



# Care Integration Collaborative

Improving Quality and Integration of Care  
For Persons with Serious and Co-occurring Mental Health  
and/or Substance Use Disorders (MH/SUD) and Health Conditions

## Pre-Work Manual

February, 2012



California Institute of Mental Health  
Care Integration Collaborative

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# Section One: Introduction

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## Getting Started

Welcome to the Care Integration Collaborative (CIC). This pilot collaborative brings together seven teams consisting of county partners from the local Medi-Cal health plan, primary care, and specialty mental health, substance use disorder agencies. Participating counties include: Los Angeles, Merced, Napa, Nevada, Orange, Riverside and San Francisco. These county partnership teams will test and make changes to achieve better health status for individuals living with serious mental illness and/or substance use disorders as well as CVD, diabetes and/or metabolic syndrome. These improvements will be accomplished through county partners working together to provide care coordination for individuals with cardiovascular disease and/or diabetes/metabolic syndrome. The structure of the pilot collaborative is based on the Institute for Healthcare Improvement (IHI) Breakthrough Series (BTS) Learning Collaborative model, which uses Associates for Process Improvement's (API) Model for Improvement methods for organizational quality improvement. The BTS model brings together organizations that share a commitment to making changes that produce significant, sustainable breakthrough results. By routinely measuring the impact of adopted innovations and sharing learning with all the CIC participants, each county's partners can accelerate their improvement process to achieve widespread implementation of successful change concepts and ideas.

The CIC county teams, including participants from mental health, substance abuse treatment and primary care organizations as well as their local public safety net health plans, will work in partnership in the collaborative for one year. While Care Coordination (CC) is becoming widely understood as critical to achieving the best possible clinical outcomes and reducing unnecessary cost of care for individuals with multiple complex/chronic health conditions, CC is an emerging field where there is yet no clear consensus on best practices. As a result, the CIC is a Pilot Learning Collaborative that is expected to contribute to emerging knowledge.

During the one year duration of the CIC, partnership teams will participate in a kickoff and pre-work period, and then four (4) learning sessions; throughout, they will maintain regular contact with each other and CIC leadership and faculty through email, website, conference calls and site visits. In early 2013, participating CIC organizations will share their learning about changes (what worked/and what changes were not as effective) and achievements at a final convening, called the Harvest.

The purpose of this Pre-Work Manual is to help lay a foundation for activities leading up to the first learning session of the CiMH Care Integration Collaborative (CIC). Principal activities during this Pre-work period include identifying team members, developing a team charter, deciding on a targeted group of clients (target population), assessing existing care coordination capabilities and summarizing the team's pre-work using a storyboard.

## The Case for Care Coordination

### What is Care Coordination?

The *Care Coordination Measures Atlas* (a 2010 AHQR publication) defines it as the: “deliberate organization of patient care activities between two or more participants (including the client/patient) involved in a patient’s care to facilitate the appropriate delivery of health care services. Organizing care involves the marshaling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care.

There is growing evidence that improved care management and integration of MH/SUD services within primary health care practices are essential strategies for improving outcomes - and may well be fundamental to the effectiveness of health care system reform strategies, including health homes and accountable care organizations. Coordination of care with specialty providers is one of the “must pass” requirements for National Committee for Quality Assurance certification of primary care practices as “Patient Centered Medical Homes” (2011 PCHM NQCA Standards).<sup>1</sup> However currently, care is often not well coordinated or managed for individuals with serious mental illness and/or substance use disorders; in particular, those with/or at risk of or chronic health conditions such as cardiovascular disease and diabetes experience poor health outcomes and dramatically decreased life expectancy compared to the general population.

It is necessary to address the serious public health crisis of shortened life span for individuals living with serious mental illness and/or with substance use disorders: “In fact, persons with serious mental illnesses (SMI) are now dying 25 years earlier than the general population. Their increased morbidity and mortality are largely due to treatable medical conditions that are caused by modifiable risk factors such as smoking, obesity, substance abuse, and inadequate access to medical care.”<sup>2</sup> Similarly, individuals with substance use disorders often have serious chronic medical conditions causing an equal, if not greater mortality gap in comparison to the general population. Individuals with (or at risk of developing) chronic diseases, particularly cardiovascular disease, diabetes and/or metabolic syndrome, who also have serious mental health or substance use disorders have difficulty obtaining the additional help they need unless the

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<sup>1</sup> National Committee for Quality Assurance, Standards for Patient Centered Medical Home, 2011

<sup>2</sup> National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council. (2006). *Morbidity and Mortality in People with Serious Mental Illness*.  
<http://theempowermentcenter.net/Articles/Technical%20Report%20on%20Morbidity%20and%20Mortality%20-%20Final%2011-06.pdf>

linkages between primary care organizations and specialty care settings for mental health or substance use disorder treatment are well developed.

Primary care practices are increasingly implementing screening and evidence based treatments for mild to moderate MH/SUD within primary care settings. Yet under-diagnosis and under-treatment of mental illness and substance use disorders in primary care settings, problems with accessing MH/SUD specialty care and the lack of evidence-based care for individuals with SMI/SUD and co-occurring chronic medical conditions remains a widespread problem.

According to the MacColl Institute for Healthcare Innovation of Group Health Cooperative's "A Toolkit for Coordinating Care" (April 2011)<sup>1</sup>: "Unlike other aspects of medical care, there has been relatively little rigorous research to direct efforts to improve care coordination. However, many innovative health care organizations have recognized the dangers of poorly coordinated care and have implemented interventions to improve it." (pg. 4) The MacColl Institute toolkit highlights the importance of high quality referrals and transitions in care and related practices that are emerging as fundamental to successful coordination of care including:

- Assuming accountability
- Providing patient support
- Building **relationships and agreements** among providers (including community agencies) that lead to share expectations for communication and care, and
- Developing **connectivity** via electronic or other information pathways that encourage timely and effective information flow between providers

The CiMH Care Integration Collaborative will integrate knowledge regarding effective treatment and support for individuals with serious mental illness and/or substance use disorders with emerging best practices in care integration and care coordination for complex health conditions. We hope and expect that the CIC pilot, through the work of your care partnerships, will contribute important knowledge to emerging strategies and reforms in healthcare in California and nationally —as well as to building a deeper commitment to addressing individuals' whole health including mental illness and substance use disorders.

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<sup>1</sup> MacColl Institute for Healthcare Innovation, "Reducing Care Fragmentation: A Toolkit for Coordinating Care", April 2011

# Care Integration Collaborative Charter

The aim, objectives, and goals of CIC listed below are provided to clarify and unify the purpose of the collaborative and to aid organizations in their identification and selection of team leaders and members who will work to achieve the CIC aim.

<b>AIM</b>	Over a 12 month period, 6 to 8 county partnerships of mental health, substance use disorder, and primary care agencies working with local public safety net health plans will increase the number of clients who receive person-centered coordinated care that improves their health outcomes.
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GOAL	MEASURABLE OBJECTIVE
<b>IDENTIFYING CLIENTS WITH SERIOUS MH/SUD AND CHRONIC HEALTH CONDITION</b>	
Increase the number and percentage of clients who have been identified as having relevant mental health/substance abuse and chronic medical conditions	75% of clients in a care setting have been evaluated (through screening or other identification method) for a second condition requiring care in a different setting, i.e., 75% of mental health and substance abuse clients evaluated for CVD/diabetes/metabolic syndrome, and 75% of clients with CVD/diabetes/ metabolic syndrome evaluated for SMI/SUD
<b>CARE COORDINATION for TARGET POPULATION</b>	
Increase the number/percentage of clients with a shared care plan that addresses physical health and specialty MH / SUD conditions	90% of target population clients will have a care plan.
Increase the number/percentage of clients who have an identified care coordinator.	75% of target population clients will have an identified care coordinator.
Improve medication reconciliation	90% of target population clients will have documentation of medication reconciliation in the last 3 months.
Improve access to medical care for clients with SMI and/or SUD	90% of target population clients will have seen a primary care provider in the last 6 months.
Reduce unnecessary ER utilization.	Reduce by 25% the rate of ER use among target population clients.
Improve client satisfaction with coordination of care	80% of target population clients will report that their satisfaction with coordination of care between their MH / SUD and medical care providers is good or excellent.
Improve tracking of health outcomes	90% of target population clients will have documented BMI, Hgb A1c, LDLc, and blood pressure in the last 6 months.
Improve health outcomes	Reduce by 25% the number of target population clients with metabolic parameters out of control: <ul style="list-style-type: none"> <li>• Hgb A1c &gt; 7</li> <li>• blood pressure &gt; 140/90</li> <li>• LDLc &gt; 100.</li> </ul>
Improve health behaviors	<ul style="list-style-type: none"> <li>• Reduce by 25% the number of target population clients who are smoking</li> <li>• Increase by 25% the number of target population clients who are physically active</li> </ul>

## GUIDANCE

The focus of CIC is on improved coordination of care for individuals with two or more health problems that overlap three aspects of health: physical, mental, and substance use.

- Candidates for care coordination will have a serious mental illness and/or substance use disorder, and a physical health condition such as metabolic or cardiovascular diseases--in other words, multiple complex conditions where MH or SUD specialty care is required in addition to primary care
- The target population is identified as patients/clients being seen in at least one of the 3 settings who need care from an additional partner. Each clinical partner has an initial population of patients who are evaluated (through screening or other identification method) for a second condition that requires care from an additional partner

***Initial Population:***

- Primary Care: clients with CVD/diabetes/metabolic syndrome
- Mental Health: SMI clients
- Substance Use Disorders: SUD clients

***Care Coordination Target Population:***

- Clients from PC, MH and SUD settings with a MH/SUD condition and CVD/diabetes/metabolic syndrome who require care coordination between PC and specialty MH/SUD
- While comprehensive client screening in each of the care settings is ultimately key to identifying the full population of clients who can benefit from care coordination, this learning collaborative is focused on improving care coordination rather than screening practices. Thus, clients may be identified for the target population by a range of strategies: client data matching, chart review as well as screening.
- The setting providing care and coordination of care should be preferred, trusted and considered “safe” by the individual.
- Due to short duration of the pilot collaborative, the CIC Aim Statement emphasizes improving care coordination processes. National experience with care coordination finds that it may require two years to achieve significant improvement in client outcomes. Therefore, while it is expected that client outcomes will improve during the pilot, the greatest measurable improvement will be related to coordination of care for clients.

<h2>GUIDANCE</h2>	<ul style="list-style-type: none"><li>• Individuals in the target population are expected to have a care plan that reflects key health goals of the individual and his/her providers, including goals relevant to mental health, substance use, and chronic medical conditions. This care plan should document agreements on overall care as well as progress towards planned goals.</li><li>• In this collaborative, care coordination occurs through a cross-disciplinary care team that provides or arranges care for individuals in the target population. Care coordination teams can be on-site, virtual or a combination. Each county's project team is expected to build clinical care coordination teams with existing clinical staff who practice in the county's partner organizations during the initial phases of the collaborative. Hiring and training of new staff to perform care coordination roles will delay participating teams in testing and implementing key improvements.</li></ul>
<h2>CARE COORDINATION</h2>	<p>Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshaling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care. (pg. 4)</p> <p>The level of care coordination need will increase with greater system fragmentation, greater clinical complexity, and decreased patient capacity for participating effectively in coordinating one's own care... The level of need is not fixed in time, nor by patient. Assessment of level of care coordination is likely important to tailor interventions appropriately and to evaluate their effectiveness. (pg. 8)</p> <p><u>Care Coordination Measures Atlas</u>, AHRQ Publication No. 11-0023-EF December, 2010</p>

# Benefits of Participating

## Expert Support

Teams will have the opportunity to interact with a diverse group of faculty with expertise in care coordination and quality improvement. Participants will receive guidance and expert technical assistance from faculty who will help organizations with testing and adapting changes, as well as using data.

## The Model for Improvement (Associates for Process Improvement)

Using this approach provides a process to improve the quality of care at an accelerated pace.

## Peer Interaction

For the duration of the Collaborative, participating primary care and specialty mental health and substance use disorder provider organizations as well as local public safety net health plan partners will test change ideas designed to improve communication, coordination, and continuity of care, and then report the results of these tests on a periodic basis. During learning sessions, participating teams will share promising practices, plan “tests of change,” analyze their progress, develop strategies for overcoming barriers, and plan for spread of successful changes.

## Exchanging Health Information

Teams will have the opportunity to design, test and implement methods of exchanging health information among providers and with clients/patients.

## Medi-Cal 1115 Waiver

Teams will have the opportunity to identify and test emerging effective practices in integrated care for persons with co-occurring physical, mental health and substance abuse conditions as California’s Medicaid population expands with implementation of the low income health plan (LHIP) as well as other initiatives related to healthcare reform.

## Performance Improvement Project (PIP) Guidance

County Mental Health Department’s have the opportunity to qualify participation in CIC to serve as one or two required Performance Improvement Projects (PIPs). CIC outcomes and related measures are structured to address administrative process improvements as well as clinical improvements. APS has approved participation in the CiMH learning collaboratives to qualify as **two separate PIPs if the team charter meets specific guidelines**. (More information about the PIP requirements will be available during the pre-work period for the mental health organizations interested in completing PIPs within the CIC.)

# The Collaborative Schedule

## Schedule

Collaborative leadership will provide more specific details regarding the timeline and schedule of activities

### Kick Off

Virtual Session ..... February 10, 2012 – 10:30am-3pm

**Pre-Work Period** ..... February 10 – March 21, 2012

Pre-Work Calls ..... 3 calls on Wednesdays, 1pm-2pm:  
February 15, 29, & March 14

Executive Sponsors Leadership Call ..... Monday March 12, 2012 – 3:30pm-5pm  
(All Partner Leaders)

### Learning Sessions

Learning Session 1 ..... March 22-23, 2012, Sacramento

Learning Session 2 ..... June 5-6, 2012, Southern CA

Learning Session 3 ..... September 13-14, 2012, Virtual

Learning Session 4 ..... November 29-30, 2012, location tbd

Harvest Session ..... January 31, 2013, location tbd

### Ongoing Calls

Action Period Calls ..... 1<sup>st</sup> and 3<sup>rd</sup> Wednesdays of each month  
1:00pm-2:00pm beginning April 4<sup>th</sup>

Leadership Action Period Calls ..... 2<sup>nd</sup> Monday, 4:00pm – 5:00pm  
of every month beginning April 9<sup>th</sup>

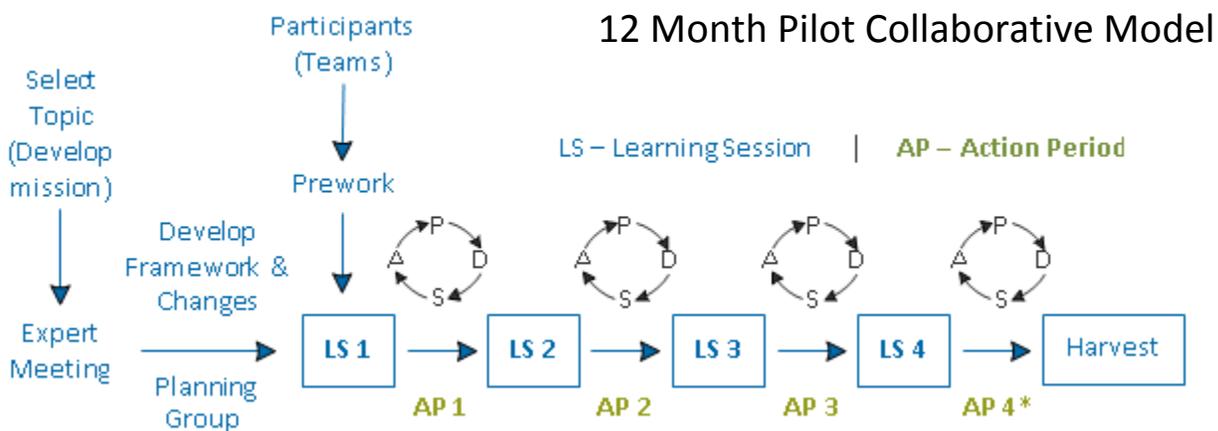
# Section Two: The Models of the Collaborative

## The Breakthrough Series Collaborative Model

There are four basic elements within CIC:

- Pre-work activities
- Learning sessions
- Action periods
- Harvest Session

These elements correspond with the key elements of the Learning Model, adapted from the Institute for Healthcare Improvement’s Breakthrough Series, depicted below.



*Adapted from The Breakthrough Series: IHI’s Collaborative Model for Achieving Breakthrough Improvement*

## Learning Model (12-month Collaborative Timeline)

### Pre-Work

Pre-Work is the period between the Kickoff and the Learning Session 1, which is scheduled for Thursday and Friday, March 22 and 23, 2012. During this time, partnership teams have several important tasks to accomplish and are expected to participate in three Pre-Work calls scheduled for Wednesdays, February 15, February 29, and March 14, 2012 from 1-2PM. Also, Executive Sponsors/senior leaders are asked to join in a Leadership Pre-Work Call that will be announced shortly. Pre-work activities/tasks are listed later in this section and described in detail in the following sections.

## Learning Sessions

Learning Sessions are the major integrative events of CIC. Teams will attend four highly interactive Learning Sessions where they explore the elements of effective care coordination and methods for testing and implementing changes.

Through plenary sessions, small group discussions, and team meetings, attendees have the opportunity to:

- Learn from faculty and colleagues
- Receive individual coaching from faculty and colleagues
- Gather new knowledge on subject matter and process improvement
- Share experience and collaborate on improvement plans
- Problem-solve improvement barriers
- Develop plans for the action periods

## Action Periods

The time between Learning Sessions is called an Action Period. During Action Periods, teams work within across their county partnerships to test and implement approaches to care coordination for their targeted clients. Teams test multiple changes required for care coordination and collect data to measure the impact of the changes. Although CIC participants focus on their own partnering organizations within their county, project teams will remain in continuing contact with other teams, CIC staff, and faculty. This communication includes conference calls, email, and accessing the CIC website and listserv. It is also possible that site visits will be scheduled for CIC staff and participants. In addition, Collaborative team members share the results of their improvement efforts in monthly reports. Participation in Action Period activities is not limited to those who attend formal Learning Sessions. It is encouraged and expected that there will be participation of senior leaders, other team members and support persons from partnering organizations.

## The Harvest

The final face-to-face meeting (Harvest Session) will occur in 2013, where teams will work together to refine the change package (innovative ideas for Care Coordination) and the measurement system to guide such efforts.

## The Model for Improvement

CIC uses an improvement model developed by Associates in Process Improvement that has been tested and used in many Collaboratives. The Model for Improvement (MFI) provides a framework for testing, adapting, and implementing changes that result in improvement of quality of care at an accelerated pace.

The Model for Improvement consists of **three fundamental questions**, and the **PDSA cycle (Plan-Do-Study-Act cycle)**, which is used to test and implement changes in real work settings:

### 1. What are we trying to accomplish?

The first question is meant to establish an aim for improvement that focuses group effort. Using data and what clients/patients and other customers, such as payers, believe are important helps to define an aim. Aims should be as concise as possible – sometimes it takes a few trials of testing an aim before it becomes truly focused.

### 2. How will we know that a change is an improvement?

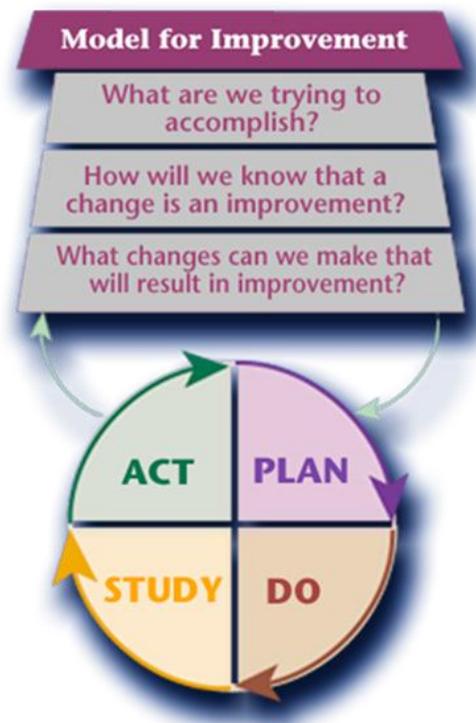
Feedback mechanisms, such as measures and observations are necessary to answer this question. Data are needed to assess and understand the impact of changes designed to meet an aim. When shared aims and data are used, learning is further enhanced because it can be shared with other organizations in the Pilot- Collaborative. In this way, superior performance and best practices are more quickly identified and disseminated through benchmarking.

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

The only way to improve a system is to make a change.

However, not all changes result in improvement. All participants in the Collaborative will be given a set of change ideas that have been shown to lead to the effective integration of mental health and primary care.

However, the details of how to make these changes work will be discovered by the participants and shared with each other.



## PDSA Cycle

The **Plan-Do-Study-Act (or PDSA) cycle** is a way to test changes quickly to learn how they work. Teams plan a change... test it out on a small scale... observe the results... and refine the change, as necessary. Teams repeat these test cycles until the change is ready for broader implementation.

This trial-and-learning (learn by test) method helps to identify effective and efficient ways to change a process. The “study” part of the cycle may require some clarification; after all, we are used to planning, doing and acting. The emphasis on study is the key to learning and establishes knowledge. It compels the team to learn from the data collected, its effects on other parts of the care coordination system and on clients and staff, and under different conditions, such as different practice teams or different sites. PDSA cycles are short and quick usually lasting from a few minutes to a maximum of several days.

The following example shows how a team may start with a small-scale test:

### PDSA Cycle Example

#### Plan

Ask one client if they would like information about blood glucose monitoring and ways to reduce A1cs and manage blood glucose levels. We predict that blood glucose monitoring will seem too complex to the client.

#### Do

Dr. Jones asked his first previously identified diabetic client on Tuesday.

#### Study

The client was interested. Is this a general approach that we can use with many clients or is the client saying this as it is something we want to hear?

#### Act

Dr. Jones will continue to ask the next five clients about their interest in information and support to reduce blood glucose levels. He will set up a planned visit for those clients who say yes. Follow up with teaching clients how to use blood glucose monitor and collect data on their use of monitor and other methods.

## SECTION 3: Pre-Work Activities

### Checklist

- Distribute the Pre-work Manual to all team members.
- Identify team members and roles and complete the roster of participating teams.
- Establish approach to team activities (i.e., when will meetings occur to plan tests and study results, who will attend those meetings, who will lead those meetings, etc.)
- Develop a Partnership Team Charter.
- Identify your target population (TP) as well as the initial specific TP members. (Note: TP is 100-300 individuals and may increase over the life of the collaborative.)
- Hold first team meeting and schedule ongoing regular team meeting times and meeting participation expectations.
- Participate in Pre-Work calls (February 15 and 29, and March 14 at 1-2pm).
- Executive Sponsors/Senior Leaders participate in Pre-Work call for Leaders (March 12, 3:30-5:00).
- Develop a strategy for sharing patient data across care partners and adopt a system to collect and use data for improving care. Include use of a client registry if possible.
- Complete the Care Coordination Team Development Tool, Steps 1, 2 and 3, which will be introduced during the Pre-work call on February 15<sup>th</sup>. Additional work on Step 3 will take place at the first Learning Session.
- Complete the measurement assignment that will be introduced during the 2/15 Pre-work call.
- Prepare and bring a storyboard to Learning Session #1 for presentation, using the format that will be provided to you via email during Pre-Work
- Complete measurement assignment from the Pre-work call on February 29 and be prepared to discuss on the Pre-Work Call on March 14
- Obtain information about the CiMH QIC website
- Register the team for Learning Session #1 – Additional details will be provided

## Composition of the Project Team

Individual members that compose the collaborative project teams should minimally reflect the following roles:

- Senior Leader(s)
- Team Leader/Key Contact
- Clinical Supervisor/Manager
- Provider (Clinician/Care Manager)
- Peer Provider (Staff or Volunteer)
- Family Member Provider (Staff or Volunteer)
- Data Analyst/Evaluator

Each Project Team should include members from each of the care coordination partners as well as the local health plan (if actively participating). It is likely that the Project Team will include duplicates of some roles; for example, there may be providers participating from each partner agency or from each discipline, mental health, substance use disorder treatment and primary care. However, in order for the Project Team to function well, the executive leaders from all the participating agencies should agree that one senior leader to take on the collaborative leader role on behalf of all the participating agencies. Similarly, identifying one team leader and one person responsible for the data and analysis will help the team function effectively.

These Project Team member roles should not be confused with who needs to be involved in local clinical care coordination teams that will be developed over the course of the collaborative. While these clinical care coordination teams may include project team members, the clinical teams are expected to include other clinicians and staff from the partnering organizations that are not members of the core Project Team.

The inclusion of Clients/Family Members is strongly encouraged in all aspects of the CIC Collaborative. The client/family member perspective is critical to developing effective care coordination approaches where the client is an active partner in improving his/her health outcomes.

### Senior Leader(s) (Mental Health Director (or Deputy), Substance Use Disorder Services Administrator and/or Primary Care Executive)

The Senior Leader has authority to allocate time and resources needed to achieve the partnership team's aims. CIC is more complex than most BTS Learning Collaboratives because CIC involves multiple partnering organizations. CIC partners are encouraged to delegate senior leadership functions for the Project Team to a single individual who is then responsible for key communications with partner agencies. The CIC Project Team's Senior Leader is strongly advised to attend all learning sessions and is expected to join Pre-Work calls, Action Period calls as well as special CIC Leadership Sessions. (Other senior leaders from partnering organizations are encouraged to attend learning sessions and are recommended to attend special Leadership Sessions described in a later section of this manual.)

In addition, each partnering PC/MH/SUD organization will need to identify a Senior Leader who has administrative authority over areas affected by the changes the team will test and who will champion the spread of successful changes throughout the organization. Effective leadership of CIC will require senior partnership leaders to communicate and collaborate regarding priorities, resources and overarching improvement strategies.

### Team Leader / Key Contact (Oversees Day-to-Day Leadership and Coordination)

The Team Leader is the day-to-day leader who will be the critical driver for the Project Team. The Team Leader assures that tests of change are implemented and oversees data collection. This role can be filled by any of the Project Team members with the concurrence of partnering organizations. It is important that the Project Team Leader understand not only the details of their care system, but also understands or can learn about the systems of the other partners to understand the effects of testing/making change(s) to promote improved care coordination across partner agencies. To do this, the team leader needs to be able to work effectively with the all team members as well as other staff members in the partnering organizations. This day-to-day leader will be CIC staff's "key contact" during the learning collaborative and will be responsible for coordinating communications between the team and CiMH staff. The team leader/key contact is expected to attend all learning sessions.

In addition to the Project Team leadership roles already described, the Project Team should include representatives from each partner agency who represent the following functions/roles: (Note: one individual may fill several roles)

### Clinical Supervisor(s) or Manager(s) (Has Clinical Practice and Supervision Expertise)

Some of the attributes of a Clinical Supervisor or Manager could include, but not be limited to:

- An understanding of evidence-based clinical practice and/or supervision of clinical care (e.g. Clinical Supervisor, Quality Improvement Director)
- An understanding of existing clinical processes and opportunities for improvement with direct benefit to clients
- A background in improvement methods, the ability to help the team determine what to measure and the capacity to assist in the design of small scale tests of change
- Knowledge of the methods and tools used to collect and report data, including expertise in clinical information systems

### Provider(s) (Clinicians and/or Case Managers)

Individuals engaged in direct service delivery are critical to the success of achieving the aim of this collaborative. To this end, each team should plan for the inclusion of necessary direct service clinical staff from partnering agencies, which may include physicians, psychologists, social workers, nurses, case managers, or medical assistants. Providers identified for the project team are expected to attend learning sessions.

## Peer Provider or Volunteer (This can be a Paid Position or a Volunteer)

The peer provider or volunteer plays a critical role in identifying appropriate changes to support client self-management and care coordination, in the planning of small scale tests, and in the assessment of the results. Given the importance of peer perspective in this collaborative, each team should consider recruiting a peer volunteer if they do not have paid peer provider staff. Consideration should be given to including a client family representative if a willing participant can be identified. The peer provider/volunteer representative is expected to attend learning sessions.

## Data Analyst/Evaluator

The Data Analyst/Evaluator will have primary responsibility for the collection of the data associated with this learning collaborative. This individual will also manage the input of data into the measurement and reporting tool supplied by the learning collaborative Improvement Advisor and upload it onto the QIC - CIC website. (Instructions will be provided during the first Learning Session. It is important that this individual is an expert in the mechanics of data collection; however, the entire team should review data monthly to assess whether improvements are being made. The data analyst is expected to attend all learning sessions.

## Additional Team Members

As discussed above, the county project teams will have representation from more than one organization. Benefits resulting from bringing together members from the different care settings include reinforcing of positive relationships between the care disciplines, diversifying perspectives on changes, and assisting in addressing historic barriers to coordinated care that may exist in the county.

## Project Team Structure and Processes

Each project team should establish team norms and structure for the improvement work including testing, data collection and data analysis. At minimum, project teams should agree during pre-work to the following:

- When will regular project team meetings will occur to plan tests and study results
- Who will attend those meetings
- Who will lead those meetings
- Attendance at collaborative activities

### ATTENDANCE

Senior Leaders are strongly encouraged to attend all Learning Sessions. The Team Leader/Key Contact, Clinical Supervisor or Manager, Provider, Peer Provider, and Data Analyst/Evaluator are expected to attend each Learning Session. It is important to insure that Project Team members attending Learning Session represent different care disciplines and different partners to insure that learning is shared and changes are tested and implemented within and across partnering organizations. Each Learning Session builds on the previous one and to ensure a strongly trained team the same members should attend as consistently as possible. Through CIC collaborative events, teams will receive technical assistance and support provided by CIC leadership including expert faculty, with on-the-ground experience in care coordination.

## Participation in Pre-Work Calls

<b>Project TEAMS</b>	<p>Initial Pre-Work Calls will focus on:</p> <ul style="list-style-type: none"><li>• Project Team structure and leadership; team member roles and responsibilities</li><li>• Development of a project charter and target population</li><li>• Building a partnership Clinical Care Coordination Team (which may function as a “virtual” team)</li><li>• Assessment of current care coordination-related activities</li><li>• Capability to collect, share and use client data</li><li>• Preparing teams to participate in the first Learning Session</li></ul> <p>Pre-Work Calls are designed to assist teams in completing Pre-Work assignments. Three Pre-Work Calls have been scheduled to help teams prepare for the CIC collaborative. It is vital that all project team members be actively involved in the Pre-Work phase in order to develop as a team that crosses and represents the collaborating agencies’ partnership. The Project Team learns the terminology of the collaborative and the models and methodology used, so that team members can relate the CIC process to everyday practices in participating organizations. Once the groundwork has been laid in the early months of the collaborative, project teams will find their own method of covering CIC conference calls and may include members of the clinical care coordination team in these activities.</p>
<b>LEADERS</b>	<p>Senior leaders from partnering organizations are strongly encouraged to participate in an Executive/Senior Leaders special (call) sessions--one of which will be scheduled during Pre-work. These sessions will focus on leadership for improvement, and will provide an opportunity for leaders of the partnering agencies across the 7 participating counties to:</p> <ul style="list-style-type: none"><li>• explore the critical role of leadership in organizational improvement,</li><li>• meet with national experts in quality improvement and care coordination, as well as to</li><li>• share strategies for success including aligning CIC with agencies’ strategic initiatives and measurement of results</li></ul>

## Developing an Aim Statement

While the Care Integration Collaborative has a charter with an overarching aim to increase the number of clients who receive patient-centered coordinated care to improve their health outcomes, each county will tailor this overarching collaborative aim to align with unique county integration goals.

The Model for Improvement is based on three questions:

1. What are we trying to accomplish?
2. How will we know that a change is an improvement?
3. What changes can we make that will result in an improvement?

The first question: “**What are we trying to accomplish?**” is meant to establish an Aim for your partnership’s integration/care coordination improvement effort. To answer this question teams should consider the needs of clients as well as the partner agencies’ goals. The Aim should be as concise as possible. Teams often find that they must test an Aim before it becomes truly focused. This testing and finalizing the Aim may continue after the Pre-work period.

In setting the partnership’s Aim, teams should be sure to do the following:

**Involve executive sponsors/senior leaders:**

Leadership from each organization must align the Aim with their organizations strategic goals.

**Base the Aim on both data and organizational needs:**

Examine data within participating organizations to help guide the establishment of an appropriate Aim. Refer to the measurement section and focus on issues that matter to your organizations.

**State the Aim clearly and develop numerical, measurable goals:**

Teams will have a clear picture of the changes that need to be made if the Aim is unambiguous and clearly stated. Including the measures that will be tracked in the aim statement is encouraged.

**Include a description of the initial group of clients where the changes in care will be tested and implemented:**

Refer to “Defining the Target Population” in the next section of this document.

**Include an optional Guidance Paragraph on approaches and methods to further explain the team’s approach:**

Describe the practice, team and target population and include specific strategies that the organization intends to follow.

# Examples of Aim Statements and Charters

From previous CiMH learning collaboratives

## Example 1

### Problem Statement

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A serious health crisis is faced by persons with mental illness and their families and this creates significant consequences for the US health care system. For example: people with serious mental illness served by public mental health systems die, on average, at least 25 years earlier than the general population; and, 60% of premature deaths in persons with schizophrenia are due to co-occurring medical conditions such as cardiovascular, pulmonary and infectious diseases

### Aim

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A partnership between the Health Plan of San Mateo, San Mateo Medical Center and San Mateo Behavioral Health and Recovery Services will employ a “Wellness Coordinator” (health care advocate) to improve the health outcomes of seriously mentally ill adults receiving atypical anti-psychotics and currently served for their physical health care needs by a Nurse Practitioner located at the North County Mental Health Clinic. The partnership will also develop a web-based resource to increase the effectiveness and frequency of communication between primary care and mental health providers working with mutual clients

### Guidance

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- The target population will consist of 100 clients receiving their mental health care at the North County Mental Health Clinic who are receiving anti-psychotic medications and receive primary health care from a Nurse Practitioner out-stationed at that same clinic.
- In general, focus on care coordination goals throughout treatment, as compared to only at discharge

### Objectives (selected)

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- 70% of clients served by the Wellness Coordinator will have appropriate medical screenings appropriate for their age and gender
- 95% of PCPs and psychiatrists serving the same clients in the target population will be able to identify each other
- 15% increase in the number of clients whose blood pressure is considered within normal range

## Example 2

### Problem Statement

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Difficulty with coordination between Co. Mental Health and Primary Care Providers is a major health problem for those individuals with severe mental illness.

### Aim

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To improve client health outcomes by creating clear processes of communication and collaboration between primary care providers and County Mental Health.

### Guidance

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Informal telephone and FAX communication is currently in place regarding shared patients. Relationships exist between individual MH and Primary Care providers. An electronic referral pathway exists for pediatric referrals to Co. Mental Health services.

### Goals

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Within the next 12 months we will achieve the following:

1. At least 90% of mental health clients will have a documented, current PCP.
2. Bi-Directional sharing of data will be evident for at least 50% of our shared clients.
3. Bi-Directional processes for referring clients will be established with more than 50 % of the FQHC, RHC, and Marshal Medical Center, primary care providers in El Dorado

## Defining the Target Population

The Target Population represents the clients that pilot teams will want to have an impact on through care coordination. Clients will be tracked for the duration of CIC to measure and understand the impact of care improvement changes that teams test and implement during the Collaborative. The Target Population is typically identified on the basis of provider(s) caseload, but can also be defined by geographic location, provider setting, or other client demographics. The CIC charter defines the target population as clients with a MH/SUD condition and CVD/diabetes/metabolic syndrome who require care coordination between PC and specialty MH/SUD. The setting where Target Population clients receive care and are initially identified as requiring coordinated care across primary care and MH or SUD is not specified since care coordination eligible clients may be engaged in service in multiple locations within a given County partnership. The size of the Target Population should be between 100 and 300 clients/patients. During the Pre-Work Phase, CIC leaders will provide examples and guidance to teams on further defining their Target Population.

## Sharing Clinical Information across Partnering Organizations

Identifying the target population is critical to achieving team Aims. To identify clients within the Target Population, teams will benefit from being able to access client data in multiple care settings involved in the partnership. Local Health Plans may also have data that will facilitate identification of clients who receive care in multiple settings. Since client data is not generally shared across provider settings due to patient protection and confidentiality, teams will need to determine how to collect and share client information. During the Pre-Work Phase, CIC faculty and participating County teams will provide examples and share approaches to client data sharing.

The tools and approaches used to collect, access and share clinical information about a specific group of clients are often referred to as clinical information systems (CIS). Simply stated, a CIS is a convenient mechanism for keeping and sharing pertinent clinical information about a specific group of clients. A client registry is an example of a CIS. The use of CIS, client registries and data base solutions applications (in the absence of a registry), will be discussed in further detail during the Kick-off session and in the early Pre-work calls. (NOTE: From this point forward, we will use the term “client registries” instead of clinical information systems and in reference to registries or tools that may be used as an alternative to a registry.)

### What a client registry will provide:

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|--|---|
| <ul style="list-style-type: none"><li>• Identify client populations and sub-populations in need of care</li><li>• Organize data from disparate information sources (EMR, paper record, client visit, claims data)</li><li>• Measure care of individuals and populations of clients</li><li>• Provide client summaries at time of visit</li></ul> | <ul style="list-style-type: none"><li>• Produce exception reports for population care planning Enable feedback to team on population outcomes</li><li>• Automate care reminders</li><li>• Allow queries of data to target at risk sub-populations</li><li>• Guide clinical care first, measurement second</li></ul> |
|--|---|

## The Change Package

A **Change Package** is a collection of change concepts and key change ideas that teams will test and where successful implement/spread during the CIC. Actual changes that primary care clinics, substance use disorder services and mental health organizations test will vary according to the local aims, priorities and needs of each County partnership. The Change Package will be provided to teams at Learning Session One. Examples of change concepts and change ideas are listed below.

- **Change Concepts** are usually at a high level of abstraction, but encompass multiple specific ideas for how to change processes;
- **Change Ideas** are actionable, specific, and can be tested to determine whether they result in improvements in the local environment.

### Change Concept

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Leaders in partnering organizations provide active support for integration of care and care coordination

#### Change Ideas

- a. Establish agreements among executive sponsors/leaders including commitment to the process and making change (Formal and Informal Agreements/MOUs)
- b. Review and communicate the results of the CIC, including key PDSA cycles and monthly data reports, to key stakeholders across partnering agencies

### Change Concept

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Design the role of care coordinator including: identifying job description, responsibilities and key functions

#### Change Ideas

- a. Identify core competencies for Care Coordinators (CCs) based on emerging national best practices and standards.
- b. Identify and analyze key elements of care coordination and match with classifications existing staff to enhance “pool” of appropriate workforce members working at the top of their skill level who can provide CC
- c. Identify and/or build a CC training curriculum

## Change Concept

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Address confidentiality as a barrier and obtain client consents to enable data sharing

### Change Ideas

- a. Develop business agreements to support sharing of client data across systems
- b. Create and a shared release form that meets to legal/regulatory and practice standards and ask clients who are identified as CIC target population to sign as they are selected for the collaborative

## Change Concept

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Develop person-centered shared care plan (SCP) to be used by all partners

### Change Ideas

- a. Develop a template for shared care plan including process for creating format inclusive of MH/SA/PC components
- b. Develop components for the SCP that cross disciplines, e.g., medication list, client goals, wellness goals (exercise, nutrition, participation in smoking cessation program...)
- c. Decide on method for communicating and updating SCP with client and his/her care team

## Key CP Theme: Coordinate Care for Shared Clients

### Getting Started on Building Care Coordination Capacity and Processes

Care Coordination has emerged as essential process that supports positive health outcomes for individuals with multiple complex and chronic conditions-including chronic health conditions that co-occur with serious mental illness and substance use/abuse disorders. National organizations including the Agency for Healthcare Research and Quality, the Institute for Medicine and the Institute for Healthcare Improvement have developed care coordination definitions and investigated and identified best practices and interventions.

The AHRQ's [Care Coordination Atlas](#) provides a broad definition of care coordination used by CIC:

“Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care.”<sup>1</sup>

For the CIC Target Population, care coordination requires primary care and other physical health providers to partner and share resources with specialty MH/SUD providers as clinical care coordination teams.

### Clinical Care Coordination Team Building

The AIMS Center of the University of Washington’s Department of Psychiatry and Behavioral Services has developed team-building tools to help organizations integrate primary care and specialty mental health as well as community support services. The tool has been used by more than 500 organizations to adapt, implement, and sustain evidence-based collaborative care for common mental disorders. Although the AIMS Center approach to care integration and care coordination has proven effective with individuals who have behavioral health problems, the CIC Collaborative is breaking new ground with its focus on best practices in care coordination for persons requiring specialty MH and SUD care. During the CIC collaborative, participants will have the opportunity to test an adaptation of this integration approach and build care coordination teams across primary and specialty MH/SUD partners. To achieve this, MH/SUD/PC partnering agencies/sites need to clearly define the roles of the care coordination clinical team members and create an effective, shared workflow that makes optimal use of existing staff resources.

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<sup>1</sup> Care Coordination Atlas, op.cit.

## Steps to Building a Clinical Care Coordination Team

Project teams will be asked to follow a 3-step Clinical Care Coordination Team (CCC Team) building process.

**STEP 1. COMPLETE A STAFF SELF-ASSESSMENT (PROJECT TEAM)**

**STEP 2. IDENTIFY GAPS, DUPLICATION OF SERVICES, AND TRAINING NEEDS (PROJECT TEAM)**

**STEP 3. CREATE A CUSTOMIZED INTEGRATED PRIMARY CARE, MENTAL HEALTH CARE AND SUBSTANCE USE DISORDER CARE  
WORKFLOW (PROJECT TEAM AND KEY CLINICIANS FROM CC PARTNERING PROVIDERS)**

## Project Team Facilitates the Building of the Clinical Care Coordination Team

During the Pre-work Period the Project Teams will:

1. Tailor worksheets based on relevant care coordination tasks that fit your charter
2. Distribute and collect completed Step 1 Worksheets for clinicians and care team staff\*
3. Tabulate all staff member responses by completing the Task Summary by Staff Worksheet

With these activities completed during CIC Pre-work, Project Teams will come to the first face-to-face Learning Session prepared to build a CCC Team. Testing the new workflows and measuring outcomes are key activities in the collaborative.

# Measurement

## The Why, What, and How Much of Measurement

CIC is about improving the health and wellness of individuals with a MH/SUD condition and CVD/diabetes/metabolic syndrome, not measurement. But measurement is critical improvement throughout CIC. Measurement will help us evaluate the impact of changes made to improve delivery of care to the Target Population. Measurement should be designed to accelerate improvement, not slow it down. Teams require just enough measurement to be convinced that changes being tested and implemented are leading to improvement.

## Measurement of Population-Based Care

Population based care is the process of identifying health problems within a defined population of clients/patients, defining, and assuring evidence based interventions for members of the population, and regularly monitoring progress and scientific literature to keep interventions state of the art.

## Measurements Related to Organization Aims

The most important measures required during CIC are measures that directly relate to the aim of each partnership team. The measures will provide the means to assess progress toward aim and goals. All teams will use a core set of measures to understand the overall impact of changes in care processes and the health outcomes of clients. A full description of core measures will be provided and discussed during Learning Session 1. Core process measures will enable the identification of the target population from the county's population at risk (e.g., Primary care patients with diabetes, SUD patients). Outcome measures will provide indications of achieving CIC client care coordination and health outcome goals.

The most important measures required during CIC are measures that directly relate to the aim of each team. The measures will provide the means to assess progress toward aims. Some examples of measures are provided below:

- Percentage of clients for which a direct consultation between SUD and/or MH and PC has occurred
- Percentage of Care Coordination clients with an assigned care coordinator
- Percentage of Care Coordination clients with a care plan shared between PC, SUD and MH
- Percentage of Care Coordination clients with a reconciled medication list between PC, SUD and MH

## SECTION FOUR: Resources

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### Glossary of Terms and Concepts

**Action Period** -The period of time between Learning Sessions when teams work on improvement activities is the Action Period. Action Period activities are supported by the Collaborative leadership team, faculty, and other Collaborative team members via a variety of resources such as distribution lists, virtual offices and web sites, teleconferences, etc.

**Aim or Aim Statement** - A written, measurable, and time sensitive statement of the accomplishments a team expects to make from its improvement efforts. The aim statement that contains a general description of the work, the Target Population, and the numerical goals can also be referred to as a **Charter**.

**Care Coordination** - The *Care Coordination Measures Atlas* (an AHQR publication) defines it as the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshaling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care.

**Change Concept** - A general idea for changing a process, usually developed by an expert panel based on literature and practical application of evidence. Change concepts are usually at a high level of abstraction, but evoke multiple specific ideas for how to change processes. "Establish shared guidelines," "involve clients/patients and families in care planning," "use existing databases to track client/patient care," are all examples of change concepts.

**Change Idea** - An actionable, specific idea for changing a process. Change ideas can be tested to determine whether they result in improvements in the local environment. An example of a change idea is, "Develop and implement use of educational materials that assist clients/patients with SMI in determining the appropriate circumstances to utilize emergency department services.

**Change Package** – Change concepts with key change ideas organized into overarching change themes.

**Change Theme** –a set of related change concepts that impact a specific process or set of processes to improve care processes and outcomes.

**Charter** – A charter contains an Aim Statement plus additional detail and guidance about the problem to be addressed by the effort and guidance for those working on the collaborative as well as related goals and specific objectives.

**Clinical Care Coordination Team (CCC Team)** – In CIC this team(s) participates in the Collaborative by testing changes for improvement and bringing their experiences back to the Project Team. A Project Team may have multiple CCC Teams that address the needs of subsets of the target population (SUD clients with diabetes, clients who seek care only at a mental health center). CCC Teams have a leader or liaison which is a member of the Project Team.

**Clinical Information System or Registry** - A Clinical Information System (CIS) or a registry incorporates the development of a comprehensive, integrated information system that is “client-centered,” includes registries, a practice management system including billing system, an electronic health record and personal health records.

**Learning Session** - A two-day meeting during which participating teams meet with faculty and collaborate to learn key changes in the topic area: including how to test and implement changes, an approach for accelerating improvement, and a method for overcoming obstacles to change. Teams leave these meetings with new knowledge, skills, and materials that prepare them to make immediate changes.

**Measure** - A focused, reportable unit that will help a team monitor its progress toward achieving its aim. CIC will provide a list of required core measures as well as a list of additional measures to assist teams in achieving excellent results.

**Model for Improvement** - An approach to process improvement, developed by Associates in Process Improvement, which helps teams accelerate the adoption of effective changes. The model includes use of “rapid-cycle improvement,” successive cycles of planning, doing, studying, and acting (PDSA cycles).

**PDSA Cycle** - Another name for a cycle (structured trial) of a change, which includes four phases: Plan, Do, Study, and Act. The PDSA cycle will naturally lead to the “plan” component of a subsequent cycle.

**Project Team** - Those individuals from each county partnering organization who attend the learning sessions and are accountable to the senior leadership for the work of the Collaborative. The Project Team drives and participates in the improvement process. A core group from each partnership organization will be members of the Project Team and attend the Learning Sessions, but a larger Clinical Care Coordination Team (generally four to eight individuals) participates in the improvement process from each organization. The Project Team and its members should be recognized as different from the broader Clinical Care Coordination Team that will test specific changes during Action Periods. (See Clinical Care Coordination Team.)

**Target Population** - A designated set of clients/patients who will be tracked to determine whether changes have resulted in improvements. The ideal size for the Target Population is between 100-300 clients/patients. The Target Population will then be the initial focus of changes tested and implemented in organizations.

**Pre-Work** - The time before the first learning session during which teams prepare for their ongoing work in CIC. Pre-Work activities include attending Pre-Work conference calls, forming a team, registering for the first learning session, scheduling initial meetings, preparing an aim statement, defining a Target Population, selecting measures, and developing a plan to implement a clinical information system.

**Test** – A small-scale trial of a new approach or a new process. A test is designed to learn if a particular change results in improvement, and to fine-tune the change to fit the organization and target population clients/patients. Tests are carried out using one/usually multiple PDSA cycles.

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