



## Care Integration Collaborative

A Breakthrough Series Learning Collaborative

# Final Report

June 2013



With funding support from the California Department of Health Care Services  
For more information, contact Jennifer Clancy, [jclancy@cimh.org](mailto:jclancy@cimh.org)

## ACKNOWLEDGEMENTS and PARTICIPANTS

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See Appendix A for Faculty Bios

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# ACKNOWLEDGEMENTS and PARTICIPANTS (continued)

## TEAMS

PARTICIPATING ORGANIZATIONS IN EACH COUNTY TEAM	
<p><b><u>Los Angeles</u></b>                      Dept. Mental Health                      JWCH Institute Inc.                      SCHARP Behavioral Health Services</p>	<p><b><u>Napa</u></b>                      Clinic Ole (FQHC)                      HHS Mental Health and Alcohol &amp; Drug Services                      Partnership Health Plan</p>
<p><b><u>Nevada</u></b>                      Nevada County Behavioral Health                      Sierra Family Medical Clinic                      Western Sierra Medical Clinic                      Turning Point Providence Center                      Community Recovery Resources                      Common Goals, Inc</p>	<p><b><u>Orange</u></b>                      County of Orange Health Care Agency</p> <ul style="list-style-type: none"> <li>• Behavioral Health Services (BHS)</li> <li>• Alcohol Drug Abuse Services (ADAS)</li> <li>• Medical Services Initiative (MSI) Community Partners</li> <li>• Asian Health Center (AHC)</li> <li>• Korean Community Services (KCS)</li> <li>• CalOptima –County Organized Health System</li> </ul>
<p><b><u>Riverside</u></b>                      Department of Mental Health                      Department of Public Health                      Inland Empire Health Plan                      Riverside Substance Abuse Clinic</p>	

See Appendix A for participants on each team.

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## 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. In addition, common treatments for one condition may actually worsen the other comorbid condition.<sup>1</sup> 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 coordinate care.

The Triple Aim<sup>2</sup>: better health, better care, and lower costs-while not explicitly adopted as the organizing framework for CIC, underscores the importance of addressing the whole health needs of persons with complex health conditions. Health promotion and prevention services which address population health are not readily accessible to persons with complex conditions. 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 risks/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.

There is growing evidence that care coordination and the integration of care improves health outcomes and lowers costs for persons with multiple complex conditions.

### WHAT IS CARE COORDINATION?

*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...*<sup>3</sup>

Coordination of care with specialty providers—including specialty MH/SUD is now one of the “must pass” requirements for National Committee for Quality Assurance certification of primary care practices as “Patient Centered Medical Homes” (2011 PCHM NQCA Standards).<sup>4</sup>

*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.*<sup>5</sup>

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<sup>1</sup> 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

<sup>2</sup> <http://www.ihl.org/IHI/Programs/StrategicInitiatives/TripleAim.htm>

<sup>3</sup> McDonald KM, Sundaram V, Bravata DM, et al. Care coordination. In: Shojania KG, McDonald KM, Wachter RM, and Owens DK, eds. Closing the quality gap: A critical analysis of quality improvement strategies. Technical Review 9 (Prepared by Stanford-UCSF Evidence-Based Practice Center under contract No. 290-02-0017). Vol 7. Rockville, MD: Agency for Healthcare Research and Quality, June 2007. AHRQ Publication No. 04(07)-0051-7.

<sup>4</sup> National Committee for Quality Assurance, Standards for Patient Centered Medical Home, 2011

<sup>5</sup> National Strategy for Quality Improvement in Health Care, 2011

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 increases the challenge to achieve effective care and cost reduction.

### **THE CARE INTEGRATION COLLABORATIVE**

The CiMH Care Integration Collaborative (CIC) was organized 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. Further, there is no single model of CC that takes into account the diversity and resources of local communities and the structure and financing of health care—including care for safety net specialty MH/SUD populations. To fill this gap, CIC synthesized 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. Over the 12-month duration of the project, the CIC learning collaborative introduced essential CC functions and supported teams in testing, implementing and spreading CC improvements.

Building effective care coordination is in and of itself a complex and challenging endeavor as has been documented in health home/medical home initiatives. In CIC, primary and specialty care health organizations/providers with distinct cultures were called upon to develop shared care coordination goals and processes which included leadership collaboration, building a CC team involving providers from multiple disciplines, testing and implementing core CC functions such as improved clinical communication, access, medication reconciliation and development and use of shared problem lists/care plans.

Integrating substance use disorder services was perhaps the most challenging aspect of the CIC partnership approach. SUD organizations participated in each CIC partnership, 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. Health Plans participated as collaborative partners, exploring the shared benefits of CC for complex target populations as well as the potential role of Health Plans as sponsors or "integrators" in California's health system reform. Perhaps a unique CIC contribution was its focus and learning about the roles and contributions of persons with lived experience (persons in MH/SUD recovery) and family members in supporting care coordination, wellness/whole health and recovery.

### **LEARNING COLLABORATIVE APPROACH**

The CIC learning collaborative was conducted over a twelve-month period, February, 2012 through January, 2013. Five 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 CIC faculty via email and a secure website. Beginning at the first Learning Session and throughout the collaborative, changes 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 refined over the course of CIC.

The CIC 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. CIC 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

CIC teams tested at least thirty-five changes related to building effective care coordination. While each team tested many change ideas, during the one-year learning collaborative, far fewer changes were sufficiently tested and implemented to be ready for “spread” on a broader system level to new sites and providers. The following are examples of changes where teams made significant progress in CC.

- Identify individuals with serious MH/SUD at risk for/with a medical condition (CVD or diabetes)
- Obtain consent of clients to share clinical information including addressing federal regulations protecting the confidentiality of SUD clients (42-CFR, Part 2)
- Deploy people with MH/SUD lived experience (peers and family) in supporting wellness and self-management
- Hold regular and ad hoc care conferences/communications between providers
- Coordinate care for shared clients through a cross agency or multidisciplinary care team
- Perform regular medication reconciliation
- Ensure substance use treatment providers are part of the design and implementation of CC

Policy and research practice organizations are increasingly focused on identifying essential elements and processes for care coordination. The CIC pilot contributes to the field through identifying foundational CC processes across specialty MH/SUD and primary care providers for persons with complex MH/SUD and medical risks/conditions.

## KEY RECOMMENDATIONS FOR CARE COORDINATION AND INTEGRATION

### Engaged and Effective Leadership

- Committed senior leader champions are essential to improvement—especially in complex change processes that involve multiple partners.
- Senior leaders must actively build and sustain accountability and the “will” for improvement within their organization and across partnering systems.
- Health plans are essential partners in designing and ultimately incentivizing CC processes that will result in better outcomes and lower costs.

### Develop Clear and Accountable Roles for Individual CC Providers and Teams

- Mapping CC workflows and processes from the client (and provider) perspective is useful to clarify resources, gaps, and roles of participating specialty MH/SUD and primary care organizations.
- CC across specialty and primary care organizations requires clear aim/purpose, goals and structure.
- Clearly define the role of care coordinator as well as related team roles and work processes.

### Key Care Coordination and Care Integration Processes

- Provide support for development of effective provider communications, Shared Problem Lists/Care Plans and routine medication reconciliation as essential CC functions.
- Specialty SUD treatment providers must be integral partners in planning and creating new systems for care coordination.
- Actively educate and engage clients in CC and develop processes to obtain clients’ consent (ROI) to share clinical information among providers involved in their care.
- Adopt and use a clinical information sharing tool (preferably electronic) to effectively coordinate care among partnering organizations.

### The Care Model (CCM) Provides a Useful Systems Framework for Care Coordination

- The “Care Model” (Ed Wagner, MD, McColl Institute) offers a framework for systems changes required to coordinate and integrate care for persons with SMI/SUD and co-occurring medical risk/conditions.

### Measurement of Client Outcomes and System’s Processes is very Challenging Across Multiple Provider Organizations Engaged in a CC Partnership

- Organizations need capacity to measure internal organizational improvement and to share integrated CC results across partnering organizations, providers and health plans.

## SECTION 2: FRAMING THE ISSUES

### THE CASE FOR CARE COORDINATION AND INTEGRATION

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. This health crisis has been compounded by 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, and the failure of specialty MH/SUD services to identify co-occurring medical conditions and insure health care access and coordination of care.

There is growing evidence that improved care coordination and integration of MH/SUD services within primary health care practices improves health outcomes - and both are fundamental to the effectiveness of health care system reform strategies including health homes and accountable care organizations. Coordination of care with specialty providers—including specialty MH/SUD is one of the “must pass” requirements for National Committee for Quality Assurance certification of primary care practices as “Patient Centered Medical Homes” (2011 PCHM NQCA Standards).<sup>6</sup> However, care is rarely well coordinated or managed for individuals with serious mental illness and/or substance use disorders; in particular, those with chronic medical conditions.

Improving the health of individuals with MH/SUD and co-occurring medical risks/conditions is critical both in terms of the impact on individuals and their families but also in terms of the other two dimensions of the Triple Aim: achieving better population health and reducing overall costs.<sup>7</sup>

### EMERGING BEST PRACTICES IN CARE COORDINATION AND INTEGRATION

The CiMH Care Integration Collaborative (CIC) was organized to improve the health outcomes of individuals with these complex needs through care coordination and related practices. In addition to the objective of improving individuals’ whole health and wellness through care coordination, the CIC pilot was expected to contribute to emerging knowledge and strategies for healthcare reform in California and nationally.

The CiMH Care Integration Collaborative (CIC) synthesized knowledge from the health field about care coordination/care integration strategies for individuals with complex health conditions 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. CIC’s approach focused on building practice knowledge through quality improvement. [Appendix K contains a comparison of the CIC key CC building blocks/principles with those cited in widely available literature.] 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)<sup>8</sup>, highlights practices that are emerging as fundamental to successful coordination of care including:

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<sup>6</sup> National Committee for Quality Assurance, Standards for Patient Centered Medical Home, 2011

<sup>7</sup> <http://www.ihl.org/IHI/Programs/StrategicInitiatives/TripleAim.htm>

<sup>8</sup> MacColl Institute for Healthcare Innovation, “Reducing Care Fragmentation: A Toolkit for Coordinating Care”, April 2011



- 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 CIC improvement strategies also reflect learning from the California Department of Health Care Services CalMEND 2010-11 Integration Pilot (led by the CiMH as contracted provider); 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. As with CalMEND, the California Department of Health Care Services contracted with the CiMH to design and implement a second pilot learning collaborative to continue the learning about integration and system changes that improve health outcomes.

In the CIC 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 specialty MH/SUD and primary care organizations to providing integrated/collaborative care where providers were physically co-located in the physical space and into workflows of partnering organizations. The May 2010 Millbank Memorial Fund Report on “Evolving Models of Behavioral Health Integration in Primary Care” provides a commonly referenced coordinated integrated care typology that provides a framework for understanding the nature and complexity of the partnership models pursued by the CIC pilot counties:

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## What is Care Coordination?

The *Care Coordination Measures Atlas*<sup>9</sup> (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 level of need is not fixed in time, or by patient. Assessment of level of care coordination is likely important to tailor interventions appropriately and to evaluate their effectiveness.

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## CIC is guided by an overall charter, elements of which follow:

<sup>9</sup> McDonald KM, Schultz E, Albin L, Pineda N, Lonhart J, Sundaram V, Smith-Spangler C, Brustrom J, and Malcolm E. Care Coordination Atlas Version 3 (Prepared by Stanford University under subcontract to Battelle on Contract No. 290-04-0020). AHRQ Publication No. 11-0023-EF. Rockville, MD: Agency for Healthcare Research and Quality. November 2010.

## **CIC 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 full CIC Charter.

### **AIM**

**Over a 12 month period, 6 to 8 county partnerships of mental health, substance use disorder, and primary care agencies working with local public safety net health plans will increase the number of clients who receive person-centered coordinated care that improves their health outcomes.**

### **CIC GOALS**

- **IDENTIFYING CLIENTS WITH SERIOUS MH/SUD AND CHRONIC HEALTH CONDITION**
  - Increase the number and percentage of clients who have been identified as having relevant mental health/substance abuse and chronic medical conditions
  
- **CARE COORDINATION for TARGET POPULATION**
  - Increase the number / percentage of clients with a shared care plan that addresses physical health and specialty MH / SUD conditions
  - Increase the number / percentage of clients who have an identified care coordinator
  - Improve medication reconciliation
  - Improve access to medical care for clients with specialty SMI and/or SUD
  - Reduce unnecessary ER utilization
  - Improve client satisfaction with coordination of care
  - Improve tracking of health outcomes
  - Improve health outcomes
  - Improve health behaviors

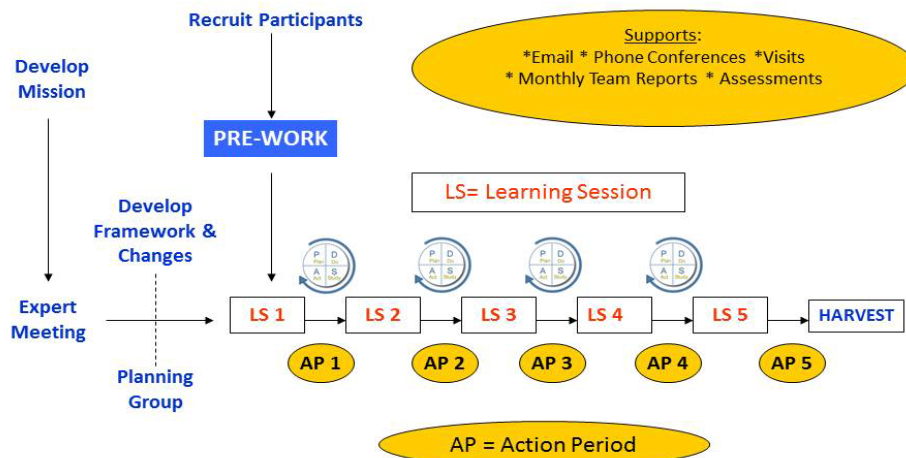
## SECTION 3: COLLABORATIVE PROCESSES

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

The CIC learning collaborative was conducted over a twelve-month period, February, 2012 through January, 2013. County partnership teams participated in face-to-face and virtual collaborative meetings, regular web-conferences, and maintained regular contact with each other and with the collaborative's faculty via email and a dedicated, secure website. This section provides a description the learning collaborative framework and activities.

#### Learning Collaborative Model (Breakthrough Series-BTS LC)

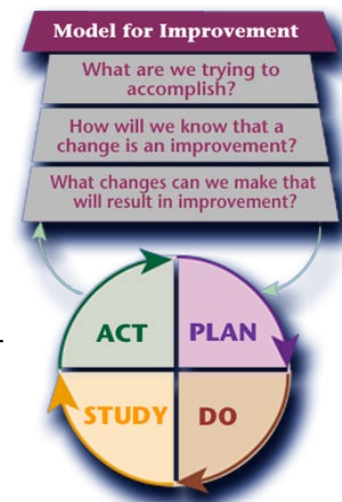
The CIC collaborative methodology was based on the Institute for Healthcare Improvement's (IHI) Breakthrough Series (BTS) model, and is an improvement approach that relies on adaptation and spread of existing knowledge to multiple settings to accomplish a common aim. CIC used a pilot variation of this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



#### The Model For Improvement

The BTS collaborative methodology uses the Model for Improvement (MFI) developed by Associates in Process Improvement<sup>10</sup>, which provides a methodology to guide the improvement of quality at an accelerated pace. Success in using this model depends on effectively addressing 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 in testing and adapting the changes within their care settings and learn from each other.



<sup>10</sup>Langley, G. J., Moen, R. D., et al., 2009. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*. Second Edition, San Francisco: Jossey-Bass Publishers. Langley et al., *The Improvement Guide*, 2<sup>nd</sup> Edition, Jossey Bass, 2009

**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 formal Kickoff meeting and the Pre-Work phase. Teams who elected to join the collaborative and participated in collaborative activities included:

<b>PARTICIPATING ORGANIZATIONS in EACH COUNTY TEAM</b>	
<p><b>Los Angeles</b>                      Dept. Mental Health                      JWCH Institute Inc.                      SCHARP                      Behavioral Health Services</p>	<p><b>Napa</b>                      Clinic Ole (FQHC)                      HHSA Mental Health and Alcohol &amp; Drug Services                      Partnership Health Plan</p>
<p><b>Nevada</b>                      Nevada County Behavioral Health                      Sierra Family Medical Clinic                      Western Sierra Medical Clinic                      Turning Point Providence Center                      Community Recovery Resources                      Common Goals, Inc</p>	<p><b>Orange</b>                      County of Orange Health Care Agency</p> <ul style="list-style-type: none"> <li>• Behavioral Health Services (BHS)</li> <li>• Alcohol Drug Abuse Services (ADAS)</li> <li>• Medical Services Initiative (MSI) Community Partners</li> <li>• Asian Health Center (AHC)</li> <li>• Korean Community Services (KCS)</li> <li>• CalOptima –County Organized Health System</li> </ul>
<p><b>Riverside</b>                      Department of Mental Health                      Department of Public Health                      Inland Empire Health Plan                      Riverside Substance Abuse Clinic</p>	

For more specific information on the teams, see Attachment A

**PRE-WORK PHASE**

Once recruited and oriented to the project, each of the teams was provided a Pre-Work Manual to guide their preparation before 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 and develop a local aim and objectives consistent with the overall Charter
- Define a target population of shared client/patients according to team’s aim and charter and explore ways to collect data for the target population
- Review and 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 in each organization

## **LEARNING SESSIONS & 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 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 remain in regular contact with other teams in the LC and with faculty via twice-monthly interactive web-conferences, a dedicated website and email.

## **LEADERSHIP FOR CHANGE**

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.
- Highly valuable activities for senior leaders were monthly web-conferences that covered topics relevant to leaders' roles in the improvement process.
- Special leadership breakouts were held during learning sessions

## **CHANGES THAT WORK AND THE CHANGE PACKAGE**

Beginning at the first Learning Session and throughout the collaborative, actionable changes to support care coordination were introduced by expert faculty and summarized in the Change Package. (See Appendix C for the sequencing of CIC changes introduced during the 12 months and for the final revision of the Change Package for CIC.)

The teams tested at least thirty-five changes required for effective care coordination. One third of these changes are perceived by the faculty as very difficult to achieve; all of the changes tested are considered at least somewhat difficult to achieve when multiple provider organizations are partnering in care. The table at the end of this section describes the changes tested, how many teams tested each change and the perceived degree of difficulty in making such a change.

While each team tested many change ideas, far fewer of the 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
- Obtain consent of clients to share clinical information including addressing federal regulations protecting the confidentiality of SUD clients (42-CFR, Part 2)

- Use people with MH/SUD lived experience (peers and family) to support care coordination and clients' self-management
- Holding care conferences and/or having ad hoc communications between providers
- Coordinate care for shared clients through a cross agency or multidisciplinary care team
- Perform regular medication reconciliation
- Ensure substance use treatment providers are part of the teams and actively involved in the new processes development.

## MEASUREMENT AND REPORTING

To support partnerships to answer the 2<sup>nd</sup> 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 Change Package. Data reports included the following measures to monitor the impact of changes on the target population:

- Screening for SUD/MH concerns (primary care), CVD/diabetes (mental health, substance use)
- Care coordinator assignment
- Shared care plans
- Reconciled medication list
- Visits to ER/hospital/urgent care
- Metabolic parameters
- Tobacco use
- Physical activity
- Client Satisfaction with Care
- Client Wellness

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

## HARVEST & CLOSING

The final collaborative activity was a daylong "Harvest Session" attended by the teams. This session was designed to generate feedback from the participants about the pilot: what changes and processes worked well, what needed improvement, what needed to be added, eliminated or sequenced differently. During this session, participants provided feedback so that teams in future collaboratives could accelerate learning, improvements and achievement of their aims.

The faculty experience throughout the collaborative and the feedback from the teams during the Harvest 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 as well as the original Charter.)

## AIM (Revised)

Over the period of the collaborative, local mental health, substance use disorder, and primary care agencies, working with local public safety net health plans, will partner to coordinate care for individuals with co-occurring serious mental health and/or substance use disorders and chronic physical health conditions. This coordination will support individual partners to provide an integrated experience of care for the people that they serve, that is person-centered, cost effective, and results in improved health and wellness.



Changes Tested and Pursued by Teams		# teams tested	Not Difficult to Very Difficult; 1-4
<b>THEME 1: LEADERS SUPPORT INTEGRATION AND CARE COORDINATION</b>			
<b>a. Leaders in partnering organizations clarify challenges and provide active support for integration of care/care coordination</b>			
<ul style="list-style-type: none"> <li>Established MOUs with &gt;5 partners</li> </ul>	1	3	
<ul style="list-style-type: none"> <li>Agency leader(s) participate in CIC activities. (Leader calls, Action Period calls, Learning Sessions).</li> </ul>	5	3	
<b>b. Designate a 'coordination ambassador' and identify key cross agency contacts/linkages.</b>	5	2	
<b>c. Create the right internal incentives for care coordination.</b>	3	3	
<ul style="list-style-type: none"> <li>Hire staff including peers for the CC role</li> </ul>			
<b>d. Create financial incentives for CC</b>	3	4	
<ul style="list-style-type: none"> <li>Health Plans participate on the CIC Team to build linkages between providers and payors and develop the business case for CC</li> </ul>			
<b>THEME 2: IDENTIFY AND ENGAGE CLIENTS (PATIENTS)</b>			
<b>a. Identify People Who have CVD or metabolic disorders who require/or are receiving MH/SUD from specialty care providers</b>	5	3	
<b>b. Screen Primary Care Clients for Mental Health / Substance Use Disorders Using Valid Measures</b>	3	3	
<b>c. Engage Client in Care Coordination Program</b>			
<ul style="list-style-type: none"> <li>Establish coverage and benefits for client</li> </ul>	1	2	
<ul style="list-style-type: none"> <li>Introduce coordinated care and the importance of signed consents/releases</li> </ul>	5	2	
<ul style="list-style-type: none"> <li>Share test results and health status information with clients</li> </ul>	5	3	
<b>d. Obtain client consent to share clinical information</b>	5	3	
<b>THEME 3: PLAN, INITIATE AND COORDINATE TREATMENT</b>			
<b>a. Use a <u>Shared Problem List</u> to identify &amp; communicate problems, TX focus/goals for MH/SUD/and health conditions among providers.</b>	5	3	
<b>b. Develop a <u>Shared Care Plan</u> including participation from client/family and providers.</b>	3	4	
<b>c. At each contact, providers &amp; other staff address the client's whole health, not just the presenting or specialty-focused concerns.</b>			
<ul style="list-style-type: none"> <li>Providers within both primary and specialty care support clients' engagement in treatment and self-management through best practice approaches—e.g., Motivational Interviewing, <u>Brief Action Planning</u></li> </ul>	5	3	
<b>d. Perform regular (monthly) Medication Reconciliation (including all substances)</b>			
<ul style="list-style-type: none"> <li>Each agency provides a summary of medications easily accessible in medical record—should include medications from all prescribers.</li> </ul>	2	3	
<ul style="list-style-type: none"> <li>Each agency develops a protocol and procedure for routinely updating clients' medications at each visit.</li> </ul>	2	2	
<ul style="list-style-type: none"> <li>Partnering agencies share each client's medication list on regular basis (preferred monthly/minimum quarterly. Determine sharing method (e.g., electronic/fax, etc.)</li> </ul>	3	3	
<ul style="list-style-type: none"> <li>Care Coordinator insures that clients have a single medication list that is reconciled across primary care and specialty MH/SUD providers.</li> </ul>	2	3	
<ul style="list-style-type: none"> <li>Shared client registry or electronic medical record contains "real time" updated/current medication list from primary <u>and</u> specialty care providers</li> </ul>	2	4	
<ul style="list-style-type: none"> <li>Identify and address substance use disorders within PC and MH as well as SUD specialty provider.</li> </ul>	2	3	
<ul style="list-style-type: none"> <li>Develop SUD protocols with PC and MH partners to clarify criteria and referral process.</li> </ul>			

Changes Tested and Pursued by Teams	# teams tested	Not Difficult; Very Difficult; 1-4
<ul style="list-style-type: none"> <li>Provide medication assisted SUD treatment or insure access to care with providers that offer medication assisted treatment for substance use disorders as is clinically indicated.</li> </ul>	2	4
<ul style="list-style-type: none"> <li>Provide PC easy/timely access to SUD consultation to help them work more effectively with their patients.</li> </ul>	5	3
<ul style="list-style-type: none"> <li><b>Use peers to support Care Coordination activities and clients' self-management.</b></li> </ul>	5	2
<ul style="list-style-type: none"> <li><b>Facilitate and track referrals and access to care among Medical Care, Specialty MH/SUD Care (and Social Services) providers.</b></li> <li>Provide opportunities for staff involved in referral and care processes to meet each other.</li> </ul>	5	2
<ul style="list-style-type: none"> <li>Develop process/protocol for referrals among primary care and specialty providers.</li> </ul>	3	2
<ul style="list-style-type: none"> <li>Use effective handoffs to facilitate client's transition from one provider to another (e.g., warm handoffs)</li> </ul>	5	2
<ul style="list-style-type: none"> <li>Contact client (and receiving provider) to follow-up on referral/linkages with other services and providers</li> </ul>	5	2
<ul style="list-style-type: none"> <li><b>Coordinate [and insure accountability] for each client's care across providers <u>through a designated Care Coordinator &amp; CC functions.</u></b></li> <li>Develop the role of care coordinator including: job description with key responsibilities and functions.</li> </ul>	3	3
<ul style="list-style-type: none"> <li>Provide active care coordination for each client through a multi-disciplinary team although no single care coordinator is designated. (This strategy is only effective for a small CC target population.)</li> </ul>	5	2
<ul style="list-style-type: none"> <li><b>Establish and support a physical activity goal.</b></li> <li>Use Brief Action Planning (or similar approach) to support clients to identify and follow through with physical activity goal.</li> </ul>	5	3
<ul style="list-style-type: none"> <li>Engage physical health experts/trainers, to help clients learn how to engage in a physical activity correctly.</li> </ul>	1	3
<b>THEME 4: TRACK TREATMENT OUTCOMES &amp; ADJUST TREATMENT IF CLIENTS ARE NOT RESPONDING CONDITIONS (TREAT TO TARGET)</b>		
<b>a. Hold regular care conferences to reconcile the medication and problem lists and address the treatment plan.</b>	5	3
<b>b. Provide a curbside/ad hoc consultation.</b>	5	2
<b>THEME 5: DEVELOP AND IMPLEMENT A SYSTEM TO SHARE CLIENT INFORMATION</b>		
<b>a. Use technology opportunities for sharing client/clinical data and if not available set up another standardized information flow.</b> <ul style="list-style-type: none"> <li>Use a registry, an existing registry 'owned' by one of the partners or one developed for the partnership</li> </ul>	1	4
<ul style="list-style-type: none"> <li>Open a "provider portal" for web information to MH/SUD and PC providers.</li> </ul>	1	4
<ul style="list-style-type: none"> <li>Enlist IT consultants to evaluate county data systems and develop bridges between systems.</li> </ul>	4	3
<b>b. Identify and address barriers to client information exchange</b>	5	4
<b>c. Develop and test reporting of clinical information to improve care coordination.</b>	5	4

## Section 4: Findings, Lessons Learned and Recommendations

### Why Care Coordination is So Necessary...

A female in her 40's was thought well of by most of the local mental health staff...She had been stable and on her medications for some time. She had housing, a part time job, socialized and participated in day activities offered by the local client operated resource center. By all of our standards she was an "ideal" mental health client. She was also morbidly obese, had difficulty walking because of her size and carried a quart bottle of soda everywhere she went. While she was an excellent "client" of the mental health system, we didn't recognize that she was dying from preventable medical problems. She joined our Integrated Health Care Clinic too late and died of heart failure, soon afterward.

The critical importance of coordinating care for individuals with complex medical conditions is receiving increasing national and international focus, however very little work has specifically focused on coordinating care for persons with complex behavioral health and co-occurring medical conditions. This was the challenge, the work—and the learning generated by the Care Integration Collaborative. This CIC improvement work generated learning in the following four broad areas:

- A. Engaged and Effective Leadership is Fundamental To Coordinating and Integrating Care
- B. Establishing Purpose, Goals and Building a Care Coordination Team
- C. Designing, Testing and Implementing Key Care Coordination Processes
- D. Support for Practice Change: The Care Model (CCM) as Framework

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 CIC processes and tools—including reference materials and tools developed by faculty and participating teams are provided in Appendices E through J.

### Engaged and Effective Leadership Is Fundamental To Coordinating and Integrating Care

During the final “Harvest” session of the CIC pilot, teams identified **committed, engaged and sustained leadership** as the single most important requisite for an initiative as complex as care coordination/integration of MH/SUD and primary health care. Effective leadership was described as essential to creating “buy-in” from partnering organizations leaders, stakeholders, community partners and line staff. The work of the CIC teams demonstrated that the complex changes required to coordinate/integrate care across specialty MH/SUD and primary health care organizations cannot succeed without the active engagement and support of senior organizational leaders. In light of health care reform and changes related to the Affordable Care Act, it is also essential that senior leaders of “payers” (health plans/Accountable Care Organizations) promote coordinated care thus supporting the alignment of financial and performance incentives. Executive leaders must foster and maintain a culture of quality improvement to sustain and spread such fundamental changes.

Committed and effective leadership is also essential at the operational level, whether the CC approach is focused within one physical/organizational entity or bridges the complex structures and cultures of

multiple organizations. Specifically, the CIC Pilot Collaborative demonstrated the following key leadership roles and activities:

- Leadership Engagement: In CIC, those teams with leaders committed to both their team’s specific CC aim as well as to supporting quality improvement processes necessary to test, implement and spread changes demonstrated the most progress and appear poised to spread successful CC changes more broadly across their systems.
- Resourcing/Financing Care Coordination: Executive leaders/sponsors played a critical role in identifying and allocating resources for testing and implementing CC, especially since there were statewide initiatives or CC funding mechanisms in California during the LC. Most of the CIC teams used MHSAs Innovations Funds to begin the development of CC. Several teams also secured small grants. In addition, management and direct service staff resources were re-allocated to test the efficacy of CC—an initial strategy that cannot be sustained or used to bring care coordination and integration activities to scale.
- Promoting the Value of Care Coordination: CIC 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. Managers of several safety net health plans consistently participated in CIC describing their involvement as an investment in the design/building of health systems’ capacity for the future ACA and related reforms.
- Improvement Team Leaders: Multi-organization partnerships require strong leadership, inter-organizational negotiation and facilitation skills as well as the ability to address technical issues including project management. Future CC initiatives should provide additional training and support to team leaders. Several teams used consultants as team leaders. While external consultants can function as team leaders, they are limited in their ability to sustain changes or establish an organizational culture of improvement.

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.**

**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 frequently communicate the collaborative aim/purpose as well as share results and successes with the improvement team, agency staff, other departments, and the larger system(s) including governing boards and stakeholders—including consumer and family members.

**RECOMMENDATION #3: Health plans (and ACOs) leaders are essential partners in designing and implementing CC structures that that will result in better outcomes and lower costs.** 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.

## Establishing Purpose, Goals and Building a Care Coordination/Care Integration Team

Although there is a growing national consensus that CC is essential in the fragmented US healthcare system, there is no single model of CC that can address the diversity of local communities, resources, structure or financing of healthcare—including care for safety net specialty MH/SUD populations. 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’ purpose and goals proved essential to designing a CC system, and required that leaders and teams consider their local environments and resources:

- What healthcare providers and organizational relationships can be leveraged to build CC? Which payers need to be involved (Medicaid health plan(s), local ACO, etc.)?
- What is the population that needs “high-touch”/intensive CC and which provider partners should be involved in coordinating this populations’ care? Are there other providers that are not core partners, but still should be involved in developing effective CC?
- What organizational arrangements are needed to support a CC partnership across specialty MH/SUD and primary/specialty care medical providers? Are there existing collaborations that can serve as a starting point? Are formal agreements (MOU’s or contracts) required? (See Appendix E for Nevada County’s Partnership Agreement.)
- 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”?

CIC teams completed capacity assessments (during the Pre-Work phase) and developed CC process flow charts (during Learning Session 1). Appendix F contains example workflows. Maps of clients’ flow through 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 from CIC improvement work was substantial and included the following:

- Understanding and appreciating partnering providers’ organizational culture: Building CC may include formal partnership agreements, 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 Goals: Since all health care is local with unique providers, culture(s), structures and resources, the goals of CC/integration, must be determined by local stakeholders.
- Mapping CC Process and Improving Process Flows – Both Agency Specific and Shared: CC strategies and processes will need to reflect each partnerships CC/integration 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 must be planned and tested. Initial delineation (mapping) of the CC model is a necessary starting point, team workflows/CC maps are then refined and updated as testing and implementation reveal both challenges and more effective and efficient ways to coordinate care. (Appendix F.)

- Establishing the Care Coordination Team: It was essential for each organizational partnership to define the structure, composition and membership of their CC team. The University of Washington’s AIMS Center provides a useful summary of core CC functions.<sup>11</sup> Appendix G. contains CIC team building tools modified from the AIMS Center teaching materials.
  - Staffing for Care Coordination: Staffing identified of CC roles/functions whether assigned across a team of providers or centralized with an assigned Care Coordinator proved challenging. CIC teams did not necessarily have staff positions/resources that could be dedicated to CC during the twelve-month collaborative time frame and spreading CC functions across multiple staff.
  - 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. Complementary roles must also be articulated for providers who are working with designated Care Coordinators.
- Including Individuals with Lived Experience: Individuals with lived experience/persons in MH/SUD recovery (and their families) can function as highly effective CC team members with unique and essential roles in supporting the health literacy, care, self-management and wellness of persons with complex and co-occurring behavioral and medical conditions. CIC teams employed persons with lived experience/persons in recovery 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.
- Providing 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 engage in CC functions, effective CC requires accountability—usually through the designation of a single individual who functions as the primary point of contact. Some CC models have identified Care Coordinators as the single point of accountability for each client—e.g. tracking effective referrals, sharing current problem lists/shared care plans, while multiple team members may handle other functions such medication reconciliation. In general, during this one-year CC pilot—often due to staffing challenges, CIC teams did not routinely specify a single CC for each client/panel of clients. However, it is difficult to ensure the accountability for care that is a cornerstone of CC without designating individual care coordinators as points of contact.

#### **LA’s Engagement through Peers**

In Los Angeles, peers/persons with lived experience were effective as outreach workers and care coordinators because of their shared lived experience, knowledge and commitment to improving the lives of downtown LA homelessness population. These care coordinators found that they could more effectively relate to and engage this population with complex needs than the traditional clinical providers on the care team.

<sup>11</sup>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](http://uwaims.org/tools/building_clinical_team.html)



**The following steps should be addressed in building a CC Team:**

**RECOMMENDATION #4: Apply emerging best practice principles to design of CC for persons with MH/SUD specialty care and primary care needs.** Emerging research and practice consensus regarding effective CC and care integration can be successfully adopted/adapted for individuals with complex behavioral health and medical conditions.

**RECOMMENDATION #5: 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 #6: CC requires design, testing, and continued updating of team goals and structure, especially when CC team integrates primary and specialty care partners.**

**RECOMMENDATION #7: Defining the role of care coordinator and related team roles and work processes should be introduced early and re-visited during the collaborative process.**

### **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. CIC focused on the introduction, testing, implementation and spread of care coordination processes including:

- 1) Identifying and engaging clients with complex conditions for “high touch” CC
- 2) Effective Communication Among Providers
- 3) Engaging Clients In Their Own Care
- 4) Shared Care Planning
- 5) Medication Reconciliation
- 6) Substance Use Disorders Must Be Identified and Addressed By All Providers
- 7) Clinical Information Sharing/Release of Information.

Other important areas of care improvement such as “treat to target”, clinical decision support/standards of care and self-management were not addressed due to the one-year duration of CIC and the complexity of designing CC across specialty MH/SUD and medical care organizations.

#### **C-1) Identifying and Engaging Clients with Complex Conditions Requiring Care Coordination (Screening and Other Methods)**

CIC focused on identification of clients in need of “high touch” care coordination. At the outset, teams were able to use informal means 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
- Matching provider and health plan client databases
- Staff from participating partners identified individuals in need of CC
- Peer and Nurse Care Coordinators education and follow-up with identified clients
- Field-based outreach and engagement by Peer Counselors/Care Coordinators

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. (See Appendix H. for tools used in Orange and Riverside counties.)

### **C-2) Effective Communication Among Providers**

CIC teams demonstrated that communication among providers, clients and families in the form of effective referrals and warm handoffs, regular and ad hoc consultation, and shared care planning are essential. Teams improved communications and working relationships through the following processes:

- Establish “Ambassador”/Organizational Problem Solver In Each Partnering Organization— Identification of “Ambassadors” in each organization with the responsibility and clout to address provider and client issues proved to be key to developing and sustaining collaboration given challenges such as access and services eligibility criteria and restrictions, streamlining referrals, and inevitable communication breakdowns.
- Engagement, Referrals And Warm Handoffs: Effective referrals, including (virtual and in-person) **warm handoffs**, is critical even when PC/MH/SUD staff is co-located. For hard-to-engage clients (e.g. homeless), additional outreach and engagement processes are often necessary. Engagement can be further enhanced and reinforced by increasing client literacy about the benefits of care coordination and providing a client friendly explanation of CC services.
- Care Conferencing and Ad Hoc Consults: Regular, multi-specialty care (case) conferences regarding shared clients provide a foundation for coordinating and adjusting care to support clinical improvement and client wellness. Clients 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. Efficient care conferencing is challenging to develop given the different cultures of provider organizations. However, regular and ad hoc care consultation must be tested and implemented for specialty and primary CC/integration to support shared care planning.
- Clinical Information Systems: Clinical information systems such as registries and Health Information Exchanges are important, but not sufficiently implemented or available to facilitate effective communication among partnering providers and clients.

### **C-3 Engaging Clients in Their Own Care**

Clients/patients and their families/significant others must be engaged in care planning and supported to actively engage in improving their health.

Jessie Gruman in a recent Health Affairs blog posting stated: *“We need to know our participation in our care is **important**... Clinicians no doubt assume that the connection is obvious, but for many of us, the process and the endpoints are not well described. As a result, we struggle to set priorities among the many actions we might take for our health and are less likely to summon the energy needed to take them on, particularly in the long term.”*

*Jessie Gruman, What Do Patients Need From Clinicians? Health Affairs, Health Care Update News Service, Policy Update Health Affairs Blog (3/25/13)*

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. The mental health field increasingly supports shared decision-making, recovery and wellness—though much more progress is needed. The substance use disorders field has long recognized the centrality of recovery. However, providers in general are still in the early phases of understanding how to support “patient activation” related to health risks/conditions. Persons with co-occurring MH, SUD and medical conditions confront multiple challenges in developing health goals and following through on their shared care plan. Several of the teams developed and tested client-informing material that explained the benefits of coordinated care. Napa County developed a CC “client informing” handout—testing and modifying the content and methods for sharing this material. The CC handout was handed to clients during their initial visit or at the point of consideration for CC.

### **Napa’s Client Information and FAQs**

(Excerpt from Appendix J.)

Dear Participant:

In an effort to provide you with the best services possible Health and Human Services Agency/Alcohol and Drug Division, Mental Health Division and Clinic Ole have developed a plan to work together to help address any health issues you may experience. By working together we can keep each other informed about your health and with one voice develop the best plan for an even better result.

...So, if a participant begins their services with the Alcohol and Drug Program and needs Mental Health Services and/or health service through Clinic Ole they can be referred easily and quickly...

Questions surface from time to time...

Why do I have to answer the same questions every time I come in? ...

Confidentiality ...

How much information do you share and with whom?

### **C-4 Shared Care Planning**

Coordinated client care requires that providers (and persons receiving care) are knowledgeable and agree on essential treatment and self-care goals. While developing a multi-provider/multi-disciplinary shared care and wellness plan is challenging, it is a fundamental requirement if clients with co-occurring conditions are to receive safe, efficient and effective care. Teams found that a useful first step towards a shared care plan is the development of a shared Problem List, where each provider routinely shares a summary Problem List summary with the clients other providers. A next step is to develop a Shared Care Plan that summarizes core health problems and treatment goals that all providers agree to monitor and support. A summary Shared Care Plan avoids the challenges associated with the difference in

documentation methods/frequency for full treatment plans in each discipline.

### **C-5 Medication Reconciliation**

Medication Reconciliation is recognized in the health care field 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, organizations had to have an up-to-date and easily accessible medication list. Teams without integrated medical records needed to develop routine processes for updating and sharing their medication lists. Though most participating teams approached reconciliation as a physician/nurse practitioner responsibility, at least one team found that non-physician care coordinators can insure that medications are regularly reviewed and reconciled. This is an important clinical skill that should be taught to all team members. Teams were in agreement that medication lists

should be updated/reconciled at each contact through routine provider to provider sharing and queries of clients about prescribed and non-prescribed medication use and changes.

### **C-6 Substance Use Disorders Must Be Identified and Addressed By All Providers**

CIC promoted screening, referral and treatment of substance use disorders as essential in CC/integrated care for persons with complex conditions. However, not all teams included SUD providers and lack of access to specialty SUD treatment capacity was experienced as a significant barrier. To address these challenges, CIC team strategies included co-locating or insuring close proximity of SUD staff to other services, testing effective screening and referral processes and providing MH/PC access to SUD partners including regular and ad hoc consultation capacity. A training session was provided on “Medication Assisted Treatment” (MAT) as an emerging evidence-based practice where PC or MH physicians prescribe medication to manage opiate or alcohol withdrawal while SUD providers provide ongoing treatment and relapse prevention support. It was noted that very few physicians are trained or offer MAT.

In California the gap between need and availability of publicly funded SUD specialty care slots for intensive outpatient or residential treatment is well-documented; however parity requirements and access to an SUD insurance benefit under the ACA may foster expanded capacity within the next few years. Future CC initiatives should increase their focus on involving SUD providers, promoting best practices in SUD treatment and relapse prevention. PC and MH organizations should be encouraged to train their behavioral health providers to routinely offer SUD screening and brief treatment when specialty SUD treatment is not required. Specialized training programs are becoming available for PC based SUD services—including some that are offered online.<sup>12</sup>

### **C-7 Sharing Clinical Information for Coordinating Care**

CC requires establishing effective and routine communications among providers in partnering organizations as well as with clients and their families/significant others. A Release of Information (ROI) is essential--enabling providers to communicate and exchange information—however ROI has frequently been cited as a substantial barrier to CC.

**Release of Information** - CIC teams collaborated and were successful in developing and securing local approval for Release of Information forms and processes that successfully addressed State and Federal regulations governing confidentiality—including 42 CFR, part 2 protecting SUD clients. The five counties’ ROI forms that have been successfully adopted with support of County Counsel and Privacy Officers can be found in Appendix I. These examples, while not eliminating local privacy review processes, should help with more rapid adoption and spread of ROI in California counties.

**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 CIC had, or were on the verge of implementing electronic health records, most providers did not have access to information beyond their own specialty service. CIC teams developed multiple ways to compensate for lack of consolidated client information. Sharing information involved

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<sup>12</sup> For example the University of Michigan offers a Certificate in Integrated Behavioral Health and Primary Care and a Certificate in Addictions. Both can be earned online. For more information see <http://ssw.umich.edu/programs/ce/>

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. Clinical information sharing processes developed by CIC teams included:

- Maintaining a centralized binder for clients/patients, which was used and updated during an all service staff morning meeting
- Holding weekly clinical meetings (phone or face-to-face) to share information about CC clients across agencies.
- Developing a clinical registry that could be accessed by participating providers for clients who provided a ROI.
- Using an EHR to share certain clinical information including reconciled medication lists thus providing one “registry-like” function.
- Developing a secure cloud-based information sharing site (the “Box”)
- Using paper, faxes to exchange clinical information.

Collecting, storing and using clinical information is critical to care coordination. As a condition of participation, future collaborative teams should agree to select and use one of two CIS options for testing and implementing core CC functions: either a clinical registry (which can be provided free of charge for the project duration) or a relational data base provided to teams.

Based on this learning, the following is recommended to successfully establish CC processes:

**RECOMMENDATION #8: Formal screening processes are not a necessary first step in developing organizational capacity to identify a CC target population.** Screening processes should be implemented when the CC population is expanded.

**RECOMMENDATION #9: 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 provide CIC sample forms/plans and processes to build on pilot learning and shorten development time.

**RECOMMENDATION #10: Specialty SUD treatment providers must be integral partners in planning and creating new systems for care coordination.** Given the current 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 #11: Actively educate and engage clients about the benefits of CC and develop processes to obtain clients’ consent (ROI) to share clinical information among providers involved in their care.**

**RECOMMENDATION #12: CC partners must adopt and use a shared electronic clinical information sharing tool to effectively coordinate care.** Partnering teams should agree on cross-organizational clinical information sharing strategy as a requirement for participation in future CC collaboratives.

## Supporting Practice Change: The Care Model (CCM) as a Framework for Care Coordination

Care coordination and care integration require major systems change; partnering organizations must improve both their internal processes and their functioning as collaborating and interconnected entities. CIC teams valued the presentation of an over-arching model that contained and contextualized the various tools and strategies for coordinating and integrating care. Specifically, participating teams found that the Care Model” (formerly the “Chronic Care Model”) as presented by Ed Wagner, MD, Emeritus Director of the McColl Institute,<sup>13</sup> provided a useful roadmap and system organizing framework. Although the Care Model does not provide specific guidance for improving systems and care across multiple partnering organizations, it offers a systems approach that can be adapted to this purpose. An initial mapping and adaptation of care coordination principles to the core elements of the Care Model is included in the revised CIC Change Package. (See Appendix C)

**RECOMMENDATION #13: Introduce the “Care Model” (Ed Wagner, MD, McColl Institute)—as a framework for systems changes required to coordinate and integrate care for persons with SMI/SUD and co-occurring medical risk/conditions.** Integrate CC into the Care Model by mapping core care coordination functions to the elements of the Care Model.

## 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 quality as a business strategy to support systems transformation. Continue monthly Leadership Calls and schedule breakouts for senior and team leaders during learning sessions.
- Measurement for Improvement-CIC partnerships had some success gathering data for and reporting CIC measures, however, this measurement was applied largely to the entire partnership—likely a much harder pursuit than measurement at an individual agency level. While CIC measurement did provide some guidance as to whether the partnership’s collective CC changes were improvements, individual agencies gained only limited useful knowledge about whether their agency specific changes led to improvement that could be sustained and spread. This was also a missed opportunity to learn to gather and use data for their own improvement efforts beyond CIC.

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

- During Prework give the participating teams a data collection form and electronic tool for collecting raw data and provide training in its use
- Begin improvement project related measurement early (during prework)
- Provide training in the use of clinical registries
- Help organizations look at their data (not just CIC data) plotted over time
- Integrate the improvement measures into the leadership discussions at the organization

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<sup>13</sup> Synthesis of research and development of the Chronic Care Model by Ed Wagner, MD and The MacColl Institute can be found through [www.improvingchroniccare.org](http://www.improvingchroniccare.org)



- Organizations participating in future improvement efforts should strive to educate all their employees in the use and interpretation of improvement data

A full description of all the measures used in CIC (Core Measures and Topic Specific Measures) is shown in Attachment D.

- Increase the length of future CC learning collaborative due to the complexity of changes and the system level changes involving specialty and primary care providers. Include a longer Pre-work Period and 5 learning sessions followed by a Harvest of learning.
- Revise the sequencing of content: Introduce the Care Model and several of the key tools for CC development-such as CC team design and process mapping during Pre-work and continue this focus in Learning Session One. Client engagement tools should be introduced during the early learning collaborative process. (Example: CC client literacy/informing tool, Brief Action Planning, etc.)

**RECOMMENDATION #14:** Organizations need capacity to measure internal organizational improvement and to share integrated CC results across partnering organizations, providers and health plans.

**RECOMMENDATION #15:** Make technical improvements to learning collaborative in areas of program duration, measurement, and sequence.