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Practice Name: IHA Primary Care
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How many physicians in practice? 109
Description of care team 2 Consulting psychiatrists (MD), 11 Behavioral Health Specialists (MSW), 1 Program Manager (LMSW)

Executive Summary

- One in five Michigan residents has a diagnosis of depression or anxiety, which are the most common mental illnesses in Michigan and the least likely to be treated.
- Mental health is the leading cause of disease burden for females and the third leading cause for males
- The Collaborative Care Model, developed at the University of Washington, effectively leverages behavioral health resources within the primary care provider office.
- Integrating primary care and behavioral health care delivery is a key recommendation of the 2019 "Access to Behavioral Health Care in Michigan" report.
- IHA launched the Behavioral Health Collaborative Care (BHCC) model in 2015, delivering this service to over 2,100 patients since then.
- For patients enrolled in IHA's BHCC, 64% experience at least a 50% drop in their symptoms of depression and anxiety by six months.
- Preliminary evidence shows that patients receiving BHCC at IHA have an average of 39 more depression-free days over six months, than those not receiving BHCC.
- Research supports $6.41 in overall health cost savings for every $1 spent on BHCC

Category of Submission: Behavioral Health Interventions

Title of Submission: IHA Behavioral Health Collaborative Care Improves Patient Outcomes

When did the intervention start and end?

In March 2015 the first pilot for Behavioral Health Collaborative Care (BHCC) started at IHA. Since then the program has extended to 10 adult primary care offices, with planned scaling as funding supports.

Goal of the Program/Intervention:

While at its core BHCC is aimed at reducing anxiety and depression symptoms, the program's larger goals are to improve patient health outcomes and quality of life, reduce health care costs, improve patient satisfaction, and increase provider satisfaction.

Who developed the program/intervention, and how?

The model of Collaborative Care that IHA uses is based on the University of Washington's AIMS Center model. Over 80 randomized control trials demonstrate Collaborative Care as more effective than usual care for depression and anxiety.

Description of the Program/Intervention:

The core principles of Collaborative Care are: Patient-Centered Team Care, Population-Based Care, Measurement-Based Treatment to Target, Evidence-Based Care, and Accountable Care. We collaborate effectively using shared treatment plans. By embedding a social worker as a Behavioral Health Specialist, and employing a consulting psychiatrist, we round out the patient's care team to meet their depression and anxiety treatment needs.

The primary care provider remains the leader of the care team, with the informed patient in the center, actively participating in their care. Our Behavioral Health Specialists (BHS) act as physician extenders, providing trusted interventions and follow up that is best practice for depression and anxiety care. Behavioral Health Specialists assess patients for mental health conditions, present the patient's case to the consulting psychiatrist, then convey recommendations for psychiatric medications to the PCP. The BHS works at the top of their license to provide education and monitoring of medications, as well as brief behavioral interventions that have evidence for efficacy in primary care. Patients receive treatment both in person, and over the phone, which improves access, efficiency, compliance, and convenience. Symptoms are monitored using validated tools, specifically the PHQ-9 and GAD-7. Patients who are not getting better by 3 months of intervention are reviewed again with the psychiatrist for needed changes in the treatment plan.

Providing behavioral health services in the patient's medical home improves health outcomes and reduces stigma. Patients engage at a higher rate than with referrals to specialty care. We are also able to reduce the burden on specialty care by diverting patients that can be effectively treated in primary care, thus those patients with more complex needs have improved access to community mental health resources.

How were patients identified for the program/intervention?

PCP's identify patients who have symptoms of depression and anxiety. Ideal patients for Collaborative Care are those whose diagnosis is new, have not responded to initial interventions, or whose symptoms are otherwise interfering with patient functioning. Patients with bipolar disorder, primary substance abuse, or severe PTSD and not appropriate for treatment in primary care (evidence supports treatment in specialized mental health), and at the same time it is not always evident if the patient's symptoms are due to these illnesses. The BHS conducts a brief and thorough assessment of the patient, using both screening tools and clinical interview. While the PCP makes the initial referrals, the BHS and consulting psychiatrist make decisions about which patients are appropriate for the model.

How was success measured? Please delineate whether metrics were process-based or outcome-based

Our commitment to quality is supported by quarterly collection and analysis of data related to both outcome and process metrics. Both measures are needed to ascertain opportunities for improvement and to establish benchmarks.

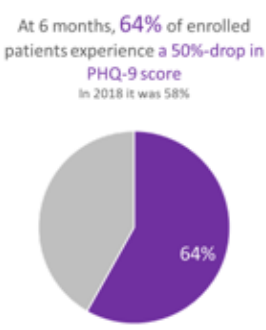
At its core, Collaborative Care targets reduction in symptoms of depression and anxiety. As set forth in the AIMS Center model, every patient completes a PHQ-9 and a GAD-7 at the time they enroll in the BHCC. Both tools are public domain, validated, and considered the standard for screenings. These tools can also be used for monitoring symptoms over time, not just for screening. We ask patients to complete the questionnaires monthly as a means of observing changes in symptoms. Measures that are at three and six months become part of our outcome metrics.

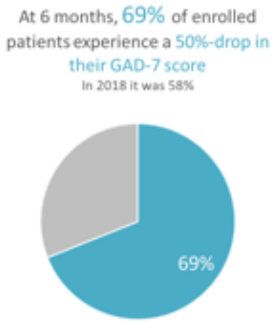
Our process metrics guide our understanding of value and efficiency. A key component of the service delivery is the recommendations made by the psychiatrist. We track the percentage of recommendations that are fully implemented – meaning that both the PCP and the patient agreed. We also note the reasons for not following a recommendation. In order to consider our reach and identify trends and opportunities, we also track the number of patients served monthly.

What were the program results? Include qualitative data/graphs

- Since the beginning of the BHCC program, 2,169 patients have been enrolled in services.
    - In addition, 1,179 additional patients received brief support, such as one-time interventions, suicide risk assessment, active management to community services, and assessment for level of care.
- For the calendar year 2018, 53% of enrolled patients had at least a 50%-drop in their depression scores, and 54% had at least a 50%-drop in anxiety scores.
    - So far in 2019 those numbers have improved to 64% and 69%.
- Preliminary analysis also reveals that patients enrolled in IHA's BHCC have 39 more depression-free days per 6 months, than the same patients were they not enrolled in BHCC.

- Over 90% of the time, both the patient and the PCP agree. with the recommendations made by our consulting psychiatrists.





Were any new tools, processes, or resources developed to aid in the implementation of the program/intervention?

IHA developed several tools, job aids, and workflows. Perhaps most significantly, we built EMR templates, including a registry, that allowed us to document, report, bill, and manage the population of patients enrolled in BHCC. We utilize new CPT codes for Behavioral Health Integration and developed not only the technology and workflow to bill, but also reports that help us analyze the revenue and denials. This led to improved collection of charges.

As we've grown our team, we created a comprehensive manual the describes the model, workflow, and data collection required to deliver excellent work. Whereas we were initially training new team members with solely on-the-job methods, we are not able to effectively deliver consistent learning through video and print material, and track learning of core competencies. Other job aids for our team include a ready-to-deliver slide deck on the program and the mode, plus laminated cards that support teaching on psychiatric medication usage. These are used in conjunction with our regular lectures on mental health topics.

What are you proudest of regarding this submission? Why does this work matter?

Our patients enrolled in BHCC experience an improved quality of life and feel that the intervention is helpful. At each office location, we ask the patients to reflect on their satisfaction with BHCC. An overwhelming majority, 91%, of patients agree that the program was helpful to them. Sometimes we are lucky, and the patient includes a note with their story. This means we heard from the woman who never knew she could feel this good, and the patient who wasn't sure she could go on living before she started working with our Behavioral Health Specialist. One patient told us about how her employees noticed she was a better manager and she attributes that to working with BHCC. Recently a patient was successfully diverted from the Emergency Department due to assessment, support, and safety planning.

Our providers recognize that the BHCC support in their practices helps them to do their jobs more effectively. As part of our ongoing quality initiatives, we survey providers and patients about their experiences regarding BHCC. Providers tell us it's been the best new initiative for their office. One of our long-serving physicians told us that due to the interventions and support created by BHCC he feels able to continue his practice for more years than he thought. BHCC is reducing the sense of burnout and increasing hope in our primary providers. One doctor stated that she can stay on schedule better, knowing she can handoff patients with depression and anxiety to our Behavioral Health team. Her productivity is improved when she is confident that patients receive appropriate care and follow up from social workers performing at the top of their licenses.

How will your organization use the funds if your submission wins?

Despite overwhelming, demonstratable success, IHA is still only able to support 12 of 22 adult primary care offices with BHCC due to challenges with revenue. We've made progress with commercial payers and Medicare to close these gaps, and there is reason to believe Medicaid will soon pay for this evidence-based service delivery. Winning this award will completely support one full-time BHCC team, including a consulting psychiatrist, which will allow us to provide care in 1 large or 2 small offices that are currently without BHCC.