Indian Health Service
2012 NATIONAL BEHAVIORAL HEALTH CONFERENCE

Welcome

**TeenScreen Primary Care:
Mental Health Screening and Integrated Care**

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Mobilizing Partnerships to Promote Wellness

House Keeping

- Please be sure to <u>sign in</u> and <u>out</u> on the Sign In Sheets located near the entrance to this room.

- Please complete the evaluation at the end of this presentation.

- For more information on Continuing Education Units (CEUs), please visit the Registration Desk

Comfort Room

- To promote wellness and self-care, a Comfort Room is available in Atrium Room 8 for your use.

- If you need further assistance, please visit the Indian Health Service Division of Behavioral Health booth.

Partnerships

- TeenScreen & Indian Health Service working together to make screening questionnaires available in primary care.
  - RPMS EHR will include PHQ-9 Modified screening tool

- Northern Navajo Medical Center
  - Implemented TS in school-based health centers
  - Point of Contact: Jeffrey.Powell@ihs.gov

Objectives

- Define the problems of mental illness, substance use, and suicide among AI/AN youth and understand how mental health screening can help identify youth-at-risk

- Administer, score and interpret results of three evidenced-based screening tools offered through TS Primary Care and discuss screening implementation

- Identify methods to document the results of screening in the IHS RPMS Electronic Health Record

Mental Illness & Suicide In Adolescents

- **11%** of U.S. children and adolescents suffer from a serious mental disorder that causes significant functional impairment at home, at school and with peers.

- Only **36%** of youth with any lifetime mental disorder receive mental health services and only half of these youth who are severely impaired by their mental disorder received professional mental health treatment.

- **Mental illness has its roots in adolescence:** half of all mood, anxiety, impulse-control and substance-use disorders start by age 14; on average, symptoms of mental illness present two to four years before the onset of a full-blown disorder.

- Suicide is the third leading cause of death for 11-18 year olds. 90% of teens who die by suicide suffer from a treatable mental illness at their time of death.

Depression & Suicide in High School

Nationwide

- **26%** sad or hopeless for 2+ weeks.

- **14%** seriously considered suicide in the last year.

- **6%** attempted suicide one or more times in the last year.

AI/AN Youth

- **40%** sad or hopeless for 2+ weeks.

- **20%** seriously considered suicide in the last year.

- **18%** attempted suicide one or more times in the last year.

Risk Factors

- Native American Youth have the highest rate of suicide in US, age 15-24 yo

- Navajo rate 16.8/100k vs. US rate 10.6

- Males – 85% suicide fatalities; females 85% suicide attempts

- More suicides attempted by middle school youth but more fatalities occur in 17-21 yo

- Substance abuse involved 50% fatalities and 65% attempts

Consequences to Untreated MI

Higher Health Care Utilization

- Youth experiencing emotional and behavioral problems seek more health care, higher costs

School Failure

- Approximately 50% of students age 14 and older who suffer from mental illness drop out of high school; this is the highest dropout rate of any disability group.

Juvenile and Criminal Justice Involvement

- 65% of boys and 75% of girls in juvenile detention suffer from mental illness.

Long Term Disability

- Mental illness is the 2nd leading cause of disability and premature mortality in the U.S.
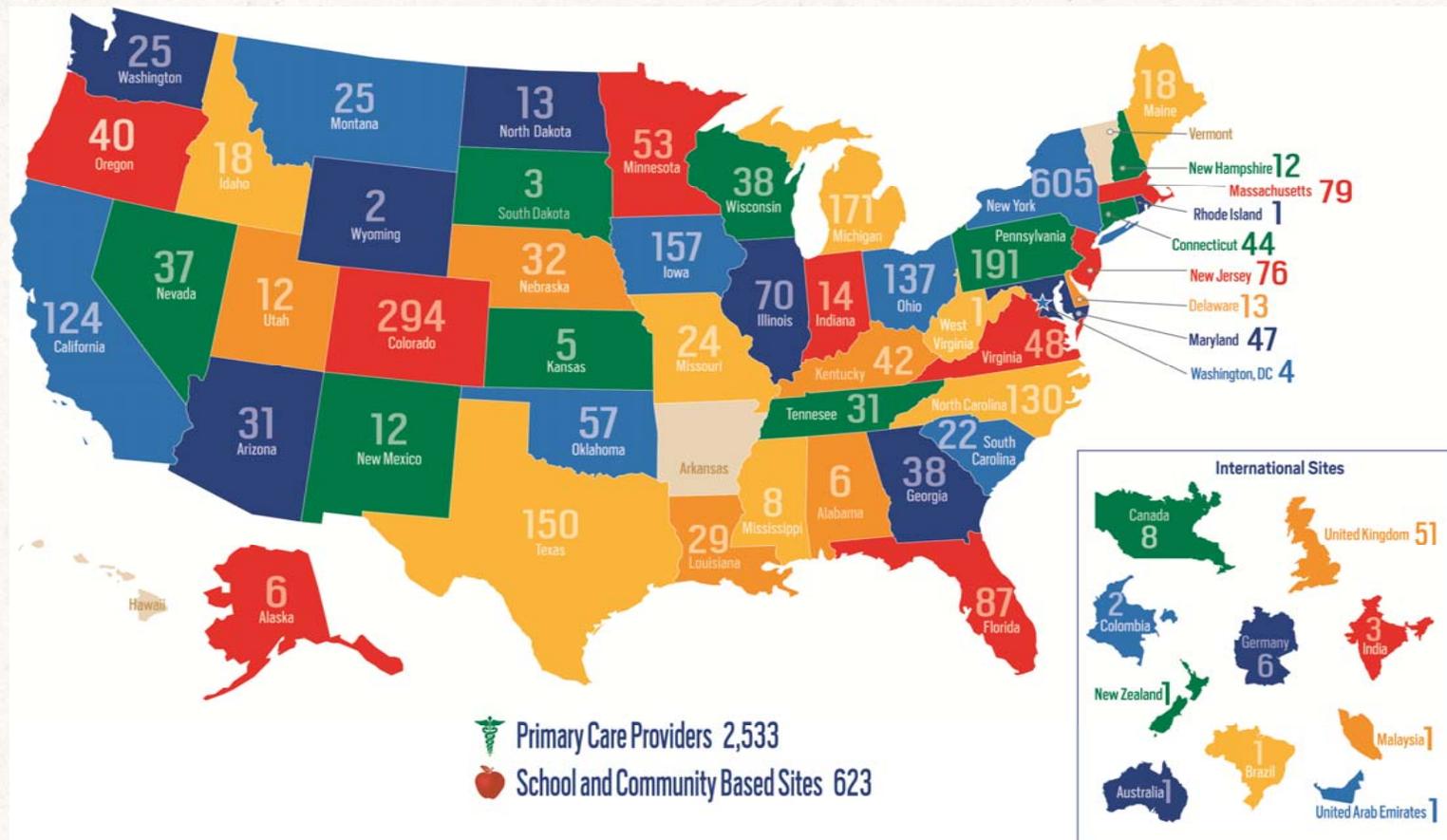
Why Screen?

- Mental illness is treatable and there is ample time to intervene before symptoms escalate to a full blown disorder and before a teen turns to suicide.

- Screening tools that effectively and accurately identify at-risk teens are available.

- Most mentally ill and suicidal youth aren't already being helped.

- No one else is asking teens these questions, but they will give us the answers if we ask.

- Expert Consensus: AAP, AAFP, SAHM, IOM and NRC, U.S. Preventive Services Task Force, Health Care Reform, EPSDT

- Clinical performance measurement: GPRA and Meaningful Use

TeenScreen National Center for Mental Health Checkups

- National resource center committed to early identification of mental illness in adolescents and prevention of teen suicide.

- **Mission:** to expand and improve early detection of mental illness by mainstreaming mental health checkups as a routine procedure in adolescent health care, schools, and other youth-serving settings.

- TeenScreen Primary Care and TeenScreen Schools and Communities.

- Non-profit, privately funded organization housed in the Columbia University Division of Child and Adolescent Psychiatry.

- The National Center provides free tools and resources to primary care, school and community partners to enable them to offer adolescent mental health checkups.

3,156 Active Screeners / 47 States

Washington 25
Montana 25
North Dakota 13
Minnesota 53
Oregon 40
Idaho 18
South Dakota 3
Wisconsin 38
Michigan 171
Maine 18
Vermont
New Hampshire 12
Massachusetts 79
Rhode Island 1
Connecticut 44
New Jersey 76
Delaware 13
Maryland 47
Washington, DC 4
Wyoming 2
Iowa 157
New York 605
Pennsylvania 191
Nevada 37
Utah 12
Colorado 294
Nebraska 32
Illinois 70
Indiana 14
Ohio 137
West Virginia 1
Virginia 48
California 124
Kansas 5
Missouri 24
Kentucky 42
North Carolina 130
Arizona 31
New Mexico 12
Oklahoma 57
Arkansas
Tennesee 31
South Carolina 22
Texas 150
Louisiana 29
Mississippi 8
Alabama 6
Georgia 38
Hawaii
Alaska 6
Florida 87

Primary Care Providers 2,533
School and Community Based Sites 623

International Sites
Canada 8
United Kingdom 51
Colombia 2
Germany 6
India 3
New Zealand 1
Malaysia 1
Brazil 1
Australia 1
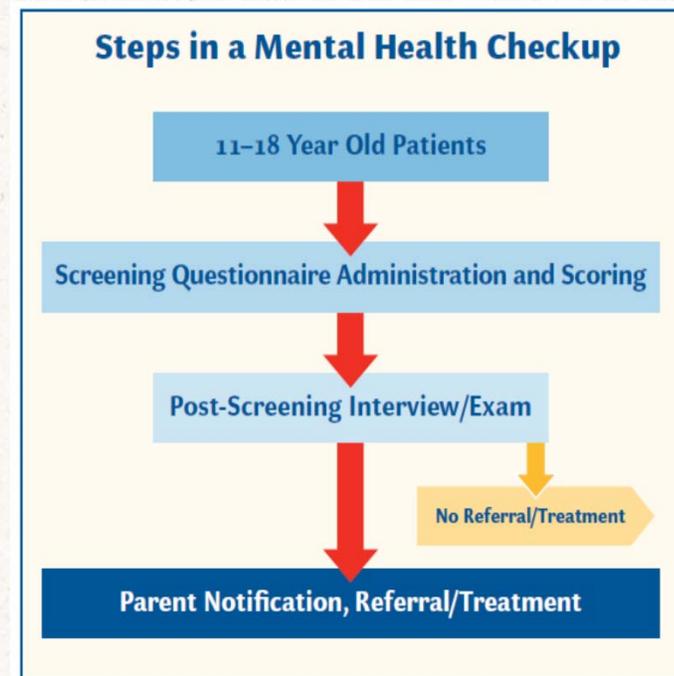United Arab Emirates 1

Mental Illness in Primary Care

- 24% of pediatric primary care visits involve behavioral, emotional or developmental concerns.

- 70% of adolescents see a primary care provider (PCP) at least once a year.

  - ✓ Only 23% of PCPs screen for mental health disorders

  - ✓ Missed opportunities, think immunizations

- Mental health screening increases identification and treatment

Steps in a Mental Health Checkup

- 5-10 minute evidence-based questionnaire given during well-child, sports physical and other routine visits.

- Screening questionnaire is completed by the teen and scored by a nurse or medical technician.

- PCPs review screening results and briefly evaluate teens who score positive.

- Teens who require a more complete evaluation or MH services are referred to a MH provider or treated by the PCP.

Steps in a Mental Health Checkup

11–18 Year Old Patients

↓

Screening Questionnaire Administration and Scoring

↓

Post-Screening Interview/Exam

→ No Referral/Treatment

↓

Parent Notification, Referral/Treatment

Pediatric Symptom Checklist for Youth (PSC-Y)

✓Developed at Harvard.

✓Designed to detect behavioral and psychosocial problems.

✓Questions cover internalizing, attention, externalizing problems.

✓Two questions regarding suicidal thinking and behavior added.

✓Symbol-coded for problem area.

✓Validated and widely used.

✓Positive score is ≥ 30 or endorsement of either suicide question.

✓Available in a number of languages.

A Survey From Your Healthcare Provider — PSC-Y　　　TeenScreen ✓ Primary Care

Name		Date	ID		
Please mark under the heading that best fits you or circle Yes or No			Never 0	Sometimes 1	Often 2
-	1. Complain of aches or pains				
-	2. Spend more time alone				
-	3. Tire easily, little energy				
●	4. Fidgety, unable to sit still				
-	5. Have trouble with teacher				
-	6. Less interested in school				
●	7. Act as if driven by motor				
●	8. Daydream too much				
●	9. Distract easily				
-	10. Are afraid of new situations				
▲	11. Feel sad, unhappy				
-	12. Are irritable, angry				
▲	13. Feel hopeless				
●	14. Have trouble concentrating				
-	15. Less interested in friends				
■	16. Fight with other children				
-	17. Absent from school				
-	18. School grades dropping				
▲	19. Down on yourself				
-	20. Visit doctor with doctor finding nothing wrong				
-	21. Have trouble sleeping				
▲	22. Worry a lot				
-	23. Want to be with parent more than before				
-	24. Feel that you are bad				
-	25. Take unnecessary risks				
-	26. Get hurt frequently				
▲	27. Seem to be having less fun				
-	28. Act younger than children your age				
■	29. Do not listen to rules				
-	30. Do not show feelings				
■	31. Do not understand other people's feelings				
■	32. Tease others				
■	33. Blame others for your troubles				
■	34. Take things that do not belong to you				
■	35. Refuse to share				
◆	36. During the past three months, have you thought of killing yourself?			Yes	No
◆	37. Have you ever tried to kill yourself?			Yes	No

FOR OFFICE USE ONLY　　　TS _____

Plan for Follow-up ☐ Annual screening ☐ Return visit w/ PCP ☐ Referred to counselor

☐ Parent declined ☐ Already in treatment ☐ Referred to other professional

Q 36 or Q 37=Y ◆　　TS ≥ 30

Source: Pediatric Symptom Checklist – Youth-Report (PSC-Y)　　　PC/PSC-Y/G.4.10/1000

Patient Health Questionnaire (PHQ-9 Modified)

✓ Depression screening questionnaire; two questions regarding suicidal thinking and behavior added.

✓ Validated and one of the two questionnaires recommended by the USPSTF.

✓ Developed at Columbia.

✓ Positive score is ≥ 11 OR endorsement of either suicide question.

✓ Can be scanned into EHRs.

✓ Available in English and Spanish

A Survey From Your Healthcare Provider — PHQ-9 Modified for Teens

TeenScreen✓ Primary Care

Name_____ Clinician_____

Medical Record or ID Number_____ Date_____

Instructions: How often have you been bothered by each of the following symptoms during the past two weeks? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself — or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

10. In the *past year* have you felt depressed or sad most days, even if you felt okay sometimes? ☐ Yes ☐ No

11. If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?
☐ Not difficult at all   ☐ Somewhat difficult   ☐ Very difficult   ☐ Extremely difficult

12. Has there been a time in the past month when you have had serious thoughts about ending your life? ☐ Yes ☐ No

13. Have you *ever*, in your *whole life*, tried to kill yourself or made a suicide attempt? ☐ Yes ☐ No

FOR OFFICE USE ONLY Score_____

Q. 12 and Q. 13 = Y or TS =≥11

Source: Patient Health Questionnaire Modified for Teens (PHQ-D) (Author: Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues)

PC/PHQ-9 Mod/6.4.10/1000

CRAFFT

- ✓ Self-administered questionnaire designed to screen adolescents for substance and alcohol use.

- ✓ Developed at Harvard.

- ✓ Validated and widely used.

- ✓ 5 minutes or less to admin and score.

- ✓ Can be used in conjunction with other mental health screening questionnaires.

- ✓ Can be scanned into EHRs.

CRAFFT — TeenScreen Primary Care

Please answer all questions *honestly*; your answers will be kept *confidential*.

Name _____

Medical Record or ID Number _____ Date _____

Part A

During the PAST 12 MONTHS, did you:

	No	Yes
1. Drink any alcohol (more than a few sips)?	☐	☐
2. Smoke any marijuana or hashish?	☐	☐
3. Use anything else to get high? "anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff"	☐	☐

If you answered NO to ALL (A1, A2, A3) answer **only B1** below, then STOP.

If you answered YES to ANY (A1 to A3), answer **B1 to B6** below.

Part B

	No	Yes
1. Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
2. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?	☐	☐
3. Do you ever use alcohol or drugs while you are by yourself, or ALONE?	☐	☐
4. Do you ever FORGET things you did while using alcohol or drugs?	☐	☐
5. Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?	☐	☐
6. Have you ever gotten into TROUBLE while you were using alcohol or drugs?	☐	☐

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PC/CRAFFT/6.4 10/500

Post-Screening Discussion

Negative Screen

✓ Quick check-in by the PCP during the appointment to inform patient that their results were negative (i.e., that they do not appear to be at risk for a mental health problem).

Positive Screen

✓ More in-depth interview with the PCP to determine if a referral for further evaluation is necessary, preferably not in the presence of parents.

✓ Cover main areas of concern identified by the questionnaire.

✓ Inquire about suicidal thoughts and behaviors.

✓ Assess the level of impairment caused by the symptoms at school, at home and with peers.

✓ When necessary, discuss with patient what information will be shared with parents and the next steps.

Parent Notification & Referral

- Engage & Inform Parents

- Compile a list of referrals

- Work with existing health benefit

TeenScreen's Guide to Referral – List of Mental Health Resources, Sample Letters and other helpful information

Screening in a Clinic Setting

Establish practice screening process:

- Identify community partners for referral / consultation / emergency care

- Select evidence-based screening tools

- Identify which visits will include formal screening

- Notify families of *routine* mental health screening " …to improve care"

- Where will screening take place and by whom?

- How will screening results be recorded? Where?

- When screening identifies a problem, how will practice follow-up?
  - ✓What is follow-up for other positive screening tests?

TeenScreen's Resources

- Screening Questionnaire Starter Kits for all 3 Questionnaires, PSC-Y, PHQ-9M, CRAFFT

- Post-Screening Discussion Guide

- Guide to Referral

- Preparing Your Office to Implement Screening

- Parent & Patient Education Materials

- Webinar Series

- Website: http://www.teenscreen.org

TeenScreen Schools & Communities Program

- Community-based partnerships to develop screening programs

- Focus on education systems and community-based youth-serving organizations
  - ✓ Schools and SBHCs
  - ✓ Clinics
  - ✓ Drop-in centers
  - ✓ Shelters
 - ✓ Residential treatment facilities
  - ✓ Juvenile justice facilities

TeenScreen Schools & Communities Program

Process differs from primary care settings:

- Screening Questionnaires – Columbia Health Screen (CHS) Diagnostic Predictive Scales (DPS)

- Development and Training Materials

- Parent Consent and Participant Assent

- Debriefing and Clinical Interview

- Case Management

Bring Screening to Your Community

- Raise awareness about the serious problem of unidentified mental illness and suicide in youth. Visit our State Resource Center for information on youth mental illness and suicide in your state.

- Educate your tribe or tribal leaders, primary care provider, school officials or community leaders on how mental health checkups work and the value of prevention programs.

- Build support for developing a local mental health checkup initiative by developing or joining group of individuals that have the authority to help facilitate local screening efforts. Include:
    - ✓ Tribes and tribal leadership
    - ✓ Medical and health care professionals
    - ✓ School officials, faculty, support staff
    - ✓ Mental health professionals
    - ✓ PTA/ PTO members or other parent groups
    - ✓ Administrators from hospitals and mental health agencies
    - ✓ Faith-based organizations
    - ✓ Local colleges and universities
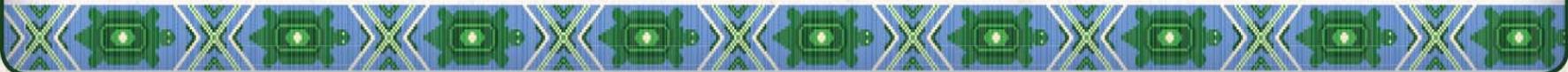
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Documenting Screening in RPMS

Resource & Patient Management System

- IHS Health Information Solution since 1984
- RPMS is an integrated Public Health information system
  - Composed of over 60 component applications/namespaces
  - Patient and Population based clinical applications
  - Patient and Population based practice management applications
- In use at approximately 400 facilities nationwide, including all Federal IHS facilities and most Tribal programs

www.ihs.gov/CIO/RPMS

RPMS Behavioral Health System

- Electronic documentation for Behavioral Health encounters
  - BHS v4.0 – graphical user interface for providers
- Data Entry in BHS includes
  - Client encounters (Individual & Group)
  - Case Management Information
  - Intake/Assessment and Treatment plans
- BHS Reports
  - Workload
  - Problem specific, provider specific, etc.
- Site Manager Utilities
  - Application set-up
  - Data exporting

RPMS Electronic Health Record

- Patient care interface for clinicians, nurses, pharmacists
- Based on VA's CPRS but more flexible and customizable to user preferences and workflow
- Information retrieval, order entry, encounter documentation, notes, and more
- RPMS EHR released in 2005, now in use at over 300 facilities nationwide including Alaska village clinics

Use of the EHR by BH Providers

- BHS or EHR - It's all RPMS
- Supports integrated Primary and Behavioral Health care
- EHR user interface can be configured to support the work flow of BH providers
- Pick lists and clinical note templates specific to BH can be created
- BHS must still be installed and monthly exports done
  – Dependency for Suicide Report Form
  – National BH data from BHS and PCC

Teen Screen Tools in RPMS

- Currently available
  - PHQ-2 and PHQ-9
  - CRAFFT
- In development
  - PHQ-9 (Modified for Teens)
  - Available Fall 2012
  - Existing depression screening reports and GPRA performance logic will be modified to include new PHQ-9 Modified
  - Can currently administer a PHQ-9 Modified and record in EHR as a PHQ-9 result

PHQ-

- Derived from Primary Care Evaluation of Mental Disorders (PRIME-MD) – Pfizer, Inc.
- 9-item depression module – both a depression severity measure and a diagnostic instrument
- Can also be used to measure response to treatment
- Includes all nine symptom criteria necessary for establishing DSM-IV depressive disorder diagnoses

PHQ9P

PATIENT HEALTH QUESTIONNAIRE-9   72883

THIS SECTION FOR USE BY STUDY PERSONNEL ONLY.

Were data collected? No ☐ *(provide reason in comments)*

If **Yes**, data collected on visit date ☐ or specify date: _____
DD-Mon-YYYY

Comments:

Only the patient (subject) should enter information onto this questionnaire.

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

SCORING FOR USE BY STUDY PERSONNEL ONLY

__0__ + ____ + ____ + ____

=Total Score: ____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

I confirm this information is accurate. | Patient's/Subject's initials: | Date:

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PHQ-9 Scoring

Range: 0 – 27

- 0 – 4 No depression
- 5 – 9 Minimal Symptoms
- 10 – 14 Mild Symptoms
- 15 – 19 Moderate Symptoms
- 20 or more – Severe Symptoms

** A depression diagnosis that warrants treatment or treatment change, needs at least one of the first two questions endorsed as positive (little pleasure, feeling depressed), more than half the time in the past two weeks.

*** Source: www.depression-primarycare.org

PHQ-2

Over the last two weeks, how often have you been bothered by any of the following problems?

- Little interest or pleasure in doing things
    - 0 = Not at all
    - 1 = Several days
    - 2 = More than half the days
    - 3 = Nearly every day
- Feeling down, depressed or hopeless
    - 0 = Not at all
    - 1 = Several days
    - 2 = More than half the days
    - 3 = Nearly every day
- Total PHQ-2 score: Range: 0 – 6

- > 3 points is considered a positive screen and further evaluation is indicated

TIU Note Templates in the EHR

- TIU = Text Integration Utility
  - Clinical note authoring tool in RPMS EHR
  - EHR uses TIU templates to create structured notes
  - Templates can pull data from RPMS (but not push) for display in notes – orders, labs, diagnoses, etc.
  - Templates can show additional text, guidance, or other information to the user that does not end up in the note.
- Template Creation
  - Content is developed by subject matter experts (i.e. the providers)
  - EHR Clinical Application Coordinators (CACs) create the template

PHQ-2

Over the past two weeks, how often have you been bothered by any of the
following problems?

Little interest or pleasure in doing things.
- ○ 0 = Not at all
- ○ 1 = Several days
- ○ 2 = More than half the days
- ○ 3 = Nearly every day

Feeling down, depressed, or hopeless.
- ○ 0 = Not at all
- ○ 1 = Several days
- ○ 2 = More than half the days
- ○ 3 = Nearly every day

Total point score: ▢

Score interpretation:

PHQ-2   Probability of major   Probability of any

Template: JSU PHQ-9

```
PHQ-9 — Nine Symptom Checklist

Date: JUL 07, 2009

1. Over the last 2 weeks, how often has the patient been bothered by any
   of the following problems? Read each item to the patient carefully,
   and indicate the response.
   a. Little interest or pleasure in doing things
      ○ 0 = Not at all
      ○ 1 = Several days
      ○ 2 = More than half the days
      ○ 3 = Nearly every day
   b. Feeling down, depressed, or hopeless
      ○ 0 = Not at all
      ○ 1 = Several days
      ○ 2 = More than half the days
      ○ 3 = Nearly every day
   c. Trouble falling asleep, staying asleep, or sleeping too much
      ○ 0 = Not at all
      ○ 1 = Several days
      ○ 2 = More than half the days
      ○ 3 = Nearly every day
   d. Feeling tired or having little energy
      ○ 0 = Not at all
      ○ 1 = Several days
      ○ 2 = More than half the days
      ○ 3 = Nearly every day
   e. Poor appetite or overeating
      ○ 0 = Not at all
      ○ 1 = Several days
```

* Indicates a Required Field   [Preview]   [OK]   [Cancel]

Vitals

	20-Jul-2004 15:07	01-Apr-2005 09:40	11-May-2005 08:15	22-May-2006 08:00	15-Aug-2006 07:53	22-v		
Respirations	16	16	20		20			/min
Blood Pressure	117/60	130/70	124/80		144/82		90-150	mmHg
Height		61.42			62			in
Weight	124	124.12	123		130			lb
Pain					10			
Body Mass Index		23.13	22.93		23.78			
PHQ2				5				
PHQ9				20				

Enter Vitals...

Today
One Week
Two Weeks
One Month
Six Months
One Year
Two Years
All Results
Date Range

Default Units

- [x] Values
- [ ] Zoom
- [ ] 3D
- [x] Grid
- [ ] Age
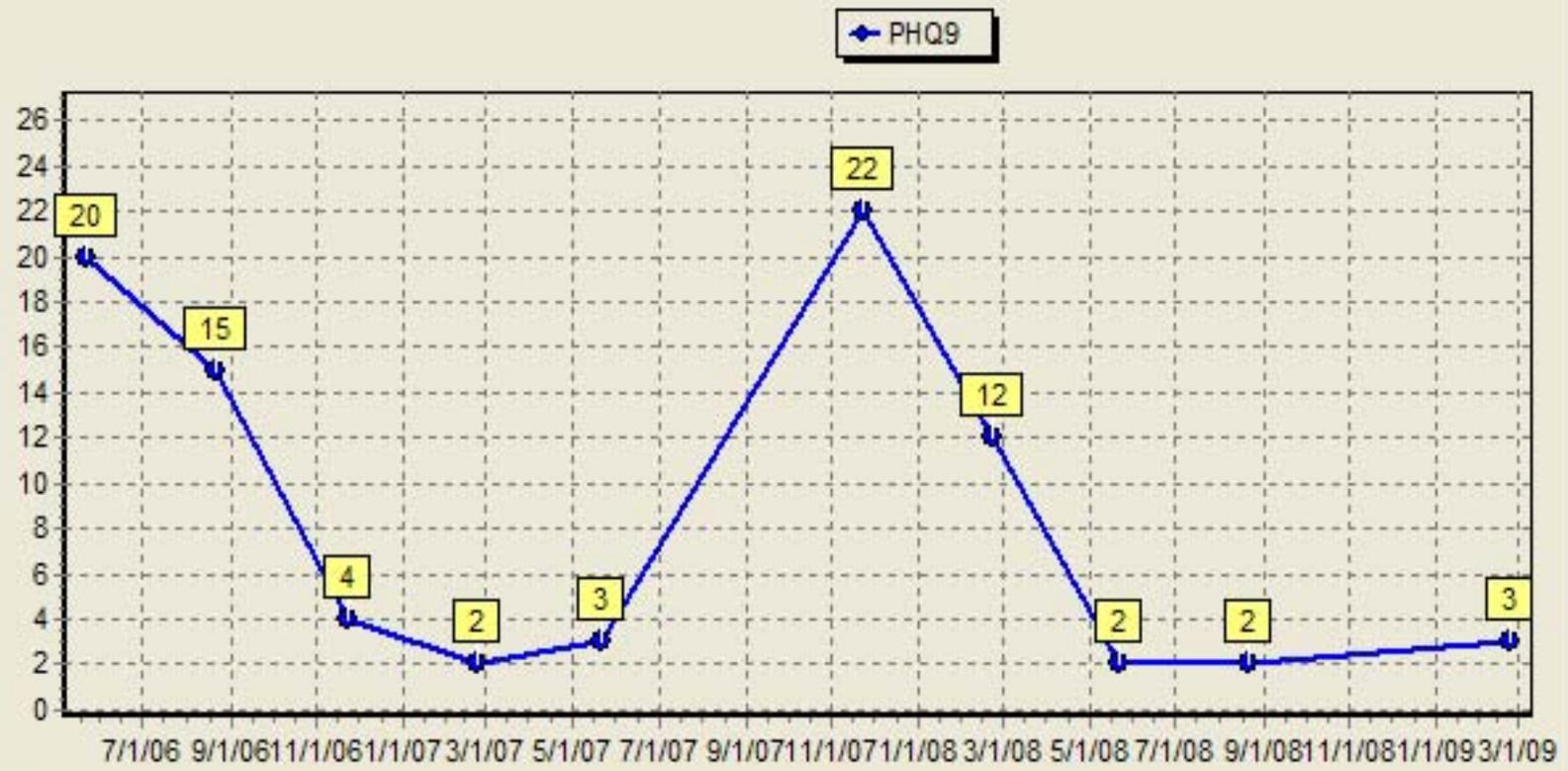
PHQ9

Documenting Screening in the EHR

- Tools for evaluating depressive symptoms are on 2 components
  - Exam (Depression Screening)
  - Measurements (PHQ2, PHQ9)
- This can pose a dilemma for some users who aren't certain where to document screening
  - Users and sites need to define locally – who does screening, what tools are used, where are they documented
- Sites using EHR Reminders can use Reminder Dialogs to file results of screening in the right location

Implementing New
Clinical Screening Initiatives

- Agree on roles and processes
  - Who will administer the screen? Patient self-administered and entered into the EHR later?
  - Who will take action on positive screens?
  - What actions will be taken?
    - Immediate clinical intervention (e.g. PCP)
    - In-house referrals (e.g. BH)
    - External referral (CHS, other)
- Analyze workflows and adapt EHR
  - EHR interface layout customized to providers
  - TIU templates or Reminder Dialogs
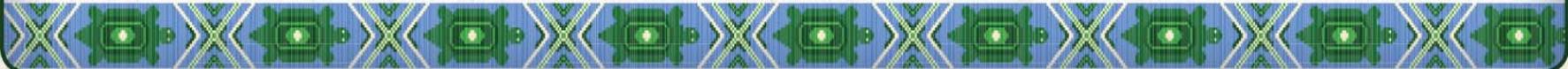
EHR Reminder Dialogs

- Documentation tool for the EHR
  - Looks like a TIU note template
  - Creates documentation (note), AND
  - Enters data into RPMS fields (such as measurements)

    … all at the same time

- Reminder Dialogs can generate orders
  - Meds
  - Labs
  - Consults

- Support treatment algorithms
  - Can be configured to guide the user through documentation and treatment (orders) depending on specific findings

PHQ-2
Screening
Dialog
Initial view

Reminder Dialog Template: TEST Depression screen dialog

```
---------------------
PREVIOUS PHQ scores:
PHQ2:   None found
PHQ9: No PHQ9 Found
---------------------

-- PHQ2/Depression Screening Exam --
  _____
  DEPRESSION SCREENING using PHQ-2:
     PHQ2 Copyright Pfizer Inc. All rights reserved. Reproduced with
  permission.   PRIME-MD is a trademark of Pfizer Inc.

  Over the past 2 weeks, patient reports being bothered by the following
  1. Little interest or pleasure in doing things:
     Response: *
  2. Feeling down, depressed or hopeless:
     Response: *

  - Report total score 0-2-Normal/Negative
  - Report total score 3-6-Positive Screening *** Further assessment is indicated ***



  Enter Total Score for PHQ2 below:



    *** Select Depression Screening Exam result below ***
     C   Score is 0-2, Depression screen exam is Negative
     C   Score is 3-6, Depression screen exam is Positive
```

* Indicates a Required Field

Enter Total Score for PHQ2 below:

Vital Measurements: **PHQ2**

Finish   Cancel

PHQ-2 Depression Screening Exam Dialog

Exam guidance from RPMS Exam and Health Factor guide

STORES IN NOTE:

- PHQ2 Questions
- PHQ2 Score
- Depression Screening Exam Score (optional)

STORES IN RPMS:

- PHQ2 Score
- Depression Screening Exam Score

Reminder Dialog Template: TEST Depression screen dialog

```
--------------------
PREVIOUS PHQ scores:
PHQ2:   None found
PHQ9: No PHQ9 Found
--------------------
-- PHQ2/Depression Screening Exam --
_____
  DEPRESSION SCREENING using PHQ-2:
    PHQ2 Copyright Pfizer Inc. All rights reserved. Reproduced with
 permission.   PRIME-MD is a trademark of Pfizer Inc.

  Over the past 2 weeks, patient reports being bothered by the following
  1. Little interest or pleasure in doing things:
      Response: * (1) Several days            [v]
  2. Feeling down, depressed or hopeless:
      Response: * (2) More than half the days [v]


  Enter Total Score for PHQ2 below:
     [ 3 ]

      *** Select Depression Screening Exam result below ***
    ( )  Score is 0-2, Depression screen exam is Negative
    (o)  Score is 3-6, Depression screen exam is Positive
                    [ Positive  [v] ]        [                          ]
      [x]  Intervention: Referred to Primary Care Provider
                  (Add as "additional signer" on note to notify.
                   Call/Advise in person if increased concern)
                  [                                             ]
```

* Indicates a Required Field

```
_____
DEPRESSION SCREENING using PHQ-2:
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permission.   PRIME-MD is a trademark of Pfizer Inc.

Over the past 2 weeks, patient reports being bothered by the following
1. Little interest or pleasure in doing things:
    Response: (1) Several days
2. Feeling down, depressed or hopeless:
    Response: (2) More than half the days


Enter Total Score for PHQ2 below:
  3

Patient provides positive answers tothe depression screening
  and further evaluation is warranted.
 Exam Result: Positive

Intervention: Referred to Primary Care Provider
```

Examinations: **DEPRESSION SCREENING**
Vital Measurements: **PHQ2**

[Finish] [Cancel]

PHQ9 Screening Dialog

Provides guidance for user to administer the tool.

Provides guidance for suicidal ideation triage, interventions and disposition

STORES IN NOTE:
- Questions and answers
- PHQ9 score

STORES IN RPMS:
- PHQ9 score

Dialog will branch depending on answer to question 9

Reminder Dialog Template: TEST PHQ9 dialog

```
----------------------
PREVIOUS PHQ scores:
PHQ2:   None found
PHQ9: No PHQ9 Found
----------------------
-- PHQ9 Assessment --
☑      PHQ9 Copyright   Pfizer Inc. All rights reserved. Reproduced with
         permission. PRIME-MD   is a trademark of Pfizer Inc.

   ASK PATIENT:  Over the LAST 2 WEEKS, how often have you been
   bothered by any of the following problems?

   1. Little interest or pleasure in doing things
      Response:  *(1) Several days          ▾

   2. Feeling low, depressed, hopeless
      Response:   *(1) Several days          ▾

   3. Trouble falling or staing asleep, or sleeping too much
      Response:  *(1) Several days          ▾

   4. Feeling tired or having little energy
      Response:  *(1) Several days          ▾

   5. Poor appetite or overeating
      Response:   *(1) Several days          ▾

   6. Feeling bad about yourself, or that you are a failure
      or have let your-self or your family down
      Response:  *(1) Several days          ▾

   7. Trouble concentrating on things, such as reading the
      newspaper or watching television
      Response:  *(1) Several days          ▾

   8. Moving or speaking so slowly that other people could
      have noticed. Or the opposite - being so fidgety
      or restless that you have been moving around a lot more
      than usual.
      Response:  *(1) Several days          ▾

   9. Thoughts that you would be better off dead, or of
      hurting yourself in some other way
      ○      Response:  (0) Not at all
      ○      Response: (more than "None at all")  *
         ○ (1) Several days
         ○ (2) More than half the days
         ○ (3) Nearly every day

         _____
      *** TOTAL the score from 1-9 and enter below:
```

* Indicates a Required Field

```
9. Thoughts that you would be better off dead, or of
   hurting yourself in some other way
```

<No encounter information entered>

[Finish] [Cancel]

PHQ-9 Reminder Dialog: No Suicidal Ideation reported – Question 9 response: "Not at All"

Score PHQ9 (stores in RPMS)

Answer question 10

Select intervention (stores in RPMS if order, patient education)

Display PHQ9 scoring guidance

9. Thoughts that you would be better off dead, or of
   hurting yourself in some other way
   ○   Response: (0) Not at all

   *** TOTAL the score from 1-9 and enter below:
   [8]

   ☑ *** If score is greater than "0" (any problems checked off)
          ask the following question ****

   10. If you checked off any problems, how
       difficult have these problems made it
       for you to work, take care of things at
       home, or get along with other people?
       Response: Not difficult at all ▼
   -- INTERVENTIONS --
   ☐ Intervention: Supportive counseling and education.
   ☐ Intervention: supportive counseling, education and
          watchful waiting.
   ☐ Intervention: Psychotherapy.
   ☐ Intervention: Antidepressant medication

   ----- PHQ Scoring ----------------------------------
   (copyright 3CMtm, September 20098 from www.depression-primarycare.org)

PHQ9 Score	Provisional dx	Treatment Recommendations
5-9	Mininal symptoms*	Support, educate to call if worse return 1 month
10-14	Minor Depression** Dysthymia* Major depression, mild	Support, watchful waiting Antidepressant or psychtherapy Antidepressant or psychotherapy
15-29	Major depression, moderately severe	Antidepressant or psychotherapy
20+	Major depression, severe	Antidepressant AND psychotherapy (especially if not improved on monotherapy)

   * If symptoms present 2 or more years then probably chronic depression
     which warrants antidepressant or psychotherapy (ask "In the past 2
     years have you felt depressed or sad most days, even if you felt ok
     sometimes?")

   ** If symptoms present 1 or more months or severe functional impairment,
      consider active treatment.

   Please see additional guidance for treatment selection and assessing
   patient response to treatment.
   _____

   http://www.depression-primarycare.org/images/pdf/phq_9_eng.pdf

                                                   * Indicates a Required Field

   home, or get along with other people?
   Response: Not difficult at all

Vital Measurements: **PHQ9**

[Finish] [Cancel]

PHQ-9 Reminder Dialog: Suicidal Ideation Present – Question 9 response: more than "None at All"

Offers links and guidance on risk assessment and ability to document interventions

Option to refer for risk assessment

Response: (more than "None at all") *
- (1) Several days
- (2) More than half the days
- (3) Nearly every day

```
*** TOTAL the score from 1-9 and enter below:
```
`9`

☑ 10. If you checked off any problems, how
    difficult have these problems made it
    for you to work, take care of things at
    home, or get along with other people?
    Response: Not difficult at all ▼

```
============= INFO ONLY - DOES NOT PRINT IN NOTE =============
If the answer to Question #9 is greater than 0, no matter what
the total score is, further evaluation of suicide risk is
indicated.  Assess patient's suicide risk and intervene
accordingly and/or refer to appropriate clinician for further
evaluation.


----------------------------------------------------------------

Assessment and Interventions with Potentially Suicidal Patients

----------------------------------------------------------------
```

http://www.sprc.org/library/PCPocketCard.pdf

```
HGH risk:  expresses suicide intent and plan,
ambivalent engagement, active signs of significant
mental illness, may be intoxicated, other
preparatory behaviors, poor social supports,
agitation, insomnia and/or dysphoria.


MODERATE risk:  has a history of attempts and/or
limited intent without clear plan, may be anxious
but remains cooperative and accepting of help.
Has reasonable support system.


LOW risk:  expresses no intention or plan, no
history of suicidal behavior, cooperative and
not anxious/agitated and is accepting of help.
=========================================================
```
☑ _____

Risk Assessment

- -Referred to Behavioral Health for assessment

- -HIGH risk:

- - MODERATE risk:

- - LOW risk:

* Indicates a Required Field

Sample Note – PHQ2/Screening

-- PHQ2/Depression Screening Exam --
_____

DEPRESSION SCREENING using PHQ-2:
  PHQ2 Copyright Pfizer Inc. All rights reserved. Reproduced with
permission. PRIME-MD is a trademark of Pfizer Inc.

Over the past 2 weeks, patient reports being bothered by the following
1. Little interest or pleasure in doing things:
   Response: (2) More than half the days
2. Feeling down, depressed or hopeless:
   Response: (2) More than half the days

Enter Total Score for PHQ2 below:
 4

Patient provides positive answers to the depression screening
  and further evaluation is warranted.
 Exam Result: Positive

Intervention: Referred to Primary Care Provider

Sample note – PHQ9 without SI

-- PHQ9 Assessment --

PHQ9 Copyright   Pfizer Inc. All rights reserved. Reproduced with permission. PRIME-MD   is a trademark of Pfizer Inc.

ASK PATIENT: Over the LAST 2 WEEKS, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things
   Response: (2) More than half the days

2. Feeling low, depressed, hopeless
   Response: (2) More than half the days

3. Trouble falling or staing asleep, or sleeping too much
   Response: (2) More than half the days

4. Feeling tired or having little energy
   Response: (2) More than half the days

5. Poor appetite or overeating
   Response: (2) More than half the days
6. Feeling bad about yourself, or that you are a failure
   or have let your-self or your family down
   Response: (2) More than half the days

7. Trouble concentrating on things, such as reading the
   newspaper or watching television
   Response: (2) More than half the days

8. Moving or speaking so slowly that other people could
   have noticed. Or the opposite - being so fidgety
   or restless that you have been moving around a lot more
   than usual.
   Response: (2) More than half the days

9. Thoughts that you would be better off dead, or of
   hurting yourself in some other way

   Response: (0) Not at all

   _____

*** TOTAL the score from 1-9 and enter below:
 16

*** If score is greater than "0" (any problems checked off)
    ask the following question ****

10. If you checked off any problems, how
    difficult have these problems made it
    for you to work, take care of things at
    home, or get along with other people?
    Response: Somewhat difficult

Intervention: Psychotherapy.

Ordered behavioral health consult for psychotherapy

Intervention: Antidepressant medication

Potential of Reminder Dialogs for Screening

- Nursing staff conducts PHQ-2 depression screen using Reminder Dialog
- Positive PHQ-2 prompts to conduct immediate PHQ-9 screen
  - Could also be configured for nursing staff to enter PHQ-2, with a positive result triggering a separate reminder for clinician to conduct PHQ-9 screen same day
- Positive PHQ-9 prompts to enter Behavioral Health or other appropriate consult (per local policy)
- Dialog can provide links to additional resources, option to enter additional note text, etc.

RPMS Suicide Report Form

- Developed in support of:
  - DHHS National Strategy for Suicide Prevention
  - IHS Division of Behavioral Health Suicide Prevention Initiative
  - Director's Health Initiatives: Behavioral Health
  - Clinical Quality Performance (GPRA measure)
- Developed by:
  - Division of Behavioral Health
  - Office of Information Technology
  - I/T/U BH providers and subject matter experts

Purpose of the SRF

- Improve data collection
- Inform suicide prevention activities

    - Standardized and systematic method for documenting incidents of suicide
    - Accurate suicide data at the point of care
    - Timely data
    - Capture specificity of location and associated risk factors

SRF Access and Database

- SRF originally released within BH applications
- Suicide events often recognized in ER and primary care setting
- SRF made available RPMS-wide in 2006
  - BHS, EHR, PCC
- Direct provider entry into RPMS encouraged
  - Data is more timely, accurate and private
- SRF data exported to IHS National Programs via BHS export process

What data does the SRF capture?

- Provider who completed the form
- Patient demographics
- Type of suicide incident
  - Ideation with intent and plan
  - Attempt
  - Completion
  - Attempted/Completed Suicide with Homicide
- Disposition
- Standard suicide epidemiological data
  - Method
  - Substances involved
  - Contributing factors

Suicide Form Data Entry - Edit Suicide Form

Local Case Number [   ]

Provider [GARCIA,RYAN ▼]

Date of Act [Monday , July 19, 2010 ▼]

Community Where Act Occurred [DEMING ▼]

Relationship Status [COHABITING/COMMON LAW ▼]

Education [COLLEGE GRADUATE ▼]

Employment Status [FULL-TIME ▼]

If less than 12 years, highest grade completed [   ]

Suicidal Behavior [ATTEMPT ▼]

Location of Act [HOME OR VICINITY ▼]

Previous Attempts [0 ▼]

if other [   ]

Disposition [IN-PATIENT MENTAL HEALTH TREATMENT (VOLUNTARY) ▼]   [   ]

| Method | Substance Use | Contributing Factors | Narrative |

Method

- ☐ Gunshot
- ☐ Carbon Monoxide
- ☐ Hanging
- ☑ Overdose
- ☐ Motor Vehicle
- ☐ Other
- ☐ Jumping [   ]
- ☐ Stabbing/Laceration
- ☐ Unknown

Overdose

Substance	Substance If Other	
OTHER	Iron vitamins	

➕ Add

✎ Edit

✕ Delete

⊙ Help   💾 Save   ✕ Close

DEMO,JOHN PAUL 169061 M 11/28/1946 63
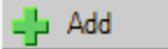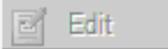
SRF: Dependencies for Use and Exporting

- RPMS Prerequisite
  - BHS v4.0 (namespace AMH) must be installed in order to utilize the Suicide Reporting Form in RPMS EHR and PCC
- Database
  - SRF data resides in the AMH database *not* the PCC database
  - SRF data is exported to IHS National Programs via the monthly BHS export – this is a separate export from the PCC export

Access to SRF

- Ability to enter or access SRF data is restricted to providers (BH, Medical and Nursing) and data entry staff
  - EHR
    - Suicide Form component (installed by EHR CAC)
    - Location in EHR will vary with different EHR user templates
  - Behavioral Health System
    - Suicide Form component (tab)
    - Embedded in the application
  - PCC
    - Entry into RPMS by data entry staff (from paper forms)
    - Entry into RPMS by providers with "SF" menu option

SRF and the Medical Record

- SRF is often completed in the context of a visit but SRF data is not visit-related (i.e. does not populate the visit record)

- Data collection tool - not a clinical intervention tool
  - Any care provided in the context of seeing a patient for suicide-related issues must be appropriately documented in the medical record.

Business Rules

- Business rules for completing a SRF are determined at the local level

  - For example, providers may be instructed to document historical events or only those that occurred within the past 72 hours

- Each field has an option of "Other" or "Unknown"
  - Providers are encouraged to address each item

- Consistent and comprehensive documentation will yield better data

Local SRF Reports

- Access
  - Controlled by security keys
    - Not all providers have access to RPMS Reports
  - SRF reports available in both BHS and PCC

- Suicide Report Forms
  - SSR   Aggregate Suicide Form Data

  - SGR   Listing of Suicide Forms by
    Selected Variables

Utility of Local RPMS SRF Reports

- Quality Improvement Measures
  - Patterns of use
    - Can determine which providers are using or not using the form and target education and training
- Local prevention efforts
  - Detailed information regarding age, gender, method, etc. can be used to inform intervention and prevention services
- Grants and Funding
  - Immediate access to data to support grant and funding opportunities

Aggregate RPMS BH Data

- Aggregate national BH data includes behavioral health clinical data and Suicide Report Form data
  - Progress notes and treatment plans are not exported
  - Aggregate data does not contain patient identifiers
- National BH reports are often comprised of behavioral health data from:
  - RPMS Patient Care Component
  - RPMS Behavioral Health System
- Robust reports depend on timely and consistent exports

RPMS Data Analysis

- RPMS data is representative of disease burden and health status among patients that seek care in the IHS, Tribal and Urban healthcare delivery system…
  - at facilities that use RPMS
  - at facilities that export RPMS data to National Programs (IHS cannot mandate that tribal programs share their data)
  - at facilities that code accurately and consistently

- RPMS data is not representative of national AI/AN population prevalence rates

Government Performance and Results Act (GPRA) Performance Reporting

- ***Federal law***
- Agencies identify performance measures, subject to approval by Office of Management and Budget (OMB)
- Measurable performance indicators to demonstrate effectiveness in meeting Agency mission
- Performance on measures can be tied to budget appropriations

RPMS Clinical Reporting System (CRS)

- RPMS software application for GPRA and other clinical performance reporting
- Provides aggregate results of performance measures
  - Facility
  - Area
  - National

- http://www.ihs.gov/CIO/CRS/

Depression Screening
GPRA Clinical Performance Measure

- FY2012

    Achieve the tentative target rate of 56.5% for the proportion of adults ages 18 and older who received annual screening for depression.

Depression Screening GPRA Measure Logic

Denominator:

1. GPRA: Active Clinical patients ages 18 and older, broken down by gender.

2. GPRA *Developmental*: Active Clinical Plus BH patients ages 18 and older.

3. GPRA *Developmental*: Active Clinical Plus BH patients ages 12 through 18.

Numerator:

1. GPRA: Patients screened for depression or diagnosed with a mood disorder at any time during the report period.

2. GPRA *Developmental*: Patients screened for depression or diagnosed with a mood disorder or suicide ideation at any time during the Report Period.

Depression Screening
GPRA Measure

GPRA Depression Screening Results

Year	2010	2011	2012
Target	53%	51.9%	56.5%
Result	52%	56.5%	

Contact Information

Christina Newport, TeenScreen Primary Care

newport@nyspi.columbia.edu

800-673-7714

TeenScreen National Center:

www.TeenScreen.org

Denise Grenier, IHS Office of Information Technology

Denise.Grenier@ihs.gov

520-260-5418

Information Technology & RPMS

www.ihs.gov/CIO/EHR/

GPRA Suicide Prevention Measure

Emphasis: Surveillance and data collection

Objective: To establish a baseline for the number of RPMS Suicide Reporting Forms exported

Goal: To increase the use of the RPMS SRF and enhance its efficacy as a measure of prevalence rates

Suicide Data Collection
GPRA Measure

RPMS Suicide Reporting Forms Submitted by Year					
Year	2006	2009	2010	2011	2012
Target	Baseline	1678	1700	1784	1807
Result	1603	1687	1908	1930	

Crisis Hotline Numbers

Suicide Prevention Lifeline Number:
- 1-800-273-TALK (8255)

National Domestic Violence Hotline:
- 1-800-799-SAFE (7233) or TTY 1-800-787-3224

National Child Abuse Hotline:
- 1-800-4-A-CHILD

Sexual Assault Hotline:
- 1-800-262-9800