

**The GNYHA-PSYCKES Quality Collaborative  
Semi-Annual Meeting ~ June 20, 2011**

# **Review of Best Practices**



# Best Practices Document

- FOCUS-PDCA Model
- Principles shared by all Continuous Quality Improvement (CQI) approaches
  - Data-driven decision making
  - Continuous efforts to improve
- Based on experience with Quality Improvement (QI) initiative in freestanding clinics and consultation with Collaborative Steering Committee

# Best Practices Document

- Review the document, consider gaps between current practices and identified best practices
- Consider ways to close the gap
- Suggestions for additional best practices?

# Best Practices Document: “Plan” Phase

- Many “Plan” activities completed
- Key processes include
  - Include medical leadership to act as project champion
  - Develop systems for tracking and sharing project outcomes that are congruent with clinic workflow
  - Review data to determine sources of positive cases (internal or external)

# Best Practices Document: “Do” Phase

- There is a system for identifying positive cases each month and notifying each provider of his/her positive cases
- There is a system for ensuring that every positive case receives a clinical review, and a policy defining what constitutes a clinical review
- There is a protocol for supporting clients through medication changes
- There is a system for educating consumers at least quarterly about the quality concern

# Best Practices Document: “Check” Phase

- The QI team meets monthly to review data about the project outcomes and activities
- There is a process by which the QI team receives data on the outcomes of reviews, and the team aggregates this data to identify and address barriers to medication changes
- Project progress and outcomes is a standing agenda item at meetings of leadership and meetings of clinical staff

# Best Practices Document: “Act” Phase

- Effective processes are institutionalized as part of ongoing clinic procedures, to include all clients
- New staff are trained in relevant aspects of the project
- QI team continues to monitor data to ensure that gains are maintained

# Clinical Tools: Structured Clinical Note

**PSYCKES QUALITY COLLABORATIVE**  
**CLINICAL NOTE**

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Clinic Prescriber: \_\_\_\_\_ Client ID Number: \_\_\_\_\_  
 Other Prescriber: \_\_\_\_\_

**CARDIOMETABOLIC RISK AND ANTIPSYCHOTIC MEDICATIONS**

The client has a diagnosis of:  
 Diabetes  Hyperlipidemia  Hypertension  Obesity  Metabolic Syndrome (≥3 CMI)  CVD  
 High-/moderate-risk antipsychotic(s): \_\_\_\_\_  
 Does the client have a psychotic disorder?  yes  no  
 If no, indication for antipsychotic use: \_\_\_\_\_

**PRESCRIBER INFORMATION**

Who currently prescribes the high-/moderate-risk antipsychotic for this client?  
 This clinic  Another part of this hospital (specify \_\_\_\_\_)  Outside of this hospital  Unknown  
 Has the client had at least two trials of a lower-risk antipsychotic at an adequate dose for an adequate time?  
 yes  no  Unknown

**CURRENT MEDICATIONS**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**MEDICATION PLAN**

<u>CHANGE</u>	<u>NO CHANGE</u>
<p><b>Plan</b></p> <input type="checkbox"/> Discontinue _____ <input type="checkbox"/> Begin taper of _____ <input type="checkbox"/> Taper of _____ in progress <p><b>Plan Supports</b></p> <input type="checkbox"/> Define/discuss early warning signs of relapse <input type="checkbox"/> Use rating scale _____ <input type="checkbox"/> Call to check in on client <input type="checkbox"/> Increase therapist/RN involvement ___ telephone check in ___ discuss med concerns/adherence at next appt. ___ meet with client/family/social supports ___ increase frequency of visits <input type="checkbox"/> Offer medication education groups <input type="checkbox"/> Other _____ <p>Notes: _____            _____            _____            _____</p>	<p><b>Rationale</b></p> <input type="checkbox"/> Client released from hospital in past 3 months <input type="checkbox"/> Client prefers to stay on current regimen <input type="checkbox"/> AOT order specifies current regimen <input type="checkbox"/> Medication prescribed by outside provider <input type="checkbox"/> Unsuccessful attempt to change medication regimen in the past 3 months <input type="checkbox"/> 2 previous trials of lower-risk antipsychotics at adequate dose for adequate time <input type="checkbox"/> Client has history of serious violence to self or others <input type="checkbox"/> Other _____ <p><b>Plan to address barriers to change</b></p> <input type="checkbox"/> Reassess in _____ months <input type="checkbox"/> Therapist to engage client around fears <input type="checkbox"/> Provide medication education materials <input type="checkbox"/> Contact other prescribers of medication ___ contact info in chart ___ consent done <input type="checkbox"/> Offer medication group/peer support <input type="checkbox"/> Other _____

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# Clinical Tools: New Starts Checklist

GNYHA PSYCKES QUALITY COLLABORATIVE  
ANTIPSYCHOTIC MEDICATIONS POSING A RISK OF CARDIOMETABOLIC SIDE EFFECTS

NEW STARTS CHECKLIST

To be completed before initiation of any antipsychotic medication posing a moderate or high risk of cardiometabolic side effects. (For adults: olanzapine, quetiapine, chlorpromazine, thioridazine. For children/adolescents: ALL antipsychotics EXCEPT aripiprazole and ziprasidone.)

Please consider the following before initiating a course of one of these medications:

- | Column |   |   |
|--------|---|---|
| A      | B   |   |
| 1      | <input type="checkbox"/> No <input type="checkbox"/> Yes  | Does the client report a diagnosis of any cardiometabolic condition (including diabetes, pre-diabetes, high triglycerides, low HDL, hypertension, obesity and/or cardiovascular disease)? |
| 2      | <input type="checkbox"/> No <input type="checkbox"/> Yes  | Is the client taking any medication used to treat the above conditions?   |
| 3      | <input type="checkbox"/> No <input type="checkbox"/> Yes  | Is there documentation indicating that the client has any of the above conditions, in the medical record (and/or in PSYCKES, if applicable)?  |
| 4      | <input type="checkbox"/> Yes <input type="checkbox"/> No  | Have you obtained a family history of cardiometabolic conditions and ischemic vascular disease, including age at onset?   |
| 5      | Do you have the results of the following diagnostic tests for the client, dated within the past 6 months (or as clinically appropriate)?          |   |
|        | <input type="checkbox"/> Yes <input type="checkbox"/> No  | Fasting glucose level   |
|        | <input type="checkbox"/> Yes <input type="checkbox"/> No  | Fasting triglyceride levels / fasting HDL cholesterol level   |
|        | <input type="checkbox"/> Yes <input type="checkbox"/> No  | Waist circumference / BMI   |
|        | <input type="checkbox"/> Yes <input type="checkbox"/> No  | Blood pressure  |
|        | <input type="checkbox"/> Yes <input type="checkbox"/> No  | ECG (if indicated)  |
| 6      | Based on all of the above data sources, is the client diagnosed with / being treated for / exhibiting signs and symptoms of any of the following? |   |
|        | <input type="checkbox"/> No <input type="checkbox"/> Yes  | Diabetes?   |
|        | <input type="checkbox"/> No <input type="checkbox"/> Yes  | Pre-diabetes?   |
|        | <input type="checkbox"/> No <input type="checkbox"/> Yes  | Hypertriglyceridemia?   |
|        | <input type="checkbox"/> No <input type="checkbox"/> Yes  | Obesity?  |
|        | <input type="checkbox"/> No <input type="checkbox"/> Yes  | Hypertension?   |
|        | <input type="checkbox"/> No <input type="checkbox"/> Yes  | Ischemic Vascular Disease (cardiovascular / cerebrovascular / peripheral vascular)?   |
|        | <input type="checkbox"/> No <input type="checkbox"/> Yes  | Metabolic syndrome?   |
|        | <input type="checkbox"/> No <input type="checkbox"/> Yes  | Strong family history of diabetes and/or ischemic vascular disease with early onset?  |

If you answered "No" to all items in question #6, then STOP, you have completed this form.  
If you have answered "Yes" to any items in question #6, please continue with this form.

- 7  Yes  No Does the client have a psychotic disorder?  
*If yes, skip to # 9*
- 8  Yes  No (If no psychotic disorder) Has the client had evidence-based psychosocial treatment and/or an adequate trial of a low-risk antipsychotic?
- 9  Yes  No (If the client has a psychotic disorder) Has the client had a trial of at least ONE medication (for children: one non-antipsychotic medication) that is in the low risk category for cardiometabolic side effects at an adequate dose for an adequate period of time? If yes, please specify: \_\_\_\_\_  
(Check No if unknown)  
if yes, specify →

If any boxes in Column B above are checked, please consult with the Program Director / Medical Director before recommending a course of a moderate- or high-risk antipsychotic medication. In addition, before initiating the medication regimen, please complete the following steps:

- 10  Yes  No Have the benefits and risks of the proposed regimen, including cardiometabolic risk, been discussed with the client, family and/or legal guardian, as appropriate?
- 11  Yes  No Is the rationale for this medication regimen clearly documented in the chart?
- 12  Yes  No (For children only) Is there a plan to provide concurrent psychosocial treatment? Specify provider(s) and frequency: \_\_\_\_\_
- 13  Yes  No Is there a plan to monitor the client regularly for changes in cardiometabolic indicators in accordance with the protocol below? Specify provider(s) and frequency: \_\_\_\_\_

# Update Your Action Plan

- 20-30 Minutes: Break out into teams and update the action plan
- Reconvene and each hospital team shares with the group: one action you will take in the next 6 months to move the project forward.