International Journal of Mental Health, vol. 34, no. 1, Srping 2005, pp. 72–89.

ISSN 0020–7411 / 2005 $9.50 + 0.00.

ALLEN DANIELS, NEAL ADAMS, AND
RICHARD DOUGHERTY

Crossing the Quality Chasm

Reforming Behavioral Health Services Through Community Collaborations

ABSTRACT: *Recent reports, including the Institute of Medicine's (IOM)* Crossing the Quality Chasm *[1] and the President's New Freedom Commission's (NFC)* Achieving the Promise: Transforming Mental Health in America *[2], raise serious concerns about the state of health and mental health-care delivery systems in the United States. Both reports call not just for systems reform but instead for a more profound transformation. Although the IOM report brings forward a renewed definition of health care quality that includes six core aims and ten operational rules and the NFC identifies mental health system change goals, neither report lays out a clear and direct strategy for effecting large systems change.*

There is increasing evidence that achieving such profound systems change will require the development of a set of strategies and change management tools that focus on priority concerns, attend to cross-cutting issues and domains of change, and are applied through locally organized and activated community collaborations and coalitions. Although this approach has met with some success in many medical specialty areas, there are only a few examples of its success in behavioral health. Certainly none have attempted to create transformation on such a large scale.

The involvement of stakeholders across all levels of the system—consumers, providers, administrators and policy makers—is critical for a coalition's success.

Allen Daniels, Ed.D., is a Professor of Clinical Psychiatry at the University of Cincinnati; Neal Adams, MD, MPH, is with the California Department of Mental Health; and Richard Dougherty, Ph.D., is the president of Dougherty Management Associates, Inc. Correspondence to: Allen Daniels, Ed.D., Medical Arts Building, University of Cincinnati, 222 Piedmont Avenue #8800, Cincinnati, OH 45219; tel.: 513-475-7606; e-mail: danielas@ucmail.uc.edu.

Together these constituents must identify their separate and shared interests in attaining the quality aims and identify how new rules can be applied to direct systems change toward identified goals. Through training in the use and development of community-learning collaboratives, the "wheels of change" can be put in motion simultaneously in many sites across a state, region, or country. There is much to suggest that the IOM's new paradigm for quality, the NFC's goals, and the process of community-learning collaboratives can be successfully employed as tools for change not only in the United States but also in other developed countries with mature but stagnant and fragmented mental health delivery systems.

Background

The Institute of Medicine (IOM) has clearly established that the American health-care system is in a serious state of disrepair and in need of transformation [1]. The full extent of the problems with the U.S. health-care service delivery system is outlined in a series of IOM reports that consider the components of medical safety [3], quality of care [1], performance measurement [4], quality improvement [5], and workforce capacity [6–7]. Together these reports clearly establish that (a) the quality of care is well below the standard that the U.S. population expects and deserves, and (b) the sources of the problems are not a lack of goodwill or good intention but rather can be found in the fundamental construction of our health-care system. In response, the IOM has advocated the strategic redesign of this structure and many components of the system.

In general, these IOM reports focus on the physical health systems that include primary and specialty care and pharmacy. The unique issues and problems related to the prevention and treatment of mental illness and substance use disorders have not been specifically examined by the IOM beyond the inclusion of depression and serious and persistent mental illness in the report on priority areas for quality improvement [5–6]. Regardless, the work that has been advanced by the IOM strongly supports the notion that health-care delivery system improvements are best accomplished at a community level and informed and supported by a larger policy and systems infrastructure.

In the spring of 2004, the IOM began an 18-month study to examine the possible adaptation and application of the *Quality Chasm* report [1] for the behavioral health field. The charge for this project is to create a blueprint for the strategic redesign of the behavioral health field. The IOM report is due to be released in late 2005 and should provide additional insight into the transformation that is needed for behavioral health care.

The IOM behavioral health study is particularly relevant and timely in light of the 2003 report from the President's Mental Health New Freedom Commission (NFC) [2], which also called for sweeping change if not radical transformation of the mental health system. The NFC's report on the current state of publicly funded behavioral health care in the United States concluded that the mental health sys-

tem is "in shambles": highly fragmented, often ineffective and all too frequently unresponsive to needs of individuals and families seeking help. As a result, the mental health system suffers from its own unnecessary and costly problems that include persistent stigma and discrimination, treatment failures, disability, homelessness, failures in school, and unnecessary incarceration. Particular gaps exist in care for children with severe emotional disturbances and adults with severe and persistent mental illness, a lack of access to age appropriate services for older adults, and a failure to identify suicide prevention as a national priority.

The NFC identified six essential goals to be achieved in a transformation of the behavioral health-care system. These include:

1. Americans understand that mental health is essential for overall health;
2. Mental health is consumer and family driven;
3. Disparities in mental health services are eliminated;
4. Early mental health screening assessment and referral services are common practice;
5. Excellent mental health care is delivered and research is accelerated; and
6. Technology is used to access mental health care and information.

Each of these goals was further delineated by a series of somewhat more focused and specific objectives. The report and its recommendations have been generally well received by the full breadth of stakeholders in the mental health sector.

Although the NFC provides a useful assessment of the problems associated with the public behavioral health system and identifies a set of important and potentially attainable goals, it fails to lay out any sort of consistent blueprint for the reform of these systems. Although it does provide key goals for behavioral health care, the report and its recommendations lack the tools to direct that change. The roadmap to get from here to there is strikingly absent. There is nothing included to suggest or indicate how the necessary transformation is to be achieved.

If major systems reform is to be realized, a process for planning and implementing strategic change in multiple sites and across health-care delivery systems is clearly needed; there should be a definition of quality and aims as well as a set of guiding principles applicable to complex systems. In addition, models for engaging all levels of the system in any change process are also needed. Taken together, the IOM's *Quality Chasm* series reports [1, 3, 5–7] and the NFC report [2] are complementary pieces that may begin to provide the framework and tools needed to initiate and direct the profound change and transformation that has been recommended [8].

The *Quality Chasm* report [1] effectively redefines prior models for considering health-care quality and proposes that there are six key aims or core values for health services. Care should be experienced as being:

- Safe
- Effective
- Person-centered

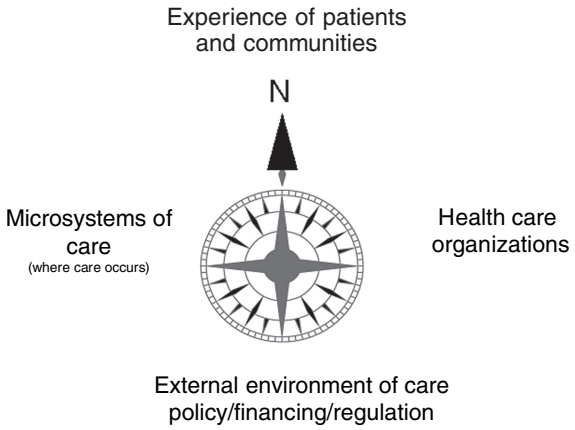
- Timely
- Efficient
- Equitable

Together these aims provide an interrelated set of overarching values and objectives that must be embedded in any systems change. They are an alternative to the prevailing paradigm for defining health care quality simply in terms of structure, process and outcome as first developed by Donabedian [9]. The IOM aims offer an opportunity for rethinking goals, objectives and strategies in the pursuit of system improvement.

In addition to the six aims, the IOM also brought forward ten relatively simple rules to guide the basic operations of a new or transformed health-care delivery system. These rules include the following principles:

1. *Care is based on continuous healing relationships.* Patients should receive care whenever they need it and in many forms, not just face-to-face visits. This implies that the health care system must be responsive at all times and access to care should be provided over the Internet, by telephone, and by other means in addition to in-person visits.
2. *Care is customized according to patient needs and values.* The system should be designed to meet the most common types of needs but should also have the capability to respond to individual patient choices and preferences.
3. *The patient is the source of control.* Patients should be given the necessary information and opportunity to exercise the degree of control they choose over health care decisions that affect them. The system should be able to accommodate differences in patient preferences, encourage shared decision making and be person-centered (i.e. driven by the preferences, choice, and values of the recipient of care).
4. *Knowledge is shared and information flows freely.* Patients should have unfettered access to their own medical information and to clinical knowledge. Clinicians and patients should communicate effectively and share information.
5. *Decision making is evidence based.* Patients should receive care based on the best available scientific knowledge. Care should not vary illogically from clinician to clinician or from place to place.
6. *Safety is a system property.* Patients should be safe from injury caused by the care system. Reducing risk and ensuring safety require greater attention to systems that help prevent and mitigate errors.
7. *Transparency is necessary.* The system should make available to patients and their families information that enables them to make informed decisions when selecting a health plan, hospital, or clinical practice or when choosing among alternative treatments. This should include information describing the system's performance on safety, evidence-based practice, and patient satisfaction.
8. *Needs are anticipated.* The system should anticipate patient needs rather than simply react to events.

Figure 1. **Experience of Patients and Communities as True North**



Source: A.S. Daniels & N. Adams, *From policy to service: A quality vision for behavioral health using the New Freedom Commission Reports as a framework for change* (Pittsburgh: American College of Mental Health Administration, 2004).

9. *Waste is continuously decreased.* The system should not waste resources, including the patient's or provider's time.
10. *Cooperation among clinicians is a priority.* Clinicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care.

The IOM has further suggested that opportunities for transformation in health care should be focused on significant changes in four principal areas. These include the financing of health care, the deployment and integration of information technology, the availability and competency of the workforce, and the consistent application of evidence-based care. Building on the *Quality Chasm* report [1], Berwick [10] has described the four conceptual levels of organization within the health-care delivery system. The levels can be defined in part by the concerns, perspectives, and experience of the stakeholders at each level and their influence on health services. These include:

1. The experience of patients, families and communities;
2. Providers and microsystems of care—the smaller units and settings where health care is provided;
3. Administrators and managers at the level of organized macro-systems of care; and
4. Policy makers, government agents, employers, and purchasers who determine the larger health care environment, including the social and political influences on systems of care.

Berwick [10] argues that in navigating a course for change a compass is required. He emphasizes the experience of patients, families and communities must always be true north and set the compass.

Complex Adaptive Systems

The IOM rules are consistent with the notion that health-care systems need to be viewed as complex systems that are naturally adaptive. Historically, particularly in the public sector, there has been a tendency to take a more controlling approach to health-care systems change: The expectation has been that specific and targeted interventions would directly produce intended and expected change. Although the extreme of "Anarchy and Chaos" in Figure 2 is for the most part to be avoided, efforts to date at tight "Control" have not yielded the desired outcomes of system transformation. Moreover, all too often attempts at systems change have produced no results; even worse, unintended consequences have lead to frustration and dismay about our ability to achieve much needed quality-driven reform. This suggests that learning to be more comfortable with risk and using the rules to guide change efforts through the zone of complexity may be the best approach to fostering necessary change.

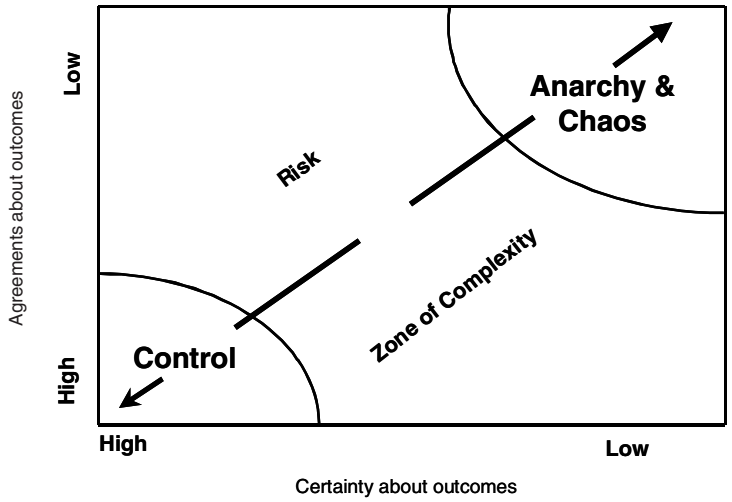
If the health-care delivery system is viewed as a complex adaptive system, then the importance of a small set of basic guidelines or rules to direct the system broadly and new strategies to create change consistent within this paradigm must be considered. We must learn new ways of facilitating change in the "Zone of Complexity" (see Figure 2). In these change efforts, relationships, feedback, and communication are central to success because they motivate, educate, and help to monitor the activities of the many people involved. This suggests new management models that maximize the opportunities for relationships, feedback, and communication to occur. These new models can provide an opportunity for change and may hold the key to successful quality driven transformation.

Challenges to Systems Changes in Behavioral Health Care

Although the mental health and substance abuse fields share many common attributes with the general health-care delivery system, there are also significant and fundamental differences that must be taken into account in any consideration of profound systems change. Some of these factors include:

- The scope and complexity of public behavioral health systems as compared to private systems;
- The divergence of public and private delivery systems based largely on the financial status, disability status, and diagnosis of the individuals served;
- The active involvement of consumers and family members in many levels of the system, from policy advocacy to individual service planning;
- The scope of multidisciplinary providers ranging from physicians and other

Figure 2. **Institute of Medicine's Zone of Complexity Outcomes**



Source: Institute of Medicine, *Crossing the quality chasm: A new health system for the 21st century* (Washington, DC: National Academy Press, 2001).

doctoral-level providers to a an array of masters-level specialists and a large cadre of paraprofessional providers;

- The relatively limited number of evidenced-based treatments in use across diverse communities and cultures;
- The unique and highly variable financing models for public behavioral health;
- The lack of parity in insurance benefits for behavioral health services aggravating problems of access and quality; and
- The challenges in coordination and linkage with general health care and the fragmentation caused by carve-out systems and complicated benefit programs.

Bishop and Dougherty [11] have noted the consistent calls for change in the behavioral health field and have compared the scope of the required transformation to the challenges of the Apollo program that took humans to the moon during the 1960s. They identified key success features of the Apollo program as (a) the development of a common vision among leaders, (b) motivating multiple project teams, and (c) active project management. Bishop and Dougherty argue that a similar vision and program focus may be necessary to achieve needed change in the behavioral health field with new approaches to managing change in complex systems.

In some respects, the mental health field may face even greater challenges than the Apollo program. Unlike NASA, the goals of mental health system transformation must be realized in 50 states plus territories, county and city behavioral health authorities, and private health plans, as well as commercial and public carve-outs

and carve-ins. The list of challenges could go on—it may be even more difficult than rocket science! Across all these sites there is the need for a unifying and organizing vision and, at the same time, a coherent, goal-directed, and accountable roadmap for change. Such a plan must appropriately allow for and support the need for local adaptation and implementation. The IOM's *Quality Chasm* report [1] and the NFC report [2] together have the potential to serve as that set of guiding principles and practical tools to facilitate the transformation that is so urgently needed.

Strategies for Change

The *Crossing the Quality Chasm* report [1] and subsequent IOM efforts have suggested that a small group of medical conditions should be identified for priority work on improving the quality of care. An initial set of 20 conditions were identified [6] based on the criteria of impact, improvability, and inclusiveness. From this group, a subset of five conditions was recommended as a starting point for evaluation and focus. These conditions included heart disease, diabetes, asthma, depression, and pain. The First Annual Priority Areas Summit was convened in 2004 to begin to address these conditions and to identify potential opportunities for improvement. In this meeting, 15 communities (defined by geographic location as well as by areas of interest) actively involved in quality improvement endeavors were brought together in an effort to begin to identify those factors critical to successful interventions [12].

The Priority Areas Summit [12] made clear the important role of communities and local, collaborative change efforts as an approach to improving health care delivery systems. In forming a coalition, key participants need to be identified and engaged in articulating common goals, objectives, and ways to measure progress. However, the most important factor in determining the success of coalitions may lie in the involvement of community leadership and activities that increase social connectedness and participation (i.e., social capital). Social capital refers to the institutions, relationships, and norms that shape the quality and quantity of a community. Increasing evidence shows that social cohesion/capital is critical for communities to prosper. Social capital is not just the sum of the institutions that underpin a community; it is the glue that holds them together.

Community-Based Collaboratives as a Strategy for Health Systems Change

Øvretveit and colleagues [13] note the increasing use of collaboratives for quality improvement in health care. In addition they note that strategic system change requires a consistent and stable mission or vision, clear goals, shared responsibility, and sufficient resources to effect the change. An examination of efforts in several different countries and settings has revealed ten principles that lead to suc-

cessful organization and implementation of community coalitions and successful change initiatives. These include the need to:

1. Select a relevant and compelling project or issue;
2. Ensure that participants define objectives and assess their capacity to benefit from the collaborative;
3. Provide clear definitions of roles and what is expected of participants;
4. Ensure appropriate preparation and team building for the collaborative;
5. Foster a mutual learning environment rather than just carrying out teaching;
6. Empower and motivate teams;
7. Articulate measurable and achievable goals for teams;
8. Assure that teams are equipped to deal with data and the challenges of change;
9. Provide postcollaborative learning opportunities and planning for how to sustain change; and
10. Learn about and planning for the dissemination of change.

The IOM's *Priority Areas* report [6] and subsequent quality summit [12] all point to and support the potentially significant role for communities to play in the improvement of behavioral health services. Building an effective community coalition to improve health services requires that all four levels of stakeholders, as described by Berwick [10], be brought together into a collaborative process. The recipients of care and their families, the direct service treatment teams and providers, the health care facilities and organizations, and the funders of care and their component community and political colleagues must all be active participants if success is to be realized.

The Institute for Healthcare Improvement has developed a model for this process in their *Breakthrough Collaborative* initiative [14]. Although this approach fosters a collaborative process, it also recognizes the importance of leadership to guide the participants through the change process. Their model for change is built on an effort to answer three central questions related to any challenge or change process:

- What are we trying to accomplish? (What is the goal?)
- How will we know when it is accomplished? (What are the objectives?)
- What changes can we make that will result in improvement? (What are the strategies?

The model also requires that the collaborative members participate in a series of plan-do-study-act cycles, a well-established quality improvement strategy, to direct progress toward their goals.

Although the development of a community collaborative approach has been well established in many medical specialty areas, it has generally not been fully developed in behavioral health. Some specific depression care initiatives have been successful at the community level, but these have been seriously challenged by a lack of both initial and ongoing funding [6]. The National Initiative for Children's Health Care Quality has used collaborative learning approaches to improve treat-

ment for children diagnosed with attention deficit and hyperactivity disorder. The Center for Health Care Strategies has used their Best Clinical and Administrative Practices on several behavioral health topics. The most extensive and far-reaching approach has been implemented with addiction treatment providers by the Network for the Improvement of Addiction Treatment (NIATx). Funded by the Robert Wood Johnson Foundation and Department of Health and Human Services' Substance Abuse and Mental Health Services Administration, NIATx recently added 13 new sites and uses learning collaboratives to improve access to and the quality of care in the various provider organizations.

A review of the components of a community collaborative provides a framework for examining how these may be used to improve behavioral health systems. First, it is important to distinguish community collaboratives from provider collaboratives (as in NIATx). One focuses the collaboration activities among providers within a specific community; the other involves providers from across the country working together to improve quality within their individual organizations. Community collaboratives can identify issues and develop solutions that are specific to each community and the specific health-care market in that community. Ideally, these health partnerships should involve collaborative efforts that focus on community connectedness and reliance as well as quality improvement in the delivery system and overall community health status. This helps to build a social infrastructure to sustain the project, a key component of social capital, and at the same time lays the groundwork for ongoing change and improvement.

There may also be potential value in a hybrid or combined model; several parallel collaborative efforts in individual/specific communities may come together to support, inform, and sustain each other. In other words, there can be a collaborative of community collaboratives. When large system mandates for change are in place, those groups and communities engaged in a change process can greatly benefit from sharing across collaboratives as well as within collaboratives. The structure and process of local collaborative efforts can be reflected in a larger systems level partnership—in some respects this depends on one's definition and scope of community.

Although each community has its own unique characteristics and attributes, some common features in the successful development of a community health partnership can be identified [15]. First, careful attention to the dynamics of change among organizations seems to be a critical factor that can have a significant impact on results. It is essential to identify an unbiased facilitator within the community as well as a strong and engaged local champion. Community collaboratives must be sensitive to issues of competition and concerns about the loss of market share among behavioral health providers; however, by actively involving other stakeholders, such as public safety, schools, and other health care organizations, they can overcome provider concerns and support transformation of the delivery system.

Consensus about the change strategy and the change itself must be built from the ground up. Participants must agree on the need for a community-wide intervention. They must share objectives and be willing to collaborate to achieve re-

sults. This often requires new relationships among providers within the community; to achieve this, it is important that the goals be broad and community wide. This consensus building process also benefits from the availability of some unrestricted funding. As a requirement of participation in a collaborative, some financial contribution from each participant (in-kind is acceptable) can help to develop investment in the project.

The successful implementation of community partnerships generally requires some initial, easily achievable tasks that can be accomplished within the first year. This increases the likelihood of some early-on success for the group and helps to establish confidence and sustain motivation. The use of expert assistance as needed, the broad visibility for successful implementation of projects, and "built-in" evaluation plans for the project are all useful tactics.

Along with the participation of service participants, the creation and implementation of a successful community collaborative requires consistent involvement of policy makers and other influential stakeholders involved in health care quality at the local and regional level. This may include payers, health departments, purchasers, insurers, and medical and professional societies. Time and resources need to be devoted to interorganizational communication that promotes cohesiveness and fosters shared goals. This can be the work of the consultant or staff from the lead provider organizations. It is important that the collaborative builds on this cohesiveness and imposes a minimal level of extra administrative and financial burden on the participants.

Leatherman [16] indicate that, although quality collaboratives are key components of system change, there are other significant strategic systems factors that can shape the change process. These include reforms in payment, regulation, the provision of incentives (or the removal of disincentives), and performance monitoring in line with the factors previously identified. Simultaneous use of multiple levers of change has the potential for the greatest effect.

The transformation called for in the President's Mental Health Commission report [2] will benefit from the use of community collaboratives as agents of change. This is an essential missing link between the vision of the report and the identification of strategies for implementation. With the right leadership and the committed involvement of key stakeholders, a process of collaborative learning, rapid-cycle testing, and evaluation of results can begin the transformation process. This process is recursive, involves a continuous feedback loop, and requires small early successes and a sustained effort.

A Step-Wise Approach to Behavioral Health-Care Systems Change

The general model of community collaboration can and should be more fully adopted by the behavioral health field. Experience demonstrates time and again that change is only possible when all of the constituents, including the recipients of care, the providers, their systems of care, and the overall social and political

environment are actively engaged. This is consistent with closely held values and traditions in behavioral health. The use of certain aspects of the IOM's *Quality Chasm* report [1] can provide useful tools for guiding this process.

There are seven specific and sequential steps that can be identified in the change process. These include:

- Developing the problem statement;
- Engaging leadership;
- Identifying a facilitator;
- Selecting participants;
- Securing financial support; and
- Establishing mission and goals.

The following steps build on the assumption that through a quality-improvement or consensus process, a need for change has been identified and the general parameters of the change initiative have been determined. There is no particular range or limit on the types of change projects that can be identified—they may range from broad system concerns to those that focus on a particular group or need defined by age, diagnosis, ethnicity, or other defining characteristic.

Step 1: Developing the Problem Statement

Before anything else can happen, key community leaders must be able to share an understanding of the problems in the current system and share the seeds of a future vision for the behavioral health care system. This will likely emerge from the natural leaders in the community, but it will be an essential element in recruiting other leaders and members of the effort. There are times, however, when the change process can be stimulated by external demands and opportunities. The recent passage of Proposition 63 in California and the generation of significant new monies to support systems enhancement and transformation are examples of a voter created mandate for change. Regardless of the impetus, the fundamental question remains: "Why do we need to change?"

Step 2: Engaging Leadership

The second step should focus on engaging the support of a champion or sponsor. This can be a state mental health system, a local board authority, or a system of care. This support typically involves some recognition that some element of the existing system is in need of change and the ability to articulate potential intended and desired results. This also requires the commitment of leadership, time, and resources to develop the necessary goals and process to stimulate and achieve change. This is often the genesis of a transformation process and requires a minimum commitment of at least 6 to 18 months. At this level, the definition of missions and goals begins, but it is crucial for the formal definition and adoption to be a part of the larger group collaborative process.

Table 1
Tool 1: Stakeholder Grid

Level	Description	Stakeholders	Focus
A	Experience of consumers, families and consumers		
B	Microsystems of care		
C	Macrosystems of care		
D	Healthcare environments		

Step 3: Identifying a Facilitator

The third step in the process requires the emergence of a facilitator or manager for the change process. This needs to be an unbiased, respected, and credible individual who has the actual position, stature, influence, and power to shepherd the process. This individual should be familiar with the fundamental framework of the *Quality Chasm* report [2] (as well as the NFC's report [1]) and the nuances of the aims, rules, and system change drivers.

This step also involves pairing the facilitator with an active community coordinator who has a keen understanding of local community dynamics and the spectrum of stakeholders across the four levels. Together, these two individuals, in consort with the sponsor, can begin to build the framework for the community collaborative. Further steps in this phase may involve raising additional financial and other resources. These individuals then constitute the core leadership of the change initiative and also charged with the identifying potential key participants in the collaborative.

Step 4: Selecting Participants

The Stakeholder Grid (see Table 1) is organized according to Berwick's [10] systems levels (as previously described) and can provide a tool for helping to determine key stakeholder participants. This helps the leadership to assure that all of the necessary community representatives have been considered. This tool also prompts for consideration of the concerns and focus of each constituency in the proposed change.

In some cases there may be an individual or organizational stakeholder who is able to fill multiple cells in the grid and may be charged with task of multiple representations. The composition of the initial collaborative is an important consideration: The need for inclusion and representation must be balanced with the need for a workable size group.

Although it is critical that these selections be made on a project-by-project basis, typically representatives of consumers and families could include established and organized advocacy groups or local members of advisory boards. The

involvement of members at Level B, the microsystems of care, will usually include providers and direct care staff. The Level C macrosystems participants should include leaders of the local systems of care and key delivery systems members. In most cases, the Level D health-care environment representatives should be involved stakeholders from the funding, employer, and political community.

Step 5: Securing Financial Support

The fourth step in the change process is the development of the financial resources necessary to accomplish the evolving tasks of the change process, which will likely need to be revisited through the life cycle of the project. For example, at initiation the champion should identify the initial funding and resources to begin the process. In the subsequent steps it is likely that all the stakeholders will need to make some sort of commitment of resources to accomplish the tasks and see the process to completion. This commitment may include direct financial support or the contribution of resources and other in-kind commitments. In this phase a beginning budget should emerge.

Step 6: Establishing Mission and Goals

The next step in the change process is establishing a formal statement of mission and goals. This sixth step is again somewhat recursive and will have begun at the inception of the process with the champion's commitment to the initiative. Here, however, the process of buy-in and ownership by all stakeholders becomes critical; the mission and goals need to be refined, brought within the scope of the project, and begin to guide development of the strategies to be pursued.

The quality chasm paradigm helps to provide a framework for developing the mission and goals of the change process. The six core quality aims provide a point of reference and help to anchor any proposed change strategy in a definition of quality. At the same time, this framework can help to establish criteria by which to evaluate the process of change and the intended outcome as well as foster a strategic discussion of the change process. Various experts may be included in the ongoing collaborative process.

The Levels of Care/Aims Grid (see Table 2) can be used to facilitate the task of clarifying both the mission and workplan while at the same time fostering consensus among stakeholders at each level of the system. Participants and leaders should carefully consider each of the cells in the grid and how the concerns of individuals and organizations in each level relate to the quality aims. Conceptually, community interventions can be designed for each cell in the grid; however, the reality is that each collaborative will want to be much more targeted in their interventions, particular in the first year of work. A discussion of priorities and strategies at this point will help participants to delineate the essential elements for each level of the care system and the corresponding aims.

Table 2
Tool 2: Level of Care/Aims Grid

	Aims					
Level	Safe	Effective	Person-centered	Timely	Efficient	Equitable
Patient and family members						
Providers and direct care teams						
Local health systems						
Larger health systems						

The representation of participants at each of the levels of care will vary across settings and systems of care. For example, in a collaborative led by the state mental health authority, the providers (microsystems) may be the funded mental health centers and other direct care staff in clinics or facilities.

System participants (macrosystems) may be representatives from the local or state Department of Mental Health or the organizations within those systems that provide care. The larger health-care environment for a public mental health system will include the federal, state, and local political entities and other related constituencies. The representatives will be quite different for collaborations that are led by employers or other community stakeholder groups.

As the Level of Care/Aims Grid is completed, there are a number of key issues to consider in the discussion. Not only should the goals of the project be reviewed, but identification of measures by which the collaborative will evaluate success should also be included. Milestones should be established on both a short-term or interim timeframe (objectives) as well as a long-term basis (goals).

The process must also consider how progress will be measured and outcomes monitored. How the goals and progress will be communicated within the collaborative and to the general public must also be a part of the planning. In larger efforts, effective project management is essential and can help in the development of a timeline for the project as well as determine workflow, barriers, and accomplishment along the way as well as resources to draw on.

Stage 7: Implementation—Making It Happen

The seventh step in the change process is the work that will actually be accomplished by the collaborative. It builds on the earlier steps and tasks. The role of the facilitator at this point is to bring together the available and required resources to foster the collaborative process and to facilitate action steps. This includes both work with the constituents and others who will guide the learning and behavior necessary to accomplish the goals.

Implementation steps are likely to be needed in the four levers of change outlined by the IOM: information technology, evidence-based care, financing, and workforce. Special attention should be paid to these areas to identify opportunities for improvement. Each of the ten rules identified by the IOM should act as guideposts for developing action plans. A matrix of these factors could be built to track progress and change.

As with earlier steps, the implementation, planning, and coordination should occur in a set of collaborative learning sessions. Sessions should frame the work to be done and build the knowledge base within the collaborative to accomplish the incremental tasks. Models for improvement should be considered and formulated for implementation. Progress toward the goals must be reviewed and measured regularly. The plan-do-study-act cycle should guide all aspects of change. Systems change should be implemented as a part of new strategic projects in the four levers of change described by the IOM and through rapid cycle change in operational business processes. As momentum builds and staff becomes more experienced in the quality framework, there are likely to be many separate efforts undertaken by individuals and organizations outside of the collaborative framework.

Finally, steps need to be taken early in the process to continue the improvement process beyond the initial effort. Even before, but certainly during, the implementation process, sustaining the transformation and communicating the results needs to be part of the plan. This may need to include additional educational and brainstorming sessions and will require that resources be identified for the effort. Ongoing efforts must also involve institutionalized funding mechanisms, either through purchaser or provider budgets.

Next Steps and Opportunities

The need for transformation in the behavioral health field is clear and well established. This has been shown in the NFC report [2] and other reports and will likely be affirmed by the ongoing work of the IOM. The question that must be considered is how best to accomplish that change in a system that is highly fragmented in its organization and inequitable in its allocation of financial and human resources. There are major differences, gaps, and disparities among public and privately funded care systems, the specialty and primary medical delivery systems, and the mental health and substance use disorder fields.

The *Quality Chasm* report [1] provides a useful framework for both conceptualizing and discussing the policy issues and the overarching criteria for quality. However, the report does not sufficiently specify the activities necessary to implement the needed changes. Although the IOM identifies key drivers for change—including evidence-based care, information technology, finance reform, and workforce development—it fails to chart the course for that change. What is needed is a systematic mechanism for strategically planned and implemented change consistent with the values and traditions of the field.

The community-based collaborative model has been effectively used in a variety of settings to foster change in the delivery of medical care and the improvement of quality. However, its use in the behavioral health field has been limited, and it also lacks a consistent framework to guide the process. Identifying the aims, rules, and levels of care/stakeholders in the system provides a potentially useful framework to guide community collaborative development and work for transformative change. The concepts of the *Crossing the Quality Chasm* report [1] have been translated into the tools for implementing systems change.

As community collaboratives develop and proliferate there will be unique opportunities to both learn from each other and further the science and practice of systems change. The common framework of the *Quality Chasm* report [1] can provide a bridge for tracking change and transformation in the behavioral health arena. Collaboratives have the potential to promote and sustain mutual support, comparison and learning amongst best practices and accomplishments, and at the same time foster the identification of new directions and creative strategies.

Community-learning collaboratives can be effective tools for supporting the effective transformation that is called for in both the *New Freedom* [2] and *Quality Chasm* [1] reports. They have the potential to promote both grass roots change from the bottom up and systematic changes that can be championed by leadership from the top levels of government, purchasers, and payers. These are critical ingredients for success. If not collaboratives, then what will be the vehicle for effecting much needed change?

References

1. Institute of Medicine (2001) *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: National Academy Press.
2. President's New Freedom Commission on Mental Health (2003) *Achieving the promise: Transforming mental care in America. Final report.* DHHS Pub. No. SMA-03-3832. Washington, DC: Department of Health and Human Services. Available at www.mentalhealthcommission.gov/reports/FinalReport/toc.html, accessed February 10, 2005.
3. Institute of Medicine (2000) *To err is human: Building a safer health system,* ed. L.T. Kohen, J.M. Corrigan, & M.S. Donaldson. Washington, DC: National Academy Press.
4. Institute of Medicine (2003) *Leadership by example: Coordinating government roles in improving health care quality,* ed. J.M. Corrigan, J. Eden, & B.M. Smith. Washington, DC: National Academies Press.
5. Institute of Medicine (2003) *Health professions education: A bridge to quality,* ed. A.C. Greiner & E. Knebel. Washington, DC: National Academies Press.
6. Institute of Medicine (2003) *Priority areas for national action: Transforming health care quality,* ed. K. Adams & J.M. Corrigan. Washington, DC: National Academies Press.
7. Institute of Medicine (2004) *Committee on the Crossing the Quality Chasm: Next steps toward a new health care system,* ed. K. Adams, A.C. Greiner, & J.M. Corrigan. Washington, DC: National Academies Press.
8. Daniels, A.S., & Adams, N. (2004) From policy to service: A quality vision for

behavioral health using the New Freedom Commission Reports as a framework for change [Monograph]. Pittsburgh: American College of Mental Health Administration. Available at www.acmha.org/publications/From_Policy_To_Service.pdf, accessed March 1, 2005.
9. Donabedian, A. (1980) *Explorations in quality assessment and monitoring: The definition of quality and approaches to its assessments, Vol. 1.* Ann Arbor, MI: Health Administration Press.
10. Berwick, D.M. (2002) A user's guide for the IOM's "Quality Chasm" report. *Health Affairs 21*(3), 80–90.
11. Bishop, A., & Dougherty, R. (2005) Does the mental health system need its own Apollo Program: Necessary steps for mental health transformation. *Mental Health Weekly, 15*(1). Available at www.namiscc.org/Editorial/2005/ReformingMental HealthSystem.htm, accessed March 3, 2005.
12. Institute of Medicine (2004) *1st annual crossing the quality chasm summit: A focus on communities.* Washington, DC: National Academies Press.
13. Øvretveit, J.; Bate, B.; Cleary, P.; Cretin, S.; Gustafson, D.; McInnes, K.; McLeod, H.; Molfenter, T.; Plsek, P.; Robert, G.; Shortell, S.; & Wilson, T. (2002) Quality collaboratives: Lessons from research. *Quality Safe Health Care 11,* 345–74.
14. Institute for Healthcare Improvement (2003) The breakthrough series: IHI's collaborative model for achieving breakthrough improvement. Boston. Available at www.ihi.org/IHI/Products/WhitePapers/TheBreakthroughSeriesIHIsCollaborative ModelforAchieving+BreakthroughImprovement.htm, accessed March 3, 2005.
15. Palsbo, S.E.; Kroll, T.; & McNeil, M. (2004) *Addressing chronic conditions through community partnerships: A formative evaluation of taking on diabetes.* New York: Commonwealth Fund. Available at www.cmwf.org/usr_doc/766_Palsbo_addressing _chronic_conditions.pdf, accessed March 3, 2005.
16. Leatherman, S. (2002) Optimizing quality collaboratives. *Quality Safe Health Care 11,* 307.