Documenting for Complex Behavioral Health Patients

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Agenda

- Discuss NCQA Behavioral Health Distinction criteria
- Learn the different behavioral health collaboration models
- Exploration of how PCC functionality can help you document for complex behavioral health patients
- Understand how to document to demonstrate integrated behavioral health

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Takeaways

- Determine what YOUR patient population needs are
- An understanding of how to utilize PCC to document complex behavioral health patients
- Closing care gaps for behavioral patients
- Formalize your behavioral health program
- Improve outcomes for your patients

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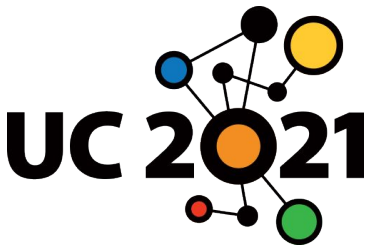
Building a Behavioral Health Program

- Identify the type of BH patients you feel comfortable treating
- Determine where the “cut-off” is – when the child needs to go to a higher level of care (e.g., suicide ideation, two failed treatment attempts, etc.)
- Build a repository of educational resources and community resources
- Properly build a care plan based on BH diagnosis
  - For each child you will add individual details
- Document everything!



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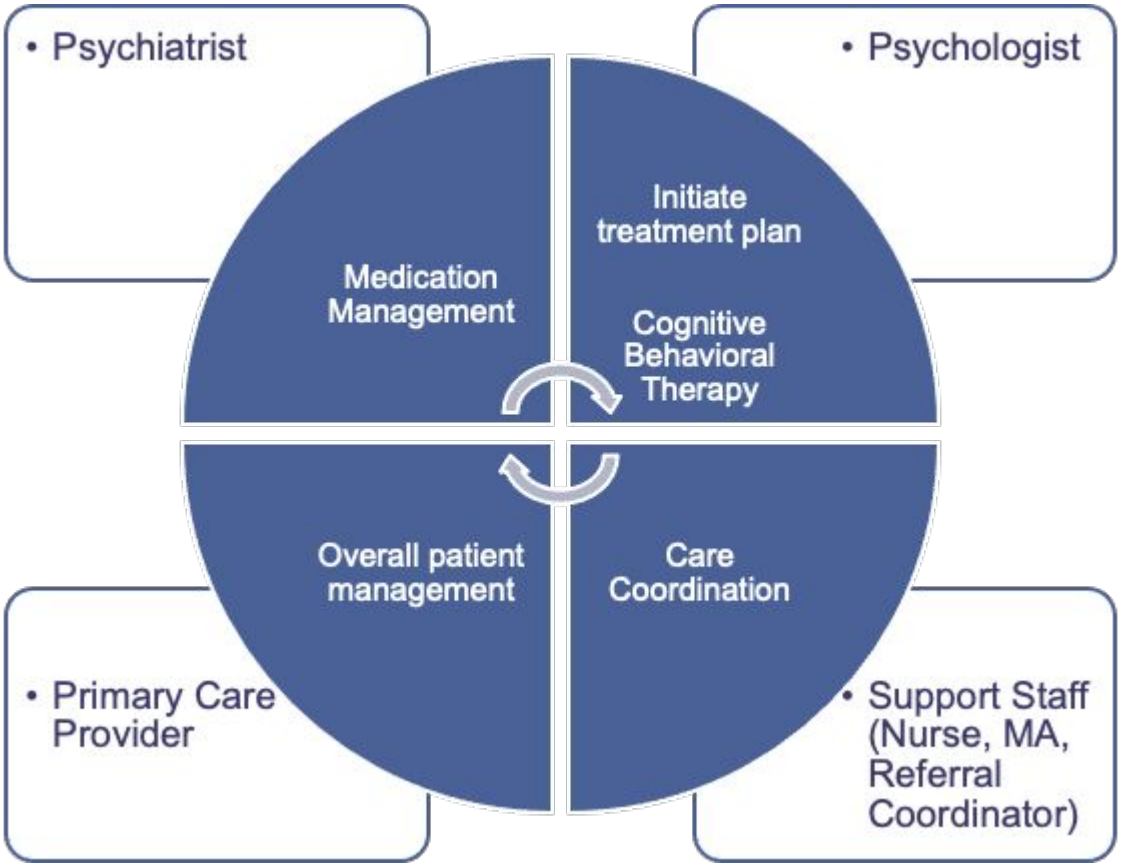
Fundamentals of Behavioral Health Documentation

- Utilize standardized assessments to make an accurate diagnosis
- Document the child's diagnosis on the problem list
- Assess the child's specific social determinants of health (e.g., foster care, family dysfunction, poverty)
- Document the child's behavioral health team, get co-management agreements or record releases where necessary
- Consider a patient agreement to create accountability
- Follow evidence-based guidelines and document everything from the diagnosis to the educational resources provided

Behavioral Health Models

- Full Integration
  - In-house services provided by employed behavioral health specialist
  - Shared systems
  - Combined staff
- Co-Location
  - Sharing or renting of space with a behavioral health specialist
  - Separate systems
  - Coordination of visits, notes and care plans
- Telehealth
  - Provide equipment for patients to connect with a behavioral specialist within your walls
  - Separate billing

Full Behavioral Health Integration



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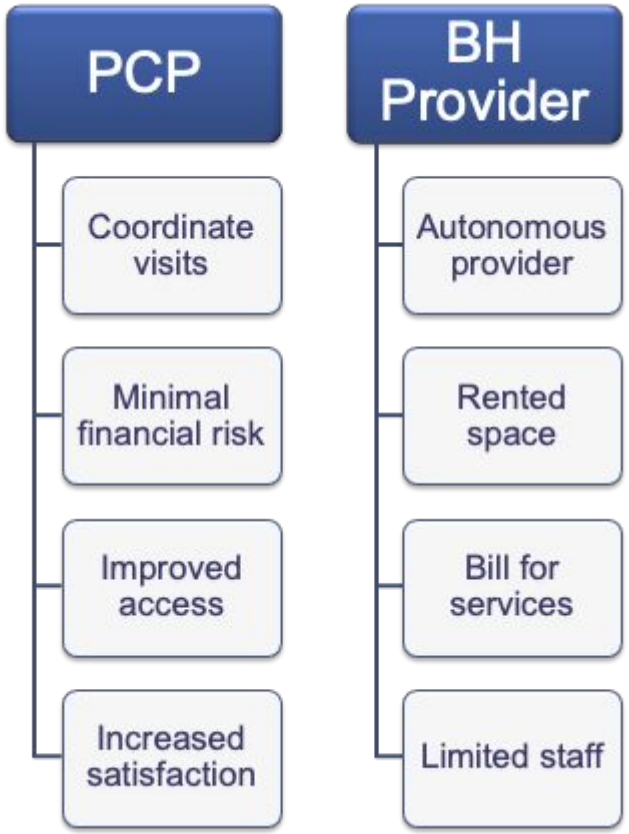
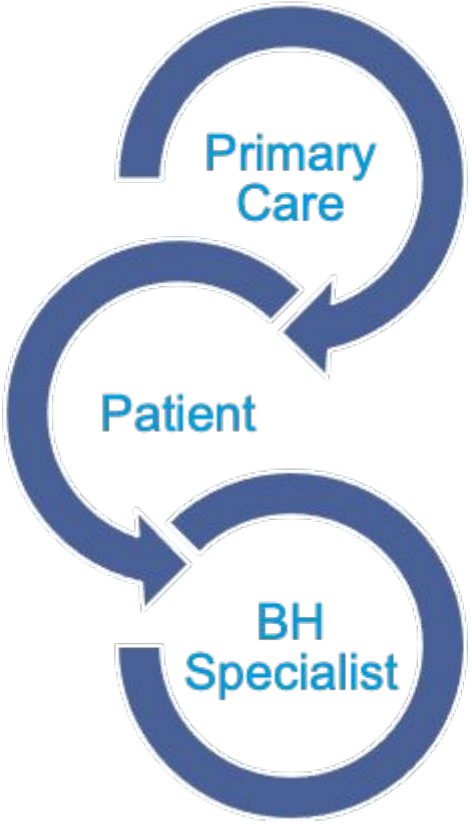
Co- Location





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Hybrid Full Integration/ Co-Location

- Psychiatrist and PCP located within same medical complex
- Shared Psychiatric Physician Assistant
  - FT at Psychiatrist (salary)
  - 1 day a week at PCP (hourly)
- Sees PCP patients hesitant to go to psychiatry
  - Helpful for those with restrictive insurance
- Limited financial impact for both practices

PCP and External Co-Management Agreements

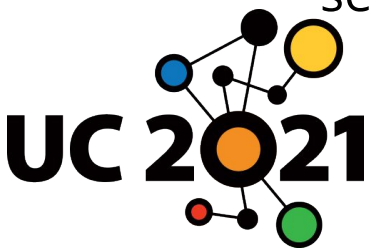
- In-house PCP with REACH training or Pediatric Primary Care Mental Health Specialist (PMHS-ARNP) for medication management
- External collaboration with a counseling facility
- Utilize psychiatry hotlines or local psychiatrist for complex cases

PROs

- Immediate access to care
- Controlled follow-up
- Improved compliance
- Reduces stigma of seeking care

CONs

- Scheduling challenges for a small practice/solo provider
- Expect BH patients to take more time and care coordination
- Increased BH patient cases
- Level of comfort with complex cases



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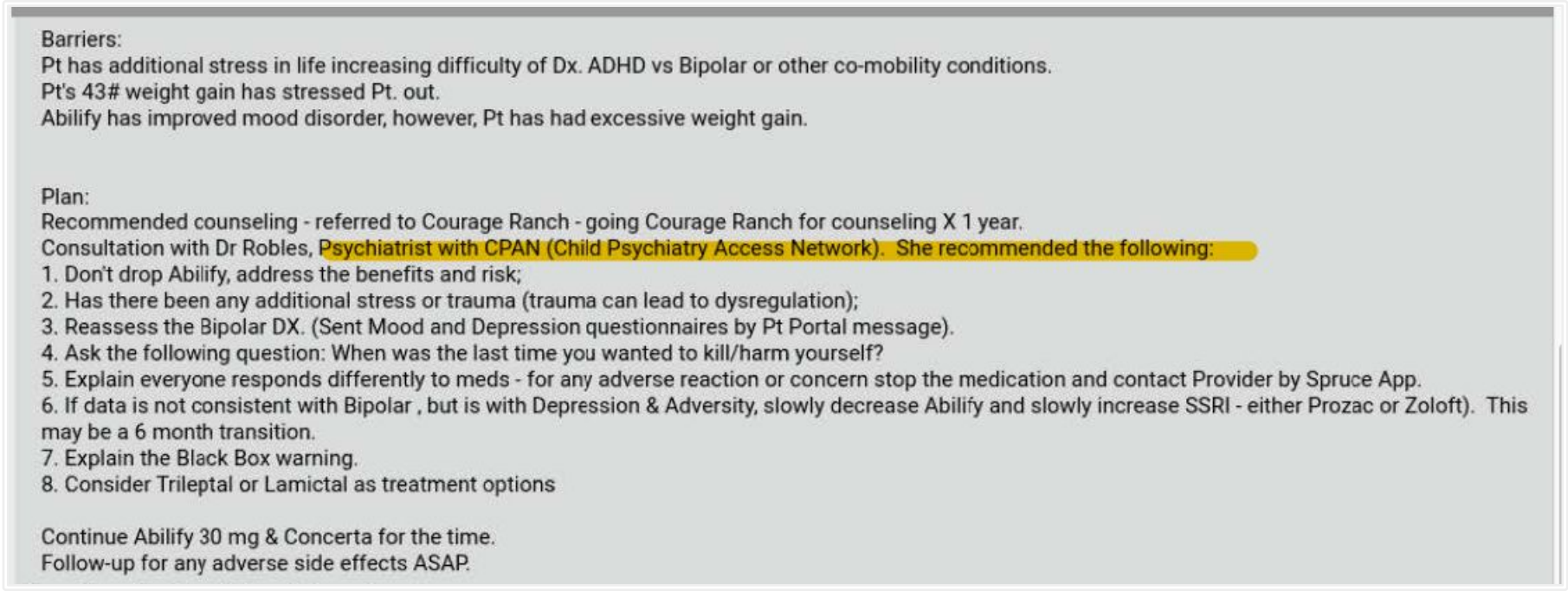
Documenting External Collaboration



Barriers:
Pt has additional stress in life increasing difficulty of Dx. ADHD vs Bipolar or other co-mobility conditions.
Pt's 43# weight gain has stressed Pt. out.
Abilify has improved mood disorder, however, Pt has had excessive weight gain.

Plan:
Recommended counseling - referred to Courage Ranch - going Courage Ranch for counseling X 1 year.
Consultation with Dr Robles, Psychiatrist with CPAN (Child Psychiatry Access Network). She recommended the following:
1. Don't drop Abilify, address the benefits and risk;
2. Has there been any additional stress or trauma (trauma can lead to dysregulation);
3. Reassess the Bipolar DX. (Sent Mood and Depression questionnaires by Pt Portal message).
4. Ask the following question: When was the last time you wanted to kill/harm yourself?
5. Explain everyone responds differently to meds - for any adverse reaction or concern stop the medication and contact Provider by Spruce App.
6. If data is not consistent with Bipolar , but is with Depression & Adversity, slowly decrease Abilify and slowly increase SSRI - either Prozac or Zoloft). This may be a 6 month transition.
7. Explain the Black Box warning.
8. Consider Trileptal or Lamictal as treatment options

Continue Abilify 30 mg & Concerta for the time.
Follow-up for any adverse side effects ASAP.

- Document the provider name/credentials
- Document their recommendations and follow-up plan
  - Can use PCC Snap Text to template the anchors.
- Let patient know about the consultation
- This type of collaboration (PCP/Psychiatry) works for BH05

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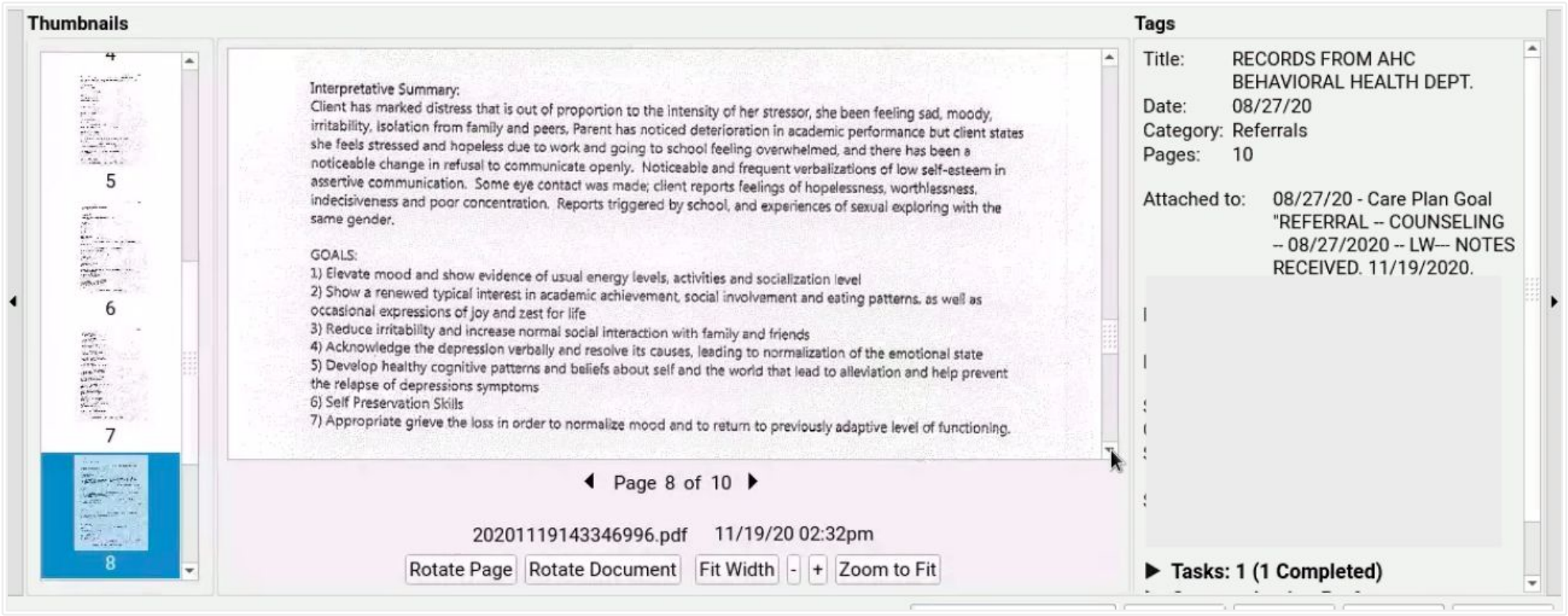
Documenting External Collaboration



- When receiving referral notes or patient updates back (hard paper) scan into the patient chart
- Having co-management agreements/record releases helps get referral notes back
- If the external provider included goals, try to note that in your chart to help keep the patient on track

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Co-Management Agreements

Co-Management Agreement

(Clinician/Practice Name) ABC Pediatrics

is initiating this Co-Management Agreement with ABC Pediatric Therapy Associates
to clarify aspects of the provision of comprehensive care for

General Agreement – Children and youth with the following conditions or

Children in need of CBT for Depression, Anxiety and or ADHD

Specific Agreement – Name child/youth and their condition

We would like to establish a set of explicit co-management roles and clarify who will take the lead with each one.

Core knowledge and services your practice/department will provide.
CBT services to children ABC Pediatrics diagnoses with depression, anxiety and/or ADHD.

Timely access, communication, and methods of reporting findings to one another
ABC Pediatrics will provide clinical information within 24-hours of request and be available within 4-hours for telephone conversations regarding patient care. ABC - PTA will provide a referral note within 10 days of the patient appointment.

Periodicity of visits to specialty care/primary care (e.g. one time, period of time, indefinite, etc)
Determined by ABC - PTA assessment and insurance approval.

Establish methods to evaluate effectiveness together and with family
Complete a co-management agreement, sign records release and share clinical information regarding patient care.
Inform family ABC Pediatrics is responsible for overall care and medication management. ABC - PTA does not prescribe.

Other
ABC - PTA will make every effort to schedule a ABC Pediatrics patient within 14 days of referral.

This Co-Management Agreement is between the following primary care and specialty clinicians (include signatures):

Primary Care Clinician

Practice

Date

- Required for BH Distinction
- For internal and/or external use
- Add time frames for communication and receiving referral notes
- These do not go to the patient
- Don’t forget to sign!

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Patient Agreements/ Protocols

ADD/ADHD Management Protocol

- **TOVA/IVA2 testing**
  - Patients for ADHD Evaluation and Management will need testing once a year
    - One (1) test while on medications **At least 2 hours after taking medication.**
    - One (1) test while off medications
    - If patient prescription is unstable, further testing may be required
- **Monthly Prescription Management appointments**
  - This time will be used to document stability and progress on the prescription's current dose, discuss adjustments needed and other diagnosis-specific issues.
  - **Parents/guardians with multiple children** under this care will only need to schedule a single appointment prior to refills. Review/evaluation for all children needing refills will be taken care of at that single appointment.
  - If child's prescription is NOT stable (current dose needs to be adjusted), the child will need to be present for vitals.
  - If child's prescription is stable (current dose is working), the child will not have to be present.
  - Length of appointment will vary but **will average 10-20 minutes.**
  - Completed prescriptions will be available (after a physician's signature) a few days after this appointment.
- **Stable prescription patients:** ***Monthly appointments NOT NECESSARY for 3 months***
  - Complete 2 TOVA/IVA2 tests (without medication(s) dosage changes)
  - Prescriptions for 3-months will be written.
  - Prior to completion of the 3-months of prescriptions, make refill appointment for additional 3-months of refills.
- **Unstable prescription patients:** ***Monthly appointments NECESSARY***
  - Complete 2 TOVA/IVA2 tests
  - Monthly appointments with Leigh Ann to discuss dosage adjustments needed as well as other diagnosis-specific issues.
  - Leigh Ann will issue 1 month prescription at a time.
  - Once prescription is stabilized, patient may request 3-month prescription (as above).
- **Telemedicine Appointments are available and recommended for refill appointments. Telemedicine appointments are done by using the SPRUCE APP on smart phones. Please check with Receptionist for further information.**

- **Medications will not be refilled if protocol is not followed.**
- **Prescriptions must be filled within 21 DAYS of the FILL Date. Failure to do so will require additional appointments. Any Lost Prescriptions will require additional appointment and lost prescription form must be completed before medicine can be refilled.**

I agree to follow the above protocol and have received a written copy.

GUARDIAN'S NAME: _____ **PATIENT'S NAME:** _____

Date: _____ **BBP STAFF:** _____

- Help create accountability for patients
- Staff can use as "standing orders"
- Part of the child's care plan
- Can be sent to other providers on the BH team

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Patient Agreements/ Protocols

Mental Health Management Protocol

- **Mental Health**
  - Patients for Mental Health Evaluation and Management will need an initial Mental Health Evaluation. Mental Health Conditions include:
    - Anxiety.
    - Depression.
    - Prior Diagnosed Mental Health conditions (Autism/Asperger's Spectrum Disorders, Bipolar, Psychosis, Schizophrenia, etc.) managed and stable by mental health specialists.
- **Monthly Prescription Management appointments**
  - This time will be used to document stability and progress on the prescription's current dose, discuss adjustments needed and other diagnosis-specific issues.
  - **Parents/guardians with multiple children** under this care will only need to schedule a single appointment prior to refills. Review/evaluation for all children needing refills will be taken care of at that single appointment.
  - The child will need to be present for vitals.
  - Length of appointment will vary but **will average 10-20 minutes**.
  - Completed prescriptions for Controlled Substances will be available (after a physician's signature) a few days after this appointment.
- **Stable prescription patients:** ***Monthly appointments NOT NECESSARY for 3 months***
  - Prior to completion of the 3-months of prescriptions, make refill appointment for additional 3-months of refills.
  - Prescriptions for 3-months will be written.
- **Unstable prescription patients:** ***Monthly appointments NECESSARY***
  - Monthly appointments with Leigh Ann Ware, Pediatric Mental Health Specialist, to discuss dosage adjustments needed as well as other diagnosis-specific issues.
  - Prescription will be issued for 1 month at a time.
  - Once prescription is stabilized, patient may request 3-month prescription (as above).
- **Telemedicine Appointments are available and recommended for refill appointments. Telemedicine appointments are done by using the SPRUCE APP on smart phones. Please check with Receptionist for further information.**

- **Medications will not be refilled if protocol is not followed.**
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I agree to follow the above protocol and have received a written copy.

GUARDIAN'S NAME: _____ **PATIENT'S NAME:** _____

Date: _____ **BBP STAFF:** _____

- Clearly spell out what conditions/situations you will treat
- Consider a protocol/agreement for each condition if the treatment plan is significantly different
- Add in what standardized assessments will be used and why

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Behavioral Health Assessments

- PSC17 or PSC35 - General psychosocial assessment
  - Good for younger children
- PHQ- 9 or PHQ(A) - Depression
  - Typically 12 y/o +
  - PHQ2 if the child tests positive will do a PHQ9
- Child Depression Inventory [CDI]
  - Good for younger children to assess for depression 7 y/o+
- SCARED - Anxiety
  - Will see practices do a PSC17 and then a SCARED on children 8 y/o+
- NICHQ Vanderbilt Assessment - ADHD
  - Parent and teacher assessments
  - Try to remeasure after 30/60 days on medication
- Conners Rating Scale - Can be used for ADHD or ODD, cognitive problems, anxiety/shyness, perfection
  - As young as 3 y/o
- CRAFT - Substance use
  - Adolescents

Screening Orders Through CHADIS

- PCC now offers integration with CHADIS.
- CHADIS screening questionnaires provide structured documentation that will auto-generate orders in your patient charts and auto-attach screening results to those orders.
- CHADIS replaces the need to print, scan, and attach screening results to your orders and visits.
- CHADIS standardizes the screenings you do for each visit.

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Adolescent Depression Screening

Required: Conducts depression screenings for adults and adolescents using a standardized tool

- Use PCC Dashboard measure - “Depression Screening - Adolescents”
  - To get credit, you’ll want to configure orders and billing to allow for appropriate tracking. Some additional adjustments to orders and follow up processes may be required for PCC’s CQM reports (not to be confused with the Dashboard report here). See Learn.pcc.com for full details: CMS2: Preventative Care and Screening: Screening for Clinical Depression and Follow-Up Plan
- No % threshold is required
- Must identify standardized screening tool
- Evidence and report or documented process required
- Use patient example of a positive assessment with follow-up plan

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Failed Assessment and Follow-up Plan

CHADIS Detail Report

Visit on 12/9/20

Name	[redacted]	Reason for Visit	[redacted]
DOB		Gender	
Today's Date		Age Today	
Report Information			
Report Date	[redacted]	Report Age	[redacted]
Report Doctor			

Priorities

No pre-visit concerns indicated.

Questionnaires

Flags	Questionnaire	Completed	Respondent	Provisional Result						
				Pass	+/-	Fail	Disorder	Problem	Variation	Challenge
**	Medication Side Effects (Parent)	12/9/20 10:17 AM EST	Mother							6
**	Vanderbilt Follow-Up Parent Informant	12/9/20 10:14 AM EST	Mother	1		6				

Please verify that respondents are the appropriate individuals and the questions were understood

Medication Side Effects (Parent)

[redacted]

- **Challenge: Possible side effect noted: Heart skipping beats
- *Challenge: Possible side effect noted: Irritability
- *Challenge: Possible side effect noted: Extreme sadness or unusual crying
- *Challenge: Possible side effect noted: Tremors/feeling shaky
- Challenge: Possible side effect noted: Headaches
- Challenge: Possible side effect noted: Dull, tired, listless behavior
- Comment made regarding potential side effects: *Chest pain alot*

Vanderbilt Follow-Up Parent Informant

[redacted]

- **Failure: Reading a concern
- **Failure: Mathematics a concern
- **Failure: Oppositional Sxs; on meds (Per Parent): *score: 6 out of 8.*
- ** Total symptom score for inattention and hyperactivity/impulsivity questions: *5 out of 18*
- *Failure: Overall school performance a concern
- *Failure: Writing a concern
- *Failure: Participation in organized activities a concern
- * Average Social Performance Score (On a scale of 1 to 5): *3.25*
- * Average Academic Performance Score (On a scale of 1 to 5): *5.0*
- Pass: Normal for ADHD; on meds (Per Parent): *Inattentive symptom score: 2 out of 9 (ave. rating 1.22 [0-3]); Hyperactive symptom score: 3 out of 9 (ave. rating 1.33 [0-3])*
- First symptoms were noted at age: *3*

Note: Any Vanderbilt ADHD diagnosis requires >5 symptoms at level 2 or 3 (>6 items if age >17) PLUS impact of >= 2 Performance items at level "Somewhat problematic" (4) or 1 item at level "Problematic" (5) PLUS onset before 12. Actual DSM diagnosis also requires impact in 2 settings and certain rule outs.

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Failed Assessment and Follow-up Plan

Mental Health Interventions Discussed Today

- ✓ Consistency of medication administration
- ✓ Consistency of routine and schedule
- ✓ Communication with school re daily expectations
- ✓ 504 or IEP initiation/alteration
- ✓ Continue with therapist

  Continue services with [redacted] [Leigh Ann Ware, RN, CPNP, PMHS]

Mental Health Goals Discussed Today

- ✓ Continued academic progress and success
- ✓ Continued development of appropriate social skills
- ✓ Tolerance of medication without side effect
- ✓ Maintain compliance with taking medication

Care Plan Intervention

Status: Active

Goals

- Mental Health Management - Coordinate with [redacted] on who and what meds are RX'd. F/U in 1 month.

Actions

- Overactivity/inattention behavior management
- Mental health care
- Medication action/side effects care

Next Steps

Barriers:
Need records from [redacted] New release sent 11/18/19 - still not received. Per MOC [redacted] are following my medication RX.
Multi-generation in 1 house, each person with different discipline methods. Per MOC - GPOC don't support her discipline and child gets what he wants.
Child has been going to school - MOC is not hearing how child is doing since favored teacher left the school and has substitute teachers now.
MOC describes pills by color and shape - not their name.

Plan:
Continue to be under [redacted] care, MOC attempted to notify them, but they haven't responded yet.
Started Abilify for Bipolar - significant weight gain, continue to monitor weight gain and behavior.
MOC to contact teachers re: any side effects of medication.

Care Coordination Notes

Team Members

[redacted]
Specialty: [redacted]
Home Phone: [redacted]
Address: [redacted]

Documents

Title: VACC CONSENT
Date: 11/04/19
Category: Forms
Pages: 1
Attached to: 12/14/20 - Care Plan Goal "Mental Health Management - Coordinate with [redacted] on who and what meds are RX'd. F/U in 1 month."
Last Modified: mbenavidez

Created by Leigh Ann Ware, RN, CPNP, PMHS 11/04/19
[Last Reviewed for this visit by Leigh Ann Ware, RN, CPNP, PMHS 12/14/20 1:06pm]

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Care Management and Support

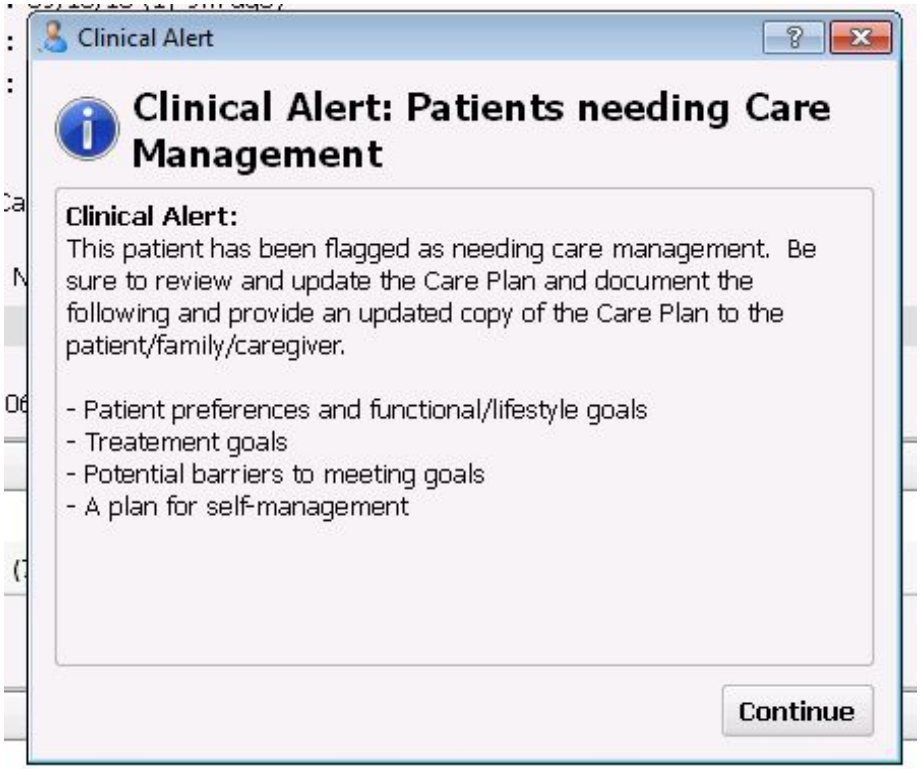
- Use EHR Patient Lists in Report Library for identifying patients needing Care Management based on diagnosis or problem list
- Add “Care Management” flag to these patients (Note: this should be added to your available flags if not yet configured)
- Create clinical alerts reminding clinicians when working with these patients

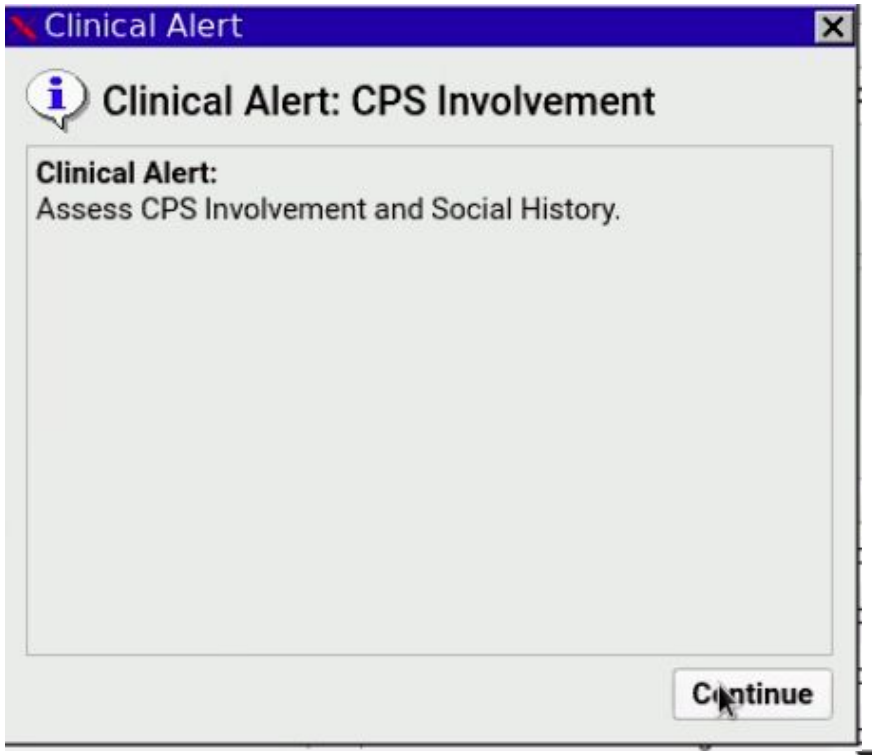
Clarify Terminology

Care Management	Activities performed by healthcare professionals to improve patient outcomes
Care Coordination	Organizing patient care between clinicians and facilities
Care Plan	Individualized instructions and interventions given to the patient in writing

Care Management and Support

- Use clinical alerts to flag/alert for care management activities





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Building a Care Plan

- Determine where the care plan will live (e.g., chart or visit note). *Note: adding the care plan to the visit note allows the individual care plan to be marked as reviewed.*
- Add ***patient*** goals (e.g., play with kids or lose 5 pounds)
- Include ***barriers*** (e.g., cost of medications, compliance issues or lack of transportation)
- Provide educational resources or tools encourage ***self-management***

Care Management and Support

03/17/21 Status: Active

Goals

- Suicide Attempt

Actions

- Potential suicide care

Next Steps

Barriers:
Pt was hospitalized at Methodist Children's for 3 days following overdose on Tylenol, Concerta & Abilify resulting in liver damage. Was Discharged to Clarity Behavior Unit.

Plan:
Reviewed Discharge record and recommendations from Clarity:
1. Medication safe for all OTC and RX medications.
2. Remove any access to weapons.
3. Limit access to risky social situations.
4. Encourage people, places that provide support, take walks & spend time with parents, karate & taekwondo.
5. Continue counseling wit[redacted]er at Courage Ranch. Continue once a week with new plan.
6. Suicide Hotline: 1-800-273- TALK (8255).
7. Clarity Guidance Center: 1-210-616-0300.
Continue current medications with monthly follow-ups.

Care Coordination Notes (internal use)

Team Members

Documents

Title: ER REPORT FROM METHODIST CHILDREN'S ER
Category: ER/Urgent Report
Attached to: 03/17/21 - Care Plan Goal "Suicide Attempt"
Signature Requested: [redacted]
Signed: [redacted]
Last Modified: [redacted]
Date: 12/02/20
Pages: 8

View Document

Use PCC's Care Plan component embedded within visit templates

Attach important documents directly to care plan

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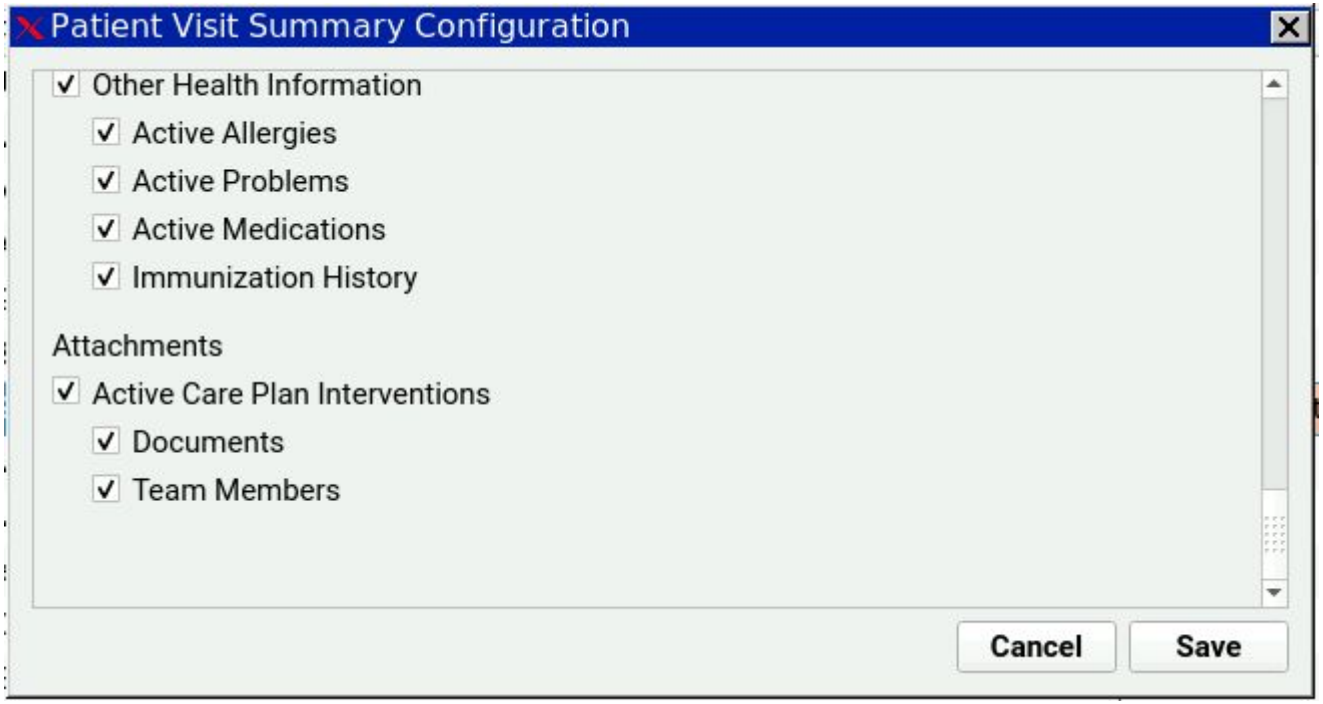
Building a Care Plan

Configure the care plan to print with the Patient Visit Summary



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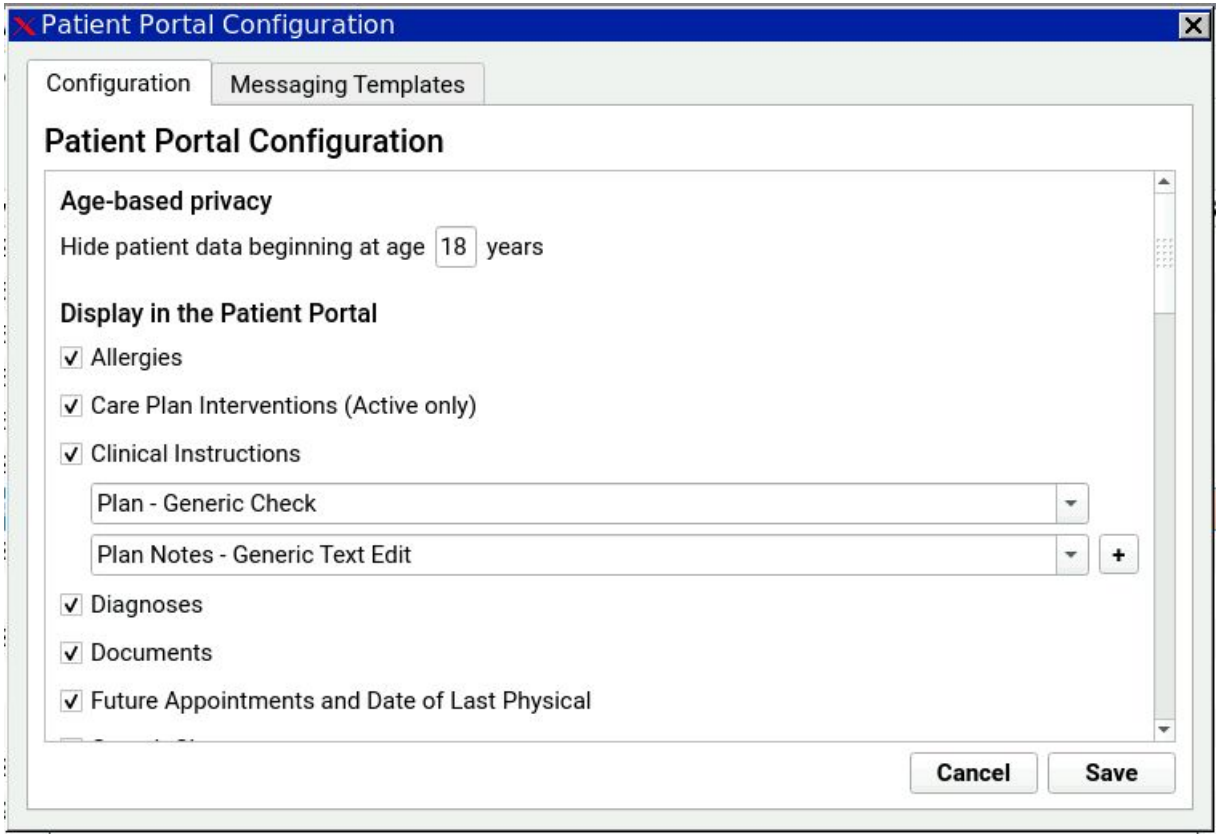
Building a Care Plan

Active Care Plans can be automatically shared to the Portal



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Organizing Data for the BH QI Worksheet

- Two behavioral health measures
- PCC Dashboard: ADHD Follow-up and Depression Assessments
- Build “homegrown” reports for more complex patients/situations based on orders or DX code
  - Vanderbilt orders for ADHD patients
  - Postpartum depression assessments
- Two data points are required - baseline and remeasurement
- The story on improvement is more important than the data
- Give YOUR reasoning for monitoring the measure and you actions for improvement

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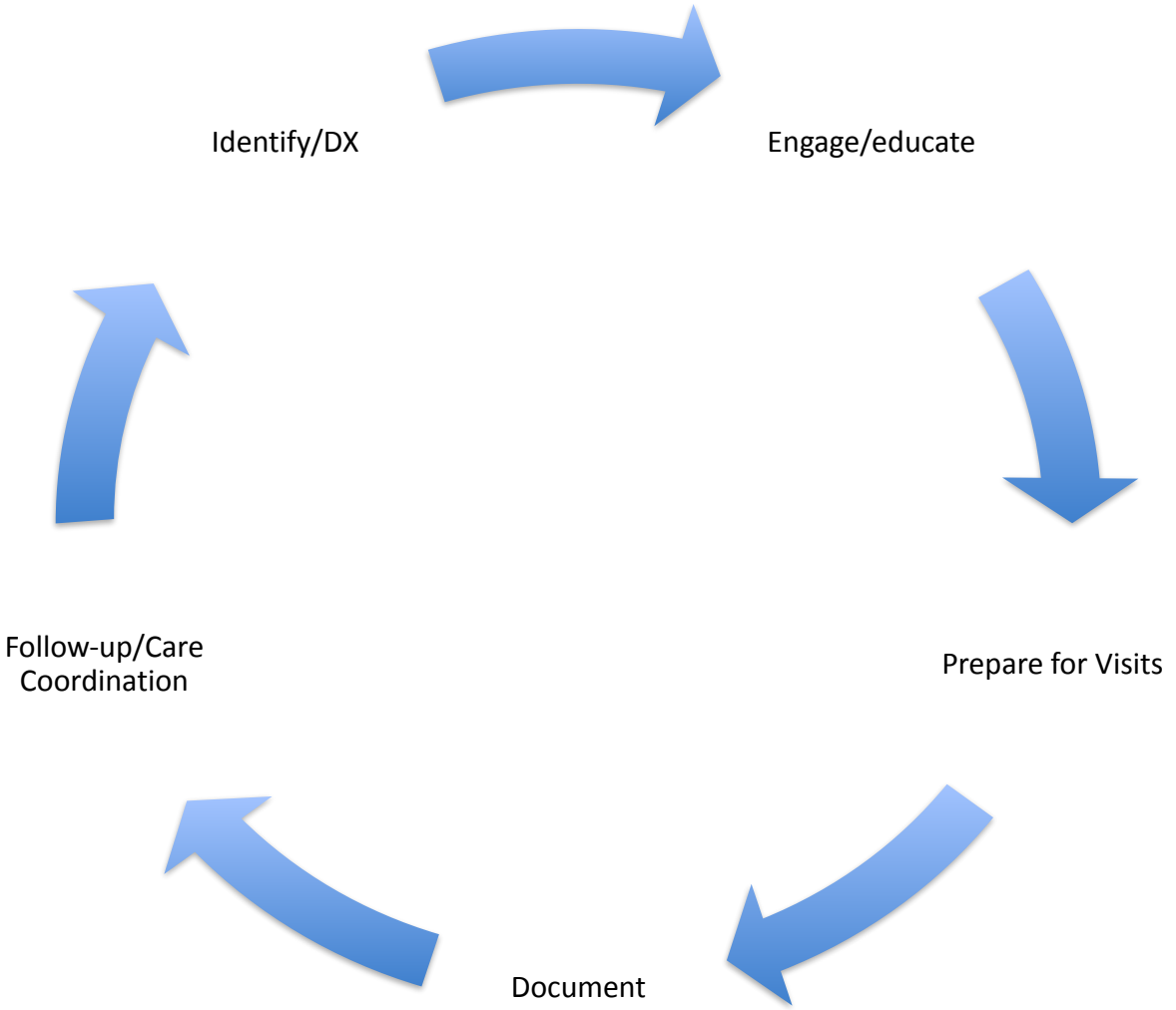
Closing a Care Gap for Behavioral Health Patients



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Branding/Marketing

- Practicing medicine is a business!
- Patients are consumers of your service
- If they do not like the service, they have the right to go to another provider
- Keep your message consistent
- Train staff to say your desired keywords
- Ask for patient feedback
- Incorporate new services
- Don’t be afraid of failure

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Offering Specialized Services

- PROMOTE, PROMOTE, PROMOTE
- If something sets you apart don't be afraid to make it known
- Integrating behavioral health is a specialized service, most do not provide this level of care
- Use your interest as a specialized service and then a new revenue stream

  In-house LCSW→ individual patients visits→ brief interventions for PCP→ family or group sessions based on condition→ BH specialist becomes a center point for BH care coordination/care management → practice becomes locally known for caring for complex BH patients

Thank you!

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- Amanda Ciadella, MPH, NCQA CCE
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- Jim Leahy
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