Instructions to join the meeting remotely:

1. Open a web browser and enter URL: www.readytalk.com
   Enter participant access code: 2093166

2. Phone in for the audio portion of the conference:
   1-866-740-1260 - then enter the access code: 2093166

MEETING HANDOUTS:
www.cchap.org/pmmeeting
Effective Integrated Care for Pediatrics: How to Get There From Here

Lori Raney, MD
Principal, Health Management Associates

Gina Lasky, PhD
Senior Consultant, Health Management Associates
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 response to treatment and adjust
  – 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
Common Approaches to Integrated Care

**Traditional Consultation**
- Limited access
- Limited feedback
- Expensive
- One Pass

**Co-Location**
- Access and interaction
- Better communication
- Long waitlists and limited available providers
- Limited ability for follow through

**Behavioral Health Consultant**
- Solidly grounded in a clinical practice culture
- Generalist BHP
- Rapid access to brief behavioral interventions
- Limited evidence base
Core Principles of Effective Integrated Care

- Team-based collaboration that is Patient-centered
- Evidence-based and practice-tested care
- Measurement-based care, treat to target
- Population-based care – registry, systematic screen
- Accountable care
Principal 1: Collaborative Team Approach

http://aims.uw.edu
The Collaborative Care Model

Effective Collaboration

Informed, Activated Patient

PRACTICE SUPPORT

PCP supported by Behavioral Health Care Coordinator

Measurement-based Treat to Target

Psychiatric Consultation

Caseload-focused Registry review

Training

http://aims.uw.edu
“Sweet” Spot:
PCPs Manage Mild to Moderate Mental Illnesses

- 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.
Principal 2: Evidence-based Integrated Care

- Model selection
- Brief therapeutic interventions
  - Proven to work in primary care settings
  - Traditional long-term psychotherapy needs referred to specialty care
  - Short term and episodic relationship
  - Rapid skill enhancement
- Psychopharmacology
Brief Psychotherapeutic Interventions

+ Include a patient engagement component. Skipping right to treatment doesn’t work
+ Be time efficient, running no more than 20-30 minutes a visit – helps to see more patients and open up more slots
+ Care managers can send the parents out of the room to collect additional information if needed (see following note on confidentiality)
+ Follow a structure-based approach. A modularized treatment with clear steps keeps the provider and patient on track despite the distractions in primary care.
+ Minimize required clinical training. The treatment should be able to be administered by non-specialists who work in a health care team.
+ Be relevant and applicable to the diverse patient populations found in primary care.
+ While evidence-based practice is preferred, there are limited studies of interventions in pediatric practice. Pediatric care manager best practice is adapting the evidence based adult brief interventions to the pediatric population – described in the following slides
+ If an intervention occurs that meets criteria for a psychotherapy code (30, 60 minute etc) or family therapy then bill it
"Anticipatory Guidance" is a common term in the field of general pediatrics. It refers to providing education to parents about what to expect, or anticipate, over the next few months or years with your child. Recommendations are specific to a child's age at the time of a visit.
Anticipatory Guidance

- Educating parents regarding normal social and emotional development
- Training parents in basic behavior-modification principles; establishment of consistent expectations and structure, clear limit-setting, praise, and positive reinforcement
- Teaching strategies to enhance parent-child relationships
- Teaching strategies to improve family cohesion and address sibling conflicts
- Coaching parents on bullying issues
- Educating parents about the impacts of toxic stress and traumatic experiences
- Helping parents become effective advocates for their children with regard to addressing special education needs

Stacy DuPont, PhD, Integrated Care: Working at the Interface of Primary Care and Behavioral Health. Editor Lori Raney MD, 2014
Evidence-based Brief Interventions

- Motivational Interviewing
- Distress Tolerance Skills
- Behavioral Activation
- Problem Solving Therapy
- Cognitive Behavioral Therapy
Frequent, Persistent Follow-up

Figure 1. Time to first clinically significant improvement in depression among patients in a collaborative care model, by follow-up contact in the first four weeks.

Bao et al: Psych Serv 2015
Principal 3: Measurement-based Treat to Target

- 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

Fixing Behavioral Healthcare in America

Our issue brief series on Fixing Behavioral Health Care in America offers key policy recommendations and clear and compelling research to support evidence-based solutions for mental health and addiction.

These briefs were developed through multiple meetings of experts in behavioral health, academia, neuroscience, pediatrics and education, as well as stakeholders from the insurance industry, provider and consumer communities, and government. Collectively, we set out to address the scope of each problem, review supporting research, and develop a series of strategies that we can implement today.

ISSUE BRIEF
A Core Set of Outcome Measures for Behavioral Health Across Service Settings

ISSUE BRIEF
A National Call for Measurement Based Care

ISSUE BRIEF
Integrating and Coordinating Specialty Behavioral Health Care with the Medical System

Includes child measures

https://www.thekennedyforum.org/issuebriefs
A Tipping Point for Measurement-Based Care

John C. Fortney, Ph.D., Jürgen Unützer, M.D., M.P.H., Glenda Wrenn, M.D., M.S.H.P., Jeffrey M. Pyne, M.D., G. Richard Smith, M.D., Michael Schoenbaum, Ph.D., Henry T. Harbin, M.D.

Objective: Measurement-based care involves the systematic administration of symptom rating scales and use of the results to drive clinical decision making at the level of the individual patient. This literature review examined the theoretical and empirical support for measurement-based care.

Methods: Articles were identified through search strategies in PubMed and Google Scholar. Additional citations in the references of retrieved articles were identified, and experts assembled for a focus group conducted by the Kennedy Forum were consulted.

Results: Fifty-one relevant articles were reviewed. There are numerous brief structured symptom rating scales that have strong psychometric properties. Virtually all randomized controlled trials with frequent and timely feedback of patient-reported symptoms to the provider during the medication management and psychotherapy encounters significantly improved outcomes. Ineffective approaches included one-time screening, assessing symptoms infrequently, and feeding back outcomes to providers outside the context of the clinical encounter. In addition to the empirical evidence about efficacy, there is mounting evidence from large-scale pragmatic trials and clinical demonstration projects that measurement-based care is feasible to implement on a large scale and is highly acceptable to patients and providers.

Conclusions: In addition to the primary gains of measurement-based care for individual patients, there are also potential secondary and tertiary gains to be made when individual patient data are aggregated. Specifically, aggregated symptom rating scale data can be used for professional development at the provider level and for quality improvement at the clinic level and to inform payers about the value of mental health services delivered at the health care system level.

*Psychiatric Services 2016; 00:1–10; doi: 10.1176/appi.ps.201500439*
MBC Concepts

Process:
• Systematic administration of symptom rating scales – use huddle or registry
• NOT a substitute for clinical judgement
• Use of the results to drive clinical decision making at the patient level – overcome clinical inertia
• Patient rated scales are equivalent to clinician rated scales
• Aggregate data for
  – Professional development at the provider level – MACRA
  – Quality improvement at the clinic level
  – Inform reimbursement at the payer level

Ineffective Approaches:
• One-time screening
• Assessing symptoms infrequently
• Feeding back outcomes outside the context of the clinical encounter

Fortney et al Psych Serv Sept 2016
“Stepped Care” Approach Using Measurement

- Uses limited resources to their greatest effect on a population basis
- Different people require different levels of care
- Finding the right level of care often depends on monitoring outcomes
- Increases effectiveness and lowers costs overall

Van Korff et al 2000
Child and Adolescent Measurement Scales

- PHQ A or 9 – 50% drop or remission (4 or less)
- Vanderbilt ADHD – drop in 1-28
- *SCARED – 41 items with subscales
- Pediatric Symptom Checklist (PSC) 35 items

*Scale Child Assessment of Anxiety and Related Emotional Disorders
## Validated Screening and Measurement Tools

### 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)

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>✓</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead, or of hurting yourself in some way</td>
<td>✓</td>
<td>1</td>
<td></td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>add columns:</th>
<th>2</th>
<th>10</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL:</td>
<td></td>
<td>15</td>
<td></td>
</tr>
</tbody>
</table>

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all
- Somewhat difficult ✓
- Very difficult
- Extremely difficult

---

**PHQ 9 > 9**
- < 5 – remission
- 5 - mild
- 10 - moderate
- 15 - moderate severe
- 20 - severe
## Vanderbilt ADHD Scale

### NICHQ Vanderbilt Assessment Scale—PARENT Informant

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Never</th>
<th>Occasionally</th>
<th>Often</th>
<th>Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does not pay attention to details or makes careless mistakes with, for example, homework</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Has difficulty keeping attention to what needs to be done</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Does not seem to listen when spoken to directly</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Has difficulty organizing tasks and activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Is easily distracted by noises or other stimuli</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Is forgetful in daily activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10. Fidgets with hands or feet or squirms in seat</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11. Leaves seat when remaining seated is expected</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12. Runs about or climbs too much when remaining seated is expected</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13. Has difficulty playing or beginning quiet play activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14. Is &quot;on the go&quot; or often acts as if &quot;driven by a motor&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>15. Talks too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>16. Blurs out answers before questions have been completed</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17. Has difficulty waiting his or her turn</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>18. Interrupts or intrudes in on others' conversations and/or activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>19. Argues with adults</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>20. Loses temper</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>21. Actively defies or refuses to go along with adults' requests or rules</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>22. Deliberately annoys people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>23. Blames others for his or her mistakes or misbehaviors</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>24. Is touchy or easily annoyed by others</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>25. Is angry or resentful</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>26. Is spiteful and wants to get even</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>27. bullies, threatens, or intimidates others</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Reduction in Scores 1-28 (combined)
Measurement Based Treatment To Target at the Patient Level
Principal 4: Population-based Care: Tracking Progress and Adjusting Treatment

<table>
<thead>
<tr>
<th>View</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</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</th>
<th>Date of Last GAD-7 Score</th>
<th>Flag</th>
<th>Most Recent Psychiatric Consultant Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>View</td>
<td>Active</td>
<td>Albert Smith</td>
<td>8/13/2015</td>
<td>1/1/2015</td>
<td>7</td>
<td>29</td>
<td>18</td>
<td>17</td>
<td>-6%</td>
<td>12/7/2015</td>
<td>14</td>
<td>10</td>
<td>-29%</td>
<td>12/1/2015</td>
<td>Flag for discussion &amp; safety risk</td>
<td></td>
</tr>
<tr>
<td>View</td>
<td>Active</td>
<td>Bob Doolittle</td>
<td>1/5/2016</td>
<td>3/1/2016</td>
<td>3</td>
<td>9</td>
<td>21</td>
<td>19</td>
<td>-10%</td>
<td>3/1/2016</td>
<td>12</td>
<td>10</td>
<td>-17%</td>
<td>3/1/2016</td>
<td>Flag for discussion</td>
<td></td>
</tr>
</tbody>
</table>

FREE UW AIMS Excel® Registry ([https://aims.uw.edu/resource-library/patient-tracking-spreadsheet-example-data](https://aims.uw.edu/resource-library/patient-tracking-spreadsheet-example-data))
Priciple 5: Performance Measures: Accountability

- **Process Metrics:**
  - Percent of patients screened for depression
  - Percent with follow-up with care manager within 2 weeks
  - Percent not improving that received case review and psychiatric recommendations
  - Percent treatment plan changed based on advice
  - Percent not improving referred to specialty BH

- **Outcome Metrics**
  - Percent with 50% reduction PHQ-9 - Clinical Response
  - Percent reaching remission (PHQ-9 < 5) NQF 710 and 711

- **Satisfaction** – patient and provider
- **Functional** – work, school, homelessness
- **Utilization/Cost**
  - ED visits, 30 day readmits, med/surg/ICU, overall cost
CPT Codes for CoCM – Looking To the Future

G0502 - $143
G0503 - $126
G0504 - $66

Billed once a month by the PCP

• 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.
Bringing Principles to Practice
Workflow

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
Prioritizing Patients Who are not Improving

http://aims.uw.edu/
Weekly Caseload Review with Psychiatric Consultant

<table>
<thead>
<tr>
<th>View</th>
<th>Treatment Status</th>
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<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</th>
<th>Initial GAD-7 Score</th>
<th>Last Available GAD-7 Score</th>
<th>% Change in GAD-7</th>
<th>Date of Last PHQ-9 Score</th>
<th>Date of Last GAD-7 Score</th>
<th>Psychiatric Consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>View</td>
<td>Active</td>
<td>Albert Smith</td>
<td>8/13/2015</td>
<td>1/1/2015</td>
<td>7</td>
<td>29</td>
<td>18</td>
<td>17</td>
<td>-6%</td>
<td>14</td>
<td>10</td>
<td>-29%</td>
<td>12/1/2015</td>
<td></td>
<td>12/1/2015</td>
</tr>
<tr>
<td>View</td>
<td>Active</td>
<td>Nancy Fake</td>
<td>2/4/2016</td>
<td>2/4/2016</td>
<td>0</td>
<td>4</td>
<td>No Score</td>
<td>No Score</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

FREE UW AIMS Excel® Registry ([https://aims.uw.edu/resource-library/patient-tracking-spreadsheet-example-data](https://aims.uw.edu/resource-library/patient-tracking-spreadsheet-example-data))
Teams are the Foundation of Culture Change

Culture Change

- Definition of “Treatment”
- Clinical & Operational Practice
- Shared Goals
- Roles and Functions
- Individual to Team Focus

Effective Components

- Outcome Based
- Formal & Informal Team Development
- Effective Communication
- Shared Vision
- Team Values

Don’t Buy the Myth

“If we hire them, they will team”
BHPs/Care Managers - Hire the Right Person

Who are the BHPs/CMs?

- Typically MSW, LCSW, PhD, PsyD, RN, paraprofessional – CHW, MA
- Need brief intervention skills – and must believe brief works!
- Registry Management

What makes a good BHP/CM?

- Organization
- Persistence – frequent FU
- Creativity and flexibility
- Tenacity
- Willingness to be interrupted
- BA, MI, SFBT, PST, DTS, etc

CAUTION:
- Prefer traditional approach to therapy
- Not willing to be interrupted
- Timid, insecure about skills
Roles of Primary Care Provider

- **IDENTIFY** individuals who need BH support and
- **ENGAGE** them in the treatment model
- Utilize screening tools to track progress (e.g., PHQ-9)
- Comfortable with basic psychopharmacology
PCP “Buy-In”

Before Implementation

• This is going to slow me down
• I don’t have time to address one more problem
• This is going to be an anchor
• I already do a good job of treating mental illness

After Implementation

• This takes a load off my plate
• This speeds me up
• I always want to practice like this
• I am giving better care to my patients
• This gives me time to finish my note

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

PCP - Colorado
Psychiatric Consultant

**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 – PCP may or may not implement **NO RX**
Psychiatric Providers Supporting Teams

50-80 patients/caseload
2-4 hrs psych/week/ care coordinator = a lot of patients getting care
Colorado Environment

The system changes should ultimately support sustainable integration and provide new opportunities.

Building Blocks for Sustaining Integration in CO

ACC increased focus on accountability supports measurement based models of care.

New BH billing in primary care (6 sessions) supports expansion of BH network and brief intervention in primary care settings.

Experimentation through ACC with payment reforms (APM and VBP) will support innovative models with demonstrated outcomes.

Focus on population health and regional health will promote ACC experimentation with innovative treatment models.
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

* Estimates were truncated when ten or fewer patients remained in treatment at each site.

Date of download:
2/23/2013
Table 1. Factors Considered Important for Implementation of DIAMOND

<table>
<thead>
<tr>
<th>Ranking</th>
<th>Implementation Factor</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Operating costs of DIAMOND not seen as a barrier</td>
<td>The clinic has adequate coverage or other financial resources for most patients to be able to afford the extra operational costs.</td>
</tr>
<tr>
<td>2</td>
<td>Engaged psychiatrist</td>
<td>The consulting psychiatrist is responsive to the care manager and to all patients, especially those not improving.</td>
</tr>
<tr>
<td>3</td>
<td>Primary care provider (PCP) “buy-in”</td>
<td>Most clinicians in the clinic support the program and refer patients to it.</td>
</tr>
<tr>
<td>4</td>
<td>Strong care manager</td>
<td>The care manager is seen as the right person for this job and works well in the clinic setting.</td>
</tr>
<tr>
<td>5</td>
<td>Warm handoff</td>
<td>Referrals from clinicians to the care manager are usually conducted face-to-face rather than through indirect means.</td>
</tr>
<tr>
<td>6</td>
<td>Strong top leadership support</td>
<td>Clinic and medical group leaders are committed and support the care model.</td>
</tr>
<tr>
<td>7</td>
<td>Strong PCP champion</td>
<td>There is a PCP in the clinic who actively promotes and supports the project.</td>
</tr>
<tr>
<td>8</td>
<td>Care manager role well defined and implemented</td>
<td>The care manager job description is well defined, with appropriate time, support, and a dedicated space.</td>
</tr>
<tr>
<td>9</td>
<td>Care manager on-site and accessible</td>
<td>The care manager is present and visible in the clinic and is available for referrals and patient care problems.</td>
</tr>
</tbody>
</table>

DIAMOND indicates Depression Improvement Across Minnesota—Offering a New Direction.

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 response to treatment and adjust
  - 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
Great Resource

- Screening Tools
- Brief Interventions
- Self-help materials
- Parent resources too

Q&A

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