Patient-Centered Care and Service Delivery Models:

Best Practices to Meet the Needs of CDCR's Patients

Introduction

This paper is intended to identify a wide range of possible governance and organizational models for seven new facilities that will deliver medical, mental health, dental, rehabilitation and related treatment services to patients in California's prison system.

In incorporating this range of services, these facilities must:

- Provide efficient and appropriate health care; and,
- Be sustainable (i.e., operable by the State over the long term).

These governance and organizational models are intended to support a philosophy that is being "designed into" these facilities, which emphasizes:

- Patient-centered care;
- Coordinated treatment; and,
- Direct supervision of patients.

The paper is divided into three sections. Part I provides background information on the concept of patient-centered care and three service delivery models. Part II offers a range of governance/organizational models, which may be more or less effective in supporting patient-centered, integrated care along a continuum of care. Part III identifies questions for discussion.

Part I. Background

A. Patient-centered Care

The Receiver's Turnaround Plan of Action dated June 6, 2008 notes that the goal is to provide a system "in which (patient) encounters are: proactive, planned, informed, patient-centered, and professional."

Much of the information in this section is derived from four sources:[1]

- The Urban Institute
- The Promising Practices Network
- The Institute of Medicine
- Institute for Healthcare Improvement

1. Definition

According to Dr. Don Berwick, head of the Institute for Healthcare Improvement (IHI), patient-centered care is "the experience of transparency, individualization, recognition, respect, and dignity related to one's person, circumstances, and relationships in health care."

Moira Stewart's research described in the February 24, 2001 printing of the British Medical Journal indicated that patients believe patient-centered care (a) explores their main reason for the visit, concerns, and need for information; (b) seeks an integrated

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[1] The Urban Institute (UI) is a non-partisan institution that provides social policy research. UI gathers data, conducts research, evaluates programs, offers technical assistance overseas, and educates Americans on social and economic issues — to foster sound public policy and effective government.

The Promising Practices Network (PPN) is operated by the RAND Corporation and is comprised of a group of individuals and organizations who are dedicated to providing quality evidence-based information about what works to improve the lives of children, families, and communities.

Established in 1970 under the charter of the National Academy of Sciences, the Institute of Medicine provides independent, objective, evidence-based advice to policymakers, health professionals, the private sector, and the public. The mission of the Institute of Medicine embraces the health of people everywhere.

The Institute for Healthcare Improvement (IHI) is an independent not-for-profit organization helping to lead the improvement of health care throughout the world. Founded in 1991 and based in Cambridge, Massachusetts, IHI works to accelerate improvement by building the will for change, cultivating promising concepts for improving patient care, and helping health care systems put those ideas into action.

understanding of their world -- that is, their whole person, emotional needs, and life issues; (c) finds common ground on what the problem is and mutually agrees on management; (d) enhances prevention and health promotion; and, (e) enhances the continuing relationship between them and the doctor. Informed patients take an active part in their care.

2. Advantages of Patient-Centered Care

Patients are actively involved in their own care in the patient-centered care model. The foundation of this model asserts that transitions between providers, departments, and health care settings are respectful, coordinated, and efficient. Research indicates that when care is patient-centered, unneeded and unwanted services can be reduced.

3. Requirements

Seven key factors are required at the organizational level to achieve patient-centered care:

1. Top leadership engagement;
2. A strategic vision clearly and constantly communicated to every member of the organization;
3. Involvement of patients and families at multiple levels;
4. A supportive work environment for all employees;
5. Systematic measurement and feedback;
6. A quality environment; and,
7. Supportive information technology.

It should be noted that the Federal Receiver's Draft Strategic Plan (2.0) dated April 21, 2008 addresses all the requirements described above.

B. Types of Service Delivery

According to the Federal Receiver's Draft Strategic Plan (2.0) dated April 21, 2008, the mission of the Receivership is to reduce avoidable morbidity and mortality and protect public health by providing patient-inmates timely access to safe, effective and efficient medical care, and coordinate the delivery of medical care with mental health, dental, rehabilitation and disability programs.

All agencies or contractors involved in providing health care to the patient-inmate population of the California prisons must commit to provide patient-centered care.

Three approaches to service delivery allow for or enable patient-centered care, as follows:

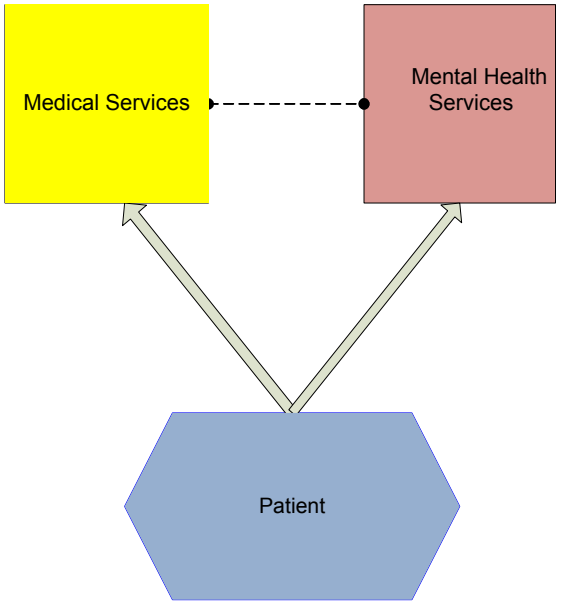
1. Type 1: Coordination

Coordination generally refers to two or more organizations or departments working side by side, through an informal arrangement, to meet one or more goals.

Goals may include improving the effectiveness and/or cost-effectiveness of programs, improving access to services, avoiding unnecessary duplication of services, and/or improving performance.[2]

Coordination requires agreement to goals and limited commitment to process changes. The coordination approach to service delivery is therefore the easiest way for departments to work together in delivering services to patients.

Coordination



[2] www.urban.org/publications/408026.html

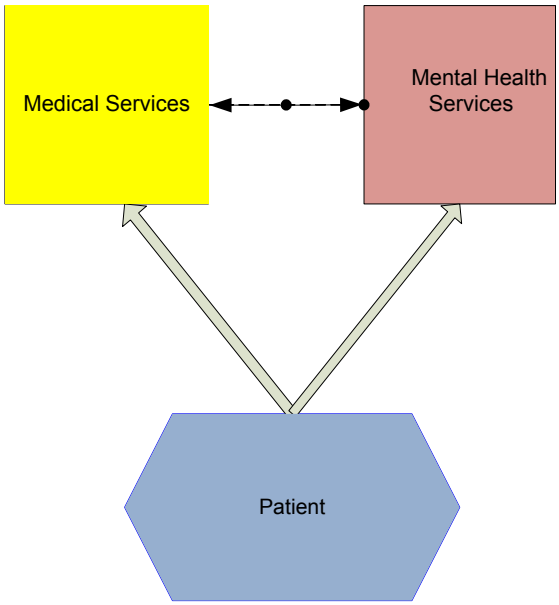
2. Type 2: Collaboration

The collaboration model involves a mutually beneficial formal relationship entered into by two or more organizations or departments to achieve common goals.

The relationship includes a commitment to specific goals, a jointly developed structure, shared responsibility, mutual authority and accountability for success, and sharing of resources and rewards.[3] Collaboration requires structures and processes that enable, support, and promote it.[4]

Collaboration is more complex than coordination and enables synchronization of care rather than simply coordination. For example, one common collaborative process is joint determination of treatment plans and goals for recovery. The collaborative approach at the system level is often mirrored in a partnership formed with the patient.

Collaboration



[3] http://www.promisingpractices.net/sd2a.asp

[4] Institute of Medicine. Improving the Quality of Health Care for Mental and Substance Abuse Conditions. *Quality Chasm Series*. National Academies Press, 2006. p. 236.

3. Type 3: Service Integration

Service integration is the most complex model of service delivery. This type of service delivery is characterized by one point of entry for the patient and seamless processes to ensure a "one stop" encounter for the patient.

The patient experience is that he/she is dealing with a single unified entity. Efficiency is achieved through close communication, increased knowledge of resources and shared vision by staff members.[5] Features often include a common patient assessment tool and joint treatment planning. Roles and responsibilities of health care professionals are defined. Patient care processes are standardized. Administrative barriers to services do not exist.

The U.S. General Accounting Office (GAO) defines two types of service integration: (1) system-oriented, in which agencies create a single structure to deliver services with new service delivery structures; and, (2) service-oriented, in which agencies link patients to services while maintaining their own structures.

The GAO has identified several characteristics necessary for successful service integration.[6] Many of these characteristics also apply to collaborations.

- Support from key political officials and other key stakeholders, and incentives to encourage participation and cooperation;
- A "common vision" among participants to enable agreement on goals and strategies;
- Identification of common needs among shared patients; and,
- New administrative and management structures that are independent of the participating agencies.

Despite its benefits, there are also challenges to establishing service integration. While the challenges are interrelated, there are several major categories of obstacles to service integration, including:[7]

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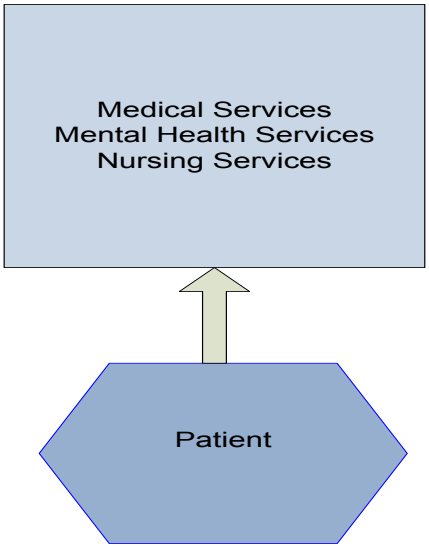
[5] Institute of Medicine. Improving the Quality of Health Care for Mental and Substance Abuse Conditions. *Quality Chasm Series*. National Academies Press, 2006. p. 240.

[6] U. S. General Accounting Office, "Integrating Human Services: Linking At-Risk Families with Services More Successful Than System Reform Efforts." Washington, D.C.: GAO, 1992. www.gao.gov, search for report number HRD-92-108.

[7] Martinson, Karin, "Literature Review on Service Coordination and Integration in the Welfare and Workforce Development Systems," Washington, D.C.: Urban Institute, 1999. www.urban.org/publications/408026.html

- Bureaucratic barriers and turf-protection;
- Different philosophies and mission;
- Differences in performance measures; and,
- Different systems for accountability.

Service Integration



Part II: Governance Models

A. Challenges

In designing these seven new facilities, the most significant challenge is to create a health care services governance structure that will enable quality care to patient-inmates with medical, dental and mental health needs.

Other challenges include minimizing boundaries between medical and mental health services and determining how mental health services will be provided to patients of the seven new facilities.

More specifically, the *Options Report* dated April 9, 2008 recommended that the proposed new facilities maximize the sharing of resources (space, staff, and equipment)

so that the traditional boundaries between medical and mental health treatment and programs are minimized.

In addition, currently the California Department of Rehabilitation and Corrections (CDCR) and the Department of Mental Health (DMH) are under the authority of the Governor. The DMH provides inpatient (Acute and Intermediate Care) mental health services at existing prisons. CDCR also has its own division of mental health that provides inpatient and outpatient mental health services (Mental Health Crisis Bed, Enhanced Outpatient Program and Coordinated Clinical Case Management System) to inmates at various prisons.

B. Key Question

What governance structure will best meet the goal of the Receivership to provide appropriate integrated medical, mental health and dental care for California's prison population?

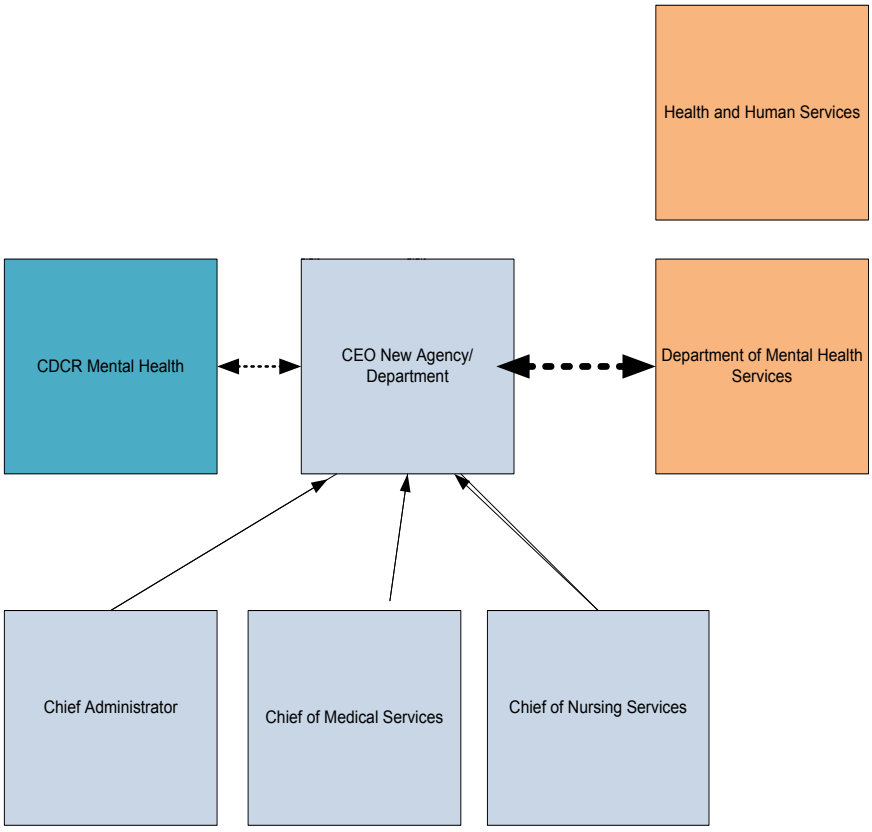
C. Advice from the Institute of Medicine

Organizations should adopt models to which they can most easily transition from their current structure, that best meets the needs of their patient populations, and that ensure accountability.[8]

[8] Institute of Medicine. Improving the Quality of Health Care for Mental and Substance Abuse Conditions. *Quality Chasm Series*. National Academies Press, 2006. p. 248.

D. Models for Discussion

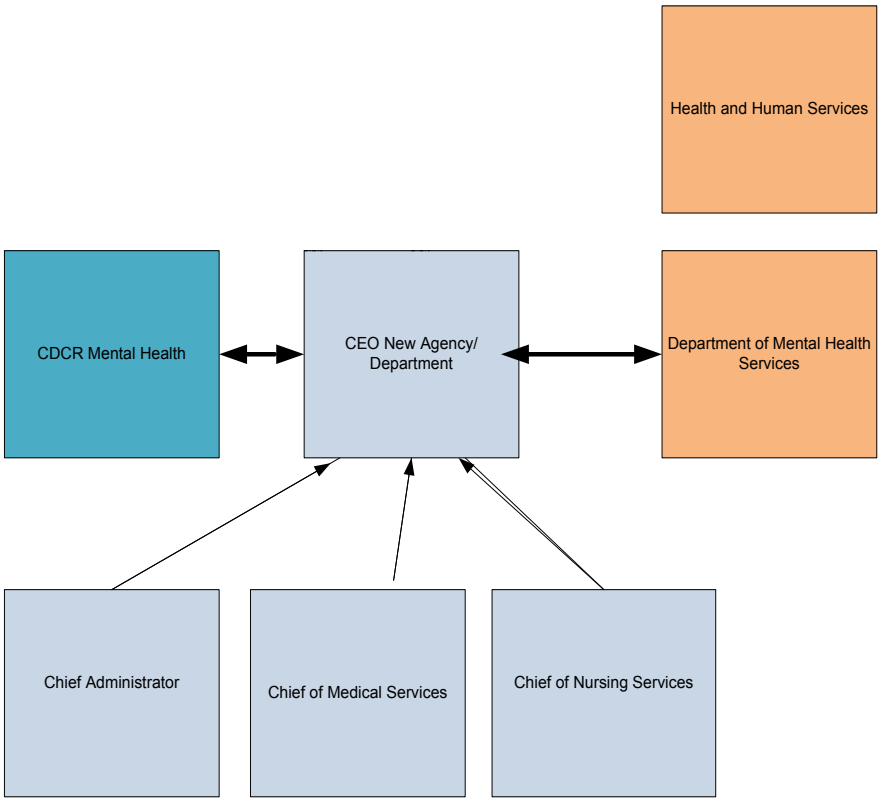
Model 1



In the new seven facilities, the Model 1 reflects an informal, dotted line relationship between the Director of Mental Health Services and the CEO of the New Agency/Department. The Director of Mental Health maintains responsibility for the mental health of the patients under the care of his staff for the work he has agreed to perform. CDCR Mental Health is also individually accountable to provide services under their direction.

On the facility level, the Health Care Manager (who reports to the Chief Administrator) is in charge of the facility, services and programs except for mental health. Mental Health staff have input into operations and programming but no decision-making. Similarly, the Health Care Manager has no decision-making or responsibility for mental health services and programs.

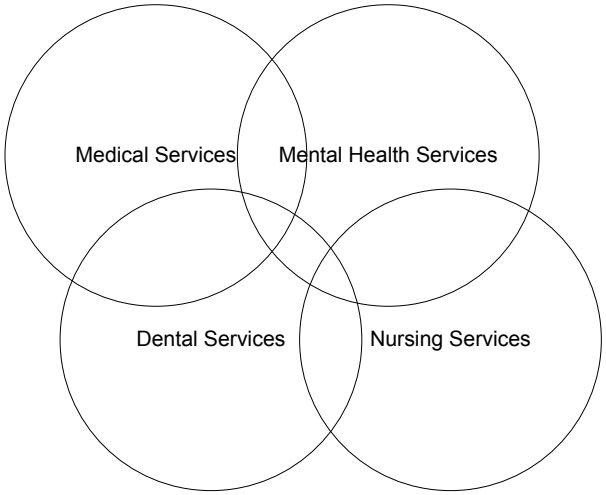
Model 2



Model 2 formalizes relationships and expectations. Through contracts, the New Agency/Department, the Department of Mental Health and CDCR Mental Health work together to deliver services to patients. The contracts spell out in detail the roles, facility level relationships, resource allocations and accountabilities. They are mutually accountable for patient outcomes and facility goals, such as ensuring staff efficiency.

On the facility level, structures are developed to support Model 2. For example, a common assessment tool is used and treatment planning is a joint activity. Medical and Mental Health Services round together on mental health patients who have medical problems. A team (Medical Services and Mental Health staff) makes decisions about care, patient programming and housing unit assignments. One assessment tool is used throughout the facility.

Model 3



Model 3 reflects a new way of doing business. New administrative and management structures are created that are independent of the participating agencies/departments. All parties serving patients are mutually accountable for patient outcomes, resource allocation and establishing and meeting financial goals, as well as compliance with legal mandates. A top-level team creates a one-stop model for patient care. Patient care processes are standardized and documented.

On the facility level, the Health Care Administrator leads a team of Medical, Dental, Mental Health and Rehabilitation staff that implements the one-stop model for patient care. Admission and discharge criteria are developed jointly. One assessment tool guides the direction of treatment planning and recovery goals. A continuum of care for medical and mental health patients is established. Interdisciplinary teams are created throughout the facility.

Part III. Questions for Discussion

A. General Questions

1. What needs to happen to ensure patient-centered care for the patients in the new seven health care facilities?
2. Do patients come in one door or two?
3. How does mental health fit into the new facilities?
4. If ICF and Acute care are contracted to DMH, what is their official role in

planning and leadership decisions?

5. Who will define the contract terms? What works? The anticipated patient outcomes?
6. Who will provide treatment in each of the mental health programs? (inpatient and outpatient)
7. What is the governance and organizational structure for all seven facilities?

B. Questions Related to the Models

1. Which model(s) meet the goals of the Receivership?
2. How can governance support patient care, an integrated approach and the IDDT?
3. Which model is most appealing, (if any)?
4. Which model is most doable, (if any)?
5. Would modification of one or more of the models to make them work for all parties? If so, how could they be modified and still maintain the integrity of the model?