

New York State Office of Mental Health Continuous Quality Improvement (CQI) Initiative for Health Promotion and Care Coordination Successful QI Strategies

The PSYCKES team met with a number of participating clinics to learn about their CQI projects and QI strategies. We have observed that high performing clinics implemented QI strategies and clinical interventions to address clients' quality concerns that resulted in improved project outcomes. The clinics appear to share the following characteristics related to the CQI project.

- Established or restructured their CQI team early in the project to set project goals and implementation strategies; the team meets at least monthly.
- Adopted a clinic-wide team approach to carry out the project by engaging various staff.
- Regularly updates the master list of clients identified with quality concerns and distributes to clinical team.
- Clinical staff review clients' PSYCKES clinical summary that includes data with special protections.
- Deliver appropriate clinical interventions to reduce quality concerns.
- Developed systems for collecting, tracking and analyzing data.
- Provide strong leadership support for the project.

The following is a compilation of workflow processes and clinical interventions implemented by clinics throughout the state. Most of the strategies can be applied to both projects.

Adopt Team Approach

Integrating core CQI practices into routine clinical processes requires a team approach and the involvement of diverse staff. Examples of such strategies include:

- The QI team with a diverse staff composition (including agency/clinic leadership) is empowered to implement the project. At larger agencies, centralized QI staff establishes agency-wide procedures and act as liaison to the clinics.
- Front desk/administration staff have an awareness of quality concerns and work directly with clinicians on the project by flagging charts, alerting clinicians of suspected non-adherence, and sending appointment reminders. Other processes include:
 - Scheduling staff asks if a client has any medication left when the client calls to reschedule a missed appointment; clinician is informed when a client is not taking an entire month's supply or requires an immediate appointment.
 - Staff creates a list of the next day's appointments the night before; PSYCKES clients are noted.
 - Staff confirms appointment (day before; day of appointment, if necessary).
 - A structured note (e.g., intervention checklist) is attached to client's chart for clinician's review.
- Clinic Director monitors intervention delivery and clients' progress; provides guidance and positive feedback.
- A nurse (if available) reviews/discusses medications with clients; educates them on health issues, wellness management and community resources (Primary Care Physician (PCP), urgent care). Monitors vitals at medication visits, approximately once a month. Trains staff to give injections, if appropriate.

- Therapists discuss medication issues and adherence with clients; educate clients, alert supervisor/psychiatrists of issues; talk to prescribers about medications.
- Supervision is provided for all staff to discuss client issues and interventions.
- Psychiatrists are receptive to clinician's concerns about client issues and medications.
- Care management staff are integrated into clinic processes and are provided access to PSYCKES data.
- Peers (if available) are integrated into staff and incorporated into committees, if applicable.
 - The peer follows-up with clients and provides outreach (e.g., see clients who missed a medication appointment, accompanies clients to medical appointments, helps clients deal with medical anxiety, accompanies clients to various meetings). For those clients who stopped visiting the clinic, the peer outreaches to reconnect them with treatment.

Integrate CQI Project into Clinic Meetings

- At the monthly CQI team meeting some standing agenda items include: review the master list; provide project status; discuss workflow issues, barriers/challenges, successes, policy changes, statistics from health assessments, and the updated PSYCKES graph comparing agency performance to region and state. New CQI team members and other staff receive PSYCKES application and use case orientation.
- The CQI project is also discussed at various agency/clinic meetings: board meetings, leadership meetings, utilization meetings, clinic manager's meetings, clinic manager/supervisor meetings, nurses meetings, adult meetings, child/youth meetings.
- Client data (e.g., health/quality concerns, high-risk clients, treatment, interventions) are discussed at various clinic meetings (e.g., supervision, case conferences).

Foster a Culture of Training

- Provide training groups.
- Provide focused training on motivational Interviewing.
- Teach a "skill of the week" (e.g., dialectical behavioral therapy).
- Train clinics to identify and handle people who are under the influence of alcohol or drugs (via stages of change).
- Educate new social workers about medications (e.g., how to read a medication sheet).
- Require new clinical staff, including interns to complete the Center for Practice Innovations (CPI) modules.

Maintain Additional Focus on High Risk Clients

- Identify high risk clients through various sources (e.g., weekly case conference, QI staff).
- Create a list that includes clients with high risk criteria (e.g., 2+ psychiatric admissions in past year; noncompliance with medications and marked impairments; drug and alcohol use with impairments).
 - Distributed weekly; reviewed frequently by leadership and the clinical team.
 - Clients receive additional attention.
 - Refer clients to health homes for care management.
- Clinical team reviews individuals with high risk of admissions, co-morbid substance abuse, poor medical adherence, suicide risk and other determinants of high risk.
- Review PSYCKES Clinical Summary (including data with special protections) with client.
- Assess client's eligibility for various community and social services; discuss options with client.
- Involve family in the treatment.

Involve Family (and/or Others in Support System) in a Client's Treatment

Clinics have observed that clients who have a family and/or support system do well and also have the best outcomes. However, in some environments the majority of clients do not have family support. Nonetheless, clinics do attempt to involve family and others in clients' care.

Children/Youth clinics have a higher number of collateral visits. Caretakers and other family members deal with myriad stressors associated with the ill health of children.

- Discuss family engagement with client at intake.
- Obtain a release for name of emergency contact.
 - Update phone numbers and file in record; obtain an alternate phone number.
 - Provide all direct care staff with a contact list.
- Send a letter to a family member (English and/or another language) reminding family to call the clinic if they have concerns.
- Call relatives of high risk patients to notify them of appointments.
- Educate family members on the services/value of PCP and other community providers; stress their utilization (especially for non-emergency care) for client and entire family.
- All clinical staff direct client/family to seek services of community providers (not hospitals) for non-emergency care.
- Clinic staff includes a family-parent advocate who works with families, including those who have children with special needs. Advocate can suggest and coordinate services.
- Coordinate prevention programs and other services aimed to minimize risk for family members.

Make Use of Technology

- Use technology (e.g., electronic medical record [EMR] and/or other software) to compare data from PSYCKES (e.g., clients on the master list) with the current clinic census to identify active clients enrolled in the clinic.
- Include a prompt in the EMR progress note template to remind staff to ask clients at each visit about significant incidents and recent hospitalizations. Conversation is documented in the progress note.
- Contract with a provider of an on-line health community for various services (e.g., postings of health information, expert discussions, group chats, and peer-to-peer support).
- Use PSYCKES Clinical Summary as catalyst for conversations with clients, and for clients to have a conversation about community providers.
- Provide on-line consultation (20-30 minutes) for parents of youths who are having difficulty.

High Utilization

Clinics deliver individualized clinical interventions to clients who are high utilizers of acute services. Examples of strategies used by clinics to address high utilization of inpatient and emergency room services include:

Promote behavioral change: shift from ER to community care for non-emergencies

- QI staff alerts clinicians of flagged clients and follows-up with clinicians to ensure they have spoken to the client about hospital/ER utilization.
- Clinical staff ask clients at every visit about significant incidents and any hospitalizations. These conversations are documented in progress notes.
- Treatment plan specifies goals to reduce hospitalizations and ER visits.
- When clinicians question clients about hospital and ER utilization, they also discuss appropriate use of the ER.

- Educate client on the services/value of PCP and other community providers; encourage appropriate service utilization for different circumstances (e.g., clinics, urgent care center).
- Clinicians encourage clients to go to clinic instead of ER, even in a crisis.
 - Ask why clients are frequently using ER instead of PCP, clinic, urgent care, etc.; address barriers to promote outpatient care.
- All clinical staff direct client to seek the services of community providers (not hospitals) for non-emergency care.
- Endorse the practice that clients see different clinical staff so that they become comfortable with a variety of clinicians; this fosters success in a crisis situation.
- An inpatient stay/ER visit is considered an untoward event. Thus, the clinician(s) fills out a "Hospitalization/ER Review Form" that asks the clinician to reflect on the client and what could have been done differently to prevent the event (knowledge that client was not taking medication; client could have had more frequent clinic appointments). Form is reviewed by compliance officer within 24 hours of the clinician's knowledge of event.
- Set client up with community health center or PCP.
- Use case conference time to identify referrals to community providers.

Community Care Linkage

- Develop relationships and educate staff within the community so that providers/institutions will refer clients to the clinic for non-emergency care:
 - Schools direct students to clinics instead of ER.
 - Adult home staff refers residents to clinic.
- Clinic leadership and outreach staff visit local providers to acquaint them with clinic services and encourage providers to contact the clinic when a mutual client has a problem.
- Local providers are invited to clinic staff meetings to present information on their services (e.g., YMCA representative discusses the Y's diabetes prevention program).
- Clinic contracts with local crisis services provider for after-hour coverage. For high risk clients, clinic informs crisis services provider about client medication/safety plan to reduce hospital/ER services. Crisis services provider informs clinic daily of those clients who called in past 24 hours; a transcript of call is sent to clinic.
- Some clients who are high utilizers of hospital/ER services may be homeless; link clients to relevant services.
- Institute a communication process between clinic and local PCPs (e.g., send a letter to client's PCP indicating that the clinic is treating PCP's client; specify diagnoses made and medications prescribed. Psychiatrist phones PCP to discuss or follow-up on client's care).

Client Education

- Display materials in waiting room (e.g., calorie counters; fast food comparisons; information sheets/brochures on health issues).
- Install TV in waiting room; procure and show DVDs on health issues.
- Clinician discusses smoking cessation with smokers.
 - Discuss smoking calculator from NY Quits.
 - Smoking cessation pamphlets about risks to pets have prompted client response.
- Clinician gives clients PSYCKES Polypharmacy and Cardiometabolic risk brochures.
- Clinicians give clients printouts of information from internet search related to clients' concerns (e.g., weight loss; portion control, especially for those who think they eat right).
- Use RX List and MedLine for user-friendly information about new medications.
- Use social media, Facebook and other websites during an appointment to help address client concerns and questions about health and healthy choices (e.g., food pyramid).
- Show clients OMH's "Quality Concerns" presentation material about the number of mentally ill patients with a medical problem. See [slide numbers 11-14](#).

Facilitate Frequent Clinic Appointments

- Ensure that clients have regular medical appointments.
- Clinic accepts walk-in sessions; provides same-day-service. Front desk contacts clinic director who assigns a clinician.
- Clinicians help clients keep appointments by:
 - Identifying barriers to keeping appointments.
 - Ensuring that they see clients consistently and on time.
 - Providing positive reinforcement when clients are on time.
- Clinician walks clients to front desk to make a future appointment.
- Confirm appointment the day before.
- Conduct outreach when appointments are missed—phone; send letter/email/text.
- Staff makes a calendar for a client. Clinician works with a client on organizational skills (e.g., especially to address keeping appointments).
- Staff regularly creates a report on clients who do not show up for 50% of their appointments; follow-up with the clients.
- Staff meet weekly to review no-shows and develop plans.
- Take a personal approach with clients; establish a strong relationship to encourage client response.
- Communicate to clients the clinic's expectations regarding appointments (e.g., a client is expected to keep an appointment. If a client cannot keep an appointment, the client must call the clinic prior to the scheduled time and reschedule the appointment).

Other

- Identify early warning signs of relapse.
- Develop an early intervention relapse prevention plan, and improve behavioral engagement; incorporate into treatment plan.
- Implement and monitor high risk list; address various needs.
 - Reviewed frequently by various clinical staff, (e.g., in supervision; weekly staff meeting; directors meetings).
 - Client receives additional attention.
- For clients identified with a high utilization flag, QI staff email therapists and follows-up to ensure intervention (e.g., motivational interviewing to support engagement in treatment).
- Peers provide support for client engagement and outreach.
- Conduct Groups:
 - Health Promotion Group:
 - Topics: asthma, diabetes and other medical conditions; medications and side effects; how to engage with primary care provider, connecting with community providers, keeping appointments, smoking cessation, exercise, physical recovery, spirituality and wellness health management.
 - Medication Management Group.

Adherence

Clinics deliver individualized clinical interventions to clients diagnosed with schizophrenia, bipolar disorder, or depression who may have difficulty taking psychotropic medication as prescribed. Examples of strategies used by clinics to address medication adherence issues include:

Conduct Targeted Medication Education

- Use PSYCKES Clinical Summary to review medications and usage, including QI flag(s).
- Use motivational interviewing to explore reasons for non-adherence.

- Discuss role of medications in promoting client's recovery goals, and incorporate other interventions (psychosocial, nutrition, exercise) as appropriate.
- Review strategies to mitigate/address side effects.
- Check blood levels to ensure appropriate dosing.
- Consider switch to different medication and/or long-acting injectable medication, as applicable.
- Provide translators for psycho-education as required.
- Conduct medication management groups.

Augment Education with Behavioral Tailoring and Medication Reminders and Tips

- Help clients integrate medications into their regular routines (e.g., for morning doses keep pills near the coffee pot or toothbrush).
- Use refrigerator magnet medication reminder.
- Teach client how to program reminders in client's phone.
- Use pill boxes.
 - Clinic provides pill boxes.
 - Clinic advises clients of free pill boxes at pharmacy.
 - Staff teaches clients how to use.

Develop a Relationship or Link with Local Pharmacy and Hospital

- Clinic staff communicates with pharmacy through ePrescribing.
- Arrange for specific clients' prescriptions to be sent directly to the clinic by the pharmacy.
- Pharmacy views electronic prescription; calls clinic when prescription is not picked up (especially for controlled substances).
- Pharmacy packages for adherence (e.g., blister packaging, specify a.m. or p.m.).
- Arrange with hospital to administer long acting injectable forms of medication for clients who have not adhered to medication and has history of frequent hospitalization.

Leverage External Electronic Sources of Clinical Information

- PSYCKES Clinical Summary: tool for conversation/education (medications, pick-up patterns, overall history).
- I-STOP (Internet System for Tracking Over-Prescribing): administrative staff runs I-STOP report for all clients seen by prescriber that day.
- e-Prescribe: used to view client pick-up history.

Substance Use

For clients who have substance use issues, clinics have established procedures to ensure that clinicians evaluate clients' risk factors, develop a treatment plan, and deliver one or more interventions.

Screening and Evaluation

- Staff use standardized screening tools such as the MSSSI-SA (Modified Simple Screening Instrument-Substance Abuse) and CAGE to assess client's substance use.
- Clinicians work with clients to identify patterns of use, past treatment and medical issues, and establish appropriate treatment goals to address the client's substance use.
- Regular urine toxicology screening at the clinic.

Clinical Interventions

- Mental health clinician integrates substance use treatment into treatment plan.
- Clinicians use a harm reduction approach.

- Educate clients about the misuse of prescription drugs and potential problems associated with substance use through distribution of pamphlets, articles and other information sources.
- Prescriber uses I-STOP to monitor a client's use of controlled substances; shares the information with the treatment team.
- Clinician makes referrals to AA, NA, detox, and rehabilitation programs, as needed.
- Refer clients to an OASAS licensed substance abuse treatment program; maintain continued services coordination and interagency communication with the recovery program.
- Provide integrated dual disorder services at the clinic specifically for individuals with co-occurring mental health and addiction issues.
- Enroll clients into clinic's on-site addiction center and relapse-prevention program.
- Clinicians work closely with drug and alcohol staff at clinics providing substance abuse services.
- Work with clients on methadone.

Other

- Clinicians receive ample training on the treatment of dual disorders.

Labs and Physicals

Screening

- Set a goal to have all clients who are taking antipsychotics receive an annual glucose/HbA1c test.
- Set a goal to have all clients diagnosed with diabetes receive an annual HbA1c test.
 - (Note: to ensure consistency of care, set a goal for *all* clients, including those not flagged in the CQI project).
- Differentiate the charts of flagged clients needing screening/monitoring as a reminder to clinicians.
- Order labs for clients needing glucose/HbA1c tests. Check to see if client also needs a lipid panel; order labs if applicable.
- When lab test comes back, discuss abnormalities with PCP.
- Use Patient Health Questionnaire (PHQ9) every 3-6 months to raise awareness about physical and behavioral health issues and how both can improve.
- Clients complete a self-administered health assessment at intake; psychiatrist reviews it.

Annual Physicals

- Set a goal to have PCP name and documentation of a PCP annual visit in the EMR for all clients, even those not flagged in the CQI project.
- Record the name of a client's PCP at intake; enter information into the EMR.
- Periodically run an EMR report specifying those who have a documented PCP in the record; follow up with those that do not.
- Set an EMR flag for clients having no PCPs on record; create a reminder to follow-up with client.

Client Education

- Psychiatrists, nurses and other clinicians provide education to clients about the importance of PCP visits and diabetes screening. Hand client lab slip.
- Provide pamphlets on various subjects.

Referrals to Health Providers in Community

- Develop a relationship with PCP in same building or close by (communicate about mutual clients).

- Make connections with physicians who are sensitive to the needs of specific client populations (e.g., LGBT).
- Use an “appointment confirmation” form for clients who have an appointment with a community provider for health physicals/monitoring. When the appointment is kept, the provider is asked to send/fax it back to clinic with results/comments (along with a signed release form). Arrangement fosters collaboration with provider and clients.
- Track referrals to community providers.
- If a client has a case manager, the case manager takes the client to the appointment or works with the client to set up an appointment with a community provider.

Mental Health Clinic Co-located with Nurse or Medical Service Unit (and other services e.g., OASAS)

- Provide health physicals and/or health monitoring services directly.
- Make health monitoring part of intake.
- Use Health Screening Form. Flag with a star (or other notation) for medical concerns (e.g., high risk, diabetes). Forms are reviewed by a nurse. Data is entered into EMR; reports are run (e.g., to see who is high risk; who has not seen a doctor).
- During intake, therapist identifies clients with medical concerns and routes them to the nurse for further evaluation, treatment or referral. If clients refuse, case managers get involved; families are sent letters.
- Clinic schedules physicals and/or lab work with onsite medical unit; follows up with clients.
- Schedule blood work within 2-3 weeks so client can be reviewed at next medical review appointment.
- Clinic Administrative Director and Quality Assurance department monitor referrals to onsite medical services; aim is for high appointment-kept rate.
- Adjust existing lab work sheets to include HbA1c tests.
- Administer injections as smoothly as possible to prevent bruising and soreness.
- Integrate nurses into CQI project:
 - Nurses keep track of diabetes monitoring and when physicals are due; encourage lab tests and physicals; review and discuss medications with clients; educate clients on health issues/wellness management and community resources (PCPs, urgent care), and train staff to give injections, if appropriate.
 - Vitals are monitored by nurses at medication visits, approximately once per month.
 - Nurses use a form for every client that assesses the many issues related to project. Health information (BMI, last lab, diagnoses etc.) is tracked on nursing assessment. Forms are compiled monthly and given to CQI Chair who aggregates data and provides feedback to team.
 - Injections are given by nurses (facilitates adherence).

Other

- Front desk “Blood Work Due” alerts are noted on desk sheet and schedule.
- Peers follow-up with clients and providers regarding clients’ appointment-keeping and health status.
- Integrate care management (CM) into clinic processes; CM staff use PSYCKES data. QI staff identifies clients with significant medical concerns, then CM staff links clients to primary care physicians, coordinates blood work, and work with the psychiatrists in order to break down silos between mental and medical health.