



Cabrillo College Student Health Services
Team of Three
SNCC PCMH Initiative
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Ok, actually....

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Cabrillo College Student Health Services

Our team AIM is...

To determine, during the 2011/12 academic year, if it is feasible to

- provide all students who come to SHS for medical/nurse appts with
 - ▣ screening for depression
 - ▣ appropriate and timely intervention as needed
- decrease “burden” on personal counseling service by nurse screen/intervene



Progress toward achieving our aim is measured by....

- ratio of PHQ-9s collected after pre-screen with PHQ-2
- scoring distribution for PHQ-9s to evaluate personal counseling capacity
- feedback from front office staff, students (survey about value)
- evaluation of time “burden” on nurses (TBD)



Our story...

How we decided what to work on

□ Evidence-based decision:

□ NCHA data 2007 (13 CA community colleges, aggregate data, n = 7898):

- 17% of students reported having ever been diagnosed with depression
- 32% diagnosed in last school year
- many aspects of students' health/well-being can affect academic performance
- depression, anxiety, SAD resulted in lower grades

□ Need for MH services at SHS has increased since 2007; resources have decreased (health fees tied to enrollment)

- 38% increase in PC visits since 07/08
 - In response, SHS added LMFT interns to staff

Our story...

How we formed our team:

- Faculty senior personal counselor, faculty senior nurse clinician/MPH, nurse director all volunteered

PDSA cycle experience:

- Started with counseling only, expanded to nurses
- Revised several times process for distributing PHQ-9s

Barriers encountered during PDSA cycles:

- SHS closed when school's not in session (6 weeks in summer; 6 weeks in winter)
- Changes to nurse and counselor schedules each semester
- New counseling interns this fall
- Staff medical leaves (unplanned)

Our story...

What helped?

- Taking small steps in testing
- Being really flexible with timeframes for testing
- Being consensus-oriented with staff in decision-making process
- Bringing in outside experts
- Being engaged in formal process with HIP:
 - ▣ Monthly check-ins with coach
 - ▣ Monthly webinars to hear from other teams
 - ▣ Funding to support process
- Keeping “eyes on prize”

What we achieved...

- MH community resource listing updated, distributed to all staff—in use
- Personal counselors:
 - Model for depression screening and other useful resources shared with us by WVC; variation implemented by personal counselors:
 - New counseling intake form incorporating PHQ-2 and -9; using folder for privacy
 - Stress management worksheet
 - Depression self-care action plan
- Nurses:
 - testing new medical intake form incorporating PHQ-2 and -9 with 3, 4, then 5 patients over 3 weeks (Oct 3-Nov 17) in pts at SHS for medical/nurse care
- SBIRT training for full staff yesterday

Depression Self-Care Action Plan

Name _____
Date _____ Providers _____
Phone Number(s) _____

1. Stay active

Make time every day to do some physical activity such as walking for 10 or 20 minutes or dancing to a favorite song.

Every day during the next week I will spend at least _____ minutes doing

2. Do something that you think is fun each day

Even though you may need to work a little more at having fun, try doing something that has always been fun such as a hobby or listening to music or watching a favorite video or TV show.

Every day during the next week I will spend at least _____ minutes doing

3. Spend time with people who help or support you

When you are feeling down it is easy to avoid people...

***During the week I will make contact for at least _____ minutes
with _____ (name), doing or talking
about _____***

Etc...

Measured results...

Quantitative data:

- Preliminary data (spring '11, counseling only): **11/17 (65%) PHQ-2s needed PHQ-9s**
- PHQ-9 distribution of scores for personal counseling clients (spring/fall '11; n = 59):

1-4 (community norm)	5-9 (mild symptoms)	10-14 (moderate symptoms)	15-19 (mod. severe symptoms)	≥ 20 (severe symptoms)
20 (34%)	16 (27%)	10 (17%)	8 (14%)	5 (8%)

- Recent data (fall '12, nurse care only): **6/19 (32%) PHQ-2s needed PHQ-9s**
- PHQ-9 distribution of scores for nurse-care clients (fall '11; n = 6):

1-4 (community norm)	5-9 (mild symptoms)	10-14 (moderate symptoms)	15-19 (mod. severe symptoms)	≥ 20 (severe symptoms)
0	2 (33%)	1 (17%)	2 (33%)	1 (17%)

Measured results...

□ Qualitative data (vignette):

- Pt here for TB surveillance symptom screen
 - 23-y/o female dance student
 - Screened “positive” for PHQ-2 (down/depressed or hopeless past 2 weeks) → PHQ-9
 - Scored 7 on PHQ-9 (eating/sleeping too little, low energy) = mild sx’s
 - Reported MJ/ETOH use on daily basis
 - Scheduled return visit with nurse for:
 - motivational interview re health behavior changes
 - decision about personal counseling referral

Lessons learned...

- Difficult to figure out if screening all patients for depression is desired goal in SHS without first trying it out on small scale
 - Went back and forth over several months between small tests and big visioning conversations
 - Identified pros/cons and concerns (“time burden,” eg)
 - Testing PHQ-9 feasibility/comfort with front office and PC was good first step (got some logistics out of way; identified privacy issues)
- PDSA cycle inspires “detachment” from testing process: “letting go” of outcome freed us up to do next PDSA cycle

Where we go from here...

- Evaluate data, burden of PHQ-9 test collection in SHS for nurse care
 - ▣ Burden: increased nurse appt time vs. decrease in demand or shorter time to next available appt with personal counselor
- Arrange for suicide risk assessment training for all staff
- Establish consistent method for bi-directional communication (between nurses/counselors)
- Test PHQ-9 in larger sample for longer period of time
 - ▣ Nurses to implement SBIRT process in next test phase
 - ▣ Reevaluate data (distribution of scores on PHQ-9), “burden”

Cabrillo team members caught up in excitement of PDSA cycle...

