



# The PSYCKES-CQI Initiative: Improving the Quality of Psychotropic Prescribing Practices in New York State

2011 Handbook



## **Acknowledgments**

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# Chapter 1. Implementing CQI Projects

## *Introduction*

The goal of the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) Continuous Quality Improvement (CQI) initiative is to decrease the prevalence of prescribing practices identified by the Office of Mental Health (OMH) Scientific Advisory Committee as posing quality concerns, specifically four quality domains selected by stakeholders: polypharmacy, cardiometabolic risk, higher than recommended dose, and psychotropic medication risk in youth (“too many, too much, too young”). Clinics entering Phase II of the project are expected to continue the indicator set identified in Phase I, and add another indicator set. Newly joining clinics will target either polypharmacy or cardiometabolic risk (new clinics serving only children and adolescents may target the new youth indicator set).

OMH requires each clinic participating in the PSYCKES-CQI initiative to use the “Plan, Do, Check, Act” (PDCA) approach or another nationally recognized quality improvement model to guide its project. Over the course of Phase I, OMH conducted over 75 site visits and conference calls with participating clinics to identify quality improvement (QI) practices associated with positive outcomes. OMH strongly recommends that participating clinics use the medication-focused CQI model described below, which incorporates these best practices, in order to achieve the project goal of reducing prevalence of the targeted quality concerns. Two case studies provide concrete examples of how the model applies to clinical and QI work in a clinic setting. A checklist of the best practices of the Medication-Focused CQI Model is available on the PSYCKES website.

## **What is Continuous Quality Improvement?**

Quality Improvement is a series of activities designed to improve processes and systems in order to achieve better client outcomes. A key principle of QI is the use of data to assess the need for change and the effectiveness of interventions. The PSYCKES-CQI project leverages the QI model of data-driven decision-making to promote the use of evidence-based practices, in which the best evidence from scientifically sound research guides health care decisions.

While there are several formal models of quality improvement, all share a similar core approach commonly known as Plan-Do-Check-Act (PDCA). In Continuous Quality Improvement, goals are achieved through cycles of change. Each cycle entails a small, focused systems intervention and an assessment of the results of that intervention. The outcomes of each PDCA cycle determine whether the target processes are adopted, adapted, or discarded, and form the basis for the Plan phase of the next PDCA cycle.

Continuous quality improvement breaks the QI process into manageable pieces. Designing a series of individual cycles that build on success and lessons learned in previous cycles can lead to significant overall change. Even so, the process is rigorous and requires resources. Carrying out cycles of change on an ongoing basis takes sustained focus and commitment. Tips for successful PDCA cycles can be found on the Institute for Healthcare Improvement (IHI) website.

## Overview of Plan-Do-Check-Act (PDCA) and FOCUS-PDCA

The Plan-Do-Check-Act (PDCA) cycle is the core process of CQI. Each PDCA cycle identifies one or more barriers to the desired outcome, implements processes to address the barriers, and uses data to determine the effectiveness of the intervention. The QI team identifies and discards ineffective interventions, and builds on successes to achieve defined objectives. PDCA can be used to make small, incremental system interventions, or to pilot large changes on a small scale, and to quickly evaluate the results. The process is data-driven and must be quantified so that the result of each cycle can be evaluated. This enables the CQI team to show results early in the process. While some PDCA cycles may only last one month, others will take longer. The point is to keep the cycles manageable and to keep up the momentum by moving quickly from one to the next.

The steps in a PDCA cycle are:

**Plan:** Plan the action, or a pilot test of the action. Include in the plan a measure of performance and means of data collection. This will enable the QI team to know if the intervention is working.

**Do:** Implement the intervention. Make sure necessary data are generated.

**Check:** Collect and analyze data to see whether the intervention works before making it part of ongoing daily operations.

**Act:** If the new process is effective, make it part of ongoing operations. If the change is an incremental step, continue on to the next step in the subsequent PDCA cycle. If the new process is not effective, use what was learned to design another intervention that will be tested in the next PDCA cycle. The “Act” of one cycle informs, or sometimes becomes, the “Plan” of the next cycle, creating a *continuous* process of improvement.

A variation of PDCA is FOCUS-PDCA. FOCUS stands for:

**Find** an opportunity to improve;

**Organize** a QI team;

**Clarify** current knowledge and processes that influence opportunities to improve;

**Understand** variation that is contributing to the problem; and

**Select/start** PDCA cycles to improve outcomes.

The FOCUS stage gives clinic QI teams a roadmap for organizing the project team and setting the stage for success in its PDCA cycles. The FOCUS-PDCA approach is particularly relevant for clinics beginning Phase II of the PSYCKES-CQI initiative, since QI teams should reflect on lessons learned in Phase I as they prepare for Phase II. Thus, the model presented below incorporates a FOCUS stage.

The project as a whole follows a Plan-Do-Check-Act sequence, as the team plans the project (Plan), engages in QI activities and PDCA cycles of change (Do), monitors the impact of its interventions (Check), and then institutionalizes effective systems changes in order to maintain gains (Act). Each small cycle of change contributes to the overall success of the project.

## ***The FOCUS-PDCA Model for Medication-Focused CQI***

OMH has worked with participating clinics around the state to identify key processes that have contributed to positive outcomes in Phase I of the PSYCKES-CQI project, and consulted with QI experts to determine the alignment of these best practices with the FOCUS-PDCA model. Working with prescribers and consumers to address quality concerns in medications is a challenging activity that differs from traditional QI projects (e.g., reducing wait times), but one that holds great promise for improving the lives and lived experience of the people we serve. OMH encourages all participating clinics to review the processes described below, and to implement any not already in place. Consultation resources, including Webinars, conference calls, and site visits, are available to assist clinics in these efforts.

### **FOCUS**

The first step in the FOCUS stage is to **find** an opportunity to improve. By agreeing to participate in the PSYCKES-CQI Initiative, your clinic has identified psychotropic prescribing practices as a target for improvement. Congratulations on completing this initial step.

The next step in FOCUS is to **organize** a QI team. The QI Team has primary responsibility for conducting the project. Since the locus of the team's activities will be at the clinic, the QI team should be organized at the clinic level (although in larger agencies a central QI director or committee could oversee and support the project). The success of the project depends on assembling the right team. Successful QI teams include representation from clinic and medical leadership, someone who can manage data, and any other staff needed to carry out the activities of the team. Clinic leadership on the QI team ensures that appropriate resources are allocated to the project and authorizes any necessary changes in clinic procedures and workflow. In a medication-focused project, a Medical Director or another prescriber can provide key input to the QI team as well as champion the project with other prescribers. The data person should be someone who can manage data in PSYCKES and Excel to provide the team with clearly organized information to drive the process. To promote active engagement of stakeholders and provide a consumer perspective on the project, the team may invite consumers or family members to participate periodically in QI meetings, such as those focusing on project selection or development of consumer education strategies.

The QI team then works to **clarify** its knowledge base about the quality concern, and reviews existing clinical and QI processes at the clinic that may interact with the project. Training materials from the PSYCKES website and other resources available from OMH can help teams orient themselves to research on the quality concerns. The team reviews PDCA cycles implemented during Phase I of the project to determine the fit between effective interventions and potential new projects. It is also important for the QI team to review clinic work processes relevant to decisions about medications, e.g. treatment plan reviews, therapist-prescriber communication, and medication education policies.

A related set of activities helps the QI team **understand** variation in observed data about the quality concerns. PSYCKES reports are an important source of information about variation, and can be supplemented with additional information collected by the QI team. Examples of variation the team could review include:

- Variation among prescribers or among clinics within the agency
- Trends among clients with a certain diagnosis or clinical history, for example
  - high prevalence of polypharmacy among clients with bipolar disorders
  - high prevalence of polypharmacy among clients recently discharged from inpatient hospitalization

- Variation between clients with different cardiometabolic risk factors, for example
  - prescribers avoid olanzapine in obese clients, but not in those with other forms of cardiometabolic risk

The FOCUS stage concludes with the **selection** of the quality project and preparation to **start** the first PDCA cycle. Baseline data from PSYCKES and other clinic information help to inform the project selection process. Important criteria for choosing a project include considerations of “high volume, problem prone, and high risk” as well as input from prescribers, alignment with other clinic initiatives and priorities, and experience gained in Phase I. Once the team has chosen a project, it needs to educate and engage clinical staff and consumers about the quality concern. This process will be most effective if leadership also clearly communicates its support for the project.

Successful QI requires engagement of key stakeholders throughout the organization, including executive leadership and governing body, prescribers, and consumers and family members. For tips on building support, please see the chapter on Stakeholder Engagement.

Taken together, the steps in the FOCUS phase lay the groundwork for a thoughtful, effective QI process. Once the FOCUS activities are complete, the team is ready to move into the first PDCA cycle.

## Root Cause Analysis and Brainstorming

Root cause analysis and brainstorming are two techniques that can be highly effective in CQI activities. In a root cause analysis, the QI team analyzes baseline data and strives to understand the underlying reasons for information revealed by the data. Brainstorming sessions then help teams to clarify the breadth and depth of the root causes.

The first step is to examine the data thoroughly to identify trends and variations. QI tools such as run charts and histograms can help to organize the information and provide visual cues for brainstorming. *Run charts* are graphs of data observed over time. A *histogram* is a bar chart that displays variations in data. (See also the “Check” section below.)

*Example:* The QI team reviewed the trend reports in PSYCKES (presented as run charts) for each summary indicator and noted that the prevalence of the cardiometabolic risk indicator has increased by 25% in the past six months. In addition, the team created a histogram displaying the number of individuals with each of the four quality concerns, and observed that the cardiometabolic risk indicator had the greatest number of positive cases.

The team then conducts a brainstorming session to develop hypotheses about the root causes underlying these trends, and to identify administrative and clinical processes that need to be modified or added in order to achieve project goals. These processes will be the targets of PDCA cycles and interventions.

*Example:* Clients who have cardiometabolic risk factors are on medications that increase cardiometabolic risk. Why?

- Because the doctor was unaware of the client’s health status. Why?
- Because the client did not provide complete information. Why?
- Because the client did not have a clear understanding of his/her health condition.

AND

- Because the clinic did not have a medical form from the PCP. Why?
- Because the clinic mailed the request for records to the PCP, and mailed forms tend to have a low response rate, AND
- Because the mental health clinic has not been able to devote staff time to making phone calls to follow up on requests for medical information.

Root cause analysis and brainstorming present an excellent opportunity to engage prescribers and program staff around the questions, “What do you see as barriers to change in the area of prescribing practices? How can we help you overcome them effectively?” Almost everyone has something to say about what makes their job hard, and everyone likes to see that people are thinking and soliciting input about how to make it easier for them to do a better job.

## PLAN

In the Plan stage of the PDCA cycle, the QI team determines the objectives of the project, identifies what processes need to be changed or implemented in order to achieve desired outcomes, defines measures of performance, and develops an Action Plan. Often, PDCA cycles target root causes identified during the FOCUS stage. The team may also choose to conduct additional analyses during the Plan stage, for example to determine the source of new starts for the targeted quality concern (people whose medication regimen is changed so that they now meet criteria for the selected indicator set).

As in clinical work, **objectives** are specific and measurable steps toward achieving overall goals. The overall goal of the PSYCKES-CQI project is to decrease the prevalence of the targeted quality concern. Clinic QI teams may set objectives for the project as a whole, in addition to objectives for specific PDCA cycles. For example, the QI team might decide that an appropriate objective for the project is to decrease the number of new starts by 30%. It is expected that one overall project objective is to conduct clinical reviews for 100% of clients with a quality flag. The QI team might also determine that in order to achieve this objective, one PDCA cycle will have an objective of conducting clinical reviews for 50% of clients with a quality flag within three months. Clearly defining the objectives of the project and of each PDCA cycle make it much easier for the QI team to develop appropriate measures of performance.

Possible interventions to address root causes identified in the example above include:

- Implement wellness group to help clients learn about important health conditions and potential side effects of psychotropic medications
- Utilize new payment rates for complex care coordination under clinic restructuring to encourage telephone contact with medical providers regarding clients on high- and moderate-risk antipsychotics
- Implement a policy requiring approval or peer review before new starts of specified medication regimens

The QI team next determines what administrative and/or clinical **processes** will be modified or implemented in order to achieve the objectives. These changes are the intervention that is the focus of the PDCA cycle. The team also decides how other **staff members** will be involved in the intervention. For example, a prescriber or nurse might be asked to lead a medication group, or the receptionist might be responsible for flagging each prescriber's schedule to highlight consumers with the quality concern. Finally, the team determines how it will **track and share data** about the project.

Work done by the QI Team during the Plan stage results in the **Action Plan** for the QI project overall as well as the current PDCA cycle. The action plan specifies the following (see sample):

- Project goals
- Measurable objectives
- Interventions to be implemented
- Individual(s) responsible
- Resources required
- Time frames
- Performance measures

Sample Quality Improvement Project Action Plan

Name of Agency/Clinic/Program: \_\_\_\_\_ Date Form Completed/Updated: \_\_\_\_\_

Goal #1: \_\_\_\_\_ Date Begun: \_\_\_\_\_

Goal #2: \_\_\_\_\_ Date Begun: \_\_\_\_\_

Objectives: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Intervention	Intended Outcome	Individual(s) Responsible	Resources Required	Start Date	End Date	Measurement of Success
<p>Flag charts of positive cases to ensure that providers are aware of the quality concern at the point of contact. Administration Assistant (overseen by Director) will pull charts of all positive cases, flag them w/ labels and re-file them. Director will inform staff in weekly meeting of what the labels mean. Director will use weekly productivity statistics to determine the number of clinical reviews conducted for current month vs. previous 2 months.</p>	<p>To increase the number of clinical reviews conducted.</p>	<ul style="list-style-type: none"> <li>• Clinic Director</li> <li>• Administrative Assistant</li> </ul>	<p>For 80 positive cases:</p> <ul style="list-style-type: none"> <li>• 3 hours of Admin Asst's time to pull, flag and re-file charts.</li> <li>• 2 sheets of 50 labels.</li> <li>• 3 hours of Director's time: 1 to supervise Admin Asst and spot-check charts, and 2 to compile and analyze data to evaluate success.</li> </ul>	<p>12/26/10</p>	<p>12/31/10 (for flagging charts)  1/31/11 (for assessing effectiveness)</p>	<ol style="list-style-type: none"> <li>1) All positive cases are flagged (per Admin Asst self-report and Clinic Director spot-check of flagged charts).</li> <li>2) Number of clinical reviews per month increases by &gt;10% in January vs. prior 2 months (per Director's analysis of weekly productivity stats).</li> </ol>

## DO

In the Do stage of the PDCA cycle, the QI team implements the Action Plan developed under Plan above. In addition, OMH has identified a set of core processes for the Do phase of medication-focused CQI that will help QI teams track and monitor the project. These processes focus on ensuring that all relevant clinical and QI staff are informed of individuals with a quality flag, that the individuals receive a clinical review, and that the outcome of the clinical review is shared with the QI team. Barriers to these core processes can serve as targets for subsequent PDCA cycles.

### *Identification of Positive Cases*

In order to decrease the prevalence of the targeted quality concern, prescribers need to know which consumers meet criteria for the selected indicator set. A key responsibility of the QI team is to **identify positive cases each month**, using PSYCKES and other data sources as necessary. The list of positive cases is shared with **prescribers** and with the **treatment team**. Ideally, this information is also shared with the **consumer** by the prescriber or other treatment team members as an educational opportunity for discussion about the impact of the person's medication regimen on their health.

OMH recommends the following strategy for identifying and tracking positive cases:

1. Initially, the QI team logs into PSYCKES and exports the list of unduplicated recipients for the summary indicator into Excel, making any corrections necessary. This forms the basis for a running, comprehensive list of positive cases identified for the project.
2. If the clinic is using additional methods to identify positive cases, these names are added to the list.
3. The team adds columns for additional information of interest (e.g. therapist name, date of clinical review, and outcome of clinical review).
4. The list is sorted by clinic and/or prescriber and distributed to appropriate staff.
5. Each month thereafter, the QI team checks the "New QI Flag" and "Dropped QI Flag" tabs in PSYCKES. After verifying the data in clinic records, the team updates the list to incorporate any changes in positive case status.

### *Clinical Reviews*

The heart of a medication-focused CQI project is the clinical encounter between the prescriber and the consumer. Therefore, it is critical to develop systems to ensure that prescribers conduct a **clinical review** of each positive case's medication regimen. A clinical review refers to a discussion between the prescriber and the client about the benefits and risks of the current medication regimen, and opportunities to change to a less risky regimen. It may also include other members of the treatment team, the client's family and/or outside providers, as appropriate. Many clinics have found it helpful to provide prescribers with copies of the PSYCKES **clinical summary** for use during the review, and to develop **protocols** that specify issues to be considered and addressed during the clinical review, including rationale for continuing the current regimen and barriers to change. Using a **structured form** to document the review can both support such a protocol and serve as a source of information for the QI team on the **outcome** of the review. OMH has developed sample tools that clinics are encouraged to adapt for their CQI project.

Clinics have implemented many successful strategies to support clinical reviews, including:

- The receptionist places a structured note in the chart of each consumer with a quality flag prior to the medication visit.
- The QI team prints out the clinical summary for each newly identified positive case and places it in the chart.
- The prescriber places completed notes in a folder, which are collected and copied periodically by a member of the QI team.

The role of the QI Team is to implement systems that support and promote the clinical review process, and not to conduct the reviews. Team members may be involved in clinical reviews to the extent required by their roles as clinicians and supervisors.

### *Medication Changes and Barriers to Change*

If the decision is made to change the medication regimen, there are many effective strategies to **support consumers and prescribers** during the time of transition. For example, the clinic may increase the frequency of visits and/or schedule longer visits during the medication change, or conduct frequent telephone check-ins with clients, family members and/or case managers. Prescribers can educate clients about the physical and psychological effects to be expected during the medication change, and therapists can work with them to develop coping skills to alleviate anxiety or distress during the transition.

If a medication change is deemed clinically inappropriate at the time of the clinical review, the QI team should develop a system to ensure that a **periodic re-assessment** is conducted.

A major advantage of using a structured form to document clinical reviews is the opportunity it provides to collect data on barriers to medication changes. As new barriers are identified, the team can modify or expand the Action Plan. Thus, information collected and analyzed in one PDCA cycle flows directly into the next. For example, the clinic might develop a strategy for contacting outside prescribers who are identified as prescribing medication regimens that meet the criteria for the selected indicator set.

### **CHECK**

In the Check stage of the PDCA cycle, the QI team uses data to evaluate the effectiveness of the actions undertaken in the Do stage. This is a critical step in determining whether the clinic is making progress towards meeting the objectives of the project. The team should **meet at least monthly** to review data about the project, including both PSYCKES reports and internally generated data such as those derived from the tracking spreadsheet described above under "Identification of Positive Cases." It is important to review both the status of individual consumers with quality flags (for example, what was the outcome of the most recent clinical review?) and to **aggregate data** at the prescriber and clinic level to understand trends and patterns. Using structured tools such as run charts and histograms provides a visual representation of the data that is often helpful to the team – a picture is worth a thousand words. Identifying important **barriers to change** provides information the team can translate into actions for the next PDCA cycle. Keep the team focused on project goals by **reviewing progress** towards the measurable objectives established by statewide leadership and in the action plan. Put the clinic's progress in perspective by **reviewing trends** in statewide and regional prevalence. Finally, share outcomes by meeting regularly with **prescribers, agency leadership, and clinical staff**.

The monthly QI team meetings generate data that is reported to OMH in the monthly on-line survey. Updating the tracking spreadsheet for review at the monthly meeting provides the team with information about the number of positive cases identified, the number of clinical reviews conducted, and the number of consumers whose medications have been changed. Logging on

to PSYCKES prior to each monthly meeting will give teams information about individual clients (e.g., those newly identified with a quality flag, or those whose quality flag has been dropped) as well as overall trends in performance. The team may also create its own run charts and histograms to track data.

### Run Charts

In order to construct a run chart, data are measured at regular intervals – typically monthly in the current CQI project. The data are then plotted on a graph. The horizontal (x) axis shows monthly intervals, and the vertical (y) axis shows the number being measured each month. PSYCKES automatically generates trend reports that show the number and percent of consumers with a quality flag over time (Figure 1). Teams can select the time period of interest, and review specific indicators within each set as well as the summary indicator.



Figure 1. Trend Report (Run Chart) from PSYCKES.

The team may also maintain run charts to track additional indicators, such as the number of new starts of a specified medication regimen each month, or the number of consumers receiving a clinical review each month (Figure 2).

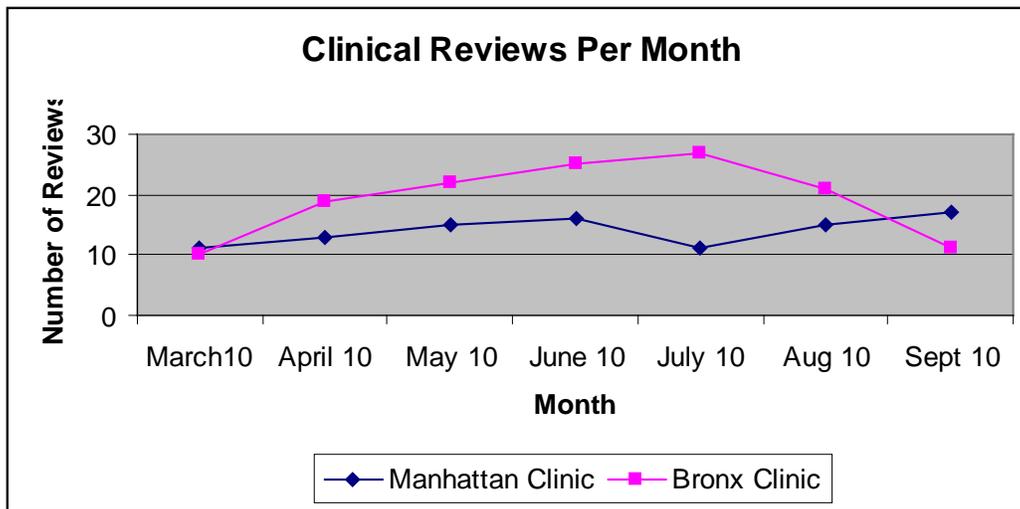


Figure 2. Run Chart for Clinical Reviews.

### Histograms

A histogram is a bar chart that graphically displays variations in data. Histograms often demonstrate “the Pareto principal,” which holds that 20% of the sources cause 80% of the problems. By revealing trends and variations, they help the team set priorities.

For example, the team might create a bar chart to examine barriers to medication changes. Based on the histogram in Figure 3, the team might decide to implement a PDCA cycle focused on engaging outside prescribers in a discussion of the quality concern targeted by the clinic’s QI project.

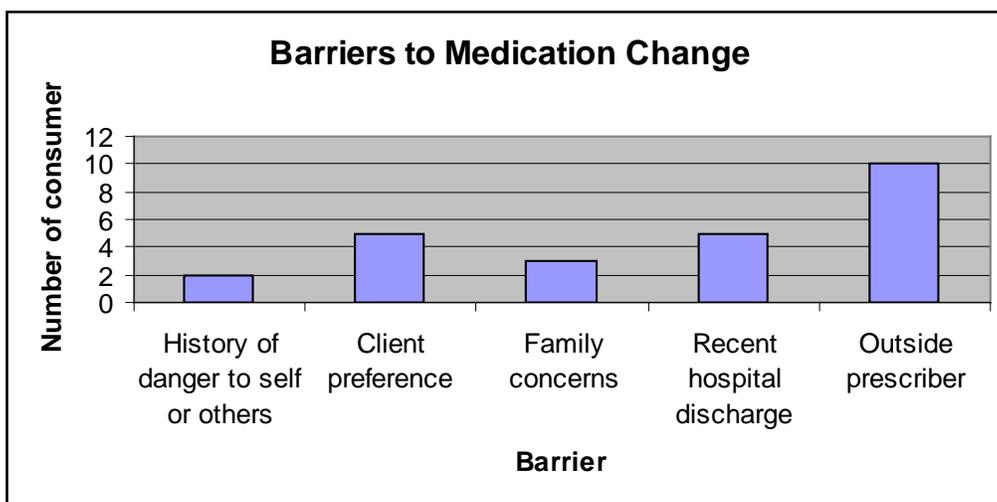


Figure 3. Bar Chart of Barriers to Medication Change.

## ACT

In the Act phase of the PDCA cycle, the QI team takes action to consolidate gains and sustain continuing success. **Effective processes are institutionalized** as part of ongoing clinic procedures and are extended to include all clients. The team continues to **monitor data**, including PSYCKES data, and ensures that **new staff members are trained** in relevant aspects of the project. The team also uses the findings produced in the Check phase to plan the next PDCA cycle targeting opportunities for improvement.

Examples of QI activities in the Act phase include:

- Incorporating a screening question for quality concerns into routine clinical documentation.
- Incorporate monthly or quarterly review of PSYCKES data into the agency's ongoing quality assurance activities.
- Incorporate CQI training into standard orientation for new clinicians.
- Incorporate OMH CME course(s) as part of new prescribers' orientation.

While a CQI project may come to a formal conclusion, its success is ultimately defined by the degree to which the clinic's subsequent ongoing activities maintain fidelity to the evidence-based best practices introduced during the initiative. This is best accomplished by ensuring that effective processes are fully integrated into the clinic's ordinary procedures and activities.

### ***Vignette 1: Implementing Medication-Focused CQI in a Large Agency***

Vanguard Mental Health Services serves approximately 4,400 clients across six mental health clinics. Five neighborhood clinics provide services to adults and youths and one clinic serves children and adolescents exclusively. Many of the clients experience severe and chronic psychiatric disorders. The agency employs 14 psychiatrists, many of whom have worked at Vanguard for years, but a recent trend has been the hiring of part-time and contract physicians when attrition occurs. Some prescribers are assigned to multiple clinics; the turnover among clinicians is moderate.

At the start of the PSYCKES CQI project, agency executive and medical staff convened and selected the reducing polypharmacy project across all six clinics. An analysis of PSYCKES data revealed that of the clients who were on any psychotropic medication, about 35% met the criteria for the polypharmacy indicator set.

#### **FOCUS**

Prior to Phase II of the PSYCKES initiative, Ms. Rojas, the agency QI director, reviewed the data from the first two years of the project and thinks it is going well. She attributes this to supportive and involved leadership that has fostered a culture in which reducing psychotropic polypharmacy is integral to a broader agency mission of promoting treatment safety and individual wellness and recovery strategies. The agency faced similar challenges in implementing the project across all clinics, including the medical model of practice favored by some prescribers and consumer concerns about changing stable medication regimens. The agency had adopted a go-slow approach to medication change, and has gradually been making progress towards reducing polypharmacy. Progress is also due to the fact that changes were made to some core QI processes. Six months ago an evaluation of their processes against the PDCA model revealed some shortcomings and bottlenecks that impeded communication and workflow. With the help of some creative staff members and additional OMH training and resources, the agency made substantial modifications that have paid off. The overall agency change rate has doubled in the past half year; it is just short of attaining a 30% rate of change among approximately 700 clients who had been identified as having a quality flag. However, there is still variation among the clinics in their rates of change.

Two major process changes resulted in this improvement. First, the agency revamped their data management and tracking processes. Ms. Rojas created an agency-wide Excel spreadsheet using PSYCKES to produce a list of Medicaid clients who received polypharmacy. She added additional clients who were identified through chart reviews and intakes. New columns were included to accommodate additional information such as the names of clinics, prescribers, and therapists; clinical review date; review outcome; and comments.

Vanguard also made a QI organizational change. Initially, Ms. Rojas had managed QI for all the clinics, but this proved ineffective since she was too far removed from the staff and daily operations, and clinical outcome reporting was untimely and cumbersome. Moreover, the agency and clinical directors came to realize the importance of project ownership at the clinic level so that clinic leadership can promote change. Now the project is managed at each clinic and the QI team composition is similar at each: the QI point is the clinic director; a QI specialist is an administrator who handles routine data tracking and management. Other members include a nurse practitioner and a psychiatrist. At the agency level, Ms. Rojas oversees QI in a consultant capacity and is the liaison between the clinics and the agency director. She meets individually with clinic directors, rotates her attendance at monthly clinic QI meetings, and is

copied on all QI-related reports. Dr. Harmon, the agency medical director, makes the rounds at clinic QI team meetings and supervises prescribers.

Ms. Rojas, Dr. Harmon, and some members of the clinic CQI teams recently attended the Phase II OMH training. Subsequently the teams met several times to discuss the selection of an additional project indicator. Meetings were scheduled so that all the prescribers could attend at least one meeting. The group evaluated the possible project choices—reducing cardiometabolic risk, higher than recommended doses of psychotropics, and medication risks in youth. The agency analyzed the prevalence for each indicator set using PSYCKES. The data revealed a high prevalence in the youth indicator. This was no surprise since all clinics have seen a marked increase in the numbers of children and adolescents coming to the clinics on multiple psychotropic medications. Clinic staff attribute this in part to increased pressures from parents and schools, media advertising, a medical model of treatment that relies heavily on medications, and the reduced availability of psychosocial services. Additionally, volume has significantly increased in the aftermath of the closing of a nearby children’s clinic. This was apparent in PSYCKES data which indicated a high percentage of medications prescribed in the past by the physicians at the former clinic. PSYCKES also showed that many community primary care providers were prescribing for the children served at Vanguard. Thus, the group made a provisional decision to add the youth indicator set. Concerns about increased workload were discussed. Ms. Rojas pointed out that their QI processes have become integrated with existing routine clinical practices so that including another project could be accomplished relatively smoothly. The prescribers had already been working towards reducing polypharmacy in children and youths and it would be logical to include reviews of those who are prescribed higher than recommended dosage and psychotropic medication under the age of six.

Representatives from each team, informed by current scientific literature on psychotropic medications and youths, met with the agency director who endorsed their decision. The director reaffirmed her commitment to the overall QI project, and insisted on playing an active role in the new project implementation. She suggested penning a letter of support to the staff, hosting clinic kick-off meetings to demonstrate her commitment, presenting an update to the Board of Directors and the consumer advocacy group, and continuing her attendance at quarterly agency-wide CQI meetings.

## **PLAN**

Team members developed an agency action plan that updated the roles and responsibilities of the CQI teams and project objectives. They set a numeric agency change goal of 35% reduction in consumers who met criteria for each indicator. While the agency is only 10 percentage points away from this goal today on the polypharmacy project, the clinic teams realize that the youth indicator set will present new challenges. Going forward they will make a concerted effort to measure progress monthly, and use PSYCKES data to aggregate and evaluate project data at the clinic and prescriber levels. For the new project the agency will gather resources for educating parents and youths on wellness, medication management and the benefits and risks of psychotropic medication in children. They will also stress non-pharmacological treatments for managing behavioral symptoms, including aggression and insomnia, and will reach out to therapists interested in training for these interventions. All youths who have been flagged as a positive case will now be required to undergo a quarterly re-assessment if a medication change was not made. Clinics will reach out to community practitioners who prescribe for children receiving services at Vanguard. For example, Ms. Rojas will develop a standard form letter that includes the clinic prescriber’s contact information and client’s/parent’s consent to coordinate care. Additionally, each clinic will track success stories and barriers to medication changes; this will serve as source material to develop interventions.

Due to the hiring of new clinicians and some turnover, the agency will invest in training for new staff and encourage use of the CME activities and other training materials on the PSYCKES website.

The implementation of Phase II commenced with a kick-off meeting at each clinic hosted by the QI team. The agency and medical directors explained the new project purpose and objectives and the agency's expectations. The QI team distributed and reviewed a binder that they created. It contained the directors' letter of support, a history of the PSYCKES project, flow chart depicting clinic CQI processes, samples of forms and reports used in their processes, and a bar chart illustrating progress. The binder also included the OMH PSYCKES project descriptions, scientific summaries of relevant articles, and consumer brochures for each project.

## **DO**

Clinic directors had been instrumental in executing and monitoring the revised processes so that clinics were well-positioned to integrate the youth project. For Phase II, prescribers will conduct clinical reviews on *all* positive cases in both indicator sets. The clinics tweaked their spreadsheet to accommodate more information about youths' medications, notations on successful medication changes, and comments on barriers. Each month the clinic QI specialist updates the spreadsheet using PSYCKES information on new and dropped clients. The prescribers and therapists receive their portion of the spreadsheet that lists their clients who meet criteria for the polypharmacy and youth indicators. The spreadsheet is comprehensive and provides *at-a-glance* client status. Clinicians like that. They also value the PSYCKES summary of a client's treatment and medication history across various treatment settings. Prescribers use it as an education tool in their discussions with clients and families about the pros/cons, risk/benefits and side effects of medications, and explain their quality flags triggered by medication prescribing practices. When a medication change is made, the prescriber and client work together to develop a safety plan that specifies clinic and outside supports. Prescribers also rely on the structured form that the QI team integrated into the clinic review processes. (The QI team used the *PSYCKES Clinical Note* developed by OMH as a template and modified it for their use.) Prescribers appreciate the simplicity of the check-box format to communicate their plan to change medication, justification for not making a change, and the strategy to address barriers to change. The form is on purple paper as a visual reminder of positive cases. A copy of the form is kept in the chart and another one is filed in a clinic QI folder. The QI specialist uses the outcome information noted on the form to update the spreadsheet, for completing the OMH monthly survey, and for aggregating data for the monthly review. Ms. Rojas believes that the agency finally has a system that works well and thinks that they've come a long way.

## **CHECK**

As Phase II progresses, the QI teams meet monthly as usual. They share the impact of their project progress and variation at the clinic and prescriber levels at routine agency leadership and clinic meetings. They continue to review aggregated project data relative to regional and state trends. They observe continued progress in reducing polypharmacy and are encouraged that their project prevalence rates fall below the state. However, the prevalence in the youth indicator set has been steadily rising. In order to focus more intently on the youth project Dr. Harmon will review outcomes and during the course of his routine supervision with prescribers will spend more time with those having large numbers of positive cases, as well as with those working with youth presenting multiple challenges. They will schedule a consultation with an OMH psychiatrist to brainstorm for more ideas related to youths.

Because they had begun to systematically track barriers in Phase II, at one point the QI teams met with the medical director to consider strategies to address the most prevalent barrier to changing medications for youth: concerns raised by parents about medication changes. They noticed from their data that the majority of parents do not want their child's medication regimen changed because they are satisfied with their child's treatment, and because they worry about the risk of decompensation. The teams decided to increase support to families and prescribers during times of medication change. They developed the following actions to be implemented in future PDCA cycles:

- Increase the clinical contact with more frequent visits (e.g., twice weekly with clinic nurse).
- Therapists will allocate additional time in their sessions to discuss medication change and education.
- Therapists will work with parents and youths to help them develop coping skills to manage stress.
- Parents will also be trained to monitor their children's symptoms using rating scales.
- Clinicians will encourage families to engage in ongoing communication, and to call the clinical staff when they encounter problems.

### **ACT**

Dr. Harmon and clinic teams met with the clinical staff to discuss the feasibility of integrating these ideas into the clinical process and modifying their action plan. With staff input, the team decided to implement a PDCA cycle to focus on teaching parents to use rating scales to monitor their child's symptoms. An OMH psychiatrist agreed to provide some training in the use of rating scales. The team asked therapists to track parents whom the psychiatrist taught. Once the parents were comfortable using the rating scales, the prescribers began to engage in conversations about potential medication change. In addition Doctor Harmon met with prescribers at the clinics to identify two youths on polypharmacy whom they felt could be transitioned to fewer medications. One family, who initially was reluctant to change, now felt the rating scale was a useful tool to monitor their child and agreed to begin tapering Seroquel.

Similar to the revamping of the data management and tracking process, the agency was cognizant of just how important it is for the QI team to evaluate their processes using a PDCA model and to develop and implement actions that will potentially result in positive change.

## ***Vignette 2: Implementing Medication-Focused CQI in a Small Agency***

River Street Health Services is a small rural agency with one clinic that serves about 800 clients. When the agency began the PSYCKES-CQI project, they chose the reducing cardiometabolic risk project because it fit within the agency's model that promoted wellness and because of a high prevalence rate. Of those on the current three-member CQI team, only Ms. Krauss, the clinic administrator who possesses excellent organizational and computer skills, has been part of the team from the start. Three months ago Ms. Swenson was hired as agency director. The former director had taken a hands-off approach to the CQI project. Ms. Swenson is looking forward to honing the QI skills that she had acquired when working elsewhere on a quality improvement project. She decided to head the CQI team and play an active role in the PSYCKES initiative. Mr. Lane is a nurse practitioner who has shown enthusiasm for the project and educates his clients to work toward reducing cardiometabolic risk. Ms. Swenson asked him to join the team last month. Four psychiatrists currently work part-time on a contract basis.

### **FOCUS**

One of Ms. Swenson's initial priorities was to assess the impact of the cardiometabolic risk project. She set out to learn about the clinic's existing QI processes, and the prescribing practices and performance variation among the five prescribers. She aimed to identify any pitfalls and develop an action plan to improve overall project performance. This was imperative since they would soon need to implement another project for the next phase of the PSYCKES-CQI project.

Ms. Swenson and Ms. Krauss met to review data from Phase I of the project. PSYCKES data showed a slight downward trend in Medicaid prevalence. Their self-report data showed that 19% of the clients with a quality flag had received a medication change such that they no longer met criteria for the indicator. PSYCKES data also showed variation in the rates of cardiometabolic risk among the prescribers; two prescribers had high prevalence. Ms. Krauss shared with Ms. Swenson that the former director had not been actively involved and that the project lacked a medical champion. Ms. Swenson felt the team would benefit by having a psychiatrist and therapist on board to move the project forward. When one of the contract psychiatrists resigned, Ms. Swenson reviewed the budget and decided to hire a medical director within six months. She also earmarked some of the Medicaid rate enhancement funds to engage staff. Ms. Clarke, a therapist who wanted to enhance her skills, expressed interest in quality improvement. Ms. Swenson invited her to join the team and indicated that a percentage of her work time could be dedicated to the project. She also offered her training in motivational interviewing.

The new CQI team attended the OMH Phase II training. Ms. Swenson knew that the team required the psychiatrists' input to help the agency select another project but the part-time psychiatrists' clinic hours did not coincide. Therefore, she provided a financial incentive for them to meet twice with the QI team at a time convenient to all to review the options and choose a second project. She aimed to promote trust and open communication, and hoped to create collaboration and gain further support for the goals of the project.

At the meeting Ms. Swenson stressed that she valued everyone's knowledge and experience. She distributed in advance relevant scientific summaries of articles posted on the PSYCKES website. She noted her expectation that all would read them and be prepared to discuss salient points and relate them to their current prescribing practices. She presented data from PSYCKES showing project prevalence rates and sources of positive cases. The polypharmacy indicator prevalence was the highest among the indicator sets, followed by youth and dose.

Close inspection of clients' medication in the PSYCKES client-level reports revealed that the majority of clients on polypharmacy who received medication management services at the clinic were being prescribed quetiapine. This is a medication that contributes to risk in both the polypharmacy and cardiometabolic indicator sets. The group felt that they had an opportunity to make improvements in reducing this medication in particular and polypharmacy in general, thus they selected that indicator. Ms. Swenson expressed her commitment to the PSYCKES initiative, stressing that she would incorporate medication-focused CQI into the wellness mission of the agency. She shared successful project strategies that she learned at the recent OMH training and from the clinic personnel that she met there. She noted that clinics who had demonstrated success had kept their project on the radar of clinicians (e.g., current list of clients, flagging charts) and clients (e.g., doctor/client collaboration and education). The group brainstormed for ideas to be implemented in Phase II PDCA cycles. She offered her support to clinicians, reiterating her open door policy. She also indicated that until a medical director was hired, she would periodically meet with the prescribers to discuss their progress toward project goals.

In a subsequent meeting the QI team developed an action plan based on the evaluation of their current processes and the ideas received at the meetings with prescribers. Individuals' roles and responsibilities were included. For both projects they set a goal of 30%, as established by statewide project leadership. The team identified several potential strategies to help achieve their goals, including:

- Flag the charts of clients who have a quality concern so that *all* clinicians can identify them.
- *All* clients that have a quality flag will receive a clinical review by a prescriber and be reassessed quarterly.
- During appointments prescribers will use educational tools to alert clients of quality concerns: (1) give OMH brochure (2) review and offer a copy of the PSYCKES client-level summary.
- Prescribers will work with the QI team to track the rationale for prescribing quetiapine for clients who have been flagged for each indicator set. When the results are in, the team will developed an initiative to address use of quetiapine for non-psychotic conditions.
- The therapists will collaborate with prescribers to work towards non-pharmacological treatment when appropriate.
- Ms. Clarke will complete motivation interviewing training and implement those techniques into her therapy practice.
- In six month the action plan will be evaluated and amended accordingly.

Ms. Swenson designated the 3<sup>rd</sup> week of the month as "Quality Week." On Monday she held a clinic meeting and presented an overview of the project, goals and expectations, and the CQI processes. Time was allocated for staff to view as a group the OMH polypharmacy CME and for a discussion period afterwards. Healthy snacks were provided to staff and clients that day. Ms. Swenson circulated all week to answer questions for those who could not attend the meeting. To introduce the project to consumers, she handed out OMH project brochures to clients in the waiting room and asked them to talk to their doctor about it. She felt they were off to a good start.

## **DO**

Ms. Krauss revised the clinic's master spreadsheet to include information relevant to the polypharmacy project. As usual, every month she distributes to clinicians their list of positive

cases. Ms. Krauss also prints the PSYCKES client level summary for prescribers to use in their reviews and to help educate clients on the medications. Some clients were eager to have the summary for their records. Prescribers were given tokens to access PSYCKES so that they can use the application directly; they find the medication information valuable.

The agency had just completed implementing an electronic medical records system. A flag had been added that identifies clients who have a quality concern. Additionally, the system was customized so they could adapt the *PSYCKES Clinical Note* developed by OMH for Phase II. Prescribers now conduct a clinical review for every positive case on both projects and reassess those clients quarterly. They use the electronic clinical note to record the outcome of their review. Then they send Ms. Krauss an e-message alerting her that a review had been conducted. Ms. Krauss uses the review outcome data on the clinical note to update her spreadsheet. There is an area on the clinical note that covers a prescriber's plan to address barriers to change. She types that information on her spreadsheet. If the prescriber's plan included engaging a therapist, Ms. Krauss notifies the appropriate one. For those clients who have had a medication change, the clinicians work with them to develop individual support plans to help them during the transition period. Clients who are in the process of change are also noted on the spreadsheet. Ms. Krauss also began tracking the clients who have made a successful medication change and meets with the prescriber to get their take on the factors that contributed to the change.

Periodically Ms. Swenson checks in with each prescriber to show her support, even those who work evenings. Because she heads the monthly QI meetings, she is aware of the details of the clients' cases. She encourages prescribers to draw on therapists who can engage clients around quality concerns and provide psychosocial interventions to help clients who are in the process of a medication change. She reminds them that Ms. Clarke has completed the motivational interviewing training and is using it in sessions with clients who are candidates for medication change but have expressed concerns. Ms. Swenson also regularly provides clinicians with evidence-based project-related information developed by OMH.

## **CHECK**

The entire CQI team meets monthly. Ms. Krauss prepares reports for every meeting showing aggregated data at clinic and prescriber levels. Project impact data is shared monthly at the clinician meetings. During the sixth month of Phase II, Ms. Swenson held a QI team meeting at a time convenient for all prescribers to attend (and paid overtime, where appropriate). Dr. Quigley, the new medical director was also in attendance. By this time they have realized gains in reducing quality flags in both projects due to their focus on reducing quetiapine. Twenty-three percent of the clients with a cardiometabolic flag and 7% receiving polypharmacy have had medication changes so that they no longer have a quality concern. The clinic's polypharmacy prevalence is still above the state level. The team is optimistic about continuing to make progress because the new medical director just started and contributed some good ideas during their meeting. The group developed these ideas to be implemented in PDCA cycles in the upcoming months:

- Integrate Dr. Quigley into the CQI process.
- A new procedure was set to *prevent* a new quality flag. When appropriate, new clients would be prescribed non-pharmacological treatment *before* psychotropic medication, especially for anxiety and sleep disorders.
- The team's investigation revealed that among the clients who were prescribed quetiapine, a large percentage of clients were being prescribed it for sleep. Therefore,

prescribers will alert clients of the risks and work with therapists to recommend a non-pharmacological alternative.

- Many River Street clients are being prescribed psychotropic medication by outside prescribers. Therefore the team will create an outreach strategy to primary care physicians and to local hospitals whose clients are discharged on multiple psychotropic medications and then go to River Street for mental health service.
- To gain an understanding of consumers' perspectives on issues related to their QI projects, they will begin a search to include a consumer on the QI team.
- Ms. Krauss compiled a list of clients who have had a medication change that eliminated the quality flag. She will follow up with prescribers and develop success stories to share with consumers and staff.

## **ACT**

Dr. Quigley is a psychiatrist who has extensive experience with psychotherapy and pharmacotherapy. He meets formally and informally with prescribers and therapists, especially those prescribers who have a high prevalence rate in each project. He offers his opinion and guidance on the cases that have shown no progress towards eliminating a quality flag. Prescribers are increasingly working with therapists to discuss alternative treatments such as cognitive behavioral therapy. Based on feedback from Ms. Clarke, Ms. Swenson has budgeted motivational interviewing training for the other therapists for the next quarter.

Ms. Swenson developed a letter for River Street prescribers to send to community prescribers, especially primary care physicians. The letter tells about the River Street's quality initiative. The prescriber fills in information about the client's quality concerns. The letter gives the contact information for the River Street prescriber who is requesting, with the client's consent, coordination of care. Additionally, Dr. Quigley and Ms. Swenson met with staff at one local hospital to begin the process of coordinating the care of those individuals who were discharged on polypharmacy and who would subsequently go to River Street for mental health services. They have a contact (and contact information) at the hospital to call or email when they need further client information beyond their own records and within PSYCKES.

Dr. Quigley reached out to the local NAMI chapter to discuss opportunities for collaboration in presenting medication issues to consumers. He is scheduled to make a presentation to the agency's Consumer Advisory Board about the project. Clinicians have started speaking to clients about potential interest in serving as advisory members of the QI team.

In addition to discussing project data at clinical meetings the QI team mounted a bulletin board in the staff break room to communicate data about the project. It has a current bar chart of each project's progress, and the total number of clients changed in the last month. The clinic staff is impressed with Ms. Swenson's leadership. They are energized by her efforts to create a QI team that makes them feel that they are part of a collaborative effort to improve treatment and to help their clients move safely towards recovery and wellness.

## Project Tools

The PSYCKES team developed an array of project tools to help QI teams manage the PSYCKES CQI Initiative. The following tools can be found on the PSYCKES website under “Project Tools” in the Freestanding Mental Health Clinics section and the Resources for QI Team section.

- Webinars are conducted live by the PSYCKES team for general PSYCKES users and clinicians during which attendees can ask questions. The *Monthly Data Submission* and *Using PSYCKES* webinars are scheduled monthly. A recorded version of these and other webinars are available on the PSYCKES website to view anytime.
- The Medication-Focused CQI Model captures core CQI processes identified by participating free-standing mental health clinics and CQI experts as practices that can lead to significant positive change. A checklist of the best practices of the Medication-Focused CQI Model is organized using the FOCUS-Plan-Do-Check-Act quality improvement model. Clinics are encouraged to use the model as a self-assessment tool to identify potential ways of improving their CQI processes.
- A chart review is an effective way to identify cases (non-Medicaid clients and Medicaid). The PSYCKES Chart Review Form helps to determine if an individual meets criteria for a specific PSYCKES indicator set. There is a chart review form for each of the four PSYCKES project indicator sets: polypharmacy, cardiometabolic risk, higher than recommended dose, and psychotropic medication risk in youth.
- A Master Tracking Spreadsheet can aid in identifying clients and tracking client status over time. OMH recommends following a specific strategy that uses PSYCKES data and a master tracking spreadsheet (see strategy in the *Identification of Positive Cases* section of this Handbook).
- The PSYCKES Clinical Note is a one-page document in a check-box format that communicates the prescriber's plan to change medication, the justification for not making a change, and the strategy to address barriers to change.

## Chapter 2. Stakeholder Engagement

Implementing continuous quality improvement requires buy-in and engagement of leadership and staff. Successful medication-focused CQI also requires engaging prescribers and consumers, which can present particular challenges and opportunities. This chapter is designed to provide CQI teams with concrete strategies for engaging stakeholders in the PSYCKES-CQI project.

### *Engaging Executive Leadership*

One of the most important factors for success in implementing a CQI process is leadership commitment and support. Leadership is needed to communicate the vision of the project to staff, emphasize the priority of the project among the many issues demanding staff time and attention, and ensure adequate resources to support the project. Depending on the table of organization at the agency, Quality Improvement teams may need to enlist the support of other managers and program leaders to engage executive leadership. To make the case for CQI to leadership, emphasize the value the project provides to the agency, for example:

- To promote the best possible treatment, with the lowest possible health risks, for the clients served at the agency.
- To maintain quality, reputation, and competitiveness.
- To demonstrate the quality of services for annual reports, program evaluations, grant applications.
- To manage risk and avoid liability by minimizing adverse outcomes and documenting the rationale for high-risk medications.
- To fulfill the requirements to receive the enhanced Medicaid rate.

### **How Executive Leadership Can Support CQI**

QI teams can engage executive leadership by suggesting concrete ways in which senior staff can be involved in QI activities. Quality improvement requires collaboration and participation at all levels of the agency. Executive leadership can **articulate a vision** of a culture of quality improvement and a commitment to evidence-based practices. Consider incorporating this into the agency's mission or vision statement.

Executive staff can also **provide visible leadership**. For example, attend the kick-off of a new QI project; include QI in annual reports, Board reports, and other summaries of agency activities; and publicly recognize and celebrate project success

In order to institutionalize CQI activities within the agency, **establish reporting lines** to ensure that the activities of the QI project team are aligned with the agency-wide quality improvement plan and have appropriate oversight by executive leadership and the Board.

Successful CQI requires adequate resources. One of most important ways executive leadership can promote success is to ensure that QI teams have **dedicated staff time**, including that of clinical staff. Consider earmarking a portion of the rate enhancement funds to offset this allocation of staff time.

## How the Board of Directors Can Support CQI

The agency Board of Directors or Governing Body also has a role to play in supporting CQI. The Board can support and guide the quality improvement program by **reviewing and approving the Quality Improvement Plan** annually. It can also **regularly review progress** of the agency's quality improvement initiatives toward established goals and objectives. This provides institutional endorsement of the QI team's work.

### ***Engaging Prescribers***

Clinician buy-in, engagement, and leadership are crucial to successful quality improvement activities in medicine. In clinics as well as in hospitals, prescribers provide crucial input into many decisions and can act as champions of either change or the status quo. However, engaging prescribers in QI is not always easy. Clinicians are required to provide increasing amounts of direct care, and are rarely provided the time to participate in QI activities. Moreover, a culture of personal responsibility for each individual client as well as a strong attachment to individual autonomy reduces focus on the larger systems perspective. The following tips on how to increase prescriber engagement are adapted from recommendations made by the Institute for Healthcare Improvement.<sup>1</sup>

#### **1. Discover a Common Purpose**

Reframing quality targets and measures can help bring the goals of the quality improvement team and prescribers' quality goals closer together to create a common purpose for both groups. For example, clinicians care deeply about individual consumer outcomes. The challenge of fitting client-care responsibilities into the time available means that they often are less focused on broader goals, such as improving the clinic's quality scores. Reframing quality improvement goals to include a prescriber-oriented perspective, such as focusing on improving consumer outcomes and reducing wasted time, can help bridge the divide between quality improvement teams and prescribers.

#### **2. Reframe Values and Beliefs**

Reframing core values and beliefs requires CQI teams to think of prescribers as partners. When prescribers and administrators come together to understand quality concerns, a focus on system factors (culture, structure, processes) rather than individual culpability promotes personal investment in the care delivery system.

#### **3. Segment the Prescriber Engagement Plan**

Developing a plan to target clinicians who are needed in the quality initiative can help increase prescriber buy-in. Prescriber roles in QI should reflect their individual strengths and interests. Prescribers who are champions, project or structural leaders, and adopters can all play different roles and can be engaged in different aspects of the quality initiative. It is important to reach out to clinicians likely to be reluctant to change. This strategy gives them a voice, and their cautious approach may prove valuable.

#### **4. Use Engaging Improvement Methods**

Overcoming prescriber concerns about quality improvement requires changing methods to ones that are more engaging and motivating to physicians. For example, being conservative in standardization efforts and soliciting prescriber input can help increase their

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<sup>1</sup> Institute for Healthcare Improvement. Engaging Physicians: how the team can incorporate quality and safety. Healthcare Executive. May/June 2008: 78-81.

buy-in. Use clinic-specific data to track and assess progress, and engage prescribers in exploring possible explanations for variations from larger trends (e.g. state and regional performance). While prescriber-specific data can help leadership and QI teams develop targeted interventions, teams should consider the culture of each clinic when deciding how to share data with clinicians. Develop tools and processes that reflect prescribers' clinical roles and make QI efforts easy to implement.

## **5. Show Courage**

Doctors can be powerful advocates for their beliefs, and the opinions of those who are supportive of change are sometimes overshadowed by one vocal naysayer in the administration or prescriber group. Providing ongoing support to clinicians who have the courage to ask hard questions and to commit to improvements is important in overcoming barriers. Promoting a positive approach to continual and gradual organizational change is critical.

## **6. Adopt an Engaging Style**

Cultural habits of prescribers include focusing on individual outcomes, valuing clinical experience over the evidence base, and overestimating risk. Some strategies for working with prescribers on QI include: invite clinicians to be involved from the beginning; work with leaders and early adopters; choose carefully who conveys the message and what is conveyed; make raw data available to improve transparency; and be considerate of their time by valuing it with yours. Take prescriber input seriously and adopt a collaborative problem-solving approach to addressing concerns. The key principle is to promote trust and open communication within the quality initiative.

Offering clinicians resources and tools about the quality concerns targeted by the PSYCKES-CQI project is often an important first step in engaging clinicians. The PSYCKES website hosts several resources for prescribers, including:

- Summaries of relevant scientific literature
- Continuing Medication Education (CME) modules
- Webinars targeted to clinicians, for example “Engaging Consumers” and “PSYCKES for Prescribers”

In addition, clinicians can access information about medications, including indications, contraindications, drug-drug interactions, and possible side effects, by clicking on any drug name in an individual client's PSYCKES Clinical Summary. The QI team should work with medical leadership and/or prescriber champions to determine the best ways to disseminate information about quality concerns.

## ***Engaging Consumers***

The mental health field in the US is moving towards a recovery orientation in which wellness, rather than symptom reduction, is the overall goal. A recovery orientation aligns with the principles of the OMH PSYCKES-CQI initiative and the processes in its *Medication-focused CQI Model*. The project is an opportunity for CQI teams and clinicians to engage clients in shared decision-making about their health and medications to address quality concerns and achieve recovery goals. This multi-faceted process requires medication education, clinical support around change, and a broader clinic environment that promotes recovery.

### ***Engage every client***

OMH encourages participating clinics to give every client the opportunity to try a lower-risk medication regimen when clinically appropriate. Regular review of PSYCKES data and additional screening strategies (for example, at intake or during treatment plan reviews) can help QI teams ensure that every consumer with a quality flag is identified. Using structured protocols for clinical reviews, implementing go-slow approaches with careful monitoring for medication changes, and tracking barriers to change are strategies that clinics have successfully used to engage consumers and prescribers in a shared decision-making process. Clients' circumstances and recovery goals change over time. Therefore, it is critical to periodically re-assess consumers with quality flags to determine whether a medication change is appropriate.

## **Medication Education**

Opportunities for medication change can occur many times during the course of treatment as clients' circumstances and preferences change over time. Education and information sharing are ongoing activities that reflect new evidence about treatments and evolving client goals.

All clients need to know the reasons why they are being prescribed medications, the short and long-term advantages and disadvantages of each medication, and potential interactions with other drugs. It is also helpful for prescribers to discuss ways in which the consumer can assess whether the medication is working as intended. **Clients who have a quality flag need to know that they have a quality flag, why they have it, and what they can do about it.** Consumer brochures, such as the OMH PSYCKES brochures, can be used to promote discussion on risks and risk reduction. Clinicians can also share the PSYCKES Clinical Summary with clients as a basis for discussion about experiences with past and present medications and treatments. For example, clinicians can ask clients when they believe their health and mental health was at its best (or worst), and review the medications and treatments in place at the time. Clients are welcome to take a copy of the summary home for their records.

## **Engaging Consumers in Medication Decisions**

The prospect of changing medications can evoke anxiety and concern among consumers, even when the prescriber feels a change is clinically indicated. In such situations, **motivational interviewing** can be a powerful therapeutic approach to exploring decisional imbalance around medications. Motivational interviewing is one approach to helping clients navigate through stages of change. "Resistance" is seen as a reaction to environmental conditions rather than an innate characteristic of the consumer. Clients are encouraged to think that change is possible and to be engaged in choosing the means to change.

Core tenets of motivational interviewing include:<sup>2</sup>

- Communicate respect and empathy for the client.
- Advocate a collaborative friendly client/clinician relationship so that clients are willing to express concerns, fears, anger and other emotions.
- Provide positive reinforcement.
- Use persuasion over coercion and argumentativeness.
- Resolve a client's ambivalence to change.
- Explore with clients a variety of therapeutic options that can include treatment and other supports.
- Promoting client choice, client responsibility and self-efficacy.
- Reflectively listen.

When a decision involves a medication change, clients' fears can be lessened when they know what they can expect. Some key messages to convey are:

- The medication change is intended to "do no harm".
- The decision need not be permanent.
- The choice to change is ultimately the client's.
- They are not alone – the clinic staff is there for them.
- Medication is merely one tool. Non-pharmacological treatments might be an option now or in the future.

Engagement with consumers around medications must be ongoing and requires **periodic reassessment**. Clients who are not ready for a medication change at one point in time may be so in the future. Drug side effects that are tolerated today might be more problematic as life circumstances change. For example, a client might not be concerned about the sedating effects of a medication shortly after discharge from the hospital, but more so once she feels ready to begin looking for a job. In addition to medication changes, prescribers may consider non-pharmacological treatment options. A consumer who is on quetiapine for insomnia may agree to begin tapering the medication while learning cognitive-behavioral techniques for sleep. Clients benefit when prescribers can anticipate their changing needs and proactively discuss both medications and psychosocial interventions.

If the client and prescriber agree to change the regimen, the clinic and treatment team can use several strategies to help consumers manage the medication transition, including:

- Scheduling more frequent/longer appointments with the prescriber, therapist and other clinical staff.
- Developing a safety plan outlining what to expect during the medication change, specifying resources and supports available to the consumer, and identifying early warning signs that could signal a problem.
- Providing the client with emergency phone numbers, including clinic and/or crisis hotlines.

The goal is to empower consumers with the information and tools they need to feel safe.

Therapists can work with consumers around many such interventions, including:

- Developing coping skills to manage stress.

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<sup>2</sup> For more information about motivational interviewing, see the Motivational Interviewing website or *Motivational interviewing: preparing people for change* by William R. Miller and Stephen Rollnick, 2002 (2<sup>nd</sup> ed.).

- Educating clients on rating scales that can be used to monitor symptoms.
- Providing or referring clients to groups such as medication management, family psychoeducation, sleep hygiene, managing stress and peer support.

## Creating an Environment for Recovery

One of the ways for clinicians and clients to think about recovery is that a brighter future and meaningful life are possible for every consumer. Clinicians can use every opportunity to plant or nurture the seeds of possibility and **promote a collaborative relationship**. When clinicians and consumers work together towards achieving the consumer's recovery goals, knowledge and information flows in both directions. Clients are likely to be open and engaged and willing to share information when a practitioner takes the time to actively listen, convey an interest in how the individual is doing, and assume the role of partner in a person's recovery journey. Clients should be encouraged to voice concerns and fears about treatment, especially when a new medication or a change has been prescribed. Clinicians can:

- Encourage clients to record their thoughts and reactions to medications (e.g., keep a journal), and to discuss side effects with clinicians at each visit.
- Begin a conversation about recovery concepts.
- Learn about a person's short- and long-term recovery and life goals.
- Encourage shared decision making.

A core tenet of recovery is **person-centered care**. Clients are more likely to respond to clinicians who will:

- Actively listen to the person to learn about illness and medication in the context of her/his life.
- Be sensitive to gender roles, sexual orientation and cultural backgrounds. A client appreciates when their views are understood and taken into account (e.g., cultural stigma of mental illness, prescriptions vs. home or alternative remedies).
- Take into account learning (dis)abilities; literacy level; language barriers; and gender, ethnic and cultural considerations.
- Show the capacity to recognize a person's strength and project faith in human resiliency.

Clinicians can also **support family involvement** by encouraging clients to reach out to people in their extended family, social, civic, religious, professional, workplace and other networks.

Trusted individuals can help in many ways, including:

- Support the consumer in making a treatment decision.
- Lessen stress and offer support.
- Provide reassurance when a person is doing well.
- Look for warning signs of relapse.
- Help an individual see himself/herself as part of a larger community.
- Stave off isolation.

When possible, clinicians can encourage families to engage in ongoing communication, and to call the clinical staff when they encounter problems. During periods of change, clients are well served when they feel they are not alone, and can trust that clinicians and significant others are there for them.

Clinicians and families can only do so much. Consumers can be encouraged and supported in **identifying peer and community supports** that promote recovery. Many communities offer recovery and wellness supports as well as associations and organizations that appeal to clients'

personal interests and goals. Peers can play a powerful role in supporting recovery by encouraging consumers to:

- Learn about others' experiences with the mental health system, mental health symptoms and diagnoses, treatment options and services, expectations, outcomes, supports, and other issues related to illness, recovery and wellness.
- Share information and experiences about medications and medication change. Hearing others' success stories can be a powerful motivation to change.
- Learn from peers about what types of questions to ask clinicians, what worked and did not work, and coping and relapse prevention skills.