



Small County Care Integration
Quality Improvement Collaborative

Pre-Work Manual

February, 2012



California Institute of Mental Health
Collaborative for Small County Care Integration

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Section One: Introduction

Getting Started

Welcome to the Small County Care Integration (SCCI) Learning Collaborative. This collaborative will bring together 13 teams consisting of Small County Mental Health Care staff and clients to achieve better health status for individuals living, or at risk for, serious mental illness. The teams will make changes to improve their support clients' physical health, with a particular focus on cardiovascular disease and diabetes, and use of physical health services. This will be accomplished by mental health agencies changing and improving systems of communication, collaboration, coordination with primary care providers that enhance client wellness. The structure of the Collaborative is based on the Institute for Healthcare Improvement (IHI) Breakthrough Series (BTS) Collaborative model. The founding principle of the model is to bring together organizations that share a commitment to making major changes that produce significant, sustainable breakthrough results. By routinely measuring the impact of innovations adopted and sharing their learning with SCERP participants, individual agencies can accelerate their improvement process and achieve widespread implementation of successful change concepts and ideas.

SCCI will involve 13 Small County Mental or Behavioral Health agencies working together intensely for just over one (1) year. During that time, SCCI partnerships will participate in four (4) learning sessions and maintain regular contact with each other and SCCI leadership and faculty through email, website, conference calls and site visits. In early 2013, participating SCCI organizations will share their findings and achievements with each other at a final convening, called the Harvest, which will highlight the accomplishments of the Collaborative and effective models of care.

The purpose of this manual is to help lay a foundation for activities leading up to the first learning session of the CiMH Collaborative for Small County Care Integration (SCCI). Principal activities include identifying team members, developing a team charter, deciding on a pilot population, completing the Assessment of Chronic Illness Care (ACIC), and summarizing the team's work using a storyboard.

The Case for Mental Health and Primary Care 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 and may even be interrelated. As such, coordinating and integrating services to provide more holistic and client centered care will yield the best results and be the most effective approach for those being served.

Care coordination between mental health and primary care is not an optional systems change. It is necessary to address the serious public health crisis of shortened life span for individuals living with serious mental illness. "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."¹ The most common diseases for individuals with serious mental illness are cardiovascular disease, diabetes, respiratory disease, and infectious disease (including HIV/AIDS). Unfortunately, while the risk factors for these diseases can be changed, clients with serious mental illness are provided with very few opportunities and needed supports to become more involved in their own physical health care, from care planning to self-management. For most clients, mental health and physical health care agency staff underestimate their opportunity to improve their clients' health outcomes.

Not only do clients' behaviors contribute to poor physical health and morbidity, but this problem is compounded by the fact that people with serious mental illness have less access to established monitoring and treatment guidelines for physical health conditions.² In general, clients do not have easy access to primary care and often when they get that care it is not coordinated with mental health. Organizational culture and regulatory differences between primary care and mental health care perpetuate discordant relationships between primary care and mental health care providers and prevent attempts to integrate systems. Treatment practices and funding for people with multiple conditions is siloed, episodic, and uncoordinated. This is demonstrated at the federal and state levels and becomes mirrored at the local level. Fractured coordination with primary care results in marginalization, stigma and poor health outcomes for those with severe mental health illnesses. While the coordination of physical and mental health care for clients with serious

¹ National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council. (2006). *Morbidity and Mortality in People with Serious Mental Illness*. Retrieved from: http://www.dsamh.utah.gov/docs/mortality-morbidity_nasmhpd.pdf

² Ibid.

mental illness is complex, lack of coordination for individuals with SMI has a harmful effect on wellness and quality of life and increases overall medical costs.

Small County Care Integration Collaborative Charter

The aim, objectives, and goals of SCCI 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 Collaborative aim.

<h1>AIM</h1>	<p>Beginning in February 2012, 13 teams consisting of Small County Mental Health Care staff and clients will achieve better health status for individuals living, or at risk for, serious mental illness. The teams will support the physical health of clients, with a particular focus on cardiovascular disease and diabetes, as well as their use of physical health services. This will be accomplished by mental health agencies changing and improving systems of communication, collaboration, coordination with primary care to enhance client wellness.</p>
<h1>OBJECTIVES</h1>	<p>Client Self-Management Objectives</p> <ol style="list-style-type: none"> 1. Reduce the number of clients who are smoking 2. Increase the average time per week that clients exercise Increase the number of SMI clients with a BMI greater than 30 who have used a self-management strategy to lose weight 3. Increase the number of SMI clients with regular primary care visits 4. Increase the number of clients with SMI and diabetes who do their own regular glucose monitoring <p>Integration Process and System Objectives</p> <ol style="list-style-type: none"> 1. Increase appropriate monitoring of clients physical health care by mental health professionals 2. Increase the number of encounters (telephone, email, in-person) between mental health professionals and primary care providers 3. Decrease the number of emergency care visits 4. Reduce the percentage of clients with SMI whose last blood pressure was greater than 140/90 Increase the percentage of clients whose BP and BMI are routinely monitored by primary care provider 5. Increase the percentage of clients that have diabetes who have had A1Cs monitored by primary care provider in the past 4 months 6. Increase the percentage of clients that are on a second generation antipsychotic who have had their A1C or fasting glucose screened in the past year 7. Reduce the percentage of clients whose A1C is above 9

	8. Increase the use of electronic collection of clients physical health data
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GOALS

Improving Clients' Use of Self-Management Techniques

1. Decrease the percentage of SMI clients who are smoking to less than 50% (from county base-line)
2. Increase by 100% the number of SMI clients that exercise a minimum of 150 minutes a week
3. Reduce by 20% all SMI clients with a BMI above 30
4. Increase the percentage of SMI clients who have had a primary care visits in the past 6 months to 80%
5. Increase the percentage of clients with SMI and DM who do regular monitoring of blood glucose to above 90%

Improving Integration Processes and Systems

1. At least 90% of SMI clients have a primary care provider
2. There will be regular and direct consultation (telephone, email, in-person) between mental health professionals and primary care providers for at least 70% of clients
3. There will be a 50% decrease in client visits to urgent care/emergency rooms/hospitals.
4. Reduce the percentage of SMI clients with blood pressure above 140/90 to less than 20%
5. Increase percentage of clients with BP and BMI documented in mental health records within the past 12 months to 90%
6. Increase the percentage of clients that have diabetes who have a documented A1Cs in mental health records the past 6 months to 80%
7. Increase the percentage of clients that are on a second generation antipsychotic who have a documented A1C in the past 12 months to 80%
8. Reduce the percentage of clients with an A1C above 9 to less than 20%
9. At least 95% of SMI clients demographics, blood pressure, body mass index, and A1C levels will be documented in a registry

Section Two: The Models of the Collaborative

The Model for Improvement

SCCI 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.

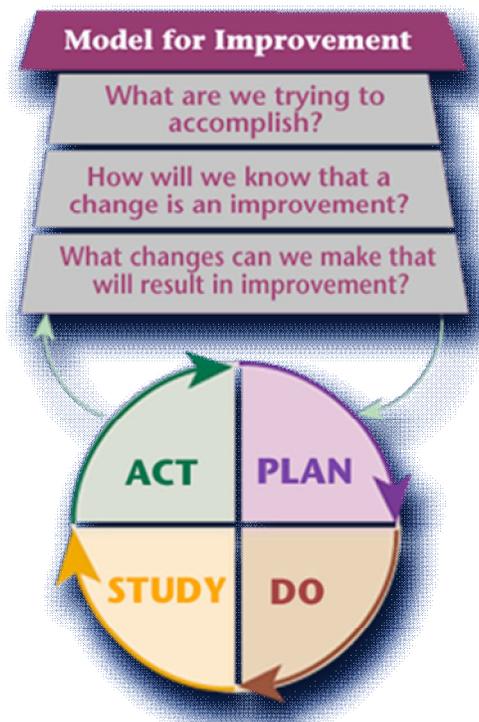
2. **How will we know that a change is an improvement?**

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 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 and staff, and under different conditions, such as different practice teams or different sites. In addition, the PDSA cycles are short and quick.

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: Understanding the Team Process and Schedule

Benefits of Participating

Expert Support

Teams will have the opportunity to interact with a diverse group of faculty with expertise in care coordination, self-management, health literacy, 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.

Performance Improvement Project (PIP) Guidance

Teams will receive structured support and collaborative learning for PIPs in completion of EQRO required Performance Improvement Projects (PIPs). APS has approved collaborative projects to serve as **two separate PIPs if the team charter meets specific guidelines** (please contact Jennifer Clancy at jclancy@cimh.org for more information)

The Model for Improvement

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

Peer Interaction

Throughout the duration of the 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.

Registry

Teams will have the opportunity to explore use of a registry to collect the data measures associated with the learning collaborative.

Financial Support

Team Members, up to a total of 5, will each receive a \$200 travel stipend for each Learning Session they attend. Funds can be used in any appropriate manner determined by participants to offset costs associated with travel to the Learning Sessions.

Composition of the Core Team

Individual members that compose partnership teams should minimally reflect the following leadership roles:

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

If the Mental Health Agency has any primary care staff embedded, add them to the team if possible. If the county already has an active partnership with a local primary care provider agency or Federally Qualified Health Center (FQHC), consider including a representative if possible. The active participation of Clients/Family Members is strongly encouraged in all phases of the Collaborative.

Senior Leader (Generally the Mental Health Director or Deputy Director)

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 strongly recommended to attend all learning sessions and expected to be on the Leadership Pre-Work and Action Period Calls.

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 of the team. They assure that tests of change are implemented and oversee data collection. This role can be filled by any of the roles below, for example the clinical supervisor or a direct service provider. 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 all team members 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 and CiMH staff. The team leader/key contact is expected to attend all learning sessions.

Clinical Supervisor or Manager (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)
- 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

The Clinical Supervisor or Manager is expected to attend all learning sessions.

Provider (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 mental health staff which may include social workers, nurses, case managers, or medical assistants. Key mental health service delivery provider (s) is 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. The peer provider 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 input the data into the measurement tool supplied by the learning collaborative Improvement Advisor and upload it onto the QIC 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

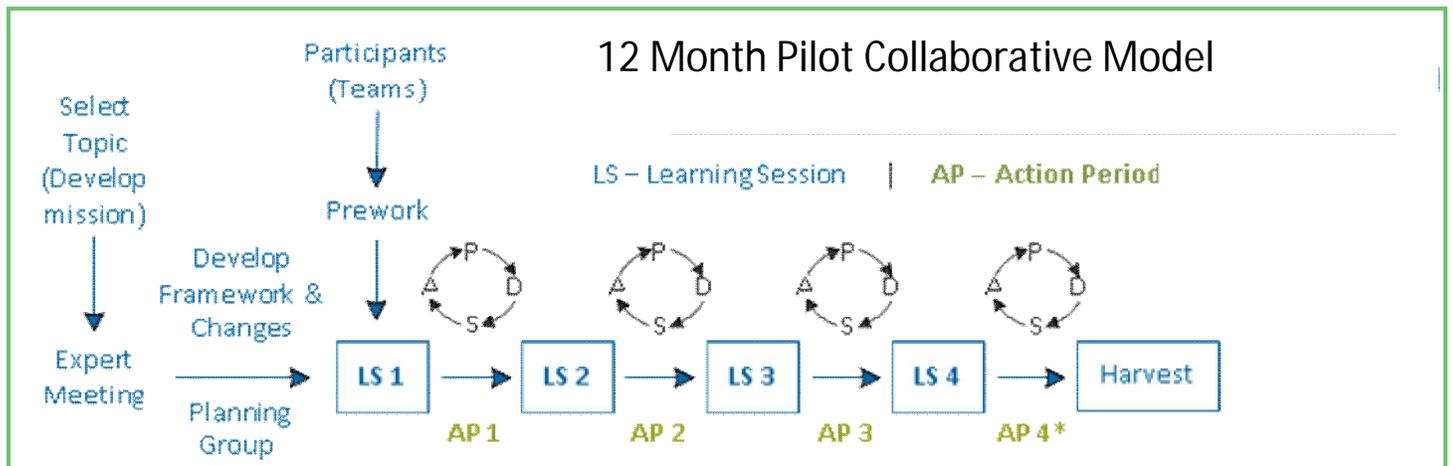
If a county team already has a good relationship with a primary care provider, they should invite this partner to be part of the team. Primary care representation on the Learning Collaborative team fosters positive relationships between mental health and primary care, diversifies perspectives on changes, and can assist in addressing historic barriers to coordinated care that may exist in the county. While it is not expected that the primary care partner will attend all Learning Sessions, their involvement can potentially have a significant impact on a county's ability to improve care coordination. In addition, there may be additional team members who are critical to the work of the team, for example additional providers or peer providers that do not attend each Learning Session. It is important that one person from each of the key team roles attends the Learning Sessions, but beyond that it is up to the Senior and Team Leader's discretion.

ATTENDANCE

The Senior Leader is 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. Given that all teams in this collaborative are Small County Mental or Behavioral Health agencies, these roles may overlap and be filled by the same person. 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 composed of individuals so that each key role is represented to successfully drive changes in and across organizations. Through SCCI, teams will receive technical assistance and support provided by CiMH leadership. Expert faculty, with on-the-ground experience in care coordination and client self-management techniques will also be available for support and guidance.

Collaborative Milestones

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



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 receipt of this manual and the beginning of Pre-Work conference calls up until Learning Session 1, which is scheduled for Tuesday and Wednesday, March 13 and 14, 2012. During this time, teams have several important tasks to accomplish, including participation in a series of Pre-Work calls scheduled for February 8, February 22, and March 7, 2012 from 4-5pm. Also, leaders will participate in a Leadership Pre-Work Call scheduled for Tuesday, February 14th, 8-9:30am. 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 SCCI. Teams 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 of Small County Care Integration for their clients. 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 Collaborative, CiMH 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 Collaborative. 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 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 2013, where teams will work together to refine the change package (innovative ideas for Small County Care Integration) and the measurement system to guide such efforts.

Schedule

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

Kick Off

Virtual Session: January 31, 2012

Pre-Work Period: February 1- March 7, 2012

Pre-Work Calls:..... Wednesdays, 4pm-5pm

February 8, 22, & March 7

Leadership Pre-Work Call:..... Tuesday, 8am-9:30am, February 14

Learning Sessions:

Learning Session 1: March 13-14, 2012, Sacramento

Learning Session 2 May 3-4, 2012, Sacramento

Learning Session 3: August 28-29, 2012, Virtual

Learning Session 4: November 13-14, 2012, Sacramento

Harvest Session: January 24, 2013, Sacramento

Ongoing Calls:

Action Period Calls:..... 2nd and 4th Wednesdays, 4-5pm
 of each month beginning March 21

Leadership Action Period Calls: . 4th Monday, 3:30-4:30pm
 of each month beginning March 26

SECTION FOUR: Pre-Work Activities

Checklist

- Distribute this manual to all team members
- Identify team members and roles and complete the team roster
- 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 team charter
- Identify those individuals in your target population
- Hold first team meeting and schedule ongoing regular team meeting times and meeting norms
- Participate in Pre-Work calls (February 8 and 22, and March 7 at 4-5pm) and leaders participate in Pre-Work call for Leaders (February 14 at 8-9:30am)
- Adopt a system to collect and use data for improving care, such as a registry. Guidance on registries and other choices to satisfy this task will be given at the Kick Off Session
- Complete and submit the Modified Assessment of Chronic Illness Care (ACIC) Survey
- Prepare and bring a storyboard, using the format provided to you via email by the Director, to Learning Session #1 for presentation
- Complete measurement assignment from the Kick Off meeting and be prepared to discuss on Pre-Work Call
- Obtain information about the CiMH QIC website
- Register the team for Learning Session #1 – Additional details will be provided

Participation in Pre-Work Calls

<p>TEAMS</p>	<p>Initial Pre-Work Calls will focus on:</p> <ul style="list-style-type: none"> • Team structure and leadership • Team member roles and responsibilities • Instructions for submitting a team roster • Expectations of the team • Preparing teams to participate in the first Learning Session <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 Kickoff. It is vital that all team members be actively involved in the Pre-Work phase in order to develop as a team and as a collaborating partnership, learn the terminology of SCCI, learn the models and methodology used, and begin to relate the SCCI 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.</p>
<p>LEADERS</p>	<p>A Pre-Work call that is limited only to Mental Health or Deputy Directors has also been scheduled. This call will focus on leadership for improvement, and include a focus on the distinction between quality assurance and improvement, the end result of improvement efforts (improving services, processes, and reducing costs), alignment of the team charter with agency strategic initiatives, and measurement for improvement. Most importantly, it is an opportunity for all 13 Mental Health and/or Deputy Directors to talk with each other and share their strategies for success in care coordination as well as other improvement projects.</p>

Developing an Aim Statement

While the Small County Care Integration Learning Collaborative has a charter with an overarching aim to achieve better health status for individuals living, or at risk for serious mental illness, each county team will establish their own aim. Each county tailors the collaborative aim to align it with their individual and unique county integration goals.

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 agency's integration improvement effort. To answer this question teams should consider the needs of clients as well as mental health service agency integration goals. 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 the organization must align the Aim with the strategic goals of the organization.
- **Base the Aim on both data and organizational needs:** Examine data within organizations to help guide the establishment of an appropriate Aim. Refer to the measurement section and focus on issues that matter to organizations.
- **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 where the changes in care will be tested and implemented:** (Refer to "Defining the Pilot 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 pilot population and include specific strategies that the organization intends to follow.

Examples of Aim Statements and Charters

Example 1

Problem Statement

Difficulty with coordination with primary care medical providers is a major health problem for those individuals with severe mental illness.

Aim

Calaveras County Mental Health Program (CCMHP) will improve the health of individuals who are consumers of CCMHP services, improve partnerships with primary care providers in the community, and improve identification of high risk conditions. CCMHP will achieve this by making changes to systems of communication and collaboration between primary care and public mental health.

Guidance

- Improving the process for linkage has a clinical purpose and is a critical first step for clinical care coordination
- In general, focus on care coordination goals throughout treatment, as compared to only at discharge

Objectives

- Increase number of CCMHP consumers with identified primary care physicians
- Increase health screening for consumers who are identified as high risk due to psychotropic medication usage

Goals

1. Achieve a 90% linkage rate of CCMHP consumers with primary care providers
2. At least 65% of consumers on psychotropic medications will have vitals check when they come in for med appointments
3. At least 75% of all consumers of CCMHP will have a signed release in their chart to facilitate the process of bi-directional sharing of information

Example 2

Problem Statement

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

Aim

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

Guidance

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

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.
- 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 County

Example 3:

Problem Statement

The Modoc County Mental Health Plan recognizes the difficulty in coordinating care with Primary Care Providers has become a major health problem for those individuals with chronic and severe mental illness. Studies show that patients with mental illness die twenty-five (25) years earlier than those without.

Aim

The Modoc County Mental Health Plan will make changes to the systems of collaboration, communication, and integration between primary care agencies and individual providers and mental health to improve the coordination of care, develop a more holistic treatment effort, and achieve better outcomes for our mutual clients/patients. By this approach to integrated health delivery, we believe that one of two scenarios will play out - 1) the cost of service delivery will drop due to faster stabilization or recovery, or 2) revenue will increase from referrals of persons who had fallen through the cracks of the healthcare delivery systems previously.

Guidance

We will begin by integrating the County Alcohol and Other Drugs Department with Mental Health to make a Behavioral Health system of care. Eventually, we intend to integrate Public Health in our Behavioral Health System as well. While we are integrating the system, we will consider formal and informal partnerships with primary care providers and agencies. Our initial focus will be on establishing relationships and identifying shared clients/patients. We will be ready to collaborate on establishing formal processes of data sharing and decision making when opportunities arise.

Goals and Objectives

Over the next (12) twelve months, we will focus on developing relationships with the Primary Care Providers in our County and we will utilize these relationships to create processes for identifying shared clients/patients and treating the whole person by seeing to both their mental and physical health needs by:

1. Bi-directional processes for transferring responsibility of care will be established with more than fifty (50) percent of the primary care agencies and individual providers in our County
2. Ninety (90) percent of our clients/patients will have a documented, current PCP
3. Seventy (70) percent of our clients will have up-to-date-vitals and lab results documented
4. Bi-directional sharing of data with the PCP will be evident for at least sixty (60) percent of our clients/patients
5. Bi-directional referrals will be evident as documented in twenty-five (25) percent of records for our client/patients with co-morbidity diagnoses that could cause stressors

Defining the Pilot Population

The Pilot Population represents the clients that pilot teams will want to have an impact on through the work of SCCI. The Pilot Population refers to the total range of clients who will be the target population and tracked throughout the team’s integration efforts. The Pilot Population is typically based on provider (clinician or case manager case-load) but can also be defined by geographic location, provider setting, or other client demographics. It can even be centered on a specific condition (e.g., individuals with co-occurring SMI and cardiovascular disease). The size of the Pilot Population should be between 100 and 300 clients/patients. During the Pre-Work Phase, SCCI leaders will provide examples and guidance to teams on defining the Pilot Population.

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

Identifying the client population is critical to the success of achieving team Aims. Without identification, changes cannot be achieved. To identify clients 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 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 and client registries will be discussed in further detail during the Kick-off session. (NOTE: From this point forward, we will use the term “client registries” instead of clinical information systems.)

What a client registry will do for teams:

- I
identify client populations and sub-populations in need of care
- O
organize data from disparate information sources (EMR, paper record, client visit, claims data)
- M
measure care of individuals and populations of clients
- P
provide client summaries at time of visit
- P
produce exception reports for population care planning
- E
enable feedback to team on population outcomes
- A
automate care reminders

- A
 allow queries of data to target at risk sub-populations
- G
 provide clinical care first, measurement second

During the SCCI Kick Off, there will be further discussion of registries. In addition, there will be a technical call on registries. At the first Learning Session, SCCI leaders will provide examples for use of a client registry, as well as explore how registries can support team’s efforts. Learning Sessions will also assist teams in understanding the essential components of a registry and how a implementing a registry can be tested on a small scale during the SCCI learning collaborative.

The Change Package

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 change concepts and ideas are listed below:

Change Concept

Provide leadership support and sustainable resources for improvement activities

Change Ideas

1. Communicate the results of the project, including key PDSA cycles and monthly data reports, to key stakeholders (e.g. get on agenda of Client Advocacy Agencies Board of Directors meetings; post results in a public place)
2. Support a 'culture of experimentation' by supporting learning associated with testing changes (before dictating untested changes) and recognizing the value of 'bottom-up' decision-making that doesn't second-guess the guidance of those who've tested

Change Concept

Educate staff and clients about importance of physical health, both for mental and physical health outcomes

Change Ideas

1. Hold an interactive orientation with staff regarding the project aims, including the message that their health and wellness is also important
2. Provide programs and support to improve staff members' physical health, for example nutrition classes, yoga classes, smoking cessation, etc.
3. Create a forum for individuals (staff and clients) who have made substantial gains in their health (weight loss, smoking cessation) to share their stories (e.g. during regular meetings when 'success stories' are shared)

Change Concept

Select, educate, and supervise staff in mental health (mental health professionals, nursing professionals, medical assistants, etc.) to monitor clients' physical health

Change Ideas

1. Develop job descriptions and classifications that include physical health care monitoring and support
2. Establish procedures for monitoring clients' physical health
3. Acquire medical equipment that clients can use for teaching them how to use the equipment
4. Place height and weight scales in a variety of settings (clinics, wellness centers, etc.)

Change Concept

Support clients to value their physical health and teach them to monitor their chronic conditions

Change Ideas

1. Teach clients how to take their own blood pressure at home.
2. Create mechanisms to track key vitals for clients (e.g. in Wellness Centers), including providing means for clients to keep track of their status
3. Use "teach-back" method with clients

Measurement

The Why, What, and How Much of Measurement

SCCI is about improving the physical and mental health of individuals with severe mental illness, not measurement. But measurement will play several important roles throughout SCCI. 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

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 SCCI are measures that directly relate to the aim of each team. The measures will provide the means to assess progress toward aims. A full description of core measures will be provided and discussed during Learning Session 1. Core process measures will enable the identification of the percent of clients screened for risk (e.g., diabetes, smoking, obesity) Outcomes measures will provide indications of achieving goals of clients self management of behaviors that increase risk of chronic health conditions. Care coordination measures will indicate progress toward improving communication, coordination, successful referrals and ongoing treatment of physical and mental health conditions.

SECTION FIVE: Resources

Glossary of Terms and Concepts

Action Period - The period of time between Learning Sessions when teams work on improvement activities. 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.

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 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.

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

Learning Session - A two-day meeting during which 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. SCCI 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).

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 SCCI. 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 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

References:

Report:

National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council. (2006). *Morbidity and Mortality in People with Serious Mental Illness*. Retrieved from: http://www.dsamh.utah.gov/docs/mortality-morbidity_nasmhpd.pdf Include the NASMHP article and reference

Websites:

Institute for Healthcare Improvement
http://www.apiweb.org/API_home_page.htm