Integrated Behavioral Health

Meeting Minutes

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| Date: 1/12/17 | | |  | Time: 7:30am to 9:00am | | |  | | |
| **Location**: Washington Room RIQI, 50 Holden St, Providence, RI | | |  | Call-in: 508.856.8222 code 4614 (host 7191) | | |  | | |
| Meeting Information: | | |  | **Attendees (marked with an \*)** | | | | | |
| **Meeting Purpose/Objective:** to establish a work group to lead the transformation of primary care in RI in the context of an integrated health care system  **Handouts/Attachments:**   * Meeting Agenda | | |  | Matt Roman, Co-Chair\*  Rena Sheehan, Co-Chair\*  Donna Bagdasarian \*  Christopher Baker  Tom Bledsoe  Michele Brown\*  Joanna Brown  David Brumley  Susan Bruce\*  Diane Block  Paul Block  Susan Boudreau  Chrystal Boza  Maggie Bublitz\*  Nelly Burdette\*  Susanne Campbell\*  Chris Campanile  Erin Campopiano  Lauren Capizzo  Chris Camillo  Liz Cantor  Marisol Carcamo\*  Sheila Capece\*  Ralph Chartier\*  Amy Chirichetti\*  Jody Cloutier\*  Matthew Collins\*  Emily Collier  Kathy Congdon | Lisa Conlan  Emily Cooper  Allison Croke  Robert Crossley\*  Vanessa Cumplido\*  Kristin David  Deidre Denning-Norton  Brenda Dowlatshahi  Susan Eagleson  Kristen Edward  Gina Eubank  Pat Flanagan  Sarah Fluery  Sarah Fessler\*  Gregory Fritz  Rick Ford\*  Elizabeth Fortin  Sarah Gambell  Stan Galek  Deidre Gifford  Richard Goldberg  Lynda Greene  Jamie Handy  Emily Harrison  Suzanne Herzberg  Scott Hewitt  William Hollinshead  Kristen Hull\* | Catherine Hunter\*  Debra Hurwitz\*  Brenda Jenkins  Christine Kennedy\*  Martin Kerzer  Jill Lamberton  Elizabeth Lange  Rachel Legend  Debra Lobato  Jim Lucht  Millie Lukens\*  Michael Lichtenstein  Elizabeth Lynch  Jason Lyon  Joanna MacLean  Matthew Malek  Linda Mahoney  Gail Martin  Amy Matos\*  Thomas Martin  Ramona Mello  Tammy Messier  Stephanie McCaffrey  Suzanne McLaughlin  Deb Morales  Mary Moore  Alcina Nickson  Luz Ospina\*  Heidi Perreault | | Putney Pyles  Angela Reda\*  Nicole Renzulli  Kelley Reilly  Helen Rock  Sarah Roderick  Jan Romagnolo  Renee Rulin  Andrew Saal\*  Marilyn Saunders  Jessica Savoca\*  Kathy Schwab  Marisa Sklar\*  Donna Soares  Michael Spoerri\*  Gregory Steinmetz\*  Sue Storti  Manuela Tambollio\*  Lois Teitz  Lucy Throckmorton\*  John Todaro  Iris Tong  Kimberley Townsend  Tilak Verma\*  Cindy Wyman  Pano Yeracaris  Sherri Zinno  Alice Zory\* | |
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| # | Time | Comments | | | | | | |
|  | Debra Hurwitz  5 minutes | * **Introductions and review of agenda** | | | | | | |
|  | All  60 minutes | * **Adult IBH Pilot Program Practice Sharing and Discussion re: PDSA for Screening/Rescreening Rate**   *Nelly Burdette gave an overview of the IBH Pilot Program funded by the Rhode Island Foundation, and reminded the practices that attendance at these quarterly meetings is part of the cooperative agreement. Each Cohort 1 practice representative then reviewed their PDSA for screening/rescreening patients with depression, anxiety and substance use disorder outlining: what was your plan; what did you do; how did you study it; what action are you taking or not taking as a result. The year one thresholds are: depression 70%, anxiety 50%, and substance use 50%. The year two thresholds are: depression 90%, anxiety 70%, and substance use 70%. Meeting or exceeding these thresholds is part of the pilot program incentive payments.*   * **Women’s Medicine Collaborative** * *The PDSA of this practice was to improve baseline screening rates on all three measures. They worked with their IT department to update their Electronic Health Record (HER) (EPIC) to develop a patient registry. From there, they were able to screen the data to see if they could develop any patterns where screenings were missed to see if they were missed systematically. Other factors may have also contributed that cannot be captured in the registry (i.e. language barriers: the forms are only available in English). The steady improvement was attributed to workflow development and implementation from the staff. The data that was presented was real time screening data, and not the screening rate which requires a 12 month look back.* * *There was some additional discussion around the measurement specification definitions for screening and follow up.* * *Overall, the practice has successfully implemented and completed this PDSA.* * **Associates in Primary Care** * *The PDSA of this practice was to incorporate the depression registry into pre-visit planning and morning huddles. They were able to add fields into the social history field of their EHR (Athena) to be tracked so that providers and staff can easily find the information. The practice manager/data analyst runs reports to see who has been screened to identify if the patient’s needs are being addressed and treated. If they are not, she will put an alert in the patient’s notes to let the staff know. The medical assistants are primarily in charge of making sure the patients are properly screened. Next steps will be to transition the patient reports to the medical assistants instead of the practice manager. The data that was presented was real time screening data, and not part of a 12 month look back.* * *There was some additional discussion around the screening all patients that come in for well and sick visits; if other practices are using Athena; and the training for the medical assistance around screening patients.* * *Overall, the practice has successfully implemented and completed this PDSA.* * **EBCAP** * *The PDSA of this practice was* *for screenings to be done for all active patients 18 years and older and 12-17 years of age for all visit types (unless waived) in the language preference of the patient including those experiencing a transition in care and pain management; Screenings may be done by any clinical care team member, especially the Health Advocates, Medical Assistants, and SBIRT clinicians. There was a discrepancy with the practice data that was presented versus the data that was submitted. The practice currently screens every patient for every visit and is at an advantage with the amount of staff they have to screen and re-screen patients. Due to staff changes and timing of the meeting, the team was not able to meet to review the PDSA and what they will do going forward. The data that was presented is part of a 12 month look back.* * *There was some additional discussion around the scores being high, and how the practice thought what might be the reason for that. The practice though that the workflows and revisions to the warm hand off for positive screens, in addition to the abundance of staff played (community mental health center staff, IBH staff, LICSWs, and SBIRTs) a very big part in the high scores.* * *The practice will meet to discuss and assess if they have successfully implemented and completed this PDSA.* * **PCHC-Chafee** * *The PDSA of this practice was to improve baseline screening of anxiety/CAGE-AID by entering score when screening administered because the EMR doesn’t recognize that the screening has been delivered without a score. They successfully implemented the universal screening in March of last year, and held a training for the Medical Assistants. They did notice that they had two different workflows, and ultimately had to update some fields in their EHR to resolve these documentation issues. After this issue was resolved, an additional training was held for the Medical Assistants. The data that was presented is using the 12 month look back, There was some additional discussion around patient feedback. It is a very good way to address the issues of patients that might not have otherwise presented symptoms. In addition, virtually every positive screen (at any level) has led to a warm hand off. Other practices did ask and had concerns around interrupting a BH specialist when they are with another patient. However, the percentage of patients that come back for a BH appointment are higher if a warm hand off is conducted, than if they just leave without meeting the BH specialist (increased return rates up to 50%).* * *Practices also had questions around the warm hand off process as this site. The BH clinician advised that there is a (non-billable code) note section built in to their EHR for folks to report on the patient visit. They are then able to track those codes for reporting purposes.* * *Overall, the practice has successfully implemented and completed this PDSA.* * **Tri-Town** * *The PDSA of this practice was to implement a screening procedure and work flow for automatic reminders to see if that would increase their screening/rescreening rates. Their first step was to research what their EHR (Nextgen) would be customizable to this process. However, they had to come up an additional process which included making notes in the detail section of the appointment screen. They would meet to look at the appointments for the following day to categorize what types of visits the patients were coming in for. In addition to which of those patients had been screened previously, but needed to be re-screened. Patients that are coming in for well visits and/or are new patients, have their screenings conducted at the front desk. If the patient’s needed to be re-screened, the MAs would conduct that screening in the room. One barrier to this process is that the rescreens and the new patient screens data is lumped together, and needs to be separated going forward. The data that was presented was using a 12 month look back.* * *The practice is also looking into incentives for provider/MA teams and can possibly do this as part of the school project of a current intern, in addition to increasing their warm hand off process, and other ways to increase the use of screening tools.* * *There was also a quick survey run with the group on which practices were conducting the screening tool by paper, oral, or electronic. All are currently either using the paper tool or completing the tool orally with patients.* * *Overall, the practice has successfully implemented and completed this PDSA, although the rates were not as high as they would like them to be.* | | | | | | |
| 3. | All  20 minutes | * **IBH Billing Lessons Learned** * *Some of the Cohort 1 practices have previously identified some issues around being able to successfully bill for the BH services. This discussion was particularly helpful for Cohort 2 practices that have just begun the pilot program.* * *The group discussed that if a patient comes in to see the therapist, because the therapist bills the health plan, if the patient then sees the psychiatrist, the billing code for the psychiatrist will be denied. This is difficult because some patients like to come in once for all of their MD visits, but there isn’t a work around for the billing of those visits.* * *Nelly provided the following link codes between psych and medical that might help practices to bill:* * *F54-Psych factors affecting physical conditions; and* * *F06.3-Mood disorder due to medical condition.* * *On a similar topic, the issue of more than one copay for a patient to see different MDs in the same office came up as well.* * *It was also mentioned that that billing and double copays have been ongoing issues. Is there a more systematic way for us to understand why these issues are happening in the health plan’s systems?* * *Suggestions for the practices to try working with the health plan billing contacts and report back on their progress.* * *Associates in Primary Care reported that they had issue initially with their IBH provider getting reimbursed by United Health Care under their tax ID number (TIN).* * *Sue Bruce from Optum mentioned that each health plan should have a billing contact that they can bring these issues to. She then provided contact information for United Health Care.* * *Michele Brown will put together a list of health plan billing contacts and send it out to the group with the meeting minutes.* | | | | | | |
| 4. | Nelly Burdette  5 minutes | * **Upcoming Deliverables**   *Nelly reviewed and reminded the practices of the upcoming deliverables that will be due to CTC or RIQI below:*   * Cohort 1 * Quarterly Report for screening patients for depression, anxiety, and substance use disorder due to RIQI on 1/15/17; * PDSA plan results for improving screening/rescreening rates due to CTC on 2/1/17; and * Quarterly Report for screening patients for depression, anxiety, and substance use disorder due to RIQI on 4/15/17. * Cohort 2 * Resume, date of hire and staffing plan due to CTC on 1/1/17; * Compact for coordination for patients with severe depression, anxiety, and SUD due to CTC on 1/1/17; and * Quarterly Report for screening patients for depression, anxiety, and substance use disorder due to RIQI on 4/15/17. | | | | | | |
| 5. | All | * **Upcoming Events/Meetings:** * 2017 Meeting Frequency * February 9, 2017- Regular Committee Meeting * March 9, 2017- Quarterly Pediatric IBH Program * **April 13, 2017- Quarterly Adult IBH Program** * May 11, 2017- Regular Committee Meeting * June 8, 2017- Quarterly Pediatric IBH Program * **July 13, 2017- Quarterly Adult IBH Program** * August 10, 2017- Regular Committee Meeting * September 14, 2017 - Quarterly Pediatric IBH Program * **October 12, 2017- Quarterly Adult IBH Program** * November 9, 2017- Regular Committee Meeting * December 14, 2017 - Quarterly Pediatric IBH Program | | | | | | |

| ACTION ITEM LOG | | | | | |
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| Added | Action # | Assignee | Action /Status | Due | Closed |
| 1/12/17 | 1 | M. Brown | Send the list of health plan billing issue contacts and measurement specifications to the group with the meeting minutes. | 1/20/17 |  |
| 1/12/17 | 2 | R. Sheehan | Look into the billing code issues for BCBSRI. | TBD |  |
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