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September 14–16, 2018

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Population Health Meets Integrated Behavioral Health within an FQHC

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CARE TRANSFORMATION COLLABORATIVE
RHODE ISLAND

Faculty Disclosure

- **Andrew Saal, MD MPH** has no financial relationships to disclose relating to the subject matter of this presentation.

- **Nelly Burdette, PsyD** has no financial relationships to disclose relating to the subject matter of this presentation.

Disclosure

The faculty have been informed of their responsibility to disclose to the audience if they will be discussing off-label or investigational uses of drugs, products, and/or devices (any use not approved by the U.S. Food and Drug Administration).

- Applicable CME staff have no relationships to disclose relating to the subject matter of this activity.
- This activity has been independently reviewed for balance.

Learning Objectives

- Describe the rationale for universal screening for depression, anxiety and substance abuse in an advanced practice medical home model
- Discuss the operational, clinical, and system changes required when scaling a pilot project up to screening the whole population in a multi-site, multi-specialty, multi-lingual primary care network
- Outline how to capture and utilize data to make better practice management decisions

Providence, Rhode Island

Providence Community Health Centers

- FQHC – now celebrating our 50th anniversary
- 8 NCQA Level 3 Medical Homes
- Urban
- Multi-specialty (OB-Gyn, Pediatrics, Family, Internal Medicine, Dental, Optometry, Podiatry, IBH, and Psychiatry)
- 60,000 patients
- 60% best-served in a language other than English

PCHC
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Providence Community Health Centers

PCHC
PROVIDENCE COMMUNITY
HEALTH CENTERS

Providence Community Health Centers

- Rhode Island launched a statewide multi-payer PCMH initiative in 2008
  - Practices receive fee-for-service ***and*** a PMPM payment from the payors to support practice transformation and infrastructure…
  - As a bridge to risk-sharing and accountable care contracting
- RI is a Medicaid expansion state
- PCHC payer mix:

  70% Medicaid, 10% Medicare

  10% Commercial, and 10% Uninsured

Rhode Island PCMH Initiative is called

Care Transformation Collaborative (CTC)

- PMPM subsidies from payors to practices
- Used to build needed infrastructure such as:

  Nurse Care Management

  Community Health Workers

  Clinical Informatics to report quality data

  And other initiatives to promote population health, most notably…

  Integrated Behavioral Health

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

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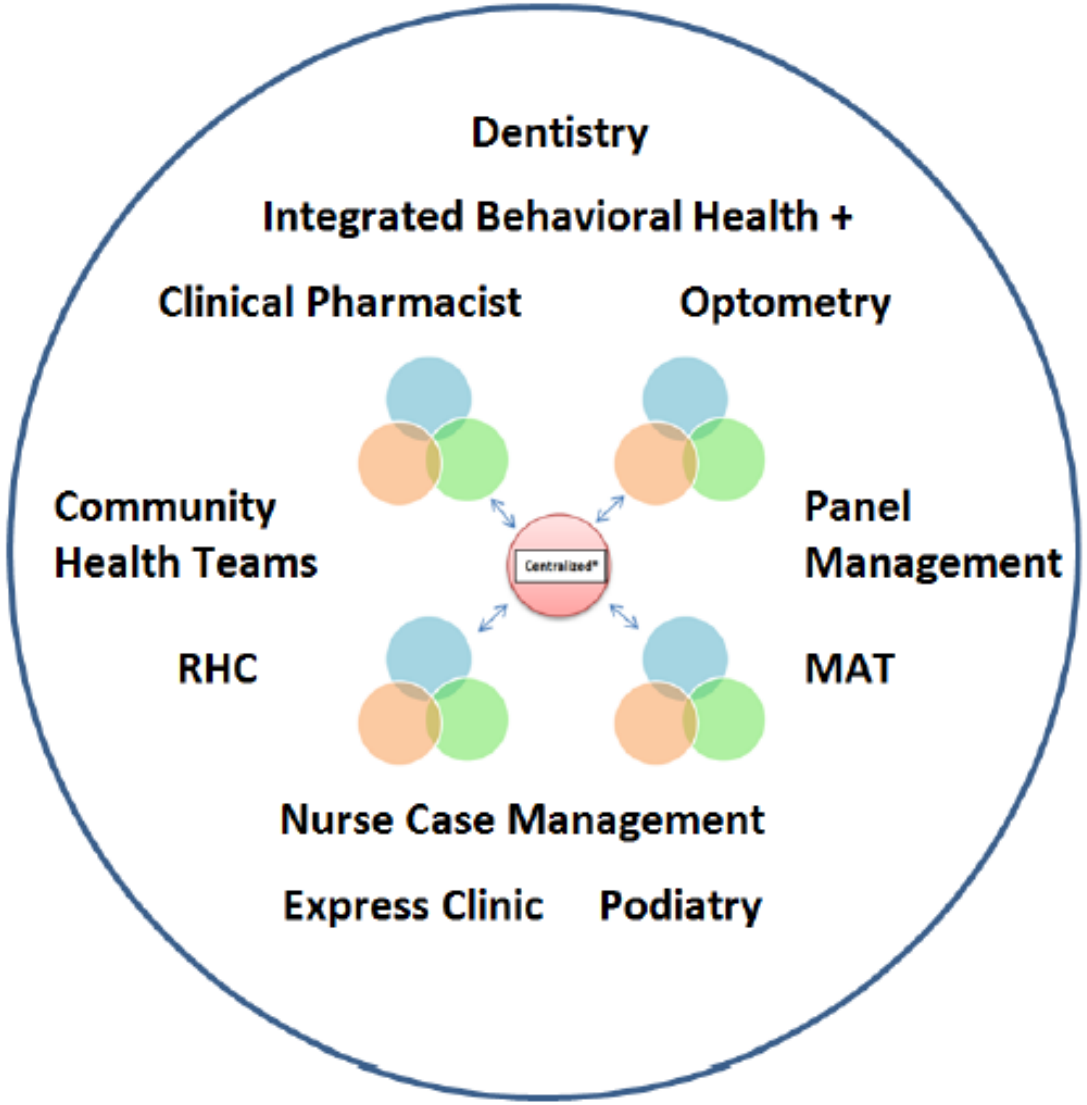
Providence Community Health Centers



Core Population Health Services:

Integrated Behavioral Health
Nurse Care Management
Community Health Workers
Clinical Informatics

Additional Services In-House:

Reproductive Health Counselors / Title X
Medication Assisted Treatment
Clinical Pharmacist
Pediatric and Adult Dentistry
Optometry
Podiatry

Providence Community Health Centers

- Participating in a Medi***care*** ACO since 2014 (MSSP)
- Medi***caid*** ACO pilot in 2016-17
- Now a formal “Accountable Entity” (ACO) and contracting with several Medicaid managed care organizations

ACOs in 10 seconds

For any population of patients:

Predicted Total Cost of Care
- Actual Total Cost of Care
Potential Savings*

If you succeed, you share the reward
If you fail, you bear the risk

* Just a few strings attached… Actual mileage may vary. See dealer for details

The Big Picture is Population Health

We have a rare convergence of:

- **Health Reformers**
- **Clinicians**
- **Legislators**
- **Payors**
- **and Consumers**

Not All Population Health Strategies Are Created Equally

Will it Move us Towards the Triple Aim?

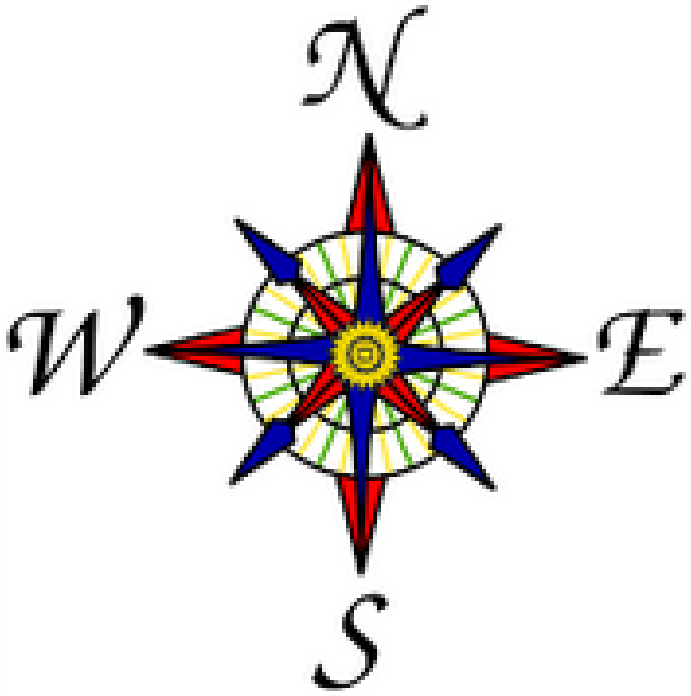
- Better Outcomes
- Lower Cost
- Happy Patients

Can We Make It Work?

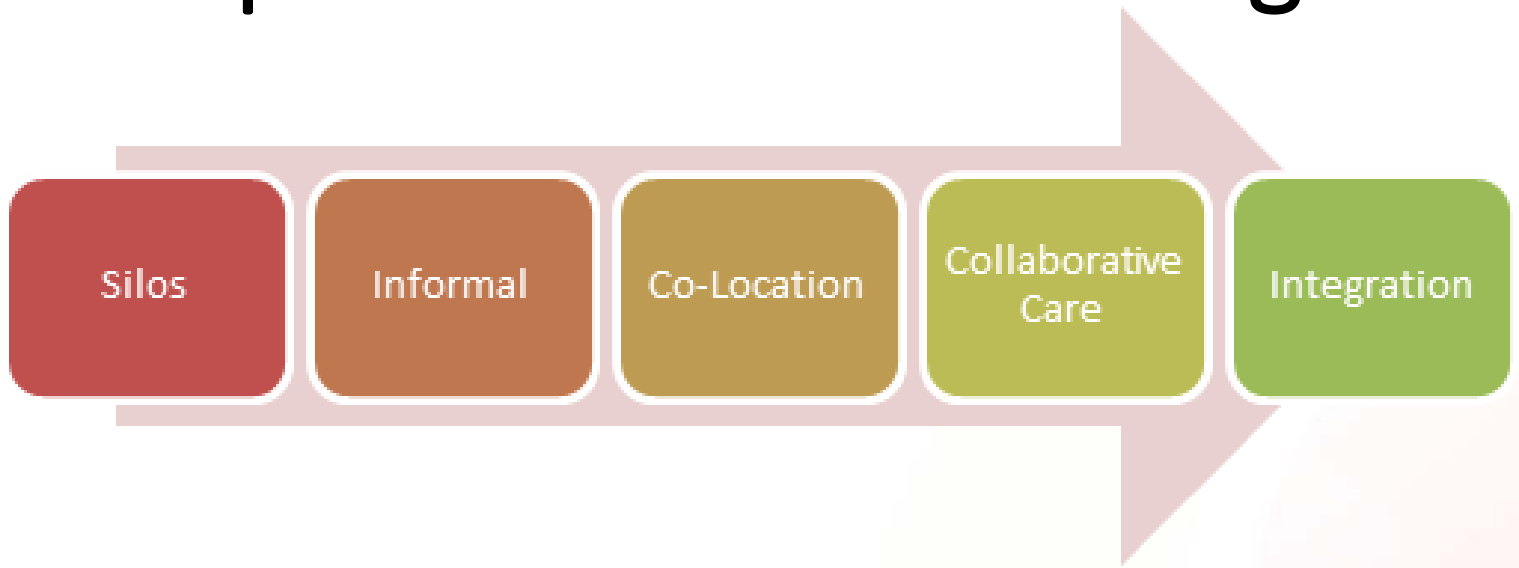
- Logistics

Can We *Prove* That It Works?

- Meaningful Data and Outcomes



Population Health Strategies



One of our core strategies has been **Integrated Behavioral Health**

- But not just ***reacting*** to the crisis at hand
- But ***actively looking*** for problems ***before*** they detonate

What is Universal Screening?

Screening the Whole Population of Patients in a Medical Home

- Those with complaints, as well as those without
- Those who are being seen, as well as those who are not

PCHC is now screening annually for:

- Depression
- Anxiety
- Substance Use

Why Screen?

Additional Costs When Someone with a Chronic Disease Also Has a Co-Occurring Mental Health Disorder

	PPPY Without MH	PPPY With MH	Cost of Co-Occurring Condition
Heart Condition	$4,697	$6,919	**+ $2,222**
High Blood Pressure	$3,481	$5,492	**+ $2,011**
Asthma	$2,908	$4,028	**+ $1,120**
Diabetes	$4,172	$5,559	**+ $1,387**

Corso, K.A., Hunter, C.L., Dahl, O., Kallenberg, G.A and Manson, L. (2016) Integrating Behavioral Health into the Medical Home: A Rapid Implementation Guide. Greenbranch Publishing: Phoenix, MD.

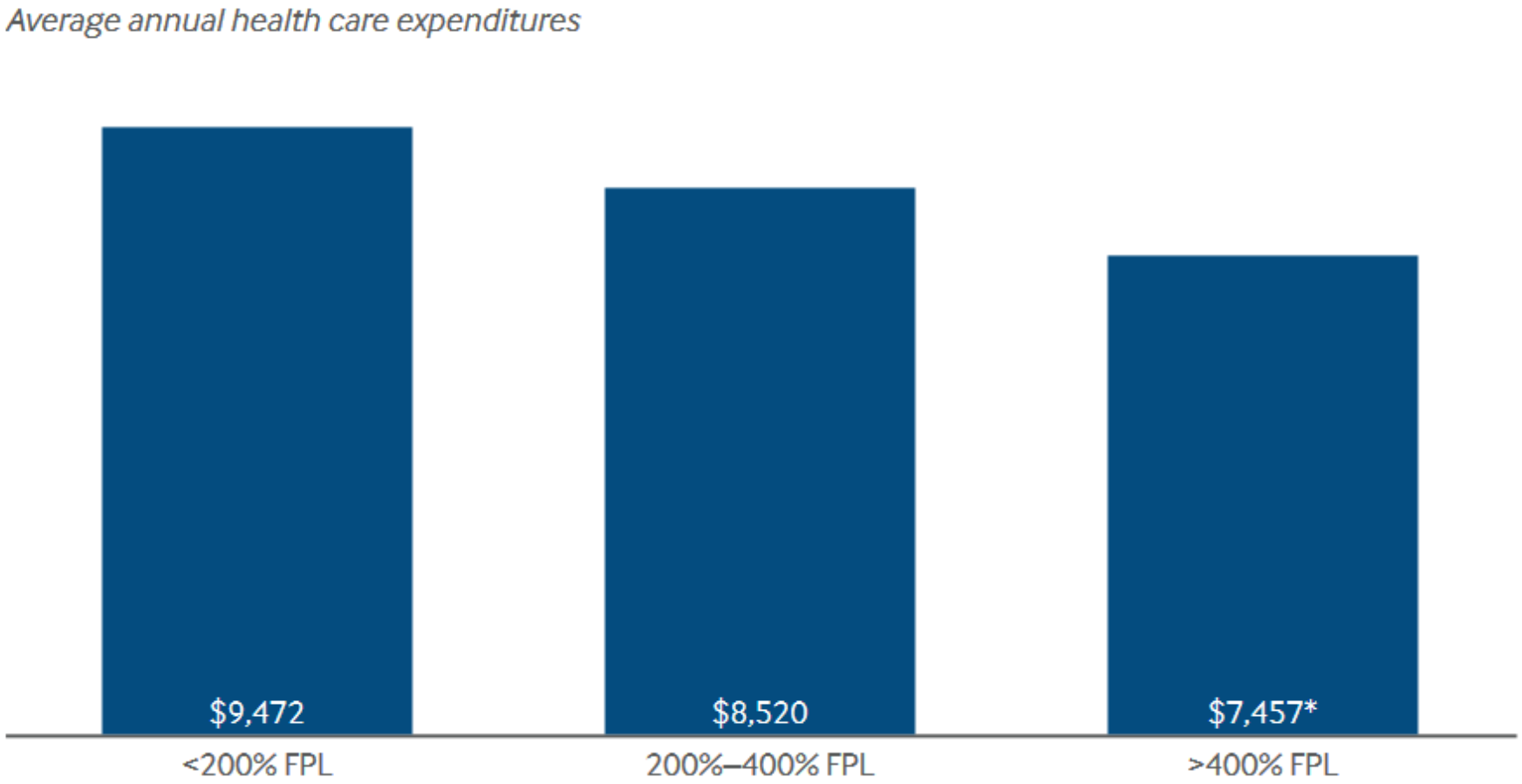
Why Screen?

- Among people with a chronic condition, those with low incomes are much more likely (32%) to have a behavioral health condition than those with moderate incomes (24%) and those with high incomes (21%).
- Rates of psychological stress are much higher among low-income people with both chronic and behavioral health problems (29%) compared to higher-income people with similar health conditions (7%).
- Low-income people with co-occurring conditions spend much more on inpatient or emergency department care than higher-income people do ($363 vs. $101).

P. J. Cunningham, T. L. Green, and R. T. Braun, Income Disparities in the Prevalence, Severity, and Costs of Co-Occurring Chronic and Behavioral Health Conditions, *Medical Care,* Feb. 2018 56(2):139–45.

Why Screen?

Of those patients with co-occurring conditions, *poverty amplifies cost*



Cunningham, Green, and Braun, "*Income Disparities in the Prevalence, Severity, and Costs of Co-occurring Chronic and Behavioral Health Conditions*," *Medical Care,* Feb. 2018 56(2):139–45.

Why Screen?

It doesn't matter what color the wallpaper is when your house is on fire!

Not coincidentally, the same metaphor is useful to explain the social determinants of health

So We Started Screening

Depression

Annually with PHQ

Follow up if positive (score ≥ 10)

Anxiety

Annually with GAD-7

Follow up if positive (score ≥ 5)

Substance Use

Annually with CAGE-AID

Follow up if positive (score ≥ 1)

So We Started Screening

UDS 2017 Depression Screening for *all* PCHC clinics combined = 70%

PCHC - Chafee (one of our urban sites)

2018 Q1 Screening Rates:

Depression	**86%**
Anxiety	**96%**
Substance Use	**95%**

CY 2017 Screenings:

~ 4300 unique people

~ 8300 screens

Why Screen for Depression in Primary Care?

- 18.8 million adults
  - 9.5% of the U.S. population aged 18 years and older in a given year.
  - More than 80% of patients with depression have a medical comorbidity
- PCPs only detect 1/3 - 1/2 of patients with major depression
- 70-80% of antidepressants prescribed in primary care
- But only 20-40% showing substantial improvement over 12 months

Egede, L. E. (2007). Failure to Recognize Depression in Primary Care: Issues and Challenges. *Journal of General Internal Medicine*, *22*(5), 701–703.
Mitchell J, Trangle M, Degnan B, Gabert T, Haight B, Kessler D, Mack N, Mallen E, Novak H, Rossmiller D, Setterlund L, Somers K, Valentino N, Vincent S. Institute for Clinical Systems Improvement. Adult Depression in Primary Care. Updated September 2013.

PHQ-9 Screening for Depression

- **Purpose**: 9 item depression screen that can establish a provisional depression diagnosis and grade depressive symptom severity
- **Target Population:** Adults age 18 and over
- **Evidence**: Validated for detecting depression; measuring severity; and monitoring response to treatment
- **Estimated Time**: 2-5 min
- **Administered by:** Patient (self-reported), Staff, Telephonically
- **Intended Settings**: Primary Care

Kroenke K, Spitzer R. (2002). The PHQ-9: A New Depression Diagnostic and Severity Measure. *Psychiatry Annals.* 32: 509-515.

Integration of the PHQ-9 in an EHR

PHQ-9

PATIENT HEALTH QUESTIONNAIRE-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	0 DAYS/wk	1-3 DAYS/wk	4-5 DAYS/wk	6-7 DAYS/wk
1. Little interest or pleasure in doing things	0 ☐ N	1 ☐ Y	2 ☐ Y	3 ☐ Y
2. Feeling down, depressed, or hopeless	0 ☐ N	1 ☐ Y	2 ☐ Y	3 ☐ Y
3. Trouble falling or staying asleep or sleeping to much	0 ☐ N	1 ☐ Y	2 ☐ Y	3 ☐ Y
4. Feeling tired or having little energy	0 ☐ N	1 ☐ Y	2 ☐ Y	3 ☐ Y
5. Poor appetite or overeating	0 ☐ N	1 ☐ Y	2 ☐ Y	3 ☐ Y
6. Feeling bad about yourself or that you are a failure or have let yourself or family down	0 ☐ N	1 ☐ Y	2 ☐ Y	3 ☐ Y
7. Trouble concentrating on things such as reading newspaper or watching television	0 ☐ N	1 ☐ Y	2 ☐ Y	3 ☐ Y
8. Moving or speaking slowly or being fidgety or restless	0 ☐ N	1 ☐ Y	2 ☐ Y	3 ☐ Y
9. Wishing to be dead or of hurting yourself	0 ☐ N	1 ☐ Y	2 ☐ Y	3 ☐ Y

10. Activities of daily living for the patient due to the depression symptoms are:	☐ Y Not difficult at all	☐ Y Very difficult
	☐ Y Somewhat difficult	☐ Y Extremely difficult

PHQ-9 Follow-up and Plan

Follow-Up Plan

PHQ-9 Score	Support Staff	Provider
0-4 No Significant Symptoms ☐ Y	Advised to repeat in 1 yr or as per PCP ☐ Y	Advised to repeat in 1 yr or as needed ☐ Y Symptoms due to acute stress/situation, advised to reassess in 3 month ☐ Y
5-9 Mild to Moderate Symptoms ☐ Y	Referral To Physician ☐ Y Depression handout provided E ☐ Y S ☐ Y	Referred to Mental Health Worker/Professional ☐ Y Referred to behavioral health consultant ☐ Y Referral To Psychiatrist ☐ Y Referred elsewhere for Psychiatric Therapy For Crisis Intervention/Baker Acted ☐ Y Under care of mental health team ☐ Y Follow up and Suicide Risk discussed ☐ Y Refusing treatment/Suicide Risk Discussed ☐ Y Results dscussed with Patient follow up plan initiated ☐ Y
10 > Clinically Significant Symptoms ☐ Y	Referral To Mental Health Worker/Professional ☐ Y Referral To Physician ☐ Y Depression handout provided E ☐ Y S ☐ Y	Referred to Mental Health Worker/Professional ☐ Y Referred to behavioral health consultant ☐ Y Referral To Psychiatrist ☐ Y Referred elsewhere for Psychiatric Therapy For Crisis Intervention/Baker Acted ☐ Y Antidepressants ☐ Y Under care of mental health team ☐ Y Follow up and Suicide Risk discussed ☐ Y Refusing treatment/Suicide Risk Discussed ☐ Y Results dscussed with Patient follow up plan initiated ☐ Y

What Did We Find?

National Data for the Prevalence of Depression

18.8 million adults

9.5% of the U.S. population aged 18 years and older

PCHC Prevalence of Depression

3,382 patients *formally* diagnosed

12% of established patients

27% have screened positive on PHQ-9 in last 2 years

Egede, L. E. (2007). Failure to Recognize Depression in Primary Care: Issues and Challenges. *Journal of General Internal Medicine*, *22*(5), 701–703.

Why Screen for Anxiety in Primary Care?

- 7-8% of primary care patients
- As high as 30% in the general population
- Generally presents as ***headaches or GI distress***, not overtly as "worry"
- Anxiety continues to be undertreated in primary care
  - Adequate pharmacotherapy received < 20%
  - Adequate psychotherapy received 14%
  - Both pharmacotherapy and psychotherapy received by 5%
  - TOTAL: Only a quarter of patients received adequate care

Stein, M.B and Sareen, J. (2015). Generalized Anxiety Disorder. *New England Journal of Medicine.* 373(21): 2059-2068.
Weisberg, R.B., Beard, C., Moitra, E., Dyck, I., Keller, M.B. (2014). Adequacy of Treatment Received by Primary Care Patients with Anxiety Disorders. *Depression Anxiety. 31 (5):* 443-450.

GAD-7 Screening for Anxiety

- **Purpose** : Screen for the presence and severity of anxiety in general practice, and monitor progress over time
- **Target Population**: Adults age 18 and over
- **Evidence**:

Panic Disorder	Sensitivity: 74% Specificity: 81%
Social Anxiety Disorder	Sensitivity: 72% Specificity: 80%
PTSD	Sensitivity: 66% Specificity: 81%

- **Estimated Time** : 2 - 5 minutes
- **Administered by** : Self-Report
- **Intended Settings** : Primary Care

Spitzer RL, Kroenke K, Williams JW, Löwe B. (2006). A Brief Measure for Assessing Generalized Anxiety Disorder: The GAD-7. *Archives Internal Medicine.* 166(10):1092-1097.
Arroll, B., Goodyear-Smith, F., Crengle, S., Gunn, J., Kerse, N., Fishman, T., Falloon, K., Hatcher, S. (2010). Validation of PHQ-2 and PHQ-9 to Screen for Major Depression in Primary Care Population. *Annals of Family Medicine,* 8 (4): 348-353

Integration of GAD7 in an EHR

Generalized Anxiety Disorder -- 7

Over the last 2 weeks, how often have you been bothered

	Not at all	Several Days	More than Half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0 ☐ N	1 ☐ Y	2 ☐ Y	3 ☐ Y
2. Not being able to stop or control worrying	0 ☐ N	1 ☐ Y	2 ☐ Y	3 ☐ Y
3. Worrying about diffrent things	0 ☐ N	1 ☐ Y	2 ☐ Y	3 ☐ Y
4. Trouble relaxing	0 ☐ N	1 ☐ Y	2 ☐ Y	3 ☐ Y
5. Being so restless that it is hard to sit still	0 ☐ N	1 ☐ Y	2 ☐ Y	3 ☐ Y
6. Becoming easily annoyed or iritable	0 ☐ N	1 ☐ Y	2 ☐ Y	3 ☐ Y
7. Feeling afraid as if something awful might happen	0 ☐ N	1 ☐ Y	2 ☐ Y	3 ☐ Y

0-2 ☐ No significant symptoms

3-9 ☐ Mild symptoms

10-14 ☐ Moderate symptoms further evaluation

15-21 ☐ Severe symptoms

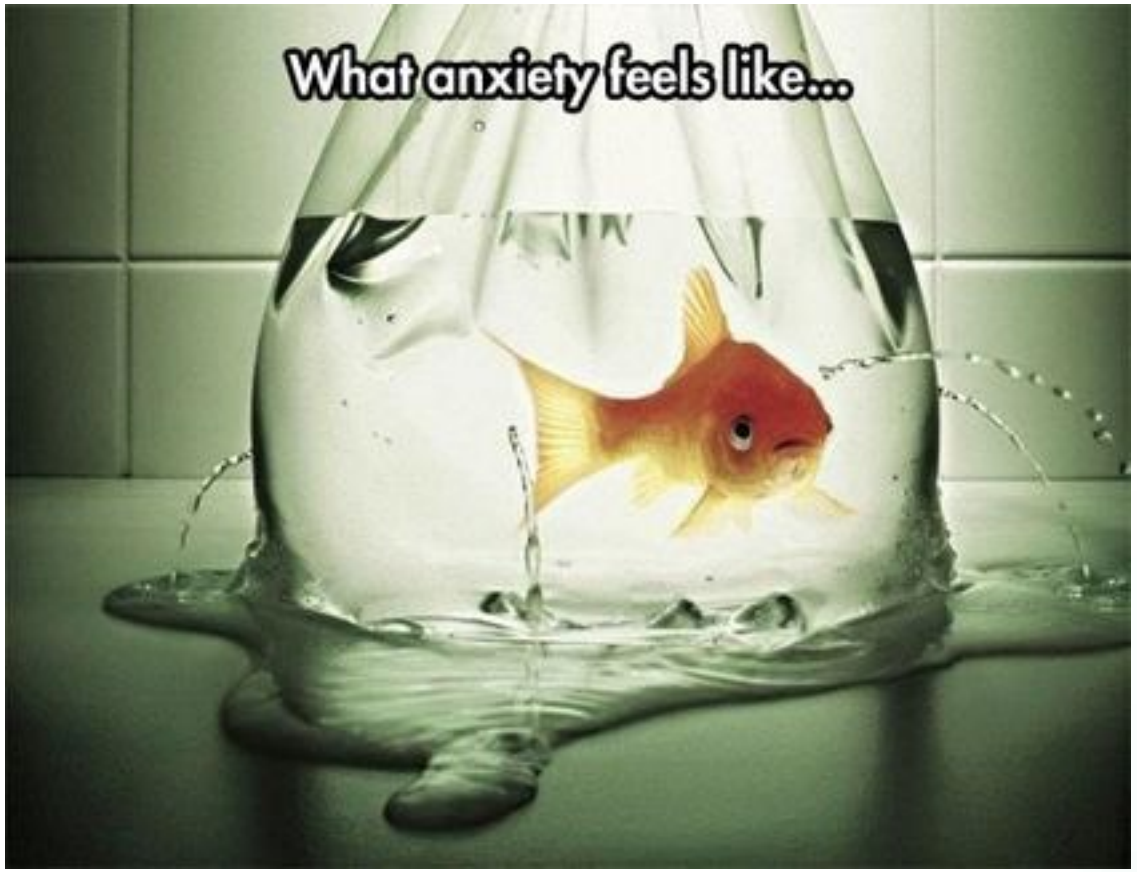
GAD7 Score

Score is required

☐ Y Is this a rescreening?

For a score of 10 or higher please refer to Behavioral Health

What Did We Find?



National Data for the Prevalence of Anxiety

7- 8% of primary care patients

30% of people 18 years and older

PCHC Prevalence of Anxiety

2,331 patients *formally* diagnosed with an anxiety disorder

8.2% of the patient population

25% have screened positive on GAD

Stein, M.B and Sareen, J. (2015). Generalized Anxiety Disorder. *New England Journal of Medicine.* 373(21): 2059-2068.

Weisberg, R.B., Beard, C., Moitra, E., Dyck, I., Keller, M.B. (2014). Adequacy of Treatment Received by Primary Care Patients with Anxiety Disorders. *Depression Anxiety. 31 (5):* 443-450.

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Why Screen for Substance Use in Primary Care?

- 22.5 million persons older than 12 years meet criteria for substance abuse or dependence.
- < 20% of PCPs described themselves as very prepared to identify alcoholism or illegal drug use.
- More than 50% of patients with substance use disorders said their PCP did nothing to address their substance abuse.

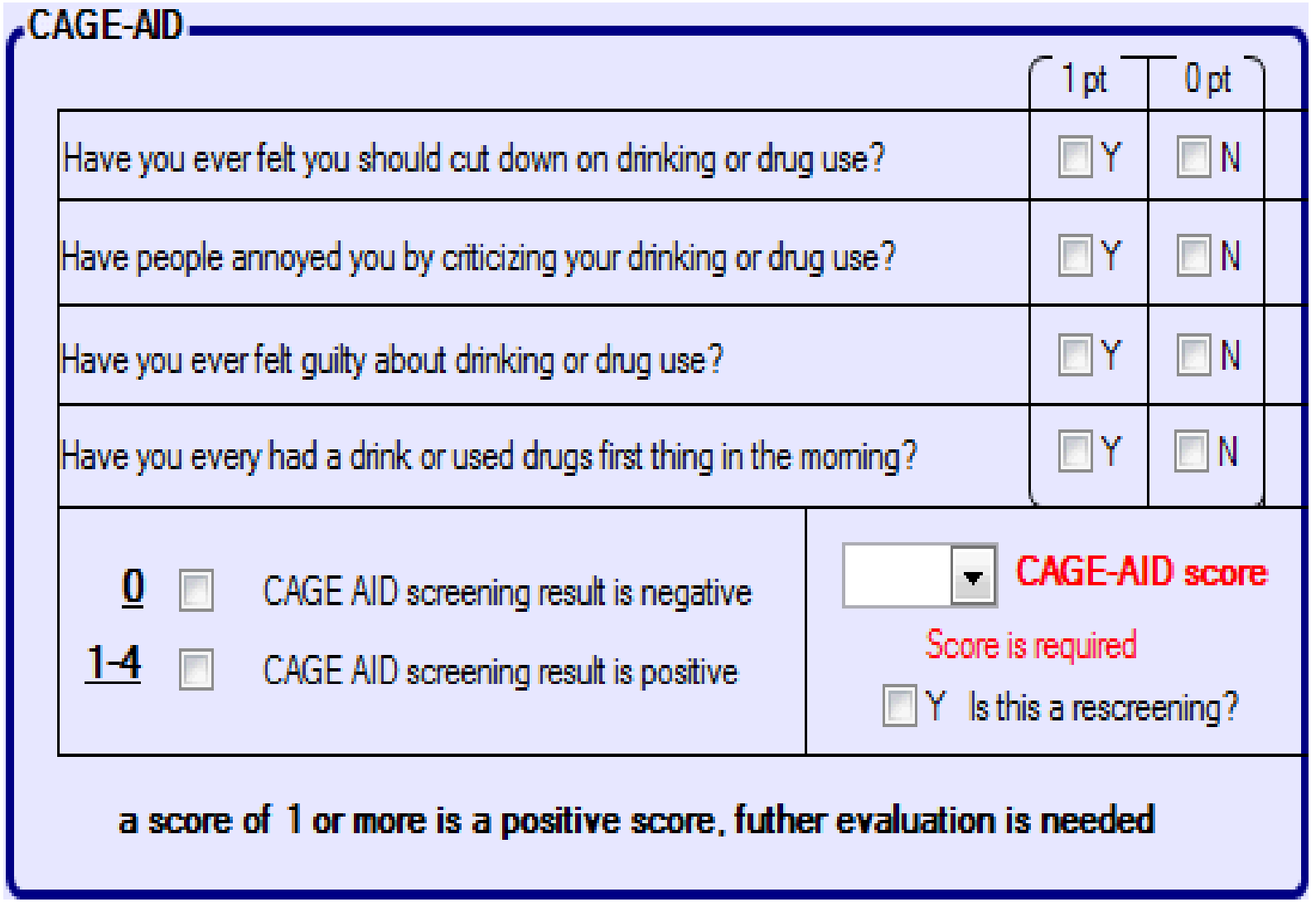
Shapiro, B., Coffa, D., McCance-Katz, E.F. (2013). A primary care approach to substance misuse. *American Family Physician.* 88 (2): 113-21.

CAGE-AID Screening for Substance

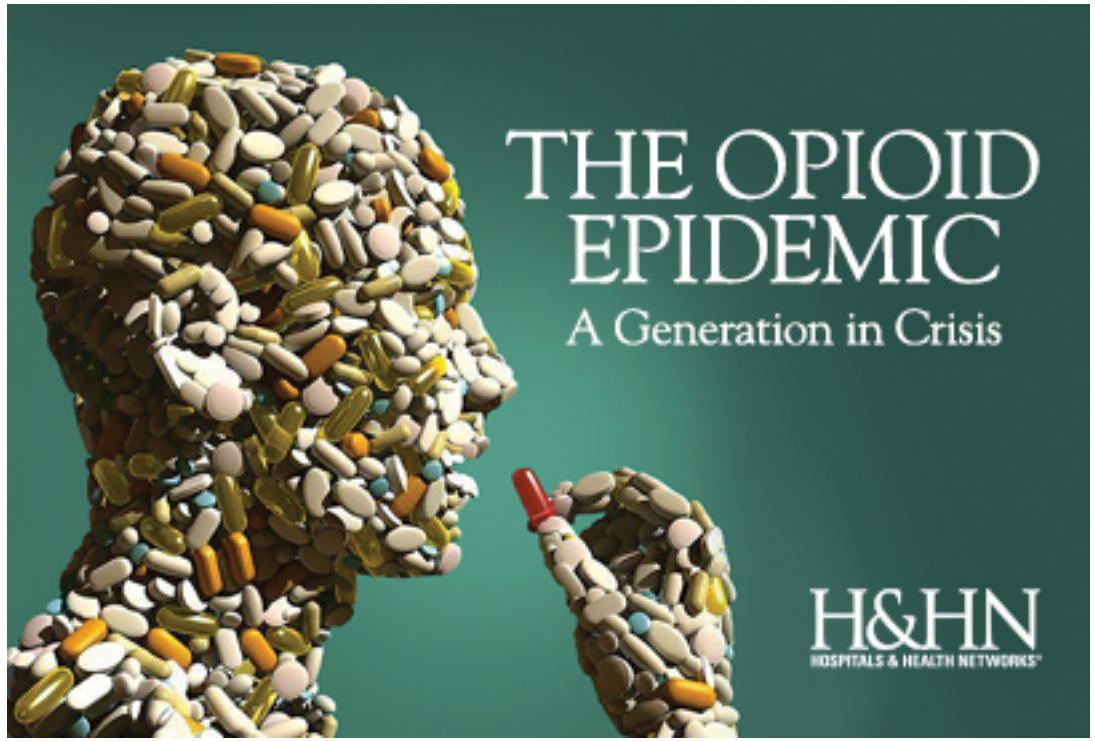
- **Purpose** : Assesses likelihood and severity of alcohol and drug use
- **Target Population** : Adults aged 18 years and older
- **Evidence** : One or more "yes" responses: sensitivity of 0.79 and specificity of 0.77
  Two of more "yes" responses: sensitivity of 0.70 and 0.85.
- **Estimated Time** : 1 minute
- **Length** : 4 yes /no questions
- **Intended Settings** : Primary care

Brown, R.L. and Rounds, L.A. (1995). Conjoint screening questionnaires for alcohol and other drug abuse: criterion validity in a primary care practice. *Wisconsin Medical Journal,* 94(3): 135-40.

Integration of CAGE-AID in an EHR



What Did We Find?



National Data for the Prevalence of Substance Use Disorder

8.7% of patients in primary care

22.5 million persons older than 12 meet criteria for substance use or dependence.

PCHC Prevalence of SUD

1,739 patients *formally* diagnosed with a substance abuse disorder

6.1% of the patient population

4% have screened positive on CAGE-AID

Shapiro, B., Coffa, D., McCance-Katz, E.F. (2013). A primary care approach to substance misuse. *American Family Physician.* 88 (2): 113-21.

Strategies to Improve Screening Rates

Standardized Process

- **Self-administered**
  - Completed by patient on laminated sheets, on-line
  - Verbally administered by medical assistant , entered directly into EHR
- **Linked to a Preventative Services reminder in EHR**
  - Support staff need to recognize during huddle or pre-visit planning
  - If it has already been done for the year and is negative, move on
  - If an element is missing, try to catch it at next visit

Strategies to Improve Screening Rates

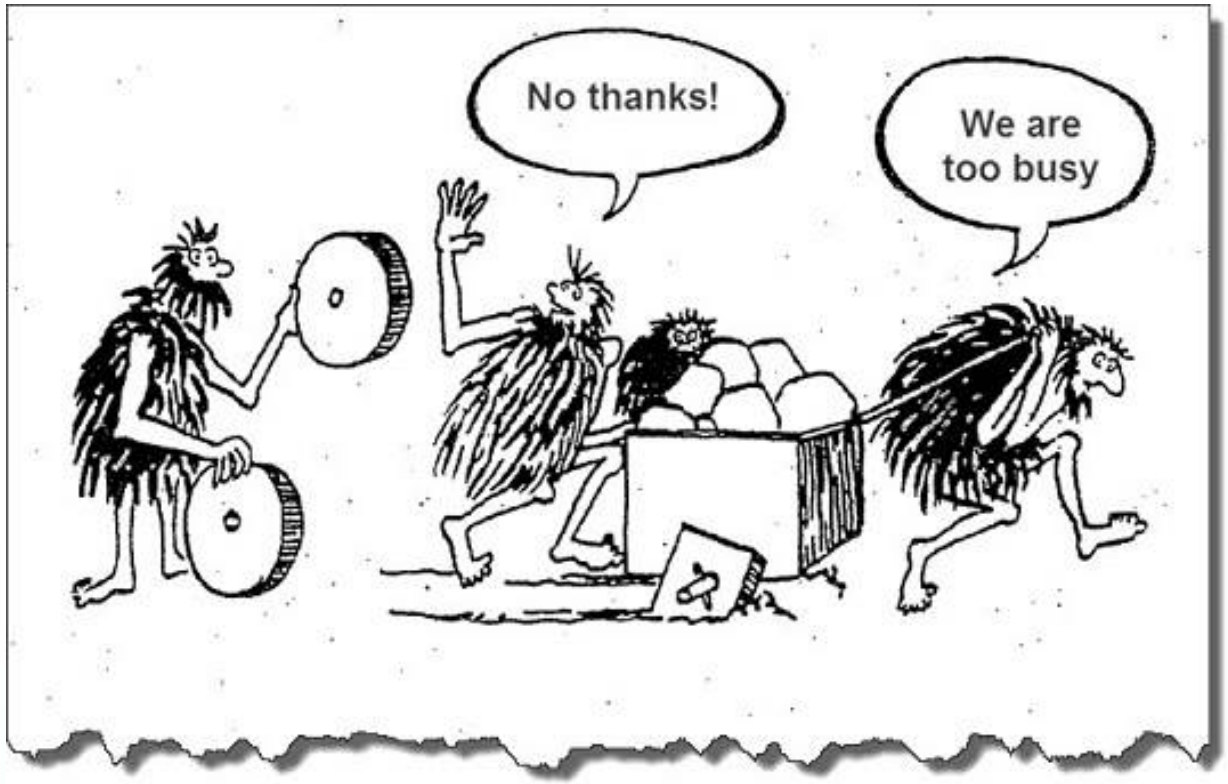
Train and Re-Training

- Emphasize the reasons we screen

- Emphasize the medical assistant's crucial role on team

- Never miss an opportunity to screen

"At least once a year, by any means necessary… regardless of visit type"



Strategies to Improve Screening Rates

Use Standing Orders

- When someone screens positive, directly refer to the IBH team and initiate warm hand-off

Clinician Support

“Don’t wait for me to verify… Go for the warm hand-off”

Strategies to Improve Screening Rates

Anticipate the Naysayers

“We can’t screen because…”

- Too busy
- It’s just a sick visit
- More work
- Opens up a can of worms

Proactively expect and address resistance before it takes root!

Strategies to Improve Screening Rates

The Essence of Team Care

Passionate people, when empowered,

deliver extraordinary results!

If that doesn't work, tie it to your Incentive Plan!

- Deliver regular team-level data
- Align team goals with organization goals
- Each member is incentivized quarterly

Consider Expanding Your Team

Creating a New Role

Behavioral Health Community Health Advocate (BH-CHA)

- Bilingual, bicultural assistant to the IBH provider to assist with medical interpretation and warm hand-offs

- Can augment your IBH clinical presence when the counselor is with other patients

- Watch out for secondary trauma! Focus on their resiliency.

Does IBH Make A Difference?

Does IBH Make A Difference?

Anecdotally…

Improved Patient Experience

“Thank you for being there for me”

“ Now that I understand my fibromyalgia, I feel like I can control it better”

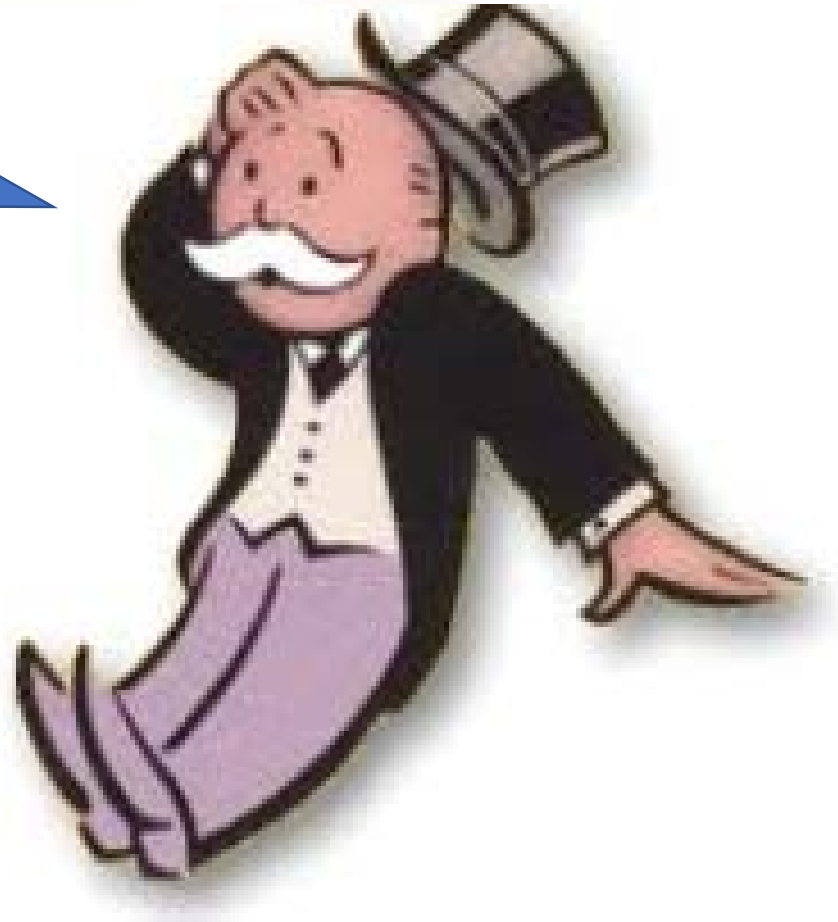
Improved Clinician and Care Team Morale

“I don’t remember how we survived before we added them to our clinic”

“I really appreciate their ‘skills not pills’ strategy. It’s so nice having someone right there to teach stress management ”

Does IBH Make A Difference?

OK… It makes people happy. But can it actually improve outcomes and save money?



Artist's sketch of an archetypal CFO

Does IBH Make A Difference?

Caveat Lector…

Let the Reader Beware

This is *observational* data

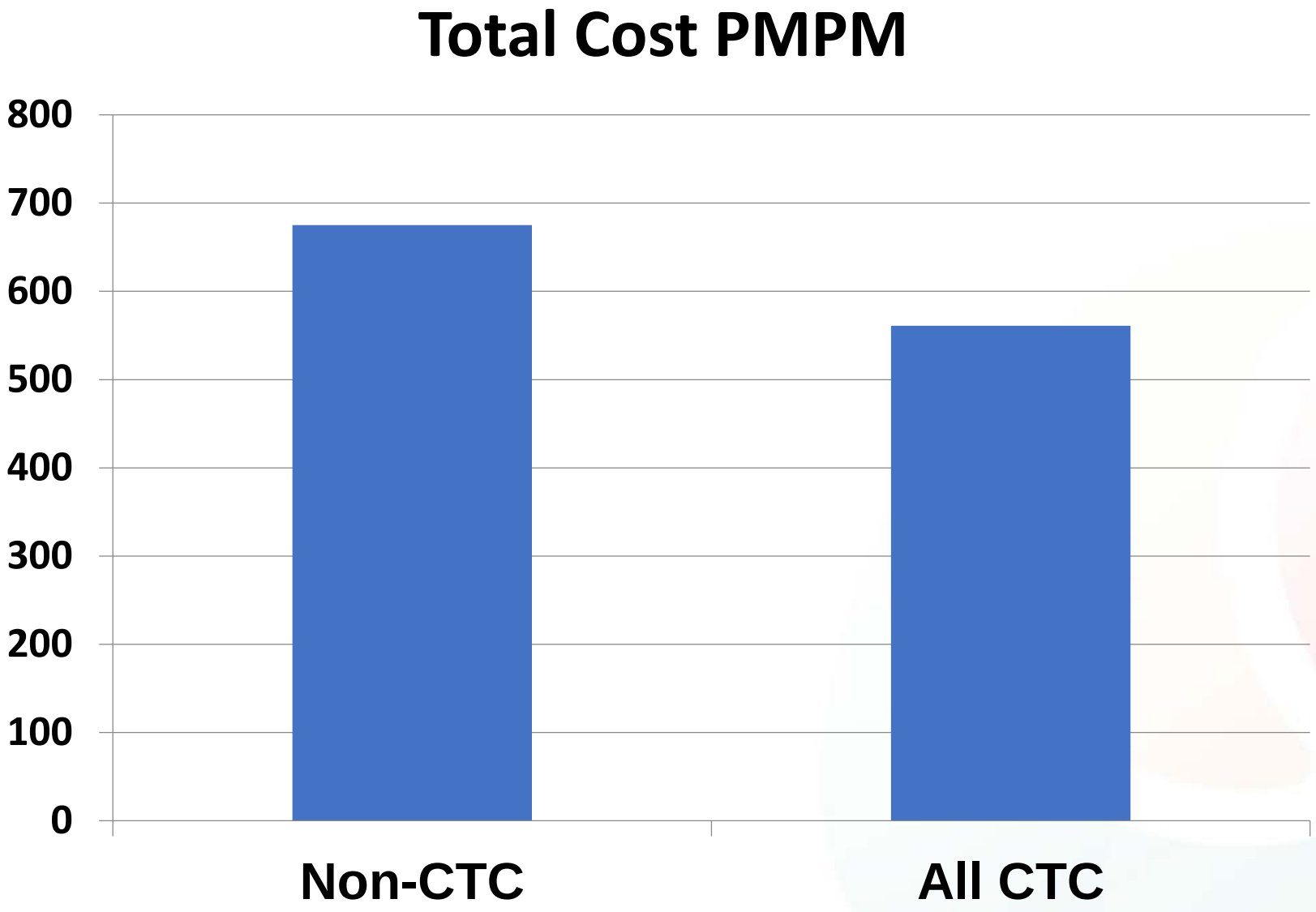
Not controlled for practice resources

No baseline for comparison

Does IBH Make A Difference?

In Other Words…

What you're about to see should *not* be used to justify a Return on Investment (ROI)



CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

Total Cost of Care

Non-PCMH = $675

PCMH = $561

Would you be attending a PCMH conference if you didn't suspect that this was true?

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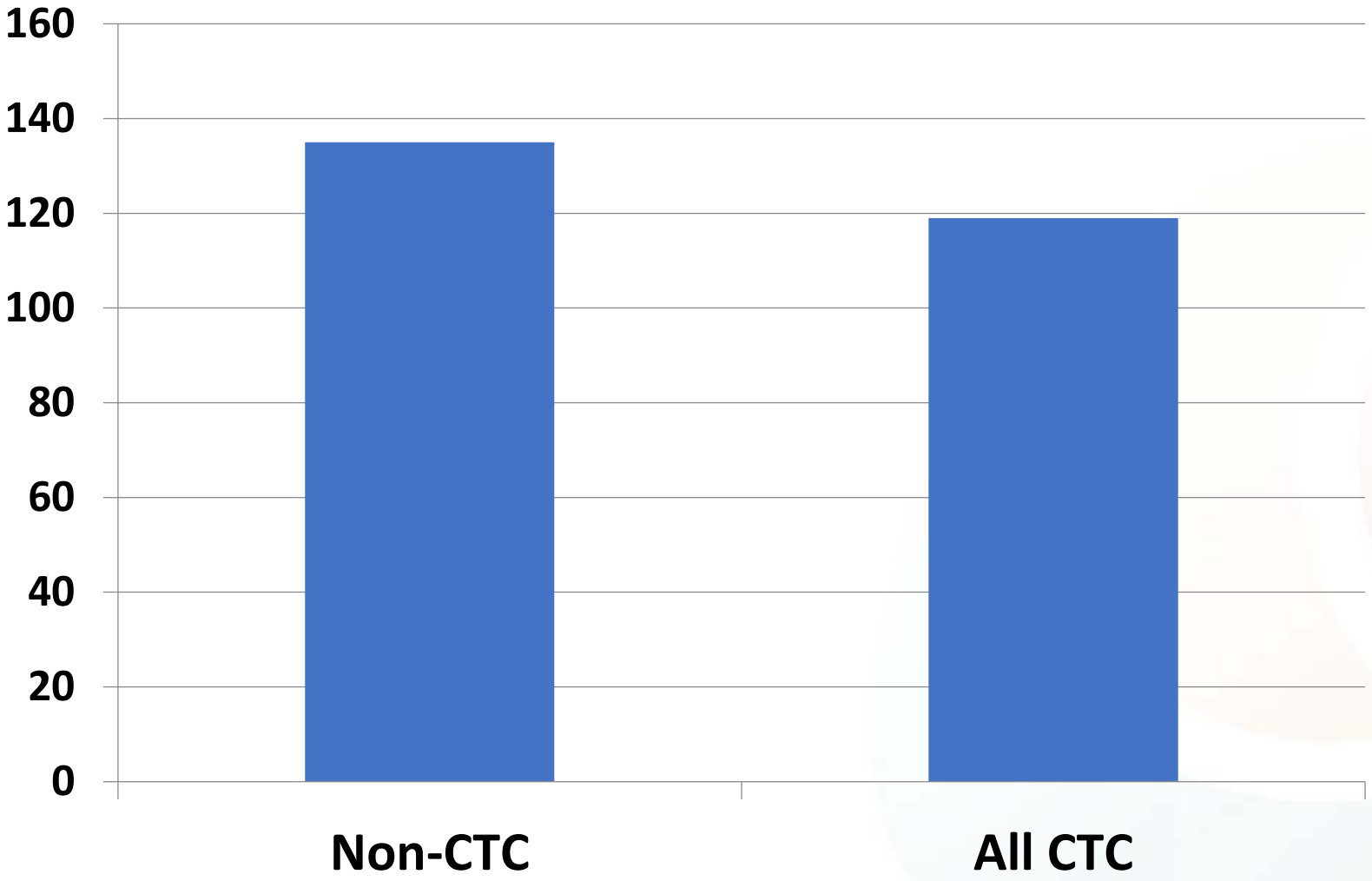
Total Pharmacy PMPM



CARE TRANSFORMATION COLLABORATIVE
RHODE ISLAND

Total Pharmacy Cost

Non-PCMH = $135

PCMH = $119

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The Rhode Island IBH Pilot

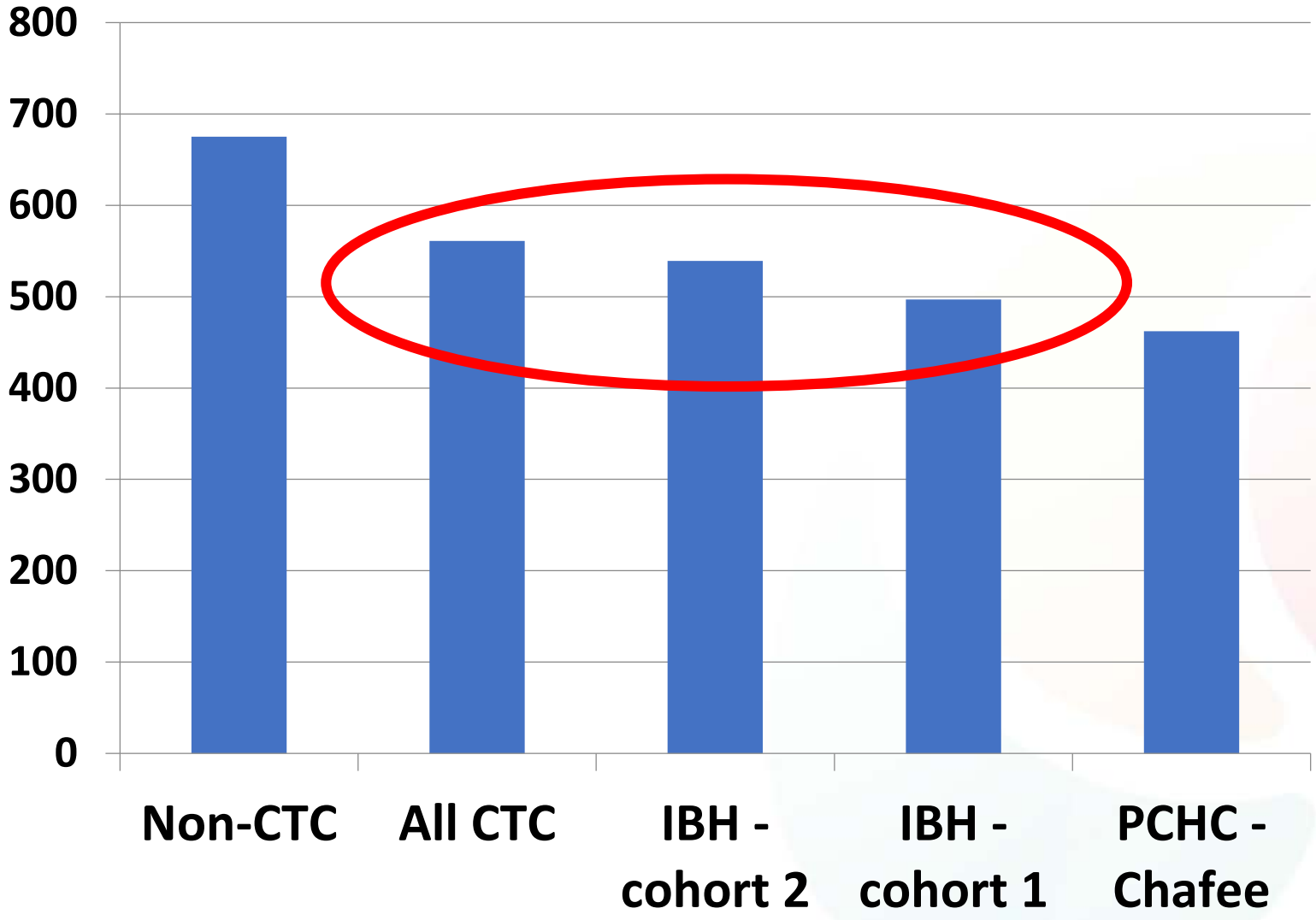
Strategy:

- Universal Screening for Depression, Anxiety, and Substance Abuse
- Support staff screen during intake
- Warm hand-offs to the embedded IBH team

Two Cohorts with Expanded IBH:

- January 2016 start (Cohort 1) and November 2016 start (Cohort 2)
- 10 Practices with a total of 55,000 lives
- Cost data is from CY 2016… So Cohort 2 had only minimal impact time

Total Cost PMPM



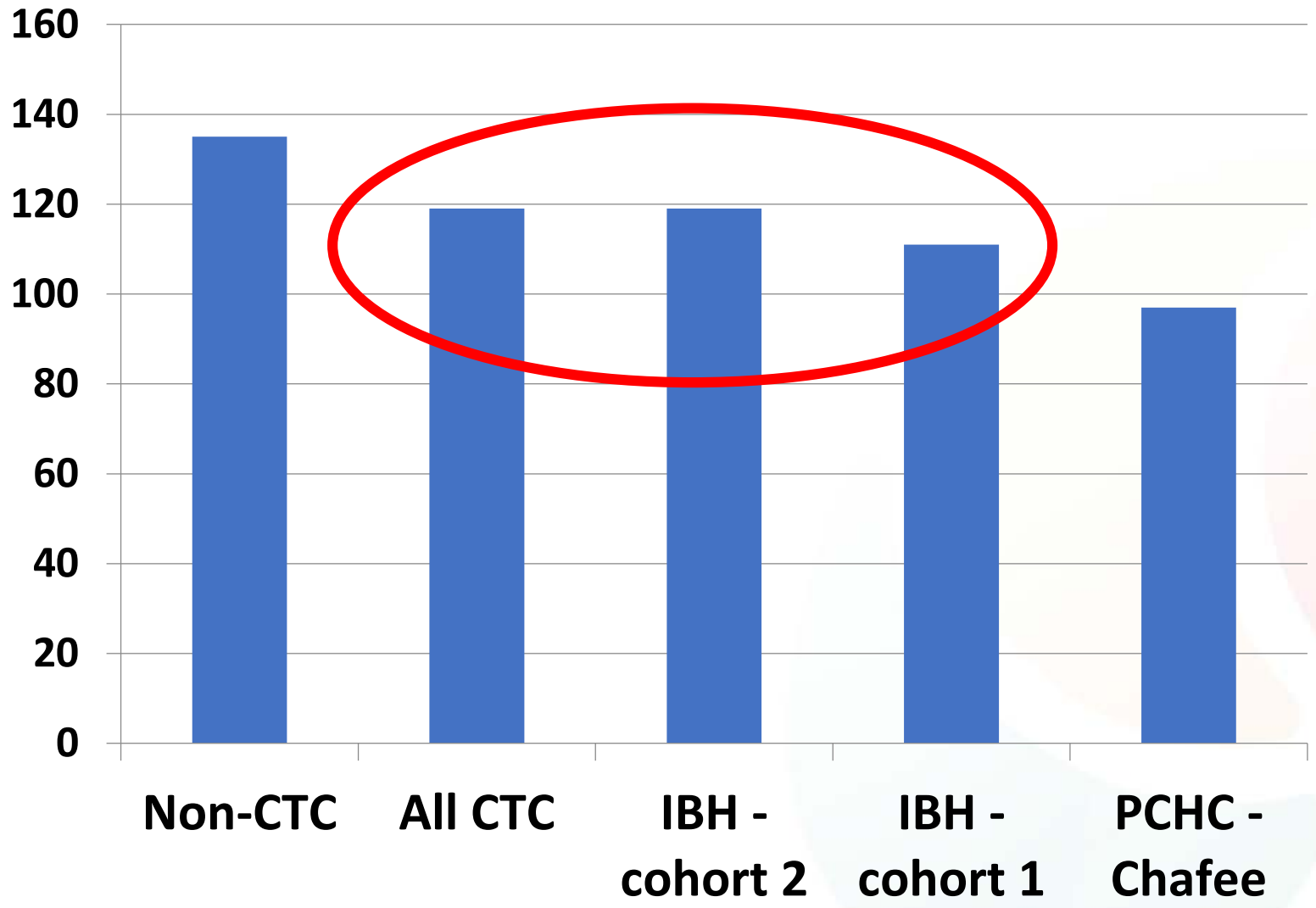
All CTC Sites:
$561

IBH cohort 2:
$539

IBH cohort 1:
$497

PCHC cohort 1:
$462

Total Pharmacy PMPM



All CTC Sites:
$119

IBH cohort 2:
$119

IBH cohort 1:
$111

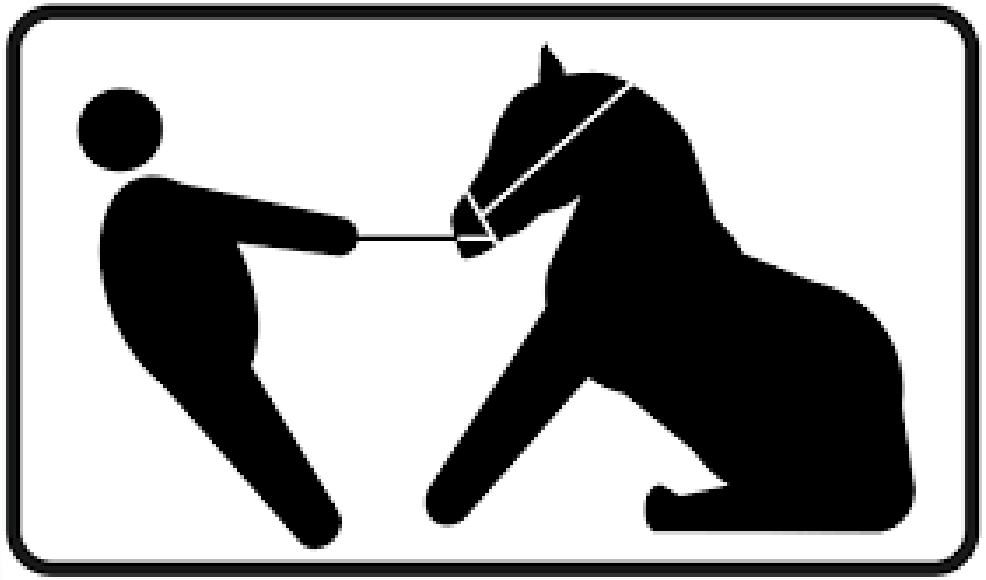
PCHC cohort 1:
$97

Next Steps

- **Primary Care Psychiatry**
  - Goal is ***NOT*** to duplicate the specialty mental health services
  - Goal is to augment the capacity of the primary care teams
  - Hoping to add Psych NPs to further increase capacity
- **Trauma-informed care**
  - Secondary trauma happens – invest in training your staff!
- **Screening for the Social Determinants of Health**
  - Affiliations with community social service agencies
  - Medical Legal Partnerships

Practice Transformation 101

The Dream and the Reality



Bottom Line and Questions

Don't look for grenades if you don't have a plan!

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