Session # B 1

Dynamic Evolution of Integrated Behavioral Health: Developing Data Management Systems for Continuous Quality Improvement

WJ Sieber, G Kallenberg, L Sudano, K Seifert, L Black

Collaborative Care

Division of Family Medicine

UC San Diego

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CFHA COLLABORATIVE FAMILY HEALTHCARE ASSOCIATION

Faculty Disclosure

The presenters of this session have NOT had any relevant financial relationships during the past 12 months.

Conference Resources

Slides and handouts shared in advance by our Conference Presenters are available on the CFHA website at http://www.cfha.net/?page=Resources_2018

Slides and handouts are also available on the mobile app.

Learning Objectives

At the conclusion of this session, the participant will be able to:

- Participants will be able to identify clinical activities that can be measured as part of continuous quality improvement.
- Participants will be able to list methods by which they can quantify their program's activities and outcomes.
- Participants will be able to outline measures and methods to help quantify the impact of their program across several domains (e.g., patient outcomes, financial, etc.)

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Learning Assessment

A learning assessment is required for CE credit.

A question and answer period will be conducted at the end of this presentation.

Presentation Overview

- Purpose/structure (clinical, operational, financial), QI essentials (Sieber)
- National trends and needs, our program history/philosophy (Kallenberg)
- Clinical & operational (Sieber/Sudano)
- Integration and population health monitoring (Sudano/Seifert)
- Financing integration (Black)
- Fiscal accountability (Kallenberg)
- Wrap-up

Our goal today is not to share all QI activities in our program over the past several years but rather examples that show our struggles so that you may learn from them.

We want this to be the start of a collaboration across programs !!

Quality Improvement Essentials

- IOM/NAM defines quality: “the degree to which health care services for individuals and populations increases the likelihood of desired health outcomes and are consistent with current professional knowledge.”
- IOM/NAM six quality dimensions
  - Safe (avoids harm)
  - Timely (reduce wait times)
  - Effective (deliver EBM to those likely to benefit)
  - Efficient (optimal use of resources to achieve goals)
  - Equitable (provide care regardless of socio-demographic or socio-economic status)
  - Patient centered (account for patient preferences and needs)
- QI = learning that informs ongoing improvement; QA = accountability
- QI is a requirement of ACA; aim: right care at the right time in the right way

Quality Improvement Essentials

"QI is a philosophy and set of tools that systematically identifies measureable and important outcomes, attempts to understand the processes that influence these outcomes, develops measures for these processes and outcomes, and then performs learning trials to attempt to continuously improve these outcomes." (Bobbit et al, 2012) (e.g., PDSA cycles ala Deming)

Juran Trilogy:

- Quality planning: establishing goals and proposed ways to achieve those goals
- Quality control: monitoring operations, and analyzing difference between actual production and goals
- Quality improvement: establishing an infrastructure to secure improvement, identify needs for improvement, and provide resources needed to achieve improvement.

3 questions central to QI:

- What are we trying to accomplish?
- How will we know a change is an improvement?
- What changes can we make that will result in improvement?

How sections will flow

- Why?
  - What drove the question and creation of data report (program improvement, research, frustration, institutional mandates)
- How?
  - How do we measure the process/outcome in ways that inform improvement efforts (Flowsheets, QI reports, other variables needed?)
- What?
  - What actions do we take with the reports generated? What future responses would further enhance our program?
- How is our process and 'lessons learned' helpful to other programs?

11:18

National Trends and Needs

Ongoing efforts to demonstrate ROI/cost-effectiveness of IBH

Requires demonstration of clinical effectiveness, as measured by:

- Reduction in psychological symptoms (e.g. PHQ-9, GAD-7, etc.)
- Improvement in other health conditions impacted by BH/MH (e.g. A1c, BP, weight, etc.)
- Reduction in use of health system resources (visits, tests ordered, ED visits, hospitals)

Requires definition and measurement of costs:

- Direct/indirect costs of providing IBH (personnel, space, IT, administration, HR, etc.)
- Cost savings (defined as broadly and inclusively as possible – often by comparison to TAU)

Requires demonstration of system efficiency (ways of decreasing direct/indirect costs)

- Time from referral or warm handoff to first visit
- Wait-list measurement
- Productivity of BHPs
- Patient experience scores
- Measures of “integration” (PIP, PPAQ)

National Trends and Needs

Ongoing efforts to demonstrate ROI/cost-savings/cost-effectiveness of IBH

Current examples:

- Pubs re: ROI evaluations – state of research
  - Gerrity – Millbank Memorial Fund: Evolving Models of Behavioral Health Integration: Evidence Update 2010-2015; May 2016 – only 17 articles (out of 140) dealt with highly integrated systems
  - Melek – Milliman Research Report: Potential Economic Impact of Integrated Medical-Behavioral Healthcare; Updated Projections for 2017: overall savings of $38-68B by integration of BH & medical care
  - Several other RCTs on much smaller scale with differing methods of measurement and generally modest positive outcomes
- 2018 CFHA meeting: only 2 presentations focusing on financial performance
- National PCORI contract – clinical outcomes but cost assessments are prohibited!

Program History & Philosophy

- Transplant from Sharp/USD program to UCSD
- Local leadership's awareness of national trends for integration (CFHA)
- Incipient conceptualization of PCMH movement (pre-2007 to IBH'd version of principles)
- Teaching program component; we are a desired clinical site for trainees in MFT, psychology and social work
- Commitment to Practice-Based Research (PBR) as a way to improve outcomes & efficiency
- Connection with new state/institutional mandates (the world catching up!); new closer partnership with Dept. of Psychiatry

Program History & Philosophy: UCSD Primary Care

3 Family Medicine & 3 Internal medicine clinics, pediatrics clinic - all within 10 mile radius

- Current patient population:
  - 80,000 patients; 80+ patient encounters/day/clinic
  - 56% female
  - Culturally diverse (53% Caucasian, 28% Hispanic,12% Asian/Pacific Islander, 7% AA)
  - Range of payers - Medicaid to PPO
- Planned expansion to new PC Network: 12 offices, 120 PCPs, 250+K patients

32 Behavioral Health Providers (BHPs)

- 15 Licensed career staff (PhDs. LMFTs, M.D.s) Breakdown total FTE: clinical ?; Admin?)
- 9 MFT Associates
- 7 MFT & PsyD students

Available for immediate consults and brief interventions approximately 80% of the time (12,000 visits in 2017)

EHR (EPIC) since 2007, continuously adding/modifying Flowsheets

- This allows for quantification and analysis
- Initially low completion rate
- Ongoing feedback form providers for improvement

Program History & Philosophy: Refinement of our model (2003 – 2018)

Co-located/collaborative specialty BH services (50" sessions) to "PCBH Plus" to population-based approach

Integrated / "PCBH PLUS" (PCBH and some specialty)

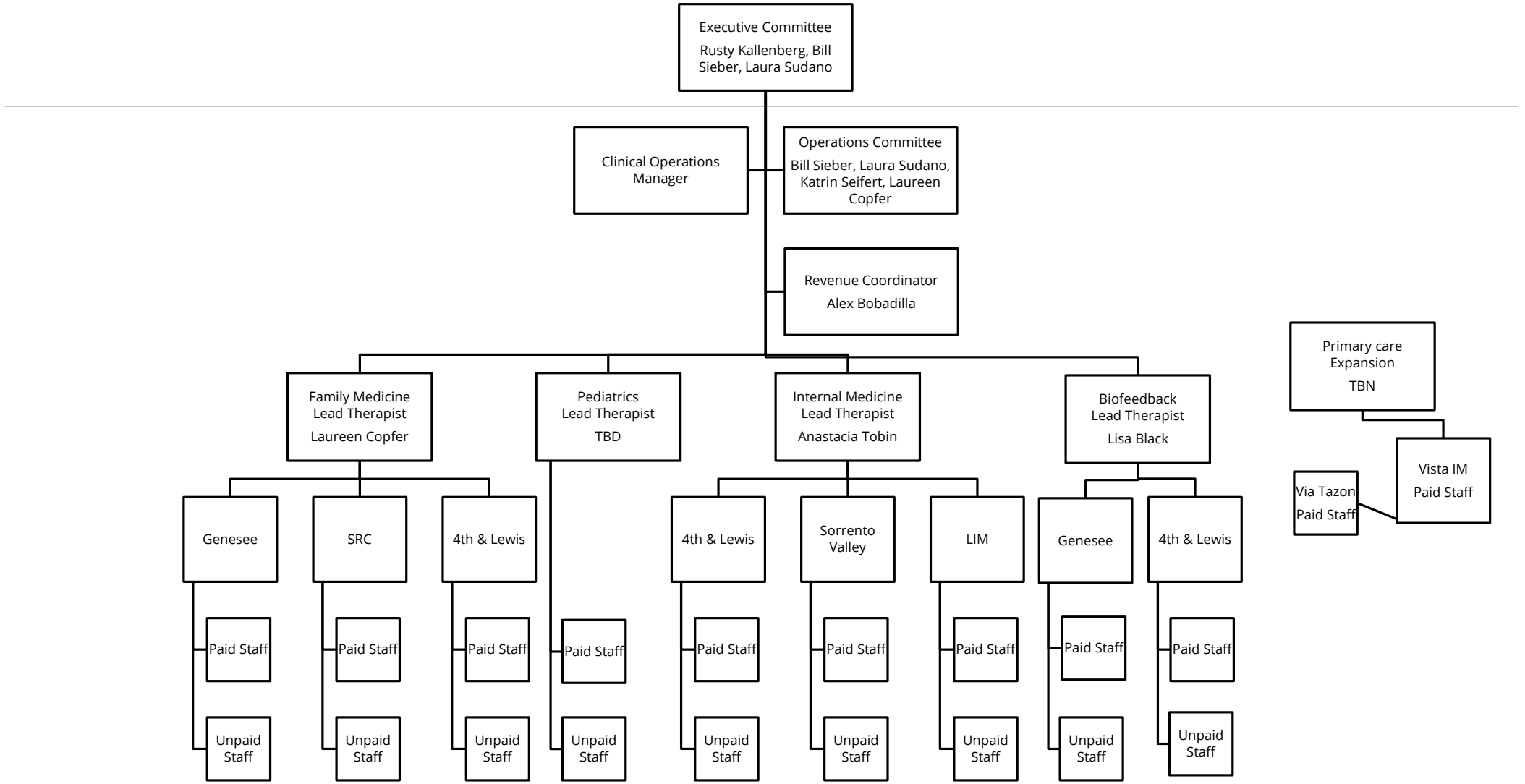
- Continuous BHP presence during clinic hours for immediate consultation and warm handoffs
- Note that though a future intake is sometimes scheduled during a BHC intervention, it may or may not be with the same BHP
- 30 – 60" visits for extended counseling (generally up to 8 sessions, with more as needed); intermittent "continuity" follow up visits as needed (similar to PCP model)
- PC Psychiatry consultation
- Other specific services including marriage/family care, pediatric/adolescent care, bio/neurofeedback, EMDR, other

"*Integration characteristics"* adhered to in ALL services delivered including:

- Close communication between BHPs and PCPs in person, telephonically and electronically
- Shared clinical space and EMR for ALL to use collaboratively
- Periodic joint sessions for mutual learning including BH skill development sessions for PCPs

11:24

Quality and Productivity



Quality and Productivity

- Why?
  - What were students learning? What treatments were patients receiving? Were paid staff seeing as many patients as expected?
- How?
  - How do we measure quality?: consistency of model used (PST, ACT) (manualized Txs in primary care?), duration of episode of care, PHQ/GAD changes, matching of Dx w/ guidelines (e.g., CBT/exposure/EMDR for PTSD), # PCP cc:d
- What?
  - What do we do with the reports generated? Use them in supervision more, provide feedback of productivity to paid staff on regular basis, assess trends on guidelines adherence (e.g., frequency of PHQs for depressed pts.)
  - What responses did we have to the information? Increased use of repeated measures, expanded drop down menu options of treatment approach

Quality and Productivity: Reports generated and used

Clinical

- Therapist Activity

Operational

- FM Monthly Visits
- IM Monthly Visits
- Therapist Productivity
- Referral - Visit delays
- Open Encounters

Clinical quality

1st_Visit	Last_Visit	Dept	#Visits	Times_PCP_Copied	Primary Dx	# PHQ9	PHQ9_Date1	PHQ9 Score1	PHQ9 Date2	PHQ9 Score2	PHQ9 Date3	PHQ9 Score3	#GAD7	GAD7_Date1	GAD7_Score1
9/11/17	12/9/17	FM	10	10	Marital conflict	3	7/24/17	17	9/11/17	14	10/3/17	8	2	9/11/17	20
9/8/17	11/27/17	FM	6	5	Depression, unspecified	3	6/24/17	13	9/8/17	17	11/18/15	10	1	9/8/17	15
3/1/17	11/16/17	IM	16	12	Persistent depressive disorder, mild	5	1/28/17	21	3/8/17	17	5/16/17	15	2	3/8/17	3
6/11/17	12/1/17	FM	13	8	GAD	3	5/17/17	5	8/25/17	3	10/29/17	3	5	6/11/17	14
7/8/17	11/16/17	IM	9	6	Anxiety	4	5/3/17	9	8/10/17	6	10/5/17	16	3	7/8/17	13
9/3/17	11/15/17	FM	6	6	Depression with anxiety	3	8/19/17	12	9/3/17	12	11/15/17	5	3	9/3/17	10

Provider productivity

BHP	Visit month/year	90832	90834	90837	96666	FM02	FM07	Total #
Staff A	8/2017				1	12	3	**16**
Staff A	9/2017				5	5	11	**21**
Staff A	10/2017				2		12	**14**
Staff A	11/2017				2		3	**5**
Staff A (became licensed)	12/2017		6	1	5		2	**14**
Staff A	1/2018		14		4			**18**
Staff A	2/2018		21		3	1		**25**
Staff A	3/2018	3	10	1	2			**16**
Staff A	4/2018	2	7	10				**19**

Operational

Referral_ Date	Refd Clinic	1st_Contact	1st_Visit	Status	Days_Referral-Contact	Days_Referral-1stVisit	1stVisit_Therapist_ Change	Postassmt_Same Therapist_Visits	Postassmt_Other Therapist_Visits
11/29/17	LWC FM	11/30/17	12/17/17	Completed	1	18	Yes		7
9/16/17	LWC FM	9/21/17		No Show	5				
6/6/18	GEN FM	6/8/18	6/20/18	Completed	2	14	No	4	
8/22/18	LIM IM	8/29/18	9/22/18	Completed	7	31	Yes		6
9/9/17	LWC FM	9/29/17	10/5/17	Completed	20	26	Yes		9
8/17/17	LWC IM	8/24/17	2/20/18	Completed	7	187	Yes		14
8/21/2017	LWC IM	8/25/2017		No Show	4				
4/3/2018	LWC IM	4/10/2018	4/11/2018	Completed	7	8	Yes		5
2/2/2017	LIM IM	2/16/2017	3/10/2017	Completed	14	36	Yes		8

Quality and Productivity: Future plans

- Expand and detail elements of treatment models (e.g., behavioral activation, mindfulness, cognitive diffusion, breathing, etc.)
- Assess frequency of EBM match: treatment model w/ diagnosis
- Assess frequency of assessments that lead to 'refer out'
- Assess proportion of patients seen at clinic other than PCP
- Automate pushing information to each staff

11:30

Measures of Integration

- Practice Integration Profile (PIP)
- PCBH-based Provider Adherence Questionnaire (PPAQ)
- TCARE

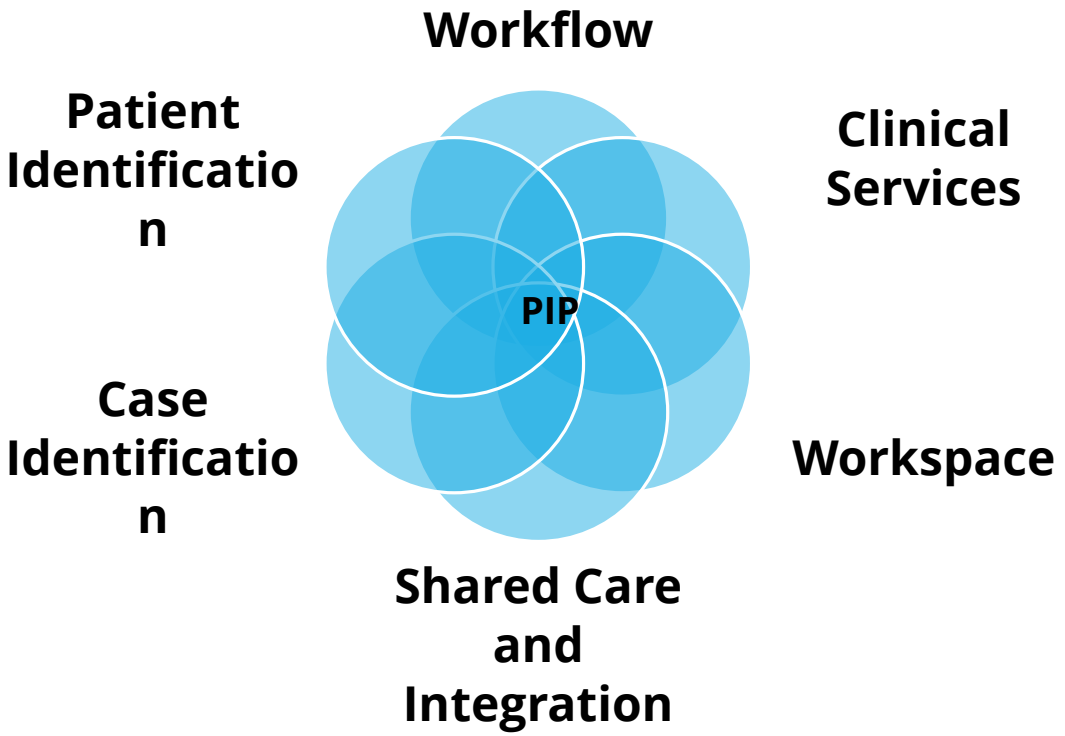
CIH
Center for Integrated Healthcare

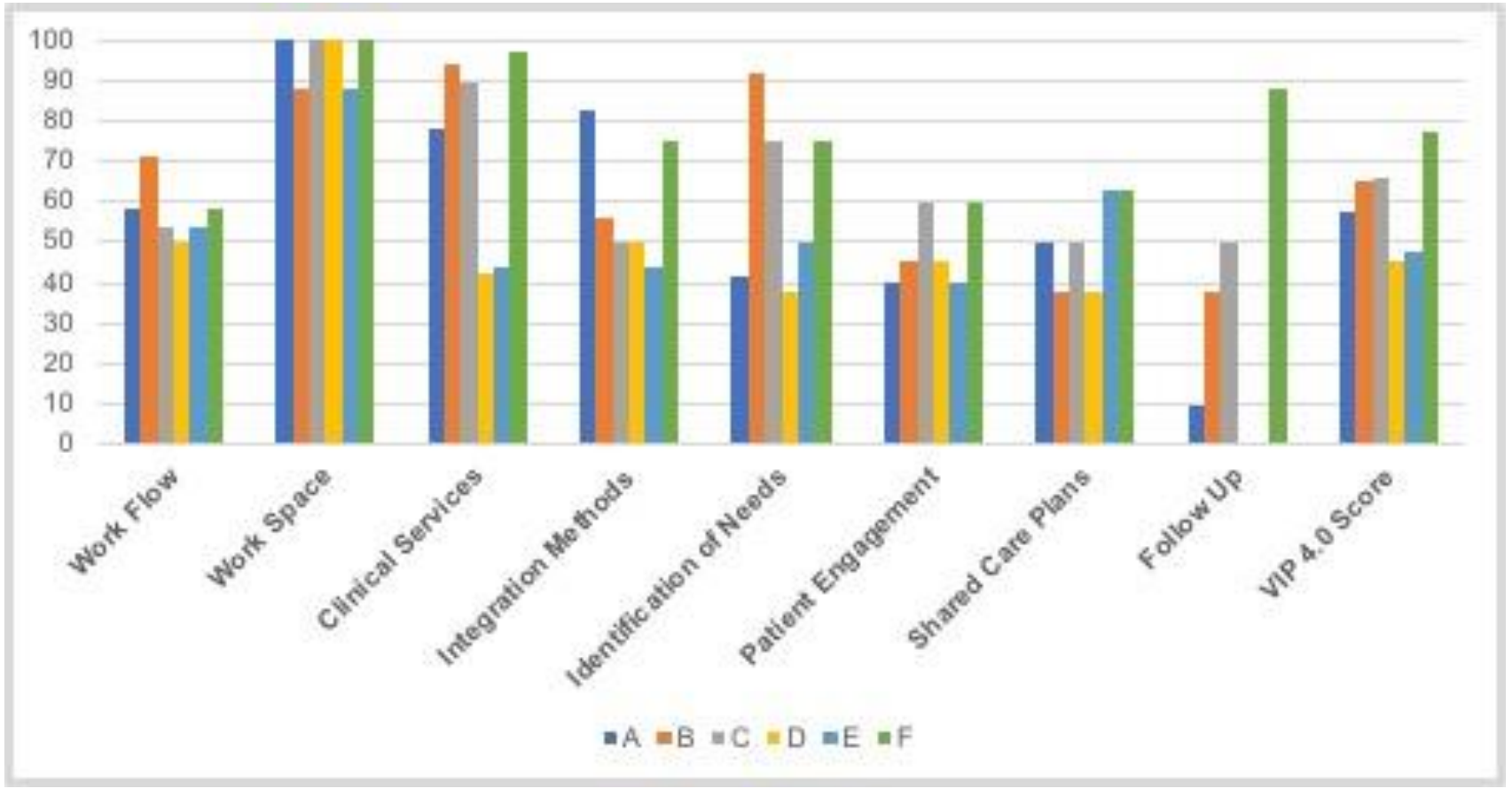
PRIMARY *CARE BEHAVIORAL HEALTH* PROVIDER ADHERENCE QUESTIONNAIRE (PPAQ)

University of Vermont College of Medicine. Practice Integration Profile, PIP. http://www.uvm.edu/~pip/pip.php
Primary Care Behavioral Health Provider Adherence Questionnaire (PPAQ). https://www.mirecc.va.gov/cih-visn2/PPAQ.asp

Practice Integration Profile (PIP)

- Describes Common Dimensions of Collaborative Care
- Compares models on six common dimensions





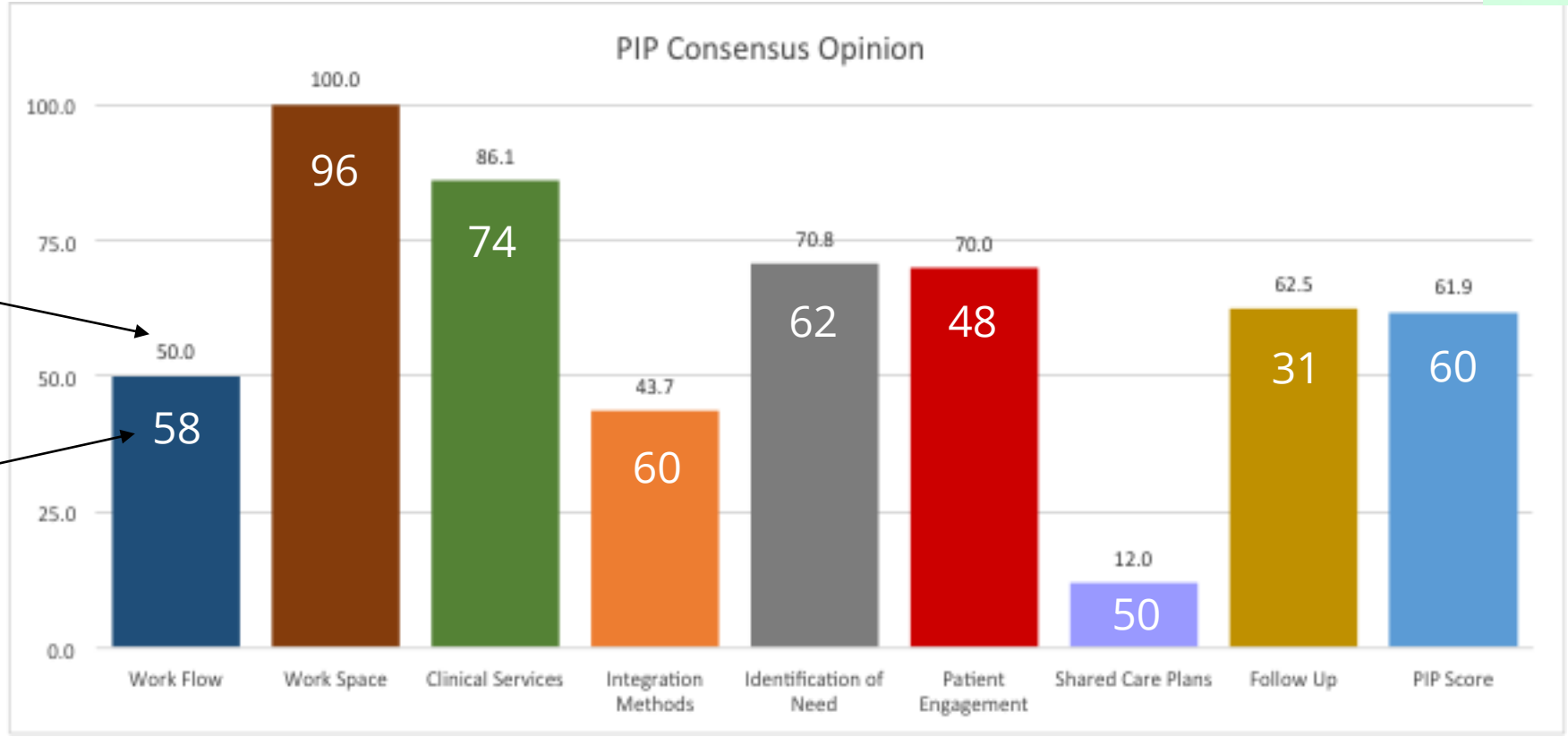
Practice Integration Profile

PIP Consensus Opinion

Practice Integration Profile

Consensus

Avg. individual scores



PPAQ

PPAQ-Essential (PPAQ-E)

- “1. During clinical encounters with patients, I see patients for 30 minutes or less.”

PPAQ-Prohibited (PPAQ-P)

- “28. I provide family or couples therapy for 10 or more appointments per episode of care.”

Primary Care Behavioral Health Provider Adherence Questionnaire (PPAQ). https://www.mirecc.va.gov/cih-visn2/PPAQ.asp

PPAQ-E Score Interpretation

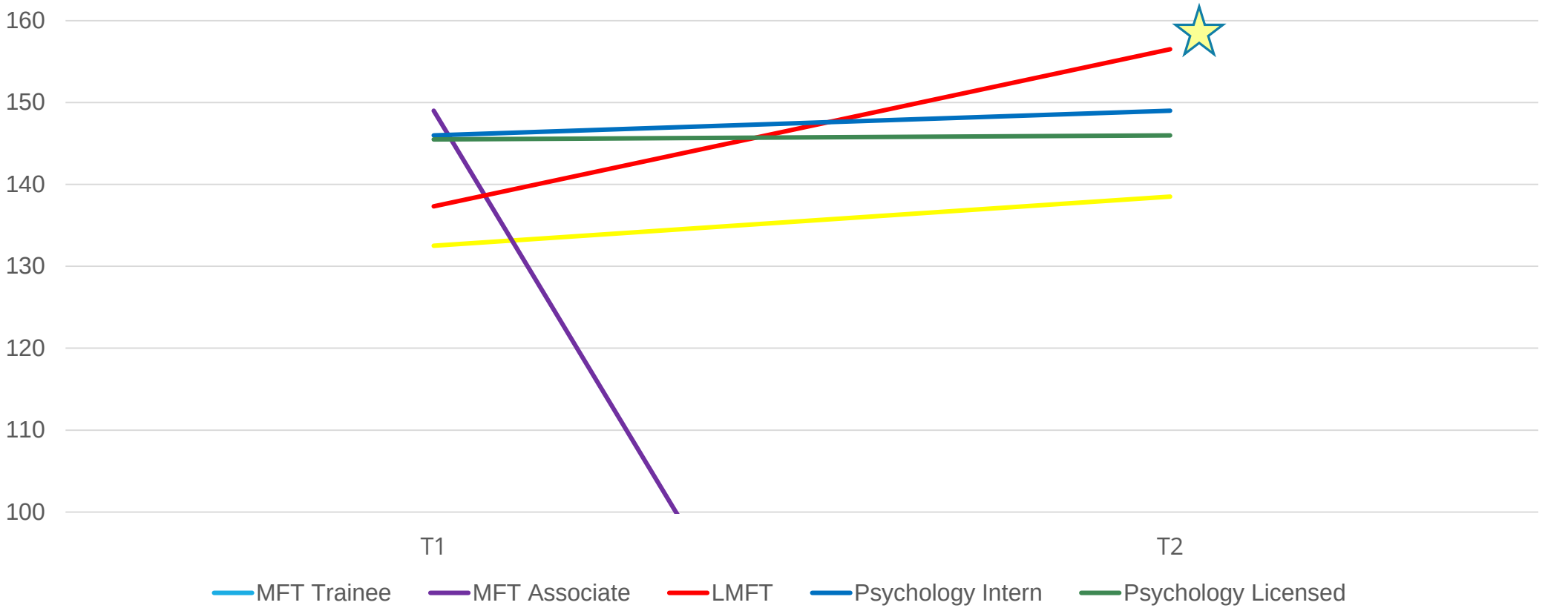
Essential Items Possible Score	Reference	Provider Score	Interpretation
190	Highest Score		Your score is in the **preferred** level of fidelity for essential items. However, even within this range your practices might be improved by modifying any low items noted in Step 4 below.
139	Top third		
			Your score indicates a **moderate** level of fidelity for essential items. Although several of your behaviors are in line with good practices, Step 4 will indicate which specific behaviors could be improved.
114	Midpoint		
88	Bottom third		Your score indicates a **low** level of fidelity for essential items. Although some of your behaviors are in line with good practices, Step 4 will assist in identifying and prioritizing areas for improvement.
38	Lowest score		

PPAQ-E

	Time 1 (November 2017)			Time 2 (June 2018)		
	N (18)	**PPAQ-E[1]**	**Interpretation**	**N (18)**	**PPAQ-E[1]**	**Interpretation**
MFT						
Trainee	7	132.5	Moderate	6	138.5	Moderate
Associate	3	149	Preferred	0	-	-
Licensed	3	137.33	Moderate	2	156.5	Preferred*
Psychologist						
Intern	3	146	Preferred	1	149	Preferred
Licensed	2	145.5	Preferred	3	146	Preferred

1. Score is out of 190. Higher scores indicate ***higher*** fidelity. These are averages and scale is altered. PPAQ-E = PPAQ-Essential.

PPAQ-E


160
150
140
130
120
110
100
T1
T2
MFT Trainee
MFT Associate
LMFT
Psychology Intern
Psychology Licensed

PPAQ-P Score Interpretation

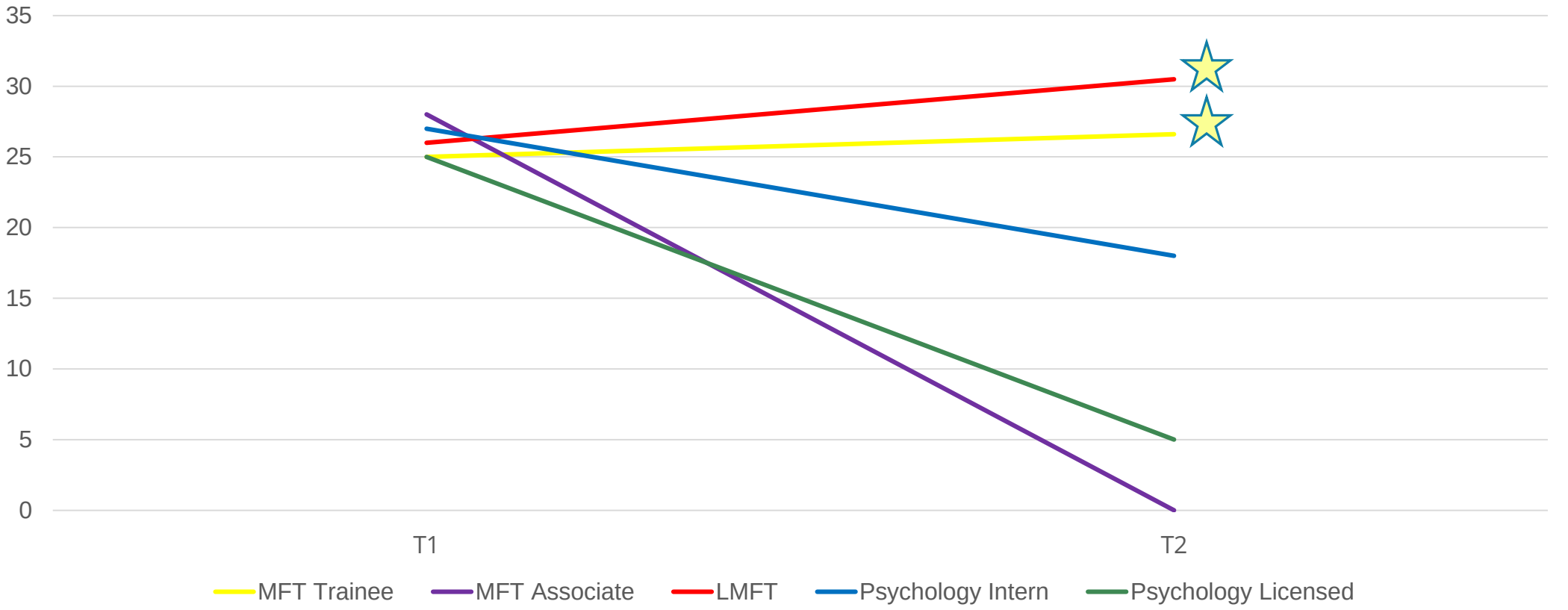
Inconsistent Items Possible Score	Reference	Provider Score	Interpretation
10	Lowest Score		Your score is the **preferred** level of fidelity for these items. However, even within this range your practices might be improved by modifying any areas of suboptimal fidelity noted in Step 4 below.
23	Top third		
			Your score indicates a **moderate** level of fidelity for these items. Although several of your behaviors are in line with good practices, Step 4 will indicate which specific behaviors could be improved.
30	Midpoint		
36	Bottom third		Your score indicates a **low** level of fidelity for these items. Although some of your behaviors are in line with good practices, Step 4 will assist in identifying and prioritizing areas for improvement.
50	Highest score		

PPAQ-P

	Time 1 (November 2017)			Time 2 (June 2018)		
	N (18)	**PPAQ-P[1]**	**Interpretation**	**N (18)**	**PPAQ-P[1]**	**Interpretation**
MFT						
Trainee	7	25	Preferred	6	26.66	Moderate*
Associate	3	28	Preferred	0	-	-
Licensed	3	26	Preferred	2	30.5	Moderate*
Psychologist						
Intern	3	27	Preferred	1	18	Preferred
Licensed	2	25	Preferred	3	5	Preferred

1. Score is out of 50. Higher scores indicate ***lower*** fidelity. These are averages and scale is altered. PPAQ-P = PPAQ-Prohibited.

PPAQ-P


35
30
25
20
15
10
5
0
T1
T2
MFT Trainee
MFT Associate
LMFT
Psychology Intern
Psychology Licensed

11:36

A measure of integration: TCARE

- TCARE (**T**argeted **C**ollaborative **A**ssessment and **R**esponse **E**mpowerment)
- UC San Diego's real-time consultation component
- Patient care data is collected in a flowsheet in the EHR
  - Details of encounter (time spent, who was present)
  - How the encounter was initiated
  - What was the focus of the encounter
  - Who participated in the collaboration
  - What was provided/accomplished during the encounter
  - What is the follow-up plan

TCARE:
Data collection considerations

- Desire to enhance integration (warm handoff) of our program
- The activity is unique enough that it needs its own data collection and management approach
- A research project stimulated a review of the existing data, which illuminated issues in data collection

TCARE Data over time: One example

Count_Referrals_TCARE	Column Labels					
	2016		2017		2018	
Month	Referral	TCARE	Referral	TCARE	Referral	TCARE
Jan	214	25	275	43	339	152
Feb	225	21	287	41	315	98
Mar	234	40	284	32	386	129
Apr	241	46	280	41	340	137
May	262	33	323	26	369	120
Jun	232	46	319	66	351	125
Jul	209	43	307	99	377	192
Aug	269	70	341	68	342	181
Sep	277	94	349	112	331	173
Oct	244	67	397	112		
Nov	251	88	291	86		
Dec	242	43	248	104		
Grand Total	**2,900**	**616**	**3,701**	**830**	**3,150**	**1,307**

Estimated total for all of 2018 = 1743

TCARE: Utilizing the data

- Noticed the data reflected fewer TCARE encounters than expected
  - As a result, enhanced training of BHPs and reinforced that BHPs should use flowsheet consistently
- Noticed there was no way to track how proactive the BHP was in approaching PCPs
  - As a result, developed a procedure to have BHPs complete a flowsheet any time they discussed a patient with another provider, even when no pt contact
  - This required updates to data collection in the flowsheet; ongoing QI to accurately capture these discussions
- As the flowsheet became more utilized, recognized a need for improvement in flowsheet
  - As a result, there is an ongoing effort to modify flowsheet

- With more useful data, can use it to:
  - Improve systems – support BHPs in chart scrubbing and huddling
  - Conduct ongoing research on the utility of TCARE encounters
  - Provide feedback to clinicians (e.g., about the number of encounters, how proactive they are in approaching physicians)
  - Compare productivity across providers, clinics and analyze why some higher or lower performing
  - Identify high performers, look at what are they doing, and provide ongoing training

Measures of Integration: Take-home for audience

- Define/identify your approach to care → identify outcomes → identify measures

- Identify resources within department to partner with to develop systems to input and extract data

Population Health Management

Depression Screening

- USPSTF recommendations and evolving standard of care led to the wish to implementation in 3 Family Medicine clinics

Depression and Alcohol and Drug Use screening

- As a stipulation of the institution receiving funding to care for underserved populations, must show that we are screening and responding to positive screens

Collecting Screening Data

Depression and Alcohol and Drug Use Screening

- Responses to screens exist in flowsheets in EHR
- Use of Registry within EHR and Data Analyst's report
- Data Analyst creates report of screening rates and follow-up by clinic, by physician
- Continuous improvement process to make report/registry more efficient and effective

Data captured in registry report – Clinical Example

- MRN, Physician
- Date and score of initial positive screen as well as last screen date and score
- When last seen and next scheduled with primary care, with behavioral health, with psychiatry
- Whether referred to Behavioral Health, to Psychiatry
- Whether there is documentation in the record of intervention provided
- Psychotropic medications prescribed

Data on Rates of Screening - Operational Example

Visit_Dept	%AUDIT_Completed	%DAST_Completed	%Depr_Screen_Completed	%AUDIT_UpToDate	%DAST_UpToDate	%Depr_Scr_UpToDate
FM	**14%**	**13%**	**36%**	**43%**	**41%**	**78%**
FM	13%	13%	37%	40%	39%	75%
FM	14%	13%	32%	46%	41%	77%
FM	14%	14%	37%	43%	42%	81%
GER	**57%**	**56%**	**34%**	**68%**	**68%**	**68%**
GER	57%	56%	34%	68%	68%	68%
IM	**48%**	**46%**	**64%**	**67%**	**65%**	**84%**
IM	46%	44%	62%	62%	60%	82%
IM	57%	52%	74%	77%	74%	91%
IM	50%	49%	60%	74%	73%	84%

Screening: Utilizing the data (clinically & operationally)

Registry in EHR and Data Analyst's report are used to track positive screens, who is due for re-screen, whether patients are getting appropriate intervention

- We can see whether pt's scores show improvement or remission, and which patients need additional intervention
- Those reviewing the registry can provide feedback to physicians and BHP to ensure intervention occurs after positive screen
- This can help identify areas where re-training is necessary

Reports of screenings completed by clinic, by provider

- Based on this data, leadership can provide feedback to clinic leadership, physicians, and staff regarding their performance
- Identify what's working and what's not, improve existing processes, and provide ongoing training

Population Health: Take-home for audience

To create your own data collection and management strategies

- Ensure that you have relevant structured data built into your EHR
- Relationship with EHR folks and data analyst
- Include data related to:
  - Screening results, including whether patient endorsed critical items
    - Changes to scores over time, including whether they have reached remission
  - Recent and planned contact with PCP
  - Whether the patient was referred to, seen by, follow-up planned with Behavioral Health and Psychiatry
  - Psychotropic medications prescribed
  - Whether there is indication in the EHR of intervention provided (e.g., did physician address the positive screen, did the BHP provide an intervention)

11:46

Program Financials: Three levels

- Overall structure
  - Students, interns, licensed (various billing capabilities)
  - Psychotherapy and H & B codes
  - Other funding/support/expenses (PRIME, shared admin/space)
- Individual level (**Sieber**)
  - Individual Profit Loss
- Program components (e.g., T-CARE) (**Black**)
- Overall Program level (**Kallenberg**)
  - Annual budget approved by system leadership
  - Resources needed: additional analyst time, referral/authorization staff

    Separate or integrated financially with primary care budget

Individual profit and loss

(paid staff only)

Month	# visits	$ Billed	$ received	Reimbursement rate	Total RVUs	Salary	Benefit rate	OH/Admin	cFTE	cFTE cost	Total FTE	Total Cost	P/L
4/2018	50	16,773	7,556	45%	150	39.52	1.37	1.1	0.70	7254	0.80	8,290	-734
5/2018	49	15,246	7,293	48%	136	39.52	1.37	1.1	0.70	7254	0.80	8,290	-997
6/2018	33	11,477	4,737	41%	104	39.52	1.37	1.1	0.70	7254	0.80	8,290	-3,553
7/2018	37	11,993	5,756	48%	107	39.52	1.37	1.1	0.70	7254	0.80	8,290	-2,534
8/2018	51	16,666	7,913	47%	149	39.52	1.37	1.1	0.70	7254	0.80	8,290	-378

Financial: Individual
Future plans

- Individualize benefit rate (improve accuracy of individual's cost)
- Pro-rate annual RVU expectation to cFTE
- Distribute reports to individuals more frequently

11:48

How can the practice be more fiscally successful?

- Team Base
  - Different professional levels w/ different costs: Students, interns, licensed
  - Students offering T-CARE is affordable, yet paid staff is questionable

- Cost of T-care coverage
  - 7 clinics
  - Full coverage (1 FTE) for BHP
  - Assumes $35/hr. (salary & benefits)
  - Per year cost = $ 509,600 (Q: how minimize that cost?)

Financial: Program component: Billing Pilot

Staff

- 1 psychologist and 1 MFT (billing under supervisor) for T-CARE

Barriers

- Available Codes
- Operational and EHR
- Financial/Reimbursement

QI reports

- What factors appear to affect reimbursement?
- Operational changes made in response to data/reports

Financial: Program component: Billing Choices

- Codes available
  - Psychotherapy codes
  - H & B codes
  - CoCM / PCCM codes
  - Psycho-education
  - Preventive services codes
    - Screening (depression, drug, alcohol, etc.)
    - Brief counseling (alcohol, drugs, smoking, cardiovascular disease, obesity, etc.)

Financial: Program component: Operational Barriers

Clinic flow

- CoCM / PCCM codes
  - Requires a shift in our system, such as needing psychiatrist on call to consult.

Psychotherapy codes

- Requires co-payment

Pre-authorization of codes

- Staffing needed for timely pre-authorization

Where to drop the codes

- E/M
  - Preventative and screening codes
- Charge capture
  - H & B codes
- LOS
  - Psychotherapy codes

Correct attribution of funds

- Collaborative Care vs. Primary Care

Financial: Program component: Specific Code and Insurance Barriers

Code restrictions

- Usage limits (e.g., annual)
- Diagnosis driven

Pre-Authorization trends

- H2027
- 96150 vs. 96152

Restrictions for type of clinician

- Student
- Intern (MFTi vs. Psychology)
- Licensed (Psych vs. LCSW vs. MFT)

Specific insurance limitations

- Specific contracts (CHG)
- No/low reimbursement

Clinical care is priority over 100% reimbursement

11:55

Financial: Overall Program

- Annual budget approved by clinical system leadership
  - Encounter-Charge-Payment-RVU Summary
  - Reports now generated by Billing and other departments who “own” them
  - Resources needed: additional analyst time, referral/authorization staff
  - Separate or integrated financially with overall primary care budget (but with continued accountability!)

How gained institutional credibility with leadership:

- Duration of experience (16+ years)
- Achievement of budget neutrality
- Assistance with reaching institutional PRIME goal of integrating BH into PC
- Market advantage – especially in new PC Network

UC San Diego Health	Clinical Practice Organization (CPO) -- Collaborative Care							
FY18 YTD thru Nov. - 1/5/2018								
	YTD BUDGET	COLLAB LA JOLLA INT MED	COLLAB LEWIS	COLLAB SCRIPPS RANCH	COLLAB GENESEE	OUTPATIENT	TOTAL	VAR($)
STATS								
Visits	-	593	1,362	802	1,174	597	4,528	4,528
wRVUs	6,475	948	2,370	1,489	1,493	845	7,145	670
REVENUE								
Gross Charges	712,307	124,810	329,926	202,594	213,363	88,721	959,414	247,107
Less: Deductions	321,777	52,935	155,357	98,908	87,914	55,902	451,016	(129,239)
Net FFS Revenue	**390,530**	**71,875**	**174,569**	**103,686**	**125,449**	**32,819**	**508,398**	**376,346**
Capitated Revenue	39,370	924	3,588	702	101	2,198	7,513	(31,857)
Other Operating Revenue	36,219	-	-	-	-	54,065	54,065	17,845
Total Operating Revenue	**466,120**	**72,798**	**178,157**	**104,388**	**125,550**	**89,082**	**569,975**	**103,856**
EXPENSES								
Total Personnel	**445,336**	**-**	**-**	**-**	**-**	**410,309**	**410,309**	**35,027**
Total Non-Personnel Expenses	**65,523**	**4,356**	**10,693**	**6,263**	**7,536**	**17,454**	**46,302**	**19,221**
Total Expenses	**510,859**	**4,356**	**10,693**	**6,263**	**7,536**	**427,763**	**456,611**	**54,248**
Gain/(Loss) from Operations	**(44,739)**	**68,443**	**167,464**	**98,125**	**118,014**	**(338,681)**	**113,364**	**158,103**
Adjusted Gain/(Loss)	**(44,739)**	**68,443**	**167,464**	**98,125**	**118,014**	**(338,681)**	**113,364**	**158,103**

Summary by Financial Class and Payor (Jul 2015 - Apr 2018)

Financial Class	payor_name	Sum_Charges	Sum_Payments
Commercial		**1,186,587**	**-436,909**
	AETNA	60,562	-24,769
	BLUE CROSS	328,931	-201,727
	BLUE SHIELD	56,261	-23,189
	CARE FIRST HEALTH PLAN	1,617	-16
	CIGNA	18,599	-10,215
Medicaid - California		**32,180**	**-897**
	MEDI-CAL	32,180	-897
Medicare		**142,124**	**-43,836**
	MEDICARE	142,124	-43,836
Other Government		**53,742**	**-12,748**
	TRICARE	53,742	-12,748
Self-pay		**104,005**	**-40,138**
Workers Compensation		**663**	**-487**
	SEDGWICK	277	-152
	WORKERS COMPENSATION	386	-334
County Medical Services		**554**	**0**
	SAN DIEGO COUNTY	554	0
Grand Total		**1,519,855**	**-535,015**

Summary by Provider Type (Jul 2015 - Apr 2018)

Provider	Sum_Charges	Sum_Payments	%Payment
Licensed Providers	**1,083,720**	**-378,292**	**-35%**
	140,626	-60,609	-43%
	50,239	-17,115	-34%
	30,215	-7,784	-26%
	24,721	-9,745	-39%
	193,540	-72,039	-37%
	89,278	-20,445	-23%
	10,442	-3,178	-30%
	152,398	-57,129	-37%
	112,782	-47,249	-42%
	51,408	-20,091	-39%
	106,001	-20,551	-19%
	94,017	-31,862	-34%
	28,053	-10,494	-37%
Paid Interns	**247,186**	**-77,560**	**-31%**
	39,308	-10,775	-27%
	76,764	-20,752	-27%
	29,799	-12,254	-41%
	12,069	-5,156	-43%
	2,386	-579	-24%
	63,794	-20,084	-31%
	23,066	-7,962	-35%
Trainees	**188,949**	**-79,163**	**-42%**
	65,674	-10,563	-16%
	3,982	-3,649	-92%
	5,377	-4,123	-77%
	8,164	-6,980	-85%
	5,855	-4,411	-75%
	5,657	-5,095	-90%
	4,410	-3,565	-81%
	3,525	-3,210	-91%
	42,186	-13,093	-31%
	32,652	-14,306	-44%
	4,347	-3,818	-88%
	515	0	0%
	3,960	-3,805	-96%
	2,645	-2,545	-96%
Grand Total	**1,519,855**	**535,015**	**-36%**

Conclusions

Lessons Learned:

- Helpful that we had team-based creation of the variables collected clinically and reported
- Investment in an IT/Analyst for data extraction and reporting is key
- We have spent more time on collecting data than acting on it; we need to create time/ structure to review the data regularly and then give formative feedback at all levels
- This QI process requires a certain amount of dedicated administrative time; need quicker ways to study & act on data
- Future improvements planned: patient satisfaction, PROMIS-10, GAD-2, PTSD, ACEs, processes to better use reports, better use of reports by Operations committee

Our process and our lessons learned: helpful to you?

Questions???

CFHA COLLABORATIVE FAMILY HEALTHCARE ASSOCIATION

Session Evaluation

Use the CFHA mobile app to complete the evaluation for this session.

Thank you!

CFHA COLLABORATIVE FAMILY HEALTHCARE ASSOCIATION