Engaging Primary Care Providers In Older Adult Mental Health

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Quality Improvement Organizations
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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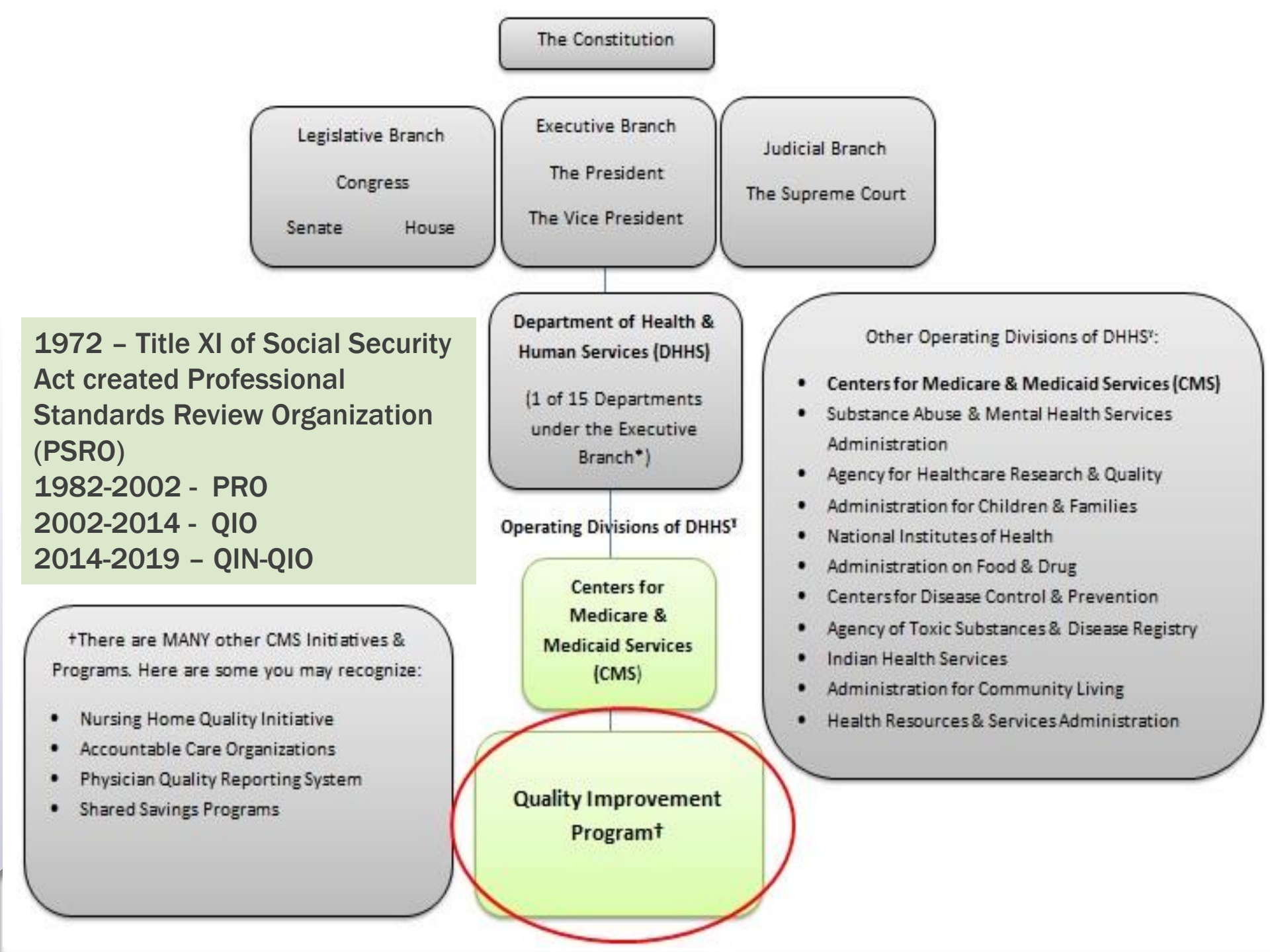
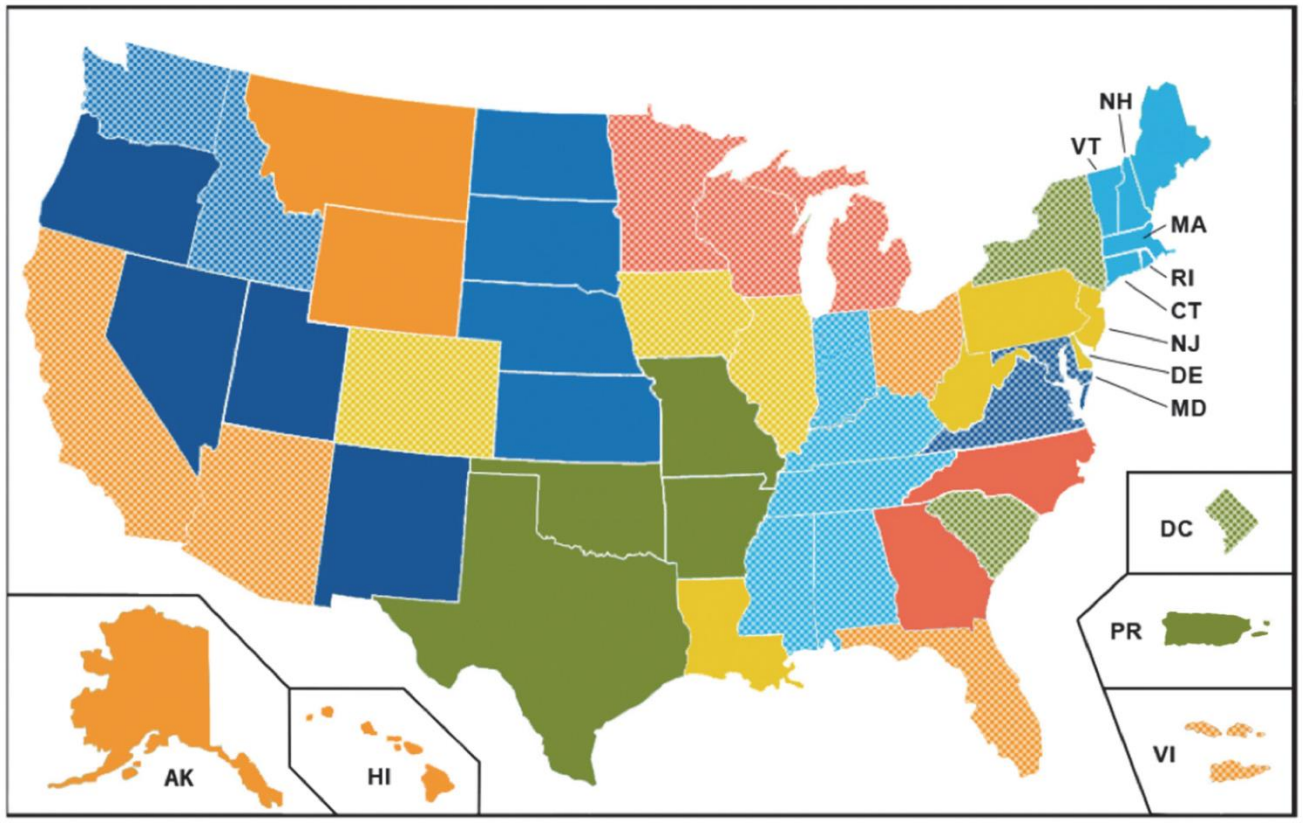

The Constitution
Legislative Branch
Congress
Senate
House
Executive Branch
The President
The Vice President
Judicial Branch
The Supreme Court
Department of Health & Human Services (DHHS)
(1 of 15 Departments under the Executive Branch*)
1972 – Title XI of Social Security Act created Professional Standards Review Organization (PSRO)
1982-2002 - PRO
2002-2014 - QIO
2014-2019 – QIN-QIO
Operating Divisions of DHHS‡
Centers for Medicare & Medicaid Services (CMS)
Quality Improvement Program†
Other Operating Divisions of DHHS‡:
Centers for Medicare & Medicaid Services (CMS)
Substance Abuse & Mental Health Services Administration
Agency for Healthcare Research & Quality
Administration for Children & Families
National Institutes of Health
Administration on Food & Drug
Centers for Disease Control & Prevention
Agency of Toxic Substances & Disease Registry
Indian Health Services
Administration for Community Living
Health Resources & Services Administration
†There are MANY other CMS Initiatives & Programs. Here are some you may recognize:
Nursing Home Quality Initiative
Accountable Care Organizations
Physician Quality Reporting System
Shared Savings Programs

Quality Improvement Network - Quality Improvement Organizations



- Alliant - Georgia Medical Care Foundation
- Atlantic Quality Improvement Network
- atom Alliance
- Great Plains Quality Innovation Network
- HealthCentric Advisors
- HealthInsight
- Health Services Advisory Group
- Lake Superior Quality Innovation Network
- Mountain Pacific Quality Health Foundation
- Qualis Health
- Quality Insights Quality Innovation Network
- Telligen
- TMF
- VHQC

11 SOW QIN-QIO
August 2014 – July 2019
Key Roles

1. **Results Oriented**
   A Multi-state & Local Change-agent Champion
2. **Learning & Action Networks**
   A Facilitator of Learning & Action
3. **Technical Assistance**
   A Teacher & Advisor
4. **Communication**
   A Highly-effective Communicator and Trusted Partner

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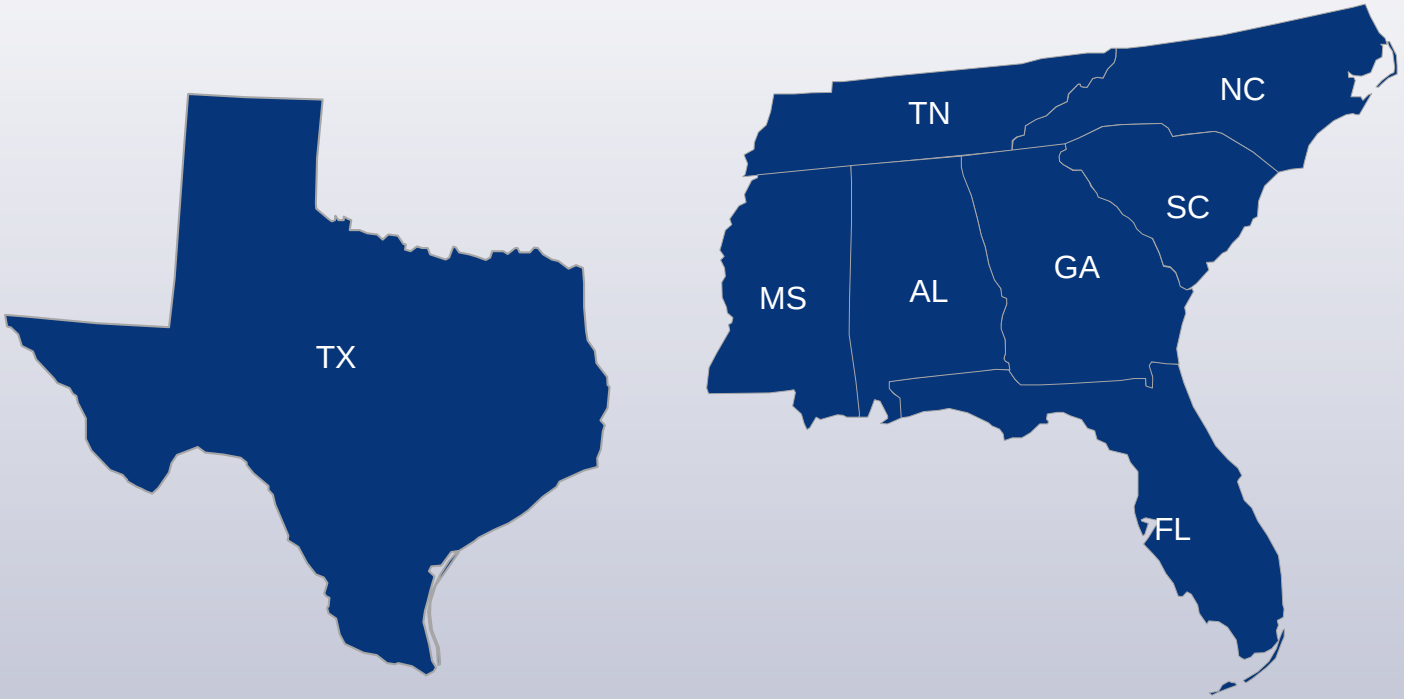
ALLIANT HEALTH SOLUTIONS

- ALLIANT GMCF
- ALLIANT ASO
- Healthcare Research
- ALLIANT INTEGRITY
- ALLIANT QUALITY

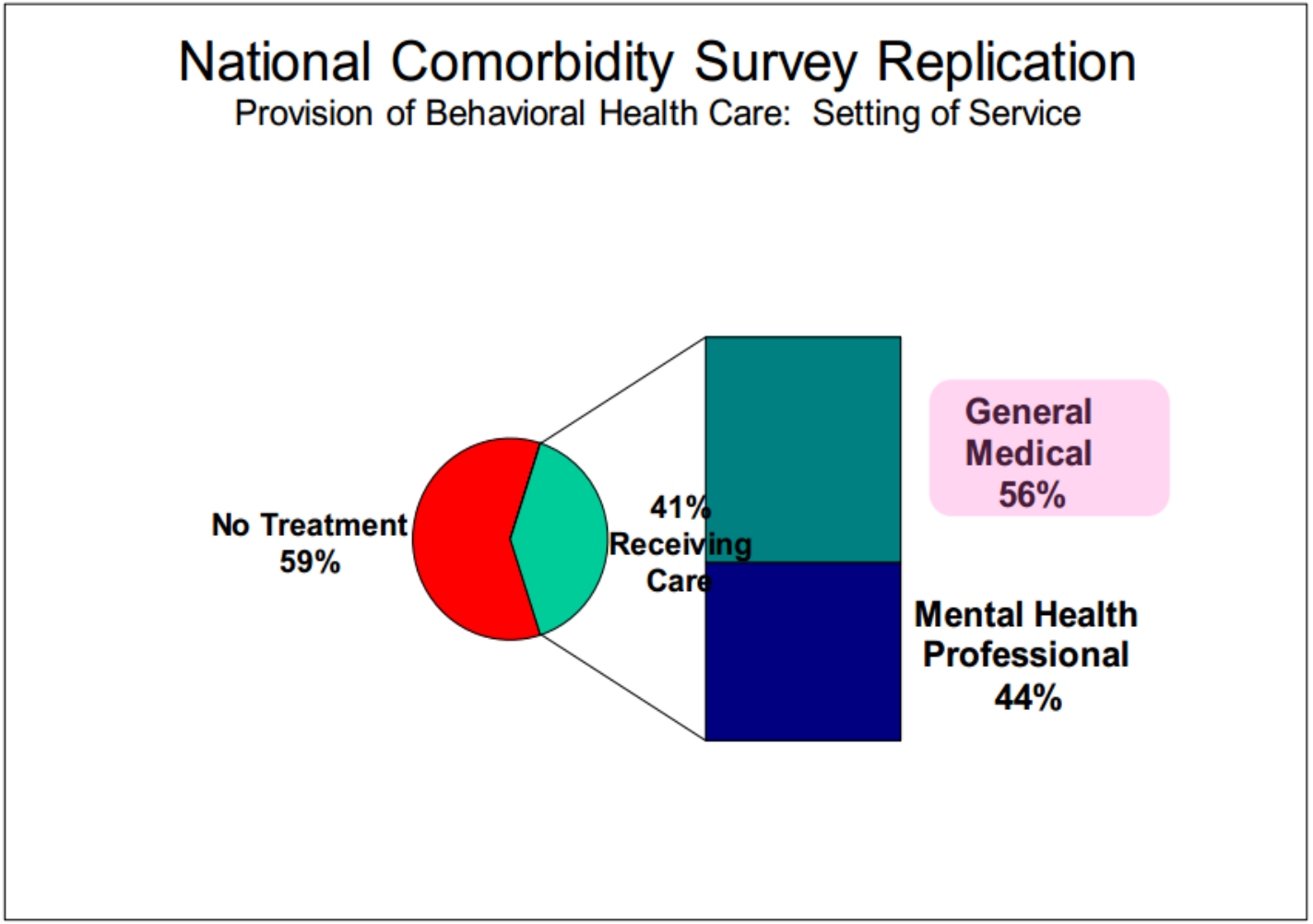


Behavioral Health and Primary Care

Actual Situation

- Physicians screen fewer than half of their patients for alcohol use disorders
- Roughly two-thirds of those with a behavioral health disorder do not get behavioral health treatment
- Depression is identified in fewer than half of primary care patients

Primary Care is the 'De Facto' Mental Health System



Source: Wang P et al. *Arch Gen Psychiatry*, 2005: 62.

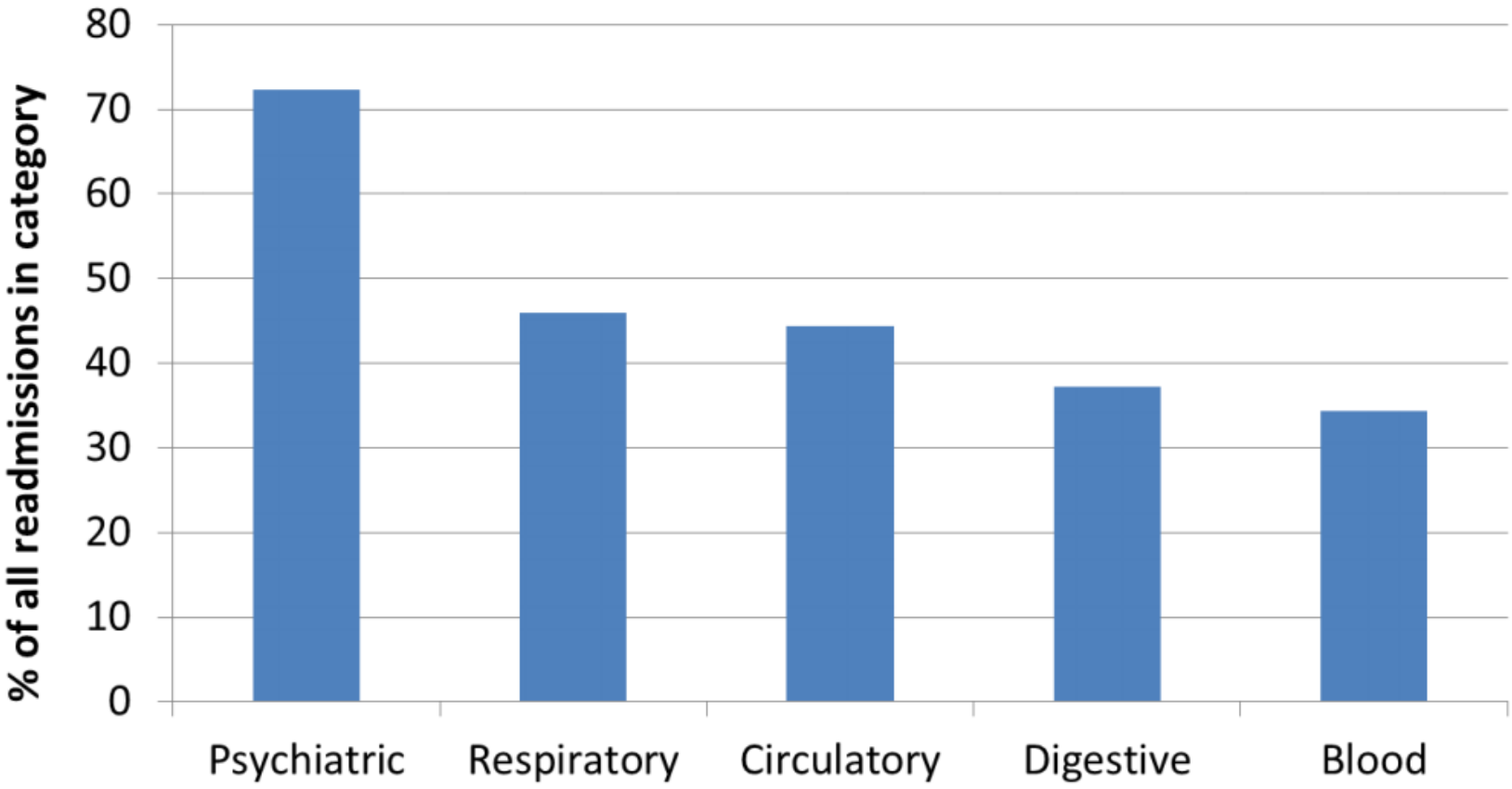
Transitions from Inpatient Psychiatric Facilities

IPFs – F/U after hospitalization

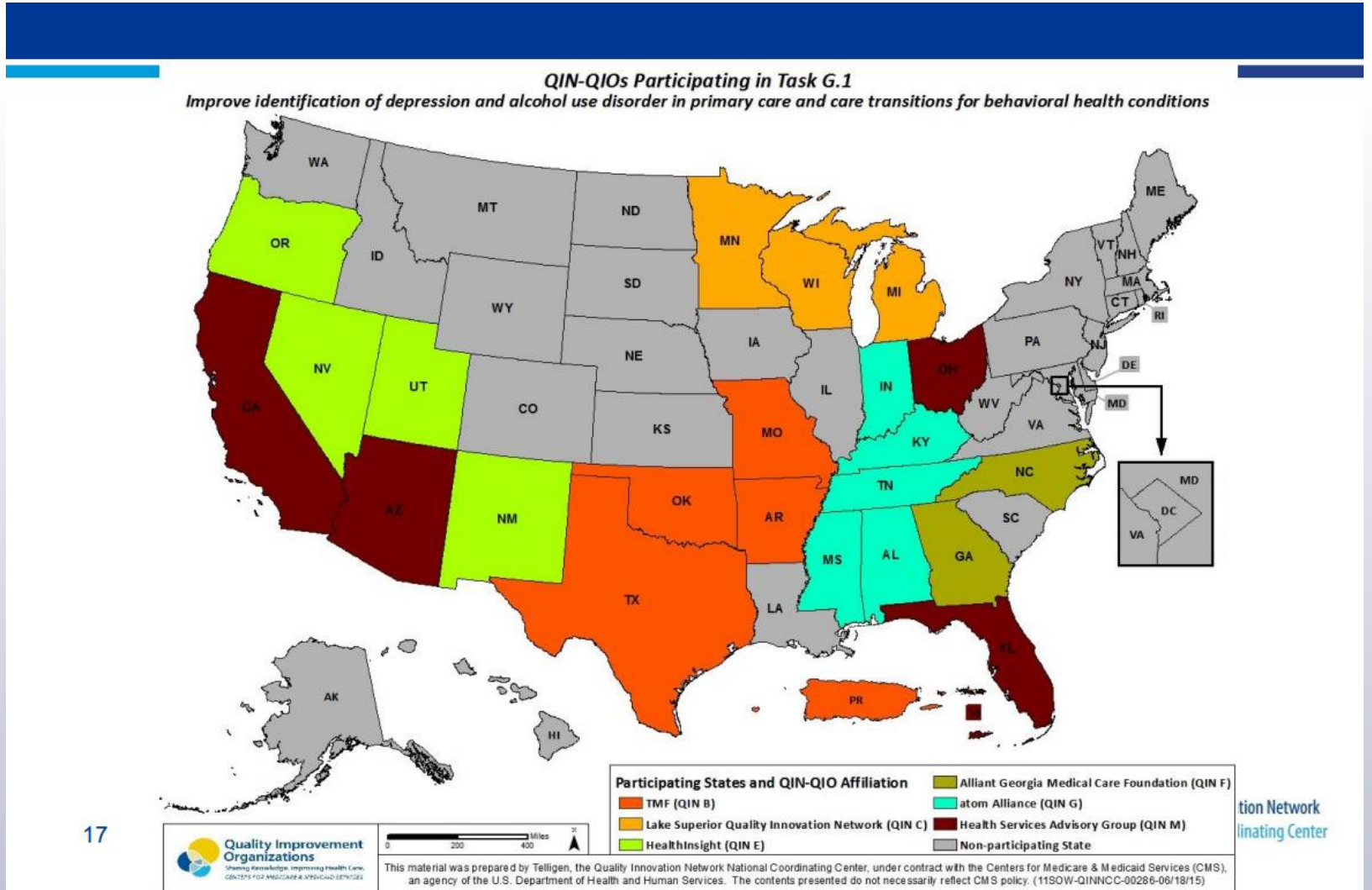
	Average (%)	Min	25th percentile	75th percentile	Max
7-day follow-up	28.7	0	16.7	39.5	100
30-day follow-up	53.5	0	42.3	67.3	100

Performance across 1,669 IPFs in 50 states with FFS Medicare-paid stays, 2008

Medicare Readmissions with Same Diagnosis as Initial Admission ("True" Readmissions)



Improving Identification of Depression and Alcohol Use Disorder in Primary Care and Care Transitions for Behavioral Health Conditions



Improve Behavioral Health Care

Recruit 200 primary care practices per state (by 2/19/2016) (currently signed 38)

Reduce readmission rates to 5 inpatient psychiatric facilities

(currently signed 13)

Increase 7 and 30 day follow up in behavioral health

Increase annual screening for depression using PHQ-2/9

Increase annual screening for risky alcohol use – AUDIT (C)

Teach primary care management of depression and risky alcohol use

Establish linkages to behavioral health referral network

Currently recruited Inpatient Psychiatric Facilities 1/7/16

Duke University Hospital
Duke Regional Hospital
Holly Hill Mental Health Services
Novant Health Forsyth
Novant Corporate
Novant Presbyterian Health
Cherry Hospital
UNC Hospital
UNC Hospital
Novant Health Rowan Medical Center
Novant Health Thomasville Medical Center
Carolinas Healthcare- Behavioral Health
Carolinas Healthcare- Davidson
Carolinas Healthcare- Kings Mountain
Stanly Regional
MOSES H. CONE MEMORIAL HOSPITAL

Benefits of Participation

- Methods to improve compliance with 7 day and 30 day post discharge appointments
- Improvement in this area can prevent payment penalties
- Involvement in a community of providers focused on reducing readmissions and quality improvement

Potential Solutions For Primary Care Clinic Adoption of Screening

- Keep the primary screening as brief as possible
- Use non-judgmental approach and allow the "patient to lead."
- Make sure clinical processes are modified to reduce redundant assessments and make the information actionable for the clinician.
- Provide clinical pathways, protocols, and referral resources to improve behavioral health access and support.

Potential Solutions For Primary Care Clinic Adoption of Screening *cont'd.*

- Train clinicians on evidence based treatment guidelines for depression and alcohol use.
- Embed guidelines and decision support in the EHR.
- Provide intuitive, actionable visualization of screening results.
- Learn the specific documentation and coding requirements to get reimbursed, and make sure this is baked into the protocols and infrastructure from the start.

Recruitment and Free Technical Assistance

- Education on screening tools, treatment and referral processes
- Workflow analysis to improve screening efficiency
- Designing process and linkages to referral programs
- Quality improvement technical assistance
- Training in quality improvement methodologies
- Education on best practices, shared successes and lessons learned

1	Total Number of Medicare FFS Patients*	6,489
2		

ACTUAL REVENUE*

	Annual Revenue	Billing Code	# Patients	PFS	Actual Revenue	Minutes/Pt
5	Alcohol Disorder Screening	G0442	0	$28.88	$0.00	3
6	Alcohol Screening/Treatment	G0396	0	$29.42	$0.00	15
7	Alcohol Screening/Treatment	G0397	0	$57.68	$0.00	30
8	15 minute Interventions	G0443	0	$25.14	$0.00	15
9	Depression Screening	G0444	45	$17.36	$777.28	3
10	Total Annually				$777.28	
11					Total $/ hr	$347.20

Potential Revenue Estimate*

	Annual Revenue	Billing Code	# Patients	PFS	Revenue Potential	Minutes/Pt
15	Alcohol Disorder Screening	G0442	3,893	$28.88	$112,441.39	3
16	Alcohol Screening/Treatment	G0396	1,298	$29.42	$38,181.28	15
17	Alcohol Screening/Treatment	G0397	1,298	$57.68	$74,857.10	30
18	15 minute Interventions	G0443	1,298	$25.14	$32,626.69	15
19	Depression Screening	G0444	6,489	$17.36	$112,649.04	3
20	Total Annually				$370,755.50	
21					Total $/ hr	$204.06

Quality Improvement Organizations | ALLIANT QUALITY

January XX, 2016

Dear Provider,

My name is **Yolonda Williams** and I am with Alliant Quality, the Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for Georgia and North Carolina. The Centers for Medicare & Medicaid Services (CMS) awarded a quality improvement grant to our organization to assist primary care practices with utilizing behavioral health and alcohol screenings among Medicare patients. We are one of six QIN-QIOs that have been awarded this cutting edge opportunity.

CMS' Medicare claims data shows that your provider/s did not bill for any depression or alcohol screenings in 2014. Listed below are the number of beneficiaries and the potential revenue for utilizing the depression and alcohol screeners.

Unique # of Medicare Patients _____
2014 Claim Count _____
Potential Revenue from codes: G0442 and G0444_____

We invite you to join us by becoming early adopters of this exciting opportunity. As we prepare to enter the New Year, we want to ensure these missed opportunities do not carry over into 2016!
We are here to provide FREE technical resources as your practice works to improve patient care by incorporating quality behavioral health measures!

If you are interested in participating in this cutting edge opportunity, please indicate **YES** by any of the following options:

Reply by Email – simply state **YES!** in the subject line or

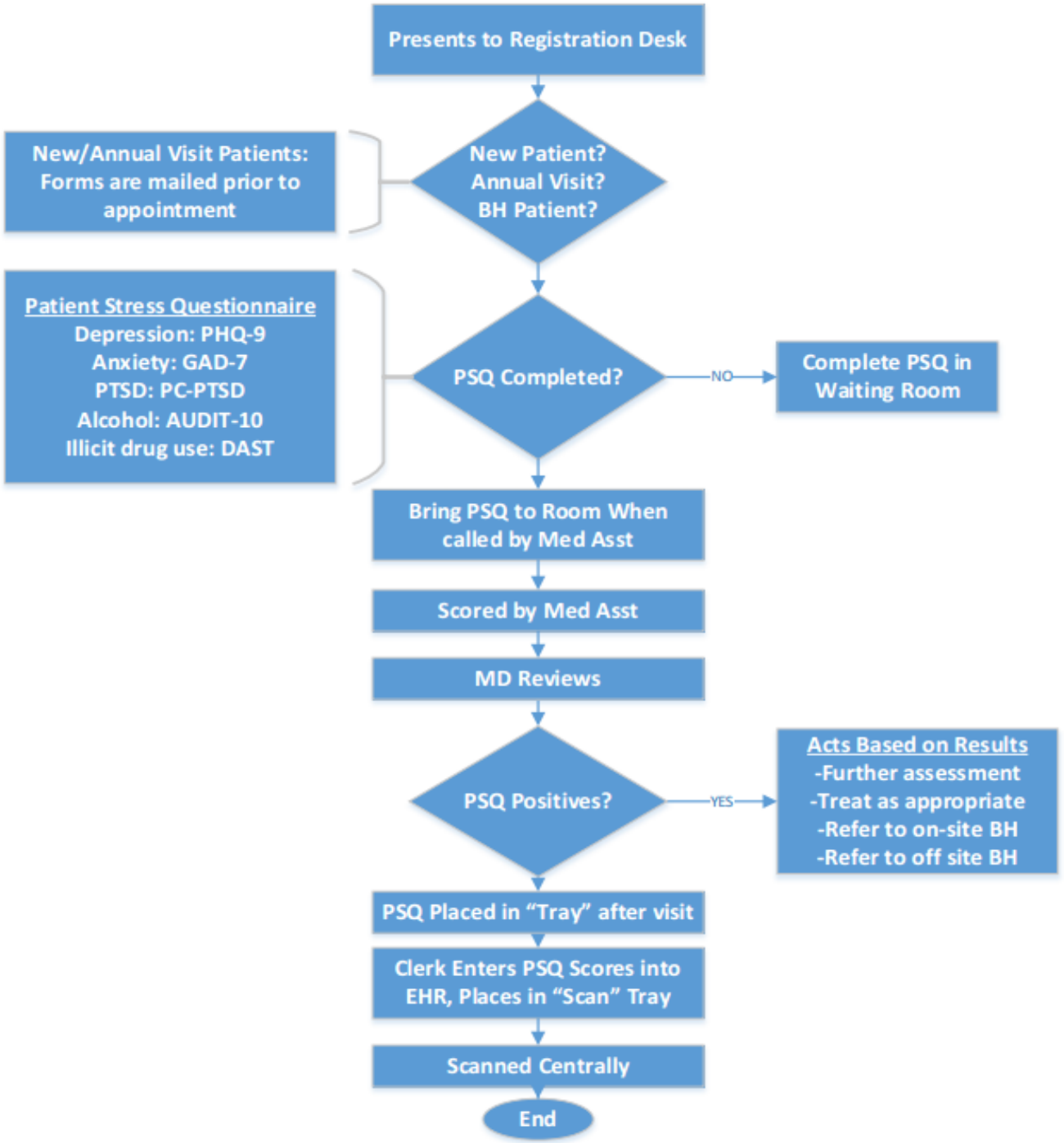
Fax – Return to this letter by fax to 678-527-3030 ☐ Yes, I want to participate! ☐ No or

Call - Yolonda Williams at (678) 892-3841

We have taken the first step by providing you with 2014 results. We will continue to provide participating practices with routinely updated practice specific data.

Sincerely,

Yolonda Williams MA, CPHQ - Task Lead, Behavioral Health
Office: 678-892-3841
Yolonda.Williams@alliantquality.org


Presents to Registration Desk
New Patient?
Annual Visit?
BH Patient?
New/Annual Visit Patients:
Forms are mailed prior to
appointment
Patient Stress Questionnaire
Depression: PHQ-9
Anxiety: GAD-7
PTSD: PC-PTSD
Alcohol: AUDIT-10
Illicit drug use: DAST
PSQ Completed?
NO
Complete PSQ in
Waiting Room
Bring PSQ to Room When
called by Med Asst
Scored by Med Asst
MD Reviews
PSQ Positives?
YES
Acts Based on Results
-Further assessment
-Treat as appropriate
-Refer to on-site BH
-Refer to off site BH
PSQ Placed in "Tray" after visit
Clerk Enters PSQ Scores into
EHR, Places in "Scan" Tray
Scanned Centrally
End

Site Information Form: Primary Care

Site Name:

Point of Contact Name:

Address:

Telephone number:

1. What proportion of patients treated have a BH condition? ____ %

2. Is the site an FQHC? ☐ Yes ☐ No

3. Is the site part of an ACO? ☐ Yes ☐ No

4. Is the site part of an existing national or state effort at screening or integrated PC? ☐ Yes ☐ No

5. Are there existing efforts for screening depression? ☐ Yes ☐ No
   Alcohol? ☐ Yes ☐ No

6. If Yes to 5: Is this screening done by paper or computer? ☐ Paper ☐ Computer

7. If no to 5: Has the practice been considering adding depression, alcohol screening? ☐ Yes ☐ No

8. Are there existing BH resources? ☐ Yes (check all that apply) ☐ No
   - ☐ Referral lists
   - ☐ Psychoeducational resources/information
   - ☐ BH clinician co-located?
   - ☐ Other:

9. Are there IT/IS resources that would be able to help computerize the screeners and/or get results into the EHR?
☐ Yes ☐ No

10. Are there local CQI resources that can help with implementation? ☐ Yes ☐ No

Current State Assessment - Depression

Site Name: _____Date of Assessment: _____

Depression Screening

Check the category that best describes the practice at the date of the assessment.

1. Policy:	☐ Depression screening is NOT a systematic practice expectation of clinicians at the site.	☐ Depression screening is supposed to be conducted periodically (e.g. annually) by all clinicians in the practice.	☐ Depression screening is supposed to be conducted across at EVERY VISIT by all clinicians in the practice.
2. Practice:	☐ Patients are sometimes screened for depression but it is not systematic (i.e., screening occurs only if there is a clinical reason for it).	☐ The vast majority of patients are screened periodically (e.g., annually) for depression.	☐ The vast majority of patients are screened at every visit for depression.
3. Screener:	☐ The depression screener used **IS NOT** a validated screener.	☐ The depression screener used **IS** a validated screener: ☐ PHQ-2 ☐ PHQ-9 ☐ Other: _____	

Approximate proportion of visits during which depression is screened:

4. Initial visits: ___% **5. Well visits: ___%** **6. Acute care visits: ___%** **7. Chronic care visits: ___%**

Gap Analysis Example

Date: 08/10/15

Title: Depression Screening in Primary Care

Future State	Current State	Actions
1. Screen >90% of all new patients for depression using the PHQ-2	We currently screen approximately 30% of all new patients for depression using a medical history checklist, not the PHQ-2	1. Build a protocol for administering the PHQ-2 to new patients. 2. Determine feasibility of including the PHQ-2 with New Patient mailer, medical history form 3. Determine feasibility of adding PHQ-2 to the Patient Health Portal 4. Identify protocol for scoring PHQ-2 and summarizing results for MD
2. Screen >90% of all Wellness Visits using the PHQ-2	We currently screen approximately 20% of all Wellness visits using a medical history checklist, not the PHQ-2	1. See action items for #1. Tailor to Wellness Visits, such as determining the trigger for sending the PHQ-2 to the patient
3. Administer the rest of the PHQ (items 3 through 9) to all individuals who are positive on the PHQ-2	There is currently no process for re-assessing patients who are positive for depression.	1. Build alert in EHR to cue medical assistant to administer the PHQ Items 3-9 for those who screen positive on PHQ-2. 2. Write protocol for how the PHQ-9 will be scored, interpreted, and entered into the EHR.

Learning and Action Network

What does the QIO do?

QIOs lead LANs through webinars, calls, forums, listserves, mentorship programs, learning sessions, and improvement collaboratives. They take what LANs learn about improving care and put it into practice.

What can LANs accomplish?

- Bring participants together
- Build the will to improve
- Advocate to put patients first
  - Learn from patients' perspectives
- Support evidence-based interventions
- Make and test multiple small changes
- Use performance data to improve
- Share best practices
- Celebrate success
- Spread improvement

Contact Information

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Making Health Care Better

This material was prepared by GMCF, for Alliant Quality, the Medicare Quality Innovation Network – Quality Improvement Organization for Georgia and North Carolina, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication No. 11SOW-GMCFQIN-G1-16-01