Optimize Primary Care Teams to Meet Patients’ Medical AND Behavioral Needs

A 12-month IHI Collaborative
Begins February 19, 2015
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Executive Summary

Overview

In order to effectively treat the whole person and improve population health, primary care must build high-functioning practice teams and seamlessly integrate behavioral health capacity into them. To help organizations do this, the Institute for Healthcare Improvement (IHI), in partnership with the MacColl Center for Health Care Innovation, invites you to join a 12-month Collaborative, **Optimize Primary Care Teams to Meet Patients’ Medical AND Behavioral Needs**, designed to create the next generation of integrated, high-performing primary care teams.

The content and approach of this Collaborative is based on: 1) IHI’s system-level approach to integrating behavioral health and primary care; and 2) evidence and insights assembled by the MacColl Center through careful study of exemplary primary care practices across the US, as part of a national program of The Robert Wood Johnson Foundation called Primary Care Teams: Learning from Effective Ambulatory Practices (PCT-LEAP).

The aim of the Collaborative is for participating organizations to redefine the composition and roles of primary care, building highly functional multidisciplinary teams that are fully equipped to address the medical and behavioral care needs of their population.

In order to achieve this aim participating organizations will need to:

- Align this new work with organizational priorities and engage the full support of clinical, administrative, and board leadership at all levels;
- Guide improvement through the use and transparency of data;
- Include community representatives on their improvement teams because the people who receive services and care are central to the success of these changes;
- Develop new management roles to effectively utilize the new workforce; and
- Ensure that each provider and care team is assigned a set number of patients while taking into account patient and family preference (this is often known as empanelment).

Within 12 months, participants will be able to do the following within their pilot sites:

- Assess and segment the population served to understand medical and behavioral health needs, identify barriers to better health, and target interventions to be tested;
- Optimize primary care team composition, roles, and activities to support integrated medical and behavioral health care (inclusive of mental health, substance abuse conditions, and healthy behaviors);
- Identify and implement an approach to integration that best meets the needs of the patient populations served, the primary care team, and the organization;
- Improve medical and behavioral health integration and care experience;
- Identify appropriate financial models, including quality contracts, global payment models, and grants to fund this transition; and
• Develop a plan to scale up and sustain the model that has been developed and tested.

Timeline

The IHI Collaborative, *Optimize Primary Care Teams to Meet Patients’ Medical AND Behavioral Needs*, will begin on February 19, 2015, and last 12 months. However, because sustained effort is needed to improve population care and achieve results, we anticipate the Collaborative will continue for more than one annual cycle, depending on the pace of improvement and the interest of the participants.

Participation Criteria

This Collaborative is appropriate for organizations committed to improving care in the primary care setting for individuals with both medical and behavioral health needs. Typically these organizations are:

• Health systems with primary care sites
• Hospitals with primary care sites (incorporated within or aligned with the hospital)
• Accountable care organizations (ACOs)
• Independent Physicians Associations/Organizations (IPAs/IPOs)
• Large group practices
• Integrated health systems
• Community health centers
• Primary care organizations that might be able to gain support from:
  o Health plans, especially coordinated/managed care organizations
  o Primary care associations
  o States participating in federal demonstration projects
  o Behavioral health services organizations
  o Local community-based organizations
• Behavioral health organizations that want to integrate primary care

Enrollment Fee

The cost for one year of participation in the Collaborative is $20,000 per organization. A reduced rate of $10,000 per team applies to federally-qualified health centers and safety net hospitals. A limited number of partial scholarships are available for safety net organizations.

Contact

For questions or further information, please email primarycare@ihi.org.
Why Participate?

Well-designed and adequately resourced primary care can meet the medical and behavioral health needs of individuals and populations, and recent changes in the United States health care system as a result of the Affordable Care Act create an ideal opportunity for primary care to meet the challenge. Primary care providers (PCPs) must strive to provide acute, chronic, and preventive care while building meaningful relationships, managing multiple diagnoses, incorporating evidence-based guidelines, and meeting targets on metrics for both quality and cost. The shortage of primary care and behavioral health providers coupled with an influx of newly insured individuals underscores the imperative that “business as usual” cannot continue. Primary care teams need new ways to treat the whole person rather than treating a series of discrete diseases.1

Evidence suggests that team-based care in the primary care setting is associated with improved quality and safety of care, better health and functioning of individuals with chronic disease, higher patient and provider satisfaction, and lower per capita costs.2,3 Primary care teams can be particularly effective when it comes to treating patients with comorbid medical and behavioral health conditions. A large body of evidence shows that patients with both behavioral health and chronic medical conditions experience poorer outcomes and higher costs than patients with a medical condition alone.4 Furthermore, all health has a behavioral component: improving lifestyle through engaging in healthy behaviors is integral to chronic disease prevention and management and must be a focus of integrated primary care just as much as treating diagnosable behavioral health conditions.

Integrating behavioral health expertise into primary care is a key step toward achieving the Triple Aim of improving the health of populations, improving patient and provider experience of care, and lowering per capita costs, particularly for individuals with multiple chronic conditions. This integration also presents new opportunities to more directly engage individuals in managing their own care and in co-designing care with providers.

Exemplary integration approaches from around the US — such as those developed by Intermountain Healthcare, Southcentral Foundation, the IMPACT (Improving Mood – Providing Access to Collaborative Treatment) Program, and Cherokee Health Systems — have shown strong evidence that primary care teams that have integrated behavioral health capacity are associated with improved medical and behavioral health outcomes, improved patient and provider experience, and lower costs of care. For example, patients enrolled in Intermountain’s Mental Health Integration program were 54 percent less likely to have an ER visit, cost the health plan $667 less than patients in the control group, and one-half of the enrollees were in remission as measured by their PHQ-9 (depression screening tool) scores in the first 12 months after the initial diagnosis of depression.3 A large study examining the effect of the IMPACT program for patients with comorbid diabetes and depression found that patients in the intervention group experienced 115 more depression-free days over 24 months when compared to patients in the usual care group; while total outpatient costs were $25 higher, the analysis also showed a net benefit of $1,129.5

While many are aware of the importance of this work, organizations have struggled with how to optimize their care teams to integrate behavioral health care due to a variety of factors such as a lack of sustainable funding models, infrastructural issues, and difficulty operationalizing behavioral health principles into a redesigned care system. Fortunately, many of the misaligned incentives that have limited progress on behavioral health integration are rapidly changing. As the US health care system moves toward value-based care, hospitals and health systems are acquiring
and/or aligning with primary care providers (PCPs) to manage the health of a population and have accountability for care that is continuous, comprehensive, and coordinated across the care continuum. As organizations form ACOs, accept capitated funds, and redesign a practice environment that is desirable to patients, “one-stop shopping” for addressing both medical and behavioral health needs as part of primary care visits may be more attractive to patients.

Medicaid expansion means an influx of millions of newly insured patients with a disproportionate burden of comorbid medical and behavioral health conditions. Managing the two separately with limited behavioral health professionals is not a viable strategy for state officials and institutions, given the well-documented shortage of both primary care and behavioral health providers and concomitant influx of newly insured patients seeking care. For primary care to help ACOs and similar organizations achieve the Triple Aim, the infrastructure, system, and funding models must be in place to effectively meet all patient needs.

Working harder will not address this problem — system-level changes are needed. Change is possible even in a deeply fragmented health care system, and in the face of payment systems that do not yet adequately support transformative efforts. This will require substantive changes for which most organizations will need guidance and support.

**Who Should Participate?**

This Collaborative is appropriate for organizations committed to improving care in the primary care setting for individuals with both medical and behavioral health needs. Typically these organizations are:

- Health systems with primary care sites
- Hospitals with primary care sites (incorporated within or aligned with the hospital)
- Accountable care organizations (ACOs)
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- Large group practices
- Integrated health systems
- Community health centers
- Primary care organizations that might be able to gain support from:
  - Health plans, especially coordinated/managed care organizations
  - Primary care associations
  - States participating in federal demonstration projects
  - Behavioral health services organizations
  - Local community-based organizations
- Behavioral health organizations that want to integrate primary care
Approach

The 12-month IHI Collaborative, Optimize Primary Care Teams to Meet Patients’ Medical AND Behavioral Needs, is based on more than 10 years of work relating to effective and optimized team-based care, evidence and insights assembled by the MacColl Center for Health Care Innovation through careful study of exemplary primary care practices across the US, IHI’s systems approach to integrating behavioral health and primary care, and a framework developed by the Safety Net Medical Home Initiative.

In the Collaborative, we will use the definition of behavioral health integration from the Agency for Healthcare Research and Quality Lexicon: “The care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health, substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.”

The foundation of our approach in the Collaborative is to design a new model of care for people with medical and behavioral comorbidities that improves their health and experience of care at lower costs. To develop and implement this new approach to care, the work of the Collaborative is organized around eight key components for change, referred to as a “change package” (a set of specific high-level changes that will lead to measureable improvements in care for the stated aim). These eight components are organized within two high-level categories, as described below.

**Lay the Foundation for Improvement**
- Engage Leadership
- Build Quality Improvement Capability
- Empanel Your Patient Population

These three components provide a strong foundation for the organization to be successful in its improvement journey, and participating organizations are expected to have these components already in place prior to the start of the Collaborative. Teams will build and strengthen these foundational components of engaged leadership, quality improvement capability, and population empanelment and management during the Collaborative.

**Engage Leadership**

Participating organizations will be expected to have an engaged and committed leadership team that sets the vision and supports the organization’s commitment to this new approach to care. This change effort requires the support of an interdisciplinary team of clinical, administrative, and financial leaders at all levels as well as board leadership. Recognizing that the care delivery models of the future cannot be managed with the staffing models of the past, leaders need to make their commitment to integrated care explicit while also ensuring that the transformation effort has the time and resources needed to be successful, such as providing education to staff and altering staff workflows to accommodate changes in practice. Developing committed and engaged leadership will be supported by IHI’s High-Impact Leadership Framework.
**Build Quality Improvement Capability**

Participating organizations are expected to have some baseline level of quality improvement capability and experience in facilitating changes in practice, including an established system for continuous quality improvement, data collection, and measurement. If an interested site does not currently have this capability and experience, the Collaborative faculty team can recommend some ways to develop this capacity prior to participation in the Collaborative. Collaborative participants will establish a data tracking and measurement system for key indicators to monitor and evaluate their improvement efforts and outcomes, and ensure that all staff members understand the defined metrics for success for the organization. To be successful, participating organizations will need a workforce that can support and help lead practice development and a clinical information system that can help practices collect, manage, and report data accurately and efficiently and that provides care teams with the information they need to improve processes and outcomes and proactively manage the health of the population.

**Empanel Your Patient Population**

Empanelment is when each provider and care team is assigned a set number of patients while taking into account patient and family preference. Participating organizations are expected to have their patient population empanelled to a care team prior to the start of the Collaborative. Empanelment is a necessary component of population management, with all patients assigned to a team panel with regular review and updating of panel assignments. In an integrated system of care, behavioral health providers are part of this team and do not have their own panel. Provider assignments are defined according to patient need and practice supply and demand are regularly assessed for all team members, with patient load balanced accordingly. Good empanelment is facilitated by utilizing person- and population-level data, which will be used to proactively contact, educate, and track patients by disease status, risk status, self-management status, community, and family need.

**Design and Implement an Integrated System of Care**

- Develop Continuous and Team-based Healing Relationships
- Ensure Person- and Family-Centered Interactions
- Integrate Behavioral Health and Primary Care Services
- Develop an Effective System of Care Coordination
- Create a Sustainable Business Model

The relationship between the patient population you serve and your care team is at the heart of high-functioning primary care. In order to move to a more team-based, efficient, population-focused, and satisfying model of care, primary care practices will need leadership and a commitment to change the culture from the traditional provider-centered, hierarchical model of practice to a more team-based culture of mutual respect and appreciation for all members of the team, including patients and their families. In a team-based model of care, primary care teams explicitly share responsibility for a defined population and have systems in place to support team-based care.

The care team generally includes a core team built around one or a small number of specific providers, one or more medical assistants (MAs), and one or more administrative staff or other community-based or peer roles such as health coach or patient advocate. To more fully meet individuals’ needs, the core team is supported by an extended team consisting of centralized health
professionals and administrative and clinical staff that include behavioral health specialists, care managers, pharmacists, and others. Once staff are in place to support a team-based care approach, system changes are implemented to ensure that each team member is working “at the top of their license,” tasks are redistributed to the most appropriate team member, communication is optimized, and standardization and protocols are in place to create a more efficient system of care.

In the Collaborative, building this type of optimized primary care team will be supported by the web-based *Improving Primary Care: A Guide to Better Care Through Teamwork*, which presents practical advice, case studies, and tools from the literature and 31 high-performing practices from across the country that were selected and studied, demonstrating that they markedly improved care, efficiency, and job satisfaction by transforming to a team-based approach. The Guide was developed as part of a national program of The Robert Wood Johnson Foundation called Primary Care Teams: Learning from Effective Ambulatory Practices (PCT-LEAP). The Guide lays out the core components of building the care team as well as the specific roles and responsibilities of each team member in a high-performing primary care team.

Organizations participating in the Collaborative will deploy optimized primary care teams to integrate behavioral health care and address patients’ medical and behavioral health needs. The primary aim of medical and behavioral health integration is to improve patient-reported outcomes for those experiencing comorbid behavioral and physical ailments. We have found that frequently, the aim of integration efforts is integration itself, rather than a patient-focused or patient-reported outcomes measure.

The foundation of our approach in the Collaborative is to design interventions that lead to improved care for people living with medical and behavioral comorbidities. This may or may not include full integration at the clinic visit as a specific part of the design; rather, organizations may implement components of service delivery integration that are applicable to their patient population and relevant and tailored to their organization’s characteristics. We firmly believe that organizations participating in the Collaborative should learn from and implement core principles from those exemplary approaches to integration that best meet the needs of their populations and practices, rather than select a specific integration model that may not necessarily be the best fit for their populations or organizations.

**Develop Continuous and Team-based Healing Relationships**

At the core of this work is a high-functioning primary care team supported by an operational infrastructure that enables team members to practice effectively and efficiently. To facilitate this, team members should be trained and engaged in a whole-person view of care, including understanding individuals’ social context and the impact of behavioral health on medical conditions. Additionally, clearly defining roles and distributing tasks among care team members to reflect the skills, abilities, and credentials of each team member is essential. Cultural differences between different types of providers can lead to less-than-optimal team functioning, so Collaborative participants will learn how to educate staff in differences in professional culture, legal regulations, and current practice in both primary and behavioral health care, and they will develop communication practices that allow for effective team communication. Teams will also pay particular attention to supporting patient self-care more effectively, and building awareness that “compassion fatigue” can diminish their ability to engage in productive healing relationships.
Ensure Person- and Family-Centered Interactions

Because individuals and their families are central to the success of these changes, participating organizations are expected to have patient and/or family member representatives as partners on their improvement teams. Organizations will work to embed person- and family-based decision making into care team roles and interactions with patients, providing self-management and self-care support at every visit through goal setting, action planning, and stepped care self-management support. The care team will be expected to: 1) clearly communicate the role of the care team in addressing patient’s medical, social, and behavioral health needs; and 2) provide an integrated care plan that is co-developed with and held by the patient, to reflect the care the patient deems to be important and valuable to address both their medical and behavioral health needs. Care team members will not only collaborate with each other, but they will also create the environment for shared responsibility to occur through listening to patients and respecting their desires, perceived needs, and future goals for health and well-being.

Integrate Behavioral Health and Primary Care Services, and Develop an Effective System of Care Coordination

These two components focus on the operational changes needed to coordinate care and build behavioral health capacity on the primary care team (the clinical, leadership, cultural, and financial changes are reflected elsewhere in the other change package components). The necessary operational changes include: 1) technology considerations (e.g., how to access the behavioral health provider, shared documentation in the electronic health record); 2) workforce development (e.g., recruitment, hiring, onboarding, staff oversight, clearly defined roles and responsibilities for each team member); 3) creating new workflows to support team-based care (e.g., daily huddles, care pathways, identification of at-risk individuals, handoffs, interventions, and follow-up); and 4) seamless information sharing and communication between care team members within the organization and others outside the organization, as necessary.

This work also includes coordinating care inside and outside of the organization and linking patients with community services outside the clinical continuum of care. Integration and coordination of care is supported by the utilization of patient and population-level data to facilitate proactive, evidence-based care. Participating organizations will select change package components to test and implement based on the needs of their patient population and existing operational infrastructure.

Organizations must understand their current readiness to provide integrated care before beginning implementation. Each organization will conduct a thorough self-assessment to understand their population’s needs, their organization’s infrastructure and existing capabilities, and their policy and financial environment. This assessment will guide participating organizations in tailoring the implementation of core components from the Collaborative change package so that implementation is aligned with their patients’ needs, organizational characteristics, and financial environment.

Create a Sustainable Business Model

Participating organizations will assess and understand their current financial environment, the total cost of care for the organization, and begin to build their business case for sustaining this new model of care. This includes identifying federal and state-level incentives to support integrated care and grants to fund the transition; clarifying current billing regulations and policies; and optimizing use of existing revenue sources to provide cost-efficient, medically necessary care. If
possible, we strongly encourage participating teams to involve health plans in conversations about alternative payment mechanisms such as global funding strategies and blended payment systems that reward value rather than volume.

System of Measurement

The use of a data and measurement system that reliably collects and analyzes patient-level data will be vital to the success of participating teams. The system of measurement to support the Collaborative will include data collected and plotted monthly, in addition to more comprehensive assessments performed pre-, mid-, and post-Collaborative.

Participants in the Collaborative will be expected to regularly collect and share the data as well as analyze and identify opportunities for improvement on measures relating to patient experience, health, costs, team functioning, and screening and follow-up. Teams will be encouraged to focus their data collection and reporting on reducing inequities in the populations they serve. Participants will begin the process of developing measures by identifying and exploring currently available data from a range of sources. The project-level measures will link logically to the care designs being tested and will be used throughout the Collaborative to track progress toward specified outcomes. Participants will gather and display time series data on measures that all Collaborative participants will track, and use this data to drive further improvements in care.

The more comprehensive assessments will be generated by Collaborative faculty and used to inform participants about their strengths, areas for improvement, and opportunities for collaboration to utilize that knowledge.

Learning Activities

Optimize Primary Care Teams to Meet Patients’ Medical AND Behavioral Needs is patterned on IHI’s Breakthrough Series Collaborative model. Using an “all teach, all learn” philosophy, Collaboratives include a “Laying the Foundation” phase, building and enhancing organizational infrastructure to participate in the Collaborative, team coaching, face-to-face and virtual meetings (or Learning Sessions), Action Periods during which teams test changes and track data, and a series of webinars and calls during which teams learn from expert faculty (see Appendix) and each other. The schedule of Collaborative activities is described below. Some activities focus on topics relevant to all teams and others focus on special topics.
Schedule of Collaborative Activities (February 2015 through January 2016)

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- **Onboarding and Laying the Foundation**: Participants will identify and organize their improvement teams, gather data on their population and potential population segments, assess their organization’s existing infrastructure and financial environment (including clinical information systems), identify data sources and measures, identify a highly engaged leadership sponsor, identify partners and assets, and assess their team’s current level of experience and skill in quality improvement methods. They will also empanel patients to a care team if this is not already in place. During this period, teams will also begin to connect with others participating in the Collaborative and gain access to IHI’s Extranet and listserv for participants.

- **Learning Sessions**: Teams will convene for a total of three Learning Sessions: one three-day, in-person meeting that includes a site visit to an exemplar organization, and two virtual Learning Sessions. These sessions provide an opportunity for learning, networking, and refinement of action plans. We strongly encourage the consistent participation of a minimum of two (and up to four) members of your team at all three meetings. For team members who cannot attend the in-person Learning Session, there will be an option to participate virtually in selected portions of the meeting. For each Learning Session, teams will prepare a written summary of their work to date (usually in the form of a storyboard presentation) that will be shared with faculty and all participants. Teams are strongly encouraged to include a representative from the community.
During Action Periods (between Learning Sessions), teams will use rapid-cycle testing of changes to advance their individual action plans. Action Periods are devoted to testing new changes and spreading those that have shown success. The intent is for participants to scale up from smaller to larger populations as quickly as possible. Teams will report monthly on their activities and measures, and they will participate in the all-team calls described below.

- **All-Team Calls:** IHI faculty members will lead monthly one-hour virtual sessions to help all teams explore the steps involved in optimizing primary care teams, integrating behavioral health care, person- and family-centered approaches to care, and meeting the medical and behavioral needs of the population served. Calls will address issues relevant to the challenges teams are facing and feature the work of participating teams as well as examples from organizations not engaged in the Collaborative.

  Initial calls will focus on building the infrastructure necessary to pursue team-based care and integrate behavioral health care to improve the health and experience of care for their populations at lower costs. IHI faculty will introduce the core principles and coach teams through a sequence of key activities, including understanding their population, developing a cogent purpose, forming the improvement team, engaging leadership, developing a measurement system, implementing approaches to care team development, and planning for getting results at full scale. The infrastructure phase will yield a specific plan for each participating organization that will be the focus of their work for the remainder of the Collaborative.

- **Special Interest Calls:** IHI faculty members will lead monthly one-hour virtual sessions to explore specific content in greater depth. Examples of call topics include business models relevant to different settings, working with payers and states, and workforce development. In each session, at least one team will have the opportunity to present its work and receive active coaching and recommendations from IHI faculty members and the other teams.

- **Measurement Calls:** Each team’s measurement lead will participate in monthly measurement calls with the Collaborative Improvement Advisor to review the Collaborative measurement system, including operational definitions of the measures, data collection methods, reporting expectations, and analysis of the data to identify opportunities for improvement. All Collaborative participants are invited to participate in this call, where we will review data results and share learning. Coaching will be provided to work through common measurement challenges.

- **Leadership Calls:** Leaders at all levels of participating care delivery organizations must organize and focus their efforts in order to achieve sustainable results for the populations they serve. Leadership calls will address critical areas to drive improvement and innovation and provide a forum for learning and feedback from peers. Each organization is expected to identify a senior sponsor, who is expected to attend these calls. Others are invited to attend as well, as desired.

- **Harvesting and Evaluation:** In January 2016, all teams will share their results and learning in a virtual harvesting session.

- **Links to Other IHI Programming:** As needed, IHI faculty members will refer teams to additional IHI improvement training related to their content focus.
Throughout the Collaborative, participants will have access to:

- Guidance and coaching from expert faculty on the key content and methodologies necessary to develop and optimize care teams and integrate behavioral health care. This guidance will be customized to each organization’s unique context and population of focus.
- Guidance on testing, implementing, and scaling up new care models with a focus on achieving financial sustainability.
- Support for developing measurement strategies and collecting, tracking, and analyzing data.
- Coaching to build each team’s capability to learn what works in its setting, using the methodologies and knowledge in the Collaborative.
- Opportunities to explore additional onsite and virtual coaching services beyond the activities of the Collaborative.

Expectations of Participating Organizations

To succeed in the IHI Collaborative, *Optimize Primary Care Teams to Meet Patients’ Medical AND Behavioral Needs*, participating organizations will need to exhibit certain characteristics as described below.

- **Senior Leadership Support**: Because of the strategic and challenging nature of primary care transformation, participating teams must have the explicit support and engagement of their senior leadership. Engaged leaders can maximize internal and external opportunities for change and primary care transformation. To optimize results, the Collaborative should be a recognized priority supported by each organization’s senior leadership and governing board. IHI faculty will convene the senior leaders periodically through a series of calls and dedicate time during Learning Sessions to discuss leadership and governance issues.

- **Dedicated Project Resources**: The organization’s identified senior leader for the Collaborative should appoint a high-level project leader for the participating team. This project leader will oversee the day-to-day activities of the team and needs the time, resources, and accountability to succeed. Because of the challenges in securing segmented population-level data, we strongly recommend also designating a data and measurement lead. We estimate this project leader will need to dedicate 20 to 40 percent of his or her time to this work.

- **Improvement Team**: Focused on the activities of the Collaborative, the multidisciplinary improvement team generally consists of 6 to 10 members who represent a wide range of stakeholders, including clinicians, frontline staff, executive leaders, individuals and their families, community partners, and payers. Teams that include patients and family members have demonstrated quicker, more focused efforts.

- **Improvement Skills and a Record of Successful Improvement**: To succeed in this work, strong improvement capabilities are required. Successful participants will commit to learning quality improvement methods prior to the start of the Collaborative, or will already be skilled and agile in using the Model for Improvement or other improvement methods. These skills include learning through iterative small tests of change, testing new designs at ever-increasing scale, and implementing change throughout the system or community. IHI has a wide array of programs that can help bolster the improvement skills of team members.
and community partners, if additional training prior to the start of the Collaborative is needed.

- **Dedicated Support for Measurement and Data Infrastructure:** Few organizations have all the data they need to understand and improve care for their population. In addition to using the data already available, most participants will need to develop new ways to collect, report, understand, and use data, including looking beyond their own data systems to external sources. IHI faculty will convene the measurement leads from each team via periodic coaching calls to work through common measurement challenges, and to share data results and learning.

- **Partnering and Inclusion:** Participating organizations will need to reach beyond their usual boundaries to develop multi-stakeholder partnerships. Partnering relationships often include health care organizations and groups such as social service agencies, local governments, public health departments, educational institutions, employers, and other community groups. These partnerships may also include civic, religious, and other nonprofit or voluntary organizations focused on improving the health of the community. IHI encourages participating sites to include patient, family, and community representatives as active team members.

## Enrollment Fee

The cost for one year of participation in the Collaborative is $20,000 per organization. A reduced rate of $10,000 per team applies to federally-qualified health centers and safety net hospitals. A limited number of partial scholarships are available for safety net organizations.

Organizations or coalitions participate in the Collaborative as a team to design and test changes at primary care sites and then to build a scale-up plan based on successful tests. Typically, there is one core team with a key contact and a measurement lead and then several primary care test sites. One fee of $20,000 covers the calls, on-site participation in Learning Sessions for all team members (excluding travel expenses), and individualized coaching sessions from the expert faculty for 12 months. Interested organizations are encouraged to partner with health care, health plan, and community participants.

## To Enroll

If your organization or system is interested in enrolling in the IHI Collaborative, *Optimize Primary Care Teams to Meet Patient’s Medical AND Behavioral Needs*, please email primarycare@ihi.org. A member of the faculty team will then schedule a phone conversation to learn more about your organization and answer your questions about participation in the Collaborative prior to enrollment. Teams are encouraged to enroll at least one month prior to the start date of February 19, 2015, in order to allow time to complete prework for the Collaborative.
Learn More

Join an upcoming informational call led by the core faculty team on Friday, November 14, 2014, at 12:00-1:00 pm Eastern Time. Visit ihi.org/OptimizePC or email primarycare@ihi.org for connection details. After November 14th, the informational call recording will be posted to the Collaborative website.

IHI faculty members are also available for individual calls with interested organizations. If you’d like to talk with a faculty member about this opportunity, please email primarycare@ihi.org.
Appendix: Core Faculty

Wendy D. Bradley, LPC, CCSAC, is responsible for the development and oversight of Behavioral Health Integration and Community Engagement at Ampersand Health in Nashville, Tennessee. Before moving to Nashville in 2013, she worked at Southcentral Foundation (SCF) in Anchorage for nine years, where she oversaw the implementation and expansion of behavioral health integration into the primary care system. SCF received the SAMSHA Science and Service Award in 2009 and the Malcolm Baldrige National Quality Award in 2011 for their innovative, relationship-based approach to health care. Ms. Bradley provides training, consultation, and results-driven solutions for organizations around the US. In addition, she supports individuals and teams in personal and professional improvement. She received two undergraduate degrees at the University of Hawaii and a master’s degree from Webster University in Counseling Psychology, with an emphasis in marriage and family therapy.

Connie Davis, MN, ARNP, RN, provides quality improvement, system design, and self-management expertise to health care systems and professionals and is a nurse practitioner specializing in care of the elderly. She is the co-director of the nonprofit Centre for Collaboration, Motivation and Innovation, which provides expertise in a stepped-care approach to self-management support, including training health care professionals, public outreach, and designing patient-centered care systems. From 2007 to 2012, she served as the quality improvement lead for “Patients as Partners” in British Columbia. Ms. Davis was the clinical director for the team at the MacColl Center for Health Care Innovation, Group Health Cooperative, that developed the Chronic Care Model. She has participated in many collaborative improvement programs at the national, state, and system levels, with the goal of improving chronic care. She is the author or coauthor of publications on health promotion, chronic illness care, quality improvement, and self-management support. She is a member of the Motivational Interviewing Network of Trainers and has a special interest in helping patients and professionals form better partnerships to improve health and health care.

Cindy Hupke, BSN, MBA, Director, Institute for Healthcare Improvement (IHI), is also a content lead for IHI’s Triple Aim for Populations. Over the last 15 years, her work has focused on leading large, strategic population health initiatives to improve population outcomes at scale, with a particular emphasis on reducing disparities and inequities. These initiatives included the US Department of Health and Human Services Health Resources and Services Administration’s Health Disparities Collaboratives and the Indian Health Service’s Improving Patient Care Collaboratives, reaching more than 800 health centers and clinics across the US. Ms. Hupke developed and leads the IHI seminar on Transforming the Primary Care Practice and she is an active participant in ongoing development of leadership and spread content within IHI.

Mara Laderman, MSPH, is a Senior Research Associate at the Institute for Healthcare Improvement (IHI). She leads IHI’s work in behavioral health, developing content and programming to improve behavioral health care in the US and globally. In addition, as a member of IHI’s Innovation Team, she researches, tests, and disseminates innovative content to advance IHI’s work within the Triple Aim for Populations focus area. Prior to joining IHI, she managed a nationally representative psychiatric epidemiologic study investigating the effect of social and environmental factors on the behavioral health outcomes of vulnerable populations. Ms. Laderman received a Master of Public Health from the Harvard School of Public Health and a Bachelor of Arts in Psychology from Smith College.
Gerald J. Langley, MS, is a statistician, author, and consultant for Associates in Process Improvement (API). His main focus in both his consulting work and in his research is helping organizations make improvements more rapidly and effectively. He has published articles on sampling and survey design, modeling, and fundamental improvement methods. He is a coauthor of *The Improvement Guide*. Much of his work in the last 10 years has been focused on reducing health disparities in underserved populations. He has also contributed his time to the improvement efforts of several educational organizations, both at the state level and with individual schools. As a Senior Fellow of the Institute for Healthcare Improvement (IHI), Mr. Langley has served on the faculty of numerous improvement initiatives. He has also supported a number of large-scale improvement initiatives, the Health Disparities Collaborative sponsored by HRSA, and Improving Patient Care for the Indian Health Service. He is currently designing and guiding the implementation of several pilot collaborative projects directed at improving care and outcomes for mental health services in California.

Benjamin F. Miller, PsyD, Assistant Professor, Department of Family Medicine, University of Colorado Denver School of Medicine, is also the Director of the Eugene S. Farley, Jr. Health Policy Center. Dr. Miller is a principal investigator on several federal grants, foundation grants, and state contracts related to comprehensive primary care and mental health, behavioral health, and substance use integration. He leads the Agency for Healthcare Research and Quality’s Academy for Integrating Behavioral and Primary Care project as well as the highly touted Sustaining Healthcare Across Integrated Primary Care Efforts (SHAPE) project. He is the co-creator of the National Research Network’s Collaborative Care Research Network, and has written and published on enhancing the evidentiary support for integrated care models, increasing the training and education of mental health providers in primary care, and the need to address specific health care policy and payment barriers for successful integration. He is the section editor for *Health and Policy for Families, Systems and Health* and reviews for several academic journals. Dr. Miller is a technical expert panelist on the Agency for Healthcare Research and Quality Innovations Exchange and on the International Advisory Board of the *British Journal of General Practice*. He is the past President of the Collaborative Family Healthcare Association, a national not-for-profit organization pushing for patient-centered integrated health care, and faculty for the Institute for Healthcare Improvement.

Kathleen Reims, MD, is a board-certified Family Medicine physician who is a Principal of CSI Solutions, LLC, and its Chief Medical Officer. She currently co-directs the Centre for Collaboration, Motivation and Innovation (CCMI), a nonprofit organization dedicated to building skills and confidence for better health and health care. She has served as an Improvement Advisor and faculty for numerous health systems improvement projects and has a strong interest in patient engagement so as to respectfully include patients’ values and preferences in their care. Dr. Reims continues to be actively involved with Denver Health and Hospital’s Lowry Clinic as a volunteer preceptor, serving a diverse population from around the world, and she holds an appointment of Assistant Clinical Professor Department of Family Medicine, School of Medicine, University of Colorado Health Sciences Center. She was a National Health Service Corps Scholar, has over 25 years of clinical experience with underserved populations, and has served as Medical Director for two federally qualified health centers. Dr. Reims received her MD degree from Baylor College of Medicine and completed her Family Medicine residency at Roanoke Memorial Hospitals.
Edward H. Wagner, MD, MPH, FACP, Emeritus Director of the MacColl Center for Health Care Innovation and Senior Investigator at the Group Health Research Institute, is a general internist and epidemiologist. His research and quality improvement work focuses on improving the care of seniors and patients with chronic illness. Since 1998, he has directed Improving Chronic Illness Care, a national program of The Robert Wood Johnson Foundation. Dr. Wagner and his MacColl colleagues developed the Chronic Care Model, which has now been used in quality improvement programs worldwide. He also is Principal Investigator for the Cancer Research Network, a National Cancer Institute–funded cancer research consortium of 12 HMO-based research programs. The author of two books and more than 250 publications, Dr. Wagner serves on the editorial boards of *Health Services Research*, the *British Medical Journal*, the *Journal of Clinical Epidemiology*, and the *Journal of Cancer Survivorship*. He is also a member of the Institute of Medicine.
References

1 Bodenheimer T. *Building Teams in Primary Care: Lessons Learned*. California HealthCare Foundation; July 2007.


