Use of a Registry in a Small County Behavioral Health Setting

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I believe that underlying all the unending dialogue and angst related to the need for accountability and demonstration of outcomes lies a common desire to provide or receive mental/behavioral health services that promote wellness and recovery. I have come to believe that the bottom line of what we accountable for is meaningful, positive change.

Today I’d like to focus on 3 major barriers to our common goal of system transformation – which from any perspective or in any language means improvement!

The three barriers are:

**Cutting to the Bottom Line**

*What are we all about?*

**Barriers to reaching our common goal:**

- Failure to use a *quality improvement* approach
- Lack of standard measures to understand both the quality of the current services we provide and the impact of the changes we make to improve services and outcomes for our clients.
- Lack of adoption of a feasible software application for collection, analysis, aggregation, and reporting of outcomes at all system levels.
Traditionally in our discipline we have used the Accountability or Research form of measurement. However, observing and participating our QI processes has led me to conclude that we have very limited understanding of measurement for improvement.

The approaches we have used have utilized have almost been largely Accountability and Research methods.

How often do we collect data for outcomes, accountability, and research and find that takes a year or more to get the findings, if at all.

25 counties, with some overlap, are currently using the improvement methodology in several CiMH coordinated collaboratives

Primary healthcare is using this methodology for integration of care

Even at it’s best using only Accountability and Research methodology is kind of like trying to drive your car down the road by only looking in the rear view mirror.
Small County Setting
Modoc County

[Map of California with Modoc County highlighted]
The Small County Challenge

• Be able to accomplish with minimal technological support
• Be able to embed as a normal part of service delivery
• Be simple enough that MH Specialists and Peer providers can use
• Be able to produce and interpret basic reports without statistical expertise
Uses of the Registry

- Collect data to manage health and wellness for a chronic condition relevant for integration of whole health
- Collect and analyze data that is useful for quality improvement
- Guide delivery of, and monitor adherence to, best practices and protocols
- Provide a mechanism to share key information across the integrated team through VPN or HIE – ACA data exchange requirements
- Demonstrate individual progress and program outcomes

Availability of a feasible software application for collection, analysis, aggregation, and reporting of outcomes at all system levels is fundamental to measurement of improvement, demonstration of outcomes, and evaluation and accountability.
Conducting multiple small tests, under various conditions or settings, and gathering data over time to build confidence that the changes we are making are positive ones.
This slide is a continuation of the previous slide in that it is a dashboard of aggregate run charts. This provides a county or larger collection of organizations (state, etc.) to see trends in a set of key quality measures on one page.

Lack of agreement on shared measures (palette of measures or indicators – PTSD Severity: Overall score – RAND measures of Wellness, Youth Outcome Questionnaire, MORS, CANS)

Holding the line on county autonomy and failure to come to agreement on a set of fixed outcome measure is a serious threat. It’s not surprising that failure to consistently demonstrate outcomes has increased the risk to our funding.
Selected Key Goals:

- Incorporate physical health monitoring into Behavioral Health Services
  • At least 90% of all new clients will receive baseline physical health monitoring (BMI, BP, Waist circumference, pulse) and a self and family health history at intake.
- Increase electronic collection of clients’ physical health data through use of a registry.
  • At least 95% of clients’ demographics, BP, BMI will be documented in a registry.

Because we were simultaneously working on an integrated behavioral health intake and assessment process, we made addressing this goal a part of how we designed and tested our plans for Behavioral Health integration.

2. Have not met this goal yet, but have been doing a lot of testing to get the right data fields into the registry, working on a cross-walk from EHR, and VPN server connections for communication with Primary Care.
Tell “Dan’s” story - A couple of weeks ago “DAN” our a peer support staff person came through my office door waving this run chart from a PDSA cycle saying “Karen, what are we going to do about “Dave’s” cumulative weight gain? I’ll bet if the staff looked at this in a narrative, over time they would just conclude that his weight was just fluctuating. But if you see it as a visual report, you can see that he’s progressively gaining weight. I think this has real potential. I really see this as usable in planning my care too. I’d like to plot my ..... see if we could find some answers in managing my disorder and overall health!”
Some of the key things we’ve learned:

• Who’s data is it anyway???
• The essential value of collecting and sharing with the client their personal reports.
  – Client level data spurs client engagement in self management discussions & whole health activities (weight, BP, activity, etc.)
– Client level data provides a venue for encouraging client participation in primary care services.
  • By using client level data with clients over time, six formerly resistant clients were connected to PCP in a less than two weeks by one nurse.
  • Staff immediately connect clients with high risk primary care needs are connected to care on a priority basis.
• Our Clinicians’ success in running and use of individual client reports, and positive feedback from both clients and their PCPs, increased their “buy-in” in use of the registry.
• Use of client level data is very promising for communication with primary healthcare setting and integration of healthcare as PCP response has been very positive to the registry reports.

As staff use the registry and the client level reports, the more excited they become about the results they are seeing.
Registry Challenges and Strategies

• Challenge: Learning a new system
  — Strategies:
    • Creating a training manual
    • Creation of “turn-key” reports for client and program outcomes
    • Incorporation of reminders for best practice adherence
  • Challenge: Dealing with double data entry
  — Strategies:
    • Developing a one-way crosswalk from Anasazi to Registry-nightly update
• Challenge: HIPPAA & 42CFR requirements
  – Strategies:
    • Set for all clients to 42CFR standard

• Challenge: Spread
  – Strategies:
    • Having the right members on the team – including representatives of key roles, especially nurses & direct services staff.
    • Key staff telling impact stories
Some Conclusions from Small Scale Testing of the Use of a Registry (PECSYS)

- Preliminary small scale testing of PECSYS has lead us to conclude, with substantial confidence, that use of a registry to gather client quality improvement and outcome data is DOABLE (viable, practical, efficient, and cost effective) as a small county with limited resources ($$, IT staff, QI staff, evaluation /statistical expertise, economy of scale).
• Use of “turn-key” reports for “fixed” data elements in a registry format is a practical, easily useable quality improvement approach for tracking, utilizing, and reporting client outcomes at the single “subject” through program, county, or even state/federal level
• “Bundling” data element reports gives a more comprehensive view of quality improvement
• Client level data in aggregate is very useful for demonstration of program/department and collaborative outcomes

• With appropriate releases of information, through VPN access, integrated team members can bi-directionally exchange information “real time”.
- The data contained in the registry is exportable to HIE.
- Fixed data elements in “searchable fields” have significant potential for TIMELY outcome measurement, evaluation and/or research at all system levels while remaining HIPPA compliant.
If I have learned anything about managing change over the years in a variety of settings is that there are small windows of opportunity, that if missed may never be there in the future. I believe this is one of those times when we are on the “tipping point” of change. In the context of healthcare reform how we approach quality improvement will at the very least the shape how we deliver care and it may well determine the survival of the gains we have made through MHSA.

Next Steps

• Expand BH measures in the registry.
• Reaching agreement for at least some shared BH outcome measures.
• Align at least a minimal number of shared BH measures with other BH entities, primary care, and with the expectations oversight entities.
• Resolve the interoperability issues of multiple data collection systems – CSI, DCR, EHR, Registries, HIE, spreadsheets, etc.