



Pilot-Collaborative to Integrate Primary Care & Mental Health Services

Pre-Work Manual

May 2010

Table of Contents

Getting Started	1
The Case for Primary Care and Mental Health Service Integration	1
Overview	1
The Pilot-Collaborative Charter	2
Collaborative Milestones	3
Schedule	4
The Models of the Pilot-Collaborative	5
Pre-Work Activities	8
Checklist of Pre-Work Activities	8
Establishing a Partnership	8
Participation in Pre-Work Calls	10
Developing an Aim Statement	11
Defining the Pilot Population	12
Using a Clinical Information System to Organize Client/Patient and Population Data to Facilitate Efficient and Effective Care	12
Measurement	14
The Change Package	15
Glossary of Terms and Concepts	17
Resource Section	18

About This Manual

The purpose of this manual is to help lay a foundation for activities leading up to the first learning session (Kick-Off) of the CalMEND Pilot-Collaborative to Integrate Primary Care and Mental Health Services (CPCI). Principal activities include identifying team members, developing an Aim, deciding on a pilot population and summarizing the partnership's work using a storyboard.

CPCI Pre-Work Manual

Getting Started

Welcome to the CalMEND Pilot-Collaborative to Integrate Primary Care and Mental Health Services (CPCI). In an effort to improve the health of individuals with severe mental illness (SMI) and co-occurring chronic medical disorders through more effective partnerships between mental health and primary care providers, CalMEND is launching a Pilot-Collaborative to integrate primary care and mental health services. Sponsored by the State of California Departments of Health Care Services and Mental Health, the structure of the Pilot-Collaborative is based on the Institute for Healthcare Improvement (IHI) Breakthrough Series (BTS) Collaborative model. Through the Pilot-Collaborative, CalMEND will bring together mental health and primary care practitioners and organizations that share a commitment to making major changes that produce significant, sustainable breakthrough results.

The Case for Primary Care and Mental Health Service Integration

What is integrated health care? It has been defined in many ways, but in essence integrated health care is the systematic and seamless coordination of physical and mental health care. The idea is that physical and mental health problems often occur at the same time. As such, integrating services to provide more holistic and client/patient-centric care will yield the best results and be the most acceptable and effective approach for those being served.

The rationale for integration is generally understood. Primary care providers know that many of their patients have mental health problems such as depression and anxiety. Mental health providers know that many of their clients have physical health problems such as diabetes and heart disease.

Although in the structure of traditional systems there has often been a significant separation between these professions – physical health problems have been seen as the domain of primary care providers, and behavioral health problems as the domain of behavioral health providers – providers in both settings increasingly are seeing the need to address both types of problems to help their clients/patients become healthy.

Overview

In CPCI, organizations will test innovations to improve the integration of mental health and primary care services using a systematic approach to healthcare quality improvement. By measuring the impact of these innovations and sharing their experiences, participants can accelerate the learning process and achieve widespread implementation of successful change concepts and ideas.

Overall Structure of the CalMEND Pilot-Collaborative

CPCI will involve four to six partnering behavioral health and primary care organizations working together intensely for eighteen months. During that time, CPCI partnerships will participate in up to four learning sessions and maintain regular contact with each other and CPCI leadership and faculty members through email, website, conference calls and site visits. In 2011, participating CPCI organizations will share their findings and achievements with each other at a final Learning Session that will highlight the accomplishments of the Pilot-Collaborative and effective models of care.

Partnerships to Achieve Integration

A critical aspect of CPCI involves partnerships between participating primary care and mental health organizations to achieve integration goals and improve the health outcomes of Medi-Cal beneficiaries with SMI and significant co-occurring chronic medical disorders. However, CPCI program staff recognizes that some organizations may require more time and assistance to solidify partnerships. Program staff also realizes that for some organizations CPCI may provide a first-time opportunity for organizations to work closely together on a joint initiative. Consequently, initial Pre-Work activities will focus on ways to effectively engage partner organizations and examples of the various partnership and team structures that may evolve.

Pilot-Collaborative Charter

The mission and aim of CPCI is listed below so that teams are grounded in the purpose of the Pilot-Collaborative and organizations are aided in the identification and selection of team leaders and members who will work to achieve the pilot-collaborative aim.

Mission:

To improve the health of individuals with severe mental illness and co-occurring chronic medical disorders through more effective partnerships between mental health and primary care providers.

Aim:

Utilizing Wagner's Care Model to guide change, CalMEND will assist organizations in improving the integration of physical and mental health care for individuals with SMI, with an emphasis on enhanced partnerships between the primary care and mental health organizations that deliver care. Although the improvements should apply to many aspects of care, the initial focus will be on improving, by at least 50%, the identification and treatment of cardiovascular disease and its risk factors, including physical inactivity, smoking, obesity, diabetes, hypertension, and dyslipidemia in the population of individuals with SMI identified at pilot sites.

Problem Statement

- People with serious mental illness served by the public mental health systems die, on average, at least 25 years earlier than the general population
- 60% of premature deaths in persons with schizophrenia are due to medical conditions such as cardiovascular, pulmonary and infectious diseases
- Severe mental illness is associated with a 31.2% increase in the odds of being hospitalized in a given year
- According to an analysis of Medi-Cal data by Jen Associates, in CY '07 the prevalence of diabetes, ischemic heart disease, cerebrovascular disease, arthritis and heart failure was three times higher among the SMI Medi-Cal population compared to the general Medi-Cal population
- About 75% of individuals with serious mental illness are tobacco dependent compared with 22% of the general population
- Recent results from the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) study found that among persons with schizophrenia, appropriate medical treatment was not received by:
 - ✓ 30.2% of persons with diabetes
 - ✓ 62.4% of persons with hypertension
 - ✓ 88.0% of persons with dyslipidemia
- Second generation antipsychotic medications have become highly associated with weight gain, diabetes, dyslipidemia, insulin resistance, and metabolic syndrome
- Established monitoring and treatment guidelines to lower risk are underutilized in SMI populations
- Nationally, Medicaid beneficiaries who are disabled represent a minority of all Medicaid beneficiaries (16%) but account for a substantial portion of Medicaid expenditures (45%)

Benefits of Participating

Expert Support - Teams will have the opportunity to interact with experts in chronic care management, integrated physical and mental health care, 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.

Peer Interaction - During the Pilot-Collaborative, participating mental health and primary care organizations 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.

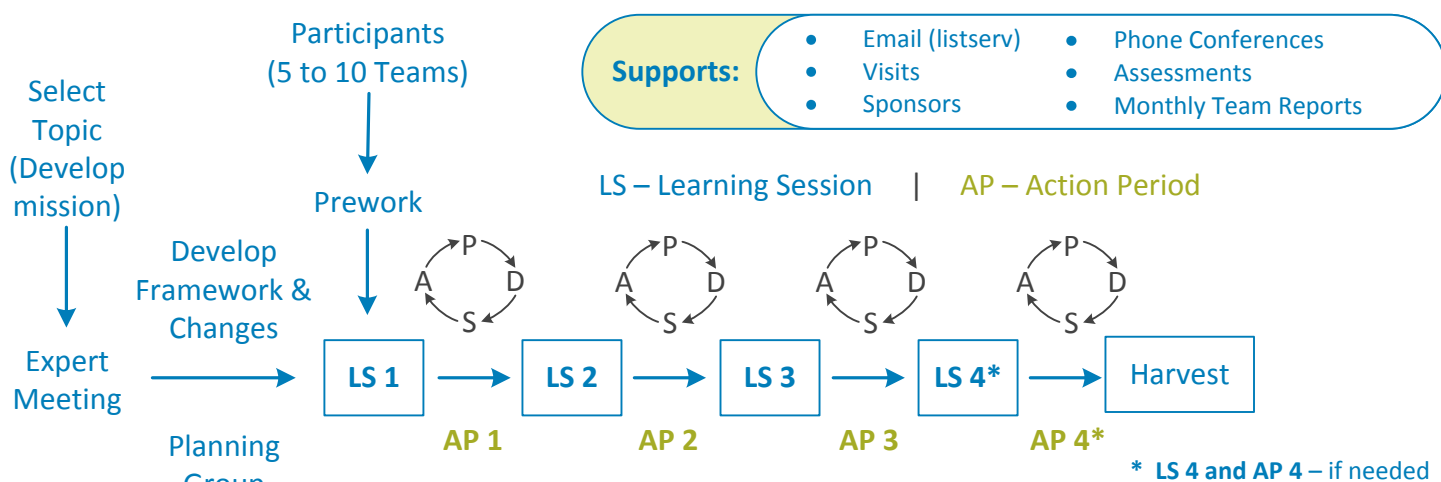
Local Aggregated Baseline Data - Organizations will also be provided with baseline data to assist in the identification of populations with co-occurring SMI and chronic medical disorders and enhance their understanding of client’s needs.

Financial Support – Each county partnership will receive at least \$40,000, the use of which will be jointly determined by the partnering primary care and mental health organization and included as part of the contract executed between DHCS and the County. Funds can be used in any appropriate manner determined by participants to offset costs associated with participating in the Pilot-Collaborative (e.g., personnel travel costs, purchase software, support staff time or other related expenses).

Collaborative Milestones

There are four basic milestones within CPCI. Those components are: pre-work activities, learning sessions, action periods and the CalMEND Learning Forum. These milestones correspond with the key elements of the Learning Model, adapted from the Institute for Healthcare Improvement’s Breakthrough Series.

Learning Model (18-month Pilot-Collaborative Timeline)



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

Pre-Work

Pre-Work is the period between the receipt of this manual and the beginning of Pre-Work conference calls up until Learning Session 1, which is scheduled for June 22-23, 2010. During this time, teams have several important tasks to accomplish, including participation in a series of pre-work calls. These 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 CPCI. Interdisciplinary teams representing partnering behavioral health and primary care organizations attend up to four highly interactive Learning Sessions where they explore the elements of effective integration 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 and across organizations to test and implement approaches and transformations for providing improved integrated care to their clients/patients. Teams test multiple changes in their organizations and collect data to measure the impact of the changes. Although participants focus on their own partnering organizations, they remain in continuous contact with other teams enrolled in the Pilot-Collaborative, CalMEND staff, and faculty. This communication takes the form of conference calls, email, accessing the website and listserv, and site visits to other organizations in the Pilot-Collaborative. In addition, Pilot-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 the learning sessions. It is encouraged and expected that there will be participation of other team members and support persons in primary care and mental health organizations, including senior leaders, during Action Period activities.

Final Learning Session and Harvest

The final face to face meeting (Harvest Session) will occur in 2011, where teams will work together to refine the change package (innovative ideas for improving integration of care) and the measurement system to guide such efforts.

Schedule

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

The sequence of events for the Pilot-Collaborative is as follows:

Pre-Work Period:	May 12 - June 9, 2010
Learning Session 1:	June 22 - 23, 2010
Learning Session 2:	TBD September 2010
Learning Session 3:	TBD January 2011
Harvest:	TBD June 2011
<i>Pre-Work Calls:</i>	<i>May 12th, May 26th & June 9th, 2010; 12:00 – 1:30 PM</i>
<i>Action Period Calls:</i>	<i>Tentatively 2nd & 4th Wednesdays, 12:00-1:30 PM</i>

The Models of the Pilot-Collaborative

The Care Model

The Care Model is typically used as an organizational approach for caring for individuals with chronic disease in primary care settings. CalMEND believes that the Care Model is also an appropriate model for use by organizations engaged in the delivery of integrated primary care and mental health services for clients/patients with SMI and co-occurring chronic medical disorders. The Care Model is population-based and creates practical, supportive, evidence-based interactions between an informed, activated client and a prepared, proactive practice team.



Description of Care Model Elements

*The Chronic Care Model was developed by Ed Wagner, MD, MPH, Director of the MacColl Institute for Healthcare Innovation, Group Health Cooperative of Puget Sound, and colleagues of the [Improving Chronic Illness Care](#) program with support from The Robert Wood Johnson Foundation.

The Care Model identifies six essential components of a health care system that encourage high-quality care and emphasizes evidence-based, planned, and integrated collaborative care.

Health Care Organization - Create a culture, organization, and mechanisms that promote safe, high quality care:

- Visibly support improvement at all levels, beginning with senior leaders
- Promote effective improvement strategies aimed at comprehensive system change
- Encourage open and systematic handling of errors and quality problems to improve care
- Provide incentives based on quality of care
- Develop agreements that facilitate care coordination within and across organizations

Community Resources and Policies - Mobilize community resources to meet needs of clients/patients:

- Encourage clients/patients to participate in effective community programs
- Form partnerships with community organizations to support and develop interventions that fill gaps in needed services
- Advocate for policies to improve client care

Self-Management Support - Empower and prepare clients/patients to manage their health and health care:

- Emphasize the client's central role in managing their health
- Use effective self-management support strategies that include assessment, goal-setting, action planning, problem-solving and follow-up
- Organize internal and community resources to provide ongoing self-management support to clients/patients

Decision Support - Promote clinical care that is consistent with scientific evidence and client preferences:

- Embed evidence-based guidelines into daily clinical practice
- Share evidence-based guidelines and information with clients/patients to encourage their participation
- Use proven provider education methods
- Integrate specialist expertise and primary care

The Models of the Pilot-Collaborative

Delivery System Design - Assure the delivery of effective, efficient clinical care and self-management support:

- Define roles and distribute tasks among team members
- Use planned interactions to support evidence-based care
- Provide clinical case management services for complex clients/patients
- Ensure regular follow-up by the care team
- Give care that clients/patients understand and that fits with their cultural background

Clinical Information Systems - Organize client and population data to facilitate efficient and effective care:

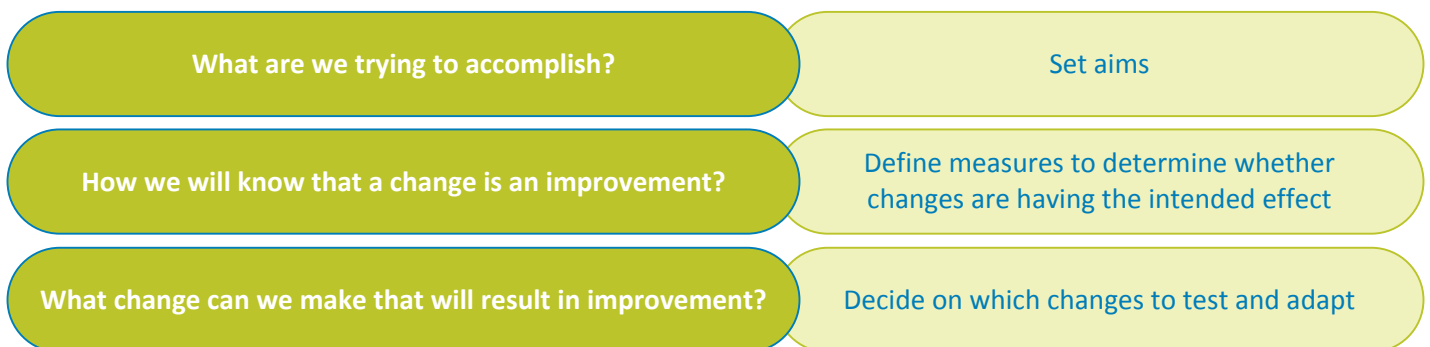
- Provide timely reminders for providers and clients/patients
- Identify relevant subpopulations for proactive care
- Facilitate individual client/patient care planning
- Share information with clients/patients and providers to coordinate care
- Monitor performance of practice team and care system

The Model for Improvement

In addition to the Care Model, CPCI uses an improvement model developed by Associates in Process Improvement that has been tested and used in many Collaboratives and Pilot-Collaboratives. The Model for Improvement 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:

Organizations use the three questions to:



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.

The Improvement Guide, Second Edition, Jossey-Bass, 2009

The Models of the Pilot-Collaborative

(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 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 Pilot-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

Testing and Learning: The PDSA Cycle- PDSA stands for Plan, Do, Study, Act and is a trial-and-learning (learn by test) method to discover what is an effective and efficient way 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 system and on clients/patients and staff, and under different conditions, such as different practice teams or different sites. Most importantly, the study phase is an ideal time to think through how the Care Model helps to generate new ideas and approaches to positive change. In addition, the PDSA cycles are short and quick.

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

Plan: Ask one client/patient if they would like more information on how to manage blood glucose levels.

Do: Dr. Jones asked his first previously identified diabetic client/patient on Tuesday.

Study: Client/patient was interested.

Act: Dr. Jones will continue with the next five clients/patients and set up a planned visit for those who say yes.

Checklist of Pre-Work Activities

- Establish a partnership approach (i.e., how organizations will structure their teams to achieve integrated primary care and mental health services)
- Identify team members and roles and complete the team roster
- Distribute this manual to all team members from both partner organizations
- Develop an aim statement and determine the pilot population
- Register the team for Learning Session #1. Additional details will be provided.
- Hold first team meeting and make decisions about team roles and regular meeting time
- Discuss required measures with team members and select additional measures, as required or desired
- Prepare for completion of the Assessment of Chronic Illness Care (ACIC)
- Prepare and bring a storyboard, using the format provided to you via email by the Director, to Learning Session #1 for presentation

Establishing a Partnership

Several factors drive selection of a primary care or mental health provider partner, including but not limited to:

- Existing relationships between organizations;
- Proximity between provider sites;
- Focus on a particular patient/client population (e.g., homeless, veterans, racial or ethnic group); or
- Innovation such as demonstrated success using a patient registry or electronic health record or improved health outcomes resulting from use of evidence-based treatment practices.

Selection of a partner organization may drive the integration model(s) employed or may assist in narrowing the scope of the organizations' pilot-collaborative aim. During the Pre-Work phase, teams will have the opportunity to hear from each other about the rationale behind partnership decisions.

Forming Teams

Establishing a partnership with a primary care or mental health provider may also drive the configuration of team members within and across organizations. Having an appropriate and effective team is a key component of successful improvement efforts. While team configuration may vary across partnerships, some core team roles are required for each partnership.

Pre-Work Activities

Composition of the Core Team

Individual members that comprise partnership teams should minimally reflect the following leadership roles: Senior Leader, Physician Champion(s), Team Leader/Key Contact, Clinical/Technical Expert and Mental Health/Primary Care Service Delivery Representative(s). The active participation of Client/Family Members is strongly encouraged in all phases of the Collaborative. As a result, partnerships in the Pilot-Collaborative may reflect team members with roles from both the primary care and mental health organization; however, configuration of each partnership will vary as organizational needs dictate.

→ **Senior Leader** (generally an executive within the organization)

The Senior Leader has ultimate authority to allocate time and resources needed to achieve the team's aims. In addition, this individual has administrative authority over all areas affected by the changes the team will test and will champion the spread of successful changes throughout the organization. The Senior Leader is encouraged to attend all learning sessions.

→ **Physician Champion(s)**

It is critical to have physician champions on the team (i.e., primary care physician representing the primary care organization and a psychiatrist representing the mental health organization). This champion(s) should have a good working relationship with colleagues and with the Team Leader described below, and be interested in driving change in the system. Physicians should be opinion leaders in the organization (individuals sought out for advice who are not afraid to test change). The physician champion is expected to attend all learning sessions.

→ **Team Leader / Key Contact** (Day-to-day leadership and coordination)

The Team Leader is the day-to-day leader who will be the critical driver of the team, assuring that tests of change are implemented and overseeing data collection. It is important that this person understand not only the details of the system, but also the various effects of making change(s) in the system. This individual also needs to be able to work effectively with the physician champion(s) as well as other staff members in the organization. The day-to-day leader will be the "key contact" at your organization. This individual should be responsible for coordinating communications between the team, to the partnering organization and staff. The team leader/key contact is expected to attend all learning sessions.

→ **Clinical/Technical Expert** (subject matter knowledge and processes of care)

A Clinical/Technical expert could include, but not be limited to:

- Someone who understands the processes of care (e.g. Quality Improvement Director).
- An expert on improvement methods who can help the team determine what to measure, assist in the design of simple, effective measurement tools and provide guidance on the design of tests.
- Someone from within the organization who has a good understanding of the methods and tools used to collect and report data. That would include expertise, interest, and knowledge in clinical information systems.
- In summary, Clinical/Technical experts may include individuals from administration, information systems, medical records, etc.
- The clinical/technical expert is expected to attend all learning sessions.

Pre-Work Activities

→ **Mental Health/Primary Care Service Delivery Representative(s)** (Front line clinical staff engage in care and treatment)

Individuals engaged in direct service delivery are critical to the success of achieving a partnership's aim. To that end, each partnership should plan for the inclusion necessary Mental Health or Primary Care Service Delivery Representatives, which may include social workers, nurses, medical assistants, as examples. Key MH/PC service delivery representatives are expected to attend learning sessions.

→ **Additional Team Members** (key staff to support project activities)

Given that several of the above roles may be held by the same individual as well as the magnitude and intensity of the work to integrate care, partnering agencies may want to assign additional individuals to the team. These individuals might include, although are not limited to the following:

- Client/Family Member
- Peer support leader or champion
- Data analyst

The Senior Leader, Physician Champion(s), Team Leader/Key Contact, Clinical/Technical Expert, and Mental Health/Primary Care Service Delivery Representative(s) **must attend all learning sessions**. Each learning session builds on the previous one and to ensure a strongly trained team the same members should attend. There may be one or more individuals on the team with skills and qualifications that enable him or her to fill more than one role. However, each team should be comprised of individuals so that each leadership role is represented to successfully drive changes in and across organizations. Through CPCI, teams will receive technical assistance and support provided by CalMEND leadership. National faculty is also available for support and guidance.

Selection of Organizational Partners and Team Members

Initial Pre-Work Calls will focus on:

- Team structure and leadership;
- Team member roles and responsibilities;
- Instructions for submitting a team roster;
- Expectations of the team; and
- Preparing teams to participate in the first Learning Session.

Participation in Pre-Work Calls

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 Learning Session #1/Kickoff. It is vital that all team members from each partnership (i.e., primary care and mental health) be actively involved in the Pre-Work phase in order to develop as a team and as a collaborating partnership, learn the terminology of CPCI, learn the models and methodology used, and begin to relate the CPCI process to everyday life in participating organizations. One of the mechanisms to accomplish that task is to attend these first calls since this is the foundation teams will build on. Once the groundwork has been laid, teams will find their own method of covering conference calls and accomplishing the work to meet their Aim.

Developing an Aim Statement

While CPCI has an overarching aim to improve the integration of physical and mental health care for individuals with SMI with an initial focus on improving the identification and treatment of cardiovascular disease and risk factors, each partnership will establish a specific aim for the partnership's integration improvement effort.

As previously described, 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 is meant to establish an Aim for your partnership's integration improvement effort. To answer this question teams should consider the needs of clients/patients as well as the primary care and mental health service integration goals of partnering organizations. The Aim should be as concise as possible. Oftentimes a team must test an Aim before it becomes truly focused.

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

- **Involve senior leaders:** Leadership from both organizations must align the Aim with the strategic goals of the organization.
- **Base the Aim on both data and organizational needs:** Examine data within and across organizations to help guide the establishment of an appropriate Aim. Refer to the measure section and focus on issues that matter to organizations.
- **The Aim should mention the “redesigning of the system of care based on the Care Model’s six components:”** The Care Model provides the framework for changing (redesigning) systems of care.
- **State the Aim clearly and use 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/patients where the changes in care will be tested and implemented:** (See the Pilot Population discussion in the next section of this document).
- **Include an optional Guidance Paragraph on approaches and methods to further explain the partnership’s approach:** Describe the practice, team and pilot population and include specific strategies that the organization intends to follow.

Examples of Aim Statements

Through cooperation with our primary care partner, Pinecrest Family Health Center, we will improve the identification and treatment of CVD or diabetes risk factors for clients/patients with SMI currently treated at Oakleaf Mental Health Agency. This will be evidenced by:

- *At least 95% of Oakleaf’s clients/patients will receive a brief health screening and risk assessment from Pinecrest within one year of CPCI;*
- *At least 90% of Oakleaf’s clients/patients without a usual source of health care will access primary care services at Pinecrest within one year of CPCI;*
- *At least 80% of Oakleaf’s clients/patients treated at Pinecrest will have a unified care plan developed within one year of CPCI; and*
- *At least 90% of shared clients/patients of Pinecrest and Keystone will have developed self-management goals within one year of CPCI.*

Pre-Work Activities

Examples of Aim Statements (continued)

To redesign the clinical practice to improve access to and retention in primary care services for clients/patients with SMI currently treated at Southeast Mental Health Agency. We will accomplish this by implementing the following measures:

- At least 90% of Southeast's SMI clients/patients without a usual source of health care will receive facilitated referral services from a Southeast case manager for treatment at Brookside Family Health Center within one year of CPCI;
- At least 80% of Southeast's SMI clients/patients with CVD or diabetes will receive behavioral health consultation services at Brookside within one year of CPCI;
- At least 80% of Southeast's SMI clients/patients with CVD or diabetes have developed self-management goals within one year of CPCI.

Defining the Pilot Population

The Pilot Population represents the clients/patients that partnership teams will want to have an impact on through the work of CPCI. The Pilot Population refers to the total range of clients/patients who will be the target population and tracked throughout the partnership's integration efforts. The Pilot Population is typically centered on individuals with SMI and who are currently seen (or could be seen) at both partnering sites. The size of the Pilot Population should be between 100 and 300 clients/patients, with Medi-Cal beneficiaries constituting a significant portion, combined across partnering organizations.

During the Pre-Work Phase, CPCI leaders will provide examples and guidance to teams on defining the Pilot Population.

Using a Clinical Information System to Organize Client/Patient and Population Data to Facilitate Efficient and Effective Care

Identifying the client/patient population is critical to the success of achieving partnership Aims. Without identification, changes cannot be achieved. To identify clients/patients within the Pilot Population, teams would benefit from being able to access data that pertains to this group. The tools used to collect and access clinical information about a specific group of clients/patients 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/patients. The following information is for informational purposes only. The use of CIS and client/patient registries will be discussed in further detail during the first Learning Session/Kick-off.

What a CIS will do for partnership teams:

- Identify client/patient populations and sub-populations in need of care
- Organize data from disparate information sources (EMR, paper record, client/patient visit, claims data)
- Measure care of individuals and populations of clients/patients
- Provide client summaries at time of visit
- Produce exception reports for population care planning
- Enable feedback to team on population outcomes
- Automate care reminders
- Allow queries of data to target at risk sub-populations

Pre-Work Activities

A CIS should:

- Be quick to implement
- Be simple to use
- Be organized by client/patient; not disease
- Be integrated into daily clinical activities
- Contain only data relevant to clinical practice and performance measurement
- When necessary, make data entry simple and efficient
- Be easy to update from other automated data sources
- Guide clinical care first, measurement second

A CIS should not:

- Contain “mountains” of data
- Require an advanced computer science degree to operate
- Require a lot of upkeep and maintenance
- Be limiting to one disease or condition population
- Become the focus of practice activity

During the first Learning Session , CPCI leaders will provide examples for use of Clinical Information Systems, as well as explore how a CIS can support integration of mental health and primary care services. Learning Sessions will also assist teams in understanding the essential components of a CIS, how CIS may be used across partnering organizations as well as considerations for developing and implementing a CIS.

Assessing Chronic Illness Care

The Assessing Chronic Illness Care (ACIC) survey is typically used by medical teams to identify areas for improvement in their care of individuals with chronic illness, as well as to evaluate the level and nature of improvements made in their system. The content of the ACIC survey was derived from specific evidence-based interventions (e.g., telephone follow-up) for the six components of the Care Model (community resources, health organization, self-management support, delivery system design, decision support and clinical information systems). Like the Care Model, the ACIC survey addresses the basic elements for improving chronic illness care at the community, organization, practice and client level.

CPCI leadership will provide teams with instructions on completing the survey during the Pre-Work phase. The survey instrument is accessible at:

improvingchroniccare.org/tools/acic.html

The ACIC survey will be utilized in CPCI as it will enable both primary care and mental health organizations to assess the extent of existing chronic illness management and identify areas for improvement, particularly with respect to identifying opportunities for enhanced coordination of primary care and mental health services.

Pre-Work Activities

The survey is divided into six sections corresponding to the six elements of care in the Care Model. A seventh section corresponds to integration of the six Care Model elements (e.g., Are client self-management goals linked to the clinical information system?). Respondents are asked to rate the degree to which each component (e.g., client treatment plans) is being implemented within their system, using a scale ranging from 0 (not at all) to 11 (fully). To aid in selecting a value, the ACIC provides general descriptions for limited, basic, good and excellent support of chronic illness care in connection with that component. One of the advantages of the ACIC is that the most advanced category (the highest possible score for each item) describes optimal practice, educating respondents about where they should be targeting their practice.

The ACIC provides six sub-scale scores corresponding to each of the six Care Model elements, as well as an overall score. An additional subscale score can be calculated for the section that addresses how well an organization integrates the Care Model elements. Guidelines for interpreting scores are provided to assist respondents in identifying where to focus improvement efforts.

Measurement

The Why, What, and How Much of Measurement

CPCI is about improving the health of individuals with severe mental illness and co-occurring chronic medical disorders, not measurement. But measurement will play several important roles throughout CPCI. Measurement will help us evaluate the impact of changes made to improve delivery of care to the pilot population. Measurement should be designed to accelerate improvement, not slow it down. Teams require just enough measurement to be convinced that the changes being made are leading to improvement.

Population-Based Care Measurement

The Care Model is population-based. 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 Partnering Organization Aims

The most important measures required during CPCI are measures that directly relate to the aim each partnership. The measures will provide the means to assess progress toward aims. A full description of core measures will be provided and discussed during the 2nd Pre-Work Call on May 26th. Core process measures will enable the identification the percent of clients/patients screened for risk (e.g., smoking, drug use, diabetes, hypertension, dyslipidemia). Outcomes measures will provide indications of goals toward use of statins, ace inhibitors and aspirin as appropriate for clients'/patients' conditions and risk. Continuity of care measures will also indicate progress toward increasing referrals and ongoing treatment for primary care or mental health services.

A **Change Package** is a collection of change concepts and key change ideas. **Change Concepts** are usually at a high level of abstraction, but evoke 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. Actual changes that primary care and mental health organizations test will vary. Some ideas are listed below:

Health Care Organization - Create a culture, organization, and mechanisms that promote safe, high quality care:

- Partner each MH organization with a PC clinic to develop a continuum of care
- Establish routine methods to collaborate on daily operations
- Identify shared patients/clients
- Share data across partnering organizations
- Enhance leadership and governance for integrated services delivery
- Establish staffing and resources to support service integration
- Develop training infrastructure and processes
- Place emphasis on clinical operations, work flows and processes
- Promote organizational “will” around integration
- Create opportunities to enhance reimbursement of integrated PC/MH services
- Assure funding for indicated lab tests ordered by MH that address physical health concerns
- Optimize use of existing coding to maximize coverage
- Anticipate/plan for and support the cultural change critical for collaboration between organizations (all levels of staff, clinical design, client needs)
- Involve all players in the change process to create ownership and commitment to the process

Community Resources and Policies - Mobilize community resources to meet needs of clients/patients:

- Connect clients to community-based programs, such as exercise classes, smoking cessation, nutrition, etc.
- Work with community organizations to provide for safe, accessible places to exercise for MH clients
- Form partnerships with community organizations to develop interventions that fill gaps in needed services

Self-Management Support - Empower and prepare clients/patients to manage their health and health care:

- Use client-completed assessment tools
- Partner with clients in treatment planning
- Jointly develop and use recovery-oriented educational approaches to help clients understand and better deal with their illness(es)
- Help clients become more involved in their mental and physical health recovery
- Host wellness groups or other similar discussion groups on health promotion and prevention
- Involve family members, as appropriate, to promote client health and wellness

Decision Support - Promote clinical care that is consistent with scientific evidence and client preferences:

- Provide real-time support to PC for mental health conditions
- Conduct PC Training on MH screening and awareness
- Develop joint UM/UR committee with MH and PC presence to review shared client cases
- Improve the competencies of PC organizations in providing care to MH clients with physical conditions and risk factors
- Improve the competencies of MH organizations in providing care to clients with physical conditions and risk factors
- Implement shared training to improve competencies of PC and MH staff providing care to clients with physical conditions and risk factors
- Embed Evidence Based Guidelines for detection and treatment of metabolic and cardiovascular diseases (for clients with SMI)
- Increase access to clinical decision/educational on line tools

Delivery System Design - Assure the delivery of effective, efficient clinical care and self-management support:

- Develop cross-consultation between clients, MH and PC providers to improve communications
- Establish and implement shared guidelines or protocols
- Develop team-driven care
- PC to provide support of select mental health needs, according to organization's "plan for integration"
- Adjust PC service delivery process to be sensitive to mental health conditions
- Establish group visits in PC and MH for clients with SMI and chronic illness
- Use USPSF practice guidelines for guidance on primary and secondary preventive medical/psychiatric care for clients with mental illness in both PC and MH settings
- Use MH evidence based treatment practices that can be useful in PC settings
- Expand MH scope of services to include some primary care (according to "plan for integration")
- Promote healthy lifestyles and weight management in MH settings
- Expand role of MH case managers to support physical health needs
- Utilize existing databases to inform daily practice
- Develop and implement processes to ensure that clients receive less intensive or more intensive levels of care depending on clients' type or severity of disorder, responsiveness to treatment, etc.

Clinical Information Systems - Organize client and population data to facilitate efficient and effective care:

- Increase sharing of clinical information within the bounds of HIPAA
- Implement a Clinical Information System (registry) in both organizations to collect clinical data on common clients

Glossary of Terms and Concepts

Action Period - The period of time between Learning Sessions when teams work on improvement activities at their respective organizations. They are supported by the Collaborative leadership team, faculty, and other Collaborative team members via a variety of resources such as listservs, 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 contains a general description of the work, the pilot population, and the numerical goals.

Care Model - A model that represents the ideal system of healthcare for individuals with chronic disease and an approach to re-designing healthcare to mirror that ideal system. Developed by Improving Chronic Illness Care, the model has six components: community resources and policies, healthcare organization, self-management support, decision support, delivery system design, and clinical information systems.

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 – A collection of change concepts and key change ideas.

Clinical Information System - A Clinical Information System (CIS) 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.

CPCI - CalMEND Pilot-Collaborative to Integrate Primary Care and Mental Health Services (CPCI), a joint effort of the California Department of Health Care Services and the California Department of Mental Health designed to improve the health of individuals with severe mental illness (SMI) and co-occurring chronic medical disorders through more effective partnerships between mental health and primary care providers.

Core Team Members - Those individuals who attend the learning sessions and are accountable to the senior leadership for the work of the pilot-collaborative.

Integration of Primary Care and Mental Health Services - The systematic and seamless coordination of physical and behavioral health care. The idea is that physical and behavioral health problems often occur at the same time. As such, integrating services to provide more holistic and client/patient-centric care will yield the best results and be the most acceptable and effective approach for those being served.

Learning Session - A two-day meeting during which participating primary care and mental health organization teams meet with faculty and collaborate to learn key changes in the topic area, including how to implement them, 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. CPCI will develop a list of required key measures as well as a list of additional key 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 proven and effective changes. The model includes use of “rapid-cycle improvement,” successive cycles of planning, doing, studying, and acting (PDSA cycles).

Partnership Team - Mental health and primary care practitioners and organizations that share a commitment to making major rapid changes to improve breakthrough results in the delivery of integrated primary care and mental health services and agree to work together intensely through CPCI to achieve jointly-developed aims.

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.

Pilot Population - A designated set of clients/patients who will be tracked to determine whether changes have resulted in improvements. The ideal size for the pilot population is between 100-300 clients/patients. It is this sub-population that will then be the initial focus of the change in organizations.

Pre-Work - The time before the first learning session when teams prepare for their ongoing work in CPCI. Pre-Work activities include attending Pre-Work conference calls, establishing partnerships, forming a team, registering for the first learning session, scheduling initial meetings, preparing an aim statement, defining a pilot population, selecting measures, and develop a plan to implement a clinical information system.

Team - The group of individuals from across organizations and multiple disciplines that drive and participate in the improvement process. A core team from each partnership organization attends the Learning Sessions, but a larger team of six to eight people participates in the improvement process from each organization.

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

Resource Section

IBHP (Integrated Behavioral Health Project), an initiative of The California Endowment and the Tides Center, published *Partners in Health: Primary Care / County Mental Health Tool Kit*. Designed to help primary care clinics and government mental health agencies forge collaborative relationships, the 180-page Tool Kit provides practical, operational advice, forms, strategies and prototypes for integrating mental and physical services. The toolkit is available at <http://www.ibhp.org/uploads/file/IBHP%20Collaborative%20Tool%20Kit%20final.pdf>

The Hogg Foundation for Mental Health published *Connecting Body and Mind: A Resource Guide to Integrated Health Care in Texas and the United States*, a comprehensive report on integrated health care models, barriers and resources. The report is accessible from http://www.hogg.utexas.edu/PDF/IHC_Resource_Guide.pdf

Health Management Associates developed a report for The Robert Wood Johnson Foundation entitled *Integrating Publicly Funded Physical and Behavioral Health Services: A Description of Selected Initiatives*, which is available at <http://www.healthmanagement.com/files/rwjfreport.pdf>

Additional information about CalMEND is available at the California Institute for Mental Health’s website at <http://www.cimh.org/>

For more information about the Care Model, see http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2

Additional information about the Improvement Model can be found at http://www.apiweb.org/API_home_page.htm