Collaborative Care Curriculum: Module 2

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Table of Contents: Collaborative Care Fundamentals

Module 2: Introduction to Mental Health Integration program and Behavioral Health Integration Program	
Brief Introduction	This module provides brief description of MHIP and BHIP programs.
Objectives - At the conclusion of this module, the resident will be able to:	
Knowledge	Describe the populations served by and typical team configuration in the MHIP and BHIP program.
Skills	Conceptually understand and be ready to use a tracking tool such as MHITS/CMTS.
Attitudes	Consider quality aims a part of routine practice for working in MHIP and BHIP
Reading	1. Unützer J, Chan YF, Hafer E, Knaster J, Shields A, Powers D, Veith RC. Quality Improvement with Pay-for-Performance Incentives in Integrated Behavioral Health Care. Am J Public Health. 2012 Jun;102(6):e41-5. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3483954/pdf/AJPH.2011.300555.pdf// 2. McGough PM et al. Integrating Behavioral Health into Primary Care. Population Health Management. 2015. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4845678/pdf/pop.2015.0039.pdf//
Synopsis of Reading	1. <u>Pay-for-Performance Incentives</u> This paper reviews the effect of monetarily incentivizing the implementation of quality aims in the MHIP Collaborative Care program. A portion of clinical payment to clinics was only given to clinics meeting quality aims including: twice monthly visits with clients, recording of clients' medications, the presence of a complete clinical assessment in the chart, and psychiatric case reviews completed for a 50% of the total caseload. Analyses showed that the median time elapsed for reaching improvement (rate of achieving a 50% or greater reduction or a score of less than 10 on thePHQ-9) was reduced from approximately 64 weeks pre-pay for performance implementation to 25 weeks post-implementation. These analyses strongly suggest that when key quality indicators are tracked and a substantial portion of payment is tied to such

	quality indicators, the effectiveness of care for safety-net populations can be substantially improved. 2. Integrating Behavioral Health into Primary Care: This paper outlines the partnership with UW neighborhood clinics and the UW psychiatry department in implementing Collaborative Care (CC) approach to integrating the management of anxiety and depression in the ambulatory primary care settings following chronic disease model. In the beginning authors make the case for CC model by describing how common depression is and the challenges in the current system of limited access to appropriate treatment, insurance problems etc. In method section Behavioral Health Integration program (BHIP) is described including the CC team with their roles (PCP, care manager and psychiatrist), settings (UW neighborhood clinics), target population (with depression and anxiety). The pilot program was initially created in one clinic with high mental health needs and based on positive outcomes the program was expanded in all UW neighborhood primary care clinics within couple of years. The BHIP program uses web-based registry, CMTS. The majority of BHIP population in these clinics presents with depression (76%) and anxiety (42%), other diagnosis include PTSD (15%), bipolar disorder (16%), substance use (12%) and positive SI (40%). Greater than 60% patients engaged in biweekly care (in person and phone contacts). The IMPACT study estimated that over 4-year period there will be overall savings of $3363 per patient.
Discussion and Reflection Questions	1 What are your past experiences of addressing mental health in primary care settings? 2 Have you had any exposure to quality aims in your clinical work before? What do you see as the advantages and challenges of using quality aims to guide clinical interactions?
Slide Set	Module 2_Introduction to MHIP and BHIP
Additional Resources	• MHIP Website: http://integratedcare-nw.org/index.html • AIMS website: http://aims.uw.edu/search/node/BHIP/