

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

**Quality Concerns:
Health Promotion and Coordination
Behavioral Health Care Coordination**

Overview

- Review of OMH CQI Initiative Achievements to Date
- Evolving Environment for Behavioral Health in NYS
- Project Option 1: Health Promotion & Coordination
 - Scope of the problem
 - Quality Indicators
 - Strategies and Interventions
- Project Option 2: Behavioral Health Care Coordination
 - Scope of the problem
 - Quality Indicators
 - Strategies and Interventions
- Resources

ACHIEVEMENTS TO DATE

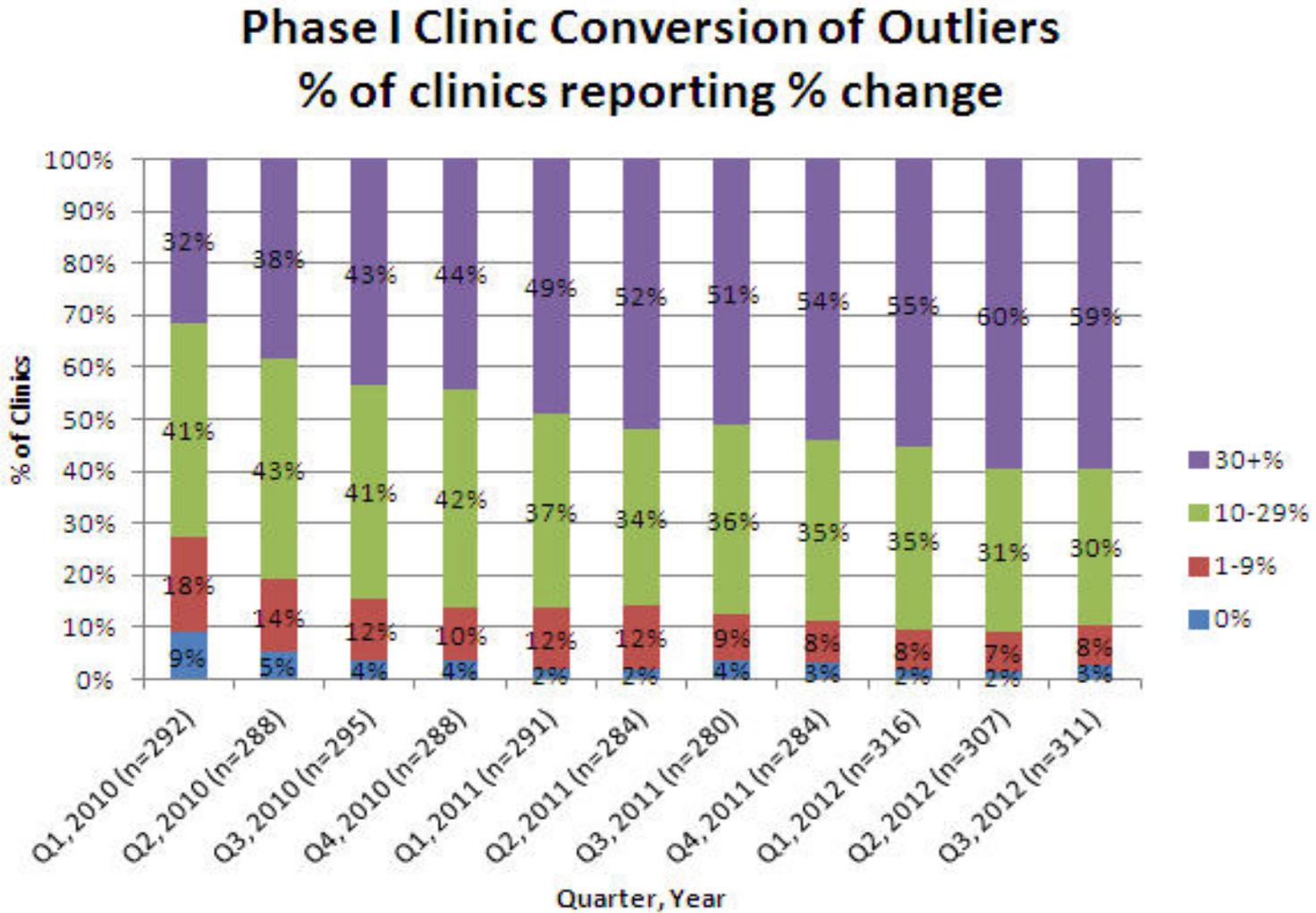
Medication-Focused CQI

- Goal: decrease the prevalence of questionable psychotropic prescribing practices among Medicaid enrollees in New York State
 - Target: medication change for 30% of flagged cases
 - All clinics expected to use a CQI approach, e.g. Plan-Do-Check-Act model
- Phase I (2008): clinics selected one project
 - Polypharmacy
 - Use of higher-risk antipsychotics for people with an existing metabolic condition
- Phase II (2010): clinics added 2nd project
 - New indicator sets: Dose and Youth

Project Activities to Date

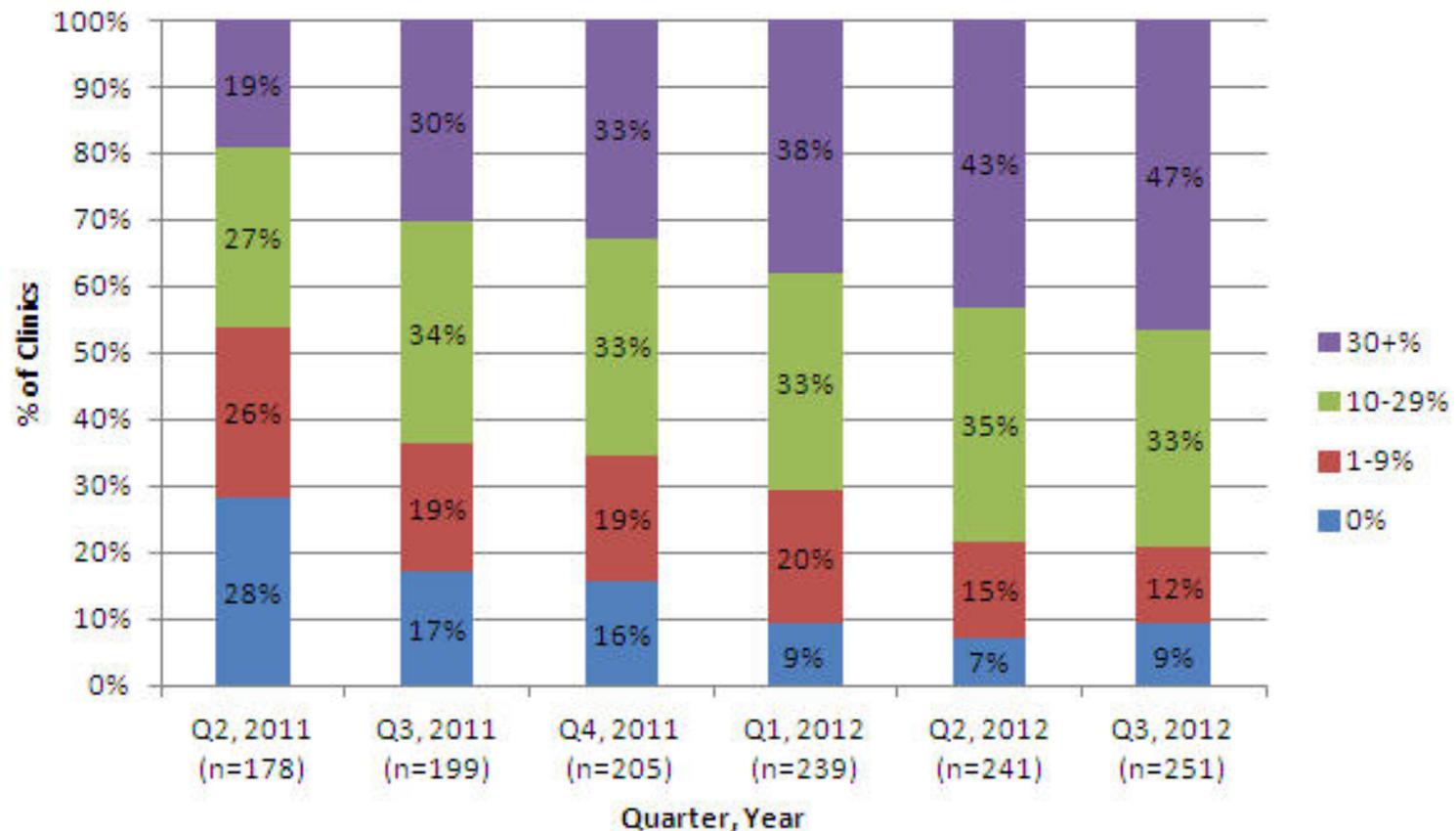
- Currently 318 participating clinics statewide
- Training and technical assistance for Phase II
 - 10 training workshops (344 attendees)
 - 56 Webinars (1498 attendees)
 - 2,472 PSYCKES-Help requests
 - Project tools available on PSYCKES website
- Monthly on-line survey to track progress
- Site visits/calls with 48 agencies to explore challenges, strategies and lessons learned

Clinic Self Report Data – Phase I



Clinic Self Report Data Phase II

Phase II Clinic Conversion of Outliers
% of clinics reporting % change



EVOLVING ENVIRONMENT FOR BEHAVIORAL HEALTH IN NYS

Changes in NYS Behavioral Health System

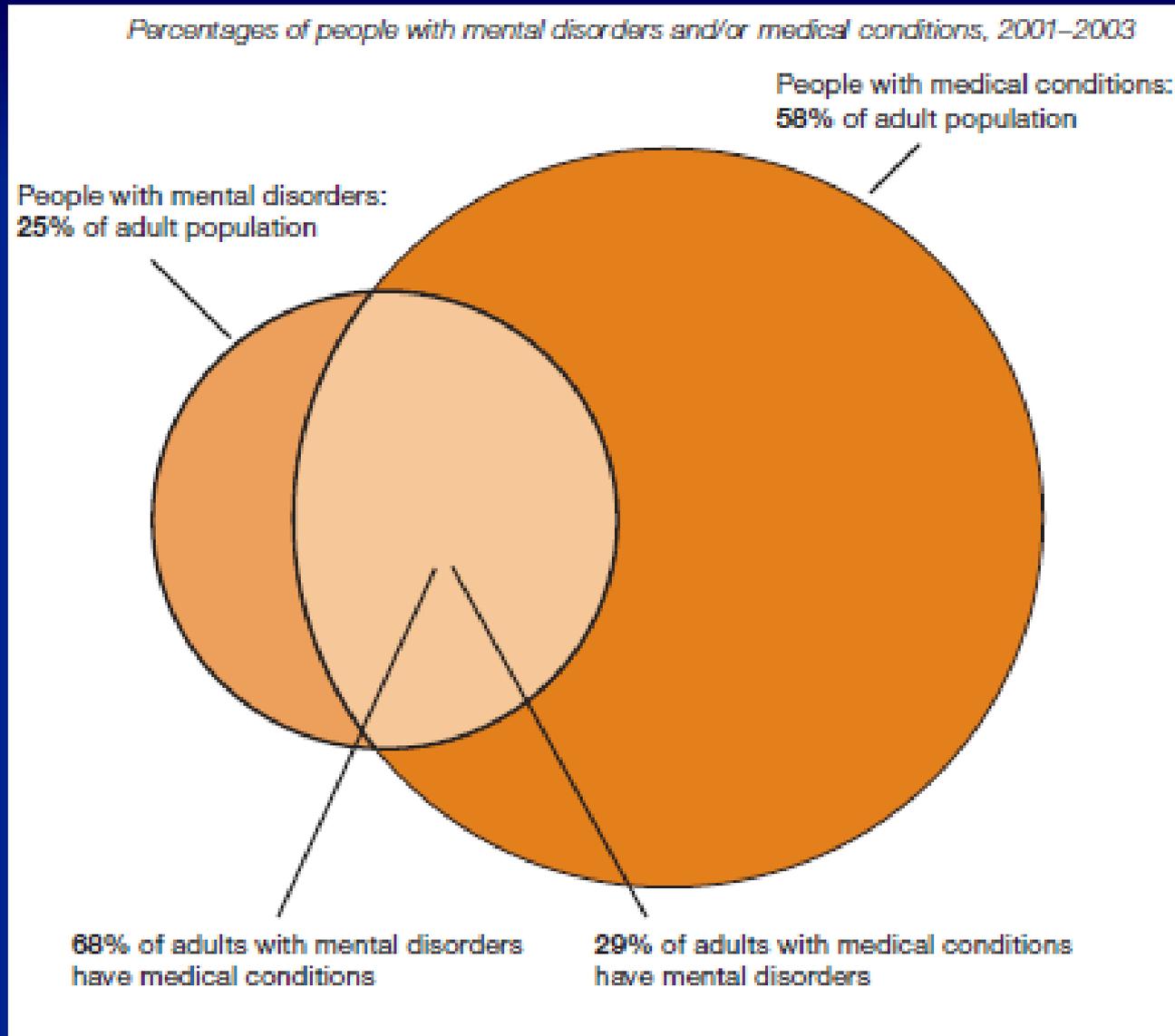
- Managed care for all Medicaid enrollees by 2013/2014
- Psychotropic medications moved to managed benefit
- Utilization threshold payment reductions
- Health Homes for MCD enrollees with one serious persistent mental health condition or 2 chronic conditions
- New CQI initiative for article 31 clinics
 - Retain Medicaid enhancement for eligible clinics to support CQI
 - Build readiness and synergies for changing environment
 - Health Promotion and Coordination
 - Behavioral Care Coordination

Project Option 1

HEALTH PROMOTION AND COORDINATION

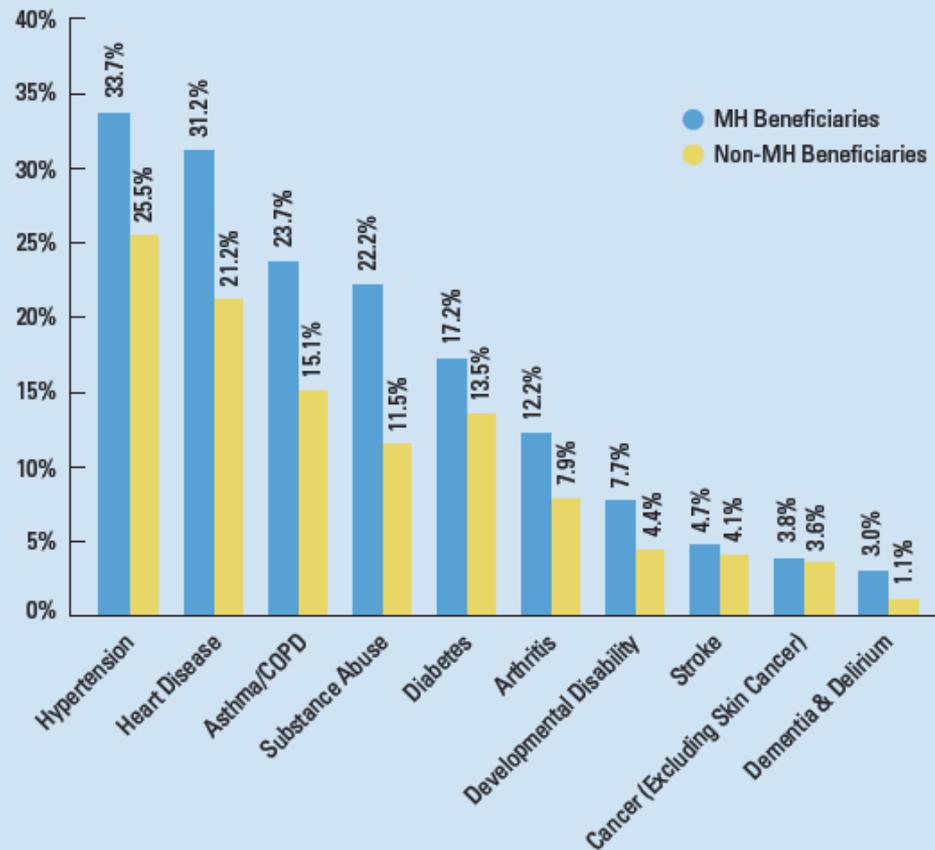
Scope of the Problem

Comorbidity in Health and Mental Health



Comorbidity among NYS Medicaid Enrollees

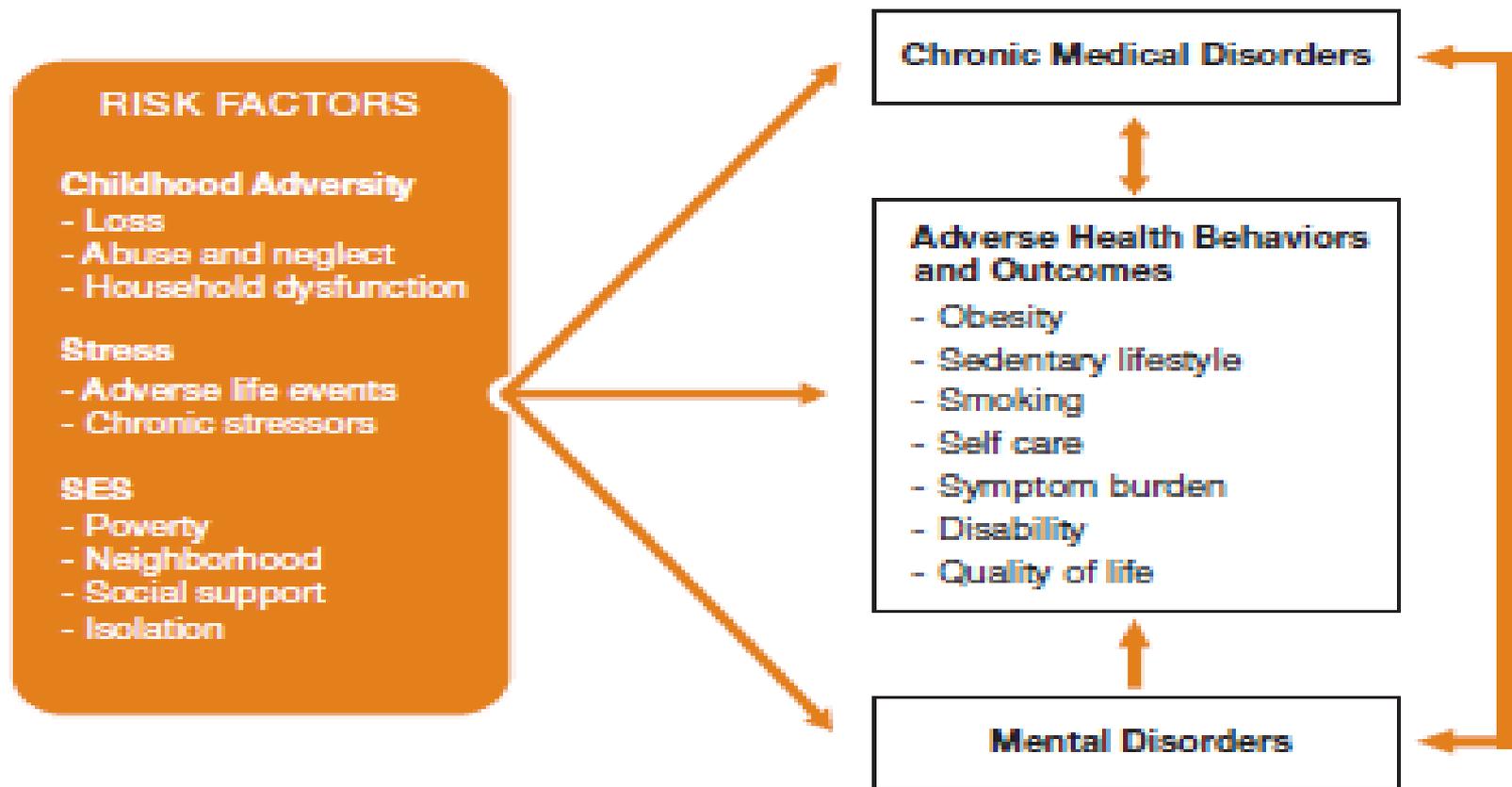
Prevalence of Selected Comorbidities by MH Treatment, 2003



(Coughlin & Shang, 2001)

Comorbidity Interaction

Model of the interaction between mental disorders and medical illness



In Druss and Walker 2001. Source: Modified from Katon 2003.

Quality Concerns Related to Comorbid Medical Conditions in the Behavioral Health Population

- People with serious mental illness die 25 years earlier than general population (NASMHPD, 2008)
- Modifiable health risks: under-treatment and iatrogenic risks
 - Risk behaviors more prevalent in behavioral health population (Druss and Walker, 2011)
 - Tobacco use
 - Excessive alcohol and illicit drug consumption
 - Sedentary lifestyle
 - Poor nutrition
 - Iatrogenic effect of psychotropic medications: weight gain, obesity and type 2 diabetes
- Low levels of recommended lab screening/ monitoring

Fiscal Impact of Comorbid Medical Conditions in the NYS Medicaid Program

- Annual cost of NYS Medicaid program for complex/chronic conditions: \$26 billion yearly, including \$6.3 billion for services to 400,000 individuals with serious behavioral health disorders (OMH, 2012)
- On average, 75% of NYS Medicaid spending for enrollees with mental health conditions is for non-MH services (Coughlin & Shang, 2011)
 - Non-MH spending for MH population is 32% higher than for non-MH population
- In 2009, NYS Medicaid covered 90,546 avoidable admissions at a cost of \$824 million (DOH Office of Health Insurance Programs Statistical Brief #6)

HEALTH PROMOTION AND COORDINATION

Quality Indicators

Health Promotion and Coordination

■ Goals:

- 1. Ensure identification, planning, and coordination of services for consumers with high utilization of medical inpatient and ER services
- 2. Increase appropriate laboratory monitoring and annual physicals

■ Aligned with

- New MH clinic regulations permitting billing for medical services
- Opportunities for coordination via health homes

■ Opportunities for MH clinics to improve health outcomes

- Mental health clinics see the client more often
- Mental health clinics may have expertise in engagement, motivational interviewing, wellness self-management, running groups, peer support or other interventions that can be used to improve health outcomes

Health Promotion and Coordination Quality Indicators by Quality Goal

- 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+ past yr)
 - Preventable medical hospitalization (1+ past yr)
- Laboratory monitoring and annual physicals
 - No diabetes screening for individuals on antipsychotic (>1yr)
 - No diabetes monitoring for individuals with diabetes (>1yr)
 - No outpatient medical visit (>1 yr)

High Utilization: Medical Inpatient Hospitalization/ Emergency Room Visits

- Denominator (eligible population): Behavioral health population
- Numerator (identified population): Individuals who in the past 12 months had 4 or more of any:
 - non-BH inpatient hospitalizations
 - non-BH ER visits
- Intended to identify those who frequently use inpatient/ER medical hospital services and may benefit from increased engagement in community-based services

Preventable Hospitalizations

- Denominator (eligible population): Behavioral health population 18 years and older
- Numerator (identified population): Individuals who were hospitalized due to
 - asthma
 - diabetes
 - dehydration
- Intended to identify those who may benefit from medical attention and better coordinated care in the community
- Based on Prevention Quality Indicators developed by the Agency for Healthcare Research and Quality (AHRQ)

No Diabetes Screening - On Antipsychotic

- Denominator (eligible population): Behavioral health population, prescribed an antipsychotic within 35 days of PSYCKES report date; non dual eligible
- Numerator (identified population): Individuals on any antipsychotic who did not have diabetes screening test (glucose/HbA1c) in past 12 months
- Intended to promote annual screening for diabetes among those at risk due to antipsychotic medication

No Diabetes Monitoring - Diabetes

- Denominator (eligible population): Behavioral health population, diagnosed with diabetes; non dual eligible
- Numerator (identified population): Individuals diagnosed with diabetes who did not have a HbA1c test in past 12 months
- Intended to promote annual monitoring of diabetes among those diagnosed with the disease

No Outpatient Medical Visit

- Denominator (eligible population): Behavioral health population
- Numerator (identified population): Individuals who did not have any outpatient medical visits in the past year
- Intended to identify individuals who may lack routine preventive care

Health Promotion and Coordination Indicators

4+ Inpatient/ER – Med	High Utilization of Medical Inpatient / Emergency Room
Prevent Hosp Asthma	Preventable Hospitalizations - Adult Asthma
Prevent Hosp Diabetes	Preventable Hospitalizations - Adult Diabetes
Prevent Hosp Dehydration	Preventable Hospitalizations - Adult Dehydration
No Diabetes Screening-On Antipsychotic	No Diabetes Screening for Individuals on Antipsychotics
Diabetes Monitoring- No HbA1c > 1 Yr	No Diabetes Monitoring for Individuals with Diabetes
No Outpatient Medical Visit >1 Yr	No Outpatient Medical Visit in Past Year

PSYCKES Data

(as of 10/1/2012)

Indicator	Eligible	Identified	%
4+ Inpatient/ER – Med	890,539	91,305	10.25
Prevent Hosp Asthma	737,665	7,211	0.98
Prevent Hosp Diabetes	737,665	8,470	1.15
Prevent Hosp Dehydration	737,665	1,831	0.25
No Diabetes Screening-On Antipsychotic	86,520	22,971	26.55
Diabetes Monitoring-No HbA1c > 1 Yr	83,016	25,319	30.50
No Outpatient Medical Visit >1 Yr	897,319	153,593	17.12

HEALTH PROMOTION AND COORDINATION

Strategies and Interventions

Overview of Strategies

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

Models and Options for Integrating / Coordinating Care

- Basic medical services provided by mental health clinic (physical exam, order labs)
 - Health Physicals - Currently 73 Art 31 clinics
 - Health Monitoring – 196 Art 31 clinics
- Develop relationship with medical provider/ lab services
 - Medical provider comes on site to clinic, and/or
 - Ongoing linkages to nearby medical provider
- Refer to Health Home to get additional Care Manager support

Reducing High Hospital and ER Utilization for Medical Conditions

- Identify clients with this quality concern
- Evaluate: why is this client a high utilizer?
 - Uses ER for primary care treatment/ poor access to care
 - Comorbid medical condition in moderate/ poor control with low adherence/ low engagement in medical care and/ or with low wellness self management
 - Inadequate support for medical condition
- Develop plan to address engagement/ outcome challenges

Plan to Improve Engagement in Medical Care and Health Outcomes

Issue	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

Self-Management Program (SMP) Models

- Growing body of evidence suggesting SMPs can be adapted for behavioral health population
 - HARP peer-led program improved visits to PCP and patient activation (Druss et al. 2010)
 - Living Well program demonstrated improvement in self-management, health functioning, and use of health care (Goldberg et al., 2012)
 - OMH Wellness Self-Management (Center for Practice Innovation, practiceinnovations.org/)
- Core components
 - Facilitated groups
 - Structured curriculum focused on disease management, problem-solving and action planning
 - Tools and resources, e.g. self-management record

Resources: Web-based Training for Staff

The Center for Practice Innovations

- Integrating medical, psychiatric, and addiction services
- Wellness Self-Management
- Stage-wise treatment
- Motivational interviewing
- Treating tobacco dependence
- Additional CPI Modules of interest
 - Engaging consumers
 - Early stages of change

Resources: Referrals

- Health Home Care Management
- Home Attendant
- Self-management training (SMT) for clients diagnosed with diabetes/asthma. NYS is one of two states in the country to cover asthma SMT. Medicaid covers asthma or diabetes SMT under the following conditions:
 - Setting: D&TC or hospital outpatient clinic
 - Health educator certified by one of the two national bodies
 - National Certification Board for Diabetes Educators, <http://www.ncbde.org>
 - National Asthma Educator Certification Board, naecb.org

Increasing Annual Physicals and Lab Monitoring

- Develop processes to support ongoing identification of labs/ physicals due
- Educate clients on
 - Benefits of regular medical assessment/ care
 - Importance of screening for diabetes
 - Importance of diabetes management and monitoring
- Interventions/ workflow redesign

Increasing Annual Physicals and Lab Monitoring

- Educational materials in waiting room: posters, pamphlets
- Flag charts with overdue lab/ physical
- Self Management Programs
- Support: facilitate scheduling, reminders, transportation support
- Develop procedures to ensure lab results are reviewed
- Incorporate into workflow

Examples of Incorporating into Clinic Work Flow

- Example 1: At the point of check in, front desk staff identify clients with overdue lab/physical and inform client, flag chart, so that RN/ MD/ therapist is aware and can address
- Example 2: After check in with front desk, see RN for weight, BP, and lab/ physical status check, prior to seeing psychiatrist (similar to medical office)
- Example 3: Psychiatrist incorporates weight, review of health status/utilization, and any labs/physical due into visit
- Example 4: Primary therapist uses motivational interviewing during session if chart is flagged for overdue lab/physical

Project Option 2

BEHAVIORAL HEALTH CARE COORDINATION

Scope of the Problem

NYS Behavioral Health System

- Mental Health (MH) System
 - Serves over 600,000 individuals
 - \$7 billion annual spending, 50% is for inpatient care
- Substance Use (SU) Disorder Treatment System
 - Serves over 250,000 individuals
 - \$1.7 billion annual spending
- Fragmented System
 - Contributes to lack of accountability and poor client outcomes
 - Collaborative care mode is not widely implemented

(OMH, 2011)

Quality Issues in Behavioral Health Care

- Quality challenges for behavioral health care include:
 - Stigma
 - Less developed infrastructure for QI
 - Need for greater linkages among multiple providers
 - More educationally diverse workforce
- 5-18% of mental health consumers utilize 27-63% of services

(Lindamer et al., 2011; National Academy of Sciences, 2006)

Hospital Readmissions NYS MCD (2003)

Population	7-day Readmission	Total \$ for 7-day Read	30-day Readmission	Total \$ for 30-day Read
MH Population				
Readmission for MH	10.2%	\$24.4 million	21.2%	\$56.9 million
Readmission for non-MH	14.0%	\$65.7 million	26.4%	\$161.2 million
Any Readmission	15.2%	\$99.3 million	28.8%	\$232.2 million
Non-MH Population				
Any Readmission	9.5%	\$60.8 million	20.1%	\$171.7 million

(Coughlin & Shang, 2011)

Outpatient Follow-Up after Mental Health Inpatient Stay, NYS MCD

Ambulatory Visit Follow-Up to Hospital Inpatient Stay for MH Treatment, 2003

	Ambulatory Visit Within	
	7 Days	30 Days
Percentage of Hospital Inpatient Stays with Any Follow-Up Visit	51.4%	65.3%
By Primary Diagnosis		
Multiple Diagnoses	53.5%	67.9%
Neurotic & Other Depressive Disorders	31.0%	37.4%
Major Depression & Affective Disorders	43.0%	54.2%
Schizophrenia	43.7%	55.8%
Stress & Adjustment Reactions	14.0%	23.6%
Other	13.1%	18.5%

Source: Urban Institute analysis of 2003 Medicaid Analytic eXtract (MAX).

(Coughlin & Shang, 2011)

Risk Factors in Behavioral Health Hospitalization

- History of hospitalizations increases risk of subsequent utilization
- Co-morbid conditions, e.g. substance use
- Low engagement in outpatient services
- Medication non-adherence
- Challenges in disease self-management

Medication Adherence in General Population

- 43-78% adherence rate for people with chronic conditions
- Poor adherence exacerbates disease, death, health care costs
- 33-59% of medication-related hospital admissions in US due to poor medication adherence
 - Resultant costs: \$100 billion/year
- Improving adherence may be best investment for addressing chronic conditions

(WHO, 2003; Osterberg and Blaschke, 2005)

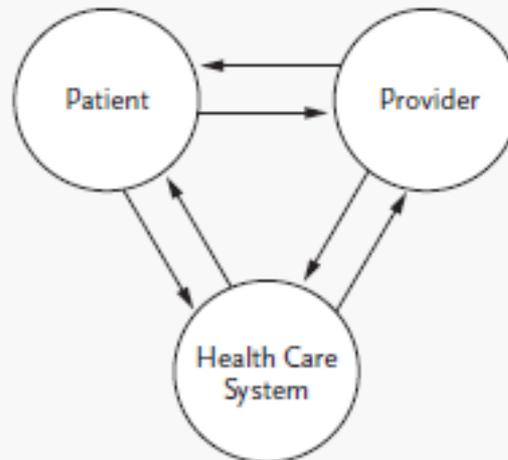
Medication Adherence in Behavioral Health Population

- Adherence rate for 2nd generation antipsychotics 50-60%; for antidepressants 65%
- Physicians overestimate adherence
- Risks of poor adherence include
 - Decreased treatment effectiveness
 - Increased symptom recurrence and higher rate of relapse
 - Greater chance and frequency of hospitalization with longer stays
 - Compromised health outcomes
- 40% of rehospitalization costs among schizophrenia patients due to non-adherence

(Stephenson et al., 2012; Svarstad et al., 2001; Weiden & Olfson, 1995)

Barriers to Medication Adherence

Poor provider–patient communication
Patient has a poor understanding of the disease
Patient has a poor understanding of the benefits and risks of treatment
Patient has a poor understanding of the proper use of the medication
Physician prescribes overly complex regimen



Patient's interaction with the health care system
Poor access or missed clinic appointments
Poor treatment by clinic staff
Poor access to medications
Switching to a different formulary
Inability of patient to access pharmacy
High medication costs

Physician's interaction with the health care system
Poor knowledge of drug costs
Poor knowledge of insurance coverage of different formularies
Low level of job satisfaction

(Osterberg and Blaschke, 2005)

BEHAVIORAL HEALTH CARE COORDINATION

Quality Indicators

Behavioral Health Care Coordination

- Goals:
 - 1. Ensure identification, planning and coordination of care for consumers at risk for high utilization of behavioral health inpatient and ER services
 - 2. Increase medication adherence for individuals with a diagnosis of schizophrenia, bipolar, or depression
- Aligned with
 - State and national initiatives to decrease hospital readmissions
 - Person centered care

Behavioral Health Care Coordination Quality Indicators

- 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+ past yr)
 - High utilization of BH inpatient services (3+ past yr)
 - High utilization of BH ER services (3+ past year)
 - BH Readmission within 45 days (in past year)
- Medication adherence / continuation
 - Antipsychotic medication adherence – schizophrenia
 - Mood stabilizer adherence – bipolar
 - Antidepressant discontinuation <12 weeks

High Utilization: BH Inpatient Hospitalization and Emergency Room Visits

- Denominator (eligible population): BH population
- Numerator (identified population): Individuals who in the past 12 months had:
 - 4+ BH inpatient / ER hospitalizations
 - 3+ BH inpatient hospitalizations
 - 3+ BH ER visits

BH Readmissions within 45 Days

- Denominator (eligible population): BH population with least one BH hospitalization in the past 12 months
- Numerator (identified population): Individuals with at least one BH hospitalization who had 1 or more BH hospitalization within 45 days of discharge in the past 12 months

Medication Adherence: Antipsychotics

- Denominator (eligible population): BH population among individuals with a diagnosis of schizophrenia in the past year
- Numerator (identified population): Individuals diagnosed with **schizophrenia** who had an **antipsychotic medication** available to them less than 80% of the time since the 1st observed antipsychotic medication to the PSYCKES report date in the past 12 months
- Adapted from the Healthcare Effectiveness Data and Information Set (HEDIS) measures developed by the National Committee for Quality Assurance

Medication Adherence: Mood Stabilizers

- Denominator (eligible population): BH population among individuals with a diagnosis of bipolar disorder in the past year
- Numerator (identified population): Individuals diagnosed with **bipolar disorder** who had **a mood stabilizer and/or antipsychotic** medication available to them less than 80% of the time since the 1st observed mood stabilizer and/or antipsychotic medication to the PSYCKES report date in the past 12 months
- Adapted from the Healthcare Effectiveness Data and Information Set (HEDIS) measures developed by the National Committee for Quality Assurance

Medication Adherence: Antidepressants

- Denominator (eligible population): BH population among individuals diagnosed with major depression and a new start of an antidepressant in the past year
- Numerator (identified population): Individuals diagnosed **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 population
- Adapted from the Healthcare Effectiveness Data and Information Set (HEDIS) measures developed by the National Committee for Quality Assurance

Behavioral Health Care Coordination Indicators

4+ Inpatient/ER – BH	High Utilization of Behavioral Health Inpatient / Emergency Room
3+ Inpatient – BH	High Utilization of Behavioral Health Inpatient Services
3+ ER – BH	High Utilization of Behavioral Health Emergency Room
Readmission - All BH 45 day	Behavioral Health Rehospitalization within 45 Days
Adherence – Antipsychotic (Schz)	Adherence to Antipsychotic Medications for Individuals with Schizophrenia
Adherence Mood Stabilizer (Bipolar)	Adherence to Mood Stabilizer Medications for Individuals with Bipolar Disorder
Antidepressant < 12 weeks (Depression)	Antidepressant Trial of less than 12 weeks for Individuals with Depression

PSYCKES Data

(as of 10/1/2012)

Indicator	Eligible	Identified	%
4+ Inpatient/ER – BH	890,539	16,021	1.80
3+ Inpatient – BH	890,539	12,822	1.44
3+ ER – BH	890,539	10,442	1.17
Readmission - All BH 45 day	75,821	17,540	23.13
Adherence – Antipsychotic (Schz)	28,191	8,516	30.21
Adherence Mood Stabilizer (Bipolar)	18,793	6,423	34.18
Antidepressant < 12 weeks (Depression)	14,411	7,040	48.85

BEHAVIORAL HEALTH CARE COORDINATION

Strategies and Interventions

Approaches to Reducing High Utilization and Increasing Engagement

- Establish a system for identifying clients with this quality concern or at risk of relapse
 - High utilization
 - Recent hospitalization
 - No show/ poor medication adherence with high risk
- Evaluate – why is this client a high utilizer/ relapsing?
 - Co-morbid substance
 - History of poor medication adherence/ engagement
 - Inadequate support
 - Homeless
 - Stressor/ coping skills

Develop Plan to Reduce Hospitalization/ ER & Improve Engagement

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

Approaches to Reducing High Utilization and Increasing Engagement

- Psychoeducation
- Medication related approaches
- Psychosocial Interventions
 - Integrated treatment for substance use disorder
 - Motivational Interviewing
 - Cognitive Behavioral Therapy
 - Skills training
- Additional supports
 - Peer support
 - Family involvement
 - Additional Health Home Care Management and support services
 - Refer for Assisted Outpatient Treatment

Medication Related Interventions

- Depot medications associated with less rehospitalization and reduced risk of relapse (Leucht et al., 2011, Tiihonen, 2012)
- Clozapine underutilized as evidence-based treatment for refractory illness (Mistry & Osborn, 2011)
- Use of medication for alcohol dependence is associated with reduced readmissions and cost. (Baser, 2011; Bryson, 2011)

Medication Adherence: Clinical Strategies

- Measure medication adherence – check for side-effects and barriers to taking medication
- Enhanced communication/ shared decision making
- Include family in client education
- Simplify daily dosing
- Use pillbox to organize daily doses
- Cue-dose training / behavioral tailoring to take medications at a specific time
- Increase clinic hours to decrease wait times
- Enlist other health care providers
- Reminders – e.g. can program in to cell phone

Medication Adherence: Motivational Interviewing (MI)

- Found to help reduce patients' ambivalence and improve adherence
- MI principles:
 - express empathy, develop discrepancy, roll with resistance, support self efficacy
- Therapeutic skills (OARS):
 - Open-ended questions, affirmations, reflective listening, summaries

(Laakso, 2012)

Integrated Dual Disorders Treatment (IDDT)

1. Integration of treatment
2. Assertive engagement
3. Comprehensiveness of services
4. Motivation-based treatment
5. Reduction of negative consequences
6. Time unlimited services
7. Multiple psychotherapeutic modalities

On-line training available via Office of Mental Health Focus on Integrated Treatment (FIT) Modules.

Cognitive Behavioral Therapy

TABLE 1. Targets and techniques of cognitive behavioral therapy for schizophrenia

TARGET	TECHNIQUE
Positive symptoms	Alternate explanations to patient
Hallucinations	Normalizing Enhancing coping strategies
Delusions	Inference chaining Peripheral questioning
Negative symptoms	Behavioral interventions
Avolition Amotivation Anhedonia Affective blunting	Behavioral self monitoring Activity scheduling Mastery and pleasure ratings Social skills training

Supports and Systems Interventions

- Health homes as new option for care coordination
 - Cochrane Review (2010) concludes intensive case management reduces hospitalizations and increases engagement in outpatient care compared to standard care and non-intensive case management, particularly for individuals with high levels of hospitalization
- Assisted Outpatient Treatment associated with improved outcomes, including reduced hospitalization and greater engagement in outpatient services (Schwartz, 2010)

RESOURCES AND NEXT STEPS

Center for Practice Innovations

- The Center for Practice Innovations (CPI) supports OMH's mission to promote the widespread availability of evidence-based practices to improve mental health services, ensure accountability, and promote recovery-oriented outcomes for consumers and families.
- CPI serves as a key resource to clinics by supporting implementation of the clinical practices identified as most critical to system-transformation

CPI Registration

- Clinics can begin registration process after they have selected their CQI project
- Clinic director clicks <http://practiceinnovations.org/LinkClick.aspx?fileticket=xQqhJk5hqI8%3d&tabid=186> to complete a brief registration form
- Approximately one week after CPI receives the brief registration form, CPI will send to the clinic director a link for staff to register in CPIs learning community.
- More information is covered in the webinar on project activities and expectations

PSYCKES

- PSYCKES Website - www.psyckes.org
 - Quality Indicator Technical Specifications
 - PSYCKES Users' Guide
 - Frequently Asked Questions
 - Recorded Webinars
 - Project Tools
 - New materials will continue to be added to the website
- New indicators available to support QI projects
- If your clinic does not already have access contact PSYCKES help at PSYCKES-help@omh.ny.gov

Next Steps

- Review your data in PSYCKES
- Begin convening clinic QI team to review data and discuss project options
- If project is selected can begin CPI registration
- If selecting Health Promotion and Coordination
 - Strongly consider obtaining revised operating certificate for optional services: Health Physicals and Health Monitoring
- Review information in the 2nd required webinar about project activities and expectations
 - “OMH CQI Initiative for Health Promotion and Care Coordination (The Next Phase) 2013 Project Activities and Expectations”

Contact Information

- PSYCKES-help@omh.ny.gov
 - PSYCKES Application
- OMH Helpdesk: 800-HELP-NYS (800-435-7697)
 - Access and token issues
 - Security Management System support
- cpihelp@nyspi.columbia.edu
 - Questions or challenges with CPI registration