

Case STUDY

 **Learning Systems**
for Accountable Care Organizations

Improving Behavioral Health Care for Medicare Beneficiaries: Atrius Health

This case study describes how Atrius Health, a participant in the Pioneer Accountable Care Organization (ACO) model¹, has worked to improve behavioral health care for Medicare beneficiaries. Its two-pronged strategy involves:

1. Triaging patients to ensure that Atrius Health's behavioral health clinicians see the most clinically-complex patients and refer high-functioning patients to an affiliated external network of behavioral health providers, referred to herein as community providers; and
2. Implementing evidence-based guidelines to provide a consistent, measurable framework for clinicians to provide solution-oriented treatment² to patients.

While Atrius Health continues to evaluate these strategies, early data suggests that they have resulted in substantially shorter wait times for new patients and reduced caseloads for clinicians. ACOs seeking to address the behavioral health needs of their patient populations may consider these approaches to improve patient care.

BACKGROUND

Based in eastern Massachusetts, Atrius Health is comprised of multi-specialty practices, home health, and hospice. Founded in 2004, Atrius Health recently merged the multi-specialty medical practices of Harvard Vanguard Medical Associates, Dedham Medical Associates, and Granite Medical Group. An integrated subsidiary of Atrius Health, Visiting Nurse Association (VNA) Care, provides home health and hospice care. The organization currently consists of approximately 750 physicians and 1,300 clinicians, across 29 primary care practices and 35 specialty departments, who deliver care to more than 675,000 patients each year. Atrius Health joined the Pioneer ACO model in January 2012 and has approximately 27,000 aligned beneficiaries as of June 2016.

CREATING A VISION FOR BEHAVIORAL HEALTH CARE TRANSFORMATION

Atrius Health changed its approach to providing behavioral health services after an internal review found:

- Full-time therapists had average caseloads of more than 100 active patients.

¹ The Center for Medicare & Medicaid Innovation operated the Pioneer ACO model from 2012 to 2016. The model provided financial incentives, in the form of shared savings and losses, to advanced healthcare organizations to improve the quality of their care and the health of their populations while reducing costs. For more information, see the CMMI website (<https://innovation.cms.gov/initiatives/pioneer-aco-model/>)

² Solution-oriented therapy is a goal-directed approach to therapy in which patients are encouraged to increase the frequency of useful behaviors (de Shazer et al., 1986; Trepper, 2008).

- The high caseload prevented clinicians from seeing many patients more than once a month, which is substantially less often than the weekly sessions recommended by the literature to achieve treatment effectiveness (Cuijpers, Huibers, Ebert, Koole, & Andersson, 2013; Erikson, Lambert, & Eggett, 2015; Stiles, Barkham, & Wheeler, 2015).
- Newly-referred patients had to wait on average 60 days for an initial therapy appointment and up to 45 days for a follow-up appointment.³
- Many therapists were not using solution-focused treatment plans, which led to patients receiving long-term and potentially unfocused therapy.

“These data [on caseloads and wait times] showed that the current approach was not working and created a burning platform for change.”

—Dr. Jacob Kagan, director of behavioral health

To obtain buy-in from leadership for the transformation process, Director of Behavioral Health Dr. Jacob Kagan and his colleagues used data to demonstrate a “burning platform for change.” They also made the case that the changes would be consistent with the Behavioral Health Department’s mission to “devise a model that enables every patient to get treatment in the lowest-cost setting—quickly.” The following set of core beliefs guided model development:

- Ensure that Atrius Health provides the best possible care.
- Engage community providers to expand access and be strategic about which patients to refer to these providers.
- Create a unified model of care across all sites.
- Track measurable outcomes for success in therapy.

Goal of behavioral health care transformation process: Devise a model that enables every patient to get treatment in the lowest-cost setting—quickly.

DEVELOPING AND IMPLEMENTING A FRAMEWORK FOR THE NEW CARE MODEL

To address the limitations of the existing care model, Dr. Kagan and the Behavioral Health Department developed a two-pronged model. The first was a triage and referral process of less complex patients to community providers. This process was designed to increase treatment frequency and reduce the caseloads of Atrius Health clinicians while ensuring access to therapy. The second was a set of evidence-

³ Data on wait times provided by Atrius Health in June 2016. They are explored in more detail in Figure 1 on page 5.

based guidelines that clinicians could use in developing treatment plans with patients to ensure consistent, solution-oriented treatment.

The behavioral health team engaged a broad range of internal personnel to help develop this model and manage the broader care transformation process. Dr. Kagan formed a core leadership team, which consisted of an internal project manager, the specialty administrator, the director of behavioral health, and the director of innovation and informatics. The core leadership team relied heavily on the Lean Care Department, a group within Atrius Health dedicated to using Lean principles to optimize workflows and improve organizational efficiency. The Lean Care Department helped the core leadership team to define the reason for action, use metrics to describe the current state of care, identify gaps and solutions, and develop a one-year project plan. Additionally, the core leadership team formed a steering committee that was instrumental in driving the timeline of the project and holding team members accountable to complete their tasks. This steering committee included members of the core leadership team, two behavioral health chiefs, an internal medicine physician, and a senior practice administrator. Finally, as described below, Atrius Health clinicians drove the development of the evidence-based guidelines.

CARE MODEL PRONG 1: TRIAGE AND REFERRAL PROCESS

The first prong of the model is the triage and referral process. This process begins with the patient seeking behavioral health care services, either through discussions with their primary care physician or by patients reaching out to the Behavioral Health Department on their own. Medical secretaries schedule a 20-minute telephone encounter between each new patient and a clinician. The clinician completes a brief assessment that includes questions about the patient’s history of behavioral health issues (for example, hospitalizations, suicide attempts, suicidal thoughts, or substance abuse) and past utilization of behavioral health services. Following each call, clinicians rank the patients by severity.

At each site, the clinicians meet weekly to review the list of patients who have been evaluated but not yet assigned to a therapist. The clinicians, led by the triage team leader, review the list and decide which patients to retain within the department based on the severity ranking, current therapist capacity, and their clinical judgement. As of June 2016, Atrius Health retains approximately 40 percent of new patients and refers the remaining, less-complex patients to community providers.⁴

If a patient is referred to a community provider, the Atrius Health staff faxes a referral letter to the provider and informs the patient that a referral has been made. The community provider takes responsibility for contacting the patient to schedule an appointment. Appendix 1 maps a patient’s journey within the care delivery site, including referral to a community provider.

⁴ Data on percent of new patients retained by the Behavioral Health Department provided by Atrius Health in June 2016.

Key staff in the Atrius Health behavioral health care transformation process:

Project leadership team: Central team that led development and implementation of new behavioral health model includes the specialty director (Jacob Kagan), the specialty administrator (Michael Macina), the director of innovation and informatics (Sam Nordberg), and the project manager (Andrea Jacobs).

Chief: The chief is responsible for all clinical processes at the location and is the lead clinician at each Atrius Health behavioral health site.

Principles of care champion: The therapist at each site who is responsible for applying the principles of care, leading the weekly case conferences, and providing guidance.

Triage team leader: The therapist who leads the weekly triage review meetings.

Clinician: May include licensed clinical social workers, nurse practitioners, Ph.D. therapists, and psychiatrists.

Developing partnerships with community providers

To expand the network of behavioral health therapists, the chief at each site was required to develop two to three community provider relationships. Most sites solicited recommendations from Atrius Health clinicians and patients about behavioral health therapists in the surrounding areas. The core leadership team then vetted potential community providers to ensure they were willing to accept referrals from Atrius Health, agree to the terms of the partnership, and maintain ongoing communication with Atrius Health. Dr. Kagan characterized the partnerships as a “flexible, ongoing, [and] changing network.”

The project leadership team drafted the letter of agreement governing the partnerships in collaboration with the contracts and legal department. The letter is a non-binding agreement that defines the basic expectations of the relationship, including frequency of communication, problem solving, and patient access requirements. The chiefs use the letter of agreement as a conversation starter with potential community providers. Once a partnership is underway, if a community provider fails to provide services according to Atrius Health’s standards, Atrius Health ends the partnership. Atrius Health is currently developing an outcomes tool that would use standard metrics to determine which providers are delivering quality services and attaining positive outcomes.

Atrius Health has found that community providers are very receptive to partnering with Atrius Health, because they can anticipate a stable number of referrals. A few community providers have agreed to hire additional personnel to increase their capacity if needed.

Future refinements

Atrius Health continues to refine the triage process. Currently, the team is developing a process for closing the loop for external referrals to ensure the patient has made an appointment and started treatment with the community provider. Developing this follow-up process was considered a less urgent priority since these individuals are typically higher-functioning patients. For patients whom Atrius Health retains, the primary care provider is able to access the therapy notes through the shared medical record.

CARE MODEL PRONG 2: EVIDENCE-BASED GUIDELINES

The second prong of the model is a series of evidence-based guidelines that aid in the development of treatment plans that are tailored to the needs of each patient. The guidelines were developed internally by a group of 60 Atrius Health clinicians with the goal of promoting a cultural shift to consistent, solution-oriented care delivery that is based on peer-reviewed literature.

The guidelines address 12 disorder areas (see Appendix 2), aggregated by Atrius Health clinicians, such as complex depression and chronic post-traumatic stress disorder. For each disorder area, the workgroup came to consensus on patient characteristics and symptoms at the beginning of treatment and what successful treatment would look like for the patient. They also reviewed the literature to determine the effective components of treatment. The workgroup identified several principles of care that underpin a range of therapy models (Barlow et al., 2010; Castonguay & Beutler, 2006), such as the importance of forming a “therapeutic alliance” between the clinician and the patient that includes trust, shared goals, and mutual agreement on the therapy approach. Members of the core leadership team collated these principles of care and organized them into a cohesive document. Atrius Health contracted with James Boswell, Assistant Professor at SUNY Albany, who has expertise in the principles of therapeutic change and the unified treatment protocol to review the document and provide feedback.

The evidence-based guidelines include the following components:

- Principles of care
- Active agents of change
- Types of services that may be appropriate for a given condition (e.g., goal-oriented weekly therapy, group therapy, care facilitators)
- Expected duration of treatment
- Other services needed
- Measureable outcomes

The evidence-based guidelines contain principles of care across multiple disorders. Each patient's treatment plan drives the therapy process and is a living document that is owned by the patient and clinician. Although clinicians are not required to follow the guidelines, they are asked to document an exception process when they have determined that it is clinically appropriate to deviate from the guidelines. The goal of the exception process is not to obtain approval but to capture the themes and patterns of each case in order to improve the guidelines in a continuous quality improvement manner.

Clinicians at each site participate in weekly case conferences, led by the principles of care champion, a clinician who is responsible for applying the principles of care at the site. During the case conferences, the group reviews active patients and discusses issues related to discharge planning and patients who are not responding to treatment. The principles of care guide the discussion about whether patients are meeting treatment goals. Based on these discussions the clinician decides how to address the patient's continued needs.

Developing evidence-based guidelines through a collaborative process

To carry out their work, the group of 60 clinicians charged with developing the guidelines for each of the 12 disorder areas formed a series of work groups and held meetings over a course of nine months. In developing the guidelines, each work group considered the following questions:

- What resources are needed to take care of the population?
- What are the principles of care for these patients?
- What would it mean for a patient with this diagnosis to improve?
- What core concepts should be the focus of therapy?

For each guideline, the work groups were instructed to develop the patient's start and end goals as discussed above, review the literature for the agents of change, and develop the standards of care that clinicians can use in tailored treatment plans with patients.

The guidelines, which took approximately 250 hours to develop, are considered living documents. Clinicians document exceptions (as discussed above) and request amendments to the guidelines on an ongoing basis. A committee of clinicians meets twice per year to review and revise the guidelines based on patterns observed in the exceptions documentation and amendment requests. The department has a review-and-ratification process to accept and disseminate the updates. The guidelines are available to all clinicians through a common "shareplace" website.

PROMOTING THE ADOPTION OF THE MODEL THROUGH PATIENT, CLINICIAN, AND STAFF ENGAGEMENT

Engaging staff throughout the development process—through the work groups to develop the principles-of-care guidelines and through the formation of the steering committee—was instrumental to getting widespread support and clinician and staff buy-in for the new model. The clinicians were implementing a model that they and their colleagues had a hand in creating. According to Dr. Kagan, despite significant engagement from staff in the development process, some clinicians found that the clinical work of the new care model, specifically highly-focused, often short-term therapy, was not suited to their therapeutic styles. Others found that they did not have the necessary training and/or skills to do the work, despite multiple training offerings. In this context, some clinicians have chosen to transition out of the practice, while new clinicians have been brought in to fill the need. While this has been a difficult period of transition, the practice is now more closely aligned with the department's strategic mission.

To ensure that frontline teams adopted and adhered to the new processes, Atrius Health developed a training program based on the principles of care. Atrius Health brought in trainers and requested that sites use their allocated continuing medical education and training funds to support the training effort. Each principles of care champion completed a training program consisting of three 8-hour sessions on the universal and specific diagnosis principles, the triage criteria, and the referral process. The champions then taught others at their individual care sites.

In addition to engaging its staff, Atrius Health also needed to help patients adjust to the new model. According to Dr. Kagan, some patients found the transition to a solution-oriented model of care difficult, as many had been seeing their therapists on an open-ended basis. Clinicians took care to work with patients throughout the transition, a process that often took six to nine months. One way clinicians supported patients during this transition was by leveraging treatment plans that are mandated by the Massachusetts Department of Health. Clinicians use these plans to determine with the patient the course of treatment and help patients understand the benefits of solution-oriented therapy or facilitate their transition to a community provider. For patients who initially refused the appropriate referral, Atrius Health worked to reiterate the importance of treatment and to provide the patient with heightened attention and empathy, in an effort to convince them to change their mind. In a number of cases if a patient struggled with the new plan or if the clinician determined the patient was too fragile to make the transition, Atrius Health continued to see the patient in an ongoing supportive manner, often monthly.

Figure 1
Change in average wait times for patients' initial appointment with clinician

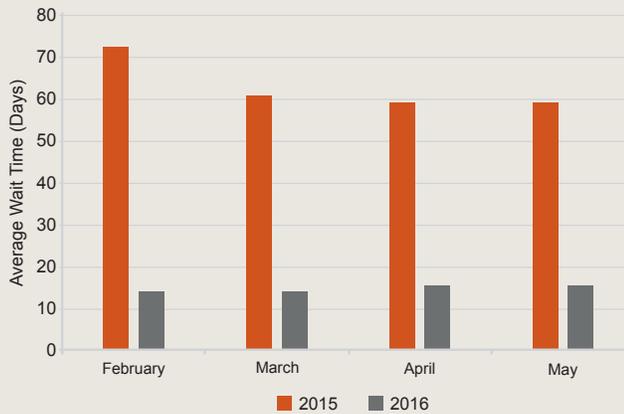
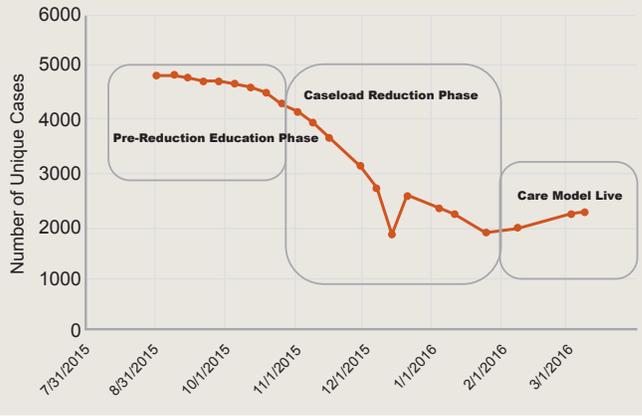


Figure 2
Overall reduction in the number of therapist cases across Atrius Health behavioral health department



RESULTS

Since launching the new behavioral health model in February 2016, Atrius Health developed several metrics to determine return on investment and project success, many of which are available to behavioral health team members through a scorecard that is updated weekly. Results to date show substantial improvements in wait times and clinician caseloads. Among the complex patients retained within the Atrius Health system, the new model increased access for these patients by decreasing the average wait time for therapist appointments from more than seven weeks to approximately 15 days (Figure 1). Therapists' caseloads have decreased substantially (Figure 2), increasing their capacity to see complex patients more frequently. Atrius Health also tracks other metrics through its scorecard, including the number of new patient slots per week, percentage referred to community providers, and number of discharges per week.

The overall impact of the new model is not yet known. Atrius Health recently partnered with the Heller School for Social Policy and Management at Brandeis University to measure the impact of the new behavioral health model on savings and other outcomes. They will focus on implementation science first and then evaluate total medical expense reduction. Data on changes in patient satisfaction are also currently unavailable due to low patient survey response rates.

LESSONS LEARNED

Atrius Health is in the early stages of implementing its behavioral health triage and referral process and using the evidence-based guidelines. Both aspects of the model will continue to evolve based on early insights from implementation. Lessons learned to date include:

- The triage and referral process highlights the importance of delivering the right treatment to the right patient at the right time. Early experience indicates that less clinically-complex patients can be seen successfully by community providers.
- Individual clinicians were resistant to changes in the care model, specifically the requirement to work towards ending therapy for their patients. Although some of these clinicians left Atrius Health, those who remained reported increased satisfaction.
- A small number of patients also found the transition to a solution-oriented model of care difficult. Existing patients who had been seeing a therapist on an open-ended basis before adoption of the new model often needed six to nine months to complete therapy or transition to a community provider. Clinicians adjusted the transition plan for a small number of patients who struggled with the change in treatment.

The transformation of behavioral health services at Atrius Health remains ongoing, and it is likely that some operational and clinical processes may take several years to optimize. Early implementation success appears to be the result of engaging numerous staff from within the Behavioral Health Department to develop evidence-based guidelines and implement the triage and referral process. Likewise, adoption of the triage and referral process and guidelines was accelerated because more than half of the clinicians in the department participated in the work groups to develop the principles of care. Dr. Kagan advises, “don't be afraid to innovate and roll something out that isn't perfect.”

ABOUT THE ACO LEARNING SYSTEMS PROJECT

This case study was prepared on behalf of CMS's Innovation Center by Elyse Pegler, Nikki McKoy, Ethan Jacobs, and Kate D'Anello of Mathematica Policy Research under the Learning Systems for ACOs contract (HHSM-500-2014-00034I/HHSM-500-T0006). CMS released this case study in September 2016. We are tremendously grateful to the many staff from Atrius Health for participating in this case study.

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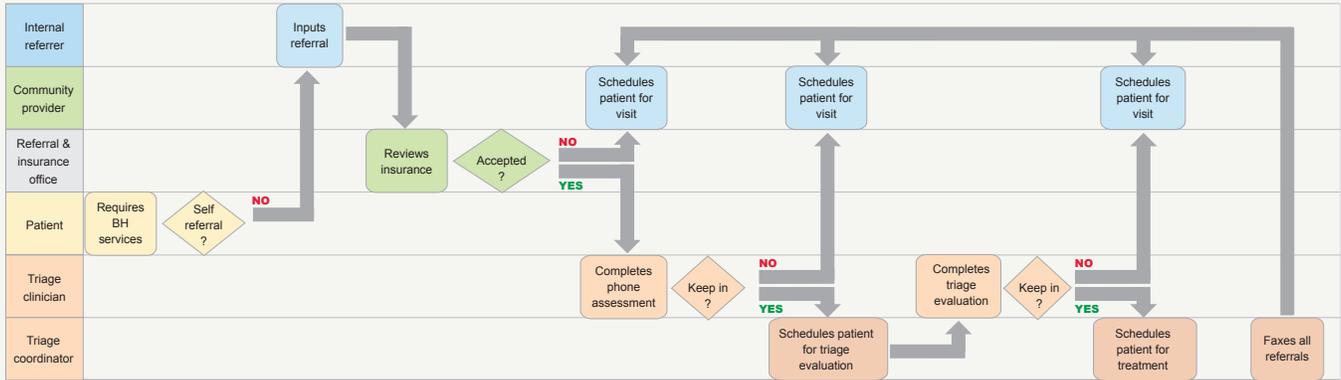
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For more information, contact the ACO Learning System at ACOLearningActivities@mathematica-mpr.com.

Appendix 1

Atrius Health’s behavioral health triage process

The image maps Atrius Health’s behavioral health (BH) triage process, starting with the initial referral to BH and ending with the scheduling of the patient for treatment either with an Atrius Health provider or a community provider.



Appendix 2

List of Atrius Health’s disorder areas for which work groups developed evidence-based guidelines

- Any Psychiatric Need with Associated Acute Medical Diagnoses
- Any Psychiatric Need with Associated Chronic Medical Diagnoses
- Insomnia
- Substance Use Disorders
- Eating Disorders
- Borderline Personality Disorder
- Dementia
- Simple Schizophrenia [typically compliant with medications, stable living situation, etc]
- Complex Anxiety [comorbidities present, particularly substance use, and/or medication resistant]
- Complex Depression [comorbidities present, particularly substance use, and/or medication resistant]
- Complex PTSD [typically chronic, often originating from childhood, comorbidities present, complex symptom presentations]
- Complex Bipolar Disorder [comorbidities present, particularly substance use, and/or medication resistant]