California Institute for Mental Health

SMALL COUNTY PATIENT REGISTRY WORKSHOP
March 5, 2012
3:30pm

AGENDA

<table>
<thead>
<tr>
<th>Time</th>
<th>Agenda Item</th>
<th>Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>3:30-3:35</td>
<td>Welcome and Introductions</td>
<td>Jennifer Clancy, CiMH</td>
</tr>
<tr>
<td>3:35-4:00</td>
<td>Overview of Registry</td>
<td>Jerry Langley, Associates in Process Improvement</td>
</tr>
<tr>
<td>4:00-4:20</td>
<td>Overview of SCCI Measures</td>
<td>Jerry Langley, Associates in Process Improvement</td>
</tr>
<tr>
<td>4:20-4:50</td>
<td>Entering SCCI Measures into the Registry</td>
<td>Jerry Langley, Associates in Process Improvement</td>
</tr>
<tr>
<td>4:50-5:00</td>
<td>Wrap-up and Next Steps</td>
<td>Jennifer Clancy, CiMH</td>
</tr>
</tbody>
</table>
Welcome and Introductions

Using a registry to improve client services and care

Clinical Information Systems

Organize client and population data to facilitate efficient and effective care

- Identify relevant subpopulations for proactive care
- Monitor performance of practice team and care system
- Facilitate individual client care planning
- Use data at the point of care
- Provide timely automated reminders for providers and clients
- Share information with clients and providers to coordinate care
Registries

Organize client and population data to facilitate efficient and effective care

- Identify relevant subpopulations for proactive care
- Monitor performance of practice team and care system
- Facilitate individual client care planning
- Use data at the point of care
- Provide timely automated reminders for providers and clients
- Share information with clients and providers to coordinate care

Principles for Using Data to Improve Care
Principles for Using Data to Improve Care

1. Whole Client Planned Care
2. Population-Based Planned Care

1. Use the registry to “see” the whole clients, not just one aspect or just today’s issue. Treat and provide services to the whole client.
2. Build lists of clients who are receiving proper care and services and lists of those who are not. Use these lists to get the proper care to those who need it.
Whole Client (Planned) Care

The data present a complete picture of the health status of the whole client, including evidence-based prompts and reminders.

• Summary of pertinent client data for planning care (on a single page)
• Evidence-based prompts and reminders
• Support for care across all conditions and health issues
• Ability to display client data over time with annotations
• Support materials for client (with client’s data)

At the Client/Client/Care Team Interface

• Pertinent data are gathered and organized in a condensed, user-friendly format (Encounter Note).
• Able to enter new data on the Encounter Note.
• Evidence-based guidelines impose content and layout of Encounter Note (e.g. use of color for reminders).
• Data customized documents for the client/client
• Full histories of client/client data (e.g. cancer screening, labs, action plans, etc.) available to care team.
Types of Data for Encounter Note

- Demographics
- Vitals
- Conditions
- Medicines
- Lab results
- Other Diagnostic Tests
- Vaccinations
- Risk Factors
- Other Measures
- Consults and Education (and referrals)
- Notes
### Population-Based Planned Care

- **Goal:** Maximize the health outcomes of a defined population (all clients for one clinic, a provider panel, clients at risk)
  - Efforts are made to assure that all relevant members of a population receive needed services
  - Use information systems, planning, and outreach
Proactive Care Between Encounters

• Care team has access to easy to use (and create) queries that produce lists of client/clients who meet certain criteria, along with display of data.
• Criteria for queries should be flexible enough to ask any question and easy enough for anyone on the care team to use.
• Summary reports on key quality measures (for any sub-group of client/clients) produced regularly.

More on Proactive Care (Using Reports)

• Client/Clients not meeting evidence-based standard goals (on Depakote/Tegretol should have blood draw to manage therapeutic level within 7 to 10 days)
• Client/Clients needing specific care (Metabolic Syndrome protocol for those on 2nd generation antipsychotics)
• Feedback on results (Which clients are not making progress on individual objectives within 3 months? – Or stages of change?)
### Depression Registry Summary Report

**Clinic:** Bishoptown Peoples Clinic  
**From:** 3/6/2011  
**To:** 3/5/2012

#### DEMOGRAPHICS

<table>
<thead>
<tr>
<th>Variable</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total registry &amp; Avg</td>
<td>364</td>
</tr>
<tr>
<td>Pri &amp; Vis visits</td>
<td>714</td>
</tr>
<tr>
<td>Pri &amp; 1 visit</td>
<td>87</td>
</tr>
<tr>
<td>Pri &amp; 2 visits</td>
<td>144</td>
</tr>
<tr>
<td>Pri &amp; 3 visits</td>
<td>6</td>
</tr>
<tr>
<td>Pri &amp; 4 visits</td>
<td>6</td>
</tr>
<tr>
<td>Pri &amp; 5 visits</td>
<td>0</td>
</tr>
</tbody>
</table>

#### VISIT INFO

**Encounter Type**

- Office: 184 (33.7%)
- Planned Office: 0 (0.0%)
- Acute Office: 0 (0.0%)
- Acute: 1 (0.2%)
- ER: 0 (0.0%)
- Walk-in: 0 (0.0%)
- Others: 69 (12.4%)

**Medications**

- SSRI: 15 (2.6%)
- SNRI: 12 (2.1%)
- TCAs: 16 (2.9%)
- Mood Stabilizer: 15 (2.6%)
- Lithium: 15 (2.6%)
- Other Antidepressants: 13 (2.3%)
- Antipsychotics: 12 (2.1%)
- Benzodiazepines: 5 (0.9%)
- Anxiolytics: 4 (0.7%)
- Other: 9 (1.6%)

**Health Profile**

- Blood Alcohol: 115 (20.2%)
- Tobacco Use: 115 (20.2%)
- Drugs: 21 (3.6%)
- Chronic Pain: 115 (20.2%)
- Depression: 0 (0.0%)
- Social Anxiety: 0 (0.0%)
- ARMS: 1 (0.2%)
- Physical Abuse: 1 (0.2%)
- Tobacco Use: 1 (0.2%)
- Exercise: 115 (20.2%)
- Other: 15 (2.6%)

#### PHO/LAB DATA

**New Episode PHQ (current time frame)**

- < 10: 76 (23.4%)
- 10 - 15: 23 (7.6%)
- 16 - 20: 24 (7.7%)
- > 20: 11 (3.6%)

**Current PHQ for CED Pres**

- < 10: 38 (11.9%)
- 10 - 15: 28 (9.3%)
- 16 - 20: 36 (11.9%)
- > 20: 14 (4.6%)

**New Episode PHQ (12 months)**

- < 10: 114 (34.1%)
- 10 - 15: 101 (31.8%)
- 16 - 20: 60 (18.7%)
- > 20: 14 (4.6%)

**CDD = clinically significant depression**

1. **Afternoon Fatigue**
2. **Depression**
3. **Loss of Interest**
4. **Sleeping disturbance**
5. **Other**
6. **Unspecified**

#### 8. Insurance

- Medicare: 359 (98.6%)
- Private: 4 (1.1%)
- Medicaid: 1 (0.3%)

#### 9. Type of Depression

- MDD: 43 (12.2%)
- ARMS: 39 (11.3%)
- Other: 4 (1.2%)

#### 10. Function Improvement (PHQ 12)

- < 4: 115 (34.1%)
- 4 - 9: 115 (34.1%)
- 10 - 15: 115 (34.1%)
- > 15: 115 (34.1%)

#### 11. Follow-up

- CED: 13 (46.4%)
- No CED: 14 (46.4%)
- Other: 4 (13.8%)

#### 12. NIMH Survey

- NIMH: 13 (46.4%)
- Medical: 13 (46.4%)
- Other: 4 (13.8%)

#### 13. PHQ-8 and PHQ-10 (6-month recall)

- PHQ-8: 13 (46.4%)
- PHQ-10: 13 (46.4%)
- Other: 4 (13.8%)

#### 14. PHQ-15 and PHQ-15 (6-month recall)

- PHQ-15: 13 (46.4%)
- PHQ-15: 13 (46.4%)
- Other: 4 (13.8%)

#### 15. PHQ-18 and PHQ-18 (6-month recall)

- PHQ-18: 13 (46.4%)
- PHQ-18: 13 (46.4%)
- Other: 4 (13.8%)

#### 16. PHQ-21 and PHQ-21 (6-month recall)

- PHQ-21: 13 (46.4%)
- PHQ-21: 13 (46.4%)
- Other: 4 (13.8%)

#### 17. PHQ-21 and PHQ-21 (6-month recall)

- PHQ-21: 13 (46.4%)
- PHQ-21: 13 (46.4%)
- Other: 4 (13.8%)

#### 18. PHQ-21 and PHQ-21 (6-month recall)

- PHQ-21: 13 (46.4%)
- PHQ-21: 13 (46.4%)
- Other: 4 (13.8%)

#### 19. PHQ-21 and PHQ-21 (6-month recall)

- PHQ-21: 13 (46.4%)
- PHQ-21: 13 (46.4%)
- Other: 4 (13.8%)

#### 20. PHQ-21 and PHQ-21 (6-month recall)

- PHQ-21: 13 (46.4%)
- PHQ-21: 13 (46.4%)
- Other: 4 (13.8%)

### Additional Information

- CDD = clinically significant depression
### 1980 Tobacco Sales Data

<table>
<thead>
<tr>
<th>Date</th>
<th>Address</th>
<th>Name</th>
<th>Age</th>
<th>Sex</th>
<th>Race</th>
<th>State</th>
<th>F1</th>
<th>F2</th>
<th>F3</th>
<th>F4</th>
<th>F5</th>
<th>F6</th>
<th>F7</th>
<th>F8</th>
<th>F9</th>
<th>F10</th>
<th>F11</th>
<th>F12</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/5/2012</td>
<td>123 Main St</td>
<td>John Doe</td>
<td>25</td>
<td>M</td>
<td>White</td>
<td>CA</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
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<td>0</td>
<td>0</td>
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</table>

### 1980 Tobacco Sales Data

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</tbody>
</table>
Depression 17. PHQ Change (New Episode - Most Recent) d. >= 50% (CSD) (ever)

Count: of those Depression pts, with a decrease in PHQ scores (New Episode - Current / New Episode)*100, how many had a fifty percent or greater decrease and whose last New Episode PHQ was 10 or greater [CSD] (only for those Depression pts with their last NE PHQ and Current PHQ within the report time frame)

Percentage: Depression pts with CSD, with a fifty percent or greater decrease in PHQ scores ((New Episode - Current) / New Episode)*100 within the report time frame / All active CSD Depression pts
Depression Registry Summary Report

List CSD Patients
List Dep Pts with no Psychotherapy Last xx+ Days
List Depression Pts no Current PHQ Last xx Days
List Depression Pts no New Episode PHQ in Days
List Depression Pts no SM Goal Set Last xx Days
List Depression Pts no Visit Last xx Days
List Depression Pts on Antipsychotic Meds
List Depression Pts on Antipsychotic Meds - No Stats
List Depression Pts on Antipsychotic Meds - No Stats - Indexed
List Depression Pts on Benzo Meds
List Depression Pts on Mood Stabilizer Meds
List Depression Pts on Other Antidepressant Meds
List Depression Pts on SSRI Meds
List Depression Pts on Tricyclic Meds
List Depression Pts Visit Due Next xx Days
List Depression Pts with PHQ Last xx Days
List Patients with Depression

Category: Depression
Registry Reports

- Aggregates an enormous amount of client/client care-related data for specific groups of client/clients over a defined time period
- Like a comprehensive chart review/report card for individual providers or groups of providers on rates of different process and outcome measures
- To monitor and evaluate care and outcomes regularly

Uses of the Registry Reports

- To track measures over time – alert to undesirable trends as well as improvements.
- To evaluate measures after changes/interventions aimed at improvement have been implemented.
- Having multiple pieces of data and measures together in one place enhances awareness of and insight into associations.
- Condensed summary data can act as a powerful motivator for improvement.
- Reports can identify “outliers” within a practice group in terms of rates of different measures.
What Can you Do?

• Registry or Clinical Information System
• If you work in a system with an EMR, test the system against the principles:
  ─ Can it produce a single flow sheet or Encounter Note?
  ─ Can it easily produce queries you want?
  ─ Can it produce summary report with statistics?
• If you have nothing electronic:
  ─ Use principles to evaluate any data system acquisitions
  ─ Start with collecting data in an Excel file or Access DB or a public domain registry (DEMS, HEMS, CVDEMS, CERF, etc.) to gain experience and knowledge
  ─ Take advantage of improvement projects that supply a registry.

Common Issues in Effective Use of a Registry

• Lack of onsite available computer expertise
• Inability to use other databases to generate Registry functionality or download into a Registry (Lab, Radiology, Financial, other facilities data)
• Integrating the use of the Registry into daily practice
• Lack of consistency between providers and Data entry/coders
• Time – data entry, monthly review
• Lack of perceived value added
Let’s explore the use of the registry to track SCCI measures

<table>
<thead>
<tr>
<th>SCCI Core Measures</th>
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<tbody>
<tr>
<td>1. Number of open clients in target population</td>
</tr>
<tr>
<td>2. Percentage of clients with designated PCP</td>
</tr>
<tr>
<td>3. Percentage of clients who have had a primary care visit within the last 12 months</td>
</tr>
<tr>
<td>4. Percentage of clients with a current ROI on file</td>
</tr>
<tr>
<td>5. Percentage of clients for which a direct consultation between MH and PC has occurred</td>
</tr>
<tr>
<td>6. Percentage of clients with BP and BMI documented in MH records the past 6 months</td>
</tr>
<tr>
<td>7. Percentage of clients that are on a second generation antipsychotic who have had their A1c or fasting glucose screened in the past 3 months</td>
</tr>
<tr>
<td>8. Rate of clients with one or more visits to ER/hospital/urgent care during the month</td>
</tr>
<tr>
<td>9. Client Satisfaction</td>
</tr>
<tr>
<td>10. Client Wellness</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diabetes - SCCI Topic Specific Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Percentage of clients with diabetes who have appropriate labs taken within the last 4 months and documented in mental health records</td>
</tr>
<tr>
<td>12. Percentage of clients with diabetes who perform regular blood glucose testing (documented in mental health records)</td>
</tr>
<tr>
<td>13. Percentage of clients with diabetes whose A1C is above 9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Blood Pressure - SCCI Topic Specific Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>14. Percentage of clients who have a documented blood pressure reading of less than 140/90 in their mental health record</td>
</tr>
</tbody>
</table>
Smoking Status and Intervention - SCCI Topic Specific Measure
15. Percentage of clients who use tobacco
16. Percentage of clients who use tobacco who have been counseled to quit

Exercise - SCCI Topic Specific Measure
17. Average number of times that clients exercise per week

Cardiovascular - SCCI Topic Specific Measure
18. Percentage of clients with cardiovascular disease who have appropriate labs taken within the last 6 months and documented in mental health records

Asthma - SCCI Topic Specific Measure
19. Percentage of clients with asthma who had a severity assessment at their last visit documented in mental health records
20. Percentage of clients with persistent asthma who are on anti-inflammatory medication, documented in mental health records

Weight (BMI) - SCCI Topic Specific Measure
21. Percentage of obese clients in the target population
22. Percentage of obese clients who are actively engaged in weight loss

<table>
<thead>
<tr>
<th>Name</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Data Collection Plan</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Number of open clients in target population</td>
<td>Count the total number of clients in the target population</td>
<td>NA</td>
<td>On the last day of the month count the total number of clients in the target population</td>
</tr>
<tr>
<td>2.</td>
<td>Percentage of clients with designated PCP</td>
<td>Number of clients in the target population who have a known primary care provider documented in their medical record</td>
<td>Number of clients in the target population</td>
<td>On the last day of the month count the total number of clients who have a known primary care provider documented in their medical record and divide this number by the count of clients in the target population (multiply by 100 to get a percentage)</td>
</tr>
<tr>
<td>3.</td>
<td>Percentage of clients who have had a primary care visit within the last 12 months</td>
<td>Number of clients in the target population who have had a primary care visit within the last 12 months</td>
<td>Number of clients in the target population</td>
<td>On the last day of the month count the total number of clients who have had a primary care visit within the last 12 months and divide this number by the count of clients in the target population (multiply by 100 to get a percentage)</td>
</tr>
<tr>
<td>4.</td>
<td>Percentage of clients with a current ROI on file</td>
<td>Number of clients in the target population who have a current ROI on file in the mental health record</td>
<td>Number of clients in the target population</td>
<td>On the last day of the month count the total number of clients who have a current ROI on file in mental health record and divide this number by the count of clients in the target population (multiply by 100 to get a percentage)</td>
</tr>
<tr>
<td>5.</td>
<td>Percentage of clients for which a direct consultation between MH and PC has occurred</td>
<td>Number of clients for whom there was a direct contact occurred during the month between mental health services staff and a primary care provider</td>
<td>Number of clients in the target population</td>
<td>On the last day of the month, count the number of clients for whom there was a direct contact occurred during the month between mental health services staff and a primary care provider and divide this number by the count of clients in the target population (multiply by 100 to get a percentage) (As a Direct Consultation is a direct communication between a mental health professional and a primary care professional through in-person meeting, phone, or email - documented in the client’s chart)</td>
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</table>