San Diego County Depression Screening and Follow-up User Story - Albert Hughes

- Age: 65
- Health Concerns: Uncontrolled Type 2 Diabetes, vision loss, obesity, polyuria, fatigue
- Medication: Metformin
- Social Needs: Lack of transportation, lacks access to grocery stores
- Location: San Diego County
- Occupation: Retired
- Insurance: Medi-Cal Plan
- Pronouns: He/him

About Albert:

- Recently widowed and adult children live out of state
- Lives in public housing in a busy city
- Attempts to connect with friends once a week but is often unable to

Goals and Expectations from the CA Health and Social Care System:

- Wants culturally-relevant services and support
- Wants more support at home but is unsure of what services are part of his Medi-Cal plan
- Would like to find grief counselor but with his vision issues and polyuria, it is challenging for him to leave his home.
- Wants to find care close to home because of the difficulty he has taking public transportation long distances

Challenges from Albert's Perspective

- Occasionally, I miss regular appointments because I feel very tired
- Since my wife passed away, I feel my mind is scattered, and I can't keep track of what I need to do, so sometimes I forget to take my medication, Metformin, when I should. I have also been unable to coordinate my care because she scheduled and kept track of everything for me
- Because I have trouble seeing and need to use the restroom frequently, I try not to leave my house too often
- When it comes to my health, my children are my main source of support, but I don't want to be a burden to them

- I don't have any grocery stores nearby, and with my wife gone, I've realized it's hard to cook healthy meals on my own. PCP recommended I take their nutrition education class, but I feel like I'm too old to join

Albert's Typical Routine & Interactions

- Albert visits his primary care providers every two months to get blood tests
- Albert tries to meet up with a friend at least once a week
- Albert visited the ER twice after falls
- Albert relies on public transportation to get around

Depression Screening and Follow-up Use Case Scene Breakdown

- Use Case 1: Office Visit for Help with Polyuria and Fatigue
    - Scene 1A: Depression Screening
    - Scene 1B: Referral for Follow up Services after Positive Screening
- Use Case 2: Internal Follow Ups
    - Scene 2A: Follow up with Behavioral Health Case Manager
    - Scene 2B: Follow up with PCP two weeks after positive screen
- Use Case 3: Follow up for Depression / Grief Counseling at County Behavioral Health
- Use Case 4: Gap Closure in MCP HEDIS Engine

Assumptions:

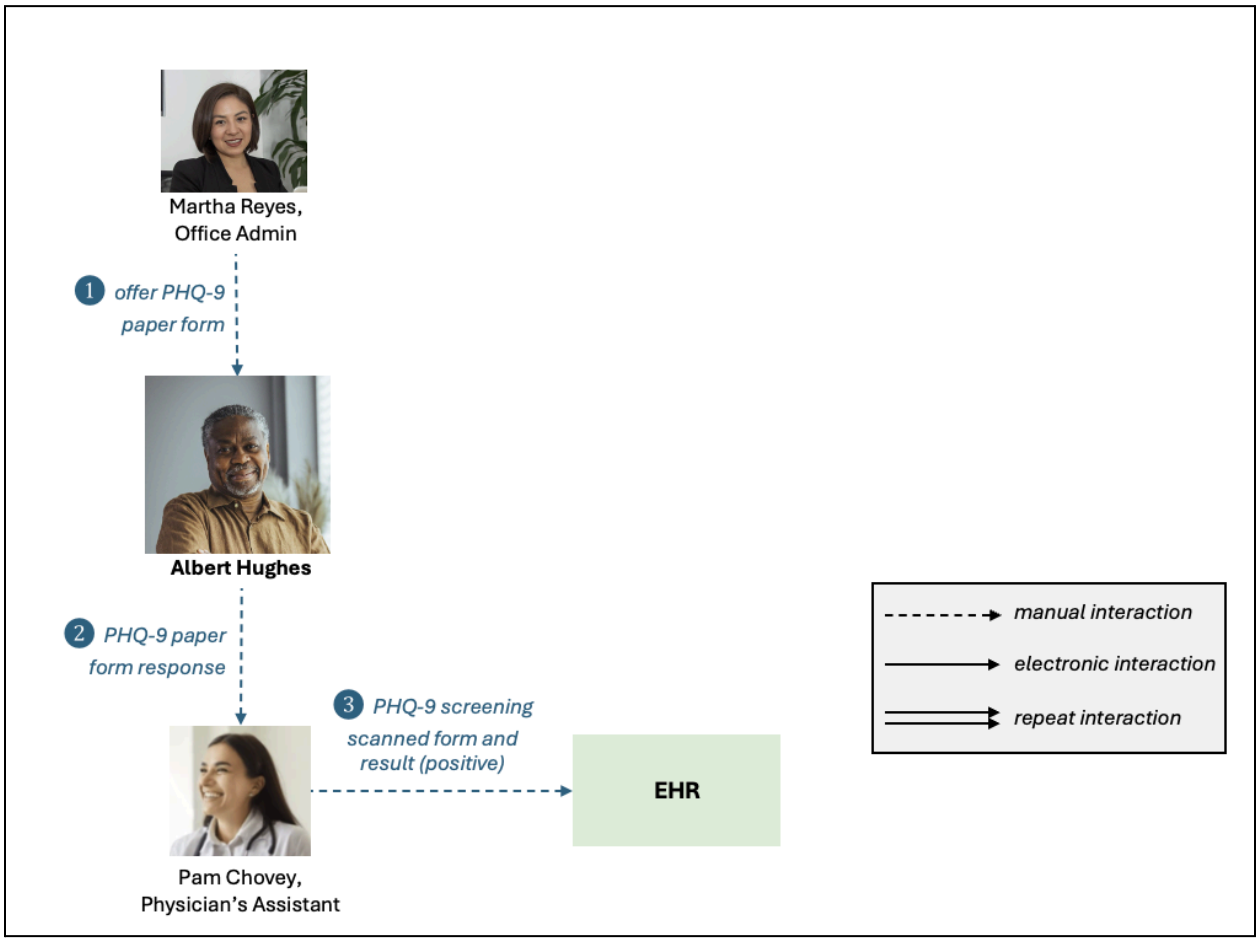
- Albert has been diagnosed with Type II diabetes
- He has been prescribed Metformin but is not taking it regularly
- He has developed symptoms that are making his life less manageable and is coming in to see his PCP for support.
- Albert is a Medi-Cal member

Use Case 1: Office Visit for Help with Polyuria and Fatigue

Scene 1A: Scene 1A: Depression Screening

- **Albert** enters the reception area and checks in with **Martha Reyes**, the Front Office Administrator
- **Martha** welcomes him back to the practice and hands him a clipboard asking him to review and update his information.
- She also hands him a PHQ-9 Depression Screening assessment and asks that he complete the questionnaire and hand it to **Dr. Amin's** assistant, **Pam**, who will be out shortly to get him.
- **Albert**, who recently lost his wife, is not doing well and indicates that most days he is not doing well.
- **Pam** walks Albert back to **Dr. Amin's** office

- **Pam** hand scores Albert's assessment and enters the score in her EHR where it will be placed within the encounter visit note.
    - Albert's score is 19, indicating moderately severe depression.
- The practice EHR flags **Albert's** record so **Dr. Amin** will see that she will need to review the results with him during the visit.
- After **Pam** completes her intake, she leaves the room and scans and uploads the completed form to Albert's chart in the EHR.



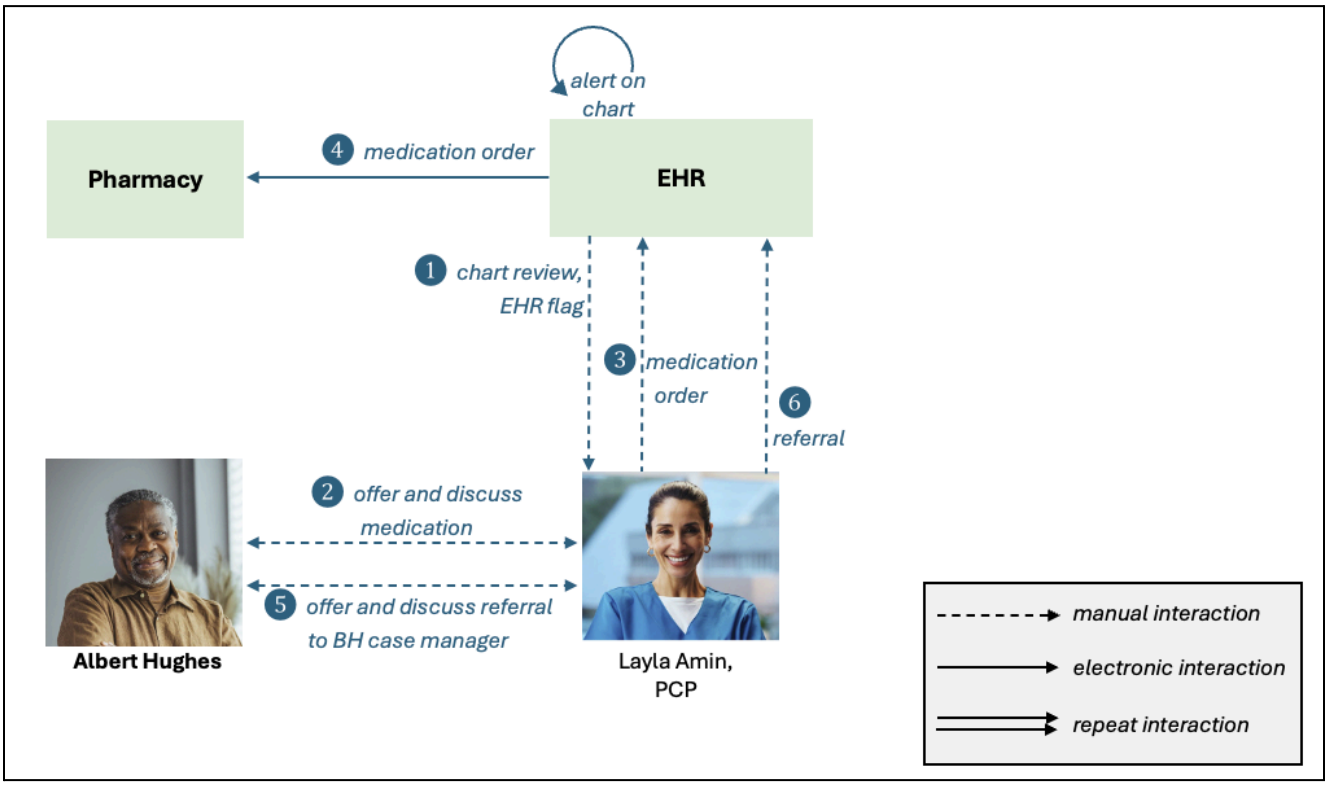
Use Case 1A: Depression Screening

Steps for Use Case 1A

1. Martha offers the PHQ-9 paper form to Albert.
2. Albert fills in the form and hands it to Pam.
3. Pam manually calculates the score and enters it in the EHR encounter notes as well as the scanned copy of Albert's original responses.

Scene 1B: Referral for Follow up Services after Positive Screening

- **Dr. Amin** reviews Albert's chart before entering the room and sees the pop-up indicating a positive score on the PHQ-9.
- She enters the room and greets **Albert** and asks him how he's feeling today and what he'd like from the visit.
- **Albert** lets her know that he lost his wife a few months ago and is having difficulty managing his diabetes. He describes his increased need to urinate and fatigue which is making it even more difficult for him to accomplish his daily activities.
- **Dr. Amin** suggests that he may be helped by taking escitalopram, an antidepressant medication. Albert agrees and **Dr. Amin** enters a medication order in her EHR.
- She continues talking with **Albert** about ways to better manage his diabetes symptoms and encourages him to speak with the inhouse Behavioral Health Case Manager for ways to connect to additional support services.
- She enters an in-house referral in her EHR for Albert to see **Michael Souris,** the inhouse BH Case Manager.



Use Case 1B: Referral for Follow up Services after Positive Screening

Steps for Use Case 1B

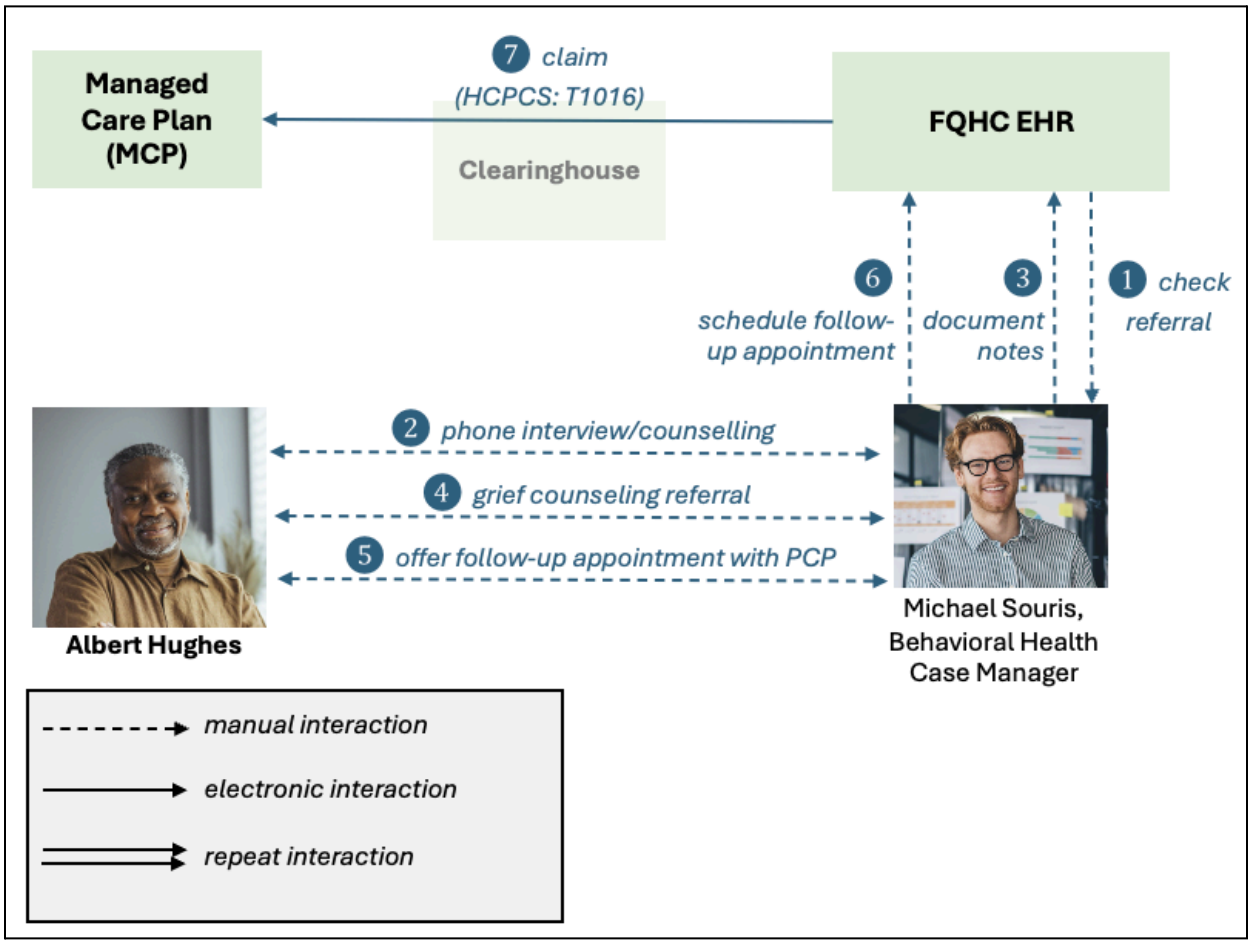
1. Dr. Amin reviews the patient chart noticing an alert for the PHQ-9 positive screening result.
2. She discusses with Albert an antidepressant medication which he accepts.

3. Dr. Amin enters the medication order into the EHR.
4. The EHR forwards the medication order to the pharmacy.
5. Dr. Amin also discusses with Albert referral to the in-house BH case manager to which he agrees.
6. Dr. Amin enters the referral into the EHR.

Use Case 2: Internal Follow Ups

Scene 2A: Follow up with Behavioral Health Case Manager

- **Michael Souris**, in-house Behavioral Health Case Manager at the FQHC, logs into the FQHC EHR the next day and sees the referral for Albert.
- **Michael** calls Albert at home, introduces himself and says that Dr. Amin referred him to talk with Albert about ways to help manage his depressive symptoms.
- **Michael** begins by assessing Albert's depression symptoms and documenting those details in the FQHC EHR.
- Learning about Albert's recent loss of his wife, **Michael** gives Albert the phone number for an online grief support group through the county.
- **Michael** then schedules Albert to come back in to see Dr. Amin in two weeks for a follow up appointment.
- After **Michael** saves the encounter, the FQHC EHR sends a claim to the Managed Care plan with a code of T1016 - Case Management for 2 units (30 minutes).
- FQHC EHR sends an X.12 837 (claim) transaction to the managed care plan via a clearinghouseMTM Client Referral Coordinator, **Abby Johnson**, receives referral



Use Case 2A: Follow up with Behavioral Health Case Manager

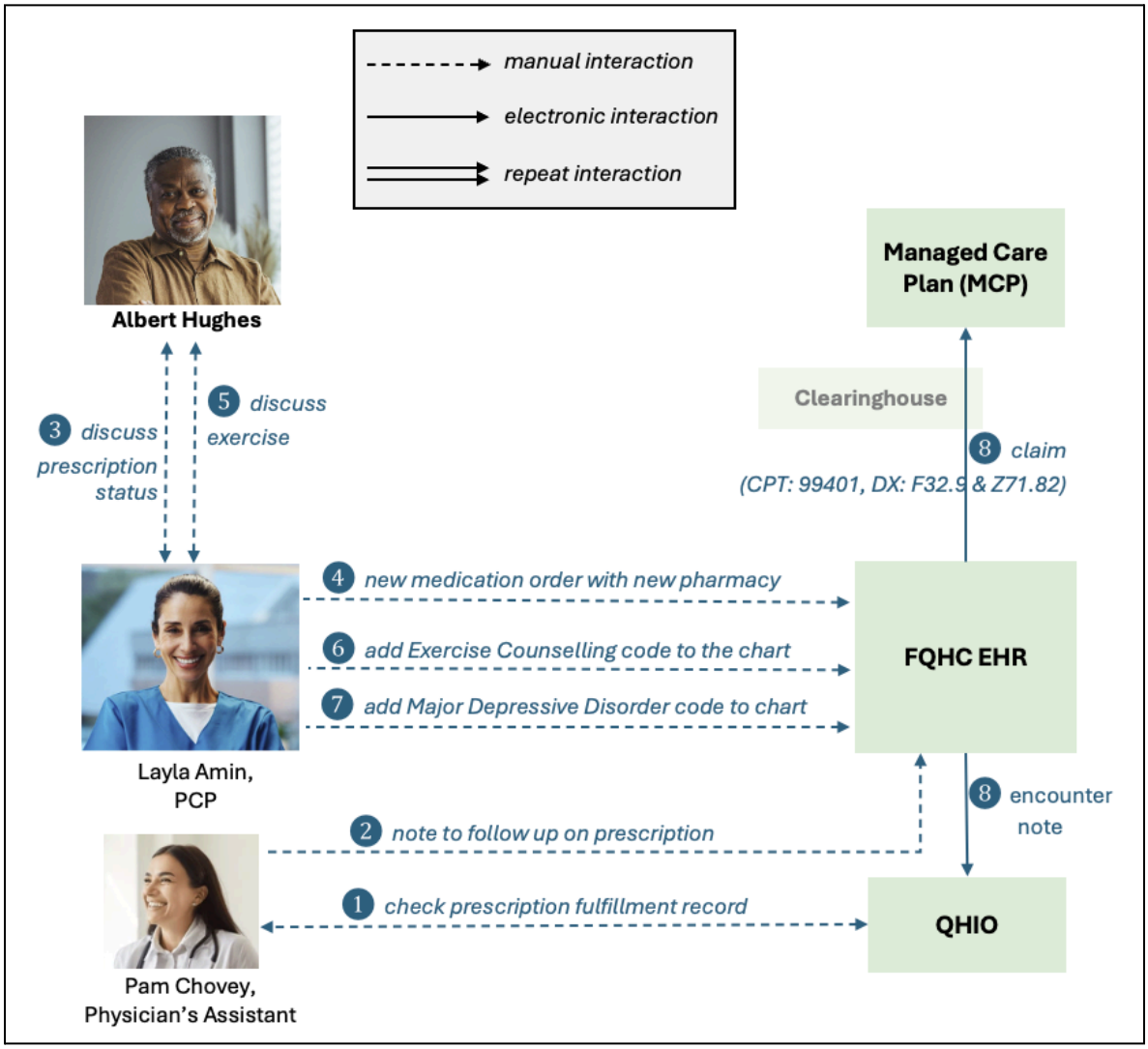
Steps for Use Case 2A

1. Michael retrieves and reviews the record of Albert's referral from FQHC EHR.
2. Michael calls Albert and conducts an interview and counselling about depressive symptoms.
3. Michael documents symptom details in the EHR.
4. Michael provides Albert with the phone number for a grief counseling program.
5. Michael offers a follow-up appointment with PCP.
6. Michael schedules the follow-up appointment in the EHR.
7. The EHR submits a claim to the Managed Care Plan (MCP).

Scene 2B: Follow up with PCP two weeks after positive screen

- Prior to Albert's two week follow up **Pam Chovey, Dr. Amin's Physician's Assistant**, looks up Albert's record in the QHIO to confirm whether he has picked up his antidepressant medication from the pharmacy.
- Seeing that he hasn't, she makes a note for **Dr. Amin** to follow up with Albert during the visit.

- When Albert comes in for his visit with **Dr. Amin,** she asks him if he needs any support to pick up his medication from the pharmacy. He asks for the prescription to be moved to a more convenient location.
    - **Dr. Amin** updates the pharmacy location and enters a new order for antidepressants in the FQHC EHR.
- **Dr. Amin** talks with Albert about how exercise is a good way to help manage his depressive symptoms and provides him with information on an easy in-home routine he can try.
    - **Dr. Amin** adds “Encounter for Exercise Counseling” (DX Z71.82) to Albert’s chart as a secondary diagnosis
- Seeing that Albert continues to have symptoms of depression, **Dr. Amin** adds a diagnosis of depression to his chart.
    - **Dr. Amin** adds “Major Depressive Disorder, Single Episode, Unspecified” (DX F32.9) to Albert’s chart as a secondary diagnosis
- After **Dr. Amin** saves the encounter, the FQHC EHR sends a claim to the Managed Care Plan.
    - FQHC EHR sends an X.12 837 (claim) transaction to the managed care plan via a clearinghouse with the following information:
        - CPT code: 99401 - “individual preventive medicine counseling session of approximately 15 minutes to promote health and prevent illness”
        - DX code: F32.9 - “Major Depressive Disorder, Single Episode, Unspecified.”
        - DX code: Z71.82 - “Exercise Counseling”
- FQHC EHR sends an Encounter Note to QHIO where it will be made available to Albert’s other providers.



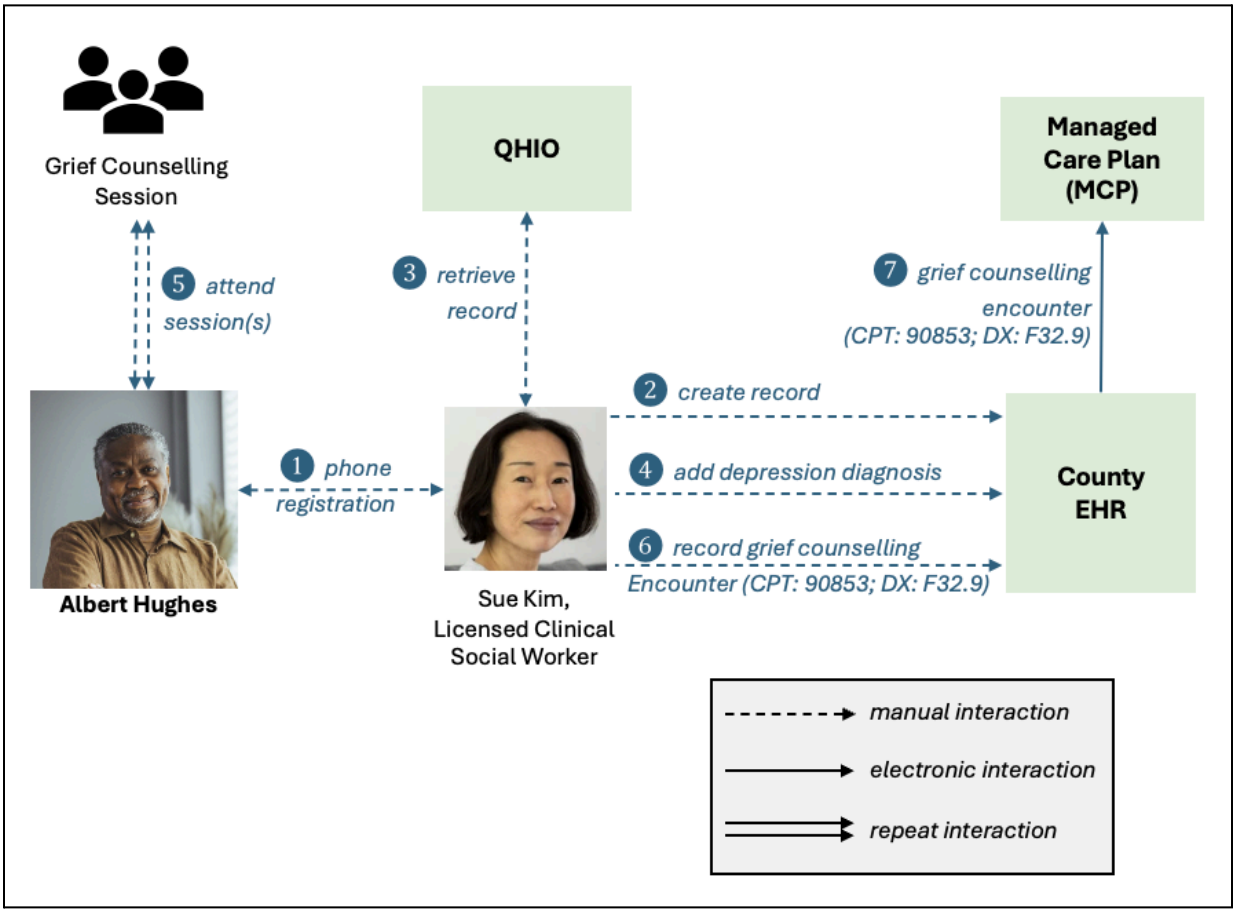
Use Case 2B: Scene 2B: Follow up with PCP two weeks after positive screen

Steps for Use Case 2B

1. Before the appointment, Pam checks Albert's record in the QHIO to confirm whether he has picked up the prescription.
2. Pam makes a note for Dr. Amin to follow up about the prescription with Albert.
3. At the encounter, Dr. Amin discusses the prescription with Albert.
4. Based on his feedback, Dr. Amin enters a new order with a new pharmacy location.
5. Dr. Amin discusses exercise as a treatment with Albert.
6. Dr. Amin adds Exercise Counselling (DX Z71.82) to Albert's chart.
7. Based on the continuing symptoms Dr. Amin adds Major Depressive Disorder, Single Episode (DX F32.9) to Albert's chart.
8. Following the conclusion of the encounter, the EHR sends a claim to the Managed Care Plan (MCP) and Encounter Note to QHIO.

Use Case 3: Follow Up for Depression / Grief Counseling at County Behavioral Health

- Albert calls the phone number given to him by **Michael Souris**, the in-house BH Case Manager, to learn more about attending the online grief support group offered through the County's Behavioral Health department.
- Albert talks with **Sue Kim**, a licensed clinical social worker with the county who runs the group and asks to register for the upcoming sessions.
    - **Sue** creates a record for Albert in the County's EHR system.
- Prior to Albert attending the group, **Sue** looks up Albert's information in the QHIO/HIE which includes the notes from his PCP where he was diagnosed with Depression.
    - **Sue** adds the depression DX to the county EHR system.
- Albert attends two meetings and finds relief at being with other widowers who are going through similar health related issues.
- After each session, **Sue** logs the encounters in the county EHR regarding Albert's attendance.
- **Tim Russell**, Quality Improvement Manager for the Managed Care plan, has an agreement with the County Behavioral Health department to receive claims for services provided to their members on a monthly basis.
    - Within the County data is a transaction for Group psychotherapy that occurred within 30 days of Albert's positive screening and includes the required information as follows:
        - CPT 90853 - "General Group Psychotherapy" (can only be used by licensed mental health professionals)
        - DX F32.9 - "Major Depressive Disorder, Single Episode, Unspecified"



Use Case 3: Follow Up for Depression / Grief Counseling at County Behavioral Health

Steps for Use Case 3

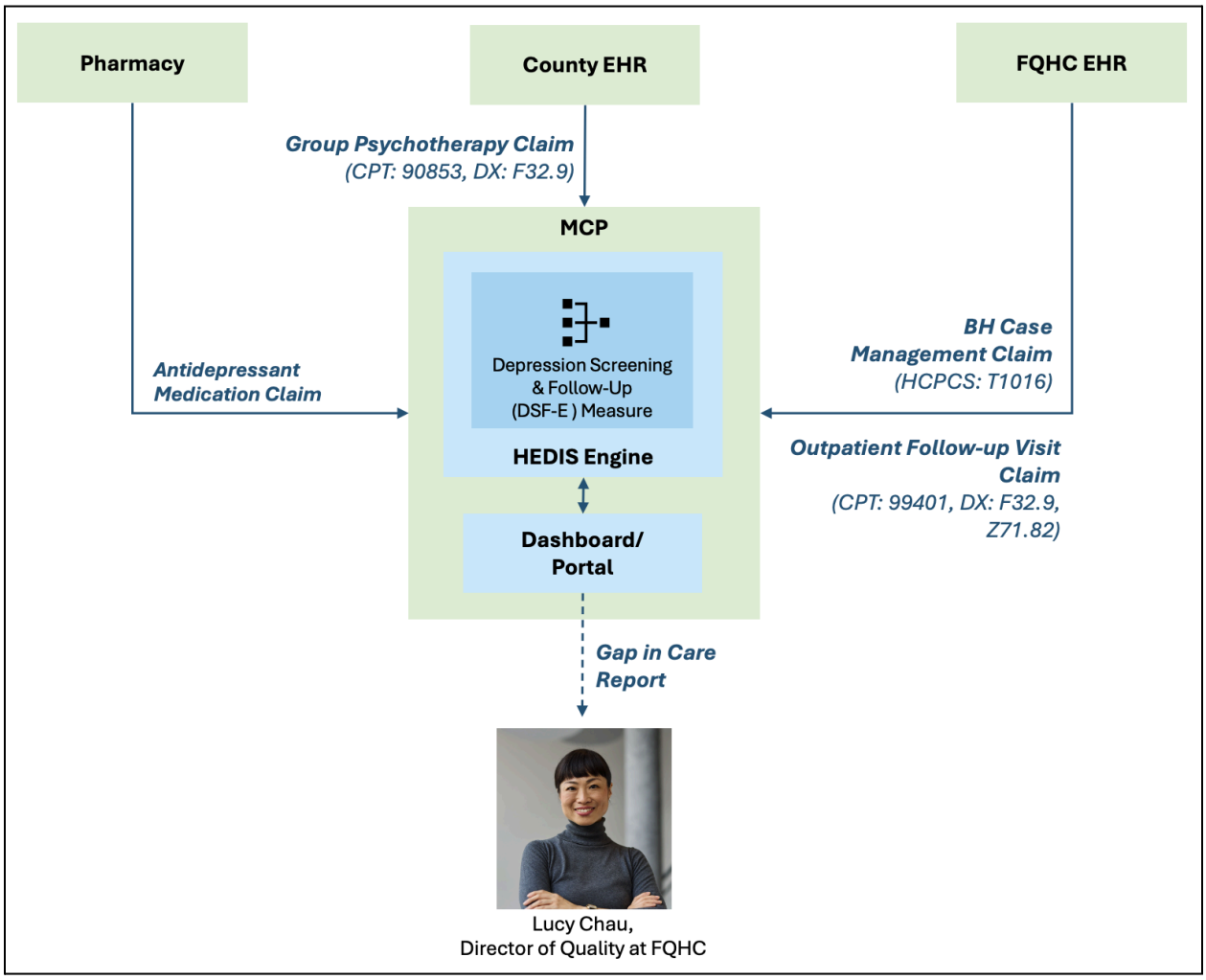
1. Albert contacts the grief counselling support group and following a conversation, Sue registers him with the service.
2. Sue creates a record for Albert in the County EHR.
3. Sue retrieves Albert's record from the QHIO.
4. Based on the depression diagnosis, Sue adds notes to Albert's record in the Country EHR.
5. Albert attends grief counselling sessions.
6. Sue records the grief counselling encounters in Albert's record after each attendance.
7. Once a month, the County sends all encounters for their attributed members to the Managed Care Plan (MCP) including the two for Albert's grief counseling sessions.

Use Case 4: Gap Closure in MCP HEDIS Engine

- **Lucy Chau**, Director of Quality for the FQHC, logs into the MCP's Provider Portal to download the most recent Gaps in Care report. In addition to showing that they have reached a new milestone

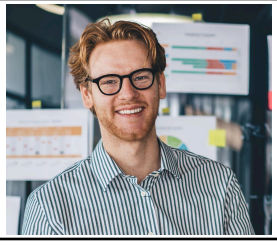
for Depression Screening - 80% of patients >= 12 years of age, she sees that the gap closure rating for those receiving a positive screening has also improved.

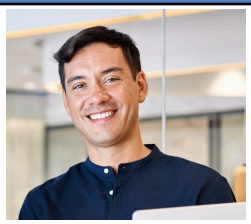
- In the case of Albert Hughes, she sees that each of the interventions that Albert's clinical team recommended have resulted in closing the measure even though only one was needed.
- These included the following activities within 30 days of Albert's positive depression screen::
    - Albert picked up his medication which was made easier when Dr. Amin re ordered the antidepressant medication to be available at a pharmacy more conveniently located for Albert to pick up.
    - Albert attended at least one virtual group grief counseling session through the County BH department. And, since the MCP recently setup data feeds from the County BH EHR to their HEDIS engine, it was able to count those BH encounters
    - Albert also received a Case Management encounter with Michael Souris which was coded with one of the CPT codes available for gap closure.
    - And, finally, Albert came back in for a followup visit with his PCP, Dr. Amin, and during that visit she diagnosed him with Depression and used one of the appropriate CPT codes for a follow-up visit. Additionally, she provided Albert with Exercise counseling during the visit and added a secondary diagnosis to reflect that.
- Again, each of the above would have closed the open Depression Screening gap for Albert although only one was necessary to close the gap, the FQHC has decided to provide all of these gap closure measures in order to have a higher degree of success with helping patients manage their depression symptoms.



Use Case 4: Gap Closure in MCP HEDIS Engine

Personas referenced in this document:

Name	Photo	Human Actor	Business Actor	System Actor
Albert Hughes		Patient		
Dr. Layla Amin		Primary Care Provider (PCP)	FQHC One	FQHC EHR
Martha Reyes		Front Office Administrator	FQHC One	FQHC EHR
Pam Chovey		Physician's Assistant	FQHC One	FQHC EHR
Michael Souris		Behavioral Health Case Manager	FQHC One	FQHC EHR
Lucy Chau		Director of Quality	FQHC One	FQHC EHR

Name	Photo	Human Actor	Business Actor	System Actor
Tim Russell		Quality Improvement Manager	Managed Care Plan (MCP)	HEDIS Engine, Provider Portal
Sue Kim		Grief Counselor / Social Worker	County Public Health	Public Health EHR