CHI Texas Division

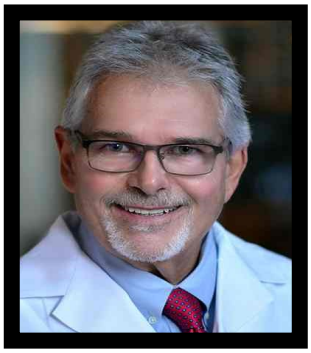
# ConnectCIN

www.chitxcin.org

August 16, 2018

## From the CMO

*Jeff Steinbauer, MD*



Clinicians recognize the importance of mental health in their patient populations. Studies, and our own data show that depression and/or anxiety are very common in people who have chronic diseases. In addition, research suggests that treatment of depression improves the quality of life for people with chronic disease. Thus, screening patients for depression on a regular basis is a requirement for both the Medicare Shared Savings Plan (MSSP) and our commercial payer plans.

### Special points of interest:

- From the CMO
- Depression Care Pathway
- Cigna Value Based Contracting Opportunities
- Optum Analytics
- Ask the CIN

The standard screening instrument is the PHQ2 followed by the PHQ9 if the patient screens positive. If you are using the Epic system, this is already programmed into the EMR. A copy of the instrument can be found online at the following web address: http://www.phqscreeners.com/sites/g/files/g10016261/f/201412/PHQ-9_English.pdf

The most common code to use when submitting a bill for a patient when you have done depression screening that was negative and no follow-up plan is required is: **G8510.** However, other codes apply if the patient is not a candidate for screening, has depression already being treated or has screened positive on the PHQ2.

**Numerator Quality-Data Coding Options:**

**Depression Screening or Follow-Up Plan not Documented, Patient not Eligible**
*Denominator Exclusion:* **G9717:** Documentation stating the patient has an active diagnosis of depression or has a diagnosed bipolar disorder, therefore screening or follow-up not required

**OR**

**Screening for Depression Documented as Positive, AND Follow-Up Plan Documented**
*Performance Met:* **G8431:** Screening for depression is documented as being positive AND a follow-up plan is documented

**OR**

**Screening for Depression Documented as Negative, Follow-Up Plan not Required**
*Performance Met:* **G8510:** Screening for depression is documented as negative, a follow-up plan is not required

**OR**

**Screening for Depression not Completed, Documented Reason**
*Denominator Exception:* **G8433:** Screening for depression not completed, documented reason

**OR**

**Screening for Depression not Documented, Reason not Given**
*Performance Not Met:* **G8432:** Depression screening not documented, reason not given

**OR**

**Screening for Depression Documented as Positive, Follow-Up Plan not Documented, Reason not Given**
*Performance Not Met:* **G8511:** Screening for depression documented as positive, follow-up plan not documented, reason not given

Depression screening is an important part of the annual exam for every patient. Please be sure to include it and document in your notes!

# Quality — Depression Care Pathway

*Tracy Maddox, JD, MSN, RN*

**Diagnosis:** Major Depressive Disorder is defined as depressed mood, markedly diminished interest or pleasure in almost all activities, >5% body weight changes in 1 month, insomnia/hypersomnia, fatigue, loss of energy, feelings of worthlessness, hopelessness, inability to concentrate and/or recurrent thoughts of death. These symptoms should be present most of the day, nearly every-day and cause significant distress or impairment in functioning.

In severe cases of mania or depression, patient may have psychotic symptoms. Anxiety is often comorbid with depression.

Screening: Use of an age appropriate depression screening tool is advised. The PHQ-2 is recommended for initial screening. A positive PHQ-2 would trigger further screening using the PHQ-9. The PHQ-9 is widely accepted evidence based self-administered screening tool for depression. Treatment recommended with scores >10.

IMPORTANT: If answer to question # 9 is "YES": assess suicide risk and take emergency action .

**Most common differential diagnoses to consider:**

- Rule out history of a "manic episode" in the patient or family history of Bipolar Disorder as giving anti-depressant medications to treat depressive episode of a Bipolar Disorder may precipitate a manic episode.
- Hypothyroidism
- Anemia
- Substance abuse or over-prescription of CNS depressant medications

## Quality Continued

**Treatment:**

A. Psychotherapy

B. Pharmacotherapy:

1. Goal of treatment is remission.

2. First line treatment is an SSRI medication such as fluoxetine, paroxetine, fluvoxamine, sertraline, citalopram and escitalopram. Maximum therapeutic benefit seen in 6 weeks. Maximize dose. Watch for gastrointestinal side effects, sexual side effects and restlessness. Gastrointestinal side effects and restlessness are usually transient. Consider potential drug- drug interactions that may occur with fluoxetine, paroxetine and fluvoxamine when used with other medications. Paroxetine is pregnancy category D, all other SSRIs are category C. Watch for QTC prolongation with citalopram. Max dose is 20mg if concomitant use of omeprazole. Max dose of citalopram in patients > 60 years in 20 mg.

3. If patient achieves REMISSION, continue treatment and monitor. If less than 2 episodes of major depression, may try taper and discontinue of medication after 12 months of sustained remission.

4. If PARTIAL RESPONSE, may refer patient for psychotherapy or augment SSRI with one of the following medications:

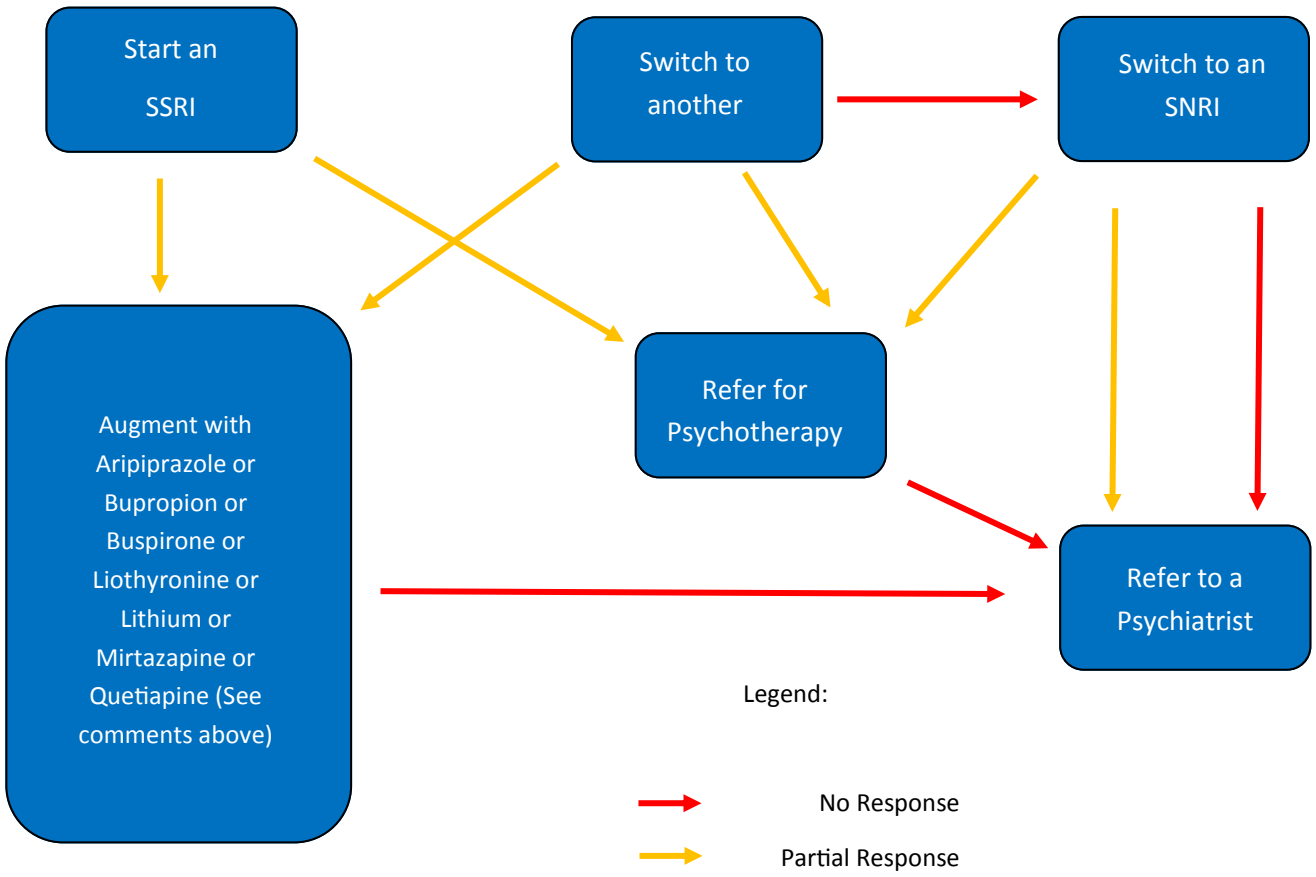
- Aripiprazole: usually not the first choice for augmentation and would not be recommended at primary care setting. Very expensive. Watch for akathisia. Avoid in patients with obesity, Diabetes Mellitus, Dyslipidemia, age >65 (risk of stroke).
- Buspirone: consider if co-morbid anxiety. Clinically only modest response observed.
- Bupropion: contraindicated in patients with seizure disorder, binging & purging behavior and hx of TBI. Avoid if co-morbid anxiety or chronic heavy alcohol use. Advantage if smoking cessation is desired. Also a good augmentation strategy if sexual side effects were problematic with SSRIs.
- Liothyronine: usually not the first choice for augmentation and would not be recommended at primary care setting. No effect on Thyroid Function Tests.
- Lithium: usually not the first choice for augmentation and would not be recommended at primary care setting. check Renal Function Tests and Thyroid Function Tests. Avoid in females of child bearing age (risk of cardiac defects) and in patients with electrolyte abnormalities. Avoid when patients are taking NSAIDs, ACE inhibitors and thiazide diuretics. Narrow therapeutic index and requires therapeutic drug monitoring with Lithium level. Avoid if high risk of suicide.
- Mirtazapine: consider if poor appetite & insomnia. A good choice if co-morbid gastrointestinal symptoms. Watch for agranulocytosis.
- Quetiapine: usually not the first choice for augmentation and would not be recommended at primary care setting. Avoid in patients with obesity, Diabetes Mellitus, Dyslipidemia, age > 65 (risk of stroke). Causes sedation, may be used if also targeting insomnia. Also watch for orthostasis which is usually transient.

## Quality Continued

*5. IF NO RESPONSE to one trial of SSRI, switch to another SSRI and follow step 3 & 4. Do not use two pharmaceutical agents from same class.*
*6. IF NO RESPONSE to two trials of SSRIs at maximum doses and maximum duration, switch to an SNRI such as duloxetine, venlafaxine, desvenlafaxine or levomilnacipran. Maximum therapeutic benefit seen in 6 weeks. Maximize dose. Watch for orthostasis, gastrointestinal side effects, sexual side effects and restlessness. Orthostasis, gastrointestinal side effects and restlessness are usually transient.*

*Other Treatment Considerations:*

- ◊ *Remove access to means of self-harm in severe phase of a depressive episode such as firearms. Avoid giving 90 day supply of medications.*
- ◊ *If patient needs emergent mental health services because of suicidal thoughts or self-care failure, send patient to nearest ED. If concerned about safety of the patient and patient is not reachable, can ask law enforcement to do a "welfare check" on the patient.*



## Quality Continued

**Reassessment:**

Use PHQ-9 to monitor treatment response (12 months out, +/- 30 days).

Therapeutic drug monitoring where applicable

**Patient Engagement:**

Psychoeducation

Encourage compliance

Sleep hygiene education

Community engagement

Exercise

**Specialist Consult:**

When to Refer:

- ◊ Poor treatment response, intolerable side effects
- ◊ Co-morbid personality disorders, substance abuse or psychotic symptoms
- ◊ Complex psychosocial environment

References:

The Diagnostic and Statistical Manual of Mental Disorders 5th ed.; DSM–5; American Psychiatric Association [APA], 2013

The American Psychiatric Publishing Textbook of Psychiatry, 6th ed. Edited By: Robert E. Hales, M.D., M.B.A., Stuart C. Yudofsky, M.D., and Laura Weiss Roberts, M.D., M.A. 2014.

Practice Guideline for the Treatment of Patients with Major Depressive Disorder. 3rd ed. American Psychiatric Association Work Group

on Major Depressive Disorder. Gelenberg AJ et al. October 2010.

The STAR*D Project Results: A Comprehensive Review of Findings. Warden D et al Current Psychiatry Reports 2007, 9:449-459

*Reviewed by Texas CHI CMO: 01-31-17*

*Initially Recommended by CPIC: 02-08-17*

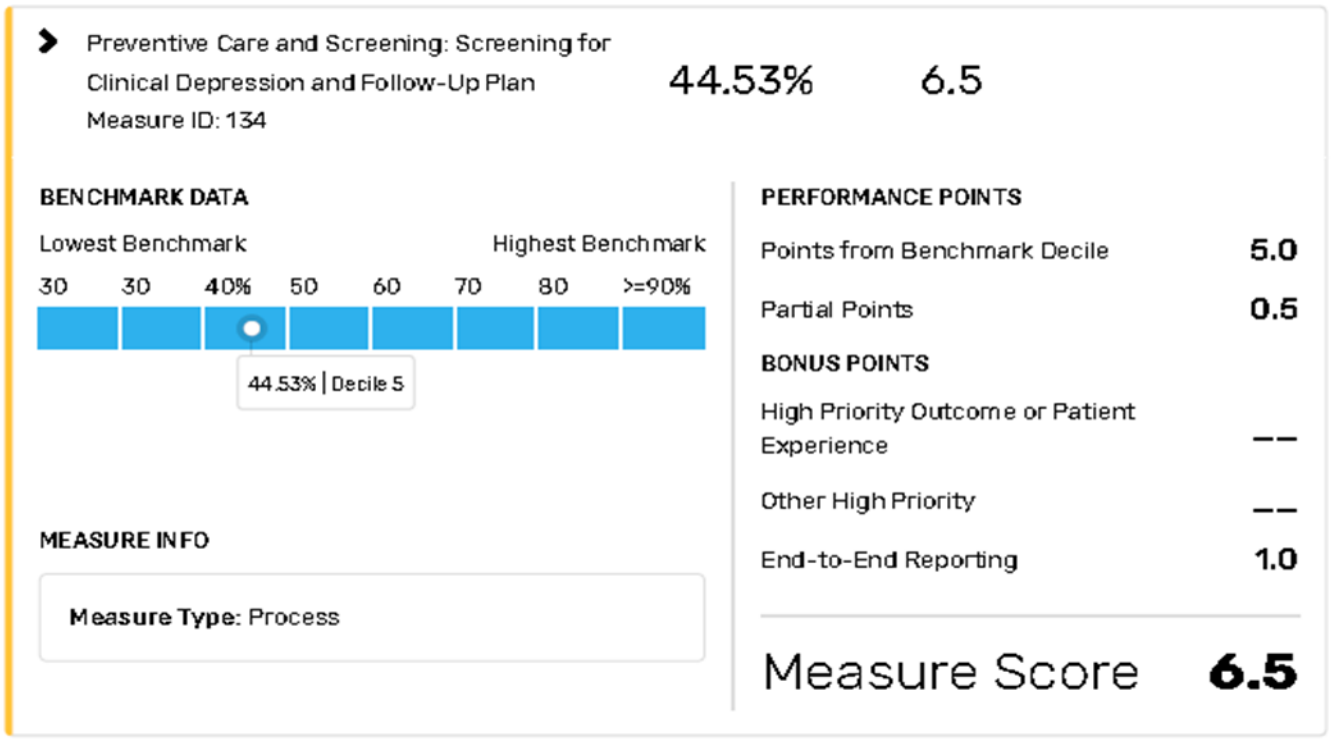
*Initially Approved by TX Division Board: 02-14-17*

## Quality Continued

Among persons older than 65 years, one in six suffers from depression. CMS covers annual screening for depression for Medicare beneficiaries in primary care settings. The ACO reports the documentation of depression screening and follow-up for its participating providers. The two measure reported on include:

| Measure Code | QPP Measure | Alternative Measure Numbers | Measure Name |
|---|---|---|---|
| ACO-18 | PREV-12 | Quality ID #134<br>NQF 0418 | Preventive Care and Screening: Screening for Depression and Follow Up Plan |
| ACO-40 | MH-1 | Quality ID#370 Registry Only<br>NQF 0710<br>CMS159v6 | Depression Remission at Twelve Months |

The ACO scored 44.53% on the reporting of Preventive Care and Screening for Clinical Depression and Follow-Up Plan during the 2017 performance year.



## From Network — New Cigna Value Based Contracting Opportunities

*Lisa Cochran*

Texas Health Network CIN has recently signed new agreements with Cigna called Collaborative Accountable Care (CAC), Provider Group Agreement, and Pay for Performance (P4P). Physicians employed by Baylor and Baylor St. Luke's Medical Group have been participating in the CAC agreement for a year, and have recently joined the Provider Group Agreement and P4P. We are now inviting our independent providers in Brazoria, Chambers, Fort Bend, Galveston, Hardin, Harris, Jefferson, Liberty, Montgomery, Orange, and Waller Counties to join these agreements. These agreements are a great introduction to Value Based Contracting because there is no downside risk!

The CAC is open only to Primary Care Physicians and Mid-Levels, whereas the P4P is open to providers of all specialties. Providers can participate in the CAC as individuals, but the entire group must participate in the P4P. This is because the P4P affects providers' base fee schedules and Cigna will only make adjustments at the tax id level.

In the first year of CAC participation by employed providers, the quality has improved 20 points over our baseline, which places us as one of the highest in the Houston area, and at the same time, our medical spend is one of the lowest in the Houston area. This is good news for participating physicians because it gives more potential for shared savings.

Following is a summary of the agreements:

**Collaborative Accountable Care (CAC)**

Value Based Agreement
CIN receives a per member per month fee that will be shared with providers depending on their performance on quality metrics
Providers receive the benefit of care coordinators who work with their patients on chronic illnesses and gaps in care
Providers will be measured on a variety of metrics, including:
- Wellness visits and screenings
- Treatment of chronic illnesses, such as diabetes, CAD, and depression
- Treatment of acute illnesses, such as bronchitis, URI, and low back pain
- Use of generic prescriptions

**Provider Group Agreement**

Sets the provider's reimbursement for **Year 1** as a percentage of the Cigna Standard Fee Schedule
Two levels of reimbursement for independent providers, depending on where their current Cigna agreement lies, as determined by Cigna, which could immediately increase the provider's fee schedule
Mid-Level Providers will stay on the Cigna Standard Fee Schedule for such providers

**Pay for Performance (P4P)**

Defines the fee schedule for **Years 2+** based on quality and utilization
**Quality** is a Success or Fail as determined by the score on the quality metrics of the Cigna CAC product for PCPs or the Cigna CCD Program for Specialists.
**Utilization** is the use of efficient facilities, as designated by Cigna. PCPs are measured based on all claims for their attributed patients in the areas of Inpatient Admissions, Outpatient Services, High Cost Radiology and Lab. Specialists are measured based on the claims they submit in the areas of Outpatient Procedures, High Cost Radiology, and Lab.

If you would like more information about these programs, please reach out to our network staff, who will be happy to share more specific information.

Janel Greig, Provider Relations – jgreig@stlukeshealth.org
Medical Center, Sugar Land, North, Northeast, Northwest, West Houston

Jodi Vella, Provider Relations – jvella@stlukeshealth.org
Pasadena, Brazosport, Pearland, South, Southeast, Southwest Houston

CHI Texas Division

# Data — CHI Texas Integrated Network Leverages Optum to Improve Quality

*Royd Hernandez*

The CHI Texas Division integrated network recognizes that preventive care and chronic disease management is critical to population health. As a result, CHI TX has invested in Optum® Analytics to help with the integration of multiple clinical and claims data sources needed to effectively manage the care of the covered population and to adequately evaluate performance in key areas that include quality, cost and utilization. The CHI integrated network is using Optum® to help with the following projects:

## ACO and CIN Quality

- Track progress against measures
- Deploy resources against patients not at goal
- Evaluate resource utilization against clinical outcomes

## Risk Management

- Isolate risk adjusted provider variation
- Identify future cost risk patients
- Support network management

## Code Improvement

- Identify and manage gaps in coding
- Track risk scores against prior periods, dropped codes
- Identify potentially un-coded chronic patients based on clinical factors

## Care Coordination & Patient Engagement

- Identify actionable clinical opportunities for care coordinators
- Identify targeted populations and refer to outreach programs
- Support Care Coordination workflow and documentation
- Track outcomes of coordinated populations

## Cohort Analytics

- Identify clinical, demographic, and risk profiles of different disease cohorts
- Understand trends in poly-chronic patient populations

## Gaps in Care

- Evaluate physician performance re process and outcomes
- Build and publish reports to the physician network to build a data-driven care framework

## Data — Continued

In 2017, Optum® helped with the identification of Medicare members in need of preventive care services and care management.

### GOAL

Increase preventive care screening rates and improve chronic disease management for Medicare Shared Savings Program (MSSP) patients.

### SOLUTION

Leveraged Optum® to:

- Quickly **identify patients** with a gap in care via Optum's Registry
- Perform and track outreach to patients via **Optum Care Coordination**
- Monitor and **trend performance** rates over time across all providers

### RESULTS

As of the end of 2017, CHI Texas achieved:

**10.9% increase** in MSSP patients meeting colorectal cancer screening
**5.3% increase** in MSSP patients meeting breast cancer screening
**4.7% increase** in Hypertensive MSSP patients moving into control (<140/90 mmHg)
**6.2% decrease** in uncontrolled Diabetic MSSP patients A1c (A1c >9%, no result, or not tested)

CHI Texas Division ⟷ OPTUM®

## Ask the CIN

Questions? Comments? Concerns?

Please refer to the staff directory below and send us your feedback. We look forward to hearing from you and assisting in any way we can. General questions can be sent through the website at www.chitxcin.org or via email to texasdivisionclinical@stlukeshealth.org.

### CIN Leaders:

Jeffrey Steinbauer, MD, Chief Medical Officer, Jeffrey@bcm.edu

Lisa Cochran, Division Director, Network Development, lcochran@stlukeshealth.org

Royd Hernandez, Division Director, Data and System Integration, rhernandez@stlukeshealth.org

Tracy Maddox, Division Director, Quality, tmaddox@stlukeshealth.org

Pamela Fails, Sr. Administrative Assistant, pfails@stlukeshealth.org

### CIN Network Staff:

Janel Greig, Provider Relations, jgreig@stlukeshealth.org

Lecey Rosen, Manager, Credentialing and Operations, lrosen@stlukeshealth.org

Marilyn Sweet, Credentialing Specialist, msweet@stlukeshealth.org

Loretta Tarwater, Credentialing Specialist, ltarwater@stlukeshealth.org

Jodi Vella, Provider Relations, jvella@stlukeshealth.org

### CIN Data Analytics Staff:

Sohail Alam, Data Analyst, salam3@stlukeshealth.org

Jacob Hoyt, Data Analyst, jhoyt@stlukeshealth.org

### CIN Quality Staff—Houston/Lufkin Market:

Deborah Dornes, MSN, BSN, RN, Population Health Coach, ddornes@stlukeshealth.org

Alexandria Jackson, BSN, RN, Population Health Coach, ajackson7@stlukeshealth.org

Meshel Stewart, BSN, RN, Population Health Coach, mstewart@stlukeshealth.org

Myriam Valdez-Saker, BSN, RN, Population Health Coach, mvaldezsaker@stlukeshealth.org

Bertha Brown, Medical Assistant, bbrown2@stlukeshealth.org

Jennifer Martir, Medical Assistant, jmartir@stlukeshealth.org

### CIN Quality Staff—Bryan Market:

Candace Dotson, Care Coordinator Associate, cdotson@st-joseph.org

Shelly Hearn, BSN, RN, Care Coordinator RN, shearn@st-joseph.org

Sarah Hilton, Project Manager, shilton@st-joseph.org

Heather Rutledge, RN, Care Coordinator RN, hrutledge@st-joseph.org