Milestone 2 Action Group: Behavioral Health Integration

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Hello everyone. This is Rose Langdon from TMF Health Quality Institute. Welcome to our Milestone 2 Action Group session entitled "Behavioral Health Integration: Data Collection and Management for Behavioral Health". I'd like to start things off today with a few announcements. A new post-event survey has been developed with the aim of capturing information that will help us understand our audience as we plan for future events. We are requesting that all attendees, practices, panelists, faculty and other guests complete the attendance and organization demographics portion of the survey, as well as provide feedback on today's discussion. Up to 10 attendees participating in the same room may be listed on one survey. We appreciate the presenters' time and effort in preparing and sharing their valuable knowledge. 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 of the Center for Medicare and Medicaid Innovation, TMF Health Quality Institute or the host of this presentation. And now I'd like to introduce you to the speakers for today's session. Leading our discussion will be representative from Grande Ronde Hospital Regional Medical Clinic from Grande Ronde, Oklahoma or Oregon, sorry, and Washington Regional Clinic for Senior Health from Arkansas. Dr. LJ Fagnan from the Oregon Regional Faculty will be facilitating the discussion. As usual, we'd like to know where each of you are from. If you could go to the upper left of your annotation toolbar and click on that marker and then select the black arrow, and let us know where you're from. And you guys have this down to an art and a science. Looks like we have all of our regions represented, and even people outside the region, this is wonderful. Excellent participation. Great. Now you're going to be using the annotation toolbar later on in the session. But for now, if you could click the black arrow off so that you do not inadvertently mark on the slides, that would be appreciated. Now this is your action group session. We want to make sure that you are as interactive as possible using Chat, we're going to do some polling on the screen and we want you to keep using the forum. More activity means more learning. If you have technical problems and need assistance, please put those in the Q and A section of the right-hand side of the screen. And now, I'd like to turn the microphone over to Dr. LJ Fagnan to kick us off. Dr. Fagnan?

Great. Thank you, Rose. So we're going to—I want to just reflect our last session, I really appreciated having three practices lead us on a discussion of space for behavioral health services looking at their strategies that they've used for space and privacy issues, Foresight Family Physicians in Colorado, Salem Health, Willamette Health Partners in Oregon and TriHealth Western Ridge in New Jersey. It was really useful to hear about what they were doing. We've posted some resources on the forum. Oftentimes

after a webinar, we want to go back and think more about what was presented. And this HIPAA resource, it's fairly detailed but it's—I think it's incredibly useful and worth your exploring if you haven't done so. We've got some additional resources that we put on the forum that we think might be of interest to you: a YouTube video, a behavioral health data exchange resource and looking at some specific case studies of using IT for behavioral health integration. And so, these are on the forum site and the forum is again a good place for us to have a discussion about what do you find useful here because you're kind of—you're teaching us a lot about, you know, there—you know, are these resources useful and are we missing some. You may have some other ones that you want to share with us, so use the forum for that. We're now going to move from space and privacy to think about data. And we're talking about measuring performance. You can't fix what you don't measure. And we recently been thinking a lot about data with another project on cardiovascular measures and sometimes data is a really difficult thing for practices to really feel comfortable with and confident of. I use the analogies at—it's like trying to do the triple axel in figure skating. It's a really high level skill. And we're going to talk about how to use patient data to improve the care of your patients and to think about quality improvement in your practice. As I mentioned, if you're not—you can't fix what you don't measure. We'll go to the next one [inaudible]. I'll let you do that. So the objectives for today's action group are to really have a discussion about what the practices are doing in terms of screening and managing behavioral health patient-level data to inform clinical care and to move the next step to also learn how practices are using this data to look at populations of patients. And we're going to learn from our presenters today about incorporating data into the workflows of routine care. So there was pre-work for today's session. We wanted to get folks thinking about, are you screening for behavioral health issues and what screeners are you using? Additionally, we wanted to think about behavioral health data again at the individual patient level and that the panel or population level and thinking about, you know, how you do this in practices or a set protocol for this? And how do you use this data to really improve processes of care and outcomes of care. So, I wanted to start with the first polling question. We're going to spend a minute or two here. We'd like to have you answer do you use your screening tools to identify patients with behavioral health needs. And in the Chat, put down what tools you're using. I really want to see the range of screening tools that folks are finding useful in their practice. Wow, this is great. So, we got 322 people registered for our behavioral health action group and looks like we're getting a fair number of them that are doing this. I don't see anybody in the no column. And if you get a chance to just jot down what screening tools, I'm seeing the PHQ-2, PHQ-9. So—And the—the gap for anxiety, great. So keep—keep adding them [inaudible] seven on there in addition to the two question, nine question depression as screeners, but there are many mental exam, great. Great, I see that. So that's good. So keep adding as we go along. And we really want to have a conversation with today's presenters. And so, use the Chat feature or raise your hand. Your input is what really makes these webinars valuable.

10:01

So just do it as we go along here. So we've got two panelists. Practice stories are incredibly important in terms of educating us—in terms of behavioral health integration and we've got two folks that are going to talk about their use with data. Tammy Winde from the Grande Ronde Hospital Regional and Gillian Woods from the Pat Walker Center for Seniors in Arkansas. And as you hear these practice stories,

reflect on your practice and think about what's going on in this Northeast Oregon practice and this Arkansas practice that'll help you with how you do things in your practice and the processes that you use in your practice. And so really if you got questions, again, raise your hand or put them in the Chat feature. So right now what I do is turn things over to Tammy Winde from La Grande, Oregon. Tammy?

Thank you, LJ. Just to give you a little brief overview of Grande Ronde Hospitals, we're located in rural Northeast Oregon and the Regional Medical Clinic is one of nine practices owned by Grande Ronde Hospital. This clinic provides primary care, neurology, general surgery, behavioral health and walk-in services. And right now is serving approximately 8,400 patients. Next slide please.

Raja, we're getting there. There we go.

OK. We started screening for depression needs and the PHQ-2 several years ago. We piloted with two providers that has our highest patient volumes. And very quickly, we are overwhelmed with the number of patients that needed additional screening, behavioral health services that completely outstripped their resources for rural Northeast Oregon. We quickly looked for an LCSW which again is difficult in Northeast Oregon. But we have retained one, she works five days a week. And how we have it set up now and we've gone through about three different plans before we've come up with one that seems to be working right now is that you could receive soft handoffs from providers, provide additional screening and some treatment. So currently, the PHQ-9 is used to screen every patient annually for depression and more frequently if we notice, a patient has had a significant life change that could impact their outlook at that time. So, positive PHQ-2 triggers the nurse or MA to administer a PHQ-9 and the test is scored prior to the visit with the provider. The provider then in our system for—discussed as the PHQ-9 results with the patient and per performance improvement plan, any PHQ-9 that is scored greater than 10 is referred to the LCSW for further evaluation. It can be in the form of the soft handoff, again while the patient is in the office, a follow-up appointment or a referral to outside community resources. And we are using this throughout the hospitals as a performance improvement product—project with this clinic and our other clinics. And next slide, please. Discrete data is stored in tables in our EHR. Currently we're using practice partner. And we can run reports either from the EHR populate registries or flow chart. Along with this capability, we also pull data from the EHR tables and do what we call bias reports but there are actually just data reports so then we can drop into different formats for presentation. We have started using the McKesson Analytics Explorer, and that is a stage one of a process that still requires the day to be uploaded. Stage two which will be later in this year will allow for all data throughout the organization to be stored in one place rather—like a data cube and that's for all hospital and clinic EHRs, and then anyone within the organization with the appropriate access will be able to create reports and compare data more effectively. Access levels are established for each type of the report. In the case of the PHQ-9, medical and behavioral health providers have full access and then board of quality, CPC and other committees within the organization see reports with the PHI excluded. The screenshot on the right is an example of a provider template. The .CEs mean clinical element. And within Practice Partner, any clinical element can be stored as discrete data and then pulled on the back side. These are just the few of our screening tools and again it's updated so the provider can see the date and the score of the last one. Next slide, please. This is an example of just an excerpt from our performance improvement plan. Follow-up PHQ's are done usually at six-week intervals. The data is

used to highlight patients that may not be responding to current treatment goals. And it's to improve the quality of care. Screenshot on the right of the slide is an example of the—again of the McKesson explorer tool. This creates visualizations of the data elements. And in this example which I've modified a lot to take out the PHI, it shows each provider is identified on the bar chart on the bottom and then the number of patients being followed is represented by the height of the chart. If you highlight any provider, there are patients that are being followed or populated on the top visualization and trended over time. So you can see their scores over a six-week period. Additional pages are available for this and include a work plan for staff and it works similar to our registry but it's much more powerful than what our EHR can provide. And the sortable pages that will tell when a service is due or a patient needs further interaction. Next slide. So, this was kind of an interesting project. Our LCSW is trying to come up with more evidence-based decision making capabilities. And our culture and this organization is changing quite a bit where we're encouraging providers to make more health care decisions and recommendations based on data. So, we've asked them to come up with questions. What would you like to know? And the LCSW questions that she didn't believe that early diagnosis and treatments with patients on the bipolar spectrum were being identified. She provided some evidence that patients with these conditions were often undiagnosed and untreated. And she asked for data that could provide a baseline to behavior prior to treatment versus post-treatment. So we're in the process of mining data and looking for specific diagnosis, medications and the ER utilization. Next slide. So, we're running reports by diagnosis code to find people who seem not to be responding to current therapies. Example is the test patient in the screenshot. So, we have providers reviewing the problem list and medication list at each visit and then performing additional screening test that they're finding a need. Next slide. So, a test group of patients have now been identified. These patients either have a high history of ER utilizers, usually some behavioral problems, poor compliance, annual patient activation. Baseline data has been collected on a test—the test group. We went retrospectively on a year back of the ER visits and other different utilization issues. We're monitoring to see if a change in medication will have any effect on their utilization. So, we are starting to track from the first of the year—we tracked all of 2014, looked at their data retrospectively as far as utilization. Now we're moving forward to see how this test group is working. It is a little difficult to keep additional variables from impacting this test just because the extra attention from behavioral health and case management may also impact their utilization. The greatest benefit of this study is we want providers to ask questions.

20:00

We want them to ask for data. Not all will yield some great eye opening trends but some will. And the goal is for providers and administration and their staff to have the information. It's required to make some health care decisions based on data. This screenshot shows we're starting to track these particular drugs when they were first prescribed and how they are currently being used. And alongside of this is their utilization for ER. So, next slide. I think that's about it.

Thank you, Tammy. So, look at—let's, you know, raise your hand or write in some questions. So, Tammy, I have—it's LJ, I had a question about the data. So you've got some really good reports that you're generating, how are those used? Who do you have the conversation with? Do you have a group

meeting, who's there and how often do you look at that? And who decides to make changes in what you're doing and to get and look at the data?

Well, actually—you know, three years ago when CPCi started, it created a lot of committees. So, we have a bi-monthly committee that meets with this group of people. And they review the data bi-weekly. Monthly, it's reported to quality. But they use it—they look at it realistically, look at it as fast as they can and we just change—you know, make changes as fast as we can. You know, it's a powerful tool that we're just really beginning to utilize.

Well that, you know, that's helpful. We do have a question about what electronic medical record does your practice use and I might tack on, how is that working for you, that EHR?

Currently we're using Practice Partner. That is going to change in the spring of 2016. We're going to McKesson ambulatory program that will interface with our hospital EHR better. Practice Partner is a little difficult. Many of the reports that are embedded within the program don't run. Reports are very slow. So, we've created workarounds for all of those. So, our data is flowing out to, again, what we call bias reports, but they're just Excel documents that are a little bit better. And then we—now we have our analytics program that we're dropping data into. But it's working good, you know, it's been a learning tool and for a place that started from zero where we weren't really looking at any data to make decisions, we've made a lot of progress in the last couple of years.

So, we also have one question, Tammy, about how many visits are the LCSW? I'm not quite sure is this for treatment. I'm not—

I probably know what they mean. Again, like I said, we've remodeled this program several times and we keep falling into the same problem is that we overschedule our LCSW, and use them too much for treatment. Now on this last remodel, we're very much trying to use them more as a coordinating service. So we take care of minor or short-term behavioral health issues and then are using our community resources to take care of the more difficult or challenging cases. So our plan is there shouldn't be over 50 percent of her day that is taken up with appointments, and her appointments are 30 minutes. And so she only sees probably six to eight people a day scheduled, but her handoff from the providers are—we could use another LCSW easily.

That's great. I think that's really helpful. So I appreciate it, Tammy. We're going to move on and, you know, keep your questions coming here. And so, as you want to advance the slide there. So we're going to move on to thinking about data and how it relates to your practice context. And we're going to hear from Gillian about a practice that’s got more of a geriatric focus. But as you listen to this, I think there's a lot that can be generalized to—more broadly to primary care practices that have a broader scope of ages, so. And because we're going to be thinking about how data retract and retrieve and using this data to inform patient care to look at populations of patients and think about how your workflows are integrated and health care is coordinated. So, to get us thinking here, for most of us that are in primary care, our practice populations are getting older and the issue of cognitive decline is there every day, and some of the practices are starting to screen. So, I'm already seeing arrows come in at—you're screening for this number of practices or that's impressive. I had—this is—because my practice I think has not

gotten there yet to where we're screening for cognitive. Well, I know we haven't been screening for cognitive decline but a number of you are. And if you get a chance to chat in what tool you're using, we're going to share a little later with you some of the tools that are at the top of the slides here. So I'm seeing the Montreal screener. What else have we got? OK. So, you know, if you got other ones that you use, let us know. That's quite helpful, because a lot of you are using screeners out there and I'd like to see which ones you're using. It'll help inform us. OK, that mini metal screen is coming up. That's helpful. Any other ones that folks want to mention, get your screener of choice up there so we can kind of learn about that. OK. Well, keep it coming, and so with that, we're going to want to go to Arkansas, Fayetteville, the Washington Regional-Pat Center for Seniors and have Gillian Woods share their practice context and their practice story around data for behavioral health integration. Gillian?

Yes, hi. Thank you. Can you hear me?

Yes.

OK, perfect. If you want to go to the next slide, that would be great. I was—I'm very surprised to see how many people are using cognitive screens, that's great. For people who are not but you're listening to this, I mean I think you can generalize this information by thinking about what is your primary population that you're dealing with and what issues with would those people be at risk for if it's like a physical diagnosis like diabetes, a cognitive issue, behavioral, mood, social issues. You know, I think young adults have a lot of social issues that you could be tracking in the EMR. So, you know, think about it in terms of that. As far as our practice, it is 10 years old and we are part of a hospital system. We have four geriatricians but also within our practice when it was first established, knowing that older adults, people 65 and over are naturally going to be higher risk for cognitive decline and specific diagnoses. This clinic was established with a neuropsychologist on staff who specialized in this area. And this—the neuropsychologist also sees patients of any age in his own clinic in the same building but really it was established so that our senior health care patients could have on-site support for any type of cognitive declines, and their family members as well. We also have a neurologist on staff who specializes in movement disorders. And anybody who's familiar with movement disorders, so Parkinson's, Huntington's, the central tremor. Those people are at higher risk for cognitive decline as well. And a lot of his patients come here for senior health care. So there's a great workflow amongst all of the different practitioners in our clinic. Next slide please. When we first established, we knew off the bat every single patient first visit was going to have the short test on mental status. That's the one that we used primarily with senior health clinic patients. With movement clinics we do a screen, who for—we use the [inaudible] for those patients, it's more effective. But general senior health care patients, regardless of what age they are when they come in to establish here, first visit they all have the SPMS. And we wanted to have a baseline for these patients, and we also wanted to be able to see, uh-oh they pinged. Maybe we should go ahead and have them scheduled either for a diagnostic interview or a complete neuropsychological assessment with our neuropsychologist on staff.

30:23

And we knew we were doing that really well. We've been doing it for 10 years, but what we didn't have in place was really tracking—if these people are coming in for restraints, tracking the population data

and—So that was something that came about more because of CPCi. We knew that data was sitting there but honestly, nobody really took the time to look at it and use it. And so now we're able to really see—I mean if you're looking at these goals, we're seeing when are we actually diagnosing these people. Ideally what we'd like to see is that we are diagnosing people earlier on in the process, so a mild cognitive impairment versus late stage Alzheimer's disease. And so, we're actually looking at that information because the earlier, like any diagnosis, the earlier you catch this, the better intervention you're going to have, more effective, more support resources and help these people along the way because this is chronic and progressive. We also wanted to look at really the intervention amongst all the different team members, the Senior Health Clinic and then also the Memory Clinic, with our neuropsychologist. Are we really intervening with these people? Are we following up and managing these people well and, you know. So, kind of a quality assurance. And also, we want to see, are there any gaps in service. So it's kind of the bottom bullet point. Are there gaps in service, if so where, where can we jump in? Where can we intervene with these people? Next slide. We—Again, we have always done the initial screening but where we—Now we know we have fallen short actually using the data. Where we have fallen short is the re-screen. And ideally we set out to annually re-screen these people, just again because age is a risk factor on its own, let alone when you start with another risk factor. And I'll talk about those in a few minutes. But just the other day we had somebody come in. We, you know, we're pulling these reports, we're seeing how overdue these people are for their re-screen and we had someone who hasn't had a screen in a number of years, and that person came in just recently for a full neuropsychological assessment and they're already diagnosed now with a moderate Alzheimer's disease. And had we been re-screening this person, maybe we would have caught it earlier, intervened earlier rather than now catching a kind of moderate later stages of the disease process. So that's really an important part of why we're pulling data on the patient level. When we actually screen these people, it is—typically it's the social worker, it's the nurse practitioner who's doing this at their visits. And then the nurse practitioner, the MD, they're the ones who are really going to be talking to the patient about a neuropsychological referral and then following up with that care. As far as the NextGen what we've done and you will see the actual template here in a few slides but what we have done is anyone who has had enough TMF, because we have a specific template that was created for us, we can pull through the crystal reports, if anybody uses NextGen Crystal Reports, we can pull a custom report saying from this date forward—or I'm sorry, this date one year prior, are people overdue, due or overdue. And then those people are contacted now and they're contacted and we talk to them about the screen. We talk to them about any other issues they've been having. Are we still looking at the chart notes? But we either schedule them just for a follow-up visit or we're scheduling some of them for annual wellness visits because they have a lot of other things that they can be talking about. And get them in and then we do the rescreen and we can see, OK, there has been no change, excellent, or there has been a change we need to refer, we need to intervene. Or possibly adjust medications, you know, get them into psychotherapy, if they're depressed, you know, all of those things. And I will say as far as working with older adults, honestly, the number one fear that people have for the patients, when they come in here, especially on their first visit, when we say we're going to do a brief cognitive screen, I don't want to get Alzheimer's, that's my biggest fear. And so, there's a huge stigma around this. And there's a huge fear out there with this population. And a lot of them have already been caregivers for their loved ones who have had a dementia syndrome. So they know what it looks like and they're terrified of that. And I

think—and this is a huge thing with regard to I know like the Milestone number 7 was your decision making, not just behavioral health but opening a dialog with patients and addressing common health concerns and just jumping in there and saying this is just like a check-up on your heart. We just need to do a check-up on your brain. And we know that there are high risks for older adults, especially as you age, and you have more complex health issues. And you know, the earlier we catch this, the better off you will be, we can help out. And there are different lifestyle changes that they can make, prescription management, chronic disease self-management. All of these things can positively impact their functioning, their cognitive functioning for the long term. So I think just opening up that dialog really educates patients, makes them a little bit more comfortable dealing with these issues or talking about them and saying, hey, I'm a little concerned. You know, they don't wait for their annual appointments. They say, hey, I'm a little concerned, can we do a re-screen? They know we're doing this and they feel more comfortable talking about it. Next slide please. So actually you can skip ahead one more too. I'll just talk about this as you see it. So this is a short test of mental status. And our neuropsychologist chose this test specifically for our population and it's just a comprehensive screen. So, you know, it can—people can ping on this. And this is what the template looks like. Now this template was actually built specifically for us just with the NextGen. It's not just something that's in NextGen. But I will say you can—depending on what screens you use, you can build a similar template or you could have just a designated box like for the MoCA with our neurologist. We're not going to put that in because obviously people are writing and you need to scan in the sheet anyway on the sheet. But you can have a designated click box and that will make it easier to generate reports about when people last had the screen done, and that's really why we wanted to do this. We also have set that Geriatric Depression Scale with a similar kind of template. And so just for reporting purposes, you know, it's great to create these things in your system. You can go to the next slide. So, as far as the panel-level data, this is—you know, the patient-level data, we've—I think we have really taken good control over that. The panel-level data, this is one where we thought, again, we have all of this information just sitting here. We have thousands of patients. You know, what can we look at about these patients? And obviously based on demographics we're going to pull that information. If they were referred ever to the neuropsychologist, we want to keep track of these people. We want to look at them as a population and look for trends. And any of the cognitive-related diagnoses—and we're talking—now the coding is different for ICD but you're talking normal aging, so age-associated cognitive decline, mild cognitive impairment, all the way to dementia syndromes or B12 deficiencies, normal pressure hydrocephalus. I mean they're all different diagnoses that we're going to pull and we're going to look at these people. And then we have to look at the receptors. And so, I mean this includes things like stroke, sleep apnea, like I said, the B12 deficiency, chronic major depression anxiety, tremor, Parkinson's, uncontrolled or poorly managed high blood pressure, high cholesterol. So, you can search in your registries by just tapping into all of these different variables and thinking what is important to you to look at as far as finding some trends and looking at, have you been managing these populations? Have you been seeing changes over the years, or even over from quarter to quarter, would you make changes? Utilization data, this is something that goes with the next bullet point that continued follow-up care. Looking at the reports, when we get those Excel sheets that come with the reports, it says what's the primary, what's the secondary diagnosis for going into the ER, going in the hospital. And, you know, oftentimes you're not going to see a cognitive diagnosis with these people. But what I want our care managers to tap into because they're the ones who do all the

follow-up after ER hospitalizations tap into—could they either be at risk for a cognitive issue. Like maybe they fell and they hit their head and they had a concussion. Maybe they had a stroke, you know, all of these things are going to put them, just that admitting diagnosis makes them jump out as OK, they will be at a higher risk. So how many of those people are we seeing as far as within the utilization reports? Or was there admitting diagnosis related to a cognitive issue? Are these people—and I always think of the social aspect, are these people living at home alone? You know, do we need to jump in and really try to contact other caregivers or in home support services or look at a transition to assisted living and things like that? And that's why we have our social workers on staff. So, really for panel data, we want to use that to just see what the changes are and the numbers of patients in the diagnoses, how those diagnoses progress, and then we want to see also the follow-up with the primary care physician. You know, are their needs being met? Are they being care planned? Are they being care managed? And over the course of time, with interactions with the neuropsychologist and other important referral sources.

40:02

You can go to the next slide. Now, this has nothing to do with—the text in here has nothing to do with cognitive issues but I wanted to share our care plan template. Now anybody who has NextGen, you should have this template in there. It's not the best but, you know, it works fine as far as just care planning. Why this is important, and this is something we're going to do now with all of our Senior Health Clinic patients who see the neuropsychologist. The neuropsychologist tech is actually going to care plan all these people and generate the care plan and then work with the team to update that. We do it anyway, but we don't do it in any kind of document that can be pulled easily for reporting. And this, if you use this template, what we have done is we've created specific care plan reports that just pull anybody with the care plan. And you can document in this care plan if it's ongoing, if it's already been closed and the issues have been addressed and the dates for that. And so this will make it a lot easier for us to see those higher needs patients, are their needs being met and what are some of the trends and, you know, their problems or goals or interventions, all of these different things. And I think it's nice data, it's nice to look at the trends but ultimately this is going to make us provide better care for these people and more comprehensive care. We're going to be on the ball. They aren't going to fall through the cracks as much. And you can go to the next slide. It just tells you as far as panel-level data. Now I'm talking NextGen. I don't know how similar it is on other—in other EMRs but if you—this just tells you exactly how to do it. Now when I say select the filter variables, this is anything that I mentioned for two slides ago with the panel-level data. You can do by provider, by diagnosis, date range that they were seen, procedures, medications, you know, all of these different things, so that makes it nice for reporting purposes. And, you know, so we have started to do this and it's just very interesting to see some of the changes over time. And how I'm using it since you asked that question of Tammy, how I'm using this, I look—I'm pulling the reports with the support of IT. I'm looking at them and then I share that information first with the neuropsychologist and then we go to the provider and the team, the senior health clinic team and we talk about, OK, what needs do we have? What gaps are there? Where have we lost track of a patient or dropped the ball and what can we do to improve that service, and have we done that with other people? So that's across the board for just the patient-level data and the panel-level data. And next slide, I think, is just questions.

Great. Gillian, that's really powerful, seeing how you take a data to—and link it to what happens in [inaudible] that—to use it in care plans. And I just wondered if you had any results that you've been able to look at in terms of utilization that really kind of helps build the case for continuing to do what you're doing with this work.

Yes, we have—I don't know the numbers, I don't have them in front of me. But, I mean now, it is kind of frightening actually how many of our patients with cognitive issues are going into the ER or going into the hospital readmits, and where we can improve our communication with the hospital team. A lot of these patients also have—are managed by a cardiologist, the urologist, and they're living—a lot of them are living on their own and it's really having those difficult conversations bringing in the social workers, bringing in myself and having more difficult conversations with family members for long-term care planning. But, you know, the—it's usually not the primary or secondary diagnosis that's listed in the utilization reports as far as cognitive issues but most of these issues are related to cognitive issues. And by tracking that instead of—and this really falls on our care managers. We are—have seen huge results with tracking the utilization reports and getting them involved. We now are on top of this and talking to our patients the day after their discharged rather than finding out six months later, a year later and then there have been so many other consequences that could have been dealt with. So, you know, I think it has been very helpful.

Yeah, that's really good. I have, you know, so right here there are other questions. Well, I've got one other question, Gillian, for you is, you know, how do you know this is working for patients? You know, how are patients informing you about your processes of care and the changes that you've made in terms of screening for cognitive decline and some—or coordination activities that you've done?

Yeah, it's not so much the initial screening where—because that has been in process since the day we opened. It is the re-screening and actually calling patients. And when we call the patients, we're also calling them, say, about DEXAs, colonoscopies. I mean, we were looking at a lot of different variables as far as the Senior Health Clinic. But they—it's funny, a lot of the patients say, oh yeah I remember, the doctor was supposed to have—I was supposed to go to that or, oh, I thought they sent a referral. And, you know, somewhere the ball was dropped there and—you know, so for the most part they actually liked that we have an open dialog, they like that we're talking about this. A lot of times it's the family members who are really pushing and the family members come in initially and visit with the social worker and the provider along with the patient. They live the room for some of the parts but, you know, it's a lot of times it's them saying thank you for asking about this. We've noticed these issues but mom won't talk about them, but she'll talk about it with you guys. So, I think just on a basic clinical care level, they've given us really good feedback about this.

That's great. So, sounds like on the individual level and you've had good feedback from caregivers and so—about how you—you've done this in the end. So, do you have patient experience of care data that give—that's been able to inform you about what you do?

Not yet with this. We have been—look like with the questionnaires just as far as Milestone number 4, the surveys. We haven't looked at this specifically. Ours is more informal just talking to patients and—but we haven't been in tracking that now.

OK. Great. Raja, do we have questions that have come in that [inaudible] either for Tammy or Gillian?

I see one that are the care managers involved, the rescreening was—if that was for me.

Yes.

As far as just the re-screening for the SGMS no, that is solely the social workers and the APNs. Now how we decided on them is because, just as far as workflow, the providers typically don't do it. They have so many other issues to address. And then the care managers typically are focused on the ER hospitalizations and following up with those people, they may talk to them saying, hey, you know, we see that you're due for this. Let's go ahead and schedule you and get you to come in or have—even having any concerns. But no it's—as we really set it up that way only because of workflow. It's the easiest way and the most efficient for our teams to function.

And, Tammy, if you're still there, maybe we can have you address the same question about whether your care managers are involved in the screening process.

Our care managers are involved especially if the patients have several other issues. This high PHQ-9 or depression score or any of our other screenings can push them over the edge where they become what we determine as very high risk, which means they're followed by case management.

And, Tammy, there are some outstanding questions for you as well. One is, who pays for your LCSW and how difficult was it to hire one?

It was very difficult to hire one because there just aren't any in our area or—and it's a little bit hard to recruit for rural Northeast Oregon. But it's paid for out of the clinic. We are doing some billing. Reimbursement is fairly low but I—it's improving. We are—people are starting to pay for it but the clinics decided that we needed this. So this part of them—medical home we wanted to provide that service and the providers really pushed it hard.

And so, on the line with billing, there is a question you're asking if you get paid per service or is your per member per month increased?

We get paid for service from the places that will pay us. Problem it's hard because for instance, Oregon health plan or Medicaid patients, those patients are contracted through another community resource that is really overwhelmed. And so we do intervene with those people but there's no reimbursement for it.

OK. And then, there's a question here about warm handoffs for the LCSW. When the LCSW gets the warm handoffs, does she see the patient then or ask them to schedule for another day?

49:58

Depending on the patient. Now, if they're in crisis right at that moment, she'll take care of them right then. If they are willing to come in for an appointment, she'll schedule an appointment but we try to get them taken care of right then. If the provider recognizes a problem that needs to be addressed, sometimes it's hard to get those people back in for another appointment. So we try to get them right then.

Great. So in that we're, you know, feel free to continue to either raise your hand or chat in questions and we've got a few more minutes with Tammy and Gillian and I think that you really demonstrated with the work you're doing volunteer practices that you really are measuring performance and it gets back—as a statement that I made earlier, you can't fix what you don't measure. And you've really been measuring things and fixing things. But what I want to know from each one of you is, what's the next big issue or the burning platform issue that you want to do in terms of using data for behavioral health integration. And it, you know, I—I don't know if you have it or not but if you do I'd like to hear about it.

Our is—I've touched on this where we're going to really formally establish the care plan process rather than just each provider entering their own notes. We're going to formally establish a care plan process for all of the patients that come through senior health that also see the neuropsychologist and really see—like I know on the questions for our quarterly reporting, you know, they have how often do the behavioral health provider and any other providers meet. You know, we don't have structured meeting times. We all just kind of visit as needed with each patient. And so I think looking at that, the care plan process will really help with that.

Great. Tammy, any parting comments from your side that you're thinking about?

Yeah. What we're working on right now and we've started developing—or we're starting to gather the data is on the follow-up. So we're pretty good about getting patients back in for a two-week follow-up but some of them seem to be following off the—off the map, I guess, for follow-up. And so we've—we're using data to track those people. And until they're being, you know, that they don't need any more follow up and we keep tracking them through the program. And it seems to be—we're getting some good data back but it's hit and miss. So that's going to be our next push is to get something a little more reliable.

Great. And again, I'm going to move on to the next slide here and—but what I have is you appreciate that the stories that—and guidance that—had at Grande Ronde and the Washington Senior Center provided for us. So I want to talk about additional resources for cognitive assessment. And up at the top [inaudible] that we were at where we kind of share just some of—these are some of the tools that we put up up here that are going to be in the forum for you to think about. This is a detection of dementia comes from the Veterans Administration. I thought I heard the geriatric depression scale being mentioned by Gillian and then the MINI-COG is up there. And then we also have the short one, don't we, Raja, that they were using in Fayetteville. Yeah, the short test for mental status. And so, you may find this useful. And so, that's going to be—that's on the forum where again—

It will be on the Collaboration site links to the forum.

So, it'll be on the Collaboration site links to the forum. Want to go ahead and see where we're at. OK, so I think we've had a very stimulating time here and it's important for each of the practices. Like I mentioned, we had 322 people signed up for this and we want to know what do you plan to implement to improve your use of behavioral health data and how do you see this improving the individual patient level and population level? And if you've got ideas for quality improvement, we'd really like to have you post your ideas on the forum. It's a great place to share the conversation. And let's see. We got—

There is one final question.

Oh good—excellent.

For Tammy, the question is what codes are you using for billing?

Oh, I can't—I don't know right off the top of my head. There's two behavioral health codes that we're using and I can't remember what the CPT code is. Sorry. I could look it up probably and post it.

That'd be great, Tammy. And we'll put that—where will we put that, Raja?

Well, on the forum will work.

OK, so we'll put it on the forum. And so, we're going to continue this. I really like hearing stories from practices because it really helps me think about, you know, what can I do in my practice that's different than what I want to do? I learned from each of you and so we're going to keep working at this and so we're going to have an additional behavioral health integration action group sessions that we're formulating. They're going to be announced in July. If you have input for us, we'd really like to hear it. Again, where—how do we hear that? Through the forum? The forum we're—keep—we're going to continue to promote the forum here for that. So kind of tell us what you want to go to next. Rose, if you want to—

I sure will take it from here, Dr. Fagnan.

Thanks.

And I want to thank all of you for attending this exciting behavioral health action group session. As the WebEx closes, you'll be automatically directed to [inaudible] survey. Your feedback on the survey is used to continually improve our learning opportunities. In addition, please remember that it is important to accurately collect information on each individual and each organization in attendance. If you are not from a region or practice, please select not applicable in both the region and practice ID and then select your organization. Should multiple people be viewing this session together, up to 10 people may be added to the same form. This recording and these slides and resources will be available in a couple of weeks on the collaborative site forum for your review. Thank you again for attending and have a great day.

Thank you all.