Morris Hospital Integrated Care

Quality Improvement Project
Who We Are

- Morris Hospital and Healthcare center is comprised of 37 employed Primary Care Providers (Family Practice, Internal Medicine, Pediatrics, Obstetrics / Gynecology) serving 23 locations.
- In 2018: 117,672 patients were treated at the Healthcare Centers.
- Rural, independent non-profit 89 bed hospital
- 70 miles southwest of Chicago
- Morris Hospital and our local county (Grundy County IL) health department are the only behavioral health providers in our county for Medicaid patients.
My Integrated Care Journey

- Jennifer Thomas, family practice physician working for Morris Hospital in Morris, IL
- 2007: graduated SIU school of Medicine, Springfield, IL
- 2010: graduated Hinsdale Family Medicine Residency, Hinsdale, IL
- 2010: joined Morris Hospital medical group
- Jan. 2018:
  - started UC Davis Train New Trainers Primary Care Psychiatry fellowship, year-long fellowship to support existing primary care providers in their knowledge and skill level at diagnosing and treating mental health conditions in the primary care setting
  - learned about AIMS Center U of Washington Collaborative Care Model at fellowship conference
Integrated Care Journey at Morris Hospital

- **May 2018:**
  - We make contact with the AIMS Center
  - AIMS administrator encourages us to implement Collaborative Care model (CoCM) for perinatal depression population as part of AIMS Center’s Maternal Infant Dyad Initiative (MlND-I project)
  - Enables Morris Hospital’s core planning team to receive implementation coaching and training in CoCM free of charge

- **August 2018:** AIMS Center staff starts weekly pre-implementation and coaching calls with Morris Hospital core planning team

- **Fall 2018:** Morris recruits and hires one LCSW care manager and one consulting psychiatrist (contracted for 4 hours per week for this model) for this pilot project
Integrated Care Journey at Morris Hospital

- **January 28-29, 2019:**
  - AIMS Center Staff travels to Morris Hospital for core team training
  - 23 Morris Hospital primary care providers (from pediatrics, Family Medicine, Internal Medicine and Obstetrics/Gynecology) attend lunch and learn sessions to receive basic orientation training in CoCM
- **February 2019:** Morris Hospital launches CoCM at two pilot sites: Gardner family medicine and Morris OB/Gyn offices
- **March 2019:** Morris Hospital decides to apply for HRSA grant 19-018, to support efforts to disseminate and implement integrated behavioral health services at their primary care offices
Our Next Chapter: HRSA Grant Application

- HRSA Grant 19-018: Small Health Care Provider Quality Improvement Program (Rural Quality Program)
- “project proposals should focus on rural chronic disease management and/or the integration of mental/behavioral health services into the rural primary care setting”
- “purpose of the Rural Quality Program is to support planning and implementation of quality improvement activities for rural primary care providers or providers of healthcare services”
- “funding under this program may be used to provide start-up funds for quality improvement initiatives that allow recipients to develop the necessary capacity and ability to obtain funding from other sources”
Project Abstract

1. **Quality Improvement Project Title:** “Integrating Behavioral Health into the Rural Primary Care Setting in Grundy County, Illinois Using the Collaborative Care Model”

2. **Target Patient Population:** This QI project aims to increase access to mental health services for the residents of Grundy County, Illinois in the primary care setting through the University of Washington AIMS Center’s Collaborative Care Model. The project will identify and track patients diagnosed with depression at three primary care sites. We will measure and track the rates at which these patients with depression receive Collaborative Care services.

3. **Patient Health Outcome & Clinical Quality Measure Overview:**
   a. Project will report Performance Improvement and Measurement System (PIMS) data, focusing specifically on Access to Care and NFQ 0418: Screening for Clinical Depression and Follow-up Plan
   b. We will also measure project specific outcomes:
      i. rates of usage of PHQ-9 scale among providers
      ii. rates of referral to Collaborative Care
      iii. measure and track depression outcomes using the standard HEDIS measure:
         1. Response: ≥50% decrease in PHQ-9 score at 4 -6 month
         2. Remison PHQ-9 score < 5
e. To demonstrate how the project will improve quality of care and delivery of services, we will measure our providers’ comfort level in the CoCM using the AIMS Center Self Assessment Tool, completed by providers at the start of the project and 6 months after implementation.
QI Model: RE-AIM

1. **Target Population**: primary care patients at Gardner, Morris OB and Minooka Ridge Rd offices that screen positive for depression (PHQ-9 score 10 or greater), patients age 12 and older
2. **Reach**: number of unique individuals from the target population that enroll in Collaborative Care (CoCM)
3. **Efficacy**: impact CoCM has on patient outcomes, as measured by the standard HEDIS measure:
   a. **Response**: ≥50% decrease in PHQ-9 score at 4 -6 month
   b. **Remison PHQ-9 score < 5
4. **Adoption**: number of providers at each practice site that enroll patients in CoCM
5. **Implementation**: how closely providers follow the work plan for referrals to CoCM, as measured by the AIMS Center Self Assessment Tool. (providers will complete this at the start of the project and 6 months after implementation begins)
6. **Maintencene**:
   - **Setting Level**: the extent to which CoCM becomes part of Morris Hospital and Healthcare Centers’ policy at other primary care sites over time
   - **Individual level**: long term effects of CoCM on patient outcomes, as measured by PHQ-9 score at 6 months after enrolling in CoCM
Current implementation: launched CoCM at two sites: Gardner FP and Morris OB in Feb. 2019
Integrated Care Diagram

- Near future implementation: expand CoCM to next site: Minooka med/peds, May 2019
Methods: Where We Need Help

- **8 providers** currently feeding into pilot Collaborative Care model, launched Feb. 2019
- **3 additional providers** will have the ability to practice CoCM at our new expansion primary expansion site, hope to launch May 2019

**Clinical Questions:**

- What percentage of patients diagnosed with depression had a PHQ-9 completed at the time of initial diagnosis?
  - For those with PHQ-9 score 10 or greater, what percentage have been referred to Collaborative Care?
    1. For those referred to Collaborative Care, how effectively has their depression been treated?
Methods

- Morris Hospital and Healthcare Centers uses the electronic health record, eClinicalWorks.
- We will perform data reports on all eleven primary care providers at the three practice sites being studied.
- We will obtain an absolute value of the number of patients diagnosed with depression (as defined by the ICD-10 codes F32*, excluding F32.3 (psychotic depression, as psychosis is not within the scope of this project), F41.8 (Depression with Anxiety) and F53.0 (Postpartum Depression) per provider (beginning at the start of our study period?)
- For that set of patients diagnosed with depression, we will measure what percent had completed a PHQ-9 at the time of diagnosis.
- Of that target population (those that screen positive with PHQ-9 score 10 or greater), we will perform a data report on what percent of those patients were referred to Collaborative Care.
Methods

- Exclusion criteria will be:
  - Patients that screen positive but that are already engaged in mental health services elsewhere (including counseling and/or psychiatry services)
  - Patients that screen positive but provider and patient decide referral to CoCM is not appropriate (such as known symptoms and/or diagnoses that may be outside the scope of CoCM, such as psychosis)
  - Patients that screen positive but CoCM services are not currently available at the practice site (ex: CoCM panel is full at time of visit)

- We will then track that cohort of Collaborative Care patients over time using the AIMS Center Caseload tracker to monitor PHQ-9 scores over time

- To measure depression outcomes, we will use the standard HEDIS measure

- Finally, we will survey our providers with the AIMS Center’s Self Assessment Tool at the start of the study and again 6 months after implementation. This will quantify providers’ comfort with the Collaborative Care model and change in utilization of the model over time.
Methodology Question

1. When should we “start” our study period?
   o Do we “start” the study period when we first starting working with AIMS-our first contact with AIMS, which was 06-13-2018?
   o Should we start the study period, once the CoCM services are in place and available? For Gardner and Morris OB, then we would “start” the study period Feb.2019. For Minooka (the expansion site), would we “start” the study period when new care coordinator is in place, May 2019?)}
2. Are we OK using codes F32\* (minus 32.3 Psychotic Depression) and F41.8, F53.0?

- We decided to include F41.8 (Depression with Anxiety) and F53.0 (Postpartum Depression) due to patient populations at our pilot sites.
- Our Gardner site is a family medicine office, and we found our providers were often diagnosing depression and comorbid anxiety.
- Our providers would often use code F41.8 to describe both diagnoses.
- Our Morris OB site has a large perinatal population. Our providers would often use the code F53.0 to describe depression in patients within 12 months of delivery.)