CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Welcome
2019 IBH Expansion Practices

2019 QUARTERLY ADULT IBH MEETING 8-8-2019

Agenda

Topic ***Presenter(s)***	**Duration**
Introductions & Review of Agenda *Susanne Campbell*	5 minutes
Practices Report Out: PDSA Plans for Improving Screening Results Discussion on BH Compacts and Hiring Plans	50 minutes
Review of EHR requirements *Dr Nelly Burdette*	20 minutes with 10-minute discussion
Next Steps *Susanne Campbell*	5 minutes

Practice Report Out:
IBH Baseline Screening Results

Practice Name	*Depression*	*Anxiety*	*Substance Use Disorder*
Screening Incentive Thresholds	*85%*	*60%*	*60%*
Blackstone Valley Community Health Care	94.9%	1.5%	6.6%
Brown Medicine - Warwick Primary Care	93.7%	85.2%	84.8%
Coastal Edgewood	85.4%	1.0%	0.0%
PCHC Central	96.4%	96.1%	95.7%
PCHC Crossroads	97.6%	16.9%	3.4%
PCHC Randall Square	93.1%	93.6%	92.5%
Prospect Charter Care Physicians	84.0%	7.5%	0.1%
Tri County - North Providence	88.8%	88.9%	85.5%
Women's Medicine Collaborative	92.4%	96.7%	96.9%

Blackstone Valley Community Health Care PDSA Plan for Improving Screening Rates

Aim:

Describe your first (or next) test of change:	Person responsible	When to be done	Where to be done
Increase substance abuse screening using the DAST	Medical Assistant	Every patient As needed	Green, Orange, and Red pod

Blackstone Valley Community Health Care PDSA Plan for Improving Screening Rates

Plan

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done
-Educate Mas about DAST -Start screening using nurse visits -Develop incentive for staff	IBH Champion Pod RN/NCM Dept Directors	During huddle and staff meetings RN/NCM encounters	Green, Orange, and Red pod
Predict what will happen when the test is carried out	**Measures to determine if prediction succeeds**		
Increase in DAST utilization rates	BVCHC data report on screening rates per unique patient		

Brown Medicine
PDSA Plan for Improving Screening Rates

Aim:

Describe your first (or next) test of change:	Person responsible	When to be done	Where to be done
The Brown Medicine Primary Care – Warwick practice would like to increase the number of warm handoffs, our IBH clinician is present at the practice 2.5 days a week. Thus, we think a reasonable goal would be 10 per week.	Care Team (Medical Assistant. Provider and Shauna – Psychologist)	When a patient has a "positive" screen result	In the exam room

Brown Medicine
PDSA Plan for Improving Screening Rates

Plan

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done
The practice created a flyer advertising the service and the flyer introduces the IBH model to the patient The workflow will be adjusted to incorporate warm handoffs Shauna will provide training to staff on how to engage patients and introduce warm handoffs The Medical Assistant will communicate with Shauna via skype or in-person Shauna's schedule will be adjusted to have available time in between appointments to account for warm handoffs	Medical Assistants, Shauna, and Practice Manager	This process was piloted on 7/30, the process will be evaluated at the end of every two weeks to monitor progress	PC- Warwick practice Staff Meeting Bi-weekly practice meetings

Brown Medicine
PDSA Plan for Improving Screening Rates

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds
The number of warm handoffs will increase The staff will feel more comfortable with the process	The warm handoffs are going into a telephone encounter, titled “BH warm handoff”. The number of “BH warm handoff” telephone encounters will be tracked on a bi-weekly basis via report.

PCHC – Central Health Center
PDSA Plan for Improving Screening Rates

Aim:

Describe your first (or next) test of change:	Person responsible	When to be done	Where to be done
To increase the amount of Warm Hand Off 's to a goal of 20 per week, in the next three months.	IBH team: Stacy/Jamie And all Central providers' teams	Within the next three months (end date 11/5/19)	Central Health Center

PCHC – Central Health Center
PDSA Plan for Improving Screening Rates

Plan

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done
• Stacy Silva will present at all Central staff meeting on 6/18/19 • Dr. Hewamudalige will assist in providing support/ education to Central Providers/teams • Amanda Andrews, AHCD will email all Central Staff describing aim and plan and also follow up at morning nursing meetings at least 1x per week. • Jamie Ramirez will identify 3 pts daily who have SDOH needs and attempt Warm Hand Off • Stacy Silva will identify 3 pts daily who have Behavioral health need and will attempt Warm Hand Off	Stacy Silva, LMHC Dr. Hewamudalige Amanda Andrews, RN	7/18/19 Through-out 3mo period 7/15/19 Weekly for 3 months	Central Health Center Via e-mail During daily huddle with providers

PCHC – Central Health Center
PDSA Plan for Improving Screening Rates

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds
• Increase in Warm Hand off number • Increase in Warm Hand off number for various population/groups (examples include: health behavior change and Social Determinates of Health	Weekly report calculating warm hand off number provided by IBH director via email.

PCHC – Crossroads
PDSA Plan for Improving Screening Rates

Aim: IBH and universal screens are new to clinic. IBH provider and BH advocate are typically present at desk in hallway outside of exam rooms when not in an appointment. This PDSA aims to increase warm handoffs for positive universal screens when IBH provider or BH advocate is not visible.

Describe your first (or next) test of change:	Person responsible	When to be done	Where to be done
If IBH provider or BH advocate are not visible in hallway staff will skype IBH provider or BH advocate for every positive screen- PHQ of 10 or higher, GAD of 10 or higher or CAGE greater than 0- to notify exam room # for positive screen (ex. Exam room #2 + screens)	RN,NP or HCA	With every positive screen	At the clinic/Skype
When warm handoff is completed by IBH provider or BH advocate- they will skype team member back to notify of completion.	IBH provider/BH Advocate	When warm handoff is complete	At the clinic/skype

PCHC – Crossroads
PDSA Plan for Improving Screening Rates

Plan

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done
HCD will notify staff and create sign for covering staff re: PDSA IBH provider will notify BH advocate of plan RN will notify covering RN and PCP of plan	Deb/HCD IBH/Sarah RN/Betina	By 08/31	At the clinic

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds
Increased warm handoffs for positive screens	Data measure of ratio of warm handoffs to positive screens will be obtained. BH advocate and IBH provider to track Skype requests for warm handoffs.

PCHC – Randall Square
PDSA Plan for Improving Screening Rates

Aim:

Describe your first (or next) test of change:	Person responsible	When to be done	Where to be done
Improving WH in clinic with absence of provider/ advocate via use of Skype	BH provider/ Advocate and care team	During admin time of Provider/Advocate	Via Skype in clinic

PCHC – Randall Square
PDSA Plan for Improving Screening Rates

Plan

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done
Create schedule of usage and work flow for use of Skype message for virtual WH	IBH Provider	X 30 days from 8/9 monthly CTC meeting	In clinic during monthly CTC meeting with care team.
Predict what will happen when the test is carried out	**Measures to determine if prediction succeeds**		
Increasing WH with absence of provider while on Admin time	Tracking number of WH on admin days vs referrals for trail care team		

Tri-County's PDSA Plan for Improving Screening Rates

Aim: Improve the percentage of warm hand-offs for the Integrated Behavioral Health Clinician for positive screens from the baseline percentage of 31% to 60%.

Test of Change	Person Responsible	When to be completed	Where to be completed
Implement strategies to improve the number of warm hand-offs from medical assistants and providers for those patients scoring positive on their depression, anxiety and substance use screenings.	IBH team: Including IBH Clinician, IBH Support Specialist, HIT Specialist, Medical Assistants and Medical Providers. Providers for this PDSA will only be those providers that visit the site on a weekly basis. It will not include the two full-time providers.	10/31/19	Health Center: North Providence Location.

Tri-County's PDSA Plan for Improving Screening Rates

Plan:

Tasks	Person Responsible	When to be completed	Where to be completed
Meet with members of IBH team to discuss current warm hand-off processes.	IBH Team members	8/2/19	Health Center
Staff to gather data on baseline of current warm hand-off percentages by visiting providers.	BH Support Specialist, IBH Clinician and HIT Specialist.	By 8/5/19	Health Center
Provide information for positive cut-off scores for screens that require a warm hand-off. (Labels for computer/laptop monitors)	IBH Clinician	By 8/9/19	Health Center
Meet with medical assistants to review cut-off scores and look at sample screens to locate scores on printed documentation.	IBH Clinician	By 8/16/19	Health Center
Post signs and other materials educating staff and patients on warm hand-offs and interrupting IBH sessions for warm hand-offs.	IBH Clinician	By 8/5/19	Health Center
Track warm hand-offs by provider on a daily and weekly basis. Follow-up with medical assistants and providers regarding missed opportunities.	IBH Clinician	Ongoing	Health Center
Review data monthly at IBH team meetings and IBH pilot project meetings.	IBH Team	Ongoing	Health Center

Tri-County's
PDSA Plan for Improving Screening Rates

Prediction of what will occur	Measure to determine if prediction succeeds
Warm hand-off rates will increase for visiting medical providers as IBH clinician and team take specific measures to educate staff and patients about warm hand-offs as well as continual tracking of positive screens and successful warm hand-offs as well as follow-up when warm hand-offs do not occur.	Study of baseline warm hand-off rates at the start of the PDSA and the rates at completing at the end of October. Increase from 31% to 60%.

Women's Medicine Collaborative PDSA Plan for Improving Screening Rates

Aim: Increase warm handoffs with patients who score positive on screening measures.

Describe your first (or next) test of change:	Person responsible	When to be done	Where to be done
For Nancy Lasson's patients who score 10 or greater on the PHQ9 or GAD7, conduct a warm handoff with the IBH clinician. The warm handoff will be provider-initiated, rather than medical assistant-initiated. We plan to conduct this PDSA between October – January.	Dr. Lasson; IBH clinicians	During Nancy's sessions on Monday and Friday AM, Wednesday and Thursday all day.	WMC Primary Care

Women's Medicine Collaborative PDSA Plan for Improving Screening Rates

Plan

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done
1. Develop a script for how to speak with patients in warm handoffs, including a description of costs/billing.	-IBH team -CathAnn Nassef in collaboration with Maggie Bublitz	-August IBH huddles -October 1st	-WMC -WMC managers meeting
2. Set up encounter types for tracking warm handoffs.			
3. Develop a way of tracking patient refusals in EPIC (this could be done by developing a smartphrase for PCP notes).			
4. Develop staffing plan so that all sessions are covered for warm handoffs.	- IBH team -IBH team/Maggie Bublitz	-August IBH huddles -August IBH huddles	-WMC -WMC

Women's Medicine Collaborative PDSA Plan for Improving Screening Rates

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds
Patient acceptance of referrals to IBH will increase, patient access to IBH will improve.	We will compare the number of warm handoffs in the 4 months prior to the PDSA to the 4 months of the PDSA. We will also compare the number of referrals from Nancy to IBH before and after the PDSA.

Discussion on Behavioral Health Compacts & Hiring Plans

- Selection and Implementation of Compacts
  - How do you anticipate using them?

- Hiring Plans & Schedules

Area	Goal
ONBOARDING BHC	Overarching Goal: Complete initial steps to successfully onboard a new clinician who will be using the practice's EHR
Training	New employee will receive training on the practice's EHR
Building BH codes into EHR	Practices may need to add BH CPT codes to their EHR billing options
SCHEDULING	Overarching Goal: To incorporate BH schedule and scheduling seamlessly into the existing workflow, so patients experience it similarly to their medical scheduling
Scheduling initial and follow up appointments with BHC	Front desk has capability to schedule BHC per predetermined schedule, and also include BLOCKED time for WHOs and urgent visits
DOCUMENTATION	Overarching Goal: BHC must be able to document easily during patient visit
Assessment	Template must meet insurer standards, including length of visit
Brief progress note	Template must meet insurer standards, including length of visit
Treatment plan (shared)	Med and BH providers all share same TP; easy access, screening data populates and is tracked, includes goals and goals met
Access to BH Diagnoses	Easy access to BH diagnoses while BHC documents
Billing through documentation	BHC can code visit easily at end of session note
INFORMATION RETRIEVAL & COMMUNICATION	Overarching Goal: All team members should be able to easily navigate between the medical and BH parts of the record
Med sees BH info	Medical providers should be able to see most recent BH Dx, date of last visit, progress note, screener scores
BH sees Med info	BH should be able to easily navigate to most recent med note/ medical dx/medication
Team members can communicate in EHR	Alert system is set up so that any team member can alert another team member to a new entry/new information/question
Scheduling/front desk communicates with providers	(Alert) System is set up so that front desk can easily let BHC know if a patient has checked in or cancelled; BHC can easily communicate with front desk through EHR

Behavioral Health EHR Requirements

Area	Goal
SCREENING	Overarching Goal: All aspects of screening protocol should be functional in EHR
Administration	If not using paper, screeners set up in portal or tablet
Scoring	If not using paper, screener is automatically scored
Data entry (if relevant)	If using paper, there are fields established to enter scores
Tracking	Screener scores can be tracked from one administration to the next
HIGH RISK REGISTRY	Overarching Goal: HRR is established in the practice's EHR
Identification	HRR is populated with patients who meet whatever criteria the practice establishes
Tracking	Relevant data is tracked for patients in the HRR
REPORTING	Overarching Goal: EHR has capability to produce reports for all relevant aspects of IBH
Individual Screener volume	Practice can track how many screeners have been given to a specific population within a specific time frame
Individual Screener scores	Practice can track the overall/average scores of a specific screener over time for the population
Individual Patient scores	Practice can track an individual's scores on each screener over time
High Risk Registry	EHR can generate reports on any specific criteria from the HRR
CONFIDENTIALITY	Overarching Goal: Practices will have policies about how to manage confidentiality with their adolescent patients and the EHR will reflect those policies
Screening	If adolescent patients are completing screeners from home, appropriate steps are taken to ensure that they have their own password/entry option to portal that parents cannot access
Access to BH info	Practices will decide who internally/externally should have access to patients' BH information and establish barriers that match their policy

Next Steps

Hire BH Staff if not already in place with staffing ratio of 1 FTE per 5,000 attributed lives	**Resume, date of hire, and staffing plan Due no later than June 30, 2019**	**Submit to: CTC-RI@ctc-ri.org**
Baseline Report for screening for depression, anxiety and substance use disorder	February 1, 2018-January 31, 2019 Due March 29, 2019	Submit to: CTC Portal
Report for screening patients for depression, anxiety and substance use disorders	February 1 – August 31, 2019 ♦ due September 30, 2019; and September 1 – January 31, 2020 ♦ due February 10, 2020	Submit to: CTC Portal
IBH Compact for coordination for patients with severe depression, anxiety and substance use disorder	. Due May 31, 2019	Submit to: CTC-RI@ctc-ri.org
PDSA Plan for improving screening/re-screening rates	Plan Due: August 5, 2019 PDSA results due: February 10, 2020	Submit to: CTC-RI@ctc-ri.org
PDSA Plan for addressing Social Determinants of Health	Plan Due: November 11, 2019 PDSA results due: February 10, 2020	Submit to: CTC-RI@ctc-ri.org
MoA with CHT or community agency that can help with health related SDOH	Due November 27, 2019	Submit to: CTC-RI@ctc-ri.org
Maine Assessment Tool (Post Intervention)	February 28, 2020	Submit to: CTC-RI@ctc-ri.org
Learning Networks: Orientation **Monthly Meetings with IBH Consultant** **Three Required Content Seminars**	February 28, 2019 Starts March 2019 7:30 -9:00AM Quarterly Nov 14, 2019 and Feb 13, 2020