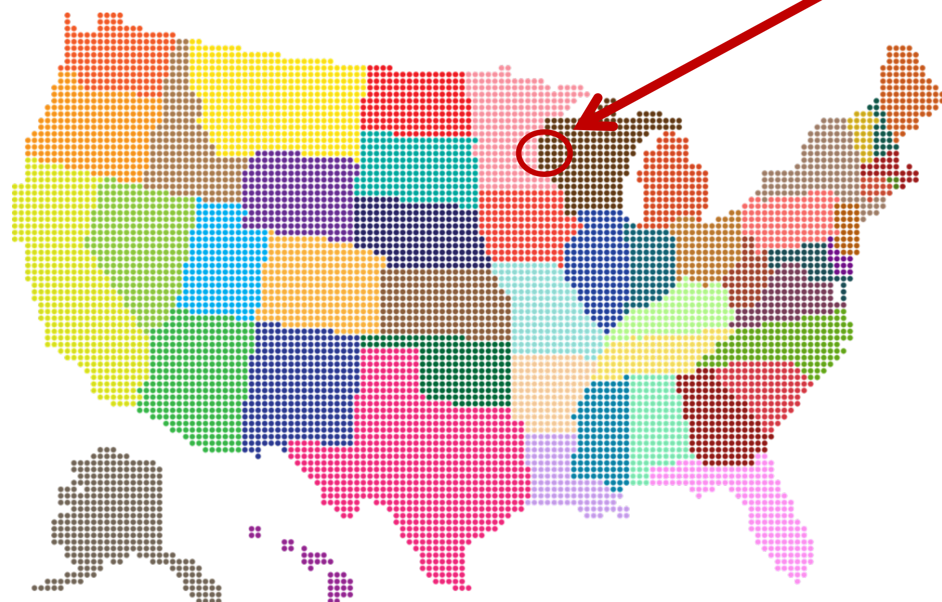
Advancing the Integration of Behavioral Health in Primary Care

Claire Neely, MD
President & CEO
ICSI

October 31, 2019

ICSI: MN and the Upper Mid-west

We are a unique collaboration of diverse stakeholders, grounded in evidence-based medicine, takeing action to tackle and solve some of our region's most complex health and healthcare system problems



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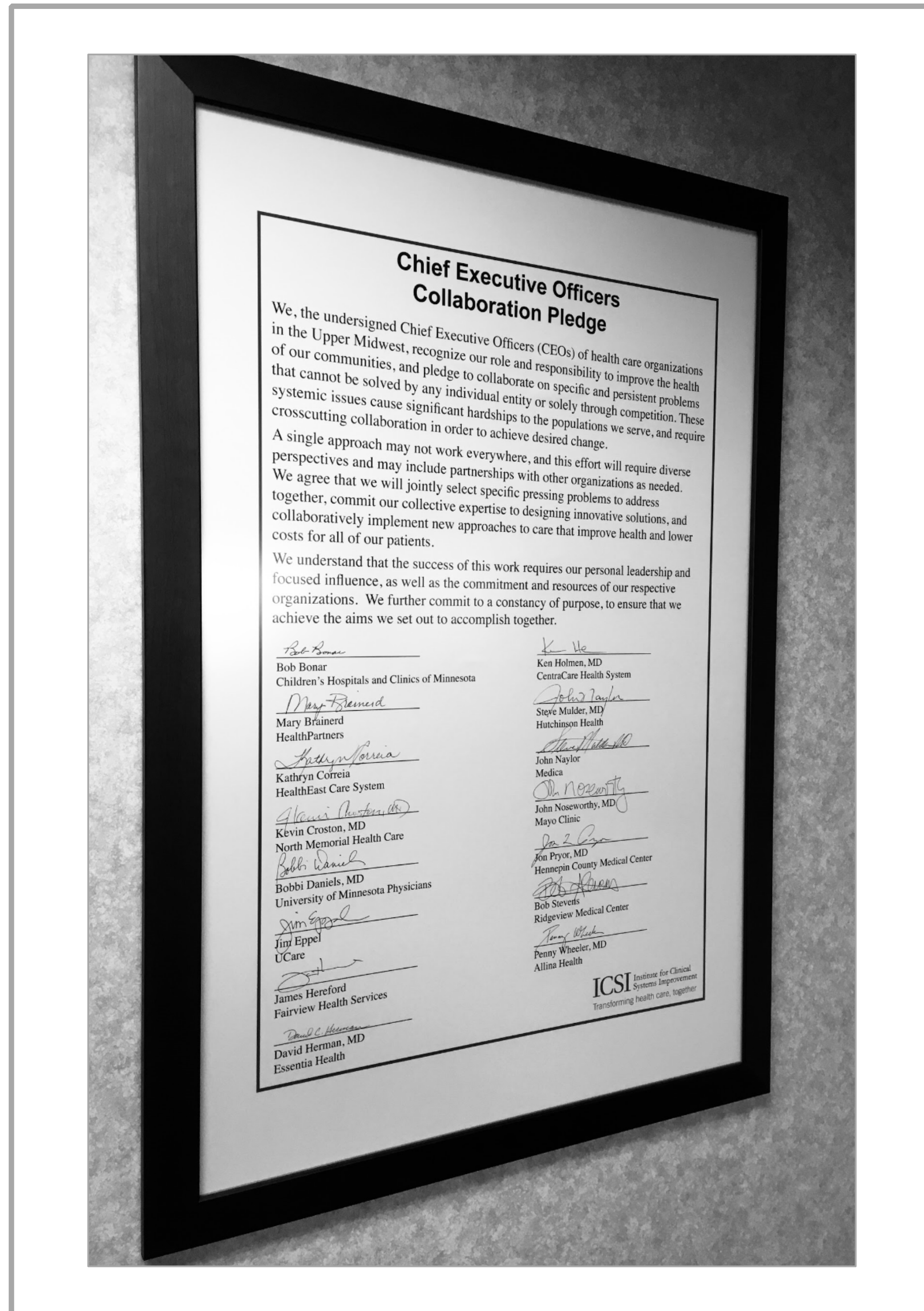
MN Health Collaborative: CEO Commitment



Chief Executive Officers Collaboration Pledge

We, the undersigned Chief Executive Officers (CEOs) of health care organizations in the Upper Midwest, recognize our role and responsibility to improve the health of our communities, and pledge to collaborate on specific and persistent problems that cannot be solved by any individual entity or solely through competition. These systemic issues cause significant hardships to the populations we serve, and require crosscutting collaboration in order to achieve desired change.

A single approach may not work everywhere, and this effort will require diverse perspectives and may include partnerships with other organizations as needed. We agree that we will jointly select specific pressing problems to address together, commit our collective expertise to designing innovative solutions, and collaboratively implement new approaches to care that improve health and lower costs for all of our patients.

We understand that the success of this work requires our personal leadership and focused influence, as well as the commitment and resources of our respective organizations. We further commit to a constancy of purpose, to ensure that we achieve the aims we set out to accomplish together.

Bob Bonar
Children's Hospitals and Clinics of Minnesota

Mary Brainerd
HealthPartners

Kathryn Correia
HealthEast Care System

Kevin Croston, MD
North Memorial Health Care

Bobbi Daniels, MD
University of Minnesota Physicians

Jim Eppel
UCare

James Hereford
Fairview Health Services

David Herman, MD
Essentia Health

Ken Holmen, MD
CentraCare Health System

Steve Mulder, MD
Hutchinson Health

John Naylor
Medica

John Noseworthy, MD
Mayo Clinic

Jon Pryor, MD
Hennepin County Medical Center

Bob Stevens
Ridgeview Medical Center

Penny Wheeler, MD
Allina Health

ICSI Institute for Clinical Systems Improvement
Transforming health care, together

"The success of this work requires our personal leadership and focused influence, as well as the commitment and resources of our respective organizations."

"We further commit to a constancy of purpose, to ensure that we achieve the aims we set out to accomplish together."

mnhealth COLLABORATIVE activated by icsi.

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MN Health Collaborative Members

- Allina Health
- BCBS of Minnesota
- CentraCare Health
- Children's Minnesota
- Essentia Health
- Fairview Health Services
- HealthPartners
- Hennepin Healthcare
- Hutchinson Health
- Mayo Clinic
- Medica
- North Memorial Health
- Ridgeview Medical Center
- Sanford Health
- UCare
- University of Minnesota Physicians

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MN Health Collaborative Working Groups

Acute Pain Prescribing

Measurement

Acute Needs in EDs

Opioid Epidemic

Mental Health

Chronic Pain Mgmt & Addiction

Communications

Integrated Behavioral Health

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Acute Mental Health Needs in EDs

WORK PRODUCTS SO FAR

- Standardizing Medical Clearance within **and across** systems
- Standardizing Suicide Screening and Identification
- Suicide Prevention and Intervention Recommendations

TO COME

- More on crisis de-escalation and intervention
- Transitions

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Our IBH Journey

The Journey: What we brought

Depression Care for Adults in Primary Care-Guideline (1995-present)
Depression Care Public Reporting- MNCM (2000-present)
DIAMOND (1996-2014)

- State-wide spread effort for AIMS IMPACT model
- Commercial only
- Health plan monthly care management fee
- Mixed results, mixed fidelity of implementation
- Mixed sustainability

COMPASS-CMMI Innovation Award (2014-2017)

- Implementation of TEAMCare model
- Depression and complex medical conditions
- 8 states, 175 clinic sites
- Improved disease markers
- Trends showed decreased utilization of acute services

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The Journey: Who came along

Collaborative Team (From care systems and health plans)

- Psychiatrists
- Primary care physicians
- Nurses
- Psychologists
- Social workers
- Operational experts
- Clinic operations
- Measurement experts
- Researcher
- Division leaders

Each site had their own implementation team

ICSI collaborative facilitation and change management expertise

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The Journey: Shared goals

Objective:

All patients will have access to a community standard for fully integrated mental and medical care within primary care and other settings to:

- improve care
- ease access
- support care teams

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The Journey: Shared action framework

- PCORI research to define an aggregated model
- The framework met these criteria:
  - Supported by current evidence
  - Supportive of local variation
  - Supportive of a progressive approach over time
  - Specific enough to provide implementation guidance

Stephens, Kari et al: Defining and Measuring Core Processes and Structures in Integrated Behavioral Health in Primary Care: A Cross-Model Framework," Translational Behavioral Medicine (accepted for publication, date pending)

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The Cross-Model Framework:
Core Principles (5) – 25 Processes, 9 Structures

Patient-centric Care	Treatment to Target	Use of EBTs	Conduct Efficient Team Care	Population Based Care	Structures Needed to Support IBH
• Orient patient • Shared decision making • Patient autonomy • Changes in symptoms / function	• Target health and quality of life • Stepped care • Goal setting • Assessment • Barriers • Outcomes • Tracking system • Caseload management	• Coordinate evidence-based treatments • Use evidence-based treatments • Psycho-education	• Roles and workflow • Brief visits • Team communicatio n • Team trust • Common language • Fast and easy access • Psychiatric consultation / care	• Resources target those most in need • Triage processes	• Financial billing sustainability • Administrative support and supervision • Quality improvement • EHR • Clinic space • Behavioral Health Provider • Protected time • Accountability • Tracking system for panel management

* PCORI funded Integrated Behavioral Health in Primary Care Trial, Kari A. Stephens, PhD investigator

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The Journey: Understanding status quo

Primary Care Satisfaction Survey

- The MN Health Collaborative created a primary care provider (PCP) satisfaction survey

- 115 survey responses came from primary care clinics with IBH; 66 survey responses came from primary care clinics with no IBH

Results showed that:

- Around 90% of PCPs that responded to the surveys agree or strongly agree with the statement:

“I believe that the mental/behavioral health professional is a highly valuable and necessary member of my health care team.”

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The Journey: Understanding status quo

- While satisfaction with MH care was high, very few respondents were satisfied with access to this care
- PCPs could rarely get a new or acute patient seen in 48 hours
- IBH sites were more likely to see follow-up patients within 14 days
- All sites expressed concerns with the referral procedures in place, including barriers created with triage or screening processes
- Factors identified as deterring PCP from referring include:
  - Patient refusing the referral
  - Payment/coverage issues
  - Mental health providers/ clinical staff is unavailable or seems busy, or the provider is unaware of resources available

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The Journey: Improving practices together

- Organizations were at different levels of adoption of IBH
- Each organization used their Deep Discovery Dive findings to select 1-2 areas of focused improvements for 2018
- Most of the groups selected:
  - Improving efficient team care
  - Improving structures to support IBH
- Teams were asked to report progress at MN Health Collaborative working group meetings in order to share promising practices and accelerate learning during the implementation phase

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The Journey: Measuring progress

Site Self Assessment Survey

- To understand depth of adoption and level of spread across the MN Health Collaborative organizations, a site self-assessment survey (SSA) was used

- Initial data is being used to help organizations:
  - Determine whether their work to improve components of the agnostic model was successful
  - Identify key focus areas for 2019 improvement work
  - Communicate strategic needs to leadership

- SSA surveys will be used periodically to measure IBH implementation

*SSA: Adapted from the PCRS – Developed by the Robert Wood Johnson Foundation Diabetes Initiative, www.diabetesintiative.org; Also adapted from the ACIC survey developed by the MacColl Institute for Healthcare Innovation, Group Health Cooperative. Used with permission by MN Health Collaborative/Institute for Clinical Systems Improvement (https://www.icsi.org/).

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Site Self Assessment Survey

I. Integrated Services and Patient and Family-Centeredness (Circle ONE NUMBER for each characteristic)

Characteristic	Levels			
1. Level of integration: primary care and mental/behavioral health care	. . . none; consumers go to separate sites for services 1	. . . are coordinated; separate sites and systems, with some communication among different types of providers; active referral linkages exist 2 3 4	. . .are co-located; both are available at the same site; separate systems, regular communication among different types of providers; some coordination of appointments and services 5 6 7	. . . are integrated, with one reception area; appointments jointly scheduled; shared site and systems, including electronic health record and shared treatment plans. Warm hand-offs occur regularly; regular team meetings. 8 9 10
2. Screening and assessment for emotional/behavioral health needs (e.g., stress, depression, anxiety, substance abuse)	. . . are not done (in this site) 1	. . .are occasionally done; screening/assessment protocols are not standardized or are nonexistent 2 3 4	. . .are integrated into care on a pilot basis; assessment results are documented prior to treatment 5 6 7	. . . tools are integrated into practice pathways to routinely assess MH/BH/PC needs of all patients; standardized screening/ assessment protocols are used and documented. 8 9 10
3. Treatment plan(s) for primary care *and* behavioral/mental health care	. . . do not exist 1	. . . exist, but are separate and uncoordinated among providers; occasional sharing of information occurs 2 3 4	. . .Providers have separate plans, but work in consultation; needs for specialty care are served separately 5 6 7	. . . are integrated and accessible to all providers and care managers; patients with high behavioral health needs have specialty services that are coordinated with primary care 8 9 10
4. Patient care that is based on (or informed by) best practice evidence for BH/MH and primary care	. . . does not exist in a systematic way 1	. . . depends on each provider's own use of the evidence; some shared evidence-based approaches occur in individual cases 2 3 4	. . .evidence-based guidelines available, but not systematically integrated into care delivery; use of evidence-based treatment depends on preferences of individual providers 5 6 7	. . . follow evidence-based guidelines for treatment and practices; is supported through provider education and reminders; is applied appropriately and consistently 8 9 10
5. Patient/family involvement in care plan	. . . does not occur 1	. . . is passive; clinician or educator directs care with occasional patient/family input 2 3 4	. . . is sometimes included in decisions about integrated care; decisions about treatment are done collaboratively with *some* patients/families and their provider(s) 5 6 7	. . . is an integral part of the system of care; collaboration occurs among patient/family and team members and takes into account family, work or community barriers and resources 8 9 10

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Crosswalk between SSA and Cross-model Framework

Crosswalk between the SSA and the Agnostic Model	Agnostic Framework					
Site Self Assessment	1. Patient-centric Care	2. Treatment to Target	3. Use EB Behavioral Tx	4. Conduct Efficient Team Care	5. Population-Based Care	6. Core Structures
1. Level of integration: primary care and mental/behavioral health care.				X		X
2. Screening and assessment for emotional/behavioral health needs (e.g., stress, depression, anxiety, substance abuse).		X		X		
3. Treatment plan(s) for primary care and behavioral/mental health care.		X		X		
4. Patient care that is based on (or informed by) best practice evidence for behavioral health/mental health and primary care.			X			X
5. Patient/family involvement in care plan.	X	X				
6. Communication with patients about integrated care.	X					
7. Follow-up of assessments, tests, treatment, referrals and other services.		X				
8. Social support (for patients to implement recommended treatment).		X	X			
9. Linking to community resources.		X	X			
10. Organizational leadership for integrated care.						X
11. Patient care team for implementing integrated care.				X		X
12. Providers' engagement with integrated care ("buy-in").				X		
13. Continuity of care between primary care and behavioral/mental health.		X		X	X	X
14. Coordination of referrals and specialists.		X			X	
15. Data systems/patient records.					X	X
16. Patient/family input to integration management.	X					X
17. Physician, team and staff education and training for integrated care.			X	X		X
18. Funding sources/resources.						X

Blue= Organization/Systems level **Red= Clinic Level** **Green= Individual/Provider level**

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MN Health Collaborative
2018 Behavioral Health Integration Level

Number of Clinics

40
30
20
10
0

No IBH
Some BH Coordination
BH Co-Location
Integrated BH

Integration Level

Integration Level is based on each clinic's score on the first question of the Site Self Assessment.
A score of 1 = No IBH, 2-4 = Some BH Coordination, 5-7 = BH Co-Location, and 8-10 = Integrated BH.

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Caution regarding co-location and full integration

Co-location may be a simple model as a start, and seem a logical step to full integration but consider the following in implementation planning:

- Co-location can easily become a “satellite clinic” with the same access problems as other MH sites
- BH providers may not make the change to brief/limited-time interactions, instead maintaining traditional therapy norms
- May not integrate into the primary care team

Shifting to a fully integrated care model may require another set of changes, rather than a gradual transition

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The Journey: Sustainability

FIGURE 1. SHIFTING THE CONDITIONS THAT HOLD THE PROBLEM IN PLACE

[FSG: The water of system change]

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Sustainability: Resources-Knowledge

- MN Health Collaborative Call to Action: A Community Standard for Integrating Behavioral Health in Primary Care (May 2019)

- IBH Learning Network: ECHO platform

Connecting to other work:

- MN Health Collaborative Call to Action: Suicide Prevention and Intervention in the Emergency Department

- Support for Addiction Treatment

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Sustainability: Resources-Financing

Previous experimentation with monthly case management fee

Collaborative Care Codes: Complex, but available

- Medicare
- Medicaid
- Commercial

Employer support

- Minnesota Health Action Group
- MN Business Partnership

American Psychiatric Association (educational support)

Health plan:Care delivery joint exploration of novel payment model

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Sustainability: Resources-Workforce

Ongoing challenge

- Wide geographic area
- Increasing need
- Shortage/underserved areas and populations

BH provider variable, based on system support and availability

- Telehealth use
- Health coaches/CHW on the team

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Sustainability: Relationships and Power

- Silo-busting: decision-making structures to support integration
- BH specialist is part of the primary care team and in person
  - Use of telehealth technology
- Leader and champion development
- “Grassroots” provider support to share information
  - MN privacy laws more restrictive than HIPAA

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Sustainability: Mental Models & Combating Stigma

- Make it OK (makeitok.org)
- Hilarious World of Depression Podcasts (hilariousworld.org)
- Call to Mind-Minnesota Public Radio series (calltomindnow.org)
- Frameworks Institute-Language research (frameworksinstitute/mental-health)
- Staff discussions to reduce their own bias and increase comfort with screening and making referrals

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THANK YOU

Contact information:

Claire Neely (cneely@icsi.org)
Jeyn Monkman (jmonkman@icsi.org)

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