Quality Improvement around a screening program for depression and alcohol and drug use in multiple integrated university-based primary care clinics
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Background
- Ample research supports screening for depression and SBIRT in primary care
- Our setting: 3 Family Medicine and 3 Internal Medicine integrated, university-based clinics, with an average of 7,500 patients per clinic (range 4,394 – 13,895)
- Driven by state funding (PRIME) to increase access to coordinated primary care in California, Informed by Oregon SBIRT
- Building on existing infrastructure and existing integrated model based mainly on PCBH model

Objectives
- Increase screening for depression and respond to positive screens (Goal to screen at least 55% in 2019)
- Increase screening for alcohol and drug use and respond to positive screens (Goal to screen at least 15% in 2019)
- Increase involvement of same-day BH consultation

Methods
- Assembled a team
- Chose screeners to use
- Built screeners into EHR
- Created workflows (process mapping)
- Hired staff
- Trained clinic staff and providers
- Designed registry
- Designed screening rates report
- Ongoing troubleshooting and retraining

Conclusion
- With the support of PRIME, there was successful increase of depression and alcohol/drug use screening that exceeded goals of at least 55% for depression and at least 15% for alcohol and drug use.
- Compared to previous years, the overall utilization of same-day BHC consultations for positive screens increased; however, the increase did not directly correlate with increased screening rates.
- In addition, increased screening did not correlate with positive screens leading to increased Behavioral Health referrals (decrease over the years in FM clinics whereas variable in IM clinics) and Psychiatry referrals (decreased over the years).

Discussion
- The variability in screening rates may be due to a variety of influences, including: changing processes (FM clinics’ depression rates went down initially), periodic booster trainings provided to clinic staff and physicians, monthly screening rates reports provided to each clinic, and EHR health maintenance reminders for depression screening.
- Screening rates increased significantly when support staff leadership began overseeing screening efforts. The leaders of this QI effort were very thoughtful about which team members to include in the planning committee; however, members were primarily physicians and no support staff leader was included in the planning committee.
• In addition to depression and alcohol/drug use screening, clinics were simultaneously expected to implement and complete other efforts for the PRIME program; these efforts would have benefited from increased introduction and buy-in prior to the expectation that clinics implement the changes.
• It was thought that electronic check-in would be helpful for increasing screening rates by decreasing the need for monitoring and manual data entry, but not many patients used this EHR capability.
• The team considered whether to rely on staff versus technology to complete screenings; the clinics most reliant on technology had lower screening rates than other clinics. This may be due to the positive relationships established with some clinic’s staff, and the ownership these staff assumed compared to “letting technology solve the problem.”

References