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2014 Model Practices

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2014 Model Practice

Responsiveness and Innovation:

Hennepin County Mental Health Center, (HCMHC) currently serves approximately 3800 adult clients annually, providing 1500 visits per month. Ninety percent of our adult clients meet criteria for Serious Mental Illness (SMI) or Severe and Persistent Mental Illness (SPMI). At least 60% have a co-occurring chemical health diagnosis. Many of our clients have co-occurring medical conditions (e.g., nicotine dependence, obesity, diabetes, hypertension), but about 66% do not have a primary care physician. Consistent with our safety net provider status, 88% of our clientele are members of households with incomes at or below the federal poverty level. Due to the nature and severity of their illnesses, many of our clients are easily and frequently lost to follow-up, discontinue psychiatric medications, and have symptom exacerbations with related medical and social concomitants that perpetuate unstable living, trigger chemical use, contribute to poor physical health, require visits to medical and psychiatric emergency rooms and often result in costly incarceration or psychiatric hospitalizations.Appointment failures for medication management are common for many of our clients. In fact, people are frequently referred to our services after being discharged from other programs/providers due to their poor attendance. We struggle to engage and retain clients who are poor and transient, often lacking practical means (e.g., phones, permanent addresses, transportation) through which we can maintain contact. Many of our SPMI clients are cognitively or situationally disorganized and are unable to navigate care systems. In an effort to treat those for whom other options may not exist, we have avoided dismissing clients due to attendance issues and have attempted to increase/improve their engagement/follow-through by establishing rapport and a strong treatment relationship, providing psychoeducation about their illnesses and the benefits of medication, and through comprehensive, responsive care when they do attend. For a portion of our clientele, these interventions have been less successful than hoped. Additionally, we have not adequately addressed the clinical, social, and financial repercussions of lack of engagement in our services.

Two years ago, the retirement of one of our staff psychiatrists necessitated the transfer of approximately 400 clients to other prescribers. In reviewing the caseload list, it was clear that many of the clients slated for reassignment had either or both sporadic attendance and high rates of appointment failure. Rather than reschedule the clients and perpetuate the no-show problem, we established a drop-in clinic for medication management services. Done initially as a pilot project, there are currently 375 clients on the drop-in clinic roster.

The drop-in clinic operates each Wednesday afternoon for approximately four hours and is staffed by two prescribers, 2-3 staff nurses and a contracted pharmacist. A clinical supervisor is available to assist with forms completion, problem-solving and general milieu management and a care coordinator is available as needed.

The benefits of this innovative quality improvement effort are demonstrated in the following ways:

1. The drop-in medication clinic was developed specifically for the segment of our population who are unable to consistently keep scheduled appointments. We recognize that due to their severe psychiatric symptomatology along with homelessness or unstable housing and other psychosocial barriers, these clients are impaired in their ability to stay organized, receive/utilize appointment reminder calls, and effectively participate in a more traditional outpatient treatment paradigm.
2. Members who were assigned to drop-in services were “invited” due to their attendance patterns. The outreach and invitation to these clients was deliberately scripted to be a welcoming invitation to come when they felt they needed to and receive the highest quality care, rather than a punitive response relegating them to a lesser service.
3. The drop-in model encourages and requires clients to practice self-efficacy and become more active participants in their wellness. They decide when to come and are encouraged to express their needs and preferences rather than being passive recipients of a behavioral health intervention.
4. Clients were informed of a maximum amount of time allowed to lapse between appointments (and were told no additional refills

would be provided beyond that) but no minimum time limit was imposed. Since clients were invited and encouraged to come as often as they felt they needed, we were aware of the potential attendance implications. However,, we felt it was vital to encourage/welcome frequent attendance for many clients who had been lost to follow-up, were not well known to us, had complicated treatment needs, and for whom we wanted to provide close monitoring due to numerous risk factors.

5. Through use of a “rooming visit” with a staff nurse, clients are assisted in organizing their thoughts and prioritizing their needs for the visit prior to their session with the prescriber. This facilitates a comprehensive assessment of their overall status and needs, ensures that the clients’ agenda is addressed, highlights the benefits of engagement and enables the prescriber and other members of the treatment team to respond appropriately. The prescribers are able to spend more time with each client, ensuring quality, comprehensive care.
6. No daily attendance cap was established. Again, we were mindful of implications of this, but wanted to communicate clearly to clients that if they managed to get to the Center during the drop-in time, they would be seen. In some cases, this may be a visit with staff nurse only, but we have found that this serves client needs quite well and is manageable for us.
7. We have integrated milieu management which is not normally done in a clinic setting. A Staff Nurse performs first level triage with every client signing in for drop-in. Clients can see that all are welcomed, witness the workflow in process, and feel confident that their turn will come and their needs attended to. The clinical supervisor also has presence in the waiting room which further supports a positive environment.
8. The drop-in clinic staff includes a pharmacist who provides comprehensive Medication Therapy Management, encompassing medication reviews, the assessment of current health and chronic disease states, client education on medications and health conditions, and communication with other Center staff and external care providers. In addition, she is able to have medications packaged and delivered to facilitate adherence to the prescribed regimen.
9. Because clients can attend when doing well or not and know that their overall health needs will be attended to, we serve as a hub or nucleus of their care and service integration. We serve as an informal health care home for many of our clients and are able to use our treatment relationship as leverage for linkage with other needed services.
10. Care coordination services enable us to “strike while the iron is hot” and assist clients with their ancillary service needs in real time.
11. More efficient use of scheduled appointment slots also allows improved access for non- drop-in clients.The development and establishment of the drop-in medication management clinic was based on the best practice evidence we had available to us as well as our own practice-based evidence. We knew we had a sizeable portion of our SMI and SPMI population that were frequently missing medication management appointments, were non-adherent to the prescribed medication regimen, struggled with co-occurring chemical health and medical conditions and were frequenting emergency rooms, the psychiatric emergency department housed in the County’s public hospital, and/or inpatient psychiatric facilities. Data showed us that scheduling appointments, often several months out, for many of these clients was neither efficient nor effective and that more flexible programming was necessary in order for us to meet the needs of the population and use our resources judiciously.

The application of evidence-based practice is evident throughout the routine interventions in the drop-in clinic. Standardized screening tools such as the Patient Health Questionnaire (PHQ-9), and the Dyskinesia Identification System: Condensed User Scale (DISCUS) are utilized for assessment, medications are prescribed in accordance with APA guidelines, illness-specific counseling is provided, and family education and support is offered. Additionally, clients are able to access other services that support more contemporary paradigms of independent housing, supported employment, socialization, and enhanced health and wellness, not simply medication adherence and avoidance of inpatient treatment.

As previously noted, the relationship between mental health and physical health has been well-researched and demonstrated. Every day in our Center we see how mental illness affects clients’ abilities to participate in health promoting-behaviors and how their poor physical health impeded their abilities to actively and consistently participate in mental health treatment and recovery. While not designed to specifically address the CDC Winnable Battles, the drop-in clinic infrastructure affords the provision of assessment and referral services for a number of co-occurring medical issues including obesity and nicotine addiction. Staff routinely collaborate with and refer to external providers for integrated care as well as to the Center’s expanded wellness education and smoking cessation services. Well aligned with the Healthy People 2020 initiative, the drop-in clinic addresses reduction of barriers to timely, proper psychiatric and medical care, assists client in obtaining and appropriately using needed medications, and engages clients with co-occurring chemical health issues who are easily lost to follow-up in more traditional treatment paradigms.

LHD and Community Collaboration:

The primary goals of the drop-in medication clinic were to reduce no-show rates while increasing engagement in services for an identified cohort of existing clients and determine the viability of this model to serve future clients who may be better served by less traditional outpatient treatment paradigms. To that end, the program aimed to increase accessibility, fortify treatment relationships, and increase clients' active participation in treatment and recovery efforts. It was hoped that these anticipated outcomes would also improve clients' functioning and quality of life, enhance their health and wellness, more aggressively target co-occurring chemical health issues, link clients to primary care and other ancillary services, and reduce the use of more costly care systems (e.g., emergency rooms, inpatient psychiatric facilities).As previously noted, the idea to pilot a drop-in medication clinic evolved in response to the retirement of a staff psychiatrist and the subsequent need to reassign several hundred clients. One-hundred twelve clients with no-show rates of at least 40% were identified for the project. One clinical supervisor acted as lead and recruited four direct service staff to participate in further planning and execution of the project: a psychiatrist, a clinical nurse specialist, a staff nurse and a pharmacist were selected based on their expertise as well as willingness to try a new method of practice. Since many of these clients had been lost to follow up and have complex needs and multiple barriers to care, we knew we needed to structure the drop-in visit differently. Typically, when a patient attends a medication management s/he is seen by the prescriber only for a 20-minute visit, except for occasional nurse visits for vital signs or DISCUS exam. It is not unusual for our under-engaged clients to attend an appointment with an emergency or under duress or pressure from a case manager, probation office, or landlord. Clients present with unmet physical and social needs in addition to their complex psychiatric conditions and the prescriber is left with the challenge of attempting to address the current crisis as well as attend to primary, underlying symptoms and issues. This can result in the client feeling like his/her priorities were not attended to and may unwittingly undermine the treatment relationship, thereby setting the stage for additional failed appointments. Additionally, this scenario is dissatisfying and demoralizing for prescribers whose commitments to providing comprehensive, quality care are compromised. In effort to address this "tyranny of the urgent" conundrum, we decided to expand the role of our staff nurse in drop-in clinic visits.

Several staff expressed reservations about implementing drop-in medication management services and we were aware that in addition to developing an infrastructure to efficiently operate the model, we need to foster staff buy-in as well. The initial skepticism about the potential benefits was overcome by constantly providing reassurance to the assigned staff, having a clinical supervisor available to address emergent difficulties, and using data to illustrate the impact of the program with respect to clinical outcomes, access to care, cost savings and client satisfaction.The success of the drop-in medication clinic is reliant and dependent on the collaboration and cooperation of Center staff. From the front desk receptionist to the psychiatrist, many staff members play an important role; we've worked together to review, refine and revise the process as necessary. For example, our support staff ensures that clients get signed in and complete forms, have word puzzles and games available to pass the time and are reassured that their turn will come. Our care coordinator may be called upon to assist a client in linking with a primary care provider. Clinicians regularly refer clients to drop-in when warranted by an appointment attendance barrier, symptom increase or concerns about medications or side effects. Our security guard assists with milieu management and ensures the safety of staff and clients. And our nurses and prescribers work collaboratively with the client and other staff to provide comprehensive, high-quality care.

While the practice is internal to the MHC, the project has strengthened our connections and fostered collaboration with community partners and stakeholders. The drop-in clinic demonstrates our commitment to ongoing efforts to improve the accessibility and responsiveness of our services. We know, anecdotally, that the project has reduced the number of visits to Acute Psychiatric Services (APS), the behavioral health emergency department in Hennepin County Medical Center and that the staff there appreciates this new, more responsive service option. Inpatient psychiatric facilities can now rely on the drop-in clinic for timely post-discharge follow-up. Clients and their family members, case managers and others in their support networks are pleased to have more immediate access to the psychiatric care team. Finally, the drop-in clinic supports and optimizes Hennepin Health (the County's safety net, integrated care system) through enhanced linkage with services across the continuum of care.

It is possible that there were unappreciated, or difficult to identify costs to the Center with the implementation of the drop-in clinic but there were no start-up costs, per se. In-kind costs included staff time to plan, develop and implement the drop-in clinic pilot. Existing staff were re-allocated requiring the adjustment to routine workflows and this may have resulted in some inefficiencies early on in the project. However, it is our perception that overall, savings were realized through reduced calls to nurse line with, for example, questions or concerns about symptoms or processing of refills, management of unrealized service capacity, and recaptured revenue.

When clients arrive for drop-in, they are asked to sign in and complete the PHQ-9 and a Drop-In Clinic Needs Form. They are greeted by a staff nurse who performs initial triage. In most cases, they then have a brief visit with a nurse who takes their vital signs, reviews the form, assesses their needs, and begins the chart note in the Electronic Health Record (EHR). Clients report that this few minutes with the nurse affords them an opportunity to settle in and better use their time with the prescriber. While the client is meeting with the prescriber, other staff are consulting and coordinating to address identified needs and are then able to follow up immediately with the client.

Evaluation:

The drop-in medication clinic achieved its primary goals of reducing no-show rates, reducing the number of clients lost to follow up, and increasing clients' participation in their treatment and recovery. Secondary goals of improved functioning, better health, enhanced quality of life, reduction in ED visits, and linkage with primary care are additional gains. In addition to the benefits realized by participating clients, the drop-in clinic has positively impacted service delivery for all of our clients as we have increased capacity for those able to attend scheduled visits. Finally, staff involved in the drop-in clinic report improved morale and job satisfaction.We achieved our goal to eliminate no-show rates and improve engagement for the initial cohort of 112 clients. The roster grew quickly; after two years in operation there are currently 375 clients, with a total of about 1300 visits, served in the Drop-In Clinic. Based on that number of clients, along with their 40% average no-show rate, it is estimated that 1200 appointments slots will have been able to be filled with clients more likely to attend their scheduled visit. Using a figure of $90 compensation from insurance per visit, we generated $108,000. Additionally, we have collected a similar amount from services provided through the drop-in clinic.

Assessing the project using the Institute of Medicine's STEEEP (safe, timely, effective, efficient, equitable and patient-centered) criteria demonstrates its value and credibility. Great care is taken to ensure that client visits to the Center are never harmful and that the accessibility afforded by the model allows for timely access to care. As previously noted, the services provided in the drop-in clinic are evidence-based. High standards and quality care are hallmarks of the program despite our client demographics and safety-net status. Efficiencies are realized by controlling no-show rates and minimizing unused, unbillable provider time. Finally, awareness of unmet client needs was a primary incentive to develop the drop-in clinic. The care is dependent on the establishment of a continuous treatment relationship with each client and is customized to suit their specific needs and preferences. (For example, some clients who refuse to participate in drop-in clinic but are unable to attend scheduled visits are offered an "appointment" in drop-in clinic; they don't have to wait in queue and we don't expend unnecessary resources if they fail to attend.) The structure of the Need Form and the initial interview communicate to the client that they control the visit; common feedback reflects client perceptions of being "heard" when they attend. Family and other caregivers are encouraged to attend and participate in accordance with the clients' wishes. We share an Electronic Health Record (EHR) with an extensive network so collaboration and information exchange among care givers is enhanced.

While we hope to devise and implement an outcome evaluation system for our services in the future, at this time we have very limited ability/resources to collect and analyze hard data. However, with regard to ED visits, psychiatric hospitalizations, etc., we feel certain that our efforts have decreased use of these more costly services. Many clients report improved medication adherence and symptom reduction contributing to increased productivity and social functioning, improved health and enhanced quality of life as illustrated by the following examples:

- One client, in service here for eight years for Bipolar Disorder and polysubstance use, reported that the drop-in clinic "saved my life." He is more comfortable on his medications and takes them as prescribed, is maintaining sobriety, has not been incarcerated in two years, and recently married.
- Another client, with a long history of Schizoaffective Disorder and challenging waiting room behaviors, has recently found housing,is following through with chemical health treatment and is considering enrolling in college. He often calls to let his provider know when he isn't coming so she doesn't worry.
- A young woman with a long history of Major Depressive Disorder, Posttraumatic Stress Disorder and polysubstance abuse is well-known to many of the staff here due to disruptive behaviors and poor treatment compliance. In the past, she has had frequent contact with substance abuse treatment programs, law enforcement, Child Protective services, etc. Her participation in the drop-in clinic has afforded the establishment of a solid working relationship with her prescriber as well as other staff and resulted in improvements that would not have been anticipated. She is sober, has extricated herself from an abusive relationship, successfully completed a Child Protection case plan, is parenting appropriately and following through with recommended services.
- Several clients are reporting/evidencing linkage with primary care and improvements in their health status. Some have been able to acquire and maintain housing due to their increased stability and have discovered enhanced ability to engage in and benefit from chemical health, educational and vocational programming as well as other rehabilitative endeavors. Others are reporting improved interpersonal functioning, helping build a more stable support system.Initially, many clients expressed skepticism and reluctance to participate in the drop-in clinic. We had challenges to the waiting room milieu with over-crowding, long wait times and client dissatisfaction with being seen out of order, but we persisted. Complaints decreased as we made adjustments to the milieu and workflow and as clients attended and discovered that they received ample attention and quality care. Client input was solicited via a four-question survey with respect to convenience, access to information, interest in returning and satisfaction with services. The most recent analysis of the data reflects overall client satisfaction with the drop-in clinic at 97%.

A desirable, but not necessarily expected benefit, has been the gains reported by the staff related to their skill enhancement, increased client contact, expanded collaboration with the prescriber, higher morale and general job satisfaction. Because the link between employee well-being and successful service delivery is well-established, we are confident that this outcome inspires and assures continued success of the program.

Sustainability:

The implementation of the drop-in medication clinic has afforded improvements in client access, efficiency in resource utilization, provision of quality care, integration of care and staff satisfaction. These gains highlight the importance of ensuring its continuation and we have made significant steps in this regard.As demonstrated, we have made numerous enhancements to the pilot utilizing a rapid cycle improvement strategy. Internal challenges of staff uncertainty, waiting room congestion, workflow struggles, etc. have been summarily addressed. For example, as problems were identified with the waiting room milieu, changes were made to the rooming process so that clients could be triaged more quickly. As the needs dictated, additional care coordination services were embedded. We have added an option to our phone line so that drop-in clients can be certain their provider is available before coming to the Center. Additional issues that threatened to undermine its success such as the potential refusal of insurance providers to offer transportation to "non-scheduled" appointments were successfully managed through consultation with the carriers.

Drop-in services for a population of adults with chronic mental illnesses who have significant biopsychosocial needs pose many challenges. It is difficult to control client volume on any given day and the needs of those presenting for services can be immensely complex and far exceed the program's stated purpose of providing outpatient psychiatric medication management. However, the barriers experienced by many of our clientele and the positive outcomes of the program serve as regular reminders of its importance and the far-reaching impact it can have on this challenging, underserved population.

As a result of the drop-in clinic's success, the Center replicated and expanded drop-in services to include all prescribers, allowing us to extend the reach of our program without sacrificing quality of care. All Center clients now have the ability to see their prescriber on a drop-in basis, offering improved accessibility and responsiveness while guaranteeing the same excellent treatment. We will continue to assess the program, and identify and implement continuous quality improvements that will ensure the sustainability of this innovative method of service for our clients.

How did you learn about the Model Practices Program:

Colleague in my LHD

Overview:

Hennepin County encompasses 46 municipalities within 600 urban and suburban square miles of the greater Minneapolis-St. Paul Twin Cities Metro area. With its staff of 300 dedicated professionals, Hennepin County Public Health is the primary provider of public health services to the county's 1.1.million residents. Hennepin County Public Health takes a comprehensive approach to:

- Promote physical and mental health
- Prevent illness and injury caused by chronic and infectious diseases and environmental conditions
- Diagnose and treat serious mental health conditions
- Reduce the impact of chronic diseases including depression, heart disease, cancer and diabetes among all county residents.

We achieve these goals by increasing access to care and opportunities for all county residents to make the choices (prenatal through lifetime) that enable longer/healthier lives; by ensuring healthy environments where we all live, learn, work and play, and by aligning our efforts with other community health improvement partners.

More recent approaches to public health now recognize mental health as part of the public health agenda. There is growing evidence that demonstrates that psychiatric disorders are among the leading causes of reduced productivity and impaired social functioning. The 2010 Global Burden of Disease study concluded that mental illnesses contributed to a lifetime of disability as much or more than cardiovascular disease or cancer. This emphasis on the contribution of psychiatric illness to disability and disease burden illustrates the need to integrate mental health prevention, treatment and recovery into public health programming.

Consistent with this paradigm shift, the Public Health Department subsumed the County's behavioral health clinic in 2010, signaling a new understanding and laying the foundation for integrated care and increased collaboration among providers. As part of the County's Human Services and Public Health Department, Hennepin County Mental Health Center (HCMHC) provides behavioral health services to adults with serious mental illness/serious and persistent mental illness. Many of our clients have several psychiatric disorders along with accompanying chemical health or medical issues. As the County's safety net provider, our clientele is comprised of many poor, often transient or homeless persons whose unmet/complicated social needs undermine their ability to adequately engage and participate in their health care. For many years, we have struggled to address the dilemma of attempting to serve a population too ill or disabled to engage in the treatment they sorely need, at least as it has been traditionally offered. Historically, the Center has providers with large caseloads, long wait times for appointments and a high no-show rate which further potentiates the challenges posed by our under-engaged clients and undermines the Center's sustainability. In addition to our practice-based evidence, the increasing awareness of untreated or under-treated mental illness as a public health problem required us to improve our clients' access to and engagement in their care.

Born of necessity, we planned, developed and implemented a drop-in medication management clinic for an identified group of clients with high no-show rates, poor engagement in care and complex treatment needs. The drop-in clinic provides needs assessment, evaluation and treatment, medication management, prescription services and care coordination and makes referral to numerous in-house and external ancillary services.

Started as a pilot project with 110 clients, there are currently 375 clients being served in the drop-in clinic. The project met its initial objectives of offering clients an alternative to scheduled medication management appointments and mitigating the impact of the high no-show rate for the identified cohort. As outlined in subsequent sections of this document, the success of the program is due to a variety of factors including the creativity and courage of the pilot staff, the deliberate marketing of the pilot as a desirable service option, and the willingness of the clients to offer thoughtful, helpful feedback. The application of rapid cycle change strategies allowed us to make quick improvements along the way. It is noteworthy that due to the success of the pilot, all Center prescribers now have drop-in hours available to better serve their clients and proactively manage schedules to minimize unused clinical time.