



Meeting the Challenge

BEHAVIORAL HEALTH INTEGRATION IN PRIMARY CARE

ROOTS

Reflections on Lessons Learned from Six Years of Experimentation

ACKNOWLEDGEMENTS

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We have been extremely fortunate to not only learn from the creators of Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) and TEAMcare (the AIMS Center team) but also from leaders who began to disseminate and adapt IMPACT and Screening, Brief Intervention, and Referral to Treatment (SBIRT) on a large scale early on (ICSI and WIPHL respectively), and from collaboratives of diverse primary care groups throughout the U.S.

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We dedicate this issue of ROOTS to the following people who have devoted their careers to behavioral health, and had a profound impact on our behavioral health work at the Pittsburgh Regional Health Initiative: Harriet Baum; David Brent, MD; Richard Brown, MD; Sheila Fine; Nancy Jaeckels; Wayne Katon, MD; John Lovelace; Sanne Magnan, MD; Tom McLellan, PhD; Joni Schwager; and Jürgen Unützer, MD.

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patients

In western Pennsylvania, nearly one third of the patients with diabetes or COPD who were readmitted to the hospital within 30 days of discharge also had depression and/or a substance use disorder.

PRHI analysis of PA Health Care Cost Containment Council data*

*PHC4, its agents, and staff, have made no representation, guarantee, or warranty, express or implied, that the data – financial, patient, payer, and physician specific information – provided to this entity, are error free, or that the use of the data will avoid differences of opinion or interpretation.

FOREWORD

Western science has excelled in deducing the structure and functions of the various organs and systems comprising the human body, and has identified the etiology of thousands of diseases affecting health. Likewise, the practice of medicine has generally been organized around these same body systems and disease groupings. Apart from an increasingly small number of primary care physicians (PCPs), most physicians specialize in particular biological systems (e.g., cardiology) or diseases (e.g., oncology). While this focus can be contributed to increases in human life expectancy over the last 100 years, a large part of the picture may be missing. At least three trends urge a “reset” in both the study and practice of medicine that take a more integrative view of human health.

Trend 1: Epidemic of Chronic Diseases

Across the western world, a growing population now manages complex, comorbid chronic diseases. In the U.S., half of all adults have at least one chronic health condition like diabetes, chronic obstructive pulmonary disease (COPD), heart disease, stroke, cancer, obesity, and arthritis. One-quarter of adults have two or more chronic health conditions. Far from being unavoidable, the Centers for Disease Control and Prevention (CDC) has concluded that chronic diseases such as these are “among the most common, costly, and preventable of all health problems.”¹

Trend 2: Growing Awareness that Behavioral Health Affects Chronic Disease Management

Often patients with chronic health problems also struggle with behavioral health conditions like substance use disorders (SUDs) or depression. The Pittsburgh Regional Health Initiative’s (PRHI) research, for example, found depression or SUDs present in 24% of 30-day hospital readmissions for asthma, 31% for COPD, and 29% for diabetes. Moreover, successfully managing chronic diseases often requires behavior changes and the development of self-management skills—the very skills that may be impaired by often undiagnosed behavioral health problems. Depression, for example, is associated with functional impairment, poor adherence to self-care regimens, increased risk of morbidity and mortality, reduced levels of healthy behaviors, and poor quality of life.^{2,3,4,5} Similarly, unhealthy alcohol and other drug use

¹ U.S. Centers for Disease Control and Prevention, Chronic Diseases and Health Promotion (2012 data), <http://www.cdc.gov/chronicdisease/overview/>. Retrieved 14 October 2014.

² Katon WJ. Epidemiology and treatment of depression in patients with chronic medical illness. *Dialogues Clin Neurosci*. 2011;13(1):7-23.

³ Piette JD, Richardson C, Valenstein M. Addressing the needs of patients with multiple chronic illnesses: The case of diabetes and depression. *American Journal of Managed Care*. 2004;10:152-162.

⁴ Lustman RJ, Clouse RE. Depression in diabetic patients: The relationship between mood and glycemic control. *Journal of Diabetes and Its Complications*. 2005;19:113-122.

⁵ Dirmaier J, Watzke B, Koch U, et al. Diabetes in primary care: prospective associations between depression, non-adherence and glycemic control. *Psychother Psychosom*. 2010;79(3):172-8.

(which includes the spectrum of risky or hazardous use, harmful use, abuse, and dependence) complicates chronic disease management and contributes to preventable injuries, hospitalizations, and deaths. Indeed, behavioral health conditions exacerbate chronic medical conditions.

In addition, it turns out that people who frequently visit emergency rooms, or who are admitted to hospitals due to system failures, are not only much more likely to have multiple chronic conditions, but also high rates of depression and substance abuse.⁶ It is not surprising to learn that healthcare costs are 50% higher among patients with depression than those without depression.⁷

Trend 3: A Disproportionate Share of Healthcare Costs

While poorly managed chronic diseases exact high non-monetary costs (measured in quality of life, morbidity, length of stay, impact on caregivers, and comorbidity of hospitalization itself), they are also drivers of unsustainable U.S. healthcare costs. Numerous studies show that a very small group of patients contributes disproportionately to those monetary costs. For example, the Agency for Healthcare Research and Quality's (AHRQ) analysis of U.S. healthcare expenditures found that 5% of the population accounted for nearly half of total medical expenditures, and the top 30% of the population accounted for 89% of total expenditures.⁸

Who are the patients who experience system failures?

These three trends challenge us to re-think the way health care is organized and delivered. "We have to think about health differently," says Pam Pietruszewski, who previously served as a project director for the Institute for Clinical Systems Improvement (ICSI) in Bloomington, Minnesota. "It's not physical, mental, or chemical health—it's overall wellness. The silos need to come down."

Unfortunately, the task falls mainly on a shrinking cohort of overworked PCPs who treat many patients with mental health diagnoses and unhealthy substance use. Nearly one out of five patients screens positive for depression or risky substance use in the primary care offices that routinely screen their patients.^{9,10,11} In addition, although estimates vary, around half of people with major depression receive treatment in a primary care setting.¹² However, behavioral health treatment in primary care is typically less proficient than care provided in behavioral health specialty settings. The shortcomings are numerous:

⁶ Elster S, Vrbin C and Hazon S, Data-guided hot spotting: Characterizing frequently admitted patients, PRHI Readmission Brief, May 2014, www.prhi.org

⁷ Katon WJ, Lin E, Russo J, Unützer J. Increased medical costs of a population-based sample of depressed elderly patients. *Arch Gen Psychiatry*. 2003;60(9):897-903. See also Katon WJ. Epidemiology and treatment of depression in patients with chronic medical illness. *Dialogues Clin Neurosci*. 2011;13(1):7-23.

⁸ Cohen S and Yu W, The concentration and persistence in the level of health expenditures over time: Estimates for the U.S. population, 2008-2009, MEPS Statistical Brief No. 354, 2012.

⁹ Philbrick JT, Connelly JE, Wofford AB. The prevalence of mental disorders in rural office practice. *Journal of General Internal Medicine*. 1996;11(1):9-15.

¹⁰ Spitzer R, Kroenke K, Williams J. Validation and utility of a self-report version of PRIME-MD: The PHQ Primary Care Study. *JAMA*. 1999;282:1737-1744.

¹¹ Unutzer et al. The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicine Health Homes. Center for Health Care Strategies and Mathematica Policy Research May 2013.

¹² Wang PS, Berglund P, Kessler RC. Recent care of common mental disorders in the United States: prevalence and conformance with evidence-based recommendations. *J Gen Intern Med*. 2000;15: 284-292.

- Depression and substance use are not regularly screened for. Therefore, only about half of primary care patients with depression are recognized as such by their PCPs.^{13,14,15} And just less than a third of primary care patients say they are asked about alcohol and other drug use.¹⁶
- Even when identified, only 41% of patients with a mental health diagnosis, including substance use disorders, actually receive treatment¹⁷
- Finally, only 13% of patients with mental health disorders who are treated in primary care settings receive treatment that meets minimal standards, compared to 48% in mental health specialty settings¹⁸

Inadequate recognition and treatment of behavioral health conditions result in poor overall health outcomes and high costs. Changing all of this will require transformations to practice, culture, training, payment, and policy, as well as the adoption of new roles and responsibilities—from patient to provider. As Sam Reynolds, MD, chief quality officer of Allegheny Health Network and then-medical director of population health at Saint Vincent Healthcare Partners, reflects: “To implement change, you need to think about the people, the process, and how to incorporate technology to get the best outcomes.”

The current condition is muddy, but, the destination is clear—fewer silos and more of a whole-person care focus. “The new primary care is focused on the whole person,” says Ken Thompson, MD, a psychiatrist who practices at the Squirrel Hill Health Center in Pittsburgh, Pennsylvania. “It’s primary health care, rather than primary medical care or primary psychiatric medical care. It’s easily accessed—people know where to go for their health care, and they get their whole mind and body attended to in those settings.”

It’s clear that primary care physicians can’t do this alone, but where to begin?

PRHI’s policy and practice work has been framed around this transformational mindset for almost a decade. Together with thought leaders from across the U.S., PRHI has engaged in a series of implementation and dissemination experiments aimed at upending and reintegrating the worlds of behavioral health and physical health into a redesigned primary care setting—starting with Integrating Treatment in Primary Care (ITPC) from 2009-2010, then expanding to Partners in Integrated Care (PIC) from 2010-2013, and then to Care of Mental, Physical and

¹³ Roundy K, Cully JA, Stanley MA, Veazey C, Soucek J, Wray NP, Kunik ME. Are Anxiety and Depression Addressed in Primary Care Patients With Chronic Obstructive Pulmonary Disease? A Chart Review. *Prim Care Companion. J Clin Psychiatry*. 2005;7(5):213-218.

¹⁴ Higgins ES. A review of unrecognized mental illness in primary care: prevalence, natural history, and efforts to change the course. *Arch Fam Med*. 1994;3(10):908-17.

¹⁵ Ani C, Bazargan M, Hindman D, Bell D, Farooq MA, Akhanjee L et al. Depression symptomatology and diagnosis: discordance between patients and physicians in primary care settings. *BMC Family Practice*. 2008;9:1.

¹⁶ D’Amico EJ, Paddock SM, Burnam A, Fuan-Yue F. Identification of and Guidance for Problem Drinking by General Medical Providers: Results From a National Survey. *Medical Care*. 2005;43(3): 229-236.

¹⁷ Wang PS, Lane M, Olfson M, Pincus HA, Wells KB, Kessler RC. Twelve-month use of mental health services in the U.S.: Results from the National Co-morbidity Survey Replication. *Archives of General Psychiatry*. 2005; 62(6): 629-640.

¹⁸ Wang PS, Lane M, Olfson M, Pincus HA, Wells KB, Kessler RC. Twelve-month use of mental health services in the U.S.: Results from the National Co-morbidity Survey Replication. *Archives of General Psychiatry*. 2005; 62(6): 629-640.

Substance Use Syndromes (COMPASS) from 2012-2015. Using well-tested methods for identifying and treating common behavioral health problems, these real-world implementation experiments provide insight into the training needs, payment approaches, practice redesign, and patient engagement strategies needed to successfully implement and sustain these methods in primary care settings across the U.S.

This publication describes these implementation experiments and the stories of health centers who were involved. While we share many anecdotes of their impact on patients, we focus on what we've learned from the clinicians and program support staff—those who will shape the future of primary care—about what it takes to support and sustain integration.

- **Section One – Integrating Behavioral Health in Primary Care Settings: Models That Work:** Sets the stage by introducing two of the most successful models for identifying and addressing depression and risky substance use in primary care
- **Section Two – Putting the Evidence to Work: Experiments in Integration:** Provides an overview of three real-world experiments that implemented these models in primary care practices in western Pennsylvania and across the U.S.
- **Section Three – How the Experiments Break through Barriers at the Practice-Level:** Records the voices of clinicians and others closest to these experiments as they reflect on what it takes to successfully deliver integrated primary and behavioral health care, including getting comfortable talking about behavioral health and behavior change, finding time by embracing a team approach to care, and reaching patients and monitoring care outcomes by customizing information technology
- **Section Four – Sustaining Behavioral Health Integration:** Explores the broader supports that need to be in place to sustain these integrated care models, including implementing new financing models, bridging the worlds of primary care and behavioral health care, and incorporating behavioral health team-based competencies in medical residency programs
- **Appendices:** Includes additional information, such as PRHI's lessons learned to inform future implementation and dissemination work. These lessons describe the importance of practice leadership and champions, health information technology systems, identifying and supporting the right integrated care team, financing integrated care models, and data-driven quality improvement.

A full-page background image featuring a warm, golden-hour scene. A bright sun is partially obscured by the branches of a large tree, creating a dramatic sunburst effect with rays of light filtering through the foliage. The sun's glow illuminates the surrounding trees and a body of water in the foreground, which reflects the light. In the immediate foreground, there are green reeds or grasses. The overall mood is peaceful and hopeful.

INTEGRATING BEHAVIORAL HEALTH IN PRIMARY CARE SETTINGS: MODELS THAT WORK

SECTION 1

Two strategies for identifying and treating depression and risky substance use in primary care settings stand out as particularly effective—Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) and Screening, Brief Intervention, and Referral to Treatment (SBIRT). Both rely on a team—or collaborative—approach to patient care.

Depression: Collaborative Care Management

In recent years, research has shown benefits to collaborative depression care management—a systematic method for expanding the capacity of primary care teams to effectively treat depression in primary care, by adding care managers to the team who help implement treatment plans for both behavioral and physical health, and serve as a link between patients, primary care providers, and mental health specialists. Systematic reviews of over 70 of these studies conclude that collaborative depression care management improves remission of depression and adherence to treatment. Based on these studies, the U.S. Preventive Services Task Force advises screening adults for depression with systems in place to “ensure accurate diagnosis, effective treatment, and appropriate follow-up.”¹⁹ Moreover, the Community Preventive Services Task Force concludes that collaborative depression care management “provides good economic value.”²⁰

The Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) Trial

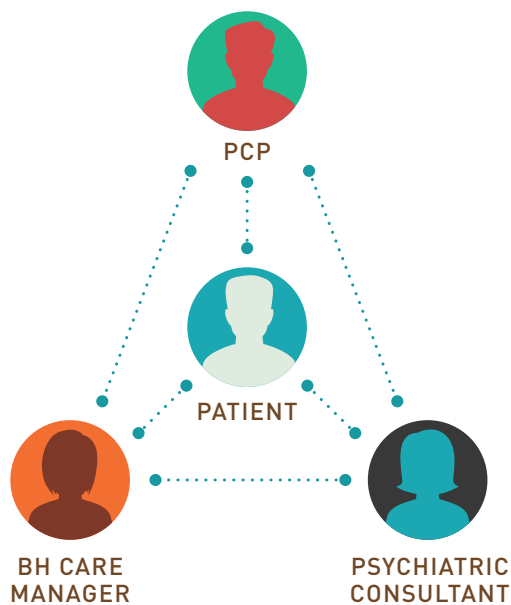
Of these studies about collaborative depression care management, the IMPACT randomized controlled trial included the largest number of participants and showed strong results: more satisfaction among patients and providers, greater quality of life, more remission of depression, and lower healthcare costs with a 6:1 return-on-investment over four years.^{21,22} Using the approach from the IMPACT trial, a collaborative care team provides a new kind of support to patients who have depression, incorporating both new care processes and new staffing roles.

¹⁹ The U.S. Preventive Services Task Force (USPSTF) recommends “screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.” Final Update Summary: Depression in Adults: Screening. U.S. Preventive Services Task Force. January 2016.

²⁰ Community Services Preventive Task Force. Economics of Collaborative Care for Management of Depressive Disorders: A Community Guide Systematic Review. *Am J Prev Med.* 2012;42(5):539-549.

²¹ Unützer et al. Long-term Cost Effects of Collaborative Care for Late-life Depression. *Am J Manag Care.* 2008;14:95-100.

²² Unützer J, Katon W, Callahan CM, Williams JW, Hunkeler E, Harpole L et al. Collaborative care management of late-life depression in the primary care setting. *JAMA.* 2002;288(22):2836-2845.



Source:
University of Washington AIMS Center

The Collaborative Care Team

The patient seeks help, discloses symptoms, participates and engages in treatment, and tracks symptoms.

The PCP identifies patients, introduces Collaborative Care, makes an initial diagnosis, and initiates treatment (prescribes medication, referral to psychotherapy, or both).

The Behavioral Health Care Manager engages patients, tracks patients in a registry, provides care management, brief crisis management, measurement-based treatment to target, and optional evidence-based therapy.

The Psychiatric Consultant provides caseload consultation (reviews patient registry), supports team assessment and treatment, and delivers optional direct evaluation (in person or televideo).

Patients who screen positive for depression, and are diagnosed with depression, meet with a care manager in person and over the telephone. The care manager uses brief, evidence-based intervention skills such as problem-solving treatment, behavioral activation, and motivational interviewing²³—a collaborative style of conversation meant to elicit and strengthen the patient’s motivation for change.

Each week, the care manager meets with the primary care team’s psychiatric consultant to review newly enrolled patients, and patients whose depression score from a repeated screen is not decreasing as expected. To help meet the patient’s treatment target, the psychiatric consultant offers recommendations to the primary care provider. The primary care physician then makes the final decision on how to adjust the treatment plan in order to reach the patient’s targeted goals—an approach known as treat-to-target.

The care manager collaborates with the patient on implementing the treatment plan, monitoring improvement and side effects, and setting patient-identified goals, such as playing with grandchildren, returning to work, or exercising. Once the goals and treatment targets are achieved, the care manager helps the patient create a relapse prevention plan.

The PHQ-9 (a nine-item Patient Health Questionnaire to screen for depression and track severity) and an electronic care management tracking system (CMTS) are used to systematically assess, measure, and track the patient’s response to the depression treatment plan. The IMPACT trial placed a unique focus on systematically following up with patients and adjusting the treatment plan to reach the patient’s goals.

²³ For more information about motivational interviewing, please visit: www.prhi.org

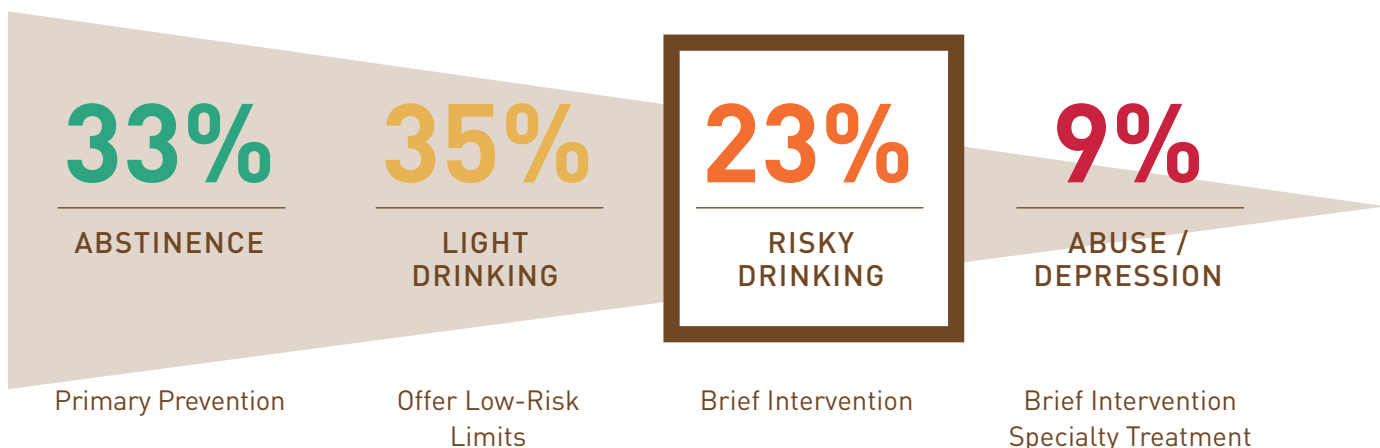
Risky Substance Use: Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Nearly a quarter (23%) of Americans engage in risky drinking, exposing themselves and their communities to the negative health and social consequences associated with unhealthy substance use. Screening and brief interventions for unhealthy alcohol use help people drink less,²⁴ leading to fewer motor vehicle accidents and hospital stays.²⁵

The term “unhealthy substance use” includes risky/hazardous drinking, harmful use, abuse, and dependence.

The benefits of screening and brief interventions in the primary care setting are based on 23 randomized controlled trials. This evidence has been translated into practice through the SBIRT model. SBIRT identifies patients using alcohol or other drugs in a risky manner, delivers brief interventions aimed at reducing risky use, and facilitates access to specialized substance abuse providers for patients with dependence or severe harm (an estimated 9% of patients). A four-year study of screening alcohol misuse and resulting interventions found a 4:1 medical benefit cost ratio and a 39:1 societal benefit cost ratio.²⁶

The Continuum of Substance Use: SBIRT Focuses on Risky Drinking



²⁴ Jonas DE, Garbutt JC, Amick HR et al. Behavioral Counseling After Screening for Alcohol Misuse in Primary Care: A Systematic Review and Meta-analysis for the U.S. Preventive Services Task Force. *Ann Intern Med.* 2012;157(9):645-54.

²⁵ Fleming MF, Mundt MP, French MT, et al. Benefit-cost analysis of brief physician advice with problem drinkers in primary care settings. *Med Care.* 2000;38(1):7-18.

²⁶ Fleming MF, Mundt MP, French MT, Manwell LB, Stauffacher EA, Barry KL. Brief physician advice for problem drinkers: long-term efficacy and benefit-cost analysis. *Alcohol Clin Exp Res.* 2002;26(1):36-43.

MOTIVATIONAL INTERVIEWING


Motivation is influenced by a blend of our life experiences, the people around us, and our perception of our environment. It affects our ability to manage our health, our relationships, and our day-to-day decisions. It is the unique viewpoint that leads a patient to follow through with their care plan...or end up in the emergency room.

Motivational Interviewing (MI) is a conversation style in which healthcare professionals and patients work together to discover the patient's own reasons to make positive behavioral changes and strengthen their commitment to change. It helps providers enter a meaningful conversation with the patient around behavior change.

This is in sharp contrast to the traditional approach to health care. Mindy Hutchinson, MD, consulting psychiatrist for the

Washington Health System Family Medicine explains, "it's easy for us to fall into thinking we're the experts...we just need to tell the patients what to do. We find that approach doesn't work for patients struggling with substance abuse or depression, or a chronic disease like diabetes that requires self-management."

MI calls on providers to understand patient perspectives, values, and thoughts. Using an MI approach, providers help patients change their behavior by evoking their motivation and commitment. The patients are empowered to consider their own reasons for change rather than receiving overwhelming health information or judgment on their current behavior.



“MI isn’t just a technique or therapy... it’s the basis for a closer relationship with patients,”

says Joyce McCadney, LCSW, care manager from Hamilton Health Center. “If we establish a relationship and listen to patients, they can make huge changes. We hear their stories and help them believe that change is possible.”

SBIRT helps patients understand the risks and consequences of unhealthy substance use, set and assess their own goals, and discover internal motivations for behavior change. It focuses on patients in the hazardous or harmful use categories of unhealthy substance use and draws from the principles of motivational interviewing.²⁷ Patients whose screening indicates possible dependence on drugs or alcohol can still receive brief interventions to increase their readiness for a referral to alcohol and other drug treatment specialists. A video demonstration of a brief intervention is available on PRHI's website.²⁸

Comparing Collaborative Depression Care Management and SBIRT

There are important model differences between SBIRT and collaborative depression care management. Collaborative depression care management enhances primary care treatment for those with a clinical level of major depression, whereas SBIRT bridges the gap between prevention and treatment by focusing on patients whose risky substance use does not meet diagnostic criteria for dependence. As such, collaborative depression care management focuses on systematic tracking and treatment adjustments for a caseload of patients with major or chronic depression. SBIRT, meanwhile, focuses on identifying risky and hazardous substance use and providing a few brief interventions to reduce the risk of experiencing the harmful consequences of substance abuse or dependence.

Both models include the role of a care manager who works with the patient to understand the health issue and its implications, elicits healthy goals identified by the patient, helps the patient work toward those goals, bolsters the patient's self-management ability, and coordinates care with a healthcare team.



Philanthropic Commitment to Behavioral Health Integration

In keeping with their role as change agents, three private philanthropies made the ITPC project possible:

“As a foundation that focuses strictly on behavioral health, we have been advocating for integrated care forever, so it was a great opportunity to give the ITPC project life.”

Joni Schwager, Executive Director, Staunton Farm Foundation

²⁷ For more information, please visit: www.prhi.org

²⁸ To watch a video demonstration of a brief intervention, please visit: www.prhi.org

PUTTING THE EVIDENCE TO WORK: IMPLEMENTATION EXPERIMENTS

SECTION 2



The evidence is clear: to succeed, primary health care must view each patient as an integrated whole – treating both body and mind. The collaborative depression care management and SBIRT models for addressing behavioral health problems are effective and efficient approaches for improving depression and unhealthy alcohol and other drug use, respectively. But these models were not widely implemented in primary care settings – particularly in combination – so PRHI began experimenting in 2009 to figure out what it would take to make effective behavioral health integration a standard part of primary care.

The work began with a southwestern Pennsylvania pilot project, Integrating Treatment in Primary Care. This led to additional experiments, first in four states (Partners in Integrated Care) and later in an eight-state project (Care of Mental, Physical and Substance Use Syndromes).

Experiment #1 Integrating Treatment in Primary Care (ITPC)

ITPC ambitiously aimed to pilot a three-pronged approach to behavioral integration at three community health centers in small, rural, or post-industrial towns in southwestern Pennsylvania: Cornerstone Care Community Dental and Medical Plaza, Mon Valley Community Health Services, and UPMC St. Margaret New Kensington Family Health Center.²⁹ The three-pronged approach entailed combining: 1) SBIRT to screen and provide brief intervention for risky substance use, 2) IMPACT to provide treat-to-target for depression, and 3) the Wagner Chronic Care Model (CCM)³⁰ to combine both IMPACT and SBIRT while addressing co-occurring chronic physical conditions. The CCM is a framework for proactively preparing patients and care teams in ways that improve chronic conditions and overall health.

ITPC focused on adult patients with common chronic physical conditions – ischemic heart disease, heart failure, asthma, diabetes, or chronic obstructive pulmonary disease (COPD) – plus depression, unhealthy substance use, or both. The participating health centers soon expanded beyond the initially targeted chronic conditions to include other groups of adult patients as well.

²⁹ The centers consisted of a Federally Qualified Health Center (FQHC), an FQHC look-alike, and a family health center with a medical residency program

³⁰ For more information on the Wagner Chronic Care Model, see PRHI website: www.prhi.org

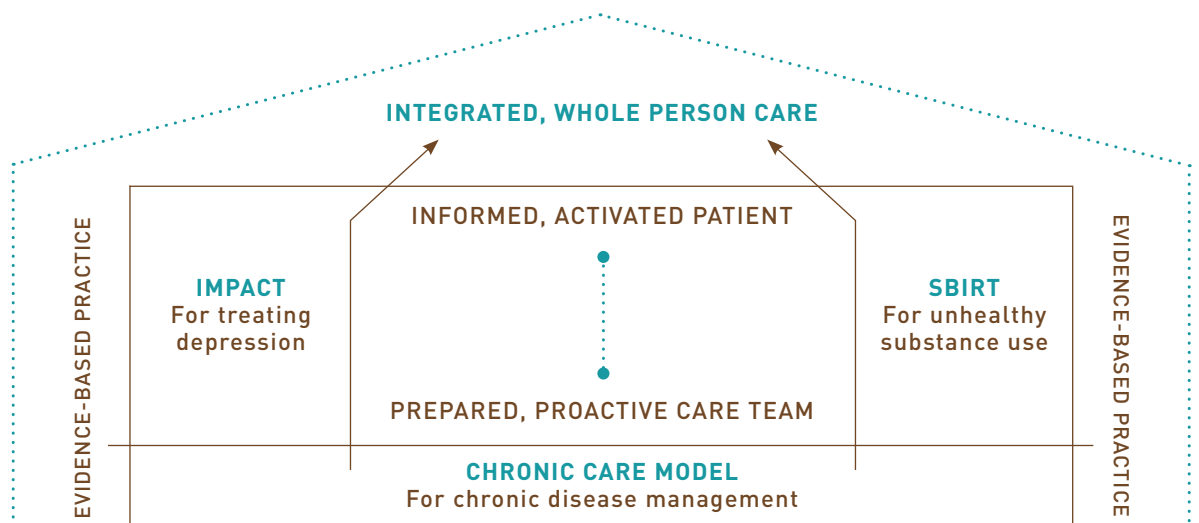
The ITPC care model consisted of five core components:

1. Systematic screening
2. Patient activation
3. Brief interventions
4. Structured follow-up
5. Treat-to-target (stepped care)

Patients received treatment from a collaborative care team, led by a PCP working with a full-time care manager, as well as a consulting pharmacist and a psychiatrist. The care managers were ITPC-trained master's level behavioral health providers or health educators.

In addition to favorable patient outcomes, which may be found in Appendix A, the ITPC project resulted in a care management tracking system (CMTS) to track appointments, follow-up care, and patient progress for depression and substance misuse. And in collaboration with the University of Pittsburgh's Evaluation Institute, staff produced an implementation toolkit to facilitate spread and evaluate ITPC.

Finally, ITPC aimed to create a sustainable model to pay for the new care team members. With that in mind, PRHI staff worked with an Advancing Integrated Mental Health Solutions (AIMS) Center consultant to identify billing codes for reimbursable and non-reimbursable services by health plan, provider type, and facility type. Despite these efforts, ITPC did not result in a sustainable billing and reimbursement model because the existing, limited payment mechanisms didn't fit the collaborative depression care management model, or generate sufficient revenue to cover the costs of important care components, such as the weekly case reviews with a consulting psychiatrist. It was clear that champions of integrated care could not rely on existing fee-for-service billing codes and instead needed to advocate for a new reimbursement model—one that is fully supportive of proven methods for treating patients' behavioral and physical health needs. (Please see Appendix B: Implementation and Dissemination Tips)



CHAMPIONS FOR INTEGRATING CARE NETWORK: SPREADING LESSONS LEARNED AND BEST PRACTICES

Other projects like ITPC were concurrently taking place across the country. Recognizing that sharing experiences could lead to project-specific improvements and spur payment reform, PRHI created a national learning network called Champions for Integrating Care in 2009. Chaired by Ken Thompson, MD, then-medical director of SAMHSA's Center for Mental Health Services, and Connie Pechura, PhD, then-executive director of the Treatment Research Institute, the group of about

50 state and federal policy officials, program directors, funders, providers, academics, and health plans sought to disseminate best practices for integrating physical and behavioral health services, and share solutions to implementation barriers. The group held webinars exploring best practices, reimbursement methods, breakthroughs in implementation and sustainability, workforce development, and policy barriers. These webinars featured the nationally renowned work of:

Institute for Clinical Systems Improvement's
DIAMOND initiative

Wisconsin Initiative to Promote
Healthy Lifestyles (WIPHL)

University of Washington's TEAMcare trial

Southcentral Foundation's Nuka Model of
Care in Alaska

Cherokee Health Systems in Tennessee

REACH NOLA in New Orleans

Veterans Affairs' Translating Initiatives for
Depression into Effective Solutions (TIDES)

Mental Health Integration Program (MHIP)
in Washington

The recordings of the 12 webinars are available on prhi.org

Core Components of the Partners in Integrated Care (PIC) Model



ICSI Institute for Clinical
Systems Improvement

WCHQ
Wisconsin Collaborative
for Healthcare Quality

Time to ask.
WIPHL
WISCONSIN INITIATIVE
to PROMOTE HEALTHY
LIFESTYLES

**PITTSBURGH
REGIONAL
HEALTH
INITIATIVE**
Spreading Quality,
Containing Costs.

nrhi Network for
Regional Healthcare Improvement

MHQP
MASSACHUSETTS
HEALTH QUALITY PARTNERS
trusted information. quality insights.

Experiment #2: Partners in Integrated Care (PIC)

Around the same time that the ITPC project was winding down, the Agency for Healthcare Research and Quality (AHRQ) issued a request for applications that provided an opportunity to further disseminate IMPACT and SBIRT in primary care settings. PRHI, together with four partners, received \$3.4 million in funding³¹ to spread this model in primary care practices across three states, and to lay the groundwork for further dissemination nationally. The joint project – named Partners in Integrated Care (PIC) – brought together the complementary experiences, resources, and expertise of the following partners:

- **Minnesota** → Institute for Clinical Systems Improvement (ICSI)
 - ICSI had implemented a depression initiative based on IMPACT in 86 primary care practices called DIAMOND (Depression Improvement across Minnesota, Offering a New Direction). The project resulted both in a reimbursement model and a 30% depression remission rate at six months of enrollment.
- **Wisconsin** → Wisconsin Initiative to Promote Healthy Lifestyles (WIPHL) and the Wisconsin Collaborative for Healthcare Quality (WCHQ)
 - With support from the Substance Abuse and Mental Health Services Administration (SAMHSA), WIPHL had implemented SBIRT in 31 clinical settings and created breakthrough solutions and results, including a fee-for-service reimbursement model for SBIRT provided by health educators, more than 26,300 brief interventions, a 20% reduction in risky drinking, and a 48% reduction in daily or almost-daily marijuana use. For the purposes of the PIC project, WIPHL worked in collaboration with WCHQ—a regional health improvement collaborative.
- **National** → Network for Regional Healthcare Improvement (NRHI)
 - NRHI, an association of regional health improvement collaboratives across the U.S. (like PRHI, ICSI, and WCHQ), served as the vehicle for further dissemination among its members.

Similar to the ITPC care model, the PIC project's care delivery services included ³²:

- Screening for depression and alcohol and other drug misuse
- A care manager for patient engagement, behavioral interventions, follow-up monitoring, and facilitating team-based collaboration
- A consulting psychiatrist for weekly caseload reviews, with a focus on depression
- Systematic follow up and tracking
- Treat-to-target approach for the primary care provider to modify the treatment plan

³¹ This project was supported by grant number R18HS019943 from AHRQ. The content of this ROOTS is solely the responsibility of the authors and does not represent the official views of AHRQ.

³² See PIC program overview on the PRHI website: www.prhi.org

Although these were the core components in the PIC project, primary care practices made adaptations to fit their cultures, workflows, and resources.

Over the course of the three-year project, the combination of SBIRT and IMPACT in PIC was implemented in 57 primary care offices across four states (initially in Pennsylvania, Minnesota, Wisconsin, and later in Massachusetts). The primary care teams received training followed by practice coaching on workflows, skill development, and quality improvement. Moreover, the partners offered regional and multi-state collaborative networking opportunities for the medical groups to learn from each other. Although the PIC partners agreed to a set of core topics and methods for training and coaching, the exact methods and intensity varied by region (see Appendix C for training details).

Three-Pronged Learning Approach Provided by PIC Partners



DIDACTIC



GROUP WORK



SIMULATED PATIENTS

The primary care offices in Pennsylvania, Minnesota, and Wisconsin implemented the combined model of SBIRT and IMPACT in the initial year of the project. The PRHI-led project team then worked with NRHI to engage the Massachusetts Health Quality Partners (MHQP) in disseminating the model in the final year of the project. MHQP embarked on a communication campaign, including press releases, websites, webinars, and information packets, to identify community partners and recruit four primary care offices. Their media blitz resulted in partnerships with the Massachusetts Screening, Brief Intervention, Referral and Treatment (MASBIRT) program and various state-level government departments.

At the conclusion of the PIC project period, the partners assembled and updated an online marketing and implementation toolkit for primary care practices around the U.S. (see Appendix D).³³

³³ Partners in Integrated Care (PIC) Toolkit: www.prhi.org

Experiment #3: Care of Mental, Physical and Substance Use Syndromes (COMPASS)

Equipped with lessons learned from PIC on how to design a dissemination project across multiple organizations and states, ICSI (as the lead) and seven other partners, including PRHI, received an \$18 million Health Care Innovation Award from the Center for Medicare & Medicaid Innovation (CMMI) to implement and evaluate a collaborative care management model for adult primary care patients with sub-optimally managed depression, plus diabetes and/or cardiovascular disease.

The resulting COMPASS initiative included 18 large medical groups with 190 primary care offices in Pennsylvania, Minnesota, California, Colorado, Washington, Michigan, Florida, and Massachusetts. In Pennsylvania, PRHI worked with three medical groups—Excela Health Medical Group, Premier Medical Associates, and Saint Vincent Healthcare Partners—to implement the collaborative care management model in 28 primary care offices. The implementation partners included Community Health Plan of Washington, the Institute for Clinical Systems Improvement, Kaiser Permanente Colorado, Kaiser Permanente Southern California, Mayo Clinic Health System, Michigan Center for Clinical Systems Improvement, Mount Auburn Cambridge Independent Practice Association, and PRHI. The AIMS Center at the University of Washington provided consultation to the eight implementation partners on how to maintain fidelity to the evidence-based model.

In addition to the collaborative care team members that were used in PIC and ITPC—a PCP, care manager, and consulting psychiatrist—the collaborative care team in COMPASS also included a medical consultant for diabetes and cardiovascular disease, since COMPASS was informed by the TEAMcare trial that improved outcomes for depression, diabetes, and heart disease. Learning from PIC’s experience with tracking processes and outcomes across multiple organizations, the COMPASS initiative provided a standard care management tracking system (CMTS) from the AIMS Center, which included functions to prompt for follow-up contacts, and sort the caseload from high to low baseline and most recent disease values to prompt for treatment intensification when there is a lack of improvement. If a medical group wasn’t able to use the specified CMTS, they were required to create their own systems with standard data fields and functions.

The HealthPartners Institute for Education and Research (HPIER) in Minnesota directed the internal evaluation of COMPASS, which assessed experience of care, quality, and costs, and provided weekly to monthly data reports for the partners and medical groups to drive quality improvement.

The preliminary data from the three Pennsylvania medical groups that PRHI worked with indicated that 740 patients were enrolled, and among those enrolled for at least four months:

- 74% had significantly improved their depression
- 29% achieved depression remission
- 58% had an A1c less than 8 compared to 41% at baseline
- 60% had a blood pressure below 140/90 (if initial blood pressure was elevated)



Dr. DiCola leads an activity with the Excelsa COMPASS care team to generate ideas for preventing avoidable admissions and emergency department visits.

“Working with PRHI in COMPASS has left me with no doubt that a person-centered, whole health approach to primary care that recognizes the strong link between physical and mental disorders is critical to patient care, especially in caring for patients with chronic diseases.”

I have patients with high blood pressure, asthma, and diabetes whom I have treated for years, but had been unable to help them to manage their diseases as well as I would have liked. Through COMPASS, we discovered that these patients had depression. We treated their depression, which significantly increased adherence to recommended lifestyle and behavioral changes...improving their mental health enabled them to access the self-motivation needed to improve their physical health.

We know that the presence of mental disorders, such as depression, adversely affects the course and complicates the treatment of chronic disease. It's a new way of thinking for primary care, but the fact is, the majority of people are served in the primary medical care setting only. And if we don't diagnose and address mental health issues here, then they most likely will remain undiagnosed and untreated, increasing adverse health behaviors and outcomes and the cost of care."

Daniel DiCola, MD, Excelsa Health Medical Group;
Clinical Associate Professor (Pennsylvania)

A photograph of a dense forest with sunlight filtering through the trees, creating a bright, hazy atmosphere. The sun is visible in the upper right corner, casting rays of light across the scene. The text is overlaid in the center.

HOW THE EXPERIMENTS BREAK THROUGH BARRIERS AND LEAD TO INTEGRATION AT THE PRACTICE LEVEL

SECTION 3

For physician Dan DiCola, a primary care physician in the COMPASS project at Excelsa Health Medical Group, it can feel like “primary care physicians are supplying 85-90% of the psychiatric care in this country.” But we know from the research that the care hasn’t been systematic or consistent across or within practices. Patients slip through the cracks. Many physicians are uncomfortable asking about behavioral health issues, and most patients are uncomfortable bringing them up. Even for the best-intentioned physician, there’s little time to ask about depression or risky drinking in a world where a growing number of patients with multiple, complex chronic diseases are confined to 15-minute office visits.

And perhaps because behavioral health has been treated as separate from physical health, collaboration between PCPs and outside behavioral health experts is also less than perfect. Dr. Parinda Khatri, chief clinical officer at Cherokee Health Systems says, “When you refer to any other specialty, you get feedback that helps you manage your patients’ health: ‘Thank you for the referral. I saw this patient, and here’s what’s going on.’ But some medical providers say referring patients to behavioral health is like putting a message in a bottle—they never hear back.”

Integrated care models break through these barriers and can improve health outcomes and decrease the cost of care. But to be implemented, initiatives like ITPC, PIC, and COMPASS must address important practice-level barriers to integrating care. For example, primary care physicians and their patients have to feel comfortable embracing behavioral health as part of overall health. This section records the voices of the clinicians and others closest to these initiatives as they reflect on what it takes to implement integrated care models.



Claire Neely, MD, chief medical officer at ICSI, utilizes a visual “Learning Ladder” at a COMPASS training for Premier Medical Associates to explain the iterative process that trainees go through when learning new skills.

Getting Comfortable with a New Conversation

Mental health and depression must be melded into a clinic’s culture in order for patients and providers to feel comfortable discussing more than mere physical symptoms. Everyone on staff—from front desk receptionists to physicians—must consider behavioral health care an integral component in helping patients thrive.

“Achieving integrated primary care requires a certain attitude, one that embraces education,” says Claire Neely, MD, director of the COMPASS project at ICSI. “This doesn’t just mean educating patients and the community—it’s also educating staff so they realize this is an important thing they can do to help the patients they serve. We approach it as helping patients make positive changes to feel better and function more optimally—whether it be the behavior of testing blood sugar or the behavior of going for a walk. The crux of it all is talking with patients about behavior change and what motivates them to live a healthier life.”

Uncovering patients’ goals through motivational interviewing (MI) and behavioral activation can serve as a catalyst for reaching health goals. For example, a man enrolled in COMPASS, whom we will refer to as Joe, longed to escape Minnesota’s Arctic winter blasts for the beaches of Hawaii. In order to do that, he had to get his diabetes under control, shed pounds, and make strides in managing his depression. Joe’s care manager embraced this dream, partnering with him to see what it would take to make a Waikiki vacation a reality.

“The care manager discovered it would be a seven-hour flight, which would be challenging for the patient because his diabetes makes it hard for him to sit for long periods of time and makes him go to the bathroom often,” Dr. Neely says. “The patient stopped and said, ‘taking this long flight, getting up all the time – that’s not going to work.’”

That revelation led to a conversation with his care manager about checking his blood sugar—which he wasn’t doing previously—eating right, and taking his antidepressants consistently. With his blood sugar down and his depression improving, Joe is making strides toward Hawaii.

“It’s crucial for practices to understand that we’re not trying to get numbers normalized, but rather help patients live a healthier, more satisfying life,” Dr. Neely says. “That’s part of our responsibility.”



At the conclusion of their COMPASS training, patient care coordinators at Premier Medical Associates unpack PHQ-9 screens for each of their offices.

MI and behavioral activation techniques represent a shift in healthcare philosophy, says Pam Pietruszewski, past PIC project leader for ICSI. “It’s about patients being equal partners with the provider,” she says. “You, as a physician or nurse, are an expert in diabetes or whatever the clinical topic may be, and the patient is an expert in their own life. No one knows them better than they do. You need both sets of expertise to make real progress.”

But this shift is hard and takes time to occur. Amy Schultz, RN and Beth Vrbanic, RN, patient care coordinators at Premier Medical Associates, reflect: “We didn’t know the motivational interviewing process as well at the beginning of COMPASS, and how it can be used to turn an hour-long conversation into a 20-minute conversation. You are not going to fix everyone, so it is about giving patients the resources and tools they need and guiding them. It is really about the patient finding a way to manage their conditions on their own.”

Reframing mental health challenges to show how they fit into the larger context of patients’ lives destigmatizes treatment, notes Ken Thompson, MD, a psychiatrist at Squirrel Hill Health Center who served as a consulting psychiatrist in PIC. “Instead of saying, ‘your life is a mess, you need to go see a psychiatrist,’ we might say, ‘boy, that’s a really hard way to live. We’ve got a specialist here who’s very good at helping people deal with this kind of stress.’”

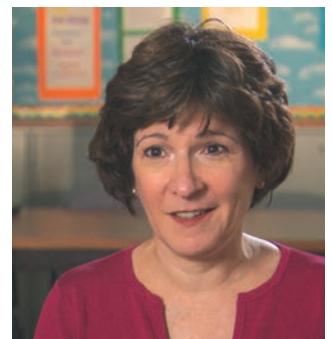
But patients, like providers, occasionally struggle with the new and expanded primary care dialogue.

Dan DiCola, MD, from the Excelsa Health Medical Group, notes that some depressed patients blame themselves, considering their condition an inherent weakness that they should be able to “fix” alone. He tries to dissolve that feeling. “I talk about how common depression is in a normal practice setting, and that we now have the means to help people,” Dr. DiCola says. “But I also tell them it’s going to involve some work on their part. It’s not like an infection, where we give them medicine and they’re better 24 hours later. I tell them that with a few months of work, we’re able to successfully treat many people.”

“Beyond finding ways to discuss behavioral health problems with patients, providers need to know that behavior change is a complicated and challenging process,” says Mindy Hutchinson, a consulting psychiatrist during Washington Health System Family Medicine’s PIC participation, and a teacher/supervisor of residents treating depressed patients. Not everyone walks in ready to start exercising, cut out junk food, or connect in social settings. Motivational interviewing primes patients to make changes, but such skills aren’t always intuitive for providers. “As doctors, we want to jump in and tell people what the answers are,” Dr. Hutchinson says. “That’s not always productive. Learning more about the patients’ internal drivers and what they like and don’t like about their current position is key.”



Amy Albright, RN, care manager at Saint Vincent Healthcare Partners, shares a similar view of motivational interviewing. “We are not just preaching to the patients. We just kind of guide them, and we figure out from the patient what their goals and priorities are. The process of repeating and reflecting patients’ words helps them open up and set goals for behavior change. And we always have a next step at the end of the contact that we elicit from the patient.”



Mindy Hutchinson, MD, psychiatrist, Washington Health System Family Medicine

With programs like ITPC, PIC, and COMPASS, physicians don't shoulder the burden of eliciting behavior change alone. Much of the work to change actually occurs in between physician visits with the care manager who receives training in MI and behavioral activation from organizations like PRHI. "They're the ones who often hear, 'I haven't told anyone this, but when my mother died, I went back to drinking,' or 'I never exercise but the doctor doesn't bring it up, so I guess it's fine,'" Pietruszewski says. "These are the stories that don't come out in the fifteen-minute primary care physician visit."

CARE MANAGEMENT – A NEW CAREER OPPORTUNITY

A big part of improving care and reducing costs (for example, those associated with preventable hospital admissions) is engaging the whole patient – to understand their treatment plans, to activate them to care for themselves, and to address the barriers to better health.

New models of care, recognizing the importance of these ingredients, present new career opportunities in care management.



“This is a natural next step from home care.”

Patricia Rennels, RN,
COMPASS Care Manager
(Excela Health Medical Group, PA)

“I’m using skills I developed working with patients with diabetes, COPD, asthma, and hypertension, and applying them to patients with behavioral health conditions.”

Judy Devenney, RN, BSN,
PIC Care Manager
(Washington Health System, PA)

Finding Time: Embracing Team Care

Star Rebarchak, RN, a past supervisor for COMPASS at Premier Medical Associates, knows from the front line the challenge of finding time for behavioral health care. “Physicians can’t address everything in a visit, so they often focus on physical health needs first. Less obvious behavioral concerns, quietly sabotaging patients’ physical health, go unaddressed.”

Making time is essential for primary care practices to treat the full array of patients’ physical and behavioral health issues. In ITPC, PIC, and COMPASS, primary care teams implemented key practice design changes to make time available for behavioral health issues:

- (1) organizing care in teams
- (2) organizing an information system that prompts for systematic patient tracking and follow up

Team-based care is a fundamental feature of behavioral health integration, but delivering it requires a marked change in the way primary care doctors have practiced for decades. Count Excela’s Dr. DiCola among the converted. “I came from the generation where the physician is king,” he says. “Yet, as I have gone further in my career, I now realize the importance of a collaborative care model. That’s especially the case with patients who have multiple diseases. If we’re going to effectively treat these complex, vulnerable patients, we need help from care managers, social workers, and psychiatrists.”

Without a team in place, using a behavioral screening tool would be impractical, Washington Health System’s Dr. Hutchison adds. “The doctor would have to spend ten minutes with a patient to administer the initial screen, decide that a more complete measurement of depression was needed, and then wait while the patient filled in the form. Instead, the medical assistant performs these tasks while rooming the patient and checking their vital signs. When the doctor walks in, there’s time to discuss the screening results with the patient.” If a diagnosis is made, the patient is then immediately connected to a care manager for support in between visits with the physician, who receives structured recommendations by a psychiatrist on how to adjust the patient’s treatment plan until the treatment goals are met. The care manager becomes the face of integrated care, often providing both brief interventions for unhealthy substance use and ongoing follow-up care for depression.



Example: A receptionist at Washington Health System Family Medicine gives a PHQ-9 and substance misuse screen to a patient at check-in.



Example: A medical assistant at Saint Vincent Healthcare Partners reviews the completed PHQ-9 with a patient prior to being seen by the physician.



Patty Rennels, RN,
health coach, Excelsa Health
Medical Group

“Physicians recognize the importance of behavioral health, and they’re hungry for someone to help them address those needs more comprehensively,” Pietruszewski says. “Once you show physicians that other team members can successfully co-manage components of the patient’s needs, the practice runs more smoothly.”

Dr. DiCola concurs: “Behavioral health issues take time, but we know they have a significant impact on physical health, especially for patients with chronic diseases. It’s not something to be ignored. I think the screening tool we use is such a time- and cost-efficient way to discover depression. And when we discover it, we can use care managers to gather more information.”

That additional information gathering often goes beyond the typical information a patient would generally bring up at an initial primary care office visit. For example, Excelsa COMPASS Care Manager Patty Rennels, RN, helps patients navigate the social, economic, and environmental factors that can impede good health. She recalls meeting a patient who lost his job, car, and house within weeks. His blood sugar and weight spiked because he was binge eating, and he couldn’t sleep. He tried to get work, but no one would hire him. Occasionally, the patient considered suicide.

“He had to rebuild his self-esteem,” Rennels says. “We just started by trying to get the binge eating under control and getting a decent night’s rest. His blood sugar, weight, and blood pressure have all come down. He was able to find a job, and he can pay his bills. When we started, the patient’s PHQ-9 score was 23 (which indicates severely depressed). During his last appointment, it was 3 (minimal symptoms). It wasn’t easy. I was there to talk him through difficult times and provide support, but he did all of the work to make these changes within a year.”

A team-based approach to primary care, featuring new players like Rennels, allows physicians to use their time more efficiently, helps patients once suffering in silence get comprehensive treatment, and strengthens the patient-physician relationship. Rennels notes, “Patients felt like I was a direct line to their doctor. They felt closer to their physicians through me.”



Example: The primary care physician exists the exam room after introducing the patient to **Joyce McCadney**, LCSW, at Hamilton Health Center (PIC Initiative).



Example: While the patient is there, a medical assistant, primary care physician, and a care manager from Saint Vincent Medical Group huddle to review next steps.

Dr. Reynolds, a PCP and then-medical director of population health at Saint Vincent Healthcare Partners during COMPASS, agrees and reflects how prior to COMPASS: “There were certain patients whom I did not have a clear sense of what happened after a visit with me. In COMPASS, I knew the care managers would keep me updated and follow up with patients to provide feedback in between my visits. I had a better connection with patients as a result, and at the same time, I was freed up to take on other responsibilities. I often hear from my patients that ‘Kelly is so great’ or ‘I love Amy’ and ‘I am so glad Kim is part of your team.’ Through these meaningful relationships, change takes place.” Amy Albright, RN, Kelly Baker, RN, and Kimberly Bell, RN—three of the care managers at Saint Vincent—tell their patients, “we are an extension of the PCP, and we are always here for you.”

“There are still frustrations—we don’t hit home runs with everybody,” Dr. DiCola says. “But my inspiration is that COMPASS has given us tools to help people that I don’t think we could have reached previously.”

Engaging the Community to Demystify Behavioral Health

With a population of fewer than 5,500 people, Montevideo, Minnesota is the sort of town where you see familiar faces at the supermarket, the bowling alley, and the bar. When a local clinic implemented SBIRT in PIC, providers worried that they would alienate friends and neighbors by asking about their drinking and substance use habits. So, at first, they rarely broached the subject.

“Clinic staff believed that patients only wanted treatment for medical concerns and would be put off by questions about behavioral health,” says Pam Pietruszewski. “Clinic screening rates for drug and alcohol use were low because of the anticipated stigma, yet we didn’t really know what the patients thought because we weren’t asking.”



Montevideo Clinic

By reaching beyond the walls of the doctor's office—and beyond the traditional medical system—the clinic discovered that the community was, in fact, ready for those behavioral health and lifestyle conversations.

The Montevideo clinic developed a survey asking patients, law enforcement, school systems, and local media about their views on the community's responsibility for promoting healthy behavioral and physical health lifestyles. Surprisingly, most respondents said they expected to be asked questions about drug and alcohol habits when they visit the doctor's office. They viewed it as a routine part of care, rather than taboo. The clinic then convened meetings with community stakeholders to gain more insight into how to effectively embed behavioral health, including substance use, into routine medical care.

The clinic staff made screening a part of every appointment, which allowed them to identify more patients coping with depression and risky substance/alcohol use, and to address those issues.

"That feedback freed up the clinic to fully embrace the PIC model and work with other community members and civic organizations," Pietruszewski says. "The community found out that a lot of people had a vested interest in addressing unhealthy alcohol and other drug use, but they were all working separately. Once the Montevideo community came together, the clinic found that they weren't alone in their mission to improve overall health."

Going Beyond Office Walls and Into the Community to Meet Patients' Needs

To emphasize the importance of community, medical care quality and access determine less than a quarter of a population's overall health, according to the CDC. Socio-economic and environmental characteristics, by contrast, account for more than half of a population's well-being.³⁴ Primary care providers must become a part of the community fabric to confront these determinants of health, says Claire Neely, MD, of the Institute for Clinical Systems Improvement.

"Many patients have unstable housing, they're socially isolated, and they're making choices between paying for medications or food," Dr. Neely says. "We're finding other non-traditional partners, like area agencies on aging, AARP, and affordable housing agencies who share a desire to remove barriers that prevent patients from getting well."

Some patients struggling with comorbid physical and behavioral health conditions are caretakers themselves, notes Washington Health System Family Medicine's Dr. Hutchinson. One of the first patients that Dr. Hutchinson treated through PIC was a middle-age woman with a disabled husband and brother who both relied on her for care. As her brother's condition deteriorated, the patient spent more of her time attending to his needs and scraped by financially. Her stress level spiked, and she was diagnosed as severely depressed with an initial PHQ-9 score of 20. A care manager at Washington Health System Family Medicine maintained weekly contact with the patient, linking her to social and home healthcare services that could shoulder some of the responsibilities that had contributed to her own decline in health.

³⁴ Centers for Disease Control and Prevention, <http://www.cdc.gov/socialdeterminants/faq.html>, retrieved 22 October 2014.

“In offering that support along with counseling and therapeutic recommendations from the prescribing physician, her PHQ-9 score went down to 3 [indicating remission from depression symptoms] in just a few months,” Dr. Hutchinson says. “We’re able to make that kind of impact in the primary care setting with the right resources.”

At Excelsa, Dr. DiCola established close ties with a local YMCA that offers COMPASS patients low-cost diet, exercise, and pre-diabetes programs. He also tapped student counseling services at nearby Seton Hill University and Saint Vincent College to refer more young adults burdened by comorbid health conditions. The team also connected COMPASS patients with community groups that assist with housing and employment.

Excelsa’s community ties enhanced the team-based care offered through COMPASS. Dr. DiCola recalls treating a man dealing with diabetes, depression, high blood pressure, high cholesterol, and sleep apnea. The patient was also unemployed and didn’t have a car. After enrolling in COMPASS, the patient started on antidepressants, watched his diet, and with the help of an employment agency, found a new job that rekindled an old passion.

“He has lost a tremendous amount of weight,” Dr. DiCola says. “He’s this dapperly dressed fellow who has just completely turned his life around, and the lives of his family in the process. We’re fortunate to have such a strong network of services.”

Creating strong health provider-neighborhood networks is difficult because few communities have a natural forum for discussion between the two, notes Dr. Neely. But improving population health requires practices to expand the continuum of care well beyond the medical realm.

“Health care can’t do it alone,” Dr. Neely says. “We need public health, community services, and affordable housing all working together. It’s thinking about health as overall wellness, rather than as the absence of disease.”

As family physician and PRHI’s Chief Learning and Informatics Officer, Bruce Block, MD, reminds us: “Health happens in between doctors’ visits.”

Reaching Patients and Monitoring Integrated Care by Investing in Information Technology

Finally, beyond using multi-disciplinary teams to reorganize care delivery, behavioral health integration requires the capacity to track patients—ensuring that screening is offered, and that the treatment plan is achieving the expected results even for patients who may be hard to reach at times.

Doing this effectively requires that practices leverage and customize information technology. For example, each morning, nurses at Allegheny Health Network’s Saint Vincent Healthcare Partners’ 16 locations access their practice’s electronic health record to view a list of scheduled patients. The night before, a program automatically scans patients’ diagnoses and lab values, honing in on those who meet the criteria for receiving a PHQ-9 depression screening to determine eligibility for COMPASS care.





Dr. Reynolds (PCP), Eric Munson (IT), and Kelly Baker (Care Manager) review the information technology program that automatically prints the PHQ-9 the night before for eligible patients at Saint Vincent.

Saint Vincent's EHR and population modules helped practices reach far more COMPASS patients than a manual system would have allowed. Among the 18 medical groups in COMPASS, Saint Vincent enrolled the second highest number of patients in the program, and more than 70% have experienced a clinically significant improvement in their depression.

Other practices participating in ITPC, PIC, and COMPASS have also harnessed the power of electronic information systems to connect with more patients facing comorbid health conditions, monitor their progress over time, enhance communication among care team members, and streamline data reporting and outcomes measurement. In ITPC and COMPASS, the practices used the care management tracking system (CMTS) from the AIMS Center. In PIC, they used several strategies, including modifications to their EHR.

"Ideally, data entry and reporting are built into the practice's workflow and care process. It becomes an integral part of helping patients manage their conditions," says Robert Ferguson, PRHI's director of government grants and policy who worked on ITPC, PIC, and COMPASS. "A CMTS prompts care managers to contact enrolled patients on a regular basis, based on severity, and shows the entire caseload's baseline and current progress to inform treatment changes." If the CMTS' functions and care management forms for physical and behavioral health are built within the practice's EHR, then data entry is streamlined and it becomes sustainable beyond the project period.

A CMTS system can create caseload summary pages that allow clinicians to see a patient's depression and substance use scores over time—at both the individual and practice (or "population") level, enabling a more methodical approach to depression care. This allows the care team to monitor behavioral health changes in a way that's similar to tracking lab results and blood pressure readings.

"The system allows us to quickly get a snapshot of a patient's mental health status over time," Dr. Hutchinson says. "When patients come in who have tried multiple treatments in the past, we can easily look back and see what plan worked best."

Care Manager Judy Devenney, RN, also notes that the customized CMTS, which they built into their EHR, was invaluable in tracking patients enrolled in PIC. As her workload grew, Devenney used the CMTS in her EHR to stay on top of her caseload review with the consulting psychiatrist. “It refreshes my memory, and when I start contacting people, I just pull up my registry, go to my list, and I know exactly whom I need to call,” Devenney says.

Excela Care Manager Patty Rennels, RN, concurs. “What I really like is the caseload summary page that shows everyone, and where you can manipulate the data from high to low disease scores like A1cs and PHQ-9s. It made my day a lot better organized because I knew whom I needed to call. When I was getting ready for the systematic case reviews with the consulting physicians, I would look from high to low scores and pick out the top 10 worst numbers and see when we talked about them last, and if we hadn’t talked about them recently, then I would include them on the list for the next case review. I loved that.”

The automated screening system that Saint Vincent created for COMPASS aligns with the health group’s goal of taking a population health-based approach to care. “That means we’re looking at the entire population, identifying at-risk populations and deploying proactive resources, rather than just waiting for them to come to us or for the phone to ring,” Dr. Reynolds says. “We’re reaching out to patients whom we haven’t seen in a while, who often aren’t compliant because they’re dealing with a mental health issue. That drives not just poor health outcomes, but also the cost of care for those patients. Through COMPASS, we can get them more connected and engaged in their own care. And the CMTS helps us do this more efficiently.”



Example: **Mindy Hutchinson, MD**, psychiatrist, and **Judy Devenney, RN**, care manager, review challenging cases using the care management tracking system in the EHR at Washington Health System Family Medicine.

A hand is shown from the wrist up, holding a single pear with a small green leaf attached to its stem. The pear is yellow with some red blush. The background is a soft-focus landscape with a warm, orange and yellow sky, suggesting a sunset or sunrise. The overall mood is calm and hopeful.

SUSTAINING BEHAVIORAL HEALTH INTEGRATION

SECTION **4**

Public and philanthropic investments made it possible for ITPC, PIC, and COMPASS to translate evidence-based service delivery models into practice. As a result, we now have a wealth of lessons learned on how to implement these services well. It takes leaders and champions who are invested care team members with the right skills and characteristics, quality trainers and coaches, and customized health information technology like the CMTS.

Integrated Primary Care: Who Pays For It?

Replicating this kind of coordinated, body-and-mind care in practices across the country will require payments and policies that recognize the broad array of determinants that influence health. Such supports remain scarce.

“Our healthcare system still pays mostly for face-to-face visits and procedures, but little else,” Dr. Khatri of Cherokee Health Systems says. “Behavioral health is a ‘carve-out,’ with different rules, funding streams, and little communication with the physical health side. Even if behavioral health providers are working with someone on self-management for diabetes or helping to improve overall health status, they’re not on medical panels. All of this causes a tremendous amount of fragmented care.”

Despite these system challenges, the ITPC, PIC, and COMPASS primary care partners in Pennsylvania—a state with a Medicaid managed care system that carves out behavioral health—were able to work through these challenges and implement the integrated care services for patients.

“Integrated primary care is a different way of looking at and quantifying health care – it’s not fee-for-service,” Dr. Neely says. “But for this to work on a grand scale, practices need to know: what’s the reimbursement for having different care team members? Who covers the time that a care manager spends understanding that a person’s phone bill isn’t being paid, and that’s what makes them hard to contact? Structurally, we need to do a better job of supporting this collaboration.”



Psychiatrist **Ken Thompson** facilitates a training on treat-to-target for depression with practice leaders from two community health centers that participated in PIC: East Liberty Family Health Care Center and Washington Health System Family Medicine.

Primary care administrators often ask: What is the appropriate billing code to receive reimbursement for these behavioral health services? Although there are billing codes for depression screening, unhealthy alcohol screening and brief interventions, chronic disease care management, and health behavior assessment and intervention, these codes are limited to specific services and certain billable provider types. As a result, practices end up fitting their integrated care services into the definitions and policies of billing codes, instead of focusing on how to implement the evidence-based components of models such as SBIRT and IMPACT with fidelity.

Instead of asking payers to reimburse certain billing codes, we can change the discussion and ask: What is the best way to configure payment to drive implementation of high-value services? Some promising payment configurations include:

- Shared savings and global budgets with quality measures, such as depression improvement and remission (going beyond just depression screening measures), or
- Monthly payments for each patient that received the evidence-based services with significant pay-for-performance incentives of at least 25% of the base payment

Health care is starting to embrace more global payment strategies, in which providers enjoy greater flexibility to allocate resources for services like care coordination, consults, and follow up from a set pool of money used to treat patients. As the industry moves further away from a fee-for-service mindset to one rooted in keeping whole communities healthy, integrated primary care could play a vital role in addressing “high utilizers”—the five percent of U.S. patients who account for nearly half of all health expenditures.

“This is where integration shows the biggest bang for its buck,” Dr. Khatri says. “These patients typically have at least one chronic health condition and one mental health or substance use condition, but those behavioral health conditions aren’t getting treated at all, except in the ER or the hospital. Even if they are getting behavioral health care, there’s no collaboration among providers about medications, treatment plans, and labs. We need a system that rewards a systematic, overarching plan to organize the best care for the whole person.”

Bridging the Worlds of Primary Care and Behavioral Health Care

Another hurdle with integrating care is adapting to the different cultures of behavioral health care and primary care, as well as finding a behavioral health specialist. “Practices are still struggling to integrate primary care into a behavioral health system that has traditionally operated separately and speaks a different language,” notes Squirrel Hill Health Center’s Dr. Thompson. Integrated care models used in projects like PIC serve as a bridge between those two realms and make collaboration viable within the larger system constraints.

Instead of waiting three to six months to see a psychiatrist after a referral, integrated care immediately connects the patient to a care manager with a treatment plan for behavioral and physical health that is systematically adjusted to achieve recovery with advice from consulting physicians, including psychiatrists.

A consulting psychiatrist can review up to 40 primary care cases with a care manager in a weekly two-hour meeting. In that time, the consulting psychiatrist can recommend to the PCP which patients should be referred to specialty behavioral health care, using an evidence-based, treat-to-target treatment guideline for depression. In addition to referrals, the adjustments to the treatment plan may also include a change in medication, advice on how to reach the patients or how to help them manage their chronic conditions, or how to talk with the patients to help them accomplish their own goals.

“Having a consulting psychiatrist allows PCPs to take their care to a new level and to improve the control of patients’ behavioral and physical health,” Dr. Reynolds says. Kim, Kelly, and Amy, the care managers from Saint Vincent Healthcare Partners, explain: “the systematic case reviews with a medical consultant and a consulting psychiatrist gave us guidance on where to go for the patient and a different knowledge base to think from. It has great value and made us better at what we do.”

Examples: Multi-disciplinary systematic case review teams at Saint Vincent Healthcare Partners (left) and Premier Medical Associates (right) discuss treatment recommendations for challenging cases.



Patty Rennels, the care manager at Excelsa Health Medical Group agrees: “The psychiatrist would give me ideas on how to talk with folks about treatment options. We were able to hone in and look at different changes. For me personally, I learned a lot about behavioral health diagnoses and treatment options.”

“In the olden days, there was a huge gap when primary care tried to link to the psychiatric specialty world,” Dr. Ken Thompson says. “Many doctors didn’t have a go-to behavioral health specialist. One of the benefits of having mental health capacity within a whole-person primary care practice is that it bolsters the relationship with the psychiatric specialty world. Doctors don’t have to do all of the interface during their very busy days. Instead, you have a behavioral health specialist who’s linked to both the primary care and secondary specialist psychiatric world.”

Medical Education Overhaul Needed to Make Integrated Primary Care the Norm

Psychiatrist Mindy Hutchinson recalls that, back in the 1990s, patients were typically referred to her by way of a 1-800 number on a business card they had received from a primary care physician, rather than a direct referral by the doctors themselves. This phone-tag approach to accessing mental health care infuriated her—patients would never get such an indirect referral to see a cardiologist, for example. It also symbolized the lack of communication between providers in treating both bodies and minds.

“If Dr. Smith refers someone to Dr. Brown for a heart problem, he’ll tell the patient, ‘I know this doctor. We serve on the medical board together, and he does a great job,’” notes Dr. Hutchinson. “That doesn’t always happen with behavioral health care.”

“Some professionals haven’t been trained in behavioral health, so they don’t like to touch the issue,” says Dr. Khatri who, in addition to serving as chief medical officer at Cherokee Health System, also serves on AHRQ’s National Integration Academy Council, which aims to make integrated primary care the norm across the country. “They’ll say, ‘I want to ask a question, but I don’t know what to do if the answer is ‘yes’ – yes I’m depressed, yes I’m drinking too much or abusing drugs. Then what?’ We find that when we give doctors training and tools, they don’t avoid the question, knowing that it’s impacting the physical issues that a patient is dealing with.”

To reiterate this point, Dr. Hutchinson discusses a first-hand experience at her facility.

“Often, the stigma surrounding behavioral health is in the eye of the beholder,” Dr. Hutchinson says. “A lot of the perceived stigma is at our end, not the patient’s. We need to keep working on it from a public health and political view. Altering the mindset of physicians is at the top of the list in eliminating that resistance to treating the whole patient.”

The 24 residents whom Dr. Hutchinson supervises at Washington Health System show varying levels of comfort in asking patients about stress factors in their lives and their psychiatric function. Participating in PIC immersed residents in teams, which removed the burden on physicians to handle behavioral health issues alone. It also made them more cognizant of the toll that depression and substance use take on patients’ bodies.



Balint group

“We’ve been able to raise our expectations so that residents are far more comfortable addressing depression or substance use as something that worsens a physical symptom,” Dr. Hutchinson says. “I think their generation, in many ways, is ahead of my generation.”

Washington Health System also normalizes behavioral health care through a monthly Balint group, in which a psychologist and a former resident facilitate conversations among current residents about their most challenging patient cases, and their personal reactions to them. By sharing their experiences in broaching behavioral health questions and hearing from others, residents learn that many patients welcome their help.

Some medical schools are shifting to a curriculum that emphasizes team-based, integrated care competencies, but such programs aren’t yet the standard across the country.

“Ten years ago when I would interview applicants, integrated care wasn’t even on the radar,” Dr. Khatri says. “Now, this concept of comprehensive behavioral health and medical care is becoming more widely accepted. But we still need significant changes in our training and educational systems. If we truly want to achieve the triple aim – improved quality of care and patient experience at a reduced cost – then we’re going to have to change the way that we deliver care. That starts with transforming how we train people to be part of that delivery system.”

CONCLUSION



This publication discussed the case for the importance of integrated care, provided results from experiments that demonstrated this point, and expressed the views of some of the practitioners who implemented an integrated care system firsthand in their facilities. It is critical that the learnings from these experiments are used as a step on the journey to transforming care. Here is one example.

A patient whom we'll call Jane is in her 60s and had a history of alcoholism, recurrent depression, and diabetes. As part of PIC, her care manager met with her monthly and personally filled her pill box, as Jane had been taking her prescribed antidepressants inconsistently. The care manager elicited her interest in becoming a more active presence in her grandchildren's lives. She also learned that when Jane felt good, she enjoyed making crafts, which she gave to others as gifts. With the support of her healthcare team, she began taking her medications consistently. Jane has returned to her craft work, is more involved with her grandchildren, and her diabetes is under control. She now needs to check in with her care manager only every few months.

"It has been PRHI's mission," says PRHI President and CEO Karen Wolk Feinstein, PhD, "to view the healthcare system through the eyes of patients, to see where it fails them, and to experiment with changes that repair that system for every patient who follows. Our work in integrating primary care is no exception. The ITPC, PIC, and COMPASS projects address multiple systems failures – from siloed medical training to a primary care practice design that overburdens the clinician and underserves the patient. We are learning that different kinds of patient-provider conversations are possible. We learned that technology is now available that frees up time and helps target care to those who need it most. We also learned that it will take more than well-designed practices with well-trained teams to get the job done. Medical schools need to step up. Communities need to embrace the fact that responsibility for health isn't solely the doctor's. Economics plays a role. Insurance reimbursement plays a role. We are going to have to work together across multiple silos to turn around America's poor health outcomes and high costs."

Psychiatrist Ken Thompson agrees, “We need to participate in the revolution and redesign of all of health care.” “It’s essential that people who have ongoing medical and psychiatric challenges are engaged in self-care, thinking about what they have to do to meet life goals. They use health care as a resource, but they also use a range of other community resources, informal networks and relationships, to help them recover. This notion of being an engaged partner and being at the center of care, rather than being at the periphery, is revolutionary.”

Implementation and dissemination projects like ITPC, PIC, and COMPASS that were founded on evidence-based integrated care models like SBIRT, IMPACT, and TEAMcare point the way. They work. Patients get better and need fewer healthcare services. The challenge now is to build a healthcare system that makes integrated models the reflexive standard of care.

This requires leadership that believes in the model and sees how it fits with other priorities, community feedback, champions who are empowered to make daily improvements, an integrated care team with the right characteristics and skills, post-training coaching for quality improvement and skills development, data-driven systematic quality improvement, a health information technology system that provides caseload summaries and prompts to catch patients who have not improved as expected, and a payment model that supports the type of care we are all aiming to achieve.

As we look to the future, we are excited about the opportunities to:

- Fold behavioral health screening, collaborative care management, and brief interventions into PRHI's ongoing practice transformation programs
- Partner with behavioral health centers on quality improvement and outcomes measurement
- Work with community providers to build systems that integrate medical, behavioral, and social services

We are optimistic that the results from ITPC, PIC, and COMPASS will continue to lead to further spread with implementing integrated care. There are many untold stories of patients like Joe, Jane, and the others. Continuing to advance the integration of behavioral health into primary care can give a voice to these patients who would otherwise continue to slip through the cracks.

APPENDIX A: ITPC DESIGN AND OUTCOMES (MARCH 2009 - OCTOBER 2010)

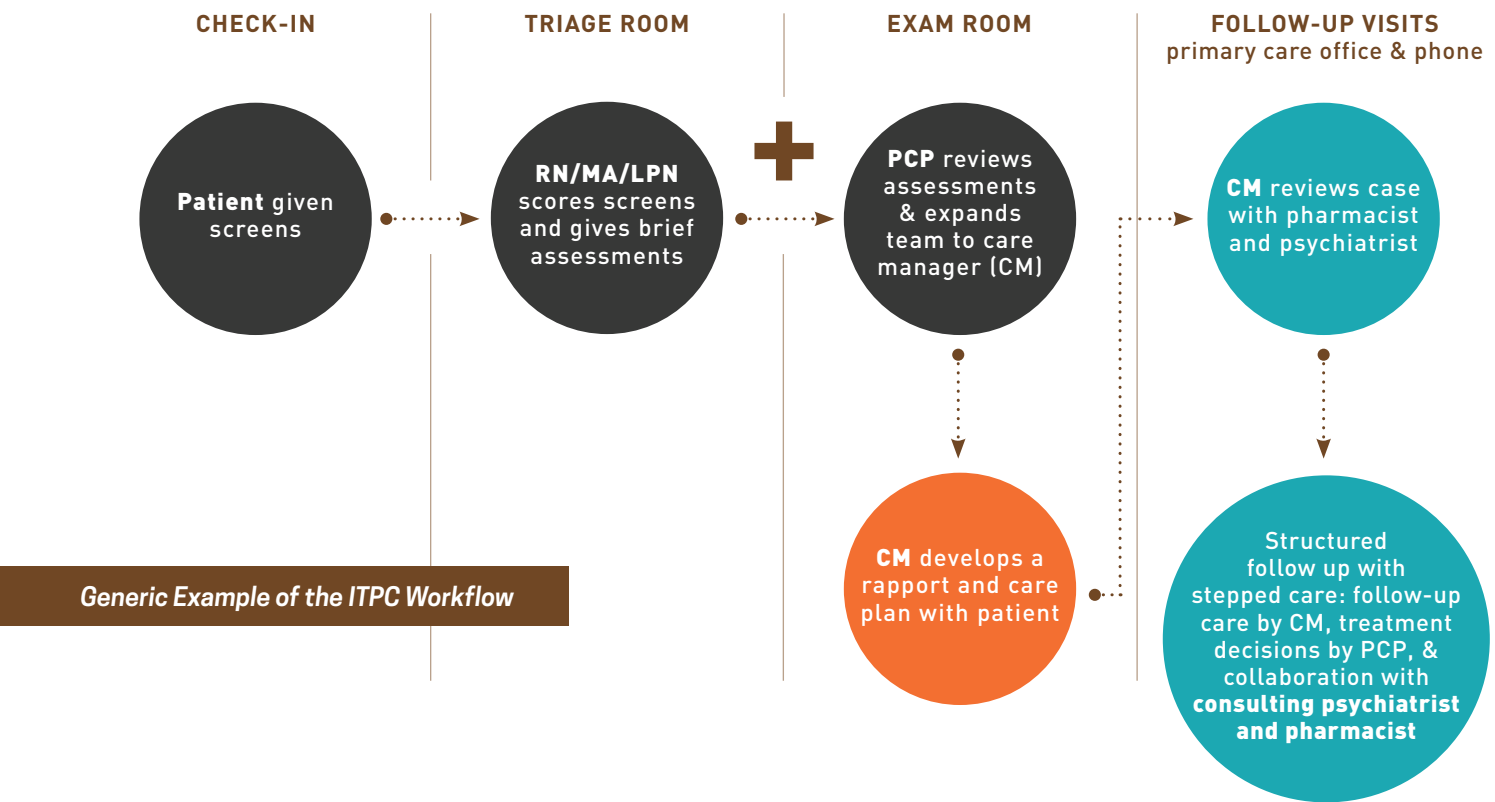
The ITPC care process:

- In the exam room or at the front desk upon arrival, patients filled out an 11-item Lifestyle Questionnaire.³⁵
- When a patient's score indicated that they may have a substance abuse problem or depression, a member of the primary care team asked them to complete a more targeted questionnaire –the Alcohol Use Disorders Identification Test (AUDIT), the ten-item Drug Abuse Screening Test (DAST-10), or, for depression, the nine-item Patient Health Questionnaire (PHQ-9).
- Following a positive score or clinical judgment, the PCP introduced the patients to the on-site, full-time care manager. The care manager confirmed the patients' understanding of the results of the screen, provided patient education using motivational interviewing and behavioral activation approaches, reinforced the PCP's treatment plan, and helped the patients establish their own goals.
- After the initial contact, the care manager followed up with the patient in a structured way over the telephone or in person at the primary care center, to monitor the implementation of the treatment plan and help the patient work towards their goals and problem solve.
- The care manager also tracked the patients' outcomes with the PHQ-9 and connected them to community resources.
- When the patient reached and sustained their goals, the care manager developed a relapse prevention plan with the patient.

Care was supported by a weekly case review between the consulting psychiatrist and care manager, and at least one meeting with the consulting pharmacist for each enrolled patient. The consulting psychiatrist reviewed the initial treatment plan for all newly enrolled patients in ITPC and patients who were not improving as expected. Based on the patient's progression and information relayed from the collaborative care team, the PCP decided whether to make treatment changes. Treatment modifications included referral to specialty behavioral health care (coupled with continued ITPC care), pharmacotherapy changes, and/or changes to behavioral interventions.³⁶

³⁵ The screen included the Cut Down, Annoyed, Guilty, Eye-opener–Adapted to Include Drugs (CAGE-AID) screen; the Alcohol Use Disorders Identification Test–Consumption (AUDIT-C) screen; and the two-item Patient Health Questionnaire (PHQ-2).

³⁶ PRHI partnered with the University of Washington Advancing Integrated Mental Health Solutions (AIMS) Center (the creators of IMPACT). The AIMS Center's electronic CMTS was implemented to support the ITPC model components, including facilitation of patient caseload management, guidance for weekly caseload review meetings with consulting providers, proactive prompts for follow-up with patients, real-time improvement tracking, and data extraction.



The work of the participating health centers was facilitated by substantial training and coaching support. Together with the University of Washington’s Advanced Integrated Mental Health Solutions (AIMS) Center, PRHI held a three-day, didactic and role-play training program for implementation teams. Following the training, PRHI and AIMS Center coaches led webinars and online learning, worked on site with primary care teams, organized collaborative learning calls, provided guidance on how to bill for behavioral health services in primary care, and shared monthly data tracking reports. These implementation supports helped the healthcare teams continuously improve the new care processes and work through challenges that included assuring continuous buy-in and support, enhancing lower than expected screening rates for unhealthy substance use, and helping staff to adapt to the new skills of behavioral activation, motivational interviewing, and problem-solving treatment.

Process Outcomes

- 23% of 1,559 patients scored positive on the PHQ-9 (score > 10), and 5% scored positive on the AUDIT (score > 6) or DAST-10 (score > 1)
- Of those who scored positive on the PHQ-9, 61% of 363 enrolled in ITPC for depression, and of those who scored positive on the AUDIT or DAST-10, 35% of 81 enrolled in ITPC for alcohol or other drugs

Quality Outcomes

- 58% of 245 enrolled patients experienced a decrease of five or more PHQ-9 points within six months (an indicator of clinically significant improvement)
- Of those with a PHQ-9 score at baseline and six months, 49% of 68 achieved at least a 50% reduction from the initial PHQ-9 score (an indicator of depression response)
- 32% of 96 enrolled patients in ITPC for at least four months had a PHQ-9 score less than five at their most recent follow-up contact (an indicator of depression remission)
- Due to low positive screening rates for unhealthy alcohol and other drug use and thus an insufficient amount of data, ITPC was unable to report outcomes for substance use

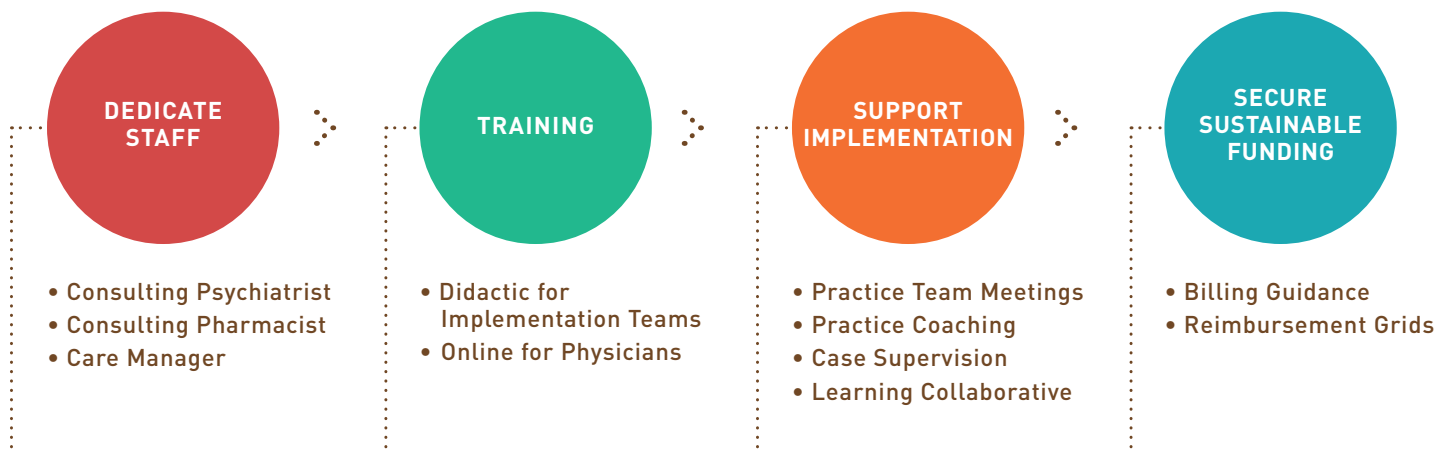
Self-Reported ER and Hospital Utilization

- At baseline, 23% of 43 patients enrolled for at least six months reported one or more emergency room (ER) visits in the previous six months. Through six months in ITPC, 14% of 43 reported one or more ER visits.
- At baseline, 16% of 43 patients enrolled for at least six months reported one or more hospitalization in the previous six months. Through six months in ITPC, 14% of 43 reported one or more hospitalization.

Orientation towards Patient-Centered Care

- On average, results from the Assessment of Chronic Illness Care survey showed a positive change in the following components that relate to Wagner's Chronic Care Model: community linkages (1.68-point increase), decision support (1.40-point increase), self-management support (0.16-point increase), delivery system design (2.33-point increase), and clinical information system (3.07-point increase)

ITPC Implementation Support Strategies



APPENDIX B: IMPLEMENTATION AND DISSEMINATION TIPS

Based on PRHI's experience with implementing evidence-based, integrated care services over the past six years, we offer several practical suggestions for those seeking to implement and disseminate evidence-based integrated care services (especially SBIRT and collaborative depression care management models based on trials like IMPACT).

1. Before recruiting medical practices, start by engaging community stakeholders.

These community conversations can be sparked by neutral conveners and regional catalysts that advance common goals and unite stakeholders, including providers, employers, health plans, patients, funders, government leaders, and law enforcement. We list several examples below.

- MHQP's community engagement work in PIC led to the involvement of a local training and coaching group, MASBIRT, which not only helped to facilitate implementation in four practices, but is continuing its work
- ICSI's multi-stakeholder community discussions led to the DIAMOND healthcare delivery model, plus a payment model
- When ICSI was experiencing lower-than-expected screening rates for unhealthy substance use in one community during the PIC project, they worked with a group to conduct a community survey on substance use and depression, and then facilitated community meetings leading to increased screening rates

2. Make recruitment of practices personal.

Meet face-to-face with physician, administration, and frontline leaders of the primary care practice. It's the best way to understand the group's perspective and readiness for implementation, to elicit their own reasons for participating, and their own understanding of how the evidence-based integrated care services compares to their existing services. It helps the recruiter to identify strengths (e.g., leadership support, experience with team care, and information technology capabilities), and to assess how the model aligns with their existing organizational priorities (e.g., patient-centered medical homes, accountable care organizations, and population health).

3. Incorporate "systems requirements" into the implementation strategy.

- Leadership and champions
 - Practice administrators, physicians, care managers, and managers need to prioritize, support, and monitor integrated care services. A designated "champion"—a staff member who has standing among their peers, promotes change, talks to their peers when expectations are not met, experiments with quality improvement cycles, and

counteracts the entropy that is present in all initiatives—can talk with their peers about their perspectives of the services and build their level of importance and confidence in providing integrated care services.

- Health information technology and data reports
 - A health information technology (HIT) system can support the core components of evidence-based integrated care models by generating lists of who has been screened and who needs to be screened, documenting behavioral and physical health information, reporting this information in a data dashboard to drive quality improvement, sorting caseloads from high to low baseline and most recent behavioral and physical health scores, and prompting for systematic follow-up contacts based on the guidelines for each condition. If there are multiple primary care offices or medical groups involved in the initiative, the data fields must be standardized in terms of how they are used and defined, and this requires training, testing, and coaching.
- A culture of and method for data-driven quality improvement
 - In addition to having an HIT system that can generate reports on process and outcome measures for integrated care, the care team at the front line also needs to be empowered with quality improvement methods that provide a series of steps to act on the information in the data reports. For example, PRHI offers Perfecting Patient CareSM—a quality improvement method that is based on the principles of Lean.

4. Talk with payers about creating and using a payment method that relies on outcomes, not an existing prescriptive billing code.

Instead of thinking about which CPT billing codes can be used to generate revenue for providing services to patients, think about which payment models could best support the type of high-value services you want to provide, and talk with your payers about these options (e.g., shared savings payment models or global budgets with quality measures, such as depression improvement and remission, or monthly payments for each enrolled patient with pay-for-performance incentives of at least 25% of the base payment).

5. Select (and build) the right care manager.

The characteristics of care managers most important to success include being visible, organized, assertive, empathetic, non-judgmental, collaborative, flexible, and perseverant. Prior knowledge of community, social, and human resources, behavioral activation, motivational interviewing, and behavioral and physical health are a plus, but can be developed on the job.

With the right characteristics, model-specific training, and supervision, the care manager can be a nurse, clinical social worker, licensed professional counselor, psychologist, or a medical assistant. The care manager role needs to be clearly defined, especially how it differs from usual behavioral or physical health care, and the care manager needs to have sufficient, protected time, and the resources to do the job.

Reflecting on both the PIC and COMPASS projects, Pam Pietruszewski and Dr. Claire Neely agree that “practices that hired care managers and gave them dedicated time were more successful. We found that the primary care team really has to make the care manager visible – they are the face of the program, both to patients and staff. Care managers have to be assertive and advocate for integrated care.” But they can’t do it alone. The teams need to be supported and led by the PCP with support from the practice’s leadership.

6. Identify trainers and coaches to build practice capacity and facilitate data-driven, systematic quality improvement.

The goal of training and coaching is to develop the medical group’s internal capacity for self-review, learning, improvement, and sustainability. Outside coaches help most when they approach the primary care practice team members in a way that mirrors the recommended approach with patients: meeting them where they are (“the current condition”), but also helping them see where they could be (“the target condition”). In this role, using Lean-based quality improvement principles and motivational interviewing, the coach uses open-ended questions to engage the care managers, leaders, physicians, and frontline staff (e.g., “What’s your experience like with patients with depression?” “What is your biggest challenge on a day-to-day basis?” and “How should things work to allow you to give the best care?”). The coach also uses affirmations of past successes to promote confidence in adopting new processes (e.g., “You certainly did a lot of work in getting everyone on board.”) Once engaged, the coach can evoke the teams’ ideas for ongoing quality improvement, help the teams use data to target their quality improvement efforts, and monitor progress and variation in outcomes of quality of care.

APPENDIX C: PIC TRAINING AND IMPLEMENTATION SUPPORT

Pennsylvania (PRHI) – SBIRT+IMPACT/DIAMOND Training and Implementation Support – Project Quarters 6-12

- 3 days of in-person training with presentations, exercises, and simulated patients
- 3.5 hours of webinar training in between the 3 days of in-person training
- Workbooks and textbooks for motivational interviewing
- 4-day, in-person training on Perfecting Patient CareSM (lean quality improvement methodology)
- On-site coaching on workflows, processes, roles, and cultures
- Feedback on MI skill development based on role playing with colleagues
- Online Tomorrow's HealthCareTM PIC community and lean quality improvement tools
- Monthly collaborative learning/networking calls
- Booster, in-person trainings on MI

Wisconsin (WIPHL) – SBIRT+IMPACT/DIAMOND Training and Implementation Support – Project Quarters 5-12

- 5 days of in-person and 5 days of distance training with a simulated patient exam, workbooks, textbooks, and short exams
- Site visits and calls, as needed
- Facilitated listserv
- Coaching and feedback on MI based on taped patient sessions
- Collaborative learning/networking calls

Minnesota (ICSI) – SBIRT Training and Implementation Support for DIAMOND – Project Quarters 5-12

- 1-hour web-based training followed by 1.5- to 3-day in-person training
- Monthly collaborative learning calls
- Practice-specific calls, as needed
- Site visits at 6 and 12 months
- Facilitated listserv
- 12-month learning collaborative meeting (2-day in-person)
- Booster webinar trainings (1.5 hrs.)
- In-person booster advanced training (1-day)

Multi-state Implementation Support – Project Quarters 10-12

- Collaborative networking calls for participating primary care teams across partners and states

APPENDIX D: COMPONENTS OF THE PIC IMPLEMENTATION TOOL KIT

Section of Toolkit	Components
Marketing and Communications Toolkit	<ul style="list-style-type: none"> ▪ Communication and Dissemination Guide and Slide Deck ▪ PIC Program Videos ▪ PIC Program Briefs ▪ Bibliographies and White Paper ▪ Fact Sheets on the Evidence, Rationale, and PCMH Alignment
Train-the-Trainer Toolkit	<ul style="list-style-type: none"> ▪ Agenda ▪ Modules ▪ Handouts
Primary Care Training Toolkit	<ul style="list-style-type: none"> ▪ Training and Implementation Work Plan ▪ Training Needs Assessments ▪ PowerPoint Training Modules (24 files) and Evaluations ▪ Exercise Templates ▪ Example of a Training Kit ▪ Training Videos
Practice Support Toolkit	<ul style="list-style-type: none"> ▪ PIC Core Components ▪ PIC Clinical Guide ▪ Job Descriptions ▪ Quality Improvement and Implementation Guides ▪ Screens for Depression and Unhealthy Substance Use ▪ Patient Education Brochures ▪ Scripts and Team Communication Forms ▪ Guides for Financing, Legal, Suicidality, and Referrals
Information Technology and Measurement Toolkit	<ul style="list-style-type: none"> ▪ Baseline Site Characteristics Form ▪ Measurement Specifications and Flows ▪ Interview Templates to Collect Recruitment & Coaching Findings ▪ Patient Tracking System and Data Fields ▪ Post-Implementation Surveys

GLOSSARY OF TERMS

AIMS	Advancing Innovative Mental Health Solutions Center
CMTS	Care Management Tracking System
COMPASS	Care of Mental, Physical and Substance Use Syndromes
DIAMOND	Depression Improvement Across Minnesota, Offering a New Direction
ICSI	Institute for Clinical Systems Improvement
IMPACT	Improving Mood-Promoting Access to Collaborative Treatment
ITPC	Integrating Treatment in Primary Care
MHQP	Massachusetts Health Quality Partners
NRHI	Network for Regional Healthcare Improvement
PHQ-9	The Patient Health Questionnaire
PIC	Partners in Integrated Care
PRHI	Pittsburgh Regional Health Initiative
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SUDs	Substance Use Disorders
WCHQ	Wisconsin Collaborative for Healthcare Quality
WIPHL	Wisconsin Initiative to Promote Healthy Lifestyles

SPECIAL THANKS

We owe a particular debt of gratitude to Sheila Fine and Joni Schwager for their early dedication to implementing collaborative care models into the primary care setting. With their support and valued contributions, ITPC became a reality and was able to blossom and inspire larger-scale demonstrations (PIC and COMPASS). The knowledge gained from the ITPC, PIC, and COMPASS experiments has been priceless.

Sheila Fine

One day while Sheila Fine was reading the Wall Street Journal, she came upon a powerful article about the tragic suicide of a successful businessman. On paper, the man seemingly had it all – brains, business acumen, family – so what could lead him to take his own life? That was an eye-opener for Fine – that merely having financial means and the potential to access treatment isn't enough. The stigma of mental illness was overpowering to that man. The story resonated with Fine in a way that she even looked at strangers differently. She recalls "I remember looking out the window – looking at business people, students, the homeless – and thinking that all of those groups struggle with mental health issues."

Inspired to make an impact, Fine worked with area leaders in the field of psychology and grew a coalition, Leading Education and Awareness for Depression (LEAD) Pittsburgh. She has been dedicated to increasing awareness of depression, attacking its stigma, and getting mental health services to the people who need it.

This passion for improving mental health made Fine's involvement with ITPC a no-brainer. Integrated care was particularly intriguing. "The brain is part of our bodies, just like our heart, our lungs, they are all interconnected.

Fine remains passionate about mental health, and advocates for strengthening the capacity of primary care to provide integrated mind-and-body care. With more supportive payment models and a stigma-free culture, barriers to accessing mental health services will be greatly reduced. "Getting people into treatment earlier is crucial," she says.

Joni Schwager

The Staunton Farm Foundation has a near 80-year history of revolutionary thinking about behavioral health. The premise on which the Staunton Farm Foundation was founded – Matilda McCready bequeathed her family estate for use as a residential treatment facility for those struggling with mental illness – was years ahead of its time. Joni Schwager, executive director of the Staunton Farm Foundation, shares McCready’s same trailblazing spirit.

With an interest in health care, particularly in aiding underserved populations, Schwager recognized that behavioral health and substance use had more noticeable gaps in the health-care system than their physical health counterparts. Her response was to earn a behavioral health degree and immerse herself in clinical practice, eventually finding her way to the Staunton Farm Foundation.

When the ITPC project discussions began, Schwager was eager to jump on board. “I have always believed that there is no health without mental health,” Schwager says. “Health encompasses the entire body. And finally ITPC was an opportunity to take a look at integrating the two. The impact and success are obvious – PRHI has landed huge, national grants and has been very active in promoting behavioral health in primary care, which we’re delighted about. There’s a greater understanding of the importance of whole health.”

Schwager recognizes a change in the healthcare culture since the early days of ITPC. “I think [the climate] has evolved,” she says. “We went from a co-location model to having behavioral health people on site to treat patients as part of a team. I think treatment has become more person-centered. Now, there’s a whole team of people who are looking at not just patients’ physical needs, but also their social and emotional needs.

But the work isn’t finished. Aside from continued efforts to push for widespread integrated care, Ms. Schwager notes that there is an important, if overlooked, opportunity. “It’s also important that some physical health services are available in behavioral health settings, not just the other way around.”

PROJECT PARTNERS FEATURED IN ROOTS (ALPHABETICAL BY FACILITY)

Excela Health Medical Group

Daniel DiCola, MD	COMPASS Primary Care Physician Champion
Patricia Rennels, RN	COMPASS Care Manager

Hamilton Health Center

Joyce McCadney, LCSW	PIC Care Manager
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Institute for Clinical Systems Improvement

Claire Neely, MD	COMPASS Project Director
Pam Pietruszewski, MA	PIC Trainer

Premier Medical Associates

Star Rebarchak, RN	COMPASS Supervisor
Amy Schultz, RN	COMPASS Care Manager
Beth Vrbanic, RN	COMPASS Care Manager

Saint Vincent Healthcare Partners

Amy Albright-Mullen, RN	COMPASS Care Manager
Kelly Baker, RN	COMPASS Care Manager
Kim Bell, RN	COMPASS Care Manager
Sam Reynolds, MD	COMPASS Primary Care Physician Champion

Squirrel Hill Health Center

Ken Thompson, MD	PIC Consulting Psychiatrist
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Washington Health System Family Medicine

Judy Devenney, RN	PIC Care Manager
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