ICSI and Nine Health Care Partners Receive Three-Year Innovation Cooperative Agreement from CMS

*Project Is to Spread Collaborative Care Model for Managing Depression and other Chronic Conditions Locally and Nationally*

Bloomington, Minn. --- June 15, 2012. The Centers for Medicare and Medicaid Services (CMS) has awarded nearly $18 million to a local and national collaboration of partner organizations with the Institute for Clinical Systems Improvement (ICSI) as lead organization.

The three-year cooperative agreement, part of a $1 billion CMS Health Care Innovation Challenge, will fund the implementation of the “collaborative care management” model for primary care adult patients with depression plus diabetes and/or cardiovascular disease, with an option to address risky substance use and abuse, in seven states. The title of the proposal is “Care Management of Mental and Physical Co-morbidities: A Triple Aim Bulls-eye.”

“We and our local and national partners are very pleased to be given the opportunity to innovate on behalf of our patients and communities,” said Sanne Magnan, MD, PhD, President and CEO of ICSI. “We will spread an innovative model that provides better health, better care and lower costs - truly a Triple Aim bulls-eye.” The project plans meet the three main criteria of the CMS Innovation Challenge -- engage a broad set of innovation partners to test new care delivery models, identify new models of workforce development and deployment that creates jobs, and leverage existing care models to improve patient care within the first year.

ICSI is a non-profit quality improvement organization comprised of 55 medical group and hospital members in Minnesota and bordering states, and is sponsored by five non-profit health plans (Blue Cross and Blue Shield of Minnesota, HealthPartners, Medica, Security HealthPlan in Wisconsin, and UCare), membership dues and grants/contracts. In addition to ICSI, other implementation sites in the national collaborative are: Mayo Clinic Health System; Kaiser Permanente Colorado; Kaiser Permanente Southern California; Community Health Plan of Washington; Pittsburgh Regional Health Initiative; Mount Auburn Cambridge Independent Practice Association (Massachusetts); and the Michigan Center for Clinical Systems Improvement.

ICSI is also partnering with HealthPartners Research Foundation and the AIMS (Advancing
Integrated Mental Health Solutions) Center at the University of Washington. AIMS will help to design and train in the model and provide technical assistance for its implementation. HealthPartners Research Foundation will lead the monitoring, data collection and assessment of the initiative’s implementation and operations costs, and explore financial models that will be needed to sustain the care model and to spread it nationally.

All participating care delivery organizations have committed to support the development of a common model and training program to implement a collaborative team approach for managing patients with depression plus diabetes and/or cardiovascular disease. The model builds on the highly successful DIAMOND (Depression Improvement Across Minnesota Offering a New Direction) model. The organizations have also agreed to enroll at least 1,000 patients with the targeted conditions within six to 12 months with ongoing enrollment over the three years.

“There is a need to target this population because studies show that more than half of patients with depression also suffer from other chronic conditions,” notes Leif Solberg, MD, Director, Care Improvement Research, HealthPartners Research Foundation. “Roughly 30% of Medicare patients have diabetes and another 30% have coronary artery disease, and when depression is present (around 15% of the time) health care costs are 65% higher.”

The majority of implementation sites will also add the SBIRT (Screening, Brief Intervention and Referral to Treatment) program to the model to address patients with risky substance use. Hazardous drinking is one of the four main contributors to chronic diseases. It is a particular issue in Minnesota, which ranks sixth in the nation for binge drinking, according to America’s Health Rankings®. Thirty-five Minnesota clinics offering the DIAMOND program are also implementing the SBIRT program.

The Innovative Collaborative Care Management Model

The collaborative care management model has seven key components:

1. A thorough initial evaluation to measure condition severity and assess the patient’s readiness for self-management support
2. Use of a computerized registry to track and monitor the patient’s progress
3. A care manager to provide patient education and self-management support, coordinate care with the primary care physician and other consultants, and provide active follow-up
4. A consulting physician to provide a weekly review of cases with the care manager and recommend changes in treatment or further evaluation from an expert consultant
5. Treatment intensification when there is a lack of improvement
6. Relapse and exacerbation prevention
7. Aggregate data evaluation and quality improvement

Providers, non-profit health plans, purchasers and patients in Minnesota created DIAMOND, the initiative that redesigned the care model and redesigned the payment model for people with depression. “Without the commitment of our medical groups and our non-profit health plan leaders, DIAMOND never would have been born,” said Dr. Magnan. “It is an excellent example of the innovation that can occur at the ICSI table and across our region. Now, that model is being recognized by CMS and spread to more patients locally and nationally.”

ICSI has helped 80+ primary care clinics implement the collaborative care management model in Minnesota through its DIAMOND program. Launched across Minnesota in 2008, the DIAMOND
program uses a team comprised of a primary care physician, a care manager and a consulting psychiatrist to manage patients with depression. More than 9,000 patients have been activated into the DIAMOND program to date. The results for those patients show that twice as many patients are in remission (no longer suffering from depression) by six months compared to patients receiving usual care in randomly controlled research studies.

“There is compelling evidence that shows collaborative care management results in better patient outcomes in managing patients with depression, diabetes and cardiovascular disease,” says Jurgen Unutzer, MD, MPH, AIMS Center Director.

Adds David Katzelnick, MD, Mayo Clinic Director of Integrated Behavioral Health, “This project will help solidify the care model as a solution for managing both mental and physical health problems, and hopefully provide a national approach to improve patient outcomes, the patient’s experience of care and the affordability of care.”

Organizations Involved in the Triple Aim Bulls-eye Innovation Project

**Institute for Clinical Systems Improvement** is a non-profit, health care improvement organization that brings together diverse stakeholders to find solutions to complex health care and health problems. Sponsored by five health plans in Minnesota and Wisconsin, ICSI helps its 55 medical group and hospital members and their 9,000 physicians in Minnesota and surrounding areas to improve the quality, patient experience and affordability of care.

**Advancing Integrated Mental Health Solutions Center,** as an integral part of the Department of Psychiatry & Behavioral Sciences at the University of Washington, is a leading center of research, training and innovation in integrated mental health programs. The department has nearly 200 full-time faculty engaged in a wide variety of clinical and research programs, plus training programs for health professionals in urban and rural sites in a five state region in the Pacific Northwest. A primary area of research interest is the development of programs in which mental health professionals collaborate effectively with primary care physicians and other health care providers to care for children, adults, and older adults with common mental disorders.

**Community Health Plan of Washington** is a not-for-profit health plan organization owned by 19 community and migrant health centers that serve as a safety net for the underserved. The network includes 19 community health centers operating 96 clinic sites, 245 affiliate providers operating 467 sites, 563 total primary care clinics and provider offices covering all Washington counties, 2,588 primary care providers, 13,571 contracted medical specialists, and more than 100 hospitals.

**HealthPartners Research Foundation** in Minnesota is a non-profit foundation dedicated to advancing scientific knowledge through public domain health care research to improve the health and health care of patients. The organization is funded by HealthPartners and through external grants, primarily from federal agencies.
**Kaiser Permanente** is the nation’s largest non-profit health plan, serving approximately 8.7 million members in nine states. It is divided into eight independent regional organizations, governed by a national board.

- **Kaiser Permanente Colorado** is a closed-panel, group-model HMO with approximately 875 physicians and 5,500 employees who provide services to more than 500,000 members.
- **Kaiser Permanente Southern California** is an integrated health care system. It provides comprehensive health services for approximately 3.3 million people through 13 hospitals and more than 150 medical offices by a partnership of more than 4,000 physicians. The system provides an ideal environment for population-based epidemiologic, and clinical and health services research, owing to the size and diversity of its population.

**Mayo Clinic** is the largest integrated, not-for-profit group practice in the world with more than 3,700 physicians and scientists and 50,000 allied staff in Minnesota, Florida, and Arizona. Mayo Clinic Health System is a network of clinics, hospitals and other health care facilities serving 70 communities in Minnesota, Iowa and Wisconsin.

**Michigan Center for Clinical Systems Improvement** is an innovative, multi-stakeholder organization made up of physicians, payers, employers and patients to address variation in clinical practice, administrative and payment policies in the health care system. Its objectives are to: create an environment for collaboration among health care stakeholders, promote systems and practices that improve patient experience and population health while lowering cost, focus on system problems that no one party can solve on its own, reduce health care disparities, and ensure that regional communities lead the effort toward health system reform.

**Mount Auburn Cambridge Independent Practice Association** is comprised of 513 physician members who admit to Mount Auburn Hospital and/or Cambridge Health Alliance. It has full risk capitation contracts with 40,000 covered lives in Blue Cross Blue Shield of Massachusetts, Tufts Health Plan and Tufts Medicare Preferred (a Medicare Advantage plan), and Harvard Pilgrim Healthcare. The association was recently selected as a Pioneer accountable care organization by CMS.

**Pittsburgh Regional Health Initiative**, a supporting organization of the Jewish Healthcare Foundation, is a multi-stakeholder, non-profit regional health care improvement collaborative. PRHI serves as a catalyst for regional improvement in health care safety, quality and efficiency. Its staff of 30+ professionals includes many with corporate and clinical experience and advanced degrees in quality improvement, research, finance, information technology, patient education, process redesign, communications and outreach.

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