The NYSOMH PSYCKES-CQI Initiative: Phase II Training

Webinar – March 2011

Agenda

- Welcome
- Project Update
- Quality Concerns in Psychotropic Prescribing
- Medication-Focused Continuous Quality Improvement (CQI)
- PSYCKES Update
- Next Steps
- Questions and Answers

Project Update

Project Impact: Medicaid Data

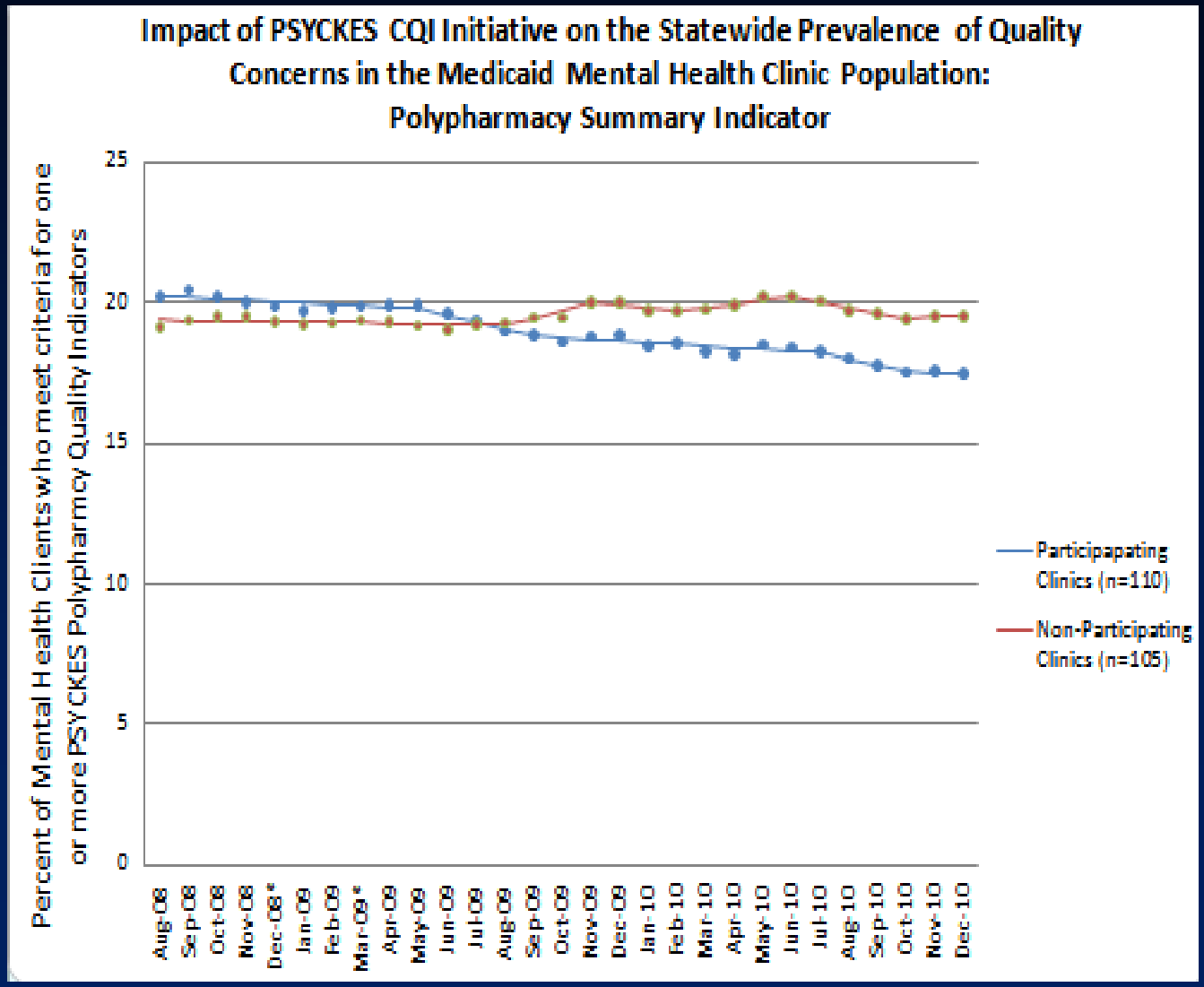
- Decrease in prevalence of quality concerns is the goal
  - PSYCKES-CQI initiative evaluated based on prevalence of quality concerns in non-dual eligible Medicaid population
- Decreases in prevalence of polypharmacy and cardiometabolic indicators are generally encouraging
  - Greater impact seen in domains with more evidence
  - Joinpoint analysis suggests trends in participating vs. non-participating clinics are significantly diverging

Polypharmacy Summary Indicator

Participating clinics have seen a decrease of 12.1% in prevalence of the Polypharmacy Summary Indicator.

Non-participating (Art. 28) clinics have seen a 0.8% increase in prevalence.

Data as of 12/30/10

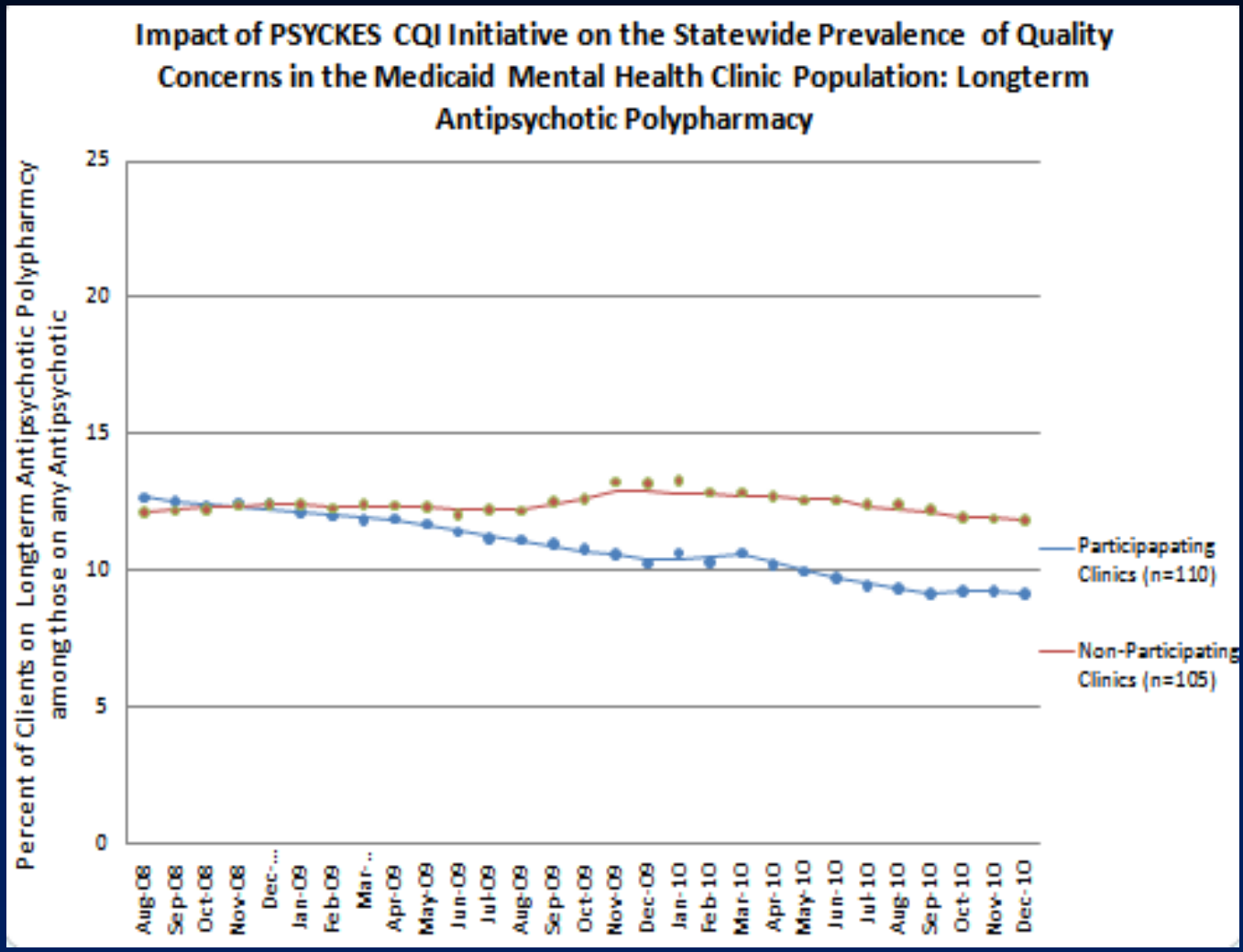


Antipsychotic Polypharmacy

Participating clinics have seen a decrease of 22.8% in prevalence of the Antipsychotic Polypharmacy Indicator.

Non-participating (Art. 28) clinics have seen a 4.7% decrease in prevalence.

Data as of 12/30/10

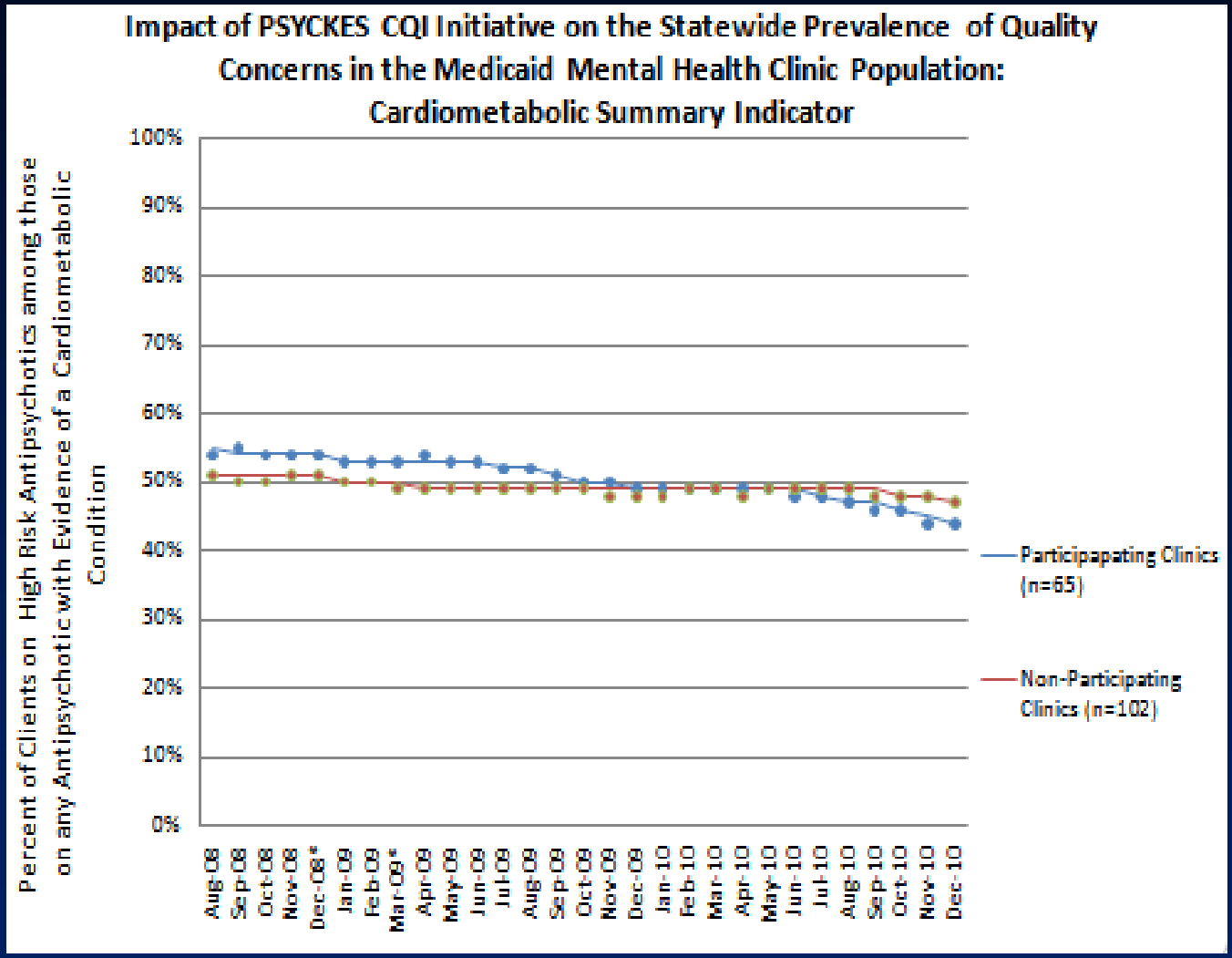


Cardiometabolic Risk Summary Indicator

Participating clinics have seen a decrease of 17.1% in prevalence of the Cardiometabolic Summary Indicator.

Non-participating (Article 28) clinics have seen a 4.2% decrease in prevalence.

Data as of 12/30/10

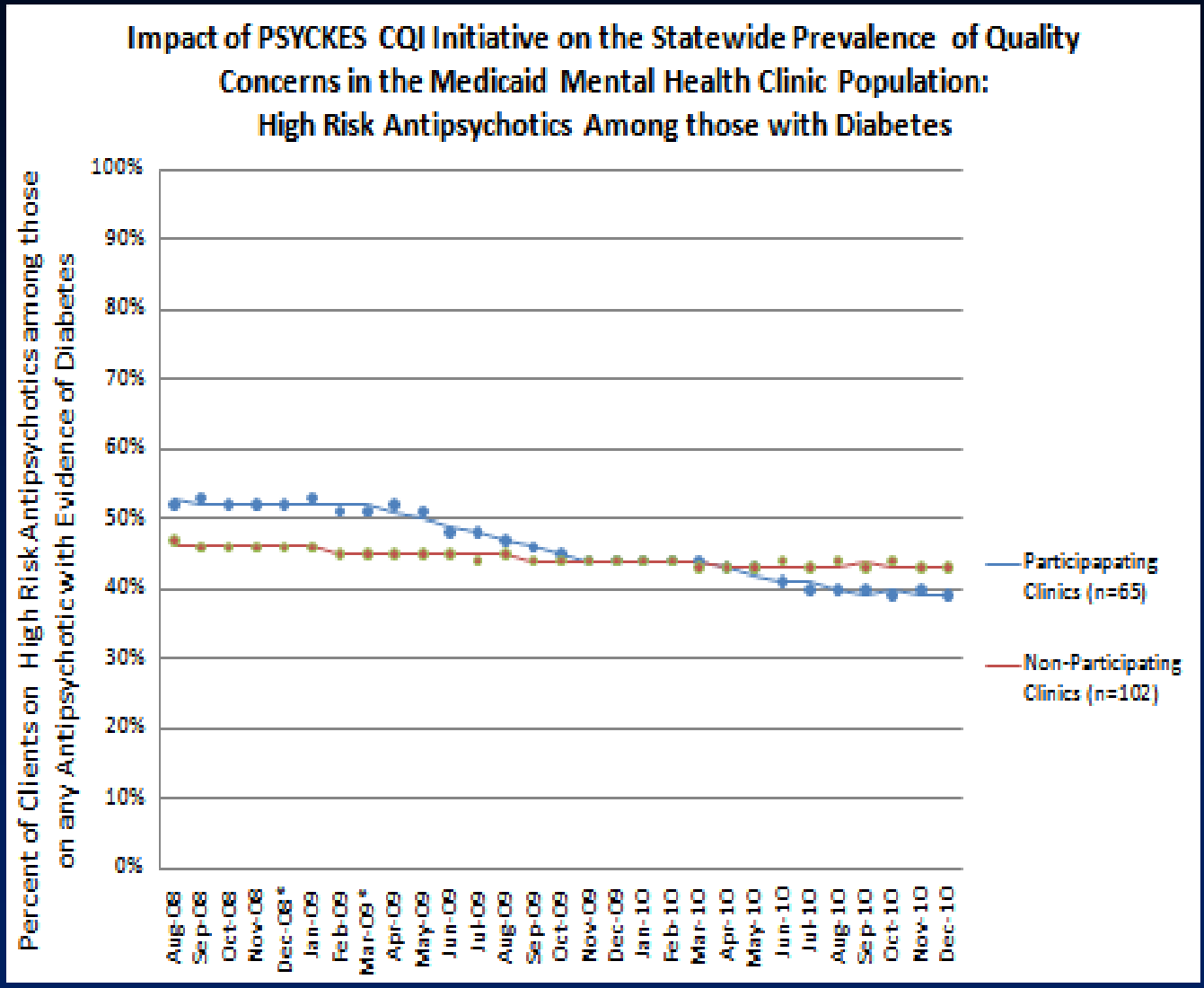


Use of Higher-Risk Antipsychotics in Clients with Diabetes

Participating clinics have seen a decrease of 24.7% in prevalence of the Diabetes Indicator.

Non-participating (Article 28) clinics have seen a 4.4% decrease in prevalence.

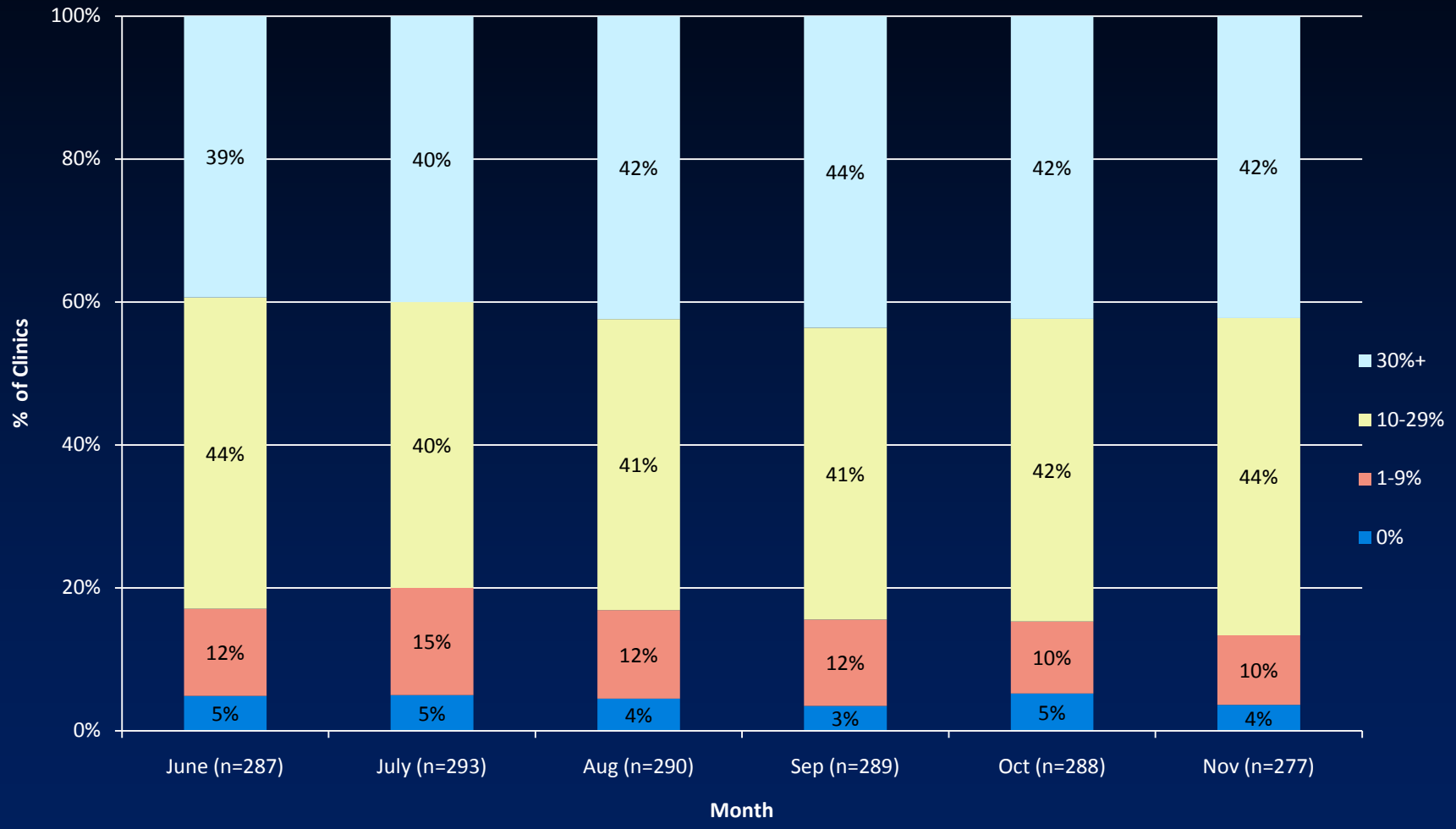
Data as of 12/30/10



Impact: Clinic Self-Report Data

- Clinics asked to report on key data elements starting July 2009
  - Tracking these outcomes is the “CHECK” phase of the Plan Do Check Act (PDCA) cycle, and is a critical component of a successful CQI project
  - Captures intentional change in medication regimen to decrease risk among Medicaid and non-Medicaid clients
- 40+% of clinics have achieved 30% or greater rate of change

Clinic Conversion of Outliers
% of Clinics



Based on self-report data submitted by clinics with at least 10 positive cases.

Impact by Region: Polypharmacy

Region	# of Positive Cases	# of Reviews	# Converted (%)
NYC	4,286	9,966	1,543 (36%)
Central	2,123	2,143	376 (18%)
Hudson River	1,380	1,596	390 (28%)
Long Island	945	2,379	256 (27%)
Western	3,285	2,821	545 (17%)
Statewide	12,019	18,905	3,110 (26%)

Based on self-report data submitted by clinics for November 2010, n=181.

Impact by Region: Cardiometabolic Risk

Region	# of Positive Cases	# of Reviews	# Converted (%)
NYC	2,521	4,467	1,006 (40%)
Central	400	689	89 (22%)
Hudson River	689	1,232	134 (19%)
Long Island	390	354	136 (35%)
Western	706	618	303 (43%)
Statewide	4,706	7,360	1,668 (35%)

Based on self-report data submitted by clinics for November 2010, n=95.

Quality Concerns in Psychotropic Prescribing

Development of Quality Indicators for PSYCKES

- Scientific Advisory Committee proposed quality concerns (Essock et al, 2009)
  - 6 workgroups: schizophrenia, bipolar disorder, depression, youth, women, and older adults
- Stakeholders select first two indicator sets
  - Psychotropic Polypharmacy Indicator Set
  - Cardiometabolic Indicator Set
- New indicator sets for Phase II
  - Dose
  - Youth

Polypharmacy

Prescriptions for Psychotropic Polypharmacy are Increasing

- National survey of outpatient visits to psychiatrists between 1996-2006 found significant increases in psychotropic prescribing
  - Individuals on 2 or more psychotropics increased from 42.6% to 59.8% ($p<.001$)
  - Individuals on 3 or more psychotropics increased from 16.9% to 33.2% ($p<.001$)
- Office-based prescribing of polypharmacy in children and youth has increased from 22% to 32% over past 12 years

Risks of Polypharmacy

- Polypharmacy is associated with increased risks of
  - Relapse due to decreased adherence
  - Extrapyramidal symptoms
  - Metabolic syndrome and diabetes
  - Drug-drug interactions
  - Mortality
- Minimal scientific evidence that polypharmacy is effective
  - Some research on clozapine augmentation

Joint Commission Action on Polypharmacy

- JC review of studies from 1966 to December 2007
  - No evidence to support antipsychotic polypharmacy in patients with schizophrenia
    - Exception: some evidence to support augmentation for clozapine
  - Antipsychotic polypharmacy associated with increased side effects.
- New measures on antipsychotic polypharmacy added to Joint Commission core set
- "Appropriate rationale" for antipsychotic polypharmacy limited to
  - History of 3 failed monotherapy trials
  - Plan to taper to monotherapy
  - Clozapine augmentation

When is antipsychotic polypharmacy supported by research evidence? Implications for QI. *The Joint Commission Journal on Quality and Patient Safety.* 2008; 34(10): 571-582.

Clinical Recommendations for Reducing Polypharmacy

- Review the PSYCKES Clinical Summary to evaluate medication history, including dose and duration of previous medication trials
- Consider psychosocial interventions as an alternative to medication for symptom management (e.g. insomnia, anxiety)
- Periodically assess consumers on polypharmacy to streamline the regimen

Polypharmacy Indicators

2AP	Antipsychotic polypharmacy of two or more agents
3AP	Antipsychotic polypharmacy of three or more agents
2AD	Antidepressant polypharmacy of two or more agents in the same subclass
3AD	Antidepressant polypharmacy of three or more agents
4PP(A)	Psychotropic polypharmacy in adults (four or more)
3PP(Y)	Psychotropic polypharmacy in children (three or more)

Cardiometabolic Risk

Metabolic Concerns in the US

- From 1991 to 2001 rates of obesity increased by 74%.
- 68% of adults and 31% of youth are either overweight or obese.
- The prevalence of diabetes has surged, increasing by 58% between 1991-2001.
- Nearly 10% of adults and more than 20% of older adults have diabetes.
- Diabetes dramatically increases the risk of cardiovascular disease.
- Management of diabetes alone costs $174 billion annually.

Criteria for the Metabolic Syndrome*

Criterion	Adults	Adolescents
High triglyceride level, mg/dl	≥150 mg/dl fasting	≥110 mg/dl fasting
Low HDL-Chol level, mg/dl Males Females	 <40 mg/dl fasting <50 mg/dl fasting	≤40 mg/dl fasting for boys and girls
Abdominal obesity, waist circumference Males Females	 > 40 inches > 35 inches	≥90th percentile for boys and girls
High fasting glucose level, mg/dl	≥110 mg/dl	≥110 mg/dl
High blood pressure, mmHG	≥ 130/85 mmHg	≥90th percentile for boys and girls

Cook S, Weitzman M, Auinger P, et al. Prevalence of a metabolic syndrome phenotype in adolescents: findings from the third National Health and Nutrition Examination Survey, 1988–1994. Arch Pediatr Adolesc Med 2003;157(8):821 – 7.

***** At least three criteria must be met

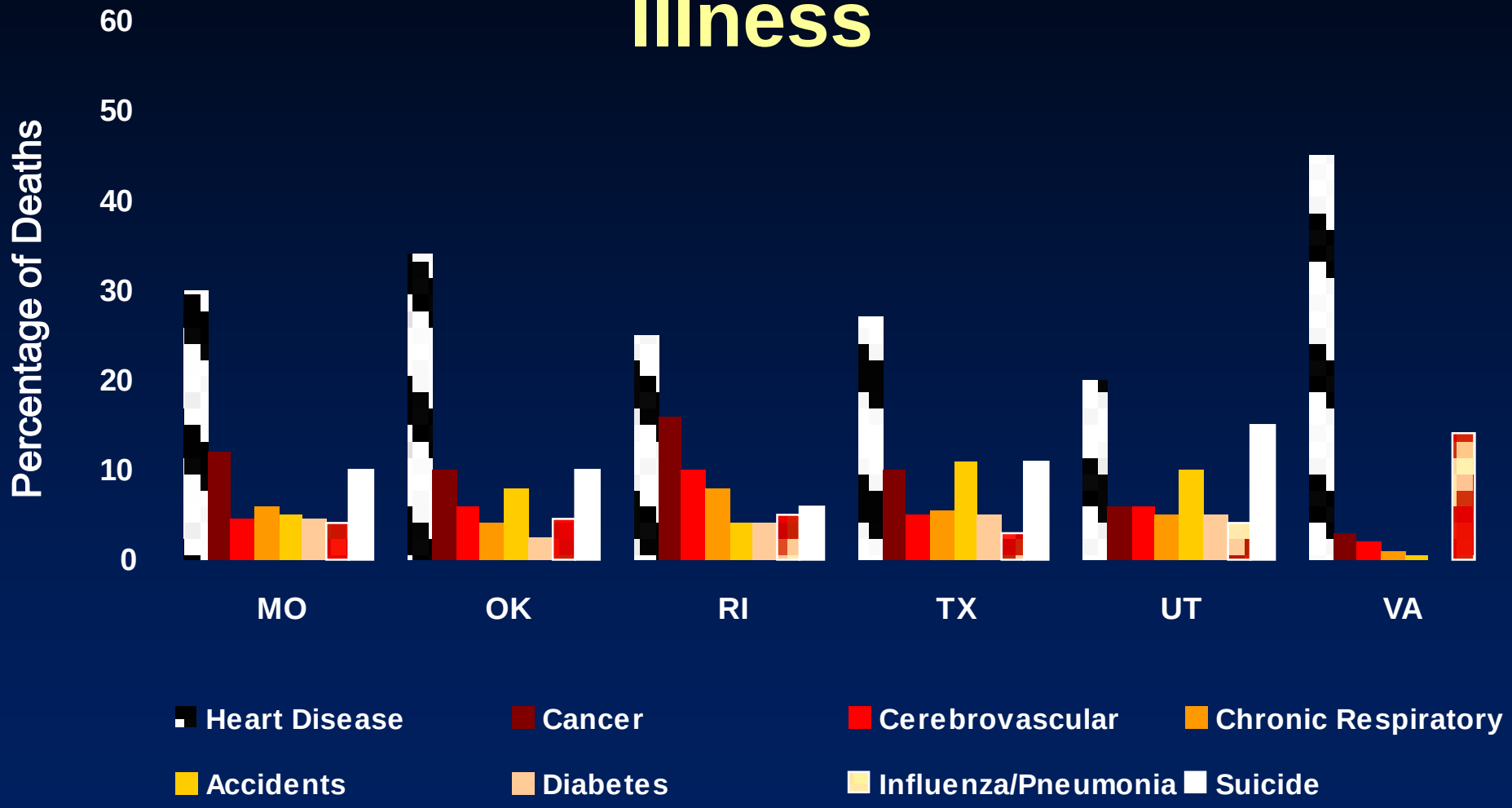
Metabolic Syndrome

- Metabolic syndrome doubles the risk of cardiovascular disease.
- The general population has rates of metabolic syndrome of 15-20%.
- Modifiable risk factors for conditions associated with metabolic syndrome include
  - Smoking
  - Food choices and quantities
  - Level of physical activity
  - Getting regular checks by a primary care provider AND
  - Choice of antipsychotic medication

Metabolic Concerns in the Mental Health Population

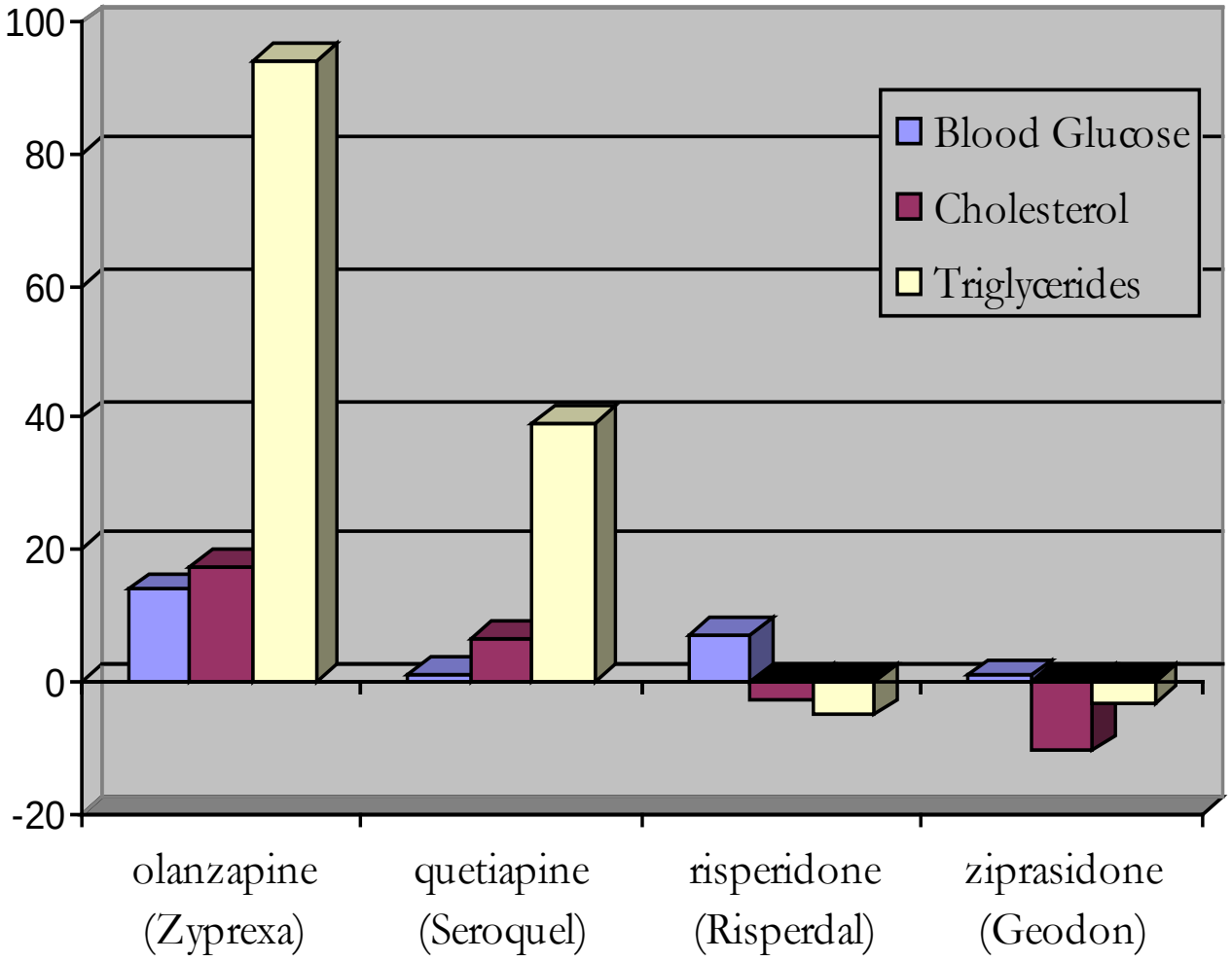
- People with mental illness are 3 times more likely to have metabolic syndrome in part due to increased rates of risk factors.
  - 80% of people with schizophrenia smoke compared to 18% of general population.
- People with mental illness have low rates of screening and treatment for metabolic syndrome.
  - Over 40% of individuals in CATIE met criteria for metabolic syndrome upon entry.
  - 30% of CATIE participants with diabetes were not receiving treatment.
- People with serious mental illness die an average of 25 years prior to the general population due to cardiovascular disease.

Cardiovascular Disease is Primary Cause of Death in Persons with Mental Illness



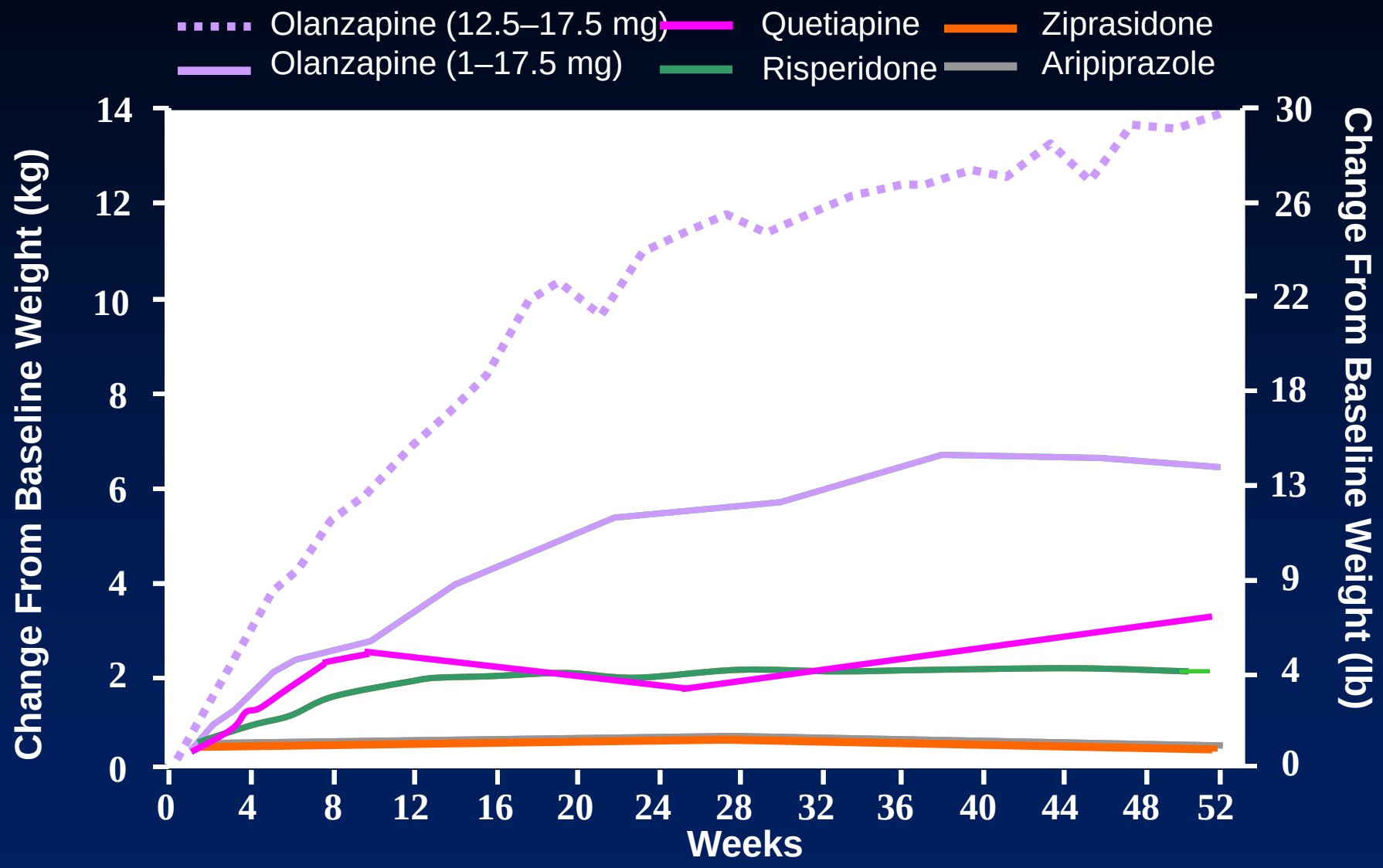
Colton CW, Manderscheid RW. Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. Prev Chronic Dis [serial online] 2006 Apr [*Apr 10, 2009*]. Available from:URL: http://www.cdc.gov/pcd/issues/2006/

Impact of Different Antipsychotics on Metabolic Measures



Meyer et al, *Schizophr Res* 2008;101:273-86

Differential Impact of Antipsychotics on Weight



Jones M et al. Poster. 2003; Marder SR. *J Clin Psychiatry*. 2003;64:1386-1387;
Nemeroff CB. *J Clin Psychiatry*. 1997;58(suppl 10):45-49; Sussman N. *J Clin Psychiatry*. 2001;62:5-12.

Cardiometabolic Risk of Second-Generation Antipsychotic Medication During First-Time Use in Children and Adolescents

Table 2. Change in Body Composition Parameters Over Time

Outcome Variable	Weeks 0-12 Mean (95% CI)	*P* Value
Weight, kg		
Aripiprazole	4.44 (3.71 to 5.18)	<.001
Olanzapine	8.54 (7.38 to 9.69)	<.001
Quetiapine	6.06 (4.90 to 7.21)	<.001
Risperidone	5.34 (4.81 to 5.87)	<.001
Untreated	0.19 (–1.04 to 1.43)	.77

Significant Changes in Metabolic Parameters Over Time

	Total Cholesterol (mg/dl)	Triglycerides (mg/dl)	Non-HDL Cholesterol (mg/dl)	TG:HDL Ratio
Olanzapine	15.58	24.34	16.81	0.59
Quetiapine	9.05	36.96	9.93	1.22
Risperidone	NS	9.74	NS	NS
Aripiprazole	NS	NS	NS	NS

Correll, Manu, Olshanskiy, et al. JAMA. 2009;302(16):1765-1773

Use of Quetiapine Contributes to Polypharmacy and CM Risk

- Statewide, 40% of individuals flagged for polypharmacy and 71% of those flagged for CM risk are on quetiapine (PSYCKES, 10/1/2010).
- Quetiapine is associated with increased risk of coronary heart disease and increases in lipids.
- Low dose quetiapine for sleep is often added to psychotropic regimens, despite lack of evidence supporting its efficacy.*
- Low dose quetiapine for sleep has been associated with weight gain and increased BMI.**

*Wine JN et al. Effects of quetiapine on sleep in nonpsychiatric and psychiatric conditions. *The Annals of Pharmacother* 2009;43:707-13.

**Cates ME et al. Metabolic consequences of using low-dose quetiapine for insomnia in psychiatric patients. *Community Ment Health J* 2009;45:251-254.

Clinical Recommendations for Reducing Cardiometabolic Risk

- Prescribers, staff, and consumers need to be aware of the different cardiometabolic risk profiles of antipsychotic medications.
- For individuals with cardiometabolic conditions, consider starting or switching to an antipsychotic with a lower risk.
- Obtain both family and individual medical history of cardiometabolic disease at intake.
- Work with clients and primary care providers to facilitate appropriate monitoring.

ADA Consensus Monitoring Protocol for Individuals on Second Generation Antipsychotics (SGAs)

	Start	4 wks	8 wks	12 wks	Every 3 mos.	Every 12 mos.	Every 5 yrs.
History	X					X	
Weight (BMI)	X	X	X	X	X		
Waist circumference	X					X	
Blood pressure	X			X		X	
Fasting glucose	X			X		X	
Fasting lipids	X			X			X

American Diabetes Association. *Diabetes Care*. 2004;27:596-601.

Cardiometabolic Indicators

- Individuals with the following conditions:

HTN	Hypertension
CVD	Cardiovascular Disease
HL	Hyperlipidemia
Obes	Obesity
DM	Diabetes/Pre-Diabetes

- AND who are taking an antipsychotic medication that poses a moderate to high risk for cardiometabolic disturbance

Antipsychotics with Moderate to High Risk for Cardiometabolic Disturbance

- Adults age 18 and over:
  - olanzapine (Zyprexa)
  - quetiapine (Seroquel)
  - chlorpromazine (Thorazine)
  - thioridazine (Mellaril)

- Children/adolescents:
  - ALL antipsychotics except for:
    - aripiprazole (Abilify)
    - ziprasidone (Geodon)

*Clozapine (Clozaril, FazaClo) not included in current Quality Improvement (QI) project.

Higher than Recommended Dosing of Psychotropics

High Dose Concerns

- Medicaid claims data show that almost 19,000 New Yorkers on a psychotropic medication are taking a dose higher than the recommended maximum.
- Up to 40% of patients being treated for schizophrenia are prescribed doses higher than recommended.
- Almost 10% of children in NYS on Medicaid who are prescribed a psychotropic medication are on a higher than recommended dose.

High Doses and Effectiveness

- In New York State (NYS), 25% of inpatients in state hospitals who are on olanzapine take more than 20 mg, the maximum recommended dose.
- A study of 50 mg of olanzapine in treatment-resistant clients demonstrated no clinical improvement in Brief Psychiatric Rating Scale (BPRS) or Clinical Global Impression (CGI) scale.
- Dose did not predict response in a meta-analysis of antidepressant trials.

High Dose Risks

- Increased intensity and number of side effects
- Increased rates of metabolic problems
- More problems with physical health
- Worsening cognition

Clinical Recommendations for Reducing Higher than Recommended Doses of Psychotropics

- Collaborate with clients to promote adherence.
- Consider psychosocial treatments for conditions less likely to respond to medications (e.g. personality disorders).
- Ensure that clients have an adequate trial of medication prior to increasing the dose.
- Return to a lower dose if a dose increase does not result in clinical benefit.

Dose Indicators

DoseAP	Higher than recommended dose of antipsychotics
DoseAD	Higher than recommended dose of antidepressants
DoseANX	Higher than recommended dose of anxiolytics/hypnotics
DoseMS	Higher than recommended dose of mood stabilizers
DoseADHD	Higher than recommended dose of ADHD medications

Determining Recommended Dose

- For adults, maximum recommended dose was determined by
  - Patient Outcomes Research Team (PORT) guidelines for antipsychotics
  - the Physicians Desk Reference (PDR) for other drug classes.

- In youth, the following hierarchy was used:
  1. If present, used Federal Drug Administration (FDA) approved maximum for children under 13 years and those 13 to 18 as specified in the PDR. If multiple indications in youth, used maximum dose for the psychiatric indication.
  2. If no FDA indication for the pediatric population, used guidelines proposed by Texas regarding the care of foster children.
  3. If neither 1 nor 2 were present, used Appendix 1 of Pediatric Psychopharmacology: Principles and Practice (2003).
  4. If none of 1, 2, or 3 include maximum recommended dose for youth, used the adult maximum specified in the PDR.

Medication Risk in Youth

“Too many, too much, too young”

- The rate of polypharmacy in outpatient settings for children on psychotropics increased from 22%-32% in the past decade.
- The rate of polypharmacy is as high as 70% for children in foster care.
- Rates of antipsychotic use in preschoolers doubled between 1999 and 2007.

Quality Concerns in Youth

- Very few randomized clinical trials of psychotropic medications have been conducted in children and adolescents.
- Response rates often decrease in younger children.
- Psychotropic medications are prescribed frequently off label and to control behavior.
- As rates of psychotropic prescribing rise, the rates of psychosocial interventions diminish.

Prescribing Risks in Youth

- Youth are more vulnerable to intensity and frequency of side effects, including growth problems, delirium, akathisia and Extrapyramical Symptoms (EPS), sleep problems, serious behavior changes, and cardiac arrhythmias.
- Youth are more likely to develop cardiometabolic concerns including obesity and type 2 diabetes.
- One study reported an increase in sudden death in children taking stimulants.

Clinical Recommendations for Reducing Medication Risk in Youth

- Treatment planning for youth and families should include psychosocial interventions as well as medications.
- The primary diagnosis determines the starting point for medication.
- “Start low, go slow” when changing doses of medications.
- Collaborate closely with pediatricians to ensure appropriate monitoring of youth on atypical antipsychotics.
- Consult with a child psychiatrist prior to initiating polypharmacy or antipsychotic medication, or in complex cases.

Youth Indicators

< 6	Very young children (less than 6 years old) on a psychotropic medication
Dose(Y)	Individuals under 18 on a higher than recommended dose of a psychotropic
3PP(Y)	Individuals under 18 on three or more psychotropic medications for longer than 90 days

Medication-Focused CQI

Project Expectations

- Phase I: Use Plan-Do-Check-Act (PDCA) or another nationally recognized QI model to guide the project.
  - Identify positive cases.
  - Conduct clinical reviews.
  - Review outcomes.
  - Implement interventions to address barriers to change.
  - Incorporate successful strategies into routine work.
- Phase II: Use CQI processes implemented in Phase I to continue existing project and add an additional indicator set.

CQI for Medication Quality Concerns

- Site visits and conference calls with agencies to explore implementation strategies and challenges (Fall 2009-2010)
- Identification of best practices associated with project success
- “CQI Checklist” reviewed at Spring 2010 training
- Refined based on continued exploration with clinics and review by CQI experts
  - “Medication-Focused CQI Model”

FOCUS-PDCA

- A variation of PDCA, FOCUS-PDCA adds a set of activities at the beginning of a project to develop a roadmap and organize for success.
- These are important steps in preparing for Phase II.
  - ***F***ind an opportunity to improve performance
  - ***O***rganize a team
  - ***C***larify the current knowledge of the process, procedure or system
  - ***U***nderstand/Uncover the variation or root cause
  - ***S***tart/Select the process to improve

FOCUS

- Find an opportunity to improve: Agree to participate in the NYSOMH CQI Initiative.
- Organize a QI team: Team is clinic-based, and includes clinic and medical leadership.
- Clarify current knowledge: Review QI activities from Phase I, clinic workflow, evidence base for quality concerns.
- Understand variation: Review prescribing patterns in PSYCKES to understand trends.
- Select/start project: Choose an additional indicator set based on criteria of “high risk, high volume, problem prone”, and educate/engage stakeholders.

Plan

- Develop an Action Plan for the project overall and for the first PDCA cycle.
  - Identify objectives.
  - Identify processes to be modified/added.
  - Define how staff will participate.
- Develop systems for tracking and sharing project outcomes.

Sample Action Plan

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
Sample Intervention: Flag charts of positive cases to ensure that providers are aware of the quality concern at the point of contact. Admin Asst (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.	To increase the number of clinical reviews conducted.	• Clinic Director • Administrative Assistant	For 80 positive cases: • 3 hours of Admin Asst's time to pull, flag and re-file charts. • 2 sheets of 50 labels. • 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.	12/26/10	12/31/10 (for flagging charts) 1/31/11 (for assessing effective-ness)	1) All positive cases are flagged (per Admin Asst self-report and Clinic Director spot-check of flagged charts). 2) Number of clinical reviews per month increases by >10% in January vs. prior 2 months (per Director's analysis of weekly productivity stats).

Do

- Implement the Action Plan for the PDCA cycle.
- Identify positive cases.
  - Disseminate lists to prescribers and staff.
- Conduct clinical reviews for all identified cases.
  - Educate consumers about the quality flag.
  - Use PSYCKES Clinical Summary.
  - Use structured notes to capture outcomes and barriers.
- Support prescribers and consumers during medication transitions.
- Re-assess consumers whose medications were not changed.

Sample PSYCKES Note

PSYCKES Clinical Note

Client Name: _____ Date: _____
Medicaid Number: _____ Psychotropic (or clinic) prescriber: _____
Other Prescriber: _____

___*Cardiometabolic Risks + High Risk* ___ Diabetes ___Hyperlipidemia ___Hypertension ___Obesity ____Metabolic Syndrome(≥ 3 CMI) ___ CVD

Antipsychotics _____ _____

___*Polypharmacy* ___ 2 AP ___3AP ___2AD 3 AD ___ 4PP (adults) ___3PP (youth)

___*High Dose:* *Adults:* ___AP ___AD ___MS ___ADHD ___ANX
Youth: ___AP ___AD ___MS ___ADHD ___ANX

___*Youth (0-18)* ___≥3PP ___Hi Dose ____psychotropics under 6 y/o

CURRENT MEDICATIONS

_____ _____
_____ _____
_____ _____
_____ _____

MEDICATION PLAN

CHANGE

Plan
__Discontinue _____
__Begin taper of _____

Plan Supports
__Define/discuss early warning signs of relapse
__Use Rating scale _____
__Call to check in on client
__Increase therapist/RN involvement
__telephone check in
__discuss med concerns/adherence at next appt.
__meet with client/family/social supports
__increase frequency of visits
__Offer medication education groups
__Other _____
_____

Notes:

NO CHANGE

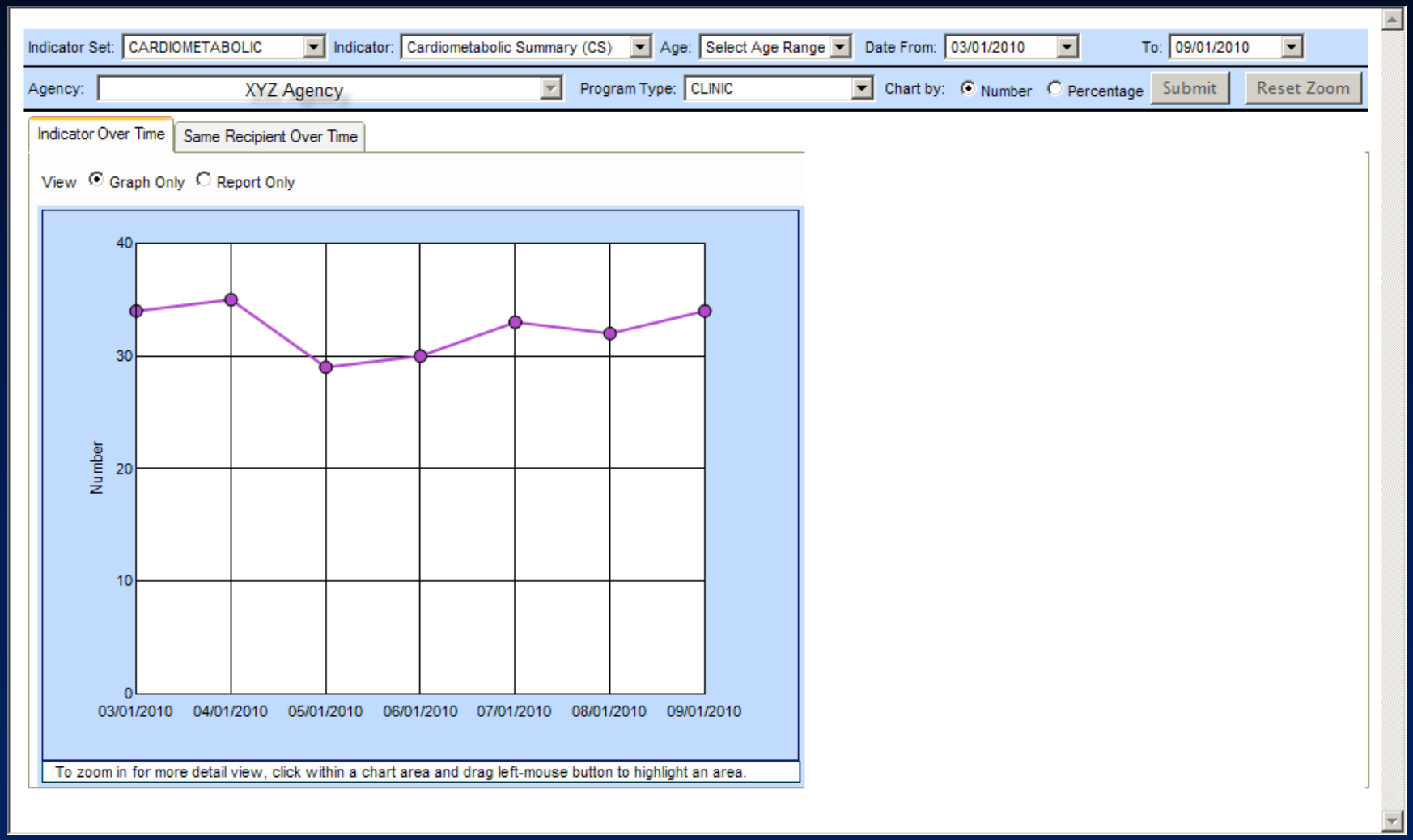
Rationale
__Client released from hospital in past 3 months
__Client prefers to stay on current regimen
__AOT order specifies current regimen
__Antipsychotic polypharm used for clozapine Augmentation
__Medication prescribed by outside provider
__Unsuccessful attempt to reduce medications in the past 3 months
__3 previous trials of monotherapy at adequate dose for adequate time
__Client has history of serious violence to self or others
__Other _____

Plan to address barriers to change
__Reassess in __ months
__Therapist to engage client around fears
__Provide medication education materials
__Contact other prescribers of medication
__contact info in chart __consent done
__Offer medication group/peer support
__Other _____

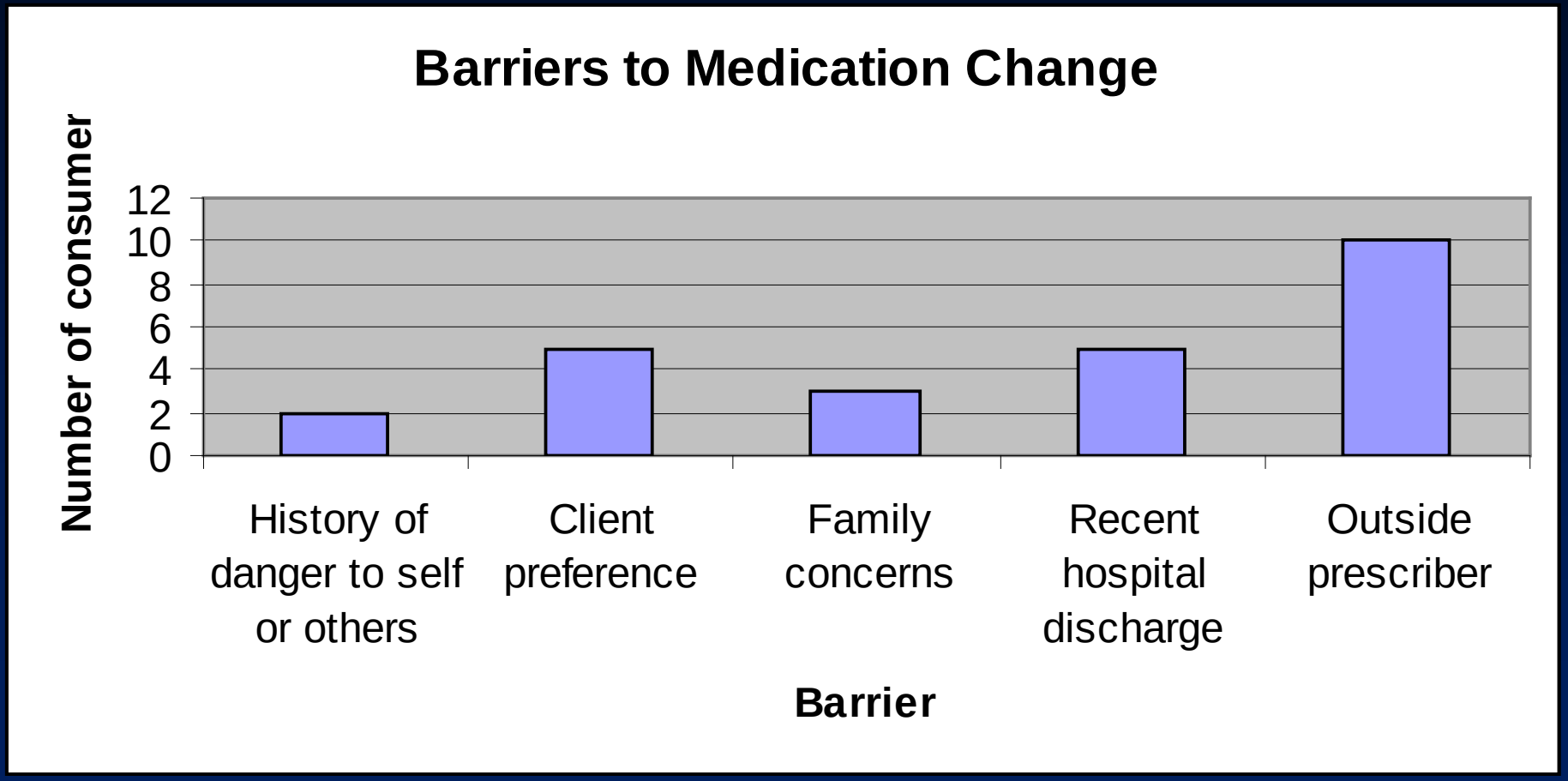
Check

- Monthly meetings of QI team to review:
  - Data at client, prescriber, and clinic level
  - Trends in performance
  - Progress towards goals
  - Barriers to change
- Regular meetings to review outcomes with:
  - Prescribers
  - Clinical staff
  - Agency leadership

Using a Run Chart to Track Progress



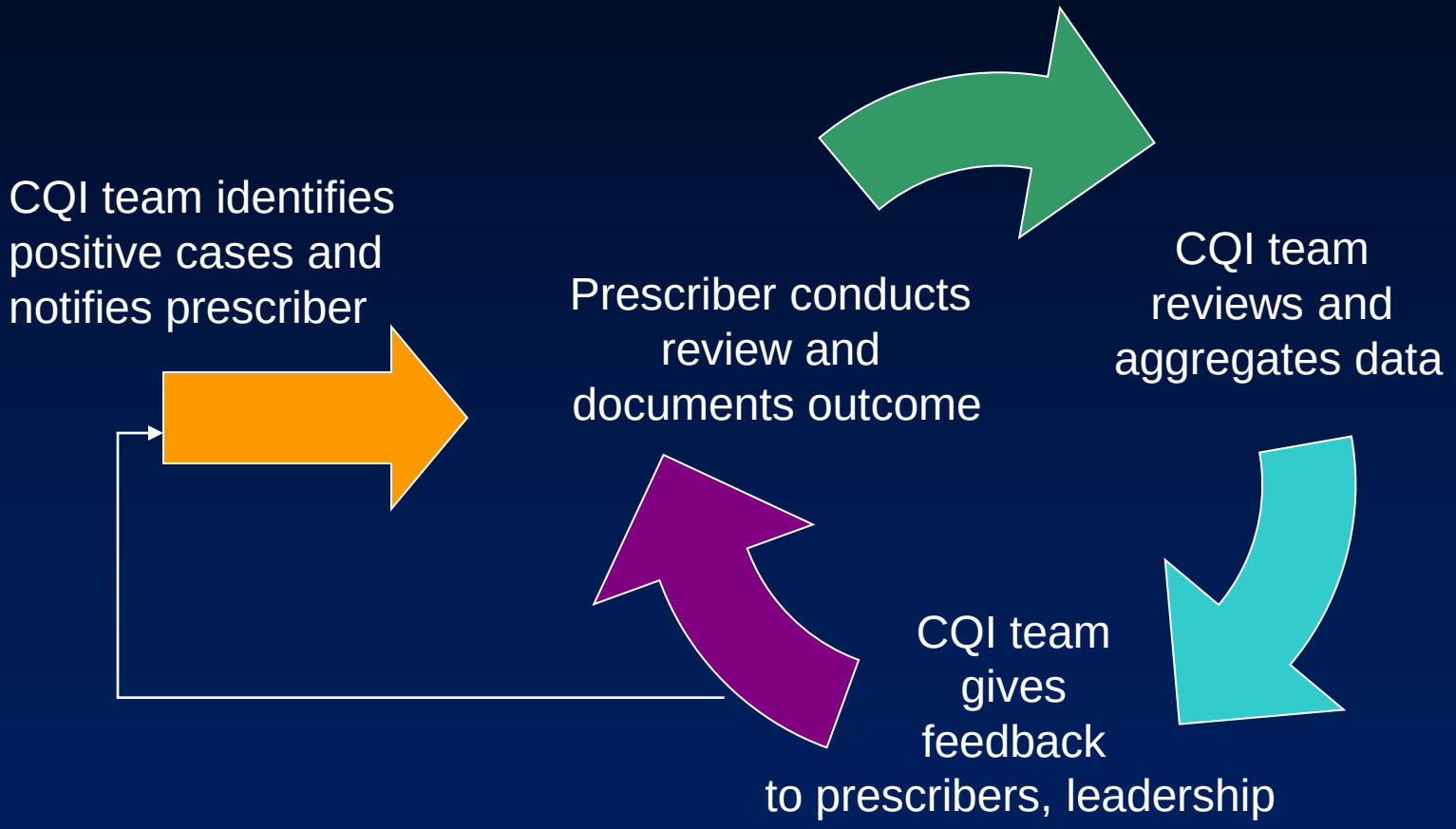
Using a Bar Chart to Identify Barriers to Change



Act

- Institutionalize effective processes.
- Monitor data to maintain gains.
- Train new staff.
- Modify Action Plan for next PDCA cycle.

Data Management Flow



Stakeholder Engagement for Medication-Focused CQI

Engaging Executive Leadership

- Make the case for PSYCKES-CQI:
  - Promotes quality and safety of services
  - Documents quality for annual reports, program evaluation, and grant applications
  - Manages risk and minimizes liability
  - Provides enhanced Medicaid reimbursement

Engaging Prescribers

- Align quality targets with prescriber goals, e.g. improve client outcomes.
- Think of prescribers as partners.
- Align prescriber involvement in QI with roles and interests.
- Present data in ways that make sense to prescribers.
- Support prescribers who ask hard questions.
- Use a collaborative, problem-solving approach.

Adapted from the Institute for Healthcare Improvement

Engaging Consumers

- Share information with every client who has a quality flag.
- Use motivational interviewing techniques to explore decisional imbalance.
- Develop strategies to help consumers feel safe during medication changes:
  - Longer/more frequent visits
  - Safety plan
  - Psychosocial interventions to promote coping and alleviate stress
- Create an environment for recovery.
  - Collaborative relationships
  - Person-centered care
  - Family, peer and community supports

PSYCKES Review and Update

What is PSYCKES?

- Web-based reports to support QI and clinical care
- Derived from Medicaid claims data
  - Current population includes all MCD enrollees with a MH diagnosis or service, or prescribed psychotropic medication in past year
  - Includes all MCD claims across treatment settings
  - Includes services but not medications for dual-eligible enrollees
- Clinical data refreshed weekly
- QI reports refreshed monthly

PSYCKES MEDICAID

Log In

New York State OMH Office of Mental Health

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Overview

Improving **Psychotropic Prescribing Practices** in New York State: The Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES)

Research across the United States shows that a majority of individuals diagnosed with a serious mental illness do not receive evidence-based care. Over the past decade a number of studies have documented quality issues including under- and overdosing of medications, inadequate duration of medication trials, frequent changes in medication regimens, medication adherence issues, off label use of psychotropic medications in children, and the use of polypharmacy. Psychotropic polypharmacy is a particular concern due to potential side effects such as weight gain, diabetes, and metabolic syndrome, as well as increased risks of drug-drug interactions.

Informed clinical decision-making and best practices require knowledge of past treatments and their results, but accurate and complete medication histories are very difficult to obtain. Consumers have long and complicated treatment histories and may lack specific information about past medications, and are often seen by many different physicians in many different treatment settings. Unfortunately communication among staff within a single health care agency often fails to convey important clinical information, and communication challenges are even greater among agencies.

In response to these concerns, the New York State Department of Health and Office of Mental Health are collaborating on a four-year initiative to improve the quality and efficiency of psychotropic prescribing practices in NYS. The project is based on the adaptation of a successful OMH program, the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES), to the Medicaid population. Initially developed for use in state psychiatric facilities, where it supported significant improvement in medication practices, PSYCKES is an award-winning portfolio of web-based tools. Users can navigate through state-, region-, county-, agency-, program-, and recipient-level reports to review quality indicators, identify consumers whose treatment could benefit from review, and obtain medication and service utilization information to support quality improvement and clinical decision-making.

In order to develop quality indicators, OMH and DOH took into account recommendations from a Scientific Advisory Committee of national experts and input from advocates, community providers, consumers, and family members. The initial set of quality indicators will focus on psychotropic polypharmacy and cardiometabolic risk, with additional portfolios of indicators to be developed over time.

Agency QI Overview

Agency Reports | Mapping | Regional Reports | Recipient Search | Common Ground | Trending Reports | Registrar Menu | MyPSYCKES Info | De-Identify Data

Quality Indicator Overview As Of 9/1/2010 — Agency Details | Find Agency | Trending | Export PDF | Excel

Agency: Sample Agency

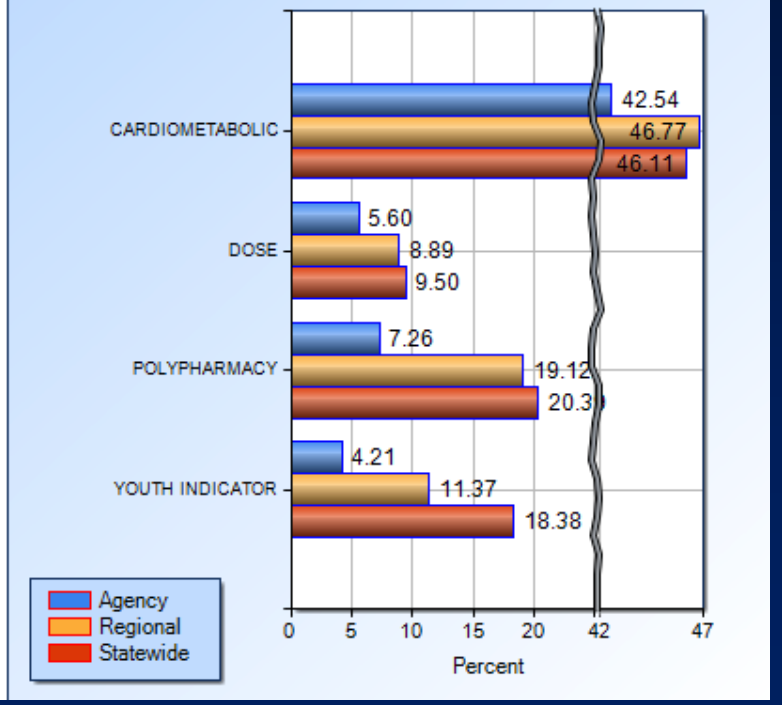
Sites: All — Program Type: All

Age: All — Prescriber: All — Show new/dropped for last: 1 Month / 3 Months — Reset

Selected Indicator: Select Indicator Type for Details — Indicator Type: All — Report View Type: Report Only / Graph Only / Both

Indicator Type

Indicator Type	Population	On Any	N	%	Regional %	Statewide %
CARDIOMETABOLIC	All	134	57	42.54	46.77	46.11
DOSE	All	500	28	5.60	8.89	9.50
POLYPHARMACY	All	358	26	7.26	19.12	20.39
YOUTH INDICATOR	Child	95	4	4.21	11.37	18.38



Drill Down on Indicator Set

Agency Reports | Regional Reports | Recipient Search | Common Ground | MyPSYCKES Info | De-Identify Data

Quality Indicator Overview As Of 9/1/2010 — Agency Details | Find Agency | Trending | Export PDF | Excel

Agency: Sample Agency

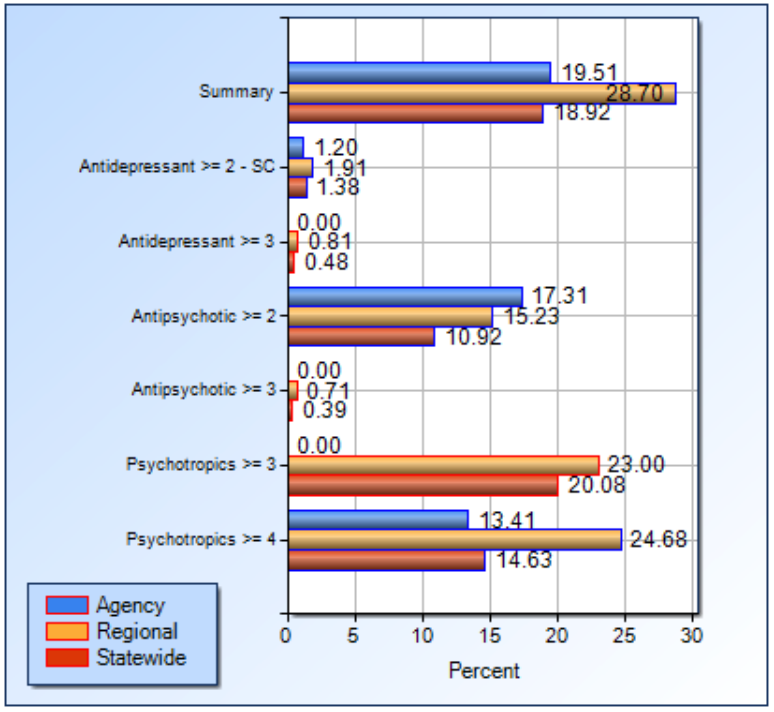
Sites: All — Program Type: CLINIC

Age: All — Prescriber: All — Show new/dropped for last: 1 Month / 3 Months — Reset

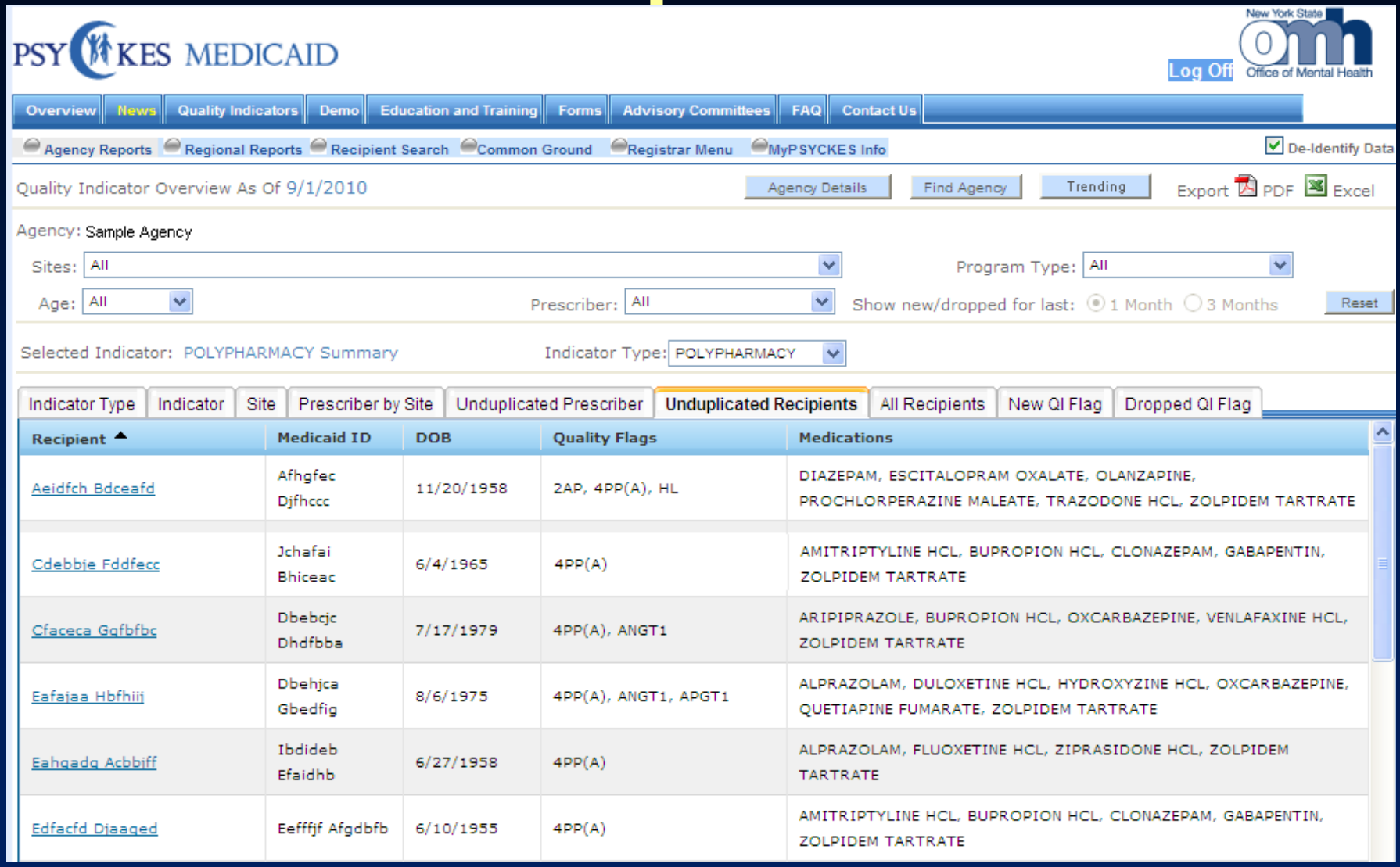
Selected Indicator: POLYPHARMACY — Indicator Type: POLYPHARMACY — Report View Type: Report Only / Graph Only / Both

Indicator Type | Indicator

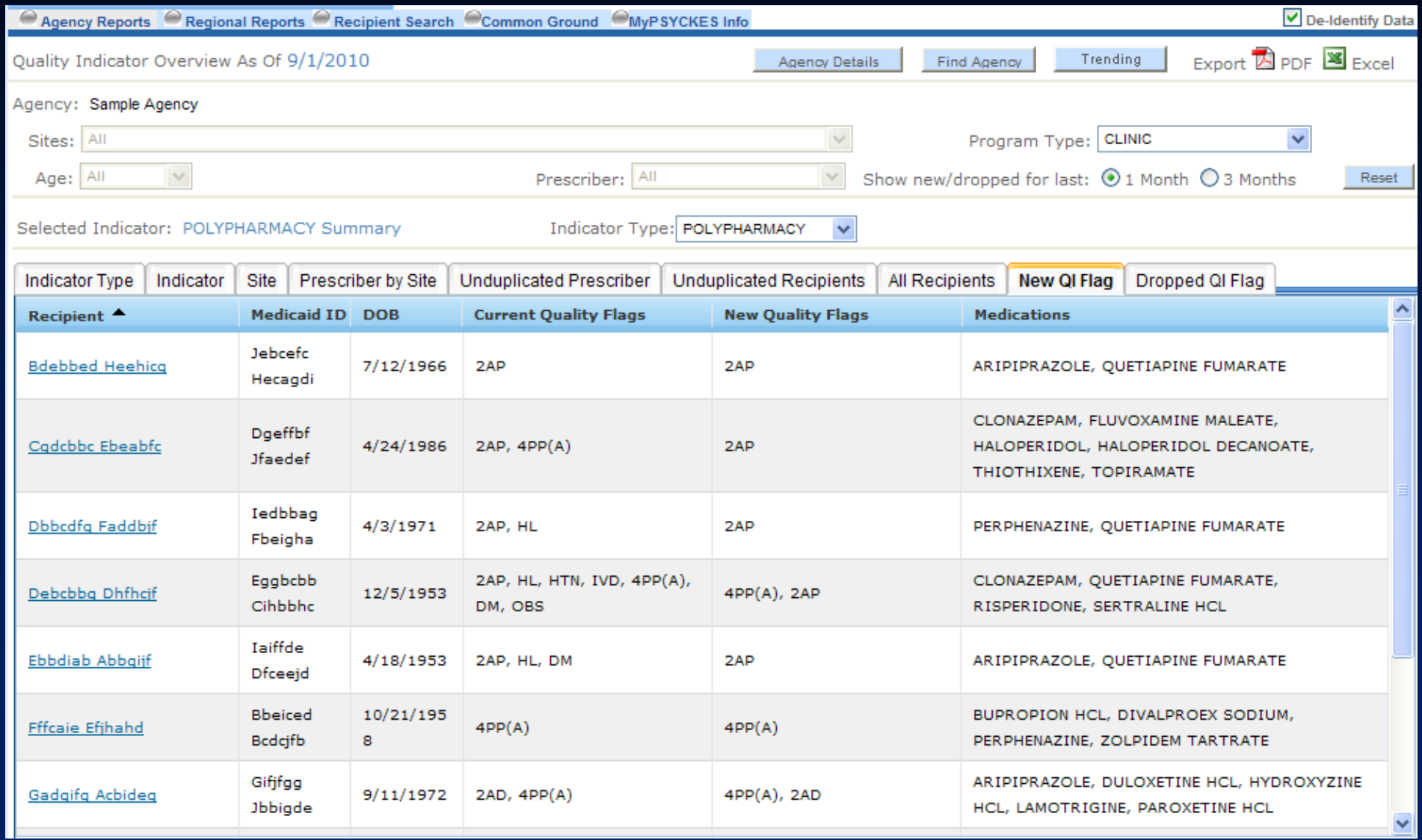
Indicator	Population	On Any	N	%	Regional %	Statewide %
Antidepressant >= 2 - SC	All	83	1	1.20	1.91	1.38
Antidepressant >= 3	All	83	0	0.00	0.81	0.48
Antipsychotic >= 2	All	104	18	17.31	15.23	10.92
Antipsychotic >= 3	All	104	0	0.00	0.71	0.39
Psychotropics >= 3	Child	0	0	0.00	23.00	20.08
Psychotropics >= 4	Adult	164	22	13.41	24.68	14.63
Summary	**All**	**164**	**32**	**19.51**	**28.70**	**18.92**



List of Unduplicated Recipients



List of New QI Flags



Agency Reports | Regional Reports | Recipient Search | Common Ground | MyPSYCKES Info | De-Identify Data

Quality Indicator Overview As Of 9/1/2010 — Agency Details | Find Agency | Trending | Export PDF Excel

Agency: Sample Agency

Sites: All — Program Type: CLINIC

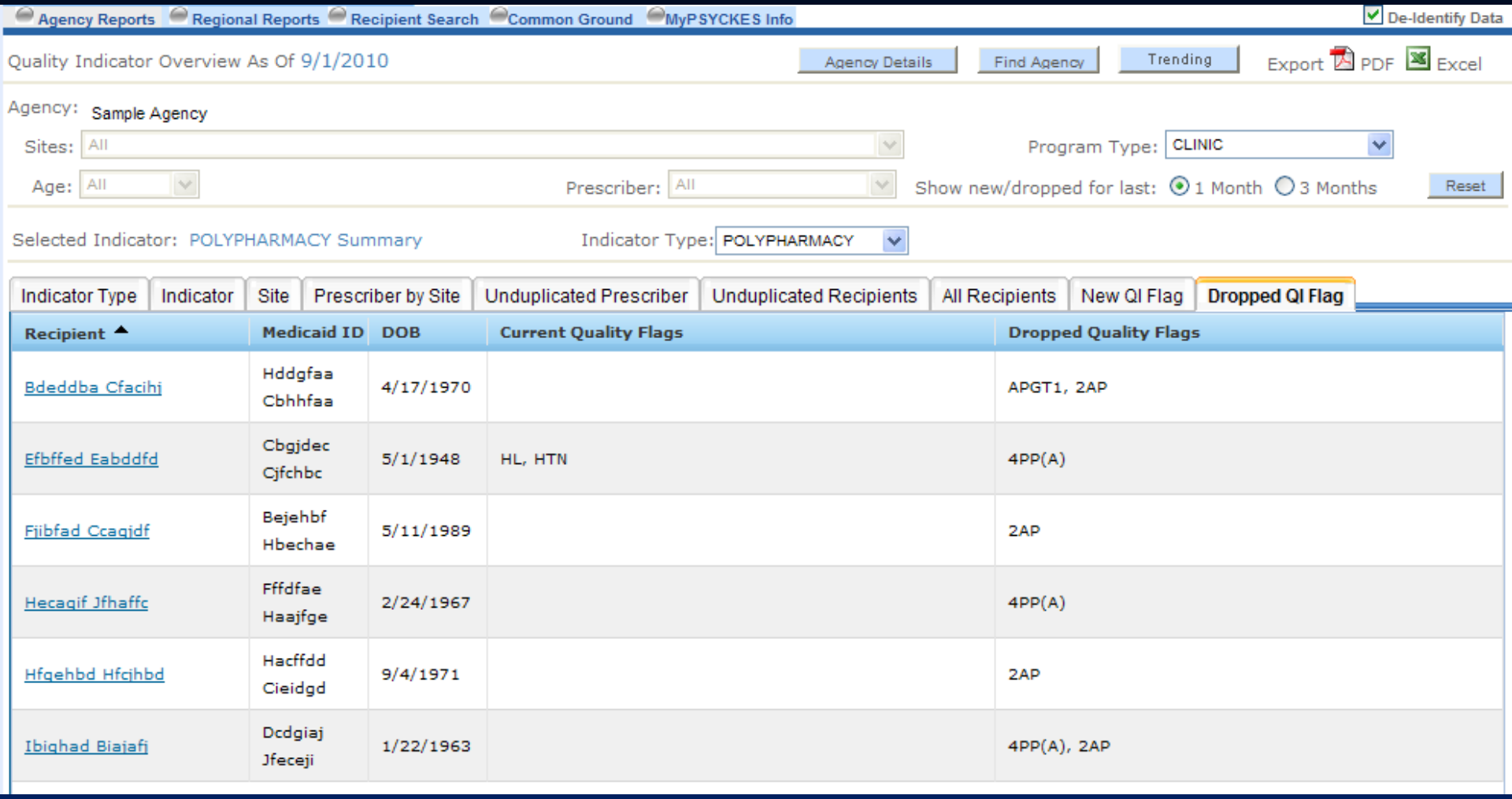
Age: All — Prescriber: All — Show new/dropped for last: 1 Month / 3 Months — Reset

Selected Indicator: POLYPHARMACY Summary — Indicator Type: POLYPHARMACY

Indicator Type | Indicator | Site | Prescriber by Site | Unduplicated Prescriber | Unduplicated Recipients | All Recipients | New QI Flag | Dropped QI Flag

Recipient	Medicaid ID	DOB	Current Quality Flags	New Quality Flags	Medications
Bdebbed Heehicg	Jebcefc Hecagdi	7/12/1966	2AP	2AP	ARIPIPRAZOLE, QUETIAPINE FUMARATE
Cgdcbbc Ebeabfc	Dgeffbf Jfaedef	4/24/1986	2AP, 4PP(A)	2AP	CLONAZEPAM, FLUVOXAMINE MALEATE, HALOPERIDOL, HALOPERIDOL DECANOATE, THIOTHIXENE, TOPIRAMATE
Dbbcdfg Faddbjf	Iedbbag Fbeigha	4/3/1971	2AP, HL	2AP	PERPHENAZINE, QUETIAPINE FUMARATE
Debcbbg Dhfhcjf	Eggbcbb Cihbbhc	12/5/1953	2AP, HL, HTN, IVD, 4PP(A), DM, OBS	4PP(A), 2AP	CLONAZEPAM, QUETIAPINE FUMARATE, RISPERIDONE, SERTRALINE HCL
Ebbdiab Abbgijf	Iaiffde Dfceejd	4/18/1953	2AP, HL, DM	2AP	ARIPIPRAZOLE, QUETIAPINE FUMARATE
Fffcaie Efjhahd	Bbeiced Bcdcjfb	10/21/1958	4PP(A)	4PP(A)	BUPROPION HCL, DIVALPROEX SODIUM, PERPHENAZINE, ZOLPIDEM TARTRATE
Gadgifg Acbideg	Gifjfgg Jbbigde	9/11/1972	2AD, 4PP(A)	4PP(A), 2AD	ARIPIPRAZOLE, DULOXETINE HCL, HYDROXYZINE HCL, LAMOTRIGINE, PAROXETINE HCL

List of Dropped QI Flags



Summary

Export to PDF Excel

Please choose summary period | Last 3 months | Last 6 months | Last Year | Last 2 Years | All Available (up to 5 years)

Mental Health Diagnoses (Most Recent Shows First)

Schizophrenia, Other Psychotic Disorder

Medical Diagnoses (Most Recent Shows First)

Endocrine, Nutritional, And Metabolic Diseases And Immunity Disorders	Diabetes mellitus without complication, Fluid and electrolyte disorders
The Circulatory System	Essential hypertension

Psychotropic Medication - See All Data

Brand Name	Generic Name	Last Dose	Duration (of current trial)	First Day Picked Up (this trial)	Last day Picked Up	Active in Past Month	Select drug for complete trial information
Fluphenazine Hcl	Fluphenazine Hcl	5 MG	11 Mon	06/18/2008	05/14/2009	Yes	Select
Lexapro	Escitalopram Oxalate	20 MG	1 Yr	05/23/2008	05/14/2009	Yes	Select

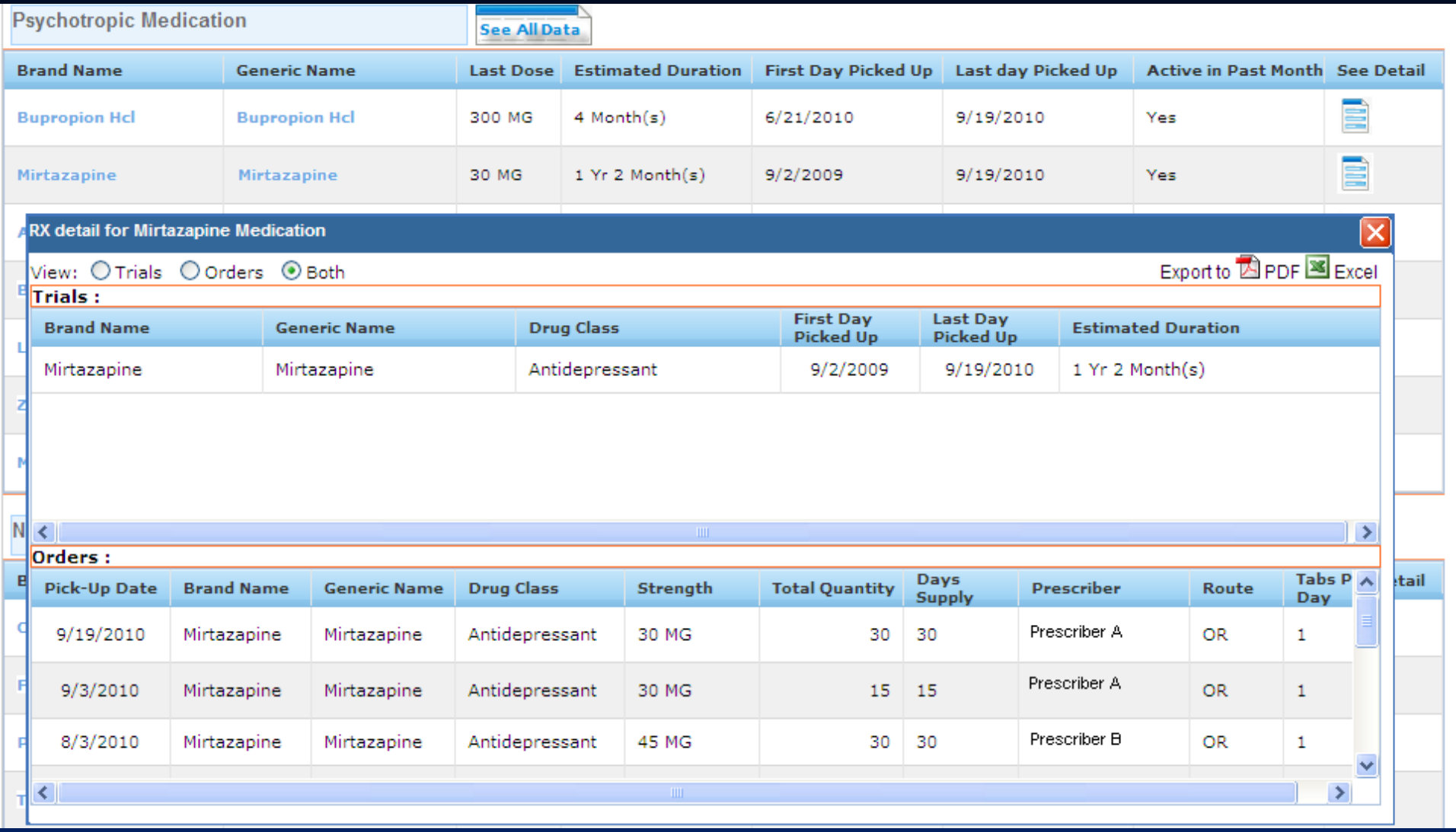
Non-Psychotropic Medication - See All Data

Brand Name	Generic Name	Last Dose	Duration (of current trial)	First Day Picked Up (this trial)	Last day Picked Up	Active in Past Month	Select drug for complete trial information
Lisinopril	Lisinopril	20 MG	1 Yr 3 Mon	02/29/2008	05/28/2009	Yes	Select
Cartia Xt	Diltiazem Hcl Coated Beads	240 MG	3 Yr 10 Mon	07/22/2005	05/21/2009	Yes	Select
Daily Vites	Multiple Vitamin	-	4 Yr 10 Mon	08/16/2004	05/21/2009	Yes	Select
Nasonex	Mometasone Furoate	28.5 MCG/ACT	4 Yr 2 Mon	03/15/2005	05/14/2009	Yes	Select
Prilosec Otc	Omeprazole Magnesium	40 MG	4 Mon	01/23/2009	05/14/2009	Yes	Select
Polyethylene Glycol 3350	Polyethylene Glycol 3350	-	14 Day(s)	05/06/2009	05/06/2009	Yes	Select
Docusate Sodium	Docusate Sodium	200 MG	1 Yr 2 Mon	04/09/2008	04/03/2009	Yes	Select
Spiriva Handihaler	Tiotropium Bromide Monohydrate	18 MCG	3 Yr 10 Mon	06/15/2005	03/22/2009	No	Select
Polyethylene Glycol 3350	Polyethylene Glycol 3350	-	9 Mon	08/21/2008	03/15/2009	No	Select

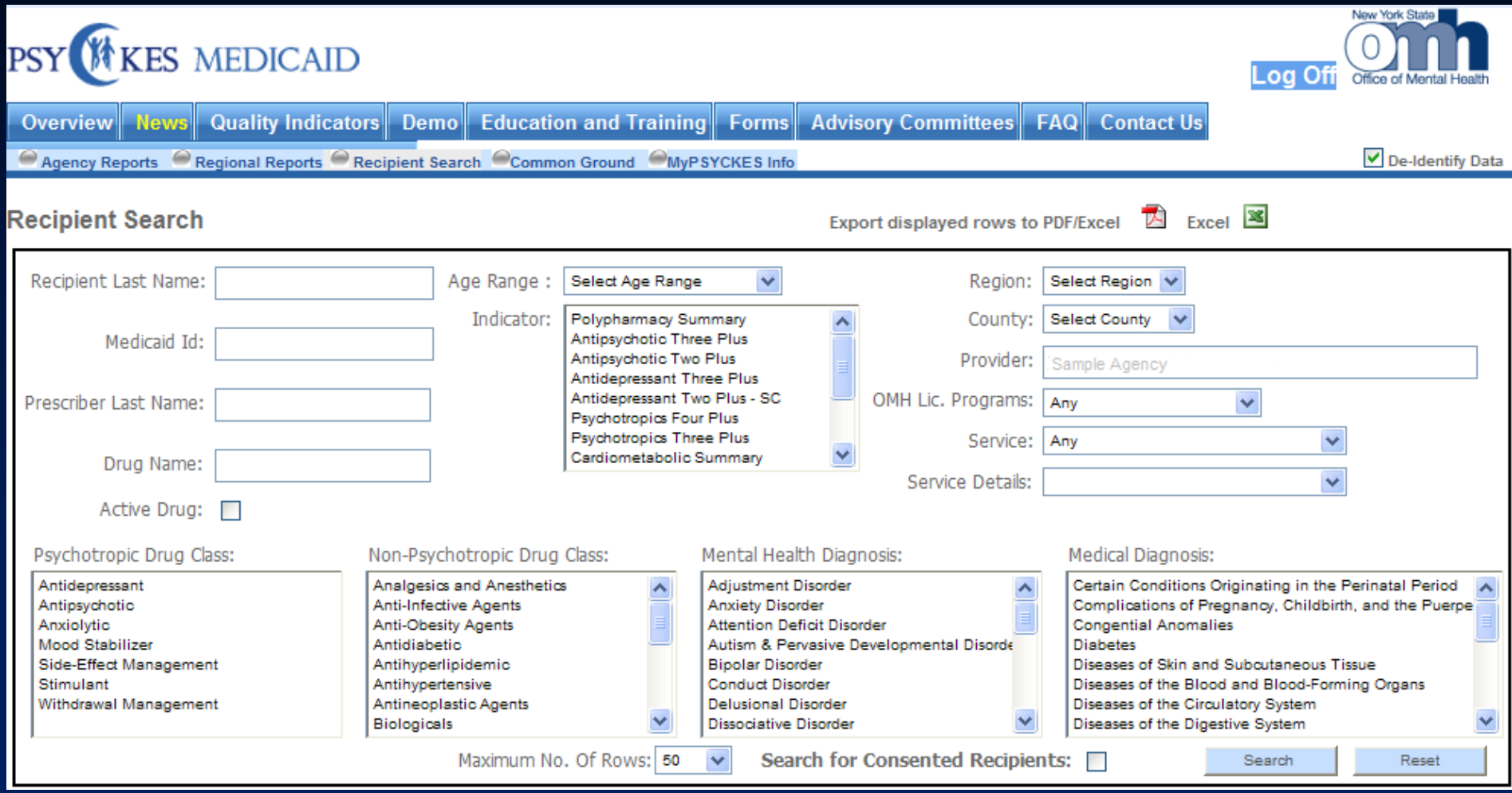
Mental Health Services - See All Data

Program/Type	Provider Name	First Date of Service(last 5 years)	Last Date Billed	Frequency	Diagnosis Group	Select PROVIDER for Historical Data
CR	LAKEVIEW MENTAL HLTH SVC INC	08/01/2004	06/01/2009	58		Select
CDT	TOMPKINS CNTY COMM M H SVC BR	07/22/2004	05/29/2009	808	Schizophrenia	Select
SCM	TOMPKINS CNTY COMM M H SVC BR	09/01/2008	05/01/2009	8	Schizophrenia	Select

See All Data for Medications



Enhanced Recipient Search

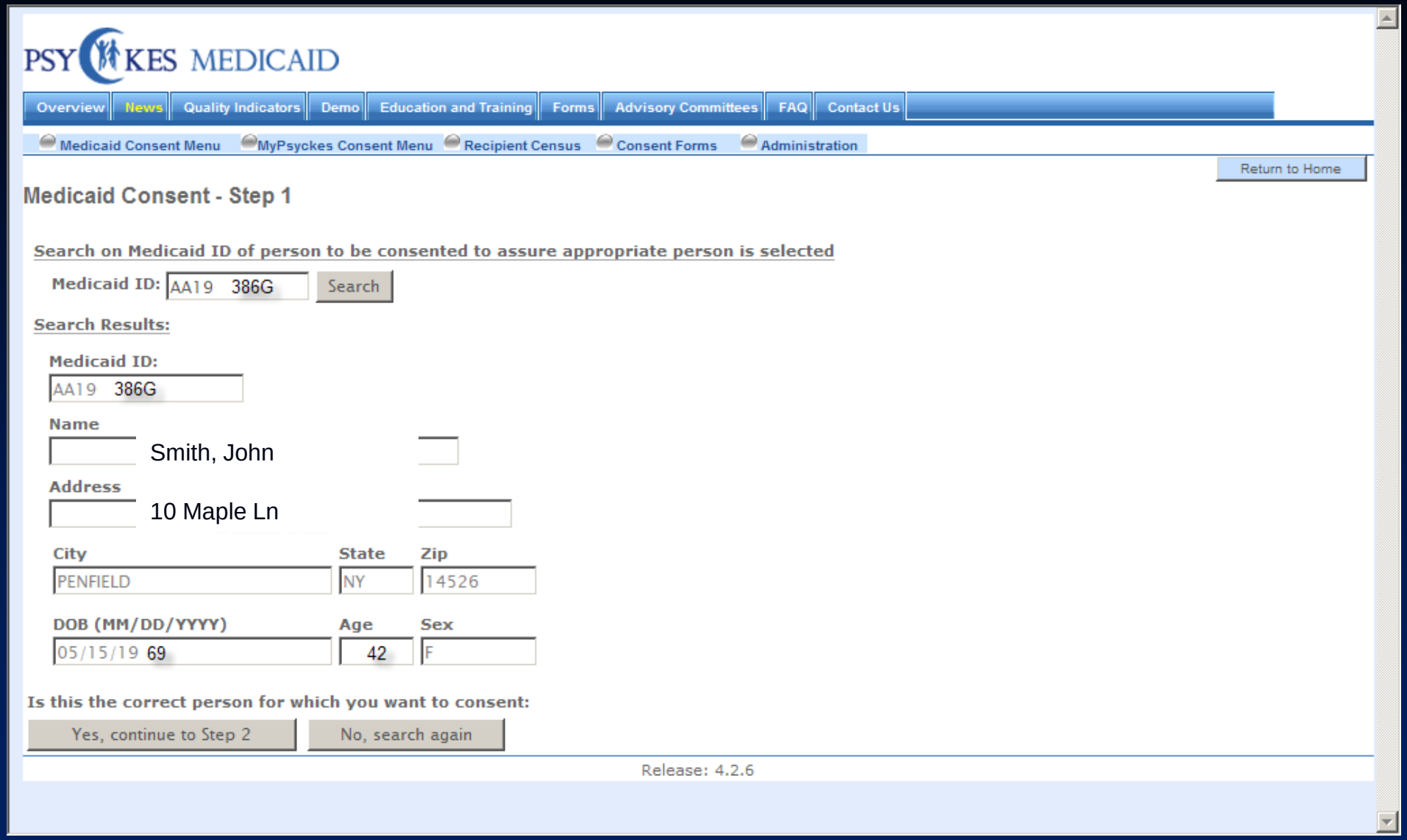


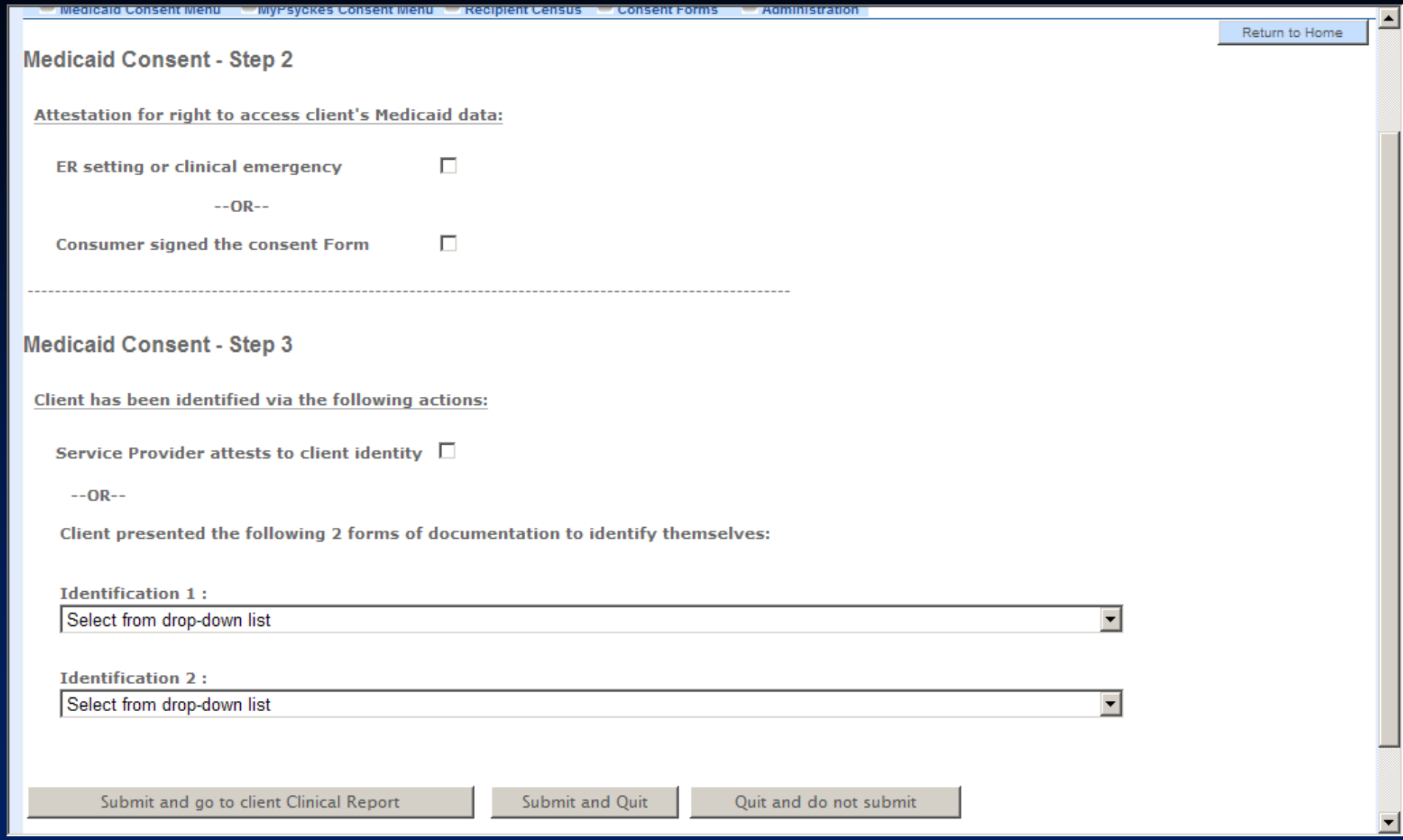
Access to client level data in PSYCKES

- Provided without consent for Medicaid enrollees with a quality flag
  - Federal mandate to monitor the safety and effectiveness of the Medicaid (MCD) program
  - Up to 5 years of MCD data across treatment settings
  - Does not include Personal Health Information (PHI) with special protections (e.g. substance abuse)
- Provided with consent for any Medicaid enrollee
  - Includes PHI with special protections
- Provided without consent for Medicaid enrollees in clinical emergencies (limited duration)
  - Includes PHI with special protections

PSYCKES Consent Module

- Clinic staff attend Consent Module Webinar .
- One or more staff with access to PSYCKES designated as Registrar.
  - This is a separate function from that of Security Manager.
- Clinic staff obtain written consent from consumers to view MCD data:
  - Include as part of standard intake process for new clients
  - Ask therapists to discuss with current clients
- Registrar uses Consent Module in PSYCKES to attest that consumer has granted consent.


PSYCKES MEDICAID
Overview
News
Quality Indicators
Demo
Education and Training
Forms
Advisory Committees
FAQ
Contact Us
Medicaid Consent Menu
MyPsyckes Consent Menu
Recipient Census
Consent Forms
Administration
Return to Home
Medicaid Consent - Step 1
Search on Medicaid ID of person to be consented to assure appropriate person is selected
Medicaid ID: AA19 386G
Search
Search Results:
Medicaid ID:
AA19 386G
Name
Smith, John
Address
10 Maple Ln
City
PENFIELD
State
NY
Zip
14526
DOB (MM/DD/YYYY)
05/15/19 69
Age
42
Sex
F
Is this the correct person for which you want to consent:
Yes, continue to Step 2
No, search again
Release: 4.2.6


Medicaid Consent Menu
MyPsyckes Consent Menu
Recipient Census
Consent Forms
Administration
Return to Home
Medicaid Consent - Step 2
Attestation for right to access client's Medicaid data:
ER setting or clinical emergency
--OR--
Consumer signed the consent Form
Medicaid Consent - Step 3
Client has been identified via the following actions:
Service Provider attests to client identity
--OR--
Client presented the following 2 forms of documentation to identify themselves:
Identification 1 :
Select from drop-down list
Identification 2 :
Select from drop-down list
Submit and go to client Clinical Report
Submit and Quit
Quit and do not submit

Withdrawal of Consent

- Consumers have right to withdraw consent at any time.
- Withdrawal of consent (WOC) form is included on the PSYCKES website.
- After consumer signs WOC form, Registrar uses Withdrawal function in PSYCKES to revoke consent.

Next Steps

Review Updated Handbook and Project Materials

- Handbook chapters include
  - Implementing medication-focused CQI
  - Modules on each quality concern (polypharmacy, cardiometabolic, dose, and youth)
    - Summary of scientific evidence
    - Annotated bibliography
    - References
  - Stakeholder engagement
  - Use of clinical rating scales
  - Psychotropic medication reference tables
- Will be available on PSYCKES website as individual chapters to promote dissemination to clinic staff
- Other materials available on website include: sample structured note, sample action plan, clinical rating scales

Phase II Project Planning Form

- Due March 15th
- Includes:
  - Update on clinic information
  - Self-assessment using Medication-Focused CQI Model
  - Update on current project
  - Selection of additional project for Phase II
- Webinar scheduled for March 1st at 10am

Monthly Reporting

- Monthly reporting on cases identified, clinical reviews conducted, and cases changed will continue.
- Report in March (for QI activities in February) and April (for QI activities in March) as usual.
  - Deadline for submission now moved to the 10th of each month
- Report on new project beginning in May 2011 (for CQI activities in April).
  - Baseline data for new project
  - Activities as usual for existing project

Prescriber Survey

- Will be adding Prescriber Survey for Phase II
- Currently being drafted
- Expected to take place in Spring 2011

Technical Assistance and Consultation

- Technical Assistance
  - Several Webinars scheduled for March/April (calendar will be sent out)
    - Using PSYCKES
    - Monthly Data
    - Clinical topics
    - Consent Module
  - PSYCKES-Help
- Updated Handbooks, clinical tools, checklists, and other resources available on the website
- QI and psychiatrist consultation opportunities

Questions and Answers