Behavioral Health at a Crossroads:

Leading for the Future

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"Behavioral Health at a Crossroads: Leading for the Future" reflects my learning and observations as a California County Behavioral Health Director as well as more recent work that has focused on the integration of behavioral health and health care, and leadership development. Several recent articles have impacted my thinking both about the future of health care and the imperative for effective leadership:

- "Applying A 3.0 Transformation Framework To Guide Large-Scale Health System Reform," Halfon et al., Health Affairs (Nov. 2014) summarize stages in the evolution of modern health care and offers a map of how health and health care systems are changing.[1]
- High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs, Swensen, Pugh, McMullan, and Kabcenell A,[2] (IHI White Paper 2013) as well as much of the work of The Institute for Health Care Improvement focus on requirements of leaders that are competent to build and sustain health care systems of the future.
- "The Dawn of System Leadership," (Stanford Social Innovation Review, Winter 2015) Peter Senge, Hal Hamilton and John Kania, and others call for a new breed of transformative cross-sector leaders that address the inter-connectedness of our global health, environmental, political, economic and social institutions.[3]

This paper was also informed by interviews with eight current and one former California county behavioral health director, who generously shared their understanding of the future of behavioral health and strategies for transformational leadership. Though no formal selection criteria were used, California behavioral health directors who were interviewed, in some measure reflect the diversity of CA counties—geography, size, and rural/suburban/urban. This paper was also enriched by interviews with several health care reform experts and leaders with lived experience with mental health and substance use conditions.

My understanding of leadership has been challenged and deepened by staff, consumers and community partners in the systems where I worked. And, finally, I wish to acknowledge the collaboration and guidance of Karen Linkens, who asked me to write a white paper on leadership and the challenges facing behavioral health in this time of continuing change.

* Appendix A includes a list of all persons interviewed for this paper.

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Executive Summary and Recommendations

> **The deep changes needed to accelerate progress against society's most intractable problems require a unique type of leader—the system leader, a person who catalyzes collective leadership.**
>
> **As these system leaders emerge, situations previously suffering from polarization and inertia become more open, and what were previously seen, as intractable problems become perceived as opportunities for innovation. Short-term reactive problem solving becomes more balanced with long-term value creation. And organizational self-interest becomes re-contextualized, as people discover that their and their organization's success depends on creating well-being within the larger systems of which they are a part.**[4]
>
> (Senge, Hamilton and Kania, 2015)

What must leaders do to insure that behavioral health systems are essential partners in achieving the Triple Aim: better experience of care, improved population health and lower costs? It is no longer enough for behavioral health leaders to focus solely on changes within their field. **Effective cross-sector system leadership is necessary to identify and respond to the forces shaping the health care landscape, to tap the potential of behavioral health to impact the social determinants of health, and to participate in creating a new health care ecosystem through:**

- Building integrated health and behavioral health systems of care that promote wellness and improve outcomes while reducing costs for persons with serious mental health and substance use conditions; and
- Collaborating with organizational partners and engaged communities to reduce disparities and achieve greater population health and social equity.

In this time of unprecedented and exponential change in health care, effective leaders of behavioral health systems must consider the following questions:

1. **What is the future of behavioral health?**
2. **How must behavioral health systems change to proactively address health care reform as well as other social, technical and environmental disruptions?**
3. **What is required to lead behavioral health system transformation?**

"Behavioral Health at a Crossroads: Leading for the Future" is intended to both enhance the practice of current executive leaders—and, most importantly to serve as a resource for emerging leaders. It explores trends in health and behavioral health care, identifying challenges, policy and practice recommendations and tools of change for behavioral health leaders. This discussion is grounded in interviews with current behavioral health leaders that offer context and practical approaches to change.

Section I explores the future of behavioral health care, focusing on key trends and areas of transformation such as care integration, increasing the capacity and quality of substance use disorder services, the continuing impact of stigma, the leadership contributions of people with lived experience with mental health and substance use disorders, the role of behavioral health in population health, quality improvement as a foundation of change, and the impact of technology.

Section II focuses on system and cross-system leadership as an imperative in this era of profound transformation in health care. Three domains of effective leadership are explored: developing a cross-system vision of the future, inclusion and accountability in designing and sustaining improvement, and, building and sustaining a learning organization. Strategies and tools for leadership are offered to support current and future behavioral health leaders in guiding their programs and systems to evolve and thrive in this era of profound transformation. Current theory regarding organizational leadership is explored and then made more concrete and relevant through the perspectives and practical experiences of behavioral health and health care leaders.

We know that health and behavioral health care must improve. Care is fragmented and the experience and outcomes of today's behavioral health services and systems are unacceptable. People with mental health and substance use conditions continue to experience stigma as well as disparities in access and quality of care—both behavioral health and health care, and, on our watch, they are continuing to die 30-40 years early. Leaders at every level—whether of programs or systems must take up the challenge of improving and transforming behavioral health? Leaders of behavioral health systems are truly at a cross road.

Key Recommendations

1. Behavioral health organizations must actively seek to partner with health plans and accountable care organizations to have a role in shaping health care systems of the future.
2. SUD, medical care services and health plans must work together—at both state and local levels, to design and implement a continuum of SUD services based on level/intensity of need, assuring access to evidence based/quality services at all points of care, and seamless transitions of care.
3. Stigma and discrimination must be widely understood as a public health issue that impacts access and outcomes for people with mental health and substance use disorders. Mental health stigma reduction campaigns, which have shown effectiveness must continue—including an emphasis on reducing stigma in health care. It is also critical to develop campaigns to reduce the stigma and blame experienced by people with substance use disorders.
4. BH systems will progress in address the need to build a larger, culturally/linguistically diverse workforce through increasing training, certification and educational support of persons with lived MH and SUD experience as frontline service providers, support staff and executive leaders.
5. BH must identify and share knowledge about engaging, motivating and sustaining healthy behaviors and community engagement to promote better population health.
6. BH systems must be supported (including financially) to rapidly adopt/adapt information technologies that improve consumers' access and experience of care as well as promote sharing of clinical and financial, and outcomes information sharing with medical care providers as well as payers.
7. Leaders must focus organizational attention (at every level) on measuring change and using data for improvement.
8. Leaders must actively promote both internal and cross-system improvement. Continuous quality improvement is at the core of transformational leadership.
9. Leaders must insure that BH is an active and contributing partner in health care and social services change processes through cross system engagement, leadership and collaboration.
10. Effective leaders can't operate in isolation. Establish learning exchanges and mutual support for transformational leadership within behavioral health professional organizations and support current and emerging behavioral health leaders to participate in health care leadership development.

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Introduction and Structure

What must leaders do to insure that behavioral health systems are included as essential partners in achieving the Triple Aim: better experience of care, improved population health and lower costs? What are the challenges for behavioral health leaders? This paper is based on the premise that **cross-sector system leadership is essential if behavioral health leaders are to be effective actors in shaping the health care landscape of the future.**

In this time of unprecedented and exponential change in health care, leaders of behavioral health systems must understand and address:

- **What is the future of behavioral health?**
- **How must behavioral health systems evolve/change to proactively address health care reform as well as other social, technical and environmental disruptions?**
- **What is required to lead behavioral health system transformation?**

"Behavioral Health at a Crossroads: Leading for the Future" examines trends in health and behavioral health care, explores organizational leadership theory and practice research as well as leadership lessons from the behavioral health field, and offers strategies and tools for system change. These trends might be reviewed as a whole, or specific domains can be used as a starting point for further research or dialogue.

Section I explores: What Is The Future Of Behavioral Health—The Next Ten Years. Historical, current and emerging trends in the organization and practice of behavioral health care are compared and contrasted with broader health care systems. (Figure 1. Two Eras of Transformation of Health and Behavioral Health Systems)

Key trends are also explored in more depth including challenges and emerging best practices illustrated by examples from the field, and recommendations for improvement. Topics include:

- Integration of Behavioral Health and Medical Care
- Substance Use Disorder Services—Increasing Capacity and Quality
- The Impact of Stigma and Discrimination in a Transforming Healthcare System
- Person's with Lived Experience: Leaders In Self-Directed Care and Wellness
- Community Engagement and Population Health
- Improving the Quality of Care
- Technology and the Use of Information

Section II provides: A Framework For Collective System Leadership examining the challenges and imperatives for effective leadership in behavioral health and health care. Three foundations of system/cross-system leadership are explored:

- Developing a Shared Cross-System Vision of the Future
- Inclusion and Accountability in Designing and Sustaining Improvement
- Building and Sustaining a Learning Organization

Current theory and research regarding effective organizational leadership is explored and made more relevant through the perspectives and practical experiences of behavioral health and health care leaders. Strategies, resources and leadership practice tools are linked to core leadership practices.

Section I: What is the Future of Behavioral Health—The Next Ten Years?

Voices from the Field: What is the Future of Behavioral Health?

Behavioral Health will be much more connected with health systems…comprehensive health and MH/SUD services (will be) available where clients/patients are accessing care and where their needs are best met.

-Maureen Bauman, LCSW, MPA, Director, Client Services and Adult Systems of Care, Placer County Health and Human Services Agency

Behavioral Health (hereafter BH)* will be considered as part of health care systems… Mind body connection will be seen as the focus of the health care delivery system and not separate.

-Khatera Aslami-Tamplen, Consumer Relations Manager, Alameda County Behavioral Health Care Services, Health Services Department

The focus will be on how the field can take care of the person's whole health and well being and how conditions in each realm affect recovery in the other realm. This movement to integration is reflected at client and system level—not just counties, but also at the State and federal level.

-Karen Larsen, MFT, Yolo County Department of Health Services, MH Director/AOD Administrator

In ten years there is a really good possibility that there won't be any BH carve-outs. Effective coordination of care and health homes will be key elements of this shift.

-Stephen Kaplan, LCSW, Director, BH and Recovery Services, San Mateo County Health System

* For brevity, Behavioral Health will be henceforth referred to as "BH". Mental Health will be referenced as "MH" and substance use disorders will be referenced as "SUD."

BH will naturally be a part of the larger health system. For persons with the most severe BH issues, there will be BH homes…which (may) include physical health care. Other health homes will have greater BH treatment capacity. The location of the provision of integrated care will be more determined by which health condition leads in impact on a person's life.

-Gail Zwier, PhD, Director, Inyo County Behavioral Health Department

I think our systems are eventually going to be carved back into the HPs…as our systems develop and integrate (SUD/MH), we are setting up an environment and a system that will transcend current issues and struggles around the carve out.

-Alfredo Aguirre, LCSW, BH Director, San Diego County Health and Human Services

There will still be specialty MH/SUD but not as much of the system will be carved out. The key…is to address and support the creation of more culturally specific/sensitive services-otherwise there will still be health and BH disparities.

-Yvonnia Brown, MSW, Mental Health Director,
Merced County Mental Health Department

We need to reposition specialty behavioral health as a vital part of a larger health system…We need to retain the commitment, passion and understanding of serious mental illness and recovery but that focus needs to expand to bringing this knowledge (as) a core element of a larger health system.

- Toni Tullys, MPA, Director, Santa Clara County Dept of Behavioral Health Services

We can agree that the future is not going to look like the present or the past. The evidence from other industries is that all industry is moving from linear to non-linear change. If we are leaders in BH systems we need to think about both scenarios.

- Dale Jarvis, CPA, Founder, Dale Jarvis and Associates, Seattle, WA

The Changing Behavioral Health and Health Care Landscape

The future of behavioral health must be understood and examined within the larger context of the evolution of health care and population health. Halfon et al. in a 2014 article in Health Affairs provide a graphic summary of the complex changes that have happened and are continuing to develop in the US health care system as it evolves from a "sick care system" to a "coordinated health care system"—and ultimately to a "community integrated health system." (Halfon et.al. Exhibit 1, Three Eras of Health and Health Care—Three Operating Systems[5]) This framework was adapted from a schema originally developed by the Centers for Medicare and Medicaid Services' Center for Medicare and Medicaid Innovation. Halfon et al. use their version of the eras of health and health care to provide a visual map "… to distinguish era-specific system design elements and to guide transformation to 3.0 systems."

I have expanded upon Halfon et al.'s work to identify goals, models of service, and key domains of behavioral health organization and practice that can be expected to drive the future of specialty behavioral health systems—and also to highlight potential contributions of the behavioral health field to wellness, self-directed care and community/population health. Figure 1 (below) is intended to provide a visual systems overview of important domains of health and behavioral health care that can be used to involve staff and stakeholders in understanding and planning for the future.

Figure 1. Two Eras of Transformation of Health and Behavioral Health Systems*

Definition	**2.0 Health Care System** - 1950s - Now	**3.0 Health System**	**2.0 Behavioral Health Now**	**3.0 Behavioral Health Systems of the Future**
Goal	Reduce chronic diseases	Optimize health	Reduce chronicity of MH/SUD and promote recovery	Optimize BH as essential to each person's whole health Promote health & healthy behaviors for MH/SUD population
Model of health/ disease		Life course development and multi-generational health	Biopsychosocial/ spiritual	Life course development and multi-generational wellness/recovery & health

Definition	2.0 Health Care System - 1950s - Now	3.0 Health System	2.0 Behavioral Health Now	3.0 Behavioral Health Systems of the Future
Focus of Services	Prevent/ manage chronic disease	Promote & optimize health of individuals and populations	No wrong door to treat Co-occurring MH/SUD, & evidence based treatment Individual/family focused Develop BH systems of care & coordinate BH/ medical care	Self care/ management Primary prevention/ early intervention with focus on life span, addressing social determinants of health Health literate & activated communities Whole health/ population health
Organiza-tional/opera-tional model	Accountable Care Organizations & Medical Homes	Community accountable health development systems	Carved out MH & SUD systems of care with developing medical care partnerships	Integrated BH as essential to whole health Community specific accountable health & social support systems
Health Information Technology	Electronic health care information exchanges connect various provider networks	Health and medical information follows the person; there is connectivity between the health and human service systems; and actors have access to real-time data on quality, costs, and outcomes for individuals and populations	Electronic medical records are widely implemented but generally do not have connectivity across MH/ SUD and do not connect or share information with health providers or payers	Health and medical information follows the person; there is connectivity between the health, behavioral health and human service systems Providers & payers have access to real-time data on quality, costs, and outcomes for individuals and populations Individuals use technology for self-care/self management and wellness promotion

Definition	2.0 Health Care System - 1950s - Now	3.0 Health System	2.0 Behavioral Health Now	3.0 Behavioral Health Systems of the Future
Quality of Care	Consistent quality; using standard quality outcomes and improvement processes through collaborative learning	High and continuously improving quality through a learning health system	Accountability driven periodic or annual outcomes data BH systems in early phase of implementing quality improvement systems	Continuous quality improvement is fully integrated into BH services and systems Providers use data for monitoring and improving population/ community health Clients use data for self-management and wellness
Payment mechanisms	Pre-paid health benefits and capitation	Health trusts and management of balanced portfolio of financing vehicles	Fee for service w/ Fed/State $ match Limited case rate/ pre-paid services	Balanced portfolio of funding with value based financing options
Role of health care provider/ provider organization	Prevent/ control risk, manage chronic disease and improve quality of care	To optimize health and well-being	Identify and manage chronic conditions & improve individual recovery	Optimize health, well being and social inclusion for individuals/families Promote community health
Role of individual in his/her health/ health care**	Not separately specified	Not separately specified	Increased focus on recovery/self-care	Activated person-driven care & Wellness
Polulation health improvement	Activated partner in care	Co-designers of health	From patients to Client Centered Care	Activated partners in addressing social determinants/ health disparities and co-designers of healthy communities

*Columns depicting BH future are this author's expansion of Halfon et al., Transformation of Health System chart.

**The role of the individual with lived experience was identified by key informants for this paper as requiring a specific and distinct focus rather than being subsumed within population health. This represents a potential contribution of BH to general health care.

Essential Domains of Behavioral Health System Transformation

A View of the Future of Behavioral Health

1. The boundaries between MH and SUD will continue to diminish. Anyone who specializes in either MH or SUD will have to be able to intervene with people receiving care in the other system. The MH/SUD fields will come together on a practice level.

2. There will be a further connection with primary care that will happen in variety of ways. Integration of MH/SUD care is part of larger health care integration. There is also need and pressures to integrate medical specialties and primary care.

3. All of health care--especially MH/SUD, must be grounded in the community in order to address social determinants of health in a systemic way. This requires multiple levels of intervention: individual, family and community.

What might this look like? The way that care is integrated should be in the context of health neighborhoods. Consortium of care providers with care integrated and shared, but also more than that. Also, will need to include link with community empowerment efforts that attempts to address the social determinants of health and wellness for each particular community. For example: Given the impacts of trauma and violence-need social/community institutions to be capable of addressing and supporting other members of the community to address. Health Plans will see costs go down if communities are empowered.

Marvin Southard, DSW, Director,
LA County Dept. of Mental Health

The following "conclusions" were generally shared as 5-10 year scenarios for BH.

- Behavioral Health will be (more) fully integrated into health care.
- Behavioral health systems are not likely to retain funding that is carved out from general healthcare, however, individuals with the most complex MH/SUD problems will continue to need specialty behavioral health care services.
- Behavioral health has much to contribute to the health care field's emerging focus on self-management/self-care and wellness.
- Persons with lived experience with mental health and substance use disorders (and their families) can make an essential contribution as teachers and leaders in the health care field, especially regarding recovery/resilience, wellness and person-directed care.
- Behavioral health systems have valuable and transferable experience in cross-sector partnerships as well as engaging and working in collaboration with diverse communities.

Payment reform and the transition to value/performance based payment systems, though beyond the scope of this paper, will increasingly drive change in BH systems. Preparing systems for value-based payment—moving from payment for volume to payment for value (outcomes) is an essential transformation focus of BH leaders. Readiness for payment reform requires delivery system re-design and using measurement for improvement—both of which are discussed in this white paper. (Dale Jarvis, who has worked extensively with payment reform for behavioral health systems is a useful source and provides links to payment reform resources through his website[6])

As states (including California) expand their Medicaid safety net services and BH funding and services are coordinated and integrated with larger healthcare provider and payer systems, it is unclear how much of the current structure of publically (county) directed systems of specialty mental health and substance use disorder services will remain; to what extent public/private partnerships will increase; and, to what extent public sector services will be privatized. Public sector specialty services and provider organizations are beginning to actively focus on partnering with health plans and to a lesser extent, accountable care organizations (ACOs) in order to participate in shaping the future of health care. ACOs while not yet dominant players in Medicaid-driven public sector BH, are a significant and growing factor in the provision of Medicare, state health exchanges, and private medical care. According to a June 2015 Health Affairs blog post,[7] the number of ACOs are continuing to expand in CA, serving more patients with 1.3 million individuals receiving care through ACOs by 2016. What is more impressive is the data regarding improved quality of care and patient satisfaction in California ACO's compared to other medical groups with the exception of Kaiser.

The scope of this paper permits discussion of only selected domains of system transformation—many of which are identified in Figure 1. "Two Eras of Health and Behavioral Health Systems Transformation."

- **Integration of Care**
- **Substance Use Disorder Services—Increasing Capacity and Quality**
- **The Impact of Stigma and Discrimination in a Transforming Health System**
- **Person's with Lived Experience: Leaders in Self-Directed Care and Wellness**
- **Community Engagement and Population Health Improvement**
- **Improving the Quality of Care**
- **Technology and the Use of Information**

Integration of Behavioral Health and Medical Care

Behavioral health is becoming a core service for a broad range of conditions in health homes, which are the emerging central locus of individual and family health care. However, for the future, specialty behavioral health systems will be necessary to insure adequate care and recovery supports for individuals with complex and/or co-occurring BH and medical conditions. For this reason, behavioral health homes that insure basic health monitoring and primary care will be developed in parallel to medical health homes. The integrated treatment of co-occurring and complex conditions will become the norm in both BH and medical care.

> **"As a BH Director in very Small County, we are a part of a larger Health and Human Services System, which has informed the leadership of BH. Integration of health and BH is the most recent stage of our health system's movement from parallel play to fuller/ true integration. Started with focus on integrating BH into Human Services.—I would like to think that integration will have fully taken place within ten years, while there will still be room for BH specialty care if needed. BH will naturally be a part of the larger health system."**
>
> Gail Zwier, PhD, Director, Inyo County BH Department

There is broad agreement that primary care health homes will continue to expand their capacity to treat mental health conditions

and substance use disorders. Collaborative care for co-occurring behavioral and medical conditions is becoming standard care in primary care clinics. With expanded Federally Qualified Health Center (FQHC) requirements for provision of BH services, clinics are hiring licensed mental health clinicians (and a smaller number of substance use disorder counselors), while larger clinics have substantial behavioral health departments. While collaborative care models were initially targeted to the treatment of depression, anxiety and more stable mood disorders, these boundaries are expanding to include treatment of more serious disorders that can be addressed in an outpatient setting with the availability of psychiatric consultation.

Integrated Care Resources

Policy, financing, administration, workforce and practice:

- **The SAMHSA-HRSA Center for Integrated Health Solutions http://www.integration.samhsa.gov**
- **AHRQ Academy for Integrating Behavioral Health and Primary Care http://integrationacademy.ahrq.gov**
- **IBHP: http://www.ibhp.org**

Small and rural counties have unique strengths and challenges in integrating care. As the only game in town, county BH has historically served all comers. At least in California, the transition to integrated care based on the 2010-15 Bridge to Health Care Reform Medicaid 1915b Waiver has actually led to more bifurcated systems of care for mild/moderate and serious BH conditions where there was previously more open access.

Over the next five years, behavioral health homes will become a core model of care for individuals with mental health and co-occurring MH/SUD conditions that require a range and intensity of services beyond the capacity of primary health homes. The challenge for behavioral health systems/organizations is to move rapidly to develop and test emerging behavioral health home models in order to assess effectiveness and identify key practices and designs that result in positive physical/behavioral health outcomes as well as cost effectiveness. In California, both the Medicaid 2020 Waiver and the CMS 2703 Health Home Innovations program provide a framework and funding for BH Homes. BH leaders must be able to demonstrate both the value of specialty BH health homes and how these systems can effectively coordinate care with broader healthcare.

Care integration also requires a continued focus on the integration of MH and SUD to identify and treat co-occurring disorders, insuring "no wrong door," improved access to care and the capacity of practitioners to be competent to provide both basic MH/SUD interventions and recovery support. In a parallel with primary care, primary behavioral health services should be integrated with rapid access to specialty MH or SUD services when needed.

Challenges in Promoting Integrated Care

- BH specialty care has demonstrated a positive impact on the correlates of serious MH/SUD such as trauma, homelessness, unemployment, and criminal justice system involvement. However, outcome measurement has not been systematized to track or measure the impact of BH in addressing larger health care utilization or costs.
- How will BH demonstrate the business case for BH homes and specialty care systems including health care and social cost offsets and/or savings for various levels of care?
- Levels of integrated/coordinated care must be linked to population needs. What MH/SUD populations will continue to need specialty BH care—including BH Homes, and what populations can benefit from primary care based integrated services?
- How will primary care and BH coordinate care and support transitions in care?
- What new opportunities are there for BH and primary health providers to work together to increase the availability of culturally/linguistically appropriate services inclusive of practice-based evidence and traditional healing?

Recommendations

- BH leaders should monitor emerging best practices in implementation of health homes—especially the experience of early implementer states/provider systems.
- Focus on health home readiness and capacity development. BH systems should begin to implement integrated care solutions based on their local resources and infrastructure to insure that the building blocks for coordinated care and health homes are designed, tested and implemented.
- Public sector specialty BH provider systems/organizations must actively partner with health plans and accountable care organizations in order to participate in shaping the health care systems of the future.

Substance Use Disorder Services—Improving Capacity and Quality

Improved access and capacity for substance use disorder treatment are essential to achieving better individual and population health. SUD services must be expanded and better integrated into all levels of health care. However there is a national crisis regarding capacity and quality of SUD services—especially in light of a well documented national increase in substance dependence/abuse (particularly prescription narcotics and heroin.)

In California, an amendment to the State's healthcare reform Medicaid waiver supports the development of an organized SUD system of care. Most BH directors interviewed for this white paper took the position that County directed SUD systems of care must be strengthened before services and funding are integrated into the broader health care system. However, the necessary of first building a separate specialty SUD system of care

and then going through a care integration process should be questioned. California's (and other states') MH carve out experience (strengths and challenges) should be examined to avoid the fragmentation that is common to specialty and primary MH services—and, to more effectively and rapidly implement a bi-directional integration of SUD at the primary and specialty levels of care.

The Call for an Organized SUD System

"What about SUD? — If you visualize concentric circles of integration, with PC in the center, MH has been integrated to some degree and SUD has considerably further to go in terms of integration with primary care not to mention SUD integration with MH. In California Medicaid SUD remains largely siloed in a separate Drug Medi-Cal system and unfortunately integration seems to be a tertiary consideration in Drug Medi Cal as we know it. Systems looking to respond to integration priorities will work around the siloed Drug Medi Cal system to address whole person care particularly when addressing prescription narcotic misuse."

Peter Currie, PhD, Director of Behavioral Health, Inland Empire Health Plan, CA

SUD, has been dramatically underfunded for such a long time, even though we know that there are immediate people and fiscal benefits SUD recovery to health systems as well as improved outcomes....Placer County has integrated adult (health and humans services) system of care...However, even in an integrated system, it is difficult to get SUD services connected to health clinics. There...(needs to) be an effort to improve access and linkages to SUD.

Maureen Bauman, LCSW, MPA, Director, Client Services and Adult System of Care, Placer County Health and Human Service Agency

The SUD system is disjointed—even though there are many good services, and at this point everything is decentralized. (Counties given their) history with health integration and children's system of care services... are in the best position to build a SUD system and to prepare for eventually turning over (a functioning system) to a health plan authority. It will be a total mess if this happens too soon. Good pockets of services, but we have no ability to control or assess costs, quality. At this point there is no solid baseline or metric for quality, but it is BH duty to have these systems better established and data driven.

Alfredo Aguirre, LCSW, BH Director, San Diego County Health and Human Services

A recent white paper by the Addiction Technology Transfer Center-ATTC, "Integrating Substance Use Disorder And Health Care Services In An Era Of Health Reform" (March 2015)[8] summarizes the case for bi-directional integration of SUD: primary care-based SUD and the inclusion of health care services in specialty SUD programs emphasizing the importance of integrating SUD into general medical care as well as the widespread adoption of evidence based SUD interventions. The CalMHSA Integrated Behavioral Health Project provides a case study that documents the progress of integrating SUD care in five community Health Clinics.[9]

ATTC cites the research evidence for the following core practices for an integrated SUD system:[10]

1. SBIRT	5. Contingency Management
2. Medication Assisted Treatment	6. Trauma Informed Care
3. Motivational Interviewing	7. Technology Assisted Care- range of services: phone-based or telehealth services, web-based or stand-alone computer applications
4. Cognitive Behavioral Therapy	

Few of these evidence-based practices are routinely offered in specialty SUD or primary care clinics. It has taken decades to make much progress in integrating treatment for co-occurring MH/SUD. We cannot afford a similar delay in medical care/SUD integration. In health care there is general awareness of the impact of SUD on medical conditions, but little urgent action. The current epidemic of prescription narcotic dependence/abuse presents an opportunity for SUD providers to work with primary care and pain management specialists to develop an integrated team-based approach to pain management that could improve care for patients while reducing service demands and cost.

Challenges For Improving SUD Services:

- What SUD services can be integrated within primary/medical care and what SUD conditions require an organized specialty SUD system of care? In CA, how can the SUD amendment to the 1115b Medicaid Waiver promote both integration and increased specialty SUD capacity?
- In building an SUD system in California, how can leaders avoid replicating the problems created by the bi-furcated system of care for mild/moderate and serious MH conditions—especially in areas such as pain management, withdrawal management?
    - What are the key design elements and steps for building an organized SUD delivery system?
    - How might proven implementation tools such as learning collaboratives, learning communities, streamline design and implementation processes?

- What is the role of Health Plans in coordinating across medical and specialty SUD services?
- What are the most effective strategies for bi-directional integration of SUD and primary health care? Can integrated care for prescription pain medication misuse/abuse provide a model for effective care for other co-occurring conditions?
- What are the most effective strategies for spreading evidence-based and promising SUD practices for prevention, treatment and recovery support?
- How can workforce capacity be rapidly expanded, including credentialed and licensed clinical practitioners as well as addiction medicine specialists?

Recommendations

- SUD, medical care services and health plans should collaboratively —at a statewide and local level, design a continuum of SUD services based on level/intensity of need, assuring access to evidence-based/quality services at all points of care, as well as seamless transitions in care for clients/patients and providers.
- BH leaders should work with statewide technical assistance organizations to insure that emerging models of integrated SUD care and best practices in SUD are promoted within BH and with partnering health care systems.

The Impact of Stigma and Discrimination in a Transforming Health System

Stigma and discrimination lead to disparities across multiple life domains for people with MH, SUD and co-occurring conditions. How stigma is defined and experienced is also defined by culture—both culture as it is traditionally understood (racial, ethnic, etc.…) and also organizational culture such as the different work cultures of primary care and behavioral health. Stigma can be differentiated as "public stigma," "self-stigma," and "institutional stigma". All of these dimensions of stigma impact the health and wellness of persons with MH and SUD conditions. Stigma contributes to lack of access to behavioral health and general health care services and leads to discriminatory and poor medical care, under-diagnosis and under-treatment. Untreated MH/SUD results in increased medical costs and poor outcomes. As a BH Director, it was not unusual to hear stories from consumers who sought emergency or primary care for a physical health concern—only to have their symptoms dismissed as symptom of their mental illness. Clients are often reluctant to disclose their mental health conditions or use of psychotropic medications because of fear of discriminatory treatment by health providers. With the movement to develop health homes and integrated care, there is an expectation that integration of behavioral and physical healthcare, will diminish stigma and improve treatment for the medical conditions of individuals with serious MH/SUD. For example, Federally Qualified Health Center regulations now require the provision of behavioral health services, which is creating greater awareness of the

impact of behavioral health conditions on general health. Some primary care clinics have developed robust behavioral health departments though these services are often segregated from medical services. SBIRT, though unevenly implemented is beginning to build more awareness of SUD. An increasing number of states and primary care provider associations offer MH and SUD training and consultation for providers. But, these are only the beginning of what is required to address the negative impacts of provider and institutional stigma in healthcare.

> **"Institutional stigma" occurs when negative attitudes and behaviors about mental illness, including social, emotional, and behavioral problems, are incorporated into the policies, practices, and cultures of organizations and social systems, such as education, health care, and employment. (CalMHSA, Stigma and Discrimination Reduction Plan, 2011, http://calmhsa.org/wp-content/uploads/2011/11/CDMH_MH_Stigma_Plan_09_V5.pdfc)**

Over the past ten years, stigma related to MH has been better addressed than the stigma associated with SUD—especially drug dependence/abuse. In order to improve SUD identification as well as access and service retention, It is critical to increase public and provider awareness that SUDs create changes in the brain that can may manifest as "chronic" and relapsing disorders; that effective treatment often requires both medical and social model services and supports; and that people do recover. SUD capacity and quality has been discussed in the previous section, however the role of stigma in poor treatment of SUD must be addressed in the health care.

In California, peer leaders as well as local and statewide organizations—most notably the California Mental Health Services Authority (CalMHSA), with funding through the 2004 Mental Health Services Act, are now leading successful stigma and discrimination reduction (SDR) campaigns[11] with initiatives targeted across the lifespan and diverse populations. Within these SDR initiatives there must be increased attention to the impact of provider and institutional stigma health care organizations.

Challenges in Addressing Stigma and Discrimination

- The integration of MH/SUD and general healthcare will not have a significant positive impact on stigma unless health care providers are not only better trained about MH/SUD conditions and impact of stigma on health outcomes.
- The rapid pace of primary care practice—especially for physicians, can serve as a barrier to the assessment and appropriate care for individuals with complex MH/SUD and medical conditions. Disparities and stigma/discrimination in treatment will

result until practices are structured to offer intensive levels of primary care and/or team based care for persons with complex conditions.

- Individuals with complex MH/SUD/medical conditions (and their families) benefit from health advocacy, care coordination and health coaching, which is often best provided by peers/persons with lived experience. Peer providers on the health team decrease provider and institutional stigma as well as the self-stigma of patients/clients. While payment for peer providers is becoming reimbursable in most states' behavioral health services, medical provider payment generally does not provide reimbursement for peer provider services.

> **"...substance use disorders are the conditions that we separate out/ compartmentalize the most. We don't give substance use disorders the proper attention and we don't treat people with SUD with the same level of respect and attention... The biggest change that has to happen is to reduce stigma regarding SUD and getting the entire systems to see SUD as chronic health condition. The SUD relapse rate is almost the same as diabetes and other chronic heath conditions and yet there is still a moral judgment regarding people with SUD."**
>
> Karen Larsen, MFT, Yolo County Dept. of Health Services, MH Director/AOD Administrator

Recommendations

- Health home and ACA waiver programs should include reimbursement of peer provider services—including peer providers for outreach, engagement of underserved people.
  - Health provider organizations (or health plans/ACO's) should assess the impact of the of peer provider services on medical service access, retention and outcomes.
- BH leaders must invest—funding and staff resources, in local stigma reduction initiatives to address the continuing impact of stigma on access, care and wellness. Local initiatives should include partnering with individuals/families, and diverse communities to develop strategies that align with community defined practices and culture – as well as involving these partners those to support/"broker" stigma reduction outreach (messaging).
- SUD stigma reduction campaigns should be aimed at both the general public and providers, to improve access and quality of care. Effective stigma reduction/social inclusion strategies should be based on successful national initiatives including the CalMHSA Stigma and Discrimination Reduction campaign.

People with Lived Experience: Leaders in Self-Directed Care and Wellness

BH systems have made progress in recognizing, hiring and supporting people with lived MH/SUD experience (and their families) as providers, advocates, and leaders. Although there is still a long way to go, counties and provider organizations are hiring consumers in a range of peer and family/parent support roles, and a growing number of systems have developed internal Consumer Affairs/Consumer Relations offices. Non-profit peer-directed agencies are operating wellness and recovery programs as well as peer-run crisis respite. Many states have adopted peer training and certification programs and are billing peer services to Medicaid. California's 1115 Waiver renewal proposal, Medicaid 2020 provides for peer provider certification.

Consumer leaders interviewed for this paper emphasized the importance of investing in consumer skill development–including leadership development. A growing number of California counties including Orange, San Mateo, Contra Costa, Los Angeles, Solano and Alameda have developed peer leadership "academies" or partnered with community colleges to develop human resource and peer certification tracks. However, skill development, effective self and system level advocacy, and executive leadership development, remain areas where more needs to be done. This must include insuring ethnic and cultural diversity of consumer leaders—very much the focus of many peer advocacy organizations. There is also recognition among consumer leaders that they need to pay attention generational changes in the wants and needs of consumers. Young adults and transition age youth do not have the same experience of institutionalization as the pioneers in the consumer rights movement—and their issues and priorities are different.

The contribution BH consumers can make to health and wellness through promoting person/patient directed care is less well understood. Consumer-designed tools have been developed to support recovery and self-management of individuals with co-occurring behavioral and medical conditions. These tools/programs can also promote the wellness of individuals with chronic medical conditions. In addition, medical providers can benefit from the BH experience with peer-led engagement, recovery support and relapse prevention services. Currently patients with chronic medical conditions are offered self-care classes that provide little individualized support. The adoption and adaptation of successful consumer developed self-care practices such as Wellness Recovery Action Plans (WRAP) and Whole Health Action Management (WHAM)[12] available in both English and Spanish and Its My Life: Social Self Directed Care[13] (sponsored by Mental Health America) can improve self-management for chronic conditions such as diabetes and cardiovascular disease.

Challenges in Supporting Consumer/Family Directed Services and Care

- How will peer providers become routinely integrated into the BH workforce in a range of meaningful paid jobs? How will positive benefits be documented re: workforce capacity and diversity?
- How can executive leadership development be promoted in BH and consumer-run organizations?
- What can be consumers teach BH about the uses of technology to promote health literacy, self-management, better health and wellness? How can this learning be transferred and adapted to physical health care?
- How can evidence-based and promising self-directed care, self-management and health promotion programs be spread across primary care and specialty BH for individuals with complex and chronic conditions?

Recommendations

- Insure/provide training, certification and educational support for persons with lived MH and SUD experience to serve as frontline providers, support staff and executive leaders to build a culturally and linguistically diverse workforce.
- Promote the use of self-directed care, self-management programs in primary care as well as specialty BH. Health plans should take state and local leadership to introduce the use of these self-management support services/programs.

Community Engagement and Population Health Improvement

Dramatic improvements in population health will not be a product of even the most sophisticated and accessible healthcare system. A new initiative co-sponsored by the Institute of Medicine and the Stanford Social Innovations Review, "Communities Creating Health" (May 2015) is focused on the importance of community partnerships and community-defined health: "a strong, healthful, and productive society which cultivates human capital and equal opportunity."[14] Halfon, et al (Health Affairs, 2014)[15] describe the fundamental challenge for the US health system to be that of insuring large-scale system reform focused on "life-course influences and on optimizing population health development."

Behavioral health can contribute to the movement for population health by synthesizing and sharing BH knowledge about how to promote behavioral change and healthy behaviors at an individual level—and through working in partnership with communities.

BH systems have a 30 plus year history of interagency partnership with education, social services/child and family services, housing, and criminal justice to address poverty and

other social determinants of health that impact MH/SUD. Uniquely in California, the 2004 Mental Health Services Act (MHSA) provided dedicated funding for prevention, early intervention and innovation within each county and at a statewide level. For example, the MHSA-funded, California Reducing Disparities Project[16] is a multi-year statewide planning and community defined effective practices evaluation initiative that is yielding groundbreaking information about effective and promising practices as defined by five under-served ethnic/cultural groupings. These community outreach and engagement collaborations should be examined as innovations that can support the broader health field's expanding focus on population health.

> **"It would be helpful for BH to really embrace the idea of being ambassadors within health care and working in the space, between BH and broader health care....If we (BH) are going to be successful, we are going to have to reach out and demonstrate where our value lies... This evolution in the scope of what we see as whole person or community health will become more important than maintaining agency integrity over time and agencies will transform in response to an overriding priority of achieving the triple aim through integration."**
>
> Peter Currie, Behavioral Health Director, CA Inland Empire Health Plan

At a local level, counties including Los Angeles and San Mateo and San Diego have large-scale initiatives to move from BH organization-centric services to active partnership with communities and consumers to develop "health neighborhoods" and "Community Service Agencies." It is important to learn, document and share the results of these initiatives, not only within the BH sector but also, more broadly with public health and community health promotion initiatives. BH organizations have significant learning about community outreach and collaboration to share with health care providers who are just now expanding beyond the four walls of clinics. At the same time, BH community partnerships are too often "silo'ed" and have failed to benefit from the work of foundations such as the California Endowment and the Robert Wood Johnson Foundation, that have made major investments in population health/building healthy communities.

Core to building effective partnerships is understanding that communities are complex social groupings, grounded in the uniqueness of "place" (geography) and also defined by factors including socio-economic status, political affiliation, faith, health status and the specific needs and priorities of diverse population groups. Chavis and Lee, in "What is Community Anyway?" describe the complexity of communities: "Most of us participate in multiple communities within a given day. The residential neighborhood

All of health care--especially MH/SUD, must be grounded in the community in order to address the social determinants of health in a systemic way. This requires multiple levels of intervention: individual, family and community. What might this look like? The way that care is integrated should be in the context of health neighborhood. Consortium of care providers with care integrated and shared, but also more than that. Also, will need to include link with community empowerment efforts that attempts to address the social determinants of health and wellness for each particular community. For example: Given the impacts of trauma and violence-need social/community institutions to be capable of addressing and supporting other members of the community to address. Health Plans will see costs go down if communities are empowered.

Marvin Southard, Director, LA County DMH

The importance of BH was judged by the absence of the visible experience of a problem as opposed to being a contributor to the health of the community. In order for BH to have a more prominent place in the community, we need to look at another way to align with the community to pick up on the values that the community holds and make sure that any changes being suggested fall in line with these community values. Sometimes it's on a very practical level where can we find the common ground for the need to make a change. If change doesn't feel relevant to the stakeholders/community, then it's not going to happen. In addition, in a small county, the community is really any of the people who live in the area.

Gail Zwier, Inyo County BH Director

remains especially important… But for many, community lies beyond. Technology and transportation have made community possible in ways that were unimaginable just a few decades ago."[17]

Improving population health requires partnership with multiple "communities." Health systems, including BH, need to learn about engaging, partnering and supporting communities to define and act on: What is health/wellness? What are each community's specific goals and priorities? How can community engagement support the role of local leaders who can mobilize the communities' resources in partnership with public sector services (including BH)? What strategies are effective in promoting community health across diverse populations? If population health is a key to health system transformation, then BH needs to be an active learner and partner in this fundamental change. This is not a natural arena for BH leaders but one that requires attention and growth.

Challenges for Community Engagement and Improving Population Health

- How can the learning of BH systems about engaging and partnering with communities, including under-served and/or diverse communities, be disseminated to health systems?
- What collaborative leadership skills/functions can BH bring to population health initiatives?
- What can BH (including consumers) teach health care providers/systems about motivating and sustaining self-care and health promoting behaviors that leads to better population health? What is the relevant research and practical applications?
- What tools/strategies can health/BH systems and community partners use to evaluate the success of population health initiatives? How can results of assessments and data be formulated and shared so that it is understandable and relevant to community members?
- What are effective strategies for knowledge transfer among health/public health organizations, community based coalitions, and organizations/foundations that are conducting population health research?

Recommendations

- BH and health care systems must identify and disseminate research and practice knowledge (often compiled by foundations) regarding community engagement for population health.
- BH must assess, evaluate and disseminate, best practice knowledge from the BH field about the role and contributions of BH in population health:
    - What has BH learned about partnering with diverse communities/communities with significant health disparities to achieve wellness goals?
    - What has BH learned about the social inclusion of persons with disabilities?

- BH organizations need to create opportunities for emerging leaders to engage in population health practice including public health leadership approaches and community engagement.
- BH leaders should support and fund community advocacy and community member leadership to increase community involvement and influence in policy and decision-making.
- BH must articulate and disseminate BH research and practice-based knowledge about engaging, motivating and sustaining healthy behaviors to promote better population health.

Quality Improvement

Quality improvement is foundational to achieving the Triple Aim. Improvement methodologies such as the Model for Improvement and LEAN are being widely disseminated and adopted by hospital and health care systems and payers. The Institute for Healthcare Improvement has led hundreds of quality improvement learning collaboratives for community health centers as well as for large and complex health care systems. The Institute of Medicine (IOM) in a recent report, "Closing the Quality Chasm: A Proposed Framework for Improving the Quality and Delivery of Psychosocial Interventions" (August, 2015) calls for adopting a system of quality improvement as a fundamental and necessary step for behavioral health systems—especially in light of health care reform and payment reform. The IOM report emphases the key role of consumers in quality improvement.

> *"Adopt a system for quality improvement. Purchasers, plans, and providers should adopt systems for measuring, monitoring, and improving quality for psychosocial interventions. These systems should be aligned across multiple levels. They should include structure, process, and outcome measures and a combination of financial and nonfinancial incentives to ensure accountability and encourage continuous quality improvement for providers and the organizations in which they practice."*[18]

However, BH as a field has been alarmingly slow to adopt quality improvement as core to organizational culture and practice. As BH directors interviewed for this paper acknowledged, fee for service funding and service regulations have emphasized quality assurance (checking for errors) rather than quality improvement.

Consumer leaders interviewed for this paper highlighted quality improvement and the movement in health care for transparency about service quality and satisfaction as critical for improving care: *"Individuals and families (should) know satisfaction scores for providers…The public should have access to have quality of care data as well... Makes data more transparent. We should have Report Cards that compare programs and services—in BH as well. (K. Aslami, Director, Office of Consumer Empowerment, Alameda County, CA)*

A growing number of California BH Directors and BH Medical Directors are adopting quality improvement methods for specific initiatives such as the integration of BH and primary care, implementation of new information systems, and improving access. Several BH Directors cited quality improvement as a key to organizational progress describing their efforts and the challenges of routinely integrating data and measures in management decisions.

- Reviews of negative outcomes led to a focus on improvement… Includes analysis of suicide and mortality rates… In San Diego, analyses of poor ER and hospital discharge outcomes led to a program where trained peer counselors provide follow up and insure care coordination for clients discharged from the county hospital. The incidence of suicide went down dramatically after this program was initiated. Learning from data made a difference.
- Counties that participated in quality improvement care integration "learning collaboratives" have used tool such as workflow analysis and process mapping to improve referrals, and medication reconciliation and other care coordination processes across BH/primary care.
- "Progress not perfection" "we're headed in the right direction." I use a rapid process improvement model on a regular basis. Will start testing changes, which may not be completely "fleshed out." Example: improving time for access and time to complete assessments. It previously took 2 months for completion of assessment—moved to daily triages and included all key staff in the change to improved access. Over past 6 months have made adjustments and includes all involved staff not just direct service but also front desk, billing staff. Make adjustments/testing as go. Assessments are now occurring within a week and there are daily triage appointments, urgent care appointments and post hospital discharge appointments. (K. Larsen)

However, most directors acknowledged that quality improvement approaches do not represent the norm. The challenge for BH systems is how to shift to quality improvement as a routine way of doing business.

> *The issue is that in general in BH, we have not been successful, except in small pockets, in using quality improvement processes to generate better outcomes. It's a struggle to get BH to routinely operationalize improvement methodologies. Models for QI and approaches to changing operations are still pretty archaic. The medical field is moving forward much more rapidly with integrating improvement methodologies. The majority of SUD/MH professionals brought into the field and rising into leadership roles where they could make change do not identify themselves as agents of change and are not trained in quality improvement. This is one of our biggest challenges.* (L. Rogers, Director, San Mateo Health System, San Mateo County, CA)

Figure 2 (next page) provides examples of BH transformation imperatives that can be achieved through quality improvement.

Figure 2. BH Transformation Imperatives and Quality Improvement Strategies

Change Imperative	Improvement Focus	QI Process/Strategy
Integrated Health/BH Care	-Rapid/same day access -Monitor physical health vitals -Use care managers to coordinate care -Medication Reconciliation -Support client smoking reduction, exercise & other healthy behaviors	-Map current integrated care processes, identify bottlenecks, redundancies and design new workflows -Test new processes and/or workflows on small scale (PDSA rapid test cycles) -Implement in with small number of providers & continue to improve processes -Spread to more providers, continuing to test and adapt as needed
Reduce criminal justice recidivism of persons with MH/SUD conditions	-Cross-sector collaboration of criminal justice, BH, health, housing & social supports, employment agencies -Insure access to health, housing, financial, employment and social support services	Develop Partnership Improvement Plan: -Specify partners shared aim and goals -Identify initial target population for criminal justice realignment (CA AB 109) -Select improvement objectives (e.g. insuring benefits are applied for before release, link to community supporter, insure care transitions) -Map workflows to identify partner's role(s) re: access to care and supports -Run PDSA cycles, measure results over time, adjust interventions -Implement and spread improvements
Using data for transformation	-ID core measures for improvement (data report card domains) -Use results of measures to guide management decisions -Routinely share data with consumers, funder and public	-Identify initial organizational area/domain(s) for testing use of data for improvement -Measure data over time for targeted improvements, e.g., time from referral to 1st appt., screenings completed, percentage of patients with medical vitals, ED use, hospital readmissions… -Test and implement changes to improve results in core measures -Leader celebrates improvement and identifies areas for continued improvement cycles.

Challenges In Developing an Organizational Commitment to Quality Improvement

- Leaders must commit to quality improvement as a personal leadership priority—in the face of competing demands, in order to build quality as a core organizational culture.
- Selecting and sustaining the use of a quality improvement method(s) that provide a practical framework for designing, testing and implementing fundamental organizational change…
- How can leaders insure that staff throughout the organization actively uses QI skills and tools, including first line supervisors?
- How can consumers/other stakeholders have meaningful involvement in quality improvement?

Recommendations

- Leaders must become knowledgeable about quality improvement and sustain organizational commitment to the routine use of measures and data for improvement. (Organization-wide)
- Leaders must develop a culture of improvement through visible executive attention over time to organizational learning.
    - Select a small number of key improvement aims to build successful experience baseline—and avoid overwhelming staff.
    - Train involved executive, management, supervisory and line staff in basic improvement technology; measure improvement/results over time; implement and spread changes—and acknowledge success.
- Involve consumers and key stakeholders in quality improvement processes: identifying aims for improvement, participating in planning and testing changes, measuring/assessing results.

Technology and the Use of Information

Information technology is disrupting health care – and yet BH systems (especially safety net providers) are at best late adopters. County BH Directors understand that technology—including currently available technology, is changing how care is accessed and provided, how information is communicated, care coordinated, how individuals track and manage their own health and wellness, and how quality is evaluated.

It is also generally understood that youth and "millennials" will drive profound change in how care is accessed and provided. Younger people may choose to rely on digital and virtual technology for health information, for communication (with providers and peers)

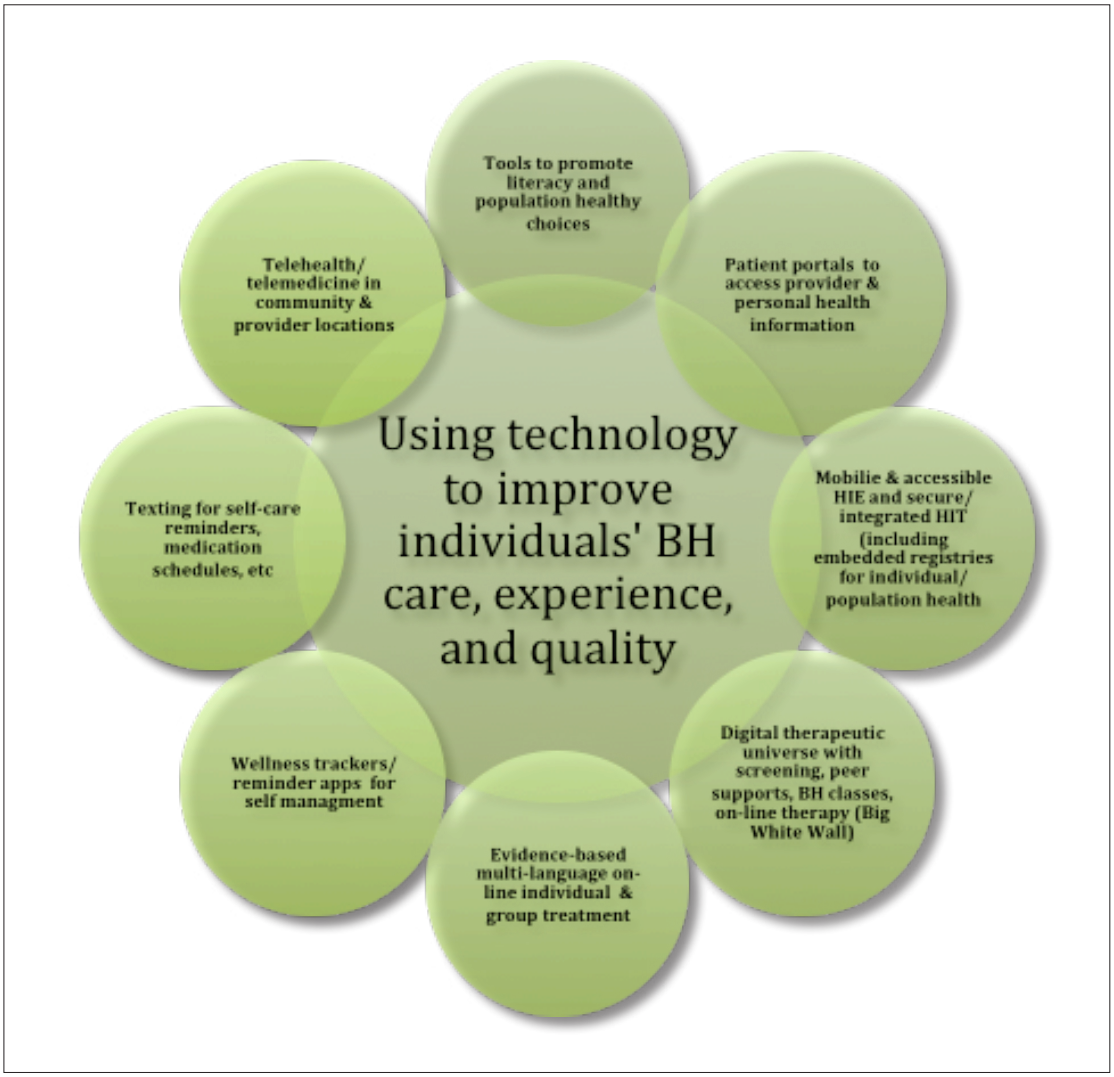
and, as a replacement for face-to-face treatment services. A June 2015, Health Affairs Blog Post describes an innovative digital mental health system that includes screening, peer support, education and on-line therapy access. "Big White Wall"[19] has been found effective in England, Australia and is now being implemented in in the in Washington, Oregon, Texas and California. Digital disruptions such as "Big White Wall" provide 24-hour access will change care in ways that are yet to be understood.

> **"Technology is going to take us to a whole other dimension. People are reluctant to think about using technology for treatment but that is where we are moving. People are fast paced and want immediate access... If we want to go where society already is—and also think about the corporate world, private entities, hospitals, they are using more technology in medicine than BH. Think about how people use technology in their daily lives, grocery stores, internet, etc. We have to move into the 21st century with out of the box thinking. Technology is where the disruptive change is going to happen."**
>
> Yvonnia Brown, MSW, Mental Health Director, Department of Behavioral Health, Merced County, CA

> *It is exciting to see how technology can make it possible to hold providers more accountable to provide the best quality and customer services. YELP allows consumers to rate providers and make sure that experience is the best. Apps are available to allow you to make appointments and email doctor. Use of watches and fitness trackers that track heart rate, exercise, etc. There was a conference in SF about information technology for public entities because they are slow in adopting new technology to support communities in need.* (K. Aslami, Director, Office of Consumer Empowerment, Alameda County, CA)

Yet beyond telemedicine, BH Directors did not seem focused on using innovative technology. It appears likely that private industry and even medical care providers will be the drivers for BH's adoption of health technology. It is also critical to understand the power of consumers as drivers of innovation that is outside the usual health care focus on electronic health records, registries and related information sharing vehicles.

Figure 3. Current and Future Uses of Technology that can be Adopted/Adapted in BH



Resources and initiatives for technology development are lagging in an inverse relationship to technology's potential for system disruption.

> *"What we might see is that the whole system will be turned on its head because consumers become empowered by technology to get care and health information in new more convenient ways. We will have to be more adaptive to consumer preferences as consumers shape health care through new technologies…The Biggest danger is repeating history, the more engrained we*

are in our agency or health delivery system silos, the more likely we are to be by-passed by change and then we will not available to advise and ensure quality care is not compromised by popular new health care delivery portals. We must be proactive in this area of change and reach (outside) of our …well-worn pathways to ensure quality BH and physical health integration solutions emerge." (Peter Currie, PhD)

Challenges in the Adoption of Technology Innovations

- Technology innovation is exponential in contrast to the relatively slower development of information technology sharing solutions being implemented in behavioral health systems.
- The ACA provides for financial incentives to the medical field for information systems and technology development, but BH has been denied this support—and treated as separate from general health care. This has slowed adoption of IT systems and other technology.
- Safety BH systems are often subject to government regulations that limit and slow the adoption and use of information technology systems and tools.
- Concern about protection of confidential MH/SUD information has led to slow adoption of technology that is increasingly common among health providers such as on-line medical records and communication portals.

Recommendations

- BH systems must focus not only on IT systems, but also on technologies that improve consumers' access and experience of BH services. Consider web portals, smart phone and tablet applications that offer provider contact, reminders, promote self-help and wellness…
- BH systems, hospitals and primary care clinics that are working to integrate care should join together to advocate for payer and State support for improved technology platforms and systems that allow clinical and financial tracking as well as outcomes information sharing.

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Section II: A Framework for Cross System Leadership

The challenges of innovation and the pace of change in behavioral health care require today's leaders to engage in their own transformational journey. The time (if ever there was a time) of the heroic leader is past. This calls for a new understanding of the role of leaders and the practice of a broad range (new) leadership skills and strategies. Today's leaders must attend to the immediate demands of service systems, anticipate changes on a two to three year horizon, all the while positioning their systems for longer term and potentially more disruptive changes. **Most importantly, effective leaders of complex systems must embody collective leadership, promoting an inclusive vision of the future and developing the capacity to function as "learning organizations."**

What Will Change Look Like?

"We can agree that the future is not going to look like the present or the past. The major question is whether change will be linear, or in a much more disruptive pattern. The evidence from other industries is that all industry is moving from linear to more non-linear change. If we are leaders in BH systems we need to think about both scenarios.... As a leader, what outcomes I would want my organization to create in ten years. Leaders need to have an opportunity to think about what 3.0-transformed system will look like. Leaders are responsible to do that thinking and to skate to where the puck is going. (Dale Jarvis)

"There will be dramatic changes. Its not clear if all changes will be progressive or some potentially regressive. Whether evolutionary or revolutionary...the hope is that change will be driven by client experience and desires. If institutional concerns are put first, change will devolve into a wild goose chase." (Marvin Southard, DSW)

"Change will be both evolutionary and disruptive. Disruptive because there are so many variables that we don't and wont have control of with the scope of the health system. The issue is how to be strategic about how to be relevant, and helpful (partner) with other health partners to influence and participate in how change is evolving."

Maureen Bauman, LCSW, MPA, Director, Client Services and Adult System of Care, Placer County Health and Human Service Agency

A Call for Collective System Leadership

The challenges of leadership are the subject of much current social and organizational research and writing. Peter Senge, Hal Hamilton and John Kania discuss the demands of change in the "The Dawn of System Leadership"(Stanford Social Innovation Review, Winter 2015) and call for **"a unique type of leader—the system leader, a person who catalyzes collective leadership."**

> *"Though they differ widely in personality and style, genuine system leaders have a remarkably similar impact. Over time, their profound commitment to the health of the whole radiates to nurture similar commitment in others…As these system leaders emerge, situations previously suffering from polarization and inertia become more open, and what were previously seen as intractable problems become perceived as opportunities for innovation. Short-term reactive problem solving becomes more balanced with long-term value creation. And organizational self-interest becomes re-contextualized, as people discover that their and their organization's success depends on creating well-being within the larger systems of which they are a part."*[20]

A 2013 Institute for Health Care Improvement white paper: High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs focuses in on health care leadership:

> *"…how leaders think and view the world — are critically important because how leaders think and what they believe shapes their leadership behaviors and provides direction to focus their leadership efforts in transforming from volume-based to value-based care delivery systems. High-impact leadership requires leaders to adopt four new mental models: 1) individuals and families are partners in their care; 2) compete on value, with continuous reduction in operating cost; 3) reorganize services to align with new payment systems; and 4) everyone is an improver…"*[21]

CA Behavioral Health system leaders generally describe their approach to systems change as adaptive and evolutionary when possible— allowing for systems to accept and adopt changes, while anticipating how to tackle more profound future disruptions in healthcare.

- *My leadership approach is focused primarily on adaptive change. Changing around the edges to allow people to have the optimal comfort level that allows them to make the necessary changes.. Change needs to be not too uncomfortable, but also not too easy, trying to find that perfect edge where people are willing to make a change. When disruptive change occurs, it is important as a leader to provide the necessary support and guidance to highlight the positive aspects of the change and to show how this might work for the best.* (Gail Zwier)
- *The pace of change is exponential…and so what is the leaders job? One needs to be very aware of what people are working on, what their resources are…*

and then calibrate for staff. You can't respond to every good idea or initiative. Leaders have to be protective of staff/people to insure that they have the help and resources to accomplish priority goals and changes. This means that leaders must sometimes say "no" to pursuing or joining even important initiatives. If something is new and important, is this the right time. (Steve Kaplan)

But whatever the nature and pace of change in BH and healthcare—evolutionary or exponential and disruptive, effective leaders must develop both intra-organizational and cross-system leadership capacity.

Figure 4. Core Strategies for System Leaders offers a synthesis of core domains of system leadership that will be explored in the remainder of this paper.

Figure 4. Core Strategies for System Leaders

System Leadership For Behavioral Health Transformation	Senge et. al: Dawn of System Leadership	IHI: Hi Impact Leadership
1. Developing a shared cross-system vision of the future	Ability to see and help others see the larger system	Create vision and build will…
2. Inclusion and accountability in designing and sustaining improvement	Fostering reflection and generative conversations that build trust and collective creativity	--Shape organizational culture and insure that persons receiving care and the "community" are engaged in change
3. Building and sustaining a learning organization	Shift from problem solving to co-creating the future (Developmental learning focus)	Everyone is an improver: develop improvement capability at all levels of organization

1. Building a Cross System Vision of the Future

Change is required on multiple levels to build resilient BH systems: appreciating and nurturing the interconnectedness of health and social systems, addressing the social determinants of health, and partnering with individuals and their communities to promote health and wellness. It is the job of the leader to promote "systems thinking" and a shared vision of the desired future that serves to guide and sustain change processes.

A 2015 Milbank Quarterly report assessed the impact of the Triple Aim (now considered a foundational framework for health care reform) and emphasized the importance of a shared purpose to sustain commitment to the difficult work of transformation.

> *Without a shared purpose, therefore, an organization's or community's projects to improve health, reduce per capita cost, or increase investments in infrastructures like health information exchanges may end up serving only a narrow purpose. In such cases, these groups may build trust but may not always be prepared for pushback from potentially threatened stakeholders or may not be able to advance the entire organization, community, or region toward the Triple Aim.*[22]

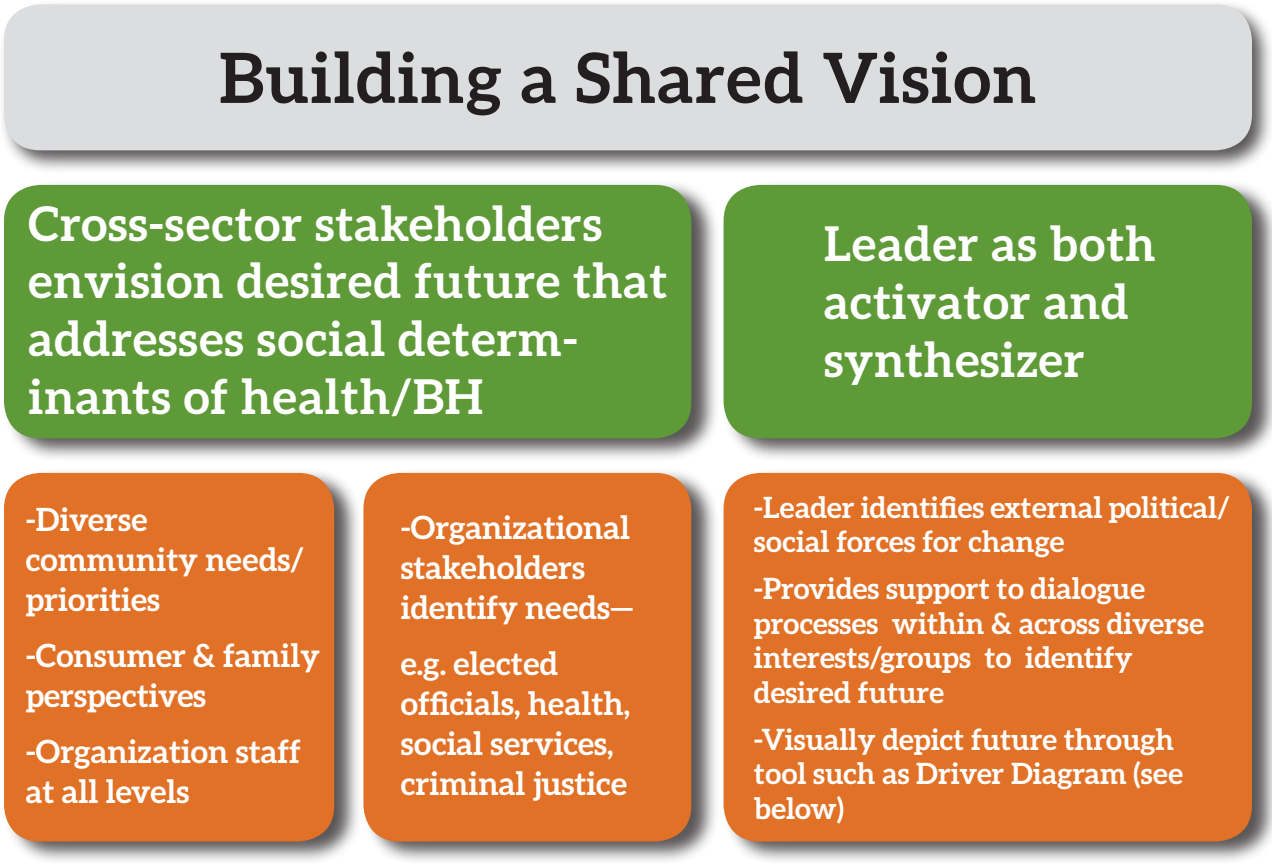
> **My approach has to do with trying to understand the parameters of the possible, conveying those parameters and trying to present that change with an inspiring vision of what could be done to a broad group of stakeholders. Work to understand and see where the stakeholders take future possibilities and vision for change. Trust the wisdom of the group.**
>
> Marvin Southard, DSW, Director, Los Angeles Department of Mental Health, CA

California BH Directors were asked: How do you include/involve others in understanding and articulating the need for system transformation? How have you communicated about change?

Leaders consistently described their approach as collaborative and focused on building partnerships across health and social systems, and with communities. All described their responsibility to identify, assess drivers of change, forces/trends— and to communicate with internal and external stakeholders about "where the tectonic plates are shifting." (S.Kaplan) The leader's role is to be a force for change, but building a dynamic vision also requires a collective process where the leader's job is to value and support the synthesis of diverse stakeholder perspectives.

Figure 5. identifies some of the core requirements and roles of leaders in building a share intra-and cross-organizational vision of a transformed future state.

Figure 5. Building a Shared Vision for Cross System Leadership



Collaborative leaders must insure the inclusion of diverse stakeholders and perspectives to promote consideration of internal and external forces for a better future. Leaders balance their roles between serving as activators and facilitators/process supporters. It is useful to visually depict the collective vision as a theory or theories of change. One tool for this process is the Driver Diagram. Developing a "Driver Diagram" can be useful because it specifies the shared aim (desired future state) as well as the forces/ factors ("Drivers") that are believed to influence the achievement of the aim. Multiple stakeholders' perspectives can be concretely represented in a Driver Diagram. The Center for Medicare and Medicaid Services, Center for CMMS Innovation (2013) providers a useful how to guide for using Aims and Drivers.[23]

The challenge is for cross-system leaders is to balance insuring momentum in the process of developing a shared vision, with having the patience to allow the perspectives and wisdom of cross sector and community stakeholders to coalesce.

Leader as Activator

- *Leadership requires…introspection and…**assessing the external forces—"where the tectonic plates are shifting."** Leader needs to figure out what these external changes mean and assess what this means/implications for the system* (S. Kaplan)
- *(I)…work with organizations/providers as an "activator" to support them for change. It is important for the leader/director to convey what the evolving system needs in order to continue to be effective regardless of the administrative structure. Must work with county system and contractors as an **"activator"** to prepare agencies and workforce for change.* (A. Aguirre)

Leader as Synthesizer of Shared Vision

- *I can't believe how slowly change occurs. It really takes a while to make and embed change. **It's about collaboration, holding the vision—and then holding on for a while.** When change occurs with early adopters…there is then a slow spread through organization where actual norms begin to change over a period of time.* (M. Bauman)
- *The involvement (of consumers) needs to be in large numbers & in meaningful ways in order to assure that we hear the diverse opinions of individuals impacted by health systems. Need leadership to include and **reflect the perspective(s) of people with lived experience.** Helps to reduce stigma and discrimination.* (K. Aslami)
- *I have had to learn the hard lesson of not being so invested in the way that the change or strategy will look when someone else wants to redefine the change. As a leader, you need to stay in sync with the priorities of the community. **I've learned not to move too quickly or press the gas pedal too fast so that you are not allowing the change to develop at a pace that is the most useful.** It is deadly to get too far ahead of or out of sync with the community, it will kill a great change idea.* (G. Zwier)

Recommendations:

- Use the Triple Aim as a foundation for a building a shared cross-system understanding (vision) of the future of BH. This shared vision must make "real" the goals of the triple aim, concretely translating its aspirations into local conditions and aims.
- Develop a shared organizational vision that supports both internal improvement and cross system engagement and collaboration. Provide a visual representation of this vision through developing a driver diagram or an equivalent graphic depiction of the change/theory of change.

2. Inclusion and Accountability for Designing and Sustaining Improvement

BH Directors described their leadership as inclusive—discussing strategies for engaging staff, consumers, organizational stakeholders and community representatives in designing and monitoring the results of services. Consistent information flow and transparency are understood as essential to building resilient organizations and positive organizational relationships.

Inclusion strategiesx:

- Regular staff workgroups and meetings with executive leaders
- All staff meetings
- "Virtual" communications including e mail, newsletters, blogs, websites, videos and u-tube videos
- On-line posting of management/executive staff meeting minutes
- Publicized open-door hours
- Monthly meetings with consumers and consumer organizations as well as family organizations such as NAMI
- Program site visits; staff exchange and shadowing
- Formal and informal executive mentoring
- Regular cross-system collaboration meetings with organizational partners

Goullart and Hallet in a recent article, ***Co-Creation in Government,*** (SSIR, Spring 2015)[24] advocate that government entities assure greater inclusion and stakeholder involvement:

> *To make further gains in performance, public sector leaders need to shift their focus away from work processes (which revolve around tasks to be performed) and toward human engagement processes (which revolve around the people who do those tasks)….In a public sector co-creation initiative, a public sector entity opens its value chain to the stakeholders whom it serves… In its optimal form, co-creation has the dual benefit of reducing public sector costs and increasing stakeholder satisfaction.*

In business as well as in national and international social justice initiatives, tools such as Appreciative Inquiry and Appreciative Inquiry Summits (https://appreciativeinquiry.case.edu, http://www.centerforappreciativeinquiry.net)[25] as well as Scenario Building[26] are used as methods to guide meaningful inclusion in designing solutions to complex problems. Both Appreciative Inquiry and Scenario Building can be adopted to promote stakeholder collaboration in transforming behavioral health systems. These skills should be taught and practiced so that leadership capacity is fostered at every level in

organizations—including at the first line supervisory level. However, inclusion is effective only if engagement is sustained and perceived as real and meaningful to stakeholders who invest in the design and improvement of services. This is particularly important for communities that have experienced health, economic and social inequities.

Counties report impressive results through collaborative cross-system inclusion and collaboration.

- **Inyo County:** What happens in a small county is that early on you are pushed to work closely with partners across systems in order to make up for the scarcity of resources and limited capacity to solve a problem within one system alone. There is a chance to connect the dots and the opportunity to look for other places to try change strategies and changes using the improvement model in different situations. For example building criminal justice re-entry plan (AB 109) or a wrap around plan, it is possible to recommend testing and implementing a change or to create a workflow to help us understand the change we are attempting. This quality improvement approach of testing, refining and then implementing is refreshing. It doesn't seem as risky or as overwhelming as writing a plan that just focuses on the end result without having any clear path as to how to get there. (G. Zwier)
- **Yolo County:** Cross system collaboration is thrilling. As a result of a housing development project, a task force was convened in August 2014 to relocate 70+ homeless persons (and their pets) who lived on the banks of the Sacramento River. The new Police Chief set up a taskforce that included City, county, private partners: CBO, faith-based organizations, Dept. of Park and Recreation, etc. Through cross system collaboration,…65 people and 40 animals were relocated to a hotel. Various agencies took responsibility for wrapping services around individuals,…for legal matters, housing/access to Section 8 (all became eligible for Section 8 vouchers) etc.

  To see what can happen with cross system, public private partnership is nothing short of inspirational. 82% ended up with health insurance, more than 2/3 received mental health and/or substance abuse services, more than half received housing vouchers allowing them permanent subsidized housing and more than 35% ended up with income. All of this occurred within less than 4 months. Now over 85 percent have insurance and are now eligible for health care, for SUD, MH, and dental care. The impact on individuals is amazing but the impact on the system are almost more amazing …with organizations coming together and then being able to see the positive outcomes. For more information go to the Bridge to Housing webpage under the Residents menu on www.yolocounty.org. (K.Larsen)

Los Angeles: Stakeholder Leadership for System Design and Accountability

The LAC-DMH has involved stakeholder groups throughout my tenure as a leader. Real, not pretend power, is the key.

LA strategic planning process began prior to the passage of the 2004 Mental Health Services Act.

DMH convened a series of community meetings that included clients, family members, and community agencies. Sometimes 300 people at a meeting. Developed a shared vision of a community-oriented system with a plan for comprehensive community care.

- When DMH shortly thereafter faced a $36 million dollar budget shortfall, the strategic plan guidance was used as a framework for making cuts that honoring strategic plan principles and priorities. Convened process including stakeholders to determine what should be cut. Ended up with consensus document re: how would take the cut. Ultimately cuts not necessary
- Used the same structure to do the planning and stakeholder engagement process for the MHSA.
- **Established a System Leadership Team (SLT) that is still the key decision making body for recommendations to the Board of Supervisors:** Stakeholder groups actually make the decisions that are forwarded to the Board of Sups for action. SLT membership includes clients, families, unions, and disabled communities—broad group of stakeholders. "The efforts of the SLT are guided by standing committees formed to address specific issues such as planning, budget mitigation, and outcomes. These standing committees are comprised of volunteers from the SLT and Department managers with responsibility for planning, implementing and managing MHSA programs."
- How do people get on the SLT? Potential members are recommended by of an organizational entity or stakeholder group—including under-represented ethnic population groups (UREP). Membership Committee of SLT recommends members to the SLT. Does not include the Department Director.
- For the MHSA, workgroups are formed and reported out of SLT. Per LA County Counsel, BOS cannot make decisions separately from the SLT. The BOS can refuse to approve the plan, but per county counsel cannot pick and choose elements of the MHSA Plan.

-Marvin Southard, LAC-DMH

Transparency and Accountability BH leaders understand the importance of program transparency and accountability. Accountability requires sharing of the results/ outcomes of programs and services. However, there are currently few examples in California of county BH outcome reporting that is easily and continuously accessible to consumers, other providers, or the public. California Mental Health Services Act annual updates and 3-year External Quality Reviews required for federal Medicaid participation are among the few generally available county-specific BH outcome reports in California. The exclusion of BH entities from the Affordable Care Act's information technology infrastructure development funding has further slowed and reduced the capacity of BH systems to routinely track, monitor and communicate individual and population health outcomes.

Using Data for Improvement Counties are making efforts to use data for improvement and program development, but acknowledge the need for significant advances. Several County BH Directors gave examples of the use of data for program improvement.

- *We implemented a "same day assistance" process whereby anyone requesting services can be seen that day. We are using data to track the percent of same day visits and follow up appointments. The data has been used as feedback to clinics regarding their performance and for modifying our approaches. We also have been implementing the "mild/moderate" benefit and have used call center activity, authorizations for service, dropped calls, etc. to ascertain our overall performance, communicate to Health Plan, and to improve quality."* (S. Kaplan)
- *Data integration is a struggle and then how to use data make better decisions with data. Example: Reviews of negative outcomes can support a focus on system improvement. A monthly review of County suicide data was used to determine how many of those individuals have been active in County services. For SUD, follow up regarding bad outcomes led to a program that included a consumer recovery element and provided follow up for clients discharged from the county hospital to insure appropriate care coordination. Incidence of suicide went down dramatically as a result of this program, which was based on learning from data.* (A. Aguirre)
- *Whenever possible I use data to drive and support decisions. An example was a difficult decision to contract out our children's system of care services. Collected data/cost per client served, FTE's etc. and compared County with contract providers. Used findings re: comparative data and outcomes to make the case and gather support for a change. (I try) to use data to support or shape perspective and use data in talking with staff. End result is not always where I started at the beginning. (K. Larsen)*
- *As a leader, I use data as a way of knowing where I am and where I want to go. Look at what are we doing well and where are the gaps, what can we do better… Using data is an integral part of my program management approach….I use data to help educate the Board of Supervisors and other people…Data is important both*

internally and externally (community) for seeking additional funding resources, etc. Also, for annual report—you need to let people to know what their tax dollars are being used for. (Y. Brown)

In order to strengthen accountability and evaluation capacity--and shorten the time for research to practice implementation, several counties, including San Diego and Los Angeles, have developed university partnerships. For example, Los Angeles DMH recently released their Mental Health Services Act (MHSA) Innovations Evaluation (Dec. 2014, http://file.lacounty.gov/dmh/cms1_226026.pdf) which was conducted in conjunction with the University of San Diego and several other independent research organizations. (Dec. 2014)

There have also been several recent county initiatives in California to provide statewide outcome reports. The Steinberg Institute for Advancing Behavioral Health Policy & Leadership partnered with the County Behavioral Health Directors Association of California (CBHDA) with the release in March 2015 of "CA Behavioral Health: Prop 63 Review: Mental Health Services Act Delivering on Promise to Californians, Steinberg Institute For Advancing Behavioral Health Policy & Leadership,

http://steinberginstitute.org/wp-content/uploads/2015/02/SteinbergReport-Final-3112015.pdf. In addition, a recently released (February 2015) Rand Report: Evaluation of California's Statewide Mental Health Prevention and Early Intervention Programs shows positive early trends in the "positive out- comes in stigma and discrimination reduction, suicide prevention, and improvement of student mental health." (http://www.rand.org/pubs/research_reports/RR971.html)

There is an even greater paucity of meaningful statewide or program specific outcomes for substance use disorder services. The availability and publication of statewide behavioral health data remains a challenge both nationally and for California while healthcare organizations are increasingly expected by both payers and the public to provide a greater transparency and to report organizational and patient outcomes as well as patient experience of care (satisfaction).

Recommendations:

- Insure that BH is an influencer in health care transformation through including key health and social services partners, as well as other local stakeholders, in BH planning and system design.
- Leaders must build organizational capacity for participating in system transformation by teaching, supporting and monitoring the use of system design processes/tools by leaders and staff throughout the organization. Share these processes with cross-organizational partners.
- To insure transparency and accountability, BH systems should routinely post outcome and client experience of care reports on their web sites—even if the range and presentation of the data requires improvement over time.

3. Building and Sustaining a Learning Organization

Learning organizations are widely discussed in organizational improvement literature. In order to thrive in this era of rapid change, BH systems must become learning organizations. This requires an internal focus on building organizational muscle for continuous learning and improvement, but also an external focus so that behavioral health can effectively contribute to the promotion of healthy behaviors and greater population health.

What is a Learning Organization?

The concept of the "learning organization" reached currency with the publication of Peter M. Senge's, *The Fifth Discipline: The Art and Practice of the Learning Organization* (1990) and was adopted by corporations and organizations striving to thrive in a time of local and global socioeconomic and political change and disruptive technology. Learning organizations engage the commitment and capacity of people (staff and stakeholders) to participate in systems thinking and action to achieve a shared vision of excellence with the capacity adjust and excel in times of rapid change. The term "learning organization" has been overused but under-realized. Embedding organization-wide capability and commitment to function as a "learning organization" takes leadership at every level-and can only be accomplished over time.

Garvin, Edmondson, and Gino, ask "Is Yours a Learning Organization?" (Harvard Business Review, 2008)[27]

> *"Leaders may think that getting their organizations to learn is only a matter of articulating a clear vision, giving employees the right incentives, and providing lots of training. This assumption is not merely flawed—it's risky in the face of intensifying competition, advances in technology, and shifts in customer preferences… Organizations need to learn more than ever as they confront these mounting forces. Each company must become a learning organization. Such learning organizations would be able to adapt to the unpredictable more quickly than their competitors could."*

Culture Trumps Strategy Every Time

Learning organizations" develop in environments that have widely adopted quality improvement as a way of doing business. This culture of improvement must pervade every level of the organization including front line providers, support staff, supervisors, administrators, and all of the layers of management that are typical in public sector organizations. While there are important tools that can be learned and deployed in organizations, it is essential that the BH leader personally demonstrate commitment to a culture of inquiry, learning with a continuous focus on improvement, partnership and teamwork. This cannot be accomplished through simply establishing a quality improvement division/department, no matter how excellent.

In their book, *Pursuing the Triple Aim,* Bisognano and Kenney[28] offer powerful case examples of health care leaders that promoted dramatic improvements in their

systems—and not all of these organizations were rich in financial resources. These are public and private sector health system reform leaders including among others:

- HealthPartners, a nonprofit consumer-governed integrated health system used the Wagner (Chronic) Care Model and improvement methods and process design to increase access, care coordination, streamline and standardize workflows to increase efficiency and quality;
- Virginia Mason in partnership with Intel applied Lean technology (including value stream mapping) across its health provider system to eliminate waste and improve results and customer satisfaction;
- Care Oregon, a Medicaid managed care plan and its affiliated safety net providers, including primary care clinics, used the incentive of a deep financial crisis to learn and implement quality improvement strategies to re-design and spread cost effective care for individuals with high cost multiple chronic conditions.

These case studies and others in "Pursuing the Triple Aim" provide detailed examples of improvement strategies and tools applicable to behavioral health as well as physical health care.

Leadership For Improvement Is Fundamental In Learning Organizations

Quality improvement methods are being adopted as essential business practice by most leading healthcare organizations. The most widely used approaches are LEAN[29] and the Model for Improvement,[30] which is taught by the Institute for Health Care Improvement (IHI) in hundreds of "learning collaboratives."

Scoville and Little in a recent IHI White Paper, "Comparing Lean and Quality Improvement," discuss LEAN and the Model for Improvement as complementary improvement methods: *"Following in the footsteps of other industries, they(e.g., healthcare organizations) must somehow figure out ways to define the work of everyone, including senior executives, point-of-care staff, clinicians, and those in support roles — to deliver excellent care and services ("doing the work"), while simultaneously designing systems and processes that build in continuous improvement ("improving how the work is done").*[31]

Donald Berwick, MD, the founding president of the Institute for Health Care Improvement (IHI), views quality as fundamental to organizational improvement. When he became the interim appointed, Director of the Center for Medicare and Medicaid Services (7/2010-12/2011), **Berwick personally taught quality improvement to all employees in order to change the culture and productivity** of this notoriously bureaucratic federal agency. In addition, a core of mid-level and regional managers received in-depth training in QI methods. Berwick and his colleagues at IHI focus on quality improvement, not just as a good idea, but also as necessary for the very survival of health care in the US and internationally—especially for people served by the safety net system.

"The choice is stark: chop or improve. If we permit chopping, I assure you that the chopping block will get very full – first with cuts to the most voiceless and poorest us, but, soon after, to more and more of us. Fewer health insurance benefits, declining access, more out-of-pocket burdens, and growing delays. If we don't improve, the cynics win.

That's what passes the buck to us. If improvement is the plan, then we own the plan. Government can't do it. Payers can't do it. Regulators can't do it. Only the people who give the care can improve the care."[32]

In the past 5 years (See Section I, Quality,) public sector BH systems have begun to adopt quality systems such as LEAN and the Model for Improvement but, these QI approaches are too often "siloed" within organizations and only implemented for payer mandated process improvement programs. Quality assurance and quality improvement are too often conflated in BH organizations. Quality assurance/ compliance is necessary to meet state and federal funding requirements, but "learning organizations" can only thrive an improvement-focused environments where testing changes and learning from failures as well as success, is not only tolerated—but also celebrated.

Using Improvement For Continuous Organizational Learning

Within BH systems, there is a growing recognition of the importance of quality improvement for system transformation. Over 25 California counties have participated in learning collaboratives that used the Model for Improvement, and at least two county BH departments have implemented LEAN. Several of the BH Directors interviewed for this paper discussed the impact of improvement processes in their counties.

Inyo County participated in the 2014/15 California Institute for Behavioral Health Solutions' Care Coordination Learning Collaborative. The BH Director and team members continue to work to spread improvement methods within the HSS Department and with cross-system partners.

"Two major things that we have taken away from the CIBHS Care Coordination Collaborative (2014/15) that informed our spread (of improvement strategies): 1) Using the Model for Improvement including the structured thinking of Aim, Feedback,…and applying the PDSA (Plan, Do, Study, Act) to break down the spread project into small manageable changes to guide us. Then using Work Flow diagraming to visualize the resulting processes to be implemented. 2) We chose the area to target for spread to be one that is relevant to our local community… coordinated care as applied to our jail system. We looked at the need to address

both BH as well as health conditions in the jail and integrated the services under the BH umbrella. We will look at ways to ensure that we have an integrated record of healthcare that connects to services outside of the jail to ensure continuity of care. We will look at the use of telemedicine to increase access within the jail setting and to reduce need for access to ED. We further defined coordinated care to go beyond BH and Physical Health care to also encompass other life domains including employment, living situation, education and culture. In our community, the health care costs in the jail are of grave concern and can become overwhelming very quickly. Our goal was to take the work and learning regarding care coordination and apply this to health care in the jail and for people as they are re-integrated into the community. This provides a win/win opportunity in an arena that might not have been the obvious one of where to implement coordinated care…It is important to look creatively at issues that really matter to the community and then apply transformational strategies to situations that might not usually jump out at you as the place to implement a change strategy." (G. Zwier)

San Mateo County—The Health Systems Agency (beginning with the county hospital) has adopted LEAN improvement technology. LEAN processes are now being used to plan, test and implement a BH regional service center re-design. This system redesign has included BH staff, health and social services system stakeholders, consumer and community members in planning services for 6 distinct geographic regions.

"The biggest area of challenge is quality of care. We are locally investing resources to use LEAN methodology and spread it throughout the organization and give managers and supervisors at all levels the structure to be able to sustain the changes made through improvement events and to be able to replicate and spread the changes. We have had some success at the medical center (and now) …planning to resource LEAN more broadly within BH. For a living, breathing model for sustainability, (we are) looking towards LEAN. What is critical about this model is engagement of workforce at all levels. Also includes a leadership model for how to work with supervisors and their staff. (L. Rogers)

Yolo County—For the BH Director of Yolo County, 15 years of work within a federally qualified health center (FQHC) led to a commitment to integrate improvement processes in all change initiatives.

"Being strategic is not just having an operational strategic plan—(Need to focus as a leader on) what are we doing/not doing….think about what steps do we need to take to get to longer range goals?

Favorite quotes: "Progress not perfection" and "we're headed in the right

direction. I use a rapid process improvement model on a regular basis, testing and making adjustments while moving through a change process. I will start changes, which may not be completely "fleshed out." For example: improving time for access and time to complete assessments. It previously took 2 months for completion of an initial assessment... Included all key staff in the process to improve access-- not just direct service but also front desk, billing staff. Over past 6 months, we have made adjustments…testing new processes as we go. Assessments are now occurring within a week and there are daily triage appointments, urgent care appointments and post hospital discharge appointments."

-Karen Larsen

Sustaining the Work of System Leadership

The openness of Behavioral Health Directors interviewed for this paper about their leadership—including their challenges, is striking. All are strong in their commitment to transform behavioral health systems to achieve the goals of the Triple Aim for individuals' with behavioral health problems as well as communities, particularly underserved and under-resourced communities. But, equally striking, is the extent to which leaders seem to be tackling leadership and system change challenges in relative isolation from each other. In California, there is strong statewide policy collaboration to address policy, financing and legislative issues but there is no similar network of leadership peers who are engaged in supporting each other in the difficult transformation and learning organization work described in this paper. As Senge, Kania and Hamilton argue in "The Dawn of System Leadership:"

> *"Growing the capabilities to become a more effective system leader is hard work. It needs to happen in difficult settings and under pressure to deliver tangible results. It is naïve, even for the most accomplished system leader, to think that she can do it alone. We know of no examples where effective system leaders achieved broad scale success without partners. You need partners who share your aspirations and challenges and who help you face difficult changes while you also attend to your own ongoing personal development—balancing task time with time for reflection, action, and silence. You need to engage with colleagues who are at different stages in their own developmental journeys. And you need help letting the unexpected emerge amid urgency and time pressure. Connecting with others who are also engaged in this journey can help lighten the load and foster the patience needed when organizations or systems seem to be changing at a slower rate than you yourself are changing."*[33]

It is our hope that in some way, this paper serves to encourage more direct leadership learning exchanges to support the important work that lies ahead.

Recommendations

- Leaders must hold continuous improvement at the core of their leadership responsibilities. This means:
    - Taking the personal responsibility to learn about "systems thinking" and improvement methods
    - Developing and implementing a phased plan to test, implement and spread—over time, the use of improvement methods within the organization/system (and with system partners when possible)
    - Promoting a "culture of improvement" through insuring that staff and key stakeholders are trained, supported and rewarded for using improvement methods
- BH executive leaders should work with their professional (policy and technical assistance/training) organizations to establish learning exchanges and mutual support for transformational leadership.

End Notes

1. Neal Halfon, Peter Long, Debbie I. Chang, James Hester, Moira Inkelas and Anthony Rodgers ,Applying A 3.0 Transformation Framework To Guide Large-Scale Health System Reform, Health Affairs, 33, no.11 (2014):2003- at 2011
2. Swensen S, Pugh M, McMullan C, Kabcenell A., High Impact Leadership: Improve Care, Improvement the Health of Populations, and Reduce Costs. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement
3. Peter Senge, Hal Hamilton and John Kania, "The Dawn of System Leadership", Stanford Social Innovation Review, Winter 2015
4. Peter Senge, Hal Hamilton and John Kania, "The Dawn of System Leadership", Stanford Social Innovation Review, Winter 2015,
5. ibid. Figure 1 is an adaptation and expansion of Halfon et. al. Exhibit 1, Three Eras of Health and Health Care—Three Operating Systems Health Affairs, 33, no.11 (2014):2003-2011 (pg. 2004 ff) to summarize key domains and trends in past, current and future behavioral health care. The content of Halfon et. al. Exhibit 1 is unchanged with the exception that "The role of the individual in his/her health care" is added as a critical domain.
6. Jarvis, Dale, Dale Jarvis and Associates Consulting, has numerous resources on behavioral health payment reform at http://www.djconsult.net/resources-1/case-rate-info as well as the stages of moving from volume to value based payment structures, Arizona Behavioral Health Reform Tool Kit Website, (2015) http://azpaymentreform.weebly.com/value-based-purchasing-basics.html
7. Stephen Shortell and Richard Scheffler, Accountable Care Organizations Taking Hold And Improving Health Care In California, Health Affairs Blog, 6/2/15 http://healthaffairs.org/blog/2015/06/02/accountable-care-organizations-taking-hold-and-improving-health-care-in-california/
8. Addiction Technology Transfer Center Network (ATTC), White Paper: Integrating Substance Use Disorder And Health Care Services In An Era Of Health Reform, Prepared by: ATTC Technology Transfer Workgroup: Stanley Sacks, PhD, and Heather J. Gotham, PhD, (Co-Chairs) with Kim Johnson, PhD, Howard Padwa, PhD, Deena Murphy, PhD, and Laurie Krom, MS, March 2015, (pg. 12)
9. Integrated Behavioral Health Project, Integrating Substance Abuse and Primary Care Services in Community Clinics and Health Centers, March 2015, http://www.ibhp.org/uploads/file/Integrating%20substance%20abuse%20services.pdf.
10. Ibid, pg 22-31
11. California Mental Health Services Authority, Stigma and Discrimination Reduction Campaign, strategies and resources are provided on line at http://calmhsa.org/programs/stigma-discrimination-reduction-sdr/
12. Whole Health Action Management: Peer Support Training (training program and Participants Guide,) SAMHSA-HRSA Center for Integrated Health Solutions, http://www.integration.samhsa.gov/health-wellness/wham

13. It's My Life: Social Self-Directed Care, Mental Health America (2015) http://www.mentalhealthamerica.net/it's-my-life-social-self-directed-care

14. Institute of Medicine, Roundtable on Population Health Improvement, December 2014, iom.edu/Activities/PublicHealth/PopulationHealthImprovementRT.aspx and, Tamber, Pritpal.S., 2014. Community, movements, and spread: It's the process that matters. Commentary, Institute of Medicine, Washington, DC. www.iom.edu/processmatterscommentary, SSIR, May 2015

15. op.cit., Halfon, Long, Chang, Hester, Inkelas and Rodgers

16. California Reducing Disparities Project, [Phase I-developing strategies to transform the public mental health system and identifying community-based promising practices in each of 5 targeted populations-- African Americans; Asians and Pacific Islanders; Latinos; Lesbian, Gay, Bisexual; and, Native Americans,) and Phase II-in process, a 4 year research program to demonstrate the effectiveness of community-defined evidence in reducing mental health disparities.] http://www.cdph.ca.gov/programs/Documents/CRDP_Fact_Sheet_04252014.pdf

17. Chavis, David M., Kien Lee, What is Community Anyway?, Communities Creating Health Series, Stanford Social Innovations Review, Spring 2015, http://www.ssireview.org/creating_health?utm_source=Enews&utm_medium=Email&utm_campaign=SSIR_Now

18. "Closing the Quality Chasm: A Proposed Framework for Improving the Quality and Delivery of Psychosocial Interventions." Psychosocial Interventions for Mental and Substance Use Disorders: A Framework for Establishing Evidence-Based Standards. Washington, DC: The National Academies Press, 2015.

19. Jen Hyatt, Big White Wall: Expanding Mental Health Access Through The Digital Sphere, Health Affairs Blog, 6/1/15, http://healthaffairs.org/blog/2015/06/01/big-white-wall-expanding-mental-health-access-through-the-digital-sphere

20. op. cit., Senge, Hal Hamilton and John Kania

21. op cit., Swensen S, Pugh M, McMullan C, Kabcenell

22. John W. Whittington, Kevin Nolan, Ninon Lewis and Trissa Torres, Pursuing the Triple Aim: The First Seven Years, Institute for Healthcare Improvement, The Milbank Quarterly, Vol. 93, No. 2, 2015 (pp. 263-300) 2015MilbankMemorialFund. PublishedbyWileyPeriodicalsInc. http://www.milbank.org/uploads/documents/featured-articles/pdf/Milbank_Quarterly_Vol-93_No-_2_Pursuing_the_Triple_Aim_The_First_7_Years.pdf

23. Defining and Using Aims and Drivers for Improvement: A How To Guide, Center for Medicare and Medicaid, Center for Medicare and Medicaid Innovation Learning and Diffusion Group, 2013, http://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf

24. Co-Creation in Government, Francis Goullart and Tina Hallet, Stanford Social Innovations Review, Spring 2015 http://www.ssireview.org/articles/entry/co_creation_in_government

25. Center for Appreciative Inquiry (cited). Also see David L. Cooperider, Diana Whitney, and Jacqueline M. Stavros, Appreciative Inquiry Handbook, second edition, Brunswick, Ohio: Crown Custom Publishing, 2008.)

26. What If: The Art of Scenario Thinking for Non Profits, Diana Scearce, Katherine Fulton, and the Global Business Network community, Global Business Network, (2004) http://www.monitorinstitute.com/downloads/what-we-think/what-if/What_If.pdf

27. Garvin, David A., Amy C. Edmondson, Francesca Gino, "Is Yours a Learning Organization?", Harvard Business Review, March 2008

28. Maureen Bisognano and Charles Kenney, Pursuing the Triple Aim: Seven Innovators Show the Way to Better Care, Better Health, and Lower Costs, Institute for Health Care Improvement, Jossey Bass (2012)

29. LEAN, Lean Enterprise Institute, http://www.lean.org. "What is LEAN? The core idea is to maximize customer value while minimizing waste. Simply, lean means creating more value for customers with fewer resources. A lean organization understands customer value and focuses its key processes to continuously increase it. The ultimate goal is to provide perfect value to the customer through a perfect value creation process that has zero waste. To accomplish this, lean thinking changes the focus of management from optimizing separate technologies, assets, and vertical departments to optimizing the flow of products and services through entire value streams that flow horizontally across technologies, assets, and departments to customers."

30. The Improvement Guide: A Practical Approach to Enhancing Organizational Performance by Gerald J. Langley, Ronald Moen, Kevin M. Nolan, Thomas W. Nolan, Clifford L. Norman, Lloyd P. Provost, Jossey-Bass Publishers; 2009. The Institute for Health Care Improvement has used the Model for Improvement as an improvement approach for hundreds of health care "Breakthrough Series Learning Collaboratives. http://www.ihi.org/Pages/default.aspx, In California, the California Institute for Behavioral Health Solutions has sponsored seven Learning Collaboratives involving at least 25 counties/partnering organizations, http://www.cibhs.org/pod/past-projects-and-activities

31. Scoville R, Little K., Comparing Lean and Quality Improvement. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2014. (Available at ihi.org)

32. Berwick, Donald, MD, The Moral Test" Keynote IHI National Forum, (Dec. 2011) http://www.ihi.org/resources/Pages/Presentations/TheMoralTestBerwickForum2011Keynote.aspx

33. op. cit. Peter Senge, Kania and Hamilton, "The Dawn of System Leadership"

Appendix A

Persons Interviewed for Behavioral Health at a Crossroads

1. Alfredo Aguirre, LCSW, Behavioral Health Director, San Diego County Health and Human Services, CA
2. Khatera Aslami-Tamplen, Consumer Relations Manager, Alameda County Behavioral Health Care Services, CA; Commissioner,
3. Maureen Bauman, LCSW, MPA, Client Services Director, Adult System of Care, Placer County Health and Human Services Agency, CA
4. Yvonnia Brown, MSW, Mental Health Director, Merced County Mental Health Department, CA
5. Jennifer Brya, MA, MPP, Principal, Owner, Desert Vista Consulting, CalMHSA Integrated Behavioral Health Project
6. Peter Currie, PhD, Director of Behavioral Health, Inland Empire Health Plan, CA
7. Linford Gale, Director, Office of Consumer and Family Affairs, Behavioral Health and Recovery Services Division, San Mateo County Health System, CA
8. Dale Jarvis, CPA, Founder and Managing Consultant, Dale Jarvis and Associates, Seattle, WA
9. Stephen Kaplan, LCSW, Director, Behavioral Health and Recovery Services, San Mateo County Health System, CA
10. Karen Larsen, MFT, Yolo County Department of Health Services, Mental Health Director/Alcohol & Drug Administrator, CA
11. Louise Rogers, MPA, Director, San Mateo County Health System, CA
12. Marvin Southard, DSW, Director, Los Angeles Department of Mental Health, CA
13. Toni Tullys, MPA, Director, Santa Clara County Department of Behavioral Health Services, CA
14. Gail Zwier, PhD, Director, Inyo County Behavioral Health Department, CA

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Appendix B

Two Eras of Transformation of Health and Behavioral Health Systems

Definition	**2.0 Health Care System** - 1950s - Now	**3.0 Health System**	**2.0 Behavioral Health Now**	**3.0 Behavioral Health Systems of the Future**
Goal	Reduce chronic diseases	Optimize health	Reduce chronicity of MH/SUD and promote recovery	Optimize BH as essential to each person's whole health Promote health & healthy behaviors for MH/SUD population
Model of health/ disease		Life course development and multi-generational health	Biopsychosocial/ spiritual	Life course development and multi-generational wellness/recovery & health
Focus of Services	Prevent/ manage chronic disease	Promote & optimize health of individuals and populations	No wrong door to treat Co-occurring MH/SUD, & evidence based treatment Individual/family focused Develop BH systems of care & coordinate BH/ medical care	Self care/ management Primary prevention/ early intervention with focus on life span, addressing social determinants of health Health literate & activated communities Whole health/ population health
Organiza-tional/opera-tional model	Accountable Care Organizations & Medical Homes	Community accountable health development systems	Carved out MH & SUD systems of care with developing medical care partnerships	Integrated BH as essential to whole health Community specific accountable health & social support systems

Definition	2.0 Health Care System - 1950s - Now	3.0 Health System	2.0 Behavioral Health Now	3.0 Behavioral Health Systems of the Future
Health Information Technology	Electronic health care information exchanges connect various provider networks	Health and medical information follows the person; there is connectivity between the health and human service systems; and actors have access to real-time data on quality, costs, and outcomes for individuals and populations	Electronic medical records are widely implemented but generally do not have connectivity across MH/SUD and do not connect or share information with health providers or payers	Health and medical information follows the person; there is connectivity between the health, behavioral health and human service systems Providers & payers have access to real-time data on quality, costs, and outcomes for individuals and populations Individuals use technology for self-care/self management and wellness promotion
Quality of Care	Consistent quality; using standard quality outcomes and improvement processes through collaborative learning	High and continuously improving quality through a learning health system	Accountability driven periodic or annual outcomes data BH systems in early phase of implementing quality improvement systems	Continuous quality improvement is fully integrated into BH services and systems Providers use data for monitoring and improving population/community health Clients use data for self-management and wellness
Payment mechanisms	Pre-paid health benefits and capitation	Health trusts and management of balanced portfolio of financing vehicles	Fee for service w/ Fed/State $ match Limited case rate/ pre-paid services	Balanced portfolio of funding with value based financing options

Definition	2.0 Health Care System - 1950s - Now	3.0 Health System	2.0 Behavioral Health Now	3.0 Behavioral Health Systems of the Future
Role of health care provider/ provider organization	Prevent/ control risk, manage chronic disease and improve quality of care	To optimize health and well-being	Identify and manage chronic conditions & improve individual recovery	Optimize health, well being and social inclusion for individuals/families Promote community health
Role of individual in his/her health/ health care**	Not separately specified	Not separately specified	Increased focus on recovery/self-care	Activated person-driven care & Wellness
Polulation health improvement	Activated partner in care	Co-designers of health	From patients to Client Centered Care	Activated partners in addressing social determinants/ health disparities and co-designers of healthy communities

*Columns depicting BH future are this author's expansion of Halfon et al., Transformation of Health System chart.

**The role of the individual with lived experience was identified by key informants for this paper as requiring a specific and distinct focus rather than being subsumed within population health. This represents a potential contribution of BH to general health care.