

# *Improving the Performance Curve ~ Winter 2007*

*Newsletter of the*



**Institute for  
Behavioral  
Healthcare  
Improvement**

***Improving the Performance Curve  
in Behavioral Healthcare***

[www.ibhcci.org](http://www.ibhcci.org)

Dear Friends and Colleagues:

IBHI passed its first anniversary and is pleased to report positive momentum in the effort to spread and accelerate the application of quality improvement culture and method in behavioral health care. In the last four months we have gathered “change agents” in two colloquiums for Behavioral Healthcare leaders. With the Institute for Healthcare Improvement, (IHI) IBHI also organized and co-hosted a Behavioral Healthcare Track at the Annual IHI Forum, December 10-13, 2007 in Orlando, FL.

**IBHI 's Aim Is: To dramatically improve behavioral health care outcomes by creating a high performing national learning organization that invites organizations out of their historical silos. IBHI seeks to encourage a movement that translates a passion for quality improvement into sustained action**

In 2007 initiatives are planned in three areas:

- Improving care of behavioral health clients in emergency departments;
- Improving behavioral health care for children and adolescents; and
- Improving leadership and integration of behavioral health.

Future learning and collaborative efforts in these areas are described below with links to references on our web site, [www.ibhcci.org](http://www.ibhcci.org) . Like most of us with more than a “full plate” of activities, we have often asked “Is there more?” And we have to acknowledge that the recent NASMHPD report on the disparity in early death, some 25 or more years of life lost, for sufferers of serious mental illness places our objectives in a much more urgent context, given the scale of the problem facing the severely mentally ill.

This revelation is only the latest and clearest indication of the problem, and it is as scandalous as the IOM reports on deaths and injuries in hospitals published with several related “Quality Chasm” Reports over the last 5 years. History records that it took over 200 years for the industry to respond to the “scandal”. We are hopeful that this gap in time between knowing and doing does not occur in Behavioral Health care. And then as noted in our guest editorial, we are all asked, what to do with a full plate? We would welcome feedback and insights as you have time. Thanks very much,

Alden T. “Joe” Doolittle  
Co-Executive Director

Peter C. Brown  
Co-Executive Director

*Dear Readers: We welcome your expressions of opinion as well. Write to us.*

## **Action Items Update and Plans**

### **Action Item: Improving behavioral health care for children and adolescents;**

IBHI is pleased to co-sponsor a **Designing Bridges to Cross the Quality Chasm for Child and Family Mental Health, Hyatt Regency, San Francisco, CA, March 19, 2007**, The Exploratorium will bring together professionals concerned with Children's mental health care to share knowledge, hear and generate new ideas and build will to re-design care. While early promising attempts will be reviewed, the intent is to build on these examples through inter-active sessions and target new insights and approaches for testing in practice. Keynote speaker is John Lyons, Ph.D. Director of the Mental Health Policy Program and Professor, Northwestern University. The Exploratorium Children will give leaders at both the policy, practice and operational levels solid references, and hopefully lead to further collaborative learning efforts.

**Don't miss the NICHQ/IBHI Exploratorium: Designing Bridges to Cross the Quality Chasm for Child and Family Mental Health, San Francisco, CA, March 19, 2007. For more information [www.nichq.org](http://www.nichq.org) <<http://www.nichq.org/> .**

### **Action Item: Improving care of behavioral health clients in emergency departments**

**AIM: To create a learning community to Improve Operational and Clinical outcomes for persons suffering mental illness and substance use cared for in the Hospital Emergency Department.**

The Hospital Emergency Department (ED) is where all the difficult and disconnected parts of the healthcare "system" become more visible. And for persons suffering mental or substance use problems (M/SU) the ED is also where other links to social, family and legal systems are often strained, as well as those between treating professionals. These factors combine to create waste, compromise clinical outcomes, and further stress the all people in the system including clients. Often systems to support BHC patients have been designed ad hoc or by organizational fiat, and have gaps. Appropriate, measurable system design or redesign efforts are few, and the results not widely deployed. Getting better care for behavioral health clients in the emergency department is a key first step to dealing with many of the issues of improving behavioral health outcomes in general.

The phenomenon is confounded by frequent presentations of co-morbidities, and the absence of adequate inpatient or referral resources. Problems are reported in facilities with discrete Psychiatric Emergency Rooms or services, as well as, acute general hospitals. It has been observed that care of acute and primary care patients in the ER can be improved by steps taken to improve care of M/SU patients and visa versa.

One successful strategy for approaching this challenge, further outlined in several reports by the Institute of Medicine, is the Learning Collaborative, developed through the Institute for Healthcare Improvement, (IHI)The Center for Health Care Strategies (CHCS) and others. With consultative assistance, IBHI proposes to create a learning collaborative and assist the collaborative as a method within Behavioral Healthcare community, for spread of the quality improvement methodology. Our goal is to hold the orientation session/kick off for the **ED collaborative in October, 2007.**

#### **Progress and Key Benchmarks: Emergency Room Collaborative**

To date we have confirmed the need to address the issue with leaders in major health systems. By March, 2007 IBHI will have identified and a Panel of Experts to assist in developing the change package and guide the Collaborative, We anticipate finalizing and testing the change

package by July 1<sup>st</sup>. Recruitment of participants will begin on March 31<sup>st</sup>, Please contact us with your thoughts with refinements on the need, potential noteworthy practices that work ,elements in the change package, and potential elements in the change package.

### **Action Item: Improving leadership and integration of behavioral health.**

In December, 2007, IBHI hosted a Colloquium, “**Behavioral HealthCare Specific Integration and Collaboration: Sharing Public and Private Examples to Meet the Challenges**” as part of the IHI Forum in Orlando, FL. The day-long program brought together leaders from the RWJ Depression in Primary Care Program, and Public and Private providers and payers to share approaches and best practices. There were echoes present of earlier session particularly one co-hosted in October with Health Partners; where in response to the challenges of the IOM Crossing the Quality Chasm in Behavioral Health Care the consensus was that the differentiation between Behavioral (M/SU) and general health care should be less define, and more integrated. Said one CEO “This is all health care!”. The issue of integration and removing the silos between care sources was reinforced by presenters from Kaiser-Permanente who noted:

- De facto, the mental health system in the US is primary medical care
- Nearly half of all MH care is delivered thru primary care
- Studies show those with diagnosable MH disorder seek no MH care from any professional but 80% will visit their primary care physician.
- Many of the most common physical complaints in primary care result in no diagnosable organic etiology
- Non-psychiatric physicians prescribe approx 75% of all psychotropic agents.

Approaches to deal with this reality, included closely integrated systems like Kaiser, Public based systems within large and medium metropolitan communities. Approaches which worked say primary care staff placed within community mental health programs and mental health professionals housed within primary care. Important connective elements of shared medical records and using implementation of electronic records as a pathway were also described. A summary along with overheads of the Colloquium is available on the IBHI web site [www.ibhci.org](http://www.ibhci.org).

### **News Items**

#### **National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council October 2006**

“It has been known for several years that persons with serious mental illness die younger than the general population. However, recent evidence reveals that the rate of serious morbidity (illness) and mortality (death) in this population has accelerated.

***In fact, persons with serious mental illness (SEMI) are now dying 25 years earlier than the general population.***

Their increased morbidity and mortality are largely due to treatable medical conditions that are caused by modifiable risk factors such as smoking, obesity, substance abuse, and inadequate access to medical care.”

[http://www.nasmhpd.org/general\\_files/publications/med\\_directors\\_pubs/Technical%20Report%20on%20Morbidity%20and%20Mortality%20-%20Final%2011-06.pdf](http://www.nasmhpd.org/general_files/publications/med_directors_pubs/Technical%20Report%20on%20Morbidity%20and%20Mortality%20-%20Final%2011-06.pdf)

#### **ECT study**

#### **The Cognitive Effects of Electroconvulsive Therapy in Community Settings**

Harold A Sackeim<sup>1,2,3</sup>, Joan Prudic<sup>1,2</sup>, Rice Fuller<sup>4</sup>, John Keilp<sup>2,5</sup>, Philip W Lavori<sup>6</sup> and Mark Olfson<sup>2,7</sup>

<http://www.nature.com/npp/journal/v32/n1/full/1301180a.html>

Despite ongoing controversy, there has never been a large-scale, prospective study of the cognitive effects of electroconvulsive therapy (ECT). The authors conducted a prospective, naturalistic, longitudinal study of clinical and cognitive outcomes in patients with major depression treated at seven facilities in the New York City metropolitan area. Of 751 patients referred for ECT with a provisional diagnosis of a depressive disorder, 347 patients were eligible and participated in at least one post-ECT outcome evaluation. The study found in part “choice of electrode placement is critical in determining the severity of long-term (cognitive) deficits. Finally, there was considerable variability within some sites in ECT technique, such as choice of waveform and electrode placement. Site differences in cognitive outcomes dissipated when controlling for treatment technique factors. Regardless, this study provides the first evidence in a large, prospective sample that adverse cognitive effects can persist for an extended period, and that they characterize routine treatment with ECT in community settings.

NCQA Press Release on lack of quality improvement : THE STATE OF HEALTH CARE QUALITY 2006 NATIONAL COMMITTEE FOR QUALITY ASSURANCE WASHINGTON, D.C. September 27, 2006

“There are, however, disturbing exceptions to this pattern of improvement. The quality of care for Americans with mental health problems remains as poor today as it was several years ago. Patients on antidepressant medication are about as likely to receive appropriate care today as they were in 1999 (Figure 5). Similarly, patients hospitalized for mental illness are only marginally more likely to receive appropriate follow-up care. Given the huge economic and societal toll of untreated or inadequately treated mental illness, new approaches must be developed to bring mental health care quality to the level of clinical effectiveness that evidence shows to be possible.”

[http://www.ncqa.org/Communications/SOHC2006/SOHC\\_2006.pdf](http://www.ncqa.org/Communications/SOHC2006/SOHC_2006.pdf)

#### **Upcoming events: Calendar**

- MHCA: Winter meeting guest Feb 20-22 –Orlando
- ACBHA meeting Santa Fe, NM, March 15-16, 2007
- NCCBH Collaboratives March 26, 28 Las Vegas
- Board meeting March 28-29, Las Vegas  
1:45 PM –5:00 PM;/ 8:00AM-12:00 PM
- MHCA: Summer meeting program May 29-31<sup>st</sup>-Pittsburgh
- Ann Arbor June 15-16: Integration of Care
- IHI Annual Forum Dec 9-12

**Share a *Passion for Improvement*; Accept the invitation and Join IBHI !** Membership in IBHI is open to any person or organizations interested in development of quality improvement in the outcomes of mental and substance use treatment, and the integration of special and general health care services.

#### **Benefits of Membership in IBHI**

Shared passion, leadership support and participation with others in the development of quality improvement efforts; Reduced cost for IBHI portion of the Behavioral Healthcare Program at the IHI Forum; Free participation in monthly IBHI “Performance-Curve” calls; Newsletters; Frequent alerts to policy initiatives.

## Membership Categories

Given these benefits, the following is offered as Membership Categories for the current period through December 31, 2007. **Charter memberships** extend through the program year ending June 30, 2008, and recognize a contribution to start-up, with continuing membership thereafter at Regular or Sustaining levels\*\*.

Membership Categories	Dues Guidelines *	
	Regular	Charter **
Individual	\$100	\$495
Organizational	\$2,500	\$5,000

**\* Guidelines are suggested, recognizing the significant variation in size and scale. Smaller and larger organizations will be considered individually**

Please fill out the form below and send the form and your membership check (made out to "Institute for Behavioral Healthcare Improvement") to:

Institute for Behavioral Healthcare Improvement  
18 Clove Road  
Castleton, New York 12033

Name	<input type="text"/>
Degrees	<input type="text"/>
Job Title	<input type="text"/>
Organization	<input type="text"/>
Street Address	<input type="text"/>
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State	<input type="text"/>
ZIP code	<input type="text"/>
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