

# SCERP PCI PIP Goal Achievement Using Continuous Quality Improvement Methods and Tools

Central Regional Training for Mental/Behavioral Health  
Boards and Commissions  
April 2, 2011

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Acknowledgments:

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# Overview

- Continuous Quality Improvement Methods
  - The Model for Improvement
  - Description of BTS Learning Collaboratives
  
- SCERP Primary Care Integration PIP
  - Collaborative Aim and Goals
  - Change Package
  - Measures
  - Learning

## Differentiating Model for Improvement and the Breakthrough Series Learning Collaborative Model

- Associates in Process Improvement (API) developed the Model for Improvement through improvement project experience in many industries throughout the 1980s and 1990s.
- Under Don Berwick's leadership, current Director of Centers for Medicare and Medicaid Services and founder of Institute for Healthcare Improvement (IHI), IHI developed the Breakthrough Series Learning Collaborative model
  - Brings together organizations that share a commitment to making major rapid changes to produce significant breakthrough results that are sustainable over time.
- Breakthrough Series LC Model teaches the Model for Improvement and quality improvement methods and tools to support organizational change, innovation, and improvement.

# Continuous Quality Improvement Methods to Address County Concerns

## Model for Improvement (MFI)

- Key Principle: All Improvement requires change, but all change is not improvement
- 3 Elements for Successful Improvement Efforts
  1. Will
  2. Ideas
  3. Execution (Skill and Measurement)
- 3 Key Questions:
  1. What are we trying to accomplish?
  2. How will we know that a change is an improvement?
  3. What change can we make that will result in improvement?

# Key Elements/Factors in County Mental Health System Learning and Goal Achievement

- **Will:**

- Leadership and staff belief in recovery, wellness, use of best practices and willingness to change in order to improve organizational willingness to change and alignment of goals.

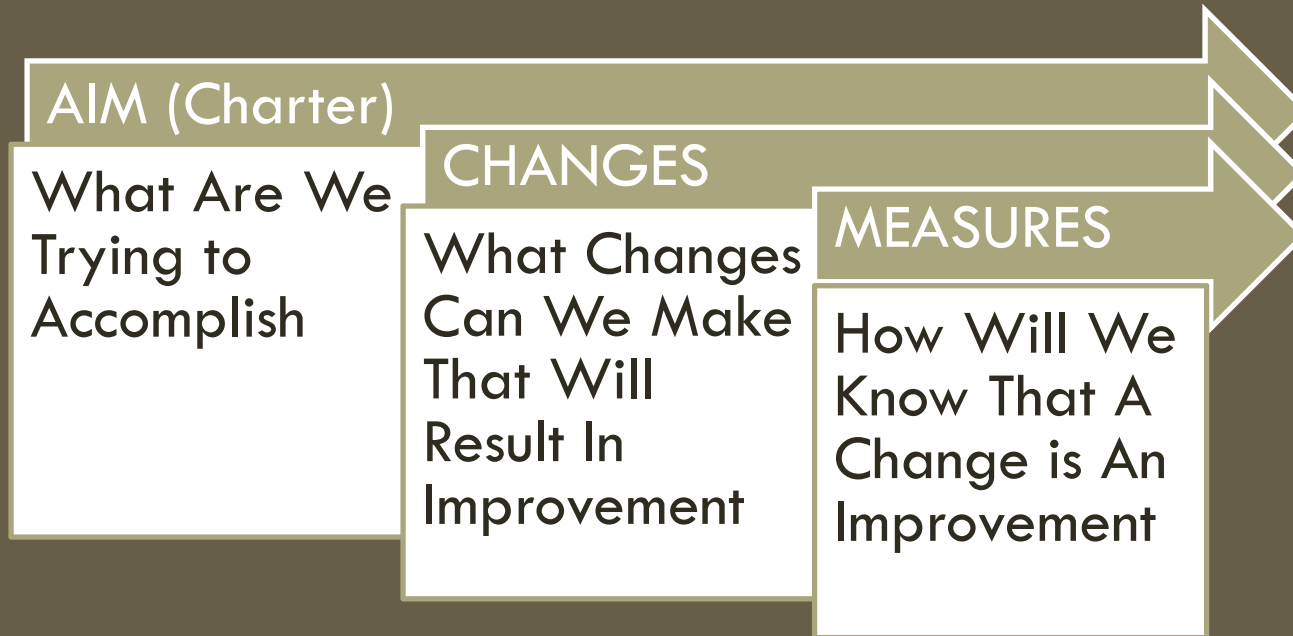
- **Skill:**

- Team ability to learn and implement continuous quality improvement tools.
  - Learn about change ideas to improve system capacity and integrate care.
  - Learn how to use PDSA cycles to test changes on a small scale.
  - Learn how to use results of PDSA cycles and data to assess if and when to implement.

- **Measurement:**

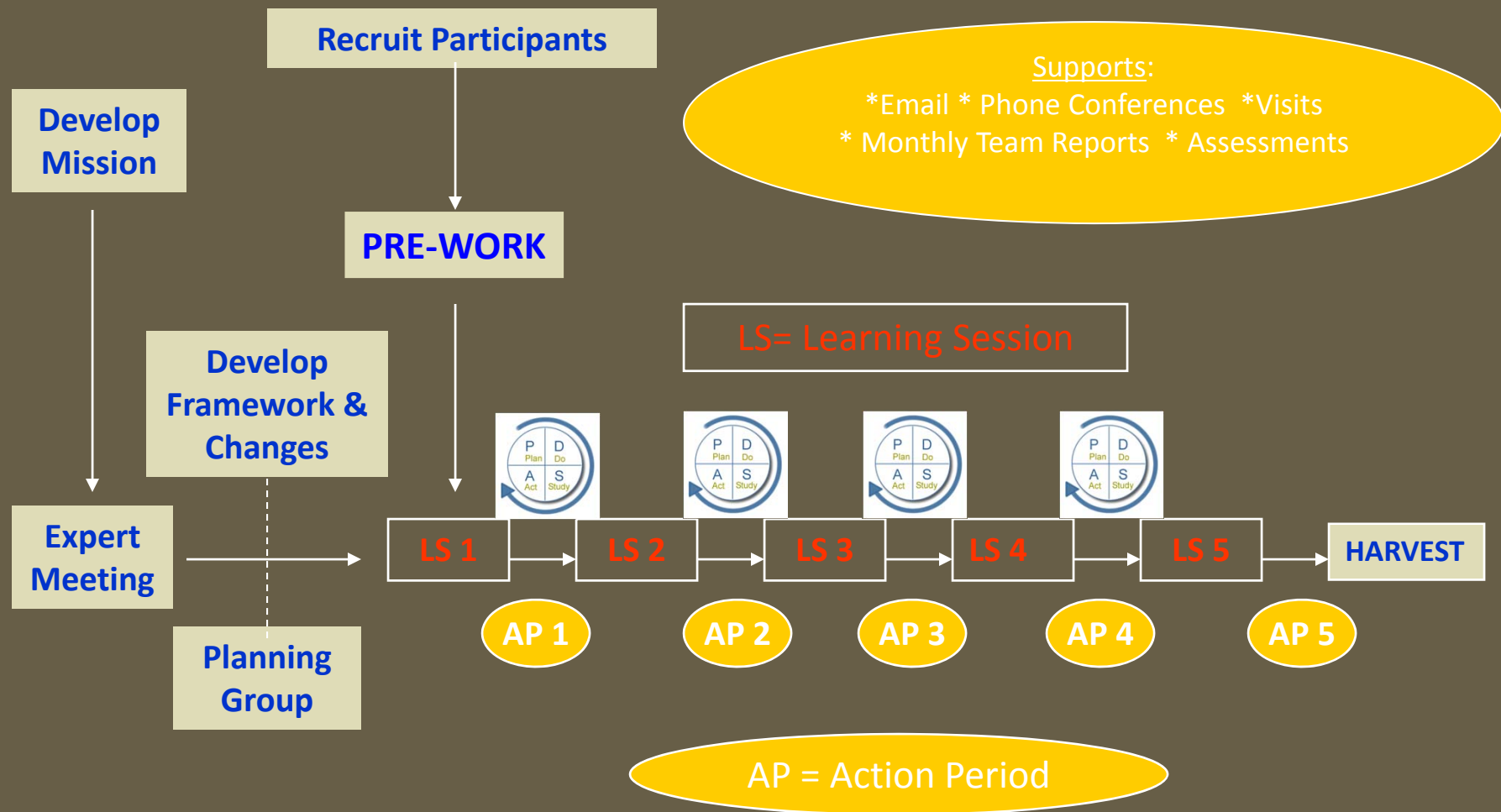
- Ability to collect data and review regularly to assess whether changes are leading to improvement-frequency of looking at data

# The Three MFI Questions Translate into Primary Components of BTS



Changes, tested on a small scale, with the potential for significant improvement

# Breakthrough Series Model



## Strategy to Address the Concerns: Use the Model for Improvement within a Breakthrough Series Learning Collaborative

### Los Angeles County

- Invited 4 large, innovative providers to join an 18 month BTS Pilot Learning Collaborative.

### 9 Small Counties (Calaveras, Colusa, El Dorado, Humboldt, Lassen, Madera, Modoc, Plumas, & Shasta)

- Created county teams and formed a 12 month BTS Pilot Learning Collaborative. The Collaborative serves as a collaborative PIP for CA EQRO

# SCERP BTS Learning Collaborative Members and Sponsors

## **SCERP County Members:**

- Colusa, Calaveras, Madera, Humboldt, Plumas, Modoc, El Dorado, Lassen, Shasta

## **SCERP County Sponsors:**

- All County Mental Health Directors
- CIMH providing staff and consultants to support the LC

## **SCERP Learning Collaborative as a PIP:**

- Approved by APS to be a PIP project; serves as a PIP for all 9 counties in the collaborative

# Project Overview: The SCERP Primary Care Integration PIP Charter

## Problem Statement

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

## Collaborative Aim

*Mental Health Plans will make changes to the systems of **communication, collaboration** and integration between primary care and public mental health to **improve coordination of care and achieve better health outcomes for clients.***

# Project Overview: The SCERP Primary Care Integration PIP Charter

## Objectives

1. Increase the number of mental health clients with a primary care physician
2. Improve the process for consultation between mental health professionals and primary care physicians
3. Increase appropriate monitoring by mental health professional of clients physical health care
4. Decrease the number of unplanned emergency care visits

# Project Overview: The SCERP Primary Care Integration PIP Charter

## Goals

1. Achieve a 90% linkage rate of mental health clients to primary care
2. There will be regular and direct consultation between mental health professionals and primary care providers for at least 70% of clients
3. Mental health will track all clients to ensure they have up to date and appropriate vitals and lab results on clients
4. There will be a 10 % decrease in unplanned client visits to urgent care/emergency rooms/hospitals.

# Examples of Change Concepts for SCERP Counties

## NEAR TERM:

- Identify target population and their health status and PCP coverage
- Increase the number of clients with a PCP
- Redesign the intake process to include consent form and discussion about physical care and recovery
- *Utilize a clinical information system to manage your clients' clinical data to support both individualized care and proactive care (this can be started at all stages)*

## MID TERM

- Increase sharing of clinical information within the bounds of HIPAA (ex: blood pressure; LDLs; A1Cs; etc.)
- Establish methods for collaborative sharing, planning and treatment between mental health and primary care.
- Develop a process for appropriate stepped care that involves both mental health and primary care.

## LATE TERM:

- Establish group treatment and educational visits in primary care and mental health for clients with serious mental illness and chronic illness.
- Create opportunities to enhance reimbursement of integrated services.

# Change Ideas (Moving from Concepts to Action)

## Identify target population and their health status and PCP coverage

### Change Ideas:

1. Review charts or access data from clinical information systems to identify client's primary care doctor and their most recent health care records
2. Initiate contact with PCP (with client consent)
3. Utilize standardized protocols or tools to identify client health concerns
4. Ask all clients who they see for physical health concerns and when they last saw this provider
5. Interview all clients and based on self report, document their current health concerns
6. Identify primary care providers that are comfortable treating and supporting clients who have serious mental illness

## Examples of Core Measures: SCERP Counties

- Number of open clients in target population
- Percentage of clients with designated PCP
- Percentage of clients who have had a primary care visit within the last 6 months
- Percentage of clients for which a direct consultation between MH and PC has occurred
- Percentage of clients with a documented BP and BMI documented in mental health records within the past 12 months
- Percentage of clients with diabetes who have appropriate vitals and labs documented in mental health records within the past 6 months
- Percentage of clients with cardiovascular disease who have appropriate vitals and labs documented in mental health records within the past 12 months
- Rate per 1,000 of clients with one or more visits to ER/hospital/urgent care centers during the month Number of clients enrolled into mental health services from primary care referrals (Optional measure)
- Number of clients who were moved to primary care for coordination of their care (Optional measure)

# What Have We Learned?

## The Benefits of the Feedback Loop

1. Establishes cultures of learning and managing data
2. Creates transparency
3. Informed decision-making

# What Have We Learned?

1. Adaptations to BTS to accommodate mental health
2. Concrete changes are difficult (Initially agencies tend to use PDSAs to gather data and learn)
3. Quality Improvement requires highly detailed and focused work; often requires external support
4. Organizational leadership needs to believe in quality improvement theory and methods as a sound business strategy to improve

## What Have We Learned?

5. Realistic perspectives on how long the change takes and resources to support the change
6. Developmental pathways to success can vary
7. Often, external facilitated support is needed
8. Leadership -“constancy of purpose”- align the project change with organizational mission and goals

# Lassen County: A Plan for Implementation

Source: Peggy Kelly, SCERP PCI PIP Chair

# Area Needing Improvement

- We needed to improve the way we approached coordination with local primary care physicians.
- We have historically had very few medical consults, although, we have had a policy and procedure for such consults.
- These consults would happen for the very ill who needed immediate interventions.
- Our hope was to exchange information for shared clients throughout care to prevent those needed immediate interventions.
- The area of improvement would include sharing of notes, labs and plans for future care.

## Proposed Change Idea (Plan)

- Develop an easy to read one page form identifying our shared client and requesting exchange of information from PCP.
- This form also identified that we would share information about our shared client to include: medications, treatment notes and plan for care.
- Peggy and Lorraine to develop a letter to fax to the providers of our adult population who have DM and/or CVD identifying them as shared clients with a need to share information for client coordination and care planning.

## Testing Experience (Do)

- Peggy and Lorraine developed the PCP letter. Lorraine identified and faxed letter to PCP's about "shared clients" (tested on 4 shared clients).
- Lorraine attached our recent labs obtained from our MD to the "Shared identified PCP" for one of our shared clients to their PCP's. We had a recent lab and felt modeling the contents of the letter would be helpful.
- All faxes were received by the PCP offices.

## Lessons Learned (Study)

- We know that MD offices are busy. However, after two weeks, we still had not received any acknowledgement, labs, notes or medication information from any of the PCP's (4 request sent) on our "Shared Clients".
- We did not expect to have this effort of coordination be ignored. Perhaps we should use this letter as more of an introduction that we have "Shared Clients" and then have a form with check boxes requesting specific responses – with date of faxing back to MH and the name of a contact person at the PCP's office.
- It may be that the key people here are the staff who receive the faxes and execute the request.
- If this is not successful, we will also be calling the offices.

## Proposed Change Idea #2 (Plan and Act)

- We will develop a second form that request specific responses with a date for faxing back to MH and the name of a contact person at the PCP's office.
- We will be faxing both the "Shared Client" letter and the new form with check boxes to the PCP's office as a reminder that we are trying to coordinate care between offices. We will also be charting in our records our attempt to contact the PCP for coordination of care. These notes will be faxed with the check box form. Therefore, if the office reads the information, they, will know that our attempts to coordinate care are logged. Hopefully this will elicit some response.
- This form will have at least 2 decision boxes (1.we will continue to be primary care provider (for your information only) 2. please review and follow up from your medical side)

## Testing Experience (Do)

- Testing was done on 3 clients. We still did not obtain any faxed information back. So, we called to see if a phone contact to PCP with a request for Labs was a viable way to obtain labs.
- The testing was done on 2/5/11. We tested two providers with one client each.
- Lorraine, LVN, contacted PCP by phone.
- The phone response was better than just a fax.

# Lessons Learned (Study)

- One PCP was willing to assist: However, the labs they faxed were not ordered from the provider, but rather they were labs from the client's most recent ER visit that were in their chart. The labs received were not appropriate (client has DM) for the labs we requested.
- The second PCP contacted by phone wanted the ROI which we sent. The office then faxed to our clinic the appropriate labs (4 times).
- Office and staff are not mind readers: Being specific about the request is key.
- Receiving 4 sets of the same labs tells us that this PCP office staff is not use to this type of request from a co-provider or the fax machine did not work.

# Plan for Implementation

- We will continue to find a process that will allow the best sharing of information between co-providers.
- We will need to reduce the stigma in our county around Mental Health Clients.
- We will need to develop a positive working relationship between mental health and co-providers.
- We will test a PDSA cycle using our Public Health Department Nurses (because of their historically good relationships with local PCP's)
- We will contact local labs to see if we can get labs on shared clients sent to us as a co-provider.
- If possible, visit PCP's offices and develop relationships with the staff who execute the fax requests to see if they would prefer a call.