

Equitable Access to Depression Screenings and Care

Nadia Kako
Eliza Kramer

Drew McGee
Summer Millwood

Genevieve Patterson
Rebecca Suzuki
Cassandra Svelnys

Professor: Kathryn Fox, PhD
University of Denver, Department of Psychology

**Presentation to the Department of Health Care Policy and Financing's Subcommittee on Performance Measurement & Member Engagement
June 24, 2021**

Overview of Today's Talk:

- Research questions
- Interview approach
- Data collection and analysis process
- Findings and Recommendations

***THANK YOU** to the many staff at the RAEs and practices who willingly gave their time and shared their ideas despite busy schedules and higher priorities. Their participation demonstrates commitment to and interest in mental health equity.*

Key Questions

- (1) What does equity mean to providers who screen Medicaid members for depression and connect them to care?
 - (2) To what extent are providers using demographics to understand performance?
 - (3) What validated screening tools are available for pediatrics (< 12 years old)?
 - (4) What are the critical equity impact points in the member journey for depression? Once these are identified, what are the pain points and opportunities?
 - (5) How should the Department think about measuring equity for depression?
-

Methods: Interviews

- 4 practices across the state
 - Serve a variety of clientele of different ages, racial/ethnic backgrounds, gender identities, sexual orientations, languages, geographies, and more
 - 3 Federally Qualified Health Centers (FQHCs) each with multiple sites and 1 Family Medicine Practice
 - Note: Due to this small sample size, the findings in this presentation should not be generalized to all practices in Colorado.
 - Conducted interviews with practices to understand:
 - Demographics of their patient population
 - Current processes for depression screening
 - Follow-up processes for positive depression screenings
 - Data collection and utilizations
 - Pain points and areas where the State or RAEs could improve processes
-

Methods: Data Collection and Analysis Process

- Literature review of best practices for depression screening in children
 - Scan of validated screening tools
 - Review of performance data
 - Qualitative review of interview data
 - Identified common trends, pain points
 - Identified resources and recommendations for practices
-

Current **Strengths** in Depression Screening and Follow Up

- All sites reported they are screening most of their patients (~ 90%)
 - Many providers have received training or have access to equity training
 - Most patients are able to meet with a behavioral health specialist quickly, especially within integrated models. Warm hand-offs and co-visits occur regularly.
 - Many clinics highlighted Spanish language resources including bilingual staff in both primary care and behavioral health roles, as well as materials available in Spanish.
-

Findings & Recommendations

Question 1: What does equity mean to providers who screen Medicaid members for depression and connect them to care?

Finding #1: Equity Is Sometimes Interpreted as the Same Treatment

- 2 of 4 practices defined equity as members receiving **the same** screening and care
 - Many shared initiatives to better serve members (e.g., language resources, clinics for unhoused people)
 - 3 of 4 practices shared initiatives to train staff in equity
-

Recommendations:

1. Update and educate on stronger definition of equity. *Health equity means giving members the care they need when they need it.*
 2. Train providers on disparities in medicine and behavioral health across levels, including via interactions with members.
 3. Work to create systems that are as **unbiased as possible**, and ensure that providers are **equipped to meet members' unique needs based on their identities**.
-

Question 2: To what extent are providers using demographics to understand performance?

Finding #2: Practices are not disaggregating their data by demographics to identify disparities.

Recommendations:

1. Collect & organize data on rates of each of the following across key demographic variables (e.g., race/ethnicity, language, gender)
 - a. Screening rates
 - b. Rates of members *declining* screening
 - c. Successful behavioral follow-up care for those with confirmed diagnosis after positive screens
 - d. Rates of successful treatment referrals for those diagnosed with depression
 - e. Rates of members *declining* referrals
 2. Collecting & analyzing these data is critical given that most inequities occur when considering *who accesses behavioral health care*
-

Question 3: What validated screening tools are available for pediatric members (< 12 years old)?

Finding #3: Validated screenings for depression in children (< 12 years) are available

- Descriptions, psychometrics, and characteristics of all researched measures:
[Spreadsheet of validated measures and characteristics](#)
- Inconsistency in primary care re: depression screening for young children (≤ 11 years)
- Numerous validated measures in behavioral health/psychology research
- All screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up
- Helpful links:
 - [Algorithm process for integrating mental health care into pediatric practice](#)
 - [Mental Health tools for Pediatrics](#)

Recommendations:

1. Screen children for BOTH anxiety and depression
 - a. Validated Measures to consider:
 - i. **Children's Depression Inventory-2 (CDI-2)** (ages 6-12 originally, up to 18)
 - ii. **Multidimensional Anxiety Scale for Children, 2nd Edition (MASC-2)** (ages 8-19)
 - iii. **Preschool Feelings Checklist (ages 3-6)**
 - iv. Pediatric Symptom Checklist (ages 4-16)*
 - v. Patient Health Questionnaire-Adolescent version (ages 11-17)*
 - vi. Beck Depression Inventory (BDI) (originally adults but validated in 13-18)
 - vii. Reynolds Child Depression Scale (ages 8-12)

Jellinek et al., 1988; Kovacs, 2014; Kroenke et al., 2009; Luby et al., 2004; Johnson, 2002

*could be used as primary screener with more specific follow-up



Question 4: What are the critical equity impact points in the member journey for depression? Once these are identified, what are the pain points and opportunities?

Finding #4: Areas identified as opportunities for improvement and/or practices expressed a need for resources:

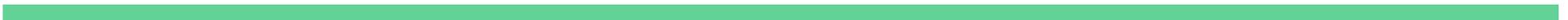
A Staff Training

B Screening Administration

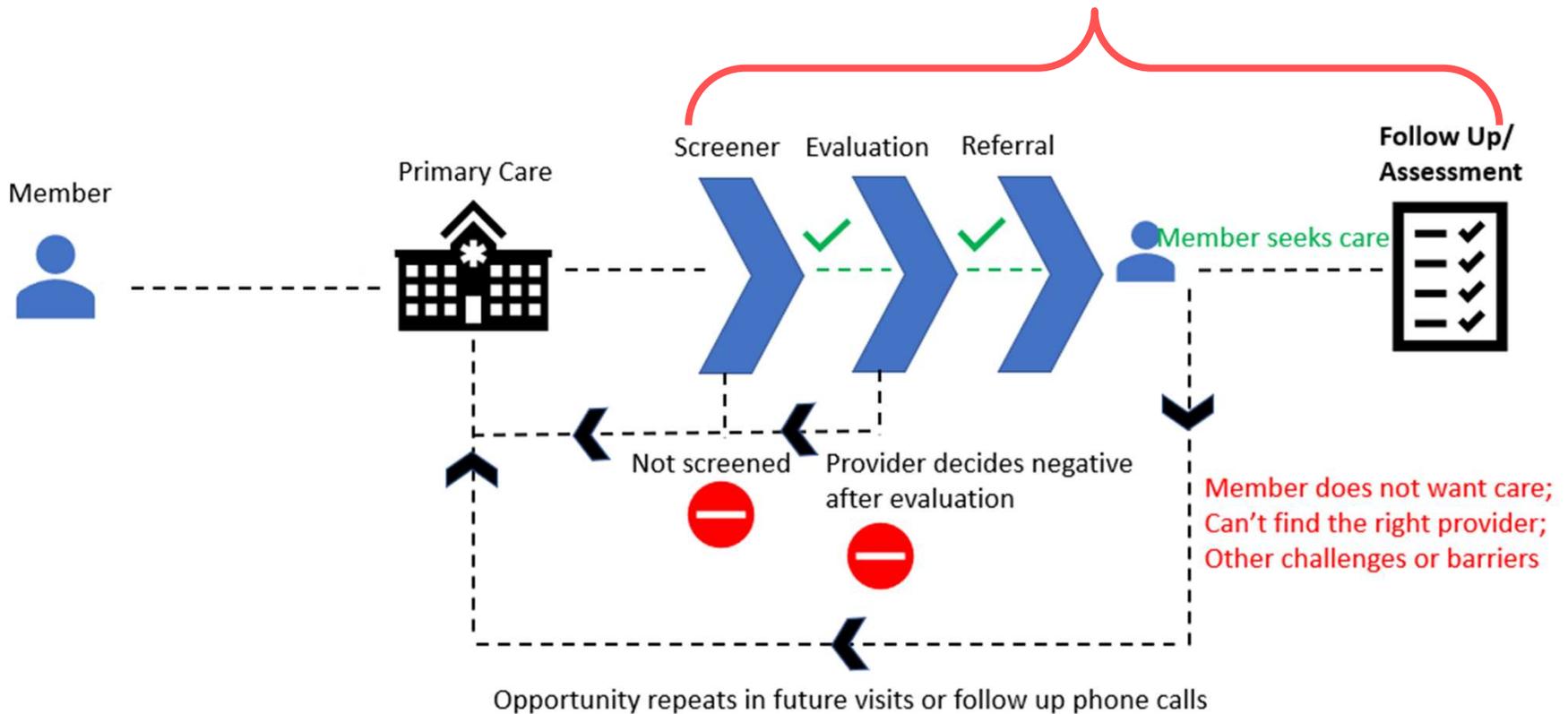
C Screening & Referral Across Languages

D Working with Gender Diverse Clients

E Ensuring Members Who Need Follow Up the Most Don't Miss Out on Care



A) Staff training impacts care at each level of this process from the individual administering the screener to the provider conducting the follow-up assessment or providing treatment



Finding #4a: Staff Training in Assessment

- Providers received different levels of training across and within sites
 - Most screenings are completed by medical assistants; high turnover in this role
 - Providers indicated that they want additional training to improve equitable care
 - Non-English speaking members, particularly those who speak languages other than Spanish
 - Transgender and gender diverse members
-

Recommendation:

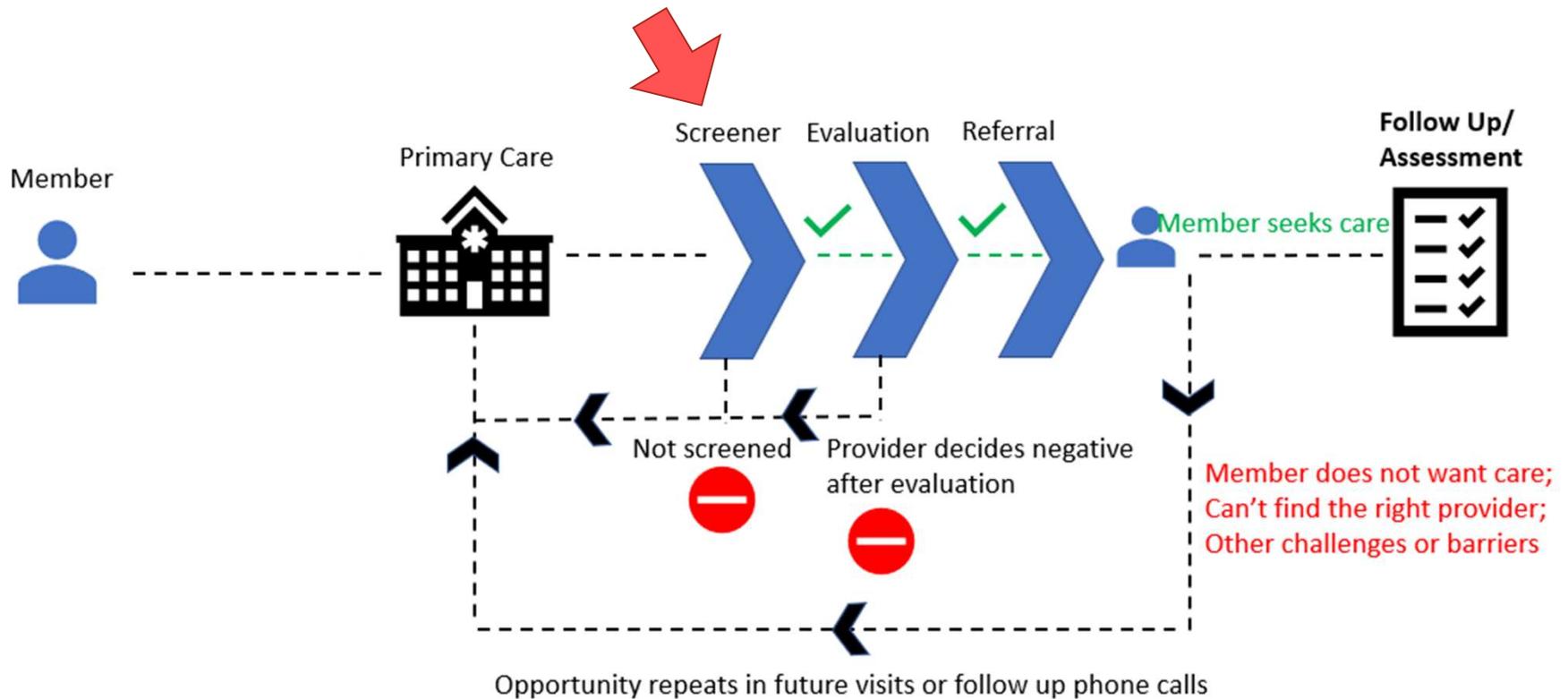
Incorporate trainings for **all** providers who administer depression screenings

- Emphasis on health equity training
 - Optimize patient involvement and prepare providers for appropriate follow-up actions (e.g., suicide safety planning, managing refusal)
-

Resources:

- Many available recorded trainings and resources focused on working with diverse patients, specifically focused on mental health
 - Association for Behavioral and Cognitive Therapies
 - (<https://www.abct.org/Conventions/index.cfm?m=mConvention&fa=Webinars>)
 - American Psychiatric Association
 - (<https://www.psychiatry.org/psychiatrists/cultural-competency/education/best-practice-highlights>)
 - *Psychological Treatment of Ethnic Minority Populations* (published by Association of Black Psychologists)
-

B) The content of the screening and how thoroughly it assesses different challenges determines which patients are referred for follow-up care



Finding #4b: Administration of Depression Screeners

- All sites had a universal screening policy, which is recommended by the US Preventive Services Task Force
 - Telehealth Gap: Some practices lack a way to screen for telehealth appointments
 - One practice has an exclusion for members with intellectual and developmental disabilities
- All sites we spoke to were administering some form of the Patient Health Questionnaire (PHQ)
 - Several sites use PHQ-2 -- useful for depression screening¹ but does not assess for suicidality² (*which can occur regardless of depressive symptoms*)
- Conflicting demands from different regulatory groups regarding billing, coding, etc. is a major pain point.
 - One practice said Medicaid's billing guidance was too confusing
 - FQHCs mentioned not billing for depression screens because they are paid an encounter rate

¹Levis et al. 2020; ²Dueweke et al. 2018

Recommendations:

1. Incorporate screening for suicidality & safety planning
 2. Consider the collective reporting demands on practices, including FQHCs, to ensure efforts result in robust data without overburdening practices
 3. Because telehealth will continue to be used, practices should find ways to implement depression screenings for tele appointments.
-

Screening for Suicidality/Self-Injury

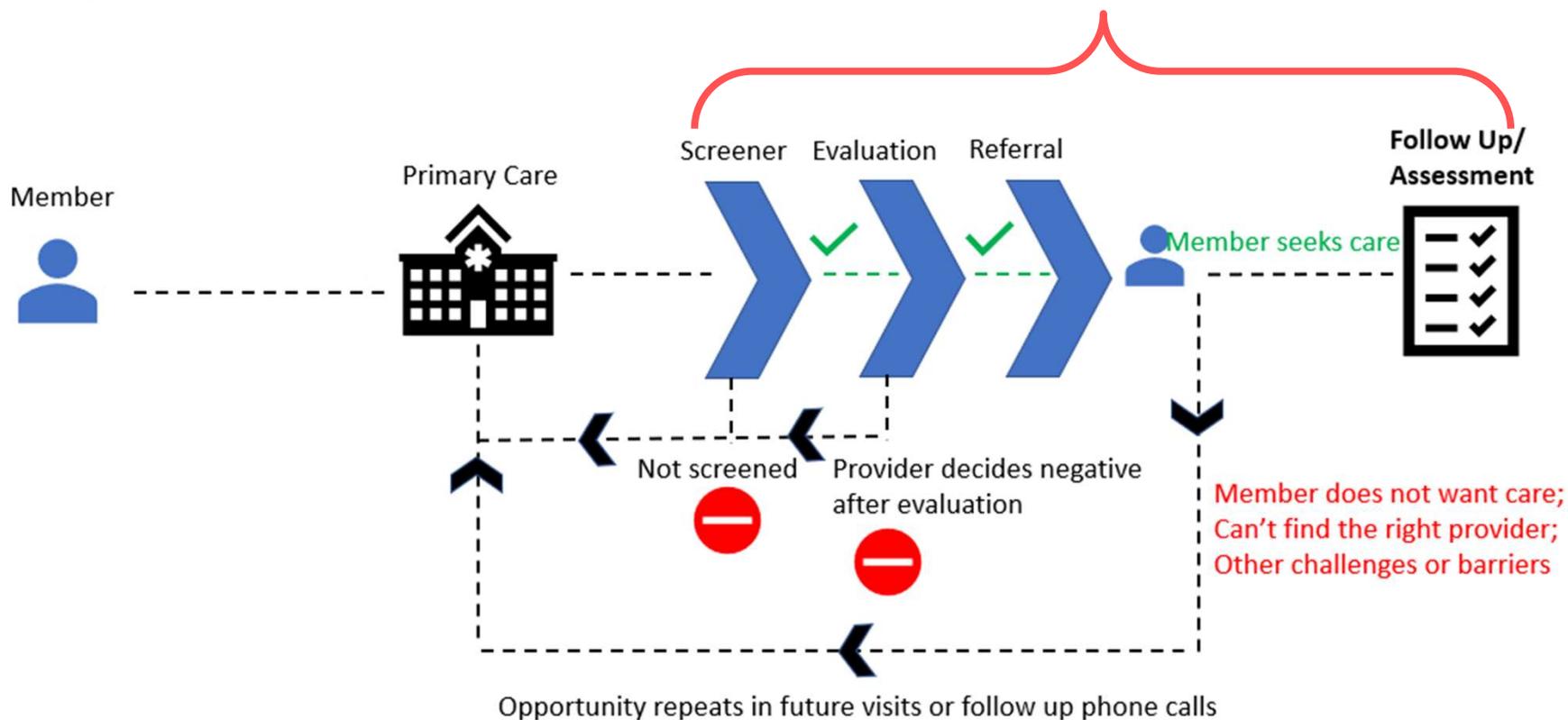
- Suicide is the 10th leading cause of death in the US
 - Most people who die by suicide have visited a PCP in the past year
- Asking about suicidality does not increase risk
- Risk factors to assess:
 - Risk: History, plan, intent, access to means; also assess protective factors/social support
- Evidence-based risk assessments:
 - Columbia Suicide Screener (C-SSRS)
- Safety Planning: evidence-based brief intervention can be done in session
- Additional resources/training options:
 - Zero Suicide: offers training at all levels of a healthcare system
 - Suicide Prevention Resource Center

Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:
1. _____
2. _____
3. _____
Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):
1. _____
2. _____
3. _____
Step 3: People and social settings that provide distraction:
1. Name _____ Phone _____
2. Name _____ Phone _____
3. Place _____ 4. Place _____
Step 4: People whom I can ask for help:
1. Name _____ Phone _____
2. Name _____ Phone _____
3. Name _____ Phone _____
Step 5: Professionals or agencies I can contact during a crisis:
1. Clinician Name _____ Phone _____ Clinician Pager or Emergency Contact # _____
2. Clinician Name _____ Phone _____ Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services _____ Urgent Care Services Address _____ Urgent Care Services Phone _____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)
Step 6: Making the environment safe:
1. _____
2. _____
<small>Safety Plan Template ©2008 Barbara Stanley and Gregory K. Brown, is reprinted with the express permission of the authors. No portion of the Safety Plan Template may be reproduced without their express permission. Completing and submitting the form on this web page http://www.suicidessafetyplan.com/Page_8.html constitutes permission to use the template.</small>

The one thing that is most important to me and worth living for is:

C) The match between patient and provider language (both in verbal & written communications) influences care at each level of this process



Finding #4c: Members who do not speak English are less likely to be screened, to report symptoms when screened, and less likely to engage in behavioral health treatment based on available research

- Patients that don't speak Spanish or English are screened at half the rate at Well Visits
 - English speakers screen positive 3.8x more often than Spanish speakers
 - This is likely not due to difference in mental health symptoms
 - Of those who screen positive, English speakers are 1.6x more likely to engage in behavioral health
 - This is DESPITE higher rates of follow up from clinics for Spanish speakers than English speakers
-

Language Needs - Themes From Interviews

- Clinics are well-equipped to offer screening in both English and Spanish, despite differences in engagement
- Services are lacking for populations who speak other languages (e.g., Mandarin, Arabic)
 - Cultural barriers and stigma prevent engagement*
- Translation services can be clunky and/or difficult to access
- Some clinics described partnerships with local organizations who serve specific populations, but demand is high and resources are low
 - Patients may have trouble accessing services at locations outside of their home clinic (issues of trust, transportation, geographic location, etc)

*Leong & Kalibatseva (2011)

Recommendation: Explore further partnerships between local organizations and clinics to connect members to staff who speak their preferred language.

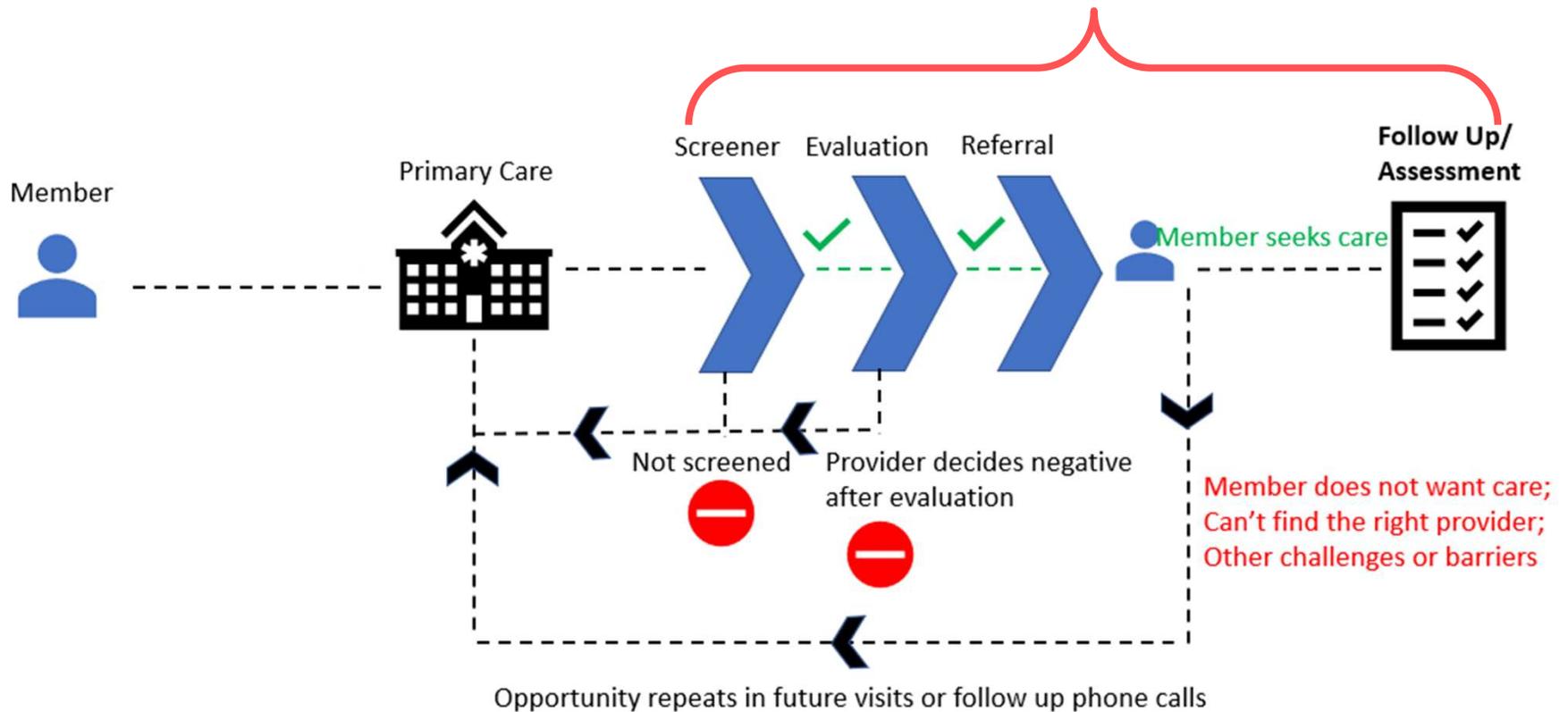
Advent of tele mental health presents opportunities for patients to continue to seek services at their local clinic with a remote provider who shares their language and cultural background

- [Asian Pacific Development Center \(APDC\)](#) currently has behavioral health providers who are native speakers of Mandarin, Cantonese, Vietnamese, Taiwanese, Burmese, Hindi, Nepali, and more.
 - [Colorado Refugee Wellness Center](#) has staff who speak Asian languages as well as Arabic, Russian, Swahili, Lingala, Lugiso, and more.
-

Recommendation: Employ best practices when using translation services (selected from Tribe & Lane, 2009)

- Conduct an assessment of translation service needs
- Provide appropriate training and support for translators (as applicable)
- Take steps to increase patient comfort
- When to avoid interpretation services
- Avoid colloquial language
- Remember that interpreters can also be cultural brokers as well as linguistic support

D) Some sites expressed a desire for more resources in working with gender diverse clients. Making the healthcare experience welcoming for gender diverse clients improves their care throughout this process

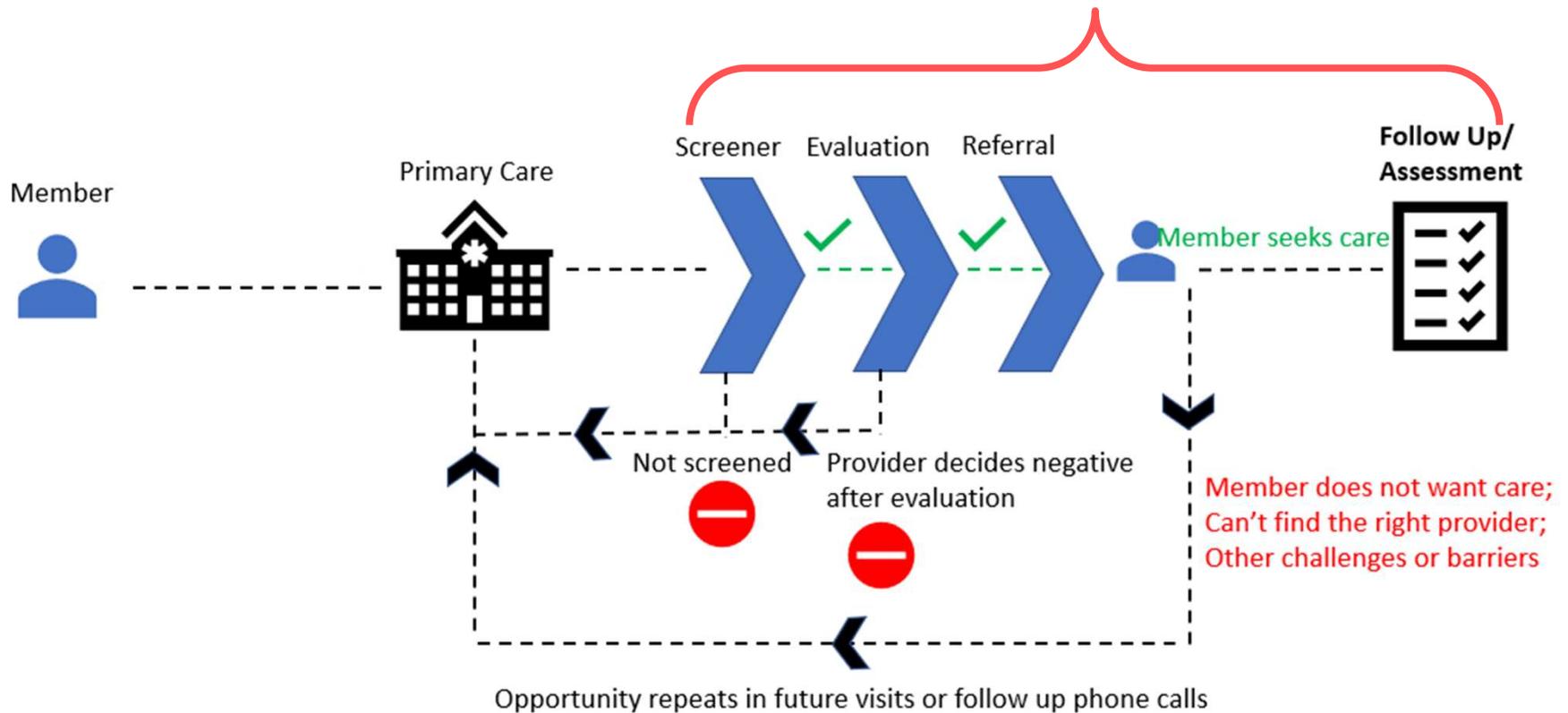


Recommendations:

- Train all staff in inclusive practices
 - Correct pronouns and name when talking WITH and ABOUT the patient
 - Document chosen name, pronouns, and gender identity in member notes
 - Introduce yourself with your pronouns
 - Establish safety around using bathrooms
- Additional Resources for Practices:
 - UCSF best practices guidelines: <https://transcare.ucsf.edu/guidelines>
 - SAMHSA specific trainings in treating substance use in LGBTQIA+ and cultural humility training: <https://www.samhsa.gov/behavioral-health-equity/lgbt/curricula>
 - National LGBTQIA+ Health Education Center: <https://www.lgbtqiahealtheducation.org/>
 - [The World Professional Association for Transgender Health - Standards of Care for the Health of Transsexual, Transgender, and Gender- Nonconforming People](#)

(Knutson, Koch,Goldbach, 2019)

E) After a referral is made, members are not always followed up with to see whether they have accessed recommended services. Follow-ups with referred patients can aid in ensuring patients don't miss out on care



Ensuring Members Who Need Care the Most Get Care Is the Biggest Equity Opportunity

- Members with more acute mental health needs or with co-occurring mental health and substance use disorder tend to be referred out. **They have a higher chance of not accessing the care they need.**
 - Members who speak languages other than English and Spanish also face more barriers. This includes members who are deaf or hard of hearing.
 - Challenge: Little data is captured about this part of the process and resources are limited to follow up with members. Also some specialists won't confirm whether they saw a member because of HIPAA.
-

Ways Practices Are Handling Follow Up Now

Example A: If member receives a referral, they stay active in the Electronic Health Record until they get care. If they “no show” at their mental health follow up, the practice follows up. But if they cancel their appointment, there’s no follow up.

Example B: Members who are diagnosed with depression (not just who screen positive) are entered into the practice’s depression registry. Allows for a focus on people who truly need and want follow up care. The registry also flags people when their depression screening scores increase.

Recommendations:

- Follow-up with patients who cancel appointments in similar fashion to “no-show” patients
 - 1-3 follow-up attempts recommended
 - Implement more accessible/inclusive forms of follow up to better address needs of deaf and non-english speaking patients
 - E.g., text, email, electronic health message
 - Using automated methods for follow-up also reduces burden on MAs or other staff
 - If resources are available and applicable, provide transportation resources (bus fare, step by step directions)
 - Follow-ups should be closely tracked to ensure that patients are not missing follow-up care due to structural barriers
 - There are likely ways to accomplish this through EHRs to reduce the burden
 - Additional disaggregation of the data will allow for identification and intervention to reduce barriers and equity gaps
-

Question 5: How should the Department think about measuring equity for depression?

Performance Data

- Data Challenges Exist Currently
 - Claims data are minimal -- though clinics report at least 80% screening, claims data indicate 20% screening.
 - In other words, right now Medicaid is not adequately capturing screenings.
 - Takeaways by race and ethnicity from CO claims data:
 - White patients most likely to engage in BH treatment; Asian patients least likely
 - Positivity rate is highest for White patients, lowest for Hispanic/Latinx patients.
 - This is not because White patients have higher rates of depression. There are elements of stigma, lack of trust disclosing mental health, and diagnosis practices that contribute to what the data show versus reality.
-

Performance Data, cont.

- Stigma, comfort with providers, mental health awareness, culture surrounding mental health symptoms, etc. lead to differential reporting of mental health symptoms
- To try to understand reporting bias, consider asking two questions at the end of the survey
 - 1. How comfortable do you feel answering questions about your mental health? (Scale 1-5)
 - 2. How comfortable do you feel talking about mental health in your community, with friends or family (Scale 1-5)?

Ojeda & Bergstresser (2008)

Recommendations:

1. The Medicaid application should include gender identity options for members, not just sex (male or female).
 2. Consider adding questions to the screening process to assess comfort with mental health discussions
 3. Claims data do not reflect what is happening in practice. RAEs could work with practices to make the case for, and technically support, disaggregating clinical data across race/ethnicity and gender.
 4. Consider ways to track data on equity concerns around follow up. Are there best practices that require reasonable resources and can be scaled? (e.g., depression registry and flagging in EHRs)
-

Discussion Questions

- What does this information tell us about what we need to consider when making recommendations about measures?
 - What do we want HCPF's takeaways to be from this (particularly when we're considering equity measures)?
 - What does this research say about the lead time or training that's needed to make a new measure effective?
 - What questions remain that may be worth exploring further?
-

References

- Dazzi, T., Gribble, R., Wessely, S., & Fear, N. T. (2014). Does asking about suicide and related behaviours induce suicidal ideation? What is the evidence?. *Psychological medicine*, 44(16), 3361–3363. <https://doi.org/10.1017/S0033291714001299>
- Dueweke, A. R., Marin, M. S., Sparkman, D. J., & Bridges, A. J. (2018). Inadequacy of the PHQ-2 depression screener for identifying suicidal primary care patients. *Families, Systems, & Health*, 36(3), 281–288. <https://doi.org/10.1037/fsh0000350>
- Knutson, D., Koch, J. M., & Goldbach, C. (2019). Recommended terminology, pronouns, and documentation for work with transgender and non-binary populations. *Practice Innovations*, 4(4), 214–224. <https://doi-org.du.idm.oclc.org/10.1037/pri0000098>
- Levis B, Sun Y, He C, et al. Accuracy of the PHQ-2 Alone and in Combination With the PHQ-9 for Screening to Detect Major Depression: Systematic Review and Meta-analysis. *JAMA*. 2020;323(22):2290–2300. doi:10.1001/jama.2020.6504
- Ojeda, V. D., & Bergstresser, S. M. (2008). Gender, race-ethnicity, and psychosocial barriers to mental health care: An examination of perceptions and attitudes among adults reporting unmet need. *Journal of health and social behavior*, 49(3), 317–334.
- Posner, K., Brown, G. K., Stanley, B., Brent, D. A., Yershova, K. V., Oquendo, M. A., Currier, G. W., Melvin, G. A., Greenhill, L., Shen, S., & Mann, J. J. (2011). The Columbia–Suicide Severity Rating Scale: Initial Validity and Internal Consistency Findings From Three Multisite Studies With Adolescents and Adults. *American Journal of Psychiatry*, 168(12), 1266–1277. <https://doi.org/10.1176/appi.ajp.2011.10111704>
- Sarchiapone, M., Mandelli, L., Iosue, M., Andrisano, C., & Roy, A. (2011). Controlling access to suicide means. *International journal of environmental research and public health*, 8(12), 4550–4562. <https://doi.org/10.3390/ijerph8124550>
- Shepherd, S., Willis-Esqueda, C., Newton, D., Sivasubramaniam, D., & Paradies, Y. (2019). The challenge of cultural competence in the workplace: perspectives of healthcare providers. *Health Services Research*, 19 (135).
- Stanley, B., & Brown, G. K. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice*, 19(2), 256–264. <https://doi.org/10.1016/j.cbpra.2011.01.001>

Contact Information for Follow Up & Future Opportunities

Rebecca Suzuki: rebecca.suzuki@du.edu

Summer Millwood: summer.millwood@du.edu

Genevieve Patterson: genevieve.patterson@du.edu

Cassandra Svelnys: cassandra.svelnys@du.edu

Nadia Kako: nadia.kako@du.edu

Drew McGee: drew.mcgee@du.edu

Eliza Kramer: eliza.kramer@du.edu

DU Professor: Dr. Kathryn Fox, kathryn.fox@du.edu

HCPF Contact: Liana Major, liana.major@state.co.us