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Teams

Amador County

Calaveras County

Colusa County

Imperial County

Madera County

Mendocino County

Modoc County

Mono County

Plumas County

Tehama County

Trinity County

Cover artwork by Lillian Bond
Executive Summary

Early in 2012, eleven behavioral health agencies in small counties of California came together to address the physical health issues of people with serious mental illness (SMI) through the Small Counties Care Integration (SCCI) learning collaborative. These agencies committed themselves to addressing a major health disparity: people with SMI live shorter lives (on average 25 years less) than those without SMI. Over 12 months the counties worked with faculty experts and each other to apply the best-known evidence and practices to their settings. They focused on preventable physical health issues, such as diabetes and cardiovascular disease, and sought to improve outcomes by increasing coordination with primary care and supporting their clients to better self-manage their health.

Even during this short period of time, behavioral health agencies began to see improvements in the physical health of their clients, as well as improved relationships with primary care providers in their communities and healthier behaviors in their clients. The experience of the counties can assist others engaged in similar work.

The organizations found four factors contributed to improved processes and outcomes:

1. Engaged Leadership

Leaders committed to supporting a “culture of experimentation” where staff are encouraged to test new ideas, understand that “failure” is necessary for learning, and demonstrate sustained involvement in redesigning the system of care. Engaged leadership is the single most important requirement for all improvement initiatives, and particularly one as complex as the coordination of care and promotion of self-management in behavioral health.

2. Test and Implement Fundamental Changes to Practice

When the behavioral health agency begins to routinely introduce the importance of physical health to clients and teaches people about the relationship between physical health and mental health, clients with SMI are likely to attend more closely to their physical health. This necessitates changes in all processes of care.

3. Invest in Clinical Information Systems to Support Individual and Population Health

Systematic collection, storage and exchange of clinical information are required for communication, collaboration, and coordination between behavioral health and primary care providers. Individuals can be supported in their physical health when pertinent clinical information is available.

4. Use Data to Improve Care

Understanding the importance of data for improvement is critical for individual client care and improving services throughout the agency. When the leaders, staff and clients can see data plotted over time and the results of their efforts, a culture of improvement is created.
Recommendations
Valuable knowledge and experience was gained through the SCCI collaborative. The following recommendations are made for others engaged in addressing this health disparity and for future learning collaboratives:

Recommendation #1: Senior leaders commit to improvement and authentic organizational change in order to create a sustainable system of care.

Recommendation #2: Senior leaders actively build will and awareness at three levels: within their organization, with the organizational partners who will be directly involved with coordinating care for their clients, and with the broader community.

Recommendation #3: Engage staff in their own health and wellness.

Recommendation #4: Promote clients’ awareness of the relationship between their physical and mental health.
   1. Routinely screen & perform an integrated mental health, substance use, and physical health assessment for clients.
   2. Routinely assess clients’ health vital signs.
   3. Routinely perform lab results for clients with or at risk for diabetes and cardiovascular disease.

Recommendation #5: Make service and practice changes in behavioral health agencies to support clients’ self-management:
   1. Offer nutrition and exercise support.
   2. Advise clients to stop smoking and assist with smoking cessation.
   3. Use effective behavioral change strategies to support clients’ self-selected goals.

Recommendation #6: To coordinate effectively with other care providers, redesign these processes:
   1. Assure that clients are connected to a primary care provider.
   2. Obtain releases of information for consented communication between behavioral health and primary care providers.
   3. Design formal and mutually agreed upon bi-directional referral forms and processes.

Recommendation #7: If a behavioral health agency’s goal is to improve the quality of care, improve population health outcomes, and reduce costs, they must use a registry. To be effective, local leadership
   1. Understands the distinction between a registry and an electronic health record.
   2. Supports the implementation and use of a registry.

Recommendation #8: Start improvement project related measurement early.

Recommendation #9: Provide training in the use of clinical registries, the use of improvement data and how to interpret improvement data.

Recommendation #10: Look at all data plotted over time.

Recommendation #11: Integrate improvement measures into leadership discussions at the organization.
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Introduction

In the wake of the passage of national health reform, the nation is focusing its efforts on how to improve quality and efficiency within the health care system. However, expenditures and gaps in care delivery are not evenly distributed throughout the population; only 5 percent of the population accounts for half of all health care spending and there is considerable variation in quality of care across different conditions and settings. Therefore, achieving the goals of improved quality and efficiency will require focusing specifically on subgroups most at risk for high costs and poor quality of care.¹

Individuals with mental health and co-occurring physical health conditions are a subgroup at significant risk for poor quality of care, poor health outcomes and high cost. These individuals die, on average, 25 years earlier than the general population. They are dying from preventable physical health disorders. The four primary causes of death in people with mental health conditions are:

- Cardiovascular disease
- Diabetes (including related conditions such as kidney failure)
- Respiratory disease (including pneumonia, influenza, chronic obstructive pulmonary disease, and lung cancer)
- Infectious disease (including HIV/AIDS)

Modifiable behaviors play a significant part in the incidence of these life-threatening conditions. The primary behaviors putting people at risk are poor nutrition, physical inactivity, smoking, and excessive use of alcohol and other drugs.² The morbidity rate of people with mental illness is a serious public health crisis; however, it is a crisis that can be prevented.

Early in 2012, eleven behavioral health agencies in small counties of California decided to confront this health crisis. These counties, defined as having populations under 200,000 people, are generally rural with close-knit communities serving large geographic areas. Even though there are limited resources for publically funded behavioral health and primary care organizations, these organizations are expected to meet a wide range of health and social needs. While there is significant evidence that systematic coordination between behavioral and primary care could improve the quality of the care and the

¹ Druss, Benjamin G. and Elizabeth Reisinger Walker. Mental Disorders and Medical Comorbidity, Robert Wood Johnson Foundation. The Synthesis Project, February 2011; 1.
² Morbidity and Mortality in People with Serious Mental Illness, National Association of State Mental Health Program Directors, October 2006, (www.nasmhpd.org)
population health outcomes while reducing costs the challenges to coordination are particularly difficult in small counties. Differences in organizational culture, business models, financing models, and regulations between safety net primary care and behavioral health care providers inhibit attempts to communicate and collaborate across systems. Episodic and uncoordinated treatment practices contribute to poor quality care and services. Separate funding streams demonstrated at the federal and state levels are mirrored at the local level. Finally, stigma and discrimination toward individuals with serious mental illness are barriers to building the relationships between behavioral health and primary care that are fundamental to coordination.

The pilot collaborative, Small County Care Integration (SCCI), was undertaken to develop a means by which behavioral health agencies in selected California counties could make the profound and essential changes needed to improve the physical health status of the people they serve. Clients with serious mental illness (SMI) have very few opportunities, lack information, and need supports to become more involved in their own physical health care. This report summarizes the accomplishments of those agencies and the collaborative learning. It presents a road map for other behavioral health agencies in early stages of designing strategies to improve the population health and the experience of care for complex clients.

http://www.ihi.org/IHI/Programs/StrategicInitiatives/TripleAim.htm
The Small Counties Care Integration Collaborative

Sponsorship and Charge

In July, 2012, the California Department of Health Care Services contracted with the California Institute for Mental Health (CIMH) to design and implement a pilot learning collaborative for small counties with an aim of improving the physical health status of people with complex mental health and co-occurring physical health conditions. CIMH worked closely with the Small County Directors Committee of the California Mental Health Directors Association to recruit eleven behavioral health agencies to the Small County Care Integration Collaborative. The counties that participated in SCCI were: Amador, Calaveras, Colusa, Imperial, Madera, Mendocino, Modoc, Mono, Plumas, Tehama and Trinity. (Appendix A provides more information on the counties.) Teams from each of the counties participated in the collaborative. These teams consisted of the agency director, providers of care, data analysts, and peer providers.

The SCCI pilot collaborative structure and process was based on the Institute for Healthcare Improvement (IHI) Breakthrough Series (BTS) Collaborative model. (See Appendix B for description of IHI BTS Collaborative Model.) From February 2012 through January 2013, the teams participated in five face-to-face Learning Sessions where they were introduced to new ideas and they tested and implemented successful ideas in their settings between Learning Sessions during Action Periods. The teams maintained regular contact with each other and with SCCI leadership and faculty through email, conference calls and site visits during the Action Periods, a name that clearly differentiates a learning collaborative from a workshop or continuing education event. Teams typically start by testing changes in a smaller target population instead of their entire system. By making changes to practice and sharing their experiences, participants accelerated their learning process and positioned themselves for widespread implementation of successful change ideas.

Collaborative Aim

The formal aim of the SCCI collaborative was: In the next 12 months, 11 teams consisting of Small County Mental Health Care staff and clients will achieve better health status for individuals living, or at risk for, serious mental illness. The teams will support the physical health of clients, with a particular focus on cardiovascular disease and diabetes risk factors, as well as their use of physical health services. This will be accomplished by mental health agencies changing and improving systems of communication, collaboration, coordination with primary care to enhance client wellness.
Collaborative Goals

The key goals of the SCCI collaborative were divided into two topic areas: client self-management and care coordination. Self-management was defined as “interventions and support aimed to develop client self-efficacy. Support is provided by the practitioner (and/or agency) and assists the client to develop their skill and capacity to ‘self-manage’ and to live with their condition”⁴ Care coordination was defined as “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.” ⁵

Client Self-Management Goals

a. Reduce the number of clients who are smoking
b. Increase the average time per week that clients exercise
c. Increase the number of SMI clients with a Body Mass Index (BMI) greater than 30 who have used a self-management strategy to lose weight
d. Increase the number of clients with SMI and diabetes who do their own regular glucose monitoring

Care Coordination Process Goals

a. Increase the percentage of clients with a designated primary care provider documented in the mental health record
b. Increase appropriate monitoring of clients physical health care by mental health professionals
c. Increase the number of encounters (telephone, email, in-person) between mental health professionals and primary care providers
d. Decrease the number of emergency care visits
e. Reduce the percentage of clients with SMI whose last Blood Pressure (BP) was greater than 140/90
f. Increase the percentage of clients that have diabetes

who have had A1Cs (a blood sugar test) monitored by primary care provider in the past 4 months
g. Increase the percentage of clients that are on a second generation antipsychotic who have had their
A1c or fasting glucose screened in the past year
h. Reduce the percentage of clients whose A1C is above 9
i. Increase the number of SMI clients with regular primary care visits

**The Change Package**

A Change Package is a catalog of evidence-based principles and ideas for improvement and forms the
basis for the collaborative content, Learning Session agendas, and Action Period activity. Beginning at
the first Learning Session and throughout the collaborative, testable principles and ideas related to the
self-management and care coordination goals were introduced to the teams by expert faculty. Teams
were encouraged to test the principles and ideas presented by the faculty, and, as the collaborative
progressed, they tested ideas presented by their peers who had new knowledge from their own tests
and implementation. The Change Package was refined throughout the collaborative based on what the
teams were learning. (Appendix C contains the original SCCI Change Package and Appendix D the refined
Change Package.) Below are three themes of changes introduced in the SCCI Change Package:

- Build processes and mechanisms within the behavioral health agency to routinely identify and
  respond to physical health care needs of clients
- Promote client self-management of physical and mental health and support clients’ healthy
  lifestyles using culturally sensitive approaches
- Develop processes for mental health and physical health organizations to coordinate care on a
  routine basis

**Measurement and Reporting**

Unlike research or evaluation, the use of measurement in learning collaboratives is specifically to assess
whether improvement is occurring. The learning collaborative measurement approach creates a
feedback system to inform teams of the results of their tests of change. The data provide teams with
just enough information to guide their efforts. Two types of reports provide this feedback, monthly
narratives and monthly data reports.

- The Narrative Report is structured to facilitate recording and tracking of changes being tested,
  implemented and spread.
- Data Reports on select measures help teams and project faculty evaluate the impact of changes
  on the target population. (For detail about the measures below see Appendix E)
- Teams use a tool for tracking the measures and teams set up the necessary data collection and
  processes so they could review data frequently and over time.
- During Action Periods, improvement advisors (faculty with expertise in improvement methods
  and measurement) coach teams on how to use run charts generated from the data, to annotate
  their run charts, and to analyze patterns.
SCCI CORE MEASURES

1. Number of open clients in target population
2. Percentage of clients with designated Primary Care Provider (PCP)
3. Percentage of clients who have had a primary care visit within the last 12 months
4. Percentage of clients with a current Release of Information (ROI) on file
5. Percentage of clients for which a direct consultation between Mental Health (MH) and Primary Care (PC) has occurred
6. Percentage of clients with BP and BMI documented in mental health records within the past 6 months
7. Percentage of clients that are on a second generation antipsychotic who have had their A1c or fasting glucose screened in the past 3 months
8. Rate per 1,000 of clients with one or more visits to Emergency Room/hospital/urgent care centers during the month
9. Client Satisfaction Care: Percentage of clients who agree or strongly agree with the statement: “I receive exactly the care I want and need exactly when and how I want and need it.”
10. Client Wellness: Percentage of clients who respond with very good or excellent to the following statement: “Describe your health during the past 14 days:”
11. Client Confidence: Percentage of clients who respond with very confident to the following statement: “How confident are you that you can control and manage most of your health problems?”

Small County Teams: Goals and Processes

While the SCCI faculty designed the overarching collaborative aim and goal, each county behavioral health agency team created their own personalized aims and goals depending on their local health environment. Teams selected which of the high leverage change ideas introduced by faculty and their peer teams they wanted to test, tested them with their target population, reviewed their data over time to see if those changes led to progress toward their goals, and implemented (made permanent) the successful changes based on data from their run charts. Over time, teams spread those changes beyond the target population to their entire organization so that the improvement could be sustained. (Appendix F highlights the individual teams’ priority goals, and key areas of change that they worked on during the collaborative.)
Results, Accomplishments and Recommendations for Future Collaboratives

Building a foundation in behavioral health care agencies to support client self-management and effective care coordination processes is a long-term endeavor that requires focused attention. Four key areas of knowledge gained from SCCI can guide the ongoing improvement of the collaborative participants and inform other agencies embarking on improvement activities.

1. Engaged Leadership

In order for behavioral health organizations to make the fundamental changes necessary to improve the physical health status of clients, they must have leaders who actively support this goal. This includes commitment to a “culture of experimentation” where staff are encouraged to test fundamental changes, understanding that “failure” is necessary for learning, and demonstrating sustained involvement in the improvement of care over the long term. Engaged leadership is the single most important requirement for all improvement initiatives, and particularly one as complex as the coordination of care and promotion of self-management. Executive leaders must be the drivers for the creation and maintenance of a culture of quality, which is necessary to sustain and spread such fundamental changes. The leaders from agencies in SCCI concentrated their efforts in four ways, described in the following paragraphs.

1a. Sponsor Improvement Work

A key leadership role is project sponsorship. This means that they provide resources to allow agency staff to be actively engaged in the collaborative. Strong leadership sponsors provide financial support for staff to attend learning sessions and free up staff time so they can engage in improvement activities. This includes support for testing, implementation, and spread of key changes within the organization as well as attending formal teaching events that are part of the Breakthrough Series Collaborative

Key Areas of Knowledge Gain through SCCI

1. Engaged Leadership

Leaders actively supported the goal to make fundamental changes

2. Testing and Implementation of Fundamental Changes in Organizational Practice

Team members used their behavioral health expertise to help clients address behaviors that put them at risk for diabetes, cardiovascular disease and respiratory diseases

3. Investing in Clinical Information Systems to Support Individual and Population Health

The use of a registry required time in small scale testing, leadership support, and investment of resources in training and technical assistance

4. Using Data for Improvement of Care

Teams developed an increased understanding of the importance of data for improvement (rather than for compliance or evaluation), as well as their increased use of data throughout the course of the collaborative
model, such as team calls and learning sessions. They also devote their own time to be actively involved in learning sessions.

Given the constrained resources of all small county behavioral health agencies, all leaders of the eleven teams can be credited as being excellent sponsors. Although there was variation among counties, an average number of three staff attended the learning sessions and all teams were represented on the twice-monthly team calls. Some county leaders offered more of their own time. For instance, in Modoc County the Director and Deputy Director attended Learning Sessions and team calls. In addition, the Director served on the Collaborative Planning Group, offering more expertise to the Collaborative faculty. The Plumas County Quality Assurance Director also served on the Collaborative Planning Group as did a peer provider leader from Trinity County. In Mendocino, Trinity, and Mono Counties the Directors attended Learning Sessions, while in Amador and Imperial Counties the Deputy Director attended. While no county could send their Director to all 5 Learning Sessions, their attendance was critical to their staff members’ perspectives on the importance of the SCCI Collaborative work.

1b. Model and Promote Whole Health and Healthy Behaviors

In a collaborative focused on promoting whole health for clients, a critical role for the engaged leader is to model health behaviors themselves and support staff members’ wellness and whole health. For example, in Mono County, the Director sponsored in-services on the importance of staff health, purchased a massage chair for staff members, and encouraged staff to use the County Wellness Program that includes partial payment of local gym memberships. She also routinely sent out emails to staff with messages such as “Sitting is the new smoking,” reminding them of the importance of healthy lifestyles even during work hours. In Modoc County, the Director and Deputy Director got involved in community health events open to staff, clients, and the broader community, such as the “Walk Club”.

This foundation of staff health and wellness motivated staff to promote clients’ physical health. For instance, Colusa and Tehama Counties both tested different types of in-service trainings for staff on smoking dependence and cessation strategies prior to attempting to test smoking cessation approaches with clients. They learned that staff members were less likely to tolerate myths about clients benefiting from smoking after they themselves gained important information about the dangers of psychological and physical dependence on tobacco. Imperial County developed a health survey for staff using 10 statements related to tobacco, weight, and exercise to find out how much staff knew about physical health. They tested different ways of organizing their staff meetings to include routine discussion among staff about the importance of their own health and wellness.

1c. Promote the Importance of Care Coordination

Leaders have a key role in working with other organizational partners and the broader community to promote the essential role of coordinated care in persons’ mental and physical health. Directors are the face of the organization with partner agencies and in the broader community. It is necessary for them to communicate clearly that the shortened life span of mental health clients is a community public health crisis and their behavioral health agency is committed to coordinating better with their partners to address this crisis. Many of the SCCI leaders actively fulfilled this role. In Mendocino County, the Director made formal invitations to a local Federally Qualified Health Center (FQHC) to collaborate on
increased coordination with primary care and initiated a shared grant application process so they could jointly apply for funds to support some of the changes needed to coordinate effectively. The Trinity Director also took a leadership role in building relationships with two local FQHCs that saw over half of their clients who had a primary care provider (PCP). He focused on key ideas taught in a SCCI Learning Session, such as working together on a process and tools for medication reconciliation (a need for both behavioral health and primary care). The Trinity Director successfully forged the path for the rest of his staff to then initiate processes with the FQHCs to improve coordination. In Mono County, the Director reviewed learning collaborative successes at the monthly Mental Health Advisory Board meetings and offered them opportunities for comment and guidance. She also sat on community committees, such as the “Chronic Health Issues Committee,” which includes county public health, the local hospital, primary care providers, the Mammoth Mountain Wellness Representative, and others. The Committee met monthly to address the community needs for a Whole Person Health model of care.

1d. Sustain Leadership
SCCI teams also demonstrated the importance of sustained leadership for improvement efforts. Addressing the morbidity crisis for people with mental illness is new to behavioral health as are quality improvement models. These changes are so fundamental and so reliant on leadership that leader transitions can extinguish early improvements. Some of the SCCI teams had real progress in the first 1-2 months of the collaborative only to have a change in leadership disrupt their progress. After observing these leadership disruptions and their damaging impact on the teams’ improvement efforts, a key learning from SCCI is that organizational stability within administration and leadership is vital for sustainable improvement efforts.

2. Testing and Implementation of Fundamental Changes in Organizational Practice
Once the eleven small counties agreed to join SCCI, they were committing to a significant redesign of how they organized their services. Accepting the challenge of addressing the public health crisis of shortened life spans for mental health clients meant they were no longer limited to working on clients’ mental health. They were called on to use their behavioral health expertise to help clients address behaviors that put them at risk for diabetes, cardiovascular disease and respiratory diseases.

2a. Raising Clients’ Awareness of the Relationship Between Physical Health and Mental Health
Individuals with serious mental health conditions generally see the behavioral health agency as their primary place of care instead of the PCP’s office. It has been noted that, “In many cases, the SMI patients’ only contact with the health service is through the mental health care team. Moreover, because of their SMI, these patients are less capable than other patients of interpreting physical signs, as well as solving their problems and caring for themselves, which places an increased responsibility on the part of mental care workers to be in the forefront for the physical health care of these patients.”

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6 De Hart, Marc, et al. Physical illness in patients with severe mental disorders II. Barriers to care, monitoring and treatment guidelines, plus recommendations at the system and individual level. World Psychiatry 10:2, 2011.
Because chronic mental health symptoms generally interfere with daily functioning in a more obvious way than physical health symptoms, the focus of attention is on mental health. But when the behavioral health agency begins to routinely introduce the importance of physical health with clients and teaches people about the relationship between the two, clients with mental health conditions are likely to attend more closely to their physical health. Key activities for behavioral health providers are:

i. Routinely assess clients’ health vital signs
ii. Routinely screen & perform an integrated mental health, substance use, and physical health assessment for clients
iii. Routinely order and review lab tests for clients with diabetes and/or CVD (or at risk for diabetes and/or CVD)

The intentional introduction of education and clinic processes that were traditionally relegated to only the primary care provider was evident among the majority of the county teams in SCCI. Modoc County held informational briefings for clients on whole health. They increased interest among the clients living in the most rural and isolated parts of the county by mailing a flyer inviting them to a lunch meeting to learn about “Whole Person Wellness.” They offered transportation and $100 grocery store gift cards as door prizes. During the meeting, behavioral health staff registered clients for a community “Walk Club” to engage clients in on-going exercise. Modoc County also used their registry to collect client-level physical health data showing changes over time. A registry is a database with selected health information used to manage care and support monitoring and improvement. They printed and reviewed the registry-derived run charts with clients so clients could visualize the relationship between their amount of exercise, their BMI, blood pressure, and their overall feeling of mental health. Colusa County empowered clients by investing in blood pressure cuffs and during weekly support groups staff encouraged clients to do routine tracking and self-monitoring of their blood pressure. As clients’ awareness of their physical health increased, so did their desire for more education on how to improve it. Colusa then partnered with a local community college and helped clients enroll in a six week “Healthier Living” class to assist them in learning more about self-managing their chronic health conditions. Amador County initiated client surveys about their health habits, not only to gather the information but also to test the use of client surveys as an organizational change to encourage clients to reflect on their health and health behaviors. They included questions that asked about their physical health conditions, such as “Do you have diabetes,” and coupled these with behavior questions such as “Do you exercise? If so, how often do you exercise and for how long? Do you get your glucose levels checked on a regular basis?” Mendocino endeavored to increase awareness among clients about smoking facts, myths, and cessation options through story boards that were posted in the client waiting room. The story boards challenged myths that smoking has a positive impact on mental health symptoms such as anxiety and instead demonstrated to clients the relationship between the smoking behaviors and their physical health. Imperial County hosted a Wellness Radio Talk Show on tobacco education with the assistance of the local Public Health Department. The Wellness Radio Talk Show continues to air shows on physical health and wellness every other month.

The changes to clinic processes to increase clients’ awareness of their physical health were also very evident. Modoc County designed and tested a new intake process. The intake became an interview
(rather than handing new clients a packet of paperwork to fill out) and was completed by a trained Intake Specialist and a Behavioral Health Nurse. Their current intake process now includes collecting information on mental health, substance use, and physical health. It also includes identifying PCP and other medical providers, and asking for clients to sign a ROI in order to assist with coordination of care. **Plumas County** learned through testing that their clinicians were not collecting physical health information in their mental health assessments. They initiated system wide training and established new behavioral health agency standards to ensure clinicians regularly ask clients questions related to physical health. They worked to get the health information transferred into electronic health records once the process had been thoroughly tested and implemented. **Trinity County** established a culture of experimentation where “successes were celebrated and failures were valued” and through testing changes were able to significantly increase the number of clients with documented primary care doctors, physical health conditions, and up to date releases of information in their Anasazi Electronic Health Record.

Many of the small county teams also learned that health screening is feasible and a clinical degree is not required to collect important vitals that can flag serious health problems. The collection of health vitals significantly increased clients’ awareness of their physical health. Screenings are the perfect opportunity for behavioral health providers to begin discussions about clients’ health and health behaviors. Teams tested ways to work vital signs into their processes. During the course of the SCCI collaborative, the following counties all initiated routine (minimum once a month) collection of health vitals on all clients, including weight, temperature, respiratory rate blood pressure, BMI: **Modoc, Amador, Mono, Plumas, Imperial, Madera, and Colusa.**

### 2b. Support Client Self-Management

Once clients had a greater awareness of the importance of their physical health and the relationship between their behaviors and their whole health, there were key service and practice changes in behavioral health agencies to support clients’ self-management of behaviors impacting their health. The ideas tested include:

i. Offer nutrition and exercise support
ii. Advise clients to stop smoking and assist with smoking cessation
iii. Use effective behavior change techniques to support clients self-selected goals
iv. Use peers for health promotion, as health and wellness coaches, as care navigators and for WRAP (Wellness Recovery Action Plan) facilitators

**Imperial County** diversified their work force and hired physical trainers for clients. They began to offer weekly in-house exercise classes for clients such as Zumba. For clients farther along in their recovery, Imperial County Behavioral Health signed a Memorandum of Understanding (MOU) with a local fitness center so that clients also had access to take classes there instead of at the center. **Imperial County** also used key self-management approaches, such as Motivational Interviewing and the 5As (Ask, Advise, Assess, Assist, Arrange) with individual clients. Their goal was to assist them in establishing concrete physical health goals as part of their treatment plans. The behavioral health agency also tested the 5As approach to work with the entire target population on smoking cessation. Once they identified clients
who were motivated to stop smoking, they assisted them by developing a smoking cessation group using an evidence-based model, SMART Recovery. **Trinity County** also began a smoking cessation group. They tested different models by viewing each session as a PDSA before determining a model to implement and spread. **Modoc County** incorporated Motivational Interviewing concepts into a client survey to not only identify the clients who smoke but also determine if clients were indicating readiness to quit and desire for support from behavioral health staff with smoking cessation. They partnered with Public Health, who already ran a smoking cessation program, to determine all smoking cessation support options they could test with clients.

A number of the SCCI county teams, including **Modoc, Trinity, and Imperial** had peer providers as key members of their improvement team. In **Modoc** a peer provider was integral to the testing of their registry and use of reports with clients to motivate healthy behaviors. In **Imperial** a peer provider served as co-facilitator of their smoking cessation support group. While SCCI teams were introduced to using peers for WRAP facilitators, formal testing of this change idea did not occur during the course of the collaborative.

### 2c. Redesign Care Coordination Processes

Critical learning also occurred as the counties began to test fundamental and innovative changes needed to coordinate effectively with primary care. Mutually beneficial relationships between behavioral health and primary care were developed to support shared communication, information, and coordination of care. A number of examples of leaders building these relationships are identified in the leadership section. However, the responsibility to build relationships is at all levels of the behavioral health agency. After these relationships were built, and while still in early stages of learning how to coordinate effectively with other care providers, there were foundational processes that had to be designed, tested, and implemented to improve coordination of care. In SCCI, the foundational care coordination processes introduced to teams at Learning Sessions and tested in Action Periods were:

1. Ensuring clients had and utilized their primary care provider
2. Obtaining ROIs for communication between primary care and behavioral health
3. Creating bi-directional referral forms and processes

The clinical supervisor from **Madera County** met with the local FQHC to discuss mutual clients that the primary care provider was having difficulty engaging. The county’s psychiatrist provided consultation services to FQHC when they were unsure how to work with psychiatric or psychological issues of shared clients. In addition they trained FQHC medical staff in Mental Health First Aid and safe TALK. Other collaborations were with the American Association of Suicidology to train all of the attending physicians from Madera Community Hospital and the Children’s Hospital Central California emergency room doctors on suicide awareness. The behavioral health agency staff spoke at the Medical Providers Luncheon about the prevalence of mental illness and the importance of screening in primary care. When primary care providers expressed interest in this, Madera behavioral health staff offered training on use of the PHQ-9 to screen for depression. It was not until Madera County Behavioral Health had built relationships through offering training and consultative services that they then initiated meetings to
build stronger communication and care coordination processes, such as mutually designing a bi-directional referral process with their local FQHC.

**Madera County Behavioral Health** was also the only county team in SCCI to test strategies to build positive relationships with their health plan. As a result of successful relationship building, Health Net Health Plan provided the behavioral health agency with real time data that is fundamental for care coordination, such as clients’ primary care providers’ contact information, last visit with primary care doctor, current medications, current health conditions, and chronic medical conditions.

**All eleven SCCI county teams** tested processes and then introduced policies and procedures to ensure all clients had a designated PCP. A number of counties, namely **Mono, Trinity, Madera**, formalized their bi-directional referral processes by working collaboratively with local FQHCs and/or primary care clinics. Releases of information forms were also a focus of work. **Imperial, Mendocino, and Trinity** counties all had key learning around the importance of building relationships with the clients prior asking for them to sign releases. They made key work flow changes to ensure that the provider, whether it was a clinician, a nurse, or an intake worker, had the time to establish rapport with the clients so that the ROI signing was a meaningful one that increased clients’ expectations that there would be communication, collaboration, and coordination between their behavioral health and primary care providers.

**3. Investing in Clinical Information Systems to Support Individual and Population Health**

Well-designed and thoughtfully implemented clinical information systems (CIS) offer providers the potential to better organize individual client as well as population data in order to facilitate planned care. Systematic collection, storage and exchange of clinical information are pre-requisites for communication, collaboration, and coordination between behavioral health and primary care providers. However, the sharing of timely clinical information across providers is a significant issue for most partnering providers attempting to coordinate care for people with serious co-morbid mental and physical health conditions. Current electronic health records store data in such a way that it does not integrate across conditions or settings, making it difficult to identify groups and subgroups of clients in need of care. Often they perpetuate silos of care with large amounts of data that are not “retrievable”. This leads to inefficient and ineffective care processes among providers. Too often, data systems primarily support billing, documentation and other administrative functions but not improvement in care or outcomes. While all county teams had or were on the verge of implementing electronic health records, none of the behavioral health agencies had access to information beyond their own organization. In addition, the electronic health record is not designed to monitor and allow for easy querying at both the individual and population levels. In effect, the counties had a place to store clinical information electronically, but lacked ease in accessing it for daily clinical services, for coordination, and for care and health outcomes improvement.

The three SCCI county teams that gave focused attention to the improvement of their clinical information systems were **Modoc, Trinity, and Imperial Counties**. Each team tested different strategies. **Modoc** tested and implemented a registry. **Imperial** tested and implemented multiple modifications to their Avatar electronic health record. They created reports for Avatar to get access to clients’ medical
information, real time information on their primary care providers, and real time information on clients’ release of information (ROI) forms. Trinity also tested the functionality of their Anasazi electronic health record. Because they could not gain easy access to information like clients’ basic medical information, such as their primary care doctor or medical conditions, they needed to test what it could do as an initial step in working toward coordinated care.

While each county had varying levels of success in their testing, Electronic Health Record (EHR) vendor support, and local IT, external training and technical support were necessary. The teams found that most EHRs can, with modification, track the existence of primary care physicians and ROIs. The addition and use of third party software such as Crystal Reports can provide enhanced capacity for retrieval and analysis of additional physical health care information, i.e. medical conditions, vitals, necessary labs.

Registries are a useful tool for tracking and querying of individual client information, i.e., vitals, and labs, and serves to enhance communication between clients and providers as well as between behavioral health and primary care providers. A registry also allows for tracking and querying of client population data that affords behavioral health agencies additional opportunities for data driven quality improvement. However, the use of a registry required significant time in small scale testing, leadership support, and investment of resources in training and technical assistance before it could be implemented across the entire target population and spread to the entire agency.

4. Using Data for Improvement of Care

The routine use of measurement is critical for improving the population health, quality of care, and reducing overall healthcare costs for people living with complex mental and physical health conditions. Accurate and current measurement is necessary for individual client care and services, but also plays an important role in proactive care and support for populations of clients. Behavioral health organizations have a difficult time learning to use data for improvement for two reasons:

a. Most current data collection is used for compliance purposes. This leads to the association of data with judgment or funding decisions.

b. Data are typically outdated. In order for data to be used to drive improvement and encourage self-management, it must be accessible, “real-time” and reviewed frequently and repeatedly.

A notable and significant accomplishment for all SCCI teams was their increased understanding of the importance of data for improvement (rather than for compliance or evaluation), as well as their increased use of data throughout the course of the collaborative.

All eleven counties were able to collect data on at least some of the Core Measures and enter the data into the Excel tracking and graphing tool. (Details about data collection are found in Appendix G.) Most of the counties could eventually collect data on demographics, PCP status, and ROI. Clinical data about physical health (vitals, medications, labs, etc.) and the client survey data were challenging for many of the counties. With earlier guidance from faculty in the collaborative on these types of data and the use of technology to track the data, all counties could improve in this area.
There was a second set of measures for the project that were topic specific, such as for diabetes, smoking status or specific lab tests. The reporting for these measures was expected to be less than for the Core Measures for two reasons. One, it was expected that the teams might have a harder time collecting these topic specific data and two, depending on the charter for the county, there may or may not be an interest in certain topic specific measures. (See Appendix H for a list of the measures and the frequency of reporting by county.)

As part of the measurement system, each county had to designate a group of clients as the target population. These subgroups of clients were the target for testing changes and for measurement for each county’s pilot participation. The smallest subgroup of clients was between 50 and 60 clients for Modoc County and the largest target population was between 200 and 300 (Calaveras, Imperial, and Trinity). (Details on the target populations are in Appendix I.)

One of the key focus areas of the SCCI collaborative was helping clients with their connections with primary care providers (PCPs). Most of the counties who were able to report enough data to see trends did in fact make progress in this measure (Figure 1).

Figure 1: Percentage of Clients with a Documented PCP

![Figure 1: Percentage of Clients with a Documented PCP](image_url)
There were two exceptions. One was **Calaveras** which started out with this measure already near goal and they maintained it at that level. The other was **Modoc**, which showed some early improvement and then changed their system of collecting the data by moving to an electronic registry system. Their data show a dramatic drop with the start of the registry (see October 2012) but then appears to start to move upwards again.

Significant improvement can be seen in the run charts for **Imperial, Madera, Mono, Plumas, and Trinity counties**. [Note that the graphs above have two Y-axis scales. The one on the left is for the statistic and corresponds with the black dots. The Y-axis on the right side of the graphs is associated with the denominator for the statistic and the smaller blue diamond shaped markers.]

The improvement clearly seen in the graphs above can also be seen in several other measures (specifically, PCP Visit and Current ROI). To a lesser extent, improvement was seen by one or two counties in the following core measures: Direct Consults, Blood Pressure-BMI, and Second Generation – A1c. (See the Appendix J for graphs of all the measures.)

Although there were not enough of the counties tracking data from the Topic Specific measures, some results were seen. For example, **Imperial County** did work on smoking cessation and reported data on the percentage of clients who use tobacco and the percentage of clients who smoke who were counseled to quit smoking. Also, **Mono County** worked on supporting client exercise and reported data on the average number of times (in a week) that clients exercised. **Imperial County**’s results on tracking tobacco use and counseling are shown in Figures 2 and 3 and the results for **Mono County**’s work on exercise are shown in Figure 4.

**Figure 2: Imperial County – Percentage of Clients Who Use Tobacco**

The data from the small multiples with white backgrounds are used in the aggregate graph (upper left corner). These are called consistent reporters.

The data from the small multiples with the light or blue background are not used in the aggregate.

No data was reported for those small multiples with the darker black background.
A full description of all the measures used in SCCI (Core Measures and Topic Specific Measures) is shown in Appendix E.

After PDSA testing of 5As task force decided that nurse & case manager would use 5As consistently with all clients who smoke; therefore the percentage each month is 100% because of application of 5As with clients who smoke.

The data from the small multiples with white backgrounds are used in the aggregate graph (upper left corner). These are called consistent reporters.

The data from the small multiples with the light or blue background are not used in the aggregate.

No data was reported for those small multiples with the darker black background.
Summary

The eleven behavioral health agencies in small counties of California that came together early in 2012 to address the physical health issues for people with serious mental illness (SMI) made significant progress in improving the health of their clients and better coordination between primary care and behavioral health. These agencies committed themselves to addressing a major health disparity: the shortened lives of people with Serious Mental Illness. The focus on preventable physical health issues provided multiple opportunities to engage leadership, broaden the scope of services, support patients to better self-manage, work across silos of care and create vital and sustainable quality improvement measurement systems.

Even during this short period of time, behavioral health agencies began to see improvements in the physical health of their clients, as well as improved relationships with primary care providers in their communities and healthier behaviors in their clients. The experience of the counties can assist others engaged in similar work.
Appendix A – SCCI Teams

Small Counties

Eleven small Counties were elected to join the Quality Improvement Collaborative. Below are basic descriptions of each county as well as their Behavioral Health mission.

Amador County

With an estimated population of 38,091, Amador County is located approximately 45 miles southeast of Sacramento in the foothills of the Sierra Nevada Mountain. Amador County Behavioral Health’s mission is to “promote the quality of life for individuals, families and the community by providing services that improve health and functioning. Amador County community members will thrive in a welcoming, safe and healthy environment. Providing both Mental Health and Substance Abuse Services, "Amador County Mental Health strives to provide high quality, accessible, and appropriate mental health services to county residents who have serious mental disabilities and/or emotional disturbances.” Through its Substance Abuse Services the counties aim is to “promote healthy community attitudes that help reduce the harmful effects associated with alcohol and drug use, while being responsive to the diversity among individuals, families and communities."

Calaveras County

With an estimated population of 45,578, Calaveras County is located in the heart of the California Gold Country. Calaveras County Behavioral Health’s mission is to “empower consumers and their families to create more satisfying, fulfilling, and productive lives by supporting wellness, recovery and hope. Calaveras County provides Behavioral Health Services provides 24/7 crisis support for all County residents; as well as counseling, service coordination, medication management and peer support are provided for those with serious mental illness and addiction disorders.”

Colusa County

With an estimated population of 21,549, Colusa County is centrally located approximately 70 miles north of Sacramento. Colusa County Behavioral Health mission is to “provide eligible persons with access to a high quality, effective, cost efficient system of mental health care which is community based, culturally competent, and consumer guided.”

Imperial County

With an estimated population of 177,057, Imperial County is located in the Imperial Valley bordering both Arizona and Mexico. Imperial County Behavioral Health mission is to “provide quality professional services to achieve independence and community integration for individuals suffering from mental illness or substance abuse.”

Madera County

With an estimated population of 152,925, Madera County is located in the Central Valley and the Sierra Nevada north of Fresno County. Madera County Behavioral Health mission is to “to promote the prevention of and recovery from mental illness and substance abuse for the individuals, families, and
communities we serve by providing accessible, caring, and culturally competent services.” The agency’s core values are: “the promotion of wellness and recovery, the integrity of individual and organizational actions, the dignity, worth, and diversity of all people, the importance of human relationships; and the contribution of each employee.”

Mendocino County
With an estimated population of 87,553, Mendocino County is located north of the greater San Francisco Bay Area. Mendocino County Behavioral Health and Recovery Services strives to: “Deliver services in a respectful, responsive and efficient manner and with sensitivity to cultural diversity, educate ourselves, individuals, families and the community about mental illness and the hopeful possibilities of treatment and recovery, maximize independent living and to improve quality of life through community-based treatment, maximize the resources available and attend to concerns for the safety of individuals and the community; and manage our fiscal resources effectively and responsibly while insuring that productivity and efficiency are important organizational values which result in maximum benefits for all concerned.”

Modoc County
With an estimated population of 9,517, Modoc County is bounded by the state of Oregon to the north and the state of Nevada to the east. Modoc County Behavioral Health strives to provide “high quality, culturally appropriate, linguistically inclusive mental health care in the least restrictive setting, with the participation of our clients and their support system where suitable.”

Mono County
With an estimated population of 14,309, Mono County is located to the east of the Sierra Nevada between Yosemite National Park and Nevada. Mono County strives to “provides a wide array of services: counseling for mental health and substance use issues, case management, psychotherapy, prevention, crisis intervention and stabilization and psychiatry.”

Plumas County
With an estimated population of 19,765, Plumas County is located in the Sierra Nevada. Plumas County Behavioral Health strives to “to provide accessible, culturally and personally sensitive quality mental health services, supported by sound, ethical business practices, to enhance people’s ability to function effectively within their community. A cornerstone to accomplishing this mission is a profound respect for each individual’s unique perspectives, problems and solutions. Plumas County Mental Health is committed to listening to and learning from consumers, community members and providers to better understand ourselves and our world.”

Tehama County
With an estimated population of 63,601, Tehama County is located in the Northern part of California. Tehama County Behavioral Health strives to “promote the mental health of the people Tehama County”. “Tehama County believes in an integrated service delivery system within the Agency and through collaborative partnerships with other public and private agencies including, but not limited to, the Drug
and Alcohol Advisory Board, SACPA Task Force Committee, Law Enforcement, Tehama County Health Partnership, Department of Education, and Social Services, as well as the residents at large.”

**Trinity County**

With an estimated population of 13,723, Trinity County is located in northwestern California. Trinity County Behavioral Health strives to provide: individual and group counseling for adults, teens & children, Case Management and Medication Services, Adolescent Mental Health/Substance Abuse Treatment; and Alcohol and Other Drug Services that include perinatal programs, adult outpatient and prevention services.
Appendix B – Description of a Breakthrough Series Learning Collaborative

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

During the twelve-month period, February, 2012 through January, 2013, the county teams participated in a series of in-person 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. These activities comprised the learning collaborative model.

Learning Collaborative Model (Breakthrough Series)

A learning collaborative is an improvement approach that relies on adaptation and spread of existing knowledge to multiple settings to accomplish a common aim. Achieving such an aim requires major system change rather than fine tuning of existing systems. In the case of pilot collaboratives, existing knowledge requires significantly more adaptation to achieve the aim and considerable uncertainty exists about the impact of known-to-be successful changes in the circumstances encountered in the pilot. Thus, the pilot’s results often augment existing knowledge more than accelerate spread.

This collaborative methodology is based on the Institute for Healthcare Improvement’s (IHI) Breakthrough Series (BTS) model. The effective and proven quality improvement framework is nationally recognized for groundbreaking improvements in the health field in areas such as reducing medical errors, controlling diabetes and asthma, and reducing health disparities.
**The Model For Improvement**
CiMH Learning Collaboratives use the improvement methodology, developed by Associates in Process Improvement. The approach is used routinely in conjunction with BTS improvement efforts. This approach, called the Model for Improvement (MFI), provides a methodology to guide the improvement of quality at an accelerated pace. Success in using MFI depends on effectively addressing three fundamental questions and the Plan-Do-Study-Act cycle (based on the teachings of W. Edwards Deming) to test and implement changes in real work settings.

Three questions that comprise the Model for Improvement are:
- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?

**Learning Resources**
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. Teams share their experiences in testing and adapting the changes within their care settings and learn from each other.

**PLANNING & PREPARATION**
To launch a collaborative, a charter is drafted by core faculty and staff. The charter is reviewed by an additional set of experts who assist in identifying the system and process changes that could be expected to accomplish the charter’s aim. Other preparatory activities include the securing of faculty, assembly of a change package, recruitment and qualifying of teams, and identifying measures to demonstrate improvement. These activities precede a Kickoff web-conference and the Pre-Work phase.

**Expert Panel and Change Package Development**
During the planning phase, project faculty convenes a panel of state and national experts to assist in the identification of changes that will achieve the improvement and accomplishment of the aim. The resulting “Change Package” is a collection of change concepts and change ideas that have proven to be effective for similar improvement efforts. As was indicated above, in a BTS pilot collaborative a set of proven changes does not exist. Thus, for our pilot collaborative, a ‘draft’ change package (CP) was developed with the experts’ help. Revisions to the draft CP were made throughout the collaborative as teams added knowledge about the changes that yield the desired improvement. A final version of the Change Package was written by core faculty.
Recruitment of Pilot Teams
During the planning and preparation phase of the project (November, 2011 through January, 2012), collaborative faculty developed and distributed informational fliers at statewide meetings, conducted informational webinars and responded to inquiries from county agencies. Interested small county agencies were asked to assemble a team to include peer and professional providers. Recruitment discussions were held with approximately 11 county organizations.

Demonstrating Improvement
Before the start of the collaborative, the collaborative faculty and the Improvement Advisers developed a set of core measures to be used by each team to measure progress throughout the pilot. The measures and their use/impact are discussed later in this section.

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 staff 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 attend three to five highly interactive Learning Sessions during a collaborative. Through these professional development sessions conducted by expert faculty with small group discussions and team meetings, attendees have the opportunity to: learn from faculty and colleagues, receive coaching from faculty and colleagues, gather new knowledge on subject matter and process improvement, and share experience and collaborate within and across teams on ways to introduce improvements and to develop action plans.

Customarily, LSs are two day face to face meetings. However recently, collaboratives have tested virtual approaches to trim costs and enable broader participation by team members who cannot schedule in travel, e.g., providers. For each of the CiMH collaboratives, LS #3 was held as a virtual session. As predicted, more providers participated and teams accommodated the use of technology. None of the participants would recommend a complete substitution of virtual for face to face meetings.

Action Periods
During the 2-3 month periods between LSs, the Action Period (AP), teams work to test and implement changes. They test multiple changes in their clinic site(s) and collect data to measure the impact of the
changes. Although teams focus 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.

During an AP web-conference, teams share the results of their improvement efforts; describing tests of changes, their learning and results from said tests. Faculty participates in web-conferences to provide additional insights. Improvement Advisors coach on testing, planning and measuring.

To further facilitate communication across teams, a dedicated, secure website was set up for the CiMH collaboratives. The site was used to share results of teams’ testing of change ideas, their monthly reporting, and Learning Session materials as well as resource materials on best practices. Learning Session and web-conference materials were distributed by email.

LEADERSHIP FOR CHANGE
The necessity of engaged leadership for successful change efforts is well documented. Therefore, the collaborative schedule included specific activities for senior leaders of the organizations participating in the teams.

- During Pre-Work as teams were formed, senior leaders were encouraged to take an active role in their teams. In most teams, one partner agency’s director served as team leader.
- Monthly web-conferences open to the senior leaders of all partner agencies covered topics relevant to leaders’ roles in the change for improvement process. The value of these sessions came from leaders themselves who shared experiences and learned from each other.
- Special leadership discussions were held during LCs to give senior leaders additional opportunities to share with each other.

CHANGES THAT WORK AND THE CHANGE PACKAGE
Beginning with the first Learning Session and throughout the collaborative, changes that lead to improvement and help to achieve the collaborative aim were introduced by expert faculty. Teams were encouraged to test these changes in their care settings and to test additional change ideas from the Change Package. Below are the primary changes introduced during the collaborative.

- Build processes and mechanisms within the behavioral health agency to routinely identify and respond to physical health care needs of clients.
- Promote client self-management of physical and mental health and support clients’ healthy lifestyles using culturally sensitive approaches.
- Develop processes for mental health and physical health organizations to coordinate care on a routine basis.

MEASUREMENT & REPORTING
For improvement unlike for research or evaluation the LC measurement approach is designed to create a feedback system to inform teams whether changes they are testing are resulting in improvement (or not). The data and set of measures are to enable teams to pursue just enough information to demonstrate that the changes being made are leading to improvement and supporting the original aim. Two types of reports provide this feedback, monthly narratives and monthly data reports.

- The Narrative Report is structured to facilitate recording and tracking of changes according to the themes and change concepts in the Change Package.
- Data reports on select measures help teams and project faculty evaluate the impact of changes for the target population.
- Teams use a tool for tracking the measures and teams were encouraged during Pre-Work to set up the necessary data collection and storage to populate the measures.
- During APs, the improvement advisors coach teams on how to use run charts generated from the data and to annotate their run charts’ values and patterns.

### SCCI CORE MEASURES

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Number of open clients in target population</td>
</tr>
<tr>
<td>2.</td>
<td>Percentage of clients with designated PCP</td>
</tr>
<tr>
<td>3.</td>
<td>Percentage of clients who have had a primary care visit within the last 12 months</td>
</tr>
<tr>
<td>4.</td>
<td>Percentage of clients with a current ROI on file</td>
</tr>
<tr>
<td>5.</td>
<td>Percentage of clients for which a direct consultation between MH and PC has occurred</td>
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<tr>
<td>6.</td>
<td>Percentage of clients with BP and BMI documented in mental health records within the past 6 months</td>
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<tr>
<td>7.</td>
<td>Percentage of clients that are on a second generation antipsychotic who have had their A1c or fasting glucose screened in the past 3 months</td>
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<tr>
<td>8.</td>
<td>Rate per 1,000 of clients with one or more visits to ER/hospital/urgent care centers during the month</td>
</tr>
<tr>
<td>9.</td>
<td>Client Satisfaction Care</td>
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<tr>
<td>10.</td>
<td>Client Wellness</td>
</tr>
<tr>
<td>11.</td>
<td>Client Confidence</td>
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### HARVEST & CLOSING
The final collaborative activity was a “Harvest Session”, which was a day-long session attended by the teams with the faculty attending in listen-only mode. This session was designed to solicit feedback from the participants about the pilot: what changes and processes worked well, what needed improvement, what needed to be added or eliminated. During this session, participants provided feedback so that teams in future collaboratives could accelerate their learning, improvements and achievement of their aims.
Appendix C – Original Change Package
Appendix D – Updated and Draft Change Package
Appendix E – Measurement Details
Appendix F – Team Goals and Key Changes
# Appendix G – Months Each County Reported for Core Measures

<table>
<thead>
<tr>
<th></th>
<th>Amador</th>
<th>Calaveras</th>
<th>Colusa</th>
<th>Imperial</th>
<th>Madera</th>
<th>Mendocino</th>
<th>Modoc</th>
<th>Mono</th>
<th>Plumas</th>
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<td><strong>Client Confidence</strong></td>
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</table>
## Appendix H – Months Each County Reported for Topic Specific Measures

<table>
<thead>
<tr>
<th>Number of Months Each County Reported for Topic Specific Measures</th>
<th>Amador</th>
<th>Calaveras</th>
<th>Colusa</th>
<th>Imperial</th>
<th>Madera</th>
<th>Mendocino</th>
<th>Modoc</th>
<th>Mono</th>
<th>Plumas</th>
<th>Tehama</th>
<th>Trinity</th>
</tr>
</thead>
<tbody>
<tr>
<td>DM and Current A1c</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>10</td>
<td>3</td>
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<td>DM and Daily Glucose</td>
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<td>DM and A1c&gt;9</td>
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<td>3</td>
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<td>Blood Pressure &lt; 140/90</td>
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<td>9</td>
<td>0</td>
<td>1</td>
<td>7</td>
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<td>0</td>
<td>3</td>
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<tr>
<td>Clients Using Tobacco</td>
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<td>9</td>
<td>0</td>
<td>8</td>
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<td>3</td>
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<td>Clients Counseled to Quit Tobacco</td>
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<td>0</td>
<td>8</td>
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<td>1</td>
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<td>0</td>
<td>3</td>
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<td>1</td>
<td>7</td>
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<td>Persistent Asthma on Anti-inflammatory</td>
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<td>8</td>
<td>3</td>
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</table>

Note that the ability to report on this set of measures was much less than for the first set (Core Measures). The frequencies are color-coded to help the readers note the lack of reporting (cells with zeroes and white background), some attempt at reporting (cells with tan backgrounds), and where a county was able to collect and report the data for at least half of the months of the collaborative (cells with blue backgrounds). Aggregation of these data (Topic Specific Measures) was not attempted, because of the spotty reporting.
Appendix I – Clients in the Target Population

Figure M1: Count of Clients in the Target Population

The graphs show a plot of the actual count of clients in the target populations for each month. The first graph is an aggregate graph showing the average client count for all eleven counties. The other 11 graphs show target population for each county.
Appendix J – Graphs of all Measures, Aggregate and Small Multiples
Appendix K – Staff, Faculty and Planning Group Experts

Core Staff and Faculty

**Jae Han,** MD, UC Davis Dept. of Psychiatry & Dept. of Family and Community Medicine,  
*Co-Chair*

**Ken Crandall,** MSW, Superior Region Workforce Education and Training Coordinator; Adjunct Faculty California State University, Chico School of Social Work; and CalMHSA Superior Region Contract Specialist  
*Co-Chair*

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*Improvement Advisor*

**Karin Kalk,** California Institute for Mental Health  
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*Project Director*

**Shoshana Zatz,** California Institute for Mental Health  
*Project Director*

**Helen Lao,** California Institute for Mental Health  
*Project Support Specialist*

Planning Group Experts

**Connie Davis,** MN, ARNP, Gerontological Nurse Practitioner

**Karen Stockton,** PhD, Director, Modoc County Health Services

**Peggy Kelly,** RN, Past Quality Assurance Manager, Lassen County

**Elizabeth McGee,** NP, Nurse Practitioner, North Fork Medical Clinic

**Michael Gunter,** MS, MFT, Quality Assurance Coordinator, Plumas County

**Barbara Demming-Lurie,** MS, Assistant Director, Integrated Behavioral Health Project

**Leah Nagy,** MA, Humboldt County Mental Health Liaison to Families

**Joyce Ott,** Small County Peer Provider, Trinity County

Teams

**Amador County**  
**Calaveras County**  
**Colusa County**  
**Imperial County**  
**Madera County**  
**Mendocino County**  
**Modoc County**  
**Mono County**  
**Plumas County**  
**Tehama County**  
**Trinity County**