CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Welcome
Pediatric IBH Practices

QUARTERLY PEDIATRIC IBH MEETING

OCTOBER 14, 2021

Agenda

Topic *Presenter(s)*	Time
Welcome ***Liz Cantor***	7:30-7:35
Cohort 2 PDSA Report Out ***Liz Cantor, facilitator*** ***Coastal Bald Hill, Coastal Waterman, Hasbro Med Peds, NRI Peds, Tri-County***	7:35-8:05
Registry Report Discussion ***Liz Cantor, facilitator***	8:05-8:15
MomsPRN & PediPRN ***Eva Ray, LCSW & Sarah Hagin, PhD***	8:15-9:00

Practices here today

- Cohort 2 (Apr 2020- Apr 2022)
  - Coastal Bald Hill
  - Coastal Waterman
  - Hasbro Med Peds Clinic
  - Northern RI Peds
  - Tri County
- Cohort 1 (July 2019-July 2021)
  - Anchor Pediatrics
  - CCAP
  - Hasbro Pediatric Primary Care

RIF Cohort 2 – Coastal - Bald Hill Report Out: PDSA

Aim: Increase IBH access to patients with elevated PHQ9 scores (score >/= 10) or positive CRAFFT

Every goal will require multiple smaller tests of change

Describe your first (or next) test of change:	**Person responsible**	**When to be done**	**Where to be done**
Establish workflow for IBH patient identification and warm handoff to increase access to IBH services	IBHC, Practice Manager	October	BHP

Plan

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds
Increased engagement between behavioral health and primary care teams.	Monitor monthly rates of warm handoffs for patients as part of these workflows
Increased warm hand offs.	
Warm hand offs will engage patients when their symptoms are mild/moderate and potentially more amenable to brief IBH interventions.	

RIF Cohort 2 – Coastal - Bald Hill Report Out: PDSA

Plan

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done
Provider and staff discussion to develop workflow	Laura/Leah	October	BHP
Train on new workflow for providers and staff	Laura/Leah	October	BHP
Review current data in past 1-2 months on warm handoff volume	Katie/Laura	October	BHP
Implement new workflow for warm handoffs	Team	November 1	BHP
Monitor “missed opportunities” in the prior month using the Closing the Loop report	Laura/Pam	December	BHP

RIF Cohort 2 – Coastal – Waterman Report Out: PDSA

Aim: Increase the support for patients with identified SDOH needs and ensure that patients are connected to resources.

Currently, 56.6% of overall patients at Waterman Pediatrics have been screened this year for SDOH (3880 patients). Of those screened, 3.25% (126 patients) have screened positive for SDOH concerns, though only 8.0% of patients screening positive requested assistance (10 patients). Of the 10 patients who have screened positive, only 30% of these patients have documentation of "closing the loop" workflow to ensure patients are connected with resources.

Describe your first (or next) test of change:	Person responsible	When to be done	Where to be done
Leverage the "closing the loop" report weekly to identify patients with SDOH needs to ensure they are connected to resources	NCM	November	

RIF Cohort 2 – Coastal – Waterman Report Out: PDSA

Plan

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done
Coordinate getting data report weekly for patient identification to NCM	Kelsey	October	
Training for NCM on how to use the Closing the Loop report and template for tracking	Kelsey/Amy	October	
Discuss potential for Unite Us training and access to Unite Us Platform for Waterman staff	Jennifer/Amy/Susan	October	
Implement “closing the loop” report and weekly workflow	Amy	November	
Present the workflow for NCM reviewing the report and outreaching to appropriate patients to providers and staff	Susan/Amy	November	
Create a monthly report for Waterman on SDOH screening and closing the loop rates	Amy/Kelsey/Data	November	

RIF Cohort 2 – Coastal – Waterman Report Out: PDSA

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds
Patients will more successfully be connected to resources	-Number of patients by week and by month that are identified as having a positive SDOH screen AND wanting assistance -Number of patients that were connected to resources (BH Closing the loop template)

RIF Cohort 2 – Hasbro Med Peds Report Out: PDSA

Aim: Ensure patients identified (self-identified, screener identified/confirmed by CSW or MD) as desiring access to counseling are able to access services on-site, or if on-site not available or if preferred, community services.

Every goal will require multiple smaller tests of change

Describe your first (or next) test of change:	**Person responsible**	**When to be done**	**Where to be done**
Facilitate referrals to community behavioral health resources	Sara Lee Sue McL Janet And	Weekly	On-site at MPPCC

RIF Cohort 2 – Hasbro Med Peds Report Out: PDSA

Plan

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done
1. Weekly outreach to assess availability (wait-to-first-appointment in-person and remote) of at least 3 community options. This information will be posted in clinic (alongside resource with "next available" info on on-site providers. And identify any issues reported in receiving our referrals.	Sara Lee Sue McL Janet Anderson	. (M/W) (F, if needed)	MPPCC MPPCC
2. Weekly direct-to-family follow-up calls by CSW on recommendations provided	Sara Lee	M/W/F	MPPCC
3. Repeat Sept Q90 day chart review to assess follow-up of positive screens (ie. Were specific resources offered, were follow-up appointments made/kept?)	Sue&Sara	Nov/Dec	MPPCC

RIF Cohort 2 – Hasbro Med Peds Report Out: PDSA

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds
Increased awareness of providers of most readily available community resource.	Weekly check to see if resources are updated.
Increased acceptance of patients from our practice by community resources (b/c we are sending them to sites that are able to support them in the time frame the patients identify as necessary, and our weekly contacts will allow us to get feedback on any challenges they are experiencing with our referrals)	CSW week-after follow-up calls show increased frequency with which families report “accessed services” or “scheduled visit”
Increased frequency of families reporting “able to access recommended care”.	90-day chart review indicates increased % of “at-risk” families have had follow-up.

RIF Cohort 2 – Northern RI Report Out: PDSA

Aim: Our aim is to identify SDOH concerns as early as possible in order to maximize intervention effects.
Every goal will require multiple smaller tests of change

Describe your first (or next) test of change:	Person responsible	When to be done	Where to be done
To begin formal SDOH screening, specifically looking at all newborns. A positive screen with request for support will trigger an action to follow family and confirm that help has been received.	-front desk -provider -NCM	-at 2-week visit	-in office visit

RIF Cohort 2 – Northern RI Report Out: PDSA

Plan

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done
-SDOH screening paperwork will need to be added to chart for family to fill out prior to visit (upon arrival.) -A resource handout will be created for parents. -MA will place completed SDOH on chart for provider to review. -Provider will review SDOH with family during visit. -If SDOH is positive (parents requesting support on 1 or more questions,) family will be given resource handout. -A positive screen will trigger provider to create an action for NCM to follow family to ensure plugged into services. -Provider will document SDOH results in body of note and will note at header of patient record.	-front desk -MA -provider	-at 2-week visit	-in office visit

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds
-We predict that by the child's 2 month visit, an appropriate intervention will have taken place to support the family. -We predict we will obtain SDOH screening from 75% of our newborn families and provide interventions for 50% of our newborn families.	-NCM outreach to families via phone -Provider follow-up at 1 month and 2 month visit. -SDOH screening rate report

RIF Cohort 2 – Tri-County Report Out: PDSA

Aim: (overall goal you wish to achieve) Tri-County Community Health Center aims to provide access to age-appropriate mental health services by ensuring completion of BH clinical screenings for all adolescent patients as well as identifying patients who need to be rescreened or followed up for IBH intervention

To improve annual BH screening (PHQ-9/A, GAD-7, and CRAFFT) for our population of adolescents aged 12-17. The goal is to achieve 70%, 70%, and 60% respectively by 7/2022.

Every goal will require multiple smaller tests of change

Describe your first (or next) test of change:	Person responsible	When to be done	Where to be done
Tri-county will create an IBH clinical screener registry for active patients 12-17.	Quality Team and CHW/MA	Begin 10/1/21	TC Health Center

RIF Cohort 2 – Tri-County Report Out: PDSA

Plan:

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done
1. Identify patients who need to be rescreened or followed up for IBH intervention 2. Contact parents/patient via phone communication. If parent/patient agrees, provide screenings necessary 3. Address and track concerns/barriers by parents/patients for IBH screenings. Track completion (BH screening forms), then follow accordingly. 4. Follow IBH workflow for warm hand offs. IBH Clinician to complete and/or follow up re: BH screenings. 5. Conduct huddles between PCP and IBH team for integrated coordination	1. Quality Team 2. IBH Clinicians 3. Supports Coordinator 4. MSW intern 5. Provider Champion	Begin 10/1/21	TC Health Center

Predict what will happen when the test is carried out	**Measures to determine if prediction succeeds**
Tri-county will have initial success with some patients/parents by completing rescreening protocol, enroll patients in IBH treatment or determine BH level of care. Barriers to care will be identified and addressed as they occur.	- Increase IBH rescreens with appropriate treatment - Increase warm hand offs and access to IBH interventions


GREAT JOB!

Registry Report

Demonstrate use of registry report which provides information on initial screening results for selected behavioral health condition and follow up screening result post intervention

- What data are you tracking? What data are most useful for your practice?
- Are you using a registry generated through your EMR or are you doing it by hand?
- Who uses it and how often is the data reviewed?
- What would you change/add, if anything?

Northern RI Pediatrics – Registry Report

Patient	PHQ Screen	Intervention	PHQ re-screen		Disposition
LG, 8/8/06	4/15/21: 21	f/u phone calls	not scheduled		open
GS,8/13/06	12/15/20: 17	community therapy	6/25/21: 6		open
BG,3/27/06	3/30/21: 22	community therapy	7/30/21:		open
MR,10/31/06	4/6/21: 11	f/u phone calls	not scheduled		open
CS,9/1/05	3/12/21: 23	community therapy	7/9/21: 13		open
BC,9/23/03	9/23/20: 17	no therapy	6/23/21: 12		open
KP,3/13/05	1/14/21: 17	medication	4/6/21: 9		open
CD,12/5/06	3/19/21: 17	community therapy	6/29/21:		open
KD,3/9/06	4/19/21: 12	community therapy	7/26/21: 13		open
JG,6/13/04	3/23/21: 19	f/u phone calls	6/28/21: 13		open
EG,7/31/03	12/15/20: 15	community therapy	4/16/21: 18		open
HD,8/4/04	1/15/21: 15	community therapy	5/28/21: 14		open
EM,10/13/07	2/19/21: 11	in-house therapy	6/28/21: 14		open
RS,4/27/06	3/16/21: 14	f/u phone calls	8/10/2021		open
SF,6/3/04	3/5/21: 21	community therapy	7/8/21: 12		open

Anchor Pediatrics - Registry Report

Includes all active patients whose Most recent GAD and/or PHQ Score prior to the last days of the previous month - 90 days AND/OR most recent score between the last day of the prior month and the last day of the prior month - 90 days is >= 9

DEPT	Patient Primary Department
PCP	Patient PCP on Quickview
NPPA	Patient NPPA on Quickview
PID	Patient ID
Last	Patient Last Name
First	Patient First Name
DOB	Patient Date of Birth
LASTSEEN	Date patient last seen
NEXTAPPT	Date patient next appt
NEXTProv	Next Appoint scheduled provider
NEXTVisit	Next Appoint visit type
IBHPanel	Last IBH appoint date in schedule table - can be in past or future, if in the last 12 month from the last of previous month considerd
BHUnscheduled	BH Ticklers that are uncheduled
BHReffered	Most recent referral to BH Specialist
BHRefDate	Date of Most recent referral to BH Specialist
dtGAD1	Most recent previous GAD Screen Date, or Most recent GAD Screen Date if prior to the last days of the previous month - 90 days
GAD1Scr	Most recent previous GAD Screen Score, or Most recent GAD Screen Score if prior to the last days of the previous month - 90 days
GAD1Sts	Most recent previous GAD Seen Status, or Most recent GAD Screen Status if prior to the last days of the previous month - 90 days
dtGAD2	Most Recent GAD Screen Date if between the last days of the previous month and the he last days of the previous month - 90
GAD2Scr	Most Recent GAD Screen Score if between the last days of the previous month and the he last days of the previous month - 90
GAD2Sts	Most Recent GAD Screen Status if between the last days of the previous month and the he last days of the previous month - 90
GADResult	Derived Result - See result logic below
dtPHQ1	Most recent previous PHQ Screen Date, or Most recent PHQ Screen Date if prior to the last days of the previous month - 90 days
PHQ1Scr	Most recent previous PHQ Screen Score, or Most recent PHQ Screen Score if prior to the last days of the previous month - 90 days
PHQ1Sts	Most recent previous PHQ Seen Status, or Most recent PHQ Screen Status if prior to the last days of the previous month - 90 days
dtPHQ2	Most Recent PHQ Screen Date if between the last days of the previous month and the he last days of the previous month - 90
PHQ2Scr	Most Recent PHQ Screen Score if between the last days of the previous month and the he last days of the previous month - 90
PHQ2Sts	Most Recent PHQ Screen Status if between the last days of the previous month and the he last days of the previous month - 90
PHQResult	Derived Result - See result logic below
Combined Status	Combination of GAD and PHQ Result - highest rank trumps other result. Includes if referral to specialist and IBH Panel if appt

Anchor Peds - snippet

BHRefDat	dtGAD1	GAD1Sc	dtGAD2	GAD2Sc	GADResult	PHQ1Scr	PHQ1Sts	PHQ2Sc	PHQ2Sts	Combined Statu	Combined Status
13-Feb-21	10-Feb-21	19	10-Mar-21	20	Over Due	10-Feb-21	20	10-Mar-21	22	Over Due	4 - Over Due GAD / PHQ - BH Referrals - IBH Panel
	27-Jul-20	19			Over Due	27-Jul-20	12			Over Due	4 - Over Due GAD / PHQ
	26-Aug-20	19	03-Jun-21	10	Decreased -	26-Aug-20	13	03-Jun-21	15	Increased	1 - Increased PHQ
	23-Jun-21	19	12-Jul-21	5	Decreased - Negative	23-Jun-21	17	12-Jul-21	1	Decreased - Negative	7 - Decreased Negative GAD / PHQ - IBH Panel
	11-May-21	18	21-Jun-21	18	No Change	11-May-21	22	21-Jun-21	18	Decreased -	2 - No Change GAD
	02-Jun-20	18	22-Jul-21	14	Decreased -	02-Jun-20	10	22-Jul-21	9	Decreased -	3 - Decreased Positive GAD / PHQ
18-Mar-21	25-Jan-21	18	03-May-21	18	No Change	25-Jan-21	12	03-May-21	17	Increased	1 - Increased PHQ - BH Referrals - IBH Panel
	18-Jun-21	18	25-Jun-21	16	Decreased -	18-Jun-21	20	25-Jun-21	19	Decreased -	3 - Decreased Positive GAD / PHQ - IBH Panel

RI MomsPRN

Maternal Psychiatry Resource Network

PCMH KIDS QUARTERLY IBH MEETING

OCTOBER 14, 2021

- **Providers** are welcome to consult with a perinatal psychiatrist or resource referral specialist via telephone, secure email, or EHR engagement. We welcome all providers, including physicians, NPs, social workers, midwives, and more.

Resource and Referral (Social worker)

- Triages and responds to calls, emails and EMR outreach
- Make connections to treatment and support services
- Schedule provider teleconsultation with perinatal behavioral health experts

Clinical Consultation (Psychiatrist and Psychologist)

- Same-day, provider-to-provider psychiatric teleconsultation services
- Diagnostic support
- Treatment planning
- Medication and dosage recommendations

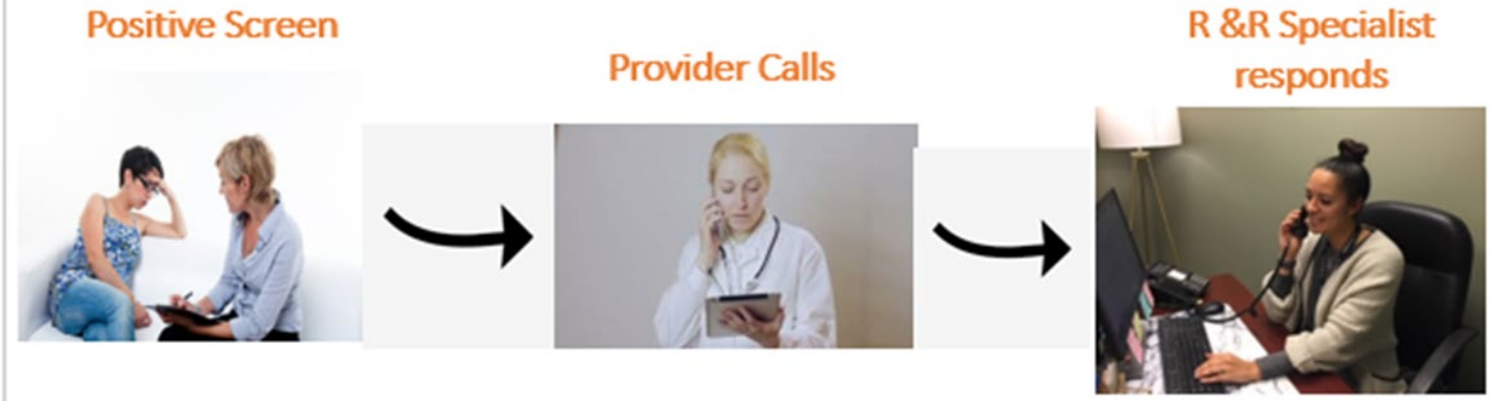
401-430-2800

RIMomsPRN@CareNE.org

RI MomsPRN 401-430-2800

A FREE PSYCHIATRIC TELECONSULTATION SERVICE FOR HEALTHCARE WORKERS

- RI MomsPRN is your one-stop shop if you need to connect a perinatal woman to MH services
- Streamlines process of referring to Women's Behavioral Health



401-430-2800

RIMomsPRN@CareNE.org

Teleconsultation Case Example

Problem

Dad brought Pt in for 2wk Well Baby visit and completed EPDS, scoring 14. Mom is on bedrest recovering from traumatic birth and both partners are interested in MH supports.

Action

Pediatrician calls MomsPRN 401-430-2800 requesting outreach to the parents of her infant patient.

Eva takes info and contact info for Dad.

Result

Eva reaches out to Dad to provide info for individual therapists for both him and Mom

Eva provides info for new dads' support groups & "Healing From Traumatic Birth" therapy group for mom

Teleconsultation Case Example

Problem

18 yr. old patient comes in 3 mos. postpartum for annual Pediatric visit. Documented Hx Anxiety, Depression and ADHD, previously treated with Adderall and Sertraline several yrs. ago.

Pediatrician pages IBH clinician to whom Pt reports worsened anxiety pp, constant worries about baby's safety, not leaving house. Was meant to return to HS last week but has been oversleeping and feeling nervous to part with baby.

Action

Pediatrician calls MomsPRN 401-430-2800 requesting guidance for initiating medication until Pt can be scheduled with IBH Psychiatrist

Eva takes initial info and transfers to Dr. Diaz

Result

Dr. Diaz recommends trial of escitalopram 2.5mg nightly x4 nights, then up to 5mg at which point Pt will be seen at CWBH. Dr. Diaz recommended asking about fam Hx of Bipolar before starting SSRI and calling back as needed

Eva outreaches to Pt to describe Day Hospital program and facilitate intake appt

Pediatrician Engagement

- Currently Pediatric providers make up only 4% of our Teleconsultation utilizers – we want to increase this!
- Do you have ideas for spreading the word to pediatricians?
  - Existing meetings or trainings?
  - Email listservs / digital engagement?
  - Large practices to target?

Thank you!

401-430-2800

MONDAY – FRIDAY, 8AM – 4PM

ERAY@WIHRI.ORG

RIMOMSPRN@CARENE.ORG

MHOWARD@WIHRI.ORG

PediPRN

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Empowering pediatricians to support children's mental health.

RI's Pediatric Psychiatry Resource Network

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PediPRN

What is PediPRN?

- Designed to help pediatric primary care providers (PPCPs) meet the mental health care needs of their patients.
- PediPRN mental health consultation services are available to all PPCPs in RI at no charge.
- Located at Bradley Hospital
- Funding support:
  - Health Resources and Services Administration (Pediatric Mental Health Care Access) grant awarded in partnership with RIDOH
  - BCBS-RI
  - Bradley Hospital

PediPRN GOALS

- Increasing PPCPs knowledge, skill, and confidence with addressing their patients' mild to moderate mental health conditions.
- Promote utilization of scarce specialty services (psychiatrists) for more severe and high-risk patients
- Support the integration of mental health care and pediatric primary care

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PediPRN

PediPRN Services

- Calls/consultation - 830am to 5pm weekdays
- Face-to-face assessments
- Website
- Office hours
- E-blasts/newsletters
- PIP (PediPRN Intensive Program)
- PIP Grad
- Resources/care coordination

Common Consultation Questions

- Diagnostic clarification
- Treatment planning
- Unable to access mental health resources
- Second opinion
- Screening support
- Medication Management – side effect, selection, dosage, etc.
- Psychotherapy – selection, linkage, monitoring

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PediPRN

Why we provide resource services

- Primary care providers need access to resources and mental treatment services to recommend to their patients
- Addressing any barriers from the beginning can help with follow-through
  - Not having contact information can be the biggest barrier to patients and families engaging in treatment
- Resources are always changing
  - Community BH connections and co-located providers have limited time/resources to maintain resource lists
- Clinicians can help triage/tailor referrals and resource recommendations based on clinical judgement and expertise in efficacious treatments
- Integrated BH providers cannot be experts of all mental health conditions
  - Community connections and co-located providers cannot take everyone

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PediPRN

How does PediPRN fit into RI's mental health care continuum

Symptoms/functioning	Response
Mild/Mild-Moderate	Outpatient referrals and monitoring, ?med? -accessing your resources or PediPRN
Moderate in tx, not responding/stagnant, not crisis	PediPRN (or KidsLink)
CRISIS, in tx or new to tx, acute (but not imminent) need for tx/tx change due to safety concerns and/or poor functioning	KidsLink -triages to Access, Crisis clinic, PACE Clinic, Gateway, PHPs, etc -Unite Us
Severe/High Risk/SI with plan	Emergency Evaluation

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PediPRN

How does PediPRN fit into integrated care practices

- See previous slide regarding resources
- MH Demand/Treatment Supply
- Specialized treatment
- Recent examples of consult calls from integrated care clinics:
  - patient c/o of "shaky hands" on current meds.
  - Patient with Autism, ADHD, tic disorder – not responding to meds?
  - Questioning bipolar disorder diagnosis

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PediPRN

Engagement and preliminary outcomes

- PediPRN currently has 349 PPCPs and 66 practices enrolled in PediPRN.
  - Approximately 58% of those enrolled participate in active engagement with PediPRN services.
- High engagers (10+consult calls and/or participation in PIP)
  - Higher rates of psychiatric prescriptions per year
  - Higher rates of mental health focused visits
  - Fewer psychiatric hospitalizations per year
- Education/training outcomes (PIP)

Comfort using rating scales to diagnosis and treatment monitor a variety of mental health conditions in their patients (ADHD, depression, anxiety, substance use disorders).	60% of responses reflected comfort with using rating scales to diagnosis & treatment monitor.	91% of responses reflected comfort with using rating scales to diagnosis & treatment monitor.
Comfort assessing safety in their patients	53% were comfortable	100% were comfortable
Comfort evaluating and managing non-suicidal self-injury in their patients	35% were comfortable	82% were comfortable
Comfort Prescribing second generation antipsychotic medications	6 % were comfortable	55% were comfortable
Knowledge about different level of mental health care available to their patients	65% reported feeling knowledgeable	100% reported feeling knowledgeable
Knowledge about different therapeutic interventions and how to choose them depending on the disorder of their patient.	41% reported feeling knowledgeable	91% reported feeling knowledgeable

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PediPRN

Increasing/Maintaining Engagement

- Solicit feedback regularly
  - Practice needs change, especially with the increase in mental health conditions in children and the development of integrated care and telehealth impacting practice workflows
    - Practice based office hours
      - Ease of utilization
      - Support with the emotional burden practitioners carrying when treating pts with mental health conditions
        - "I LOVE having Dr. Song support us once/month and we all feel better after we meet with her."
        - "Even though not your intention these calls can be somewhat therapeutic for me."
    - New website
      - increase utility as a resource
      - Web-based consultation scheduling
      - expand education tools/resources
    - Tele behavioral health tips and treatment

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PediPRN

Increasing/Maintaining Engagement

- Regular contact about new/updated/actively recruiting treatment programs and services.
  - pediprn-newsletter-mental-health-treatment-programs
  - Most practices do not have mental health supports that can keep up with all the new programming/services available
  - Practitioners often get in a routine of going to the same handful of mental health resources for their patients and benefit from regular reminders of additional resources available
- Connection with partners and stakeholders

How to Contact PediPRN

- **Call PediPRN at (401) 432-1KID (432-1543)**
- **Email: PediPRN@lifespan.org**
- **Visit website www.pediprn.org**
  - Resources
  - Registration
  - Upcoming Educational Events
  - Educational Resources

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Stay Healthy & Safe

Next Quarterly Pedi IBH meeting January 13, 2022

Ask the Experts?