Attachment 7 Refresh Workgroup
Mental Health and Substance Use Disorder Treatment

November 6, 2019

AGENDA

Time	Topic	Presenter
10am-10:10	◆ Welcome and Introductions	Thai Lee
10:10-10:25	◆ Covered California Proposed Behavioral Health Expectations for 2022-2024 Refresh	Margareta Brandt Lance Lang
10:25-10:45	◆ Department of Health Care Services Behavioral Health Initiatives ◆ Opportunities for Alignment	Kelly Pfeifer, MD DHCS Deputy Director for Behavioral Health
10:45-11:05	◆ California Health and Human Services Agency Behavioral Health Initiatives ◆ Opportunities for Alignment	John Connolly, PhD, MSEd CHHS Deputy Secretary for Behavioral Health
11:05-11:35	◆ Behavioral Health Access, Treatment, Monitoring Outcomes and Integration with Primary Care from a Provider's Perspective ◆ Discussion	Sara Gavin, LMFT, LPCC Chief Behavioral Health Officer, CommuniCare
11:35-12:05	◆ LA Care's Experience with Behavioral Health Integration and Use of PHQ-9 ○ Initiatives, Results and Lessons Learned ○ Discussion	Michael Brodsky, MD Medical Director, LA Care
12:05-12:30pm	◆ Open Discussion ◆ Wrap Up & Next Steps	All Thai Lee

COVERED CALIFORNIA PROPOSED BEHAVIORAL HEALTH EXPECTATIONS FOR 2022-2024 REFRESH

BEHAVIORAL HEALTH: APPROACHES 2017-2019

- At the time of developing the 2017-2019 QHP Issuer Model Contract, there were no clearly established best practices for integrating medical and behavioral health.
- Covered California required issuers to report progress for:
  - Making behavioral health services available to enrollees
  - Integrating behavioral health services with medical services
  - Reporting the percent of enrollees cared for under an integrated behavioral health model (IBHM)

BEHAVIORAL HEALTH: MEASURES 2017-2019

- Covered California currently requires issuers to report on the following behavioral health measures through the Quality Rating System (QRS):
  - Antidepressant Medication Management (AMM) (HEDIS)
  - Follow Up After Hospitalization for Mental Illness (FUH) (HEDIS)
  - Follow Up Care for Children Prescribed ADHD Medication (ADD) (HEDIS)
  - Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment (IET) (HEDIS)
- Covered California recognizes that there are additional behavioral health measures, such as Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS), that use clinical data to monitor patient outcomes.

BEHAVIORAL HEALTH: SELECT RESULTS 2017-2019

- Average percent of Covered California enrollees cared for in an integrated behavioral health model (IBHM) increased from 2% to 11% from 2015-2018.
  - IBHM data collection is challenging due to (1) no standard definition of IBHM; (2) incomplete data reported by issuers and year-to-year inconsistencies.
- Issuers described a broad spectrum of behavioral health integration efforts, including co-location of services, increased coordination with carve-out vendors, and embedded behavioral health staff in primary care clinics.

HMA & PWC RECOMMENDATIONS

- HMA Suggested Considerations for Covered California
  - Improve access to behavioral health services: Covered California can encourage issuers to remove or decrease prior authorizations, step therapy and other treatment limits, consistent with MHPAEA requirements. Covered California could also require issuers to monitor behavioral health penetration rate.
  - Enhance behavioral health treatment quality: Covered California can enhance treatment quality by enforcing more stringent reporting requirements for issuers of provider network quality and performance measures.
  - Increase the prevalence of integrated behavioral health services: Covered California can encourage issuers to remove administrative barriers to integrating mental health and substance use disorder services into primary care by decreasing burdensome documentation requirements and adopting the proposed billing codes for Collaborative Care services.

- PwC Measures & Benchmark Recommendations for Covered California
  - Use QHP national benchmarks reported from QRS.
  - Recommend Healthcare Effectiveness Data Information Set (HEDIS) measures: Adult Access to Care and Hospitalization for Potentially Preventable Complications; Integrated Healthcare Association (IHA) Align Measure Perform (AMP) measure: Encounter Rate by Service Type.
  - Consider analyzing QHP data to develop baseline values:
    - Utilization and expenditure of services;
    - Prevalence of diagnoses and comorbid conditions;
    - PCP visits per thousand; % enrollees with PCP or no visit;
    - Emergency Department visits and admits with ambulatory care sensitive conditions.

BEHAVIORAL HEALTH: POTENTIAL APPROACHES 2022-2024

Covered California Goals 2022-2024	2022-2024 Potential Refresh Elements

• Ensure access to behavioral health services
• Promote consistent use of screening and follow-up tools for depression, anxiety and substance use disorders starting with focus on depression
• Promote shared accountability for behavioral health through integrated behavioral health with primary care based on Collaborative Care model, co-location, and/or telehealth
• Evaluate strategies to improve care of patients with serious mental illness
	• Establish requirements for:
	  • Care of patients with serious mental illness
	  • Collection of PHQ-9 as a standard measure
	• Establish targets for PHQ-9 use for screening, diagnosis and 6-month follow-up
	• Require behavioral health integration through contracting strategies being tested in IHA and CQC programs
	• Continue focus on improving in current behavioral health measures

KELLY PFEIFER

DHCS Deputy Director for Behavioral Health

- Department of Health Care Services Behavioral Health Initiatives
- Opportunities for Alignment

People with serious mental illness die 25 years earlier

People with a substance use disorder die 22.5 years earlier

….many from preventable physical illnesses

It is time for change in California.

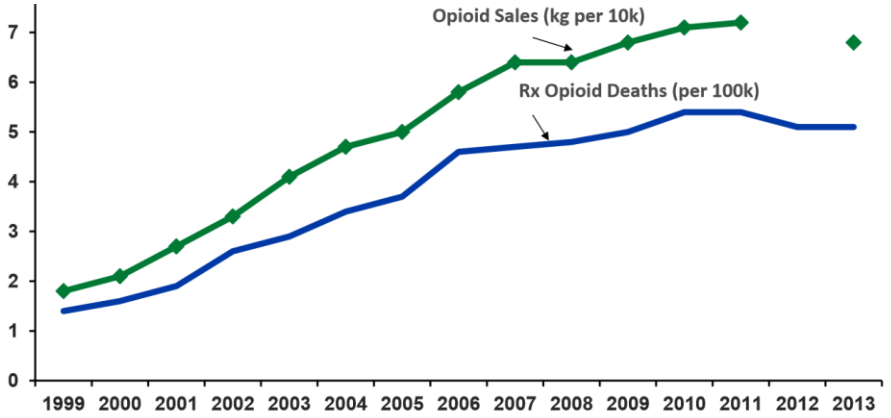
Covered California
November 6, 2019

Kelly Pfeifer, MD
Kelly.Pfeifer@dhcs.ca.gov

Agenda

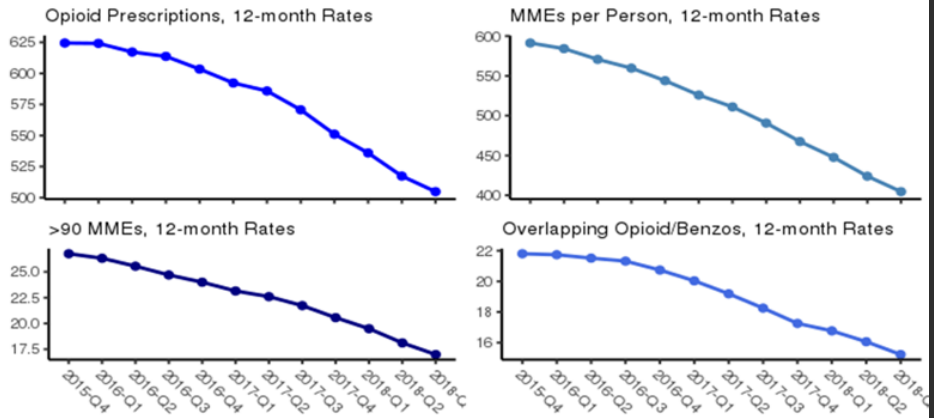
1. State of BH in California
2. DHCS initiatives:
    - CalAIM
    - BH Integration
    - MAT Expansion

Direct correlation between opioid sales and opioid deaths



National Vital Statistics System, DEA's Automation of Reports and Consolidated Orders System.

Dramatic drop in CA opioid prescribing 2015-18



“Everyone has a plan until they’re punched in the mouth.”

-Mike Tyson

“Opioid refugees” are at real risk of harm.

Patients on chronic opioid prescriptions were **3x more likely to die of an overdose** in the year that followed opioid discontinuation.

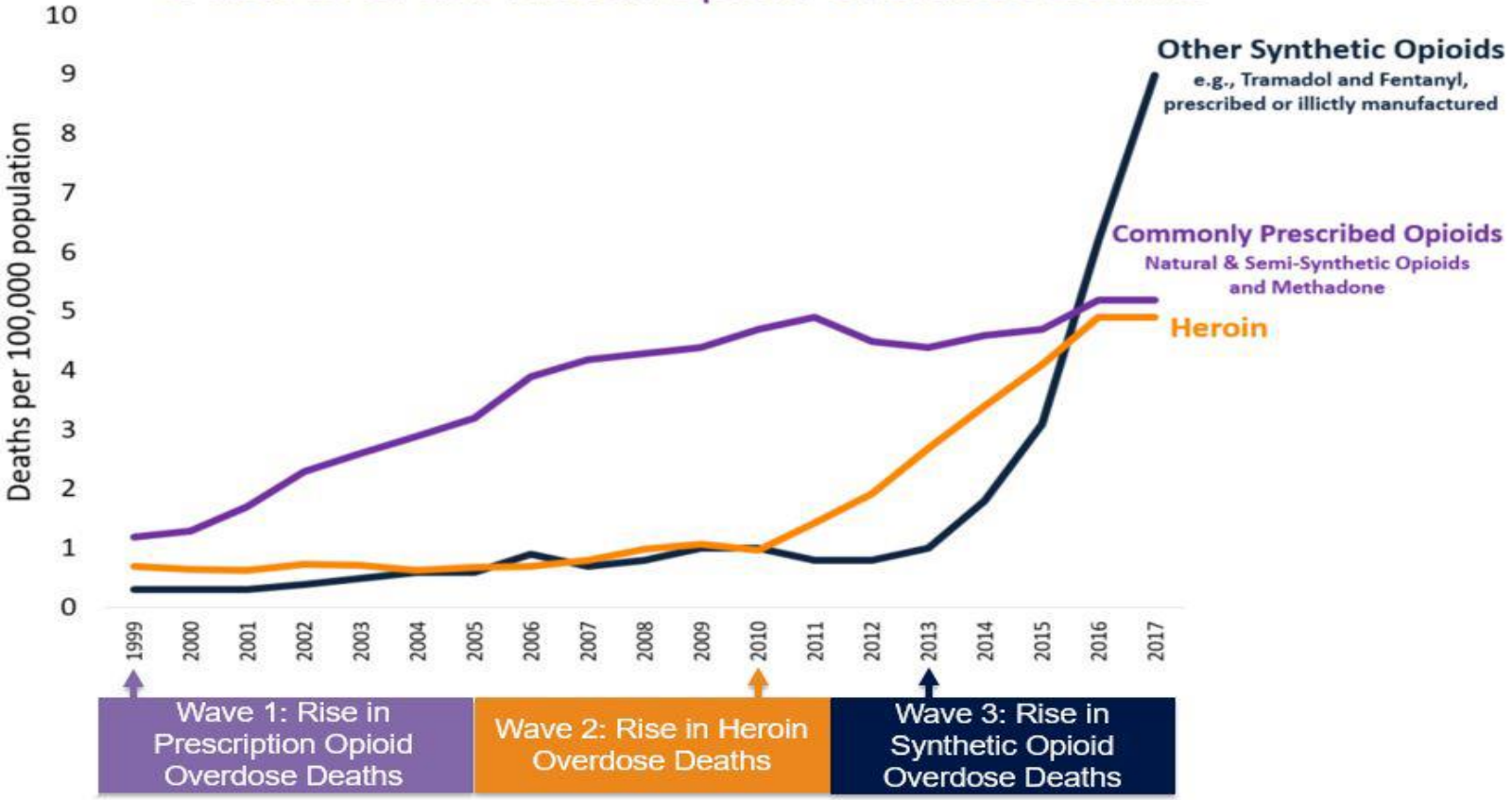
More than half of patients on long-term, high-dose opioid meds **were discontinued suddenly:**

- 49% subsequently had **an adverse opioid-related ED visit or hospitalization**
- 60% had SUD, but **<1% received MAT**

McKinney, Mortality after discontinuation of primary care-based chronic opioid therapy for pain: a retrospective cohort study, J Gen Intern Med 2019 Aug 29

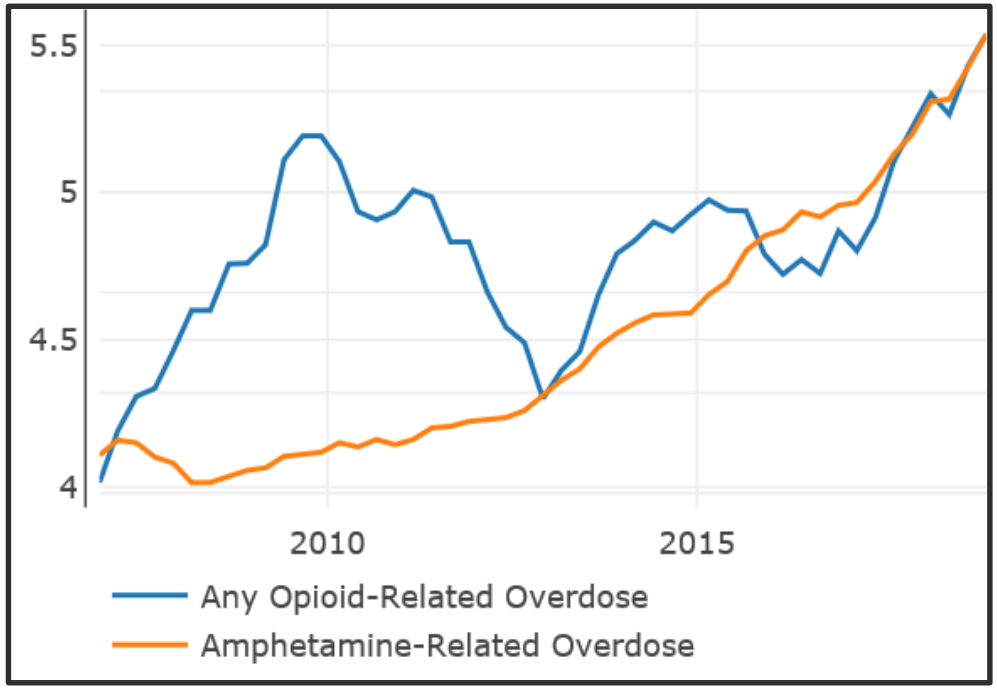
Mark, Opioid medication discontinuation and risk of adverse opioid-related health care events, J of Substance Abuse Treatment, Vol 103, August 2019

3 Waves of the Rise in Opioid Overdose Deaths



SOURCE: National Vital Statistics System Mortality File.

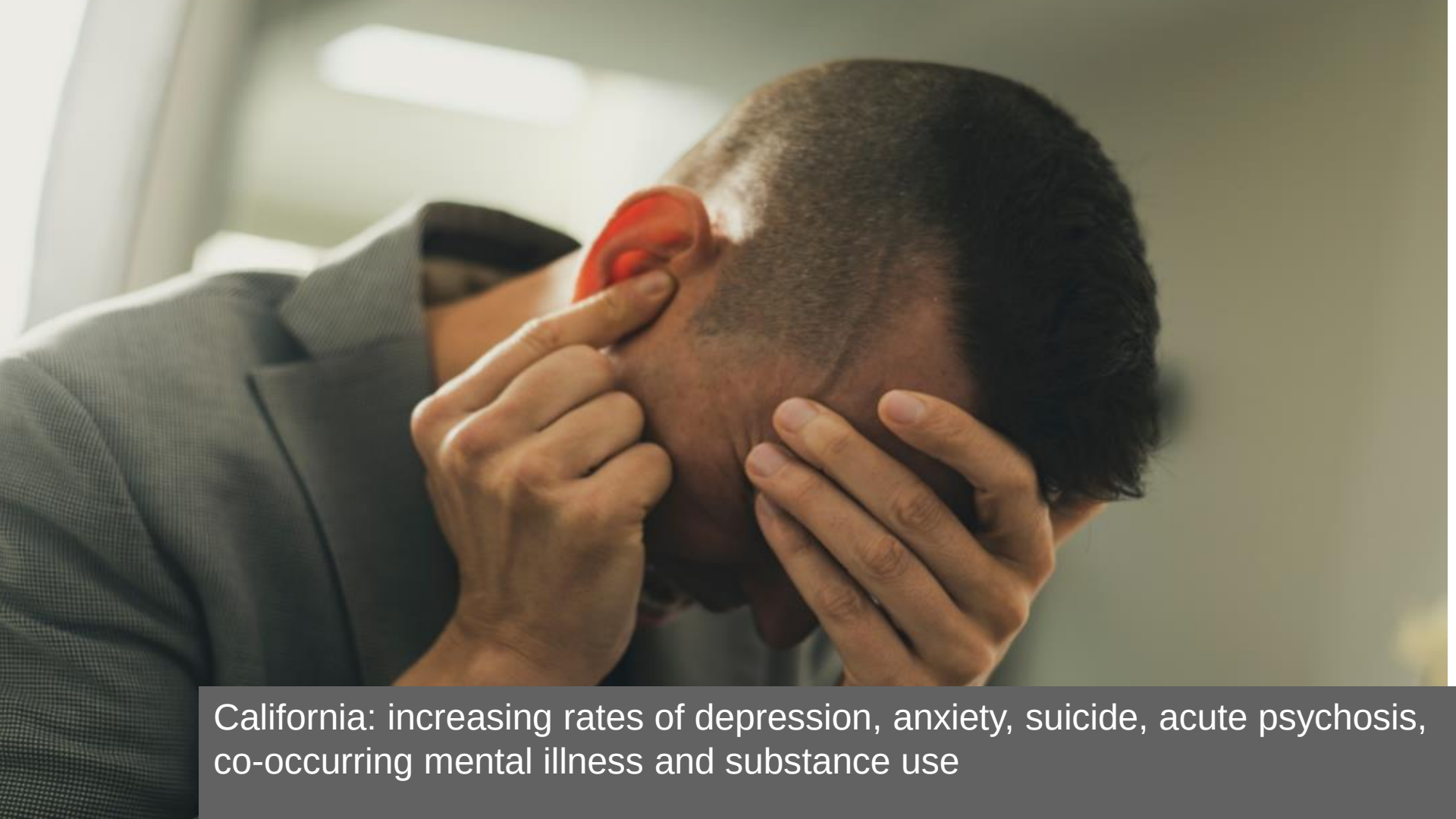
Opioids are one piece of the problem in California.



2018 ODs: meth > opioids

Alcohol-related ED visits are 10x that of opioids.

Source: CDPH Opioid Dashboard



California: increasing rates of depression, anxiety, suicide, acute psychosis, co-occurring mental illness and substance use

What do Californians say they want?

- Treat me like a person.
- Treat all of me.
- Don’t just give me a pill.

2019 California Health Care Foundation
Medi-Cal beneficiary focus groups

Mental health treatment was the TOP concern in 2018 California poll.

1 in 4 Medi-Cal families sought mental health treatment.

1 in 12 sought SUD treatment.

Only 1 in 3 people with mental health conditions get treatment.

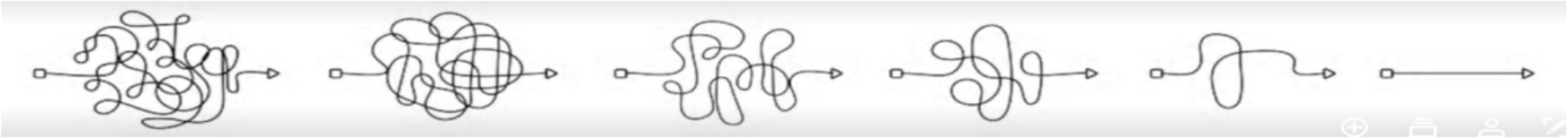
Only 1 in 10 people with SUD access treatment.

We can do better.

DHCS BH initiatives

- CalAIM (Advancing and Innovating Medi-Cal)
- Integrated Behavioral Health incentive program
- MAT Expansion Project

CalAIM: Advancing and Innovating Medi-Cal



Simpler:	*Reducing variation and complexity across delivery systems*
Well-designed:	*Identifying and managing member risk and need through population health management strategies*
Better:	*Improving quality outcomes and driving delivery system transformation through value-based initiatives and payment reform*

CalAIM: Behavioral health integration

Payment: *How to support innovation, evidence-based practice, and pay for what matters?*

MH and SUD plans: *How can financing and oversight support treating whole people?*

IMD exclusion: *Should we (and can we) expand access to residential treatment services through Institutes for Mental Disease (IMDs)?*

Full integration models: *Could plans and counties collaborate to integrate financing for physical, behavioral, and dental health?*

Behavioral Health Integration incentive program

Goals: improve outcomes, efficiency, and patient experience by integrating care teams

Basics:

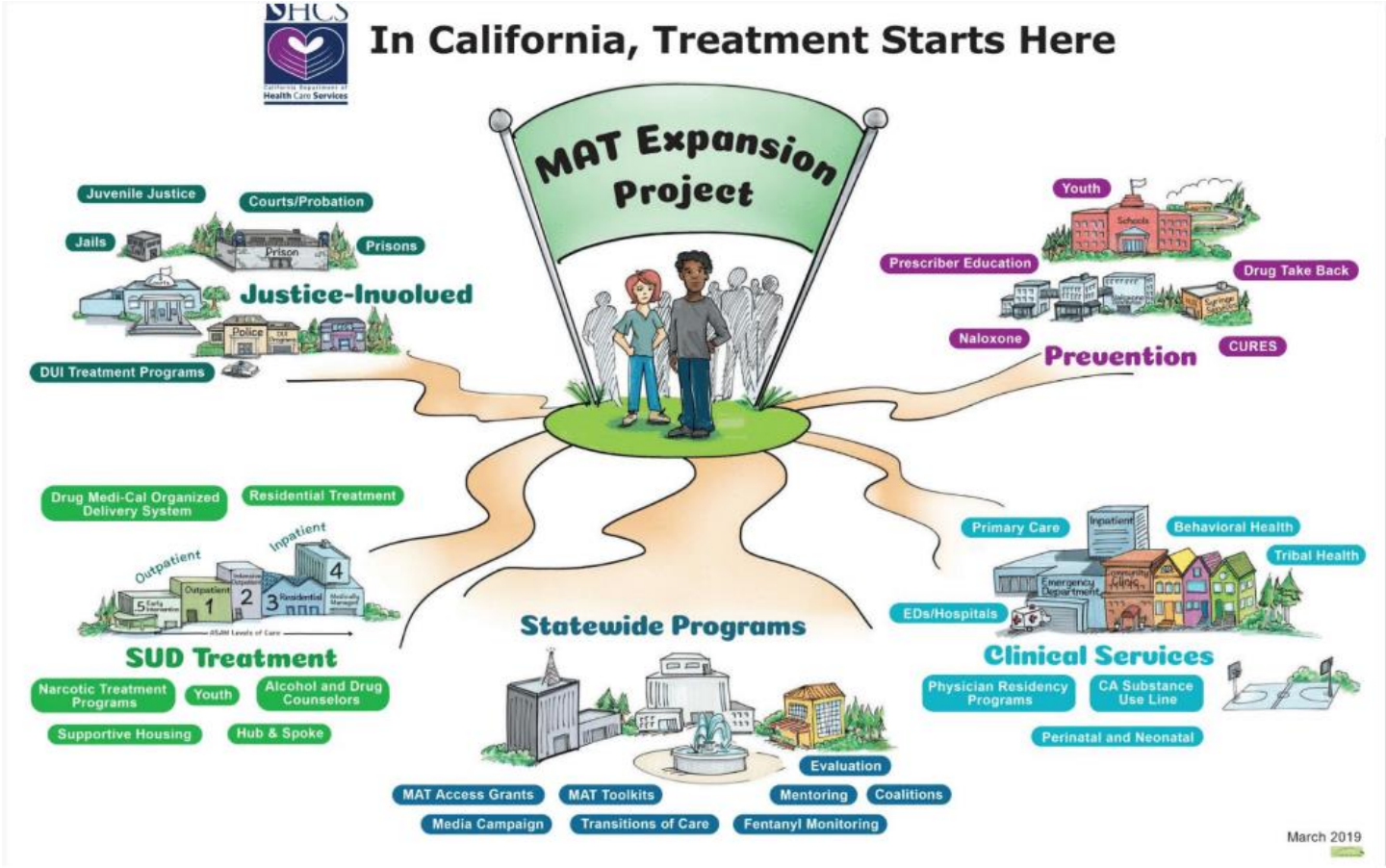
- Prop 56 funding supporting practice change, through managed care plans
- Start early 2020, end in 2022
- Payments based on operational milestones, reporting on health outcomes

Examples:

- Basic Behavioral Health Integration
- Maternal Mental Health and Substance Use
- Medication Management for Beneficiaries with Co-occurring Chronic Medical and Behavioral Diagnoses
- Diabetes Screening and Treatment for People with Serious Mental Illness
- Improving Follow-Up after Hospitalization for Mental Illness
- Improving Follow-Up after Emergency Department Visit

MAT Expansion Project

- >$200M in federal funding
- Supporting “no wrong door” MAT access:
  - Primary care
  - Mental health
  - EDs and hospitals
  - Jails and prisons, collaborative courts, DUI programs
  - Hubs and spokes (narcotic treatment programs)
  - Tribal health system


In California, Treatment Starts Here
MAT Expansion Project
Juvenile Justice
Courts/Probation
Jails
Prisons
Prison
Police
Justice-Involved
DUI Treatment Programs
Youth
Schools
Prescriber Education
Drug Take Back
Naloxone
CURES
Prevention
Drug Medi-Cal Organized Delivery System
Residential Treatment
Outpatient
Inpatient
SUD Treatment
Narcotic Treatment Programs
Youth
Alcohol and Drug Counselors
Supportive Housing
Hub & Spoke
Statewide Programs
Primary Care
Behavioral Health
Tribal Health
Inpatient
Emergency Department
EDs/Hospitals
Clinical Services
Physician Residency Programs
CA Substance Use Line
Perinatal and Neonatal
Evaluation
MAT Access Grants
MAT Toolkits
Mentoring
Coalitions
Media Campaign
Transitions of Care
Fentanyl Monitoring
March 2019

Discussion

Kelly.Pfeifer@dhcs.ca.gov

JOHN CONNOLLY

CHHS Deputy Secretary for
Behavioral Health

- California Health and Human Services Agency Behavioral Health Initiatives
- Opportunities for Alignment

Together We Can Build a Healthy California for All

California Health and Human Services Agency

Person Centered. Data Driven.

Who We Serve

12.9 million
Californians receive benefits from the Medi-Cal Program

13,000
Californians receive services through the Department of State Hospitals

1 million
Californians receive benefits from the Temporary Assistance for Needy Families Program (CalWORKs)

556,000
Californians receive services from the In-Home Supportive Services Program

314,000
Californians receive services from the Developmental Services System

4 million
Californians receive benefits from the Supplemental Nutrition Assistance Program (CalFresh)

63,000
Californians receive services from the Child Welfare System

1.3 million
Californians receive benefits from the Women, Infant, and Children Program

Our Strategic Priorites

Person Centered. Data Driven.

Build a Healthy California for All

Improve the Lives of California's Most Vulnerable

Integrate Health and Human Services

Build a Healthy California for All

1. Create a system in which every Californian has access to high-quality, affordable, health coverage
2. Whole-person orientation to care: Human-centered, culturally and linguistically specific
3. Increase affordability by reducing the rate of growth in health care costs in California

Integrate Health and Human Services

1. Advancing behavioral health care with an emphasis on community-based systems of care
2. Integrate clinical, financial, and structural elements of service delivery systems to facilitate seamless care delivery
3. Focus on social determinants and population health

Improve the Lives of California's Most Vulnerable

1. Reduce homelessness
2. Expand diversion and reentry
3. Improve outcomes for children living in poverty and foster care
4. Address the needs of persons with disabilities and our growing aging population

Covered California

Model Contract Refresh

- Focus on measurable outcomes
- Assuring quality Care
- Effective care delivery

Increased focus on improving quality provided by Covered California plans

SARA GAVIN

Chief Behavioral Health Officer, CommuniCare

Behavioral Health Access, Treatment, Monitoring Outcomes and Integration with Primary Care from a Provider's Perspective

Successes and Challenges of Mental Health and Substance Use Integration at a Federally Qualified Health Center

Sara Gavin, LMFT, LPCC

Chief Behavioral Health Officer: CommuniCare Health Centers

Federally Qualified Health Centers

- Integrated Care, Non-Profit
- 1,330 Health Centers in California
- 6.9 Million People Served
- 1 in 6 Californians

CommuniCare Health Centers: FQHC

SUBSTANCE USE AND PRIMARY CARE SERVICES SINCE 1972

1 OUT OF 9 YOLO COUNTY RESIDENTS

27,038 UNIQUE INDIVIDUALS

134,326 VISITS

32 % BH/SUD

SPECIALTY MENTAL HEALTH, MEDICATION ASSISTED TREATMENT AND DRUG MEDI-CAL PROVIDER

CommuniCare Health Centers Primary:

- Outpatient Drug Medi-Cal Treatment
- Juvenile Justice Youth in Yolo
- CalWORKs families in Yolo
- Access/triage for County
- Medication Assisted Treatment
- Schools
- Prop 47

FQHC Services

PRIMARY CARE	DENTAL CARE	BEHAVIORAL HEALTH	MAT	SPECIALTY MH	(DRUG MEDI-CAL)
100%	96%	90%	58%	15%	17%

What's Working?

Behavioral Health is Health Care

FQHC Model:

- Services under one roof
- Integrated, whole person care
- Mental Health/Substance Use screening in Primary Care
- Navigation- Warm Hand-offs
- Expansion of Medication Assisted Treatment
- Familiar, de-stigmatized setting

One House

Specialty MH	Substance Use	Criminal Justice	Integrated Primary Care
Kids/Adults	Walk-in Screening	Prop 47	Mild-Moderate MH
Navigation Center	Outpatient	JDF/Jail	Psychiatry
	Medication Assisted Treatment		

Warm Hand-offs Integrated Care

WHO Training Video- 5 Minutes

https://youtu.be/Z5fwZMH6kAk

Screening Tools

- PHQ-9
- Trauma (ACEs, UCLA PTSD Screening, CATS: Child/Ad Trauma Screen)
- ASAM/ Brief SUD Screening tool
- CANS (Child Adolescent Needs Assessment)
- PRAPARE: The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences
- GAD 7 (Anxiety)

Outcomes/Quality

- Access
- Pre/post screening tools
- Recidivism (criminal justice)
- Engagement/ retention
- Language/place of service
- Symptom reduction/quality of life
- Employment/school/criminal justice involvement/housing

What's not Working?

ACCESS

- Documentation standards
- Workforce
- Trifurcated System – Complicated!
- Transitions of Care

Hopes for the Future

- Change complicated system into one source of payment for all acuity levels/diagnosis.
- Move toward innovative payment methodologies- expand billable providers.
- Reduce documentation requirements.
- Establish objective, Statewide criteria to assess acuity level and process

Questions?

Sara Gavin LMFT, LPCC

Chief Behavioral Health Officer

CommuniCare Health Centers

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MICHAEL BRODSKY

Medical Director, LA Care

- LA Care's Experience with Behavioral Health Integration and Use of PHQ-9
  - Initiatives, Results and Lessons Learned
  - Discussion

Behavioral Health Integration and Use of the PHQ-9

Attachment 7 Refresh Workgroup
Covered California
November 6, 2019

Michael Brodsky, MD
L.A. Care Health Plan
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L.A. Care HEALTH PLAN
For All of L.A.

ELEVATING HEALTHCARE IN LOS ANGELES COUNTY SINCE 1997

Agenda

- Background
  - Transformation Support

    1) Los Angeles Practice Transformation Network (LAPTN) & Transforming Clinical Practice Initiative (TCPI)
       - Clinical Quality Measures (CQMs)
       - Exemplary Practice Stories

    2) eManagement
  - Discussion

Why invest in Transformation Support around Behavioral Health Integration?

- Members want:
  - Access
  - Affordability/Value
  - Quality
- Right care, right time
  - Many barriers around timely behavioral health access; need to support a whole-person system of care
- Practice-level support to transform and advance care delivery improves quality and member experience

TCPI/LAPTN – Transformation Support Program

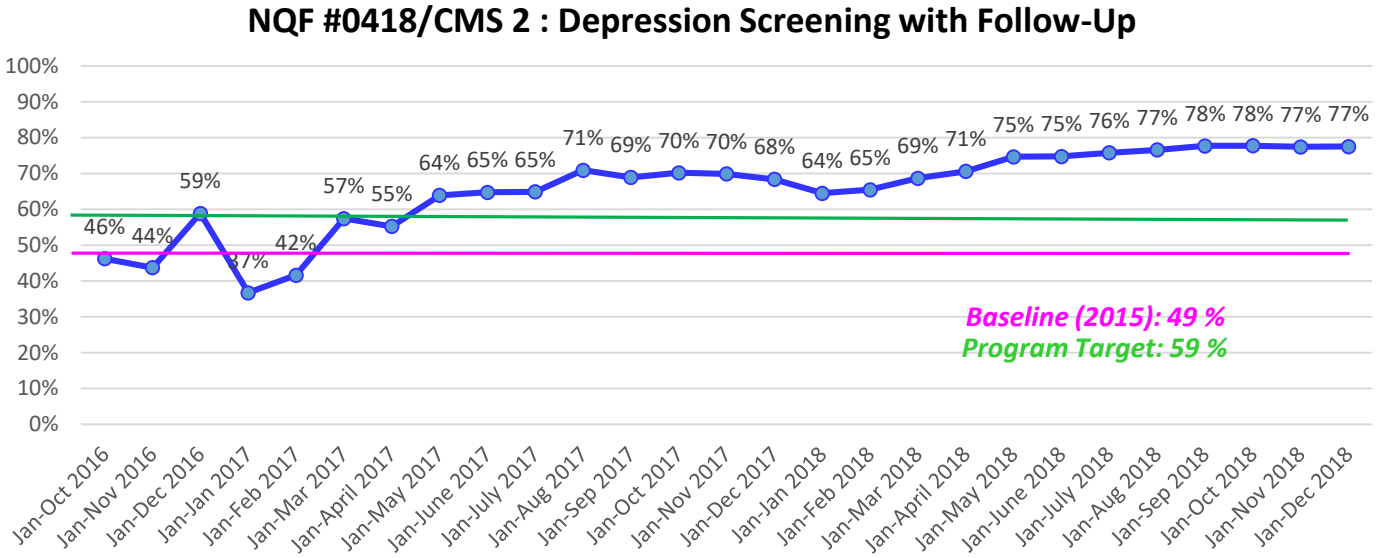
- L.A. Care is a Practice Transformation Network (LAPTN) funded through the CMS Transforming Clinical Practice Initiative (TCPI)
  - 37 Practice Facilitators (“coaches”) in the field working directly with 64 practices, 3200 clinicians
  - Improved capacity to manage population health at the practice level
  - Clinical quality measure (CQM) improvement, initially focused on diabetes and depression
  - Achieved reductions of in ER and Hospital admissions resulting in **$136.7 million** in cost avoidance

LAPTN Utilization & Cost Savings*

		Utilization Reduction			Cost Savings			
Category	Total Utilization Reduction	Y1 (2015-2016)	Y2 (2016-2017)	Y3 (2017-2018)	Y1 (2015-2016	Y2 (2016-2017)	Y3 (2017-2018)	Total Cost Savings Achieved
Total no. of All Cause Admissions with Diabetes and/or Depression reduced from Baseline	13,381	3,919	5,937	3,525	$21,517,002	$31,711,257	$18,827,023	$72,055,283
Total no. of All Cause ER Visits with Diabetes and/or Depression reduced from Baseline	44,724	8,556	16,574	19,594	$5,273,574	$9,395,862	$10,972,472	$25,641,908
Total no. of All Cause Readmissions with Diabetes and/or Depression reduced from Baseline	6,047	1,620	3,095	1,332	$10,609,869	$19,978,838	$8,446,842	$39,035,549
Total	64,152	14,095	25,606	24,451	$37,400,445	$61,085,957	$38,246,337	**$136,732,740**

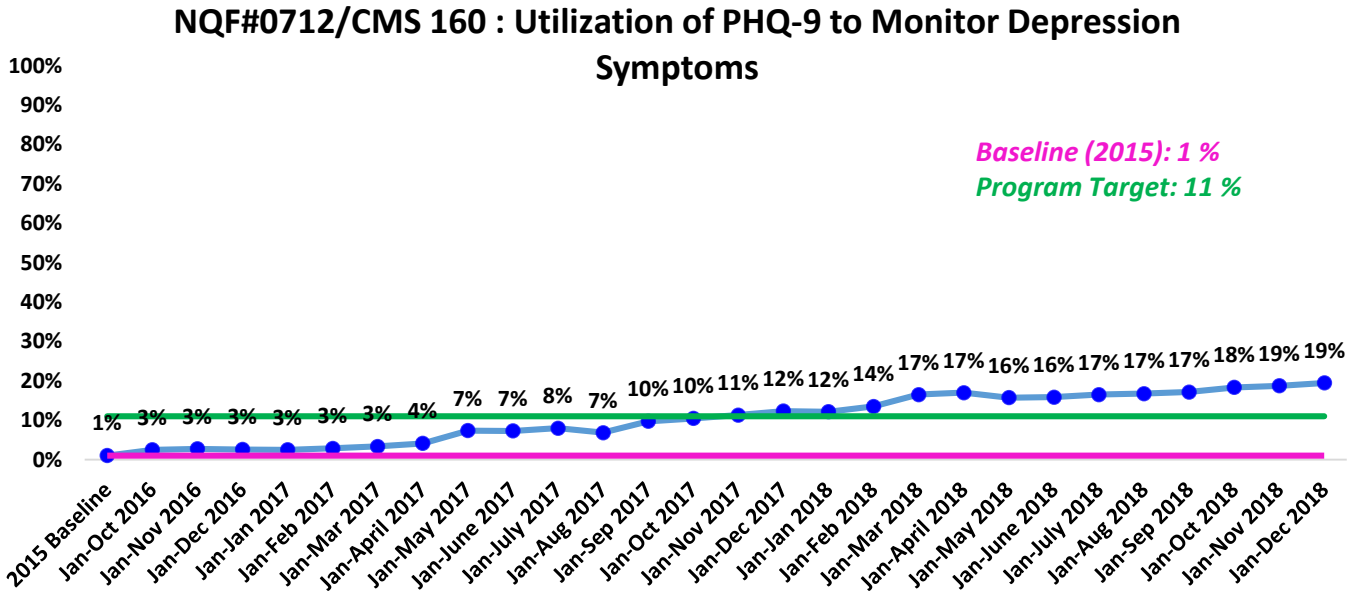
* Utilization data source: L.A Care claims data 2014/15 - 2018, extrapolated for LAPTN patients. Savings calculated based upon Medi-Cal rates.

LAPTN Metric Performance, Depression Screening & F/U



NQF #0418/CMS *2 : Depression Screening with Follow-Up*						
Year	**Num**	**Den**	**Rate**	**Improvement**	**No. of Clinicians**	**No. of Practices**
2015 Baseline	175799	359559	49%		1096	37
Jan-Dec 2016	233032	395943	59%	10%	1200	42
Jan-Dec 2017	375404	549377	68%	19%	1055	49
Jan-Dec 2018	416756	537929	77%	29%	1294	48

LAPTN Metric Performance, Depression Monitoring



NQF#0712/CMS 160 : Utilization of PHQ-9 to Monitor Depression Symptoms						
Year	**Num**	**Den**	**Rate**	**Improvement**	**No. of Clinicians**	**No. of Practices**
2015 Baseline	336	31433	1%		465	12
Jan-Dec 2016	926	35635	3%	2%	525	12
Jan-Dec 2017	4292	34741	12%	11%	622	12
Jan-Dec 2018	6439	33030	19%	18%	583	12

Depression Screening and Monitoring – Lessons Learned from TCPI/LAPTN

- Use of PHQ-2/9 in primary care for screening
  - Success linked to building in tool to EHR and staff intake workflows; seen as just another vital sign
  - Barriers mainly around positive screenings and linking externally to BH resources; limited referral loop closure
- Use of PHQ-9 in behavioral health for monitoring
  - Usefulness linked to ability to trend score over time and determine changes to the patient care plan
  - Barriers around use of quantitative measure in behavioral health (measure specs, attitudes)

Follow-up after Psychiatric Hospitalization - 7/30-days (FUH)

Quality withhold measure for Cal Medi Connect; a quality measure for Covered CA; and a focus for LAC-DMH (Medi-Cal)

- Barriers to coordination for post-hospitalization follow-up visit:
  - Timeliness of psychiatric admission data
  - Apprehension re: sharing data (even when permissible)
  - Matching of current clients to “BH homes” and available slots
  - Reliance on patient’s family to learn about psychiatric admission

- LAPTN successes :
  - Tight communication between BH clinics and local psychiatric hospitals/departments for timely information sharing
  - DMH use of Cognos report within EHR that matches existing clients to their “BH Home”/clinician to get patient in for timely follow-up

- Opportunity for improvement in hospital contracting to require discharge coordination

LAPTN and Behavioral Health Integration

- BH Integration into primary care is well underway for larger practices and community clinics
  - Seen as vital part of managing population health/risk/care for the whole person, especially those with chronic conditions
  - Lays the groundwork for current participation in Medi-Cal Health Homes and future participation in Medi-Cal Enhanced Care Management
- Primary Care integration into BH (aka “Reverse Integration”) is less of a focus on the national stage, but many local collaborations are developing within LAPTN.
  - Harbor Community Clinic (video)
  - Didi Hirsch Mental Health Services: works with several FQHCs to co-manage shared patients; primary care mobile services available onsite.
  - American Indian Counseling Center: robust workflows to improve hospitalization; Gardening for Health research project to understand the correlation between cultural traditions and gardening to improve diabetes and depression.
  - Edelman Mental Health Center: linkage with an FQHC and follow-up of high-risk clients with direct messaging and electronic file sharing.

eManagement – Behavioral Health Screening Incentive Program

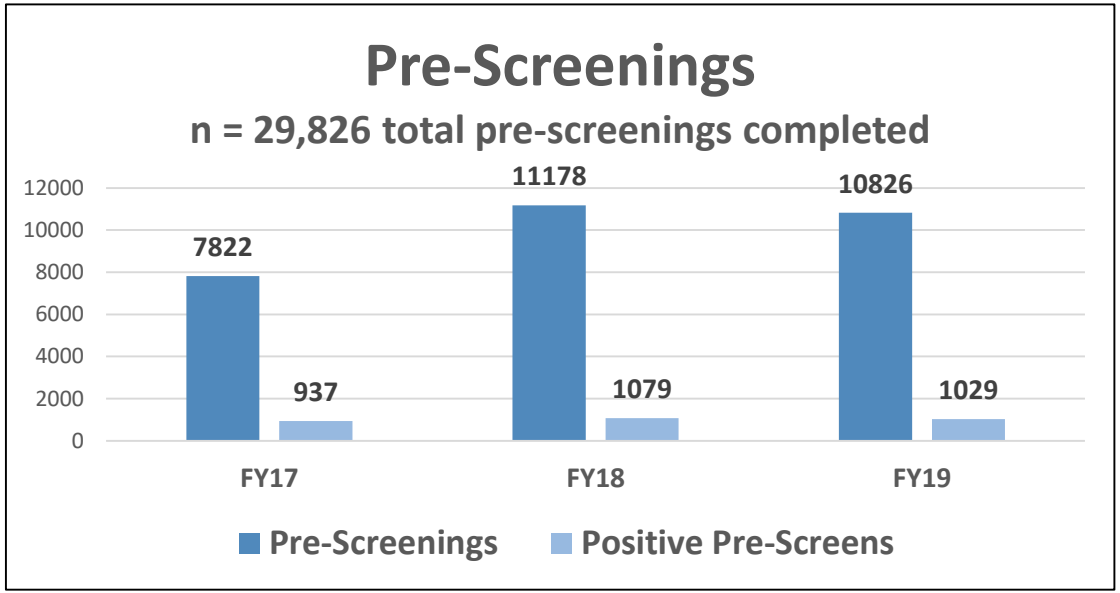
- Program start: October 1, 2016
- Solo and Small Practice Providers enrolled: 228
- Program objectives:
  - Increase screening for Behavioral Health conditions (mild-moderate)
  - Consultation between PCP and BH specialists (asynchronous)
  - Primary care management of BH patients

eManagement – Behavioral Health Screening Incentive Program

How It Works

- Patients are given a 5 question pre-screening at least once per year
  - Staff score the pre-screen for depression, anxiety, SUD
  - Positive pre-screens -> PHQ-9, GAD-7, and/or AUDIT-C formal screenings
  - PCP may use eConsult platform to review cases with a psychiatrist
- PCP incentivized financially for 1) completion of behavioral health screening tools and 2) meaningful engagement with consulting psychiatrist

eManagement



	FY17	FY18	FY19
Pre-Screenings	7822	11178	10826
Positive Pre-Screens	937	1079	1029
% Positive	12%	10%	10%

eManagement: Sample Dialogue

03/20/2017 03:40 PM Sarla Karan To: Dan Kahen
I would recommend SSRI like Zoloft and gradually taper Ativan. Long term use of Benzos. incraeses the risk of dependance and cause depression.

1

03/19/2017 09:19 PM Dan Kahen To: Sarla Karan
She's taking ativan 1mg tid.
Thank you, that was very helpful

03/13/2017 03:45 PM Sarla Karan To: Dan Kahen
How much Ativan is she using?

Brain surgery increases the risk for depression and anxiety.

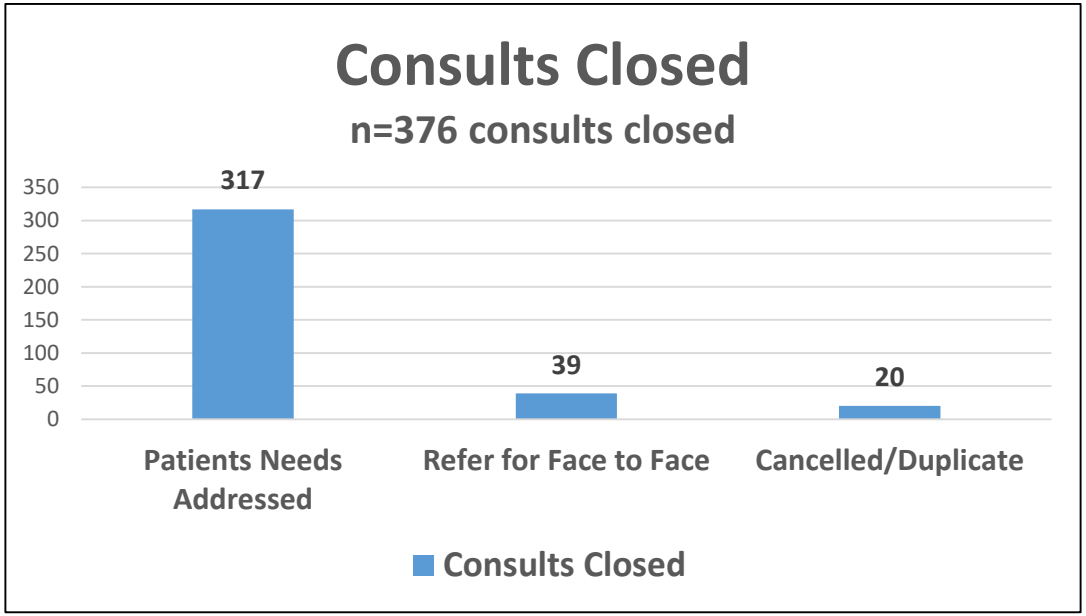
Recommend treating with Zoloft 25 mg for a week and than increase to 50 mg if no side effcets.

If not meds should consider short term individual therapy to help learn about disease and learn coping skills.

Treatment may help improve compliance with appointments.

03/13/2017 03:23 PM Dan Kahen To: Sarla Karan
39 yo F with diagnoses above (except brain tumor was benign s/p resection years ago and dm is type 2 and well-controlled on diet only).
She is taking lasix, keppra, topamax and ativan.
gad7 score was 18 and phq9 score was 17.
she reports minimal effects on daily life from anxiety and mdd. I'm hesitant to put her on an anti-depressant due to possible interactions with her regular meds.
She does not come in for f/u's every 3 months although i'd like her to (and she really needs to).
Please advise on what med to start and how to make sure it doesn't cause problems due to non-compliance issues (at least with appts).

eManagement Consults



Close Codes	Consults Closed	% of Total Closed
Patients Needs Addressed	317	84.31%
Refer for Face to Face	39	10.37%
Cancelled/Duplicate	20	5.32%

eManagement – Lessons Learned

- Outreach:
  - Some providers were motivated to participate in the program for the monetary incentives
  - High-user provider champions saw eManagement as a much needed intervention to improve quality of care and bring additional resources and guidance to their patients
- Utilization
  - Many providers stated that lack of time as the main reason for lower utilization of eConsult option
  - Some providers did not feel comfortable prescribing/managing medications for behavioral health issues and only felt comfortable participating in the screening process
- Concerns
  - Platform does not integrate with EHRs which made associated workflows difficult to implement consistently
  - **Limited access to mental health providers continues to be problematic when referring out for BH services**
- Opportunities
  - Allow the option for an eConsult not only at the mild to moderate level but also for severe cases in the event a referred patient is unable or refuses to be referred out
  - Enable the platform to integrate with EHRs; ideally having notifications when/if a screening has already been done for the patient

Conclusions

- Both primary care and behavioral health entities can be successful in integrating use of PHQ-2/9 into practice
- Smaller practices may need more incentives, hand-holding, and referral support. Larger practices may incorporate BH screening into more holistic Practice Transformation/QI initiatives.
- Opportunities for improvement:
  - Increase alignment across coverage systems (Medi-Cal, Covered California) to promote BH integration and decrease practice/provider “abrasion” and frustration
  - Reduce system fragmentation to enhanced patient access to coordinated BH care (see CalAIM proposal)
  - Increase familiarity with care coordination workflows and privacy protections among all provider types
  - Enhance interoperability of medical record systems
  - Clarify expectations for screening, intervention and follow-up for clinical quality measures

Questions & Discussion

Supplementary Slides

Appendix: Measure Specifications
Screening for Clinical Depression and Follow-Up Plan

NQF #0418/CMS 2

Patients whose most recent depression screening (negative) + (positive & F/U)

Patients 12 years of age and older

Examples of depression screening tools:

- ❖ Adolescent Screening Tools (12-17 years)
  - Patient Health Questionnaire for Adolescents (PHQ-A)
  - Beck Depression Inventory-Primary Care Version (BDI-PC)
  - Mood Feeling Questionnaire(MFQ)
  - Center for Epidemiologic Studies Depression Scale (CES-D)
  - **PRIME MD-PHQ2**
- ❖ Adult Screening Tools (18 years and older)
  - Patient Health Questionnaire (PHQ9)
  - Beck Depression Inventory (BDI or BDI-II)
  - Center for Epidemiologic Studies Depression Scale (CES-D)
  - Depression Scale (DEPS)
  - Duke Anxiety-Depression Scale (DADS)
  - Geriatric Depression Scale (SDS)
  - Cornell Scale Screening
  - **PRIME MD-PHQ2**

Follow-up plan – for a positive depression screening, f/u must include one or more of the following:

- Additional evaluation for depression
- Suicide Risk Assessment
- Referral to a practitioner who is qualified to diagnose and treat depression
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression

Appendix: Measure Specifications
Depression Utilization of the PHQ-9 Tool

NQF #0712/CMS 160

Patients with PHQ-9 tool administered

Patients 18 years of age and older with a dx of MDD who had a visit during a 4-month period

(January-April) (May-August) (September-December)

Note:

- This process measure for using the PHQ-9 tool is directly related to the desired outcomes of demonstrating improvement in symptoms of depression (remission, score <5).
- It excludes patients with diagnoses of bipolar disorder or personality disorders at any time during the whole-year measurement period

Calculation details:

- If a patient sees an EP for a visit and has a current diagnosis of MDD in 1-3 of the four-month periods, they will be added to the denominator.
- The patient will only be counted in the numerator if they have a PHQ-9 for **EACH** four-month period in which they have the visit/diagnosis.

OPEN DISCUSSION

DISCUSSION QUESTIONS

- After hearing from our presenters today, what are the opportunities you see for alignment?
- How does your organization integrate behavioral health with primary care?
- How does your organization address patient access to behavioral health services?
- What screening or diagnostic tools do your providers use for mental health disorders?
- Do your primary care providers feel comfortable managing patients with mental health disorders?
  - What type of trainings or support do you offer your primary care providers?
- Do your primary care providers feel comfortable managing patients with substance use disorders?
  - What type of trainings or support do you offer your primary care providers?
- As a consumer/patient, what kind of behavioral health support would you like to see from your primary care provider? From your health plan?

THANK YOU