Robert Lee Sutherland Seminar XV
Hogg Foundation for Mental Health

National Integrated Health Care Initiatives – Part I
Summary Notes

I. Jane Foy
- A. Pediatricians typically have trusting relationships with children and families
  - 1. Opportunity for early intervention
  - 3. Pediatricians' familiar with chronic care principles
  - 4. Variable in comfort level as mental health providers
- B. Pediatricians have 18.3 minutes for well child visit, much less for acute visit
  - 1. Most insurance plans don't recognize pediatricians as mental health providers
  - 2. Primary care clinicians work in wide variety of settings
  - 3. Even if surrounded by resources, may not have access to specialty mental health providers
- C. Finding access to child psychiatrist is virtually impossible in many regions of the country
  - 1. Pediatricians often don't have collegial relationships with mental health professionals
  - 2. Nature of mental health and substance abuse concerns- Families are reluctant to seek or accept mental health care
  - 3. Stigma, conflict, lack of trust in mental health system
  - 4. Parents maybe have own issues that make it difficult to focus on child's needs
- D. Examples of Success
  - - NC: Medicaid policies/payment supportive of co-location models
  - - MA: MA child psychiatry project
  - - AZ: tele-psychiatry consultation to remote sites
  - - NY skills training
  - - SC: routine screening for child mental health (MH) problems and family distress
- E. AAP Task Force on Mental Health's Goals:
  - 1. Facilitate system change
  - 2. Build competence
  - 3. Incrementally change practice
  - 4. Monitor functioning over time, integrate MH professional
  - 5. Task Force strategies to achieve goal 1:
    - a. Facilitate system change
    - b. Negotiations with insurers and business leaders at the national level
    - c. Position paper with AACAP on administrative and financial barriers
    - d. Recommendations for collaboration at the community level (e.g. psychiatric emergencies, school interface, foster care)
  - 6. Task force strategies to achieve goal 2: build competence
    - a. Policy statement on MH and substance abuse (SA) competencies for primary care of children and adolescents
    - b. Educational programs keyed to competencies

7. Task force strategies to achieve goal 3: incrementally change practice

II. Gary Oftedahl - DIAMOND-Depression Improvement Across Minnesota Offering a New Direction

A. American health care system is in need of fundamental change - gap that exists between what patients get and what they deserve is not a gap but a chasm

1. Depression-lack of diagnosis/coding/documentation
2. Stigma-don't talk about it
3. Lack of diagnostic criteria
4. Lack of measurement of improvement
5. Poor follow-up

B. No demonstrated successes or even efforts

1. Fragmented care, patients lost to follow up

C. Black hole: lack of reimbursement, fragmented care, lack of coding

D. Collaboration of 57 medical organizations and over 9600 providers

1. Sponsored by 6 non-profit health plans: Blue Cross, Healthpartners, Medica, Metropolitan health place, PreferredOne, UCare
2. New strategic direction-convener and facilitator for redesign of healthcare
3. Identification of key opportunities/elements
    a. Coding issues reimbursement perceptions
    b. Poor follow up
    c. Use of standard screening and follow up tool (PHQ 9)
    d. Multiple obstacles to improving care – lack of systems to support needed elements
    e. Lack supportive payment mechanism

E. Parent of Diamond: IMPACT Study – model based on work of Jurgen Unutzer

1. Redesign of Care-new model that escapes the "tyranny of the visit"
2. PHQ-9-measure-outcome measure
3. Registry (tracking system)
4. Stepped care

F. DIAMOND initiative-limitations of purely competitive model and think of collaborative model

1. If here to improve care that we deliver, then shouldn't we collaborate irrespective of financial incentives
    -collaborative agreement on model and then look at fundamental change to how pay for model as delivered
    -engage 6 commercial health plans: Dept of Human Services, ICSI, providers, purchasers, patients involved in efforts
2. External expert-J. Unutzer,-creator of IMPACT model
    -Linked to NIMH research project
3. Diamond structure-steering committee, participation from all collaborators in each element of process
    1. Continued meeting during entire program-facilitated by Institute for Clinical Systems Improvement (ICSI) staff
    2. Key features: evidence based approach - needed to remove economic barriers to this medically necessary care

3. Participation by critical mass of payers

4. DIAMOND payment model-one methodology across all 6 plans

1. Had to agree on common way of doing this-bundled set of services paid on a monthly basis

2. Redesign of care/payment system for depression follow-up in adult primary care

-provides experience and a model for other chronic care conditions

-change the way we've started to approach dealing with problems in healthcare

-getting stakeholders to table

5. Keys to Success

1. Ability to engage multiple stakeholders

2. Lack of existing successful interventions supported urgency for change

3. Identification of evidence based model

4. Ability to align measures-focusing on outcomes not processes

5. Creating holding environment for difficult conversations

6. Focus on fair processes

7. Creation of enthusiasm and sense of personal and organizational commitment

III. Kathleen Reynolds

A. Eliminated community mental health board, and created Washtenaw Community Health Organization

1. Receive all the Medicaid for severely and persistently mentally ill

2. University of Michigan brings 85% of primary care money

B. Medical Home-Can be at primary care clinic, or at community mental health center

1. Assumes that behavioral services are already integrated and ready to forward integrate with primary healthcare

2. 4 Quadrant model-use it for communication and conversation

-also use it for who's going to pay

-Quadrant 1-low BH/PH-provided in primary care provider (PCP) setting

3. Psychiatric consultant is available-only on site 4-5 hours a week

-available by pager when PCP is seeing someone and to consult on medication

-all the hours when clinic is open

4. Joint primary care and mental health record-created, web-based

-Care Web - University of Michigan primary care record

-can share information

-Encompass-computerize primary care clinic

Within next 24 months, personal health record for consumers themselves

C. Current Washtenaw Initiatives-psychiatric consultation, Care Web, medical management center with care navigators for University of Michigan Health System

-50% reduction in no-shows by changing site to primary care setting

-no new money, existing resources and people

-have to create culture of change, have to create culture of management

-have to have will/passion-don't accept no

-partner with consumers/family members-can do it now