### Primary Care Collaborative:
Optimize Primary Care Teams to Meet Patients' Medical and Behavioral Needs

**Informational Call Session Questions and Answers**

**November 14, 2014**

1. **Does it make sense to have 1) organizations that already have some level of behavioral/primary care integration and wish to refine/expand/improve, 2) organizations that are starting out on integration, or 3) both of these types of organizations?**

   It makes sense for both types of organizations to participate. For those just starting out, we have plenty of content that will help you determine the best approach for integration. For those a bit further along, this Collaborative will help to make your current approach more effective and allow you to operate at a higher level. We appreciate the change to discuss your goals and work with you to achieve them.

2. **Do your integration guidelines follow those of the Health Resources and Service Administration (HRSA)?**

   Yes, the Collaborative’s change package for behavioral health integration is very much aligned with HRSA’s guidelines for their Health Center grantees to work on integration. HRSA’s guidelines are quite broad, focusing on using a team-based, integrated model of care and using screening, brief intervention, and referral to treatment (SBIRT) and other evidence-based practices. The four Focus Areas HRSA lays out are:
   - Adoption or enhancement of current primary and behavioral health care integration
   - Collaboration in a fully integrated system
   - Addition of at least one new, onsite licensed behavioral health
   - Training to support integration of primary medical and behavioral health care and use of SBIRT and other evidence-based practices

   The Collaborative will help organizations work towards their goals in each of these four focus areas. Additionally, HRSA stipulates that grantees must use the “depression screening and follow-up performance measure”, which is a measure that will be collected in the Collaborative.

3. **Please define "building quality improvement capability".**

   A simple framework for getting results from strategic improvement work is Will-Ideas-Execution. Achieving results at the system or organizational level requires will at all levels. The new system will require new ideas about how work gets done. Each organization needs to understand how to execute change. It is a strength and focus of the Institute for Healthcare Improvement (IHI) to ensure that improvement science drives our work and that we extend the reach and impact of this approach and knowledge to those with whom we are privileged to work.

   Improving quality and safety in health care is challenging and requires active participation from a health care workforce that is skilled in using methods of improvement and is accustomed to...
multidisciplinary collaboration. The Model for Improvement and Collaborative learning and improvement anchor our approach to project design and evaluation, implementation, spread, and scale-up in diverse environments and contexts. Improvement capability is foundational and crucial to success in this Collaborative. It is expected that organizations participating in this collaborative already have improvement capability. The link above and other offerings are available to build this capability before the collaborative begins. Please contact us if you need guidance on next steps for your organization.

Within IHI, Improvement Capability can be defined as, ensuring that improvement science drives our work and that we extend the reach and impact of the improvement community.

4. **What effective approaches are available to not only develop the integrated model within a particular practice or health care system, but across multiple practices/systems in one community?**

This refers to spread, which we define as actively disseminating best practice and knowledge about every intervention and implementing each intervention in every available care setting.

Our experience indicates that spread generally begins with testing and implementing an effective, sustainable model in a pilot clinic or department. When scaling up to include the entire organization, there are multiple components of support that must be considered. We will make sure that participating organizations understand the importance of an environment that is receptive to the new approaches and an infrastructure that can support it.

In 1999, IHI chartered a team to develop a "Framework for Spread." The team conducted a review of organizational and healthcare literature on the diffusion of innovations, and interviewed organizations both within and outside of healthcare that had been successful in spreading new ideas and processes. Since that time, the Framework for Spread and our deeper understanding of its content have continued to evolve. We will share that knowledge and apply the theory and tools to the Collaborative work, with an expectation that each site will develop a plan to spread each intervention in every available care setting in their organization. Spread planning is initiated when the collaborative begins.

5. **How much will this process focus on developing or using roles on the care team, for example RNs, panel managers, care coordinators, patient navigators, peer support specialists, etc., in addition to the behavioral health providers?**

The collaborative will help organizations develop high performing primary care teams. That care team includes multiple roles, including those listed here. The first part of the collaborative will focus on developing and optimizing these different care team roles, including but not limited to the behavioral health provider.

6. **Can you define how you are using the term "primary care team"? What roles are you including? Is it specific to behavioral health (BH) and primary care providers (PCP) or is it broader?**

Our definition includes everyone you would find in a primary care organization or site. We have found it helpful to distinguish the ‘core team’ linked to specific providers and panels of patients (usually provider(s) and medical assistant). Then there is the extended team, that includes the behavioral health specialist, care managers, non-professional staff, and others involved in the provision of care.
7. **Are there funds available to facilitate implementation of behavioral health integration?**

This varies based on the current payment system, type, and location of the organization. In the first part of the Collaborative, as part of the organizational self-assessment, we will guide you through identifying financial incentives that will help facilitate integration.

8. **Does your practice team model include lay health care providers? In addition, what skills and competencies will be needed to ensure the team is fully prepared to support clients to improve their health outcomes?**

Some models do include non-professional staff as members of the care team. In the first phase of the collaborative faculty will help participants determine the appropriate roles and staff for your care team. We will work with organizations to build skills and competencies of team members in patient-centered care and self-management support. The goal is a team that has a shared understanding of effective behavior change approaches and matches team member’s skills with population and individual needs.

9. **Are there empanelled care teams of the entire organization or care teams within each practice?**

Empanelment is a term that is typically used within the U.S. referring to the act of assigning individual patients to individual PCPs and care teams with designated providers to cover academic practices, shared practices, etc., with sensitivity to patient and family preference. In other countries, there will likely be another name for this process, for example, the term “attachment” is used in some provinces in Canada. Whatever the terminology, it is the foundation for excellent population health management and continuity of care and there is an expectation that the participating “team” will be empanelled or in the process of becoming empanelled, with a strong emphasis on planning to achieve the same across the entire organization.

We will be focusing on the development of highly functional teams that can address and meet the physical and behavioral needs of their population. This cannot be achieved without the ability to use panel data and registries to proactively contact, educate, and track patients by disease status, risk status, self-management status, community, and family need. The practice team needs to know which patients they are responsible for and the person needs to know their care team.

10. **How does this approach fit with TEAMcare, from Training Xchange, University of Washington?**

TEAMcare evidence is incorporated and consistent with this work.

11. **I would be interested in any references Connie can share about peer members in the care team.**


12. **What does the Affordable Care Act (ACA) Annual Wellness Visit (AWV) funding mean "for specific patients?"**

It is provided in the ACA through the AWV, only available to specific patients.

13. **How can primary care practices/healthcare settings with no experience managing billing/reimbursement/contracting with behavioral health carve outs learn and grow capacity in this area to allow for integration at this level?**
We will be having special interest calls focused on funding and contract reimbursement. We will be focusing part of the Collaborative on making the business case. As part of this, you will learn how to identify and work with behavioral health services and organizations under your specific constraints.

14. **What kind of outcomes are you considering for BH?**

We will be asking organizations to report on improvements in PHQ-9 scores to assess changes in depression symptoms. We encourage organizations to select supplementary measures based on the BH needs of their population that align with the screening and treatment they will be implementing (e.g., GAD-7 scores for anxiety disorder, or CAGE scores for alcohol and substance abuse). In addition, improved physical outcomes such as reductions in HbA1c and blood pressure and weight control will also reflect a well-integrated approach that combines both physical and behavioral needs.

**General Program and Cost-Related Questions**

15. **How much would it cost my community health center to join?**

General membership fees are $20,000; however, scholarships and discounts are available for Federally-qualified health centers (FQHCs) and safety net hospitals. If you are unsure about your organization’s status or qualifications for these options, we are happy to connect with you directly to discuss other options.

16. **Can we discuss the process of partial scholarships for safety net organizations?**

Once an organization has determined their readiness to enroll into the program and are recognized as a safety net hospital, Betty Janey at PrimaryCare@ihi.org will enroll them into the program under the appropriate rate, at which point they will receive an invoice for their participation.

17. **What about non-FQHC primary care organizations who are known safety net organizations but not otherwise qualified by the last slide?**

Organizations who serve a predominately safety net population are eligible for a reduced rate to participate in the collaborative.

18. **Does the fee have to be made upfront for FQHCs or can it be paid in installments?**

Organizations will receive a monthly invoice until the full balance of the enrollment fee is realized.

19. **Are the feds ready to support our efforts with funding?**

We encourage organizations to identify policy and financial incentives at the federal, state, and local levels that could help support integration.

20. **Will there be a certificate of achievement for completion of the Collaborative?**

We are not providing certificates of achievement for completion of the Collaborative at this time. If you or your organization need some sort of record of completion, we would be happy to provide you with this to meet your needs.

21. **When is the deadline to apply?**

The program will commence in February 2015, so we encourage all applicants and potential teams to have enrolled or near the completion of the enrollment process by early January, 2015.
22. **Will there be a screening process for agencies to know if they are ready to join the Collaborative?**

We would like the opportunity to meet with all applicants who are in the final stage of their decision process to participate in the program. The purpose of this meeting will be to address any final questions about fit or readiness to participate to ensure that teams are strategically set up for support and success in this program. If there are organizations that would like to conduct learning activities prior to starting the Collaborative, we can refer you to multiple asynchronous, virtual learning opportunities.

23. **We have 10 primary care providers. Can we qualify if one or two participate in the project year?**

It is really up to your organization how to choose to structure provider and care team participation in the Collaborative. We expect that the practices that will be represented in the Collaborative will encompass the spectrum of primary care, from a one-physician private office to large multispecialty groups with hundreds of primary care clinicians and team members.

For each participating organization, we suggest that you look for and select a site where the participating care team has shared responsibilities and could be defined as “a group with a specific task or tasks, the accomplishment of which requires the interdependent and Collaborative efforts of its members.” In a small practice, this might be one clinician and all of the team members working with that clinician. In a very large practice, this might be multiple providers/clinicians working in a pod, each with a medical assistant and with shared social work, pharmacy, etc. support. We can help you define that prior to the start of the Collaborative based upon your clinic structure and functionality. The specific mix of staff (number of physicians, nurses, assistants, technicians, clerks, etc.) will vary from clinic to clinic.

Whatever the definition or composition of the team that is selected, optimizing the care team will be a critical component to the Collaborative. As such, the participants must be individuals who typically work together to meet the needs of a defined set of patients, sharing responsibility for clinical and behavioral outcomes.

24. **Are we a good fit for the Collaborative as we have 12 clinics applying for National Committee for Quality Assurance (NCQA) recognition this month?**

NCQA’s new criteria require the integration of behavioral health and this Collaborative will help organizations meet these criteria.

25. **How many people will visit our site (trying to figure out total cost to bring back to management)?**

We will not have the opportunity to go to each organization. Instead, we invite all teams to attend the virtual and in-person learning sessions. The cost for attending the in-person meeting is included in your enrollment fees, so the only additional cost that each team will need to plan for will be any travel and hotel-related fees for the in-person event.

We will incorporate virtual site visits into the curriculum throughout the year, so if you would like your site to be considered for a virtual visit, please let us know.

26. **Will calls be re-broadcasted? How can we access the materials?**

Access a recording of Friday’s meeting [here](#). The slides have been included as a link on the web page and in the email you received and can be accessed [here](#).