How to Accomplish Practice Change in Behavioral Healthcare in Less Than One Year

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ABSTRACT:

This a challenging time in the field of public mental health. State and federal funding for public behavioral healthcare is declining in a time when the demand for services is increasing. Philosophical changes in mental health care service delivery, underscored by the tenants from the President's New Freedom Commission on Mental Health, are creating additional challenges for practitioners. The Adult Network of Pikes Peak Mental Health (PPMH) has developed a model for providing behavioral healthcare that meets these challenges while providing greater access to care, holistic care delivered in natural settings and, at the same time, maintaining the quality clinical outcomes at reduced costs.

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Background

For more than six years this community mental health center in Colorado Springs tried to convert its traditional behavioral healthcare system to a Recovery oriented system. Three different directors had tried and failed to accomplish this. Like many mental health centers, staff knew the language of recovery, they could talk the talk, but the elements of practice that would define a Recovery oriented system of care were never implemented. As Jacobson and Curtis (2000) point out: Some states simply rename their existing programs, failing to acknowledge the necessity for a fundamental shift toward sharing both power and responsibility[1]. The stakes for accomplishing this change were increasing exponentially. Soon, incentives would be based upon the recovery oriented performance measures for community mental health; funding for the severe and persistently mentally ill (SPMI) was decreased 30% over a two year period with further cuts expected; and accountability expectations were facing the public mental health field across the nation, with numerous centers closing or being privatized or outsourced[2]. Time was running short.

Our task was:

1. To define, develop and implement a service delivery model congruent with recovery principles;
2. To improve access to care from 40 days (time to first appointment) to within 7 days;

[1] Jacobson and Curtis. (2000) Psychiatric Rehabilitation Journal p. 335
[2] David Lloyd (2002). How to Deliver Accountable Care

3. To increase staff productivity from 46% to 60%;
4. To reduce the no show rate from 30% to 10%;
5. To serve more consumers with fewer dollars without a reduction in the quality of outcomes; and
6. To improve staff job satisfaction from 2.1 to 3.0 on a 4.0 scale.

We achieved these results as identified in the table below. T tests and chi square tests of selected data found the changes to be statistically significant at $p \leq .01$ levels. The story that follows is how we accomplished all of this in less than one year.

COMPARISON 2002 AND 2003 PERFORMANCE METRICS

Metric	2002	2003
Ave. time to 1st appt	40 days	2 days
Consumers active in consumer driven services	15 people	92 people
Cost to serve individuals with severe and persistent mental illness (SPMI)	74% received >$500 of services / year	61% received >$500 of services / year
Clinical productivity	48%	65%
Staff satisfaction	2.3 on a 4.0 scale	3.5 on a 4.0 scale
Average length of stay	1936 days	1840 days
Average cost of services / year	$385	$237
No show rate for ongoing appts.	33%	13%

The Transformation Process

New management was brought in with competency in change management. The Network Director spearheaded sweeping changes in accountability, service delivery systems, philosophy of care and team cohesion. One of the key principles in this change process was the belief that the staff who had been serving individuals with severe and persistent mental illness for 10-20 years had deep expertise regarding the needs of this population. Their expertise was valued, respected and integral to determining both what needed to be done and how it could be accomplished given the corporate culture. Thus, the first steps in bringing this organization to a new level of performance was to form focus groups of consumers and staff to identify what was working and what was not, and to generate ideas regarding what needed to be done in order to improve care, improve morale and be more productive and cost efficient.

This project had unwavering support from the Change Champions, our CEO and COO, and followed the change management best practices as defined by Daryl Connor (1995). Connor defines seven elements as critical in order to orchestrate a change initiative that achieves the desired outcomes:

- Burning Platform
- Project Champion

- Stakeholder Buy In
- Expectation Setting
- Incentivizing Change
- Marketing and Communication
- Project Planning

These elements guided the change process and provided the leadership team the vision they needed to stay on course during the change process.

The focus groups produced a well-defined model for the needs of consumers at various stages in their recovery based upon the Ohio Department of Mental Health (ODMH) consumer outcomes initiative[3] The research from ODMH identified the stages of recovery, the needs of consumers and the roles of providers during these different stages. While this model was widely publicized, there was no known model identifying what programming should look like based upon the ODMH research. The Adult Network designed our continuum of care based upon dose response studies in traditional care settings and redefined these for application to a stepped care model of treatment based upon Recovery Model principles.

Philosophical Changes

The Recovery Model: Tighter financial constraints occurred with capitated funding for mental health in the 1980's. This began a period of increasing accountability for monies spent in community mental health care service delivery. Not long after this, the best practice guidelines for treatment of SPMI began to recognize some changes in basic tenants away from a medical model of treatment to a recovery model[4].

1. Mental illness was no longer considered a terminal life sentence.
2. The provider was now viewed as a partner in care, not as directing treatment.
3. The treatment goal needed to be to help consumers develop meaningful roles in their communities, not to develop a long-term therapeutic relationship with the therapist.
4. Consumers would play a more active role in decision-making and responsibility for their recovery.
5. Delivering in-vivo care became the ideal, rather that treatment rendered within the mental health center
6. The importance of support systems, to include family, peers and community, became more and more central to attaining and maintaining recovery

All of these changes required a shift in philosophy and service delivery model for the Adult Network. How could we change an institution that had built its operational systems and business processes to support an office-based treatment delivery model to something that was much more dynamic?

[3] ODMH
[4] www.mh.state.oh.us/initiatives/outcomes/resrecovprinc.html

PHILOSOPHY CHANGES REQUIRED

RECOVERY PRINCIPLES	MEDICAL MODEL
Strength based	illness focused
doing with	doing for
integrated team	individual provider
graduated disengagement	long term therapy relationship
case management	50 minute hours
community based	clinic based
present focused	focus on past traumas

The Service Delivery Model

The ODMH four-stage model of recovery - engagement / motivation / commitment / recovery & rehabilitation - became the philosophical basis for our programming. Four different types of service systems based upon evidenced-based treatment protocols were designed to be congruent with the differing needs of consumers at each stage. These treatment options were aligned with the four stages of recovery defined by ODMH.

1. Engagement: The CORE program (**C**ommunity **O**utreach **R**ecovery and **E**ngagement) was designed around the needs of consumers at this bottoming-out stage of recovery. The assertive community treatment model was identified as the most appropriate for this level of care. Intensive case management of individuals who did not acknowledge their mental illness or who were resistive to treatment in a traditional setting were served by the CORE team.
2. Motivation: The Discovery team created a psychosocial rehabilitation model for consumers at this level of care. Consumers served by this team did not yet have the support systems in place to help them buffer routine life challenges and did not yet have confidence in the providers or themselves in terms of the ability or commitment to setting and attaining realistic goals. Therefore, community-based case management and psychoeducational groups became the model for treatment at this stage.
3. Commitment: The Passages team was designed to support the recovery process for consumers at this stage. Individuals served through this team received more standard in-clinic treatment such as cognitive behavioral therapy and dialectical behavioral group therapy. Individuals at this stage of recovery were not expected to require a significant amount of case management and would be able to keep regularly scheduled appointments.
4. Recovery and rehabilitation (medication-only treatment status): Individuals at this stage are fairly well integrated into the community and have adopted a life-long approach to wellness. They receive medication evaluations and may participate in the consumer driven clubhouse or drop-in groups at the mental health center.

Community Integration

We developed a task force to seek out opportunities for our staff to work with consumers in their communities and ways to create liaisons with other community agencies. We received great corporate support from our community which is helping to break down stigma about mental illness.

We designed a new intake model that allowed consumers to be scheduled within two days. We implemented an electronic transfer system that created more fluidity for consumers to move within the different levels of care, and we increased our available group programs to provide more options for skill building, developing support systems and problem solving. Consumers were encouraged to take our core curriculum, Recovery 101, to help understand illness management and recovery principles and their role in the recovery process.

All of these service changes required new performance-based job descriptions so that staff would know what their expectations were within this new system of care and so that we could identify any new skill sets that we would need to develop to accomplish this new service model.

Facing the Hardest Challenges

Internal resistance: The new model was presented to the executive team of the mental health center. The reaction was: "This is a great model, but we can't do it because it would change the whole way we do business." In response to this, the CEO exercised his Change Champion role by responding: "We *will* implement this model, and it is the role of the business systems to support the service delivery model, not to drive it." And so we proceeded to tackle the biggest challenge of all: How to get a bifurcated system (clinical versus operational) to align with a new service delivery structure.

Infrastructure Changes

A year-long focus group at the Colorado State Mental Health Services division examined best practice in providing evidenced-based care concluded: "We don't know how to execute practice change." Well, at PPMH we do; and we have done it; and it works. Our challenges were:

CHALLENGES

System	Existing State	Desired State
Admissions	Individually scheduled appts. with 50% no show rate and 40 days out	Intake clinic model with 2 days to first appointment
Medical records	Request charts only two times per day	Records available on demand
Appointment scheduling	Set by central scheduling	Dynamically set by providers
Groups	Only preassigned	Drop-in groups to meet dynamic needs of consumers
Reports	Standardized reports for measuring all clinical performance metrics	Tailored reports with targets for each different type of service delivery system

System	Existing State	Desired State
Human Resources	Standardized job descriptions for all clinicians	New performance-based job descriptions built upon different competencies required in each program
Information Systems	Programmed to support 8 teams, individual primary therapist model	Reprogrammed to delineate 4 teams and a therapeutic team treatment concept
Transfers of clinical responsibilities for cases between teams or between clinicians	A manual system with centralized control that takes weeks	Electronic transfer systems managed at the local level that takes minutes

Change Model:

According to best practice guidelines for change management, the following principles need to be kept in mind:

- The #1 contributor to project success is strong, visible and effective sponsorship.
- The top obstacle to successful change is employee resistance at all levels: frontline, middle managers, and senior managers.
- Employees want to hear messages about change from two people: the CEO or their immediate supervisor (and these messages are not the same).
- When asked what they would do differently next time, most teams would begin their change management activities earlier in their next project, instead of viewing it as an add-on or afterthought.
- The top reasons for employee resistance are a lack of awareness about the change, comfort with the ways things are and fear of the unknown. Middle managers resist change because of fear of losing control and overload of current tasks and responsibilities[5].

Key to success in accomplishing change at PPMH was recognizing the importance of the executive champion, involving stakeholders from the grass roots level, developing a common language about the changes and putting into place systems to reinforce the changes. It is also important to provide an incentive system to ensure that changes implemented take root, thus, we developed a variety of additional tools to help maintain the changes implemented.

Maintaining Change

Performance-based job descriptions: Performance management requires clear communication about job role expectations. We invested time with our staff to define those skill sets that were essential to being effective in our new team structure and service delivery model. Frontline staff participated in defining those traits that they wanted in their teammates, and management developed the performance targets and required skill sets for each service delivery type. All of these were incorporated into performance-based job descriptions that are tailored for each position. Supervisors use these as a tool in individual supervision sessions, and managers view aggregated data on a monthly basis to ensure that each service delivery unit with fidelity to the treatment model.

[5] http://www.prosci.com/benchmark.htm

Performance data reporting: In an organization that had only measured productivity based upon self-reported numbers of clients seen, we realized we needed reliable, valid measures of the impact of our changes on both productivity and clinical outcomes. We had to develop new reports and generate buy-in for management by data. Accountable care was an unfamiliar concept to staff and one that was quite scary at first. It took nine months of working with our report writers and having staff scrub the data until we developed reports that were accurate and useful to staff. They now clearly can view their own performance compared to goals. These reports help staff stay on target for caseload management, which is critical to providing quality care.

Developing staff incentives on a shoestring budget: One of the basic tenants in performance management is to reward those behaviors you wish to see maintained. Doing that on the typical community mental health budget has always been challenging, and this last fiscal year even more so. Our staff generated a list of low budget rewards that helped to bond us as a community and recognize individuals who met performance targets.

INCENTIVES ON A SHOESTRING

Incentive Program	Eligibility
Pancake breakfast served by management	Everyone could attend
Training dollars awarded to those who met performance metrics	Meeting 100% of performance targets
A special office supply product	Meeting minimum performance standards
Day off with pay to top two performers	Two highest scorers on annual performance evaluations
Summer perk of time off: four 9 hour days and every other Friday off	Meeting 100% of performance targets
Breakfast brought to your door by the boss	Meeting minimum performance standards

Such efforts generated levity while at the same time underscoring the value of staying true to our performance goals. The most privileged benefits, i.e., time off and professional development funding, were reserved for those who demonstrated the strongest commitment to the goals of the organization in serving consumers. The community celebrations shared by all helped builds cohesiveness and a stronger sense of shared joy and spirit.

Outcomes

While budget cuts have required us to cut staff and some services, such as transportation, we have seen morale rise and consumer satisfaction increase. This is a testimony to believing in the wisdom of those on the frontline and providing them with the support and resources they need to do their job. There are three statements that capture the heart of what we have accomplished here: one from a consumer, one from clinical staff and one from support staff. These are a testament to our success.

On the day of the launch of our Recovery Model, one of the consumers who was beginning her first day with the Discovery Team sat in the waiting room and said:

> "I feel so important now; look at all the things I can choose from."

One of our veteran clinical staff said recently:

> "These are the good times now."

One support staff that had been with the network nine years said:

> "This is the most fun I have had in my nine years with the Center."

Change can revitalize us even in these trying times.

References

Beer, M., & Nohra, N., (2000). *Cracking the Code of Change.* Harvard Business Review 78(3), 32-144.

Connor, D.R., (1992). *Managing at the Speed of Change.* New York: Villard Books.

http://www.mhrecovery.com/ (Ohio Dept of Mental Health)

http://www.prosci.com/benchmark.htm

http://www.state.h.us/initiatives/outcomes/resrecovprinc.html

Jacobson, N & Curtis L (2000). *Recovery as a Policy in Mental Health Services: Strategies Emerging Form the States.* Psychiatric Rehabilitation Journal 23(4), 333-341.

Lloyd, D. *How to Deliver Accountable Care.* (2002)