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CARE INTEGRATION LEARNING COLLABORATIVE

KYLE ROESLER, PROGRAM MANAGER

JANUARY 29, 2019

# Welcome and Introduction

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Introduce yourself: Name and Organization

What are you hoping to get out of today?

# Agenda

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- ✓ CPAA updates and announcements
- ✓ Learning Collaborative
- ✓ Next Steps

# CPAA Updates

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# CPAA Updates & Announcements

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- Changes to 2019 schedule of meetings
  - Council Meetings: every other month starting in February
  - Workgroups transitioning to a joint Learning Collaborative
- AIMS Center Training Program
  - First cohort did in-person training
  - Pediatric cohort

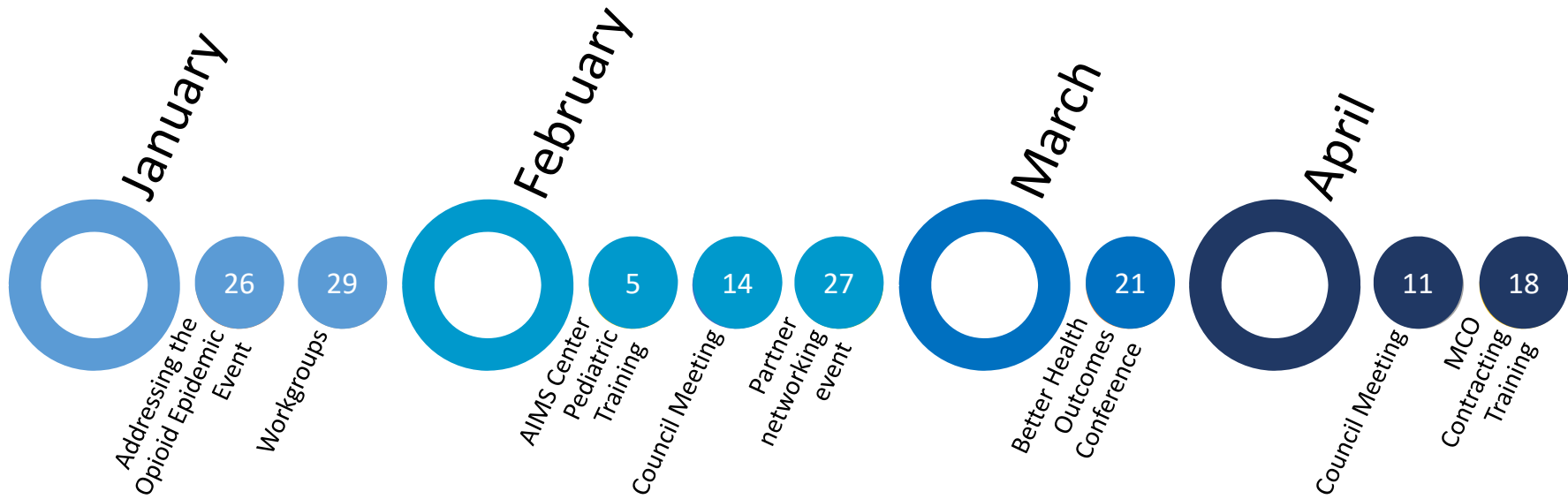
# HCA Update

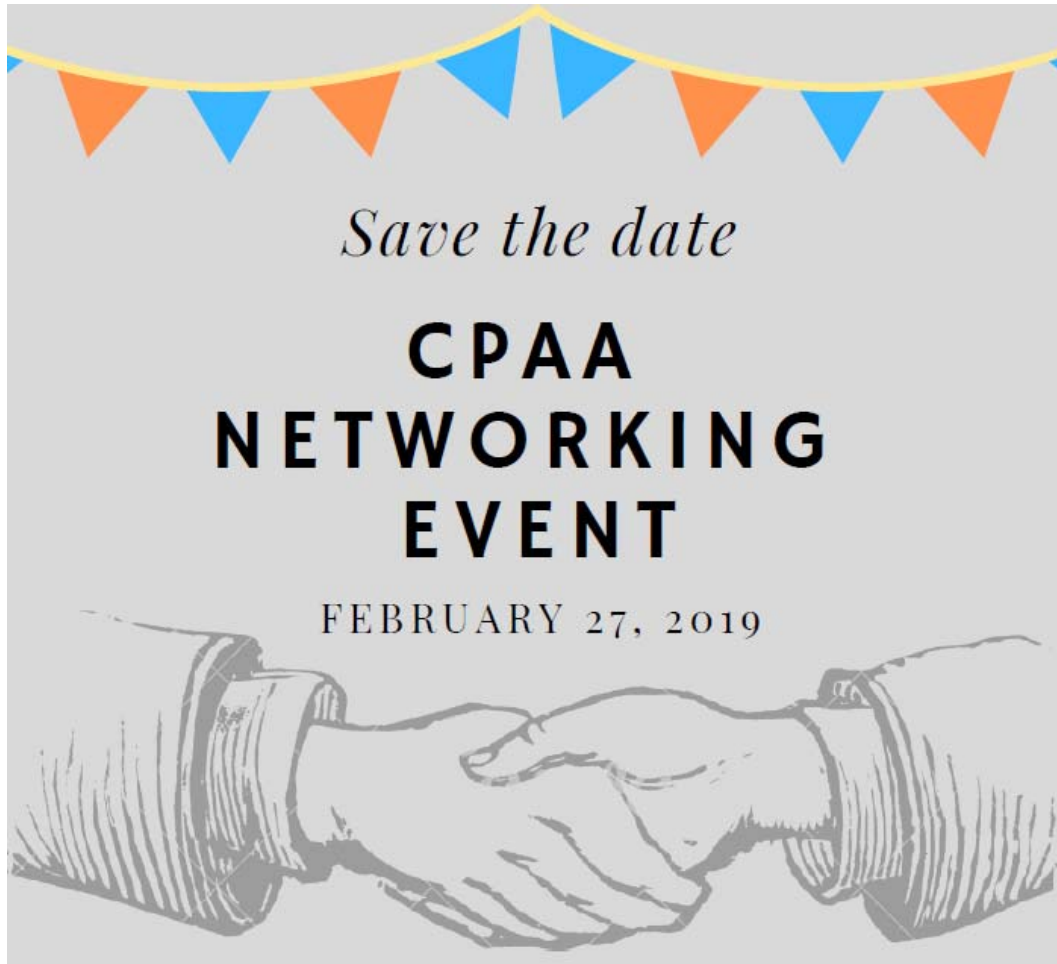
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- Status of removing current limits:
  - Health and Behavior codes (Matrix 1): anticipated effective date January 1, 2019
  - Psychotherapy and Tobacco Cessation (Matrix 2): anticipated effective date July 1, 2019
- Decision Package with the rate increase is in development

# Upcoming Events

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## Centralia Square Grand Ballroom

11:30am to 3:00pm

Join regional partners in conversations about transformation work, ways to collaborate, and learn more about projects in your community. **Lunch provided.**

More information coming soon.



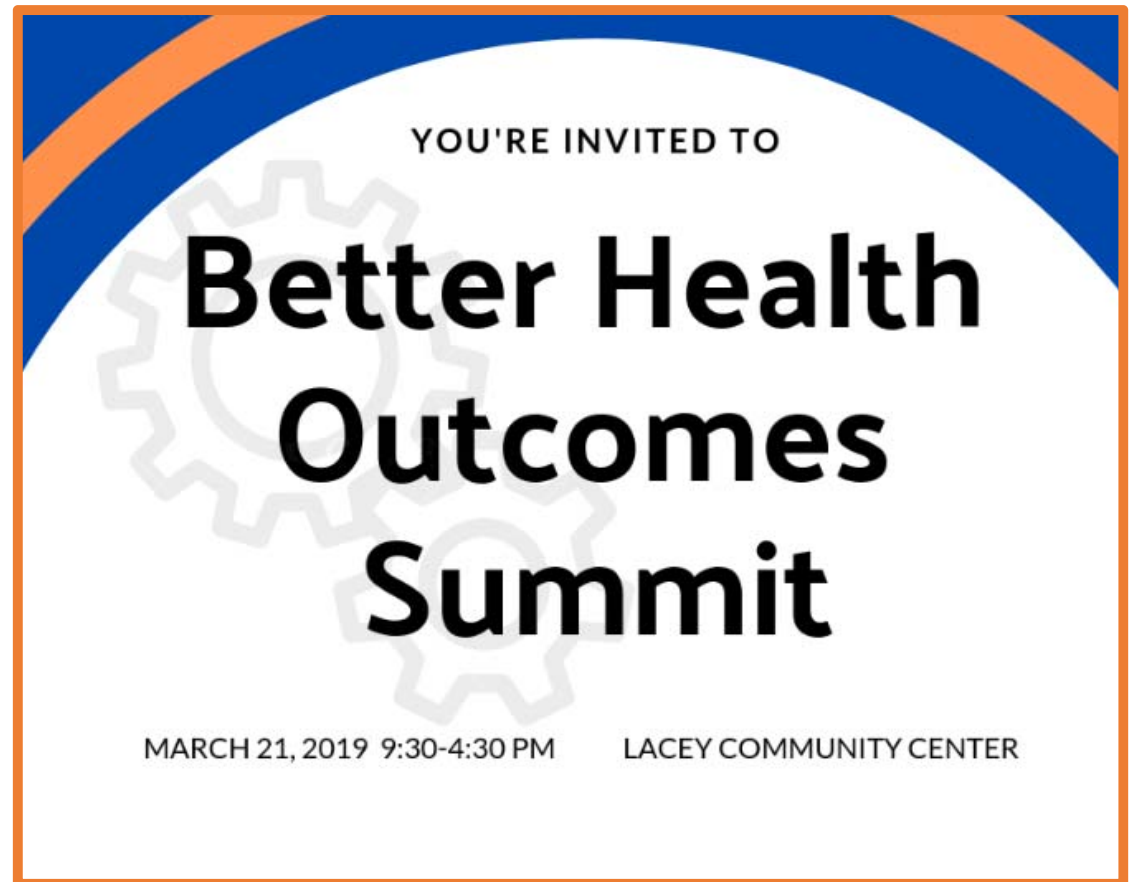
## Lacey Community Center

9:30am – 4:30pm

CPAA is hosting a conference to share best practices, quality improvement methods, and strategies to improve health outcomes in our region.

**Lunch provided.**

More information coming soon.



# Transition to Regional Learning Collaborative

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# Purpose

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- Make better use of our partner's time as many attend multiple workgroups.
- Increase our ability to deliver meaningful and deeper dives into content by working collaboratively to plan events rather than five independent workgroups.
- Increase participation
- Deliver meaningful content

# Benefits

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- Targeted content
- Build community capacity
- Networking for cross-project stakeholders
- Reduce silos
- One shared learning community

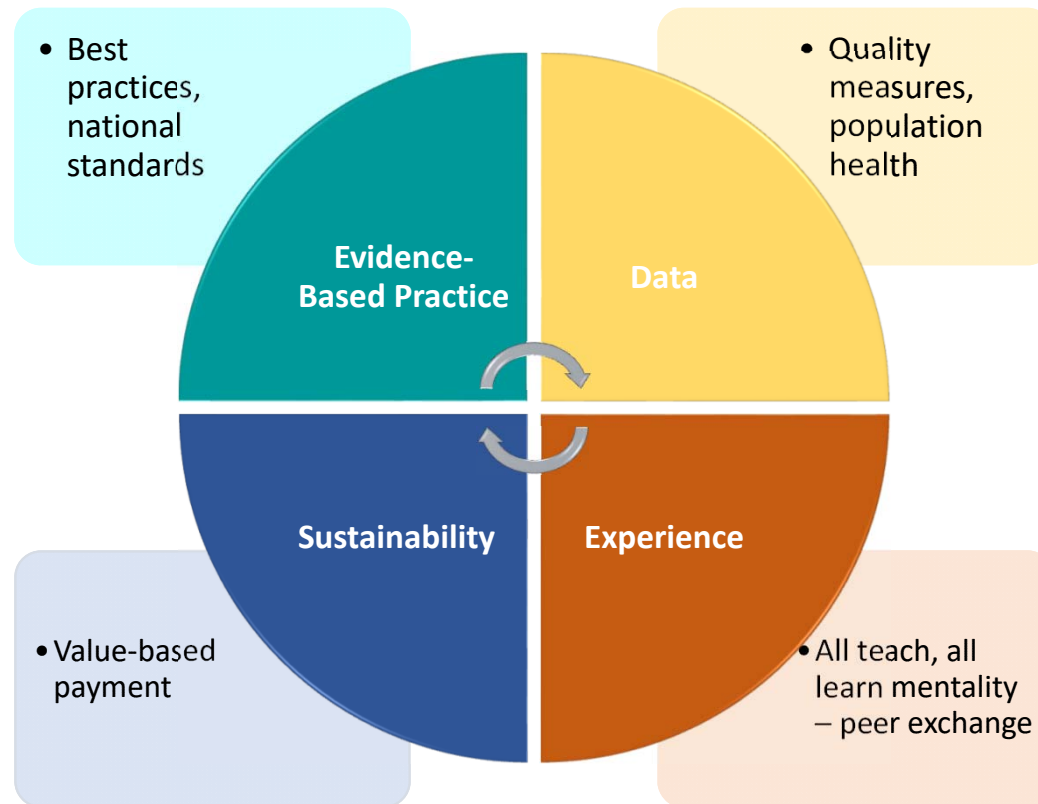
# Structure

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- Every other month
- Half-day, 3-4 hours with a networking lunch
  - Centered on regional data
  - Shared learning or training, guest speakers
  - Small group breakouts by region or project area
  - Content targeted to regional partners, events open to all
- Focus on peer learning
- Include resource/sharing table and events calendar
- Last hour optional Hub Advisory Committee

# Structure for Today

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# Best Practices: Screening for Depression

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1. Understand importance of depression screening
2. Able to score and interpret PHQ results
3. Regular screenings
4. When PHQ is +, diagnosis, education, and plan is documented
5. When PHQ is +, appropriate referrals are offered
6. Appropriate follow-up after +PHQ
7. Collaborative depression care improves outcomes
8. Screening and treatment are culturally appropriate

# Data: Depression Metrics

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## Process Measures

1. Utilization of the PHQ-9 or PHQ-a to monitor patient following depression diagnosis (DMS)

## Outcomes Measures

2. Depression Remission and Response (DRR)
3. Depression screening and follow up for adolescents and adults (DSF)



# 1. Monitor PHQ (HEDIS 2018)

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- Utilization of the PHQ-9 or PHQ-A to monitor depression symptoms for adolescents and adults (DMS)
- At least one PHQ score recorded within four months of depression diagnosis
- Not in the Medicaid Core Measure Set
- CPAA change plan metric

## 2. Depression Remission and Response to Treatment (DRR) (HEDIS 2018)

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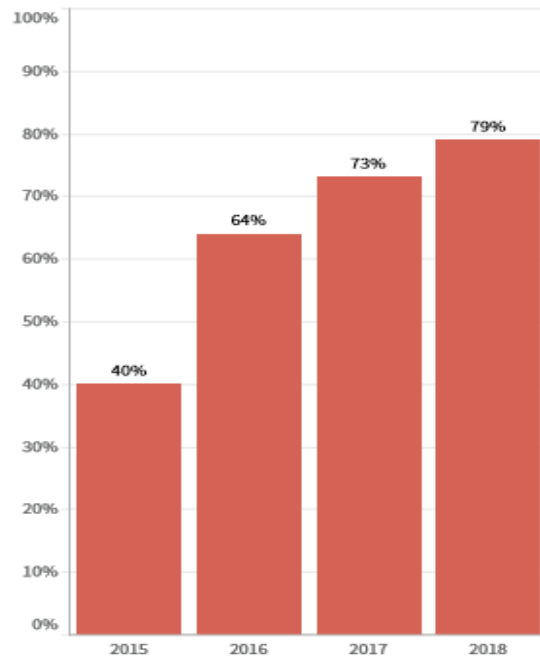
- Remission: PHQ-9 score of less than five
  - Suggested benchmark: >20%
- Response: 50% improvement over first elevated PHQ-9
  - Suggested benchmark: >40%
- DRR within 4-8 months of first elevated PHQ-9
- Core Quality Measures Collaborative ACO & PCMH
- Not in Core Measure Set
- CPAA change plan metric

### 3. Depression Screening and Follow up (DSF) (HEDIS 2018)

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- Preventative measure
- Included in the Core Measure Set (adults/pediatrics)
- Percentage of patients aged 12 years and older screened for depression on the date of the encounter AND if positive, a follow-up plan is documented on the date of the positive screen

## Adolescent Depression Measure: Trend



Total number of patients:  
2015 = 108,188  
2016 = 119,450  
2017 = 137,033  
2018 = 142,959

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*Most medical groups in Minnesota are currently administering a depression screening tool to their adolescent patients. The percentage of adolescents who were screened for mental health and/or depression has increased significantly since 2015 (when the measure was first implemented) and has improved every year.*

# Check In

- Does anyone do universal screening?  
Annually or at every visit?
- What has been the reception of depression screening at your organization?

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)				
Over the last 2 weeks, how often have you been bothered by any of the following problems? <i>(Use "✓" to indicate your answer)</i>	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + \_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_  
=Total Score: \_\_\_\_\_

# Sustainability: Quality AIMS

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- Community Health Plan of Washington
- Mental Health Integration Program (MHIP)
- Value-based payment

# Value Based Payment in MHIP

*Pay for Performance in Collaborative Care*

Stephanie Shushan

CPAA Bi-Directional Care Meeting

January 29, 2019



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# MHIP

- Mental Health Integration Program
- Collaborative Care program developed in 2008 with CHPW, Public Health – Seattle & King County and AIMS Center
- Expanded in 2009 statewide
- Includes
  - Patient Registry
  - Psychiatric Consultation
  - Training
  - Value-Based Payment





# Collaborative Care Model



## **Patient-Centered Team Care**

Team members collaborate effectively.



## **Population-Based Care**

Patients are tracked in a registry; no one 'falls through the cracks.'



## **Measurement-Based Treatment to Target**

Treatments are actively changed until the clinical goals are achieved.



## **Evidence-Based Care**

Treatments used are evidence-based.



## **Accountable Care**

Providers are accountable and reimbursed for quality care and outcomes.

*Used with permission from University of Washington AIMS Center.*



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# Value-Based Payment

## “Quality Aims”

- Goal to improve care
- Align with Collaborative Care best practices
  - Use of registry
  - Patient engagement
  - Treatment to Target
- Measured on the population level, includes targets for the population
- Performance tracked monthly
- Payment withheld and paid out annually according to performance



# Current Clinical Measures

## Provider Organizations

- **Caseload Requirement** – Maintain contracted active caseload
  - *Population-Based Care*
- **Early Engagement** – Follow-up twice per month between 1-6 months of enrollment
  - *Evidence-Based Care*
- **Depression Remission or Response** – HEDIS DDR for enrolled clients
  - *Measurement-Based Treatment to Target*
- **Psychiatric Caseload Consultation** – Psychiatric consultation for clients not improving within 2 months or PHQ-9 range
  - *Measurement-Based Treatment to Target*

## Psychiatric Consultant Organizations

- **Psychiatric Caseload Consultation** – Psychiatric consultation for clients not improving
  - *Measurement-Based Treatment to Target*



# MHIP VBP Publications

- Unutzer, J, et al. **Quality Improvement With Pay-for-Performance Incentives in Integrated Behavioral Health Care.** *Am J Public Health.* 2012;102: e41–e45. doi:10.2105/AJPH.2011.300555
- Bao, Y, et al. **Unpacking Collaborative Care for Depression: Examining Two Essential Tasks for Implementation.** *Psychiatric Services* 67:4, April 2016
- Bao, Y, et al. **Value-Based Payment in Implementing Evidence-Based Care: The Mental Health Integration Program in Washington State** *Am J Manag Care.* 2017;23(1):48-53



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# Questions



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# Experience: Small Group Breakout

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## Questions

1. What is your approach to depression screening?
  - Universal? Annual or at every visit?
  - Who does the screening?
  - Adults and/or adolescents?
  - PHQ-2 vs PHQ-9?
2. What is your approach to quality improvement?
  - How are you reporting and tracking depression metrics?
  - How is depression screening evaluated at your organization?
  - If you can, share your experience doing PDSAs on depression screening.
3. What are one or two things you want to share with the group from your experience or group discussion?
4. What are one or two questions you would like to pose to the group?

# Large Group

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Think of answers to these questions...

1. What are one or two things you want to share with the group from your experience or group discussion?
2. What are one or two questions you would like to pose to the group?

# What's next

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- Did anything stand out for you today?
- What is one thing you are taking away from today's meeting?
- How could today have been better?



## References (links included in post-meeting email)

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- Not Missing the Opportunity: Improving Depression Screening and Follow-Up in a Multicultural Community
- Depression Screening: A Practical Strategy
- Screening Your Adult Patients for Depression
- Unpacking Collaborative Care for Depression: Examining Two Essential Tasks for Implementation
- Value-Based Payment in Implementing Evidence-Based Care: The Mental Health Integration Program in WA State
- Integrated Care: A Guide for Effective Implementation

# Summary and Next Steps

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- Next steps
  - Next meeting is February 26, 2019
  - Exercise:
    - Do gap analysis with best practices for depression screening