CALIFORNIA ASSOCIATION of PUBLIC HOSPITALS AND HEALTH SYSTEMS

CALIFORNIA HEALTH CARE SAFETY NET INSTITUTE

Care Delivery Workshop

Better Screening for Improved Health

Thursday, May 2, 2019
Oakland, CA

Breakfast, Networking & Registration

8:30—9:00

2

Welcome, Why We're Here & Introductions

Care Delivery Workshop
Better Screening for Improved Health

Giovanna Giuliani, Executive Director
Safety Net Institute

Hunter Gatewood, Signal Key Consulting

3

Why focus on screening?

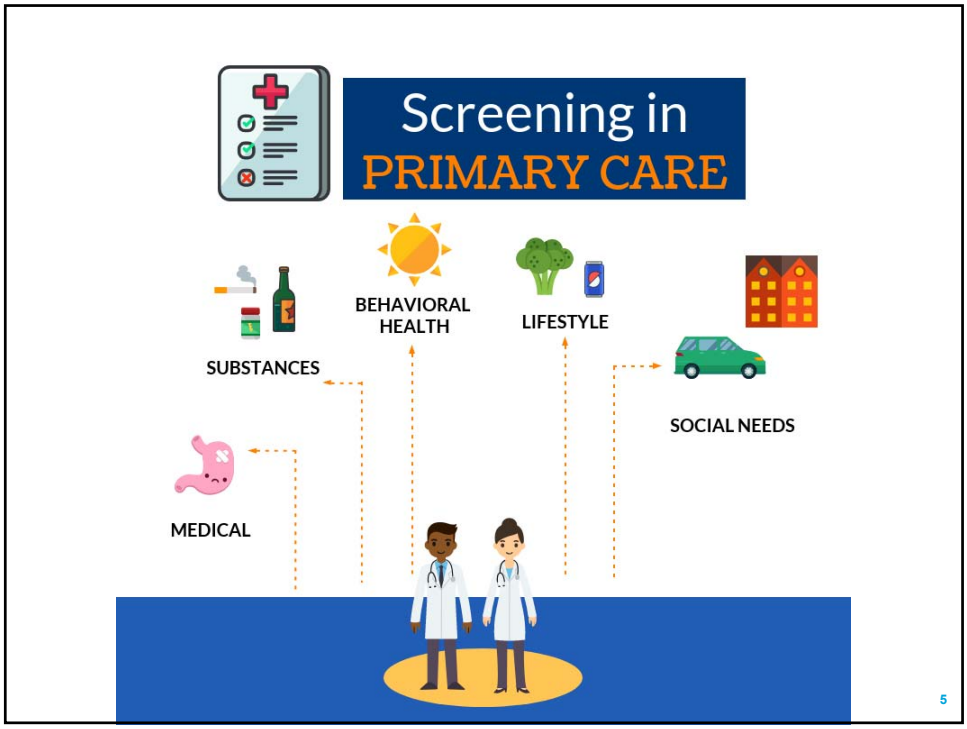
~20% % of PRIME & QIP measures related to screening and follow up

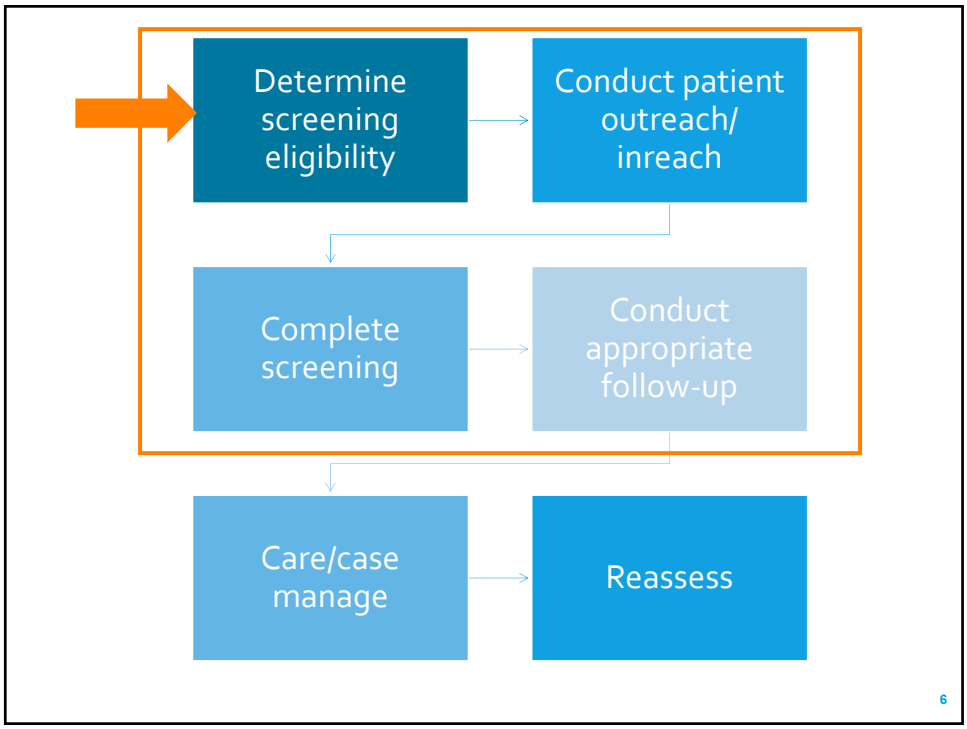
7.4 Hours in a primary care provider's work day needed to fully satisfy national recommendations for the provision of preventive services *

26 Possible social needs screening domains **

*Am J Public Health. 2003 Apr;93(4):635-41. Primary care: is there enough time for prevention?
** Domains on SIREN UCSF screening tool comparison

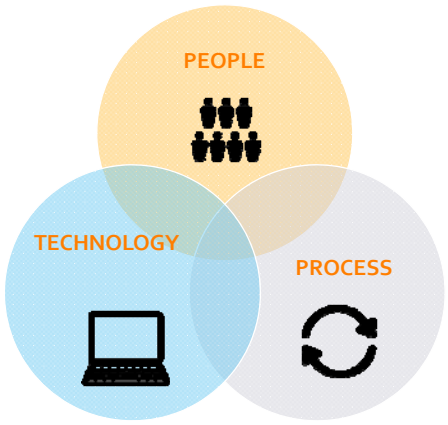
4


Screening in
PRIMARY CARE
BEHAVIORAL HEALTH
LIFESTYLE
SUBSTANCES
SOCIAL NEEDS
MEDICAL
5


Determine screening eligibility
Conduct patient outreach/ inreach
Complete screening
Conduct appropriate follow-up
Care/case manage
Reassess
6

How are care teams trained and engaged to improve care?

How can we address provider and staff burnout?

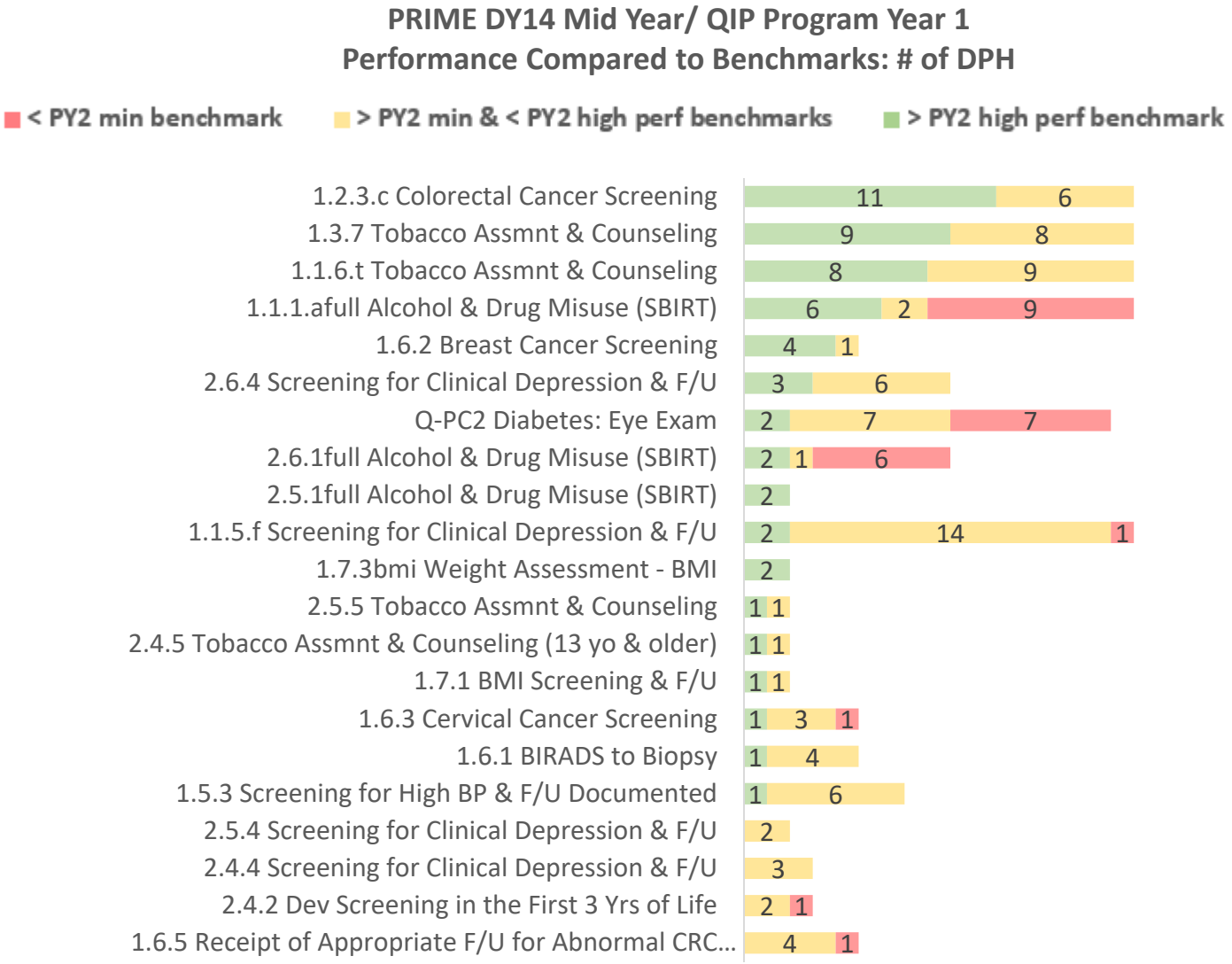


How can technology improve screening?

What are recommended roles and workflows to successfully collect screening data and follow up?

7

How is our progress in screening?

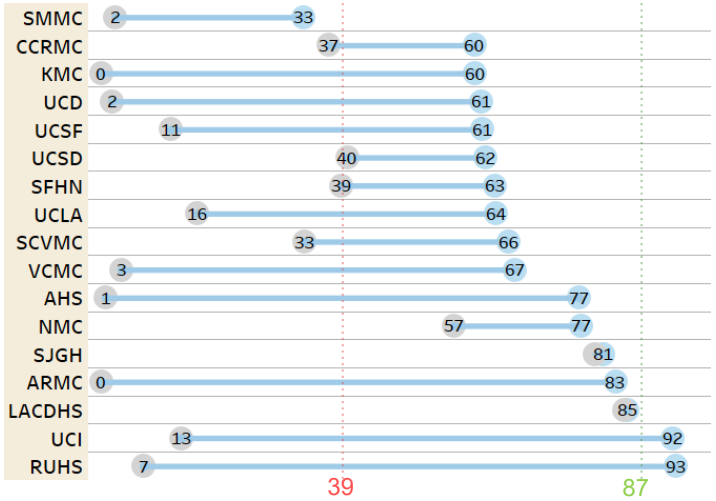


DPH with denominator <30 are excluded from the count for that measure. DY14MY data not yet approved by DHCS.

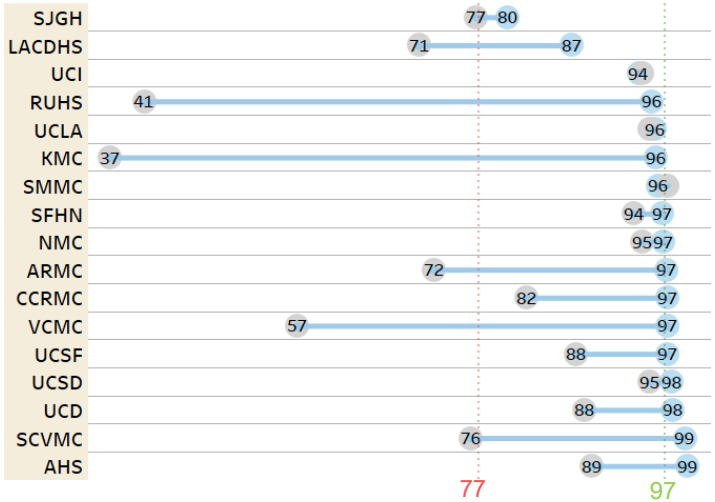
Progress in PRIME: DY11 → DY14 MY

DY11 rate | DY14 MY rate | DY14 min. benchmark | DY14 high perf. benchmark

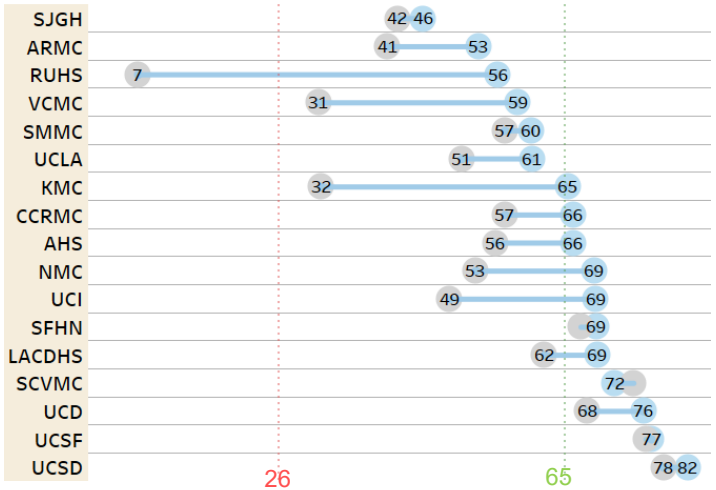
Screening for Depression & Follow-Up



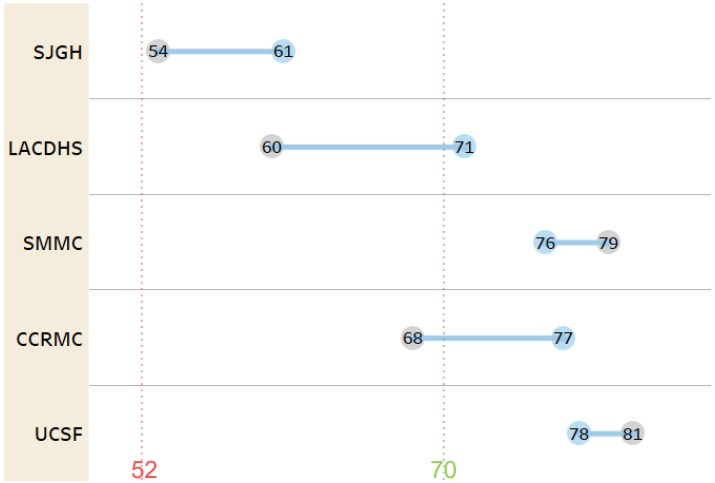
Tobacco Assessment & Counseling



Colorectal Cancer Screening



Breast Cancer Screening



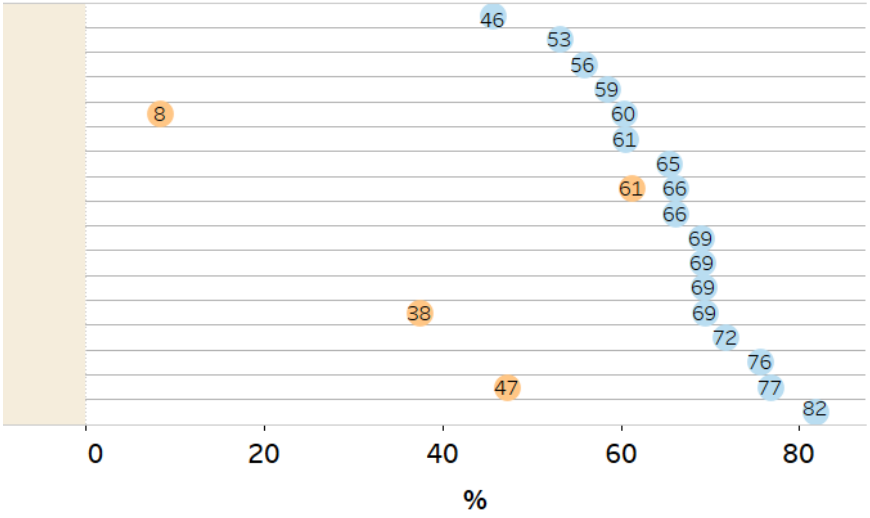
DPH with denominator <30 are excluded. DY14MY data not yet approved by DHCS.

How is our progress in follow up care?

DY14MY Follow-Up Action Rate DY14 MY Screening Rate

Colorectal Cancer:

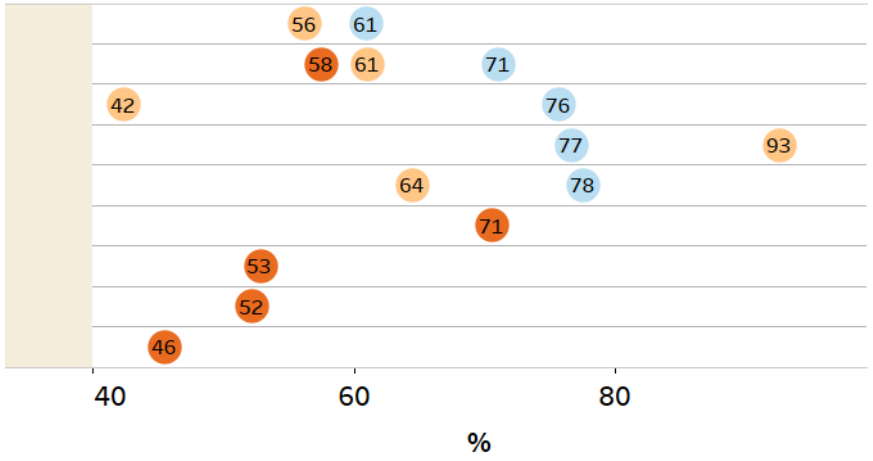
Screening v. Appr. F/U for Abnormal Screen



Colorectal Cancer Screening
Receipt of Appropriate F/U for abnormal CRC screening

Breast Cancer:

Screening v. BIRADS to Biopsy/ Abnormal BIRADS Followup



Breast Cancer Screening
BIRADS to Biopsy
Abnormal BIRADS Follow-up

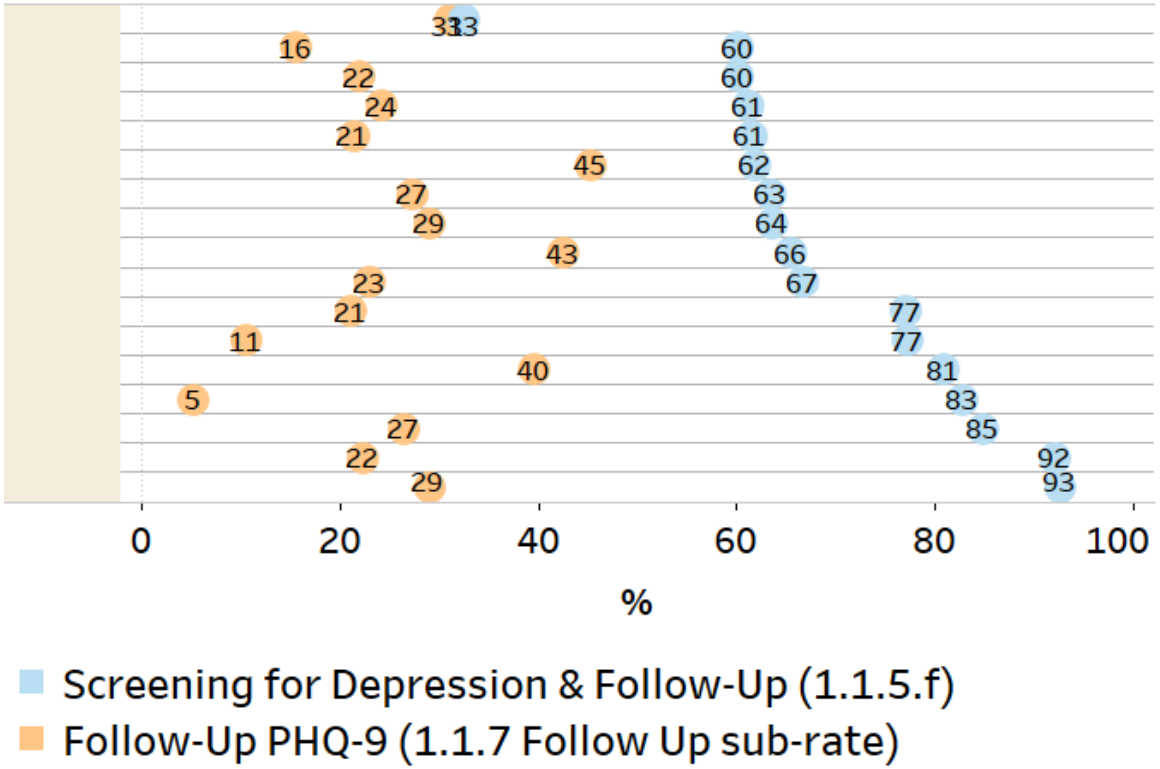
DPH with denominator <30 are excluded. DY14MY data not yet approved by DHCS.

How is our progress in follow up care?

DY14MY Follow-Up Action Rate DY14 MY Screening Rate

Depression:

Screening and Follow-Up Plan Documented v. Follow-Up PHQ9



DPH with denominator <30 are excluded. DY14MY data not yet approved by DHCS.

Screening measures
Future state

1. Alignment with CMS Core Measure sets (& California health plan P4P reporting)
2. Continued focus on screening measures when PRIME → QIP
3. National trends in SDOH standardization, integration and eventual risk stratification

12

Today's agenda

8:30-9:00am	Breakfast, networking & registration
9:00-9:35am	Welcome, why we're here & introductions
9:35-10:30am	Effective modalities to screen and interview for multiple needs
10:30-10:45am	Break
10:45-11:15am	Progress and next steps: screening for multiple needs and conditions
11:15-12:00pm	After the screening: managing physical and mental health needs
12:00-1:00pm	Lunch & networking
1:00-2:15pm	Starting and scaling screenings for social needs
2:15-2:50pm	Next steps on social needs
2:50 – 3:00pm	Wrap-up
3:00 – 4:00pm	Informal collaboration

13

Logistics

- Materials / packets
  - Materials on SNI Link/Care Delivery
  - **Evaluations!**

Resource alert!

- Restrooms
- Wifi
- See Abby at front desk for
  - Parking sticker
  - Reimbursement form

14

Parking lot

- Outside primary care (WPC, specialty, care mgmt)
- For later today
- Ideas for future meetings
- For 1:1 with other members

15

Effective modalities to screen & interview for multiple needs

Care Delivery Workshop
Better Screening for Improved Health

Steve Kilgore, Director of Nursing, Alameda Health System
Pagan Morris, Project Manager, UC San Francisco
Facilitator: Hunter Gatewood, Signal Key Consulting

16

Framing & Goal

No one perfect way, but we assume it will require multiple modalities and a team approach.

Focus on staff capacity, roles, making discussions safe and useful for patients.

Variables

- **Condition or need**: blood pressure, depression, food insecurity, etc.
- **Which staff**: front desk, MA, provider, BH clinician, etc.
- **Modality**: patient self-admin on paper, self-admin tablet, staff → EHR, etc.
- **Time/space**: pre-visit, clinic waiting room, exam room, etc.
- **Data management**: in EHR, in separate database, in Excel lists, etc.

17

Resources

How are CAPH peers using different care team members in their behavioral health workflows?

PHS Behavioral Health Workflow grid from July 2018 BHI Roundtable Meeting ➲ in packet; on SNI Link

18

Q&A

Steve Kilgore
Director of Nursing
Alameda Health System
skilgore@alamedahealthsystem.org

Pagan Morris
Project Manager
UC San Francisco
Pagan.Morris@ucsf.edu

19

Break

20

How many screenings can you find?

H D A S T I D U A N

Y J A R D Z P H H X

I D I G I X E B S K

J B Y R W K U E J A

S V V M P P K H B A

W C J F I V W V J H

F R F U O H V C R B

L O Q O C K R W Z N

G N B I H N B T X J

U V A X L G T W K G

First one to complete & return to reg desk wins prize!

21

Progress and next steps: screening for multiple needs and conditions

Care Delivery Workshop
Better Screening for Improved Health

- **Electronic self-administration in clinic**
- **Outreach to increase completion rates**
- **Staff training and process for SUD**

22

Succeeding with multiple screenings

Breakout discussions

First: What is working? What are the best ideas from other systems?

Second: What is a next step for your organization?

Third (in your own notes): Who do you need to talk to, and what is your question or request of that person?

- **Electronic self-administration in clinic** – Kristina
- **Outreach to increase completion rates** – David
- **Staff training and process for SUD** – Amanda

23

After the screening: Managing physical and mental health needs

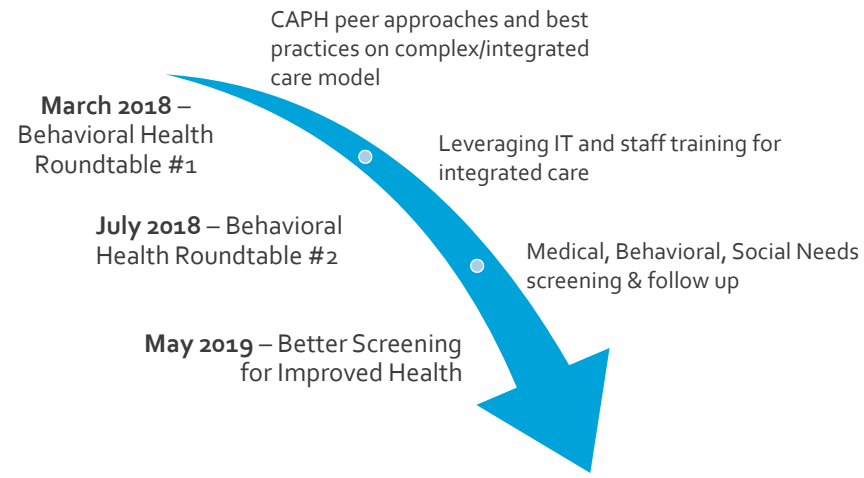
Care Delivery Workshop
Better Screening for Improved Health

Elena Tindall, Transformation Program Manager (PRIME/ QIP), Santa Clara Valley Medical Center

Facilitator: Kristina Mody, Sr. Program Associate, SNI

24

Integrating Behavioral & Medical
SNI Support



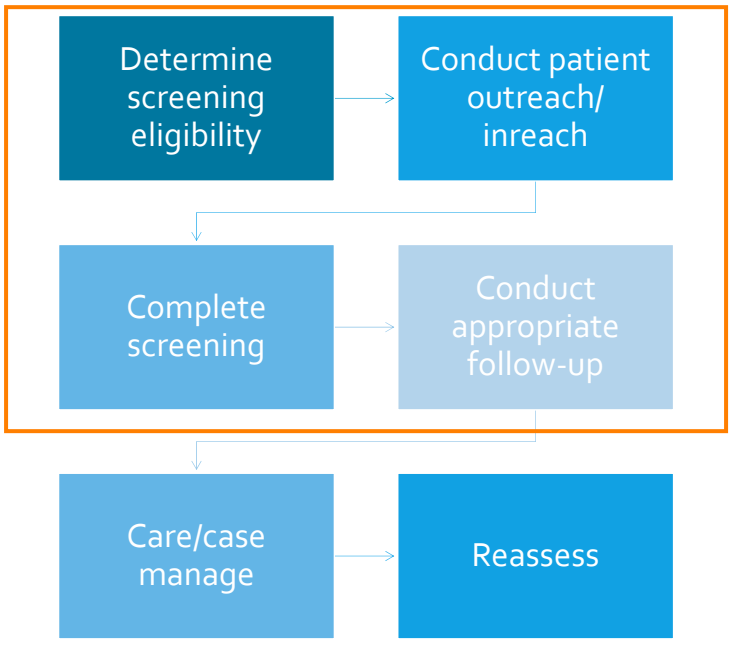
25

Screening and Management

Elena Tindall
Transformation Program Manager (PRIME/ QIP)
Santa Clara Valley Medical Center

- SCVMC achieved HIMSS Stage 7 recognition in 2018.
- Maximize utilization of EMR for both medical and behavioral health
  - screening alerts at registration
  - referral management
  - health maintenance activities and
  - documentation standardization
  - reporting

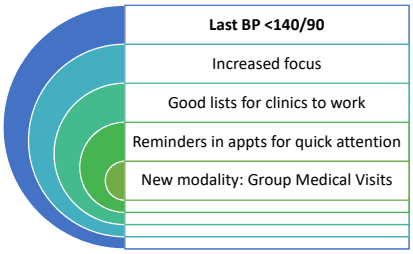
For medical only
- lab alerts



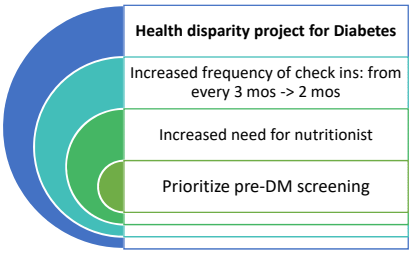
27

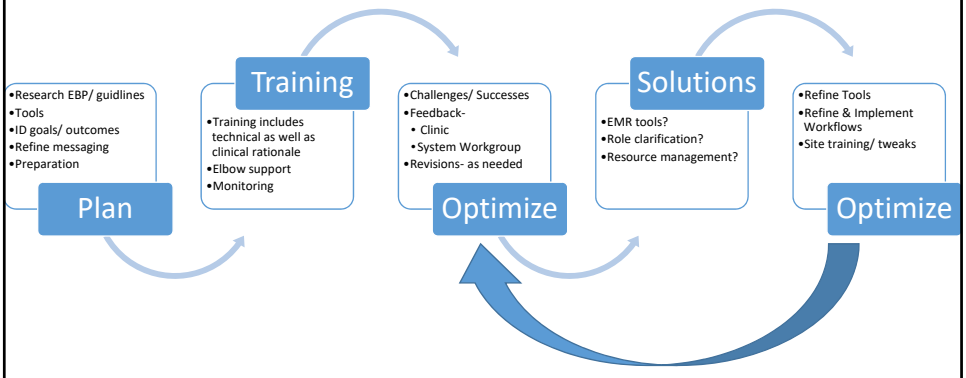
Medical Screening => Discovery

Medical: HTN



Medical: DM





Iterative Processes for Screening and Management

Behavioral Health Screening => Discovery

BH: SBIRT- in practice but not standardized

Process/ Workflow	• Annual Screen
All-Staff Training	• Dependence= Chronic Disease • ASAM Training for LCSWs • DEA license training to PCPs
Clinical Interventions	• MAT/ Vivitrol clinic pilots
Needs	• group modality • greater integration of community resources • greater PCP buy-in • More support staff • Prompts for ongoing BI • Need management tools • Expanded service access • Ongoing refresher trainings: Brief Intervention and Stages of Change

Behavioral Health- Depression- standardized

Screening	• Build in tools • Build alerts for when to screen
Clarification	• Mild to Moderate vs • Specialty
HIMSS stage 7 Tools	• Population Management Tools • Pt tracker • Outcomes monitoring tool
Thruput	• Depressed pts with BPD/ Personality D/O • Repatriation to PCP for refills • Alerts and triggers for labs

Medical

Then	• Limited Screening- 6* medical conditions • Reactive care- addressing missing screens • Individualized focus
Now	• Population Health screening across 14* medical conditions • Dedicated staff working = achieving desired outcomes • Implementing Group Visit modality
Future	• Balance out demands on rooming staff • Identify new opportunities to manage proactively • Creatively address needs • Increase screening to 16* health conditions

*Pop health screening measures: Before: Lipid, Breast Cancer, Colorectal Cancer, Pneumovax vaccine, Zoster vaccine, Flu Vaccine. Now: Added Triple A (A.A.A-Screening for Abdominal Aortic Aneurysm) and Hepatitis C Screening. Pre-DM Screen Pilot implemented. Depression, Substance Use.
Future: One Time Universal HIV screening; TDAP/Td vaccine. Universal Pre-DM Screen

Behavioral Health

Then

- Limited Screening started in 2012
- Reactive care- only pts who came in served
- Individualized focus

Now

- Population Health screening across two areas: Depression and SU
- Growing PC BH team to include Psychologists
- Refining working relationship with SU Tx Service specialty system
- Building EMR tools for Pop Management of Depressed Pts

Future

- Train staff on new workflows and approaches
- Improve Depressed Pts outcomes
- Improve Consultative Psychiatry model and PCP comfort with Rx refills
- Identify additional support tools and builds in EMR for depression and SU populations

Q&A

Elena Tindall

Transformation Program Manager (PRIME/ QIP)

Santa Clara Valley Medical Center

Elena.Tindall@hhs.sccgov.org

33

Lunch

12:00—1:00

Please update SDOH Tracking Sheet and return to front desk (1 per system)

34

Starting and scaling screenings for social needs

Care Delivery Workshop
Better Screening for Improved Health

Hunter Gatewood, Signal Key Consulting

Jagruti Shukla, MD, Director of Primary Care, LAC+USC

35

Intro: Social needs screenings, services

- **Screenings: Do right by your patients.**
  - Start small: Either with a few patients or a few conditions, or both
  - Use patient-centered and therapeutic communication.
- **Helping patients with needs: Both are big lifts. Surprise?!**
  - **Build?**
  - **Partner?**
- Check out the social needs (SDH) resource list.
- Consider how LAC+USC has handled these issues and decision points.
- Terms: *social needs, social determinants of health*

36

Resources

What are CAPH systems doing in primary care to address SDOH (screening, partnerships)?

Please return updated SDOH Tracking Sheet by PHS to front desk!

How have other systems created tools and launched interventions?

Contra Costa: Developing a Social Needs Screening Tool
White Paper ➲ **@ front desk; on SNI Link**

Where can I learn more about starting or improving SDOH work?

SDOH Resource guide (May 2019) ➲ in packet; on SNI Link

Gravity Project – national collaborative to advance SDOH documentation
Kickoff today (sorry!) https://sirenetwork.ucsf.edu/TheGravityProject

37

Screening for Social Needs

Jagruti Shukla, MD, MPH

LAC+USC Medical Center, Los Angeles County Department of Health Services

May 2, 2019

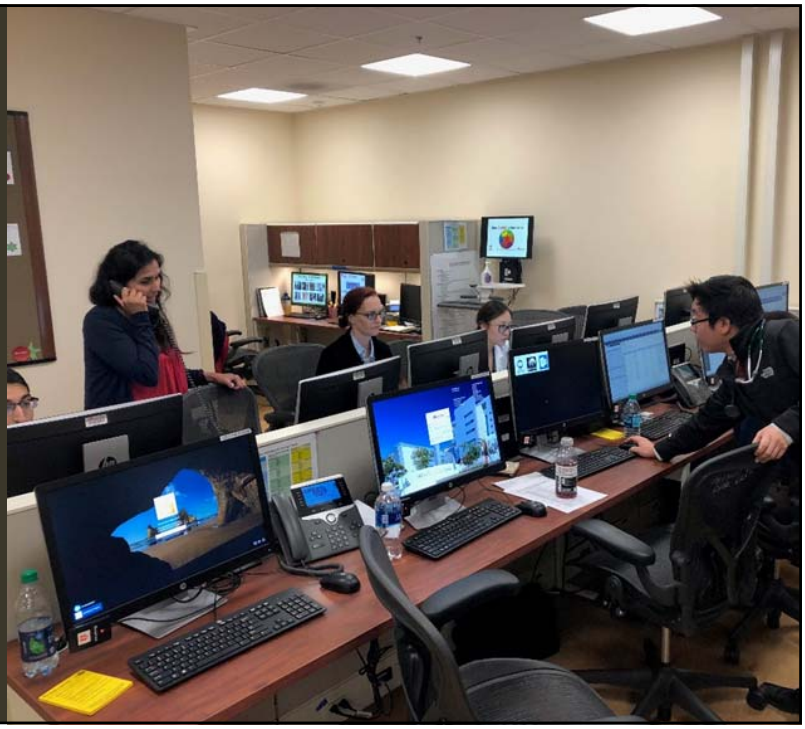
LAC+USC Medical Center

LAC+USC Medical Center

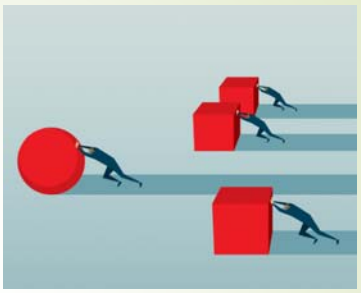
- Academic teaching hospital run by L.A. County Department of Health Services – "Safety Net"
- Largest teaching hospital 'West of the Mississippi'
- Training site for physician post-graduates in nearly every specialty/sub-specialty
- 965 Interns & Residents completing medical education
- 1,500 Faculty Physicians
- 9,000 hospital employees

LAC+USC Primary Care

- 10 Primary Care Clinics:
  - Adult West
  - Adult East
  - MedPeds
  - Geriatrics
  - Women's
  - Pediatrics
  - Preemie
  - Teen
  - MCA
  - Rand Schrader
- 54,350 empaneled patients



- Space Redesign
- Population Health and Outreach
- Home Visits
- Phone Visits
- Smart Phone Apps
- Navigators
- Groups & Classes
- Staff Wellness Program
- Patient Portal
- Social/Behavioral Determinants



Innovative Approaches in Primary Care

6

Our Integrated Behavioral and Social Health Model

- Universal screening for SBDOH needs
- Integration of behavioral health care service providers
- Use of evidenced-based screeners and interventions
- Systematically track and follow-up on referrals and outcomes

7

Our Goals Prior to Implementation

- **Educate, engage, and elevate all primary care staff on their respective roles in addressing social and behavioral needs**
- Improve primary care patients' access to behavioral health services
- Increase patient and primary care clinician's satisfaction with the behavioral health interventions within the clinic setting
- Improve health outcomes
  - (both physical and mental health)
- Decrease rates of homelessness, food insecurity, and other social stressors in our patient population
- Demonstrate cost savings

8

Our Roadmap

Month 1 (May 2016)

- Ensure that this work is a priority among all key stakeholders
- Create/develop vision, objectives, and timeline
- Identify available resources and **allocate time**

9

Our Roadmap

Month 2 (June 2016)

- Develop readiness assessment and survey staff*
- Work with MPH student on model development and evidence basis

10

Our Readiness Assessment

Across various social/behavioral health needs:

- How common do you think these problems are for our patients?
- How comfortable do you feel discussing them?
- How confident do you feel in your ability to address these needs?
- How interested are you in obtaining more training education?

Reinforce the Message

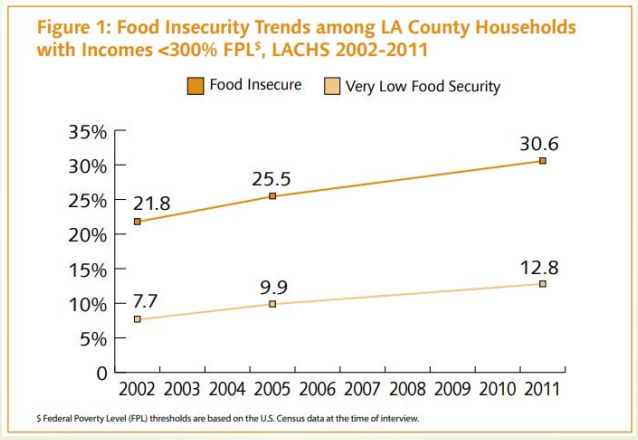
11

- Compare Readiness Assessment results with public health/publicly available data sources
  - CDC.gov
  - cdph.ca.gov (state)
  - publichealth.lacounty.gov (county)
- How common are these problems in your own community? Patient population? County?

12

Start the Discussion…

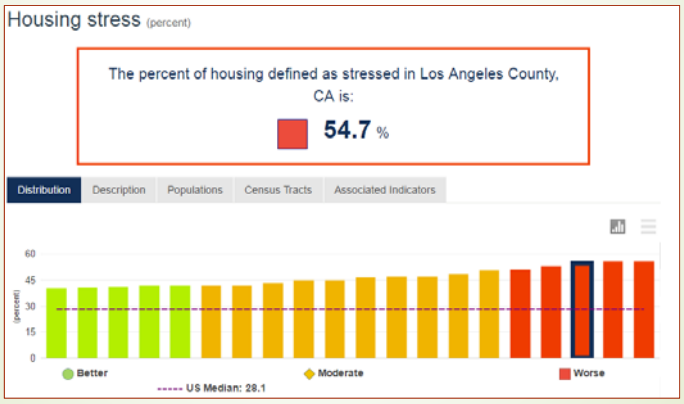
- Staff said food insecurity among our patients was uncommon/rare (1.82)
- Public health data tell us otherwise:



13

Start the Discussion…

- Staff said housing insecurity among our patients was rare/occasional (2.4)
- Public health data tell us otherwise:



http://wwwn.cdc.gov/CommunityHealth/profile/currentprofile/CA/Los%20Angeles

14

Our Roadmap

Month 3 (July 2016)

- Hold Quarterly Retreat with focus on Social Needs
- Discussion/reflection of readiness assessment with staff
- Share vision, objectives, and timeline of upcoming program plan

15

Our Roadmap

Month 4 (August 2016)

- Start training sessions with staff in small groups
- Staff development and feedback

16

Sample Training Tools, Resources, Ideas

- Readiness Assessment
- Group Activity
  - Share 1 representative patient story
- Online Videos with facilitated discussion
- Guest speakers: Dr. Rishi Manchanda
- Consultants (HMA)
- Didactic sessions on social needs (MPH student-led)
- Specialty-Staff Q&A Sessions
  - Share respective roles, available resources, what they do
  - Led by Social Workers, Psychiatrists, etc.
- Workshops
  - Bring real patient case examples
- Staff Retreat with focus on social needs
- Site Visits which included frontline staff
- Trainings

17

Our Roadmap

Month 5 (September 2016)

- Go live with Phase 1 of social needs screening (Tobacco, EtOH & drug use, IPV, depression, anxiety)

Survey Questions

Social and Behavioral Determinants of Health Suggested Script

Tobacco

1) Do you currently smoke tobacco, e-cigarettes, "vap" or use Hookah?
   ❑Yes ❑No
   Notified ❑Provider ❑LCSW ❑ RN
2) Have you ever smoked tobacco, e-cigarettes, "vap" or Hookah and you are worried about picking up the habits again?
   ❑Yes ❑No
   Notified ❑Provider ❑LCSW ❑ RN

Alcohol

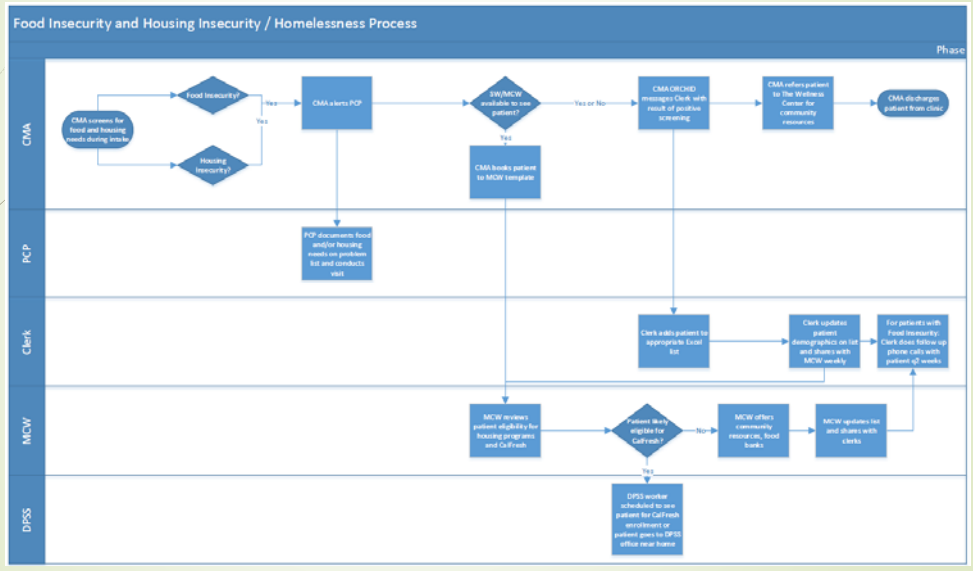
1) In the past year, have you had: (Men) 5 or more drinks in one day? Or (women) 4 or more drinks in one day?
   ❑Yes ❑No
   AUDIT-C Completed?
   ❑Yes
   ❑No
   Why not?
   ❑Unable to perform ❑Patient refused

Substance Use: Have you ever used OR do you currently use any IV drugs, marijuana, prescription pain medication other than what your provider prescribes, cocaine, amphetamines, ecstasy, methamphetamines, heroin or other illicit substances?
❑Yes ❑No
Notified ❑Provider ❑LCSW ❑ RN

Depression: Over the past two weeks, how often have you been bothered by the following problems?
1. Little interest or pleasure in doing things 0 Not at all / 1 Several Days / 2 More than Half the Days / 3 Nearly Every Day
2. Feeling down, depressed, or hopeless 0 Not at all / 1 Several Days / 2 More than Half the Days / 3 Nearly Every Day

Anxiety: Over the past two weeks, how often have you been bothered by the following problems?
1. Feeling nervous, anxious, or on edge 0 Not at all / 1 Several Days / 2 More than Half the Days / 3 Nearly Every Day
2. Not being able to stop or control worrying 0 Not at all / 1 Several Days / 2 More than Half the Days / 3 Nearly Every Day

Workflows: Food/Housing Insecurity



20

Our Roadmap

Month 6 (October 2016)

- Hold feedback sessions
- Retrain, case conference

21

Our Roadmap

Month 7 (October 2016)
- Leadership participation in training webinars, conferences
- Collect staff feedback

Month 8-9 (Nov-Dec 2016)
- Staff development and retraining using didactics, workshops (IPV, having difficulty conversations, etc.).

Month 10 (Jan 2017)
- Collaborate with outside departments including social work and psychiatry on trainings
- Clarify roles, responsibilities

22

Training Topics

- **Empathic Inquiry**
- **Cultural Humility & Implicit Bias**
- **Trauma Informed Care**
- **Intimate Partner Violence**
- **Collaborative Care/Mental Health**
- **Social Needs**
  - **Food Insecurity**
  - **Housing Insecurity**
- **SBIRT, Substance Use Disorders**
- **Motivational Interviewing**

Survey Questions

Intimate Partner Violence

1) Have you ever been slapped, kicked, hit or physically hurt by someone in the past year?
❑Yes ❑No
Notified ❑Provider ❑LCSW ❑ RN

2) Are you currently in or have you ever been in an abusive relationship?
❑Yes ❑No
Notified ❑Provider ❑LCSW ❑ RN

3) Have you ever been pressured or forced to have sex?
❑Yes ❑No
Notified ❑Provider ❑LCSW ❑ RN

Food Security: Within the past 12 months, did you worry whether your food would run out before you got money to buy more?
❑Yes ❑No
Notified ❑Provider ❑LCSW ❑ RN

Housing Security: Are you worried or concerned that you may NOT have stable housing that you own, rent, or stay in as part of a household?
❑Yes, worried about housing in the near future ❑No
Notified ❑Provider ❑LCSW ❑ RN

24

Our Roadmap

Month 11 (Feb 2017)
- Quarterly Retreat focus on social needs
  - (housing, food insecurity)
- Use video to facilitate discussion

Month 12 (March 2017)
- Go-Live with Phase 2 of social needs screening
  - (food insecurity, housing insecurity, homelessness)

Ongoing
- Refine workflows
- Revisit team roles
- Continue to support staff, re-train, revisit

Outcomes: Depression (PHQ9)

Six months **Before** initiating Care with Psych and/or Social Worker

Six months **After** initiating Care with Psych and/or Social Worker

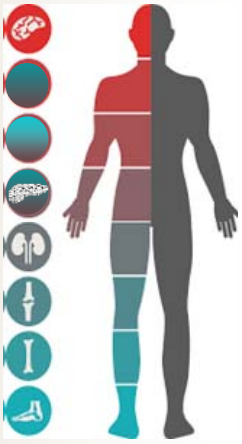
PHQ9 16.17

12.55 Among patients with moderately severe depression, average score decreased by 4 points.
n=132 p<.01

PHQ9 22.42

14.12 Among patients with severe depression, average score decreased by 8 points.
n=39 p<.05

Improved Mental Health Outcomes



Includes 1,125 patients seen between Dec 2016 and April 2017

Outcomes: Impact on Blood Pressure and Diabetes Control

Six months **Before** initiating Care with Psych and/or Social Worker

Six months **After** initiating Care with Psych and/or Social Worker

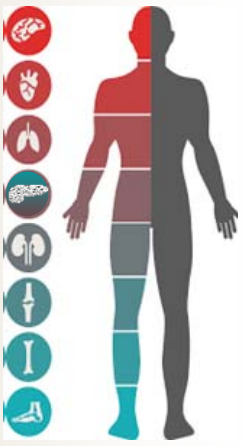
BP 149/182

137/75 Average systolic blood pressure decreased by 12mmHg, diastolic decreased by 7mmHg
n=404 p<.01

HbA1c 8.84

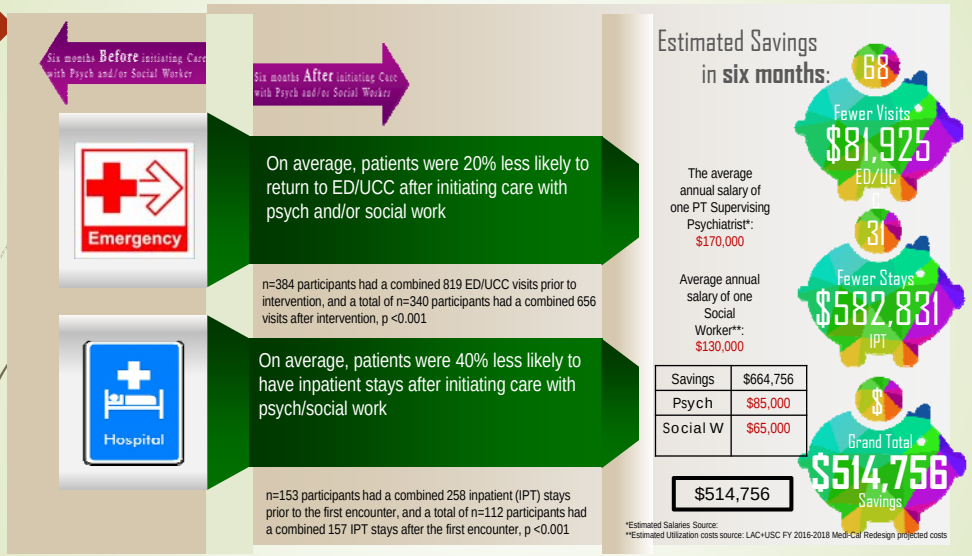
8.84 Average HbA1c decreased by 0.39%
n=230 p<.01

Improved Primary Care Outcomes



Includes 1,125 patients seen between Dec 2016 and April 2017

Outcomes: Cost-Savings



Includes 1,125 patients seen between Dec 2016 and April 2017

Spread across Los Angeles County Department of Health Services

- Second largest municipal health system in the nation
- 21 Health Centers and 4 Hospitals
- Over 70 individual primary care clinics
- Over 420,000 unique patients empaneled
- Over 300,000 unique managed care patients

LAC DHS Concurrent Efforts Underway…

- Designation of a Health Agency Social and Behavioral Health (SBDOH) Work Group which includes LAC DHS, DMH, and DPH to develop an evidence-based, validated list of SBDOH primary and secondary screeners
- Budget request for creating behavioral health teams which will be integrated into primary care and includes Social Worker Supervisor, Social Worker, Medical Case Worker, Substance Use Counselor, and Community health Worker
- Certification for a first phase of primary care clinics with California's Drug Medi-Cal Organized Deliver System (DMC-ODS) waiver
- Work with health plans to secure contracts to allow us to provide and receive reimbursement for mental health services provided within the local PCMH setting
- Creation of a LAC DHS Behavioral Health Integration in PC Work Group
- Further collaboration with DMH and DPH
- HMA Consultation

30

LAC DHS Roadmap for BHI

Month 1 (Dec 2018)
- Assessment of the current state, including prevalence data
- Develop BHI model, staff roles, and timeline for implementation
- Configuration of EHR to include screeners, registry, reports, etc.

Month 2-6
- Identify clinic teams and leads for Phase One
- Hold half-day Pre-Launch and full-day Kick-Off
- Weekly BHI Workgroup meetings, Bi-weekly Phase One team calls
- Site Visits, Trainings, Webinars, Data/Report review

Month 6 & Onwards
- Continue monthly check-in calls
- Process Improvement through ongoing monitoring and reporting
- Continue to support staff, re-train, revisit workflows and staff roles
- Planning to launch Phase Two

Questions?

Jagruti Shukla, MD, MPH

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Los Angeles County
Department of Health
Services

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Next steps on social needs

Care Delivery Workshop
Better Screening for Improved Health

- **Training staff to talk about social needs**
- **Screenings: Data management**
- **Community partnerships**
- **Build capacity in-house**

38

Next steps on social needs

Breakout discussions

First: What is working? What are the best ideas from other systems?

Second: What is a next step for your organization?

Third (in your own notes): Who do you need to talk to, and what is your question or request of that person?

- **Training staff to talk about social needs – Kristina**
- **Screenings: Data management – David**
- **Community partnerships – Amanda**
- **Build capacity in-house – Hunter**

39

Wrap Up

Care Delivery Workshop
Better Screening for Improved Health

40

Quality Leaders Awards

AWARD CATAGORIES:

- TOP HONOR
- AMBULATORY CARE REDESIGN
- DATA DRIVEN ORGANIZATION
- PERFORMANCE EXCELLENCE

ABOUT THE AWARDS:

For more than 20 years, CAPH/SNI has delivered the QLAs to recognize outstanding initiatives across California's public health care systems. The awards highlight forward-thinking and innovative approaches to improve care and advance population health.

Awards are presented at the CAPH/SNI Annual Conference on December 4-6 at the Paradise Point Resort in San Diego.

APPLY NOW!
safetynetinstitute.org/qla

DEADLINE TO APPLY IS AUGUST 31, 2019

http://safetynetinstitute.org/qla

41

Evaluation & Wrap Up

Feedback on today:

What worked? Where to improved?

More importantly:

How to continue progress & momentum?

Find one person you didn't know this morning, and **tell them something you learned today, from them or someone else**

SNC CALIFORNIA HEALTH CARE SAFETY NET INSTITUTE

42

Informal Collaboration

3:00—4:00

43

Appendix

Managing physical and mental health needs

Applying Medical EMR Support Tools to BH

Elena Tindall
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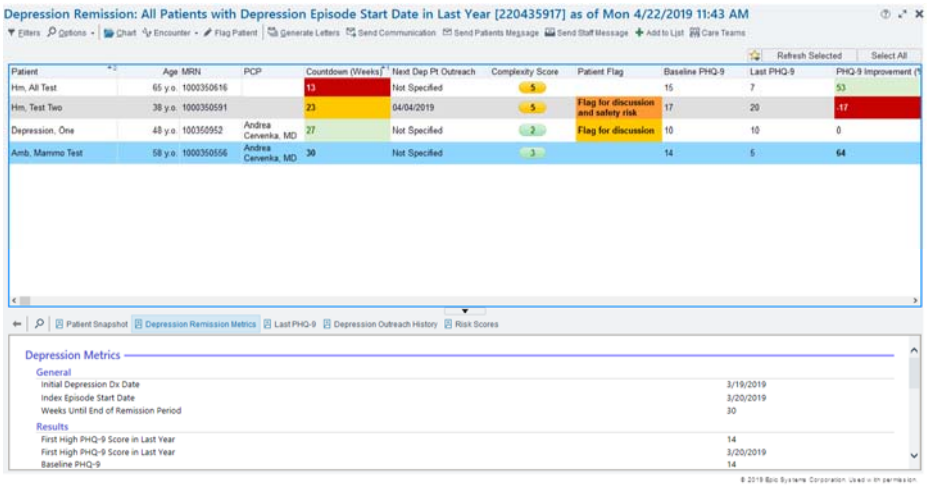
44

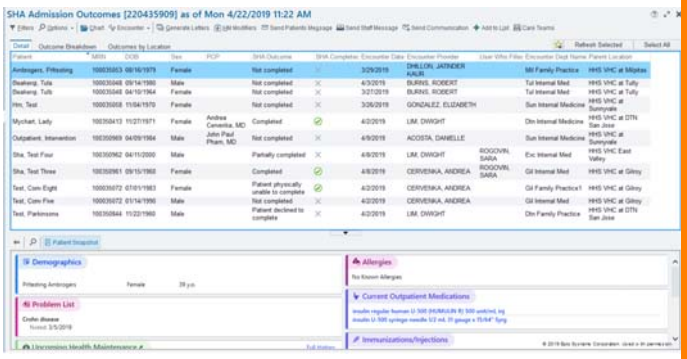
Operational report for Depression Remission/ Response



No PHI- All data dummy data for testing.

45

Monitoring tools: Detailed

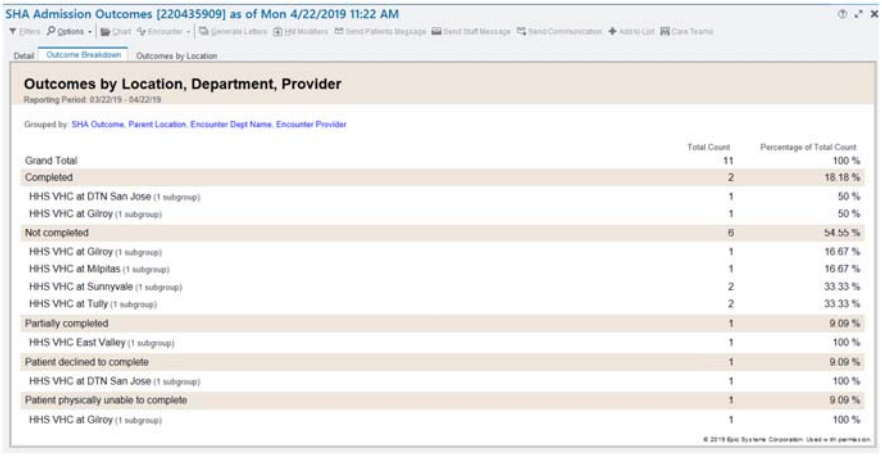


- Consolidated adult screening tool
- SHA Annual- ALL pts every year
- Used for WPC Health Assessment
- Still pending Health Plan approval. So far positive response- no alarm bells.

No PHI- All data dummy data for testing.

46

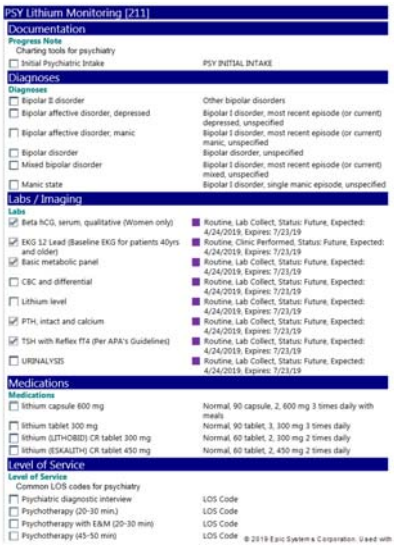
Monitoring tools: Roll up report



47

Smartsets for Psych meds

- Support PCPs refilling psychotropic meds
- Support Psychiatry that has no smart sets
- Next steps: include lab alerts needed for a first grouping of antipsychotic meds most commonly used as adjunct to antidepressant meds



PSY Lithium Monitoring [211]

Documentation

Progress Note

Charting tools for psychiatry

☐ Initial Psychiatric Intake	PSY INITIAL INTAKE

Diagnoses

Diagnoses

☐ Bipolar II disorder	Other bipolar disorders
☐ Bipolar affective disorder, depressed	Bipolar I disorder, most recent episode (or current) depressed, unspecified
☐ Bipolar affective disorder, manic	Bipolar I disorder, most recent episode (or current) manic, unspecified
☐ Bipolar disorder	Bipolar disorder, unspecified
☐ Mixed bipolar disorder	Bipolar I disorder, most recent episode (or current) mixed, unspecified
☐ Manic state	Bipolar I disorder, single manic episode, unspecified

Labs / Imaging

Labs

☑ Beta hCG, serum, qualitative (Women only)	■ Routine, Lab Collect, Status: Future, Expected: 4/24/2019, Expires: 7/23/19
☑ EKG 12 Lead (Baseline EKG for patients 40yrs and older)	■ Routine, Clinic Performed, Status: Future, Expected: 4/24/2019, Expires: 7/23/19
☑ Basic metabolic panel	■ Routine, Lab Collect, Status: Future, Expected: 4/24/2019, Expires: 7/23/19
☐ CBC and differential	■ Routine, Lab Collect, Status: Future, Expected: 4/24/2019, Expires: 7/23/19
☐ Lithium level	■ Routine, Lab Collect, Status: Future, Expected: 4/24/2019, Expires: 7/23/19
☑ PTH, intact and calcium	■ Routine, Lab Collect, Status: Future, Expected: 4/24/2019, Expires: 7/23/19
☑ TSH with Reflex ft4 (Per APA's Guidelines)	■ Routine, Lab Collect, Status: Future, Expected: 4/24/2019, Expires: 7/23/19
☐ URINALYSIS	■ Routine, Lab Collect, Status: Future, Expected: 4/24/2019, Expires: 7/23/19

Medications

Medications

☐ lithium capsule 600 mg	Normal, 90 capsule, 2, 600 mg 3 times daily with meals
☐ lithium tablet 300 mg	Normal, 90 tablet, 3, 300 mg 3 times daily
☐ lithium (LITHOBID) CR tablet 300 mg	Normal, 60 tablet, 2, 300 mg 2 times daily
☐ lithium (ESKALITH) CR tablet 450 mg	Normal, 60 tablet, 2, 450 mg 2 times daily

Level of Service

Level of Service

Common LOS codes for psychiatry

☐ Psychiatric diagnostic interview	LOS Code
☐ Psychotherapy (20-30 min.)	LOS Code
☐ Psychotherapy with E&M (20-30 min)	LOS Code
☐ Psychotherapy (45-50 min)	LOS Code

48