SAMHSA-HRSA CENTER for INTEGRATED HEALTH SOLUTIONS

Understanding and Implementing UDS measures for Depression Screening, Documentation, and Practice

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HRSA Health Resources & Services Administration

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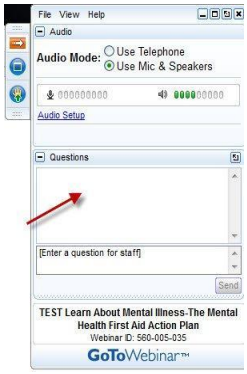

Today's Objectives

- **Health Center Program Impact**
- **Key Strategies**
- **Clarification on reporting for UDS**

  What population needs to be screened? What screening tools do I use?" What "counts" as a brief intervention, referral to treatment? How do I document and record?
- **What "counts" as documentation?**
- **Identify barriers and challenges that CHCs might be facing in screening for depression and reporting results**
- **How to utilize the EHR to produce meaningful data**
- **Provide a vehicle for peer sharing via the CIHS BH Expansion listserv**
- **Generate discussion, clarification and questions**

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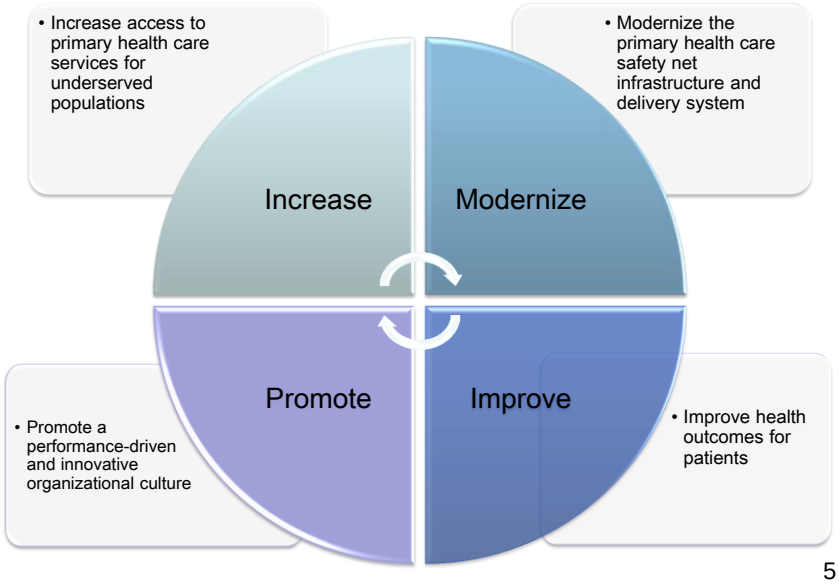
Bureau of Primary Health Care Overview

Laura Makaroff, DO
Senior Clinical Advisor – Office of Quality Improvement, -HRSA Bureau of Primary Health Care

Primary Care: Key Strategies

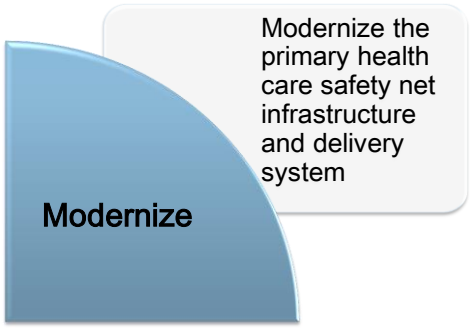


5

Primary Care Strategy: Modernize Infrastructure and Systems

Accomplishments:

- Modernized over 2,300 service delivery sites
- 96% of health centers have installed Electronic Health Records (EHR)
- 61% of health centers are Patient Centered Medical Home (PCMH) recognized



Program Goals:

- Increase % of health centers that report UDS data using an EHR
- Increase % of health centers reaching Stage 2 Meaningful Use Standards
- Increase % of health centers with PCMH at all sites
- Increase % of health centers with modernized facilities

6

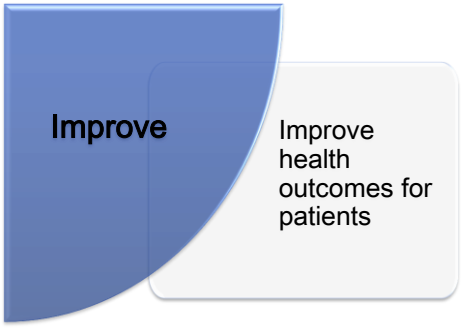
Primary Care Strategy: Improve Health Outcomes

Accomplishments:

- $36 million in Quality Improvement Awards
- Over $100 million in Behavioral Health Integration Awards

Clinical outcomes in certain areas routinely:

- Surpass national averages; and
- Close the gap on disparities



Program Goals:

- Increase % of health centers exceeding Healthy People 2020 goals
- Increase % of health centers improving performance on quality measures
- Increase % of health centers that provide integrated care

7

February 15, 2015

In 2014 HRSA launched the new depression UDS measures and changes for CY 2014 data collection.

BH Grantees are required to permit accurate UDS data analysis and submission on February 15, 2015.

UDS Depression Screening and Follow-Up Measure

PERFORMANCE MEASURE: The performance measure is percentage of *patients* aged 12 years and older *screened* for clinical depression using an *age appropriate standardized tool* AND *follow-up plan* documented.

Health Center 2014 National Average = 38.8%

Table 6B: Depression Screening and Follow-up

Numerator: Number of patients aged 12 and older who were 1) screened for depression with a standardized tool and, if screened positive for depression, 2) had a follow-up plan documented

Denominator: Number of patients who were aged 12 or older at some point during the measurement year and who had at least one medical visit during the reporting year.

Exclusions:

Patients with an active diagnosis for Depression or Bipolar Disorder

Patients who are already participating in on-going treatment for depression

Measure Alignment

UDS	NQF 0418	CMS2v4
Numerator: Number of patients aged 12 and older who were 1) screened for depression with a standardized tool and, if screened positive for depression, 2) had a follow-up plan documented **Denominator**: Number of patients who were aged 12 or older at some point during the measurement year and who had at least one medical visit during the reporting year	**Numerator:** Patient's screening for clinical depression using an age appropriate standardized tool AND follow-up plan is documented **Denominator:** All patients aged 12 years and older	**Numerator:** Patients screened for clinical depression on the date of the encounter using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the positive screen **Denominator:** All patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period.

Note: There are minor differences in exclusion criteria for each measure definition.

What population needs to be screened?

Screening of (medical) patients age 12 and older

What screening tools do I use?

A Standardized Depression Screening Tool

A normalized and validated depression screening tool developed for the patient population in which it is being utilized

Details

Standardized Depression Screening Tool: A normalized and validated depression screening tool developed for the patient population in which it is being utilized

Examples of depression screening tools include but are not limited to:

Adolescent Screening Tools (12-17 years): Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory

Primary Care Version (BDI-PC), Mood Feeling Questionnaire,

Center for Epidemiologic Studies Depression Scale (CES-D) and PRIME MD-PHQ2

Adult Screening Tools (18 years and older):

Patient Health Questionnaire (PHQ9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (SDS), Cornell Scale Screening and PRIME MD-PHQ2

Follow-Up Plan

Proposed outline of treatment to be conducted as a result of positive clinical depression screening. Follow-up for a positive depression screening must include one (1) or more of the following:

- **additional evaluation**
- **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**

What "counts" as a brief intervention, referral to treatment?

"and had a follow-up plan documented if screened positive"

- Sounds like SBIRT?
- We are probably doing this already?
- Looks different for different health centers, patients, and situations

How do I document and record?

- Utilizing the EHR
- V79.0 Screening performed 3725F
- Making it part of the daily workflow
- Who can administer the PHQ9?

Why is this important?

- Improve Quality of Care
- Requirements of the grant
- Outcomes support the work we do
- Data can help change behavior
- Improves quality of care – ex: med compliance – data to help patient's choice, patient awareness of mood, data to help PCP with med management

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How to Implement/Operationalize the Measure

Teodoro 'Teo' Anderson Diaz, LICSW
Director of Behavioral Health at First Choice Health Centers – East Hartford, Connecticut

An example of a successful roll out of a Depression Screening project at the First Choice Health Centers of Connecticut. 1.

Plan Phase

- Baseline Data: Compliance rate of less than 15% by 12/1/14 (*20.60% 2014)
- Goal: 80% compliance rate
- Identify assigned staff
- Mobilize a multi-disciplinary work group
- Homework: Answer 2 Questions

Do Phase

- Committee structure & public agreements
- Addressing the why
- Develop an intervention
- Pilot the intervention
- Provide feedback

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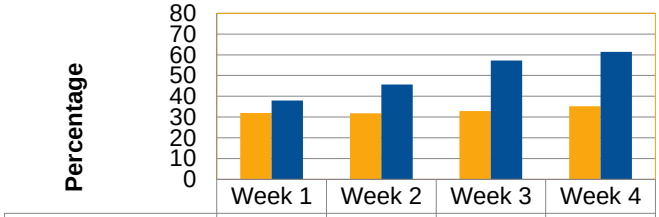
An example of a successful roll out of a Depression Screening project at the First Choice Health Centers of Connecticut. 2.

Study Phase

January 6, 2015 through January 31, 2015



	Week 1	Week 2	Week 3	Week 4
Control GRP	31.93	31.81	32.95	35.19
Intervention GRP	37.93	45.71	57.3	61.35

Control GRP: Total Nu. of Eligible Pts: 1,972. Total Nu. Screened: 694

Intervention GRP: Total Nu. of Eligible Pts: 326. Total Nu. Screened: 200

An example of a successful roll out of a Depression Screening project at the First Choice Health Centers of Connecticut. 3.

Act Phase/Roll Out

- Parallel training of medical assistants and provider
- Weekly monitoring and sharing of data
- Coaching
- Seeking consumer representation
- Sharing results with our consumer base

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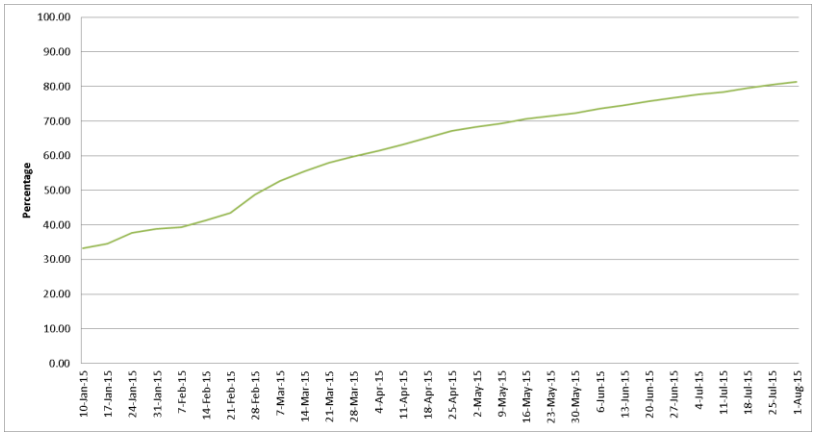
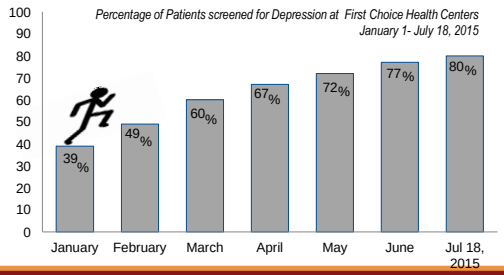
Example of Internal posting and sharing of weekly data at First Choice Health Centers Jan 1- Aug 1, 2015 (81.37%)



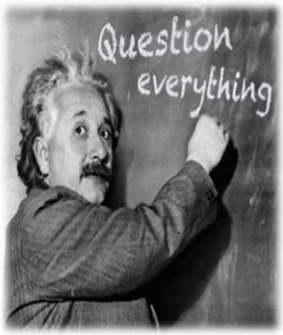
Depression Screening: One more reason why you can feel confident that First Choice is the Best Choice for all your health care needs.

In August 2014, First Choice Health Centers launched their behavior health services. In December 2014, medical and mental health providers and other staff at First Choice Health Centers united efforts to increase the screening of patients ages 12 and older for depression. This is important because untreated clinical depression can negatively impact health outcomes for people who have other chronic diseases such as diabetes, hypertension, asthma, and angina (CDC, 2012). Today, First Choice Health Centers has screened 80% of all eligible patients for depression and is on track to exceed the national benchmark in 2015. This is one more reason why you can feel confident that First Choice is your best choice for all your health care needs.



For more information about this performance improvement project please contact Ivette Santiago, Behavior Health Care Coordinator at (860) 528-1359 ext. 261 or at isantiago@firstchc.org

Questions, Comments, Clarification



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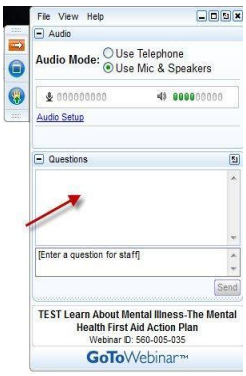

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