UHF Quality Institute

Patient-Reported Outcomes in Primary Care – New York
PROPC-NY

Module 2 Webinar: Bronx Behavioral Health Integration Project (BHIP) and Patient Reported Outcomes

Henry Chung, MD

Vice President and Chief Medical Officer, The Care Management Company (CMO), Montefiore Medical Center

April 24, 2017

Supported by The Engelberg Foundation

United Hospital Fund

Agenda

2:00 – 2:07	**Welcome, Roll Call, Context**
2:07 – 2:15	**Presentation by Northwell**
2:15 – 2:35	**Presentation by Dr. Henry Chung**
2:35 – 2:50	**Q&A**
2:50 – 3:00	**Looking Ahead**
	PROPC-NY Website

We are happy to introduce…
New faculty member Regina Neal!

Director of Practice Transformation Consulting,
Qualis Health

Module 2: January – May

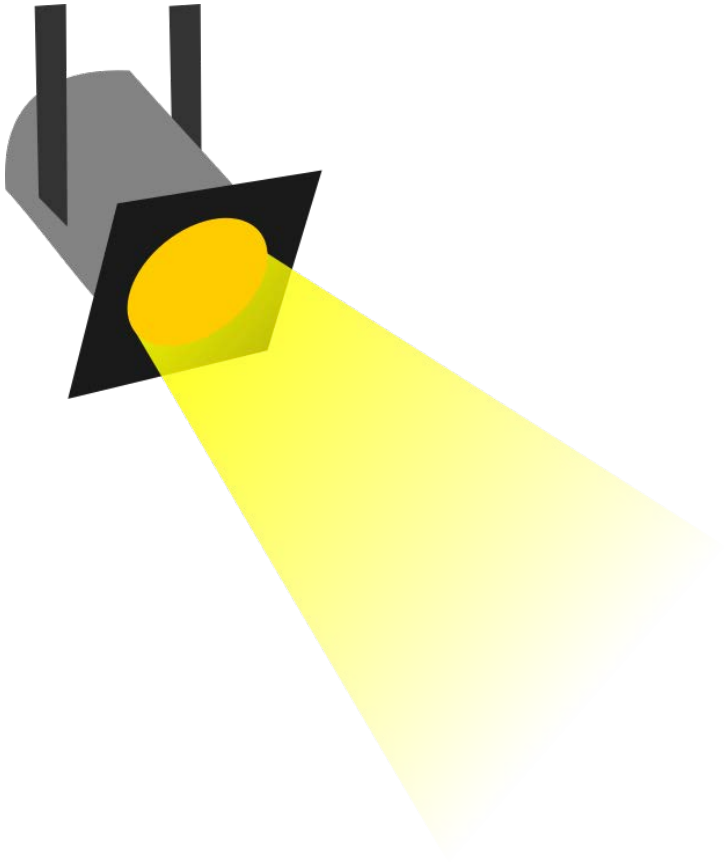
September 2016 – February 2018*

	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
In-person meeting			X							X							X	
Deep-dive call (or site visits) with each participating organization	X	X				X			X				X			X		
Collaborative call with all participants								X						X				X
Webinars				X	X		X				X				X			
Module 1: Planning phase, establishing the foundation	X	X	X	X														
Module 2: Process mapping of PROs and clinical workflows					X	X	X	X	X									
Module 3: Piloting										X	X	X	X	X	X			
Module 4: Synthesize Learnings and Identify Next Steps																X	X	X

**Tentative schedule – actual schedule will be flexible to the collaborative's needs*

MODULE	TEAM ACTIVITIES
2. Process mapping of PROs and clinical workflows	• Describe process map of how this information is collected, when, by whom, and for what uses. • Develop a new draft process to implement PROs. • *Report accomplishments, barriers, and lessons learned to UHF.*
3. Piloting	• Design and carry out pilot tests of the PROs process which could include: o Pilot tools with patients o Pilot tool with staff o Pilot tools with providers • Report on major findings of pilots • *Report accomplishments, barriers, and lessons learned to UHF.*
4. Synthesize learnings and identify next steps	• Submit final project report describing: o Feasibility and usefulness of integrating PROs in routine care at the practice site o Major findings from each module o Plans for next steps (e.g., continued testing, full PROs implementation plan)

Spotlight on PROPC-NY



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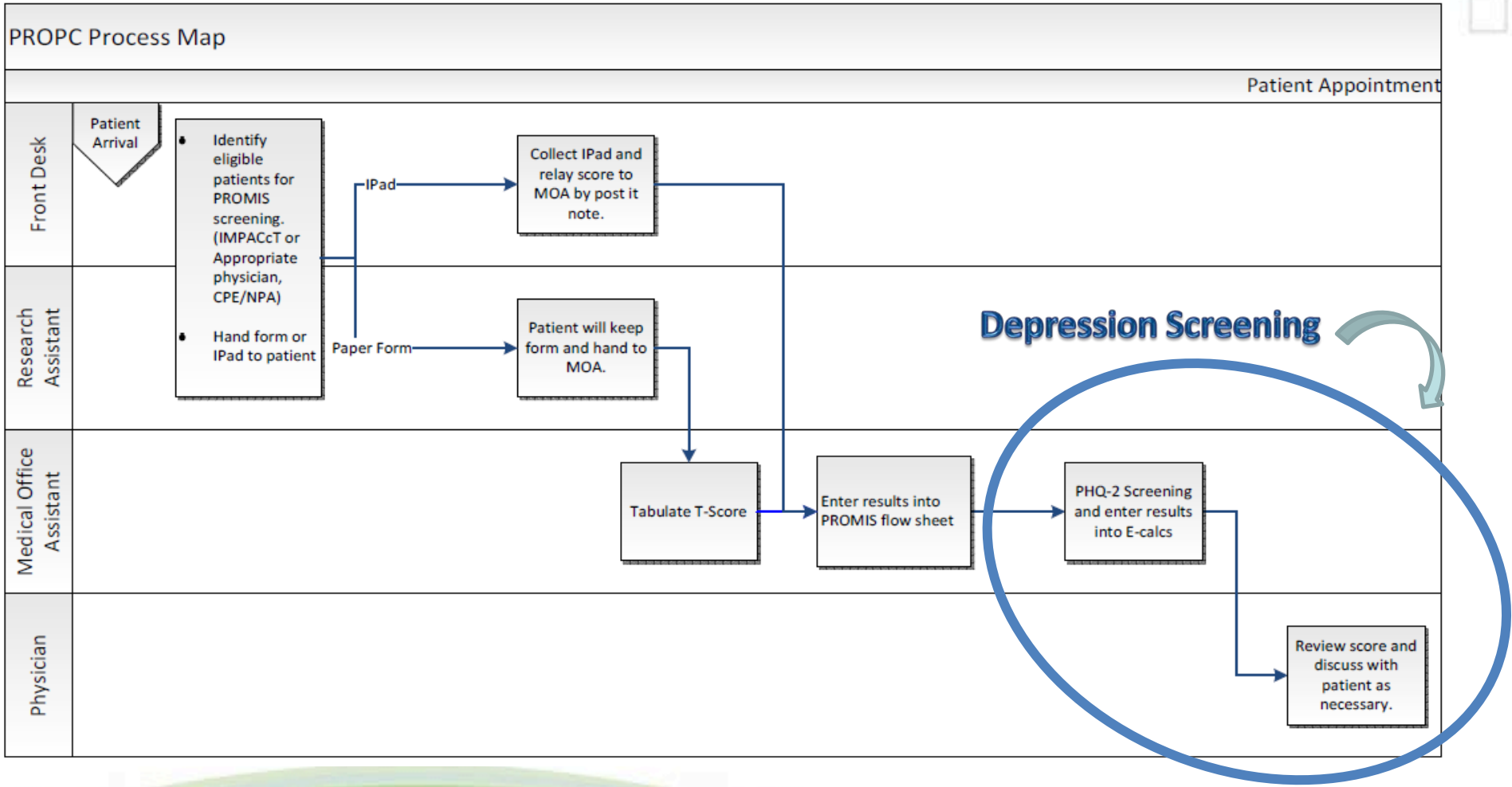
- PROs in behavioral health care
- Primary care setting
- Workflow for implementation of PHQ-2/9
- Challenges

Northwell PROMs Process Map



PHQ-2/9 PROM Workflow

- We will screen for depression in all initial appointments and comprehensive [annual] physical exams.
- Patients complete the PHQ-2 with the MOA at the time of rooming/obtaining vitals.

Challenges:

- **Competing workflows:**
  - **SBIRT *universal* screening already in place- PHQ-2 will be added to MOA responsibilities for only a subset of patients.**
  - **DSRIP project encouraging *universal* PHQ-2 plus monthly follow-up in identified high risk patients.**
- **MOAs concerned about the sensitive nature of depression items, are reluctant to provide Spanish version of PHQ *[✓training completed in 2016].***

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PHQ-2/9 PROM Workflow

If PHQ-2= 0

MOA documents the result in the EMR for the provider.

PHQ-2 > 0

MOA leaves PHQ-9 paper questionnaire in the examining room- provider completes and records in the EMR.

Challenges:

- **Two ways to record scores in EMR- ensuring compliance with the correct method.**
- **Encourage clinical review of a negative score if patient is being treated (i.e. identifying positive response to treatment).**
- **Paper method is an extra step- need to ensure all scores are entered.**

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PHQ-2/9 PROM Workflow

- Follow-up/treatment is up to the provider/patient.

Challenges:

- **Should we set formal guidelines for management based on PHQ scores or other criteria?**
- **For *medication management*– following standardizing SSRI treatment (e.g. 2 week post initiation f/up) in a 4 + 1 residency training model.**
- **For *psychotherapy*- using embedded providers (PhD, SWs) vs. making community-based referrals. Attempting to standardized psychological treatments (e.g. CBT).**
- **For treatment refusers: ways to follow-up/encourage/motivate?**
- **Defining/measuring:**

  Treatment success vs. non-response and going to "Plan B."

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PHQ-2/9 PROM Workflow

- PHQ scores are saved and tracked within the EMR
- PHQ reporting tool to assess % completed is a work-in-progress

Challenges:

- **Obtaining timely, usable reports.**

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Henry Chung, MD

Vice President and Chief Medical Officer, The Care Management Company (CMO), Montefiore Medical Center

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Bronx Behavioral Health Integration Project (BHIP) and Patient Reported Outcomes

The project described was supported by Grant Number 1C1CMS331333 from the Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents of this publication are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies. The preliminary findings and outcomes presented in these slides may or may not be consistent with or confirmed by the findings of the project's independent evaluation contractor.

Agenda

- Bronx BHIP Goals and Progress
- Patient Reported Outcome Measures
  - Screening and Monitoring: Tools Sensitive to Change
  - Telehealth Platforms & Pilot Data
- Discussion

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BHIP Goals

- Implement collaborative care for prevalent mood and anxiety disorders
- Site maintains active caseload ~ 100- 150 patients
- Engagement rate ≥ **75%**
- Improved clinical outcomes:
  - PHQ-9 & GAD-7: ≥ 50% of pts demonstrate 50% decrease or score < 10 at 10 weeks in treatment
  - *Balance Billable and Non-billable activities*: especially social work therapy visits, psychiatric visits and case reviews, and enhanced "between visit" care (e.g. behavioral activation, monitoring symptoms, med check ins)

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Prelim Results for CMMI Sites

Total enrollment: 3,849 patients (Data through August 2016)

Gender	N (%)
Female	3002 **(78%)**
Male	847 **(22%)**

Payor Status	N (%)
Emblem	686 **(18%)**
HealthFirst	970 **(25%)**
Affinity	272 **(7%)**
Medicare FFS	192 **(5%)**

Age Range	N(%)
0-8 years	84 **(2%)**
9-17 years	169 **(4%)**
18-25 years	377 **(10%)**
26-54 years	1951 **(51%)**
55-64 years	694 **(18%)**
65+ years	574 **(15%)**

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Prelim Results for CMMI Sites

Total enrollment: 3,849 patients (Data through August 2016)

Ethnicity	N (%)
Hispanic/Latino	1151 **(30%)**
Non-Hispanic/Latino	1524 **(40%)**
Not Recorded	1174 **(30%)**
Race	**N (%)**
Black or African American	1224 **(32%)**
White	326 **(8%)**
American Indian/Alaskan Native	10 **(<1%)**
Asian	5 **(<1%)**
Multiracial	25 **(<1%)**
Other/Not recorded	2259 **(57%)**
Diagnosis	**N (%)**
MDD/Dysthymia	2607 **(68%)**
Gen Anxiety Disorder	1844 **(48%)**
Adjustment Disorder	440 **(11%)**
Alcohol/Substance Abuse	431 **(11%)**
PTSD	329 **(9%)**
Panic Disorder	220 **(6%)**
ADHD	81 **(2%)**
Social Anxiety	27 **(<1%)**

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Prelim Results for CMMI Sites

(Data through August 2016)

Overall Improvement Outcomes		
Outcomes	**First visit after 10+ weeks (Completer)**	**Intent to Treat***
PHQ9: 50% decrease or score < 10	503/952 **(53%)**	1039/2353 **(44%)**
PHQ9: 5+ point decrease	556/925 **(58%)**	1113/2353 **(47%)**
GAD7: 50% decrease or score < 10	437/804 **(54%)**	953/2094 **(46%)**
GAD7: 5+ point decrease	435/804 **(54%)**	914/2094 **(44%)**

Depression outcomes by payer: First visit after 10+ weeks			
Outcomes	**Emblem**	**HealthFirst**	**Affinity**
PHQ9: 50% decrease or score < than 10	100/187 **(53%)**	143/273 **(52%)**	42/79 **(53%)**
PHQ9: 5+ point decrease	109/187 **(58%)**	153/273 **(56%)**	48/79 **(61%)**

*Must have 1+ F/U; 1st visit between 9-13 weeks or used carry forward method

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Prelim Results for CMMI Sites

(Data through August 2016)

Behavioral Health Disorder Screening Rates					
N Screened **(5-item)**	**N +**	**% +**	N Screened **(AUDIT-C)**	**N +**	**% +**
56,206	2007	4%	1992	223	11%

AUDIT-C: Change in Mean Score* Baseline/Last Available (% decrease)			
Emblem N=41	**HealthFirst N=58**	**Affinity N=14**	**Overall N=223**
6.7/3.2 **(52% improvement)**	6.9/3.7 **(46% improvement)**	6.8/3.3 **(50% improvement)**	6.7/3.6 **(46% improvement)**

*Must be positive at baseline

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Key Features of Successful PROM

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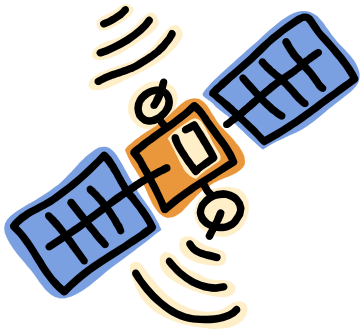
Measures

- Valid and Reliable
- Reasonable Literacy Level
- High quality translations meeting validity and reliability parameters
- Fidelity to administration and supports workflow
- If used for outcomes: sensitive to change (discriminant options, time frame, comparison to a “gold standard”)
- Supports treatment change

Expand Technology Tools



Maximizes resources & improves b/w visit care

Assist with:

- Developing self-management goals
- Health screening & engagement (PHQ9, GAD7, Audit-C, Sheehan, etc)
- Education
- Monitoring response to treatment, meds, & adherence
- Coaching
- Behavioral Activation
- Referrals
- Communication w/i the team (includes the patient) & w/ off-site BH specialists

IVR & Smartphone Technology: Preliminary Pilot Data

Interactive Voice Response (IVR) (March – August 2016)	
Enrolled	322
Engaged in 1+ call	202/322 **(63%)**
Completed 1+ **symptom scale** (PHQ9, GAD7)	99/202 **(49%)**
Rated IVR as **"easy to use"**	51/77 **(66%)**
Agreed to answer **follow up** IVR calls	61/75 **(81%)**
Reported IVR made them **"feel like the team cared"**	68/75 **(91%)**

Smartphone Application (July – September 2016)	
Enrolled	71
Engaged in the app	32/71 **(45%)**
Reviewed an article sent through the app	21/32 **(66%)**
Completed 1+ **symptom scale** (PHQ9, GAD7, AUDIT-C)	15/32 **(47%)**
Engaged in **"chat"** with a care manager	9/32 **(28%)**
Responded to a **"sentiment"** 1+ time	6/32 **(19%)**

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Discussion

Questions? Next Steps?

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Upcoming Dates

- **In-person Deep Dive Visit**
  - Being scheduled for mid-late May
- **PCORI Conference**
  - *Integrating PROs in EHRs: Presentation of a User's Guide and Discussion of Standardization*
  - May 25 – 26, Arlington VA
- **In-person meeting at UHF**
  - Tuesday, June 20: 8 am – 3 pm

Unveiling our PROPC-NY Virtual Community!

- http://www.propc-ny.org/
- One-stop-shop for programmatic and administrative resources
- Password-protected
- Login process and terms of use
- Notification of updates
- Future iterations – e.g., discussion board
- Would love your feedback!


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Faculty

Regina Neal

Director of Practice Transformation Consulting, Qualis Health

Regina Neal is Qualis Health's Director of Practice Transformation Consulting. Her passion is helping clients achieve their goals of delivering high quality care by implementing changes to transform practice and ensuring accountable, sustainable and patient-centered systems of care.

Ms. Neal's perspective on implementing new models of primary care delivery is informed by more than 25 years of experience gained through positions within care delivery systems, health plans, public health departments and consulting firms. She is an experienced consultant, practice coach and trainer, and has substantial experience with the PCMH Model of Care.

Robert Panzer

Chief Quality Officer, University of Rochester Medical Center

Robert Panzer, M.D. is Chief Quality Officer for the University of Rochester Medical Center (URMC) and Strong Memorial Hospital. He is also Associate Vice President for Patient Care Quality and Safety for

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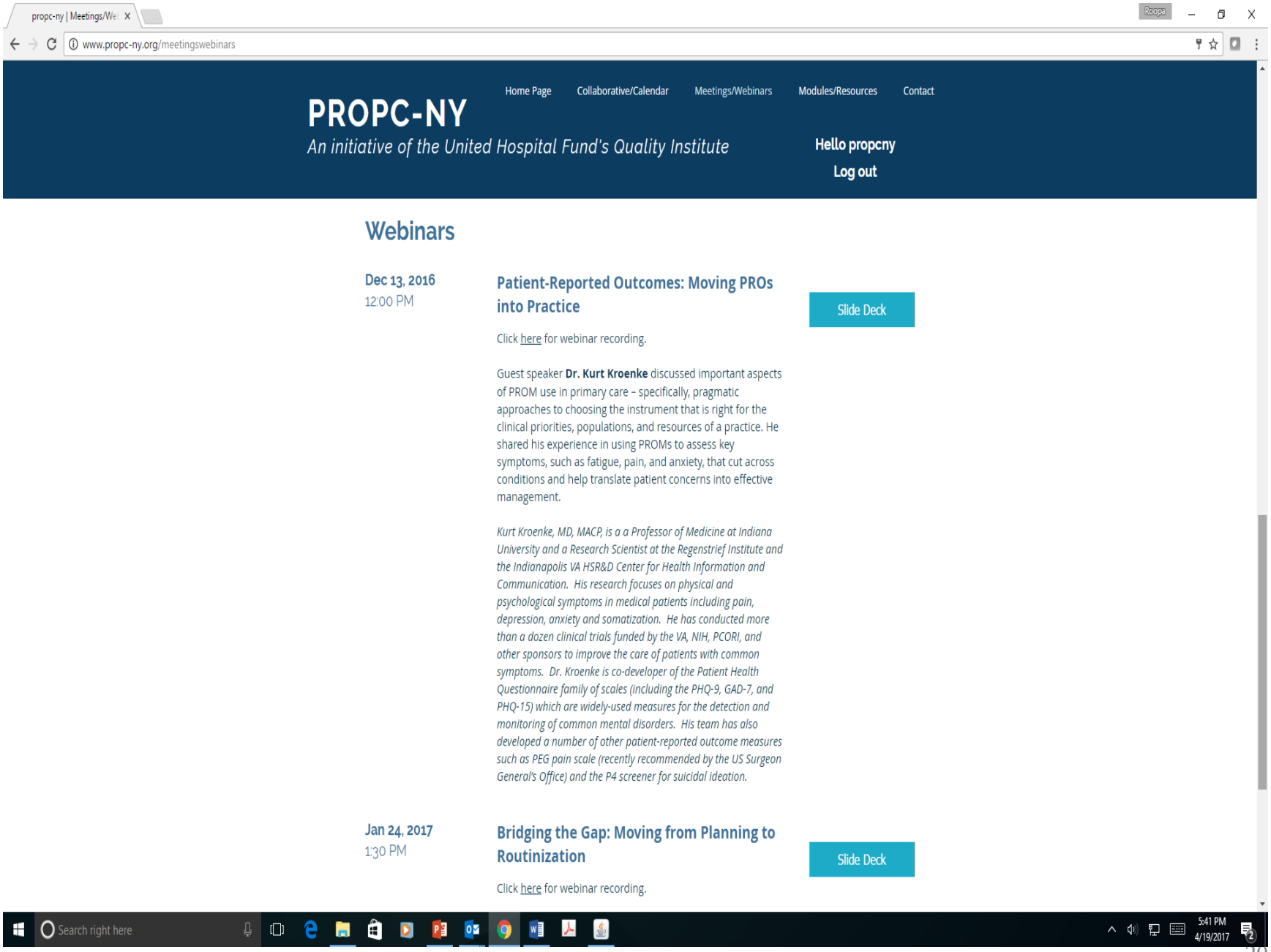
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Dec 13, 2016
12:00 PM
Patient-Reported Outcomes: Moving PROs into Practice
Slide Deck
Click here for webinar recording.
Guest speaker Dr. Kurt Kroenke discussed important aspects of PROM use in primary care – specifically, pragmatic approaches to choosing the instrument that is right for the clinical priorities, populations, and resources of a practice. He shared his experience in using PROMs to assess key symptoms, such as fatigue, pain, and anxiety, that cut across conditions and help translate patient concerns into effective management.
Kurt Kroenke, MD, MACP, is a a Professor of Medicine at Indiana University and a Research Scientist at the Regenstrief Institute and the Indianapolis VA HSR&D Center for Health Information and Communication. His research focuses on physical and psychological symptoms in medical patients including pain, depression, anxiety and somatization. He has conducted more than a dozen clinical trials funded by the VA, NIH, PCORI, and other sponsors to improve the care of patients with common symptoms. Dr. Kroenke is co-developer of the Patient Health Questionnaire family of scales (including the PHQ-9, GAD-7, and PHQ-15) which are widely-used measures for the detection and monitoring of common mental disorders. His team has also developed a number of other patient-reported outcome measures such as PEG pain scale (recently recommended by the US Surgeon General's Office) and the P4 screener for suicidal ideation.
Jan 24, 2017
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Bridging the Gap: Moving from Planning to Routinization
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Questions? Contact UHF Quality Institute

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Thank you for your hard work and commitment to PROPC-NY!