NYC Health

THE NEW YORK CITY DEPARTMENT of HEALTH and MENTAL HYGIENE

DIVISION OF MENTAL HYGIENE

FY07 CQI Project Workbook

Improving Mental Health Services for Children and Families

Quality IMPACT: An Initiative of the Division of Mental Hygiene New York City Department of Health and Mental Hygiene

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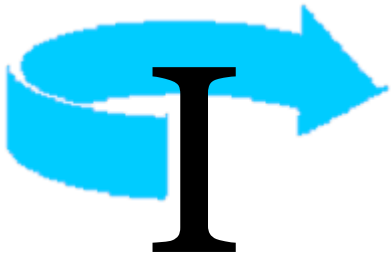

INTRODUCTION TO QUALITY IMPACT

Introduction to Quality IMPACT

We welcome your participation in the Quality IMPACT initiative in FY07. This workbook has been designed to assist you in implementing your Quality IMPACT Priority Project.

The workbook will guide you through the key steps in implementing your project. It includes the tools and information necessary to establish timeframes; develop, implement and evaluate interventions; collect baseline and outcome data; and integrate improvements into the program workflow. Along with the three Interactive Project Group meetings, the monthly team leader phone calls, and technical assistance from your special consultant and the Quality IMPACT team, this workbook will aid you in successfully completing a Quality IMPACT CQI project.

We welcome you as a participating provider in the third year of Quality IMPACT. We look forward to working and learning with you!

Dr. Lily Tom and Cheryl King, Co-Chairpersons

DMH Quality IMPACT Initiative

Acknowledgments

FY07 Workgroup

DOHMH is grateful to the following persons who served on the CQI project Workgroup, which helped to shape this project. This workgroup helped plan the project's indicators, and work on overall project design. We are very grateful for their commitment of time and their expertise.

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II

Project Overview & Timeline

Improving Mental Health Services for Children and Families

Project Introduction

The Importance of Improving Services for Children and Families

Recent studies suggest that 17% to 26% of the children in the U.S. are in need of mental health care, and that rates for those in urban, low-income communities may be as high as 40%. The majority of children with mental health problems do not receive any type of mental health services. Furthermore, among those who receive some services, no-show rates for appointments may be as high as 50% and premature terminations after two or three sessions are common. Research findings suggest family/caregiver perceived involvement in the treatment planning process is key to the engagement of families in mental health services.[1]

From 2004 to 2005, the New York State Office of Mental Health (OMH), the Citizens' Committee for Children, the New York City Department of Health and Mental Hygiene (DOHMH), and the Mount Sinai School of Medicine implemented the 9-month quality improvement project the "Learning Collaborative to Improve Engagement and Retention of Children and Families in Treatment." The Collaborative found that evidence-based engagement interventions and quality improvement methods were effective in improving rates of initial engagement of children in outpatient mental health clinic services.

The goal of this continuous quality improvement (CQI) project is to improve the quality of mental health care for children by expanding upon the quality improvement collaborative project mentioned above. This project will incorporate family-oriented and strength-based approaches in the development of trainings and interventions to enhance the effectiveness of services for children and their families/caregivers.

Description of the CQI Project

This DOHMH Quality IMPACT priority project was developed by incorporating the experiences of programs in the Learning Collaborative, with input from a workgroup of local stakeholders (community providers, family and youth advocates, OMH staff, and DOHMH staff). This workgroup met regularly to discuss the key issues in child and family/caregiver engagement, and to construct meaningful and measurable indicators of quality in these areas.

Two of the indicators for this project are the show rate for first visits and the show rate for ongoing visits, as these are areas perceived by many clinics to be useful indicators of initial and continuing consumer engagement. Programs will also submit data on the proportion of discharges due to nonattendance along with a measure of the extent

[1] McKay, M., Bannon, W. (2004). Engaging families in child mental health services. Child and Adolescent Psychiatric Clinics of North America, 13, 905-921.

to which family members/caregivers perceive participation in the treatment planning process. The latter is to be measured with the Family Participation Measure[2] (FPM), a short self-administered questionnaire, to be completed at the time of first treatment plan review. This questionnaire is designed to elicit family member/caregiver perceptions of involvement in treatment planning for the child.

Implementing the CQI Project

Provider participation and progress in the project will be documented through the submission of data collected each month and submitted four times throughout the project year along with a summary of interventions the program has implemented to effect change in the target areas. Specifically, programs will collect data pertaining to: 1) the attendance of youth for first appointments; 2) the ongoing show rate of youth for all subsequent appointments; 3) the percentage of youth discharges due to nonattendance, and 4) the participation of families/caregivers in the treatment planning process as indicated by scores on the Family Participation Measure. On a bimonthly basis, programs will also submit an updated *Interventions for Incremental Change* summary worksheet detailing the interventions they have initiated.

Providers will submit data on the four core indicators listed above to DMH and, in addition to these required indicators and the summary of interventions worksheet, they are encouraged to collect data on additional optional indicators designed to determine the success of their quality improvement efforts. DMH has developed a menu of optional indicators that providers can choose from to assist their team in measuring success.

In addition to the submission of materials described above, programs will participate in monthly conference calls with the CQI team leaders and other programs participating in the project. Finally, programs will attend three interactive project group (IPG) meetings during the 9-month project year. DOHMH requests that two members of the quality improvement team from participating programs attend each IPG. Throughout the project, DOHMH will offer technical assistance, statistical support, guidance, training, and feedback to participating programs.

[2] The Family Participation Measure (FPM) is a 7-item instrument developed and validated by the Research and Training Center on Family Support and Children's Mental Health at Portland State University in Portland, Oregon. For more information on the FPM, see www.rtc.pdx.edu/pgProjParticipation.php.

Improving Mental Health Services for Children and Families

FY07 PROJECT TIMELINE

Important Dates:

- **June 23, 2006:** First Interactive Project Group (IPG) Meeting
- **September 8, 2006:** FY07 Project Plan Sheet due
- **September 2006:** Second IPG Meeting —To Be Announced
- **January 2007:** Third IPG Meeting —To Be Announced
- **April 30, 2007:** FY07 Final Project Outcomes Sheet and completed FY07 PDCA Cycles Worksheet due

Bi-Monthly Reporting:

- Submissions include Data Reporting Form (DRF) and FY07 PDCA Cycle Worksheet (August 2006 – March 2007)

Monthly Conference Calls:

- Participate in monthly conference calls with CQI team leaders and DMH Staff (July 2006 – April 2007).

- The calls are scheduled for **11am-12pm** on the second or third **Tuesday** of each month except September and January which will instead feature an IPG:

    - July 18th
    - August 8th
    - October 10th
    - November 21st
    - December 12th
    - February 13th
    - March 13th
    - April 10th

The calls will last for one hour. A toll free dial in number participant code for access to the conference call will be provided.

Improving Mental Health Services for Children and Families

Baseline Indicators

The goal of this project is to improve the engagement and continuation of children in mental health programs, as well as to increase family/caregiver participation in treatment planning. The indicators defined below measure progress toward this goal. **These indicators are required of all participating programs.**

The baseline indicators are a "snap-shot" in time, designed to identify specific measures of engagement at your program before the start of this CQI project. Programs will submit baseline data for the time period April 1 –June 30, 2006.

For important information on these indicators and their definitions, see the "Detailed Description of Indicators" section.

INDICATOR 1: INITIAL ENGAGEMENT

- For visits from April 1-June 30, 2006, determine the percentage of expected **first** visits kept.

$$\frac{\text{\# of expected first visits kept}}{\text{\# of expected first visits}}$$

INDICATOR 2: ONGOING ENGAGEMENT

- For visits from April 1-June 30, 2006, determine the percentage of expected **ongoing** visits kept (ongoing visits are visits after a consumer's first face-to-face visit).

$$\frac{\text{\# of expected ongoing visits kept}}{\text{\# of expected ongoing visits}}$$

INDICATOR 3: DISCHARGE DUE TO NON-ATTENDANCE

- For discharges completed from April 1-June 30, 2006, determine the percentage of all discharges due to consumer non-attendance.

$$\frac{\text{\# of discharges due to non-attendance}}{\text{Total \# of discharges}}$$

Improving Mental Health Services for Children and Families

Core Indicators

The goal of this project is to improve the engagement and continuation of children in mental health programs, as well as to increase family/caregiver participation in treatment planning. The indicators defined below measure progress toward these goals. **These indicators are required of all participating programs.**

Core Indicators will be collected monthly and submitted to DOHMH throughout the CQI project year. Comparing your baseline and core indicators allows you to measure your progress over time. Each core indicator has a target to be met. All indicators are constructed as ratios with a numerator (on the top) and denominator (on the bottom). This ratio will be multiplied by one hundred, to yield a percentage.

For important information on these indicators and their definitions, see the "Detailed Description of Indicators" section.

INDICATOR 1: INITIAL ENGAGEMENT

- Show rate for **first** visits: Determine the percentage of expected first visits kept. *The target for this indicator is 80%.*

$$\frac{\text{\# of expected first visits kept}}{\text{\# of expected first visits}}$$

INDICATOR 2: ONGOING ENGAGEMENT

- Show rate for **ongoing** visits: Determine the percentage of expected visits kept after consumers' first face-to-face visit. *The target for this indicator is 80%.*

$$\frac{\text{\# of expected ongoing visits kept}}{\text{\# of expected ongoing visits}}$$

INDICATOR 3: DISCHARGE DUE TO NON-ATTENDANCE

- Determine the percentage of all discharges due to consumer non-attendance. *There is no set target for this indicator; programs should set a target based on their baseline information.*

$$\frac{\text{\# of discharges due to non-attendance}}{\text{Total \# of discharges}}$$

INDICATOR 4: FAMILY PARTICIPATION

- Family participation in treatment planning at the time of first treatment plan review, as measured by scores on the Family Participation Measure (FPM). Determine the percentage of family members/caregivers who score higher than 3 on the FPM. *There is no set target for this indicator; programs should set a target based on their data from the first month of data collection.*

$$\frac{\text{\# of family members/caregivers scoring higher than 3 on the FPM}}{\text{\# of family members/caregivers completing the FPM}}$$

Also, calculate the FPM response rate:

$$\frac{\text{\# of FPM questionnaires completed}}{\text{\# of children with a completed first treatment plan review}}$$

Detailed Description of Indicators

INITIAL AND ONGOING ENGAGEMENT (INDICATORS 1 & 2):

SEE CHARTS OF EXAMPLES AT THE END OF THIS SECTION*

- **"Expected visits":**
  Expected visits are visits that, at the time of appointment, were expected to occur. If a consumer cancels an appointment at any point before the visit, the appointment is no longer "expected."
    - Include all types of appointments for visits (assessment, treatment, group therapy, etc.)

- **"Visits kept":**
  If a consumer shows up during the appointment time (even if he or she shows up late), the visit is considered to be "kept."
    - If your program already has specific guidelines regarding how late a consumer can be before a scheduled visit can no longer take place, you can instead use this guideline to define "visits kept." Please tell DMH what criteria you are using.

    - If a consumer arrives for a visit, but the visit cannot take place due to circumstances in the clinic, the visit should be considered kept.

- **"First visits":**
  Expected first visits are visits that, if kept, would be a consumer's first face-to-face visit with your program.
    - *If a consumer's first visit is a walk-in*, this indicator is not relevant.[1]
        - *In examples section, see Jane's pattern of engagement*
    - *If a consumer cancels the first scheduled visit and reschedules*, the rescheduled visit is the one counted in the denominator of this indicator (because it would be their first face-to-face visit with your program, and the cancelled visit was no longer "expected").
        - *In examples section, see John's Week 2 and 3*
    - *If a consumer does not show up for the first scheduled visit and then reschedules*, both visits are counted in the denominator of this indicator (and the numerator will include only one *kept* first visit).
        - *In examples section, see John's Week 1 and 3*

[1] For programs with only walk-ins for their first face-to-face contact, Indicator 1 does not apply. However, such programs are encouraged to gather data on the first contacts at their program for which consumers make appointments, or to gather data for another indicator related to consumer engagement.

- **"Ongoing visits":**
  Ongoing visits are all face-to-face visits that occur after a consumer has had a first face-to-face visit at your program.
  - For programs in which all first visits are walk-ins, all visits scheduled afterwards by appointment are "ongoing visits." (See footnote 1)
    - *In examples section, see Jane's pattern of engagement*
  - Ongoing visits may all be treatment visits, or may also include assessment visits if your program has more than one assessment visit.

DISCHARGE DUE TO NON-ATTENDANCE (INDICATOR 3)

Your program should determine and consistently use a specific definition for "discharge due to non-attendance." In order to be consistent and meaningful, it should address issues such as how many no-shows are cause for discharge, how to handle cases in which a consumer expresses interest in continuing treatment, and whether to count cases in which a consumer does not attend but also verbally expresses that they want to discontinue treatment. **On your data submission sheet, please note what definition you are using.**

FAMILY PARTICIPATION (INDICATOR 4)

Based on scores on the FPM survey that will be administered at first treatment plan reviews, determine the proportion of surveys with a score of *higher than 3* (*do not* include those equal to 3).

For information about administering and scoring the FPM, as well as collecting the necessary response rate data, see the Family Participation Measure section on page 16.

EXAMPLES FOR CALCULATING ENGAGEMENT INDICATORS:

Indicators 1 and 2 can be calculated from an appointment book. One way to calculate aggregate show rates is for each clinician to track their appointments. For example:

CLINICIAN 1'S APPOINTMENTS ON MONDAY:

		APPOINTMENT 1	APPOINTMENT 2	APPOINTMENT 3	APPOINTMENT 4	TOTAL FOR EACH INDICATOR:
	MONDAY →	Consumer A cancelled scheduled *1st visit*	Consumer B showed up for *ongoing visit*	Consumer C didn't show for scheduled *ongoing visit*	Consumer D showed up 15 minutes late for *1st visit*	
INDICATOR 1 INITIAL ENGAGEMENT	**NUMERATOR**	0 *(cancellations not counted)*	Not applicable	Not applicable	1	= **1** / **1**
	DENOMINATOR	0 *(cancellations not counted)*	Not applicable	Not applicable	1	
INDICATOR 2 ONGOING ENGAGEMENT	**NUMERATOR**	Not applicable	1	0	Not applicable	= **1** / **2**
	DENOMINATOR	Not applicable	1	1	Not applicable	

ILLUSTRATION OF INITIAL AND ONGOING ENGAGEMENT (FOR INDICATORS 1 AND 2):
You do not need to track show-rates by individual consumers in order to calculate the aggregate show-rate indicators (Indicators 1 and 2). However, the following hypothetical examples of individual consumers are provided to illustrate the concepts of initial and ongoing engagement.

JOHN'S PATTERN OF ENGAGEMENT DURING MONTH X AT PROGRAM Y:

		WEEK 1	**WEEK 2**	**WEEK 3**	**WEEK 4**	**TOTAL** FOR MONTH X INDICATOR:
	WHAT DID JOHN DO? →	No-show for scheduled 1st visit	Cancelled scheduled 1st visit	Showed up, *1st visit*	Showed up, *Ongoing visit*	
INDICATOR 1 INITIAL ENGAGEMENT	**NUMERATOR**	0	0 *(cancellations not counted)*	1	Not applicable	= **1**
	DENOMINATOR	1	0 *(cancellations not counted)*	1	Not applicable	**2**
INDICATOR 2 ONGOING ENGAGEMENT	**NUMERATOR**	Not applicable	Not applicable	Not applicable	1	= **1**
	DENOMINATOR	Not applicable	Not applicable	Not applicable	1	**1**

JANE'S PATTERN OF ENGAGEMENT DURING MONTH X AT PROGRAM Y:

		WEEK 1	**WEEK 2**	**WEEK 3**	**WEEK 4**	**TOTAL** FOR MONTH X INDICATOR:
	WHAT DID JANE DO? →	Walk-In, *1st visit*	Showed up, *Ongoing visit*	Showed up 15 minutes late, *Ongoing visit*	No-show for scheduled visit	
INDICATOR 1 INITIAL ENGAGEMENT	**NUMERATOR**	0 *(walk-ins not counted)*	Not applicable	Not applicable	Not applicable	= **0**
	DENOMINATOR	0 *(walk-ins not counted)*	Not applicable	Not applicable	Not applicable	**0**
INDICATOR 2 ONGOING ENGAGEMENT	**NUMERATOR**	Not applicable	1	1	0	= **2**
	DENOMINATOR	Not applicable	1	1	1	**3**

AGGREGATE FOR MONTH X AT PROGRAM Y (John's show rates + Jane's show rates):

INDICATOR 1 INITIAL ENGAGEMENT	=	# of expected 1st visits kept / # of expected 1st visits	= **1/2**
INDICATOR 2 ONGOING ENGAGEMENT	=	# of expected ongoing visits kept / # of expected ongoing visits	= **3/4**

Improving Mental Health Services for Children and Families

Optional Indicators

While the required core indicators are quite general, we strongly encourage you to also gather data that will be more specific to issues on which you will focus in your CQI project. Below are suggestions for optional indicators that you can use to track the effects of your quality improvement efforts. These indicators are written in a general format; for each indicator that you will use in your program, be sure to develop specific definitions of terms (see example at the end of this section).

For each indicator, you should set a target based in part on your baseline data. You do not need to submit bimonthly data on these indicators to DMH, however, you should include them in your final project outcomes sheet (and in your submissions of PDCA cycles, when relevant).

1. WAITING LIST AND TIMELINESS

Programs aiming to address a waiting list or other periods of "lag time" in services can choose from a variety of indicators to collect data on time spans. Spans can be measured as mean, median, or proportion with time span less/greater than X days. COPS programs in particular may wish to develop an indicator about the time between first and second visits. You can use these indicators to track either when a visit is scheduled or when a visit is kept, depending on what aspect of services you want to address.

Examples:

a. Average number of days between referral date and 1st scheduled treatment appointment:

$$\frac{\text{Sum (Days of wait time between referral and 1st scheduled treatment appointment for each consumer)}}{\text{\# of consumers given 1st treatment appointment}}$$

b. Proportion of consumers waiting less than X days between admission and 1st treatment appointment:

$$\frac{\text{\# of consumers given 1st treatment appointment within X days after admission}}{\text{\# of consumers given 1st treatment appointment}}$$

c. Average number of days between admission and 1st kept visit:

$$\frac{\text{Sum (Days of wait time between admission and 1st kept visit for each consumer)}}{\text{\# of consumers attending 1st visit}}$$

2. CANCELLATIONS

Proportion of scheduled visits cancelled within 24 hours of an appointment.

$$\frac{\text{\# of visits cancelled within 24 hours before the appointment}}{\text{\# of visits scheduled}}$$

3. Engagement of Specific Consumer Subgroups

Engagement for specific subgroups (e.g. demographic groups, consumers with a particular diagnosis or treatment modality, etc) of the overall consumer population. *For explanations of "expected" and "kept" visits, see the Appendix on "Detailed description of indicators."*

Examples:

$$\frac{\text{\# expected visits kept by new consumers}}{\text{\# expected visits by new consumers}}$$

$$\frac{\text{\# expected visits for group therapy kept}}{\text{\# expected visits for group therapy}}$$

4. Punctuality

The proportion of visits beginning on time or within a specific set time span of the appointment time.

$$\frac{\text{\# of visits beginning within X minutes of appointment time}}{\text{\# of appointments for which consumers show up}}$$

5. Continuation

Consumers' continuing engagement in services. These indicators are especially helpful in measuring individual-level engagement (as opposed to aggregate show-rates). Be sure to include only consumers with the same scheduled frequency of visits (e.g., weekly visits), or to account for frequency when interpreting the data.

Examples:

a. Continuation for consumers 30 days after admission:

$$\frac{\text{\# of consumers attending at least X visits in 30 days since admission}}{\text{\# of consumers who, this month, completed their } 30^{th} \text{ day since admission}}$$

b. Continuation for consumers being discharged:

$$\frac{\text{\# of discharged clients who attended at least X visits since admission}}{\text{\# of clients discharged}}$$

6. Capacity

The capacity of a program to serve new clients. In order to be able to increase capacity, you must first address the timeliness of intake, treatment, and discharge.

$$\text{\# of new client admissions in a month}$$

7. Referrals Out

The number of, and/or reasons for, a program's referral to another facility of consumers who they have not admitted into treatment. You can track this for consumers who request services by phone and are referred out at that point, for consumers that were assessed at your program, or for both.

Examples:

a. Number of referrals:

$$\frac{\text{\# of consumers in the denominator who were referred to another program}}{\text{\# of consumers who requested services or were assessed by the program}}$$

b. Reason for referrals:

$$\frac{\text{\# of consumers in denominator who were referred out due to the program's lack of services in their language}}{\text{\# of consumers who requested services or were assessed by the program}}$$

8. FOLLOW-UP AFTER DISCHARGE FROM INPATIENT FACILITY

Proportion of consumers attending follow up visits within a specific amount of time after being discharged from an inpatient facility.

$$\frac{\text{\# of consumers discharged from inpatient units who attend their first follow-up appointment}}{\text{\# of consumers discharged from inpatient units who have a follow-up appointment scheduled}}$$

9. ATTENDANCE OF FAMILY MEMBERS / CAREGIVERS AT VISITS

Examples:

a. Attendance of assessment appointments:

$$\frac{\text{\# of assessment appointments attended by a family member/caregiver}}{\text{\# of assessment appointments}}$$

b. Attendance of visits at which family member / caregiver is expected:

$$\frac{\text{\# of visits in denominator at which a family member/caregiver is present}}{\text{\# of visits at which a family member / caregiver is expected}}$$

c. Attendance at a minimum frequency determined by the program:

$$\frac{\text{\# of children in denominator whose family member/caregiver attended at least 1 visit in a month}}{\text{\# of children for whom we want family attendance at a minimum of 1 visit per month}}$$

Example of an indicator that has been tailored for use in a program

Continuation

On which consumers will we collect this data?

We will include all consumers who, according to their clinician, should be coming for weekly visits during the beginning stages of treatment (we will define the "beginning stages" as a consumer's first 40 days in treatment).

How many visits are we setting as a standard for this indicator, and over what time span (and why)?

We will look at the proportion of these consumers who have attended 4 visits or more in their first 40 days since admission. Our team has decided that this number of visits and this duration is appropriate because ….

The indicator will therefore be:

$$\frac{\text{\# of consumers attending at least 4 visits in 40 days since admission}}{\text{\# of weekly consumers who completed their } 40^{th} \text{ day since admission}}$$

How will we define a "visit"?

"Visits" are any type of face-to-face therapy in our program (individual or group). For consumers who show up late for an appointment, the visit is still counted as long as a clinician was still able to speak with the consumer for a minimum of 15 minutes.

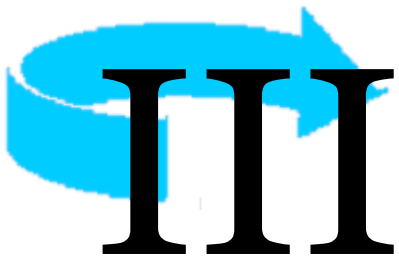
What will our target for this indicator be?

After we collect our baseline data, we will decide on a challenging, yet realistic, target percentage for this indicator.

What should we do if a consumer is discharged before completing 40 post-admission days in our program?

If a consumer had completed at least 4 visits before being discharged, we will count them in the indicator, since they still received the targeted amount of care.

For those that didn't complete 4 visits: If a discharge was due to a consumer meeting treatment goals, we will not count the consumer in this indicator because he or she wasn't expected to stay with our program. If the discharge was due to non-attendance, we will not count the consumer in this indicator, but we will collect a separate count of the number of consumers in this category. If a discharge was due to reasons X, Y, or Z ….



PROJECT TOOLS

Improving Mental Health Services for Children and Families

Family Participation Measure (FPM)

ADMINISTERING THE FPM

- *Who & when?*: When a family member or caregiver signs a first treatment plan review, or documents their refusal to sign it, the clinician should give him or her the FPM to complete. Family members/caregivers have the right to refuse to complete the FPM questionnaire.
- *How many?*: The clinician should offer the FPM to each family member or caregiver present at the first treatment plan review to complete individually or collaboratively if preferred.
- *Where?*: The family member or caregiver should be asked to complete the FPM and, to maintain anonymity, put it in a clearly designated drop box that has been placed in a visible and convenient area in your program (such as near the waiting room receptionist).
- Your team should discuss how best to integrate the FPM into the treatment planning process, and what to do in order to ease its use by clinicians and families/caregivers (such as train clinicians about the measure and decide how clinicians should inform families/caregivers about it and explain it to them).

SCORING THE FPM AND COLLECTING DATA

- *Collecting the FPM*: In order to maintain anonymity, the drop box should be checked only once per month, at the time of data collection.
- *Scoring*: Each FPM form contains instructions for determining the score (an average of circled numbers); a staff member should calculate the score on each FPM and the QI team leader should read any write-in comments.
- *Determining the core indicator*: Each month, calculate:

Numerator: The number of FPMs with a score *greater than 3*
Denominator: The total number of FPMs completed and returned in the month

- *Keep each FPM that you receive* and mark each with the month in which you received it. You'll need them for your audit, future activities at an IPG meeting, and/or for more detailed research.
- We strongly encourage you to do more detailed analysis of the data that is on the FPM surveys (such as analysis of responses to each question, frequencies of overall scores, etc.)

RESPONSE RATE DATA

- To supplement the data on FPM scores, report the number of completed FPM questionnaires.

    - *Completed FPM questionnaires* include all FPMs on which at least five of the seven questions have been answered.

    - *Completed first treatment plan reviews* are those that have been signed by a family member or caregiver and those that have documentation of refusal to sign.

To obtain the Family Participation Measure in languages other than English, please contact DMH.

For more information on the FPM, see:
http://www.rtc.pdx.edu/pgProjParticipation.php

Family Participation Measure

We are interested in hearing your opinion about your participation in planning services for your child. Please take a moment to complete this short, anonymous survey, which will help us to improve the quality of our program.
After completing the survey, please put it in the designated drop box.

Circle your choice

To What Extent…	A lot	Some	A little	Not at all
1. Were your ideas valued in planning services for your child?	4	3	2	1
2. Were your family's values and culture taken into account when planning for your child?	4	3	2	1
3. Did you agree with the service planning for your child?	4	3	2	1
4. Were the needs/circumstances of your family considered in this planning?	4	3	2	1
5. Were you able to influence planning for your child's treatment or services?	4	3	2	1
6. How much did staff listen to your ideas about ways to change or improve treatment or service planning?	4	3	2	1
7. How much did staff make changes in the service plan for your child as a result of your suggestions?	4	3	2	1

Please write any additional comments below:

_____

_____

_____

_____

_____

For program use:
Scoring information: To tally the overall score, sum all scores and divide by seven. (If the respondent circled fewer than seven items but at least five, then divide by the number of items answered).
Sum of scores = _____
Sum of scores divided by the number of items answered = _____

SUBMISSION FORMS

Division of Mental Hygiene
FY07 Project Plan Sheet
Due: September 8, 2006

Improving Mental Health Services for Children and Families

Agency Name: _____ DMH Contract #: _____

Program Name: _____ Facility Code: _____

County: _____ Unit Code/ PRU: _____

Directions: Please complete all items on this page and the signatures section on the following page, then return both pages to DOHMH.

1. What have you determined are the root causes of the problem you have targeted for improvement? Attach the results of at least one formal exercise (Flowchart or Fishbone) that you used to develop your root cause analysis. List your actionable root causes below.

_____
_____
_____
_____
_____
_____
_____

2. ☐ Attach the results of your baseline data collection. Describe conclusions below.

_____
_____
_____
_____
_____
_____
_____

3. ☐ Fill in and attach the "FY07 PDCA Cycle Worksheet" to submit your first 3 interventions. Only one intervention must be complete. The other two interventions can be projected, and only the "PLAN" section must be filled-in.

Signatures:

Agency Director: _____

Program Director: _____

CQI Team Members (2 signatures required):

_____

_____

Mail, E-Mail or Fax to:

Attn: Odessa Peterkin
New York City Department of Health and Mental Hygiene
Bureau of Planning, Evaluation & Quality Improvement
93 Worth Street, Room 803
New York, New York 10013
Tel: 212-219-5114
Fax: 212-219-5710
E-mail qualityimpact@health.nyc.gov

For DOHMH use only:

Date Submitted: _____

Date Approved: _____

Approved By: _____

Date entered: _____

Entered By: _____

NYC Health
THE NEW YORK CITY DEPARTMENT of HEALTH and MENTAL HYGIENE

QualityIMPACT

Division of Mental Hygiene
FY07 Final Project Outcomes Sheet
Due: April 30, 2007

Improving Mental Health Services for Children and Families

Agency Name: _____ DMH Contract #: _____

Program Name: _____ Facility Code: _____

County: _____ Unit Code/ PRU: _____

Directions: Please complete all items below and the signatures section on the following page, then return both pages to DOHMH.

DO:

1. ☐ Attach your cumulative "FY07 PDCA Cycles Worksheet," This form should now include the list of **all** PDCA cycles that you completed throughout the FY07 project cycle.

CHECK:

2. ☐ Attach your final data run charts (or any graphs or other summary documents used to analyze the project).

3. Based on your data and any additional qualitative observations, evaluate how successful your project was in improving clinical services.

_____
_____
_____
_____
_____
_____
_____

ACT:

4. Based on the results of your improvement efforts, describe the steps you are taking to either integrate improvements into your program operations and/or to develop additional improvement efforts to achieve your goals.

_____
_____
_____
_____

_____
_____
_____
_____
_____

Signatures:

Agency Director: _____

Program Director: _____

CQI Team Members: _____

_____

_____

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For DOHMH use only:

Date Submitted: _____

Date Approved: _____

Approved By: _____

Date Entered: _____

Entered By: _____

FY07 PDCA Cycles Worksheet

Interventions for: August 1, 2006 to March 31, 2007
Cumulative Report Due: April 30, 2007

Name of Project: Improving Mental Health Services for Children and Families

Name of Program: _____

Date Submitted: _____

Directions: Please document each PDCA cycle on one row of this sheet. Add new PDCA cycles as they are planned, then fill in the Do, Check and Act information as the cycle is completed. Add rows as needed. When the Project Plan Sheet is submitted, three cycles should be planned, and at least one of these completed. When the Final Project Outcomes Sheet is submitted, all cycles between August 1, 2006 and March 31, 2007 should be complete.

	PLAN			DO / CHECK	ACT	
Intervention (Who, What, When)	**Date Begun**	**How will we measure?**	**Predicted Results**	**Actual Results**	**Next Steps**	**Date Ended**
1.						
2.						

Intervention (Who, What, When)	**Date Begun**	**How will we measure?**	**Predicted Results**	**Actual Results**	**Next Steps**	**Date Ended**
3.						
4.						
5.						
6.						

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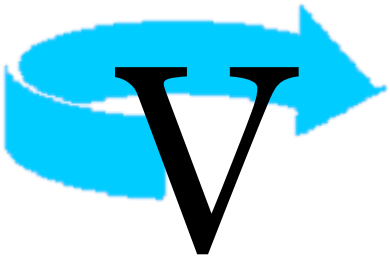

RESOURCES

Understanding PDCA Cycles, Interventions and Implementations: Getting started with your Quality IMPACT Project

Most of us have experienced frustration with how long it can take even well-planned changes to occur. Whether based on research evidence, or strategically planned as innovative interventions, CQI projects designed in clinical settings to address real, practical issues can sometimes take years to implement.

Developed by the Institute of Healthcare Improvement (IHI), the method of change we are endorsing in Quality IMPACT involves performing rapid tests of small changes rather than implementing major changes all at once.[1] All parts of your project should be conceptualized as PDCA (Plan, Do, Check, Act) cycles, or small interventions. From preparation of staff or consumers involved in the process, to data collection and analysis, to implementing the final improvement into your everyday operations, PDCA cycles help you test change and identify useful interventions.

The idea is to start small. As changes appear successful, build on them, and keep moving in the direction of your overall indicators and standards. Sometimes, more than one intervention can be implemented at once. Small cycles can be useful in:

- Increasing the belief that change will result in improvement and helping to minimize resistance to change;
- Giving an opportunity to find out that something does not work, without having a large impact on your organization or clients;
- Giving the team a way to document how much improvement can be expected;
- Learning how to adapt changes to specific, localized environments; and
- Evaluating unexpected side effects of the intervention.

Once you have planned and performed your first PDCA cycle, you are ready to move on to the next one. Testing interventions is an iterative process: the completion of each cycle rolls directly into the next. A team learns from the test, what worked, what did not work, and then can determine what should be kept, changed or abandoned. The team then uses the new knowledge to plan the next PDCA cycle. The team continues linking cycles in this way, refining the change until it is ready for broader implementation. People are far more willing to test a change when they know that changes can and will be modified as needed. Linking small interventions helps to overcome an organization's natural resistance to change and helps to ensure staff buy-in.

[1] You may want to review the definitions in the glossary prior to proceeding with this section.

Remember the measures you use and things you learn while performing a PDCA cycle are distinct from the Project Indicators. When you link multiple PDCA cycles together, you will gather quantitative or qualitative data that will aid in studying small changes. These terms and processes may seem confusing at first, but will become clearer as you apply them to your project.

EXAMPLES: FY07 PDCA Cycles Worksheet

Interventions for: August 1, 2006 to March 31, 2007
Cumulative Report Due: April 30, 2007

Name of Project: Sample Agengy

Name of Program: Sample Program

Date Submitted: _____

Directions: Please document each PDCA cycle on one row of this sheet. Add new PDCA cycles as they are planned, then fill in the Do, Check and Act information as the cycle is completed. Add rows as needed. When the Project Plan Sheet is submitted, three cycles should be planned, and at least one completed. When the Final Project Outcomes Sheet is submitted, all cycles between August 1, 2006 and March 31, 2007 should be complete.

Below are examples of PDCA Cycles that have been completed in various mental hygiene programs. These examples are provided to guide your program on how to fill out the FY07 PDCA Cycles Worksheet.

	PLAN			DO / CHECK	ACT	
Intervention (Who, What, When)	**Date Begun**	**How will we measure?**	**Predicted Results**	**Actual Results**	**Next Steps**	**Date Ended**
Ex. Evaluate and develop new policy and procedures for telephone screening so that voluntary completion of the MSSI-SA is completed prior to intake. The telephone screening takes places at our mental health site by our support/intake staff.	8/1/05	We will get feedback from our clinic/intake staff who are conducting intakes.	Telephone screening will be viewed positively by clinic/intake staff.	Sampling of intakes confirmed that the revised policy and procedures for telephone screening was a positive variable leading to a successful intake outcome.	Incorporate new policy and procedure for telephone screening and provide supports to ensure that all new referrals complete the MSSI-SA.	8/8/05

Ex. Pilot-test a culturally competent flyer at an inner-city domestic violence shelter in a different borough than our potential recruitment borough by distributing the flyer.	10/1/05	We will get feedback and collect information regarding the cultural appropriateness of the flyer and whether or not the advertised program would engage the interest of women in need of services.	The information that we receive regarding the flyer will enable us to make any necessary revisions to the flyer.	Positive response to the culturally competent flyer was extensive. Peer-based piloting and pre-testing is an excellent way to design recruitment materials.	Staff will be trained on how to develop a culturally competent flyer and all future flyers/recruitment materials will be piloted before they are distributed to the target audience.	10/1/05
Ex. Implement a Patient Indicator Tracking Form to assess patients' need for annual physical exam, blood pressure and smoking reduction. Clinicians will review patient charts and complete the form at the time of the patients' quarterly treatment plan.	9/1/05	We will get feedback from clinicians to see if the form provides useful information and if it is a reliable tool for collecting data.	The Patient Indicator Tracking Form will enable us to ensure that all aspects of patient healthcare are being addressed.	Clinicians gave feedback regarding the appropriateness of the form and offered suggestions on how to improve the form.	Edit and finalize form. Clinicians use new form.	9/30/05
Ex. Train two staff on how to use the CCA at intake and at assessment in the clinic.	1/15/05	Create a 3-question client satisfaction survey on cultural competence of the intake process. Intake staff will give the survey to the client upon completing the assessment.	If staff have been properly trained, client satisfaction survey will show positive results.	Feedback was gathered from the client satisfaction survey.	Evaluate results from client satisfaction survey, make changes and expand on successes.	1/31/05

Below are examples of small PDCA Cycles that are continuous and have led to new PDCA cycles. These examples are provided to guide your program on how to fill out the Rapid PDCA Cycles Worksheet.

Intervention (Who, What, When)	**Date Begun**	**How will we measure?**	**Predicted Results**	**Actual Results**	**Next Steps**	**Date Ended**
1. Find a measure for visual task performance, identify a visual functional questionnaire (VFQ) and test it on five clinic treatment clients.	6/1/05	Feedback from clients on VFQ.	Feedback from clients will help us to identify domains of intervention.	Test on five clients gave specific task performance measures on three domains, and the level of difficulty the client experienced when performing them. The VFQ meets criteria of measuring task performance.	Use the modified form of the VFQ as a screening tool and train staff on how to use it.	6/15/05
2. Implement staff training on how to use VFQ at a staff meeting.	6/15/05	Discuss and demonstrate administration of the test with staff. We will review the first two questionnaires that staff has administered.	Staff will successfully use VFQ or ask questions if they are unsure of how to administer VFQ.	Staff were trained and began using VFQ.	Develop training/education materials for mental health staff to use with clients on use of adaptive skills to cope with vision loss and increase independence.	6/30/05
1. Decide on which clients to include in project to improve adaptive visual performance of persons with vision impairment and mental health needs (depression).	10/1/05	Staff review charts of August and September 2005 and look at the intake time frame (pre-admission visits) and admission dates of clients and compare to when screens, initial	Reviewing this information will help us identify early project drop-out rates.	Admission to clinic is a better date for client inclusion in project than at Intake (pre-admission visits) because of lower drop-out rate after	Use admission to clinic date for project inclusion.	10/7/05

		treatment plan, and client still remain in treatment.		admission.		
2. Determine if admission to clinic and completion of treatment plan is a better time frame than during the first three intake visits for client project inclusion.	10/1/05	Review admission/treatment time frames and intake of clients during September and August 2005.	Reviewing this information will help us identify early project drop-out rates.	Admission to clinic and two visits or 30 days later, whichever comes first, is a better indicator for project inclusion than during intake.	Change time frame for project inclusion from intake to clinic admission and two visits or 30 days, whichever comes first.	10/7/05
3. Determine if clients who score with minimal depression should be included in the project.	10/10/05	Review depression scores of clients screened during August and September 2005 and look at the number of clients who have BDI scores of 0 to 13 (present entry score for project is 14).	Include clients with early symptoms of depression and who are at greater risk to develop more severe forms of depression	Review of BDI scores showed that a large number of clients scored from 10 to 13.	We will define clients with minimal depression as those with BDI scores of 10 to 13 and will change entry score for depression from 14 to 10 (minimal depression).	10/14/05

SUGGESTIONS FOR CQI TEAMS

This section of your workbook offers suggestions on how to successfully establish and work together as a Continuous Quality Improvement team.

USING TEAMS TO IMPROVE QUALITY

Sometimes an individual, working alone, knows enough to improve a process on his or her own. However, to gain enough knowledge to enable good decision-making, a team of people who see the process from a variety of perspectives is beneficial. Working together as a team to improve processes can be both challenging and rewarding. Structure and tools are needed to enable the team to function effectively and make wise decisions.

IDENTIFY TEAM ROLES AND RESPONSIBILITIES

An effective team clearly outlines and shares responsibilities. One way to support the division of responsibility is to clearly define roles. All teams need to have members and a leader, but you may wish to ask some of the members to take on the role of recorder, timekeeper or facilitator, depending on the needs of your team.

Member – CQI teams are usually made up of 3 to 6 members. Members are chosen because they work in, have knowledge of, or receive benefit from the identified CQI project.

Leader – The leader coordinates and directs the work of the team as it proceeds through the process and implements improvements. Traditionally, CQI de-emphasizes hierarchical structures. Team leaders do not necessarily hold managerial or administrative roles in the organization. They will contribute ideas, interpret data, and participate with other team members, but will also be responsible for seeing that the team progresses and that everyone participates fully. They also accept responsibility for project oversight.

Recorder – Recorder is a rotating role assigned to maintain records of the team's work. The recorder logs significant content on a flipchart that all members can see. S/he can also keep minutes of the meetings.

Timekeeper – The role of timekeeper can also be rotated among members, and is assigned to help the team manage time. The timekeeper will call out time remaining on each agenda item at intervals determined by the team, but it is the entire team's responsibility to remain on task.

Facilitator – The facilitator is a team advisor or consultant who has expertise in the CQI process. The facilitator teaches CQI methods and provides feedback to the team on the progress of their work. The goal of the facilitator is to help the team develop self-sufficiency, and can be useful if the team members and/or leader are inexperienced in

quality improvement. The facilitator may have a high level of involvement with a newly formed team, but decrease participation as the team becomes self-sufficient.

EARLY TEAM TASKS

To help a new CQI team learn to function successfully, they can perform some simple tasks to help members work together.

- Members should be oriented to the purpose of the team and how it fits with the organization's objectives. Members should receive training in the principles and tools of quality improvement.

- New teams may want to perform simple, but fun ice-breaking exercises to facilitate team building.

- Setting ground rules at the very beginning can help set team norms, eliminate confusion over roles and responsibilities, and facilitate efficient use of the team's time. Teams can set ground rules regarding attendance, participation, interruptions, communication courtesies, conflict management, between meeting work, record keeping, and assignment of roles.

ONGOING MEETING PROCESSES

Defining a meeting process by which to conduct all meetings will assist in the effective execution of the team's critical tasks. Steps may include:

- Clarifying objectives of the meeting, assigning roles and reviewing agenda items at the start of each meeting;

- Working through the agenda items;

- Reviewing the meeting record (on the flip chart);

- Planning steps to be taken before the next meeting and setting a tentative agenda;

- Evaluating the meeting and identifying what the team is doing well, and what could be improved.

Finally, remember that most teams go through periods of "forming, storming and norming." Members may initially come together full of excitement and motivation, but may quickly find themselves working through disagreements and challenges. This happens as individuals develop their roles and work styles within the group setting. All members, including the leader, are responsible for helping the team follow ground rules and set the structure, and for staying focused on the task at hand.

Contact Information

The Division of Mental Hygiene staff members listed below are available to assist you with the implementation of your Quality IMPACT project.

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Additional Resources

Agency for Healthcare Research and Quality (AHRQ)
http://www.ahrq.gov

Center for Quality Assessment and Improvement in Mental Health (CQAIMH)
http://www.cqaimh.org

- Website includes searchable inventory of mental hygiene quality indicators.

Forum on Performance Measures in Behavioral Health and Related Systems
http://www.mhindicators.org/

Institute for Healthcare Improvement (IHI)
http://www.ihi.org

- Website includes tool that can be used to track and chart data on an indicator of your choice (See http://www.ihi.org/ihi/workspace/tracker/)

Mental Health Statistics Improvement Project (MHSIP)
http://www.mhsip.org

Network for the Improvement of Addiction Treatment (NIATx)
http://niatx.org

- NIATx works with chemical dependency providers to improve treatment access and engagement by decreasing waiting times and no-shows, and increasing admissions and continuation.

President's New Freedom Commission on Mental Health
http://www.mentalhealthcommission.gov/

Research and Training Center on Family Support and Children's Mental Health
http://rtc.pdx.edu/

- Website includes background information on the Family Participation Measure (See http://www.rtc.pdx.edu/pgProjParticipation.php)

Substance Abuse and Mental Health Services Administration (SAMHSA)
http://www.samhsa.gov/

Washington Circle Group
http://www.washingtoncircle.org/

Bibliography

Berry LL, Seiders K, Wilder SS. (2003). Innovations in Access to Care: A Patient-Centered Approach. *Annals of Internal Medicine,* 139(7), 568-574.

Friesen BJ, & Pullmann MD. (2001). Family participation in planning services: A brief measure. Paper presented at the A System of Care for Children's Mental Health: Expanding the Research Base, Tampa.
(See http://www.rri.pdx.edu/ClarkCo/ProceedingsRTC2003conf.pdf)

Harrison ME, McKay MM, Bannon WM Jr. (2004). Inner-city child mental health service use: the real question is why youth and families do not use services. *Community Mental Health Journal,* 40(2):119-31.

Herman SE, Marcenko MO, Hazel KL. (1996). Parents' perspectives on quality in family support programs. *Journal of Mental Health Administration,* 23(2):156-69.

Hermann RC. (2005). *Improving Mental Healthcare: A Guide to Measurement-Based Quality Improvement.* Washington DC: American Psychiatric Press, Inc.

Institute of Medicine. (2005). *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series.* Washington DC: National Academies Press. (Available online at http://darwin.nap.edu/books/0309100445/html/)

Keller GA. (1997). Management for quality: continuous quality improvement to increase access to outpatient mental health services. *Psychiatric Services,* 48(6):821-5.

Jivanjee P, Friesen BJ, Kruzich JM, Robinson A, Pullman M. (2002). Family participation in systems of care: frequently asked questions (and some answers). CWTAC Updates: Series on Family and Professional Partnerships, 5(1): 1-8.
(See http://www.cimh.org/downloads/Jan-Feb02.pdf)

McKay MM, & Bannon WM Jr. (2004). Engaging families in child mental health services. *Child and Adolescent Psychiatric Clinics of N America,*13(4):905-21.

McKay MM, Harrison ME, Gonzalez J, Kim L, Quintana E. (2002). Multiple-family groups for urban children with conduct difficulties and their families. *Psychiatric Services,* 53(11), 146-8.

Pullmann MD, Guthrie L, Rhodes R, Savage P. (2003). Is caregiver participation in service planning related to child outcomes? Paper presented at Building on Family Strengths, Portland, OR.
(See www.rri.pdx.edu/ClarkCo/ProceedingsRTC2003conf.pdf)

APPENDIX

Improving Mental Health Services for Children and Families

Examples of Initial and Ongoing Engagement Interventions

Following are examples of engagement-related interventions designed and implemented by programs that participated in the Learning Collaborative to Improve Engagement and Retention of Children and Families in Treatment.

Target Area	Intervention	Ideas for variation
Initial Engagement	To engage client, enhance connection between client and clinic, and offer any additional assistance and support, add "engagement call" to clinic intake process (which occurs prior to in-person intake appointments and is in addition to call made to confirm intake appointment made the day before the scheduled intake appointment.)	• Have intake coordinator or therapist make call. • Create script to ensure consistency, ensure engagement strategies covered, and modify as needed.
	To improve engagement, reduce time-consuming in-person translation of intake documents by providing forms in Spanish to be filled out in Spanish. Responses will be translated at a later time.	• In addition to English and Spanish, provide forms in other languages (e.g. Chinese).
	To proactively identify possible barriers to attendance, identify process by which the information gathered during engagement/intake call (if not done by therapist) that assesses client's obstacles to coming to treatment is conveyed to therapist.	
	To increase staff awareness of engagement philosophies and techniques, schedule clinical, intake, management and administrative staff to attend training on Engagement Model.	• Include in training the opportunity for clinical and intake staff to practice engagement practices (e.g. initial phone call) and get feedback from peers.

Initial Engagement	To increase initial engagement of family, have a one time Orientation group for family members/careivers. Authorization, consent forms, Patient's Rights, HIPAA, etc. can be signed during this group. Information on these forms including confidentiality, importance of attendance, co-payments, etc. can be discussed by director & supervisor. Vital information such as address and phone numbers can be confirmed. Any questions that guardians had can be answered after the group ended on an individual basis.	• Include discussion of the intake and treatment process. • Include discussion of clinic rules, attendance expectations, and other important clinic procedures. • Have clinical director and/or clinical supervisor lead the group. • Have parent advocate lead orientation group. • Target orientation group toward specific groups of clients identified as needing improvement on attendance.
	To increase engagement of the family with their assigned therapist, at case disposition, when a new client is admitted, the disposition team completes a form and places it in the newly assigned therapist's mailbox (which is not usually the same person as the Intake Worker). This form, "First Telephone Contact With Newly Assigned Client" prompts the therapist to make contact with the guardian within 24 hours of receipt of the form. This form is to be returned to the Clinic Director/QI Leader with outcomes of contact attempts, as well as the date of the first appointment with the assigned therapist.	

Ongoing engagement	To support ongoing engagement, if the client misses the first appointment after intake, the parent advocate contacts the family member/caregiver. Advocate introduces self, states relationship to clinic within agency, and role. The advocate outlines how he or she can be helpful to the family member/caregiver and client, explores thoughts about services received thus far, and makes mention that the first session was already missed, towards the goal of getting feedback from family member/caregiver, and to learn the reason for the missed session.	• Identify other staff to make this contact if parent advocate is unavailable.
	To encourage ongoing engagement, conduct a follow-up from intake call. After 3rd appointment, conduct a follow-up call with client: "During intake, we asked you about your past experiences with mental health/social service agencies. We wanted to follow up with you, now that you've been coming here a few times: how are we doing?"	• Have therapist or parent advocate make call.
	To improve kept appointments with psychiatrist, a telephone call was place by the secretarial staff a day before the scheduled appointment.	• Reminder calls could be targeted toward other specific types of appointments with high rates of missed visits.

Improving Mental Health Services for Children and Families

PROMISING PRACTICES FOR IMPROVING TIMELINESS, REDUCING NO-SHOWS, INCREASING ADMISSIONS & INCREASING CONTINUATION IN CHILDREN'S MENTAL HEALTH TREATMENT CLINICS[1]

This document summarizes five promising practices for each of four areas believed to be important in improving the engagement and retention of youth and their families in mental health treatment: Improving timeliness, decreasing no-shows, increasing admissions, and increasing continuation. The four aims were identified by the Network for the Improvement of Addiction Treatment (NIATx) as key areas in behavioral health care that providers can address to improve client outcomes. Based on the work of its member organizations, NIATx identified five practices most successful for achieving each of the four aims. Following each practice are examples of how the practice was operationalized by NIATx members. While these programs specialize in chemical dependency treatment, these examples apply to mental health treatment programs as well.

A promising practice:

- generates staff enthusiasm and positive youth & family/caregiver response
- is easy to implement and measure
- has a positive impact on the bottom line
- can be sustained successfully

5 Promising Practices for Improving Timeliness

1. Reduce Intake and Assessment Paperwork

This is arguably the most significant change that an organization can make to improve timeliness to assessment. Paperwork can be excessive and duplicative, absorbing many more staff hours than necessary. In addition, paperwork can also take the entire first appointment, requiring youth to return for assessment.

[1] This document is adapted with permission from the work of the Network for the Improvement of Addiction Treatment (NIATx), University of Wisconsin, Madison. For examples of these promising practices or more information on these and other promising practices, visit the NIATx website at www.NIATx.net.

Treatment agencies can implement various process changes to support a youth receiving treatment. While individual process changes target different aspects of the assessment and admission process, they all move the agency towards open access. The four processes highlighted below represent changes designed to provide open access to treatment.

Example: The Center for Drug-Free Living in Orlando, FL, reduced outpatient paperwork by decreasing duplication across forms. In doing so, all counselors were able to double assessment slots, decreasing the time between screening and second assessment by 7 days.

2. Offer Assessments Every Day and in the Evenings

The times a clinic sets aside for assessment appointments may be inconvenient for youth and their families/caregivers in need of treatment. Furthermore, limiting the days and/or times that assessment appointments are available also reduces the volume of youth that can be assessed and admitted to treatment. Organizations can consider offering assessments every day of the week, and making some time available in the evenings for youth who cannot attend assessments during the day.

Example: Kentucky River Community Care in Hazard, KY, trained eight additional staff to conduct outpatient assessments, increasing the number of assessment slots and reducing time from 1st contact to 1st treatment by 39%, from 22.3 to 13.6 days. Same day appointments are also offered.

Example: Cornerstone Counseling added additional intake slots to allow all intakes to be scheduled the week that the client first called. This reduced the time from 1st contact to assessment by 69%, from 13 to 4 days.

3. Use Open Schedules

An open schedule means that assessments are available at any time a clinician has available. Rather than restricting assessments to certain times or days of the week, this approach makes scheduling for assessments more flexible for the youth and their families/caregivers and encourages increased staff productivity by maximizing a clinician's billable hours.

Example: Prairie Ridge in Mason City, IA, made all open time slots available for assessment, in all levels of care. This reduced wait time from contact to assessment by 45%, from 9 to 5 days.

Example: Steps at Liberty Center in Wooster, OH, opened counselor schedules by making a set time for an "assessment clinic" and having all therapists available. Time from 1st contact to 1st treatment decreased by 68%.

4. Double-Book Assessments

No-shows are common for assessment in mental health treatment. Even after implementing changes to reduce no-show rates, a clinic will still have a certain percentage of missed appointments. To make full use of staff time and see more youth for assessment, double-booking assessments is often an effective approach. Agencies may want to double-book only during those time slots that are commonly missed, or double-book only a certain percentage of appointments.

Example: Sinnissippi Centers in Dixon, IL, double-booked a portion of intensive outpatient assessment slots, booking 4 assessment appointments for 2 time slots.

5. Allow Walk-In Appointments

In some instances, scheduling appointments for intake/assessment can be ineffective. Any time delay may prevent a family from returning to the clinic. Walk-in appointments completely eliminate the time between request for treatment and assessment, so that youth can be admitted to treatment rapidly.

Example: Southwest Florida Addiction Services in Ft. Myers, FL, scheduled times for outpatient walk-in assessments; clients can generally be assessed in 0-2 days after 1st contact.

Example: VIP Community Services in the Bronx, NY, adopted *all* walk-ins for intensive outpatient assessment, contributing to an 89% reduction in time from 1st contact to assessment, to <1 day.

5 Promising Practices for Reducing No-Shows

1. Address Barriers Youth & Families/Caregivers Face in Attending Assessment

Improving attendance at first appointments or subsequent appointments requires understanding the barriers that youth and families/caregivers face as they schedule an assessment. The following issues, among others, may prevent clients from attending assessment appointments:

- lack of transportation
- lack of childcare
- worry about ability to pay for treatment
- conflicting appointments

Many agencies have programs to assist youth and families/caregivers with these problems, such as free rides to the clinic. During the first call for scheduling an assessment, intake staff should elicit the youth and family's/caregiver's reservations or concerns about the first appointment and address them directly. This simply helps them identify and problem-solve potential barriers. If a clinic does not provide services or

scheduling that address their needs, staff may want to consider implementing such services as part of the change project.

Example: Perinatal Treatment Services in Seattle, WA, offered transportation to outpatient services from a downtown area.

2. Clearly Explain to the Youth and Their Family/Caregiver What to Expect at First Appointment

A youth or their family/caregiver may feel nervous or uncomfortable about their first appointment. They may worry about confidentiality, or simply not know what to expect. In other instances, they may have heard—sometimes correctly—that the first appointment involves no treatment and only paperwork. When scheduling an appointment, customer service staff can go over the different steps that may be included in an assessment: insurance paperwork, health history, and meeting with a clinician. Letting them know what information they should bring to the appointment can also help youth and their families/caregiver feel prepared.

Example: Kentucky River Community Care in Jackson, KY, described the first visit to new outpatient clients over the phone, followed by appointment letters and reminder calls. These changes reduced no-shows to assessment from 65% to 39%.

3. Model Communication on Motivational Interviewing Techniques

Staff should connect with youth and families/caregivers in a supportive, empowering, and accepting way. Instead of asking yes/no questions, asking open-ended questions allows the client to talk about what he or she feels is important. During the conversation, staff can connect with youth and families/caregivers by expressing empathy and concern. Reflective listening—including summarizing the situation—also helps youth and their families/caregivers feel accepted and supported by staff members.

4. Get the Youth to the First Appointment Quickly

The greater the delay between first contact and assessment, the more likely it is that the youth or their family/caregiver will forget about an appointment or lose interest in treatment. To reduce the time between the first contact and the assessment appointment, treatment agencies can create linkages with key referral sources (e.g., PCP), implementing walk-in appointments, on-demand scheduling, or ensure that appointments are available within 24 hours of the first call.

Example: The Center for Drug-Free Living in Orlando, FL, implemented walk-in screenings for all adult outpatient clients, resulting in a 52.9% decrease in no-shows.

5. Make Reminder Calls to the Family/Caregiver of Youth Scheduled for an Assessment

Youth or their family/caregiver can easily forget to mark their calendars, lose appointment cards, or they may get "cold feet" prior to the first appointment. Reminder calls, which are typically scheduled for a day prior to the appointment, can keep them on track for the appointments, as well as establish a more personal link between the service organization and the family. By notifying the youth and their family/caregiver in a neutral way that they are expected for an appointment, reminder calls can help overcome last-minute reluctance to show for an intake appointment.

Example: TERROS in Phoenix, AZ, used reminder calls for all newly-scheduled outpatient clients.

Example: MECCA in Des Moines, IA, called clients to remind them of their appointment, reducing no-shows by 44%

5 Promising Practices for Increasing Admissions

1. Targeted Marketing

A useful strategy for increasing the number of people entering treatment involves the marketing of services to specific groups or organizations. Targeted marketing allows an agency to draw attention to their services by providing information tailored to the target, based on pre-determined needs. The target may be a referral organization, the prospective youth, or a family member. The goal is to increase awareness, knowledge, and interest, from which further relationships can develop.

Example: Boston Public Health Commission in Mattapan, MA, trained staff on outreach strategies and assigned them to specific agencies to do outpatient outreach. Admissions increased by 49%, to 8.4 per month.

2. Build Lasting Relationship with Referral Organizations and Measure Referrals

Admissions to mental health treatment often come from referrals. Establishing strong relationships with major referral institutions will encourage more client referrals and, subsequently, more admissions. Once an agency has attracted attention by targeting a specific referral organization, it provides a perfect opportunity for the development of a more personal, loyal, and sustainable relationship.

Some guidelines for forming such alliances include:

a. Understand referral agencies' needs and involve them in building the relationship
b. Assign one person within your organization to correspond directly with the referral source

Measuring the number of referrals and the source from which they came allows an agency to identify places where more effort is required to foster relationships that will benefit the agency.

Example: Connecticut Renaissance in Norwalk, CT, provided their top 3 referral sources with details of the admissions process. Personal communication from the program director helped secure a connection with the major referral source and contributed to an increase of 83.3% in outpatient admissions.

Example: Vanguard Services in Arlington, VA, established relationships with various sources, such as EAPs, and conducted site-visits. This contributed to a 112% increase in monthly outpatient admissions.

3. Building Capacity: Develop/Expand New or Existing Programs

In many cases, organizations find themselves overwhelmed and unable to meet the high demand for services. In such cases, the only suitable means for successfully increasing admissions requires an increase in capacity. A popular method for achieving this involves the expansion of existing programs/resources or the creation of new programs. Usually, these require some initial investment to put in place. However, agencies that examine current capacity often find that a few minor shifts in resources and processes can uncover "hidden" capacity at low cost.

Example: Women's Recovery Association in Burlingame, CA, started an evening intensive outpatient program for all clients, resulting in a sustained admissions increase of 53%.

Example: Sinnissippi Centers in Dixon, IL, opened youth groups at an additional location, increasing intensive outpatient adolescent admissions by 11.1%. Subsequent service treatment hours increased to 480 per quarter versus 45 per quarter prior to creating the youth groups, boosting revenues from $1,000 to $10,000 per quarter.

4. Reshaping Capacity: Reduce Admission Steps

The number of steps required to admit youth to treatment can substantially influence admissions. Extra steps, such as multiple appointments, unnecessarily prolong the time between first contact and assessment, and promote drop-out. Reducing admission steps frees up staff time, especially clinicians', to perform other activities that directly impact admissions and timeliness to treatment.

Example: Daybreak of Spokane, WA, eliminated steps in the outpatient assessment process. Combined with other strategies, the number of people assessed but not admitted decreased from 36% to 15%.

Example: Fayette Companies in Peoria, IL, combined the assessment and admission process for adolescents, including an opportunity to start treatment immediately. This increased admissions by 10.5%

5. Reshaping Capacity: Reduce Paperwork

Medical and administrative records pose significant challenges. Information requested frequently places unnecessary burden on both staff and youth and their families/caregivers with little justification. Key ingredients to managing this problem include (1) elimination of duplication; (2) forms design; and (3) efficient processing, transmission, and storage of information. Paperwork reduction allows organizations to increase capacity by providing additional time, usually spent completing paperwork, for clinical staff to treat youth.

Example: Daybreak of Spokane, WA, streamlined paperwork by creating a new discharge form, and combining assessment and admission forms into one. Time spent on outpatient admission paperwork was reduced 50%.

Example: Steps at Liberty Center in Wooster, OH, reduced initial paperwork by eliminating duplication and facilitating support staff to take registration data directly from the diagnostic assessment. This reduced the time taken to complete paperwork from an average of 45 minutes to <5 minutes.

Example: The Center for Drug Free Living in Orlando, FL, reduced and streamlined outpatient admissions and assessment paperwork, contributing to a 57% admissions increase, and a 50% reduction in non-billable counselor time spent on admission paperwork, saving the agency $43 per client admitted.

5 Promising Practices for Increasing Continuation

1. Scheduling: Make It as Easy as Possible for Youth to Continue in Treatment

To make it as easy as possible for youth to continue in treatment, organizations should consider adjusting staff schedules so that sessions are available at times most convenient for the youth and their family/caregiver. This may require changing the days that staff work, staff hours, staggering staff start and ending times, rotating lunch breaks, and so on. Additionally, to help youth and their family/caregiver keep track of their appointments, organizations can provide clients with appointment cards that list the next four appointments.

Example: PROTOTYPES of Pomona, CA, added new evening sessions to its outpatient program, making it more convenient for individuals who work during regular business hours to attend.

Example: Mid-Columbia Center for Living in The Dalles, OR, gives outpatient clients a multi-session appointment card to track attendance.

2. Provide Orientation (Live or Video) and Establish Clear Two-Way Expectations

An effective orientation can be a key component in securing a youth and their family's/caregiver's commitment to continue in treatment. Organizations should involve the youth and their family/caregiver in the development of the treatment plan and inform them of the attendance and participation expectations, and how they will progress through levels of care.

Example: The Women's Recovery Association in Burlingame, CA, developed an orientation for new clients in all levels of care. This included a handout written by an individual who had experienced the program.

3. Discuss Barriers to Continuing in Treatment; Identify Clients at Risk of Leaving Early; Ensure that Needs are Being Met

There are many barriers that, if not addressed early on, can cause youth to prematurely cease treatment. Organizations must understand the circumstances of those they treat, and explore ways to help them overcome barriers to continuing in treatment, such as childcare, issues related to other family members, and so on. It's important to have a mechanism in place to regularly monitor barriers and identify those at risk of leaving early, so that triggers can be identified and addressed before the youth actually leaves.

Example: Gosnold integrated a system that empowered staff to identify clients at risk of drop-out and discretely alert all staff of risk. This was associated with a 10% improvement in completion rate.

4. Integrate Youth and Their Families/Caregivers into Treatment Community Immediately After Admission

Youth and families/caregivers entering treatment should feel comfortable in the treatment environment and have opportunities to bond with others as early as possible. Increasing the level of comfort and connection helps with initial and ongoing engagement in treatment. Therefore, agencies should schedule individual sessions with the clinician, the casework manager, medical staff, and any others who will help meet the youth's treatment needs as early as possible after admission.

5. Contingency Management

Once admitted to treatment, many youth and their families/caregivers simply do not have the commitment or motivation to continue with treatment. Several organizations address this issue by implementing contingency management, otherwise known as incentives. Strategies, including the use of gift cards for individuals completing four treatment sessions, recognition for completing treatment, and pizza parties for groups with 100% attendance are considered useful in increasing the length of time youth stay in, and even complete, treatment.

Improving Mental Health Services for Children and Families

Conducting a Walk-through Exercise[1]

What is a Walk-through and Why Do it?

A walk-through is an exercise where staff members walk through the treatment processes just as a youth or family member/caregiver does. The goal is to see the agency from the *client's perspective*. Taking this perspective of treatment services – from the first call for help, to the intake process, and through final discharge – is the most useful way to understand how the youth and family/caregiver feels, and to discover how to make improvements that will serve them better.

Steps for Conducting a Walk-Through

1. Select two people from your organization to play the roles of "youth" and "family member/caregiver."
The two of you will need to be detail-oriented and committed to making the most of this exercise. To ensure that your experiences will be as realistic and informative as possible, make sure you present yourselves as dealing with a mental illness you are familiar with, and thus are able to consider the needs of people dealing with these particular mental health issues.

2. Let the staff know in advance that you will be doing the walk-through exercise.
Staff might be on their best behavior, but it is far better to include them than to go behind their backs. Ask them to treat you as they would anyone else.

3. Go through the experience just as a typical youth and family member/caregiver would.
The walk-through should begin with a youth's and family member's/caregiver's first contact with your agency (i.e., making an initial call for services from the perspective of a family member/caregiver interested in obtaining treatment services) and extend through the third visit.

4. Try to think and feel as a youth or family member/caregiver would.
Look around as they might. What are they thinking? How do they feel at any given moment? Note your observations and feelings.

5. At each step, ask the staff to tell you what changes (other than hiring new staff)

[1] This tool is adapted with permission from the "Conducting a Walk-through" document created by the Network for the Improvement of Addiction Treatment (NIATx), University of Wisconsin, Madison. www.NIATx.net.

would make it better for youth and families/caregivers, and what changes would make it better for the staff.
Write down their ideas and your own. Write down your feelings as well.

6. Finally, between the two of you (youth and family member/caregiver), write down a list of the needs you found and the improvements that could be made to address these needs.
Be sure to address what the needs are from both the client and staff perspectives.

What to Note in Your Observations and Assessments:

1. Call for an appointment. Were you told to call back, or transferred to voicemail? Were you given an appointment on your first call? How long would a typical family need to wait for an appointment? Would the youth or family member/caregiver have to miss school/work to get an appointment? Record your experience.

2. On the day of the appointment, arrive at the clinic or office, thinking what it would be like if you had never been to the site before. Is transportation to your site an issue? Are parking, directions and signage adequate? Does the site feel welcoming or cold and harsh? Record your experience.

3. Once you arrive, think about the perspective of the youth and family/caregiver coming in for the first time. Go through the entire intake process. Fill out all required forms. Does the family member typically accompany the youth through the entire intake process? How long does a typical youth spend in the waiting room? Wait for that amount of time. Will you have to wait between your assessment and your first treatment session, and if so, how long? Experience it all, and record your experience.

4. Experience the process of transferring between intake and your first treatment appointment. How much paperwork do you have to fill out? Are you answering the same questions you did initially? Do you feel like you've had a smooth and consistent transition, or are you starting again from the beginning?

5. What most surprised you during your walk-through? What two things would you most want to change?

Improving Mental Health Services for Children and Families

Measures of Processes of Care for Service Providers (MPOC-SP)

MPOC-SP developed by *CanChild* Centre for Childhood Disability Research, McMaster University

ABOUT THE MPOC-SP:
The MPOC-SP is a self-assessment questionnaire for pediatric service providers, designed to measure their perceptions of their provision of family-centered service in caring for children with chronic health or development problems (and their families). It is a discriminative tool that can be used to contribute to professional development initiatives, program evaluation, and research on health service delivery.

The MPOC-SP is a service provider version of the MPOC, a well-validated and reliable parent questionnaire of family-centered services. Various studies indicate the MPOC-SP is a reliable and valid tool. For more information on these studies, see http://www.canchild.ca/Default.aspx?tabid=201

USING THE MPOC-SP IN YOUR QUALITY IMPACT PROJECT:
The MPOC-SP is provided as an optional tool for your program. Examples of how your program can use the MPOC-SP as part of this project are:

- Administer it to all clinicians anonymously at or near the beginning of your project, using it to explore the strengths and room for improvement in clinicians' practices. When discussing the administration of the survey and its potential uses, be sure to do so in a non-judgmental and open way. You should discuss the results with clinicians, and may be able to use it to determine areas for potential interventions.
- Ask clinicians to fill out the MPOC-SP as a self-evaluation (not to be collected), and afterwards use it as a discussion tool in a meeting about family-centered practices.

We do not recommend that you administer the MPOC-SP multiple times within a relatively short time span in an attempt to look for incremental changes in scores.

Scoring the MPOC-SP: There is no total score. The MPOC-SP yields 5 scores, one for each scale, which are obtained by computing the average of the relevant items' ratings. For more information on MPOC-SP subscales and scoring, please contact DMH or *CanChild* (contact information is on their website). Also, please note that changing the wording of items may affect the quality of the questionnaire and is not recommended.

Note: There is also a version of the MPOC for parents, which can be obtained from *CanChild* for a fee.

The Welcoming Clinic: Improving Access through Client-Centered Services in Mental Hygiene Treatment Programs

Sample Clinician Appointment Tracking Form

Clinician: _____

Week: _____

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
# **initial** individual appointments scheduled*							
# **initial** individual appointments kept							
# **ongoing** individual appointments scheduled*							
# **ongoing** individual appointments kept							
# **group** therapy clients expected							
# **group** therapy clients attending							

*Number of scheduled appointments does not include appointments that were cancelled.

The Welcoming Clinic: Improving Access through Client-Centered Services in Mental Hygiene Treatment Programs

Sample Clinician Appointment Tracking Form Summary Sheet

Week: _____

Clinician	# **initial** individual appointments scheduled*	# **initial** individual appointments kept	# **ongoing** individual appointments scheduled*	# **ongoing** individual appointments kept	# **group** therapy clients expected	# **group** therapy clients attending
TOTAL ALL CLINICIANS						

*Number of scheduled appointments does not include appointments that were cancelled.