



# **New York State Office of Mental Health (OMH) Continuous Quality Improvement (CQI) Initiative for Health Promotion and Care Coordination**

## **CQI Handbook**

## Acknowledgements

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## Chapter 1. Project Overview

### Introduction

The New York State Office of Mental Health (OMH) welcomes the participation of freestanding mental health clinics and diagnostic and treatment centers in the OMH Continuous Quality Improvement Initiative (CQI) for Health Promotion and Care Coordination. The initiative, which was launched in December 2012, aligns with statewide priorities of the Medicaid Redesign Team by focusing on quality concerns related to health promotion and behavioral health care coordination in the New York State (NYS) Medicaid population. It builds on the success of the OMH Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES)-CQI Initiative (2008-2012) to improve psychotropic prescribing practices among NYS Medicaid enrollees.

OMH licensed mental health clinics (other than state-operated clinics) and diagnostic and treatment centers receive a Medicaid fee enhancement for their active participation in the CQI initiative. The enhancement is available for fee-for-service and managed care Medicaid services. The enhancement will be offered at least through March 31, 2015 (the end of the State Fiscal Year 2014-15). For details, see the “Brief Financial History and Status of OMH’s Quality Improvement Initiative for Clinics in the Appendix.

The two project options for the current initiative are the Health Promotion and Coordination project and the Behavioral Health Care Coordination project.

- The goal of the Health Promotion and Coordination project is to ensure that appropriate planning and coordination takes place for individuals at risk for high utilization of medical inpatient services and medical emergency room (ER) services. It also aims to increase appropriate laboratory monitoring/screening and outpatient medical visits.
- The goal of the Behavioral Health Care Coordination project is to ensure the planning and coordination for individuals with histories of high utilization of inpatient and emergency room behavioral health services, as well as individuals with a diagnosis of schizophrenia, bipolar, or depression and who might have concerns related to adherence and continuation of certain medications.

Indicator sets aligned with the two projects are available in the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES). For a description of the seven indicators within both sets, see the Indicator Descriptions in Chapter 2. Participating clinics are strongly encouraged to use PSYCKES to identify individuals who have been flagged as having a quality concern and to access client-level information for clinical decision-making.

A new feature of the current initiative is the on-line training provided through The Center for Practice Innovations (CPI) at Columbia Psychiatry and New York State Psychiatric Institute. Developed for real-world settings, CPI’s practical approach features concise online learning modules that allow practitioners to choose when and where to take their training. Along with the learning modules, CPI offers free online implementation supports to program leaders, clinical supervisors, and practitioners through webinars and teleconferences.

### Project Requirements

During the course of the initiative, clinics are expected to actively participate by fulfilling the following project requirements:

**Enrollment:** Clinics invited to participate in the CQI Initiative must enroll by completing the Participating Clinic Contact Form via a survey. New clinics interested in participating must contact PSYCKES-Help.

**Project Related Training:** Initial training for the project included two mandatory webinars, Quality Concerns and Project Activities and Expectations, and an optional webinar, Project Planning Form Review. Each participating clinic was expected to send two staff members to the mandatory webinars. Recorded versions of CQI project-related webinars are available on the PSYCKES Website to view anytime, but do not count toward meeting the training requirement.

**CPI On-line Training:** Clinics must ensure that at least 25% of eligible staff complete 10 CPI on-line training modules identified for each project option. Eligible staff are defined as direct care staff and clinical supervisors (including prescribers and medical directors) working at least 20 hours per week at the clinic. For an overview of CPI, on-line training and additional CPI resources, see Chapter 6 – Center for Practice Innovations.

**Project Selection:** Clinics must select a project (either the Health Promotion and Coordination project or the Behavioral Health Care Coordination project). Quality indicator sets are available in PSYCKES for each project. During the course of the initiative, clinics are expected to address quality issues associated with all of the indicators within the selected indicator set. Important criteria for selecting a project include considerations of “high volume, problem prone and high risk,” as well as input from clinical and CQI staff, alignment with agency and clinic priorities and other agency/clinic projects, and experience gained in the previous phases of the CQI initiative. Clinics should review data from PSYCKES and other clinic information to inform the project selection process.

**Project Planning Form:** All participating clinics must submit a Project Planning Form (PPF) that documents agency/clinic demographic data, project selection, and information about clinic workflow processes and clinical interventions identified or planned to support the selected QI project. Clinics are expected to use the PPF as the basis for their action plan(s) over the course of project implementation.

**Define-Measure-Analyze-Improve-Control (DMAIC):** Clinics must use DMAIC or another robust CQI model to structure their project work. In earlier phases of the initiative, clinics implemented best practices using the FOCUS-Plan-Do-Check-Act (PDCA) model. OMH has transitioned to the Define-Measure-Analyze-Improve-Control (DMAIC) model and recommends that clinics adopt the DMAIC approach. Though the terminology of the DMAIC model is different from PDCA, many of the concepts are similar. For an overview of the DMAIC processes and the steps for implementing a CQI project within the DMAIC model, see Chapter 4 - Implementing a CQI Project.

**On-line monthly data reporting:** Online monthly reporting began in August 2013. Clinics initially report each month on progress towards key project milestones. At an appropriate point, monthly reporting will transition towards quantitative reporting of key project metrics.

**Site Visits and Conference Calls:** OMH will conduct site visits or conference calls with select clinics to review challenges, lessons learned, and best practices.

**Interim project report:** Approximately mid-way through the initiative, clinics will be required to report more comprehensively on workflow processes, clinical strategies and interventions and project impact.

## Chapter 2. PSYCKES Indicators for CQI Initiative for Health Promotion and Care Coordination

Quality measures to support the CQI Initiative are available in the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES). These quality measures are organized into two indicator sets, one associated with each project option:

- Health Promotion and Coordination
- Behavioral Health Care Coordination

Below are descriptions of the indicator sets and the quality measures included in each set.

### Health Promotion and Coordination

The goal of the Health Promotion and Coordination project is to improve care planning and coordination for individuals with serious medical conditions, or who are not engaged in outpatient medical care. Quality measures aligned with the Health Promotion and Coordination project identify individuals with histories of high utilization of medical inpatient services and medical emergency room (ER) services, and those who may be in need of appropriate laboratory monitoring/screening and outpatient medical visits. The indicator set includes a summary indicator identifying the number of unique individuals who meet criteria for any of the Health Promotion and Coordination indicators. Three indicators focused on preventable hospitalization are targeted to adults, and four apply to both adults and children. In addition to the summary indicator, the Health Promotion and Coordination set includes the following measures:

- **High Utilization of Medical Inpatient / Emergency Room** (*4+ Inpatient/ER – Med*)<sup>1</sup> Medicaid enrollees of all ages who have had 4 or more non-behavioral health inpatient hospitalizations or ER visits in the past 12 months<sup>2</sup>.
- **Preventable Hospitalizations - Adult Asthma**<sup>3</sup> (*Prevent Hosp Asthma*) Adult Medicaid enrollees who had one or more hospitalizations due to asthma in the past 12 months.
- **Preventable Hospitalizations - Adult Diabetes** (*Prevent Hosp Diabetes*) Adult Medicaid enrollees who had one or more hospitalizations due to diabetes in the past 12 months.
- **Preventable Hospitalizations - Adult Dehydration** (*Prevent Hosp Dehydration*) Adult Medicaid enrollees who had one or more hospitalizations due to dehydration in the past 12 months.
- **No Diabetes Screening for Individuals on Antipsychotics** (*No Diabetes Screening-On Antipsychotic*) Non-dual eligible Medicaid enrollees of all ages on any antipsychotic without a diabetes screening test (glucose/HbA1c) in the past 12 months.

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<sup>1</sup> The italicized text in parentheses is the name of the indicator displayed in PSYCKES.

<sup>2</sup> For all indicators, “in the past 12 months” is defined as 12 months prior to the PSYCKES report date (located on the top left corner of the Quality Indicator Overview screen in PSYCKES).

<sup>3</sup> The indicators related to preventable hospitalization are based on Prevention Quality Indicators developed by the Agency for Healthcare Research and Quality (AHRQ), which are intended to identify population rates of hospitalizations for conditions that should be preventable with adequate outpatient care ([http://www.qualityindicators.ahrq.gov/Modules/pqi\\_overview.aspx](http://www.qualityindicators.ahrq.gov/Modules/pqi_overview.aspx)).

- **No Diabetes Monitoring for Individuals with Diabetes** (*Diabetes Monitoring-No HbA1c >1Yr*) Non-dual eligible Medicaid enrollees of all ages diagnosed with diabetes who did not have a diabetes HbA1c test in the past 12 months.
- **No Outpatient Medical Visit** (*No Outpatient Medical Visit >1 Yr*) Medicaid enrollees of all ages without any outpatient medical visit (non-behavioral health office visits, home services, preventive services, medical exams, ob/gyn or prostate screenings) in the past 12 months.

## Behavioral Health Care Coordination

The goal of the Behavioral Health Care Coordination project is to improve care planning and coordination for individuals who may be poorly engaged in outpatient behavioral health services. Quality measures aligned with the Behavioral Health (BH) Care Coordination project identify individuals with histories of high utilization of inpatient and emergency room behavioral health services, or who may have difficulty taking psychotropic medication as prescribed. The indicator set includes a summary indicator identifying the number of unique individuals who meet criteria for any of the Behavioral Health Care Coordination indicators. All measures apply to both adults and children. In addition to the summary indicator, the Behavioral Health Care Coordination set includes the following measures:

- **High Utilization of Behavioral Health Inpatient / Emergency Room**<sup>4</sup> (*4+ Inpatient/ER – BH*)<sup>5</sup> Medicaid enrollees of all ages who have had 4 or more BH inpatient/ER stays in the past 12 months.<sup>6</sup>
- **High Utilization of Behavioral Health Inpatient Services** (*3+ Inpatient – BH*) Medicaid enrollees of all ages who have had 3 or more BH inpatient hospitalizations in the past 12 months.
- **High Utilization of Behavioral Health Emergency Room** (*3+ ER – BH*) Medicaid enrollees of all ages who have had 3 or more BH ER visits in the past 12 months.
- **Behavioral Health Rehospitalization within 45 Days** (*Readmission - All BH 45 day*) Medicaid enrollees of all ages with at least one BH hospitalization who had 1 or more BH hospitalization within 45 days of discharge in the past 12 months.
- **Adherence to Antipsychotic Medications for Individuals with Schizophrenia** (*Adherence – Antipsychotic (Schz)*) Medicaid enrollees (ages 0-64) diagnosed with schizophrenia who had an antipsychotic medication available to them less than 80 percent of the time from the first observed antipsychotic medication to the PSYCKES report date in the past 12 months.
- **Adherence to Mood Stabilizer Medications for Individuals with Bipolar Disorder** (*Adherence - Mood Stabilizer (Bipolar)*) Medicaid enrollees (ages 0-64) diagnosed with bipolar disorder who had a mood stabilizer or antipsychotic medication available to them

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<sup>4</sup> The episodes include mental health and substance use (detoxification and rehabilitation).

<sup>5</sup> The italicized text in parentheses is the name of the indicator displayed in PSYCKES.

<sup>6</sup> For all indicators, “in the past 12 months” is defined as 12 months prior to the PSYCKES report date (located on the top left corner of the Quality Indicator Overview screen in PSYCKES).

less than 80 percent of the time from the first observed mood stabilizer or antipsychotic medication to the PSYCKES report date in the past 12 months.

- **Antidepressant Trial of less than 12 weeks for Individuals with Depression**  
(*Antidepressant < 12 weeks (Depression)*) Medicaid enrollees (ages 0-64) diagnosed with major depression who were newly started on an antidepressant medication in the past 12 months, but did not remain on any antidepressant for a minimum of 12 weeks.

## Chapter 3. Quality Concerns

### CQI Initiative Project Option 1: Health Promotion and Coordination

#### Quality Goals

The goals of the Health Promotion and Coordination project are to ensure identification, planning, and coordination of services for clients with high utilization of medical inpatient and emergency room (ER) services and to increase appropriate laboratory monitoring and annual physicals.

There are several reasons why mental health clinics could be well-positioned to support improved health outcomes among their clients, many of whom may have co-morbid medical conditions. Mental health clinics may see their clients several times per month, providing frequent opportunities for engagement and intervention. Clinics may have expertise in motivational interviewing, wellness self-management, group work, peer support, and other interventions that can be used to promote health outcomes. Finally, systems changes in New York State include new mental health clinic regulations that permit billing for optional medical services, and opportunities for care coordination through Medicaid Health Homes.

Indicators in the Health Promotion and Coordination set fall under two quality improvement aims:

1. Identification, planning, and coordination of services for consumers with high utilization of medical inpatient and ER services:
  - High utilization of medical inpatient/ER services (4+ in the past year)
  - Preventable medical hospitalization (1+ in the past year)
2. Increased, appropriate laboratory monitoring and annual physicals:
  - No diabetes screening for individuals on antipsychotic (within the past year)
  - No diabetes monitoring for individuals with diabetes (within the past 1 year)
  - No outpatient medical visit (within the past year)

#### Scope of the Problem

##### Comorbidity in Health and Mental Health

On average, persons with serious mental illness die approximately 25 years earlier than the general population (Parks, Radke, Mazade & Mauer, 2008), with the leading causes of death concentrated among medical concerns such as heart disease. This reality emphasizes the critical role of health promotion and care coordination initiatives in the behavioral health population (Parks et al., 2008).

Research suggests high levels of medical and mental health co-morbidity. A national survey found that 68 percent of adults with mental health issues also suffered from medical conditions, and 29 percent of adults with medical conditions were found to have had concurrent mental health conditions (Druss & Reisinger-Walker, 2011). In the NYS Medicaid population, rates of many serious medical conditions are higher in the mental health population than among the non-MH population, including hypertension (33.7% compared to 25.5%), heart disease (31.2% compared to 21.2%), asthma/COPD (23.7% compared to 15.1%), and diabetes (17.2% compared to 13.5%) (Coughlin and Shang, 2011). The relationship between physical and mental health is a complex set of pathways with shared risk factors (Druss & Reisinger-Walker,

2011). Behaviors associated with poor health outcomes (e.g., tobacco and other substance use, poor nutrition, sedentary lifestyle) are more prevalent in the behavioral health population (Druss and Reisinger-Walker, 2011). Iatrogenic risks such as weight gain, obesity, and diabetes related to certain psychotropic medications interact with these behaviors and contribute to high rates of comorbidity. Low rates of recommended lab screening and monitoring as well as low adherence to medication contribute to poor client outcomes.

## **Fiscal Impact of Comorbid Medical Conditions in the NYS Medicaid Program**

Comorbidity contributes substantially to state expenditures for the Medicaid population. The annual cost of the NYS Medicaid program for complex/chronic conditions is \$26 billion, including \$6.3 billion for services to 400,000 individuals with serious behavioral health disorders (New York State Office of Mental Health, 2012a). On average, 74% of NYS Medicaid spending for enrollees with mental health conditions is for non-MH services); moreover, non-MH spending for the MH population is 32% higher than for the non-MH population (Coughlin & Shang, 2011. In 2009, NYS Medicaid covered 90,546 avoidable admissions at a cost of \$824 million (Patterson & Lindsey, 2012).

For these reasons, the Health Promotion and Coordination project focuses on intervening to improve control over medical conditions, prevent high utilization of acute medical services, and increase client engagement in outpatient medical care.

## **Strategies and Interventions: Health Promotion and Coordination**

### **Overview of Strategies**

To address these quality concerns, the Health Promotion and Coordination project identifies several areas for potential improvement:

- Integrating/coordinating physical and mental health services for mental health clinics.
- Identifying, planning, and coordination of services for clients with high utilization of medical inpatient and ER services.
- Promoting laboratory monitoring and annual physicals.

### **Models and Options for Integrating / Coordinating Care**

Increasingly, opportunities exist for mental health clinics to provide basic medical services (e.g., providing physical exam, ordering labs). In 2010, OMH adopted new clinic regulations—14 New York Code, Rules and Regulations (NYCRR) Part 599. For more information on optional clinic services, see the [guidance document](#) on the OMH website (New York State Office of Mental Health, 2012b). Section 599.8 identifies several new optional clinic services. The two that are most relevant for the Health Promotion and Coordination project are Health Physicals and Health Monitoring Services. A *Health Physical* is defined as the evaluation of an individual, including an age/gender appropriate history, exam, and the ordering of laboratory/diagnostic procedures. Health physicals may be provided by a medical doctor, nurse practitioner, or physician's assistant. *Health Monitoring* is defined as the continued measuring of specific health indicators associated with increased risk of medical illness and early death. Specific health indicators for adults are blood pressure, body mass index (BMI), substance use and smoking cessation. Specific health indicators for children are BMI percentile, activity/exercise level, and smoking status. Health monitoring may be conducted by a medical doctor, nurse practitioner, registered nurse, licensed practical nurse, or physician's assistant.

Additional approaches to integrating and coordinating care focus on developing relationships with medical providers and lab services. One option is for a clinic to partner with medical

providers who provide health physicals for clients on-site at its clinic or at the provider's clinic/office. Ongoing links may be forged with nearby medical providers and clinics may refer clients to those medical providers for health care services. Some providers may include Office of Alcoholism and Substance Abuse (OASAS) providers, Office for Persons with Developmental Disabilities (OPWDD) providers, foster care providers, and medical providers to support ongoing treatment of medical co-morbidity. Clients may also be referred to a Health Home to obtain additional care management support.

### **Approaches to Reducing High Utilization and Increasing Engagement**

Strategies to reduce high utilization of medical inpatient and ER services should begin by identifying clients with this quality concern and determining the factors contributing to the client's hospital utilization. Clinics can use quality flags available in PSYCKES as well as collateral information to identify clients who have a history of acute service utilization for medical reasons. QI teams should develop processes to ensure that all relevant staff are aware of these clients. We strongly recommend that QI teams develop a Master Spreadsheet to facilitate the work of the project. See the Appendix for instructions on how to create an Excel spreadsheet using PSYCKES.

Clinical staff conducting a client evaluation should review the client's Clinical Summary to review data on inpatient and ER high utilization patterns, recent hospitalizations, medication use, and conversely, for gaps in services and/or medication. The PSYCKES Clinical Summary provides up to five years of individual client data across all treatment settings, including both physical and behavioral health. The QI team should determine a process for ensuring that clinical staff have access to the Clinical Summary. For example, a designated person could download the Clinical Summary and put it in the client's medical record, or distribute it to clinicians conducting the evaluation. Or, clinical staff could be granted access to PSYCKES and expected to access PSYCKES directly to review a Clinical Summary.

Evaluation of the client should include a face-to-face discussion between the client and one or more members of the clinical team to evaluate the client's reasons and risk factors for high utilization of medical health inpatient and ER services. Some reasons may include comorbidity, poor access to primary care, using the ER for primary care, low engagement in outpatient services, medication non-adherence, and self-management challenges. Pinpointing where inadequate support for medical conditions exist is crucial for developing interventions for high utilizers. Potential interventions to address identified risks are given below.

Issue	Possible Interventions
Uses ER for primary care treatment	Support linkage to primary care Client education
Comorbid condition in poor control, low adherence/ low engagement in medical care and/or low wellness self management	Self management program Motivational interviewing - adherence Other interventions to decrease risks (smoking, nutrition, exercise) Refer to health educator Support relationship with medical provider
Comorbid condition in poor control, inadequate support	Interventions identified above Refer for additional services, e.g. health home care management, home attendant

Clients who are at increased risk for medical inpatient and ER service utilization may benefit from interventions to improve medication access and adherence. Possible strategies may include refill monitoring and reminders; management of logistical barriers, pre-packed medications for consumers with cognitive impairment, and consumer education. Care management is a further support for high utilizers, which addresses both mental and medical health as well as concrete services. Care managers can facilitate and monitor consumers' access to substance abuse treatment and regular primary care checkups.

### Self-Management Program (SMP) Models

Enabling clients to manage their medical conditions is another potential intervention. Self-Management Programs (SMPs) employ several core components in their approach: facilitated groups; structured curriculum focused on disease management; problem-solving and action planning; and tools and resources (e.g. self-management records). There is a growing body of evidence suggesting SMPs can be adapted for the behavioral health population, such as the Health and Recovery Peer Program (Druss et al., 2010) and the Living Well program (Goldberg et al., 2013). The Office of Mental Health has developed a Wellness Self-Management curriculum that is available to interested clinics. For more information, please contact the Center for Practice Innovations.

### Referrals

Mental health clinics should consider which services are appropriate to a client's needs based on the initial assessment of factors contributing to the client's use of inpatient and/or ER services. If the clinic identifies gaps in services, possible referrals might include health home care management or home attendants. Clinics are encouraged to work with the client's other providers, such as a primary care doctor if available, to ensure appropriate referral and follow-up.

Self-management training (SMT) is an increasingly viable option for Medicaid clients with asthma or diabetes. Medicaid covers asthma or diabetes SMT delivered in a diagnostic and Treatment Center or hospital outpatient clinic by a certified health educator (see [National Certification Board for Diabetes Educators](#) and [National Asthma Educator Certification Board](#)).

## Increasing Annual Physicals and Lab Monitoring

The Health Promotion and Coordination project emphasizes interventions to increase engagement in outpatient services as a means of decreasing avoidable, costlier inpatient and ER care for clients in the behavioral health population. One component of this project is to ensure that clients receive appropriate laboratory monitoring and at least one outpatient medical visit (e.g., an annual physical) each year. Clinics can use quality flags available in PSYCKES as well as collateral information to identify clients who are overdue for labs and/or physicals. QI teams should develop processes to ensure that all relevant staff are aware of these clients. We strongly recommend that QI teams develop a Master Spreadsheet to facilitate the work of the project. See the Appendix for instructions on how to create an Excel spreadsheet using PSYCKES.

To complement this effort, clinic staff should educate clients on the rationale behind increasing their use of these services. For instance, communicating the benefits and long-term importance of regular medical assessment/care, screening for diabetes, and disease management and monitoring are all subjects around which to engage clients.

Clinics should consider a variety of strategies to promote annual physicals and laboratory monitoring. As described above, clinics might obtain operating certificates in order to provide health physicals at the clinic, or partner with another provider to offer physicals on-site or at another location. Clinics may flag charts of clients with overdue labs and physicals in order to ensure that all staff are aware of the quality concern, and offer support around scheduling, appointment reminders, and transportation. Patient education and activation efforts could range from provision of educational materials in the waiting room to implementation of Self Management Programs. Finally, clinics should develop procedures to ensure that records of lab tests and physicals are reviewed by appropriate clinical staff to inform treatment decisions.

Interventions should be incorporated into clinic workflows, and clearly define which staff is responsible for each component of the intervention. Some sample interventions include:

- At check-in, front desk staff identify clients with overdue labs and/or physicals. They notify the client and flag the chart so that the registered nurse, medical doctor and/or therapist are aware and can follow up with the client.
- After checking in with the front desk, the client sees a nurse who checks weight, blood pressure, and lab/ physical status prior to seeing the psychiatrist.
- The psychiatrist incorporates weight, review of health status/utilization, and any labs/physical due into the medication visit.
- The primary therapist uses motivational interviewing during the client's session to explore barriers to engagement in primary care.

## Project Option 2: Behavioral Health Care Coordination

### Quality Goals

The goals of the Behavioral Health Care Coordination project are to increase identification, planning and coordination of care for clients at risk for high utilization of behavioral health inpatient and emergency room services, as well as increasing medication adherence for individuals with a diagnosis of schizophrenia, bipolar, or depression. This project is aligned with both state and national initiatives to decrease hospital readmissions as well as the shift toward person-centered models of care.

Indicators within the Behavioral Health Care Coordination set fall under two categories of quality concerns:

1. Identification, planning and coordination of care for consumers with high utilization of behavioral health inpatient and ER services
  - High utilization of BH Inpatient/ER services (4+ in past year)
  - High utilization of BH inpatient services (3+ in past year)
  - High utilization of BH ER services (3+ in past year)
  - BH Readmission within 45 days (in past year)
2. Medication adherence / continuation
  - Antipsychotic medication adherence – schizophrenia
  - Mood stabilizer adherence – bipolar
  - Antidepressant discontinuation

## Scope of the Problem

### NYS Behavioral Health System

Around 50 percent of the \$7 billion annual spending in the NYS mental health system is for inpatient care. Fragmentation across the New York State behavioral health system in part drives poor client outcomes (New York State Department of Health, 2011).

Approximately one-third of MH Medicaid enrollees with inpatient hospital stays do not receive subsequent outpatient follow up within 30 days (Coughlin and Shang, 2011).

A history of inpatient utilization increases the risk for subsequent hospitalizations. Other risk factors for behavioral health hospitalization include substance use, low engagement in outpatient services, challenges in disease self-management and medication non-adherence.

Research has shown that adherence rates in the behavioral health population for second generation antipsychotics is 50-60 percent and 65 percent for antidepressants. Low adherence increases the risks of relapse, decreased treatment effectiveness, and hospitalizations (Stephenson et al., 2012; Svarstad, Shireman & Sweeney, 2001; Weiden & Olfson, 1995). In addition, research found large discrepancies between providers' perception of their clients' medication adherence and the actual adherence rates (Stephenson et al., 2012). Common barriers to adherence include forgetfulness, other priorities, omitting doses, lack of information, and emotional factors (Osterberg and Blaschke, 2005).

## Strategies and Interventions

### Approaches to Reducing High Utilization and Increasing Engagement

Clinics should establish processes for identifying clients with this quality concern or at risk of relapse. Clinics can use quality flags available in PSYCKES as well as collateral information to identify clients who have a history of or risk factors associated with acute service utilization for behavioral health reasons. QI teams should develop processes to ensure that all relevant staff are aware of these clients. We strongly recommend that QI teams develop a Master Spreadsheet to facilitate the work of the project. See the Appendix for instructions on how to create an Excel spreadsheet using PSYCKES.

Clinical staff conducting a client evaluation should review the client's Clinical Summary to review data on inpatient and ER high utilization patterns, recent hospitalizations, medication use, and conversely, for gaps in services and/or medication. The PSYCKES Clinical Summary provides up to five years of individual client data across all treatment settings, including both physical and behavioral health. The QI team should determine a process for ensuring that clinical staff have access to the Clinical Summary. For example, a designated person could download the Clinical Summary and put it in the client's medical record, or distribute it to clinicians conducting the evaluation. Or, clinical staff could be granted access to PSYCKES and expected to access PSYCKES directly to review a Clinical Summary. Evaluation of the client must include a face-to-face discussion between the client and one or more members of the treatment team to evaluate the client's reasons and risk factors for high utilization of behavioral health inpatient and ER services. Some reasons may include comorbid substance use, gaps in outpatient care, challenges in taking medication as prescribed, inadequate social supports, and self-management challenges. Potential interventions to address identified risks are given below.

Issue	Possible Interventions
Co-morbid substance	Integrated Dual Diagnosis Treatment; coordinate with OASAS provider; motivational interviewing; medication-assisted alcohol treatment
History of poor medication adherence	Long-acting injectable medications; clozapine; CBT or motivational Interviewing focusing on adherence; behavioral tailoring/cue-dose training; pill boxes; medication reminders
History of poor engagement	CBT or motivational interviewing focusing on engagement; peer support; appointment reminders; self-management programs; family involvement; assisted outpatient treatment
Inadequate support, or homeless	Refer for Health Home Care Management services; link to community resources and social support services; housing services
Stressor/ coping skills	CBT; self-management program; peer support; skill training; family/social network involvement

Clinics should consider a multi-faceted approach when working to improve client engagement. Interventions may be on-site, or clinics can develop linkages with additional service providers through referrals. Possible strategies to reduce high utilization of behavioral health inpatient/ER services include:

- Identifying early warning signs of relapse
- Medication related approaches
  - Use of teach back methods to ensure that clients understand their medications
  - Reminders
- Psychosocial Interventions

- Integrated treatment for substance use disorder
- Motivational Interviewing
- Cognitive Behavioral Therapy
- Skills training
- Additional supports
  - Peer support
  - Family involvement
  - Refer to Health Home for care management support
  - Refer for Assisted Outpatient Treatment via OMH field office or local government unit
  - Referral to community resources and social support services
  - Linking to housing services

### **Medication Related Interventions**

Research has shown medication related approaches to low engagement are effective in treating behavioral health conditions. Several studies of note include:

1. Depot medications associated with less rehospitalization and reduced risk of relapse (Leucht et al., 2011; Tiihonen et al., 2011)
2. Clozapine underutilized as evidence-based treatment for refractory illness (Mistry & Osborn, 2011)
3. Use of medication for alcohol dependence is associated with reduced readmissions and cost. (Baser, Chalk, Rawson & Gastfriend, 2011; Bryson, McConnell, Korthuis & McCarty, 2011)

### **Medication Adherence: Clinical Strategies**

Other approaches address the opportunities for provider dialogue and joint planning with clients to improve adherence. First, identifying where side-effects and barriers to taking medication are present enables enhanced communication and shared decision making. In some cases, family members may be included in a client's education and medication monitoring. Several other clinical strategies are:

- Simplify daily dosing
- Use pillbox to organize daily doses
- Cue-dose training / behavioral tailoring to take medications at a specific time
- Provide feedback to clients

In addition, beyond the interpersonal interaction with clients, clinics can implement changes to their work flow and organization to reduce barriers to adherence:

- Increase clinic hours to decrease wait times
- Enlist other health care providers
- Reminders – e.g. notifications programmed in to cell phone

## **Medication Adherence: Motivational Interviewing (MI)**

MI has been shown to be a promising intervention for engaging clients in their treatment by reducing patients' ambivalence and improving adherence. MI principles encourage providers to express empathy, develop discrepancy, roll with resistance, and support client self-efficacy. The method through which this is accomplished is a set of therapeutic skills: open-ended questions, affirmations, reflective listening, and summaries (Laakso, 2012).

## **Other Approaches**

As part of the CQI Initiative, clinics have the opportunity to access online trainings via Center for Practice Innovations modules.

Integrated Dual Disorders Treatment (IDDT) focuses on the improved integration of treatment for multiple disorders by implementing the following practices: assertive engagement, comprehensiveness of services, motivation-based treatment, reduction of negative consequences, time unlimited services, and multiple psychotherapeutic modalities. On-line training available via OMH Health Focus on Integrated Treatment (FIT) Module.

Cognitive Behavioral Therapy, which aims to improve consumers' ability to recognize and develop coping strategies for target symptoms, is also an effective approach to improving client outcomes (Morrison, 2009).

The implementation of New York State Medicaid Health Homes new options for individuals who could benefit from a higher level of care through the coordination of health care needs, including intensive case management. Intensive case management has been found to reduce hospitalizations and increase engagement in outpatient care compared to standard care and non-intensive case management, particularly for individuals with high levels of hospitalization (Dieterich, Irving, Park & Marshall, 2010). Similarly, Assisted Outpatient Treatment is associated with improved outcomes, including reduced hospitalization and greater engagement in outpatient services (Swartz et al., 2010).

## Chapter 4. Implementing a Continuous Quality Improvement Project Using the Six Sigma (DMAIC) Model

Six Sigma is a quality improvement methodology originally developed by Motorola in 1985 to improve manufacturing processes. The term “Six Sigma” refers to the goal of reducing errors to 3.4 parts per million. Six Sigma emphasizes the use of data to improve process capabilities, reduce variability, and minimize defects. Teams focus on customer requirements to identify and define processes that are critical to quality.

Embraced by companies such as Honeywell and General Electric, Six Sigma moved into healthcare in the late 1990s as a method of improving safety, quality, and efficiency (Chassin, 1998). The Six Sigma approach has been used to improve referral processes (Deckhard, Borkowski, Diaz, Sanchez & Boissette, 2010), compliance with the Centers for Disease Control and Prevention (CDC) guidelines (Eldridge et al., 2006), patient satisfaction (DuPree et al., 2009), postoperative handoff procedures (Mistry et al., 2008), and infection rates (Frankel et al., 2005; Hansen, 2006). See Vest & Gamm (2009) for an assessment of the research literature on Six Sigma healthcare.

Six Sigma uses a modified version of Deming’s Plan-Do-Check-Act quality control cycle, Define-Measure-Analyze-Improve-Control (DMAIC). The Six Sigma emphasis on data and planning shows in the elaboration of the Plan step into separate phases of Define, Measure, and Analyze. The Do-Check steps are contained within the Improve step, where clinics implement change and assess whether the changes are having the desired effect. The Control phase of DMAIC is analogous to the Act step, as both envision the routinization of changes validated in the previous step.

Deming PDCA	Six Sigma
Plan	Define Measure Analyze
Do Check	Improve
Act	Control

The DMAIC steps are presented below within the context of the OMH Health Promotion and Care Coordination Initiative.

### Recognize

Many organizations begin their Six Sigma quality work with a Recognize step (similar to the FOCUS step of FOCUS-PDCA) to assess gaps in performance. These gaps represent opportunities for improvement. In this step, the quality improvement (QI) team should review training materials with the team and other key staff (available at [www.psyckes.org](http://www.psyckes.org)); review prevalence of relevant indicators (Health Promotion and Coordination/Behavioral Health Care Coordination) within PSYCKES, and select a project.

Factors to consider in project selection include:

1. Baseline prevalence of PSYCKES indicators: opportunities for improvement include quality concerns where the agency prevalence is high compared to regional/state prevalence, and those that identify greater numbers of clients with quality flags.
2. Input from staff: what do staff think are critical concerns for clients served at the clinic?
3. Alignment with clinic's priorities: are there other projects underway that align with one of the indicator sets? Does the clinic have experience with certain interventions?
4. Quality concerns that are "high risk, high volume, problem prone."
5. Experience gained from other quality improvement projects

## Define

In the Define phase, QI teams begin to define the quality concern to be addressed, the critical process relevant to the issue, and the timeframe for the QI project. This often is captured in a Project Charter or Action Plan. In this step, the QI team should establish a team, identify overarching goals for the project, assess organizational resources and supports, review organizational processes, and determine a timeline for the project.

For example, a clinic working on Health Promotion may wish to include a nurse or other clinician with expertise in this area, or determine whether there are plans to apply for an operating certificate to provide optional services associated with health promotion.

## Measure

The Six Sigma focus on data is reflected in the Measure phase. During this period, teams consider what data will be needed to guide the project and how it will be collected and analyzed. QI teams should identify key project metrics, and build on the review of organizational processes to develop detailed process maps of relevant workflow. For example, QI teams may wish to track how many clients have had an assessment of risk factors. Understanding the workflow involved in client assessment will identify where project-related activities could best be integrated. Development of a data collection plan (*what* data will be collected, *how* will it be collected, and *who* will collect it) is critical to support data-driven decisions by the QI team. Examples of data that clinics may need to track include:

- For Health Promotion and Coordination: who needs lab work, when referrals are made, when lab results are put in the chart
- For Behavioral Health Care Coordination: who is at high risk of admission, whether a clinical evaluation to determine appropriate intervention(s) has been done, whether intervention(s) were delivered

The team should also develop a plan for communicating project data to staff and leadership, e.g. through staff meetings, e-mail, bulletin board materials, or other reporting mechanisms.

## Analyze

Six Sigma emphasizes careful planning to promote project success. In the Analyze phase, teams use information collected during the Define and Measure phases to identify sources of variation: what factors seem to be associated with the quality flags? For example, does substance use play a role in readmissions? Are there language barriers that may be contributing to low rates of engagement in primary care? Review of process maps can help

determine whether there are activities that don't seem to be working well and could be retooled to support the project. For example, clinics working on Health Promotion may wish to review procedures currently in place to ensure clients obtain an annual physical and re-design those that don't seem to be successful. After reviewing potential sources of variation in the data, the team should consider which may be the most important to address. For example, if there is variation by prescriber in the number of clients flagged for potential medication adherence issues, clinics may consider exploring this further to identify potential interventions such as training. Finally, the team should use data to understand how the clinic is performing at baseline, and set a target for improvement.

## **Improve**

During the Improve phase, clinics implement strategies to address opportunities for improvement and root causes of variation identified in the Measure and Analyze phases. Clinic QI teams should identify, implement and monitor processes and strategies to achieve project goals, including 1) strategies to build capacity for targeted clinical interventions, such as motivational interviewing or behavioral tailoring, and 2) workflow redesign to ensure that clients with quality concerns are identified, evaluated, and receive one or more relevant interventions.

Capacity-building interventions, such as on-line training through the Center for Practice Innovation, and supervision sessions focused on the clinical intervention, support the ability of clinical staff to deliver appropriate interventions to reduce risk factors associated with behavioral health service utilization and promote behavioral health care coordination. Workflow redesign provides the structure to ensure that the right interventions are delivered to the right clients at the right time, and that the QI team can track and assess progress towards project goals.

Clinics are strongly encouraged to develop Action Plans with measurable steps to achieve project goals. An Action Plan includes documentation of specific tasks linked to project strategies and goals, and specifies key details such as the staff responsible, resources required, timeframe for completion, and the definition of success/completion

## **Control**

In the Control phase, clinics work to ensure that strategies found to be effective in the Improve phase are sustained through integration into routine workflow. Clinic QI teams should review performance to sustain improvement, establish corrective plans as needed, and translate/transfer learning. For example, if a clinic develops a risk assessment tool that proves to help clinicians target interventions, that could become part of the intake packet and quarterly treatment plan review. The team should meet at least monthly to review data at the client, clinician, and clinic level; progress towards goals; and barriers to change. Finally, the team should regularly inform staff and leadership about the project's progress and outcomes.

## Chapter 5. Using PSYCKES to Support Project Goals

Clinics participating in the CQI Initiative for Health Promotion and Care Coordination will use the PSYCKES-Medicaid application in various ways to help support project goals. The use cases below are presented within the framework of the Define-Measure- Analyze-Improve-Control (DMAIC) model. See Chapter 4 for an overview of the DMAIC model within the context of the OMH Initiative for Health Promotion and Care Coordination.

### Using PSYCKES and the DMAIC Model

#### Review Prevalence of Quality Indicators (Recognize, Define and Measure Phases)

Throughout the CQI project, (especially in the DMAIC Recognize, Define and Measurement phases), clinics should review prevalence data in PSYCKES. To view prevalence data for your agency, after you log into PSYCKES:

- Display Quality Indicator Overview screen (“My QI Report” tab)
- Click Modify Filter.
- Change Program Type filter and then click “Submit”:
  - Article 31 mental health clinics and Diagnostic and Treatment Centers: filter for MHClinic – Free standing.
  - State operated clinics: filter for MH Clinic/PMHP – State Operated

The screen shot below shows a partial view of the PSYCKES Quality Indicator Overview Report listing the indicator sets and associated prevalence data. The two indicator sets associated with the CQI initiative are BH Care Coordination and Health Promotion and Coordination. See Chapter 2 for an overview of the indicators.

Quality Indicator Overview As Of 10/01/2012

Agency: Main Street Health Clinic

Modify Filter Site:ALL, Attending:ALL, Program Type:MHClinic - Free Standing, Age:ALL, Popul

Select Indicator Set for Details

Indicator Set

Indicator Set ^	Population	On Any	N	%	Regional %	Statewide %
<a href="#">BH Care Coordination</a>	All	7,590	530	6.98	6.68	6.57
<a href="#">Cardiometabolic</a>	All	1,098	482	43.90	42.63	43.43
<a href="#">Dose</a>	All	4,041	207	5.12	5.22	5.80
<a href="#">Health Promotion and Coordination</a>	All	7,595	1,798	23.67	22.82	25.40
<a href="#">High Need - Ineffectively Engaged</a>	All	0	41	0.00	0.00	0.00

## Review Variation in PSYCKES (Analyze Phase)

Staff should review the prevalence data for all indicators within an indicator set relative to regional and statewide comparisons. (How to: on the QI Overview Report, click on the indicator set name; that will take you to a summary of the prevalence for each indicator in the project indicator set.).

Take note if your agency is higher or lower on any indicator compared to regional and statewide numbers. Take note if some indicators appear to be responsible for your agency's overall prevalence on the summary measure.

At the beginning of the project, analysis of variation facilitates project selection. Once the project is underway, prevalence data should be reviewed to analyze change. If a clinic serves a large number of children, you may also want to filter by age (children are likely to have lower prevalence on most indicators).

Below is a screen shot of a partial view of the PSYCKES Quality Indicator Overview Report showing the seven indicators in the Health Promotion and Coordination Indicator set.

Indicator Set		Indicator				
Indicator	Population	On Any	N	%	Regional %	Statewide %
<a href="#">Diabetes Monitoring-No HbA1c &gt;1 Yr</a>	All	857	222	25.90	21.52	24.38
<a href="#">No Outpatient Medical Visit &gt;1 Yr</a>	All	7,595	990	13.03	12.94	14.27
<a href="#">No Diabetes Screening-On Antipsychotic</a>	All	1,641	467	28.46	24.86	29.87
<a href="#">4+ Inpatient/ER - Med</a>	All	7,590	335	4.41	4.66	5.63
<a href="#">Prevent Hosp Asthma</a>	Adult	6,567	44	0.67	0.84	0.58
<a href="#">Prevent Hosp Diabetes</a>	Adult	6,567	42	0.64	0.67	0.52
<a href="#">Prevent Hosp Dehydration</a>	Adult	6,567	8	0.12	0.11	0.11
<b>Summary</b>	<b>All</b>	<b>7,595</b>	<b>1,798</b>	<b>23.67</b>	<b>22.82</b>	<b>25.40</b>

## Define Target Population (Improve Phase)

Use PSYCKES to help define/identify a target population for a CQI project. (How to: Click "Summary" (located on the last line of the table on the Indicator report. A new screen will open, [see below] displaying an unduplicated list of recipients and their Medicaid identification number, date of birth, quality flag(s) and medication(s).

Indicator Set: Health Promotion and Coordination, Indicator: Summary

Indicator Set	Indicator	Site	Unduplicated Attending	Unduplicated Recipients	New QI Flag	Dropped QI Flag
Recipient ^	Medicaid ID	DOB	Quality Flags	Medications (BH; excludes enhanced PHI)		
<a href="#">Aaahcfq Dedddhc</a>	Jbcdjde AfehdaF	12/31/9999	No Outpt Med	RISPERIDONE		
<a href="#">Aabadff Ffdecaq</a>	Ebjagec Fieihfj	12/31/9999	No DM Screen-AP	ARIPIPRAZOLE, CITALOPRAM HYDROBROMIDE, ZOLPIDEM TARTRATE		
<a href="#">Aabqjih Gqacaca</a>	Ejffbhb Bedafca	12/31/9999	3+ ER-BH, 4+ Inpt/ER-All, No Outpt Med			
<a href="#">Aabdjcc Dcfbehb</a>	Icajfee Dfedbfb	12/31/9999	3PP(Y), No DM Screen-AP, No Outpt Med	METHYLPHENIDATE HCL, QUETIAPINE FUMARATE, PAROXETINE HCL		
<a href="#">Aabiiea Ajabfcd</a>	Edhcfe Egcggde	12/31/9999	3+ Inpatient - BH, 4+ Inpt/ER-All, 4+ Inpt/ER-BH, No Outpt Med			

This list of unduplicated recipients can be exported to Excel to create a master list of identified clients having a quality flag. See the Appendix for instructions on how to create an Excel spreadsheet using PSYCKES.

### Review the PSYCKES Clinical Summary (Analyze Phase)

The PSYCKES Clinical Summary provides up to five years of individual client data across all treatment settings, including both physical and behavioral health. This screen shot shows the top section of a Clinic Summary.

**Clinical Summary** [Return to Quality Indicator Results](#) [Export to PDF](#) [Excel](#)

OMH PHI **Please choose summary period** [Last 3 months](#) [Last 6 months](#) [Last Year](#) [Last 2 Years](#) [All Available \(up to 5 years\)](#)

Clinical Report Date: 9/20/2013 (This report contains all available clinical data.) Enhanced PHI  Show  Hide

Name: [Djbbhia Cedbfbd](#) Medicaid ID: EFJGHGF BICCAHJ DOB: 01/01/9999 Age: 999

Medicaid Eligibility: SSI Managed Care Plan: MetroPlus Health Plan Medicare: No

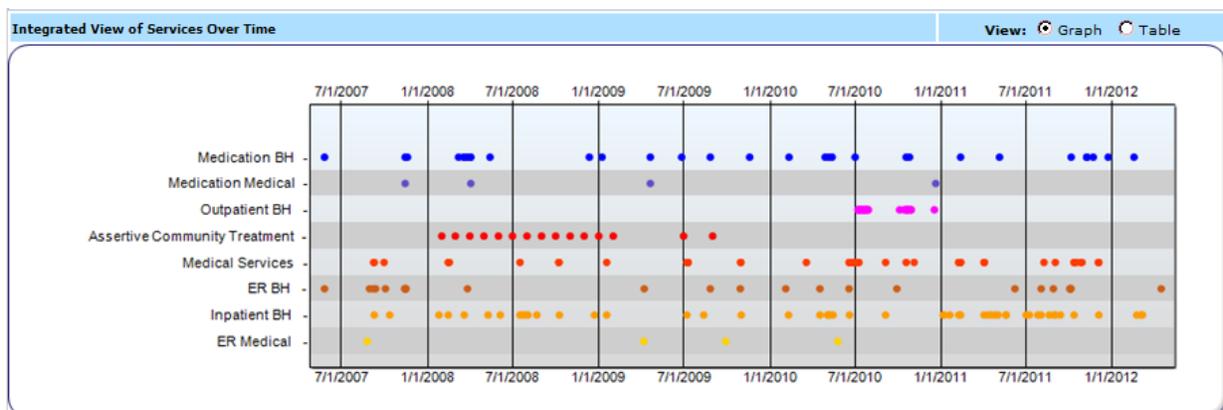
Indicator Set	Quality Flags (as of monthly QI report 7/1/2013)	Quality Flag Definitions ?
BH Care Coordination	Adherence - Mood Stabilizer (Bipolar)   Adherence - Antipsychotic (Schz)   3+ Inpatient - BH	
Hospital ER Utilization	4+ Inpatient/ER - All   4+ Inpatient/ER - BH   4+ Inpatient/ER - Med   Readmission - All BH 7 day	
<b>Behavioral Health Diagnoses - Primary and Secondary Dx (Most Recent Shows First)</b>		
Bipolar Disorder   Substance Abuse		
<b>Medical Diagnoses - Primary and Secondary Dx (Most Recent Shows First)</b>		
Skin And Subcutaneous Tissue	Allergic reactions	
Symptoms, Signs, And Ill-Defined Conditions	Residual codes; unclassified	
The Circulatory System	Essential hypertension	

In the Clinical Summary data are available on diagnoses (including comorbid medical/substance use/mental health conditions), medications, behavioral/medical outpatient and inpatient services, laboratory/X-ray tests, dental and vision services and living support/transportation. Users can view data at the level of an individual order or service claim. The default view displays the individual's treatment history over the past three months. Users can choose a different time period—last 3 months, last 6 months, last year, last 2 years, and all available for up to 5 years. The clinical summary data is refreshed weekly.

It is important for clinical staff conducting a client evaluation to review the individual's Clinical Summary. Specified staff (e.g., QI team member) can download the Clinical Summary and put it in the client's medical record, or distribute it to clinicians conducting the evaluation. Or, clinical staff who are PSYCKES users can access PSYCKES directly to review a Clinical Summary.

Reducing high utilization of inpatient and emergency room services (either medical or behavioral health) is a goal for both CQI Initiative project options. Clinical staff can use the Clinical Summary to analyze service utilization patterns (e.g., a client's engagement in primary care and the use of inpatient and emergency room services).

The Integrated Graph section of the Clinical Summary displays all services in graphic form for easy identification of service and medication use, and conversely, for gaps in services and/or medication.



For detailed information on the Clinical Summary, see the [PSYCKES User's Guide](#) on the PSYCKES website.

## Access Levels within PSYCKES

Within the PSYCKES application there are different levels of access to client data.

- If a client has been billed in the past nine months by your agency, but does not have a quality flag and has not given consent for agency staff to view their data in PSYCKES, the only information available in PSYCKES is the person’s name.
- Users are able to view certain client-level protected health information (PHI) without consent for individuals with a quality flag who have been served at the provider.
- Access to **all** client-level data for individuals without a quality flag, for individuals with no Medicaid billing history at the provider, and for all federally protected data (including substance abuse, HIV, family planning, and genetic disorders related data) is available only with the individual’s written consent or in the case of a clinical emergency, and through the use of the PSYCKES Consent Module.

Below is a chart that summarizes the different levels of access.

Access Type	Includes Data with Special Protections? (SUD, HIV, Family Planning, Genetic)	Duration
Provided service in past 9 months	No, get client name only	Up to 9 months after last service
Quality Flag	No, but get all other data	As long as flag is active; up to 9 months after last service
Client Consent	Yes, all data	3 years after last service
Clinical Emergency	Yes, all data	72 Hours

## The PSYCKES Consent Module

In PSYCKES-Medicaid, users can view client level Medicaid data that does not have special protections for clients who are positive for a quality flag; this is due to a federal mandate to monitor the quality of care for Medicaid clients. Certain categories of protected health information (PHI) including data associated with HIV, family planning, genetic information and substance abuse, are legally subject to additional protection and will not be displayed in PSYCKES without client consent (See above for access levels within PSYCKES)

OMH has developed procedures and functionality in PSYCKES that allows providers to obtain consent from clients and record the consent in PSYCKES for expanded access to their Medicaid data. The Consent Module allows users to view the Clinical Summary for those who do not have a quality flag in PSYCKES, for individuals with no Medicaid billing history at the provider, and for all federally protected data, provided the client has given written consent or in the case of a clinical emergency.

Below is a screen shot of an example of a Clinical Summary. The text in heading reads: “This report contains all available clinical data,” which includes all federally protected data, also

known as “enhanced PHI. Enhanced PHI is evident in this summary in the Behavioral Health Diagnoses section (“Substance Abuse,” “Alcohol Abuse” “and Alcohol Related Organic Mental Disorder” are shown) and in the Medical Diagnoses section (HIV Infection is shown). If the registrar did not attest to the rationale for access (written consent or emergency) in the Consent Module, this enhanced PHI would not be shown in the Clinical Summary.

Clinical Summary		Common Ground	Return to Search Results	Export to PDF	Excel		
OMH PHI	Please choose summary period	Last 3 months	Last 6 months	Last Year	Last 2 Years	All Available (up to 5 years)	
Clinical Report Date: 4/26/2013 (This report contains all available clinical data.) Enhanced PHI <input checked="" type="radio"/> Show <input type="radio"/> Hide							
Name:	Bffdeef Bfaafce	Medicaid ID:	EDEEDGH HCIBBJF	DOB:	01/01/9999	Age:	999
Medicaid Eligibility:	SSI	Managed Care Plan:	ABC Health Choice	Medicare:	No		
Indicator Set	Quality Flag Evidence						
BH Care Coordination	Adherence - Antipsychotic (Schz)   3+ ER - BH   3+ Inpatient - BH						
Health Promotion and Coordination	Diabetes Monitoring-No HbA1c >1 Yr						
High Need - Ineffectively Engaged	Individuals with multiple MH Inpatient or ER admissions or a prior AOT order or forensic MH service use who also have no current connection to TCM (ICM/SCM/BCM) and limited outpatient MH service use (4 or FEWER visits in prior 6 months)						
Hospital ER Utilization	4+ Inpt/ER-All, 4+ Inpt/ER-BH, 4+ Inpt/ER-Med   Readmission - All BH 30 day   Readmission - All BH 45 day   Readmission - All BH 7 day   Readmission - Hosp BH d/c 30 day   Readmission - Hosp BH d/c 45 day   Readmission - Hosp BH d/c 15 day						
Behavioral Health Diagnoses - Primary and Secondary Dx (Most Recent Shows First)							
Other Psychotic Disorder   Major Depressive Disorder   Schizoaffective Disorder   Bipolar Disorder   Schizophrenia   Personality, Impulse Control Disorders   Substance Abuse   Alcohol Abuse   Alcohol Related Organic Mental Disorder							
Medical Diagnoses - Primary and Secondary Dx (Most Recent Shows First)							
Endocrine, Nutritional, And Metabolic Diseases And Immunity Disorders	Diabetes mellitus with complications						
Infectious And Parasitic Diseases	HIV infection						

## Obtain Written Consent and Using the Consent Module to Support the CQI Initiative

Obtaining consent from clients to view **all** their data in PSYCKES is important for both CQI Initiative projects. OMH strongly encourages clinics to use the PSYCKES Consent Module so that clinical staff can use the version of the PSYCKES clinical summary that contains **all** available clinical data in PSYCKES to address quality concerns during a client’s appointment.

### Registrar Role

Only staff with “PSYCKES-Registrar” role can use the Consent Module. A PSYCKES Registrar is responsible for enabling the provider’s access to client level data in PSYCKES. This involves using the PSYCKES Consent Module to attest and record that a client has granted consent to access PHI, or that PHI may be disclosed due to an emergency. The Registrar role also involves recording a client’s withdrawal of consent and revoking that consent in the Consent Module.

To learn more about obtaining consent and using the Consent Module, see the [PSYCKES User’s Guide](#) and the [Consent Module Webinar](#) on the PSYCKES website.

## PSYCKES Training

The PSYCKES team conducts webinars to help clinics implement and sustain the CQI initiative. For example:

- The Using PSYCKES for Clinicians provides an introduction to the clinical use of PSYCKES. It reviews the procedures for logging in and searching for clients, the information available in the Clinical Summary, and the process of using the Consent Module to enable access to client data.
- The PSYCKES Consent Module webinar provides an overview of the PSYCKES-Medicaid Consent Module and the procedures for obtaining client consent.

See the PSYCKES website for upcoming live webinar; recorded versions are available to view anytime.

## Chapter 6. Center for Practice Innovations

The Center for Practice Innovations (CPI) at Columbia Psychiatry and New York State Psychiatric Institute helps institutions implement evidence-based treatments. Developed for real-world settings, CPI's practical approach features concise online learning modules that allow practitioners to choose when and where to take their training. Modules include inspiring personal recovery stories, clinical vignettes, interactive exercises, and expert panel presentations. Along with the learning modules, CPI offers free online implementation supports to program leaders, clinical supervisors, and practitioners through webinars and teleconferences.

### Continuous Quality Improvement (CQI) Initiative for Health Promotion and Care Coordination and CPI Online Training Modules

As part of the CQI Initiative, CPI provides no-cost training and implementation aids to clinics to support their project activities. Clinics must ensure that at least 25% of eligible staff complete 10 CPI on-line training modules identified for each project option. Eligible staff are defined as direct care staff and clinical supervisors (including prescribers and medical directors) working at least 20 hours per week at the clinic.

There are 10 modules for each CQI project:

#### Health Promotion and Coordination Adults; CPI Modules:

1. Integrating Medical, Psychiatric, and Addiction Treatment Services
2. Wellness Self-Management
3. Stage-wise Treatment
4. Motivational Interviewing I
5. Motivational Interviewing II
6. Motivational Interviewing III
7. Motivational Interviewing and Harm Reduction
8. Practitioner Tools for Treating Tobacco Dependence
9. Understanding the Use of Medications to Treat Tobacco Dependence
10. Implementing Tobacco Dependence Treatment

#### Health Promotion and Coordination, Youth; CPI Modules:

1. Co-Occurring Disorders in Adolescents
2. Integrating Medical, Psychiatric, and Addiction Treatment Services
3. Stage-wise Treatment
4. Motivational Interviewing I
5. Motivational Interviewing II
6. Motivational Interviewing III
7. Motivational Interviewing and Harm Reduction
8. Practitioner Tools for Treating Tobacco Dependence
9. Understanding the Use of Medications to Treat Tobacco Dependence
10. Implementing Tobacco Dependence Treatment

Behavioral Health Care Coordination, Adults; CPI Modules:

1. Engaging Consumers
2. Stage-wise Treatment
3. Early Stages of Change
4. Motivational Interviewing I
5. Motivational Interviewing II
6. Motivational Interviewing III
7. Motivational Interviewing and Harm Reduction
8. Individual Interventions
9. Generating the Collaborative Treatment Plan
10. Persuasion Groups

Behavioral Health Care Coordination, Youth; CPI Modules:

11. Co-Occurring Disorders in Adolescents
12. Engaging Consumers
13. Stage-wise Treatment
14. Early Stages of Change
15. Motivational Interviewing I
16. Motivational Interviewing II
17. Motivational Interviewing III
18. Motivational Interviewing and Harm Reduction
19. Individual Interventions
20. Generating the Collaborative Treatment Plan

## Additional Resources

In addition to the CQI modules related to a clinic's project, direct care staff are welcome to view all available modules and participate in any of the supports offered by CPI.

CPI has a growing library of online training modules that are available for free to staff in participating programs; some topics include:

- Clinical Supervision
- Individual Placement and Support (IPS) model of supported employment.
- Screening/assessment for co-occurring mental health and substance use disorders
- Stage-wise treatment groups
- Cognitive-behavioral therapy
- Helping people consider clozapine (in production)
- Suicide prevention (in production)

CPI also offers free live and archived webinars to help practitioners and supervisors apply the information that they are learning in the modules to everyday practice. CPI will send emails announcing registration for upcoming webinars to staff who are enrolled in the learning community.

The online learning community includes a resource library with links to practical tools that staff can download or link to on the internet. For example, staff can download curricula for groups,

handouts to use with people such as the decisional balance matrix, tools for supervisors to help staff develop skills in motivational interviewing and much, much more.

### **Estimated Time Requirements for Training**

Most CPI modules associated with the CQI initiative can be completed in approximately 30 minutes, for a total time requirement of 5 hours for all ten modules. For staff who need longer than 30 minutes, the module is bookmarked so that they can return to the page at their next training session.

### **Incentive Strategies to Promote Training Completion**

Some facilities have used different strategies and incentives to promote staff to complete the CPI training modules. For example, in some facilities staff watch the modules together as a group during a regularly scheduled staff meeting. Another approach is to allow interested staff to cover some days/shifts that are typically less busy. Clinics often use incentives such as to raffle inexpensive or free prizes monthly (e.g., seasonal baskets, books, employee of the month parking spot, extra dress down day). For each module completed, staff would earn one ticket in the raffle. Clinics have also provided lunch once a month for staff who agree to use their personal lunch (or other) time to complete the training.

### **CPI On-line Tracking System**

- Supervisors have the ability to assign and track training in the online system.
- Supervisors can pull summary reports and to view progress for any given individual or training item.
- Each supervisor has, on her/his learning transcript, a short video describing how to assign training and view what people have done.

See appendix for instructions for using the tracking system.

## Appendix

1. "Brief Financial History and Status of OMH's Quality Improvement Initiative for Clinics
2. Instructions for Tracking How Many Staff Completed the Center for Practice Innovations (CPI) Modules Using the CPI On-Line System
3. Instructions to Create a Master Spreadsheet Using PSYCKES

## Appendix 1: Brief Financial History and Status of OMH's Quality Improvement Initiative for Clinics



State of New York  
Andrew M. Cuomo  
Governor



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**To:** Marcia Fazio, Deputy Commissioner, Quality Management  
Molly Finnerty, M.D., Director, Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES)

**From:** Norman Brier, Director, Financial Planning

**Date:** January 29, 2013

**Subject:** Brief Financial History and Status of the New York State Office of Mental Health's (OMH) Quality Improvement Initiative for Clinics

OMH licensed mental health clinics, other than hospital-based and State-operated clinics, have had the opportunity to receive a Medicaid fee enhancement if they enroll in and actively participate in "quality improvement" (QI) initiatives coordinated by OMH's PSYCKES program since 2005.

The original value of the increment was a more than 6% increase in a participating clinic's "base Medicaid fee", i.e., the regulatory fee excluding any Comprehensive Outpatient Programs (COPs) and/or Community Support Program (CSP) supplemental rate. This enhancement was only available for fee-for-service (FFS) reimbursed Medicaid services.

The dollar value of this enhancement was continued when OMH licensed clinics transitioned to the current reimbursement system, Ambulatory Patient Groups (APGs), although the percentage value of the QI participation enhancement was reduced to about 3.84% because the clinic base rates were substantially increased.

Initially, under APGs, the QI payment was only available for FFS reimbursed services. Beginning September 2012, the State mandated that Medicaid Managed Care plans reimburse OMH licensed clinics at "government rates", i.e., the same rates as paid FFS. The rates include the QI enhancement as applicable.

Current plans continue the QI payments for both FFS reimbursed clinic services and Medicaid Managed Care reimbursed clinic services through at least the end of State Fiscal Year 2014-15 (March 31, 2015).

New enrollments into the QI initiative and disenrollments of current QI participating clinics will add or eliminate the QI enhancement from the clinics' base rates as applicable. The FFS rates will reflect the addition or deletion of the QI payment from the effective date of the status change. The Medicaid Managed Care payments will change only prospectively, beginning about a month after OMH Central Office is notified of the status change.



## Appendix 2: Instructions for Tracking How Many Staff Completed the Center for Practice Innovations (CPI) Modules Using the CPI On-Line System

1. Log into CPI's Learning Community using your username and password
2. Click on the "reports" tab
3. Choose "Training Progress Pie Chart"
4. On the "Report Criteria" page (see screen shot below):
  - Leave the "Date Criteria" blank
  - Click on the arrow next to the box called "Training Title" and then type in the name of your CQI project and Adult/Youth depending upon your population, and then click on "Search". Training title must be one of the four project names listed below:
    - Care Coordination, Adults
    - Care Coordination, Youth
    - Health Promotion, Adults
    - Health Promotion, Youth
  - When the project name shows on the list, click the "+" to the left of the project name to add it to the list
  - Under "Options", make sure "Include Indirect Subordinates" box is checked
  - Under "Display", make sure "All Training" is selected
  - Click on the "Search" button at the bottom of the page

**Report Criteria**

View training progress information for your subordinates. The date filters below refer to the date the training was requested/assigned. Click on a slice of the pie to see a detailed breakdown of users with that status. To return to the overview of all statuses, click on the "View All Statuses" link that appears in the detailed breakdown view

**DATE CRITERIA**

Date Criteria: Select From: To:

**ADVANCED CRITERIA**

Training Type:  Online Class  Event  Quick Course  Curriculum  Test  Session  External Training  Library  Material  Posting  Video

Training Title: [ ]

Options:  Hide Archived Training  Include Indirect Subordinates

Display:  All Training  Assigned Training

Equivalent Training:  Include users who have completed equivalent courses in the report

Include Removed Training:  Include training that was removed from user transcript

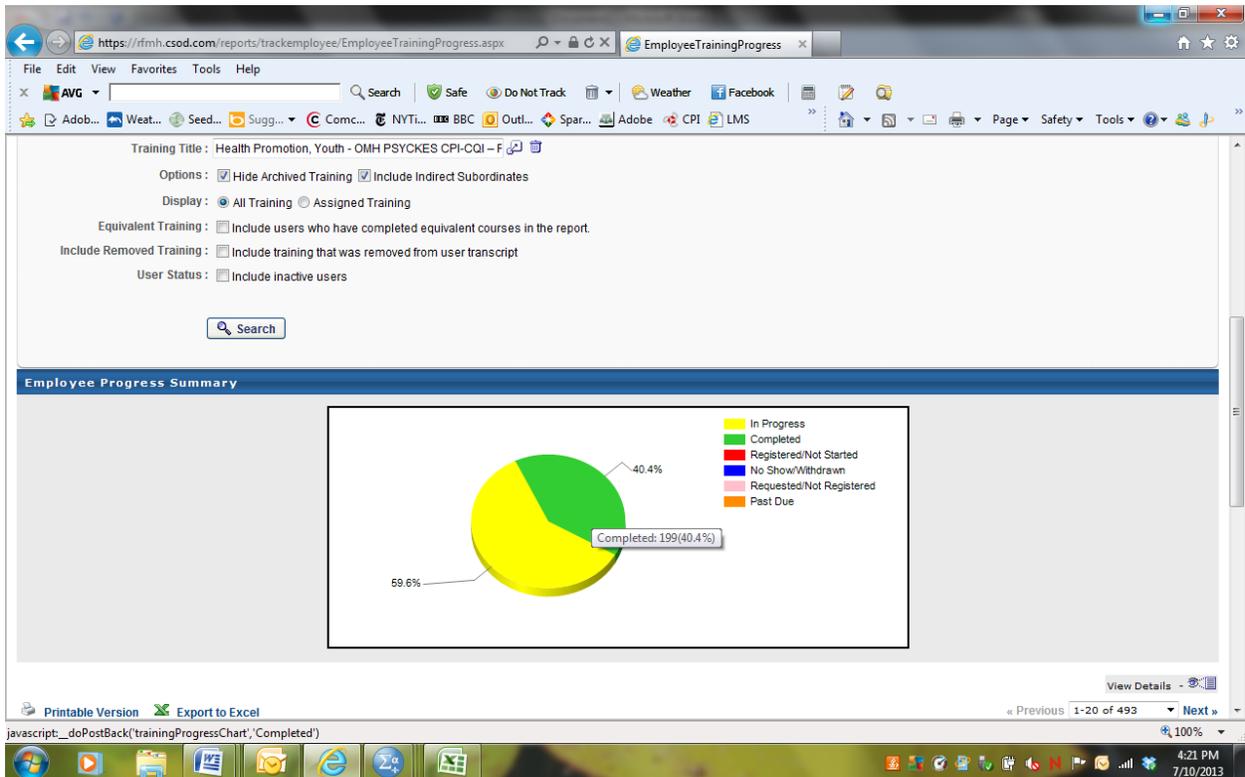
User Status:  Include inactive users

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Once the page refreshes, scroll down to see the pie chart and detailed information for each of your staff enrolled in the CPI system (just below the pie chart). If you hover your cursor over any slice of the pie chart, the number of staff in that category will appear as a hover bubble. If

you hover your cursor over the green slice (completed slice) of the pie chart, the number of staff who have completed the 10 required modules associated with your CQI project will show up in a box (see screen shot below).



## Appendix 3: Instructions to Create a Master Spreadsheet Using PSYCKES

1. Create a Master Spreadsheet (you only need to do this one time and update monthly):
  - Display Quality Indicator Overview screen (“My QI Report” tab)
  - Click Modify Filter.
  - Change Program Type filter and then click “Submit”:
    - Article 31 mental health clinics and Diagnostic and Treatment Centers: filter for MHClinic – Free standing.
    - State operated clinics: filter for MH Clinic/PMHP – State Operated
  - Click your project indicator under “Indicator Set” (e.g., BH Care Coordination, Health Promotion and Coordination).
  - Click “Summary” (located on the last line of the table). A new report will open displaying an unduplicated list of recipients with a quality flag.
  - Click “Excel” icon on the upper right side of the screen to export PSYCKES data to an Excel spreadsheet (Select “Unduplicated Recipients” from drop-down menu, click “Export”).
  - Save the Excel spreadsheet to your computer (follow your institution’s protocols for saving protected health information).
2. Modify and Customize Spreadsheet:
  - Adjust column width.
  - Hide unwanted rows and columns (tip: keep exported columns in place, so in the future when you update the spreadsheet, you can easily paste new information exported from PSYCKES into the same format).
  - Add new columns to the right of existing columns to accommodate new information:
    - For each indicator, add a new column (e.g., add the indicators associated with your CQI project such as 4+ Inpatient/ER, 3+ Inpatient, 3+ ER, Readmit 45, Adher-AP, Adher-MS, D/C-AD<12wks).
    - Add more columns (e.g., clinic name, therapist name, date identified, date evaluated, intervention, date intervention started, date intervention completed, outcome, date no longer positive for a quality concern, notes). In the columns, type in any information that you know at this point in time.
    - Optional: If you identified other recipients using sources other than PSYCKES, (e.g., screening, chart review), add new lines and type the client’s name and all relevant information.
3. Identify Clients Served by a Clinic:
  - For single-clinic agencies:
    - Since all of the clients on the list are served by your agency/clinic, skip to the “Identify Quality Flags Section” below (section #4).
  - For multi-clinic agencies:
    - If you are identifying clients for only your clinic, type in your clinic’s name in the “Clinic Name” column you created. After you identified all the clients served by your clinic, sort on the “Clinic Name” column to group together all the clients for your clinic. Delete all the recipient names that do not belong to your clinic.
    - If you are identifying clients for more than one clinic in your agency, type the relevant clinic name in the “Clinic Name” column for each recipient. After you identified all the clients served by each clinic, sort on the “Clinic Name” to group together all the clients for each clinic.

4. Identify Quality Flags:
  - For each recipient, look at all the flags in the “Quality Flags” column. Type a number ‘1’ in each of the individual indicator columns (that you created) for all of the indicators that apply.
5. Calculate Indicator Totals (optional):
  - After you typed a ‘1’ in all individual indicator columns:
    - Count how many ‘1s’ there are in each column to obtain the total for each indicator.
6. Distribute Master List to All Relevant Staff (following clinics’ guidelines to secure protected health information).
7. Update Spreadsheet:
  - Update the spreadsheet with recipient data from the “New QI Flag” tab by exporting the “New QI Flag” list and copy/pasting new recipients to the end of your Master List.
  - Update spreadsheet periodically as you receive new status information from clinical staff.

NOTE: See the PSYCKES website for a [sample spreadsheet](#) using this technique.

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