PRIMARY CARE AND BEHAVIORAL HEALTH INTEGRATION:
CO-LOCATION FOR ARTICLE 28, ARTICLE 31 AND ARTICLE 32 CLINICS

Implementation Toolkit
Implementation Planning for Co-located Primary Care and Behavioral Health Services

Last Updated: 02/2018
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This Implementation Toolkit: Primary Care and Behavioral Health Co-location was developed by OneCity Health to enable primary care and behavioral health partners/sites to plan for the integration and co-location of primary care and behavioral health services.

The intended audience for this toolkit is Article 31, Article 32 and/or Article 28 clinics.

This toolkit provides guidance as to implementation planning for co-location, but is not intended to replace a health care organization’s independent legal, regulatory, and financial analysis as part of its internal planning activities. In addition, please note that the legal, regulatory, and financial environment is subsequent to change over time.

**SYMBOL KEY**

- ⚠️ – Important implementation consideration

**ONECITY HEALTH SUPPORT DESK**

If you have any questions, please contact the OneCity Health support desk:

**Phone Number:** 646-694-7090

**Email:** ochsupportdesk@nychhc.org, with the subject line “PCBH Co-location Question”

**Hours of Operation:** Monday through Friday from 9am to 5pm ET
### Implementation Planning Goals Checklist

#### PREPARING FOR IMPLEMENTATION

<table>
<thead>
<tr>
<th>Key Tasks</th>
<th>Owner</th>
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<tr>
<td>Establish a PCBH Co-location Workgroup</td>
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#### IMPLEMENTATION PLANNING

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<th>Implementation Planning Goals</th>
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<td>Goal 7: Conduct Ongoing Quality Improvement Activities to Assess Implementation</td>
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OVERVIEW: PRIMARY CARE AND BEHAVIORAL HEALTH CO-LOCATION

BACKGROUND

In the United States, 29% of the adult population has both a mental health condition and a chronic medical condition. Medical and behavioral comorbidities are burdensome for patients and families and fragmented care results in poor outcomes and higher costs. Individuals with behavioral and/or substance abuse disorders often have untreated and preventable chronic illnesses like hypertension, diabetes, obesity, and cardiovascular disease that are aggravated by lack of access to appropriate primary care services and challenges navigating complex healthcare systems.

Integrated, collaborative care is the systematic coordination of primary care and behavioral health services and the most effective approach to caring for people with multiple healthcare needs. Providing options for coordinated, accessible behavioral health and primary care services to meet a spectrum of patient needs across settings can improve both mental and physical health outcomes. Co-location of behavioral health services into primary care, and/or of primary care services into outpatient behavioral health settings, allows for greater access of services within a single setting.

PROJECT OBJECTIVE

The objective of this project is to integrate behavioral health, including mental health and substance abuse, with primary care to ensure coordination of care for both services. Co-location of behavioral health and primary care services can serve to: 1) identify behavioral and physical comorbid diagnoses early, allowing for more efficient and timely treatment; 2) ensure treatments for medical and behavioral health conditions are compatible and do not cause adverse effects; and 3) de-stigmatize treatment for behavioral health diagnoses.

This toolkit supports implementation planning for co-located services to meet patient needs. The approach is applicable to both the co-location of behavioral health into primary care (Article 28 host site) and the co-location of primary care into behavioral health (Article 31 or Article 32 host site). The toolkit also provides guidance on integrating substance abuse services into either an Article 28 and/or Article 31 host site.
PREPARING FOR IMPLEMENTATION

Establish Project Workgroup

PCBH Co-location Workgroup
As appropriate for your practice, establish a workgroup that includes individuals you think will be critical to your success in planning for implementation of this project. It will be important to include expertise from both primary care and psychiatry. Consider including workgroup members from a variety of backgrounds and roles, such as:

- Physician
- Nursing
- Social work
- Psychiatry
- Substance abuse specialists
- Care coordination/case management
- Pharmacy
- Health education
- Other relevant resources available in your setting

Implementation Leader
Identify an implementation leader to oversee the implementation. Specific tasks include:

- Engaging with clinical and administrative leadership to advocate for implementation and provide progress updates and reports
- Organizing workgroup and scheduling and facilitating meetings
- Ensuring that any necessary trainings are scheduled and attended
- Collaborating with OneCity Health to access support, training and materials
- Monitoring and troubleshooting implementation
- Ensuring that all steps of the project are completed on time

Clinical Champion(s)
A clinical champion must be well-positioned and able to engage, educate and lead others in the site-level implementation. Specific activities of the champion include:

- Engaging and advocating for co-location with clinical leaders
- Collaborating with clinical staff to ensure they have the tools and resources needed
- Working closely with the implementation leader to ensure that necessary training and support, including staff time, is in place
- Ensuring that the site’s implementation planning is geared towards effectively improving patient outcomes
IMPLEMENTATION PLANNING

<table>
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<th>Implementation Planning Goals</th>
<th>Implementation Toolkit Resources</th>
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<td>Appendix A: Standards of Care for Co-location of Primary Care and Behavioral Health Services</td>
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<td>Needs Assessment Tools</td>
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<td>Appendix B: Quality Improvement (QI) Activities</td>
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**Goal 1: Establish Clinical and Operational Standards for Co-location**

As the work of implementation planning begins, the workgroup should begin to discuss clinical and operational standards of care.

A framework for clinical and operational standards of care is provided in Appendix A. This framework addresses co-location of behavioral health services in primary care, co-location of primary care health services in behavioral health settings, and integration of substance abuse screening and treatment into both these settings. Review the Standards of Care for Co-location with your Workgroup to encourage a shared understanding of the goals for program design and planning. These standards may need to be adjusted to meet the needs and capabilities of your organization.

The workgroup may wish to consider both aspirational goals for clinical and operational standards that the organization can work towards over time, and short-term goals that can be operationalized in the shorter term with available staff, space, and funding.

**Goal 2: Conduct a Needs Assessment**

**PURPOSE**

A needs assessment will enable your organization to better understand the potential unmet demand for co-located services, and to estimate the percentage of patients with those needs who would be likely to engage the service. This projected volume will be used to plan for the...
number and type of staff required, as well as for space and equipment needed for co-located services.

**APPROACH TO NEEDS ASSESSMENT**

The site-specific needs-assessment process takes into account clinical data, current service utilization, and patient preferences.

If the host site is an Article 31 or an Article 32 behavioral health clinic, the needs assessment focuses on physical health conditions that would be triggers for utilization of primary care services. If the host site is an Article 28 primary care clinic, then the assessment focuses on behavioral health needs. Both Article 31 and Article 28 host sites should also consider the substance abuse treatment needs of their patients.

The following tools are available on the OneCity Health Website to conduct a needs assessment:

1. Tool for Article 28 Host Site: Needs Assessment and Estimation of Potential Patient Volume
2. Tool for Article 31 or Article 32 Host Site: Needs Assessment and Estimation of Potential Patient Volume

Using the information gathered in the needs assessment, the anticipated patient volume and characteristics of the patient population should be used to estimate needed resources for staffing and space.

When the ability to increase staffing or space is limited, the workgroup should consider approaches that target a manageable subset of the potential patient demand, for example, by focusing on subgroups of patients that clinical leadership identifies as being at higher risk of poor outcomes in the absence of co-located services.

**Goal 3: Explore Regulatory Options**

The workgroup should explore the various regulatory options that will facilitate co-location at their site. Practice sites have several regulatory options to support the co-location of primary care and behavioral health services:

- Existing license threshold limitations
- Integrated Outpatient Services (IOS) License
Implementation Toolkit: Primary Care and Behavioral Health Co-location

- DSRIP Threshold Waiver
- Establish a satellite clinic
- Partner with an outside organization

The following supporting materials are available on the OneCity Health Website to help guide the site to understand their regulatory options and decide which option to pursue:

- [Regulatory Options Webinar](#)
- [Regulatory Option Decision Tree for Article 28 Clinics to Co-locate Mental Health (MH) Services](#)
- [Regulatory Option Decision Tree for Article 28 and/or 31 Clinics to Co-locate Substance Use Disorder (SUD) Services](#)
- [Regulatory Option Decision Tree for Article 31 Clinics to Co-locate Primary Care (PC) Services](#)
- [DSRIP 3.a.i Waiver Application Steps](#)
- [Steps for applying for an Integrated Outpatient Services (IOS) License](#)
- [DOH Resources for PC-BH Integration](#)
- [Telehealth Guidance to Support the Integration of Primary Care and Behavioral Health](#)

The final decisions on regulatory options may not be made until further implementation planning is completed. Nonetheless, it is important to understand the regulatory options early in the implementation planning process.

⚠️ This toolkit provides guidance as to regulatory options, but is not intended to replace a health care organization’s independent legal, regulatory, and financial analysis as part of its internal planning activities. In addition, please note that the regulatory environment is subsequent to change over time.

**Goal 4: Conduct IT Assessment and Gap Analysis**

The workgroup should conduct an IT assessment and gap analysis to determine if any modifications need to made to the current IT systems to support co-location of services. The purpose of the Information Technology (IT) Assessment and Gap Analysis is to assess (1) readiness for clinical documentation of integrated services and (2) ability to provide information to the organization’s billing system to enable claims submission. The IT Assessment also evaluates the ability of the system to support best practices for use of electronic systems, such as “two level assessment” (in which a positive screening tests automatically leads to initiation of a follow-up assessment tool).

The IT Assessment and Gap Analysis tool is available on the OneCity Health website and is designed to be completed by a clinic administrator familiar with the operational use of the EHR.
Goal 5: Evaluate Financial Impact of Co-location

The financial impact of co-location will depend on site-specific factors including the result of the needs assessment, staffing models and related costs, and decisions about regulatory options.

The following Excel-based financial model templates are available on the OneCity Health website:

- Co-location Financial Model Template – Article 28 Host
- Co-location Financial Model Template – Article 31 or Article 32 Host

The model allows organizations to test the impact of different co-location approaches on financial outcomes. The workgroup should explore various implementation scenarios using the financial model to refine the implementation model.

Goal 6: Develop Implementation Plan

Based on the information gathered and the options that have been explored during this process, the workgroup should establish what model of integration the site would like to pursue and develop an implementation plan.

An Implementation Plan Template is available on the OneCity Health website and can be used to structure and document an implementation plan.

Goal 7: Conduct Ongoing Quality Improvement Activities to Assess Implementation

The workgroup should work to determine process and outcomes measures to be used to monitor progress and impact of implementation based on the co-location program design. The work will also include evaluate potential data sources that can be used to report on measures, designing regular reports for identified metrics to monitor implementation, and developing quality improvement activities to improve performance on process and outcomes metrics. Quality improvement (QI) resources can be found in Appendix B.
APPENDIX A: STANDARDS OF CARE FOR CO-LOCATION OF PRIMARY CARE AND BEHAVIORAL HEALTH SERVICES

INTRODUCTION

This section describes a suggested framework for co-location of behavioral health and adult primary care services. These standards of care address co-location of behavioral health services in primary care, co-location of primary care health services in behavioral health settings, and integration of substance abuse screening and treatment into both these settings.

This suggested framework should be reviewed and adjusted to meet the needs of your organization.

Principles that underlie this framework include:

- Organizations planning for co-location should define what populations they wish to serve in the co-located setting to inform resource needs assessment and allocation
- For patients whose needs cannot be adequately met in the co-located setting, they should be referred to an appropriate care setting
- Co-located care requires non-physician staffing roles, processes, and supplies; therefore, organizations should plan for these needs in advance
- In most primary care settings, the collaborative care/IMPACT model should be in place as a foundational requirement for embarking on co-location
- Over time, organizations may evolve their co-location model(s), for example, by broadening the scope of patients served by co-located providers and/or creating internal resources for services that previously required referral

PRIMARY CARE SETTING: TIERED APPROACH TO BEHAVIORAL HEALTH TREATMENT

- Patients with lower acuity behavioral health needs are appropriate for a collaborative care/IMPACT model supported by the primary care team:
  - Mild to moderate depression
  - Anxiety with mild symptoms
  - Severe mental illness (SMI) with stability
  - Uncomplicated substance use disorder

- Patients with serious mental health disorders (e.g., schizophrenia, bipolar disorder, severe depression, psychoses) may choose to be seen by a co-located psychiatrist or psychiatric nurse practitioner, preferably supported by psychologist or social worker

- Patients who are highly unstable and require substantial outreach will be offered care and others may choose to be seen in a discrete behavioral health setting
Patients may also benefit from a broader array of therapeutic interventions or may need access to specialized behavioral health care with high frequency that is available in a discrete behavioral health setting.

BEHAVIORAL HEALTH SETTING: APPROACH TO PRIMARY CARE SERVICES

- Patients in a behavioral health setting who have no or limited ongoing engagement with primary care may benefit from initiating care in an integrated setting.
- Patients are closely monitored and treated for side effects of drug therapy (e.g., cardiovascular disease and diabetes mellitus).
- Patients receiving primary care in a behavioral health setting should receive a standard range of primary care services either on site or via referral, including:
  - Annual physical examination and health assessment, vital signs with pulse oximetry, lab work, electrocardiogram, peak flow measurement
  - Age and risk factor driven disease screening and preventive care, including vaccinations and tobacco cessation
  - Women’s health services, including pap smears and contraception
  - Point of care testing as appropriate, such as pregnancy tests, stool for occult blood, urinalysis, rapid strep testing, and blood glucose
  - Periodic monitoring of chronic health conditions per plan of care, with registry functions to support panel management approach as available
  - Episodic care of acute conditions such as upper respiratory infection, rashes, minor injuries, etc.
  - Referral and coordination of care by specialists as needed
  - Referral to care management resources as appropriate
  - Processes to address quality metrics, including those monitored by managed care organizations

TIERED APPROACH TO CARE OF PERSONS WITH SUBSTANCE USE DISORDER IN EITHER PRIMARY CARE OR BEHAVIORAL HEALTH SETTINGS

- Patients with lower acuity substance use disorder needs may receive care by a primary care or behavioral health provider, in a collaborative care/IMPACT model with support as needed by an addiction specialist
  - Implementation of screening tools requires staff orientation and training, and integration of the use of such tools into clinic workflows
- Patients with more complicated substance use disorder issues may have a “warm hand-off” to a co-located substance use disorder professional who is embedded in the care setting.
Patients who are unstable and require substantial outreach will be offered an episode of brief treatment and encouraged to engage with a specialty substance use disorder treatment clinic for long-term or complicated substance use disorder services.

APPENDIX B: QUALITY IMPROVEMENT (QI) RESOURCES

The Plan, Do Study, Act (PDSA) Cycles is an example Quality Improvement resource to help your practice evaluate the implementation of linking high risk patients to care management resources through Health Home At-Risk at your site, and troubleshoot identified issues.

Plan, Do, Study, Act (PDSA) Cycles

The Plan-Do-Study-Act (PDSA) cycle is part of the Institute for Healthcare Improvement Model for Improvement, a simple yet powerful tool for accelerating quality improvement. Once a team has set an aim, established its membership, and developed measures to determine whether a change leads to an improvement, the next step is to test a change in the real work setting. The PDSA cycle is shorthand for testing a change—by planning it, trying it, observing the results, and acting on what is learned. This is the scientific method, used for action-oriented learning.

The steps in the PDSA cycle are:

Step 1: Plan—Plan the test or observation, including a plan for collecting data
Step 2: Do—Try out the test on a small scale
Step 3: Study—Set aside time to analyze the data and study the results
Step 4: Act—Refine the change, based on what was learned from the test

For more information:
http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx

# PDSA Worksheet for Testing Change - Template

## AIM

<table>
<thead>
<tr>
<th>PDSA Cycle #1</th>
<th>Person(s) Responsible</th>
<th>When to complete</th>
<th>Where to complete</th>
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<tr>
<td>(Every Aim will require multiple small tests of change)</td>
<td>Describe your test of change:</td>
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## PLAN

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<th>Person(s) Responsible</th>
<th>When to complete</th>
<th>Where to complete</th>
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## Predict what will happen when the test is carried out

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<tr>
<th>Indicator to measure if prediction succeeds</th>
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<tr>
<th>STUDY</th>
<th>Describe the measured results and how they compared to the predictions.</th>
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<th>ACT</th>
<th>Describe what modifications to the plan will be made for the next cycle from what you learned.</th>
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Sample QI Project Charter: Screening for Clinical Depression and Follow-Up Plan

What are we trying to accomplish?
To improve processes for universal screening for depression so that the screening rate increases to 90% and to ensure at least 40% of patients with a positive screen co-develop a follow-up plan with their primary care team as appropriate. We will accomplish this by:

- Developing a protocol for screening for depression so that each patient seen in primary care receives at least one PHQ-2/9 screening annually
- Developing a protocol for follow up plans for patients with a positive depression screen including referral criteria for Collaborative Care
- In-servicing staff on the depression screening protocol and follow up for positive screens
- Creating outreach strategies for patients that have not completed a PHQ-2/9 screen annually

How will we know that the change is an improvement?

- % of patients seen for any reason in a quarter that have had an annual depression screen
  - EMR report will be developed with analyst
- % of patients with a positive depression screen that received appropriate follow-up care
  - Clinical champion will conduct chart review of patients with a positive screen and evaluation of a follow up plan created in alignment with their preferences and clinic protocol
- % of staff and clinicians in-serviced on depression screening and follow up protocols
  - Implementation lead to track in-service attendance
- % of patients have not completed a PHQ-2/9 screen annually with at least one outreach attempt
  - EMR report will be developed with analyst

What changes can we make that will result in an improvement?
This quality improvement activity will include PDSAs conducted every quarter to test approaches to improve outcomes. Possible tests of change include:

- Does the depression screening rate improve when staff are trained on using a script to administer the PHQ-2/9?
- Will warm handoffs to the Collaborative Care team improve the percentage of patients with a positive depression screen that develop a follow up plan?
- Will telephonic outreach to patients that have not completed a PHQ-2/9 screen annually, improve the depression screening rate?
Sample QI Project Charter: Antidepressant Medication Management

What are we trying to accomplish?
To increase the rate of antidepressant medication management for patients prescribed an antidepressant to 40%. We will accomplish this by:

• Developing a protocol for treatment of depression and follow up by the Collaborative Care team
• In-servicing clinicians on depression treatment protocol and patient education regarding duration of antidepressant therapy and side effects
• Creating outreach strategies for patients that are prescribed an antidepressant to assess if medication is taken as prescribed

How will we know that the change is an improvement?

• % of patients with a diagnosis of depression and who were treated with antidepressants that remained on an antidepressant medication treatment for at least 6 months
  ○ EMR report will be developed with analyst
• % of clinicians in-serviced on the protocol for treatment of depression and follow up by the Collaborative Care team
  ○ Implementation lead to track in-service attendance
• % of patients diagnosed with depression and prescribed an antidepressant with at least one outreach attempt every 3 months
  ○ Registry report will be developed with analyst

What changes can we make that will result in an improvement?
This quality improvement activity will include PDSAs conducted every quarter to test approaches to improve outcomes. Possible tests of change include:

• Does antidepressant medication adherence improve with more frequent contact between the patient and the Collaborative Care team?
• Will telephonic outreach to patients diagnosed with depression and prescribed an antidepressant, improve medication adherence?
• Will a patient activation or self-management mobile app help patients improved medication adherence?
Sample QI Project Charter: Initiation and/or Engagement of Alcohol and Other Drug Dependence Treatment

What are we trying to accomplish?

To increase the rate to 18% of patients 13 years of age and older with a new episode of alcohol and other drug (AOD) dependence who initiated treatment within 14 days of the diagnosis and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit. We will accomplish this by:

- Developing a protocol for screening for substance abuse and engagement of treatment for those with a positive screen
- In-servicing clinicians on the protocol for screening for substance abuse and engagement of treatment for those with a positive screen
- Creating outreach strategies for patients that engaged in alcohol or other drug dependence treatment

How will we know that the change is an improvement?

- % of patients 13 years of age and older with a new episode of alcohol and other drug (AOD) dependence who initiated treatment within 14 days of the diagnosis and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit
  - EMR report will be developed with analyst
- % of clinicians in-serviced on the protocol for screening for substance abuse and engagement of treatment for those with a positive screen
  - Implementation lead to track in-service attendance
- % of patients diagnosed with alcohol and other drug dependence with at least one outreach attempt every week
  - Registry report will be developed with analyst

What changes can we make that will result in an improvement?

This quality improvement activity will include PDSAs conducted every quarter to test approaches to improve outcomes. Possible tests of change include:

- Will warm handoffs to the Collaborative Care team improve the percentage of patients with a positive substance abuse screen that develop initiate treatment within 14 days of the diagnosis?
- Does engagement in AOD treatment improve with more frequent contact between the patient and the Collaborative Care team?
- Will telephonic outreach to patients diagnosed with alcohol and other drug dependence improve initiation and engagement of treatment?
Sample QI Project Charter: Diabetes Screening for People with Schizophrenia or Bipolar Disease who are Using Antipsychotic Medication

What are we trying to accomplish?
To increase the percentage of diabetes screening tests to 80% over the next 6 months for adult patients diagnosed with schizophrenia or bipolar disorder that are dispensed antipsychotic medications. We will accomplish this by:

- Developing a protocol in one clinic setting to ensure these patients obtain a screening for diabetes at least annually
- In-servicing clinicians to obtain necessary information about the protocol to ensure their understanding
- Creating outreach strategies to effectively communicate the need to patients that they must come to the clinic to complete the test

How will we know that the change is an improvement?

- % of diabetes screening tests given to adult patients with schizophrenia or bipolar disorder that are dispensed antipsychotic medications
  - Utilize QI report in PSYCKES\(^2\) and data report developed in EMR
- % of providers in-serviced about the screening protocol
  - Implementation lead to track in-service attendance
- % of patients contacted to come to the specific clinic setting to complete the diabetes screening test
  - EMR report will be developed with analyst

What changes can we make that will result in an improvement?
This quality improvement activity will include PDSAs conducted every quarter to test approaches to improve outcomes. Possible tests of change include:

- Will telephonic reminders increase the diabetes screening rate for patients diagnosed with schizophrenia or bipolar disorder that are dispensed antipsychotic medications?
- Can monthly interdisciplinary team meetings with the on-site primary care team improve the diabetes screening rate for patients diagnosed with schizophrenia or bipolar disorder that are dispensed antipsychotic medications?

\(^2\) Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) for Medicaid: [https://www.omh.ny.gov/omhweb/psyckes_medicaid/about/](https://www.omh.ny.gov/omhweb/psyckes_medicaid/about/)
Sample QI Project Charter: Diabetes Monitoring for People with Diabetes and Schizophrenia

What are we trying to accomplish?
To increase the percentage of diabetes monitoring to 80% for adult patients diagnosed with diabetes and schizophrenia so that they have both an LDL-C and HbA1c test annually. We will accomplish this by:
- Developing a protocol in one clinic setting to ensure that patients diagnosed with diabetes and schizophrenia receive an LDL-C and HbA1c test at least once a year
- In-servicing clinicians to obtain necessary information about the protocol to ensure their understanding
- Creating outreach strategies to effectively communicate the need to patients that they must come to the clinic to complete appropriate tests

How will we know that the change is an improvement?
- % of patients diagnosed with diabetes and schizophrenia that have both an LDL-C and HbA1c test annually
  ▪ Utilize QI report in PSYCKES³ and data report developed in EMR
- % of providers in-serviced about the protocol
  ▪ Implementation lead to track in-service attendance
- % of patients contacted to come to the specific clinic setting to complete the appropriate tests
  ▪ EMR report will be developed with analyst

What changes can we make that will result in an improvement?
This quality improvement activity will include PDSAs conducted every quarter to test approaches to improve outcomes. Possible tests of change include:
- Will telephonic reminders increase the diabetes monitoring rate for patients diagnosed with diabetes and schizophrenia?
- Can monthly interdisciplinary team meetings with the on-site primary care team improve the diabetes monitoring rate for patients diagnosed with diabetes and schizophrenia?
- Will the creation of a registry of patients with diabetes and schizophrenia improve the care team’s ability to manage the diabetes control of this group of patients?
- Will additional health education/motivational interviewing improve compliance to diabetes monitoring?

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³ Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) for Medicaid: https://www.omh.ny.gov/omhweb/psyckes_medicaid/about/
Sample QI Project Charter: Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia

What are we trying to accomplish?
To increase the percentage of cardiovascular disease monitoring to 80% for adult patients diagnosed with cardiovascular disease and schizophrenia so that they have an LDL-C test annually. We will accomplish this by:

- Developing a protocol in one clinic setting to ensure that patients diagnosed with cardiovascular disease and schizophrenia receive an LDL-C test at least once a year
- In-servicing clinicians to obtain necessary information about the protocol to ensure their understanding
- Creating outreach strategies to effectively communicate the need to patients that they must come to the clinic to complete appropriate tests

How will we know that the change is an improvement?
- % of patients diagnosed with cardiovascular disease and schizophrenia that have an LDL-C test annually
  - Utilize QI report in PSYCKES⁴ and data report developed in EMR
- % of providers in-serviced about the protocol
  - Implementation lead to track in-service attendance
- % of patients contacted to come to the specific clinic setting to complete the appropriate tests
  - EMR report will be developed with analyst

What changes can we make that will result in an improvement?
This quality improvement activity will include PDSAs conducted every quarter to test approaches to improve outcomes. Possible tests of change include:

- Will telephonic reminders increase the cardiovascular disease monitoring rate for patients diagnosed with cardiovascular disease and schizophrenia?
- Can monthly interdisciplinary team meetings with the on-site primary care team improve the cardiovascular disease monitoring rate for patients diagnosed with cardiovascular disease and schizophrenia?
- Will the creation of a registry of patients with cardiovascular disease and schizophrenia improve the care team’s ability to manage the cardiovascular disease control of this group of patients?
- Will additional health education/motivational interviewing improve compliance to cardiovascular disease monitoring?

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⁴ Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) for Medicaid:
https://www.omh.ny.gov/omhweb/psyckes_medicaid/about/
Sample QI Project Charter: Preventive Care Screening for Physical Health Conditions (e.g. diabetes, cardiovascular disease, etc.)

What are we trying to accomplish?
To increase the percentage of at least one preventative care visit annually to 80% for patients enrolled in the substance use disorder clinic. We will accomplish this by:

- Developing a protocol in one clinic setting to ensure that patients diagnosed with a substance use disorder receive at least one preventative care visit at least once a year
- In-servicing clinicians to obtain necessary information about the protocol to ensure their understanding
- Creating outreach strategies to effectively communicate the need to patients that they must come to the clinic to complete appropriate screenings in their preventative care visit

How will we know that the change is an improvement?

- % of patients with at least one preventative care visit annually
  - Develop EMR report to track on-site and external preventative care visits
- % of providers in-serviced about the protocol
  - Implementation lead to track in-service attendance
- % of patients contacted to come to the specific clinic setting to complete their preventative care visit
  - EMR report will be developed with analyst

What changes can we make that will result in an improvement?
This quality improvement activity will include PDSAs conducted every quarter to test approaches to improve outcomes. Possible tests of change include:

- Will telephonic reminders increase adherence with recommendations to have an annual preventative care visits?
- Will additional health education/motivational interviewing improve recommendations to have an annual preventative care visits?
Sample QI Project Charter: Linkage to Primary Care Services

What are we trying to accomplish?
To increase the percentage of patients engaged in routine primary care services to 80%. We will accomplish this by:

- Developing a protocol in one clinic setting to assess if a patient’s physical health needs are being addressed by a co-located primary care provider or a primary care provider in the community
- In-servicing clinicians to obtain necessary information about the protocol to ensure their understanding
- Creating outreach strategies to effectively engage patients with co-located primary care provider

How will we know that the change is an improvement?

- % of patients that report seeing a primary care provider at least once a year
  - Develop EMR report to track on-site and external preventative care visits
- % of providers in-serviced about the protocol
  - Implementation lead to track in-service attendance
- % of patients contacted to come to the specific clinic setting to complete see the primary care provider
  - EMR report will be developed with analyst

What changes can we make that will result in an improvement?
This quality improvement activity will include PDSAs conducted every quarter to test approaches to improve outcomes. Possible tests of change include:

- Will telephonic reminders increase the engagement of patients with the co-located primary care providers?
- Will partnerships with primary care providers improve referrals and linkages to primary care?
- Will warm hand-offs to the co-located primary care provider improve engagement in care?
- Can monthly interdisciplinary team meetings with the on-site primary care team improve the engagement of patients in their physical health care?
- Will additional health education/motivational interviewing improve engagement with primary care?
Sample QI Project Charter: Management of Physical Health Conditions (e.g. diabetes, cardiovascular disease, etc.)

What are we trying to accomplish?
To increase the percentage to 50% of chronic disease management provided by the RN care manager for adult patients diagnosed with cardiovascular disease and/or diabetes. We will accomplish this by:

- Developing a protocol in one clinic setting to ensure that patients diagnosed with cardiovascular disease and/or diabetes receive treat-to-target interventions from the co-located primary care provider and the RN care manager
- In-servicing clinicians to obtain necessary information about the protocol to ensure their understanding
- Creating outreach strategies to effectively engage patients in ongoing chronic disease management activities

How will we know that the change is an improvement?
- % of patients diagnosed with cardiovascular disease with blood pressure control
  - Develop EMR report
- % of patients diagnosed with diabetes with HbA1c control
  - Develop EMR report
- % of providers in-serviced about the protocol
  - Implementation lead to track in-service attendance
- # of patients enrolled in the treat-to-target program with the RN care manager
  - EMR report will be developed with analyst

What changes can we make that will result in an improvement?
This quality improvement activity will include PDSAs conducted every quarter to test approaches to improve outcomes. Possible tests of change include:

- Can monthly interdisciplinary team meetings with the on-site primary care team improve the cardiovascular disease and diabetes care management?
- Will the creation of a registry of patients with cardiovascular disease and/or diabetes improve the care team’s ability to manage the chronic diseases of this group of patients?
- Will additional health education/motivational interviewing improve chronic disease management for patients with cardiovascular disease and/or diabetes?
Sample QI Project Charter: Improve Follow Up After Hospitalization for Mental Illness

What are we trying to accomplish?
To increase the percentage to 55% of patients who were discharged from an acute inpatient setting with a principal diagnosis of mental illness and who received follow-up care with a mental health practitioner within 7 days or 30 days after discharge.

- Identify data sources to receive timely alerts on discharges (e.g. PSYCKES\(^5\), alerts from the Regional Health Information Exchange (RHIO))
- Developing a protocol to identify appropriate patients for outreach and reach out to patients to ensure they have a follow-up appointment with a behavioral health provider and reschedule missed appointments as appropriate
- In-servicing clinicians to obtain necessary information about the protocol to ensure their understanding
- Create same-day appointment slots for follow up visits with a mental health practitioner

How will we know that the change is an improvement?

- % of patients who were discharged from an acute inpatient setting with a principal diagnosis of mental illness and who received follow-up care with a mental health practitioner within 7 days after discharge
  - Utilize QI report in PSYCKES
- % of patients who were discharged from an acute inpatient setting with a principal diagnosis of mental illness and who received follow-up care with a mental health practitioner within 30 days after discharge.
  - Utilize QI report in PSYCKES
- % of providers in-serviced about the outreach protocol
  - Implementation lead to track in-service attendance
- % of scheduled appointments for follow up after a mental health hospitalization
  - Scheduling report will be developed with analyst

What changes can we make that will result in an improvement?
This quality improvement activity will include PDSAs conducted every quarter to test approaches to improve outcomes. Possible tests of change include:

- Will same-day appointment availability improve the rate of follow up after a mental health hospitalization?
- Will telephonic reminders decrease the no-show rate for follow up appointments after a mental health hospitalization?
- Will partnership with nearby psychiatric inpatient units improve ability to connect patients to a follow up appointment upon discharge?

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\(^5\) Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) for Medicaid: [https://www.omh.ny.gov/omhweb/psyckes_medicaid/about/](https://www.omh.ny.gov/omhweb/psyckes_medicaid/about/)
OneCity Health Co-location of Primary Care and Behavioral Health Services Webinar Series. Throughout August 2017, OneCity Health hosted a series of webinars on the Co-Location of Primary Care and Behavioral Health Services for our ten pilot sites currently planning for co-location. Led by consultants from Grassi & Co., our vendor currently working with our pilot sites, the webinar recordings were posted on the following topics:

- Implementation
- Measures and Quality Improvement
- Billing Considerations
- Screening Tools and Approaches

To view the webinar recordings, click [here](https://example.com).

Mental Health Service Corps (MHSC). For sites who are participating in MHSC, a number of webinars (and some in person training) are offered throughout the year to support behavioral health integration. The information should be disseminated regularly via email to site champions as training opportunities are scheduled. If you are interesting in learning more about the MHSC and how to apply, please click [here](https://example.com).

SBIRT (Screening, Brief Intervention and Referral to Treatment). New York City Department of Health and Mental Hygiene’s (DOHMH’s) Online Learning Module in Screening, Brief Intervention and Referral to Treatment (SBIRT) is available [here](https://example.com) with continuing medical education (CME) for physicians.

Additionally, the New York State Office of Alcoholism and Substance Abuse Services (OASAS) is offering technical assistance resources and trainings to help our partners implement the [Screening, Brief Intervention and Referral to Treatment (SBIRT) program](https://example.com). To request OASAS SBIRT technical assistance and/or training, email SBIRTNY@oasas.ny.gov.

Bupreprophine. NYC DOHMH’s Buprenorphine Training and Technical Assistance Initiative provides free buprenorphine waiver training and technical assistance for physicians practicing in NYC. Buprenorphine is an effective medication for treatment of opioid use disorders, and can be prescribed in office-based primary care settings. Under current regulations, physicians are required to obtain a waiver to prescribe buprenorphine by completing a standardized, approved 8-hour training course on buprenorphine prescribing. For more information, including dates of upcoming trainings, please email buprenorphine@health.nyc.gov.