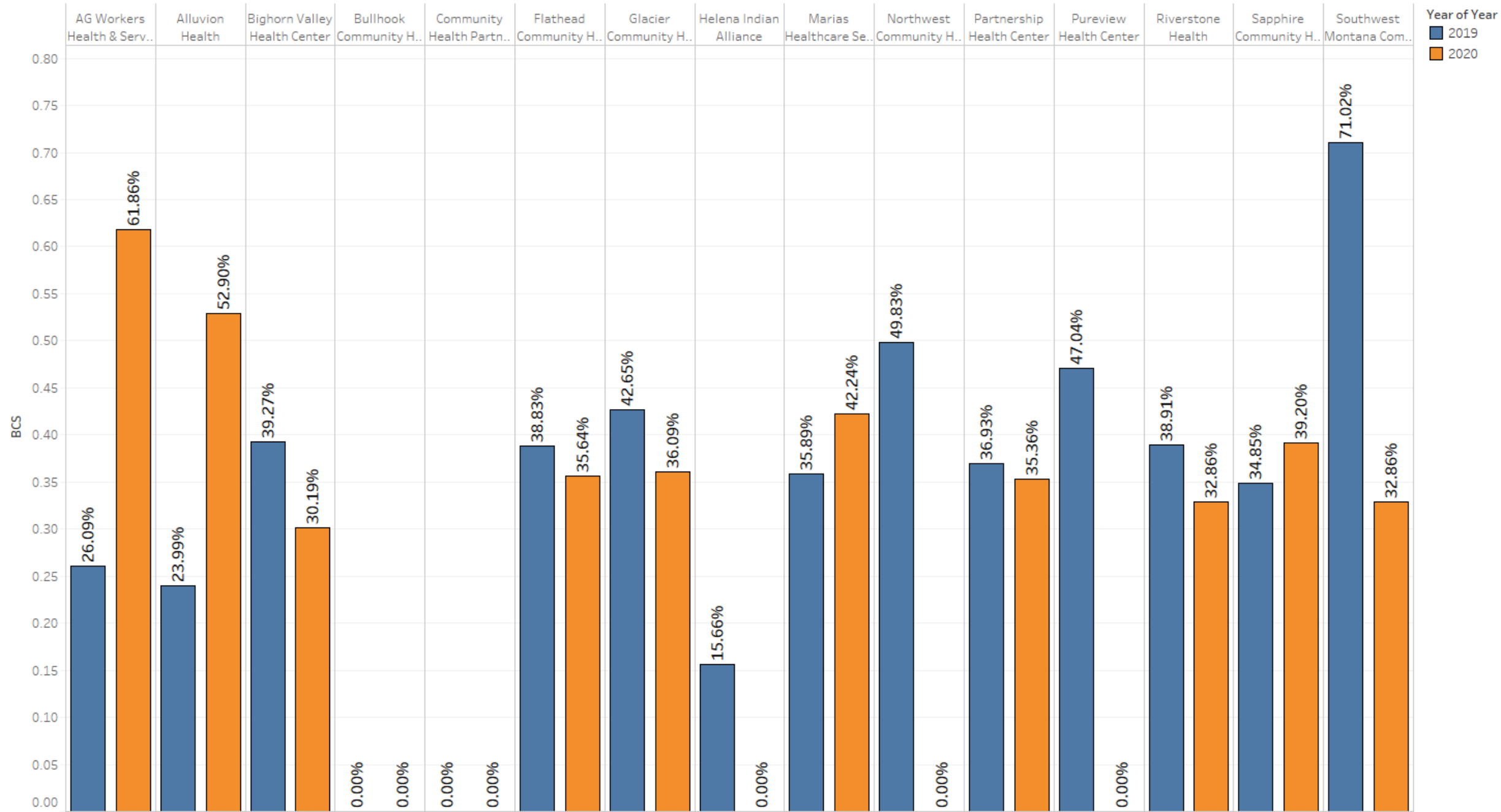
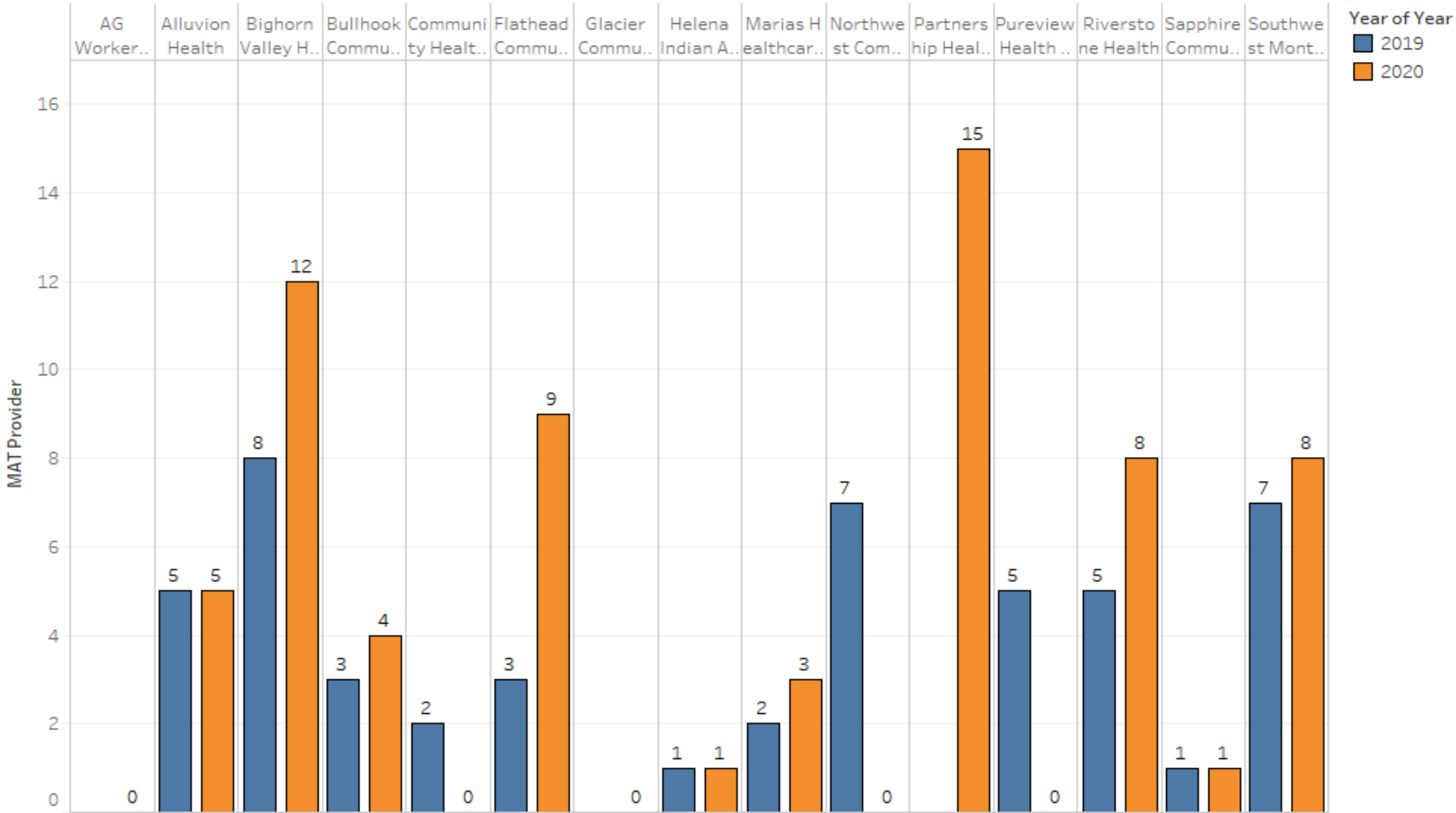

Breast Cancer Screening
Bullhook Community Health Center
0.00%
Community Health Partners
0.00%
Helena Indian Alliance
0.00%
Pureview Health Center
0.00%
Bighorn Valley Health Center
30.19%
Riverstone Health
32.86%
Southwest Montana Community He..
32.86%
Partnership Health Center
35.36%
Flathead Community Health Center
35.64%
Glacier Community He..
36.09%
Sapphire Community Health
39.20%
Marias Healthcare Services
42.24%
Alluvion Health
52.90%
Northwest Community He..
59.04%
AG Workers Health & Services
61.86%
Medicaid PCMH Benchmark (55.26%)
0% 2% 4% 6% 8% 10% 12% 14% 16% 18% 20% 22% 24% 26% 28% 30% 32% 34% 36% 38% 40% 42% 44% 46% 48% 50% 52% 54% 56% 58% 60% 62% 64%
Breast Cancer Screening

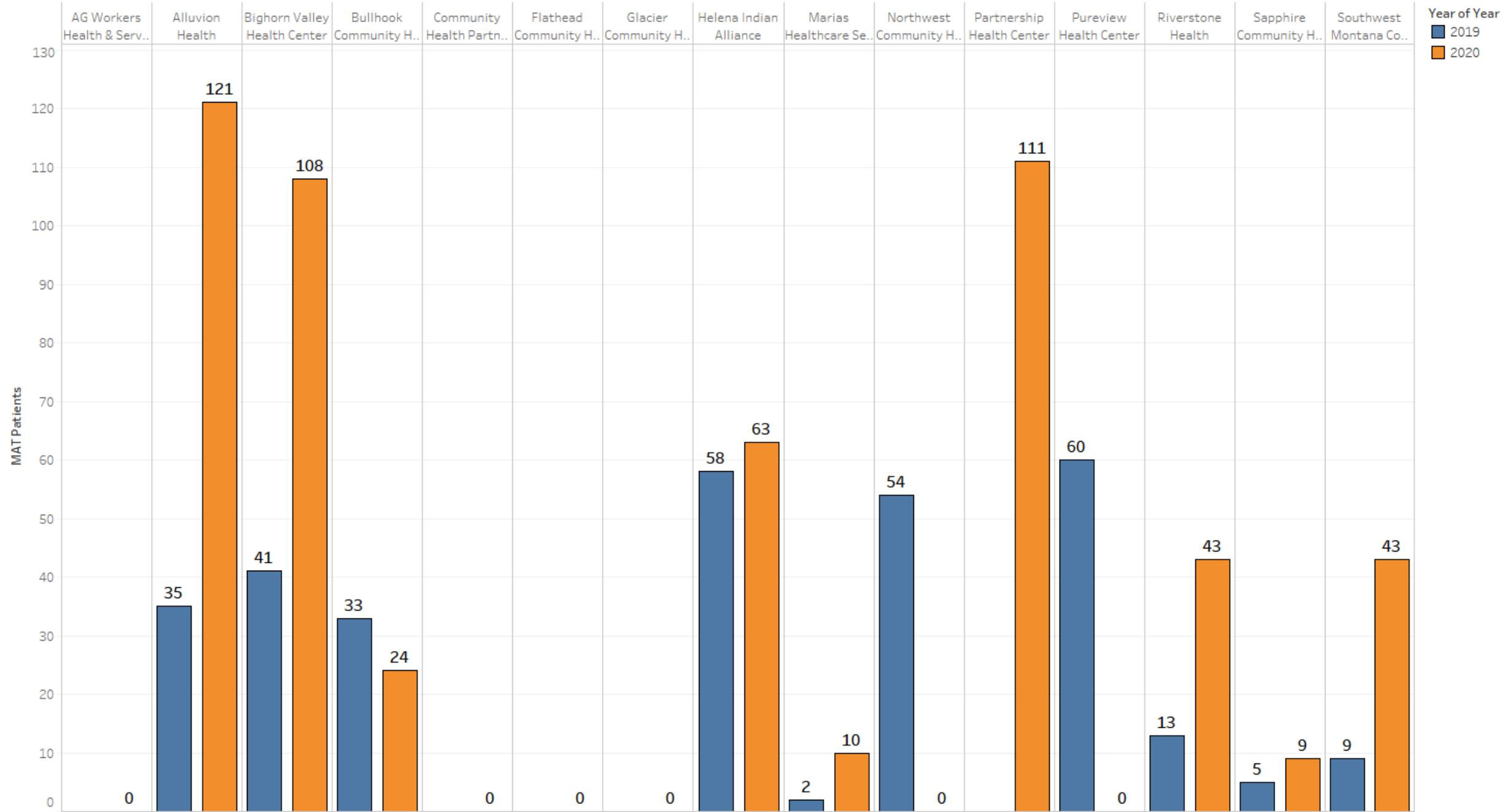
Breast Cancer Screening (June 2019 vs June 2020)



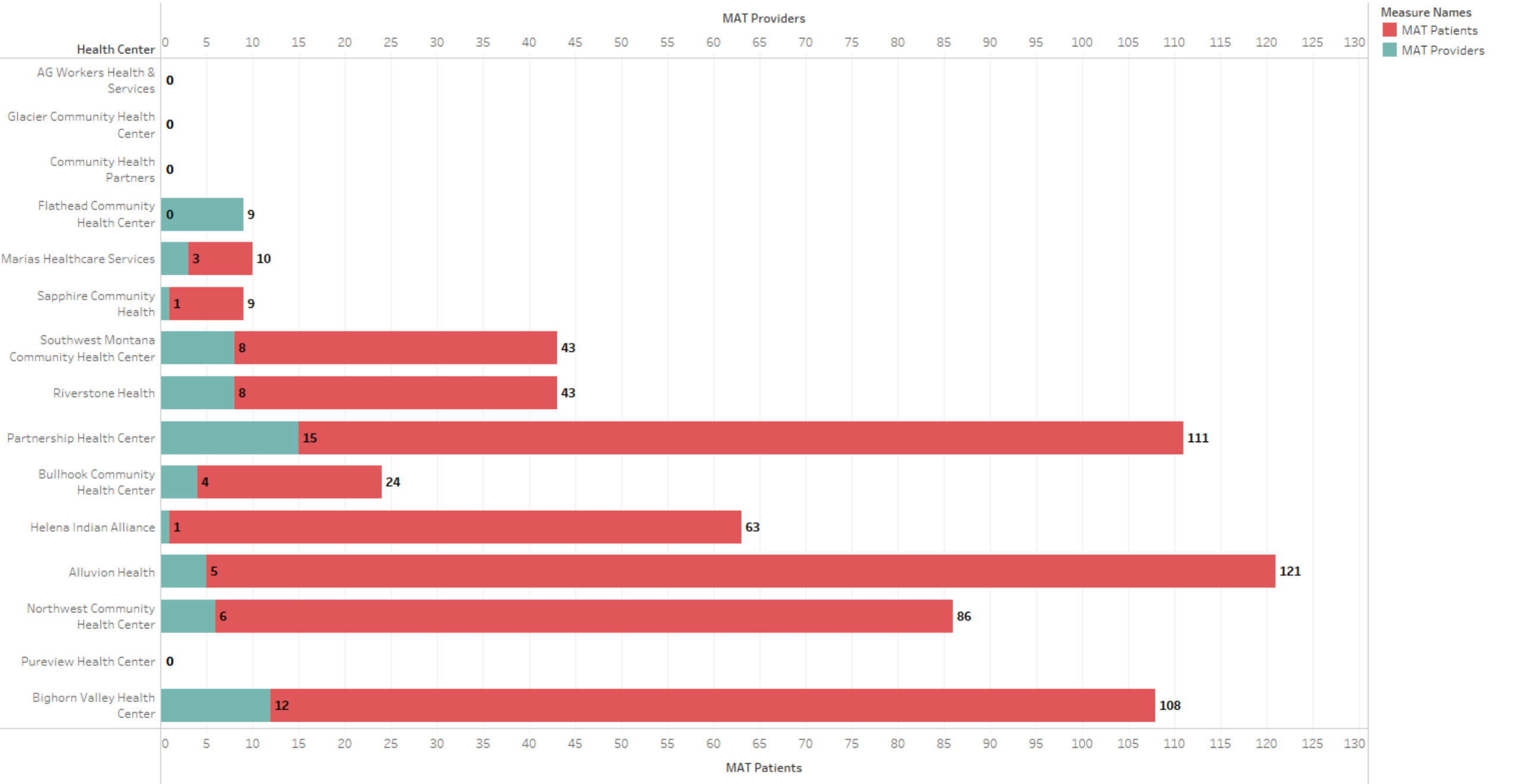
MAT Providers (June 2019 vs June 2020)



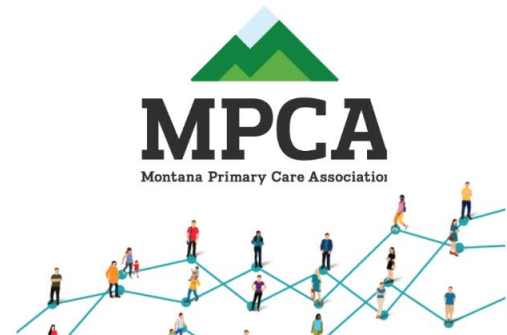
MAT Patients (June 2019 vs June 2020)



MAT Providers and Physicians



Measure	2020 QDI Goal	2019 UDS (MT)	2019 UDS (National)	HP 2020	2023 QDI Goal
A1c>9 or untested	15%	25.94%	31.95%	16.2% (not the exact measure- does not include untested)	15%
Screening for Depression	-	67.64%	71.61%	2.4% (not the exact measure- does not include f/u)	80%
Cervical Cancer Screening	45% (PCMH Benchmark)	53.82%	56.53%	93.0%	65%
CRC Screening	45%	46.06%	45.56%	70.5%	55%
Breast Cancer Screening	55.26% (PCMH Benchmark)	-	-	81.1%	55%



Coming Soon…. Screening for Depression and Follow-Up Plan

Measure Description Percentage of patients aged 12 years and older screened for depression on the date of the visit or 14 days prior to the visit using an age-appropriate standardized depression screening tool and, if positive, had a follow-up plan documented on the date of the visit

Denominator: Patients aged 12 years and older with at least one medical visit during the measurement period

Numerator: Patients who:

-were screened for depression on the date of the visit or up to 14 days prior to the date of the visit using an age-appropriate standardized tool and,

-if screened positive for depression, had a follow-up plan documented on the date of the visit.

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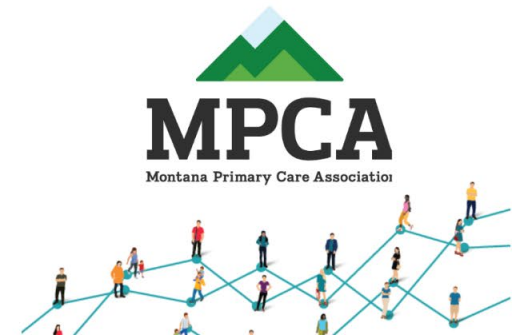
Mailed FIT Kit Project



Project Rational

COVID-19 has led to a decrease in primary care visits and therefore, reduced cancer screenings

Surgery centers are backlogged and cannot keep up with the number of patients that are due for procedures, such as colonoscopy

A mailed FIT project aims to prioritize those that are uninsured and underinsured, while also facilitating screening without a primary care visit

FIT allows for prioritization of those patients that truly need a colonoscopy

According to the American Cancer Society, a FIT performed annually has similar reductions in mortality rates as a colonoscopy completed every 10 years

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Project Description

MPCA will pay for the cost of the kits and will reimburse the rate that Medicaid would pay minus the FIT kit

MPCA will ask participating health centers to adhere to guidelines (provided in the manual) and will ask that clinics participate in regular check-ins

Clinics must be prepared and ready to help those with a positive FIT get into a surgical center for a colonoscopy within 6 months

Next Steps

MPCA will distribute project manual and ask health centers to fill out application and MOU

For this project, we have a limited number of FITS and will be distributing them based on health center interest and capacity

Any questions can be directed towards Laura Gottschalk lgottschalk@mtpca.org or Courtney Buys cbuys@mtpca.org

Deadline to apply and request number of FIT kits- October 9th

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Depression Screening

HCCN

Depression Screening

QDI 2020

Table 6B: Line 21
Screening for Depression and Follow-up Plan

CMS002v9

Percentage of patients aged 12 years and older screened for depression on the date of the visit **or 14 days prior to the visit** using an age-appropriate standardized depression screening tool ***AND,*** if positive, had a follow-up plan documented **on the date of the visit**

IN 2019, there was no screen 14 days prior to the visit and the follow-up plan was documented on the date of the positive screen

Documentation of a follow-up plan "on the date of the visit" can refer to ANY reportable visit, not only a medical visit.

Follow-up for a positive depression screening MUST include one or more of the following: Additional evaluation or assessment 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.

Measure break down

DENOMINATOR

Patients aged 12 years and older with at least one *medical* visit during the measurement period

NUMERATOR

Patients who were screened for depression on the date of the visit or up to 14 days prior to the date of the visit using an age-appropriate standardized tool ***AND***

if screened positive for depression, had a follow-up plan documented on the date of the visit

Include patients with a negative screen in the numerator

Screening Tools

ADOLESCENT SCREENING TOOLS (12–17 YEARS)

Patient Health Questionnaire for Adolescents (PHQ-A)

Beck Depression Inventory-Primary Care Version (BDI-PC)

Mood Feeling Questionnaire (MFQ)

Center for Epidemiologic Studies Depression Scale (CES-D)

Patient Health Questionnaire (PHQ-9)

Pediatric Symptom Checklist (PSC-17)

Primary Care Evaluation of Mental Disorders (PRIME MD)-PHQ-2

ADULT SCREENING TOOLS (18 YEARS AND OLDER)

PHQ-9

Beck Depression Inventory (BDI or BDI-II)

CES-D

Depression Scale (DEPS)

Duke Anxiety-Depression Scale (DADS)

Geriatric Depression Scale (GDS)

Cornell Scale for Depression in Dementia (CSDD)

PRIME MD-PHQ-2

Hamilton Rating Scale for Depression (HAM-D)

Quick Inventory of Depressive Symptomatology Self-Report (QID-SR)

Computerized Adaptive Testing Depression Inventory (CAT-DI)

Computerized Adaptive Diagnostic

Examples of Depression Screening Tools can be found on page 149 of the 2020 UDS Manual

Documenting Follow-up

HRSA Manual

AND if positive, either additional evaluation for depression, suicide risk assessment, referral to a practitioner who is qualified to diagnose and treat depression, pharmacological interventions, or other interventions or follow-up for the diagnosis or treatment of depression is documented on the date of the eligible encounter.

CMS002v9

Additional evaluation or assessment for depression such as psychiatric interview, psychiatric evaluation, or assessment for bipolar disorder

* Completion of any Suicide Risk Assessment such as Beck Depression Inventory or Beck Hopelessness Scale

* Referral to a practitioner or program for further evaluation for depression, for example, referral to a psychiatrist, psychologist, social worker, mental health counselor, or other mental health service such as family or group therapy, support group, depression management program, or other service for treatment of depression

* Other interventions designed to treat depression such as psychotherapy, pharmacological interventions, or additional treatment options

Denominator Exclusions

EXCLUSIONS

Patients with an active diagnosis for depression or a diagnosis of bipolar disorder

EXCEPTIONS

Who refuse to participate

Who are in urgent or emergent situations where time is of the essence and to delay treatment would jeopardize the patient's health status (Do not exclude patients who are seen for routine care in urgent care centers)

Whose cognitive or functional capacity or motivation to improve may impact the accuracy of results of standardized assessment tools

NOTE: There are no numerator exclusions for this measure

Guidance

HRSA Manual- “in the office of the provider”

Depression screening is required once per measurement period, not at all encounters; this is patient based and not an encounter-based measure.

Use the *most recent* screening results

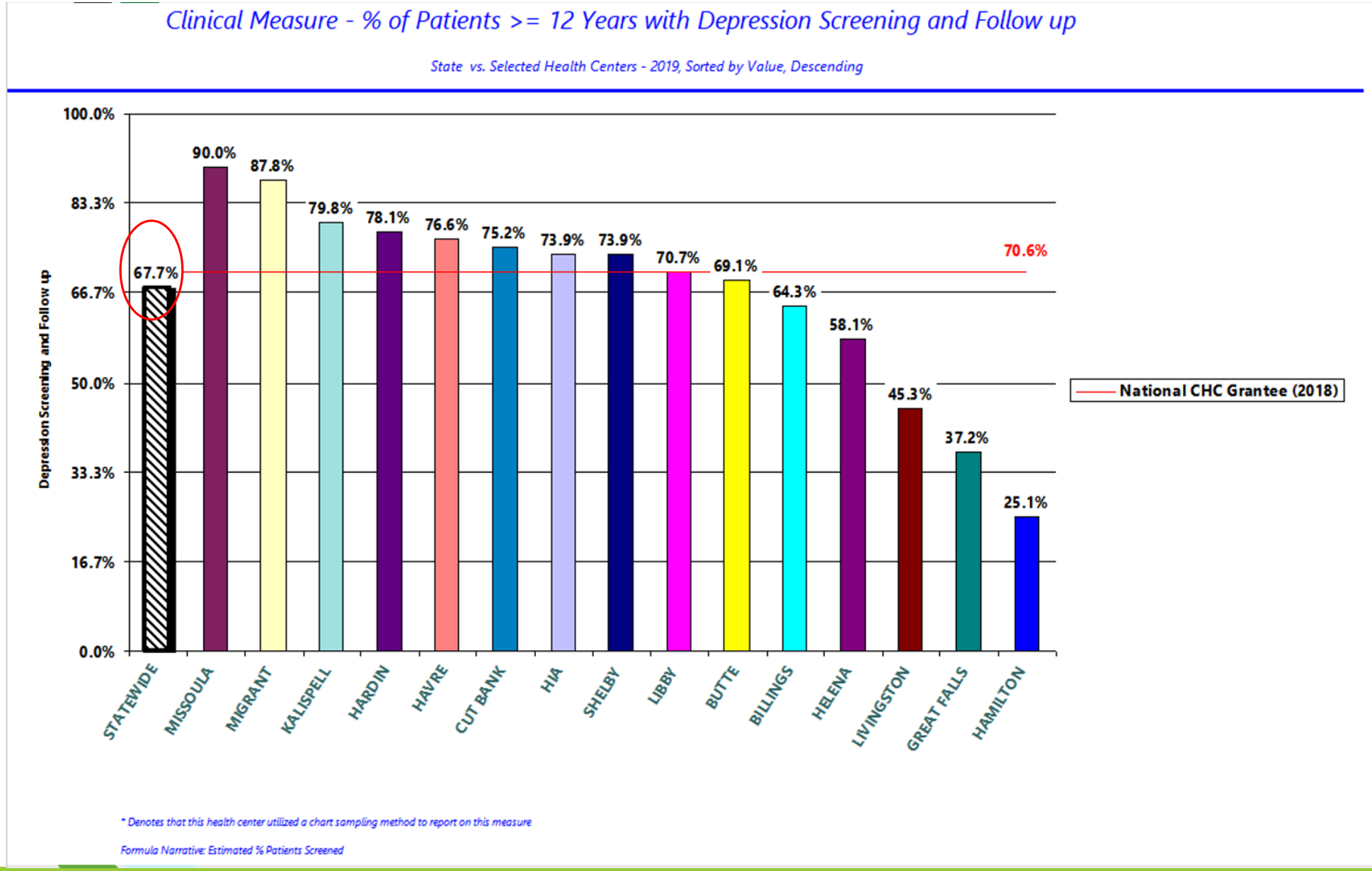
The name of the *age appropriate standardized* depression screening tool utilized MUST be documented in the medical record

The follow-up plan must be related to a positive depression screening, example: "Patient referred for psychiatric evaluation due to positive depression screening."

Guidance continued

Do not count patients who are *re-screened* as meeting the measurement standard as a follow-up plan to a positive screen.

Do not count a PHQ-9 screening that follows a positive PHQ-2 screening during the measurement period as meeting the measurement standard for a ***follow-up* plan** to a positive depression screening.



National CHC Grantee (2019) 71.61%

Smart Form	Responses	Result	Follow-Up Options
PHQ2 (Old)	*No* to Both Questions	Negative	N/A
PHQ2: 2015 Edition (New)	Score = 0, 1, or 2	Negative	N/A
PHQ9 Only	▪ PHQ2 (Not Done) ▪ PHQ9 (Score = 0, 1, 2, 3, 4)	Negative	N/A
PHQA Only	▪ PHQ2 (Not Done ▪ PHQA (Score = 0, 1, 2, 3, 4 or *No* to Question 12 or 13)	Negative	N/A
PHQ2 (Old)	*Yes* to Either Question	Positive	▪ Medication ▪ Referral ▪ Structured Data
PHQ2: 2015 Edition (New)	Score ≥3	Positive	▪ Medication ▪ Referral ▪ Structured Data
PHQ9 Only	▪ PHQ2 (Not Done) ▪ PHQ9 (Score ≥5)	Positive	▪ Medication ▪ Referral ▪ Structured Data
PHQA Only	▪ PHQ2 (Not Done) ▪ PHQA (Score ≥5 or *Yes* to Question 12 or 13)	Positive	▪ Medication ▪ Referral ▪ Structured Data

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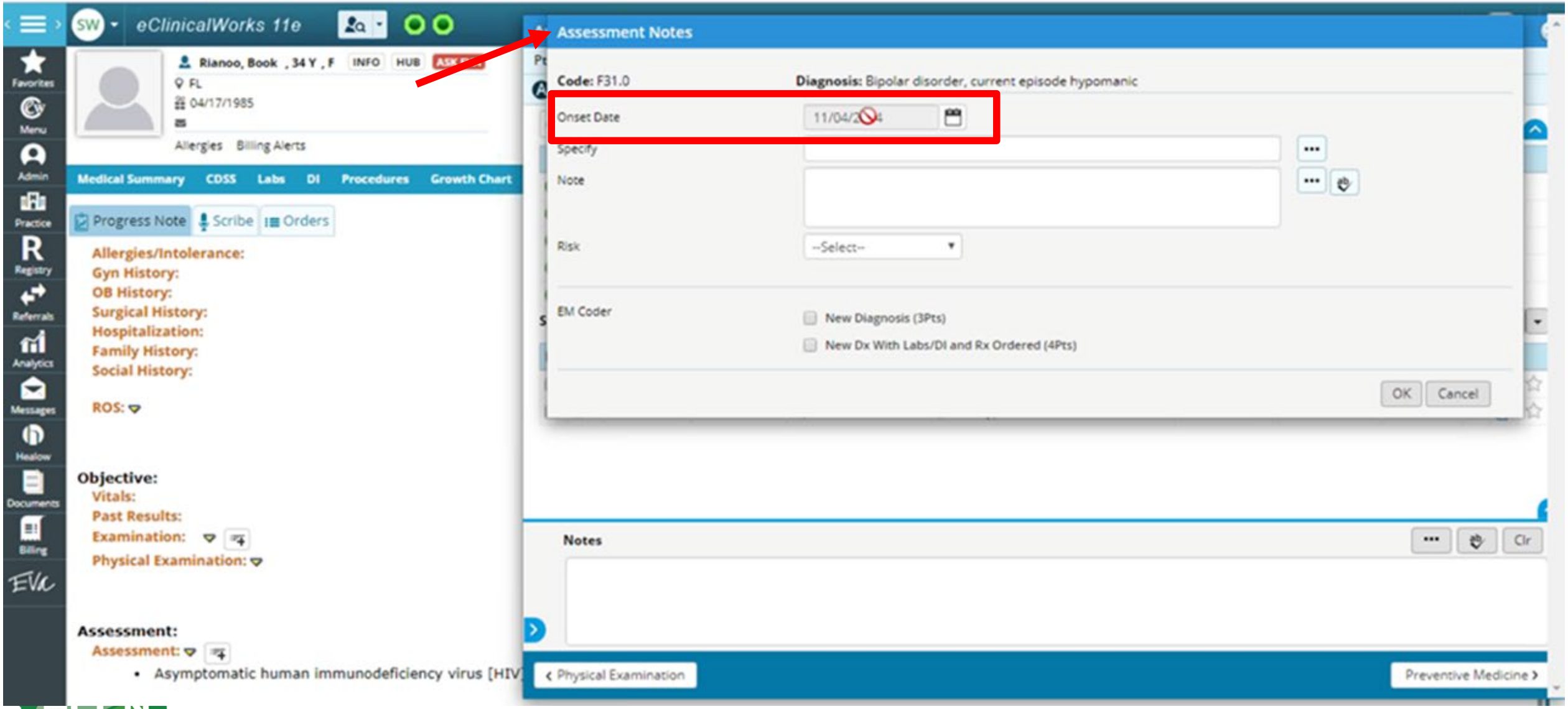
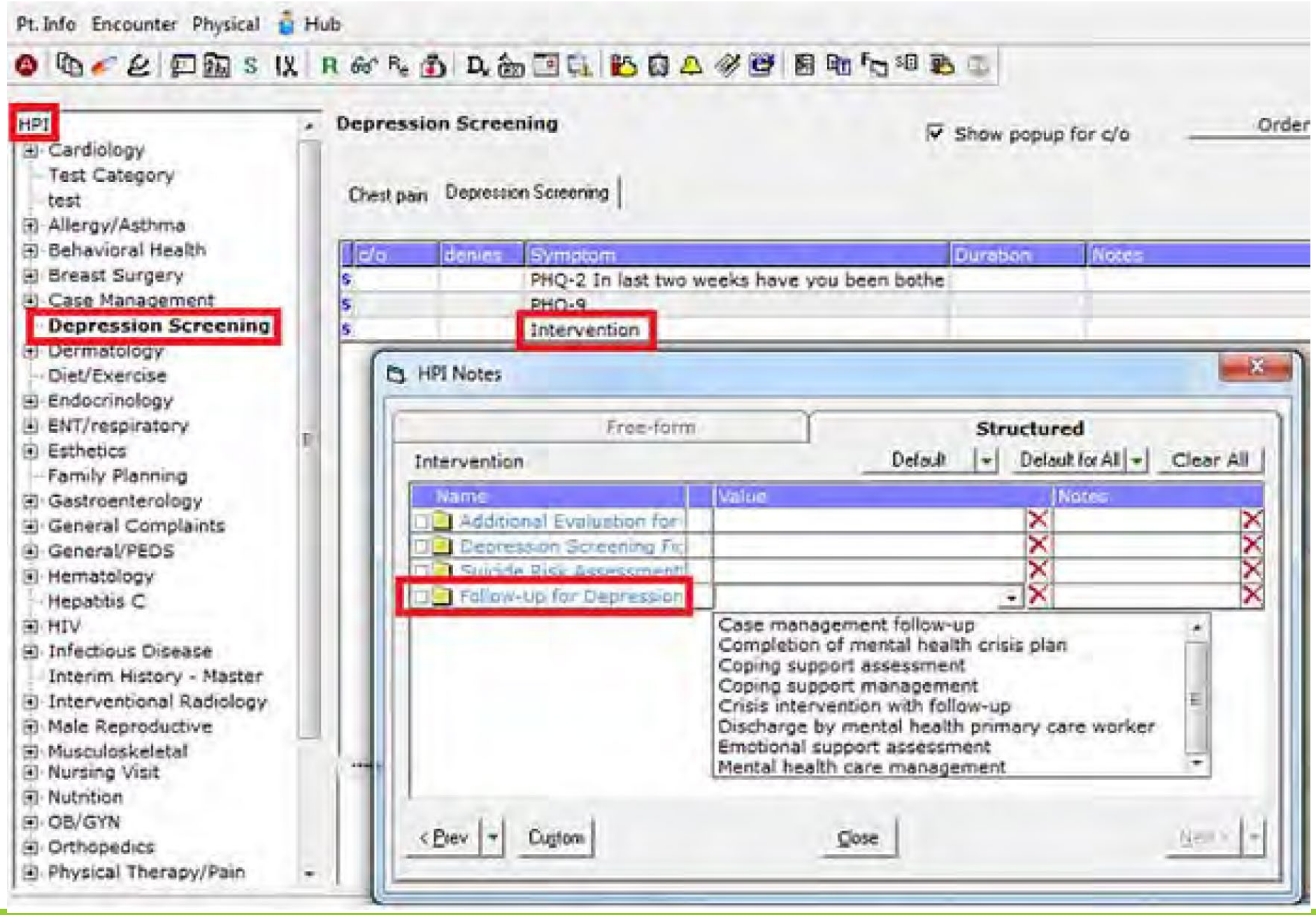


When documenting a Diagnosis for the Exclusion-Select Onset Date from the Calendar Dropdown



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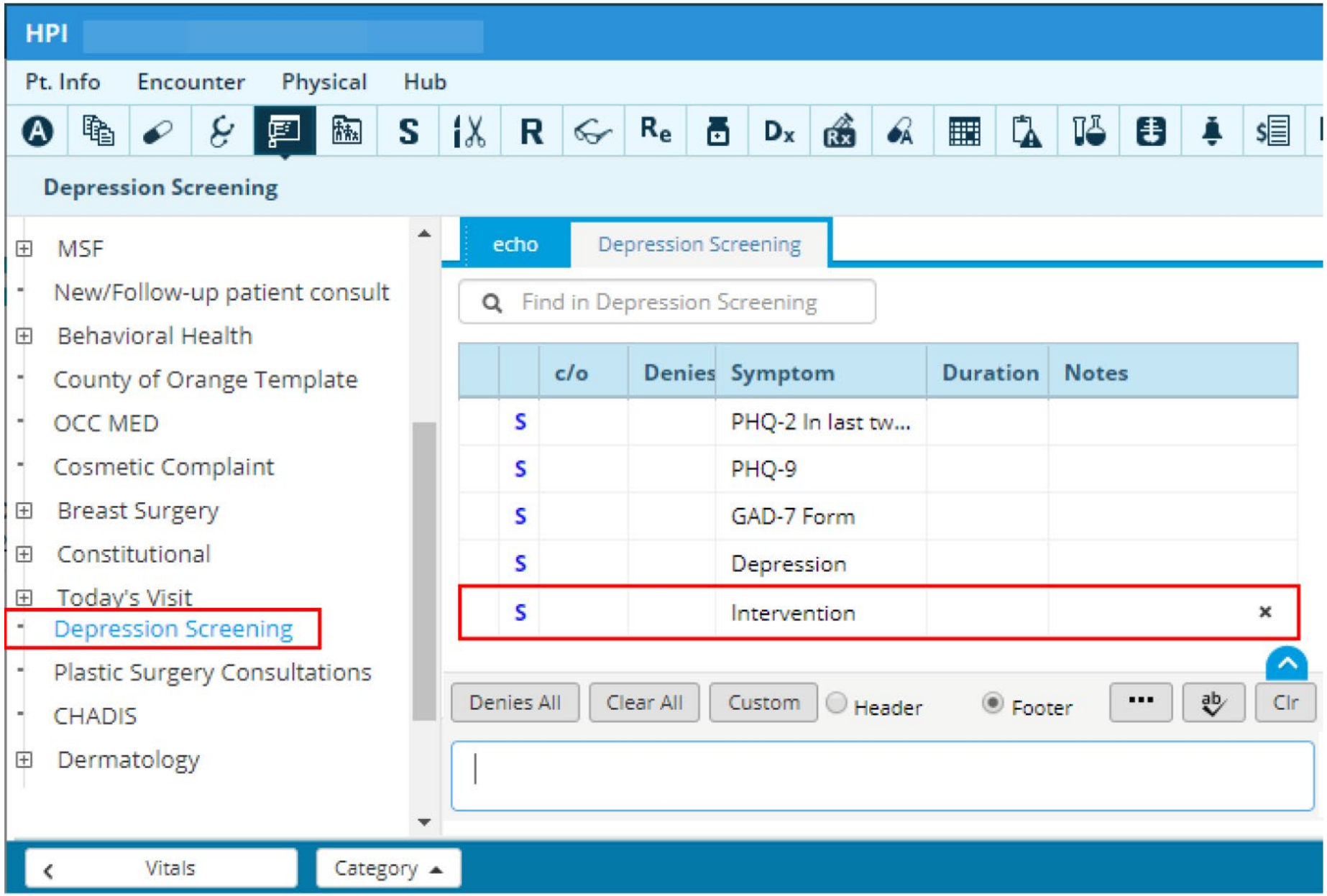
Documenting Follow-up in Structured Data


HPI
Pt. Info
Encounter
Physical
Hub
Depression Screening
MSF
New/Follow-up patient consult
Behavioral Health
County of Orange Template
OCC MED
Cosmetic Complaint
Breast Surgery
Constitutional
Today's Visit
Depression Screening
Plastic Surgery Consultations
CHADIS
Dermatology
echo
Depression Screening
Find in Depression Screening
c/o
Denies
Symptom
Duration
Notes
S
PHQ-2 In last tw...
S
PHQ-9
S
GAD-7 Form
S
Depression
S
Intervention
Denies All
Clear All
Custom
Header
Footer
Clr
Vitals
Category

Screening Not Performed

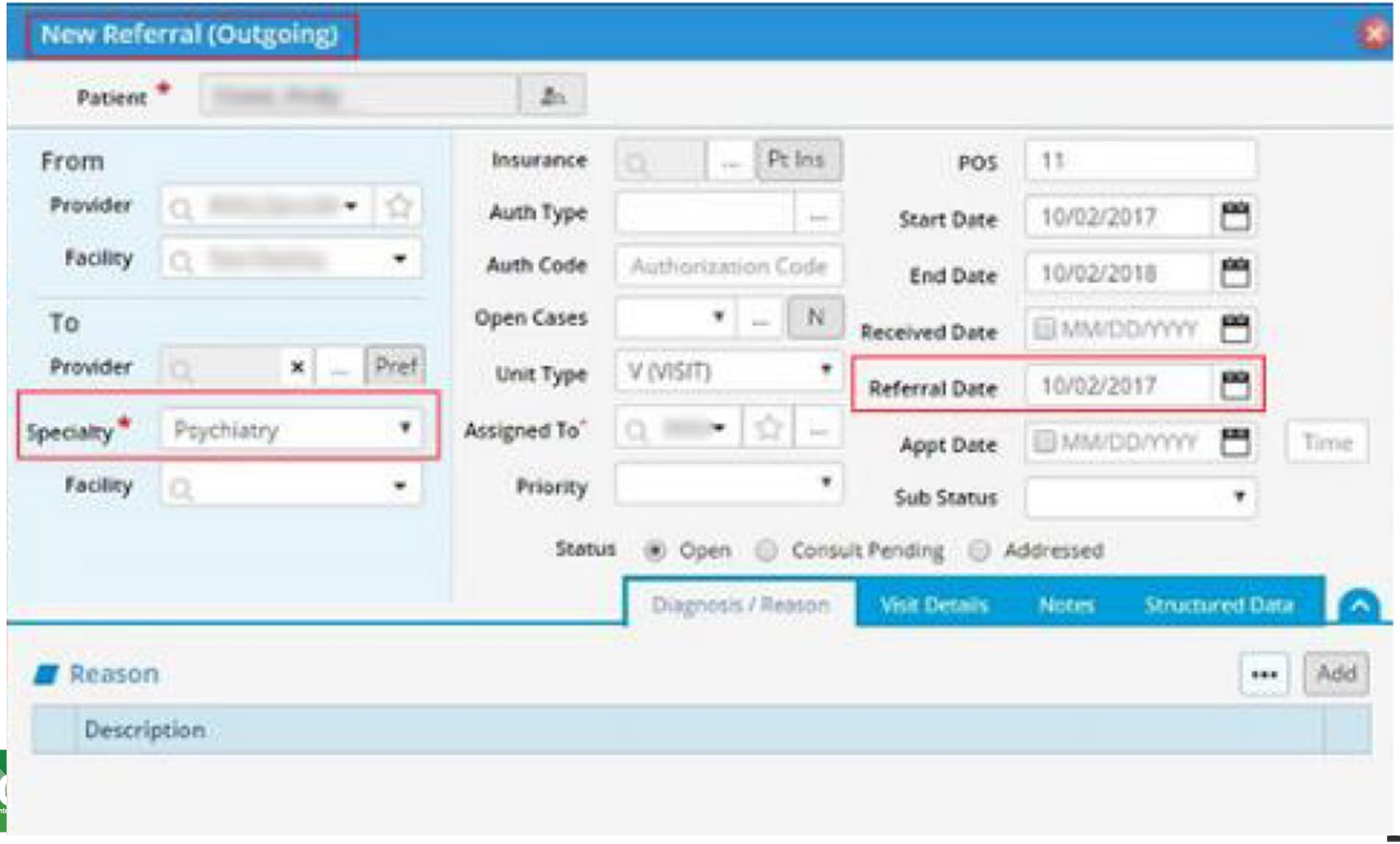
Path: *Progress Notes > HPI > Depression Screening > Screening not performed > Reason*

Document the reason a depression screening was not performed as structured data in the HPI section of the Progress Notes.

To document the reason screening was not performed:

1. Click *Depression Screening* from the left pane.
2. Click the *Duration* column next to Screening not performed on the right pane.
3. Select one of the following options from the Value drop-down list next to Reason:
   - *patient refusal to participate*
   - *urgent/emergent visit*
   - *patient lacks the functional capacity*

   The Reason is documented.


New Referral (Outgoing)
Patient
From
Provider
Facility
To
Provider
Pref
Specialty
Psychiatry
Facility
Insurance
Pt Ins
Auth Type
Auth Code
Authorization Code
Open Cases
N
Unit Type
V (VISIT)
Assigned To
Priority
POS
11
Start Date
10/02/2017
End Date
10/02/2018
Received Date
MM/DD/YYYY
Referral Date
10/02/2017
Appt Date
MM/DD/YYYY
Time
Sub Status
Status
Open
Consult Pending
Addressed
Diagnosis / Reason
Visit Details
Notes
Structured Data
Reason
Add
Description

To document an Outgoing Referral the **Specialist** must be one of these below. May have to submit a ticket to have them mapped in your system.

Psychiatry, child & adolescent psychiatry, clinic, clinical psychologist, depression management program, emergency clinic, liaison psychiatry service, mental handicap psychiatry service, mental health counseling, mental health counseling service, mental health counselor, mental health team, mental health worker, psychiatric aftercare, psychiatrist for the elderly mentally ill, psychiatry service, psychogeriatric day hospital, psychogeriatric service, psychologist.

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Questions?

Leslie Southworth

Director of the MT HCCN

lsouthworth@mtpca.org

(406) 594-3863

Depression Screening- Why Screen?

INTEGRATED BEHAVIORAL HEALTH

Why Screen for Depression

Lacey Alexander-Small, LCSW

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Why Screening for Depression Matters?

- Primary care clinics are a **gateway** for individuals with behavioral health and primary care needs.
- Primary Care Providers (PCPs) prescribe 80% of antidepressants, 67% of psychoactive agents, and 92% of elderly patients receive their mental health services in primary care
- High levels of stigma and discrimination against this population create lack of access to services.
- Around 50% of Americans will experience a diagnosable Substance Use Disorder (SUD) or Mental Health (MH) disorder at some time in their life.
- Montana's suicide rate is more than twice the national average. 45% of completed suicide patients had a PC visit within one month, 20% of those had visited within 24 hours.
- Alcohol was found in the bloodstream at a 2 times higher rate than national average for completed suicide patients.

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Why Screening for Depression Matters Cont.

- Depression is among the leading causes of disability in persons 15 years or older.[3]
- It accounts for $30–50 billion in lost productivity and direct medical costs annually in the U.S.[4]
- Major depression disproportionately affects women
- Depressed mothers may have infants that display delayed:
  - psychological
  - Cognitive
  - Neurologic
  - Motor development.

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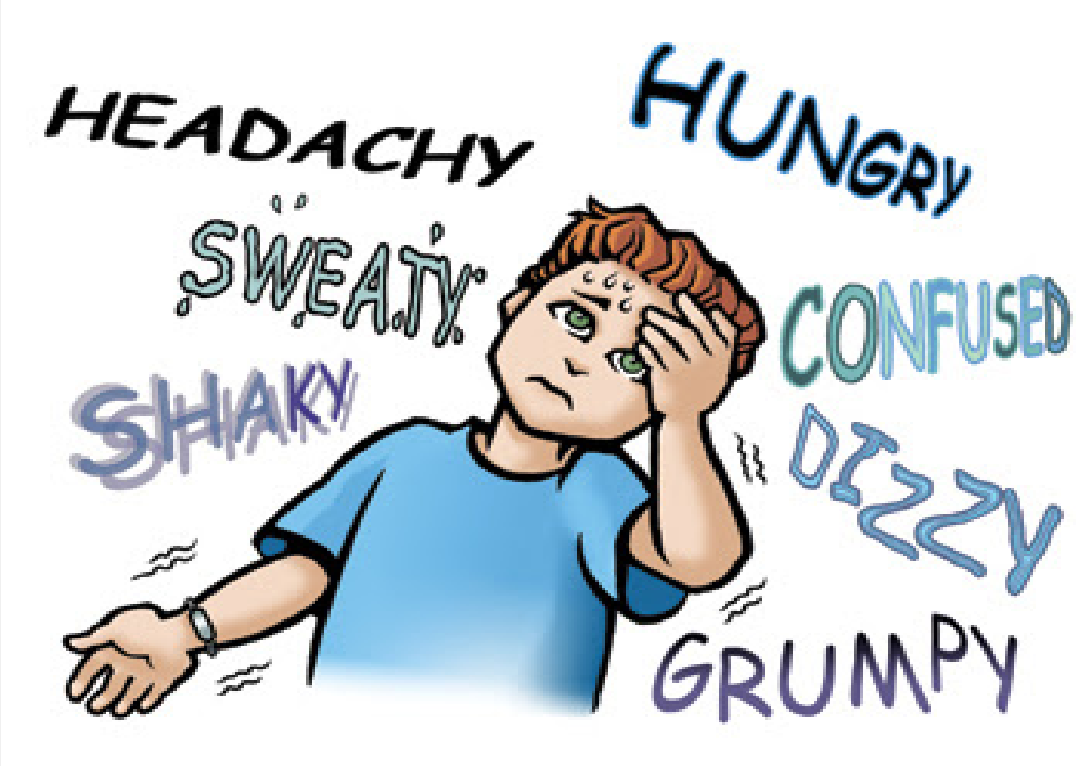
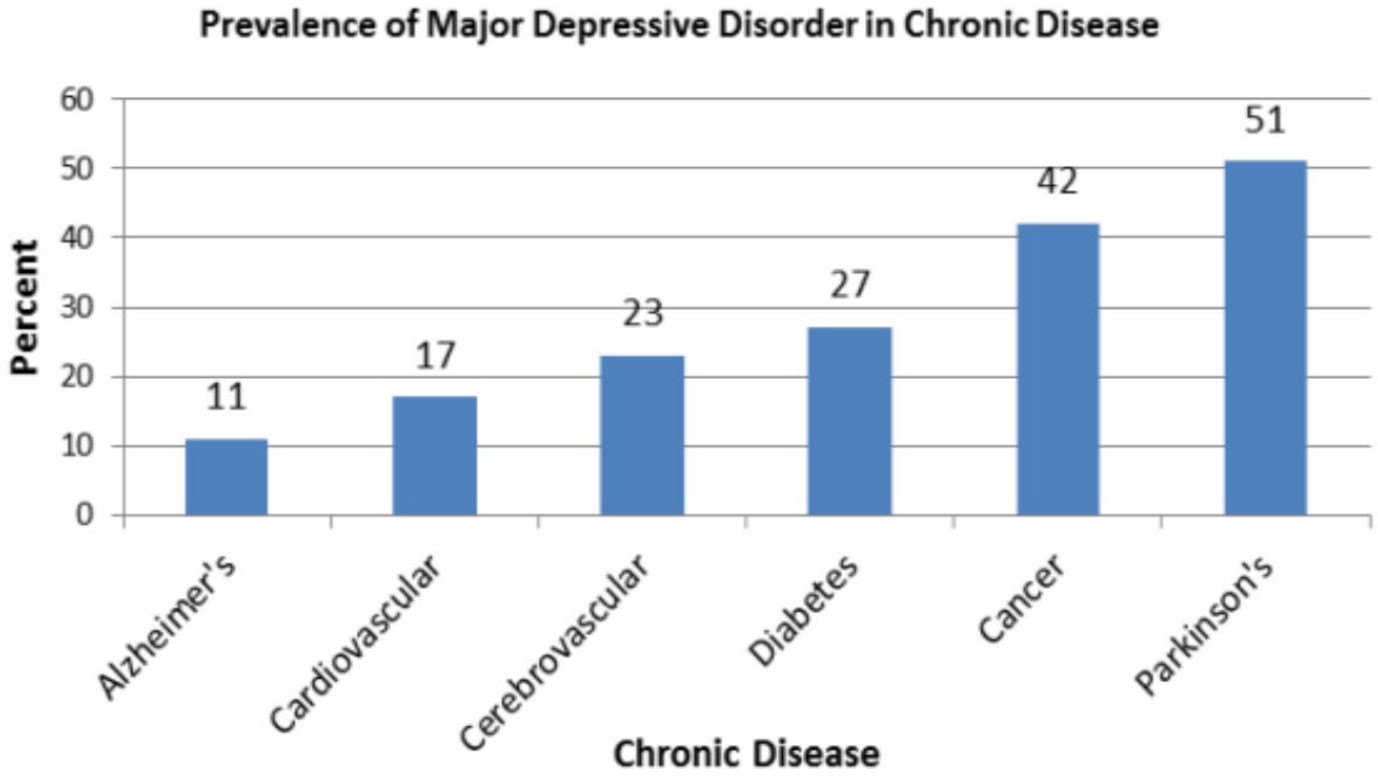
At some point in your lifetime you will have symptoms of Depression





Source: NHDS,NAMCS,NHAMCS, Mayo Clin. Proc.73:329

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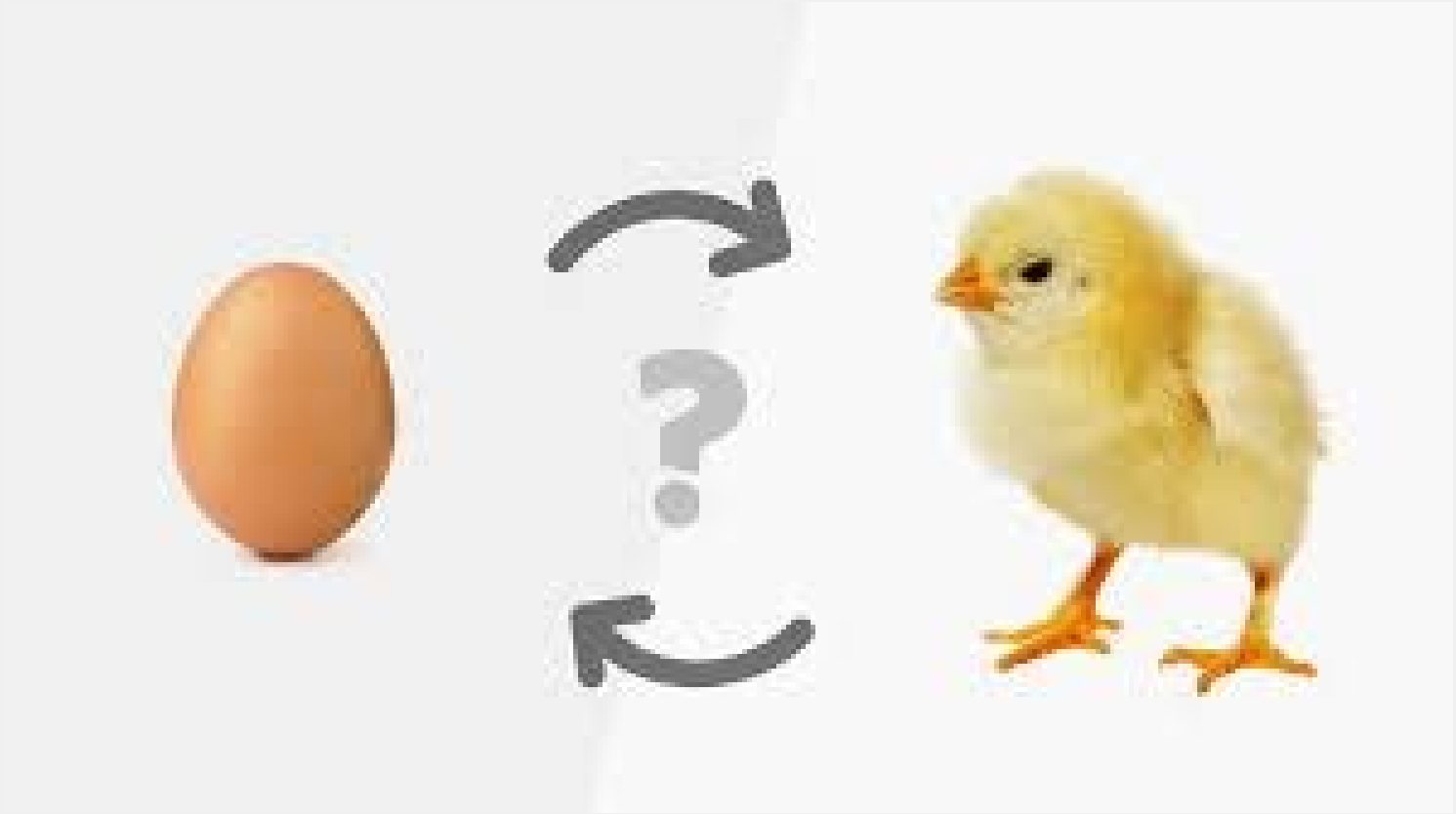
Chronic Illnesses Improvement rates Increase



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Is it Depression or Diabetes-Related Distress

Clinical Depression	Diabetes-Related Distress
• "I have persistent sad, anxious, or empty feelings"	• "I have feel that diabetes is taking up too much of my mental and physical energy every day"
• "I have feelings of hopelessness and/or pessimism"	• "I feel angry, scared, and/or depressed when I think of living with diabetes"
• "I have feelings of guilt, worthlessness, and/or helplessness"	• "I feel like I'm failing my diabetes regimens"
• I have irritability and/or restlessness"	• "I feel that my family or friends are not supportive enough of my self-care efforts"
• "I have lost interest in activities or hobbies that were once pleasurable"	• "I feel that diabetes controls my life"
• "I have fatigue and decreased energy"	• "I do not feel confident in my day-to-day ability to manage my diabetes"
• "I have difficulty concentrating, remembering details and making decisions"	• "I feel that serious long-term complications will happen regardless of my efforts to prevent them"
• "I have insomnia, early morning wakefulness or excessive sleeping"	• "I feel that my family and friends don't appreciate the difficulty of living with diabetes"
• "I overeat or I have appetite loss"	• "I feel overwhelmed by the demands of living with diabetes"
• "I have thoughts of suicide or have attempted suicide"	• "I don not feel motivated to keep up with diabetes self-management
• "I have persistent aches or pains, headaches, cramps or digestive problems that done ease even with treatment"	

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PHQ-9 Question

	Not at all	Several days	More than half the days	Nearly every day
1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
h. 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.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐

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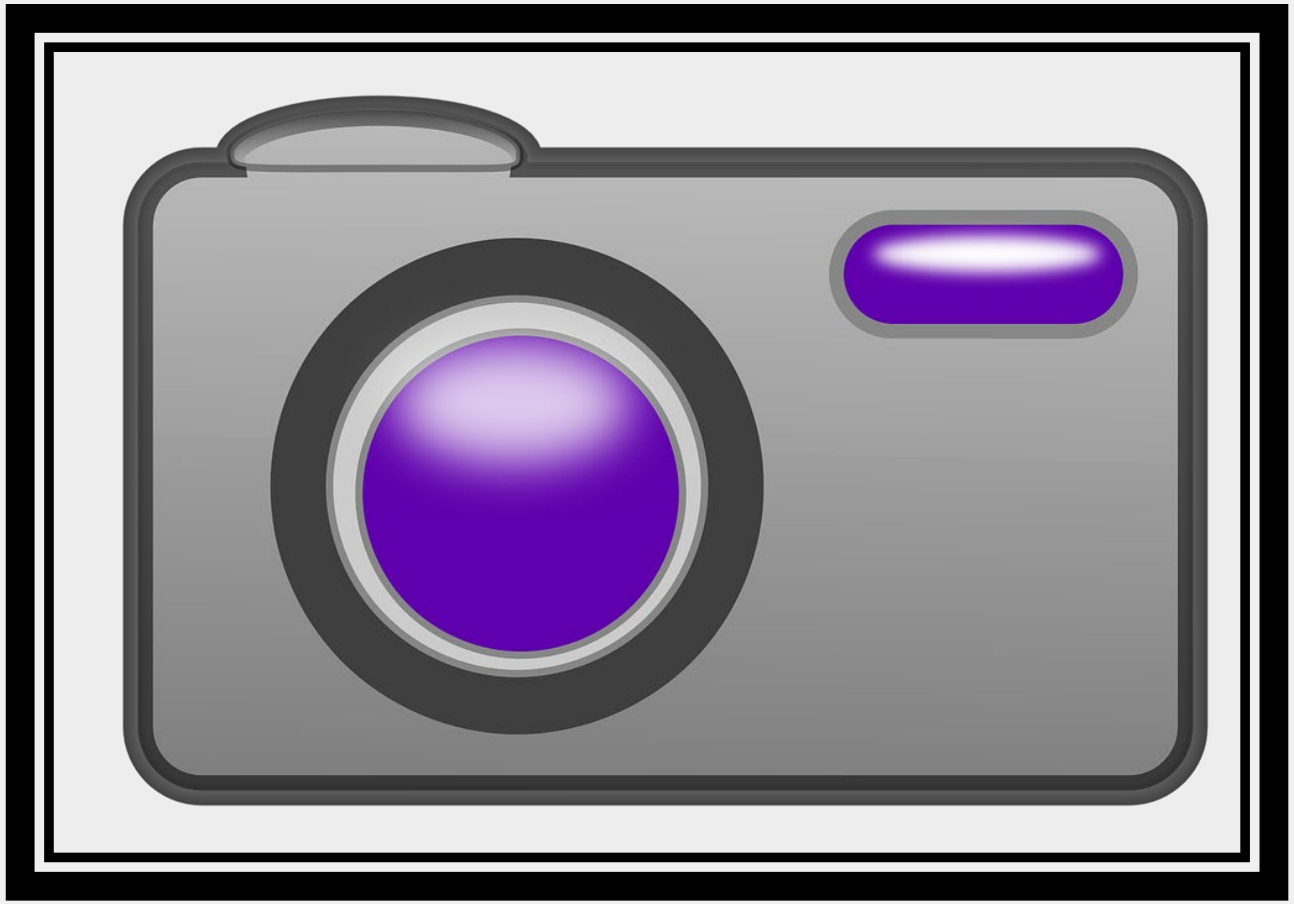
Snap-Shot of Whole Health Of Patient



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RECAP

- ✓ Misdiagnoses and/or playing whack a mole game
- ✓ Better outcomes –patients get better faster
- ✓ Education patient of symptoms
- ✓ Decrease on High utilizers
- ✓ Addresses Motivation or Lack of Motivation
- ✓ Screening provides snapshot of Whole health for better tx
- ✓ Provides opportunities to identify further social determents of health and resources needed
- ✓ Decrease in medical cost and increase of other screening
- ✓ Decrease Stigma
  - ✓ normalizing mental health connection to physical Health

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Questions/Comments

Thank You for Screening!

Breakout Session

Is your clinic currently screening for depression via telehealth? If so how? (portal, visit, etc)

Is a social needs screening being done in conjunction with a depression screening?

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Quality Awards

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Congratulations!

Health Center Grantee	State	Clinical Quality Improvers	Health Center Quality Leaders	National Quality Leaders	Access Enhancers	Value Enhancers	Health Disparities Reducers	Advancing Health Information Technology (HIT) for Quality	Patient Centered Medical Home (PCMH) Recognition
Yellowstone City-County Health Department	MT	$0	$0	$0	$0	$0	$0	$10,750	$45,000
Missoula, County Of	MT	$22,068	$0	$0	$0	$0	$0	$10,750	$30,000
Montana Migrant & Seasonal Farm Workers Council Inc	MT	$5,982	$0	$0	$0	$0	$0	$9,600	$45,000
Community Health Partners, Inc.	MT	$0	$0	$0	$0	$0	$0	$10,750	$45,000
Butte-silver Bow Primary Health Care Clinic, Inc.	MT	$22,521	$0	$0	$0	$0	$0	$10,750	$35,000
LINCOLN COUNTY COMMUNITY HEALTH CENTER	MT	$14,448	$25,373	$0	$0	$0	$0	$5,750	$35,000
GLACIER COMMUNITY HEALTH CENTER, INC.	MT	$6,246	$20,333	$0	$0	$0	$0	$10,750	$30,000
Bullhook Community Health Center, Inc.	MT	$7,694	$0	$0	$0	$0	$0	$8,250	$30,000
FLATHEAD, COUNTY OF	MT	$11,321	$0	$0	$0	$0	$0	$8,250	$30,000
Bighorn Valley Health Center, Inc	MT	$13,211	$0	$0	$0	$0	$0	$10,750	$50,000
Sapphire Community Health, Inc.	MT	$0	$0	$0	$0	$0	$0	$7,100	$30,000
Marias Healthcare Services Inc	MT	$0	$23,231	$34,731	$11,500	$0	$8,625	$8,250	$30,000
Community Health Care Center, Incorporated	MT	$0	$0	$0	$0	$0	$0	$7,100	$30,000

Upcoming Events

- **August 26 12:00pm Advancing Health Center Excellence** The Advancing Health Center Excellence Framework aims to help HRSA and health centers advance health center maturity and innovation in key domain areas that align with HRSA's mission and the mission of the Health Center Program. The framework will also help HRSA make decisions about deploying resources, including providing technical assistance (TA) and funding, with more intention and transparency.
- September 15 11:00 am Telehealth Tuesdays: Emerging Trends in Telehealth
- September 22-24 The Azara 2020 Virtual User Conference
- September 30th QDI Peer Learning Call
- October 5-8 The VIRTUAL 2020 Montana Healthcare Conference

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