**Meeting Overview**

The Alliance of Community Health Plans Behavioral Health Medical Directors group convened for the first time in New Orleans on April 15 and 16, 2013. Dr. James Schuster, chief medical officer, Community Care Behavioral Health Organization, part of UMPC Health Insurance Division and Dr. Judy Feld, associate medical director of behavioral health at Independent Health, served as the group chairs and led the two days of meetings.

The collection of 13 behavioral health specialists from ACHP plans focused on working to bridge the connection between behavioral health and primary care with the hope of strengthening the quality of and access to care for patients with behavioral health needs. Through a series of presentations and roundtable talks, the group heard both presentations from ACHP members and held subject-specific roundtable discussions.

Discussions at the Behavioral Health Directors meeting centered on:

* Reviewing the current state of integration using the Millbank report on “[Evolving Models of Behavioral Health Integration in Primary Care](http://www.milbank.org/uploads/documents/10430EvolvingCare/10430EvolvingCare.html)” from May 2010.
* Hearing from representatives from HealthPartners, SelectHealth, Capital District Physicians’ Health Plan, and UPMC Health Plan on their efforts to better and further integrate primary care.
* Payment models in behavioral health care.
* Identifying the most valuable behavioral health measures and discussing which measures not currently in existence could be useful.
* Hearing from Karen DeSalvo, the Health Commissioner for the city of New Orleans.
* Joining with the Medical Directors to hear from representatives from HealthPartners on promoting population health and from the Institute for Clinical Systems Improvement on a model to integrate physical and mental health.

**Introduction**

Dr. Pat Courneya, chairman of the medical directors and the medical director at HealthPartners Heath Plan, joined with Lynne Cuppernull, director of clinical learning and innovation at ACHP, to provide the opening remarks for the inaugural meeting of the Behavioral Health Medical Directors. Both Dr. Courneya and Ms. Cuppernull emphasized the importance of integrating behavioral and medical health.

“In order to make the connections work, we need curiosity,” Dr. Courneya said. “We need to structure the triple aim benefits and articulate them so that behavioral health is a large part of it.”

The meeting was structured around two core topics: integration and measurement. The directors spent half of the meeting hearing from different organizations on their efforts to integrate behavioral health and primary care, and then turned their attention to discussing and identifying which measures have been the most useful, and deciding potential measures that could prove valuable in the future.

During the day-long meeting, representatives from a number of ACHP member organization shared the work that they have been doing to increase access, increase the quality of care and reduce costs in behavioral health

**Integration**

***Current State of Integration***

Dr. Feld and Dr. Schuster reviewed the [collaboration continuum model](http://www.milbank.org/uploads/documents/10430EvolvingCare/EvolvingCareTable12C.gif) of primary care and behavioral health integration. In looking at the responses to the baseline survey created by ACHP, the directors observed a general trend to move away from HMOs, though they noted that everyone will likely continue to have very different levels of integration and vary across the continuum.

They highlighted four general quadrants of behavioral health integration and needs, and where those needs are served:

1. Patients with low behavioral and low physical health needs: served in a primary care setting.
2. Patients with high behavioral health needs and low physical health needs: served in primary care and specialty mental health settings.
3. Patients with low behavioral health needs and high physical health needs: served in a primary care setting.
4. Patients with high behavioral health needs and high physical health needs: served in primary care and specialty mental health settings.

Dr. Schuster articulated the goal of trying to engage patients where they are, and using the four quadrants to shape the approach to treatment. He highlighted that all the models in the four quadrants offer some form of resource at the provider level.

Dr. Feld and Dr. Schuster stressed that the first step in the integration process is improving the line of communication between behavioral health specialists and primary care physicians. Primary care and behavioral health providers have separate systems at separate sites, they noted, but now engage in periodic communication, typically by telephone or letter, about shared patients.

However, significant obstacles to improving coordination do exist, most notably that:

* Primary care physicians are already limited on time
* Providers are not fully aware of community behavioral health resources
* There is a lack of community behavioral health capacity
* There is a lack of billing coding and how to structure payment models in behavioral health.

“Engaging primary care physicians can be as challenging as engaging members,” Dr. Feld said. “A lot of [behavioral health] work is not necessarily therapy, but supporting the primary care physician,” caveating that sentiment by noting that there is not an easy and obvious way to bill for that kind of support.

Dr. Schuster echoed that statement, saying that “The content of what we do is important, but the process is probably more important.”

While some primary care settings have integrated a behavioral health specialist into the fold by means of shared office space, the reverse has also been true. A primary care provider (which can be either a physician, physician’s assistant, nurse practitioner, or nurse) can be out stationed part-time or full-time in a psychiatric specialty in order to monitor the physical health of patients and ensure that the connection between behavioral and mental health remains integrated.

Even as the path towards integration becomes clear, feedback from fully integrated sites shows that only about one-third of people take advantage of an integrated system. Dr. Feld attributed this to patient’s reluctance to embrace change.

Representatives from four different ACHP member plans (HealthPartners, Select Health, CDPHP and UPMC Health Plan) gave case study presentations on the work that they have been doing to integrate behavioral health and primary care.

***HealthPartners***

Dr. Karen Lloyd, senior director of behavioral health at HealthPartners in Minnesota gave a presentation on her organization’s work to integrate behavioral health into primary care and reported on the measurements.

In the past six months, the organization has installed tele-video capabilities in all HealthPartners clinics as part of a program that allows for mobile behavioral health consults and offers on-call therapists for urgent care needs. Additionally, they have used a relationship with a patient’s primary care physician to continue delivering effective behavioral health care.

Dr. Lloyd noted that a patient is most commonly lost after they miss a scheduled visit. Hence, they implemented a Centralized Care Coordination system in which they used phone outreach to contact the patient through their primary care physician, documented in electronic health records all visits so that members of the medical team could review it, and focused on reengaging the patient in care.

During 2012, HealthPartners referred 475 patients to the Centralized Care Coordination system, and 54 percent of those patients engaged in phone discussions and follow up visits, a number Dr. Lloyd said is “good, but not as good as we’d like.” However, of that 54 percent, 133 of them completed an in-person session, and many of those patients were dual-eligible Medicare/Medicaid patients who were only marginally interested in receiving behavioral health treatment. In order to further hold these patients accountable, HealthPartners created a system in which ten days after a patient has missed a prescription refill, the prescribing physician is notified and can set in motion the network’s efforts to reengage the patient in the treatment process. Of those patients that were reengaged, 43 percent of them had a claim for a refill within seven days of contact, saving a potential crises, hospital visit or high cost scenario downstream.

***SelectHealth***

Dr. Scott Whittle, medical director, behavioral health at SelectHealth presented on Intermountain Healthcare’s – to which SelectHealth is the affiliated insurance company - project to integrate mental health care services into primary care practice. Dr. Whittle dubbed it a hybrid group plan that aims to place mental health as a complementary component of wellness and healing for life, and he said it provides the opportunity to try to integrate health care.

[The Mental Health Integration (MHI) program](http://www.achp.org/wp-content/uploads/downloads/2013/04/Cost-and-Quality-Impact-2.pdf) – a collaborative approach between primary care providers and office staff with care managers and mental health specialists - currently supports over 480,000 patients in 79 different clinics. The program uses a set of [MHI packets](http://www.achp.org/wp-content/uploads/downloads/2013/04/Care-Process-Model-MHI.pdf) - completed by patients/parents – which are designed to help evaluate symptoms and identify issues that may impact treatment, or to evaluate and track progress and outcomes. They include specific reference action plans that cater to different types of patient needs, such as youth assessment, adult assessment, and substance abuse. In the integrated system, the primary care physician scores the baseline MHI packet, evaluates the severity and complexity of the patient and determines the level of team management to develop a treatment plan.

Dr. Whittle reported that in addition to an increased quality of care, physician satisfaction has significantly risen since the MHI system was put in place. That included both the ability to identify patients with needs and then consequently work with them, as well as having the needed resources to care for a patient with behavioral health issues and the potential for effective mental health integration in the clinic.

***Capital District Physicians’ Health Plan***

Robert Holtz, vice president of behavioral health services at Capital District Physicians’ Health Plan (CDPHP), reported on his plan’s behavioral health work.

In January of 2011, CDPHP’s Behavioral Health Department piloted a program that featured an onsite case manager at the Albany Family Practice Group (AFPG), an Enhanced Primary Care (EPC) office. The goal was for the behavioral care case manager to develop a working, trusting relationship with the doctors, nurses and office staff, and to develop a workflow with the EPC for the referral process, collaboration, and consultation.

The case manager helped augment the primary care physician’s ability to monitor and treat behavioral health conditions through actions such as coordinating care with family members, monitoring symptoms and medications, assisting the primary care physician with the referral process to outpatient behavioral health providers and facilitating a continued line of communication between all of the involved parties.

Mr. Holtz acknowledged that there were implementation issues that included the medical practice not having a clear understanding of the role of behavioral health case management, nor fully recognizing the behavioral health needs of their patient population. As well, the physicians found problems identifying enough time to handle their expanded responsibilities and encountered a lack of screening tools to effectively streamline the process.

CDPHP collected data for 161 members who were referred to the Behavioral Health Case Management system, pulling data from claims, electronic health records and case notes. Of those 161 members, 34 (21%) members worked with both the behavioral health case manager and the medical case manager. Of those members who had face-to-face contact, 97 percent received an intervention and 86 percent were positively engaged. “The positives outcomes were those who agreed to be in a care management model,” Mr. Holtz said.

Their data showed that the organizations saved a substantial amount of money in the total combined hospital admissions and emergency department visits, going from spending $746,000 before intervention to $542,100 post-intervention, for a total savings of $203,900. When looking at savings in behavioral health admissions specifically, a $77,000 savings was witnessed post intervention.

“The data in this report shows that working with our members face to face increases the level of compliance with referrals and recommendations, which in turn, improves health outcomes and demonstrates cost savings,” Mr. Holtz concluded.

Medical staff was also pleased with the program, with most survey responders reporting that the program has “significant value” or “very significant value.”

***UPMC Health Plan***

Dr. Schuster spoke of his plan’s efforts to improve the well-being of the individual through focusing on recovery transformation, peer and family involvement, respecting each patient’s unique situation, integrating systems and behavioral and physical health, and using a care management model.

The theme of helping people recover from their illness, Dr. Schuster said, with the aim of supporting a longer-term recovery so that people can live independently in their community.

UPMC Health Plan features two complementary approaches: an insurance collaboration supporting member engagement and enhanced provider coordination, called Connected Care, and a behavioral health home model in mental health and drug and alcohol settings, known as the Behavioral Health Home Plus. “They support coordination to address both physical and behavioral health needs,” Dr. Schuster said.

Connected Care is based on the patient centered medical home model. It has an integrated care team and care plan for patients with serious mental illness to address all medical, behavioral and social needs with the aim to improve the connection and coordination among health plans, primary care physicians, and behavioral health providers in outpatient, inpatient, and emergency department care settings. The framework encourages providers to share information, and Dr. Schuster noted that the admission piece and prep work is more robust than the discharge work.

A two year study of the Connected Care initiative saw readmission rates drop 10 percent overall, and it saw a 20 percent readmission rate drop among those patients who enrolled in the plan in only its second year.

The Behavioral Health Home Plus is aimed at improving overall physical wellness. The system does not ask an individual to change his or her existing provider, but rather attempts to enhance and build upon the individual’s provider and support network. Dr. Schuster noted that many people with behavioral health issues are overweight and smokers. Patients are assigned case managers and peer specialists that focus on physical health and overall wellness challenges.

At the request of workers within the Behavioral Health Home Plus, a self-management module was recently introduced. It addresses diet and nutrition for healthy weight, physical activity, sleep and rest, relaxation and stress management, medical care and screening, smoking cessation, and medication adherence. The initiative is also training psychiatrists on the comorbid medical conditions that often accompany serious mental health illness.

The Patient-Outcomes Center Research Institute (PCORI) recently awarded UMPC Health Plan a $1.7 million grant to expand and assess this model, and they will consequently open eight additional sites in 2013.

“Feedback has been very positive,” Dr. Schuster said, highlighting that a side benefit is that a lot of staff has become more engaged in wellness activities.

***Roundtable Discussion***

After the individual presentations, the directors broke into smaller groups to discuss where their provider network currently stands as far as behavioral health and primary care integration for those with severe and persistent mental illness.

While all of the participating behavioral health directors hailed from uniquely structured organizations, they agreed that reimbursement and the viability of the fee-for-service payment model is an ongoing challenge they all face. Dr. Feld stated that rather than increasing the number of behavioral health specialists, a strong plan of action is to train existing primary care physicians to handle a greater amount of the behavioral health workload. More specifically, Dr. Andrew Bertagnolli of Kaiser Permanente landed on transitioning depression to primary care, and highlighted substance abuse and anxiety as two areas where primary care physicians could receive further training.

James Van Den Brandt, behavioral health services manager at the Group Health Cooperative of South Central Wisconsin said that as the health care community continues to look at Accountable Care Organizations (ACOs) and emerging payment models, the medical side of practices will drive the interest in having integrated behavioral health care, creating what would be much more of a patient centered medical home than there is today. There was a consensus that a grant or up front health plan funding would help facilitate putting new models in place. “Part of the ACO,” Dr. Feld said, “is that there is going to be more skin in the game for hospitals and medical groups, and they’ll think differently about how we partner with them.”

***Proposed Deliverables Specific to Integration***

The directors drafted a uniform set of challenges, and came up with the following issues as uniform problems that need to be addressed in the integration process:

* People with mental illness are often in poverty or are low-income working patients.
* There needs to be constant work done to engage providers and ask them to continually think about behavioral health needs.
* There is a need to develop public policy strategies to ask states to further integrate and acknowledge behavioral health care.
* Many agencies are still focused on short term management of symptoms rather than long-term solutions focused on a patient’s overall well-being.

Dr. Schuster and Dr. Feld then asked to group to generate a set of goals and deliverable proposals for the Behavioral Health Medical Directors group. They settled on the primary goal to brainstorm and think about financially viable models, and find sustainable models for commercial, Medicare and Medicaid, observing that much of the past integration work has been grant or plan funded, but it has not been much of a demonstration of financial viability.

The directors proposed conducting a survey on the integration strategies in place at ACHP member plans and drafting a paper highlighting the commonalities and differences with a directive towards developing actionable strategies that could be implemented at other health care organizations.

More specifically, they showed an interest in exploring ways to support behavioral health in primary care settings, and how to enhance the capacity of behavioral health system.

They also suggested development of an internal resource guide to house studies, websites and additional documents related to behavioral health management and cost savings strategies.

**Lunch Discussion with Karen DeSalvo**

Over lunch, ACHP had the opportunity to hear from Dr. Karen DeSalvo, health commissioner of the City of New Orleans. Dr. DeSalvo described the challenges and opportunities in rebuilding a health system after Hurricane Katrina, and the continued efforts to create a health system that is available, accessible, and high-quality for everyone.

Since the complete destruction of the New Orleans health system after Katrina, the work of Dr. DeSalvo and others who stayed to rebuild the city have grown it from one of the lowest primary care physician rates in the country to being in the top ten percent. The city has created a regional network with 103 access points, including several NCQA-recognized health centers, many of which are on their second iteration of Meaningful Use. The city has a functioning health information exchange thanks to a Beacon grant and interconnected medical records. To date, this work has been funded by grants, waivers, and philanthropy; however, a continued challenge is how to sustain changes going forward.

Because New Orleans was building its health care system from the ground up, it could design it based on the community’s needs rather than existing supply. “If you build healthcare in the air, in boys’ dormitories, abandoned churches and on sidewalks,” said Dr. DeSalvo, “what grows is a medical home. You meet patients where they are and realize immediately that they have social and mental health needs, which are often more important than their physical health ones.” The public health department grew from one of the worst in the country to a nationally-recognized agency on its way to accreditation.

The system she fostered was team-based, accessible and included legal and social services, paid for through capitation thanks to an HHS Primary Care Access and Stabilization Grant. Unfortunately, when the grant ran out in 2010, the system was pushed back toward fee-for-service, which reverted much of the progress that had been made. New Orleans has worked to maintain these services through care coordination payments on top of fee-for-service, but is struggling with how to pay for primary care once the waiver ends in December 2014 and is trying to ensure that if Louisiana expands Medicaid coverage, it will not come as a purely fee-for-service model.

Ultimately, full-service care for every uninsured person in the community came to $462 per year, paying for unlimited visits, social workers, and counseling, which amounts to half of a visit to the ER. Dr. DeSalvo laments that misaligned financing systems are threatening these valuable services. In addition to money, she said, the city also needs a shared agenda, skill sets and vision: how to share data in ways that are focused on real population health (not just users of the system), how to reach out to people who are not engaged in the health care system, and how to structure rewards to foster population health.

Conversation after her presentation focused on the challenges she faced, and how such changes could be brought about in other communities that lack such a clear catalyst. Dr. DeSalvo stressed the importance of figuring out how to expand ACHP plans’ payment and delivery models “to everybody,” including uninsured and underinsured community members.

**Measurement**

Following lunch, the directors moved onto the second primary topic of their meeting: measurement. The goal of the discussion was to identify the measures of the greatest and least use, and identify measures that are not currently in existence, but would be valuable.

Dr. Feld opened the discussion with a summary of the measurement survey responses ­– by [measure](https://s3.amazonaws.com/achp_downloads_wordpress/downloads/2013/03/ACHP%20Measurement%20Survey%20Summary%20By%20Measure.docx) and [category](https://s3.amazonaws.com/achp_downloads_wordpress/downloads/2013/03/ACHP%20Measurement%20Survey%20Summary%20By%20Category.docx) – collected from the ACHP organizations before the meeting.

***HealthPartners: Integration and Measurement***

Drs. Mike Trangle and Karen Lloyd presented on HealthPartners’ efforts to change the behavioral health measurement system; referencing the use of [clinical indicators](http://www.achp.org/wp-content/uploads/downloads/2013/04/HealthPartners-Clinical-Indicator-Measures.doc).

HealthPartners categorizes measurements into two sections: [process measures and outcomes measures](https://s3.amazonaws.com/achp_downloads_wordpress/downloads/2013/04/Categorization%20of%20Measures.pdf). Within each of those categories, they divide into three subsets: the quality of care, the cost of care and the patient experience. They chose to highlight depression as an example of their measurement process, and emphasized that the measures linked to HealthPartners’ overall Triple Aim goal.

Their measurement process includes utilizing the PHQ-9 tool, follow-ups after hospitalization for mental illness, and in-patient surveys to better understand patient satisfaction. Their outcome measures were related to the depression remission after six months and the hospital readmission rate within 30 days.

Of patients who sought help for major clinical depression, the rate of HealthPartners’ patients who experienced remission has hovered between 10 and 12 percent since 2009, significantly higher than the statewide average of 4-6 percent. Drs. Trangle and Lloyd said that offices make sure to reach out to patients before the measurement period. They added that it is important to note that when a measurement is conducted using only patients who intend to be engaged, rather than everyone HealthPartners treats, the rate of remission is significantly higher.

HealthPartners measures depression and decides what constitutes optimal care by documenting five or more symptoms of major depression as defined in the DSM-IV. In an effort to generate an understanding of the full patient care experience they continue to monitor and measure individual symptoms that accompany serious mental illness, such as high BMI, high blood pressure and tobacco use.

As a result, when patients were asked if they would recommend HealthPartners to others, the positive response rate grew from 79 percent to 87 percent over a two year period from 2010-2012. The 30-day hospital readmission rate also declined from 14 percent to 10 percent over the same two year period.

***Why Measure?***

The behavioral health directors broke into a number of subgroups to identify and discuss the number of measurement issues that face the behavioral health profession.

Robert Holtz said that when talking about measurement, it is important to think on two levels: Health plan quality and the provider community. All of the directors agreed that finding ways to have comparable measures across practices is a complicated issue.

Dr. Bertagnolli stated that a problem with behavioral health is that all measurements are patient reported outcomes, not a lab study. He spoke of the need to find a way to measure issues such as depression.

The group discussed three primary subtopics: qualitative measures, process measures and performance measures.

They identified three different possible qualitative measures: overall functionality based on a scale measured on a serial basis, screening tools to measure improvement, and looking at the cost of care. Depression, alcohol abuse, anxiety and bipolar disorders were four possible areas where the directors felt developing screening tools could be helpful. As a method for developing the cost of care, the group suggested using existing cost formulas, and weighing the providers against each other. Measuring against all other providers would lead to a norm, at which point it would reveal if the subject is either above or below the norm.

The consensus on process measurement was that they were helpful and that bundling process measures showed promise. In a bundle, one would start with current measures and add additional measurements on top of them. The directors did emphasize a goal of staying away from chart review as a tool for process measurement.

The group agreed the greatest challenge in performance measurement is developing a lean management model and getting a team of physician to effectively work in a cross-disciplinary setting. Standard performance measurement was important, they concluded, but noted that it must be done on a regional basis so as to cater it to the specific challenges of each area across the country.

***Proposed Deliverables Specific to Measurement***

After the full discussion, the directors settled on a set of measurement deliverables relating to depression that included benchmarking performance on two or three measures, including PHQ-9 assessment and remission at 6 and/or 12 months, for both primary care and behavioral health providers. The group also proposed encouraging NCQA to modify HEDIS measure requirements to incorporate telephonic contact rather than in-person visits for completion of certain measures, namely antidepressant and ADHD medication management, follow-ups after hospitalization, and substance abuse.

**Joint Session: Behavioral Health Medical Directors and Medical Directors**

On the conference’s second day, the ACHP Medical Directors and Behavioral Health Medical Directors convened to share broader perspectives on health, including social and environmental determinants of health and the integration of behavioral with physical health.

Dr. Courneya launched the session with a video of [Trevor](http://www.ihi.org/offerings/IHIOpenSchool/resources/Pages/TrevorAndThePerksOfDiabetes.aspx), a teenager with Type 1 diabetes, speaking about his experiences with the health care system. Although he is a “professional diabetic” who manages his condition well, he says his doctors speak down to him and do not explain the reasoning behind their treatment choices, which decreases his ability to self-manage. Practices, said Dr. Courneya, should not only ensure that providers are operating at the top of their licenses, but should do what they can to let patients like Trevor operate at the top of their capabilities.

***Thomas Kottke, M.D.: Promoting Population Health***

Dr. Thomas Kottke, Medical Director for Population Health at HealthPartners, reviewed the health plan’s approach to understanding determinants of health and disease, frameworks to rethink well-being as not merely the lack of illness, and the organization’s work to improve population health. HealthPartners has engaged people through community meetings, in schools, online, and even with smartphone apps, with a focus on building local capacity to sustain improvements.

Dr. Kottke uses the University of Wisconsin Population Health Institute [County Health Rankings Mode**l**](http://www.countyhealthrankings.org/our-approach) as a framework for assessing drivers of health, which fall into four main categories: health behaviors like diet, exercise, alcohol use and unsafe sex; clinical care, including access to and quality of care; social and economic factors, such as education, employment, income, social support and community safety; and physical environment. While the County Health Rankings Model assesses effects on mortality and morbidity, HealthPartners chooses to instead focus on *well-being*, asking patients about their emotional health, personal relationships, satisfaction, altruism, financial management, and comfort in their community.

Dr. Kottke reviewed a number of initiatives that HealthPartners either leads or supports in the community, including yumPower, which promotes healthy eating among children and adults; its EBAN quality improvement teams, which aim to reduce health disparities in immigrant communities; and Healthy Homes / Healthy People, which promotes smoke-free housing and mental health. The ultimate goal of such programs is to increase the plan’s sphere of influence from a single visit during a clinical encounter to structured initiatives and programs aimed at specific groups, to partnerships and relationship-building in communities, and ultimately to building healthy environments for all for prolonged, sustainable change.

Two continued challenges include measuring and evaluating the impact of these interventions and finding ways to fund them. In order to make the case for these investments, said Dr. Courneya, HealthPartners will eventually have to be able to measure their impact on the total cost of care.

***Gary Oftedahl, M.D.: Developing the DIAMOND Model***

In 2002, when the Institute for Clinical Systems Improvement (ICSI) in Minnesota began a project on depression care, they found it to be plagued with inadequacies and inconsistencies in coding and reimbursement, stigma, fragmentation, a lack of follow-up with patients, and low take-up of the evidence-based IMPACT model. Dr. Gary Oftedahl, the chief knowledge officer at ICSI, described the process that led to the development and dissemination of the DIAMOND (Depression Improvement Across Minnesota, Offering a New Direction) model for integration of depression care into primary care physicians’ offices.

ICSI, in its role as facilitator, convened a group of health plans, primary care and behavioral health providers, the Minnesota Department of Human Services, purchasers, patients, and an expert in the field. Over the course of six months, this steering committee developed what became the DIAMOND model, recommending use of a care manager fee and identifying a billing code that providers could use. The health plans would negotiate a bundled payment with providers to cover the cost of the care manager and consulting psychiatrist, who would meet with the team once a week to review patient files.

Key to the success of this committee and initiative more broadly, said Dr. Oftedahl, was ICSI’s ability to pull stakeholders together, the steering committee’s sense of ownership over the project, a sense of urgency instilled by ICSI, and the creation of subcommittees to free up time. It also faced challenges, such as the rise of medical homes and Accountable Care Organizations, provider resistance, and high care manager workloads.

Dr. Oftedahl hopes that the next steps for DIAMOND include greater integration of the framework into medical homes as standard practice. Discussion after the presentation focused on how such collaborative organizations could be convened in a state without an organization like ICSI. Dr. Courneya emphasized that each community has resources it can draw on in creating a space for such conversation. “Go start this in your communities on your own,” Dr. Oftedahl said.

***Presentation to Medical Directors and Plan of Action***

The Behavioral Health Directors used the time with the Medical Directors to present the results of their first meeting and share their plan of action.

Jennifer Phillips, manager of innovation programs at the Alliance of Community Health Plans, Dr. Schuster and Dr. Feld presented on the activities of the Behavioral Health Directors over the past few months, reviewed their discussion from the previous day, and proposed several future steps and deliverables for the workgroup. The ultimate goal they communicated with the Medical Directors was moving past simply discussing behavioral health models at each plan, and working together to standardize initiatives and push each other to improve.

Dr. Schuster first described how the integration discussion included both improving the capacity of physical health providers to deal with and manage behavioral health conditions, and also strategies to ensure that people with SPMI (severe and persistent mental illness) can access adequate physical health services. The Behavioral Health Directors proposed the development of an online resource guide to existing integration models, followed by a paper on plans’ existing integration models that would lead into either a grant funding for testing of new interventions or other improvement work.

Behavioral health providers, acknowledged Dr. Feld, have traditionally not endorsed measurement, though some of the fragmentation seen between physical and behavioral health may be specialists’ fault, as their work and outcomes were not seen as credible. However, she said, much has changed within the past 10-15 years, and the Behavioral Health Directors at the meeting were eager to discuss measurement and benchmarking.

Deliverables proposed by the group included benchmarking performance on two or three measures related to depression, including PHQ-9 assessment and remission at 6 and/or 12 months, for both primary care and behavioral health providers. The group also proposed encouraging NCQA to modify HEDIS measure requirements to allow telephonic contact for completion of certain measures (such as antidepressant and ADHD medication management, follow-up after hospitalization, and substance abuse) rather than requiring face-to-face visits.

The Medical Directors were supportive of the Behavioral Health Directors’ goals, particularly of the virtual visit option in HEDIS, and pushed them to have specific goals and a narrow focus. There was agreement that the Pharmacy Directors could be brought in for conversations on opioids treatment, ADHD, atypical antipsychotic use and other topics that span both workgroups. With regards to medication, most physicians, said Dr. Feld, should transition from asking “which meds should I use?” to “do I need to use medication?”

In the long term, said Dr. Schuster, the behavioral health directors would consider adopting a format that Kaiser Permanente uses to categorize behavioral health-initiatives: those focusing on general health (such as anxiety and depression), substance abuse and chemical dependency, and pediatrics.

Dr. Patrick Courneya, Chairman of the Medical Directors and the Medical Director at HealthPartners Heath Plan, was heartened by the momentum of the discussion and encouraged the Behavioral Health Directors to continue working together, networking with each other, and focusing on specific, concrete actions that they could take together.

**Visit to the Community Health Center**

After conclusion of the Medical Directors meeting, a dozen medical directors visited The Ruth U. Fertel/Tulane Community Health Center, which was built on the site of the original Ruth’s Chris Steak House after Katrina. They met with Dr. Eboni Price-Haywood, director of the center and a faculty member at Tulane, who described the journey that the center has taken thus far and their current work to engage the community in health and wellness.

Dr. Price had just joined Tulane when Hurricane Katrina struck. The city already had 40% of its population below the poverty line and a 70% un-insurance rate; after the hurricane, these metrics got even more dire. Most of those uninsured patients were seeking care in hospitals and emergency rooms, and financial incentives existed to treat them there rather than with a primary care physician.

The original clinics, created after the hurricane, were set up on sidewalks and in abandoned buildings; later, residents mapped out clinic sites using data on where flooding had occurred. As the state hospital scrambled to retain its accreditation, and the Tulane Medical School began rebuilding its records, a group of stakeholders called the [Louisiana Health Care Redesign Collaborative](http://archive.hhs.gov/louisianahealth/collaborative/Charter/charter.html) came together to develop a blueprint for an evidence-based, quality healthcare system in Louisiana. 504 Health Net was formed to design neighborhood health clinics to bring care to patients and collaborated with the Louisiana Public Health Institute.

In 2007, Louisiana was awarded $100 million through the HHS’s Primary Care Access Stabilization Grant (PCASG), with the goal of creating sustainable models of integrating behavioral and mental health; Dr. Price and other stakeholders recognized that the loss of paper records presented an opportunity to integrate electronic health records in clinics, so dozens of clinics were equipped with EMRs.

The center brought together a patient advisory council, recognizing that there was significant mistrust in the community. The population that the centers served was 70% uninsured, and most of them were under 100% of the poverty line. Patients provided feedback on what they needed to be able to take care of themselves; the most important thing to them wasn’t the ability to receive a prescription, but everything else: housing, access to food and legal aid, and other resources and supports. The center additionally brought an LCSW on site in 2007 for mental health work and case management, and the center worked on addressing depression, grief and the social stigmas that hindered treating behavioral issues. Since private physicians largely left New Orleans after the hurricane, the Ruth U. Fertel Center made use of residents, who gained valuable clinical and public health experience in return for their work. The center also partnered with other educational institutions, like the school of nursing and the Xavier College of Pharmacy.

After the PCASG ended in 2010, New Orleans received a Beacon grant for funding and began implementing a city-wide health information exchange (HIE) to link each of 75 clinics’ EHR, with embedded population health management capabilities. One long-term issue, however, is sustainability of the HIE; Dr. Price is examining whether payers would be willing to support it and use it for their own purposes as well.

The Ruth U. Fertel Center supports a legal aid worker once a week, community outreach workers for peer support, telephonic coaching, computer classes and literacy programs, and a health advocate to help residents navigate wellness (such as how to shop healthy in supermarkets and read nutrition labels). Younger patients are recruited to coach older ones, for example on computer skills. Dr. Price considers the building a community center, not just a health center, and hosts health and nutrition programs, offer meeting spaces to faith leaders, and partner with schools. Community health workers go into communities to inform residents about programs available for them.

As many of their patients are low-income workers, they have spoken about instituting extended and weekend hours so that access continues to increase. They are partnering with schools and pediatricians to staff school based clinics.

In addition to serving as a resource for people who visit the center, Dr. Price would like to reach people in their communities and homes, and is working on creating sustainable change, encouraging the construction of walkable spaces, meeting with neighborhood groups, identifying leaders, and fostering community ownership of their projects and initiatives. “We want to leave our mark by helping people help themselves,” said Dr. Price.

A significant cultural shift has to take place among the primary care physicians who work in New Orleans and at the center in particular, said Dr. Price. The center naturally attracted people who had an interest in social justice, which facilitated engaging patients in development of the center and its programming. The center is also encouraging medical students and residents to learn public health concepts like PDSA, train in communities, and get involved in quality improvement activities. She tells clinical staff not to come to her with a problem unless they have a solution to offer. “Don’t walk into a neighborhood group with solutions and drop it at their door,” she noted. “Go and ask what their priorities are, then use your expertise and skills to make that happen.”