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

March 2013
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

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

% of Clinics

- 30+% (purple)
- 10-29% (green)
- 1-9% (red)
- 0% (blue)

Quarter, Year
- Q1, 2010 (n=292)
- Q2, 2010 (n=288)
- Q3, 2010 (n=295)
- Q4, 2010 (n=288)
- Q1, 2011 (n=291)
- Q2, 2011 (n=284)
- Q3, 2011 (n=280)
- Q4, 2011 (n=316)
- Q1, 2012 (n=307)
- Q2, 2012 (n=311)
- Q3, 2012 (n=311)
Clinic Self Report Data Phase II

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

<table>
<thead>
<tr>
<th>Quarter, Year</th>
<th>% of Clinics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2, 2011 (n=178)</td>
<td>28% 19%</td>
</tr>
<tr>
<td>Q3, 2011 (n=199)</td>
<td>17% 34%</td>
</tr>
<tr>
<td>Q4, 2011 (n=205)</td>
<td>19% 33%</td>
</tr>
<tr>
<td>Q1, 2012 (n=239)</td>
<td>20% 33%</td>
</tr>
<tr>
<td>Q2, 2012 (n=241)</td>
<td>15% 35%</td>
</tr>
<tr>
<td>Q3, 2012 (n=251)</td>
<td>12% 33%</td>
</tr>
</tbody>
</table>
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

Percentages of people with mental disorders and/or medical conditions, 2001–2003

People with medical conditions: 58% of adult population

People with mental disorders: 25% of adult population

68% of adults with mental disorders have medical conditions

29% of adults with medical conditions have mental disorders

(Druss and Walker 2005)
Comorbidity among NYS Medicaid Enrollees

Prevalence of Selected Comorbidities by MH Treatment, 2003

(Coughlin & Shang, 2001)
Model of the interaction between mental disorders and medical illness

RISK FACTORS

Childhood Adversity
- Loss
- Abuse and neglect
- Household dysfunction

Stress
- Adverse life events
- Chronic stressors

SES
- Poverty
- Neighborhood
- Social support
- Isolation

Chronic Medical Disorders

Adverse Health Behaviors and Outcomes
- Obesity
- Sedentary lifestyle
- Smoking
- Self care
- Symptom burden
- Disability
- Quality of life

Mental Disorders

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
Heath 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
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4+ Inpatient/ER – Med</td>
<td>High Utilization of Medical Inpatient / Emergency Room</td>
</tr>
<tr>
<td>Prevent Hosp Asthma</td>
<td>Preventable Hospitalizations - Adult Asthma</td>
</tr>
<tr>
<td>Prevent Hosp Diabetes</td>
<td>Preventable Hospitalizations - Adult Diabetes</td>
</tr>
<tr>
<td>Prevent Hosp Dehydration</td>
<td>Preventable Hospitalizations - Adult Dehydration</td>
</tr>
<tr>
<td>No Diabetes Screening-On Antipsychotic</td>
<td>No Diabetes Screening for Individuals on Antipsychotics</td>
</tr>
<tr>
<td>Diabetes Monitoring- No HbA1c &gt; 1 Yr</td>
<td>No Diabetes Monitoring for Individuals with Diabetes</td>
</tr>
<tr>
<td>No Outpatient Medical Visit &gt;1 Yr</td>
<td>No Outpatient Medical Visit in Past Year</td>
</tr>
</tbody>
</table>
## PSYCKES Data
(as of 10/1/2012)

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

<table>
<thead>
<tr>
<th>Issue</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uses ER for primary care treatment</td>
<td>Support linkage to primary care</td>
</tr>
<tr>
<td></td>
<td>Client education</td>
</tr>
<tr>
<td>Comorbid condition in poor control, low adherence/ low engagement in medical care and/or low wellness self management</td>
<td>Self management program</td>
</tr>
<tr>
<td></td>
<td>Motivational interviewing - adherence</td>
</tr>
<tr>
<td></td>
<td>Other interventions to decrease risks (smoking, nutrition, exercise)</td>
</tr>
<tr>
<td></td>
<td>Refer to health educator</td>
</tr>
<tr>
<td></td>
<td>Support relationship with medical provider</td>
</tr>
<tr>
<td>Comorbid condition in poor control, inadequate support</td>
<td>Interventions identified above</td>
</tr>
<tr>
<td></td>
<td>Refer for additional services, e.g. health home care management, home attendant</td>
</tr>
</tbody>
</table>
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](http://www.ncbde.org)
    - National Asthma Educator Certification Board, [naecb.org](http://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)

<table>
<thead>
<tr>
<th>Population</th>
<th>7-day Readmission</th>
<th>Total $ for 7-day Read</th>
<th>30-day Readmission</th>
<th>Total $ for 30-day Read</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH Population</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Readmission for MH</td>
<td>10.2%</td>
<td>$24.4 million</td>
<td>21.2%</td>
<td>$56.9 million</td>
</tr>
<tr>
<td>Readmission for non-MH</td>
<td>14.0%</td>
<td>$65.7 million</td>
<td>26.4%</td>
<td>$161.2 million</td>
</tr>
<tr>
<td>Any Readmission</td>
<td>15.2%</td>
<td>$99.3 million</td>
<td>28.8%</td>
<td>$232.2 million</td>
</tr>
<tr>
<td>Non-MH Population</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any Readmission</td>
<td>9.5%</td>
<td>$60.8 million</td>
<td>20.1%</td>
<td>$171.7 million</td>
</tr>
</tbody>
</table>

(Coughlin & Shang, 2011)
## Ambulatory Visit Follow-Up to Hospital Inpatient Stay for MH Treatment, 2003

<table>
<thead>
<tr>
<th></th>
<th>Ambulatory Visit Within</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7 Days</td>
</tr>
<tr>
<td>Percentage of Hospital Inpatient Stays with Any Follow-Up Visit</td>
<td>51.4%</td>
</tr>
<tr>
<td><strong>By Primary Diagnosis</strong></td>
<td></td>
</tr>
<tr>
<td>Multiple Diagnoses</td>
<td>53.5%</td>
</tr>
<tr>
<td>Neurotic &amp; Other Depressive Disorders</td>
<td>31.0%</td>
</tr>
<tr>
<td>Major Depression &amp; Affective Disorders</td>
<td>43.0%</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>43.7%</td>
</tr>
<tr>
<td>Stress &amp; Adjustment Reactions</td>
<td>14.0%</td>
</tr>
<tr>
<td>Other</td>
<td>13.1%</td>
</tr>
</tbody>
</table>


(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

(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 at 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 with major depression who were newly started on an antidepressant medication in the past 12 months, but did not remain on any antidepressant for a minimum of 12 weeks 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

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4+ Inpatient/ER – BH</td>
<td>High Utilization of Behavioral Health Inpatient / Emergency Room</td>
</tr>
<tr>
<td>3+ Inpatient – BH</td>
<td>High Utilization of Behavioral Health Inpatient Services</td>
</tr>
<tr>
<td>3+ ER – BH</td>
<td>High Utilization of Behavioral Health Emergency Room</td>
</tr>
<tr>
<td>Readmission - All BH 45 day</td>
<td>Behavioral Health Rehospitalization within 45 Days</td>
</tr>
<tr>
<td>Adherence – Antipsychotic (Schz)</td>
<td>Adherence to Antipsychotic Medications for Individuals with Schizophrenia</td>
</tr>
<tr>
<td>Adherence Mood Stabilizer (Bipolar)</td>
<td>Adherence to Mood Stabilizer Medications for Individuals with Bipolar Disorder</td>
</tr>
<tr>
<td>Antidepressant &lt; 12 weeks (Depression)</td>
<td>Antidepressant Trial of less than 12 weeks for Individuals with Depression</td>
</tr>
</tbody>
</table>
# PSYCKES Data
(as of 10/1/2012)

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

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

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

Morrison, 2009
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](http://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](mailto: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