Story Board Presentation:

Karin Kalk and Jae Han

Group B: 5 sites present their story boards and changes (Plumas; Madera; Trinity; Tehama; Colusa)

Group B (Secondary GoToMeeting Connection)

Secondary Link: https://www4.gotomeeting.com/join/840898423

Plumas County Mental Health

Celebrating Successes
Valuing Failures

SCCI Learning Session #3

August 28-29, 2012

Project Team

- Senior Leader(s): Patricia Leslie MA, PCMH Interim Director
  PCMH Management Team
- Team Leader: Michael Gunter MS MFT, QA Coordinator
- Team Members: Jacque Martinez-Blanton, ASW
  Bethany Ring, RN
  Elizabeth McGee, NP
  Denise Pyper, Consumer Family Member
  Yvonne Leishman, I.T. Support

Charter

• Aim

Plumas County Mental Health (PCMH) will increase its coordination with primary care to insure that SMI patients at risk of physical health problems have access to services for early detection and treatment, to expand communication between PCMH and PCPs regarding treatment of shared patients, and to develop a cross referral process and extend mutual access.

• Objectives

- 80% of new mental health clients will have primary care information on file, including primary care providers, general medical conditions, and a list of current medications.
- PCMH will screen SMI clients in the Quincy area to identify those at high risk for medical problems.
- PCMH will coordinate with Northfork Family Medicine for follow up of at-risk SMI clients.
- Coordinate treatment for clients who have diagnoses which are manageable in the PC setting.
- Develop action plans for clients who suffer or are at risk of, obesity, diabetes, or CVD.
- Engage case management staff when bridging communication between clients and PCPs, and to assist in the implementation of client action plans targeting life style changes.
- Increase the number of SMI clients who are diabetic to obtain A1C labs as recommended.

• Target Population

The initial target population will included all PCMH MediCal clients receiving services at the PCMH Quincy Office, and the Drop in Center (DIC). A review of client Care Plans, Axis I, II, and III diagnoses, and medication lists are reviewed to determine those clients considered SMI and at risk for medical problems.

Highlighting Successes

Most Promising Results

- **Implementation of Medical Data Recording**
  - Allows for the tracking of SMI client contacts with PC providers and entry of medical data into the mental health record.
- **Placement of a primary care provider in the mental health setting**
  - SMI clients can be seen by a primary care provider at the Drop in Center outpatient mental health facility every month.
- **SMI clients introduced to smoking cessation**
  - A group therapy setting is being utilized to provide tobacco awareness, smoking cessation support, and dietary changes.
- **Mental health clinical staff engaged in identifying clients at risk**
  - In addition to assessment tools, direct consultation with clinical staff has led to the identification of additional mental health clients in need of linkage to primary care.

Useful, Instructive Learning

- **Learning from tests that did not go as planned**
  - Attempts to engage mental health clinical staff in the collection of core measures did not show constructive results.
- **How did this learning inform next steps and pursuit of changes that work**
  - Advancing the customization of the PCMH EHR (Anasazi) has led to possibilities to collect primary care information which was not collected in the past.

How We Did It

Changes implemented

- Some detail about the changes you made
- How you used that change in your program

Increased integration with primary care has led to significant changes in the delivery of mental health services:

- **At intake, information regarding clients’ current physical health status, current medications, and life style choices are documented.**
- **Treatment plans include linkage and referrals to primary care services when needed, and tracked as part of case management.**
- **Information such as client’s blood pressure, BMI, A1c, etc, is scanned into the EHR and is available to the psychiatrist, nurses, and clinical staff electronically.**
- **Offering a PCP on site at one PCMH facility has opened immediate communication between clinicians and the PCP as well as an in-house referral for clients.**

Tests that Helped

- **The most important PDSA cycles included tests designed to closely follow individual client responses during efforts to “link” clients to the PCP provided at the mental health site.**
  - Observations suggested that the “linkage” of clients to primary care could easily be lost.
  - “Linkage” to primary care needed be more than a treatment arrangement; and became an integral part of clients’ plan of care.

Planning Ahead: The Next Six Months

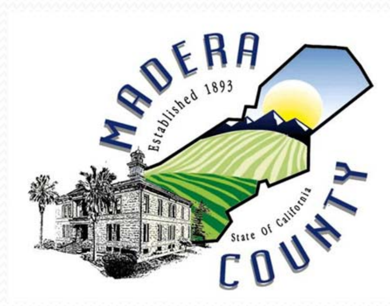
- **Changes Planned:**
  - PCMH will arrange for a PCP to be available at the main outpatient clinic in Quincy once a month.
  - PCMH will expand its customization of EHR to include the capacity to enter client vitals without scanning paper documents.

Madera County

Celebrating Successes
Valuing Failures

SCCI Learning Session #3

August 28-29, 2012



Project Team

Senior Leader: Debbie DiNoto, LMFT

Team Leader: Larry Penner, LMFT

Team Members:

- Michelle Richardson, LMFT
- Sal Cervantes, Analyst
- Aura Partridge, Case Manager
- Shari Stoops, RN
- Marizela Terkildsen, Health Educator

Madera Co. Charter

Aim

- MCBHS will improve systems of communication, collaboration and integration between clients, their PCP's and MCBHS to coordinate physical/behavioral health care through monitoring and documentation of physical health status.
- MCBHS will improve health status for Medication Only clients receiving services through Madera Counseling Center, through health education referrals/services and monitoring for those with a BMI over 30 and/or high blood pressure.

Objectives

- 70% of "Medication Only" adult clients will get a physical by their PCP annually.
- We will obtain the results of 80% of the annual physical exams performed by the PCP.
- Train 100% of medical staff and Meds Only Case Manager to document physical health status, chronic health conditions and non-MCBHS medications.
- 50% of clients with a BMI over 30 and/or high blood pressure, after being referred to the health educator for health education, will have an increase in knowledge of their health issues (measured through a questionnaire).
- 30% of those clients receiving health education/monitoring with a BMI over 30 and/or high blood pressure will show a reduction in weight and/or blood pressure.

Target Population

All "Medication Only" adult clients who receive services at the Madera Counseling Center.
Approximately 180 clients.

Highlighting Successes

- Partnering with Anthem & Health Net to obtain physical health information.
- Started entering data on Doctor's Homepage.
- Increased number of clients who volunteer for vitals check.
- Initiated referrals to health educator coordinator based on BMI over 30 and high blood pressure.
- Learned that its more effective to complete PDSAs, etc., in our team meetings.
- Team meets consistently.
- Snacks are gooooooooooooooood!!!!!!!!!!!!!!!

Useful, Instructive Learning

Learning from Tests that did not go as planned:

- PDSAs—completing them individually.
- Information from Anthem & Health Net were not the same.
- Target population decreased to under 90.

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

- Started doing PDSAs in our team meetings. Also lengthened meetings. Snacks are gooooooooood!!!!
- Changed our target population to include all Meds Only clients.

- Changes implemented:
  - Brought snacks
  - Complete tasks in our team meeting
  - Brought laptop and projector to meetings
  - Dedicated case manager to PIP activities.
  - Increased target population.
  - Designated agenda for each week.
  - Lengthened weekly meeting time.

Tests that Helped

- The most important PDSA cycles that helped you be successful with one or two of the key changes
  - what you tried-PDSA #1
  - what happened—increased target population
  - what you learned as you went along-need to begin the process of spreading to other populations (all Meds Only and Chowchilla).

Planning Ahead: The Next 6 Mos.

Changes Planned for the Next 6 Months:

- Spread referrals to health educator from the Chowchilla Clinic.
- CDC-HRQOL-4 questionnaire will be completed by health educator and Meds Only case manager.
- Co-location of staff in new building.

TRINITY COUNTY BEHAVIORAL HEALTH SERVICES

CELEBRATING SUCCESS
VALUING FAILURES

Small County Care Integration Collaborative

Team Storyboard – Learning Collaborative #3

August 28-29,2012

Project Team Members & Their Roles

TEAM MEMBER ROLE	Team Member Name	Title
Senior Leader	Noel O'Neill, LMFT	Director
Team Coordinator/Key Contact	Sue Sirlin	Consultant
Clinical Supervisor or Manager	Ann Houle, LMFT	Clinical Director
Provider (Clinician and/or Case Manager)	Dow Angspatt, LMFT	Clinician
Peer Provider	Joyce Ott	Patient Rights Advocate
Data Analyst/ Evaluator	Rachel Sanger	Deputy Director
Data Analyst/ Evaluator	Karen Reimer	Medical Records

Charter – Goals and Objectives

Goals: Over the next twelve months, TCBHS will collect and document the PCP and medical condition information on all open clients and begin working with the local FQHC to establish opportunities for care coordination. TCBHS goals include:

1. **Goal:** Increase the percentage of mental health clients who have their PCP information recorded in the TCBHS EHR (Anasazi Software).

   Measurable Objective: By July 1, 2012, 85% of mental health clients have their PCP information recorded in the TCBHS EHR (Anasazi Software).

   ***Objective Reached: On June 29th, 87% of the target population report that they have a PCP.

2. **Goal:** Increase the percentage of mental health clients who have any reported medical conditions recorded in the TCBHS EHR (Anasazi Software).

   Measurable Objective: By September 1, 2012, 90% of mental health clients have any reported medical conditions recorded in the TCBHS EHR (Anasazi Software).

   ***Objective Reached: On June 29th, 94% of the target population reported their medical conditions.

Charter – Goals and Objectives

Goals (continued)

3. **Goal: Increase the percentage of mental health clients who have a current Release of Information Form (ROI) on file.**

   Measurable Objective: By September 1, 2012, 85% of mental health clients have a current Release of Information Form (ROI) on file

   *****Progress toward objective: As of July 31st, 60% of the target population have an accurate and up to date ROI on file.**

4. **Goal: Increase the frequency of TCBHS and the local FQHC meetings to discuss the importance of and to document the process for sharing data as a means of improving care integration and coordination.**

   Measurable Objective: By October 1, 2012, TCBHS has met with at least 80% of the local primary care providers at least one time to discuss the importance of and to document the process for sharing data as a means of improving care integration and coordination.

Charter – Goals and Objectives

Goals (continued)

5. **Goal: Increase the number of TCBHS staff contacts with a client's PCP for those mental health clients with a documented PCP and medical condition.**

   Measurable Objective: By May 31, 2013, TCBHS staff makes contact with a client's PCP at least one time per year for 90% of the mental health clients with a documented PCP and medical condition.

6. **Participate in improving the health of Trinity County residents by providing education, tools, resources and encouragement to mental health clients to help them quit smoking.**

   Measurable Objective: By May 31, 2013, TCBS will reduce the percentage of mental health clients that smoke by 10% and for those that continue to smoke will reduce the number of cigarettes per day by 10%.

Charter-Guidance/Target Population

Guidance:

- **TCBHS will need to begin gathering Primary Care Provider (PCP) and medical condition information in order to identify those for which care integration would be most beneficial. The initial focus will be on identifying the workflow for collecting the data and how the TCBHS EHR can be utilized to collect the data.**
- **TCBHS will continue efforts to coordinate with the local FQHC. Previous efforts have been met with some barriers. Identification of shared clients/patients and a focused effort to demonstrate the mutual benefit of care coordination will be the first step.**

Target Population:

All open clients - As of 7/31/12 the TARGET POPULATION is 213 unduplicated clients.

Highlighting Success-Most Promising Results So Far

- Better understanding of how to analyze data coming from Anasazi
- Met two goals/objectives in project charter:

  Measurable Objective: By July 1, 2012, 85% of mental health clients have their PCP information recorded in the TCBHS EHR (Anasazi Software).

  ***Objective Reached: On June 29th, 87% of the target population report that they have a PCP.

  Measurable Objective: By September 1, 2012, 90% of mental health clients have any reported medical conditions recorded in the TCBHS EHR (Anasazi Software).

  ***Objective Reached: On June 29th, 94% of the target population reported their medical conditions.

- Embracing the PDSA process; small tests of change give freedom to keep the process moving without blindly making sweeping changes
- We have a lot of people talking about smoking cessation

Useful, Instructive Learning

- Learning from tests that did not go as planned and How did this learning Inform next steps and pursuit of changes that work
  - Learning: Not as easy as we thought to get community doctors interested in what we are doing
  - Informing: Pursuing contact with FQHC, a larger provider

  - Learning: Getting what we need in Anasazi from Kings View takes time
  - Informing: We used Excel spreadsheets/chart review for some data collection in the meantime to prevent delays in moving forward

  - Learning: Had fewer accurate ROIs than predicted
  - Informing: Clinical Director clarified how to record information about PCPs and ROIs

Changes Implemented

- Improved process for assuring ROIs are up to date
  - Clarified how to record data for ROI
    - Correct identification of PCP (doctor vs. mid-level provider vs. clinic)
    - Date range vs. “Ongoing”
  - Check ROI’s for clients on the schedule
  - Notify clinician if ROI needs updating
  - Track via spreadsheet by SCCI Team until Anasazi ready
    - Fields present
    - Still need to enter data on current ROIs
  - % ROI increased from 49% to 60% in one month

Tests that Helped

Team:	Trinity	Cycle Number:	4	Date Started	7/10/2012	Date Completed	7/23/2012
Change or Idea Being Tested	ROI Data Collection						
SCERP Change Package	THEME #1: CONNECT CLIENTS TO PRIMARY MEDICAL CARE - 3. Redesign the intake process to include consent form and discussion about physical care and recovery						
SCCI Change Package	THEME #1: Increase mental health staff awareness of the importance of whole health. Build mechanisms for mental health agency staff to routinely identify and respond to physical health care needs within mental health. * Design clinical processes for routine monitoring of clients' physical health * Develop and use clinical information systems, including registries, in mental health.						
Objectives for Cycle:	Sample to see how many clients in the target population have an accurate and up to date ROI on file						
Question for Cycle:	What percentage of client charts reviewed have ROI forms that match the PCP and are up to date.						
Plan							
	Karen will check more charts						
	Karen will outline the findings in an email and send to the team.						
	Prediction: ROI forms are not that accurate and up to date.						
Do							
	Karen has completed inputting all of the ROI's for PCPs in an Excel Spread Sheet, with the following results: Of the Target Population of 199 – 118 (59%) had ROIs for their corresponding PCP. – of that number: 87 had current ROIs – which only makes us 44% compliant – the remaining 31 (15%) had expired ROIs. 45 (23%) had PCPs named, but no corresponding ROI. – adding the 31 expired ROIs for a total of 76, increases the percentage to 38% having no or current ROI's. 15 (8%) were charts I could not locate at the time of the counting (Missing in Action: MIAs!) 21 (10%) didn't have a PCP, therefore no ROI.						
Study							
	The percentages are very close to the PDSA cycle done prior to taking on the entire Target Population. Karen will be tracking down the "MIA" charts to get more accurate numbers, but in the meantime, these statistics can be used for our ROI baseline report. We will need to discuss at the next telephone meeting how we can increase our number of ROIs – ask the front desk to catch clients as they walk in the door or ask the clinicians to obtain the ROIs for the clients' PCPs, etc.						
Act							
	Karen will monitor schedule and notify front desk and clinician of anyone coming in that needs an updated ROI. Dow will share numbers at the clinical meeting.						

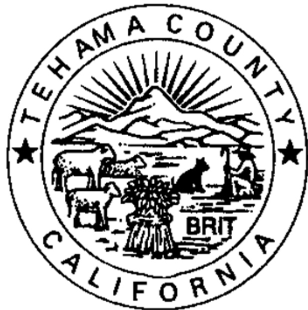
Planning Ahead: The Next Six Months

- Ongoing refinement and monitoring of PCP and medical condition data collection
- Improve the collection of accurate ROIs and use Anasazi to record and report ROI information
- Meet with local FQHC and set up ongoing approach to communication about mutual clients
- Start smoking cessation interventions
  - Group through Milestones
  - Resource Center/Peer Support in Milestones
  - Staff education
  - Community support

Tehama Co. Health Services Agency

Mental Health Division

Celebrating Successes
Valuing Failures



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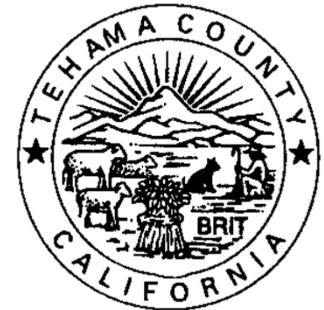


Project Team

Senior Leader	Michael Pena		Mental Health Director
Team Coordinator/Key Contact	Linda Russell		Business Operations Supervisor
Clinical Supervisor or Manager	Rod Green Lori Strahan John Hermanson Edie Burnett		Licensed Clinical Supervisors
Provider (Clinician and/or Case Manager)	Wanda Cossairt		Clinician III
Collaborative Partner	Vicky Reilly		Medical Clinic Director
Data Analyst/ Evaluator	Steve Remington Linda Russell		Fiscal Data Supv. B.O.S.
Case Manager Supervisor	Renee Timmons		Case Resource Specialist Supervisor
Team Co-Coordinator	**Maria Los**	Resigned	**Quality Assurance Mgr.**

Charter

- ## Aim

  Tehama County Health Services Agency, Mental Health Division aims to spend the next 12 months improving the physical health of clients with SMI who have high risk, co-occurring medical conditions such as cardio vascular disease and diabetes or are at risk or suspected risk of polypharmacy complications. This will be accomplished by improving systems of communication, collaboration and coordination with our county Health Clinic to enhance client wellness. Additionally, the Mental Health Division will collaborate with clients and their support systems to adopt healthier eating and exercise routines as well as decrease their smoking and alcohol consumption.

- ## Target Population

  Mental health clients who receive medication support services with our Physician Assistant

- ## Objectives

Clinical:

Increase by 25% the number of clients that exercise at least 3 times per week for at least 20 minutes

Decrease the percentage of clients who are smoking to less than 50% (from county base-line)

Increase the percentage of clients who have had a primary care visits in the past 6 months to 80%

Increase the percentage of obese clients who are engaging in self-management weight loss activities to at least 50%.

System:

Ensure that 90% of SMI clients have a Primary Care Physician.

Establish regular and direct consultation (phone, email, in person) between mental health providers and PCPs for at least 70% of SMI clients.

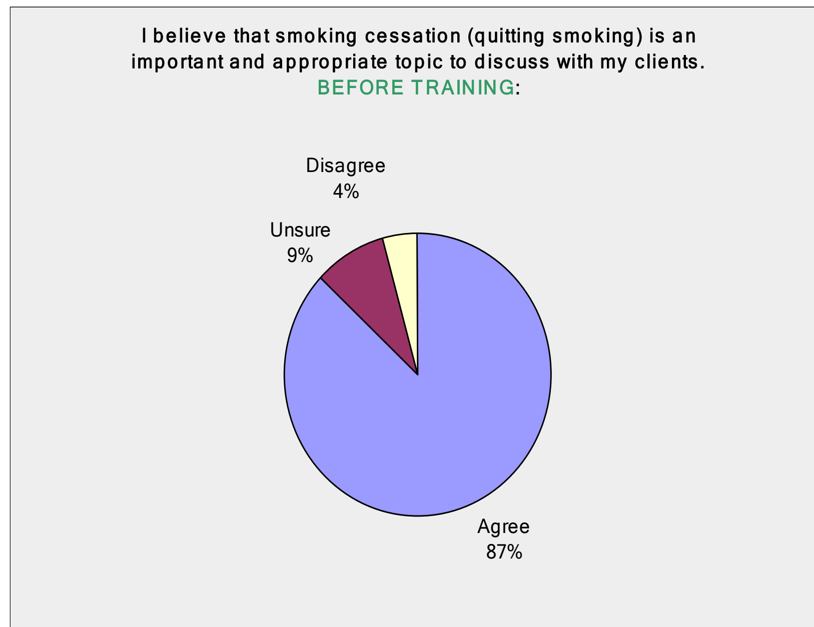
95% of target population’s service plans will address the target medical conditions and behaviors.

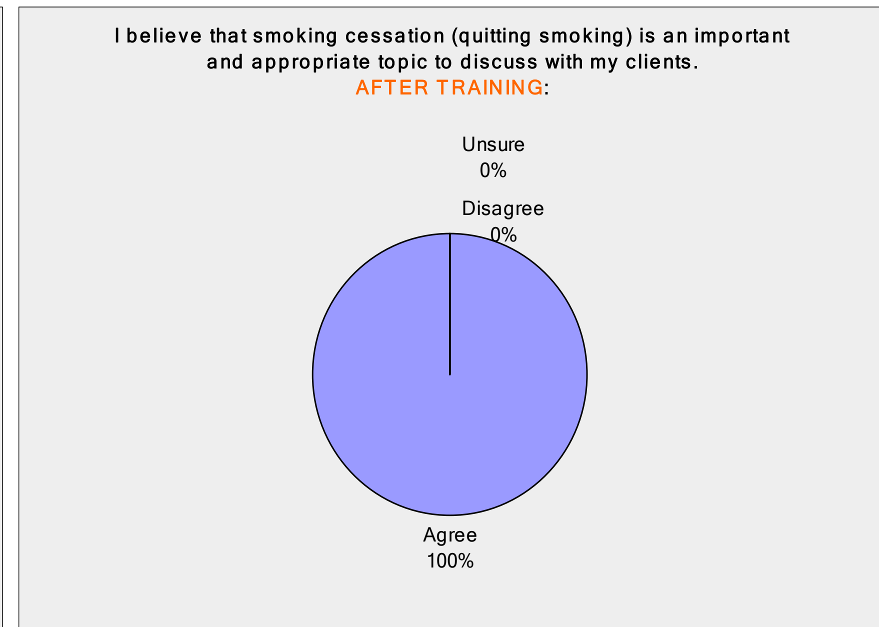
Increase percentage of clients with BP and BMI documented in mental health records within the past 12 months to 90%

Increase the documentation of A1C’s within the last 6 months in the mental health record for diabetic clients to 80%

Highlighting Successes

To our surprise, a survey of staff revealed that 13% of them disagreed with the statement that smoking cessation is an important topic to discuss with clients. After receiving training, 100% of staff agreed!





And…the training made such an impact that 2-3 staff members have chosen to model healthier lifestyles by quitting smoking.

Highlighting Successes
(Cont’d.)

- It came to light early in our collaboration with PCPs that polypharmacy issues were common among shared clients (as a result, we updated our AIM to include this issue)
- In the collaboration meetings, providers discussed mutual clients at risk or suspected risk of polypharmacy complications, some of whom had experienced overdose or near overdose events in the past
- Providers gained access to Dept. of Justice/Bureau of Narcotic Enforcement (DOJ/BNF) database and have been able to intervene with clients attempting to obtain multiple Rx’s for potentially lethal doses of controlled medications
- Due to collaboration, a shared medical history form is now in use by providers in both mental health and our county Health Clinic

Useful, Instructive Learning

- **Learning from Tests that did not go as planned**
  - Trying to collect Medical History from Crisis clients doesn't work
  - Referring hypertensive clients to their PCP to get a BP cuff Rx for home monitoring doesn't work (Medi-Cal and Medicare won't pay for it)
- **How Did this Learning Inform Next Steps and Pursuit of Changes that Work**
  - We are collecting history from OP clients only
  - We haven't given up on getting BP cuffs for clients who need them! We are exploring vendors to find lower-cost cuffs, finding out if lower-cost cuffs work reasonably well, and exploring possible other funding sources to help pay when clients can't afford buying their own.
  - If clients can't monitor BP at home, it's all the more important to educate and make sure we collaborate to get them monitored. Other PDSAs are also planned around this topic.

How You Did It

- **Changes implemented:**
  - We developed a new Medical History form that our county Health Clinic also uses for their intakes. This form is the basis for sharing information with PCPs.
  - We facilitated weekly collaboration between our Mental Health P.A. and our county Health Clinic's M.D. on shared clients. Our locums sometimes participate as well.
  - Our P.A. began utilizing the Dept. of Justice Narcotics Database to help identify clients receiving multiple RXs. In at least one case a client had a history of hospitalization. This helped reduce the chances of rehospitalization due to multiple RXs received.

Tests that Helped

- **The most important PDSA cycles that helped you be successful with one or two of the key changes**
  - What you tried
    - We tried to find out if staff were on board with addressing smoking cessation with clients. We wanted to know if staff supported our Aim, rather than just assuming that they did. We also wanted to know if they had the knowledge and tools they needed to do this successfully.
  - What happened
    - We arranged training on the 5 A's, and a presentation on smoking cessation from our Public Health Division. We found out by conducting surveys both before and after providing training, that staff did not necessarily support the Aim of the PIP regarding the importance and appropriateness of smoking cessation. They also lacked the knowledge on the health effects of smoking and the tools to counsel clients.
  - What you learned as you went along
    - We learned we were wrong in assuming that all staff were on board with targeting smoking cessation. Some of them were unsure if it was an appropriate topic for mental health to address, some didn't feel they had the knowledge they needed, some didn't feel they had the tools.

Planning Ahead: The Next 6 Mo.

- **Changes Planned for the Next 6 Months:**

✓ Continue educating clients on readiness for change, provide staff with materials to support clients in making the change, check in again with staff to see if they're using the 5 A's, find out if there are any barriers, etc.

✓ Further our efforts to educate clients on the importance of blood pressure monitoring, continue to explore ways to get BP cuffs to clients who need but can't afford them.

✓ Move toward capturing more of the PIP data elements.

✓ Continue collaboration while exploring ways to refine and improve the process; develop ways to measure outcomes.