

# CiMH Quality Improvement Collaboratives

## An Overview of Recent Accomplishment

The poor health outcomes and dramatically decreased life expectancy of individuals with serious mental illness and/or substance use disorders, particularly for those at risk of or experiencing chronic health conditions such as cardiovascular disease and diabetes, is well documented. This health crisis has been compounded by poor recovery outcomes, primary care access to Mental Health Substance Use Disorder specialty care services, and the failure of specialty MH/SUD services to identify co-occurring medical conditions and insure health care access and coordination of care. CiMH, in its ongoing commitment to support the improvement of the health and well-being of these individuals, recently conducted three multi-agency learning collaboratives to support providers and their partners in addressing these challenges. These collaboratives were organized to support participating teams to make system changes to improve clients total health outcomes, prepare for health care reform, and maximize the use of constrained public health care resources. 18 teams from 23 counties participated in the following:

- **Advancing Recovery Practices** focused on making changes within the public mental health system to support improved recovery for individuals with serious mental health problems (or illness);
- **Care Integration Collaborative** brought together primary care, mental health and substance use disorder providers with safety net health plans to develop care coordination processes to support the complex needs of clients with co-occurring physical and behavioral health needs.
- **Small County Care Integration** supported behavioral health agencies in small counties to better identify and address the physical health and wellness needs of their clients as well as build linkages with primary care providers;



From January 2012 and continuing through January 2013, 16 teams from community-based and county operated mental

health programs tested and implemented changes that advance the recovery of the clients they serve. Over the course of the Advancing Recovery Practices Collaborative, teams from Full Service Partnerships, traditional outpatient programs and wellness settings improved:

- Staff belief in and expectations of clients' potential for recovery, independence, and self-sufficiency;
- Clients' hope for and engagement with activities supporting their recovery and independence;
- Clients' natural community supports, including peer supports;
- Use of recovery oriented assessment tools to identify and make use of clients' strengths in support of their personal goals;
- Clients' management of their conditions and personal goals, and;
- Rate of clients' transitions into lower levels of care and out of public mental health services.

### ARP Teams:

- Anaheim Outpatient-Orange County Health Care Agency (HCA) Behavioral Health Adult outpatient clinic
- Caminar Wellness & Recovery Services (San Mateo)
- Didi Hirsch Mental Health Services (Los Angeles)
- El Dorado County Health & Human Services (Placer)
- Fresno County Dept. of Mental Health
- Citywide Forensics, San Francisco Community Behavioral Health Services
- Humboldt Dept. of Health & Human Services
- Kedren Mental Health Organization (Los Angeles)
- Mental Health Association of Orange County, Lake Forest
- Monterey County Behavioral Health Services
- Providence Corporation, Opportunity Knocks (Orange)
- Narvaez CalWorks-Santa Clara Mental Health Dept.
- San Diego County Behavioral Health (San Diego)
- San Mateo County Behavioral Health & Recovery Services
- OMI Family Resource Center, Community Behavioral Health Services (San Francisco)



The Care Integration Collaborative (CIC) brought together five county teams consisting of partners from a local Medi-Cal health plan, primary care, and specialty mental health and substance use disorder organizations. From January 2012 to February 2013, these teams tested and implemented changes to person-centered coordinated care to shared clients to improve their health

outcomes. CIC synthesized knowledge regarding effective treatment and support for individuals with serious mental illness and/or substance use disorders with emerging best practices in care integration and care coordination for individuals with complex health conditions.

CIC partnerships worked to:

- Increase the number of clients with an care coordinator
- Improve medication reconciliation with clients and amongst providers
- Improve access to medical care for clients with Serious Mental Illness and/or SUD
- Use a shared care plans to address physical health and MH/SUD conditions
- Reduce unnecessary ER utilization
- Improve tracking of health outcomes and clinical information sharing
- Improve health outcomes



Beginning in February 2012, 11 teams from small county behavioral health care agencies worked to achieve better health status for individuals living, or at risk for, serious

mental illness. The teams supported the physical health of clients, with a particular focus on cardiovascular disease and diabetes risk factors, and use of physical health services. While participating in the Small County Integration Collaborative, these agencies tested and implemented changes to their system in order to:

- Increase monitoring of clients physical health status
- Increase access to and linkage with primary care
- Reduce the number of clients who use tobacco
- Increase the average time per week that clients exercise
- Reduce Body Mass Index (BMI) for clients with a BMI greater than 30
- Increase the number of clients who use self-management techniques for their diabetes
- Decrease the number of emergency care visits
- Increase the use of electronic collection of clients physical health data

CiMH's collaborative methodology, based on the Institute for Healthcare Improvement's (IHI) Breakthrough Series (BTS), promotes the adaptation and spread of existing knowledge about what works to multiple settings to accomplish a common aim.

**County Partners**

- Departments of Mental Health, Behavioral Health, and Public Health
- Primary Care Organizations, e.g. FQHC
- SUD Treatment Organizations
- MediCal Health Plans

**Counties**

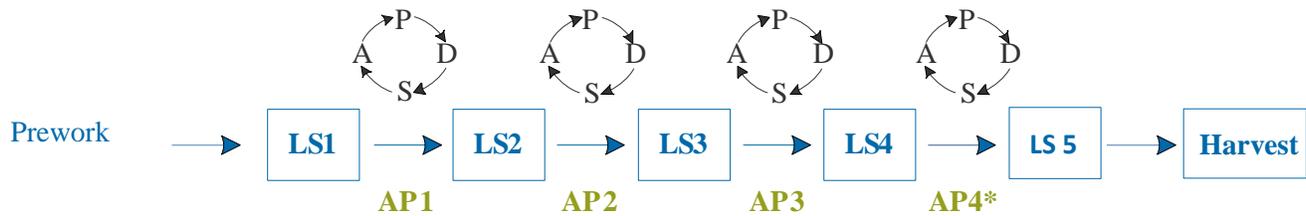
- Los Angeles
- Napa
- Nevada
- Orange
- Riverside

**SCCI Teams:**

- Amador County Behavioral Health
- Calaveras County
- Colusa County
- Imperial County
- Madera County
- Mendocino County
- Modoc County
- Mono County
- Plumas County
- Tehama County
- Trinity County

**Collaborative Model**

LS – Learning Session | AP – Action Period



The BTS collaborative approach included use of the Model for Improvement (developed by Associates in Process Improvement), which provided a methodology to accelerate improvement. Participants learned to use three fundamental questions and the Plan-Do-Study-Act cycle (based on the teachings of W. Edwards Deming) to test, implement and spread changes in real work settings.