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MS 2 Action Group: Behavioral Health Integration

Data Collection and Data Management for Behavioral Health

June 2nd, 2015 @ 1pm ET

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Facilitator:

LJ Fagnan, MD

Oregon Rural Practice-based Research Network

Oregon Health & Science University

Moderator:

Rose Langdon

TMF Health Care Quality Institute

Discussion Leaders:

- **Grande Ronde Hospital Regional Medical Clinic**
  -La Grande, Oregon (12 clinicians, independent)

- **Washington Regional Clinic for Senior Health**
  -Fayetteville, AR (4 clinicians)

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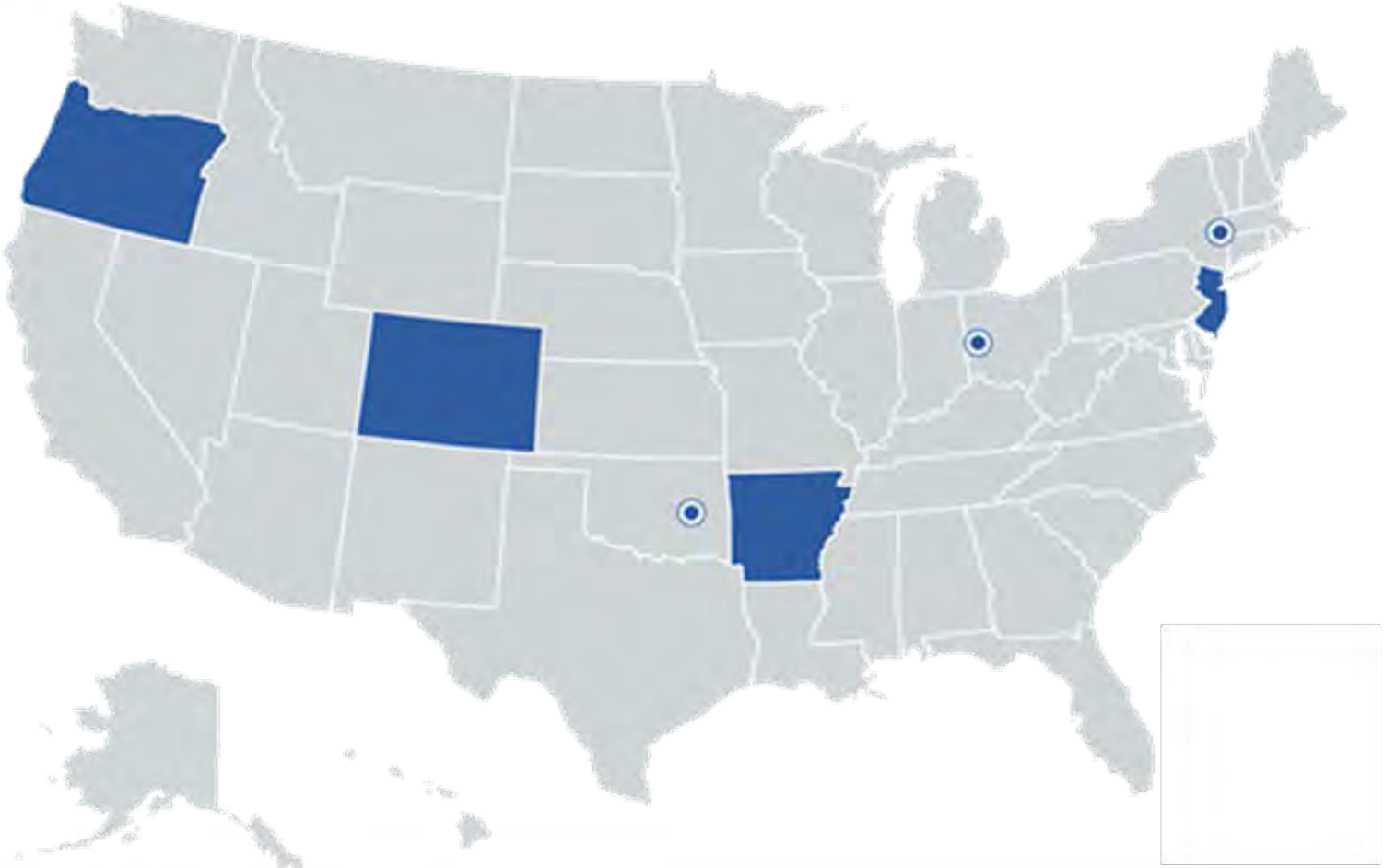
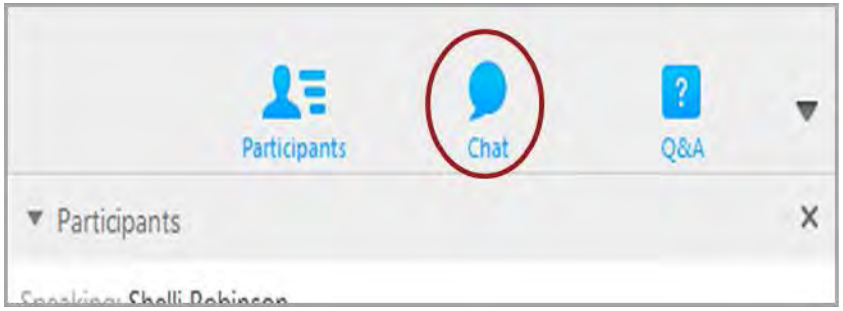
Click the arrow on the annotation toolbar, then point to your location…

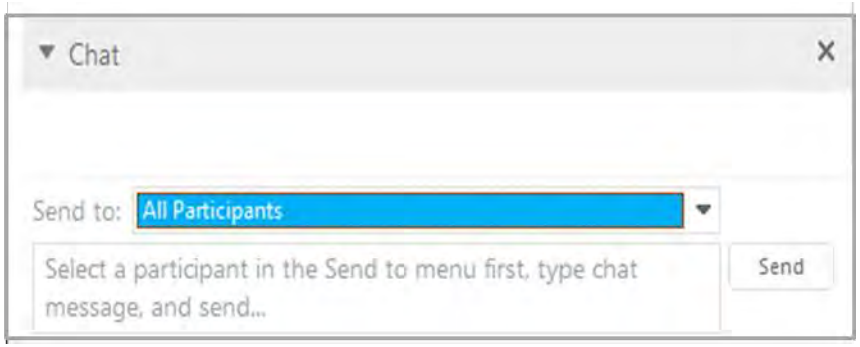


Source: Centers for Medicare & Medicaid Services

Live Session Pointers

- This is YOUR Action Group!
- Will be interactive, using chat, polls and the forum
- More activity means more learning!
- ***Chat now:*** ***What question would you like answered about BHI TODAY!***





Overview of Last Session

- Make the best of your available space for BH services
- Strategies to address space and privacy issues

HIPAA Resource

- http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/privacysummary.pdf

Follow Up from Last Session

FROM THE FORUM

Check the forum for these resources! Post your thoughts!

Webinar- "Overcoming Barriers to Collaboration Among Providers"
https://www.youtube.com/watch?v=xCV77vUA_kY

Behavioral Health Data Exchange/ Primary Care and Behavioral Health Integration
http://www.healthit.gov/policy-researchers-implementers/behavioral-health-data-exchange

Case Studies of HIT and BHI
http://integrationacademy.ahrq.gov/content/Case%20Studies%20of%20HIT%20for%20Behavioral%20Health%20Integration

Where we are going now…

- How to use patient data to improve patient care and quality improvement in your practice.

Objectives for today's Action Group

1. Learn how practices screen, re-screen, and manage behavioral health patient-level data to inform clinical care.
2. Learn how practices use behavioral health data to assess population health.
3. Learn how to incorporate data into workflows.

Pre-work for Today's Session– Measurement and Data

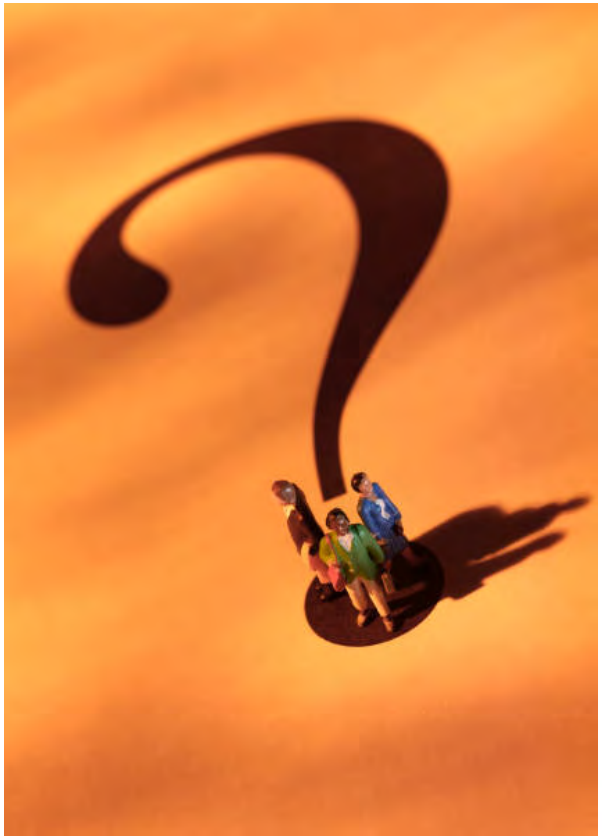
1. Are you screening for behavioral health, and what screeners are you using?
2. Are you tracking behavioral health data, including patient- or panel-level? If so, how and how often?
3. How do you use data to improve patient care and quality improvement?

Does your practice use screening tools for identifying patients with behavioral health needs? (Chat in which screening tool(s) you use, and why.)

Yes

No

Questions……



Use the Chat feature or raise your hand to ask questions during the discussion. No need to wait!

Today's Panelists

- **Tammy Winde, MHA,** Grande Ronde Hospital Regional Medical Clinic (Oregon)

- **Gillian Woods, PhD, LPE**, Pat Walker Center for Seniors (Arkansas)

As you listen to the following practice stories, think about the ideas and approaches that you hear that will help you with the structures and processes involved in BHI in your own practice setting.

Grande Ronde Hospital Regional Medical Clinic La Grande, OR

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- 12 providers
  - Primary Care
  - Neurology
  - General Surgery
  - Behavioral Health
  - Walk-in Services
- 8,396 active patients

Tammy Winde, MHA
trw02@grh.org
541-963-2861

Patient-Level Data: Depression Screening and Identification Process

Screening Steps for all Active patients:

- Every patient is screened using the Phq-2 annually
- A positive Phq-2 triggers administration of the Phq-9
- Phq9 score greater than 10 requires referral to LCSW
- Retesting occurs at approximately 6 week interval

Patient-Level Data: Storing PHQ Data in the EHR

- Phq-9 data is stored in the EHR as a discreet data
- Each Phq-9 documented is stored and trended to monitor treatment efficacy
- Report is available to Clinical and necessary Administrative personnel

PRACTICE PARTNER

.H: Depression Screen X
.CE: Adult Depression Screen: Positive

.CE: Depression Intervention: X

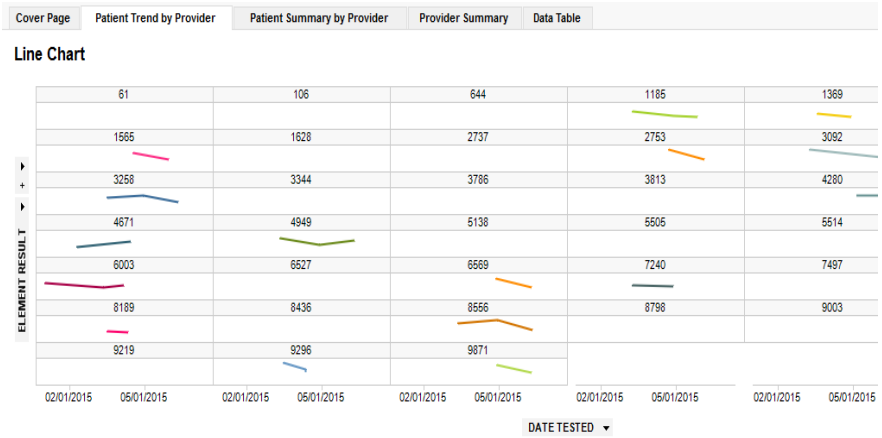
.CE: PHQ9: 15
Previous PHQ9 score: 10 on 05/14/2015

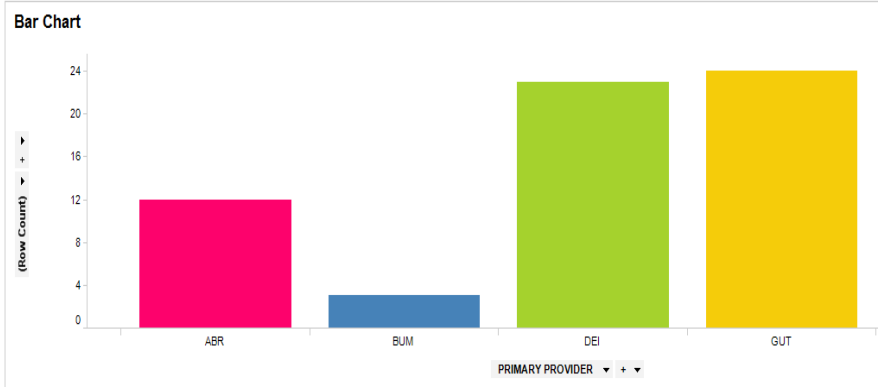
Emotional Health-
Abuse Screen Done on 05/14/15

Source: Centers for Medicare & Medicaid Services

Patient-Level Data: PHQ Follow-Up

- PHQ-9 Follow-up occurs every 6 weeks by:
  - Medical Provider
  - Behavioral Health Provider
  - Case Management
- Re-testing can occur at the next scheduled appointment or via phone
- The EHR and Analytics program is used to measure efficacy of treatment – If a patient is not responding the plan of care will be reassessed
- Goal is to Improve the patients quality of care





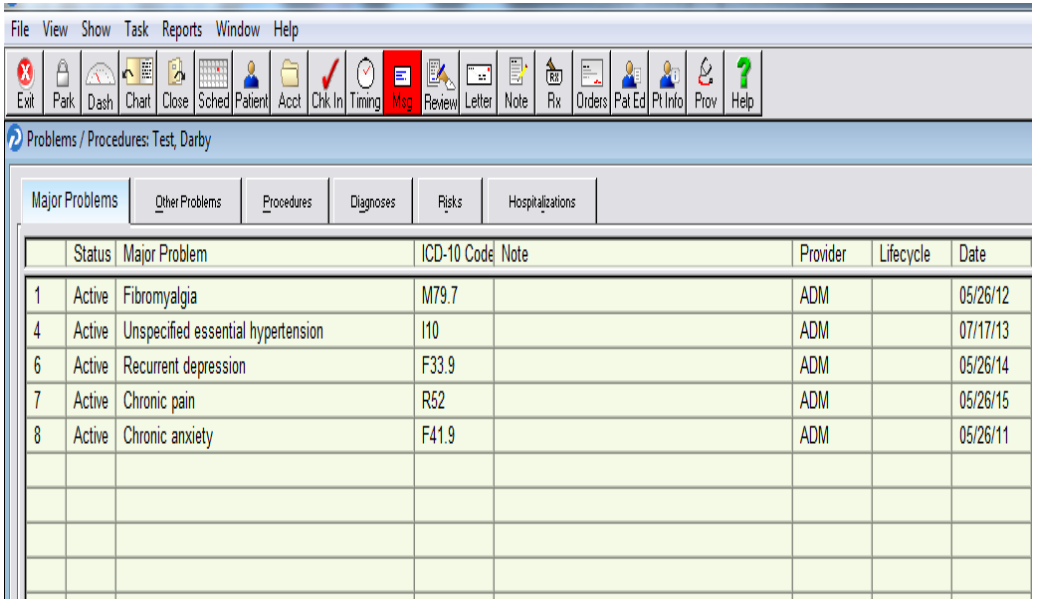
Panel-Level Data: Bipolar Patients

Currently working on a project for early identification of patients on the Bipolar Spectrum

- Anecdotal evidence suggests that these patients are often left untreated or misdiagnosed
- Hypothesis – that with appropriate treatment these patients stabilize, reducing ER and clinic utilization

Panel-Level Data: Identifying Patients with Bipolar Disorder

- Searching the problem lists for patients that have long-term or episodes of anxiety, depression, mood cycles, and other behavioral diagnoses.



	Status	Major Problem	ICD-10 Code	Note	Provider	Lifecycle	Date
1	Active	Fibromyalgia	M79.7		ADM		05/26/12
4	Active	Unspecified essential hypertension	I10		ADM		07/17/13
6	Active	Recurrent depression	F33.9		ADM		05/26/14
7	Active	Chronic pain	R52		ADM		05/26/15
8	Active	Chronic anxiety	F41.9		ADM		05/26/11

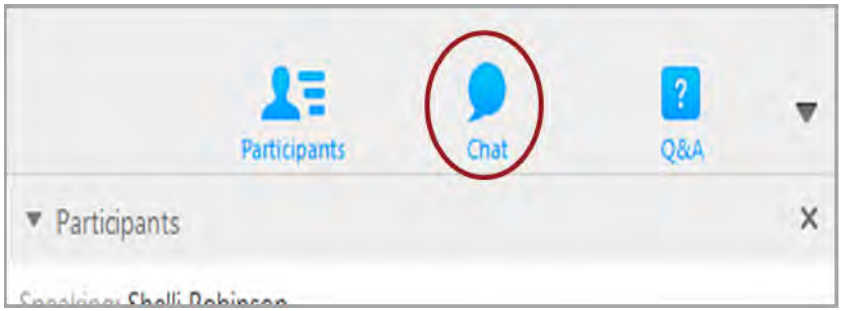
Panel-Level Data: Tracking Patients with Bipolar Disorder

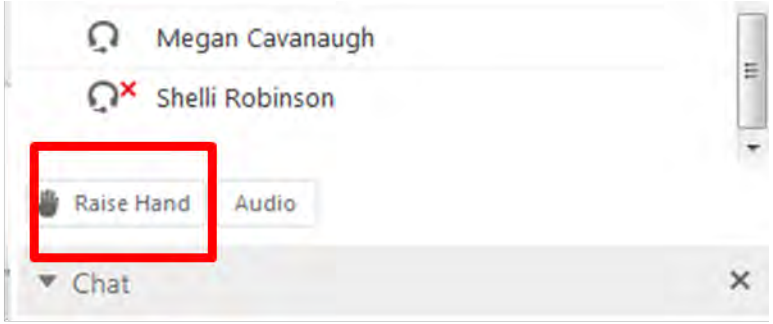
- Monitoring patients with multiple ER visits, Clinic Visits, and Inpatient Hospitalizations, and underlying behavioral/mental health problems.
- Test Group of Patients Identified

PATIENT ID	MEDICATION	Date Current RX	Date Original RX
2221			
	LAMICTAL	4/1/2015	1/1/2015
222			
	LAMOTRIGINE ER	3/16/2015	3/16/2015
2345			
	LAMICTAL	5/15/2014	12/15/2014
1234			
	LAMOTRIGINE	5/20/2015	12/20/2015

Questions for Grande Ronde RMC?

- Chat them in, or raise your hand





Thinking about data in a geriatric practice

- How can we generalize the experience of Washington Regional to apply to family practice or general internal medicine?
- Think about how data are tracked and retrieved
- Think about how data inform patient care and the integration model

Does your practice use a tool to screen for cognitive decline in older adults? (Chat in which tool you use, and why.)

Yes

No

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Washington Regional-
Pat Walker Center for Seniors
Fayetteville, AR

Gillian Woods, Ph.D., LPE

gwoods@wregional.com

479-463-4419

- 4 Geriatricians with APRNs
- 2 social workers
- 1 neurologist
- 1 neuropsychologist
- 2,098 active patients (Q1 2015)

Data Tracking

- Why track patient- and panel-level data?
  - Cognitive screening and neuropsychologist involvement have always been an integral part of care in-clinic.
  - However, neither patient nor panel-level data has been evaluated formally prior to the CPCI.

Goals:

- Diagnose as early as possible in the disease process
- Evaluate the intervention impact
- Assess neuropsychological services (quality assurance)
- Enhance practice and patient care (e.g., based on risk variables, diagnoses, utilization trends, formal CP and tracking, etc.)

Patient-Level Data: STMS Rescreening and Tracking

- Who is involved?
  - Screening/data entry: LCSW or APRN
  - Assessment review and possible referral: APRN or MD

- How is **NextGen** used for tracking?
  - A custom Excel file report is created.
  - This report pulls STMS patient data from 1 year *before* the report date.
  - Patients who are overdue for a rescreen can be identified.

- How is the data used to *improve patient care*?
  - Early identification and intervention are key as age is a risk factor
  - Healthier, more functional patients
  - Better informed and prepared patients & caregivers
  - Improved treatment, thus function and long-term care planning

Patient-Level Data: Storing BH Data in NextGen

- Designated The Short Test of Mental Status (STMS) template was created in **NextGen EMR**.

- Data is directly entered into EMR template during test administration.

- After assessment data is saved, a narrative report is generated.

Source: Centers for Medicare & Medicaid Services

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☐ Patient is hard of hearing.
Dexterity ○ R ○ L

The Short Test of Mental Status (STMS)

ORIENTATION

Name	○ Yes ○ No		State	○ Yes ○ No	
Address	○ Yes ○ No		Date	○ Yes ○ No	
Current Location	○ Yes ○ No		Month	○ Yes ○ No	
City	○ Yes ○ No		Year	○ Yes ○ No	

Total: ____ (8)

ATTENTION Digit Span (1 second between each number. Record the longest span.) Longest Span: ____ (7)

○ 8-3-5 ○ 7-2-4-6 ○ 2-9-6-8-3 ○ 5-7-1-9-4-6 ○ 2-1-5-9-3-6-2

IMMEDIATE RECALL Four unrelated words: ____ (4)

☐ Apple ☐ Mr. Johnson ☐ Charity ☐ Tunnel ____ # of trials needed

CALCULATION ____ (4)

5 X 13 = ____ ☐ (65) 58 / 2 = ____ ☐ (29) 65 - 7 = ____ ☐ (58) 29 + 11 = ____ ☐ (40)

ABSTRACTION ____ (3)

☐ Orange/Banana (fruits) ☐ Dog/Horse (animals) ☐ Table/Bookcase (furniture)

CONSTRUCTION ____ (4)

☐ Visually Impaired. Unable to test.

Command clock: ____ (2)
Clock copy: ____ (2)

INFORMATION ____ (4)

Who is the current president? ☐ ____ Define an island? ☐ ____
Who was the first president? ☐ ____ How many weeks are in a year? ☐ ____

RECALL ____ (4)

Apple	Mr. Johnson	Charity	Tunnel
☐ correct w/cue	☐ correct w/cue	☐ correct w/cue	☐ correct w/cue

Age score	Cut-off
50-59	31
60-69	30
70-79	29
80-89	28
90-100	27

Total Score ____ 38
Number of learning trials from Immediate Recall ____
ADJUSTED TOTAL SCORE ____ 38

☐ Test was not completed. (see notes
☐ Within normal limits
☐ Congnitive impairment

Save & Close

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Source: Centers for Medicare & Medicaid Services

Panel-Level Data: Identifying Cognitively Declining Patients to be Tracked

- Who is involved?
  - IT, Gillian Woods, neuropsychologist and tech, Interdisciplinary Team as appropriate
- What *variables* are used to identify patients to be tracked at a panel-level?
  - Basic demographics
  - Referred for neuropsychological assessment
  - Cognitive-related diagnoses
  - Diagnoses increasing risk of cognitive impairment
  - Utilization (ER, hospitalization)
  - Continued follow-up care
    - In process of creating neuropsychological CP template workflow
    - By using CP template, reports can be generated to assess on-going individual CPs and trends based on the patients being care managed.

Washington Regional

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Specialty ▼ select a specialty Visit Type ▼ select a visit type

Care Guidelines | Global Days Panel Control: Toggle Cycle

Care Plan History

Generate Care Plan History

Problem	Goal	Outcome	Intervention	Role	Status
Patient is at risk of recurrent hypoglycemia related to diabetes.	Patient will have no hypoglycemic events as evidenced by blood glucose levels greater than 75.		Educate patient on importance of compliance to medication regimen.	Nursing	New
Patient will monitor blood pressure daily or as directed and will call clinic with complaints of Dizziness, Headache, or Flushing	Patient will not experience any symptoms related to Blood Pressure.		Patient will take Medication as prescribed, keep scheduled lab and office appointments, and reduce stress of daily living.		

Add Edit

Care Plan Interventions

Problem: Patient will monitor blood pressure daily or as directed and will call clinic with complaints of Dizziness, Headache, or Flushing.

Goal: Patient will not experience any symptoms related to Blood Pressure.

Interdisciplinary Team Member:

	Due	Interventions	Due Date	Role
All	Due	Patient will take Medication as prescribed, keep scheduled lab and office appointments, and reduce stress of daily living.	09/17/2013	
Nursing				

Panel-Level Data: Tracking Cognitively Declining Patients

- **NextGen** reports pulled based on aforementioned variables.

- Reports → Generate Report → By Enterprise → select filter variables
  - At present, point-in-time reports are generated.
  - Plan to schedule automated reports for either monthly or quarterly.
  - Reports saved in Excel format.

- Payer reports used to look at utilization data.
  - Plan to have CMs formally track utilization information from TCM appointments.

Questions for Washington Regional

- Chat them in, or raise your hand

Additional Resources for Cognitive Assessment

REMINDER: ACTION ITEM for you after the session:

Learning Experience:

- What do you plan to implement to improve your practice's use of behavioral health data? How will this improve patient care and quality improvement?

- Post your ideas on the forum!

What's Next

- Continue to build on your skills – additional BHI action group sessions will be announced in July.

- Continue to post on the forum!

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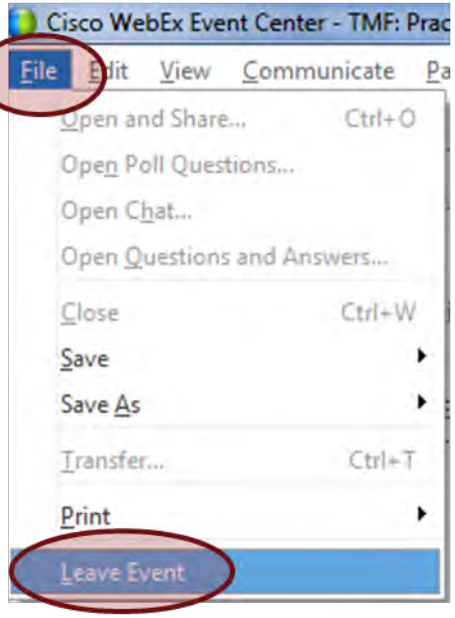
NEW: All attendees, including faculty, MUST complete a survey.

You may add multiple participants on one form if you participated as a group.

1.



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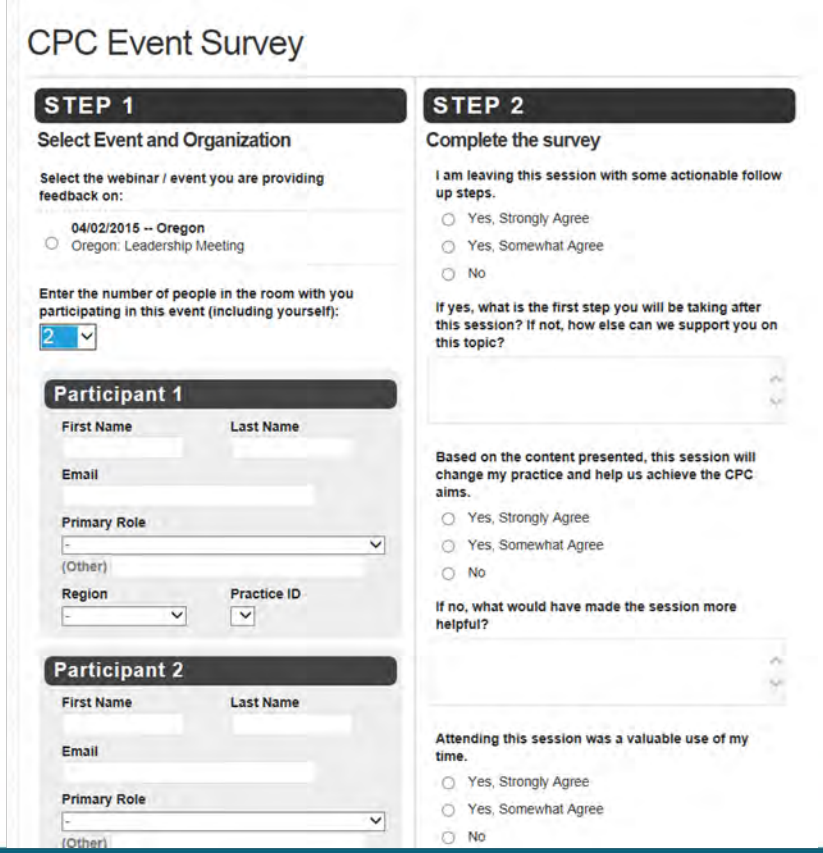
3.