# Overview of Outcomes-Based Care

## Overview

The purpose of this paper is to begin a process to advance to use of outcomes-based mental health service planning and delivery to accelerate clinical and functional improvement for individuals with behavioral health disorders. Material for this paper has been drawn from seven nationally recognized improvement projects. (See Appendix A for more information).

- The National Council for Behavioral Health's **Behavioral Health Center of Excellence** (BHCOE) initiative
- The University of Washington AIMS Center's **Mental Health Improvement Program** (MHIP)
- The California Institute for Mental Health's **Advancing Recovery** Collaborative
- Group Health and the University of Washington's Collaborative Care **TEAMcare** model
- Institute for Healthcare Improvement's **Breakthrough Series** Model for Improvement
- The **NIATx Model** of process improvement for behavioral health settings
- The National Council for Behavioral Health's **Learning Community** Model

## What Does Outcomes-Base Care Look Like?

The University of Washington and Group Health Cooperative in Seattle are hotbeds of research in outcomes based, integrated care for individuals with chronic health conditions and behavioral health disorders.

This work began in 1990 with internationally recognized work on the treatment of anxiety and depression in primary care and the development of the chronic care model – a proactive, organized approach to treating chronic illnesses. These efforts lead to the development of IMPACT (Improving Mood: Providing Access to Collaborative Treatment), which is now one of the most widely used approaches for treating behavioral health disorders in primary care.

Variations on this model have been used in behavioral health, especially in the Children's System of Care initiatives throughout the country. Variations of the model can also be found in a number of SAMHSA endorsed evidence-based practices.

Unlike IMPACT in primary care, we are still in the early stages of developing the Outcomes-Based Care model for specialty behavioral health provider organizations. The current version, which could be tested and improved during a Health Share initiative, includes the following components.

## The Components of Outcomes-Based Care

1. A **multidisciplinary care team** works with an individual with behavioral health disorders to complete a multi-dimensional assessment;

2. The assessment is used to identify **specific and measurable goals** for the individual including at least one clinical goal (e.g. reduce my depression or anxiety) and one personal goal (get a job or a girlfriend);

3. The client and their team develop a **professional care plan** and **self-care plan** that includes setting targets related to the goals, utilizing validated tools to measure improvement related to the clinical goal and self-reporting for the personal goal; this includes determining the role of each member of the team (e.g. care management, medication support, treatment, recovery supports);

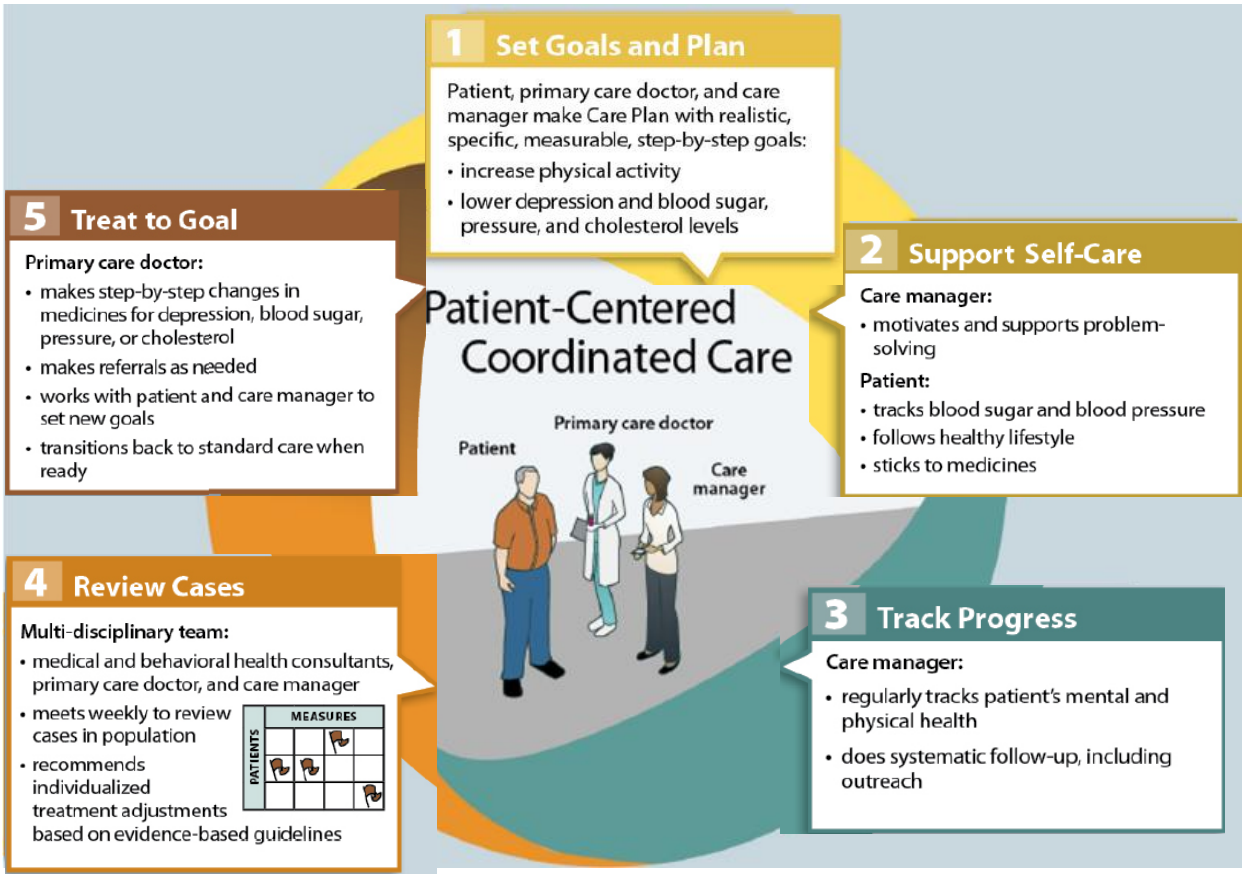
4. The team supports **client engagement** throughout the process, engaging the client in all aspects of the care planning and treatment, understanding how the client is progressing through the stages of change, and providing high-touch care management;

5. The client and team **monitor progress** in a persistent and individualized way to determine whether the care is working, using the clinical measurement tools to determine whether the targets are being reached;

6. There are **regular case reviews** with the team and with the client to determine whether the care plan is working or needs adjusting; if targets are not being met, care plans are changed;

7. **Electronically shared information** is available to all members of the care team, ideally through the use of a patient registry, including the care plans, medication list, and results from the outcomes tracking tools;

The diagram on the following page illustrates this process for an individual with multiple health and behavioral health co-morbidities being treated in primary care.




(Katon, Lin, Von Korff, et al 2010, 2011, 2012, TEAMcare, www.Teamcarehealth.org)

There is an increasing body of research demonstrating that this approach improves outcomes, reduces length of stay, increases client satisfaction, and saves money. This has been primarily demonstrated for individuals with behavioral health disorders treated in primary care, but results are coming in from the specialty behavioral healthcare system. The Mental Health Center of Denver, EMQ Families First and the Centerstone Research Institute are among the growing number of community mental health centers demonstrating these types of results for youth and adults with serious behavioral health disorders.

## Outcomes-Based Care in Specialty Behavioral Health

Outcomes-based care has a longer history in the child behavioral health system because of the system of care/wraparound initiatives that have been pushed out throughout the country. Many of these programs have been based on evidence-based practices that have included validated measurement instruments. When this is combined with team-based care and a family-systems oriented approach to treatment, the result is very close to the emerging definition of outcomes-based behavioral healthcare. There are fewer examples on the adult side, but as mentioned above, this is quickly changing.

One of the big holes in the specialty behavioral health is the absence of a menu or toolkit of identified clinical outcome measurement tools that are compatible with outcomes-based care. While they exist, we have not seen any initiatives to compile this menu/toolkit. An important

part of any specialty behavioral health outcomes based care initiative will be to compile this menu/toolkit.

## Accelerating Improvement

There is a "new language of improvement" that was brought to healthcare by the Institute for Healthcare Improvement (IHI) in 1995 and to behavioral health by NIATx in 2003. These approaches have saved lives, reduced medical errors, improved outcomes for patients and, if implemented properly, increase employee engagement and satisfaction.

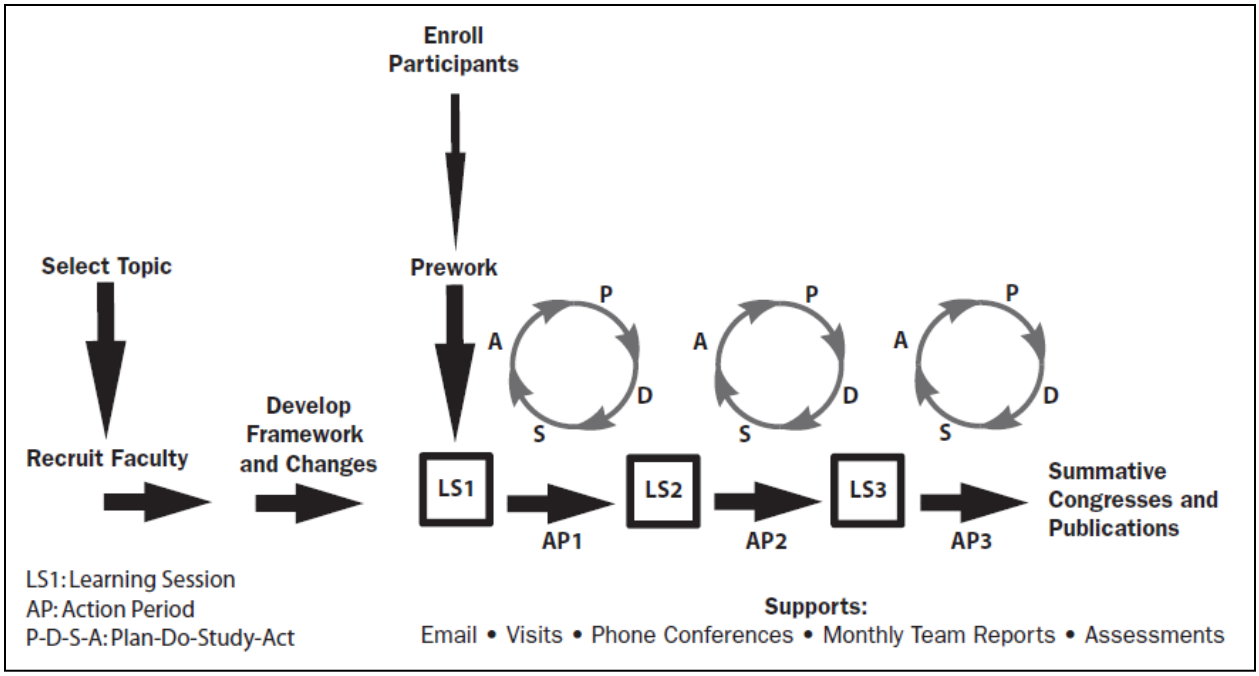
If the Health Share provider network were to adopt or adapt the IHI and NIATx approaches for accelerating improvement, they might work with the Health Share mental health RAEs as follows:

- **Learning Collaborative:** An early adopter group of providers would organize a formal Learning Collaborative to pilot an outcomes-based mental health service planning and delivery improvement model.
- **Learning Community:** A second and larger group of clinicians from the entire network would participate in a less intensive **Learning Community** that will run parallel to the Learning Collaborative.

The number of Learning Collaborative teams and Learning Community participants would be determined during a Project Organization Phase of the Outcomes Based Care Initiative. The curriculum for the initiative would be organized into a **Change Package** that consists of research-based clinical improvement concepts and research-based process improvement concepts that, together, support accelerated improvement for individuals with behavioral health disorders.

## Distinguishing Between Learning Collaboratives and Learning Communities

A **Learning Collaborative** is organized around Teams that have been recruited from provider organizations. Individuals on the Teams, with support from their supervisors and senior management, commit to participating in all of the face to face Learning Sessions and working together during the Pre-Work phase and Action periods between Learning Sessions. The core work of Team members is to try new ideas, gather data to determine whether those new ideas are making a difference, make changes to the new ideas if they're not working, and expand the use of the new ideas when they do work. Teams are supported by the Learning Collaborative faculty and an assigned Coach. Faculty members have content expertise in the clinical improvement concepts. Coaches have expertise in process improvement to help teams make, sustain, and spread the improvements. The following diagram illustrates the model.




A **Learning Community** consists of participants from provider organizations that are <u>not</u> part of the Learning Collaborative and are included in the initiative through a series of webinars that present key ideas that can be used outside the formal Learning Collaborative. Often Teams are required for participation in the Learning Community, homework assignments are made at the end of each webinar, teams work on homework (which requires less time than participation in a Learning Collaborative), and homework learnings are shared at the beginning of each webinar.

A third approach – **Train the Trainer** – is sometimes used when a system change is relatively straightforward or of lower priority. Under this model, one or more "trainers" at each participating organization is identified, a training toolkit is prepared, the trainers are trained on the toolkit, and each trainer goes back to their organization to teach staff within their agency. Most train the trainer approaches do not involve cross-organization collaboration and learning, which saves time, but often reduces the effectiveness of the process.

## Designing an Outcomes-Based Care Learning Collaborative and Learning Community

This type of project would be organized around the development of an Outcomes-Based Care Toolkit that focuses on some or all of the seven outcomes-based care components:

1. Building Multidisciplinary Care Teams
2. Identifying Specific and Measureable Client Goals
3. Developing Professional Care Plans and Self-Care Plans
4. Client Engagement
5. Monitoring Progress to Client Goals
6. Regular Team-Based Case Reviews to Support Treat to Target Progress
7. Implementation and Use of Clinical Data Sharing Tools

There are a set of design decisions that would need to precede the rollout of the Learning Collaborative and Learning Community including:

- **Leadership Support:** There needs to be an Executive Leadership Group for the Learning Collaborative that consists of a senior leader at each participating agency. This group would play an important role, championing the project, removing local obstacles, and giving out the message that "this is really important". They would meet on a regular basis to learn about the key concepts and discuss and solve executive level problems that may be shared.
- **Tools:** Identify the current tools in use and add additional tools to round out the initial suite of tools; we should be careful not to overly restrict what tools are included; as long as they have some validity, we should consider them for inclusion. We want each provider organization participating in the early adopter process to select tools from the menu that they would work with, not every single one.
- **Measures:** Identify the measures we want to track that are related to the measures in the tools and other key performance measures that help us determine whether what we're doing is working (e.g. inpatient, emergency room, and crisis utilization).
- **Improvement Model:** Develop a streamlined improvement model that teams would be trained in so they can do simple rapid cycle improvement at the team level with ongoing support as they work through the issues that come up.
- **Number of Teams:** Often you will see 6 – 12 teams participate in a Learning Collaborative. Each team might have 3 – 6 clinicians plus supervisor(s). Each clinician would start doing treat to target with a few clients in week one; share experiences early in week 2 and decide whether everything is working okay or not; if okay, decide whether they can add a few more clients in week 3 or whether they need to change something in the process before they add more clients; etc. It's often preferable to have a single team at an agency with a single supervisor making up the team. This also may not be possible and a Plan B would be invoked (members from 2 or 3 clinical teams).
- **Populations:** One of the first tasks of each Learning Collaborative Team is to develop their aims. This includes identifying the population they will be working with. This will partially depend on who the early adopter teams are. For this project we should consider leaving this decision to the provider organizations and, hopefully, they will come back with a mix of populations/ages so that we can learn about how treat to target works for different populations.
- **Teaching Methods:** The change package includes detailed curriculum and the training occurs through the kick-off and pre-work activities, learning sessions, and action periods with the support of coaches. The learning concepts are sequenced and doled out in digestible quantities, and include learnings around how to do outcomes based care with the tools, how to measure progress, and how to revise what you're doing each week.
- **IT:** We need to make sure that the IT infrastructure doesn't delay the project. We should assess what we have and then develop workarounds. Working with small groups of clinicians and small groups of clients in Phase 1 allows this to occur, giving us time for create a proper IT infrastructure if it's not already available.

## Appendix A: Outcomes-Based Initiative Resources

Further information on each improvement project can be found at the following links.

**The National Council for Behavioral Health's Behavioral Health Center of Excellence (BHCOE) initiative**

https://www.thenationalcouncil.org/conference-365/category/behavioral-health-centers-of-excellence/

**The University of Washington AIMS Center's Mental Health Improvement Program (MHIP)**

http://aims.uw.edu/

**The California Institute for Mental Health's Advancing Recovery Collaborative**

http://www.cimh.org/advancing-recovery-collaborative-arc

(Please contact Dale Jarvis at dale@djconsult.net for additional information.

**Group Health and the University of Washington's Collaborative Care TEAMcare model**

http://www.ncbi.nlm.nih.gov/pubmed/22230825

http://www.grouphealthresearch.org/faculty/profiles/lin.aspx

**Institute for Healthcare Improvement's Breakthrough Series Model for Improvement**

http://www.ihi.org/resources/Pages/IHIWhitePapers/TheBreakthroughSeriesIHIsCollaborativeModelforAchievingBreakthroughImprovement.aspx

**The NIATx Model of process improvement for behavioral health settings**

http://www.niatx.net/Home/Home.aspx

**The National Council for Behavioral Health's Learning Community Model**

http://www.thenationalcouncil.org/consulting-best-practices/practice-improvement-initiatives/