APPLYING THE INTEGRATED CARE APPROACH: INTEGRATING PRIMARY CARE AND BEHAVIORAL HEALTH

LORI RANEY, MD
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FACULTY DISCLOSURES: LORI RANEY, MD

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- No off-label discussion of pharmaceuticals
TRANSFORMING CLINICAL PRACTICE INITIATIVE
APA Support and Alignment Network
In September 2015, the Centers for Medicare and Medicaid Services (CMS) awarded $685 million to 39 national and regional collaborative healthcare transformation networks (PTNs) and supporting organizations (SANs) for the Transforming Clinical Practice Initiative (TCPI).

TCPI supports practice transformation through nationwide, collaborative, and peer-based learning networks.
Support and Alignment Networks (SANs)

• national and regional professional associations and public-private partnerships

Practice Transformation Networks (PTNs)

• large health systems
• Collaborative Care model – Integrating psychiatric care into primary care practices

• Psychiatrists will gain the clinical and leadership skills needed to support primary care practices

• Training includes:
  • Population health management
  • Use of registries and real-time clinical outcome data
  • Telephonic, tele-video, and caseload-focused psychiatric consultation methods
  • Skill development for coordinating with a primary care team
  • Use of evidence-based methods for managing patients with common mental disorders in primary care
## INTEGRATION
### ENVIRONMENTAL DRIVERS

<table>
<thead>
<tr>
<th>ACA</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Insurance Expansion</td>
<td>• CMS ACO quality measures 6 are now for</td>
</tr>
<tr>
<td>• Triple Aim Initiatives –</td>
<td>behavioral health – newest is depression</td>
</tr>
<tr>
<td>better outcomes, lower</td>
<td>remission at 12 mos</td>
</tr>
<tr>
<td>costs, better experience</td>
<td>• NCQA PCMH – 2017 standards – “Advanced”</td>
</tr>
<tr>
<td>of care</td>
<td>• HEDIS decision to phase in new</td>
</tr>
<tr>
<td>• Innovation Grants</td>
<td>depression outcome measures</td>
</tr>
<tr>
<td>– Collaborative Care</td>
<td>• CMS – CCM new codes for CoCM</td>
</tr>
<tr>
<td>– Payment Structures</td>
<td>• JCAHO required quality measures as of 2011 on</td>
</tr>
<tr>
<td>• Behavioral Health</td>
<td>universal screening (tobacco, alcohol, and</td>
</tr>
<tr>
<td>Homes – SPAs</td>
<td>behavioral health)</td>
</tr>
<tr>
<td>• Expand CHC</td>
<td>• MACRA</td>
</tr>
<tr>
<td>• Expand PBHCI</td>
<td>– MIPS</td>
</tr>
<tr>
<td></td>
<td>– Alternative Payment Methods</td>
</tr>
</tbody>
</table>

**Other**

- CMS ACO: quality measures 6 are now for behavioral health – newest is depression remission at 12 mos.
- NCQA PCMH: 2017 standards – “Advanced”.
- HEDIS: decision to phase in new depression outcome measures.
- CMS: CCM new codes for CoCM.
- JCAHO: required quality measures as of 2011 on universal screening (tobacco, alcohol, and behavioral health).
- MACRA:
  - MIPS
  - Alternative Payment Methods
Mortality Risk: 2.2 times the general population

10 years of potential life lost

8 million deaths annually

RATES OF NON-TREATMENT

No Treatment

Primary Care Provider

Wang P, et al., Twelve-Month Use of Mental Health Services in the United States, Arch Gen Psychiatry, 62, June 2005

Mental Health Provider (Psychiatrist and therapists)
## ANNUAL PER PERSON COST OF CARE

### COMMON CHRONIC MEDICAL ILLNESSES WITH COMORBID MENTAL CONDITION

"VALUE ADDED OPPORTUNITIES"

<table>
<thead>
<tr>
<th>Patient Groups</th>
<th>Annual Cost of Care</th>
<th>Illness Prevalence</th>
<th>% with Comorbid Mental Condition*</th>
<th>Annual Cost with Mental Condition</th>
<th>% Increase with Mental Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Insured</td>
<td>$2,920</td>
<td></td>
<td>10%-15%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arthritis</td>
<td>$5,220</td>
<td>6.6%</td>
<td>36%</td>
<td>$10,710</td>
<td>94%</td>
</tr>
<tr>
<td>Asthma</td>
<td>$3,730</td>
<td>5.9%</td>
<td>35%</td>
<td>$10,030</td>
<td>169%</td>
</tr>
<tr>
<td>Cancer</td>
<td>$11,650</td>
<td>4.3%</td>
<td>37%</td>
<td>$18,870</td>
<td>62%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>$5,480</td>
<td>8.9%</td>
<td>30%</td>
<td>$12,280</td>
<td>124%</td>
</tr>
<tr>
<td>CHF</td>
<td>$9,770</td>
<td>1.3%</td>
<td>40%</td>
<td>$17,200</td>
<td>76%</td>
</tr>
<tr>
<td>Migraine</td>
<td>$4,340</td>
<td>8.2%</td>
<td>43%</td>
<td>$10,810</td>
<td>149%</td>
</tr>
<tr>
<td>COPD</td>
<td>$3,840</td>
<td>8.2%</td>
<td>38%</td>
<td>$10,980</td>
<td>186%</td>
</tr>
</tbody>
</table>

Cartesian Solutions, Inc.™—consolidated health plan claims data

**Melek S et al APA 2013 [www.psych.org](http://www.psych.org)**
Issues with depression and substance abuse must be pre-empted, rather than treated once advanced.

Goal is to detect early and apply early interventions to prevent from getting more severe.
The Chronic Care Model

Community
- Resources and Policies
- Self-Management Support

Health Systems
- Organization of Health Care
  - Delivery System Design
  - Decision Support
  - Clinical Information Systems

Informed, Activated Patient

Productive Interactions

Prepared, Proactive Practice Team

Improved Outcomes

Developed by The MacColl Institute
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PRINCIPLES OF COLLABORATIVE CARE

- Population-Based Care
- Measurement-Based Treatment to Target
- Patient-Centered Collaboration
- Evidence-Based Care
- Accountable Care
PCBHI MODEL –
“BHC OR CHEROKEE MODEL”

• Team-driven collaboration that is patient-centered
• Immediate access in primary care
• Practice-tested, limited evidence-base
  – Mental health and substance use disorders
  – Health behaviors
  – Life stressors
  – Crises
  – Stress-related physical symptoms
  – Ineffective patterns of health care utilization
• Evidence-based behavioral interventions
• Typically not measurement guided - no regular repeat PHQ9, etc
• Do not track with registry as a standard practice
• No caseload review with psychiatric provider to address patients who are not progressing, provide medication recommendations to PCP, etc
BLENDED MODEL - BEST OF BOTH

- Team-driven collaboration that is patient-centered
- Evidence-based, practice-tested - immediate access in primary care
  - Mental health and substance use disorders
  - Health behaviors, life stressors, crises, stress-related physical symptoms, ineffective patterns of health care utilization
  - Evidence-based behavioral interventions
- Measurement guided - standardized repeat PHQ9, etc
- Population-based
  - Track with registry as a standard practice
  - Caseload review with psychiatric provider to address patients who are not progressing, provide medication recommendations to PCP
PRINCIPLE: PATIENT-CENTERED COLLABORATION

New Roles

PCP

Patient

BHP/Care Manager

Psychiatric Consultant

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TRADITIONAL MODEL VS. COLLABORATIVE CARE MODEL

Traditional Model

PCP

Patients

Psychiatrist

? 

? 

Collaborative Care Model

PCP

Psychiatrist (Part-Time)

Care Manager

Telepsychiatry

Patients
THE COLLABORATIVE CARE MODEL

Effective Collaboration

Informed, Activated Patient

Practice Support

Measurement-guided Treat to Target

Psychiatric Consultation

Caseload-focused Registry review

Training

PCP supported by Behavioral Health Care Manager
DOUBLES EFFECTIVENESS OF CARE FOR DEPRESSION

50% or greater improvement in depression at 12 months

Usual Care
IMPACT

Participating Organizations

Co-located Therapist

Unützer, Katon et al., JAMA 2002
COLLABORATIVE CARE: THE RESEARCH EVIDENCE

- Now over 80 Randomized Controlled Trials (RCTs)
  - Meta analysis of Collaborative Care (CC) for depression in primary care (US and Europe)

Collaborative care is consistently more effective than care as usual.

Archer, J. et al., 2012
### HOW WELL DOES IT WORK WITH OTHER DISORDERS?

#### Evidence Base Established
- Depression
  - Adolescent Depression
  - Depression, Diabetes, and Heart Disease
  - Depression and Cancer
  - Depression in Women’s Health Care
- Anxiety
- Post Traumatic Stress Disorder
- Chronic Pain
- Dementia

#### Emerging Evidence
- Substance Use Disorders
- ADHD
- Bipolar Disorder
### BUSINESS CASE:
**REDUCES HEALTH CARE COSTS**

<table>
<thead>
<tr>
<th>Cost Category</th>
<th>4-year costs in $</th>
<th>Intervention group cost in $</th>
<th>Usual care group cost in $</th>
<th>Difference in $</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMPACT program cost</td>
<td>522</td>
<td>0</td>
<td>522</td>
<td></td>
</tr>
<tr>
<td>Outpatient mental health costs</td>
<td>661</td>
<td>558</td>
<td>767</td>
<td>-210</td>
</tr>
<tr>
<td>Pharmacy costs</td>
<td>7,284</td>
<td>6,942</td>
<td>7,636</td>
<td>-694</td>
</tr>
<tr>
<td>Other outpatient costs</td>
<td>14,306</td>
<td>14,160</td>
<td>14,456</td>
<td>-296</td>
</tr>
<tr>
<td>Inpatient medical costs</td>
<td>8,452</td>
<td>7,179</td>
<td>9,757</td>
<td>-2578</td>
</tr>
<tr>
<td>Inpatient mental health / substance abuse costs</td>
<td>114</td>
<td>61</td>
<td>169</td>
<td>-108</td>
</tr>
<tr>
<td>Total health care cost</td>
<td>31,082</td>
<td>29,422</td>
<td>32,785</td>
<td>-$3363</td>
</tr>
</tbody>
</table>

**Savings**

**ROI**

$6 : $1

Unützer et al., *Am J Managed Care 2008.*
**EVOLUTION OF THE MODEL: TEAMCARE MULTI-CONDITION COLLABORATIVE CARE**

- **diabetes nurse educators**
- **Caseload supervision**
  - Depression: psychiatrist
  - Diabetes and CAD: family doctor
  - E-Mail to diabetologist for complex cases

Cost Savings $600-1100/pt

STEPPED CARE APPROACH

1. Different people need different levels of care for the same problem
2. Monitoring outcomes helps determine the right level
3. Stepped care can improve outcomes and contain costs

Vonkorff WJM 2000
COLLABORATIVE CARE: CORE COMPONENTS AND TASKS

1. Patient Identification and Diagnosis
2. Engagement in Integrated Care Program
3. Evidence Based Treatment
4. Systematic Follow-up, Treatment Adjustment, Relapse Prevention
5. Communication, Care coordination and Referrals
6. Systematic Case Review and Psychiatric Consultation
7. Program Oversight and Quality Improvement
PHQ-9

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: John Q. Sample

DATE: 

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use “✓” to indicate your answer)

1. Little interest or pleasure in doing things
   - 0
   - 1
   - 2
   - 3

2. Feeling down, depressed, or hopeless
   - 0
   - 1
   - 2
   - 3

3. Trouble falling or staying asleep, or sleeping too much
   - 0
   - 1
   - 2
   - 3

4. Feeling tired or having little energy
   - 0
   - 1
   - 2
   - 3

5. Poor appetite or overeating
   - 0
   - 1
   - 2
   - 3

6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down
   - 0
   - 1
   - 2
   - 3

7. Trouble concentrating on things, such as reading the newspaper or watching television
   - 0
   - 1
   - 2
   - 3

8. Moving or speaking so slowly that other people could have noticed—Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual
   - 0
   - 1
   - 2
   - 3

9. Thoughts that you would be better off dead, or of hurting yourself in some way
   - 0
   - 1
   - 2
   - 3

Total: 15

(Checkbox: Total

Healthcare professionals: For interpretation of TOTAL, please refer to accompanying scoring card.)

PHQ 9 > 9

- < 5 – none/remission
- 5 - mild
- 10 - moderate
- 15- moderate severe
- 20 - severe

www.uspreventiveservicestaskforce.org
ROLES OF PRIMARY CARE PROVIDER

- **IDENTIFY** individuals who need BH support and **ENGAGE** them in the treatment model
- Willing to prescribe medications for behavioral health
- Collaborate and consult with BHP and Psychiatric prescriber to enhance BH Care
  - WARM HAND OFFS
- Utilize screening tools to track progress (e.g., PHQ-9)
**PCPS - MUST HAVE BUY-IN**

<table>
<thead>
<tr>
<th>Before Implementation</th>
<th>After Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• This is going to slow me down</td>
<td>• This takes a load off my plate</td>
</tr>
<tr>
<td>• I don’t have time to address one more problem</td>
<td>• This speeds me up</td>
</tr>
<tr>
<td>• This is going to be an anchor</td>
<td>• I always want to practice like this</td>
</tr>
<tr>
<td>• I already do a good job of treating mental illness</td>
<td>• I am giving better care to many patients</td>
</tr>
<tr>
<td></td>
<td>• This gives me time to finish my note</td>
</tr>
</tbody>
</table>

“If you aren’t uncomfortable with your practice you aren’t practicing integrated care.”

PCP - Colorado
BHPS/CARE MANAGERS-HIRE THE RIGHT PERSON

Who are the BHPs/CMs?

- Typically MSW, LCSW, PhD, PsyD, RN – could be MA, CHW
- Variable clinical experience
- Need brief intervention skills – BA, MI, PST, SFBT, DTS
- Health Behavior Change Experts

What makes a good BHP/CM?

- Organization
- Persistence - tenacity
- Creativity and flexibility
- Strong patient advocate
- Willingness to be interrupted
- Ability to work in a team

CAUTION:
- Prefer traditional approach to therapy
- Not willing to be interrupted
- Timid, insecure about skills
EVIDENCE-BASED BRIEF INTERVENTIONS

Motivational Interviewing

Distress Tolerance Skills

Behavioral Activation

Problem Solving Therapy
EXPERTS IN BEHAVIOR CHANGE
REGISTRIES TO TRACK PROGRESS

Caseload Overview

<table>
<thead>
<tr>
<th>View Record</th>
<th>Treatment Status</th>
<th>Name</th>
<th>Date of Initial Assessment</th>
<th>Date of Most Recent Contact</th>
<th>Number of Follow-up Contacts</th>
<th>Weeks in Treatment</th>
<th>Initial PHQ-9 Score</th>
<th>Last Available PHQ-9 Score</th>
<th>% Change in PHQ-9 Score</th>
<th>Date of Last PHQ-9 Score</th>
<th>Initial GAD-7 Score</th>
<th>Last Available GAD-7 Score</th>
<th>% Change in GAD-7 Score</th>
<th>Date of Last GAD-7 Score</th>
<th>Psychiatric Consultation</th>
<th>Flag</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year: Active</td>
<td>Albert Smith</td>
<td>8/13/2015</td>
<td>12/2/2015</td>
<td>7</td>
<td>29</td>
<td>18</td>
<td>17</td>
<td>-6%</td>
<td>12/2/2015</td>
<td>14</td>
<td>10</td>
<td>-29%</td>
<td>12/2/2015</td>
<td>Flag for Discussion &amp; Safety Risk</td>
<td>2/2/2015</td>
<td></td>
</tr>
</tbody>
</table>

FREE UW AIMS Excel® Registry (https://aims.uw.edu/resource-library/patient-tracking-spreadsheet-example-data)

Allows proactive engagement ("no one falls through the cracks") and treatment adjustment
Availability to Consult Promptly

- Diagnostic dilemmas
- Education about diagnosis or medications
- Complex patients, such as pregnant or medical complicated
- Pattern recognition**
- Education**
- Build confidence and competence**

Caseload Reviews

- Scheduled (ideally weekly)
- Prioritize patients that are not improving – extends psychiatric expertise to more people in need
- Make recommendations – may or may not implement
### REGISTRIES TO TRACK:

**PHQ-9 MEASUREMENT TOOL**

<table>
<thead>
<tr>
<th>Patient</th>
<th>Caseload</th>
<th>Program</th>
<th>Tools</th>
<th>Logout</th>
<th>Search Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHITS ID</td>
<td>Population</td>
<td>Date Enrolled</td>
<td>Status</td>
<td>SRS</td>
<td>WIS in Tx</td>
</tr>
<tr>
<td>3400011</td>
<td>U</td>
<td>12/14/2010</td>
<td>L1</td>
<td>12/14/2010</td>
<td>17</td>
</tr>
<tr>
<td>3400016</td>
<td>U</td>
<td>1/20/2011</td>
<td>L1</td>
<td>1/20/2011</td>
<td>19</td>
</tr>
</tbody>
</table>

AIMS Center: [http://aims.uw.edu](http://aims.uw.edu)
MEASUREMENT-BASED CARE VERSUS STANDARD CARE FOR MAJOR DEPRESSION: A RANDOMIZED CONTROLLED TRIAL WITH BLIND Raters


- HAM-D 50% or <8
- Paroxetine and mirtazapine
- Greater response
- Shorter time to response
- More treatment adjustments (44 vs 23)
- Higher doses antidepressants
- Similar drop out, side effects
<table>
<thead>
<tr>
<th>REASON FOR CONSULT</th>
<th>DIAGNOSIS</th>
<th>RECOMMENDATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Side effects from lithium</td>
<td>BP 1</td>
<td>Switch to valproic acid</td>
</tr>
<tr>
<td>SE from lisdexamfetamine</td>
<td>ADHD</td>
<td>Try another per protocol</td>
</tr>
<tr>
<td>Lithium level is 1.2</td>
<td>BP 1</td>
<td>Continue unless having side effects</td>
</tr>
<tr>
<td>Inc depression symptoms</td>
<td>MDNOS</td>
<td>TSH, if normal start lamotrigine</td>
</tr>
<tr>
<td>Poss SE from quetiapine</td>
<td>BP 1/PD</td>
<td>Decrease Seroquel to 100 mg</td>
</tr>
<tr>
<td>Paroxetine not effective</td>
<td>MDD</td>
<td>Add bupropion</td>
</tr>
<tr>
<td>Regular lamotrigine or XR?</td>
<td>BP 2</td>
<td>No difference</td>
</tr>
<tr>
<td>Side effects with citalopram</td>
<td>MDD</td>
<td>Switch to bupropion</td>
</tr>
<tr>
<td>Depression symptoms increase</td>
<td>BP1</td>
<td>Check lithium level first, maximize if low, may need to add lamotrigine</td>
</tr>
<tr>
<td>Suicidal, acute distress</td>
<td>PD</td>
<td>Safety plan, DBT referral</td>
</tr>
<tr>
<td>High doses of meds, confused</td>
<td>MDD</td>
<td>Stop hydroxyzine, reduce lorazepam, call collateral</td>
</tr>
<tr>
<td>Anxious, wants alprazolam, nipple</td>
<td>GAD</td>
<td>No alprazolam, increase sertraline, coping skills</td>
</tr>
</tbody>
</table>
PSYCHIATRISTS SUPPORTING TEAMS

Care Manager 1

Care Manager 2

Care Manager 3

Care Manager 4

50-80 patients/caseload
2-4 hrs psych/week/ care manager
= a lot of patients getting care
PSYCHIATRISTS BEST SUITED FOR THIS WORK

- Flexible – expect the unexpected
- Adaptable - child and other populations
- Willing to tolerate interruptions
- Able to manage liability concerns
- Like teaching
- Enjoy being part of a team
- Willing to lead
- **Extending psychiatric expertise to a larger population

Blessed are the flexible for they shall not get bent out of shape.
GPPP1/GPPP2

- Outreach and engagement by BHP
- Initial assessment of the patient, including administration of validated rating scales
- Entering patient data in a registry and tracking patient follow-up and progress
- Participation in weekly caseload review with the psychiatric consultant
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.
PERFORMANCE MEASURES

• **Process Measures**
  – Percent of patients screened for depression
  – Percent follow-up within 2 weeks
  – Percent not improving that received case review and psychiatric recommendations
  – Percent with recommendation implemented by PCP
  – Percent not improving referred to specialty BH

• **Outcome Measures**
  – Percent with 50% reduction PHQ-9
  – Percent to remission 6 and 12 mos (PHQ-9 < 5) – NQF 0710/0711

• **Cost/Utilization Measures**
  – ED, Inpatient, Overall healthcare cost
TWO CULTURES, ONE PATIENT

**PRIMARY CARE**
- Continuity is goal
- Empathy and compassion
- Data shared
- Large panels
- Flexible scheduling
- Fast Paced
- Time is independent
- Flexible Boundaries
- Treatment External (labs, x-ray, etc)
- Patient not responsible for illness
- 24 hour communication
- Saved lives
- Disease management

**BEHAVIORAL HEALTH**
- Termination is goal – “discharge”
- Professional distance
- Data private
- Small panels
- Fixed scheduling
- Slower pace
- Time is dependent – “50 min hour”
- Firm Boundaries
- Relationship with provider IS tx
- Patient responsible for participating
- Mutual accountability
- Meaningful lives
- Recovery model
Figure 1

Estimated time elapsed between initial assessment and improvement of depression during the first year of treatment at six organizations

Figure Legend:
Estimated time elapsed between initial assessment and improvement of depression during the first year of treatment at six organizations.

"Champions"

Existing BH
“SECRET SAUCE”: TWO KEY AREAS OF EFFECTIVENESS

Patient Activation and Engagement:

- Strong leadership support and a strong physician champion are essential for patient activation into the program.
- The more well defined and implemented the care manager role, the higher the rate of patient activation.

Patients Reaching Remission (PHQ-9 < 5):

- The more engaged a psychiatrist was and the more often in-person communication occurred, the more frequently patients experienced remission from their depression.
- The less likely a group experienced operating costs as a barrier, the more likely their patients were to experience remission.

“ENGAGED”

• Do you/care managers meet routinely with the psychiatrist for the weekly 2 hour meetings?
• Is the psychiatrist friendly and helpful with your/cm review of patients in your caseload?
• Does he/she give feedback, direction, suggestions for both pharma and other therapeutic approaches to getting the patient to goal
• Do the psychiatrist and PCP’s ever connect?
• If the PCP contacts the consulting psych in between the weekly sessions, does he/she typically get back to the PCP in a timely manner?
• Has the psychiatrist done any other types of in-services or education sessions for your PCPs, your care managers, and/or care teams?
• Do you have any concerns about the consulting psychiatrist working on your team?
RECIPE FOR SUCCESS

• **Ingredients – TEMP**
  – Team that consists at a minimum of a PCP, BHP and psychiatric consultant
  – Evidence-based behavioral and pharmacologic interventions
  – Measuring care continuously to reach defined targets
  – Population is tracked in registry, reviewed, used for quality improvement
  – Accountability for outcomes on individual and population level

• **Process of Care Tasks**
  – 2 or more contacts per month by BHP
  – Track with registry
  – Measure, measure, measure response to treatment
  – Caseload review with psychiatric consultant

• **Secret Sauce: Whitebird Brand**
  – Strong leadership support
  – A strong PCP champion and PCP buy-in
  – Well-defined and implemented BHP/Care manager role
  – An engaged psychiatric provider
  – Operating costs are not a barrier
THE CYCLE OF COLLABORATIVE CARE

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RESOURCES

- IPS – DC Oct 6-9
- APA Website: www.psych.org and list serve
- AIMS Center: http://aims.uw.edu
- Center for Integrated Health Solutions: http://www.integration.samhsa.gov/
- ARHQ Integration Academy: http://integrationacademy.ahrq.gov/
- Books:
  - Integrated Care: Working at the Interface of Primary Care and Behavioral Health – edited by Lori Raney, MD
  - Integrated Care: Creating Effective Mental and PC Teams - AIMS
  - Prevention in Psychiatry – Robert McCarron and colleagues
  - Integrated Care and Psychiatry – Summergrad, Kathol
APA SAN OBJECTIVE: TRAIN, READY, CONNECT

The APA SAN will train 3500 psychiatrists in collaborative care through online and live trainings; offer certificates to those who complete learning collaboratives, and connect trained psychiatrists with PTNs across the country.
Stay up-to-date on APA’s SAN and training offerings at:

www.psychiatry.org

For more information or questions, email SAN@psych.org
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