IMPLEMENTATION GUIDE
for
DEPRESSION SCREENING
and
TREATMENT

Community Care
of North Carolina
Carolina Collaborative Community Care

UNC
THE NORTH CAROLINA
TRANSLATIONAL & CLINICAL
SCIENCES INSTITUTE

CONSORTIUM FOR
IMPLEMENTATION SCIENCE

ACKNOWLEDGEMENTS

WE WOULD LIKE TO THANK THE FOLLOWING PRACTICES AND INDIVIDUALS FOR CONTRIBUTING THEIR VALUABLE INSIGHTS TO THE DEVELOPMENT OF THIS GUIDE:

Providers and office staff affiliated with the Carolina Collaborative Community Care Network:

- Cumberland Internal Medicine
- Eastover Family Care
- Elitecare of Fayetteville
- Hanora Medical
- Pinnacle Family Care
- Polymedic Primary Care
- Statcare
- Valley Internal Medicine

Michael Lancaster, MD and Amelia Mahan, MSW, LCSW, Behavioral Health Program Director and Program Manager respectively with Community Care of North Carolina during the development phase of this guide.

We would also like to thank the 4C Executive Committee for their support.

This guide was written by a team from the University of North Carolina at Chapel Hill[1], RTI International[2], and Carolina Collaborative Community Care[3]:

- Catherine L. Rohweder, DrPH[1]
- Leila C. Kahwati, MD, MPH[2]
- Bryan J. Weiner, PhD[1]
- Karin Suess, MS, MBA, PharmD[3]
- Heidi Middendorf, MD[3]
- Kara Gagnon, PharmD, BCPS[3]
- Christine Nelson[3]

Reference: Rohweder C, Kahwati L, Weiner B, Suess K, Middendorf H, Gagnon K, Nelson C. Implementation Guide for Depression Screening and Treatment. The University of North Carolina at Chapel Hill. Chapel Hill, NC: June, 2016.

The project described was supported by the National Center for Advancing Translational Sciences (NCATS), National Institutes of Health, through Grant Award Number UL1TR001111. The content is solely the responsibility of the authors and does not necessarily represent the official views of the NIH.

INTRODUCTION

DESIGNED SPECIFICALLY FOR PRACTICE FACILITATORS, THIS GUIDE IS INTENDED to serve as a companion document to CCNC's Adult Depression Screening and Treatment Toolkit. The toolkit care process describes the gold standard for adult depression care (the IMPACT model), while the guide provides specific implementation strategies that practice facilitators can use with individual practices and providers. The recommendations are based in part on focus group results from eight primary care practices affiliated with the Carolina Collaborative Community Care Network in the Fayetteville, NC region.

Part 1 includes strategies that primary care practices can implement independently; Part 2 describes strategies that require collaboration with external entities such as behavioral health providers in the community. Each strategy is followed by suggestions for practice facilitators as they work with health care teams to create office systems in support of depression screening and treatment. Examples of local resources provided by the Carolina Collaborative Community Care Network are included in the appendix and illustrate how other CCNC networks can tailor similar resources for their own geographic regions.

WHAT IS A PRACTICE FACILITATOR?

Practice facilitators, as defined by the Agency for Healthcare Research and Quality (AHRQ), are trained professionals who promote office systems changes in support of evidence-based interventions. Some CCNC networks have staff who serve exclusively as practice facilitators, but the strategies in this guide can be applied by anyone inside or outside the practice who has a working knowledge of quality improvement approaches and population management.

PART 1: Strategies Involving the Individual Practice

IMPLEMENTATION STRATEGY 1A.

Practices want office systems that routinize depression screening and treatment and move them towards proactive population management of behavioral health issues.

Providers prefer that the PHQ2/PHQ9 depression screening questions are integrated into the Electronic Health Record (EHR), as well as automated reminders to follow-up with patients who are receiving treatment. But in cases where they are not using EHRs, providers want alternative options for assessing depression at specified intervals. They also asked for patient flow diagrams that illustrate which office staff are responsible for specific tasks related to depression screening, documentation, and follow-up.

HOW CAN PRACTICE FACILITATORS HELP?

- Suggest that practices include the PHQ2 items in their new patient packets (either paper based or on the practice's patient web portal) and help them create a process for recording the information in the EHR.
- Tailor the depression screening algorithm in the CCNC Depression Toolkit for each practice that takes into account provider capacity and staffing patterns.
- Assist the practice with programming reminders/alerts into the EHR that will cue the practice to administer the PHQ2/9 on patients who are: 1) due for screening, or 2) due for follow-up after a diagnosis is made and treatment is initiated.

UNIVERSAL SCREENING VERSUS SUB-POPULATION SCREENING

Screening with the PHQ2 is recommended for all adults; this is referred to as universal screening. Some practices may be resistant to universal screening with concerns over increased staff burden and may opt to only screen selected subpopulations. For example only screening patients with diabetes or cardiovascular disease. The PHQ2 is a brief 2 item instrument and any effort saved by limiting screening to subpopulations is offset by the effort required to determine who needs screening based on clinical conditions. Further, a strategy that only screens subpopulations may have negative impact on a practice's quality measures related to depression screening and follow-up and may be more challenging to build clinical reminders/alerts for within the EHR.

IMPLEMENTATION STRATEGY 1B.

Practices want to use documentation of depression screening and treatment as a quality measure for other reporting requirements such as Centers for Medicare and Medicaid Services Meaningful Use Electronic Health Record (EHR) Incentive Programs and Patient Centered Medical Home (PCMH) recognition.

Providers know that they can more easily pull data for reporting quality of care measures to external entities when the PHQ2 and PHQ9 depression screening assessments are available within the practice EHR. But for systems that do not yet have that capacity, other options should be made available.

HOW CAN PRACTICE FACILITATORS HELP?

- Help practices figure out whether the PHQ2/PHQ9 assessments are already available within the EHR in a computable field. If not, determine whether a configuration that includes these assessments in separately identifiable and computable fields can be turned "on," is available to the practice upon request, or can be purchased from the EHR vendor.
  - Advise practices on how to run aggregated reports involving these assessments using EHR dashboards or reporting tools that might be available within the EHR platform.
- Work with practices that do not have an EHR or do not have the PHQ2/PHQ9 as computable fields within the EHR to create a standardized system for documenting screening results within the medical record and a method of tracking results across records and/or auditing of charts for quality measure reporting purposes.

QUALITY MEASURES

As of 2016, Screening for Clinical Depression and Follow-Up Plan is a cross-cutting quality measure in the Physician Quality Reporting System (PQRS) and can also be used to meet requirements in Meaningful Use Incentive Programs. Providers can avoid the PQRS negative Medicare payment adjustment by reporting measures electronically using a certified EHR or by extracting data from a certified EHR to a qualified EHR data submission vendor who submits the data on behalf of the provider.

PART 2: Strategies Involving the Larger Community

IMPLEMENTATION STRATEGY 2A.

Practices want shared patient treatment plans for patients who receive care from behavioral health providers in order to promote continuity of care and avoid the dangers of polypharmacy.

Providers expressed a desire to have better relationships and communication with the psychiatrists, therapists, and other mental health providers in their communities. They would like timely access to their patient's medical records when they are seen by a behavioral health provider so they have accurate information about services being provided, especially medications that are being prescribed.

HOW CAN PRACTICE FACILITATORS HELP?

- Develop standardized referral and treatment summary forms for both primary care and behavioral health practices that establish expectations and ensure consistency. Referring primary care providers should include the reason for referral, treatments attempted, pertinent medical history, and medications and allergies. Behavioral health providers should include information related to diagnosis and prognosis, and a summary of treatment services rendered, particularly medication initiation, changes, or discontinuation.
- Communicate with both primary care and behavioral health practices about HIPAA laws pertaining to covered entities and the release of medical information between treating providers. Clarify any misconceptions about privacy regulations that may prevent behavioral health providers from being willing to share such information.

EXAMPLE FROM CAROLINA COLLABORATIVE COMMUNITY CARE

> The CCNC central office developed templates, which 4C adapted, to facilitate communication between providers in Cumberland County (see Appendix A, pages 15–17).

IMPLEMENTATION STRATEGY 2B.

Practices want written, standardized crisis care protocols that include information on how to access locally available resources when a patient is determined to be at high risk of suicide.

Providers typically send suicidal patients to the emergency room, but they expressed a need for a written document that they could refer to specifically in cases where the patient refuses to go to the hospital or when a family member asks for assistance with a suicidal relative. They would like a protocol that covers the legal and ethical procedures for addressing multiple situations in which a patient discloses the intention to harm him/herself.

HOW CAN PRACTICE FACILITATORS HELP?

- Ensure that each practice has a written protocol for involuntary commitment procedures including copies of the appropriate NC DHHS forms and the number for the local magistrate's office.
- Create a listing of resources for crisis mental health care within your local community including transportation options, and any available mobile crisis management teams.
- Consider offering a workshop or other dedicated training opportunity for practices to review resources, forms, and sample protocols and work with staff to design their own practice protocol for handling patients in crisis.

EXAMPLE FROM CAROLINA COLLABORATIVE COMMUNITY CARE

> 4C developed guidance for Cumberland County providers in managing a suicidal patient (see Appendix A, pages 3–4).

IMPLEMENTATION STRATEGY 2C.

Practices want assistance with determining the appropriate medications to prescribe and therapy to recommend given patients' insurance coverage.

While providers generally know about anti-depressants and the benefits of combining medications with therapy, insurance coverage is the main driver of what they prescribe for symptoms and where they refer for counseling. They would benefit from having access to "point of care" information on each patient's insurance plan and the types of medications it covers, whether pre-authorization is required, and what co-pays are involved. They would like the same information related to insurance coverage for counseling services, and whether local service providers accept their patient's insurance plan.

HOW CAN PRACTICE FACILITATORS HELP?

- Assist practices in determining whether their EHR includes functionality to "turn on" formulary information. This may include embedding links to external websites for formulary information for all relevant insurers, including Medicaid. For practices without EHR formulary access, help them establish separate bookmarks to external websites where formulary information can be found.
- Help practices compile information related to coverage for behavioral health service providers and schedule periodic updates to the document. Work with them to determine how to disseminate the information among practice staff. The best approach may differ according to size of practice, existing clinical workflows related to referrals, or other considerations. Key questions to ask practice staff include: who needs this information, when do they need it, and where do they want to access it?

EXAMPLE FROM CAROLINA COLLABORATIVE COMMUNITY CARE

4C documented point of care information for their providers in Cumberland County (see Appendix A, page 25).

IMPLEMENTATION STRATEGY 2D.

Practices are interested in the services and assistance that CCNC regional offices and practice facilitators can provide in the area of behavioral health as they are not always aware of what is available.

HOW CAN PRACTICE FACILITATORS HELP?

- Link the practice to the behavioral health team or pharmacy team at their CCNC regional network.
- Create and disseminate a local resource guide such as the one in this appendix in order to increase provider awareness of and referrals to additional community and clinical resources for behavioral health services.
- Provide in-services or brief site visits to discuss the CCNC toolkit and how to implement office systems for depression screening and treatment.

CONCLUSION

Practice facilitators, or any staff person with responsibility for quality improvement activities within a provider office, can apply one or more of these strategies to help increase adherence to evidence-based depression screening and treatment guidelines. While not every practice has sufficient capacity to implement the full IMPACT model as described in the CCNC toolkit, there are substantial benefits for providers and patients when depression is diagnosed and appropriately treated. Practices are rewarded for achieving quality benchmarks related to behavioral health. Patients are better able to manage their chronic conditions and adhere to their medication regimens when depression is brought under control. The tools and implementation approaches introduced by practice facilitators can make a big difference, and we hope that you will adapt this guide and the related resources for your own community.

This implementation guide and other behavioral health resources can be found at:

https://www.communitycarenc.org/search/?search_text=depression+toolkit

APPENDICES

Behavioral Health Resources for Primary Care Providers: Cumberland County
Authors: Carolina Collaborative Community Care
Date: May 2016
URL: **http://www.carolinaccc.com/#!providers/fpblo**

CCNC Adult Depression Toolkit for Primary Care
Authors: CCNC Behavioral Health Integration Team
Date: September 2015
URL: **https://www.communitycarenc.org/media/related-downloads/ccnc-adult-depression-toolkit.pdf**

Adolescent Depression: Screening, Follow-Up, and Co-Management Guidelines
Authors: CCNC Adolescent Depression Screening and Co-management Workgroup
Date: July 2015
URL: **https://www.communitycarenc.org/media/related-downloads/ccnc-adolescent-depression-toolkit.pdf**