NCC_EdBoudreaux10_02272017

Exemplary Integrated Primary Care Sites: Lessons for Depression and Alcohol Screening
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Hello, this is Ed Boudreaux. Today I'm going to talk about Exemplary Integrated Premiere Care Sites and how we can use those observations from these exemplary sites to screen better for depression and alcohol.

Today I'm going to be talking about a "Guidebook for Professional Practices for Behavior Health and Primary Care Integration." I'm going to talk about what the guidebook is and we're going to discuss some key implications for improving screening for depression and risky alcohol use derived from these exemplary practices.

Following this video our expectation is that you will be better prepared to use lessons learned from the "Guidebook of Professionals Practices for Behavior Health and Primary Care Integration" to improve screening for depression and alcohol misuse in primary care settings.

Let's start out with a little bit of information about what this guidebook is. So it was released in 2015 by the Agency for Healthcare Research and Quality, I've provided a PDF here. It was an expert panel and integrated primary care that reviewed the literature on integrated primary care. And they also identified eight exemplary practices from across the country. They made observations on site. They interviewed practitioners and administrators and they collected documents from these eight sites and they pulled all of the information together into a guidebook that summarized their observations about what made those practices so exemplary. They organized the results in two primary domains, an organizational level professional practices and interpersonal and individual professional practices.

So what we're going today is we're going to review the exemplar observations, the observations from those exemplary sites; apply them to screening for depression and risky alcohol use. So there are, probably, 40 or so principle findings that were published in the guide and we're only going to focus today on the five that are the most relevant to screening for depression and risky alcohol use.

First principal that was observed is that the members of the organizations, the clinics that they were looking at, paid really close attention to the organization's mission and vision, particularly, as it related to population health and healthcare integration. So you see here in this table; I've put the observation that was made in the guidebook and I've applied that observation to screening. So I'm going to review primarily the second column on these slides that show how these principles apply to screening for depression and alcohol use.

So this principle would require the site to clearly identify how screening for depression and risky alcohol use aligns with the practice's mission of population health. It should also consider onsite behavior

health providers. Clearly if onsite behavioral health providers are available it will be easier to screen and to refer patients if they're positive for depression or risky alcohol use. But this isn't always practical so the site will really need to consider strengthening relations with community based behavioral health providers if on site health providers aren't available. The site should also develop an approach to handling positive screens regardless of whether they have a behavioral health provider or not and they need to integrate this approach into their clinical workflow.

Some questions to guide your, the approach with the clinic might be does the practice have a population health mission, was it either explicitly or implicitly implied? So for example, FQHCs often formally embrace such a mission. What's the level of integration care present at the site? Is there a behavioral health provider on site? How integrated is the behavioral health provider with the clinical workflow? If there isn't someone there, is there a list of regional providers? Is the list organized in a way to improve matching such as by insurance, or language or population served? And is there a connection to care facilitated by the practice? In other words, are there personnel available to help connect the patient to a referred organization?

I mentioned the level of integration. This is a table that's available online that talks about the different levels of integrated care. This is also described in one of our previous BSLs on integrated primary care.

So the second principle that evolved from the observations with the exemplary sites is that the organizations create a structure to support the delivery of integrated care. So this is applied to screening for the following recommendations; each team member, in other words, each person in the clinic would have clearly identified roles and responsibilities for screening and management of depression and risky alcohol use. So the nurses, physicians and other care personnel would have clear roles.

Structured protocols should be built and readily available for reference outlining the pathways associated with depression and alcohol screening and management so that there's no confusion among all of the staff. And the screening tools and the clinical decisions support related to depression and risky alcohol use should be imbedded in electronic health records to further provide infrastructure.

Some questions that one can ask about the structural support at a clinic are: Does the practice have their teams clearly identified and what is the role and responsibility of each team member or clinician for screening and management of depression and risky alcohol use? Are the screening and related assessment tools imbedded in the electronic record; and is there a clinical decisions support such as risk threshold and associated guidance that are imbedded in the EHR or which can be readily located by the clinicians?

Here's an example of a protocol that is very clearly spelled out in terms of screening for a depression including follow-up actions when a person is positive. This was also shared in a previous Bite Sized Learning and is also available from the Internet and is published by the Institute for Family Health.

The third principle that was observed is that organizations embrace continuous quality improvement practices and principles. How is this applied to screening? Well, the organization should acknowledge that there is some risk in identifying depression and risky alcohol use and the organization will have to kind of embrace that there's some risk involved and focus on the care processes and improvement cycles rather than on the risk.

They should create clear protocols and workflows that guide practice for both, screening and handling positive screens as we mentioned earlier. And they should roll out the protocols in steps or phases, piloting the new protocols and gathering feedback from clinicians and patients and using the data to drive decision making and to identify areas for continued improvement.

Some key questions to ask about the CQI approach or model available at the site is: Does a practice have a formal or informal CQI approach? Are there personnel dedicated to such a role? Does the practice have a clearly and identified workflow for screening and handling positives? And see the BSL titled "Handling positive screens" for some additional suggestions on how to build a workflow for handling positive screens. Does the clinic embrace a "Plan-Do-Study-Act" approach? In other words do they implement both small steps and solicit feedback? Do they collect data on key performance elements? And do they share the results with their clinicians?

This is an example of a CQI model from the Institute for Health Improvement. The link here can be taken to the Institute for Healthcare Improvement to find out more information about using CQI in healthcare.

Training and learning at these sites were ongoing so how does this apply to screening? The staffs are trained in screening and management protocols focusing on their roles and pathways. The training on screening and protocols is imbedded in initial on-board training and there are annual refresher trainings that continue to occur to make sure that the change is sustainable. There's also "as needed training" that occur based off of the data so when the data implies that there is a problem the training can target the problems that the data reveals. The training is tracked as part of professional development and promotion.

Some key questions to ask about ongoing training at a site is: Does the practice have training materials created to support depression and risky alcohol use screening? Is there a process in place to help remediate training in individuals who may have knowledge or performance deficits? Is there ongoing training incorporated at least annually including a process for identifying and circulating training opportunities related to screening or management of depression and alcohol use?

Final observation is that the sites will manage their finances to support the organization's mission and vision for integrated care; how is this applied to screening? Clearly identify billing and reimbursement for screening as allowed by various payers that are common among the patients seen in the clinic so

which payers are actually going to reimburse for the screening of depression and risky use; and create standard documentation guidelines and billing practices that support the reimbursement for screening.

Key questions to ask about financial support for screening: Does the practice bill currently for depression and alcohol screening? Are the clinicians trained on what they need to document and are the billers and coders, if they're available, and the managers or administrators trained in how to bill for these procedures? What documentation is required to support the reimbursement and is there a feedback loop to help train clinicians on documentation requirements? In other words, if claims are denied how are they managed and how is this information sent back to the clinicians so they can do a better job with documentation?

So in summary an organization that is going to promote and practice screening for depression and alcohol use that aligns with observation from the AHRQ Guidebook will clearly align their practices with the mission and values of the organization. They'll create structure to support the screenings, such as EHR tools and workflows. They use continuous quality improvement principles to pilot and refine the protocols. They train all their staff on the screening and the related protocols in an ongoing and sustainable way. And they align their financial resources to support the screening.

Thank you. My information is here if you'd like to contact me for further questions.