

Story Board Presentation:



Jerry Langley and Ken Crandall

Group A: 6 sites present their story boards and changes
(Modoc; Mono; Mendocino; Calaveras; Amador)

Group A (Primary GoToMeeting Connection)

Primary Link: <https://www4.gotomeeting.com/join/773319983>

CALAVERAS COUNTY BEHAVIORAL HEALTH SERVICES

Celebrating Successes Valuing Failures



SCCI Learning Session #3

August 28-29, 2012



Project Team



- Senior Leader(s): David Sackman, MFT
Deputy Director CCBHS
- Team Leader: Denise Giblin, MFT
QI Management Supervisor
- Team Members:
Suzanna Gonzalez, MSW-Case Manager
Henning Schreiber, PhD-IT Business Analyst
Stacey Meily-Administrative Assistant
Jana Molnar-Clerical Assistant QI
Leisa Olivieri, RN-Medication Services
Mark McCormick, LCSW-Clinic Supervisor



Charter

Processes and System Change



Aim: Integration processes and systems to improve overall coordination with primary care providers (PCP) so that consumers receiving medication services can be moved to a lower level of care whenever possible. In order to do this, CCBHS has a two-fold plan.

Objectives:

1. To increase staff awareness about the importance of health care coordination with PCPs with hope that this will lead to increased emphasis on ensuring that all consumers have a PCP. This would include developing a process for a smooth transition to PCP upon conclusion of treatment at CCBHS.
2. CCBHS would improve readiness of PCP to accept referrals from CCBHS through improved communication, education and consultation with PCPs.

Target population: All consumers receiving medication services which currently numbers about 305

Charter

Consumer Self Management



Aim:

To increase consumer awareness of the importance of health life style changes to improve health. Specifically, CCBHS will concentrate on the harmful effects of cigarette smoking to reduce or eliminate smoking behavior in consumer population.

Objectives:

1. Complete a chart review to determine number of consumers who currently smoke
2. Provide consumer education about the negative consequences of smoking
3. Provide support for consumers indicating a desire to quit smoking
4. Develop ways to increase consumer awareness of the importance of developing healthy life style habits

Highlighting Successes

Most promising results



Processes and System PIP

- Staff are willing to learn new ways to integrate healthcare into treatment discussions
- Many staff would be open to including some time in treatment sessions to discuss health care topics.
- PCP community are willing to talk with CCBHS about barriers to referrals

Consumer Self Management PIP

- Smoking is a change priority for many consumers, so we are on the right track.
- There are plenty of free resources out there for smoking cessation which we could make available to consumers.

Useful, Instructive Learning

Learning from Tests that did not go as planned



Process and Systems PIP

Despite early findings that staff would be willing to devote time to healthcare topics with consumers, the practice so far has not shown this to be true.



Consumer Self Management PIP

Consumers do not respond well to written surveys.



How Did this Learning Inform Next Steps and Pursuit of Changes that Work



Process and Systems PIP

- CCBHS plans to continue discussions with PCP community through informal meetings such as Drug Rep. dinners etc.
- Presently testing a brief treatment model which has particular emphasis on referral process at conclusion of treatment

Consumer Self Management PIP

- CCBHS is planning to do a pilot Project using Peers to query consumers about their satisfaction with services as well as offer smoking cessation materials. This will be done through a phone interview.





How You Did It

Changes implemented:

Process and Systems PIP

- All PCP information gathered is entered into the Electronic health record by clerical staff during intake process.
- Ongoing involvement of CCBHS staff in community PCP meetings to build relationships and communication

Consumer Self Management PIP

Presently working on developing consent forms and reading script for peers to use for pilot project.





Tests that Helped

Process and Systems PIP

The test of having a number of the PIP team attend the PCP Drug Rep dinner was very successful. It is clear from that initial meeting, that CCBHS staff must increase their presence at such meetings to build relationships and communication. We can also reduce barriers to cross referrals by listening to PCP concerns and making efforts to educate and help them get their needs met.

Consumer Self Management PIP

Written “Priorities Survey” helped us know that we were on the right track with smoking cessation. It also showed us that written surveys are not well received by consumers, so we need to focus on a different way to communicate with consumers. This is why we are now looking to do a pilot project with phone calls to consumers.

Planning Ahead The Next 6 Mos.



Changes Planned

1. Continuation of Pilot project of brief treatment model and referral to PCP at conclusion of treatment.
2. Continued work at developing partnerships with primary care through regular contact at PCP community meetings
3. Start of pilot project on use of peers for satisfaction surveys and smoking cessation





Small County Care Integration
Quality Improvement Collaborative



Adult Services MHSA-Recovery Center Program

Celebrating Successes Valuing Failures

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August 28-29, 2012

Project Team Members & Their Roles

Senior Leader: Andrea Kuhlen, MPA, Deputy Director of Clinical Services

Team Coordinator: Isabel Chavez, Behavioral Health Manager

Team Members:

- ▶ Francisco Ortiz , IMF, Sr. Behavioral Health Manager, Manager/Clinician
- ▶ Patricia Arevalo–Caro, LPT, Program Supervisor II, Supervisor
- ▶ Rosemary Jones, LVN, Provider/Nurse Case Manager
- ▶ Joaquin Zambrano, Mental Health Rehab. Tech., Provider/Case Manager
- ▶ Amanda McDowell, Peer Provider
- ▶ Leticia V. Garcia, MBA, Administrative Analyst III, Data Analyst/Evaluator
- ▶ Christine Garcia, MSW, Administrative Analyst I, Data Analyst/Evaluator
- ▶ Nancy Del Real, MPA, Behavioral Health Manager, Information Systems
- ▶ Martha Miramontes, RN, Nursing Supervisor
- ▶ Eddie Sanchez, Program Supervisor
- ▶ Gina Ramirez, Office Supervisor, Data Analyst/Evaluator
- ▶ Margie Caro, Office Technician, Data Analyst/Evaluator




Charter

AIM

Over the next 12 months, Imperial County Behavioral Health Services will improve communication, collaboration, and coordination with community healthcare providers and improve consumers' active involvement in the management of their overall health and wellness.

Target Population

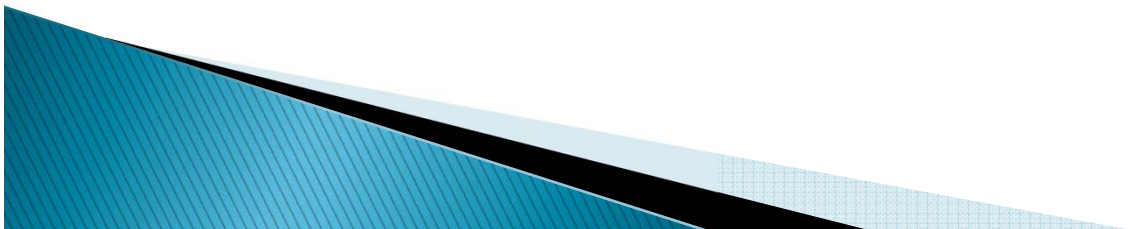
All consumers with serious mental illness (SMI) who are assigned to one specific nurse (Rosemary) as part of their medication support treatment at the MHSA-Recovery Center Program.



Charter

Non-Clinical Objectives:

1. Increase the identification of consumers medical health conditions recorded in EHR to 85%.
2. Increase bidirectional communication between ICBHS and PCP for consumers within the target population to 75%.
3. Increase the number of consumers with an identified PCP in their EHR to 75%.



Highlighting Non-Clinical Successes

Most Promising Results so far...

- ▶ **Use of tab in Avatar to record**
 - Clients' PCP
 - Clients' most recent PCP visit
 - *Medical Health Conditions as reported by Client
- ▶ **Developing a PCP/Clinic Referral List for clients (currently accepting Medi-Cal)**
- ▶ **Promoting physical healthcare through ICBHS Radio Show and quarterly newsletter.**

*Currently Testing



Useful, Instructive Non-Clinical Learning

Learning from Tests that did not go as planned:

- ▶ *Initially, in testing bi-directional communication we did not receive requested information back from provider as expected.

How Did this Learning Inform next Steps and pursuit

of Changes that Work:

- ▶ *We learned that we need to have a contact person at the PCP/Provider office to facilitate communication.

- ▶ *Currently Testing
- 

Non-Clinical – How It Was Accomplished

Changes Implemented:

- ▶ The clients' PCP information and date of last visit with PCP is recorded more frequently.
 - Previously recorded in the initial nursing assessment and annual nursing assessment
 - Now data is readily available for staff to coordinate care
- ▶ Promoting physical health by the use of our quarterly newsletter and the Radio Show
 - Staff learns health education via
 - Newsletter & Radio Show
 - Radio Show: June “Tobacco” & August “Nutrition”
 - At Adult Service staff meeting
 - Introduced the SCCI project
 - Shared the 5As informational sheet
 - Staff promotes physical health with their clients



Charter

Clinical Objectives:

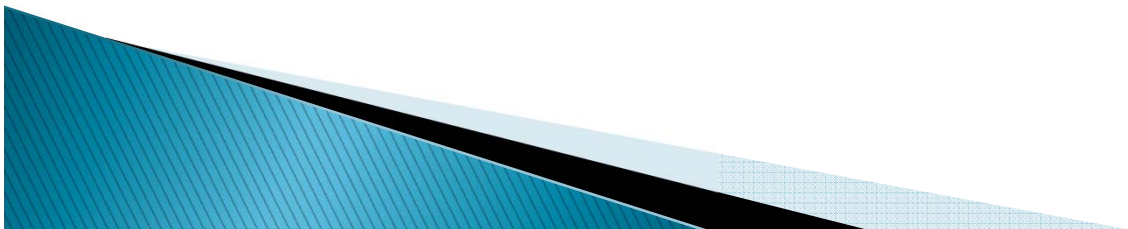
1. Increase the percentage of consumers who have had primary care visits in the past 12 months to 75%.
2. Increase the number of times consumers exercise, at least 3 times per week for at least 20 minutes each time, to 70%.
3. Decrease the number of consumers who report smoking by 20% from baseline.



Highlighting Clinical Successes

Most Promising Results so far...

- ▶ **Nurse's & Case Manager's use of 5As with clients.**
 - Clients are reporting :
 - They are interested in quitting smoking
 - Inquiring start date for smoking cessation support groups
- ▶ **Obtained 1(800) NO-BUTT materials for clients to receive additional support/counseling.**
- ▶ **Contact with County Public Health and Tobacco Coalition as informational resource.**
- ▶ **Case Manager and Peer Member preparing to use SMART Recovery facilitator guide to run support groups in Spanish and English (currently testing).**



Useful, Instructive Clinical Learning

Learning from Tests that did not go as planned

- ▶ Tested with additional home visits by case manager to clients who stated they would not quit smoking
 - Out of 3 clients
 - 1 refused the visit
 - 1 reported he/she would continue smoking
 - 1 reported he/she would think about quitting
 - Although additional home visits appeared to “fail” it gave feedback for those clients.
 - We learned that using the 5As with clients is a process

How Did this Learning Inform next Steps and pursuit of Changes that Work

- ▶ Adopted regular use of 5As with clients
- ▶ Nurse and case manager will use 5As with their clients.



Clinical – How It was accomplished

Changes Implemented:

- ▶ Task Force decided that nurse and case manager will use 5As regularly with clients in the target population.

How used in program:

- ▶ Use of 5As will identify clients for smoking cessation support groups
- ▶ 5As were introduced to staff at Adult Services





Modoc County

Behavioral Health

Celebrating Successes

Valuing Failures

SCCI Learning Session #3

August 28-29, 2012

Modoc SCCI Project Team

- Senior Leader: Karen Stockton
- Team Leader: Tara Shepherd
- Team Coordinator: Tristin Harer
- Team Members:
 - Billy Diaz, Tiffany Ford
 - New:* Dolores Navarro-Turner
 - No longer on team:* Brian Johnson,
Lacy Summers

Modoc SCCI Charter

Aim: Better health status for individuals with SMI through support of physical health of clients & clients' use of physical health services ...

Objectives: 1) Increase PCP Visits; 2) Increase exercise; 3) Reduce BMI; 4) Increase consults w/ PCP; and 5) Document demographics and vitals in a registry.

Target Population: **Adults with SMI**

Highlighting Successes



Aqua Exercise

Monday and Wednesday evenings there is an aqua exercise class offered at our local pool. Three Behavioral Health staff have been attending, including Tara, who decided to purchase 8 slots in the class for our clients. They were not assigned to any one person and if more than 8 attended then BH would then pay for those slots also. The clinicians then told clients about the opportunity and that they could attend free of charge.

Successes:

- Clients are interested in exercising.
- Word of mouth is powerful.
- 9 clients have attended so far.

Highlighting Successes



WALK ON! WITH Health Services

- **Successes**

- 58 Total Participants
- 18 Behavioral Health Clients Participated
- 14/18 were Target Pop/SMI
- All participants walked a minimum of 1 mile. Majority of participants walked 2 miles and 2 walked 3 miles
- 19 clients signed up for the Walking Club
- 11 of the 19 that signed up for the walking club were Target Pop/SMI

Modoc National Wildlife Refuge Walk

Subcommittee members from Behavioral Health and Public health organized a Walk at the Wildlife Refuge. The walk was a two mile loop. There was a table at the Walk for those interested in signing up for a Walk Club.

Promotional flyers were mailed to all clients with details of the Walk. Raffle prizes, healthy snacks, water, nutrition information and incentives (pedometer, caps, water bottles, and medals) were included.

Highlighting Successes



PECSYS

Modoc is a “Pilot” County for use of the PECSYS electronic registry.

Successes:

- Nurses (end-users) have identified & reported user documentation changes needed;
- Nurses have identified and reported user inter-face changes needed.
- Nurses have identified reporting capabilities needed.
- Through testing, collaborated w/ Jerry Langley to make PECSYS more user-friendly.

Purposes: 1) Determine efficacy of using PECSYS registry for tracking SCCI core data elements; 2) Successful rollout for other SCCI counties who wish to use it; 3) Identify documentation requirements for end-users and technical staff; 4) Identify and troubleshoot program changes for user interface; and 5) Identify and troubleshoot program reports to meet SCCI core measurement documentation.

Useful, Instructive Learning

- Learning from Tests that did not go as planned:
The upgrades and modifications of PECSYS depend support of Modoc Co. I.T., since they are the only ones that have access to the server.
We found out, after we got a revised version of PECSYS, that they would be unavailable for two weeks. This affected our schedule.
- How Did this Learning Inform Next Steps and Pursuit of Changes that Work:
This experience has taught us to check for their availability in advance when it relates to PECSYS upgrades and changes.

How You Did It

- There were enough clients interested in aqua exercise that the local pool was able to extend the length of the class.
- With the interest and number of people that we had attend the Wildlife Refuge Walk we will be organizing and establishing a walk club and more fitness times/events.
- We found that our clients are willing to fill out surveys and return them to us completed. We found this very helpful and we were able to gain a lot of information including their Primary Care Providers and their tobacco habits.
- Our SCCI Team has accomplished a great deal since the last learning sessions. We have learned valuable information about our clients' health status. We were happily surprised that so many are interested in exercise and participating in wellness events that BH offers.

Tests that Helped

- The most important PDSA cycles that helped MCBH be successful
 - **Exercise PDSA & Walk On PDSA**
 - What we tried - Encouraged and provided opportunities to exercise
 - What happened - People showed up and were enthusiastic about exercising
 - What we learned – The clients do want to exercise!
 - **Core Measure Questionnaire PDSA**
 - What we tried – Mailed a questionnaire to each SMI client with a chance to win \$100 grocery gift card
 - What happened – Received core measure (medical information) for 28 SMI clients to enter into the PECSYS registry
 - What we learned – People are willing to fill out a survey with an incentive attached

Planning Ahead: The Next 6 Mos.

- We are currently organizing a SMI Client Wellness meeting. We will send out invitations inviting our TP to come meet with our SCCI Team and discuss whole person wellness and its importance. They will also have a chance to win a \$100.00 gift card to a local grocery store, the opportunity to have the blood pressure and weight taken, and also will be making their own healthy wraps for lunch (something quick, easy, and healthy that they can do at home).
- We are also in the process of establishing a Walking Club. We had offered the clients that participated in the Refuge Walk the opportunity to sign up for the club and found that several of them are interested. We will form a team to discuss what our next events will be and generate ideas about how to continue our club through our harsh winter coming up.

Mendocino

Celebrating Successes Valuing Failures



SCCI Learning Session #3
August 28-29, 2012





Project Team

- **Senior Leader: Tom Pinizzotto**
- **Team Leader: Cheryl Tamblyn**
- **Team Members:**
 - Jenine Miller, BHRS Clinical Supervisor
 - Mary Williamson-Ingoldsby, AOD Program Administrator
 - Jane Berry, MH Board Member
 - Susan “Wynd” Novotny, Peer Provider
 - Lisa Gosslyn, Consumer Advocate
 - CJ Vokoun, Tech Application Specialist
 - Karen Lovato – no longer on team
 - Trayce Beards – left agency
 - Leila Lamun – left agency

Charter



- **Aim:** To revitalize and strengthen our current system in order to improve consumers outcomes.

- **Objectives**

- Increase consumers who have a PCP to 80%
- Increase consumers who have had a PCV in the last 6 months to 80%
- Increase consumers with active ROIs between their PCP and support team staff to 80%
- Increase consumers' communication between PCP and support team to 80%
- Increase the number of encounters between mental health providers and PCP
- Establish the use of electronic collection of consumer's physical health data

- **Target Population:** SMI consumers at an Adult / Older Adult Peer-Supported Mental Health and Recovery Wellness Center (Manzanita). Between the two sites there is a total of 140 consumers utilizing services.

Highlighting Successes



- Developed Smoking Cessation awareness in-house and Manzanita with staff and consumers.
- Consumers attended the SAMHSA Smoking Cessation webinar
- Staff attended SAMHSA Motivational Interviewing webinar
- Began to identify consumers with 3-way ROIs.
- Began to indentify bi-directional ROIs for clients receiving behavioral health through FQHC.
- Through collaboration with MH staff, a form was designed to document Core Measures for use with MH, Manzanita and FQHC
- Ordered, received and distributed Blood pressure cuffs and BMI scales to sites.
- Utilizing Stanford “Personal Medication Card” and WRAP (Wellness Recovery Action Plan) to support clients in tracking, evaluating and monitoring their personal wellness.
- Attended SAMHSA-HRSA Integrating Behavioral Health & Primary Care webinar



Useful, Instructive Learning

- **Learning from Tests that did not go as planned:**
 - Consumers stating they want to quit smoking then stated “I’m not ready”.
 - Staff educated by Public Health Smoking Cessation Coordinator that “quit attempts” is a natural progression towards cessation.
 - Beta testing Registry showed a need for improving existing clinical database for ease of data entry. Modeling tabs will document information. Scanning capabilities of current database will document ROIs, labs and assessments in electronic charts.
- **How Did this Learning Inform Next Steps and Pursuit of Changes that Work?**
 - Changed format for smoking cessation from a small limited group to a presentation in the group education room, facilitated more group interaction and discussion about cessation. (SAMSHA Smoking Cessation webinar 7-31-12).
 - Clients want substitutes and change in routines to develop a new environment to support their cessation efforts.
 - Practice designing tabs to include core measures for electronic data entry in MH database.



Tests that Helped

- **Smoking Cessation**

- Presentations for staff regarding the effects of tobacco use. Knowledge gave staff the motivation to consider their own smoking cessation and be a role model for clients.
- Building processes and relationships to develop a collaborative between MH, FQHC, and community agencies for consumers' physical and mental health
- All were in agreement to acquire a “universal ROI” and method to access mutual client's information that can give us a knowledgeable starting point

- **Contracted Psychiatrist has experience with integrated health care.**

- His expertise helped established a process and form
- His caseload will focus on gathering information



How You Did It

- **Changes implemented:**
 - Raised awareness through education and distribution of smoking cessation materials.
 - Collaboration with Public Health and other resources for tobacco cessation education materials.
 - Development of “Effects of Smoking” poster boards during Manzanita education groups. These boards were placed in consumer group rooms and MH waiting room.
 - Use 3-way ROI and core measures form
 - All parties agreed to a universal ROI.
 - Integrated Health care document developed for electronic data entry and stored in MH chart.

Planning Ahead: The Next 6 Months

- **Changes Planned for the Next 6 Months:**
 - Newly contracted MH Psychiatrist will interview consumers to document Core Measures in chart.
 - Plans for smoking policy to include MHSA supportive programs and sites.
 - Attend Sept. SAMHSA-HRSA Integrating BH & Primary Care webinar
 - Increase the 3-way and bi-directional ROIs
 - Implementing Patient Navigation SSU internship at Manzanita Services to assist clients in primary care/behavioral health integration.



Mono County Behavioral Health
Celebrating Successes
Valuing Failures

SCCI Learning Session #3
August 28-29, 2012

Project Team



- **Senior Leader: Robin K. Roberts, MFT, Behavioral Health Clinical Director**
- **Team Leader: Shirley K. Martin, ASS**
- **Team Members: Christina Caro, Ph.D., Clinical Psychologist & IT Integration Consultant**
- **Jennifer Gaffney, FTS IV – Front Office Team**
- **Tiffany Henschel, FTS I –Front Office Team**

Charter



- **Aim – Mono County Behavioral Health intends to move from an ad-hoc clinical practice of primary healthcare coordination (pre-contemplative), to engaging behavioral healthcare consumers and PCPs in a routine practice of addressing co-occurring physical healthcare factors and proactive coordination with PCPs.**

- **Objectives – MCBH’s vision for coordinated whole-person wellness documented and disseminated. 100% of staff is aware of the organization vision and can identify their role in realizing the vision.**
- **100% MCBH staff “buy-in” and engagement in organization vision.**
- **80% of target consumers contributed to base-line data collection effort.**
- **80% of consumer charts reviewed to identify baseline level of PCP coordination.**
- **80% of consumers have signed releases in their charts with all data entered into EHR system.**
- **80% of treatment plans include a physical health milestone.**
- **60% increase in PCP coordination from baseline.**
- **100% MCBH staff participation in technology needs assessment.**
- **80% of consumers with no payor source informed of and linked with possible resources (i.e. Medi-Cal, CMSP, low cost local clinics, etc.)**

- **Target Population – MCBH is using our entire consumer caseload for our Target Population as it runs between 100 and 120.**

Highlighting Successes



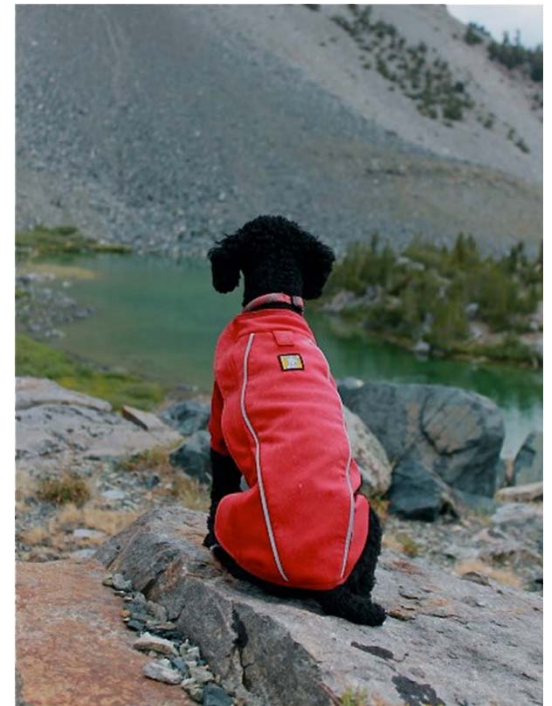
- ☑ MCBH vision/mission for coordinated whole-person wellness documented and disseminated
 . 100% of staff is aware of the organization vision and can identify his or her role in realizing the vision.
- ☑ 100% MCBH staff buy-in and engagement in organization vision.
- ☑ One practitioner-to-practitioner informational exchange held each month.
- ☑ 80% of consumer charts reviewed to identify baseline level of PCP coordination
 - ⇌ 80% of target consumers provided education information on the value of coordinated, whole-person health care.
- ☑ 80% or consumers with no payor source informed of and linked with possible resources (i.e. MediCal, CMSP, low cost local clinics, etc.)
 - ⇌ 80% of target consumers have signed releases in their charts with all data entered into EHR system.
- ☑ 100% completion of EHR evaluation.
- ☑ 100% completion of research and identification of desired certified meaningful use EHR
- ☑ 60% of current BHP policies and clinical practices reviewed.
 - ⇌ 100% of current BHP policies requiring modification are modified.
 - 100% BHP staff trained in modifications and additions to policies and clinical practices.
- ☑ 100% Completion of assessment revision to include physical health information
 - ⇌ 80% treatment plans include a physical health milestone.
 - ⇌ 60% increase in PCP coordination from baseline.
- ☑ 100% completion of technology needs assessment.

- | |
|---------------|
| ☑ Completed |
| ⇌ In progress |
| – In planning |

Useful, Instructive Learning



- Learning from Tests that did not go as planned
- Primarily anything we ask of staff to do differently or to add needs follow up. For example, we have added taking each consumers weight to our front office list of things to do. Staff has been on board and open to the idea, but since we did not set a date to begin the process of collecting this data, it has not happened.
- Willingness and enthusiasm, while great for generating ideas, are not enough to create a new system.
- How Did this Learning Inform Next Steps and Pursuit of Changes that Work
- We work together as a team to harness the willingness and enthusiasm around a new idea and develop timelines and designated people for all necessary tasks.





How You Did It

- **Changes implemented:**

- All consumers who come into our main office are asked if they are willing to have their blood pressure checked.
- All consumers have a chart specifically for vitals where the results are documented.
- Any BP over “normal” the consumer is encouraged to make an appointment with their PCP that day. Consumers are asked if they want help from front office staff to make an appointment and if they answer “yes” the phone calls are made by staff with the client present.
- Since we are providing this service to all consumers at MCBH, the resulting conversations between consumers and staff have been inviting and consumers have been more engaged in their services.
- All staff is now educated and engaged in the discussion about Primary Care with all clients.
- Our intake and assessment process now includes questions regarding.....



Tests that Helped

- The most important PDSA cycles that helped you be successful with one or two of the key changes
- **CONSUMER VITALS**
 - Implementing vitals being taken in the front office.
 - All staff wants to implement change – yet, changing even a small business system can be difficult.
 - As with any change, all must be committed and through repetitive steps, we have made the change and now take all consumer's vitals when they come to an appointment.



Planning Ahead: The Next 6 Mos.



- Within the next six months we will have a Psychiatric Nurse Practitioner joining our staff. This person will be working with our local Health Clinic (Sierra Park Clinic) two days per week and in our office three days. We intend to begin the process of working as a collaborative with Sierra Park Clinic with regard to any patient/consumer who presents with or is identified as having psychiatric and/or psychological needs. Conversely, we will be referring our consumers who are not yet linked with a PCP to Sierra Park Clinic via our Psychiatric NP.
- We will begin our planning for Health Care Reform and how we will expand services and/or staff to meet the needs of consumers who will become Medi-Cal eligible.
- We will continue to institutionalize our “Whole Person Wellness” into our daily work.
- We will plan and implement a Wellness Project within our office for all staff. This will include incentives for exercise/movement, smoking cessation, weight or BMI loss, and self care like taking time off, getting massage, or visiting our wild and wonderful hot springs.



AMADOR COUNTY BEHAVIORAL HEALTH

CELEBRATING SUCCESSES
VALUING FAILURES

SCCI Learning Session #3
August 28-29, 2012



PROJECT TEAM

- ◉ Senior Leader:

Sherry Parkey

- ◉ Team Leader:

Michelle Turner

- ◉ Team Members:

Jennifer Kromm

Renee Paul

Dena Sehr

CHARTER

- ◉ Aim - Develop an integrated system of care between ACBH and PCPs to improve health care delivery and outcomes for our clients.

- ◉ Clinical Objectives



- Time spent exercising
- Weight loss with optimal health
- Quality of sleep hygiene



- BMI
- Anxiety

- ◉ Process Objectives



- Number of clients with a PCP
- Direct consultation with PCP
- Number of clients with clearly defined Axis III entry
- Percentage of diabetic clients taking antipsychotic meds who have regular lab testing

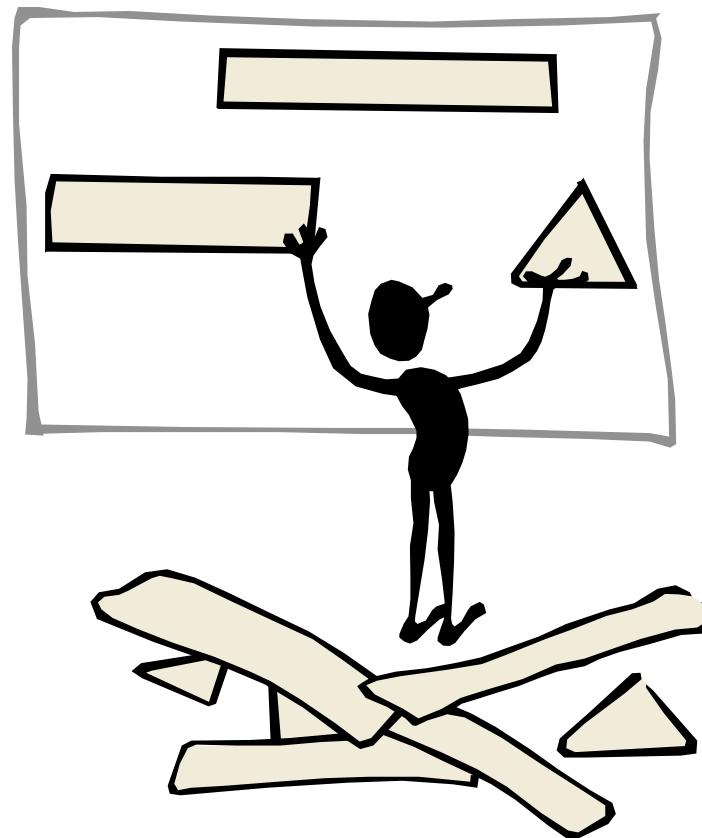
Target Population - All meds only adult clients

HIGHLIGHTING SUCCESSES

- ◉ Comprehensive database of PCPs in the county
- ◉ Updated brochure detailing services
- ◉ Client Health Form and Vital Signs Log Sheet for inclusion in new Health section of charts
- ◉ Referral process for PCPs

PITFALLS OF PARADIGM CHANGE

- ◉ Shotgun Approach - Too Many Ideas
- ◉ The Issue of Scale - Micro-Managing
- ◉ We've Always Done it This Way
- ◉ Organizational Growing Pains



A WORK IN PROGRESS

◉ Refocus the Team

- Revisit the Charter
- Weekly Team Meetings

◉ Reason for Documentation

- Not just to check off the box
- Meaningful chunks

◉ Nurse Renee

- Better connection with the psychiatrist
- Ability to directly implement changes



PLANNING AHEAD: THE NEXT 6 MOS.

- ◉ Implement Client Health Form
- ◉ Bigger Push to Communicate with PCPs
- ◉ Revise Data Collection Techniques to Increase the Number of Core Measures we Collect
- ◉ Revise PDSA Tracking to Take Advantage of Trinity County's Work in this Area
- ◉ Outreach to Colleagues

