Wait, We've Gotta Ask That Too? - Navigating Preventive Screening in Integrated Care

PRIMARY CARE DEVELOPMENT CORPORATION

CoE Center of Excellence for Integrated Health Solutions

Funded by Substance Abuse and Mental Health Services Administration
Operated by the National Council for Behavioral Health

Today's Moderator

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About PCDC

Primary Care Development Corporation (PCDC) is a national nonprofit organization and a community development financial institution catalyzing excellence in primary care through strategic community investment, capacity building, and policy initiatives to achieve health equity.

Disclaimer

The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), or the U.S. Department of Health and Human Services (HHS).

SAMHSA
Substance Abuse and Mental Health Services Administration

www.samhsa.gov

Integration at Work

This year we will be covering critical concepts to support your practice of integrated care such as:

- Integration models
- Quality improvement
- Funding and relationship development
- Behavioral health screenings for primary care
- Primary care considerations for behavioral health

Audience Demographics Poll

Do you work in a:

- Primary care setting
- Behavioral health setting
- Integrated care setting

Are you working primarily as a:

- MD/DO
- Nurse Practitioner/Registered Nurse
- Physician Assistant
- Medical Assistant
- Therapist
- Social Worker
- Care Manager
- QI Manager
- Informatics
- Other

Please rate your current skills and comfort with selecting and utilizing screening tools and approaches to adopting screening protocols.

1. Very Low
2. Low
3. Moderate
4. High
5. Very High

Tip Sheet

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Quality Improvement Tips for Integrated Care Settings

Types of Integration

Coordinated Care (off-site)

Level 1: Minimal Collaboration

Patients are referred to a provider at another practice site, and providers have minimal communication

Level 2: Basic Collaboration

Providers at separate sites periodically communicate about shared patients

Co-located Care (on-site)

Level 3: Basic Collaboration

Providers share the same facility, but maintain separate cultures and develop separate treatment plans for patients

Level 4: Close Collaboration

Providers share records and some system integration

Highly Integrated Care

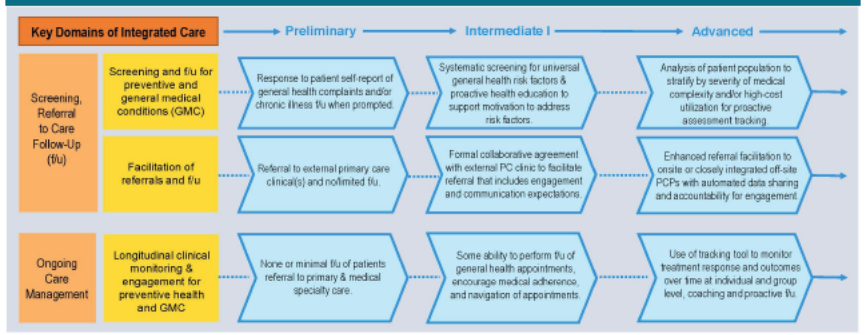
Level 5: Close Collaboration

Providers develop and implement collaborative treatment planning for shared patients but not for other patients

Level 6: Full Collaboration

Providers develop and implement collaborative treatment planning for all patients

Integration Continuum



QI Considerations for Integrated Settings Checklist

- Physical and behavioral health staff collaborate on chronic disease management AND common conditions.
- Physical and behavioral health staff all contribute to shared outcomes and measures.
- Clinicians are familiar with effective, brief interventions and screenings.
- Population health data is reviewed regularly to determine what services are necessary.
- Key staff are prepared to successfully support integrated care.
- Warm and efficient patient hand-offs are provided between service lines. (both virtual and in-person)
- Barriers for patients to see an initial provider are minimized. (i.e. same day appointment availability)
- Physical space designed in a way that facilitates integration.

Bringing It All Together

Look for Opportunities for Improvement:

- Do patients understand the restrictions and protections regarding sharing of their patient health information (PHI)?
- Are all levels of staff provided with upskilling on motivational interviewing techniques?
- What tools, trainings or scripts are available to aid with difficult conversations?
- How regularly are consent rates monitored and data shared broadly with all involved staff members?

Support Best Practices:

- Earn buy in from all staff on the value of patient consents and collecting PHI
- Build trust with patients by clearly communicating what consents for PHI are and how PHI is used

Stability and success for your integrated care setting!

- Stronger data and tracking give the ability to celebrate organizational and staff "wins"
- More informed retention and recruitment efforts
- Positioned for funding opportunities
- Building trust

Presenters

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Senior Director

Maia Bhirud Morse, MPH, CPC
Senior Program Manager

Today's Key Objectives

Screenings, screenings, and more screenings

- Selecting Tools for Preventive Care
- Identifying and Operationalizing Sustainable Processes
- Staff Training and Documentation
- Case Studies

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Recommended Screenings for Adults

Adult Preventive Health Care Schedule: Recommendations from the USPSTF (as of August 16, 2019)

To be used in conjunction with USPSTF recommendation statements for additional details (see tables and references at https://www.aafp.org/afp/PHCS)

Only grade A/B recommendations are shown

Age	*18*	*21*	*24*	*25*	*35*	*40*	*45*	*50*	*55*	*59*	*65*	*70*	*74*	*75*	*80*
USPSTF screening recommendations															
Alcohol misuse[1]	(B)														
Depression[2]	(B)														
Hypertension[3]	(A)														
Obesity/weight loss[4]	(B) if BMI 30 kg per m² or greater														
Tobacco use and cessation[5]	(A)														
HIV infection[6]	(A)											(A) if at increased risk			
Hepatitis B virus infection[7]	(B) if at increased risk														
Syphilis[8]	(A) if at increased risk														
Tuberculosis[9]	(B) if at increased risk														
BRCA gene risk assessment[10]	(B) if appropriate personal or family history of *BRCA*-related cancer or ar														
Chlamydia and gonorrhea[11]	(B) if sexually active			(B) if at increased risk											
Intimate partner violence[12]	(B) women of childbearing age														
Cervical cancer[13]		(A) See p. 3 for test options and screening intervals													
Abnormal glucose/type 2 diabetes mellitus[14]						(B) if overweight or obese									
Hepatitis C virus infection[15]	(B) if at high risk							(B) birth years 1945-1965							
Colorectal cancer[16]								(A)							
Breast cancer[17]								(B) biennial screening							
Lung cancer[18]									(B) if 30-pack-year histo former smoker (quit i						
Osteoporosis[19]							(B) if postmenopausal and elevated risk				(B)				
Abdominal aortic aneurysm[20]											(B) if an "				
USPSTF preventive therapies recommendations															
HIV preexposure prophylaxis[21]	(A) if at high risk of HIV infection														
Primary prevention of breast cancer[22]	(B) if at increased risk and only after shared decision making														
Folic acid supplementation[23]	(A) if capable of conceiving														
Statins for primary prevention of CVD[24]						(B) see criteria on p. 4									
Aspirin for primary prevention of CVD and colorectal cancer[25]								(B) if ≥ 10% 10-year CVD risk							
Fall prevention in community-dwelling older adults[26]											(B) exercis increased				

USPSTF preventive therapies recommendations	
HIV preexposure prophylaxis[21]	(A) if at high risk of HIV infection
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Folic acid supplementation[23]	(A) if capable of conceiving
Statins for primary prevention of CVD[24]	(B) see criteri
Aspirin for primary prevention of CVD and colorectal cancer[25]	
Fall prevention in community-dwelling older adults[26]	
USPSTF counseling recommendations	
Sexually transmitted infection prevention[27]	(B) if at increased risk
Diet/activity for CVD prevention[28]	(B) if overweight or obese and with additional
Skin cancer prevention[29]	(B) if fair skinned

Legend	*Normal risk*	*With specific risk factor*	*Rec*
Recommendation for men and women			A
Recommendation for men only			B
Recommendation for women only			C
			D
			I

BMI = body mass index; CVD = cardiovascular disease; USPSTF = U.S. Preventive Services Task Force.

Visual adaptation from recommendation statements by Swenson PF, Lindberg C, Carrillo C, and Clutter J.

PRAPARE

Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

PRAPARE®: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences

Paper Version of PRAPARE® for Implementation as of September 2, 2016

Personal Characteristics

1. Are you Hispanic or Latino?

	Yes		No		I choose not to answer this question

2. Which race(s) are you? Check all that apply

	Asian		Native Hawaiian
	Pacific Islander		Black/African American
	White		American Indian/Alaskan Native
	Other (please write):		
	I choose not to answer this question		

3. At any point in the past 2 years, has season or migrant farm work been your or your family's main source of income?

	Yes		No		I choose not to answer this question

4. Have you been discharged from the armed forces of the United States?

	Yes		No		I choose not to answer this question

5. What language are you most comfortable speaking?

Family & Home

6. How many family members, including yourself, do you currently live with? _____

	I choose not to answer this question

8. Are you worried about losing your housing?

	Yes		No		I choose not to answer this question

9. What address do you live at?
Street:_____
City, State, Zip code: _____

Money & Resources

10. What is the highest level of school that you have finished?

	Less than high school degree		High school diploma or GED
	More than high school		I choose not to answer this question

11. What is your current work situation?

	Unemployed		Part-time or temporary work		Full-time work
	Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver) Please write:				
	I choose not to answer this question				

12. What is your main insurance?

	None/uninsured		Medicaid
	CHIP Medicaid		Medicare
	Other public insurance (not CHIP)		Other Public Insurance (CHIP)
	Private Insurance		

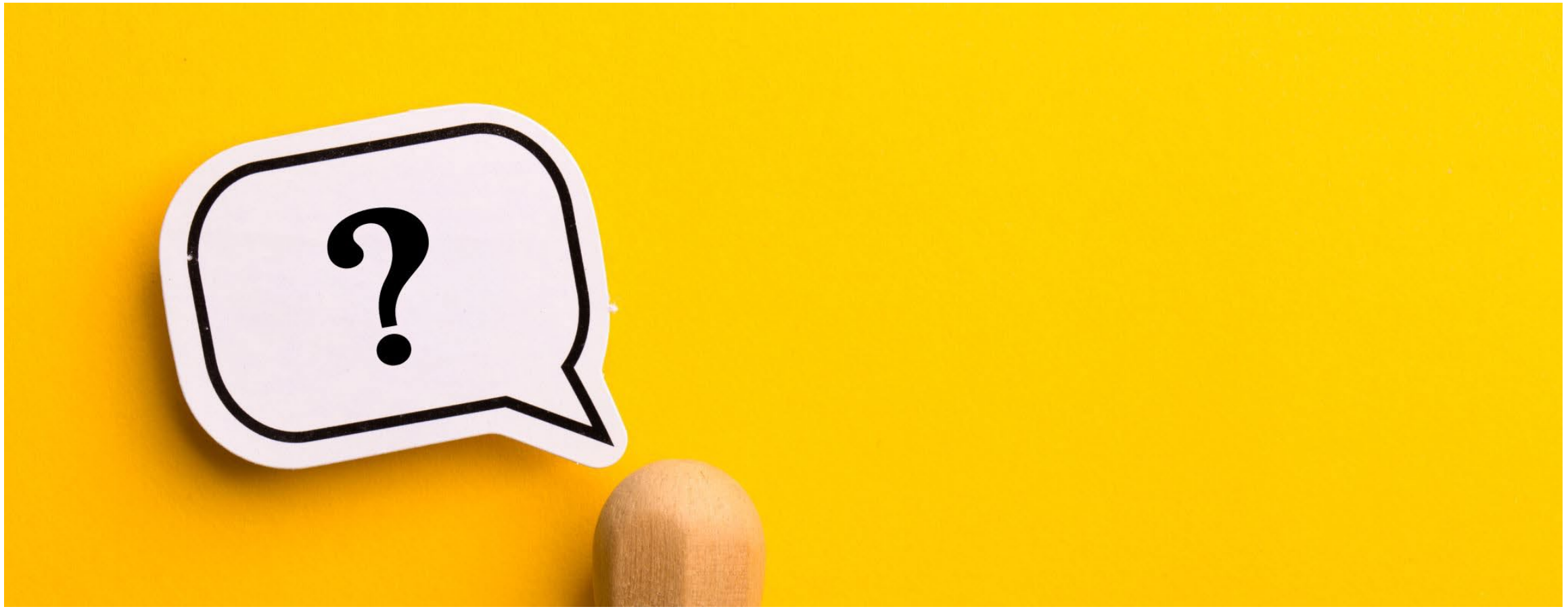
https://www.aafp.org/dam/AAFP/documents/journals/afp/USPSTFHealthCareSchedule2019.pdf

Case Study

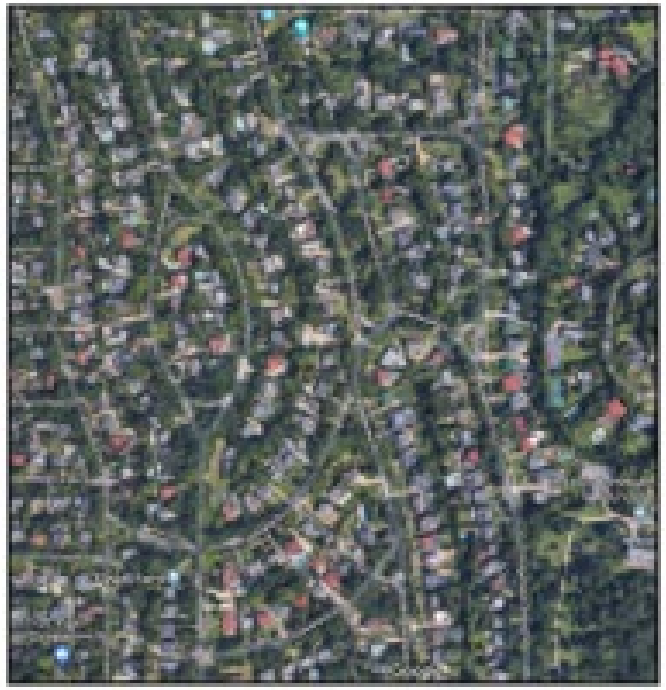
- The U.S. Preventive Services Task Force (USPSTF) is an independent voluntary panel of experts in primary care, prevention, and evidence-based practice. As of April 2016, the USPSTF has recommendation statements for more than 80 active topics, most of which are endorsed by the American Academy of Family Physicians.[1] Its process has been recognized by the Institute of Medicine as a model for development of evidence-based practice guidelines.[2]
- However, numerous barriers exist to implementing these guidelines, including knowledge, time, insurance, and social barriers.[3] For example, knowledge of USPSTF colorectal cancer screening components ranged from 22% to 53% in first- through third-year medical residents.[4] One recent survey from the Centers for Disease Control and Prevention (CDC) found significant gaps in physicians' knowledge regarding the value of screening tests for ovarian and colorectal cancer.[5] Another survey found significant levels of nonadherence to USPSTF recommendations, including beginning cervical cancer screening too early, continuing it too long, and performing it annually rather than every three years as recommended.[6]
- In addition, recommendations for behavioral counseling are often not implemented. For example, counseling for tobacco cessation was documented in only 21% of visits in which tobacco use was documented.[7] This gap between guideline recommendations and actual practice has the potential to worsen as recommendations become more complex, vary by age group, and increasingly require risk assessment, as with recommendations for mammography, breast cancer chemoprevention, screening for the *BRCA* gene mutation, and screening for hepatitis B and C virus infections.

https://www.aafp.org/afp/2016/0501/p738.html

What is your criteria to decide what screenings a practice will conduct routinely



Reflection on your Practice's Community Demographic



Urban
Suburban
Rural

Reflection on the Social and Economic Conditions

Condition	Considerations
Age	What is the average age? What does an aging population mean to your practice?
Sex/Sexual Identity	There are more than 2 categories.
Race/Language	Is health equity on your agenda - CLASS awareness? Do your patients trust you/your practice?
Income	Low, Median, High Income
Built Environment	Buildings, parks, transportation, healthy food access, walk-ability, bike-ability

Reflection on your Products & Services

What products and services do we provide at – PCDC Community Health Center Diagnostic and Treatment Center

- Internal Medicine
- Pediatrics
- Prenatal and Postpartum Care
- OB/GYN/ Reproductive Health
- Cardiology
- Family Practice
- Behavioral Health
- Dietitian/Nutritionist
- Dentistry
- Podiatry
- Lab and Radiology
- Education
- Substance Use/Alcohol Use
- Smoking Cessation

Benefits of an Analysis on your Population

HELPS SHAPE YOUR SERVICE LINE

HELPS TO VALIDATE THE INVESTMENT IN STAFF

HELPS TO INFORM YOUR SCREENING TOOLS AND PROTOCOLS

Resources for the data…

- Electronic Health Records (internal)
- Patient intake forms (internal)
- Screening tools SDOH/SOGI (internal)
- Retrospective coding and billing (internal)
- Community needs assessment (external)

https://www.cdc.gov/globalhealth/healthprotection/fetp/training_modules/15/community-needs_pw_final_9252013.pdf

Implement and Roll out Screening Tools

- **Decisions made leveraging information**
  - Evidence based - National Preventive Service Task Force
  - Internal and external data
  - What would serve my population best?
- **Tools selected**
  - PHQ 2, PHQ 9, GAD, AUDIT, etc.
- **Develop a plan, inform all stakeholders**
  - Workflow created – Policy and procedure completed

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Fast forward one year…
Conduct your due diligence work again…

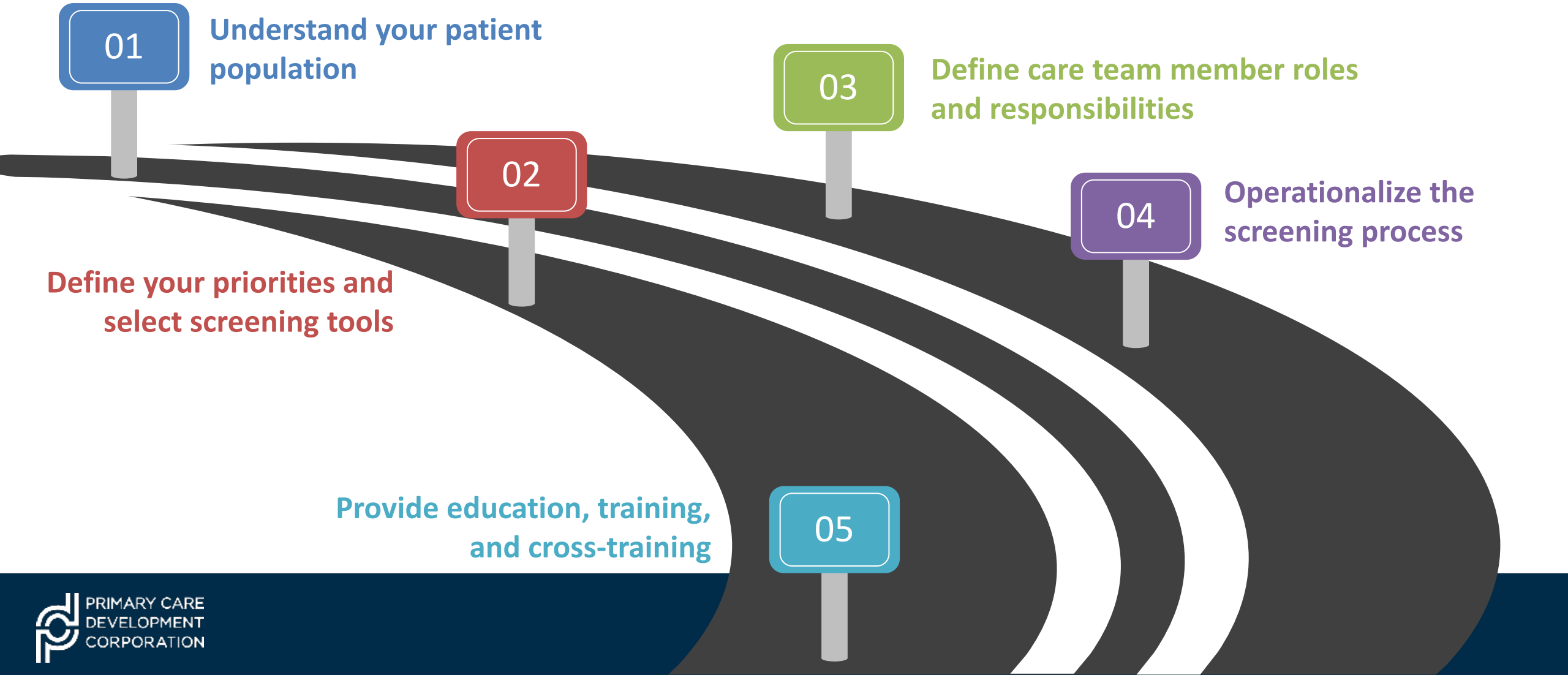
- Electronic Health Records (internal)
- Patient Intake forms (internal)
- Screening tools SDOH/SOGI (internal)
- Retrospective coding and billing (internal)
- Community needs assessment (external)

Screening needs to be linked to support/referrals… reality check list

- Screening for BH conditions behavior doesn’t automatically mean you have access to support/referrals
- Screening doesn’t mean increase billable service
- Screening and patient education doesn’t equal adherence
- Finding referral support may require the PCP network with BH providers/develop referral compacts

Identifying and Operationalizing Sustainable Screening Processes

Preventive Screening Roadmap



Establishing 'Buy In' Among ALL Staff

- Communicate the 'why' before the 'must'
- Include discussion of population specific factors or outcomes
  - E.g., Breast Cancer screening among African American women
- Discuss plans for sharing of data once screenings are initiated

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Defining the Care Team

Primary Care Core Team

- **Doctors, Nurse Practitioners, Physician Assistants, Midwives**
- **Patients/Caregivers**
- **Peer Advocates/Patient Advocates/Patient Navigators**
- **Nurses**
- **Front Desk**
- **Medical Assistant**
- Practice Manager
- Care Managers/ Care Coordinators

Extended Care Team

- Administrative Managers/Directors
- Clinical Specialists
- Addiction Specialists and Counselors, Case Workers
- Phlebotomist
- Pharmacists
- Social workers, Psychiatrists, Psychologists
- Legal Aides
- Community Health Workers
- Housing Navigators & Community Providers
- Health Educators

Real World Example
Diverse Staffing Structure

Delineate Roles and Responsibilities

Patient-Centered Medical Home: Team Roles and Responsibilities - Updated 2015, reflecting the NCQA PCMH 2014 Standards and Guidelines for Practice Transformation									
			PCMH Duties and Responsibilties						
Job Role	*Access*	*PCP Designation*	*Team Huddle*	*Pt Intake including Depression Screening PHQ-2*	*Provide Self-Management Support Tools and Resources to Patients*	*Population Health - Proactively Close Gaps in Care - Preventive and Chronic*	*Population Health- Identify High Risk Patients and Provide Care Management Services*	Referral Coordination	Performance Improvement
Physician	In collaboration with Health Center Manager & Master Scheduler creates a scheduling template that meets organizational standards for patient access and provider productivity, while being flexibile to accommodate provider individual needs.	Reports PCP Errors to Office Assistant for correction	Active Participant. Leads the team huddles or designates another appropriate clinical person to lead the daily huddles.	Reviews results of PHQ-2 Depression Screening. If results are positive, completes PHQ-9 for further assessment. If PHQ-9 Positive, begins treatment, refers for treatment or both.	Attach Patient Education Materials to Patient After Visit Summary (AVS) or My Chart Messages as appropriate for New Dx, Meds or Chronic Conditions	Review and Approve Pended Orders as Appropriate to Pt.	Review identified High Risk Patients with Care Manager. Review and approve Individual Care Plan for Patient as developed by Care Manager. Discuss patient progress and provide clinical advice and direction to Care Manager as needed.	Create New Orders in EMR or Review & Approve pended orders	Active Participant. MD - Medical Director leads Team in review of practice level data on via electronic dashboard or paper reports. Team sets goals, documents action plans to improve clinical outcomes. Monitors results of action taken and modifies

Who Does Screenings and When?

Medical Assistant

Job Role	*Access*	*PCP Designation*	*Team Huddle*	*Pt Intake including Depression Screening PHQ-2*	*Provide Self-Management Support Tools and Resources to Patients*	*Population Health - Proactively Close Gaps in Care - Preventive and Chronic*	*Population Health- Identify High Risk Patients and Provide Care Management Services*	Referral Coordination	Performance Improvement
LPN	Collects clinical information from the patient and relays this to an RN, APC or MD for triage.	Reports PCP Errors to Office Assistant for correction	Active Participant	Completes PHQ-2 Depression Screening on each patient 1x/yr	Discuss and document Wellness Goals with Patient. Provide Patient with Self-Management Tools & Resources. Identify Barriers to Goals. Provide Motivational Coaching.	Pend Orders for Identified Gaps in Care - Tests, Immunizations. Perform any approved Point of Care Tests or Immunizations as ordered by Provider.	Share with PCP patients who may benefit from Care Management Services.	Pend Orders in EMR for Provider's Review and approval	Active Participant in review of practice clinical performance and patient experience data, setting goals, creating action plan and monitoring results.

Technology is your assistant

- Clinical Decision Support Systems (CDSS) alerts remind clinicians that patients are due for screenings
  - Can be adjusted according to a standard or individualized time frame

- Registries
  - Can be run manually to identify patients due for screening followed by outreach to individual patients
  - May also be more sophisticated population management programs integrated into the electronic health record

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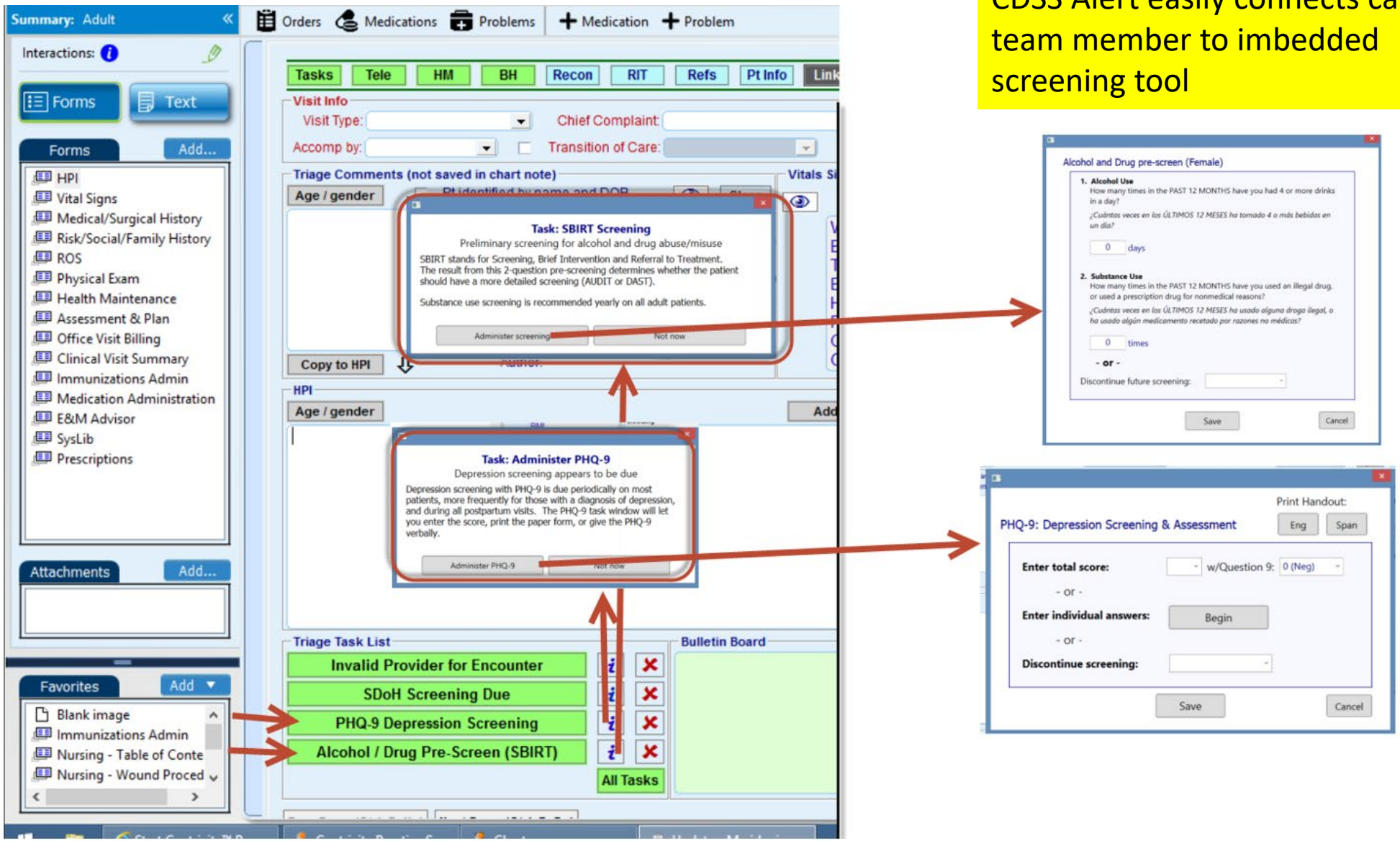
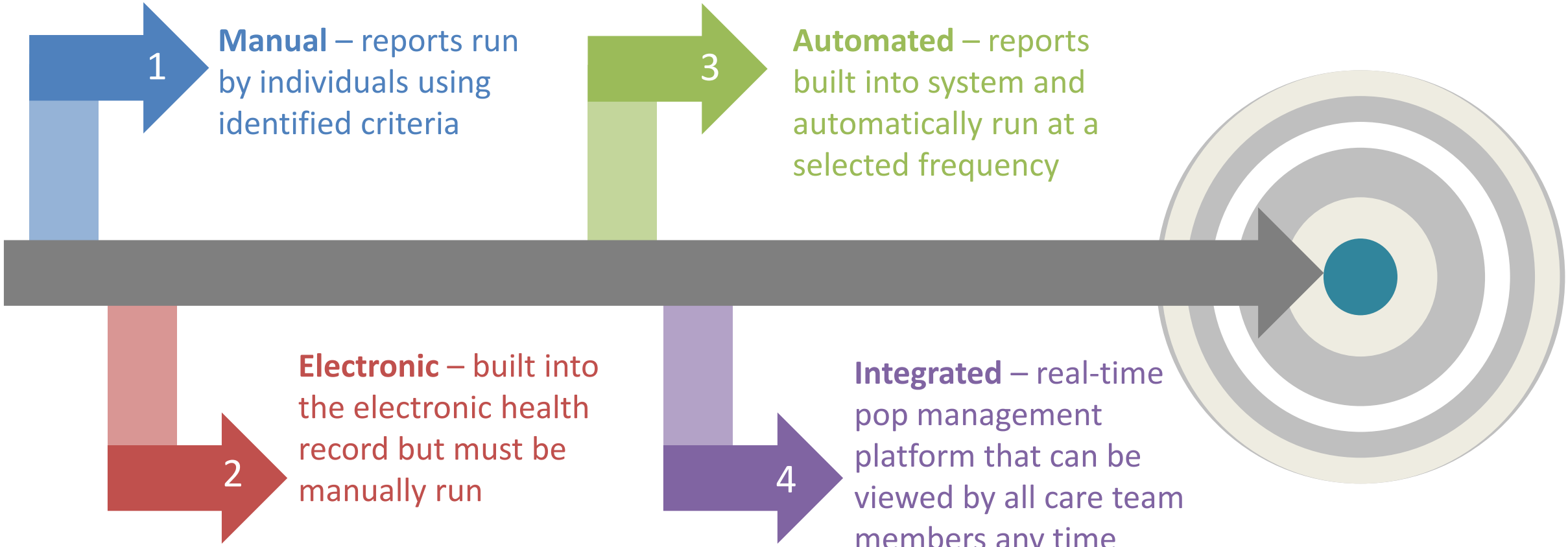
CDSS Alert easily connects care team member to imbedded screening tool



Registries


1
Manual – reports run by individuals using identified criteria
3
Automated – reports built into system and automatically run at a selected frequency
2
Electronic – built into the electronic health record but must be manually run
4
Integrated – real-time pop management platform that can be viewed by all care team members any time

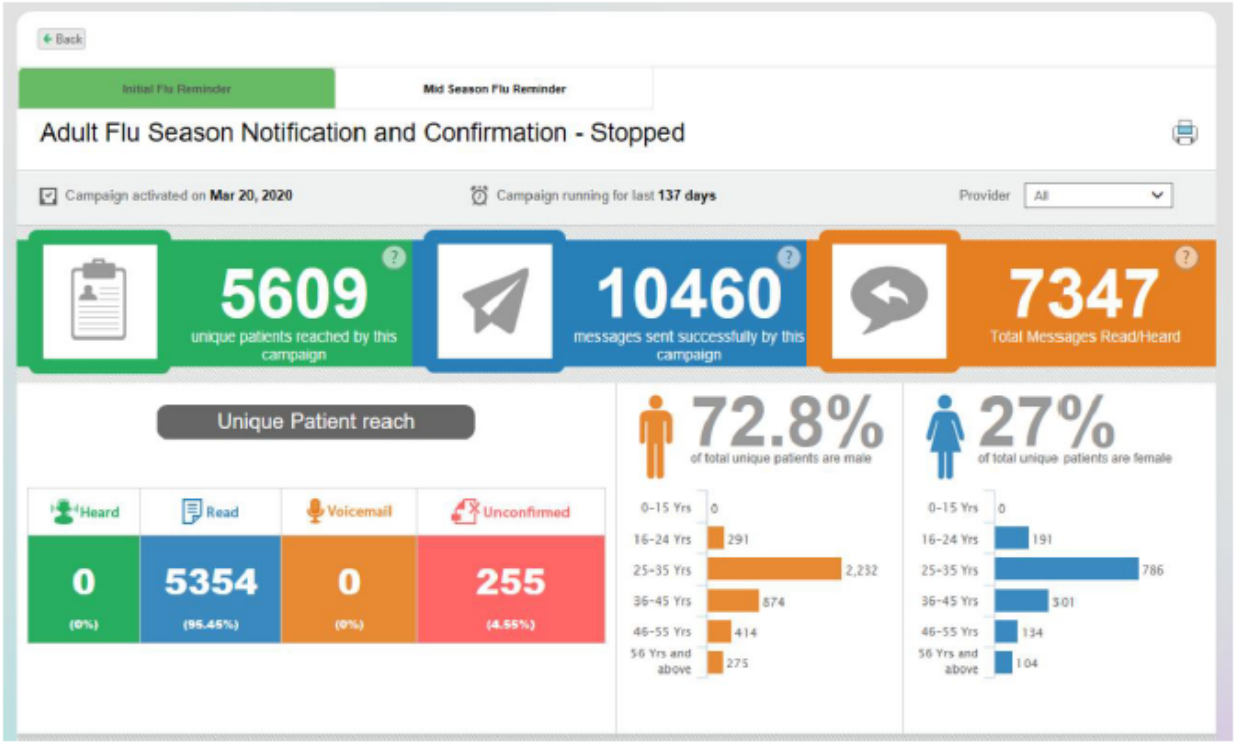
Registries – One Size Does Not Fit All

Used to identify patients due for screenings to allow for proactive outreach from the practice

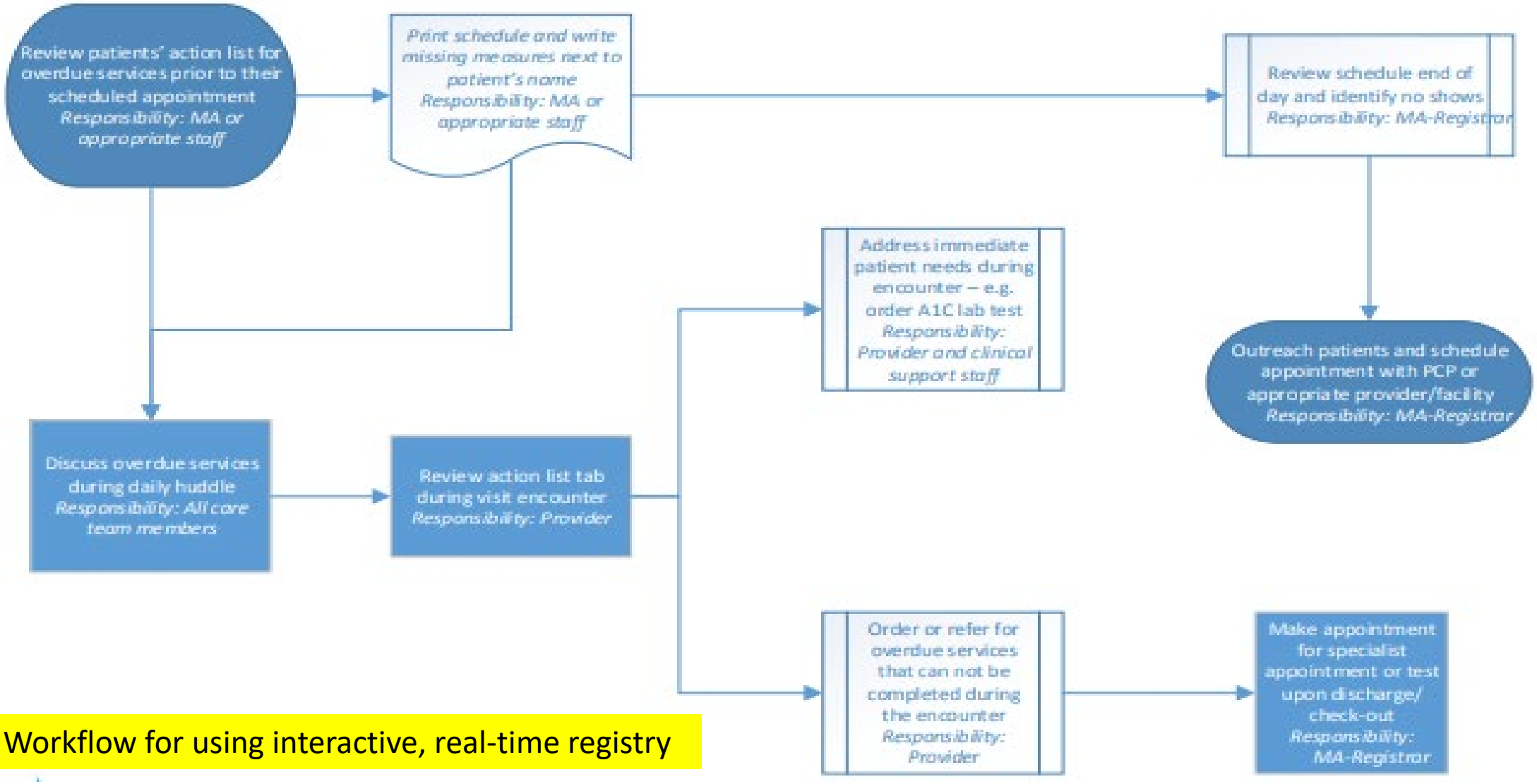
AliasName	MeasureDisplay	DOS	Phone Num	DOB	Sex	Add_1	Add_2	City	State	Zip	Email
Measure: CMS 125v4 (NQF 0031) Breast Cancer Sc	CMS125v4	4/11/2016									
Measure: CMS 125v4 (NQF 0031) Breast Cancer Sc	CMS125v4	3/15/2016									
Measure: CMS 125v4 (NQF 0031) Breast Cancer Sc	CMS125v4	3/18/2016									
Measure: CMS 125v4 (NQF 0031) Breast Cancer Sc	CMS125v4	10/18/2016									
Measure: CMS 125v4 (NQF 0031) Breast Cancer Sc	CMS125v4	9/26/2016									
Measure: CMS 125v4 (NQF 0031) Breast Cancer Sc	CMS125v4	8/22/2016									
Measure: CMS 125v4 (NQF 0031) Breast Cancer Sc	CMS125v4	1/11/2016									
Measure: CMS 125v4 (NQF 0031) Breast Cancer Sc	CMS125v4	5/26/2016									
Measure: CMS 125v4 (NQF 0031) Breast Cancer Sc	CMS125v4	8/22/2016									

Basic List run in the EMR and viewable in Excel

Robust dashboard integrated into the electronic health record to perform advanced population management activities



Patient Id	Facility Name	Age	Sex	Modality of messages	Sent on
[redacted]		31	Male	eMessage	12/14/2019
		30	Male	eMessage	12/13/2019
		33	Male	eMessage	12/13/2019
		30	Female	eMessage	12/13/2019
		45	Male	eMessage	12/13/2019
		27	Male	eMessage	12/13/2019
		30	Male	eMessage	12/12/2019
		21	Male	eMessage	12/12/2019
		21	Male	eMessage	12/11/2019
		44	Female	eMessage	12/11/2019
		26	Male	eMessage	12/10/2019



Workflow for using interactive, real-time registry

Write Policy and Procedures for the People

- Staff training to conduct any activity is typically informed by practice/org. policy
- A policy is written set of guidelines
  - outlines plan for addressing certain issues
  - communicates values, philosophy, and culture

No matter the industry, every organization needs policies and procedures to operate effectively

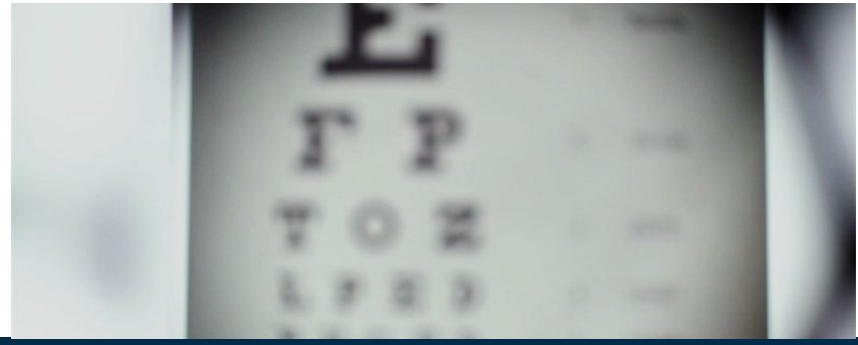
Procedures tell me “How to conduct the policy”

To understand why we need procedures we must look at what needs to be in control

What are areas of variability in your practice?

Examples:

- How staff ‘rooms’ a patient
- How are patients informed about same day appointments or screenings
- How the care team is organized to conduct SBIRT screening



Best Practices

- Clearly identify which standardized tools will be used to complete the screenings
- Ensure the tools are integrated into the electronic health record
- Clarify ‘who’ will conduct the screening and frequency

Evidence-based, standardized tools selected for screening purposes

1. Tobacco Screening
2. Depression – PHQ-2 and PHQ-9 for all patients 18 and older
3. Alcohol and Substance Abuse – SBIRT pre-screen for Adults, CRAFFT for Adolescents
    a. Alcohol – Audit and Audit C for Adults, CRAFFT for Adolescents
    b. Substance Use – DAST-10 for Adults
4. Childhood Developmental Screening
    a. PEDS administered during WCC for ages 0 to 7
    b. PSC administered during WCC for ages 8 to 13
    c. CRAFFT administered during WCC for ages 14 to 17
5. Social Determinants of Health Screening (SDOH) –
    a. PRAPARE tool used for all patients

Sample Documentation – Quiz #1

Depression Screening

i. Depression Screening will be conducted using the PHQ-2 and PHQ-9 screening tools. All patients 18 years of age and older will receive PHQ-2 screening annually. PHQ-9 screenings will be conducted for patients who receive a positive PHQ-2 screening. Staff should complete the PHQ-2 screen when an alert for PHQ-9 is visible in a patient record.

- What is good about this policy documentation?
- What could be improved?

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Sample Documentation – Quiz #2

- Further down in the policy…..

> i. For any positive screen, the clinician will assess patient to determine if diagnostic criteria are met and identify if treatment or referral to treatment is needed.

- How could this action be improved?
- How would it look different in an integrated care environment?

Team Training – Invest In Your Team!

- Commit to culture of continuous learning
- Continually add descriptions to job roles and responsibilities
- Develop structured communication methods
- Provide outside training and cross-training
- Provide ongoing training for all team members in new skills, information, etc.

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Post-webinar Skills and Comfort Poll

After attending this webinar, please rate your skills and comfort with selecting and utilizing screening tools and approaches to adopting screening protocols.

1. Very Low
2. Low
3. Moderate
4. High
5. Very High

Office Hour

Contact Us

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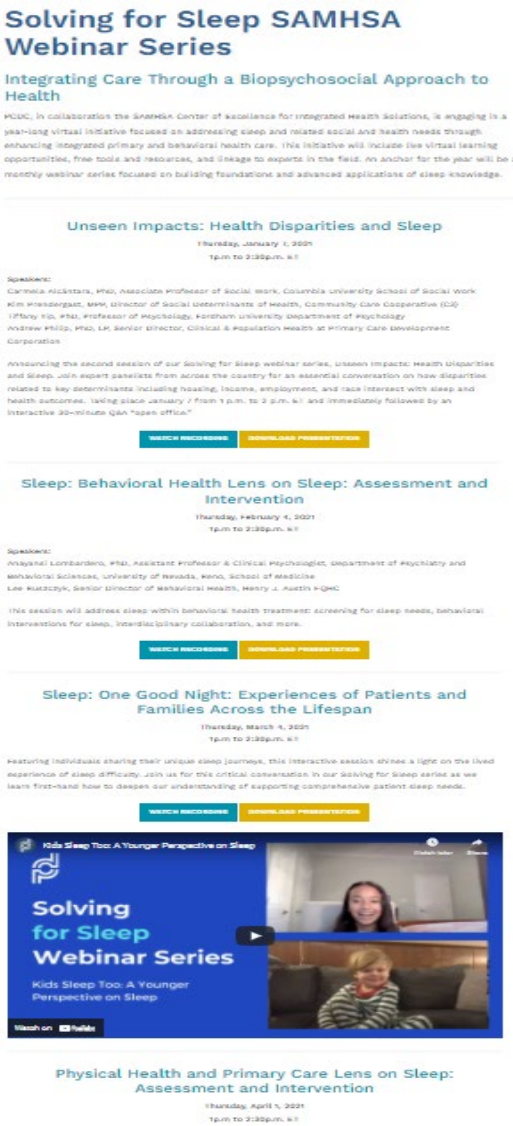
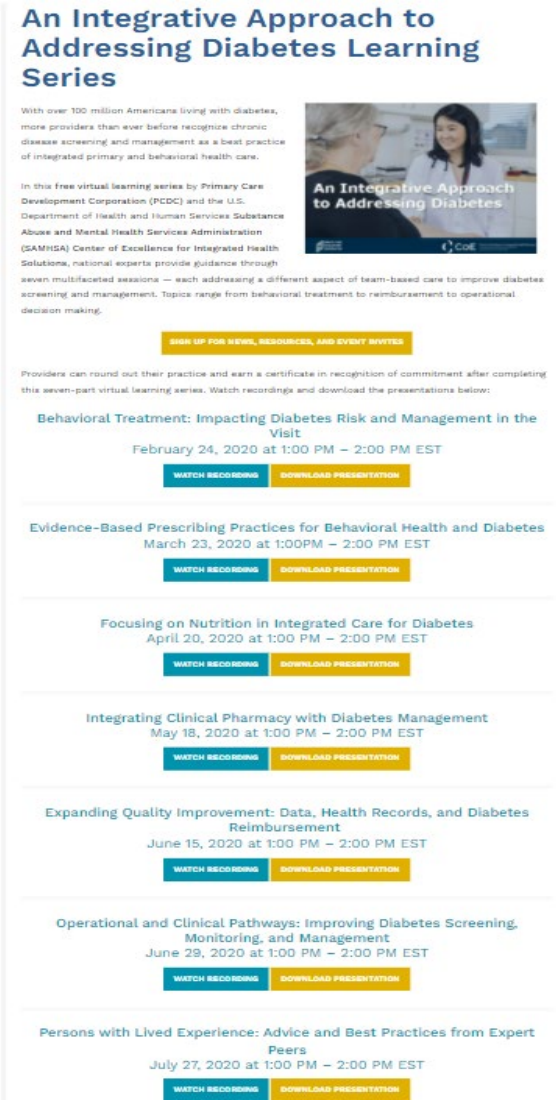


pcdc.org/sleep



pcdc.org/diabetes