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

A 12-month IHI Collaborative

Informational Call
November 14th, 2014
Goals of Today’s Call

- Describe the background, methods, and content to be used in the Optimize Primary Care Teams to Meet Patients’ Medical AND Behavioral Needs Collaborative.
- Describe the activities for the Collaborative.
- Answer your questions about the Collaborative.
Ways to share your questions and comments

Using the chat box:

Raise your hand for your line to be opened:
Please share with us:

- Your name
- Your organization
- Where you are joining from
Collaborative Faculty

Wendy Bradley, LPC, CCSAC
Connie Davis, MN, ARNP, RN
Mara Laderman, MSPH
Benjamin F. Miller, PsyD
Edward H. Wagner, MD, MPH, MACP
Gerald Langley, MS
Cindy Hupke, BSN, MBA
Kathleen Reims, MD
Why do we need to work on this?

- Poor outcomes and high costs for patients with medical + behavioral comorbidities.
- Getting to the Triple Aim will require addressing behavioral health in primary care.
- Changing incentives will facilitate this – the time is right to work on this now.
Why focus on primary care teams?

High performing primary care teams that include behavioral health capacity can effectively meet patients’ multiple medical and behavioral needs.

Evidence shows that team-based primary care can improve quality and move towards the Triple Aim:

- Better health and functioning of individuals with chronic disease
- Better patient and provider satisfaction
- Lower per capita costs
Answering Important Questions

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What changes can we make that might result in improvement?
Collaborative Aim

- Participating organizations will redefine the composition and roles of primary care, building highly functional multidisciplinary teams that are fully equipped to address the physical and behavioral care needs of their population.
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 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.
- Develop a plan to scale up and sustain the model that has been developed and tested.
Definition of Integration

“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.”
Measurement Strategy

- Participants will collect and share data monthly to analyze and identify opportunities for improvement on measures relating to:
  - Person Experience
  - Screening and Follow-up
  - Health
  - Team functionality
  - Health Costs
What changes can I make.....?
Building a Medical Home

Lay the Foundation for Improvement

Participants should have these elements in place and will continue to build and strengthen them throughout the Collaborative:

- Engage leadership
- Build quality improvement capability
- Empanel your patient population

Adapted from the Safety Net Medical Home Initiative Framework
http://www.safetynetmedicalhome.org/change-concepts
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

Adapted from the Safety Net Medical Home Initiative Framework
http://www.safetynetmedicalhome.org/change-concepts
Primary Care Team Guide

Improving Primary Care: A guide to better care through teamwork.

GET STARTED NOW

A program of:

The Primary Care Team leap

Support provided by Robert Wood Johnson Foundation
Results Collaborative

- 12-month Collaborative
- 40-50 organizations
- 3 Learning Sessions, one will be face-to-face and will include a site visit
- Expectation: Engagement!
  - Regular calls: All-team, measurement, leadership, and special interest calls
  - Listserv
  - Monthly reporting
- National Forum meeting – December, 2015
- Use of QI methods- Model for Improvement and rapid, iterative learning shared among participants
- Shared measurement strategy
- Starts February 19, 2015
Who Should Participate?

- Organizations committed to improving care in the primary care setting for individuals with both medical and behavioral health needs.
Participants May Include:

- 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:
  - 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
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.
- One fee 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.
Questions and Discussion
February, 2015

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