Rapid Cycle Action Group: From Screening to Treatment in Behavioral Health, Session 4

Presenter: Elisha Jewett, HealthTeamWorks (CO faculty)

Moderator: Rose Langdon, TMF Health Quality Institute

Oct. 28, 2015

Hello, everyone. This is Rose Langdon from TMF Health Quality Institute and welcome to our fourth and final Rapid Cycle Action Group live discussion for the group From Screening to Recognition in Behavioral Health. Today's focus will be Moving Your Care Forward. Today we have several faculty to help guide this discussion including Elisha Jewett from HealthTeamWorks who will be facilitating our discussion. And we'll also hear from Betsy Duckett, who is with Boulder Community Health, Aimee Ducharme from Family Care Southwest and Christine Baron from Banner Health Network. We have a great session planned for today, but I'd like to make a few announcements before we get this discussion started. First of all, thank you so much for each and every one of you that put time and effort into preparing for today's session. As a reminder, any statements about the quality or utility of any product or vendor made in this presentation is an expression of the opinion of the person making the statement only and is not an opinion or endorsement for the Center for Medicare and Medicaid Innovation, TMF Health Quality Institute or the host of this program. Again, this is your discussion so we want you to be as interactive as you possibly can. Now there's several ways that you can join in the conversation. First of all, above your name in the right-hand panel you'll see the Chat icon. Click on that icon to open up the Chat box. It will not be open automatically for you. Then make sure that the send to box is set for All Participants and not All Attendees. When you set it for all participants this communicates with everyone that is on this session, panel and audience included. You may also use the hand icon just under your name to be unmuted and ask questions and share an idea verbally and we do encourage that activity. And now as you've done so many times before, please tell us where you're joining us from. To do that you can click on the annotation arrow at the top left of your screen and then click on your location on the map. And it's quite obvious most of you have really caught onto this activity. If you don't see your annotation bar, click on the black marker and a sidebar will become available to you to select the black annotation arrow. And I'm seeing people it looks like from pretty much all regions. There we've got all regions represented. They're all check in. That's wonderful. This should lend us Elisha to a wonderful discussion. And now what I'd like you to do is to use your annotation arrow and share with us your role within the practice. As is often the case, Elisha, we see a lot of care managers and coordinators, some practice managers. I'm glad to see the behavioral health specialist represented here. That's a key component of what we're going to be talking about, some nurses, physicians, quality specialists. And if you are indicating other on this screen could you do us a favor and please chat in what your role is in the practice and how you participate in the behavioral health care of the client population. It looks like

we're going to have a good discussion and what I'd like to do now is turn the conversation over to Elisha Jewett who will guide our discussion. Elisha.

Elisha. Yes, thank you so much, Rose. So thank you everyone for joining us today for our fourth live session. So during today's session we will discuss some of the highlights from our live Session 3 two weeks ago. We'll have some practice sharing. We're going to be doing an interview format this time thanks to a recommendation from one of you from the evaluations, which we do review and take very seriously. And we want to talk about what's going on on CPC Connect. So as you recall, the CPC Connect aspect is kind of the big report part of the live, or excuse me part of the Rapid Cycle Action Groups. We do like to utilize that to continue the conversation in between the live sessions since the live sessions are just one component of the rapid cycle action groups. We're going to look at some useful resources that were identified by your peers and go through a process example that was shared on CPC Connect. There is pre-work for this live session. So basically in between each live session we do hope that each of you are working with your team to make some improvements or changes in your practice, identify areas of opportunity that sort of thing. The app was to complete a next test of change. For some of you that might be your third or fourth, some it might have been your first. Document and track your changes. That's always an important component of any kind of quality improvement. And utilize CPC Connect to learn and share with your peers. We did have a little more action on our behavioral health group this week. So that was exciting to see. We do encourage you to continue to post test of change and process measures along the way. Last time hopefully most of you were on that call. But just to refresh some of the topics we talked about and what your peers shared about their work we discussed tailoring interventions and care to the patients, complex care meetings and case studies, describing the range of behavioral health services, SBIRT resources and how to use it in practice and we have some discussion around utilizing team-based care following identification of a behavioral health need. So those are some really great topics and really critical to what we're talking about in these live sessions. As a reminder the focus is on behavioral health from that point of identifying a care need and going forward. Do fortunately we've had some great sharing opportunity from your peers in this group. Now I'd like to introduce Betsy Duckett who is an RN from Boulder Community Health in Colorado. Betsy if you want to share a little bit about your practice and your role there.

Great. Hi, everyone. I'm the Manager of Integrated Clinical Services. Boulder Community Health has 12 primary care clinics. Five are CPC practice sites. And our integrated clinical service team includes transitional care nurses, care coordinators, our behavioral health team and as well diabetic education is part of our group.

Great. And BCH has provided training for a lot of their care team members including their care coordinators or care managers. Will you tell us a little bit about this and why you guys decided to pursue that?

Absolutely. When we started we rolled out with initially just care coordination and transitional care. The care coordinators came from both RN level training as well as from our MA pool. And one of the things that we were rolling out as far as PCMH and for CPC was depression screening. And there was a lot of angst in the clinic of now we screen, what do we do when we get a positive result? And the initial was

well, we just send them all to the care coordinators. And you know my reaction was – wait a minute, this isn't behavioral health staff. But let's make sure that we're all at least comfortable working and have some, you know, necessary resources ourselves to be able to you know move forward with this. So the whole care coordinator and actual transitional care team has gone through mental health first aid training. And we did that and then any new staff I've brought on I continue to have go through mental health first aid training to increase their comfort level. Did a lot of work bringing community resources into the team so that they would know who they were interacting with over the phone. And one of the most important was the behavioral health navigator from our local mental health center. And she has continued to be really valuable to the team for resources. I also have put and a few new team members who have not been through yet but had all the care coordinators go through a strength based care manager training. And as well we provided a boundary setting for caregivers for the team. We did that internally ourselves.

That's great. I'm sure that was very important for those folks to be all comfortable in the care they were providing.

10:03

We definitely see with care managers and care coordinators that it's sort of inevitable that behavioral health things do come up. So it's fantastic that you've been able provide that kind of training. You've done some great work engaging with your community and resources there as well. What have been some of your greatest successes around that?

You know, I think one of the things that has been interesting to me and certainly concerns me you know for the future going forward is dementia, which is a little off track of this behavioral health. But I think one of our most valuable resources has been the Alzheimer's Association and the work that they'll do. If we have a rapid referral with them they have a special process. They actually have a licensed clinical social worker that'll contact the family and work with the family and the patient. And if we've done that referral we get information back to the practice. So, that's been very valuable. It used to be the Area Agency on Aging and now it's the Aging and Disability Resources for Colorado. Our local Boulder County group provides a lot of services and I've had them come in and do presentations for the group about what's available for patients through them.

That's really nice and have they been receptive to that for the most part when you've reached out to those organizations?

Some, absolutely the Alzheimer's Association has really stepped up. What we find is sometimes when we're reaching out to ADRC that these are such complicated patients that they almost feel that they're a little too complicated for their case managers. So, that's been a little bit of you know how do we work together you know and who can do what with them. But again, they have valuable resources to help us.

Yeah, well and that's definitely a good approach to kind of identify what level of care they can provide and where you may be able to fill the gaps. So that's great. Will you tell us a little bit about your staffing

model and how you've utilized your folks in behavioral health services and your behavioral health specialists beyond the clinic's base support?

Sure. We, it's been a little over a year and a half, almost going on two years since we hired our first behavioral health specialist and then our second came on board about six or eight months after the first. And the first I really placed by gut instinct of where I was hearing about the most behavioral health concerns and mental health concerns from those clinics and two CPC sites. And then when we hired the second we actually used data at that point to place the second. And we looked at our clinics with the highest number of behavioral, I'm sorry PHQ-9 screens greater than 20, and placed the second person based on that. What we've done, and I guess I can get to a little bit more about how they work within the clinics, but how they support all the clinics is we do run a depression registry monthly. And we're looking for everybody who's had a PHQ-9 15 and greater, 20 and greater in some sites depending on the numbers in the last month. And chart, actually greater than four weeks. So we're looking back at a four-week period and the behavioral health specialists not only do their own two clinics or have time in each clinic, but they have an additional four sites. Julie, our first person, has all the CPCi clinics. And they do chart review of all those patients with a PHQ-9 greater than 20. If they scored high on the suicidality question, either a two or a three, the behavioral health specialist reaches out if they have not had a follow-up appointment or don't have something scheduled on the books, you know, within a short period of time. If the suicidality question was zero or one and they don't have follow-up that we can see scheduled in a reasonable timeframe, those are passed to the care coordinator on that site to reach out and provide follow-up. And so and also they are available to each of their, you know, six clinics, the four where they're not embedded to help with referrals. So when somebody is showing up that needs an outside or specialty referral for mental health the behavioral health specialist can be tasked to help find appropriate referrals for those people.

Thanks. That's a really good example of how you can utilize behavioral health specialists in different capacities. And we really encourage practices to do case reviews with their behavioral health specialists that they do referrals with and really take advantage of those relationships to access things that they may know about that provider may not like resources. I know you guys have also used Julie to do some training with staff and that sort of thing. So I think those are great examples.

Elisha, there's one thing in particular around those referrals that I think has been particularly valuable that we've seen is that we make them, I mean, Julie and Vickie will take time, look at the patient's insurance, look at the reason for the referral and give three really targeted referrals to a patient rather than just saying call the number on your card or here's a list of 10 people or check Psychology Today. We feel like we're getting a better response to those referrals and people are more likely to follow up when they have those three specific recommendations. And that, it just it feels that way. We don't have a way to actually document that and prove it, but we feel that we're getting a better response to referrals.

Sure. I can imagine. I think that's great advice. I mean, if you're working with someone who has behavioral health needs, the last thing they may feel equipped to do is call 10 different numbers to see, deal with their insurance and that sort of thing. So, I think that's a wonderful thing to do for your patients. Another successful area of behavioral health in your clinics have been treatment of patients

with really high scores on the depression screening. We, you guys actually did some data tracking around that, is that correct?

That's correct. If you want to, we just recently had a Spotlight article published for CPC. So, it's fine to bring that up now. You know we really have, thanks to Elisha really, we pushed a little bit to say how can we prove that having behavioral health really makes a difference? How can we show this is valuable in the clinics? So we started tracking repeat PHQ-9s. Initially they were just rolled out in the screening. But for the folks that have had behavioral health intervention with our BHPs, they– we do a repeat screening anywhere from four weeks to, you know, further out, depending on when we're seeing them. And we looked to see if there was a change in those scores. And initially we started and we just, we looked at all patients that we had screened and were just looking at a more general number that had the PHQ-9 and the results were only about a four percent difference, four point difference in their screening. But then as we thought about it realizing that is a very depression-specific screening, so rather than taking somebody you know who had a six on there that maybe or maybe not was depression, maybe it was insomnia really going for those with that higher score. And so when we looked at people who scored 15s and above on their PHQ-9 and had intervention and a repeat, that they had you know close to nine or a little bit higher than a nine-point decrease in their PHQ-9 score after that behavioral health short-term intervention. And the folks who had a 20 or greater actually had as much as an 11, slightly greater than 11 percent improvement in their PHQ-9 score. I will say this is sort of a rough measure. I mean we've even been talking, you know, do we look at this. Do we then add in their medication management. You know is there a medication change or you know was there adherence to the medication? During that period of time it may not all be, I mean chances are it's really a combination of the intervention and medication with some of these folks. But, it really kind of spoke to us that we were seeing some significant change in people receiving the service.

That's amazing. Thank you. I think finding ways to track data to show that your added resources are effective is huge right now. So, that's a really exciting piece. I want to go ahead and open it up for questions for Betsy since Betsy will have to jump off the line here in a few minutes. So, please feel free to raise your hand or utilize the Chat for questions. Rose, are there any questions right now?

We're getting a number of comments. We had a comment that in regarding to the use of behavioral health specialists with referrals Lee has admitted that yes, she can, she can attest to that.

20:14

At UMAS, I'm trying to make it more of routine that the physicians may want to reach out to the community in specific instances. The big piece is really trying to differentiate the internal and external needs, being new to the system and working toward a balance to what can be done internally. So, that is her comment. There are not any questions that have come up in the Chat this time.

Elisha.

Yes, I can just put something else out there. One of the things that we're doing in the community with the behavioral health specialists and myself and even our chief medical officer who I report to, is

reaching out to the other community providers. And I think one of our frustrations is HIPAA around behavioral health. And being a PCMH and primary care we want to know what's happening with our patients. We want information back. We want the most updated med list. We'd like to know if they showed up for that referral. So we are doing a lot of reach out to our local community to say our expectation is that we're going to hear back from you. We understand there's a lot of regulation about behavioral health and, you know, we're successful in some places. Others we still are finding a lot of difficulty with that. But I'm really hoping to see some changes as we recognize the importance of integrated behavioral health and how primary care and behavioral health can speak with each other.

And this is Rose. Again we are getting people that are now asking questions of this wonderful panelist that we have. First of all, how did your behavioral health specialist educate other professionals on the time management roles, etc., in an organized and consistent manner?

In a time manage, I'm not totally sure I understand that. Can you repeat that?

So the question is how did your behavioral health specialist educate other professionals of the time management and the roles in an organized and consistent manner?

We've done–

And I welcome Lee to raise her hand if she would like to address that directly.

We spent a lot of time, if I'm understanding is how are we working within the team and the team understanding everybody's role and that's ongoing. I mean we did rollout in all the clinics where we went to a meeting for staff and explained behavioral health resources, explained what it looked like having an integrated record where you know there was documentation on behavioral health in the medical record, on who could make a referral, how the referral would happen. We really try and keep them available so when they're doing scheduled sessions with our patients, we try not to schedule more than four a day absolutely, preferably three. And we make it clear to the patients they may be pulled for a warm handoff or a consult by a provider. They work closely with their care coordinator in that clinic so that the medical needs can be meshed with the behavioral health needs. But it's continually ongoing education and getting in front of the providers and other staff.

That's wonderful and the audience is also wondering if your behavioral health providers bill for their services and, if so, how are you doing? That has been a number-one question, I think, through this whole group, so.

Million dollar question.

It is.

And we've been talking about it for a year and have not flipped the switch on billing. We still provide it for free. I think at any time, you know, particularly in Colorado, you know, what happens with the SIM grants and all, but at this point we felt like we would decrease the availability of services to people if we billed; that the people who needed it the most would not access for some of the some reasons they

don't access it in the community or we couldn't provide it to some because of the way payer panels are set up around behavioral health. So, at this time we're not billing, but you know I think at any time that could change.

Alright, Betsy, thank you so much for sharing all this wonderful information. I know you have to jump off the line now, so.

I do, and I'm happy, Elisha, if you want to hook anybody up with me by email or anything. I'm happy, ready to communicate with anybody, so.

And what I would suggest, and this is Rose, Betsy. I would suggest that we communicate with each other on CPC Connect so that each and every one can take part in that conversation.

Absolutely.

Thank you.

Thank you.

Thank you. Bye.

Alright for the folks on the line we are going to jump into an interactive piece here. So using that annotation tool on the left-hand side of your screen, if you will use the space on the left side to put where your team is around team-based care in behavioral health. So are you kind of at the point of behavioral health is only involving providers, behavioral health maybe involves MAs or one other person, or does your behavioral health involve many team members? So if you can use those annotation tools. Again, that's the arrow on the left side of the screen. Wow, look at you guys. It's amazing. So it looks like almost everybody is kind of either at or approaching that involving many team members. I honestly didn't expect that, so that's fantastic. Very, very happy to see that and hopefully for those who maybe aren't quite there yet, you've learned something from what Betsy shared today. As you can tell, at Boulder Community Health, they've really done a lot of involvement with team members and actually Julie, Julie Youngman's arrow was there as well, and she's also with Boulder Community Health. So, good example there. Alright, so I would encourage you to continue this conversation on CPC Connect around team-based care and behavioral health because it's certainly an important one. Alright so on the left side of your screen if you want to hit that arrow again and turn off your pointer, I will go onto the next slide. If you mark future slides, don't worry I'll try to clear it if I can, but we've all done it. Alright, so our next practice that's going to share is Family Care Southwest, and we have Aimee Ducharme who is their care manager. She's also an MSW and LCSW. So Aimee if you want to go ahead and take yourself off mute, I will let you tell us a little bit more about your practice.

Okay, thank you. Hi, everybody. So my name is Aimee Ducharme, and we are from Family Care Southwest which is located in Littleton, Colorado. We have a total of six providers, two of which are MDs and four are PAs and a total of about 6,800 patients that are active in our practice. So we are contracted with Jefferson Center for Mental Health and have two licensed clinical social workers through that organization that come to our office a total of three days per week. One of those LCSWs has been with

us for three years now, and then we just added on another licensed clinical social worker in July. It's because we were finding that we had really high demand for our previous social worker or our current social worker as well. And so we felt like it would be beneficial to add on another behavioral health specialist to provide more access. So right now they're seeing about a maximum of 18 patients per week. And that is kind of where we're at with that and the care manager as well and I'm a social worker. So I work really closely with them here in the office.

Great. So you guys have been working on this for a while now. What kinds of behavioral health needs are you commonly treating?

We see patients for many different diagnoses, but the most common one to be depression, anxiety, often stress or grief and loss. The new social worker that just started with us in July; she is also a licensed addiction counselor. So she is now seeing patients with substance abuse needs, which is really great because prior to this our other social worker would tend to refer out those needs. So now we're able to see patients in the office for that.

Are you getting, this is Rose. Are you getting a high usage for your substance abuse?

Yeah, we are. She's actually been filled out for her schedule for the last couple months. She started in July, so in the beginning it was a little bit slower getting people in to see her, but now she's pretty much filled up. She is here on Tuesdays, that one particular licensed clinical social worker that's also the addiction counselor.

30:24

So she's been seeing six patients for the last couple months, which is the maximum.

Wonderful. How do you chart this? Does your social worker know it's going to the clinic EHR?

They do, yes. So they're able to go into our EHR and the only people that can access the notes right now are the providers. And what normally happens is upon an initial visit with a patient, a behavioral health specialist has a release of information that they go over for the patient to sign in order for their provider to consult with a behavioral health specialist and access those records. And they do have the option to decline that, but that doesn't often occur.

Thank you so much. So it's really wonderful that you have so many resources for your patients. Once your provider has recognized a behavioral health need, how do you handle the handoff or the referrals?

So, usually it's the providers or myself that do the referrals. Warm handoffs are great if the behavioral health specialist has time during the day the provider will check their schedule. If they're available, they'll go and grab them. If it's a patient that's interested in seeing the behavioral health specialist so that they can meet with the patient and introduce themselves. I think that provides a level of comfort prior to the initial appointment. For referrals often that happens in the office during an office visit. So our providers or myself will –if a need is identified for mental health services –they'll explain that we have two therapists here in the office and talk about their hours and days of the week that they're here,

talk about their individual specialties for each behavioral health specialist, and also it helps to say that we take– the behavioral health specialist takes their insurance, because they take all the insurances that we take in the office. So that never presents an issue, whereas in the community sometimes that can create a barrier. So, also we'll give patients the phone line to Jefferson Center for Mental Health. They have a billing department that's able to let the patient know about what their co-pay may be prior to their appointment which is also helpful, especially for patients where financial aspects are a barrier. So that's kind of how we do our referrals and warm handoffs.

Great. And then you guys have this wonderful welcome sheet. Do you want to tell us a little bit about how this came to be?

Sure. So, like I said often the referrals occur in the office. So if a patient is interested they are able to schedule on their way out of an office visit with our front desk staff. And so this sheet is available for our front desk staff to hand to the patient or if our providers, our providers can also hand it to them in the office as well. And basically it's kind of just a welcome sheet introducing what are office offers and how we're contracted through Jefferson Center for Mental Health and kind of just an introduction into our relationship with them.

Great. I think this really would be a useful tool because a lot of patients are still kind of trying to understand why behavioral health is coming into primary care and what that might mean for them and why we see it as a bonus. So I think that's really wonderful. Thanks for sharing that tool with us. And how do you guys handle the consent forms to communicate between your counselors and providers.

So the consent forms, those usually take place during the initial office visit. So, but behavioral health specialists will go over that with the patient as well as the welcome packet and just explain that if they signed the consent form and the release of information, the behavioral health specialist is able to consult with their provider and coordinate care. And so as long as they sign that then we're able to input that information into our EHR and their providers have access to how they're doing.

And you said that most patients do that is that correct?

Yeah.

Yeah, I'm sure that's really helpful. So something else you guys have done is a lot of data tracking. I know you have several process measures that you actively track. Can you tell us a little bit about those?

Sure, so over the past year we've tried to implement some improved tracking measures, so what we were noticing was that a lot of patients would cancel or no show and we were really tracking that to the best of our ability. So what we started doing is after each day that the behavioral health specialist is here in the office, they would take their schedule of their patients that they were supposed to see and they would know whether the patient kept their appointment, canceled the appointment or did not show up for the appointment and so they would write down that data and hand it to myself. And I input that data now into the EHR flow sheet so that it's accessible to the providers. So they're able to now see when their patients are showing up to the appointment and when they're no-showing or canceling and

see that consistently over time. So it's been helpful because if a patient cancels without rescheduling or no-shows, then we're able to track how many times that's occurring. So if a no-show or cancellation occurs more than twice, we reach out to the patient and it's usually the behavioral health specialist that will do that reaching out. Occasionally, if it's a patient that the provider wants to reach out to or if I see the patient myself, then I'll do that as well just to make sure that everything's going okay. And then also if the patient cancels without rescheduling or no-shows, our front desk staff will send a flag in the EHR to the providers to notify them as well.

That's great. It's nice that you guys have been able to put into place a way to follow up with patients that haven't been able to follow through on those visits. That's probably very helpful.

Yeah, so at this time I would encourage you guys to start putting your questions into the Chat box for Aimee. I'm going to do a quick pole while you guys are thinking about your questions. So what do you guys do to follow up after diagnosis and/or referral? So use the space to place your arrows. So either you don't have a process for follow up and that's an opportunity area for you or you have an inconsistent process for follow up but maybe it's not, not everyone knows about it or you're not doing it every time. Or you might have started to work on some standard work or protocols for follow up with patients that are involved in behavioral health or need behavioral health. Well it looks like we're all over the board here, and we're getting– we have quite a few in kind of that middle area, maybe an inconsistent process. Maybe it's a process that's just not documented. But it looks like quite a few of you have started to do the standard work or protocols. I know we have a few practices that we've heard from that have started to create kind of a standard workflow where if a patient hasn't followed up with a behavioral health specialist within six weeks, they require them to come back in for an office visit or other standards like that. So wonderful. It looks like this might be a good area to think about for further process improvement, doing small tests of change for a lot of you. And it looks like you also have a good handful of folks that might lend a little insight to this. So please continue to utilize CPC Connect even following this session to continue to have conversations around some of these topics. Alright do we have any questions for Aimee, any raised hands or anything in the Chat at this time? Or Aimee is there anything further you want to add?

I don't think so. I mean I think it's been really helpful to have a behavioral specialist here in the office three days a week. It tends to be a more comfortable setting for patients, and often we'll kind of offer both community options as well as our office. And most often patients would prefer to stay in the office because they're comfortable. Here our behavioral health specialist uses an exam room, so it's a comfortable setting and it's something that they can schedule in a way that they're familiar with. So it's been really helpful.

Great.

The major thing I'm seeing is people once again want to know about the billing? And I think you covered that quite well Aimee, but if you could reiterate how you're doing the billing for your behavioral health I think our participants would appreciate that.

40:25

Sure. So, because they're contracted with an organization they do all of the billing on their end. So, the great thing about Jefferson Center for Mental Health is the wide range of insurances they accept, which is helpful. So they accept all the same insurances that we accept. So we never worry about a patient coming in for an office visit that's interested in behavioral health not being able to access that here in our office. And then we have the phone number that we give out for patients to call at Jefferson Center to find out what their co-pay is before the office visit. Because a lot of the time that will be something that patients bring up, you know, as I'm not sure if I can afford it. So that phone number is helpful so they can find out if their co-pay, what their co-pay is prior to the office visit.

Great. Okay, alright well, Aimee, thank you so much, and Aimee is going to be on the line. So if you think of more questions for her you might be able to come back to them at the end.

And, Elisha, there was one question. Are you billing mental health codes?

So we don't do any of the billing. It's all through Jefferson Center for Mental Health, and I do believe that they do bill mental health codes, but I'm not sure if that's for all patients or only some of the patients depending on what their needs are.

Wonderful. Thank you for responding.

Aimee, I think that she might be wondering if the providers when they see and identify behavioral health needs if there's any mental health billing coding on at that point, and you may not know that or maybe you do.

No. We, no, the providers do not bill mental health at all.

Okay, thank you.

You're welcome.

Alright well thank you again, Aimee.

Thank you.

Alright. So again, one of the tools we have as part of the Rapid Cycle Action Groups is this CPC Connect site. So I just want to highlight a couple things for you all since we did have some activity on there. Dr. Ben Miller had routed us to a HealthTeamWorks site where there's a lot of guidelines and information around depression. And one of the tools that Andrea had just pointed out as a possible value tool for their practice is this treatment tracking log for depression. So I just want to highlight that there are tools being shared on CPC Connect, and here's one that one of your peers is considering utilizing in some capacity at their practice. So feel free to get on CPC Connect. We had a comment in one of the evaluations that you were looking for some guidelines around care and one of the links that you provided does give you guidelines for use in primary care around depression. So there's a lot going on there. Here we go. Alright and at this point, I want to turn it over to Christine Baron, who is someone,

their team at Banner Health actually shared on the CPC Connect site their improvement activities. And since that is the focus of this group, I think it's great that we can look at their tool and what they're creating. So Christine, if you could go ahead and take yourself off mute, I will let you introduce yourself.

Hi. Can you hear me?

Yes we can.

Okay. Well, I'm Christy Baron. I'm a social worker with Banner Health Ambulatory Case Management Unit up here in northern Colorado. We have 13 clinics and nine of those are CPCi clinics. In our group for this action group there are five of us– me, another social worker, a nurse case manager, a practice coordinator and a practice manager. So, we have gotten together and figured out what is it that we need to do.

Great. So I'm going to go ahead and pull up the document that you posted on CPC Connect, and it's your Rapid Cycle Action Group improvement plan. And just so everyone remembers when we go to these tabs you are able to scroll through this document on your own. So feel free to do that as Christine is sharing.

Okay, well first I want to give kudos to Kathy for typing this up, or Kelly. I can't remember which one of you did it, but they were very vital in getting this written up for us. So basically what, when we got together and discussed the issue we, what we kept kind of going around and around about, what is it that we want to measure? What is it that we actually need to change? And you know we thought well it would be awesome if we could put a behavioral health clinician in every clinic, but how feasible is that actually? How feasible of a goal actually is that? So what we, some of our clinics actually do have behavioral health providers there. Some do not and those would refer people to the communities. So what we realized was we really need to find out how big of a need or demand this is for us and what we in discussing between all of us about or different experiences at all the different clinics, what we realize is we don't even know how big of a deal it is, because we're not tracking it consistently. So we decided probably the best place for us to start would be there. So, Kathy being the practice manager had a meeting with the practice managers in the other clinics and made a determination that they would start documenting in the EHR when they would refer patients for behavioral health needs. And we decided we would pull a report for a two week period before we changed to make the documentation required. Hopefully that makes sense and then we would pull another report later after the change was made and see if we could, see if there was a difference between the two. If actually requiring consistent documentation would be, we would see a change in numbers.

So you did a small test of change before you rolled it out?

Right, right.

So actually coincidentally this morning we got our first results on that first report for the two week period before we made the change. And we found out that out of the nine clinics we ended up with five of them, only five them having referrals but we had nine referrals total. So we'll be able to at least see

will there be a difference next week when we pulled the other report. Will we have more clinics, more referrals? It'll be interesting to see that change.

Sure, absolutely.

So then our plan will be once we get the information we will depending on the numbers figure out if you down on there on the sheet where it says test of change two, we would look at the numbers depending on what they are doing. We need to follow up on everyone. Are there so many that we maybe just want to stick to a particular diagnosis, be it depression, anxiety or something else? Who will make the follow up calls? What will, what will we say if we make the follow-up calls and kind of figure out where we go from there.

That's fantastic. So it sounds like you guys were able to find a way to do a small test of change in order to collect the data before you made a required thing for every practice. And now you'll be able to think about the different possibilities depending on what that data shows when you do your next cycle.

Great.

Absolutely.

That's great.

And was it helpful having a team to talk about this?

Oh gosh, well it was so helpful because initially most of us, even though there's only five of us, half of us didn't know that the other half were even on our team. So it was kind of funny. We had a little mix up in communication at the beginning, but once we all got together it was so nice to have different perspectives. Me being a social worker, and I primarily work in only one clinic and so it was nice for us all to come from you know just different perspectives and being able to put, put the input together and put our brains together to come up with a good idea.

Yeah, that's– we definitely always encourage folks to utilize a team and you kind of hit the nail on the head there that one of the keys to it is having the different perspectives. And know you have had a couple different job functions. You mentioned that Kathy your manager is involved so that's always really helpful. Do you think it would have turned out differently had it just been one person's view, maybe needed more adjustments along the way?

I'm absolutely, I think I mean just the fact that there were five of us and we struggled to just kind of get us narrowed down to where we are now says a lot. And I think, I mean if just thinking you know internally if I would have had to take this on myself as– I think I would have probably still been at square one trying to figure out where do I go?

50:36

Because I tend to think of big picture stuff and realize, oh, sometimes you got to reel that in a little bit when you're looking at you know 13 different clinics and who knows how many providers and you know so many patients. And so it was, it was definitely, definitely beneficial.

Wonderful. Is there anything else you want to share about this test of change or the process in general?

I don't think so. Thank you very much.

Alright, well than you so much for sharing, Christine. I know I kind of had to ask you at that last minute once you posted this. But we appreciate your willingness to share. I think it's really valuable for folks to see different activities that their peers are taking on.

Thanks a lot. I appreciate the opportunity.

Alright. So if there's any questions for Christine please feel free to put them in the Chat or raise your hand. And I'm not, I don't think I'm seeing any questions. Rose, have you seen any?

Nope. I just saw a major thank you to Christine.

Great. Alright so if everyone can get those annotation tools out again I'd love to hear from you guys what everyone has been working on for the last two weeks since our last live session. So on the left-hand side of your screen if you can grab that annotation tool. Love to hear more about what you guys have been working on. So one person is working on case reviews and other kinds of follow up so I think that's been a little bit of a theme today. It sounds like several folks have been working on that. A couple of presenters indeed have. Expanding that behavioral health umbrella, definitely a hot topic and we heard Betsy talk about the dementia as she said maybe it's outside of the scope of behavioral health. But within this we are definitely concerning the behavioral umbrella very vague and definitely think dementia falls under that. So hopefully that was kind of some useful tips for folks that are also interested. Team-based care and workflow, basically workflows can be a huge area and connecting with patients with resources. So hopefully some of you guys have been able to reach out to your communities in thinking about what types of resources you might have available or other things in the community can bring in to support your work in behavioral health. Very fantastic. Alright, so can we go onto the next slide? You can go ahead and use that arrow again to put away your annotation tool. Alright, so as always we do want to hear from you guys. So feel free to raise your hand over these next couple minutes or utilize the Chat to share your test of change. I'd love to hear more about the things you guys have been working on since a lot of you participated in that last slide.

And I just want to mention, Elisha, that Julie says that they use the 99420 administration and interpretation of health to risk assessment instrument. They believe that it pays anywhere from nine to 14 dollars per screen. And, of course, some insurances don't pay, but we've been getting paid from Medicare.

Great. That's really helpful information. I know I've seen a question in there about coding which is not my area of expertise. So thank you guys for using the Chat to further the conversation. So, again we

want to reiterate that you guys can continue to use Chat. And one of the most important things that I want you to know is that you can continue to use this group by, if you're not already part of the Screening to Treatment group, you can join that group and continue the conversation. Just because this is the last slide session, by no means does this group end. There's been some great conversation in there already, and I would encourage all of you guys to continue to use that. You might be able to bring in some of your billing conversation or your HIPAA conversation or other things that have been really integral. So please utilize that resource. Alright and Rose has some updates on the upcoming action next round of the Rapid Cycle Action Group. So we will go ahead and turn it over to Rose.

Thank you so much Elisha. Just remember that the next group of action groups is starting in November. They run through November of 2016 and the registration is open now. I have posted that registration link in the Chat for your benefit. So that you know that this winter there's going to be four Rapid Cycle Action Groups and they may appeal to your area of focus for your practice. So please review the course catalog and sign up for those action groups as they apply to your practice. And I want you to remember to complete your post-event survey, and I want to thank you for attending this particular action group. I think we've learned a lot and there's been a lot of information shared not only here but on CPC Connect. As WebEx closes, you'll automatically be directed to a post-event survey. This feedback form is used to continually improve our learning opportunities. We're requesting that all attendees, practices, panelists, faculty and other guests complete the attendance and organization demographics portion of the form as well as provide feedback for today's discussion. Some of you have had problems where a pop-up blocker blocks your pop-up of the survey. I want to let you know that I have posted a link here in the Chat so that you can put that into your browser and it will pop up then for you so that you can evaluate this session and you can receive credit for participating. Up to ten attendees can be indicated on one form. Please complete all sections and then scroll to the bottom and hit Submit. Once you hit Submit you'll receive a message that your form has been received. Again, I want to thank you, and I want you to continue this discussion on CPC Connect as we work forward in our CPC practices. Thank you so much.