

Depression and Alcohol: Enabling Screening and Better Care with the Electronic Health Record
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Hello, there. I'm going to be talking today about depression and alcohol screening and how to enable screening and improve care using the electronic health record.

Today we're going to talk about the best practices for leveraging the EHR to implement, promote, and track screening for depression and alcohol.

Following the presentation, our expectation is that you will be better prepared to integrate depression and alcohol screening into your electronic health record and tie the screening into clinical decision support and reporting capabilities.

Let's talk about some general principles. We're going to review each of these in more depth. This effort is not an easy one. It's going to require a team. We'll talk about that team in a little while. You are going to try to build the screening tools into the electronic health record. Along with those tools, you'll need to decide what clinical decision support guidance you want also embedded in the electronic health record to help guide when the screening should be done and how to handle positive screens. And you're going to want to leverage the data in the electronic health record to help you track performance and report on it.

So, first let's talk about your team. A team is needed to do this, because you're going to have to have both subject matter experts, as well as a technical team from your IS or IT department. This task of building a screener into the electronic health record is not easy. It has to be aligned with the clinical work flow. And this team probably will need clinic leadership, so the leadership of your clinic, some line level clinicians who actually are using the electronic health record. It'd be ideal if you could have a behavioral health subject matter expert on your team and of course you're going to need the information technology or information services specialists to help to integrate the screening into the electronic health record. And if possible, it's a good idea to have a performance improvement specialist, because these specialists are trained on how to understand how new protocols can dovetail in with existing work flow.

Step two, you have to choose the screening tools that you want to use. We've talked about this in previous bite-size learnings and in the resource guide that was developed and the tools that are most often used and probably most widely promoted are the PHQ2 or the PHQ9 for depression in the audit for alcohol. Many electronic health records already have these common screeners available for use, so that would be a strong advantage for your site is if your electronic health record has the screener available for use already. And more electronic health records are complying with these recommendations because of the IOM, the Institute of Medicine's report on electronic health records that we have also discussed in a previous bite-size learning that is promoting the use of these tools within electronic health records. Many EHRs, however, just have a field to document depression and-- or alcohol and it is not an evidence-based screener. So that's not generally considered sufficient for our purposes and you would have to consider whether it would be feasible for an evidence-based screener to be implemented in your electronic health record. As an item to note is most sites, or many sites, will have a content provider for their electronic health record. This is an external party that provides content for their EHR. So even though the EHR itself may not have the screeners, the content provider may actually have the screeners and can provide them to the site.

Okay, step three is to determine the screener format. There are two main options for determining the screener format: the clinician-entered versus the patient-reported measure. For the clinician entry, this is often referred to as a flow sheet or a form or a template and it's completed by the clinician or another staff member. So, it generally requires the patient to complete the screener on paper or to complete it verbally and then someone, the clinician or another staff member, must enter the responses into the flow sheet. The second option is a patient-reported measure. This is done usually through the electronic health record's patient portal if it's turned on, or it's hosted by an external vendor. And in this case, the patient actually completes the measure on a computer, him or herself, and the results are sent to the EHR for the clinician to view. Sometimes the patient-reported measure actually populates a flow sheet, item by item, or sometimes it just sends a summary of the results to the clinician.

Step four, you'll have to build and/or activate the screeners. So even if the screener is available in the electronic health record already, they don't often come standard off the shelf and they have to be turned on. So your IS service will have to turn on the screener, even if it's something that's already baked into the EHR. If the screener has to be built, then your IT and IS department will require a detailed specification document from you, so you'll have to build this document, which includes the items, the scoring, and any other decision support you want to incorporate. They'll need this from you, so they know how to program it into the EHR.

So, step five, in addition to the screeners who really need to ask some essential questions about clinical decision support, so when should the screeners or the measures be administered? So, in other words, is it just annually or is it at every visit? How and when are the clinicians alerted when an individual screens positive or whenever their severity or risk range comes across? How should the alerts be handled by the clinician? Are they required to acknowledge the alert when it comes through? Do they have to act by completing an assessment or doing some other task? Or can they just easily dismiss it? How can the clinicians access guidance on what to do with a positive screen? So are there best practice alerts or other flow documents that are available for the clinician to access within the EHR? And finally, is there a summary of work flow that's accessible? So, sometimes the clinicians will need to know when and how to integrate the screening with their existing work flow, and often a summary is used for this.

Step six is to determine the reporting parameters for tracking. So most EHRs have the capability to directly report on data, such as the information obtained by the screeners. Or they can download the data for external reporting. So reporting can be aggregated, in other words, what proportion of the total visits in a clinic had a PHQ2 administered or what proportion of the total patients screened positive on the PHQ2? So this would be a clinic-level reporting, but also, if you can do it, reporting at the individual provider level can be really useful. So in other words, what proportion of Dr. Jones' patients were screened at a well visit with the audit C. At the individual level, provider reporting is the most useful for performance improvement. So the more specific the reporting, the better you can use this as a tool to help improve performance. You have to work closely with the IT/IS professionals to determine the reporting parameters, so they know what to program.

Step seven, user acceptance testing and quality assurance. So each component that you've incorporated into the EHR needs to undergo thorough quality assurance and user acceptance testing prior to deployment. This is an essential step, because if the clinicians, who are actually supposed to be using the materials, don't find them useful, then they won't use them. And so the user testing is key to making sure that the tools are useful and can be deployed in the clinical work flow. This usually requires testing between the clinician, a subject and matter expert like a behavioral health expert, and IT or IS

personnel. And if you can do that testing together at the same time, either in person or through some kind of electronic medium like GoToMeetings or WebEx, then it can really bend the curve and help to get this done much quicker than doing the testing separately.

Step eight, release the screeners and the clinical decision support to production and train the clinicians. So the clinicians who are going to be using the tools need to be trained, along with the associated work flow, shortly before or contemporaneous with the release of the tools in the electronic health record. Training them too soon or too early with a big delay often is problematic. So this needs to be time carefully. And the tools should be continuously adjusted based off of feedback from the clinicians and evolutions in practice.

So, in sum, it's ideal to have a multidisciplinary team oversee the build and implementation of the screeners in the electronic health record. If you can use embedded screeners that are available already in the EHR system, that's ideal. You have to carefully think through the conditions for when to screen and how to guide clinicians for handling positive screens, program clinician decision support in alignment with acceptable work flow, use the data to track and report and understand and encourage performance improvement, and pre-release and post-release feedback should be used to adjust the tools and the protocols to make them functional for clinicians who are using it.

Thank you. Appreciate your attention. If you have any questions, feel free to contact me.