Integrated Behavioral Health at Mayo – Bringing Together Mental Health Disciplines in Primary Care to Better Address a Population

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Faculty Disclosure

The presenters of this session have NOT had any relevant financial relationships during the past 12 months.
Conference Resources

Slides and handouts shared in advance by our Conference Presenters are available on the CFHA website at http://www.cfha.net/?page=Resources_2018

Slides and handouts are also available on the mobile app.
Learning Objectives

At the conclusion of this session, the participant will be able to:

1. Describe a multidisciplinary model of integrated care that is developing to be applicable in a wide variety of settings, highlighting teamwork, translational methods, and learning from your population with retrospective research.

2. Identify key components in delivering high quality collaborative care coordination in primary care and key challenges to overcome both for outcomes and sustainability.

3. Describe a model of integration of evidence-based psychotherapy into primary care with the capacity to track outcomes.
Bibliography / Reference


Learning Assessment

A learning assessment is required for CE credit.
A question and answer period will be conducted at the end of this presentation.
Outline

1. An introduction to Integrated Behavioral Health at Mayo
2. Our experience with care coordination
3. Imbedding evidence-based psychotherapy into primary care
4. Implementing new models, preserving teamwork, operational challenges
5. Adapting the model to rural settings – opportunities and challenges
6. Questions and answers
Integrated Behavioral Health (IBH) at Mayo

William Leasure, MD
Co-Chair, Division of Integrated Behavioral Health
Mayo Clinic, Rochester, MN
Psychiatry at Mayo

• Mayo started in late 1800’s
  • Mayo brothers were surgeons
  • Other specialties needed
  • One of the first group practices

• Mayo Psychiatry roots in consultation-liaison
  • Excellent Psychiatric evaluations
  • Brief treatments in areas of excellence
    • Addiction, mood, pain, etc.
Challenge – Specialty approach

• Non-local patients
  • Complex problems; in town for intensive work-up and an answer
    • Fee-for-service payment

• Local community patient
  • Typically don’t have a rare condition
    • Growing population insured by Mayo
    • Intensive work-up costly and often unnecessary
    • 2-3 month wait
    • High no show rate (waiting plus stigma)

• Need for a population-based approach
Creation of IBH

• One clinic using PDSA cycles then spread
  • Therapy, Medications, Care coordination, etc.

• Work out system issues
  • Change ordering system, standardized tools
  • Clarify psychiatric emergency plan
  • Develop weekly huddle

• Clarify roles
  • MD and APRN
  • PHD and LICSW
  • RN care coordinator
The Multidisciplinary IBH Team

Care Coordinators
Psychiatrist
Social Work
Psychologists
Social Worker role change

• Triple role:
  • Evidence-based assessment and psychotherapy
  • Triage visits; warm handoffs; right-step level of care
  • General social work resources
Roles on Our Team – all part of Primary Care

• Psychiatry (1/33,000) – plus academic responsibilities
  • Direct patient care
  • Indirect patient care – curbsides, e-consults, reviewing cases for care coordination
  • Supervision of care – nurses, residents

• Advance Practice Registered Nurse (1/23,000)
  • Follow and stabilize patients needing meds
  • Often have earlier access
  • Backup by psychiatrist
Roles on Our Team

• LICSW (1/8,000)
  • Triage, CBT, traditional social work

• PHD (1/55,000)
  • Tougher cases, support LICSW, fellows
  • Pts with treatment resistant behaviors
  • Group therapy with LICSW

• RN Care coordinators (1/10,000)

• Others – desk staff familiar with schedules, secretarial support
  • We also spend time on supporting teams
Our Population Based Program Development Process

• Define population – most pressing need?
• Find examples in literature of evidence-based treatment models for that need
• Adapt the model to one clinic and assess outcomes.
  • Publish effort for peer review
• Spread to other sites if achieving good results
• Integrate programs to increase efficiency
Examples of IBH resources available to our patients (partial list)

- Direct patient care (MD/APRN/LICSW/LP/PHD/RN)
- Care coordination (depression, bipolar, anxiety, medically complex)
  - Adults for all, adolescent patients focus on depression
- Short term evidence-based psychotherapy on-site
  - Group therapy
    - Anxiety and Depression
    - Insomnia
    - Chronic Pain
- Link to local DBT program for borderline personality disorder
- Indirect support of their primary care providers (e.g. allows direct admission)
# Integrated Behavioral Health Model (assume higher level has all features of lower levels)

<table>
<thead>
<tr>
<th>Level</th>
<th>Mental health team</th>
<th>Training</th>
<th>Treatment Options</th>
<th>Registry</th>
<th>Outcome tracking</th>
<th>Referral process</th>
<th>Population Screening</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Specialty psychiatric programs and consults integration. Complex behavioral health coordination.</td>
<td>Specialty practice learn IBH model and IBH learn specialty practice</td>
<td>Intensive individualized treatments</td>
<td>Integrated registry</td>
<td>Track appropriate additional outcomes including access to specialty care.</td>
<td>Easy transition between primary and specialty care</td>
<td>Additional mental health diagnoses</td>
</tr>
<tr>
<td>5</td>
<td>On site psychologists and/or psychiatrist</td>
<td>Working relationship with primary care providers. Psychologists participate in monthly therapy training.</td>
<td>Short term consultations/therapy and co-management. Close collaboration with social work and care coordinator</td>
<td>Integrated registry</td>
<td>Same as level 4</td>
<td>LICSW helps coordinate mental health referrals</td>
<td>Same as level 4</td>
</tr>
<tr>
<td>4</td>
<td>On site CNS/NP and/or telepsychiatry</td>
<td>Working relationship with primary care providers. Spend time on site</td>
<td>Short term consultations and co-management</td>
<td>Integrated registry</td>
<td>Same as level 3 and all level 2. Track access to providers</td>
<td>LICSW helps coordinate mental health referrals</td>
<td>All patients once a year. Includes all patients in practice</td>
</tr>
<tr>
<td>3</td>
<td>LICSW on site</td>
<td>Expertise in triple Social work model: therapy, triage visit, and general social work consultation. Participate monthly therapy training.</td>
<td>Evidence-based psychotherapy for patients. Collaborate with Care Coordinators.</td>
<td>Integrated registry: includes coordinator panel, contacts, care plan and outcomes.</td>
<td>Track psychotherapy progress and treat to target. Also track access.</td>
<td>LICSW helps coordinate mental health and community referrals. Patients having general social work and triage visits.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Supervising psychiatrist (does not need to be on site)</td>
<td>Psychiatrist trained to participate in SCR and use registry</td>
<td>SCR process with recommended adjustments to treatment</td>
<td>Treat to target. Document SCR reviews</td>
<td>Add GAD-7, AUDIT, and MDQ</td>
<td>Psychiatrist can recommend referrals</td>
<td>Same as level 1</td>
</tr>
<tr>
<td>1</td>
<td>Hybrid Model Coordinator and primary care teams</td>
<td>Understand depression treatment options and Motivational Interviewing (MI) and Behavioral Activation (BA).</td>
<td>Antidepressant prescribed by primary care provider. MI and BA. Self-management. Computer CBT. Emergency behavioral health plan in place.</td>
<td>Track depression outcomes if possible in same registry as medical illnesses.</td>
<td>Longitudinally track PHQ-9 scores for patients diagnosed with depression and hospitalizations and ER visits</td>
<td>Electronic list of mental health resources updated and available to providers.</td>
<td>Screen all hybrid model patients for depression. Population wide screening not recommended.</td>
</tr>
</tbody>
</table>
Care coordination

Mark Williams, MD
Associate Professor
Division of Integrated Behavioral Health
Mayo Clinic, Rochester, MN
Definitions – Care Coordination

• Over 40 definitions in literature

• For this presentation:
  • Care coordination (or care management)
    • Time limited/goal directed based on self management targets
      • Improved health outcome (e.g. Blood pressure)
      • Improved experience of care
      • Improved efficiency of care (?)
  • Case management
    • Ongoing support for a patient who for whatever reason cannot or is not likely to return to self management of health burden
Evidence for Collaborative Care: Cochrane Systematic Review

- 79 Randomized Controlled Trials involving 24,308 patients worldwide testing collaborative care models vs. usual care

- Depression outcomes for adults
  - Short-term (6m) RR 1.32 (1.22 - 1.43)
  - Medium-term (7-12m) RR 1.31 (1.17 - 1.48)
  - Long-term (13-24m) RR 1.29 (1.18 - 1.41)
  - Very long term (25 m +) RR 1.12 (0.98 – 1.27)*

- Anxiety outcomes for adults
  - Short-term RR 1.50 (1.21 - 1.87)
  - Medium-term RR 1.41 (1.18 - 1.69)
  - Long-term RR 1.26 (1.11 - 1.42)
  - Very long term unavailable

• **Depression Initiative Across Minnesota, Offering a New Direction (2007-2010)**
  
  • Modeled after collaborative care work (Katon/ Unutzer).
  • Created by the Institute for Clinical Systems Improvement (ICSI)
  • Implemented in over 80 clinics in Minnesota

How does it work?

• Patient see by Primary Care
  • PHQ-9 given – score $\geq 10$ (moderate)

• Patient introduced to RN care coordinator

• Data gathered from patient
  • GAD7, MDQ, AUDIT, WPAI
  • Past history, social situation, meds, etc.

• Data entered into a registry and presented to Psychiatrist (meet once/week)
  • Access to mental health input reduced from 2-3 months (face-to-face visit) to 1-2 weeks.
A simple column sorting tool lets the supervising physician sort by patients with (in this example) a PHQ-9 of 10 or more to make sure to review them all and make suggestions. Same concept with LDL/HgBA1C etc.
Secrets of success of this model

• Do not slow down the primary care system!!
  • Respect the team (primary care provider, nurse, patient, etc.)

• Improve access to psych (input in 1 week vs 2-3 months)

• Weekly review of patients is critical to success
  • Better triage – who needs more care and match to service
  • Allows patients to start on any reasonable plan as long as we follow up

• Treat to target – brainstorming and cheerleading
  • Patient inertia - depressed
  • Clinical inertia – too busy
Collaborative care (DIAMOND) was better than practice as usual at 3 & 6 months
DIAMOND and Time to Remission

Figure 1. Time to remission (9-item Patient Health Questionnaire score <5) with collaborative care management versus usual care.
IMPACT of DIAMOND for IBH

• Data from DIAMOND demonstrated outcomes to primary care
  • more resources offered- creation of IBH

• Nursing invested in care coordinator role
  • Requires ongoing training on motivational interviewing

• Data in a registry allowed us to see which patients were not improving
  • Those with anxiety for example*
    • Led to development of therapy resources in primary care

Angstman et al. DEPRESSION AND ANXIETY 30:143–148 (2013)
## Mayo IBH Experience in Evidence to Practice

<table>
<thead>
<tr>
<th>Problem/Population</th>
<th>RCT research trial</th>
<th>Real world implementing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression in adults</td>
<td>IMPACT (elderly)</td>
<td>DIAMOND (all adults)</td>
</tr>
<tr>
<td>Adolescent depression</td>
<td>Richardson 2014 JAMA</td>
<td>EMERALD</td>
</tr>
<tr>
<td>Anxiety CBT in PC</td>
<td>CALM trial (adults)</td>
<td>Mayo CBT (all ages)</td>
</tr>
<tr>
<td>Diabetic/CVD Depressed</td>
<td>TEAMcare (adults)</td>
<td>COMPASS (adapting to other chronic illnesses)</td>
</tr>
</tbody>
</table>

Also available: Research examples for primary care models for PTSD (VA based research), alcohol misuse (SBIRT), bipolar disorder in adults, telemedicine models, etc.
Imbedding Evidence-Based Psychotherapy in Primary Care

Craig N. Sawchuk, PhD, ABPP
Professor
Co-Chair, Division of Integrated Behavioral Health
Mayo Clinic, Rochester, MN
Advantages to Primary Care CBT

- Evidence-based
- Goal-oriented and time limited
- Emphasis on collaboration and coaching
- Durable effects of treatment – reduces relapse
- Highly preferable to patients
- Can be delivered in self-help, individual, and group formats
- Easy* to learn; easy* to teach
Challenges to Primary Care CBT

- Doing CBT vs. doing CBT – quality and fidelity
- Negative beliefs (patients and providers)
- Between-session engagement with homework
- Limited resources to assist in tracking outcomes
- Salaried vs. fee-for-service models
  - Not everyone needs the same treatment
- Translation from research to practice
Laying the Groundwork

- Finding space
- Recruiting the right provider
  - Training, experience, specialty certification
- Constructing the schedule and continuing education to prevent drift
- Educating primary care colleagues
- Gaining infrastructure support to show outcomes
  - Screening, materials, database development
Ongoing Challenges

- Balancing the needs of the population
- Keeping up with the evidence-base
- Navigating the witness relocation program
- Differing opinions on quantity vs. quality metrics
- Killing innovation
Operational Opportunities

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Nurse Administrator
Division of Integrated Behavioral Health
Department of Nursing
Model Planning & Implementation

• Understand the problem and opportunity
  • It may not be what you think
• Utilize Plan-Do-Study-Act cycles
• Address systems concerns
• Start where you are, do what you can
• Clarify collaborative team roles
• Build a burning platform and ignite support
Original IBH Model Outcomes

• Start small and disseminate
  • One provider > Care Team > Clinic > Region
• Multiple PDSAs – e.g. order type of service versus type of provider
• Results
  • High provider satisfaction
  • Improved access

Vickers et al. 2013 General Hospital Psychiatry
Selecting the Team

- Seek out individuals who can:
  - Tolerate ambiguity
  - Build relationship
  - Resist rigid bounds
  - Want to do the work
- Relevant work experiences to support collaborative care
- Willingness to grow beyond traditional norms
- Don’t rush identifying the right person
Patient Reported Outcomes

• Measurement matters
  • Clinical outcomes support growth

• Look for shared measurement opportunities
  • MIPS and insurance contracts
  • Minnesota Community Measures & Wisconsin Collaborative for Healthcare Quality

• Anticipate challenges
  • Time
  • Intervention for concerning results
  • Available support
  • Imbedding in culture
Reporting Structures & Training

• Formal supervision (HR) can look different than clinical supervision

• Create culture of openness that all disciplines and can learn form and teach each other

• Create space for ongoing discussions with formal and clinical supervisors
  • Interprofessional huddle
  • Case consultation
  • Observation and feedback
  • Systematic case review
Maintaining Access

• How target population is defined can impact access
  • Implement evidence based models
  • Short term vs long term interventions
  • Alignment with organizational priorities
  • Collaboration with community partners and specialty practice

• Build clinical calendars with defined standards for visit and non-visit care time

• Set access targets
Dissemination & Integration

• Model consensus
  • Functions vs individual roles

• Fidelity and adaptation
  • Rural Settings
  • Resource constraints
  • Outcome targets

• Clinical and administrative outcomes
  • Can be competing priorities

• Understanding who the decision makers are
Productivity

• Value based or fee-for-service environment

• Define standard set of metrics
  • Access metrics
    • Standard patient contact hours
    • Fill Rates
  • Non-Visit Care workload
    • Triage, resource referral, EHR messaging
  • Clinical outcomes
    • Response and remission
  • Financial metrics
    • Billing and utilization
Sustainability

- Define outcomes from the beginning
- Utilize population based registries, access dashboards, etc. for ongoing evaluation
- Consider tele options for expanding reach
- Support primary care teams in outcomes they are impacted by
- Use data for clinical and administrative decision making at point of care
- Influence contracting and policy
Ideas That Did Not Work

• Simply educating the primary care providers, care team, and RN care coordinators on psychiatric issues
• Put out algorithms for everyone to use
• Integrating substance abuse program into a small town clinic
• Trust that resources would be made available based on models from the literature alone
  • Need to develop internal data from your own practices
Adapting the model to rural settings – opportunities and challenges

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Assistant Professor
Division of Integrated Behavioral Health
Mayo Clinic Health System, La Crosse, WI
2017 US RURAL HEALTHCARE REPORT CARD

What we learned along the way

Laying Groundwork

• Start as sociologist
• Needs assessment
• Local resources are creative by necessity – Learn from them. Use them.
• Champion Teams!
How to Call or Page in LASK

**Pediatric IBH:** Dr. Trane/Janice  (608)304-2931

**Social Worker:** Ashley Sammann  2-4165

**Behavioral Health RN:** Isaiah/Craig  2-2836

Feel free to refer to Pediatric IBH about any number of conditions including:

- Medical adherence
- Sleep issues
- ADHD
- Encopresis/enuresis
- Behavior Problems
- Headaches
- Suicidal ideation/crisis
- Depression
- Life adjustments
- Anxiety
- Picky/restrictive eating
- Postpartum
- Adolescent Drug/Alcohol use
- Pediatric weight management

Also able to engage with schools, county services, and other agencies
What we learned along the way

Becoming part of the team
- Daily huddle
- Lunch and learn
- Shared record

Ongoing opportunities
- Becoming the best generalist
- Using colleagues and consultation
- Remembering to set boundaries
- Self care
Remember - You are not alone

https://www.ruralhealthinfo.org/toolkits/services-integration/2/primary-care-behavioral-health
Thanks to our IBH colleagues!!

Questions??

Williams.mark@mayo.edu
Session Evaluation

Use the CFHA mobile app to complete the evaluation for this session.

Thank you!