Care Coordination Collaborative
A Breakthrough Series Learning Collaborative
Final Report

June 2015

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# Care Coordination Collaborative Partnerships

## Participating County/Agency and Partners

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For electronic version of appendices, please contact William Rhett-Mariscal, wrhettmariscal@cibhs.org.
SECTION 1: EXECUTIVE SUMMARY

Background

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, has been well documented. Druss and Reisinger Walker found that in addition to the high prevalence of co-occurring MH/SUD and medical conditions, having one condition is a risk factor for the other. Common treatments for one condition may actually worsen the other comorbid condition.¹ This health crisis has been compounded by the under-diagnosis and under-treatment of mental illness and substance use disorders in primary care settings, a lack of primary care access to MH/SUD specialty care services, poor access to medical care, the failure of specialty MH/SUD services to identify medical risks and conditions, and the failure of all providers to adequately coordinate care and transitions in care.

The coordination of care is key to improving care and reducing costs for persons with serious medical conditions who struggle to navigate the US health care system. Care coordination is even more critical for individuals with serious mental illness and substance use/abuse disorders and co-occurring medical conditions as they confront not only the complexity of the health care system and health and economic disparities, but also social disparities rooted in prejudice and discrimination. However, care is rarely well coordinated or managed for individuals with serious mental illness and/or substance use disorders and co-occurring chronic medical conditions. In California, the carve-out of specialty MH and SUD, the lack of an adequate substance use disorder treatment system of care, and the provision of mild to moderate mental health conditions through managed care plans has increased the complexity of coordinating care and integrating care.

Care coordination and the integration of care for persons with complex conditions—including mental health and substance use disorders are core components of California’s Medicaid 1115 Waiver Renewal, Medi-Cal 2020. Enhanced care coordination is outlined as a key strategy in the proposed “Public Safety Net Transformation & Improvement Program,” which addresses systems redesign and “Care Coordination for High Risk/High Utilizing Populations” – focused on complex care management, health homes, and advanced illness planning and care,” as well as Waiver initiatives for “Increased Access to Housing and Supportive Services” and “Whole Person Care Pilots.”²

¹ Druss, MD, MPH, Benjamin G. and Elizabeth Reisinger Walker, MAT, MPH; Mental Disorders and Medical Comorbidity, Robert Wood Johnson Foundation, The Synthesis Project, February 2011
What is Care Coordination?

Care coordination is generally defined as:

Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery of health care services. Organizing care involves the marshaling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care.1

When all of a patient’s health care providers coordinate their efforts, it helps ensure that the patient gets the care and support s/he needs and wants, when and how s/he needs and wants it. Effective care coordination models have begun to show that they can deliver better quality and lower costs in settings that range from small physician practices to large hospital centers.3

The Care Coordination Collaborative

The CA Institute for Behavioral Healthcare Solutions’ (CIBHS) Care Coordination Collaborative (CCC) was developed to improve the health outcomes of individuals with complex needs through care coordination (CC) and related practices. While a number of nationally recognized organizations are developing and promoting effective care coordination practices, none have specifically addressed CC for persons with co-occurring serious MH/SUD and medical conditions. The CCC is the third CIBHS-sponsored learning collaborative designed to address this knowledge and practice gap in California. CCC expanded on the learning from the 2012-2013 Care Integration Collaborative synthesizing emerging care coordination/care integration research and practice knowledge with effective treatment and wellness and recovery support practices from MH/SUD, and focused on core CC functions. The CCC supported participating county teams (MH/SUD/primary care organizations) to work with health plans to develop and implement agreements re: care coordination for individuals with complex conditions requiring both specialty behavioral health and medical care. Over the 12-month duration of the project, the CCC learning collaborative introduced essential CC functions and supported teams and health plans in testing, implementing and spreading CC improvements.

Building effective care coordination is a complex and challenging endeavor as has been documented in health home/medical home initiatives and previous CIBHS care coordination learning collaboratives. In CCC, ten county teams that included primary and specialty care health organizations/providers and health plans were supported to develop shared care coordination goals, target populations, and implement key processes which included leadership collaboration, building a CC team, testing and implementing core CC functions such as improved clinical communication, access, medication reconciliation, development and use of shared care plans, coordinating transitions in care and reporting/monitoring outcomes.

Health Plans actively participated as collaborative partners, exploring the shared benefits of CC for complex target populations as well as the potential role of Health Plans as “integrators” in California’s
health system reform. The CCC also offered county teams and health plans an opportunity to build more effective administrative and clinical communication processes, which due to the timing of the CCC also supported the designing and implementing the Memoranda of Understanding (MOU) between the county Mental Health Plans (MHPs) and managed care plans (MCPs) to coordinate specialty mental health care and mental health services for persons with mild to moderate impairment. (Reference: CA Department of Health Care Service’s All Plan Letter No. 13-018.) Required MOU elements such as “covered services and populations; screening, assessment and referral; care coordination; information exchange; and, reporting and quality improvement,” corresponded to core processes addressed during the CCC. Integrating substance use disorder services was a challenging aspect of the CCC partnership approach. SUD organizations were considered part of many CCC county teams, but the dramatic gap between need and capacity of specialty SUD services impacted all providers’ ability to better coordinate care and support for their clients with substance use disorders. An important CCC contribution was its focus and learning about the roles and contributions of persons with lived experience (persons in MH/SUD recovery) in supporting care coordination, wellness/whole health and recovery.

Learning Collaborative Approach

The CCC learning collaborative was conducted over a twelve-month period, with Pre-work beginning in November 2013 through a final Learning Session in January, 2015. Ten county partnerships of mental health, substance use disorder, and primary care agencies worked with local public safety net health plans to increase the number of clients receiving person-centered coordinated care to improve health outcomes. Partnership teams participated in face-to-face and virtual collaborative meetings, regular web-conferences, and maintained contact with each other and with CCC faculty via email. Beginning with the Pre-Work phase and throughout the collaborative, changes/practices to support care coordination were introduced by expert faculty. These change concepts and related actionable change ideas were also summarized in a Change Package that was provided to the participating teams and further refined over the course of CCC.

The CCC collaborative methodology was based on the Institute for Healthcare Improvement’s (IHI) Breakthrough Series (BTS) model—an improvement approach that relies on adaptation and spread of existing knowledge to multiple settings to accomplish a common aim. CCC used a pilot variation of this model, which provides an opportunity to test and refine system improvements and learning strategies related to these improvements with a small number of teams.

Learning and Recommendations

CCC teams (e.g. behavioral health, primary care and health plan partners) worked to:

1. Develop effective coordinated care relationships
2. Engage clients/patients in self-management support to address their whole health needs
3. Deliver Coordinated Services; and
4. Develop the Infrastructure for Care Coordination
Within these broad domains, teams tested and implemented specific changes contained in the CCC Change Package that related to 13 Core Care Coordination Processes. Each team tested many change ideas, during the 14-month learning collaborative—some of which were implemented ready for “spread” on a broader system level to new sites and providers. The following are examples of changes where teams made significant progress.

- Outreach and engaging individuals with serious MH/SUD at risk for/with a medical condition (CVD or diabetes) in care coordination processes
- Developing processes for defining care coordinator role and care coordination team—including BH, primary care organizations and health plans for high need clients
- Addressing release of information (ROI) and obtaining clients’ consent to share clinical information including addressing federal regulations protecting the confidentiality of SUD clients (42-CFR, Part 2)
- Facilitating access and tracking of referrals among BH and primary care providers
- Using a Shared Care Plan (My Total Health Plan) to develop client-centered goals and coordinate support for goals among partnering providers
- Involve peers with MH/SUD lived experience on each CC team to support clients’/patients’ wellness and self-management
- Coordinating care for shared clients through cross agency systemic caseload review processes and multidisciplinary care conferences
- Performing regular medication reconciliation within each agency and developing processes to reconcile medications across multiple providers

Policy and research to practice organizations are increasingly focused on identifying essential elements and processes for care coordination. The CCC pilot contributes to the field through identifying foundational CC processes and tools that can be used across specialty MH/SUD and primary care providers for persons with complex MH/SUD and medical risks/conditions. In addition, by bringing together county-based and regional care coordination partnerships that included safety net managed care plans, CCC facilitated the development of provider/health plan relationships that will advance California’s management of care integration across BH and medical care, as well as addressing gaps and issues in care related to the implementation of separately financed and managed levels of BH care for individuals mild/moderate and serious conditions.
Key Recommendations for Building Care Coordination

Insure Engaged and Effective Leadership
1. Committed senior leader champions are essential to improvement—especially for complex change processes. In a multi-partner systems change process, each participating system/organization needs an executive level advocate to support change and allocate necessary resources.
2. Senior leaders must actively build and sustain accountability and the “will” for improvement within his/her organization and across the partnership.
3. Specialty SUD treatment providers must be integral partners in planning and creating new systems for care coordination.
4. Health plans are essential partners in designing and ultimately incentivizing CC processes and must be involved in designing and building the business case for care coordination for individuals with complex conditions.
5. Designation of an organizational lead agency or “integrator” is necessary for effective care coordination across multiple BH/health providers.

Develop Clear and Accountable Roles for Individual CC Providers and Teams
1. Apply emerging best practices to the design of CC for persons with MH/SUD specialty care and primary care needs.
2. Mapping CC processes and workflows is an effective way to clarify the client experience, resources, gaps, and roles of participating specialty MH/SUD and primary care organizations.
3. Provide support for further development of training and tools to support essential CC processes such as shared care planning, systematic caseload review/CC case conferences, and routine medication reconciliation.
4. Define both care coordinator and team roles, and develop training for staff performing the role/responsibilities of care coordination.

Designing, Testing and Implementing Key Care Coordination Processes
1. Provide accessible training and consultation in team based care/care coordination roles and work processes.
2. Promote the inclusion of persons with lived BH experience as uniquely qualified to engage clients/patient with complex conditions and to support self-management/wellness.
3. CC partners must have access to a shared electronic clinical information sharing tool to effectively coordinate care.

Provide Technical Support and Resources for Care Coordination
1. Organizations must build capacity to measure internal organizational improvement and to share integrated CC results across partnering organizations, providers and health plans.
2. Make technical improvements to learning collaborative in areas of program duration, measurement, and sequence.
SECTION 2: CARE COORDINATION AND THE CCC CHARTER

Emerging Best Practices in Care Coordination

The CIBHS Care Coordination Collaborative (CCC) was organized to improve the health outcomes of individuals with complex behavioral and physical health conditions through care coordination and related practices. In addition, the CCC pilot was expected to contribute to emerging knowledge and strategies to support healthcare reform in California and nationally.

The CCC synthesized care coordination/care integration best practices for individuals with complex health conditions from the medical field with evidence-based and emerging practices from MH/SUD regarding effective treatment and wellness and recovery support for individuals with serious mental illness and/or substance use disorders. These key processes were formulated as the 13 Key Care Coordination Processes. CCC’s approach focused on building practice knowledge through quality improvement as a key source of emerging best practice, the MacColl Institute for Healthcare Innovation of Group Health Cooperative’s “A Toolkit for Coordinating Care” (April 2011), highlights practices fundamental to successful coordination of care including:

- Assuming accountability
- Providing patient/client support
- Building relationships and agreements among providers (including community agencies) that lead to shared expectations for communication and care, and
- Developing connectivity via electronic or other information pathways that encourage timely and effective information flow between providers

Specific CCC improvement strategies also reflect learning from the CIBHS 2012-13 Care Integration Collaborative and the California Department of Health Care Services CalMEND 2010-11 Integration Pilot; a 2012-13 Small Count, y care integration pilot learning collaborative SAMHSA’s Screening, Brief Intervention and Referral to Treatment (SBIRT), UCLA’s Integrated Substance Abuse Programs at the Semel Institute for Neuroscience and Human Behavior, and the widely replicated research and practice experience of the University of Washington’s AIMS Center, which is dedicated to improving care/care coordination for persons with co-occurring MH and medical conditions. The California Department of Health Care Services contracted with the CIBHS to design and implement a 3rd pilot integration learning collaborative to continue to advance knowledge about integration and system changes that improve health outcomes.

In the CCC report, we refer to care coordination/care integration to acknowledge the diversity of the goals of CC partnerships/teams, which ranged from coordinating care across freestanding

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3 CCC Key Care Coordination Processes-See Appendix E
4 MacColl Institute for Healthcare Innovation, “Reducing Care Fragmentation: A Toolkit for Coordinating Care”, April 2011
specialty MH/SUD and primary care organizations to providing integrated/collaborative care where providers were physically co-located. Two Millbank Memorial Fund Reports: “Integrating Primary Care into Behavioral Health Settings: What Works for Individuals with Serious Mental Illness” (2014) and “Evolving Models of Behavioral Health Integration in Primary Care”\(^5\) offer framework(s) for understanding the nature and complexity of the partnership models pursued by the CCC pilot teams.

**What is Care Coordination?**

The *Care Coordination Measures Atlas*\(^1\) (a 2010 AHQR publication) defines it as the: “deliberate organization of patient care activities between two or more participants (including the client/patient) involved in a patient’s care to facilitate the appropriate delivery of health care services. Organizing care involves the marshaling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care...

The level of care coordination need will increase with greater system fragmentation, greater clinical complexity, and decreased patient capacity for participating effectively in coordinating one’s own care.

**The CCC is guided by an overall charter, a short version of which follows:**

**CCC Charter**

To address the opportunities for care coordination and integration to improve outcomes for persons with serious mental illness and/or substance use disorders plus co-occurring medical conditions, CIC faculty developed a Charter, which includes an over-arching Aim Statement and more specific Goals with Measurable Objectives to demonstrate improvement. Additional guidance was included in the Charter to help participating MH/SUD/PC partnership teams understand the target population for “high touch” care coordination and additional requirements. See **Appendix B** for the revised CCC Charter that reflects learning from the collaborative process.

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Problem Statement
Individuals with chronic medical conditions and serious mental health and/or substance use disorders experience services that are poorly coordinated and fragmented: poor and confusing care access and follow-through, care redundancies and gaps, inefficient and inadequate services, often in inappropriate settings (Emergency Rooms, jails, etc.), higher health care costs, reduced satisfaction for clients and providers, poor health outcomes, and lower life expectancies.

Aim
Over a period of 15 months, teams consisting of primary care, mental health, substance use disorder, and other safety net providers, working with local public safety net health plans, will design new systems and redesign existing systems to provide coordinated medical and behavioral services to improve the health status of individuals who have complex, co-occurring conditions. Teams will work to establish multiagency communication, create workflows for coordinated care, promote self-management, and use clinical information systems to guide care planning and performance improvement efforts and to facilitate date sharing and track outcomes. As result of these efforts, teams will build a seamless experience of care that is person-centered, cost effective, and results in improved health and wellness.

Goals
CCC will support teams to:
1. Increase the screening of individuals for mental health/substance abuse and chronic medical conditions within each care and follow-up for positive screens.
2. Increase the percentage of individuals with health and wellness goals shared between providers.
3. Increase the percentage of individuals with a care coordinator assigned by a lead partner (health home) and with whom your staff work to coordinate care.
4. Improve satisfaction with the experience of care.
5. Reduce avoidable emergency room visits

Objectives
To achieve these goals, teams will pursue the following objectives:
1. 75% of individuals have been evaluated (through screening or other identification method) for a second condition.
2. 90% of individuals in the target population will have health and wellness goals shared between multiple service agencies.
3. 75% of target population individuals will have an identified care coordinator
4. 80% of target population will report that their satisfaction/experience with care is good/excellent.
5. Reduce by 25% avoidable emergency room visits.
SECTION 3: COLLABORATIVE PROCESSES

LEARNING COLLABORATIVE MODEL: THE BREAKTHROUGH SERIES AND THE MODEL FOR IMPROVEMENT

The CCC learning collaborative was conducted over a fourteen-month period, November 2013 through January, 2015. County partnership teams participated in face-to-face and virtual collaborative team and leadership meetings, regular web-conferences, and maintained regular contact with each other and with the collaborative’s faculty via email and a dedicated, secure website. In addition, teams were organized into 4 pilots to develop the local “business case for care coordination” based on health plan(s) geographic areas of responsibility. This section provides a description the learning collaborative framework and activities.

Learning Collaborative Model (Breakthrough Series-BTS LC)

The CCC collaborative methodology was based on the Institute for Healthcare Improvement’s (IHI) Breakthrough Series (BTS) model, and is an improvement approach that relies on adaptation and spread of existing knowledge to multiple settings to accomplish a common aim. CCC expanded the previous Care Integration Collaborative pilot from 5 to 10 teams, which provided an opportunity to test and refine system improvements and learning strategies related to these improvements with a small number of teams.

The Model for Improvement

The BTS collaborative methodology uses the Model for Improvement (MFI) developed by Associates in Process Improvement\(^6\), which provides a methodology to guide the improvement of quality at an accelerated pace. Success in using this model depends on effectively addressing

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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.

Two types of learning resources are central to supporting improvement efforts. Experts with knowledge of changes that result in improvement participate as consultants and faculty. (See Attachment A for biographies of faculty and experts.) Teams share their experiences and new practices developed through testing and adapting the changes within their care settings.

Planning and Preparation
Preparing for a collaborative requires the following activities:
- Development of an overarching charter by core faculty and staff, as well as with the guidance of experts in the aim topic
- Recruiting faculty to guide collaborative tools and processes and present change content in collaborative sessions
- Creation of a change package
- Development of measures to demonstrate improvement, and
- Recruitment of participating teams.
These activities precede a virtual Kickoff Meeting and the Pre-Work phase.

Pre-Work Phase
Following recruitment and basic orientation to CCC requirements, each team was provided with a Pre-Work Manual to orient teams’ to the learning collaborative process. A day-long virtual “Kickoff” and two pre-work calls formally introduced the teams to care coordination and to the work that teams needed to accomplish prior to the first face-to-face learning session. This pre-work, included the following activities:
- Introduce the core faculty, BTS concepts and the pilot LC expectations
- Identify a team leader and team members, define team member roles, complete the team roster
- Develop a local Charter including aim and objectives consistent with the overall CCC Charter
- Agree on the target population of shared client/patients according to team’s aim and charter and explore ways to collect data for the target population
- Introduce basic quality improvement methods (PDSA cycles) through testing a core CC concept (Medication Reconciliation)
- Prepare for required data collection and storage to identify shared clients, measure
health outcomes and continue improving collection and storage systems
• Complete a self-assessment including each partnerships participating organizations

Learning Sessions and Action Periods
Focused learning and improvement activities are supported through two types of activities: learning sessions and action periods.

Learning Sessions
Teams attended five highly interactive Learning Sessions, which were led by expert faculty and included, content presentations, team exercises, small group discussions, team presentations and team meetings. Participants learned from faculty and from their peers, received coaching from faculty and colleagues, gathered new knowledge on subject matter and process improvement, shared experiences and collaborated within and across teams to identify effective testing and implementation strategies for improvements, and developed action plans to be completed prior to the next learning session.

Action Periods
During the 2-3 month periods between LSs, the Action Period (AP), teams worked to test and implement changes. They tested multiple changes in their clinic site(s) and collected data to measure the impact of the changes. Although teams focused on change within their county organizations, teams remained in regular contact with other LC teams and with faculty via twice-monthly interactive web-conferences, a dedicated website and email.

Supporting Engaged Senior Leadership
Engaged senior leadership is necessary for successful change efforts—especially changes such as CC that address multiple systems/organizations. Therefore, the collaborative schedule included specific activities for senior leaders of participating organizations.

• During Pre-Work as teams were formed, senior leaders were encouraged to take an active role in their teams.
• Senior leaders participated in monthly web-conferences that covered topics relevant to leaders’ roles in the improvement process.
• Special leadership breakouts were held during learning sessions

Building the Business Case for Care Coordination Pilot
Within the CCC, executive leaders from BH and primary care provider organizations along with health plan leader/representatives were convened to develop their local/regional business case for care coordination. Four pilot teams were organized on the basis of health plan assignment for medical and mental health mild to moderate care. The initial goal of the Business Case Pilot was to test the impact of CC on utilization and costs contrasting two prior years of utilization and fiscal data with CCC outcomes. However, it quickly became apparent that a more realistic aim was to develop communication processes among BH, primary care and HPs and the
programmatic and financial building blocks—e.g., the capacity to document the business case for care coordination.

Change that Works and the Change Package
Beginning at the first Learning Session and throughout the collaborative, actionable changes to support care coordination (summarized in the Change Package) were introduced by expert faculty. (See Appendix C for the sequencing/organization of CCC changes and for the revised Change Package.)

The teams tested changes related to 13 core care coordination processes. Many of these changes are difficult to achieve with in a single organization and even more difficult to achieve when multiple provider organizations are partnering in care.

While each team tested many of the 28 change concepts included in the CCC Change Package, fewer changes were tested sufficiently to enable teams to fully implement the improvement within the partnership team or to spread the change on a broader system level to new sites and providers. Examples of ‘ready to spread’ changes for several teams are listed below.

- Identify individuals who have serious mental illness and/or substance use disorder and have, or are at risk for, a significant medical condition such as CVD or metabolic disorders
- Screen clients/patients’ whole health-physical, mental health, substance use, and social needs
- Implement clinical sharing agreements-Business Associate Agreements, Release of Information to obtain consent of clients to share information, including compliance with federal regulations protecting the confidentiality of SUD clients (42-CFR, Part 2)
- Implement improved access and referral processes for CC target population
- Engage clients/patients in their care planning (Using Brief Action Planning and Shared Care Plan)
- Develop role and integrate people with MH/SUD lived experience to support care coordination and clients’ self-management
- Systematic caseload review--holding care conferences and processes for case consultation and ad hoc communications between providers
- Coordinate care for shared clients through a cross agency or multidisciplinary care team
- Perform regular medication reconciliation and share reconciled medication lists with other providers of care for individual client

Measurement and Reporting
To support partnerships in answering the 2nd question in the Model for Improvement (How will we know that a change is an improvement?), teams prepared two types of reports on a monthly basis: narratives and data. The Narrative Report facilitated tracking of changes (tested, implemented, spread) based on the Care Coordination Change Package. Data reports included the following measures to monitor the impact of changes on the target population:
• Release of Information status
• Care coordinator assignment
• Shared care goals
• Reconciled medication list
• ER/hospital utilization
• Client experience, confidence, and satisfaction
• Referral status
• Medication reconciliation
• Vitals screening and outcomes
• Primary Care – screening for Behavioral Health issues, Diabetes testing and outcomes, and CVD testing and outcomes
• Mental Health – SUD screening, mental health treatment, PCP designation and visits, and A1c with 2nd generation antipsychotic medications
• SUD – Screening for mental health issues, SUD treatment, and PCP designation and visits
• Health Plans – Two 2nd generation antipsychotic medications, cost per member per month, hospital admissions, ER utilization, and hospital days

**Measurement Experience & Learning**

All CCC partnerships were able to collect data on at least some of the CCC Measures and enter the data into the Excel tracking and graphing tool. The actual extent of the reporting by measure and by partnership is shown in below. With the exception of the “Case per Member per Month” measure, all CCC measures by some of the partnerships.
While there was large variation in the reporting capability of the partnerships, most were eventually able to collect data on demographics, some care coordination processes and some health indicators. Almost all struggled with tracking client’s healthy behaviors and client survey data. With earlier guidance from faculty in the collaborative on these types of data and the use of technology to track the data, all partners in a given partnership should be able to improve in this area. For a full set of run charts from each partnership, see Appendix D.
Target Population and Screening:
As part of the measurement system, each partner and partnership had to designate a group of clients as the target population. These subgroups of clients were the focus for testing changes and for measurement of each partner or partnership’s participation. Most partnerships had a steady target population, with only two growing their target populations during the collaborative (Lake and Mendocino). While most of the partnerships had a target population near 100, three had smaller groups of clients that they focused on (Modoc, Tuolumne, and Solano). The target populations ranged from 17 to 192 over the 10 partnerships and the 12 months of the collaborative.

Care Coordination Activities:
Several of the CCC measures monitored progress with key care coordination functions. These measures were:

- Release of Information among Partners
- Care coordinator assignment
- Care goals shared between PC, SUD and/or MH
- Reconciled medication list
- Shared medication list

All teams were able to report at least one of these measures, although in a few cases, the measures remained at zero because the associated change had not been pursued. College community Services, Fresno, Madera, Project RENEW, Solano, and Tuolumne teams had the staff resources for individual care coordinators and reported 100% of clients assigned a care coordinator. The remaining three teams, Inyo, Modoc, and Mendocino struggled to move the percentage up.

Teams struggled to report on Shared Care Goals with three teams not reporting at all (Lake, Madera, and Modoc). This limited reporting is most likely due to how challenging it is to generate and maintain shared care goals, rather than the process of reporting it. Comparable results were achieved with reconciling medication. Most teams were not able to develop the additional process of tracking reconciliation status. However, two partnerships showed improvement in their ability to share medication lists (Madera and Tuolumne).
Reported progress with shared care goals is below:

**Health Impacts:**
As means of determining if clients’ health status was improving as a result of increased care coordination, the following measures were offered:

- Documenting body mass index and blood pressure
- Elevated body mass index and blood pressure
- Tobacco use screening and follow-up
- ER/hospital utilization

All but one team was able to collect data and report on measures associated with physical health issues (blood pressure and BMI). This is big shift from a few years ago when most mental health organizations did not collect this type of data. Two teams showed an improvement in their ability to document BMI and blood pressure (Madera and Inyo). While visits to the
Emergency room and hospitals are a well-accepted and valuable proxy measure of health, only three teams were able to report this – College Community Services, Inyo, and Tuolumne. This, again, is a big increase in collection of this type of data compared to a few years ago.

**Client Reported Measures:** Partnerships struggled to collect and report data on client reported measures:

- Client Experience with Care
- Client Confidence in their own ability to manage their care
- Client Satisfaction with Coordination of Care

In the sister collaborative for Advancing Recovery (ARC) reporting on these types of measures was much stronger. The assumption for the weak collection and reporting of these measures in the CCC is due to the cross agency nature of CCC. For any future collaboratives on care coordination across agencies, design considerations need to be a focus to increase client reported data. The data for Client Confidence is shown in the small multiple display shown below. Only three teams were able to report and results are inconclusive.
Client Referrals: Partnerships struggled to collect and report data on client referral measures:

- Pending Referrals Made to Partners
- Pending Referrals from Partners
- Referrals Completed

From the weak reporting (and from discussions with teams during the collaborative) it is clear that the referral measures were not useful. Further research is advised for the development of useful referral measures. It is clear from the small multiples below of the Pending Referrals Made to Partners that no useful information about improvement came from this measure.

Measurement Recommendations: The measurement of the impact of changes being tested and implemented is critical to successful improvement efforts. The following recommendations would help organizations to collect and utilize data in more effective ways:
• During Pre-work give the participating teams a data collection form and electronic tool for collecting raw data and provide training
• Start the improvement project related measurement early (during Pre-work)
• Provide training in the use of clinical registries
• Help organizations look at their data (not just CCC data) plotted over time
• Integrate the improvement measures into the leadership discussions at the organization
• Organizations participating in future improvement efforts should strive to educate all their employees in the use and interpretation of improvement data
• Further development needed on measures associated with referrals, client reported measures, and emergency room and hospitalization.

A full description of all the measures used in CCC is shown in Attachment D.

A complete discussion of the measures, teams’ reporting and trends, and faculty assessment of CCC measurement can be found in Appendix D.

SYNTHESIS
The final collaborative activity was a daylong Synthesis of learning attended by the CCC faculty. This session was designed to generate an assessment of the CCC: what changes and processes worked well, what needed improvement, what needed to be added, eliminated or sequenced differently. This goal of this process is to critically assess what worked and where improvements in the CCC tools and processes can accelerate learning and improvement in future collaboratives.

The faculty experience throughout the collaborative and the feedback from the teams, including team presentations at the final Learning Session (Session 5) on accomplishments, challenges and next steps contributed to the revised Change Package in Appendix C. Additionally, the Core Team faculty made changes to the measures (Appendix D) as well as revisions to the Charter. The revised Aim Statement emphasizes care coordination as the focus for the organizations’ partnership. (Appendix B contains the complete revised Charter.)
<table>
<thead>
<tr>
<th>1. Outreaching, engaging, and facilitating clients’ access to appropriate services</th>
<th>The process of reaching out to persons (especially those persons who are difficult to engage), enlisting their participation in care, and ensuring their access to needed services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Defining the Care Team (including natural supports) for each client/patient</td>
<td>The process of identifying and entering into the registry, all of the key members of an individual patient’s care team.</td>
</tr>
<tr>
<td>3. Ensuring and monitoring consent to share clinical information (ROI)</td>
<td>The process of ensuring that all consents for treatment and sharing information has been obtained prior to the sharing of clinical information (PHI).</td>
</tr>
<tr>
<td>4. Ensuring and monitoring appropriate screening for medical, mental health and substance use conditions</td>
<td>The process of systematic planning, administering, interpreting, and adjusting care based on standardized screening tools and measures.</td>
</tr>
<tr>
<td>5. Facilitating referrals</td>
<td>The process of facilitating referral, performing “warm handoffs”, monitoring receipt of referral materials from other providers, and tracking completion of referrals. Intra-team referrals are streamlined.</td>
</tr>
<tr>
<td>6. Entering clinical information into caseload registry tool</td>
<td>The process of serving as primary “custodian” of the clinical registry data, and routinely updating information to ensure its accuracy.</td>
</tr>
<tr>
<td>7. Conducting multidisciplinary clinical care conferences</td>
<td>The process of performing systematic, population-based caseload review.</td>
</tr>
<tr>
<td>8. Ensuring and monitoring routine medication reconciliation</td>
<td>The process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider.</td>
</tr>
<tr>
<td>9. Supporting client self-management</td>
<td>The process of engaging the patient, family, and other natural supports in developing skills and abilities for self-care.</td>
</tr>
<tr>
<td>10. Ensuring and communicating shared care plan goals among client/patient and providers (primary care, mental health, and substance use providers)</td>
<td>The process of communicating for high-level goals shared by all providers in a coordinated care team.</td>
</tr>
<tr>
<td>11. Ensuring availability of ad hoc clinical case consultation</td>
<td>The process of ensuring availability of ongoing, as needed, impromptu consultations between all providers, but especially to primary care provider by specialty providers.</td>
</tr>
<tr>
<td>12. Ensuring urgent care access to specialty MH, SUD or primary care</td>
<td>The process of ensuring that patients have access to appropriate urgent care services as clinically needed.</td>
</tr>
<tr>
<td>13. Monitoring transitions in care</td>
<td>The process of monitoring critical healthcare transitions (such as discharge from a hospital) so that patients don’t “fall through the cracks”.</td>
</tr>
</tbody>
</table>
SECTIONS 4: FINDINGS, LESSONS LEARNED & RECOMMENDATIONS

The critical importance of coordinating care for individuals with complex medical conditions is receiving increasing national and international focus, however relatively little work has specifically focused on coordinating care for persons with complex behavioral health and co-occurring medical conditions whose care is provided by more than one provider organization. This was the challenge, the work—and the learning generated by the Care Coordination Collaborative. This CCC improvement work generated learning in the following four broad areas:

A. Insure Engaged and Effective Leadership
B. Develop Clear and Accountable Roles for Individual CC Providers and Teams
C. Provide Technical Support and Resources for Care Coordination
D. Provide Technical Assistance for Clinical Information Sharing and Measurement of Client Outcomes and System Processes

These learning areas and a brief assessment of the methodological and technical work of the collaborative are summarized below with recommendations for future improvement initiatives. Examples of useful CCC processes and tools—including reference materials and tools developed by faculty and participating teams are provided in Appendices E through H.

A. Engaged and Effective Leadership Is Essential to Improvement—Especially Complex Multi-Organization Processes Such as Care Coordination

Teams identified committed, engaged and sustained leadership as the single most important requisite for care coordination across specialty MH/SUD and physical health care providers. The active participation of executive leaders of health plans in the learning collaborative was also essential given California’s “carve-out” of services to persons with serious mental illness and substance use disorders. Executive leaders within each partnership were able to mutually identify and begin to form better local/regional working relationships and to address some of the communication and information sharing issues and transitions in care issues across behavioral and medical systems of care. In light of health care reform and changes related to 1115 Medicaid Waiver, executive leaders must actively address barriers to coordinated care and foster a culture of quality improvement to sustain and spread such fundamental change.

Committed executive leadership/sponsorship is also essential at the operational level, since even if the CC approach is focused within one organizational entity, it is necessary to bridge and coordinate services with the responsible health plans. Specifically, the CCC Pilot Collaborative demonstrated the following key leadership roles and activities:

- **Leadership Engagement**: In CCC, those teams with engaged leaders committed to both their team’s specific CC aim as well as to test, implement and spread changes demonstrated the most progress and appear poised to spread successful CC changes more broadly across their systems.
• **Support for Improvement Team leadership:** At least a third of the partnership teams experienced staff turn-over at the executive sponsor or team leader level. Teams were most able sustain improvement work through staff turnovers (which are inevitable) when the executive sponsor was either directly involved or made CCC a clear priority.

• **Resourcing/Financing Care Coordination:** Executive leaders/sponsors played a critical role in identifying and allocating resources for testing and implementing CC. During the CCC there were no statewide initiatives or funding mechanisms that could directly support this work—even though CC is now a federal priority and a core component of the CA’s Medi-Cal 2020 1115 Waiver proposal. Most of the CCC teams used MHSA funding to begin the development of CC. In addition, management and direct service staff resources were re-allocated to test the efficacy of CC—an initial strategy that while not sustainable may better position CCC partners to bring care coordination and quality improvement activities to scale.

• **Promoting the Value of Care Coordination:** CCC partnership leaders shared their learning and success with other local leaders in order to generate the broader support necessary for long-term maintenance and spread of care coordination and quality improvement methods.

• **Improvement Team Leaders:** Multi-organization partnerships require strong operational team leadership, inter-organizational negotiation and facilitation skills as well as the ability to address technical issues including project management. CCC initiatives provided additional training and support to team leaders through monthly Team Lead web meetings. Core faculties were also assigned to each of the ten teams to provide individualized technical support to Team Leaders.

• **Specialty SUD Treatment Provider Participation:** SUD providers must be integral partners in planning and creating new systems for care coordination, however, CCC teams had only limited success in actively engaging SUD leaders and service providers. The limited participation of SUD partners is probably a reflection and result of the limited capacity of SUD services in CA. In addition, developing a multi-organization partnership was very challenging—and it seemed that most teams either assumed that BH Department participation addressed SUD participation or simply did not have the band-width or financial capacity to actively include SUD.

**Recommendations**

The following roles and activities are recommended for leaders of care coordination and integration initiatives both for single agencies and multi-agency partnerships:

**RECOMMENDATION #1:** Committed senior leader champions are essential to improvement—especially for complex change processes. In a multi-partner systems change process, each participating system/organization needs an executive level advocate to support change and allocate necessary resources.
Senior leader champions were County BH Directors on about 50% of the teams and actively participated in face-to-face learning sessions. This provided an important experience in leading for quality improvement and also a key opportunity to establish working relationships with health plans.

**RECOMMENDATION #2:** Senior leaders must actively build and sustain accountability and the “will” for improvement within his/her organization and across the partnership.

Leaders must communicate the collaborative aim/purpose as well as share results and improvement team successes with agency staff, other departments, and the larger system(s) including governing boards and stakeholders--including consumer and family members in order to build an investment for specific changes related to care coordination but also to spread quality improvement methods to other system change processes.

**RECOMMENDATION #3:** Specialty SUD treatment providers must be integral partners in planning and creating new systems for care coordination.

The recent SUD Medicaid Waiver amendment to California’s 1115 Medicaid Waiver underscores the imperative of the development of an SUD system of care that meets Federal parity requirements and has the capacity to address SUD. Consideration should be given by DHCS and CIBHS to the development of SUD care coordination collaborative. Given the historical lack of adequate public sector funding and capacity to provide needed specialty SUD treatment, CC programs and partnerships must continue to emphasize SUD as the responsibility of all providers. Efforts should include improving SUD screening, brief interventions, treatment, and recovery support capacity. Where access to specialty care is available, improving referral processes to include warm handoffs is also important.

**RECOMMENDATION #4:** Health plans are essential partners in designing and ultimately incentivizing CC processes and must be involved in designing and building the business case for care coordination for individuals with complex conditions.

Health Plans have a critical local/regional role in promoting and incentivizing care coordination and integration for improved care, outcomes and reduced costs, even in the absence of statewide funding or a formal initiative for the MH/SUD population.

**RECOMMENDATION #5:** Designation of an organizational lead agency or “integrator” is necessary for effective care coordination across multiple BH/health providers.

In the CCC, each team partnership was responsible for designating a “lead agency” to insure coordination of CC tasks across providers, collect measures and attend to communication or other issues that arose. In 7 of the 10 teams, the “lead agency” was County BH/MH. While this was a local decision, the counties and their safety net health plans were generally in the early phases of relationship building and thus did not consider whether the potential role of HPs as
“integrators” for BH/physical health CC. HP’s have taken this role in States such as Washington. In future care coordination planning, there should be further exploration of whether Health Plans can/should function as “integrator.” This must include consideration of the financing of care coordination, designing levels of care coordination including site-based/high touch CC and the implications for coordination with the carve out of care for serious BH conditions.

B. Developing Clear and Accountable Roles for Individual CC Providers and Teams

There is now consensus that CC is essential in the fragmented US healthcare system, however, there is no single model of CC that can address the diversity of local communities, resources, structure or financing of healthcare. California’s realignment of funding and carve out of specialty MH and SUD clearly requires that CC reflect local resources and conditions.

Establishing the local health partners’ shared purpose and roles is essential to designing a CC system. It is also necessary to consider their local environments and resources since there is no single model or statewide resourcing of CC. Consideration must be given to:

- What healthcare providers and organizational relationships can be leveraged to build CC?
- Agreement must be reached on the target population that needs “high-touch”/intensive CC and which provider partners should be involved in coordinating this populations’ care?
- What organizational arrangements are needed to support a CC partnership across specialty MH/SUD and primary/specialty care medical providers?
- What is the proposed CC design and the related structure of the CC team? Will active CC be provided by a single entity or will CC involve a team of providers from multiple agencies? Is the CC team located at one site or is the CC team “virtual”?
- Given design and capacity, what are the specific CC roles and responsibilities that each participating partner will fulfill?
- What are the training, supervision and technical supports are needed by individuals/and organizations to effectively perform what are generally new CC functions?

CCC teams completed capacity assessments (during the Pre-Work phase) and developed CC process flow charts (during Learning Session 2). The Description of Key Care Coordination Processes (Appendix E), identifying 13 core processes also provided teams with guidance regarding the critical functions/process that they would be testing and implementing during the CCC learning collaborative. The CC Capacity Assessment and Process Mapping examples are included in Appendices E and F. Maps of clients’ flow though CC processes documented identified care transitions and identified functions of each participating provider and varied based on each team’s CC model as well as the specific aim and goals of each partnership. This process mapping work also underscored the need for CIC to accommodate multiple CC approaches to reflect local systems and resource capacity. CC designs ranged from
coordinating freestanding specialty MH/SUD and primary care organizations to co-located providers.

Collaborative learning about core processes, roles and accountabilities was substantial and included the following:

- **Understanding and appreciating partnering providers’ organizational culture:** Building CC may require informal or formal partnership agreements (including at the time of the CCC, the DHCS mental health/health plan MOU, but organizations must also learn about and appreciate each other’s organizational culture and operating environment to develop CC and effective collaborative care.

- **Setting Team-Specific Aim and Goals:** Since all health care is local with unique providers, culture(s), structures and resources, the goals of CC must reflect local conditions and needs.

- **Mapping CC Process and Improving Work Flows:** Teams developed process maps of core CC processes to reflect each partnership’s CC model—e.g., geographically separate locations or co-located care within single sites. Internal CC processes within each participating organization as well as new processes spanning intersecting systems were planned and tested. Initial delineation (mapping) of the CC model is a starting point, but workflows must then be refined as testing and implementation reveal both challenges and more effective and efficient ways to coordinate care. Several of the teams actively used process mapping for improvement work throughout the CCC and in spreading improvement processes. However, the complexity of CC across multiple organizations also means that process mapping of workflows is more complicated and difficult, especially if this is a new tool for the team leader/members. (Appendix F.)

- **Establishing the Care Coordination Team:** Each partnership team was asked to define the structure, composition and membership of their CC team—beginning during Pre-work. The University of Washington’s AIMS Center provides a useful summary of core CC functions. It is also important to provide orientation and training for individuals assuming the role of CC since this is a new discipline for most organizations. A day-long Care Coordinator orientation was offered and well-attended prior to Learning Session 2 when most teams had successfully filled these roles.
  - **CC Roles/Functions:** Agencies/partnerships must understand the qualities/skills of effective Care Coordinators and develop job descriptions. Cross training is important to promote CC staff competency and team effectiveness and to address staff turnover which occurred in several of the teams. Complementary roles must also be articulated for providers who are working with designated Care Coordinators.

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7 Millbank Memorial Fund, Evolving Models of Behavioral Health Integration in Primary Care Chris Collins, Denise Levis Hewson, Richard Munger, and Torlen Wade, May 2010
http://uwaims.org/tools/building_clinical_team.html
• **Peers as Care Coordinators and CC Partners**: Individuals with lived experience/persons in MH/SUD recovery (and their families) can function as highly effective CC team members performing essential roles in supporting the health literacy, care, self-management and wellness of persons with complex and co-occurring behavioral and medical conditions. Peer providers can perform in a range of roles: Care Coordinators, outreach and engagement, system navigators, health partners/coaches. The contribution of persons with lived experience in supporting CC is an important area for continued development.

• **Provide a Single Point of Contact for Clients and Providers**: Although multiple providers (e.g., a “virtual team”) participate in a client’s care and may perform CC functions, effective CC requires accountability through the designation of a single individual who functions as the primary point of contact. CCC identified Care Coordinators as the single point of accountability for each client—through tracking referrals, developing and sharing care plans, and insuring that core CC processes such as medication reconciliation are carried out.

**Recommendations**

The following steps should be addressed to develop clear accountability and roles for care coordinators and teams:

**RECOMMENDATION #6**: Apply emerging best practices to the design of CC for persons with MH/SUD specialty care and primary care needs.

While the majority of CC research has focused on CC practices for individuals with complex medical conditions, these practices can be successfully adopted/adapted for individuals with complex behavioral health and medical conditions. In addition, there is a growing body of work in providing CC/integrated care for persons with co-occurring MH/SUD and medical conditions. The SAMHSA-HRSA Center for Integrated Health Solutions functions as a clearing house for this emerging practice. The CA Health Care Foundation (CHCF) has also synthesized national care management programs for complex conditions and while the focus is on health care/managed care organizations, the learning has applicability.

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8 SAMHSA-HRSA Center for Integrated Health Solutions, [http://www.integration.samhsa.gov](http://www.integration.samhsa.gov)

9 CHCF, California Improvement Network, Complex Care Management Program Overview, (July 2013) [http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/C/PDF%20ComplexCareManagementOverviewsGeneral.pdf](http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/C/PDF%20ComplexCareManagementOverviewsGeneral.pdf)
RECOMMENDATION #7: *Mapping CC processes and workflows is an effective way to clarify the client experience, resources, gaps, and roles of participating specialty MH/SUD and primary care organizations.*

Process maps and workflows should be periodically updated as CC systems are tested and implemented.

RECOMMENDATION #8: *Provide support for further development of training and tools to support essential CC processes such as shared care planning, systematic caseload review/CC case conferences, and routine medication reconciliation.*

The CCC developed and piloted several tools and templates to support care coordinators and teams to define and perform key CC roles and work processes. These tools should be further refined for use by entities implementing CC. This may be particularly relevant the commitment of CA to implementing care coordination as a component of the new 1115 MediCal Waiver.

RECOMMENDATION #9: *Define both care coordinator and team roles, and develop training for staff performing the role/responsibilities of care coordination.*

CCC provided well-received CC training however, it is recommended that CA establish criteria and develop accessible resources for CC training-especially in light of the focus on CC in the 1115 Waiver Proposal-Medicaid 2020.

**Designing, Testing and Implementing Key Care Coordination Processes**

Care coordination requires the implementation of key processes within each provider organization as well as coordination of these processes across the CC partnership. CCC focused on the introduction, testing, implementation and spread of care coordination processes including:

- **Outreach and engaging individuals** with serious MH/SUD at risk for/with a medical condition (CVD or diabetes) in care coordination processes
- **Screen clients/patients’ for whole health needs** (physical, mental health, substance use)
- **Release of information** (ROI) and obtaining clients’ consent to share clinical information including addressing federal regulations protecting the confidentiality of SUD clients (42-CFR, Part 2)
- **Facilitate timely access to care and effective referrals** among BH and primary care providers
- **Develop shared care plans** (My Total Health Plan) to develop client-centered goals and coordinate support for goals among partnering providers
- **Support clients'/patients’ wellness and self-management**
- **Conduct systemic caseload review processes** and multidisciplinary care conferences to coordinate and improve care for individuals and targeted population health problems
- **Perform regular medication reconciliation** within each agency and developing processes to reconcile medications across multiple providers
• Use clinical information systems to coordinate/monitor services and measure outcomes of care coordination for individuals and populations

**Identifying and Engaging Clients with Complex Conditions Requiring Care Coordination**-- CCC focused on identification of clients in need of “high touch” care coordination. At the outset, teams used informal methods to identify clients for program development and later pursued more formalized and reliable means of screening and identification of clients in need of CC. For individuals with complex BH/medical conditions, active outreach and engagement were critical to ensure client consent and participation as a member of his/her CC. Successful methods of client identification and engagement included:

- Collaboration with local hospital emergency departments to identify frequent users with MH/SUD co-occurring with medical risk/conditions
- Efforts were made to work with health plans to cross walk clients with chronic medical conditions to BH specialty health care client databases. This often required work around due to confidentiality, but strategies were identified.
- Staff from participating partners identified individuals in need of CC
- Care Coordinators (including Peer Providers) worked with identified high need clients to introduce the benefits of CC
- Field-based outreach and engagement by Peer Counselors/Care Coordinators

**Screen clients/patients’ for whole health needs**-- To establish more consistent and reliable screening processes, several teams developed and/or adopted validated screening instruments such as PHQ-9, Audit-C, GAD-2 & -7, etc. integrating them into routine business processes and their electronic records.

**Release of information (ROI) and obtaining clients’ consent** to share clinical information including addressing federal regulations -- All BH and provider organizations on the teams embedded routine release of information processes or functioned as business associates within the same health system. The key issue that teams struggled with was how to efficiently share clinical information across carved out specialty BH and health plans.

**Facilitate timely access to care and effective referrals**-- Effective referrals, including (virtual and in-person) warm handoffs, is critical even when PC/MH/SUD staff is co-located. Teams focused on streamlining access and referral processes between BH and primary care providers. They designated access point persons, designated intake and consultation time slots in primary care clinics and clarified criteria for specialty BH care. Teams used process mapping to identify and improve access and referrals processes for individuals with complex conditions.
Develop shared care plans to develop client-centered goals and coordinate support for goals among partnering providers—CCC faculty developed a template for a shared care plan that was designed to engage clients in determining their health goals and to share critical information among each client’s providers. The My Total Health Plan (Appendix G) was widely adopted and adapted by teams. Tuolumne County developed a pocket version of shared care plan to be carried by clients to support their personal health goals and to share with treating providers. Care Coordinators were responsible for insuring and sharing care plans among providers but this process remained a challenge for teams since they lacked shared registries or EHRs.

Support clients’/patients’ wellness and self-management -- Clients with SMI/SUD and co-occurring medical conditions must be educated and supported to engage in the choices and decisions that affect their health. Shared decision-making is increasingly understood as a key practice in care planning—and in supporting clients/patients to become active in their self-care, recovery and wellness—though much more progress is needed. Brief Action Planning/BAP was taught to teams and was integrated by a number of teams into care planning and identification of individual wellness goals. In addition, this was a key area of focus for Peer providers and peer provider organizations that were involved in teams.

Conduct systemic caseload review processes and multidisciplinary care conferences to coordinate and improve care for individuals and targeted population health problems-- The Coordinated Care Systemic Caseload Review (CC-SCR), sometimes called a Multi-Disciplinary Team meeting, is a foundation of an effective integrated care program. (See Appendix H.) Though most clinicians have had experience with clinical case conferences of one type or another, the format and pace are very different in primary care and behavioral health settings. The CC-SCR meeting is a primary activity that supports the following elements of an effective population-based care coordination program that is focused on assuring that all patients in a given target population or caseload receive systematic care oversight and care coordination. In a CC-SCR meeting, a list of the patients (paper or electronic—or if available, a registry) is used to identify and track the CC target population and populations are selected for review. Clients/patient in need of special focus must be triaged while the status/progress of the entire CC caseload/panel must be monitored. Efficient monitoring and case conferencing/consultation is critical as the size of CC population increases. The care coordinator is generally responsible for coordinating caseload reviews (generally conducted face-to-face at regular intervals--minimum of monthly but preferably more frequent) and for tracking follow up care recommendations. In addition to CC-SCR, teams also utilized specific client oriented care conferences and ad hoc consultations.

Though most CCC teams initiated some kind of structured care coordination meeting, only about a third implemented population-focused systemic caseload review processes. Barriers
Madera: We get information on a regular basis from Camarena Health Center and Family Health Services on client’s physical health conditions and medications as well as labs. We exchange information back to those agencies regarding medications.

**Perform regular medication reconciliation**
within each agency developing processes to reconcile medications across multiple providers -- Medication Reconciliation is recognized as a standard of care with a reconciliation that in addition to prescriptions from all providers includes over-the-counter, supplements, and illicit substances. This activity is a critical CC function for clients whose multiple conditions require an array of medications with high potential for drug interactions and negative side effects. In order to reconcile medications, each organization had to develop a process to insure an up-to-date and easily accessible medication list as well as protocols for sharing medication changes across each patient’s providers. Though some participating teams approached medication reconciliation as a physician/nurse practitioner responsibility, other teams were able to use non-physician care coordinators to insure that medications were regularly reviewed and reconciled. Reconciled medication lists were also included as an element of the My Total Health Plan and clients/patients were encouraged to carry medication lists with them. By the end of the CCC, all teams had developed regular processes to insure regular medication reconciliation however, sharing of reconciled medication lists across BH and medical providers remained a challenge.

**Use clinical information systems to coordinate/monitor services and measure outcomes of care coordination for individuals and populations**: CC requires establishing effective and routine communications among providers in partnering organizations as well as with clients and their families/significant others.

- **Systematic Collection, Storage and Exchange of Clinical Information** - Sharing of timely (close to real-time) clinical information across providers is essential to partnering providers. While most provider organizations in CCC had electronic health records, most providers did not have access to information beyond their own specialty service. CCC teams developed multiple ways to compensate for lack of consolidated client information. Sharing information involved complex, often manual processes to access multiple patient records. Once health information was obtained, sharing of this information required additional steps such as faxing test results or filling out a standard form for the other provider.
When CCC was designed, it was understood that collecting, storing and using clinical information is critical to care coordination. A pilot registry was offered to teams to test at the beginning of the collaborative process. However the pilot registry, which was used in other CIBHS projects, was not effective for multi-agency care coordination, which requires real-time access and client data tracking. In addition, required duplicate data entry proved a barrier to teams. Accessible clinical information sharing though a registry like function remains a challenge—and is a challenge that is not addressed in most EHRs. Based on learning through the CCC, the following is recommended to more successfully establish CC processes:

**Recommendations**

**RECOMMENDATION #10: Provide accessible training and consultation in team based care/care coordination roles and work processes.**

Effective provider communications, Shared Problem Lists/Care Plans and routine Medication Reconciliation are essential CC functions. Effective provider interactions create the foundation for CC during the early phases of a LC. Future LCs should continue to develop and provide CCC sample forms/plans and processes to build on pilot learning and shorten development time.

**RECOMMENDATION #11: Promote the inclusion of persons with lived BH experience as uniquely qualified to engage clients/patient with complex conditions and to support self-management/wellness.**

While BH organizations have made substantial progress in employing peers in recovery support services, peer services proved to be an integral component of CC for clients/patients with complex conditions. In addition, wellness support programs such as WRAP and WHAM are evidence-based client/patient supports for healthy behaviors and wellness that should be routinely integrated into CC.

**RECOMMENDATION #12: CC partners must have access to a shared electronic clinical information sharing tool to effectively coordinate care.**

Clinical information sharing platforms need to be developed/disseminated to support sharing and monitoring of client transitions and care across multiple organizations including BH, primary care organizations and Health Plans. Providers use different EHR’s that do not include patient registries and do facilitate communication across multiple organizations. Partnering teams should agree on a cross-organizational clinical information sharing strategy as a requirement for participation in future CC collaboratives.

**Methodological and Technical Findings and Recommendations**

These findings and recommendations are kept brief since they are primarily of interest to sponsors and faculty of future Care Coordination learning collaboratives.
• Enhance supports and emphasis on essential role of executive leadership: Provide orientation sessions for Senior Leaders focusing on their role in using data to support systems transformation. Continue monthly Leadership Calls and schedule breakouts for senior and team leaders during learning sessions.

• Measurement for Improvement – Individual agencies had some success gathering data and reporting for CCC measures, however, measurement from across the multiple agencies and sharing data across agencies was sparse — a much harder pursuit than measurement at an individual agency level. While CCC measurement did provide some guidance as to whether the agency collective Care Coordination changes were improvements, the partnerships gained only limited useful knowledge about whether the partnerships had achieved improvement or if the improvement could be sustained and spread. This was also a missed opportunity for partnerships to learn to gather and use data for improvement efforts beyond CCC.

• There was an attempt during CCC to develop and provide a web-based care coordination registry tool to the partnerships. This had limited success due to data sharing issues across agencies (e.g. HIPAA). Even though the experts told participating agencies that data sharing for the purposes of care coordination was permitted under HIPAA, internal controls in agencies prevented adoption.

The following recommendations build on the measurement challenges and successes of CCC agencies and partnerships, and would increase each agency’s data collection and use of measurement for improvement:

• Develop and test a web-based care coordination registry before the collaborative

• Work with major EHR vendors to develop data sharing and reporting capabilities needed to support care coordination, including interfaces with a care coordination registry

• During Pre-work give the participating teams a data collection form and electronic tool (web-based care coordination registry mentioned earlier) for collecting raw data and provide training in its use

• Begin improvement project related measurement early (during Pre-work)

• Provide training in the use of clinical registries

• Help organizations look at their data (not just CCC data) plotted over time

• Integrate the improvement measures into the leadership discussions at the organization

• Organizations participating in future improvement efforts should strive to educate all their employees in improvement methods with specific focus on the use and interpretation of data for improvement

• Provide support for further development of training and tools to support essential CC processes such as shared care planning, systematic caseload review/CC case conferences, and routine medication reconciliation.

• Increase the length of future CC learning collaborative to 18 to 24 months due to the complexity of changes and the system level changes involving specialty, primary care providers and health plans. Include a longer Pre-work Period and 5 learning sessions followed by a Harvest of learning.
Recommendations:

RECOMMENDATION #13: Organizations must build capacity to measure internal organizational improvement and to share integrated CC results across partnering organizations, providers and health plans.

RECOMMENDATION #14: Make technical improvements to learning collaborative in areas of program duration, measurement, and sequence.