Healthcare Reform: Supporting Change

Counties and community-based organizations face a future with intense change. Preparing for healthcare reform requires California's behavioral health system to make changes required to become high performing organization in an integrated future. Integration is necessary to improve health outcomes and to control costs. Integration must occur with primary care, mental health, and substance use disorder services. CiMH is focused on nine competencies for behavioral health organizations: 1) A Full Array of Specialty Behavioral Health Services; 2) A Well Defined Assessment Process and Level of Care System; 3) Measurement Systems and Tools to Measure Consumer Improvement; 4) Demonstrated use of Clinical Guidelines and Evidence Based Practices: 5) A robust Electronic Health Record that includes Patient Registries; 6) Quality Improvement Processes and Supporting Data Systems; 7) A Solid Approach to PEI and Recovery; 8) The Ability to Practice as a Team to Coordinate Care/Work with Primary Care; and 9) Financial Systems to Manage New Payment Systems.

CiMH is currently working on activities to support each of the competencies and two methodologies for supporting change in California's behavioral health systems. Both our work and research clearly indicates that implementing and sustaining change is a challenge to all systems.

Community Development Team Model

Over the past several decades, numerous empirically supported practices have been developed that have been shown to improve outcomes for children, families, and adults. But the uptake of these practices into the real world has been slow and complicated. Few of these practices are currently in real world settings assisting clients in need.

Recognizing this problem, several CiMH staff, Bill Carter, Dr. Todd Sosna, and Lynne Marsenich came up with a model, the community development team, for implementing and sustaining evidence-based practices in California systems.

The Community Development Team (CDT) model is an organizational development dissemination strategy designed to promote selection and the model-adherent, sustainable installation of evidence-based practices by a broad segment of the public mental health system.

CDT activities assist agencies, in the context of a peer-to-peer learning environment, to develop the infrastructure and internal controls to plan, monitor, and support learning and sustaining an evidence-based practice. Primary activities include implementation planning, developing and coordinating use of thorough training protocols, forming practice-specific clinical supervision, and establishing program performance evaluation.

This model has had considerable success in California (see Appendix A) and has become the largest evidence-based practices initiative in the nation. We currently operate the CDT model to support and sustain ten evidence-based programs in 38 of the 58 California counties.

NIMH Grant: As a result of the apparent success, CiMH is the recipient of an NIMH grant to test the effectiveness of the community development team as an implementation model. This five year study is being carried out in partnership with Patricia Chamberlain from Center for Research to Practice in Oregon and Hendricks Brown from the University of Miami. Counties in California and Ohio are implementing Multidimensional Treatment Foster Care (MTFC) under two implementation conditions: 1) Individual implementation; and 2) Community Development Team implementation. To date, the CDT is the only implementation strategy that is the subject of a randomized trial. What we are learning holds promise for better understanding what factors contribute to successful implementation and sustainability of evidence-based programs. Data analysis is not yet complete but is trending in favor of the CDT. Preliminary data indicates that the CDT is significantly more effective than usual practice.

Two products are also being developed as a result of the grant. The first is a measure of the stages of implementation completion and the second is a cost analysis comparing cost and outcomes for individual implementation and CDT implementation. This study is the **only** empirical test of an implementation model and as a result has generated strong interest from the National Institute of Mental Health, National Institute of Drug Abuse and the federal Children's Bureau.

Institute for Healthcare Improvement Break Through Series Collaborative Model

CiMH seeks to improve behavioral health care by supporting change. One of the many ways we do this is via collaborative learning — specifically, using a model for achieving breakthrough improvement that the Institute for Healthcare Improvement innovated in 1995 and has been continuously improving ever since, called the Breakthrough Series. The driving vision behind the Breakthrough Series is that sound science exists on the basis of which the costs and outcomes of current health care practices can be greatly improved, but much of this science lies fallow and unused in daily work. There is a gap between what is known and what happens in practice.

The Breakthrough Series is designed to help organizations close that gap by creating a structure in which interested organizations can easily learn from each other and from recognized experts in topic areas where they want to make improvements.

A Breakthrough Series Collaborative is a short-term (6-to 15-month) learning system that brings together a large number of teams from behavioral health sites to seek improvement in a focused topic area. Since 1995, IHI has sponsored over 50 such Collaborative projects on several dozen topics involving over 2,000 teams from 1,000 health care organizations. CiMH is building on this work, starting with three pilot collaboratives in FY 2010/11 and expanding to four collaboratives in 2011/12. Our pilot collaboratives ranged in size from 4 to 9 organizational teams. Each team typically sends three of its members to attend Learning Sessions (four face-to-face meetings over the course of the Collaborative), with additional members working on improvements in the local organization. Once pilots are completed, IHI collaboratives can expand to 16 to 160 sites.

2010/2011 Learning Collaboratives

CPCI: Counties have learned about challenges and strategies for identifying and sharing client/ patient information among MH and PC providers.

- Counties developed/deepened effective relationships with local Health Plans regarding business case and strategies for integrating care.
- County MH/PC partnerships learned and began to test evidence based practices related to team-based care, treat-to-target/decision algorithms for complex co-occurring conditions, and care coordination--and most of the counties are actively working to implement and spread these practices subsequent to the completion of the learning collaborative.
- Partnerships learned that clients/patients and their families must be actively engaged and supported in self-management of chronic health conditions including smoking cessation, physical activity, healthy eating and monitoring their own health indicators such as blood pressure, and blood sugar levels in order to improve their health outcomes. CPCI partners tested various health literacy and self-management support strategies as as well as the role of providers as client partners.

ICSC (Agency ICSC): Provider organizations in Los Angeles County did improve their agency capacity to serve new clients by increasing the rate of flow to lower levels of care as well as transitions out of the agencies into the community by:

- Increasing the use of objective tools to assess client's stage of recovery (such as the MORS or LOCUS) and adjusting the intensity and mix of services and supports based on clients stage of recovery.
- Assisting clients to establish meaningful roles and activities in their life outside of the mental health system.
- Establishing at intake the expectation that clients will be transitioning out of the mental health system (involvement in the system is a transition not a destination.)

SCERP (Small County Risk Pool):

- Small Counties that were unprepared for healthcare reform now have a roadmap- a tested set of concrete steps as well as a tested sequence-to better communicate and collaborate with primary care. This results in improved quality of physical and mental health care for clients as it is coordinated.
- Small Counties were introduced to monthly analysis of data and outcome assessment/ reporting. The emphasis on using data to guide clinical and administrative decision making is also key to being an effective partner provider in the integrated systems being shaped by healthcare reform.

- Design of integrated intakes that maintain a recovery focus but gather critical physical health care data to support clients physical health.
- Increased identification of physical health monitoring that can occur in mental health agencies and help identify clients at risk with CVD and diabetes.

Future Directions: CiMH is currently working on a comparative analysis to determine which type of change method to use for which type of project. Generally, the CDT is used to implement evidence-based practices and the IHI BTS is used for system change though there is significant overlap.

2011/2012 Learning Collaboratives

Advancing Recovery Practices: designed to improve clients' lives by preparing specialty mental health agencies to be high performing organizations. County and community-based mental health programs will focus on increasing access, system flow and capacity by supporting clients' transition through stages of recovery and out of the public mental health system to more meaningful lives in their communities.

Mental Health, Substance Use Disorder and Primary Care Integration: integrate care to improve the health outcomes of individuals with serious mental illness and substance use disorders at risk/ experiencing chronic health conditions through screening/monitoring of risk and treatment effectiveness, care coordination and a focus on client/family health literacy and self-management.

Small County Care Integration: achieve better health outcomes for clients and their family members living in California's small counties by changing and improving systems of communication, collaboration and co-ordination with primary care, alcohol and other drugs and public mental health. In addition, the collaborative also aims to increase clients' and family members' participation in their physical and behavioral health care and incorporate clients' needs and wishes into their care plans.

Strategies for Integrating Health, Prevention and Community: develop effective partnerships between community health centers and community organizations. Target health centers are those that have behavioral health services/departments and serve low-income ethnically and racially diverse populations with or at risk for a mental health concern co-occurring with other health conditions. Assist them to offer wellness promotion, prevention and self-management services that will lead to improved emotional and physical health outcomes. These health center/community partnerships will also help to increase health center capacity to serve a patient population that is expected to grow as a result of healthcare reform coverage expansion.