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Medical leadership for mind, brain and body.

APPLYING THE INTEGRATED CARE APPROACH:

INTEGRATING PRIMARY CARE AND BEHAVIORAL HEALTH

LORI RANEY, MD

FUNDING ACKNOWLEDGEMENT

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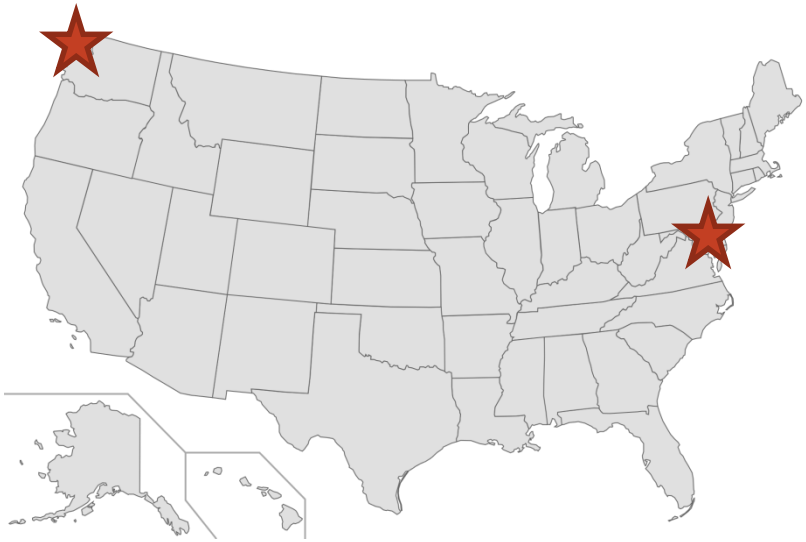

FACULTY DISCLOSURES: LORI RANEY, MD

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- Royalties: American Psychiatric Publishing for Integrated Care: Working at the Interface of Primary Care and Behavioral Health
- No pharmaceutical or device manufacturing funding
- No off-label discussion of pharmaceuticals

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TRANSFORMING CLINICAL PRACTICE INITIATIVE

APA Support and Alignment Network

TRANSFORMING CLINICAL PRACTICE INITIATIVE (TCPI)

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TCPi | Transforming Clinical Practices Initiative

In September 2015, the Centers for Medicare and Medicaid Services (CMS) awarded $685 million to 39 national and regional collaborative healthcare transformation networks (PTNs) and supporting organizations (SANs) for the Transforming Clinical Practice Initiative (TCPI).

TCPI supports practice transformation through nationwide, collaborative, and peer-based learning networks.

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Support and Alignment Networks (SANs)

- national and regional professional associations and public-private partnerships

Practice Transformation Networks (PTNs)

- large health systems

APA SAN

- Collaborative Care model – Integrating psychiatric care into primary care practices

- Psychiatrists with gain the clinical and leadership skills needed to support primary care practices

- Training includes:
  - Population health management
  - Use of registries and real-time clinical outcome data
  - Telephonic, tele-video, and caseload-focused psychiatric consultation methods
  - Skill development for coordinating with a primary care team
  - Use of evidence-based methods for managing patients with common mental disorders in primary care

INTEGRATION ENVIRONMENTAL DRIVERS

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ACA

- **Insurance Expansion**
- **Triple Aim Initiatives** – better outcomes, lower costs, better experience of care
  - Innovation Grants
    - Collaborative Care
    - Payment Structures
  - Behavioral Health Homes – SPAs
  - Expand CHC
  - Expand PBHCI

Other

- **CMS ACO** quality measures 6 are now for behavioral health – newest is depression remission at 12 mos
- **NCQA PCMH** – 2017 standards – "Advanced"
- **HEDIS** decision to phase in new depression outcome measures
- **CMS** – CCM new codes for CoCM
- **JCAHO** required quality measures as of 2011 on universal screening (tobacco, alcohol, and behavioral health)
- **MACRA**
  - MIPS
  - Alternative Payment Methods

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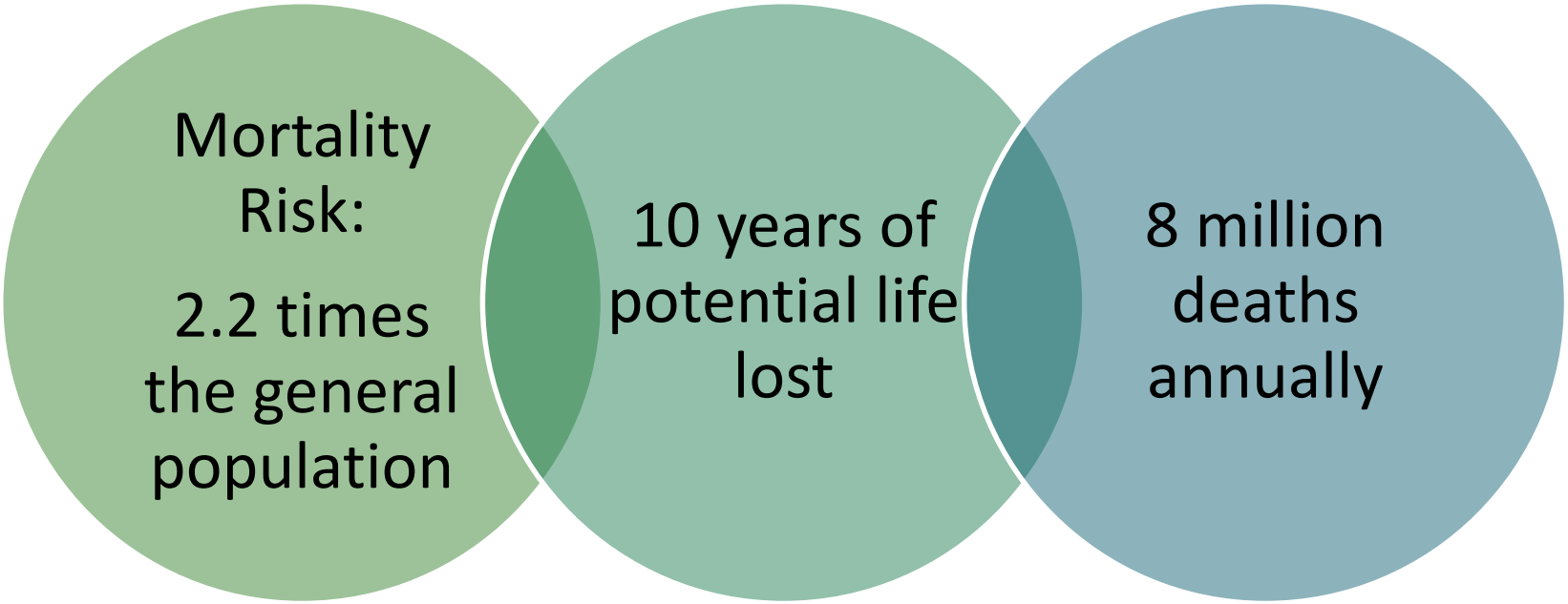
MENTAL ILLNESS AND MORTALITY



Walker, E.R., McGee, R.E., Druss, B.G. *JAMA Psychiatry.* Epub, doi:10.1001/jamapsychiatry.2014.2502

RATES OF NON-TREATMENT

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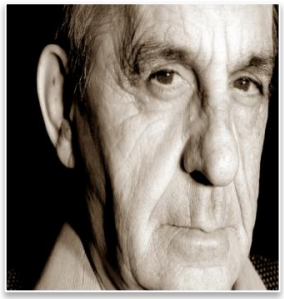
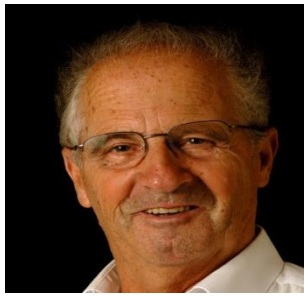
No Treatment



Wang P, et al., Twelve-Month Use of Mental Health Services in the United States, Arch Gen Psychiatry, 62, June 2005

Primary Care Provider




Mental Health Provider (Psychiatrist and therapists)

ANNUAL PER PERSON COST OF CARE

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COMMON CHRONIC MEDICAL ILLNESSES WITH COMORBID MENTAL CONDITION

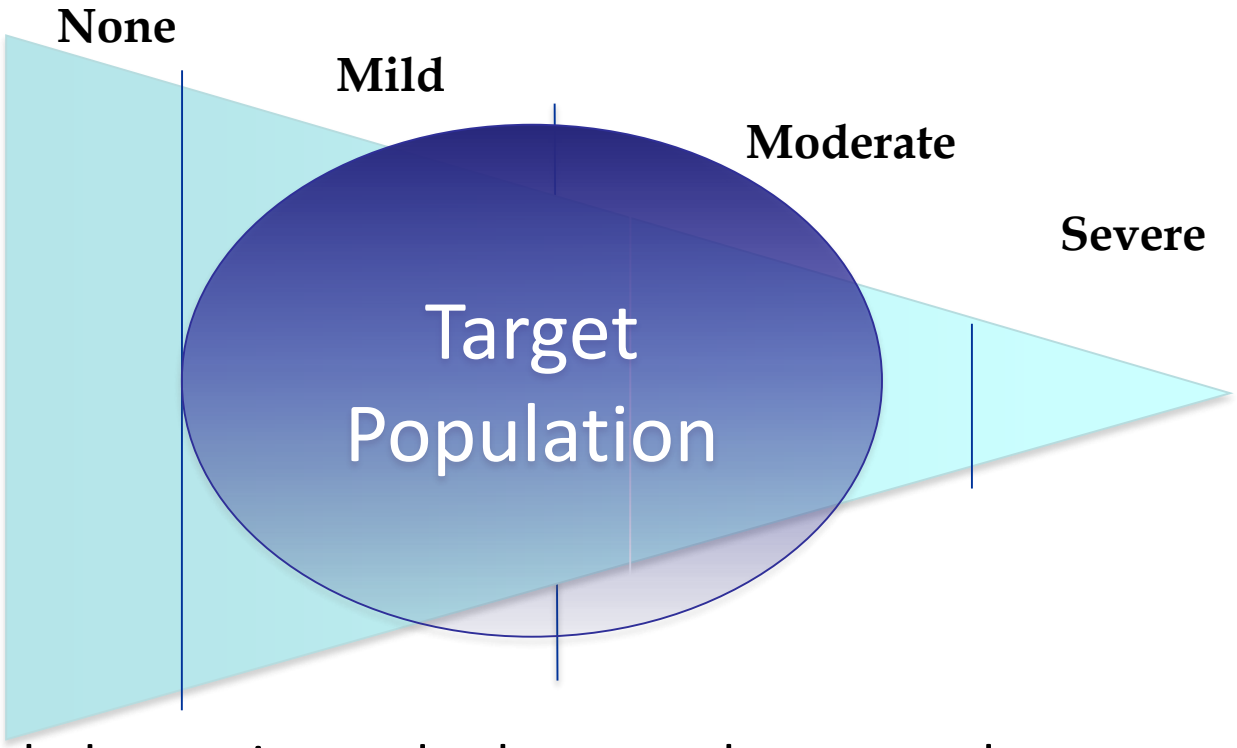
"VALUE ADDED OPPORTUNITIES"

Patient Groups	Annual Cost of Care	Illness Prevalence	% with Comorbid Mental Condition*	Annual Cost with Mental Condition	% Increase with Mental Condition
All Insured	$2,920		10%-15%		
Arthritis	$5,220	6.6%	36%	$10,710	94%
Asthma	$3,730	5.9%	35%	$10,030	169%
Cancer	$11,650	4.3%	37%	$18,870	62%
Diabetes	$5,480	8.9%	30%	$12,280	124%
CHF	$9,770	1.3%	40%	$17,200	76%
Migraine	$4,340	8.2%	43%	$10,810	149%
COPD	$3,840	8.2%	38%	$10,980	186%

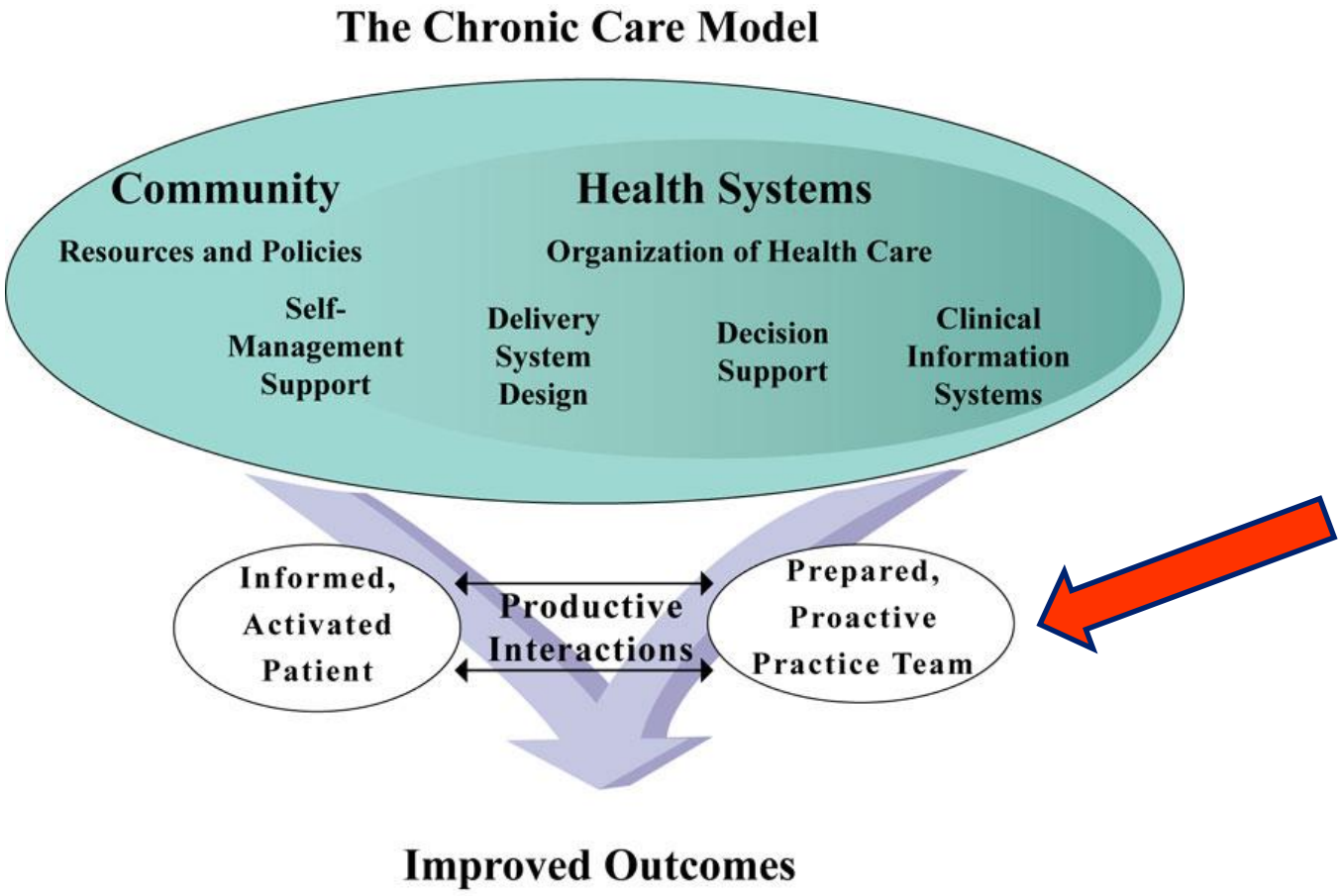
**Melek S et al APA 2013 www.psych.org

Cartesian Solutions, Inc.™--consolidated health plan claims data

"SWEET" SPOT FOR THE COLLABORATIVE CARE MODEL



- 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



PRINCIPLES OF COLLABORATIVE CARE

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Population-Based Care

Measurement-Based Treatment to Target

Patient-Centered Collaboration

Evidence-Based Care

Accountable Care

Principles © University of Washington

PCBHI MODEL – "BHC OR CHEROKEE MODEL"

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- Team-driven collaboration that is patient-centered
- Immediate access in primary care
- Practice-tested, limited evidence-base
  - Mental health and substance use disorders
  - Health behaviors
  - Life stressors
  - Crises
  - Stress-related physical symptoms
  - Ineffective patterns of health care utilization
- Evidence-based behavioral interventions
- Typically not measurement guided - no regular repeat PHQ9, etc
- Do not track with registry as a standard practice
- No caseload review with psychiatric provider to address patients who are not progressing, provide medication recommendations to PCP, etc

BLENDED MODEL - BEST OF BOTH

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- ***T*eam-driven collaboration that is patient-centered**
- ***E*vidence-based, practice-tested - immediate access in primary care**
  - **Mental health and substance use disorders**
  - **Health behaviors, life stressors, crises, stress-related physical symptoms, ineffective patterns of health care utilization**
  - **Evidence-based behavioral interventions**
- ***M*easurement guided - standardized repeat PHQ9, etc**
- ***P*opulation- based**
  - **Track with registry as a standard practice**
  - **Caseload review with psychiatric provider to address patients who are not progressing, provide medication recommendations to PCP**

PRINCIPLE: **PATIENT-CENTERED COLLABORATION**

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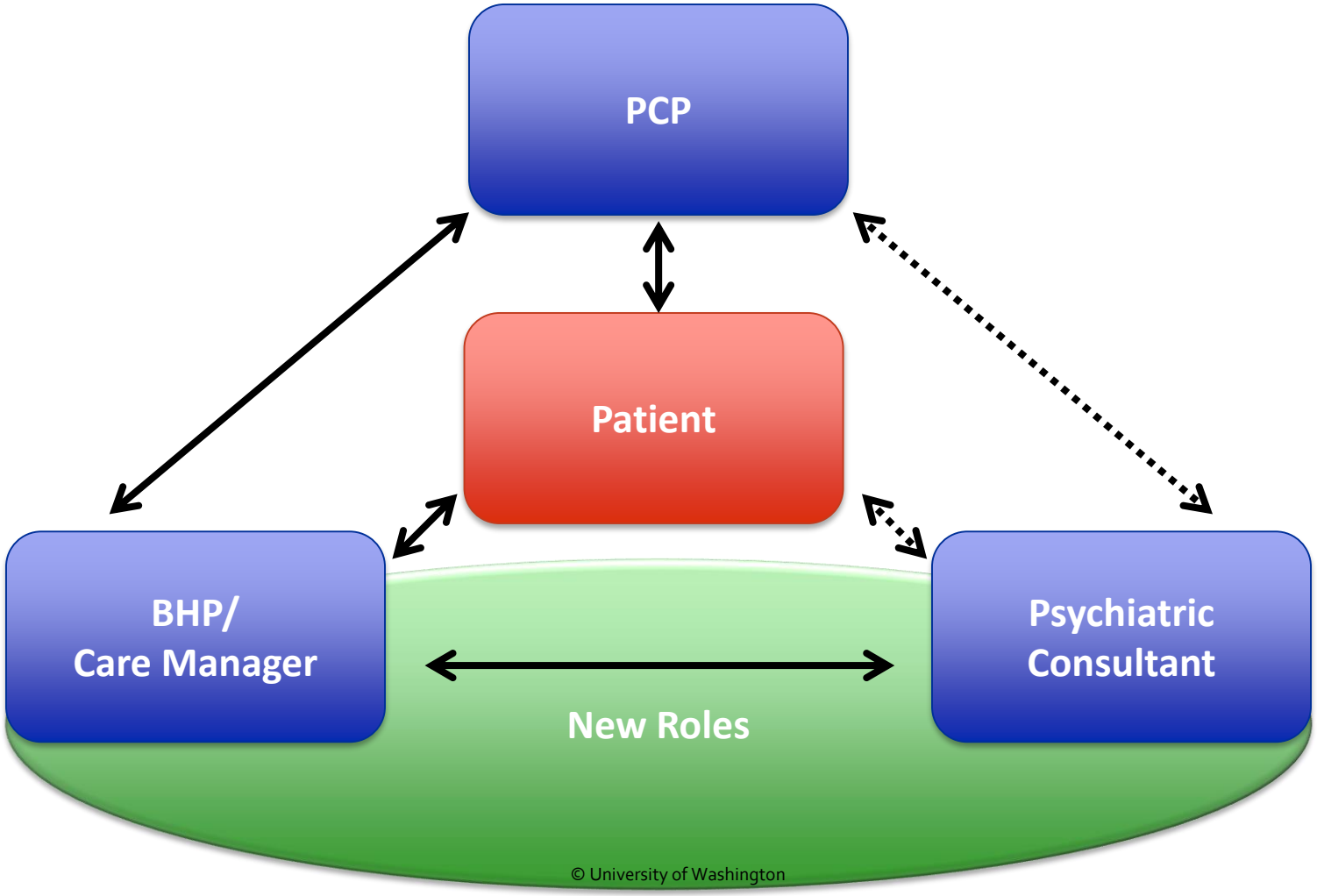
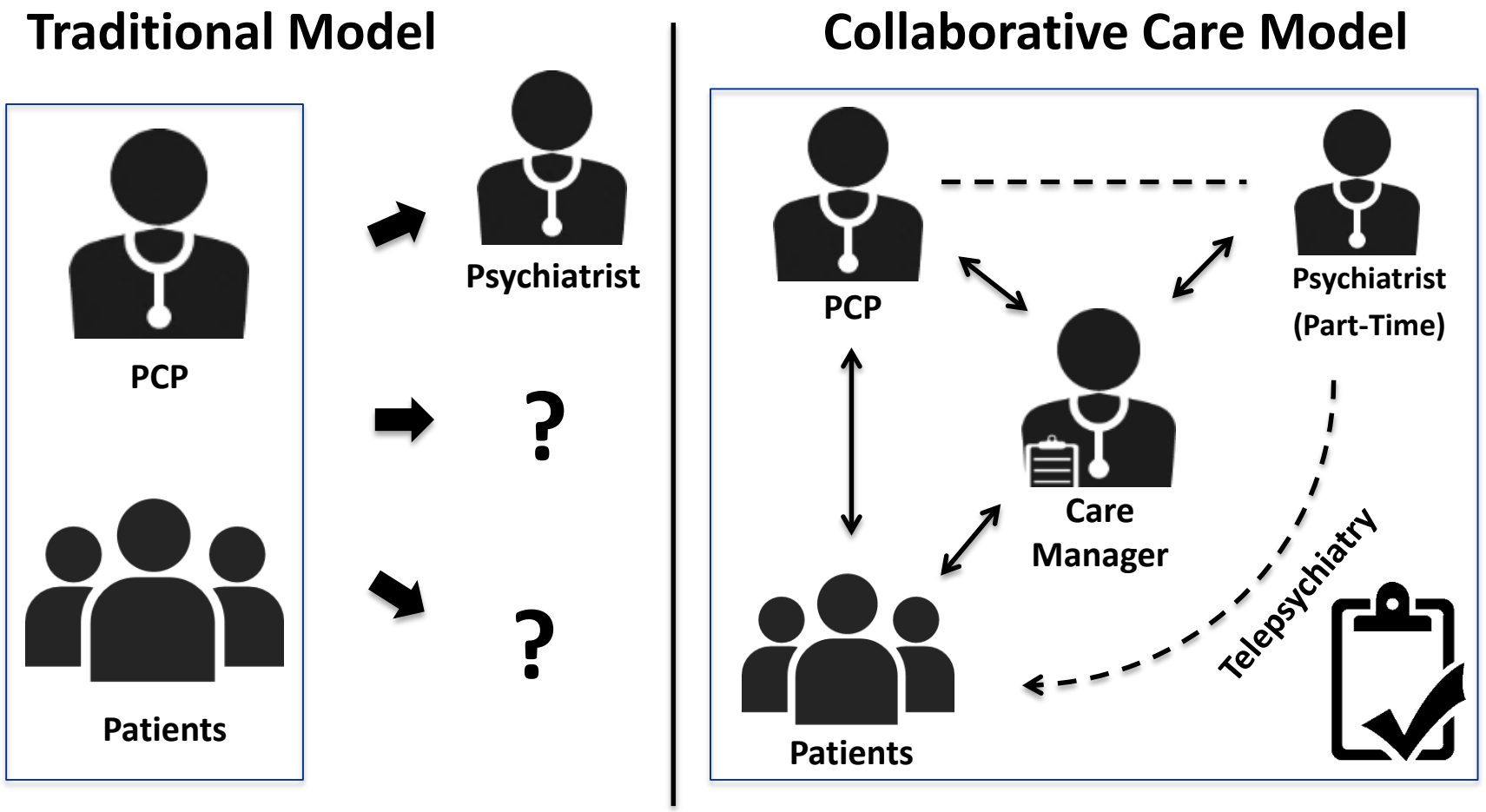


TRADITIONAL MODEL VS. COLLABORATIVE CARE MODEL



THE COLLABORATIVE CARE MODEL

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Informed, Activated Patient

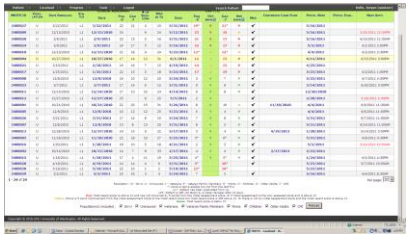
Effective Collaboration

PRACTICE SUPPORT

PCP supported by Behavioral Health Care Manager

Measurement-guided Treat to Target

Psychiatric Consultation



Caseload-focused Registry review

Training

DOUBLES EFFECTIVENESS OF CARE FOR DEPRESSION

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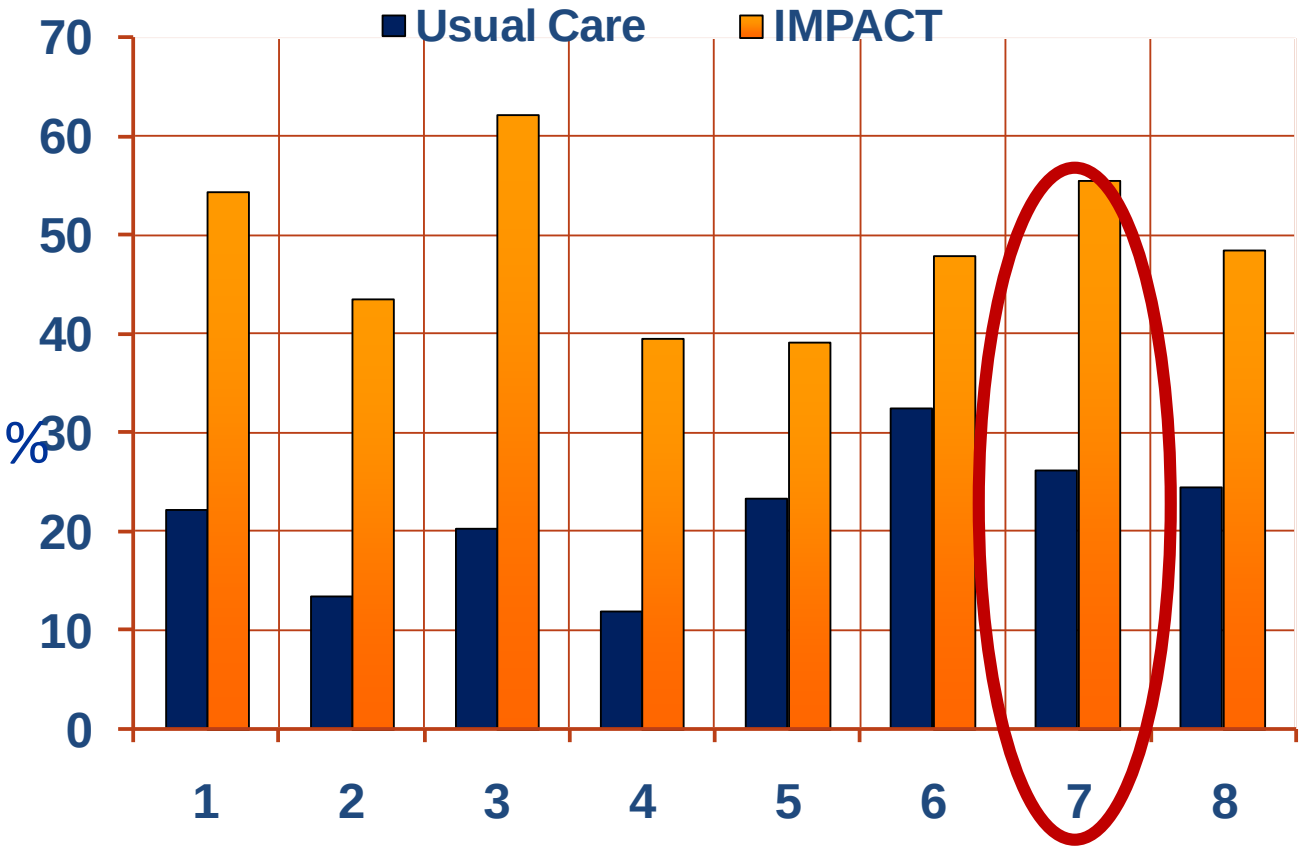
50 % or greater improvement in depression at 12 months



Co-located Therapist

Participating Organizations

IMPACT

Unützer, Katon et al., JAMA 2002

COLLABORATIVE CARE: THE RESEARCH EVIDENCE

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- Now over 80 Randomized Controlled Trials (RCTs)
  - Meta analysis of Collaborative Care (CC) for depression in primary care (US and Europe)

Collaborative care is consistently more effective than care as usual.

Archer, J. et al., 2012

HOW WELL DOES IT WORK WITH OTHER DISORDERS?

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Evidence Base Established	Emerging Evidence

• Depression
  - Adolescent Depression
  - Depression, Diabetes, and Heart Disease
  - Depression and Cancer
  - Depression in Women's Health Care
• Anxiety
• Post Traumatic Stress Disorder
• Chronic Pain
• Dementia
	• Substance Use Disorders
	• ADHD
	• Bipolar Disorder

BUSINESS CASE: REDUCES HEALTH CARE COSTS

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Cost Category	4-year costs in $	Intervention group cost in $	Usual care group cost in $	Difference in $
IMPACT program cost		522	0	522
Outpatient mental health costs	661	558	767	-210
Pharmacy costs	7,284	6,942	7,636	-694
Other outpatient costs	14,306	14,160	14,456	-296
Inpatient medical costs	8,452	7,179	9,757	-2578
Inpatient mental health / substance abuse costs	114	61	169	-108
Total health care cost	**31,082**	29,422	32,785	**-$3363**

Savings

ROI
$6 : $1

Unützer et al., *Am J Managed Care 2008.*

EVOLUTION OF THE MODEL: TEAMCARE MULTI-CONDITION COLLABORATIVE CARE

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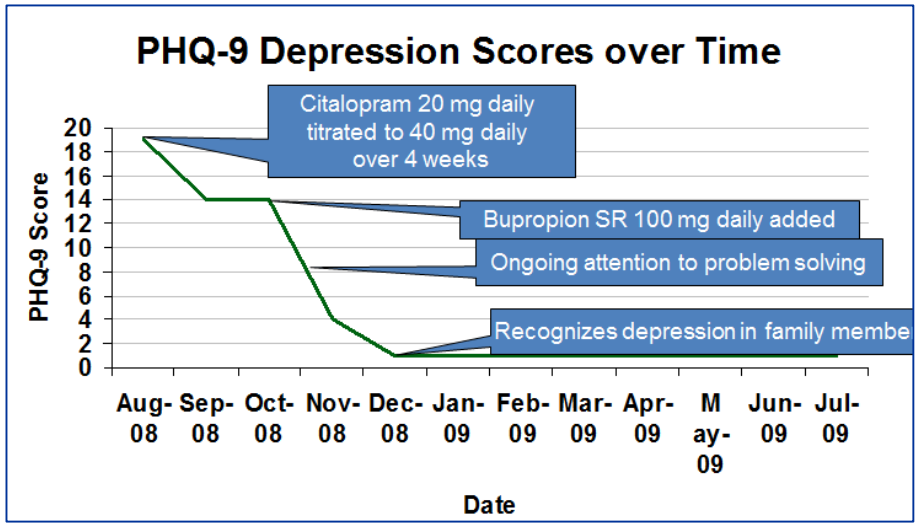
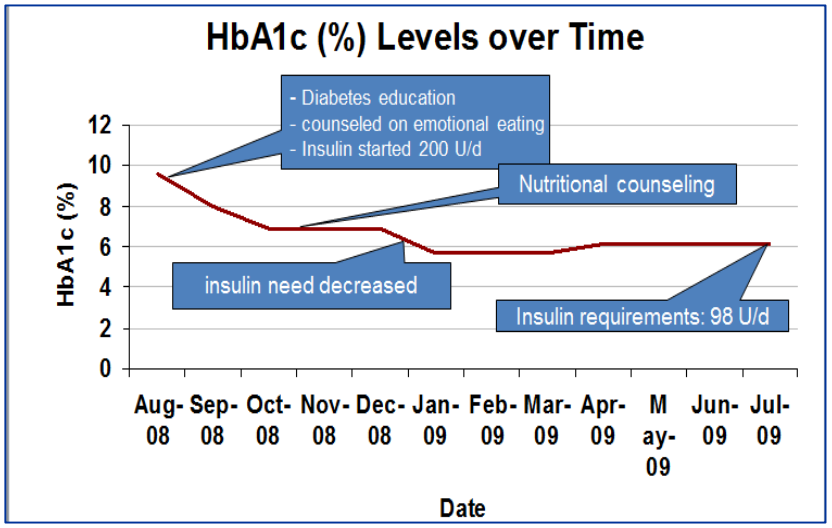




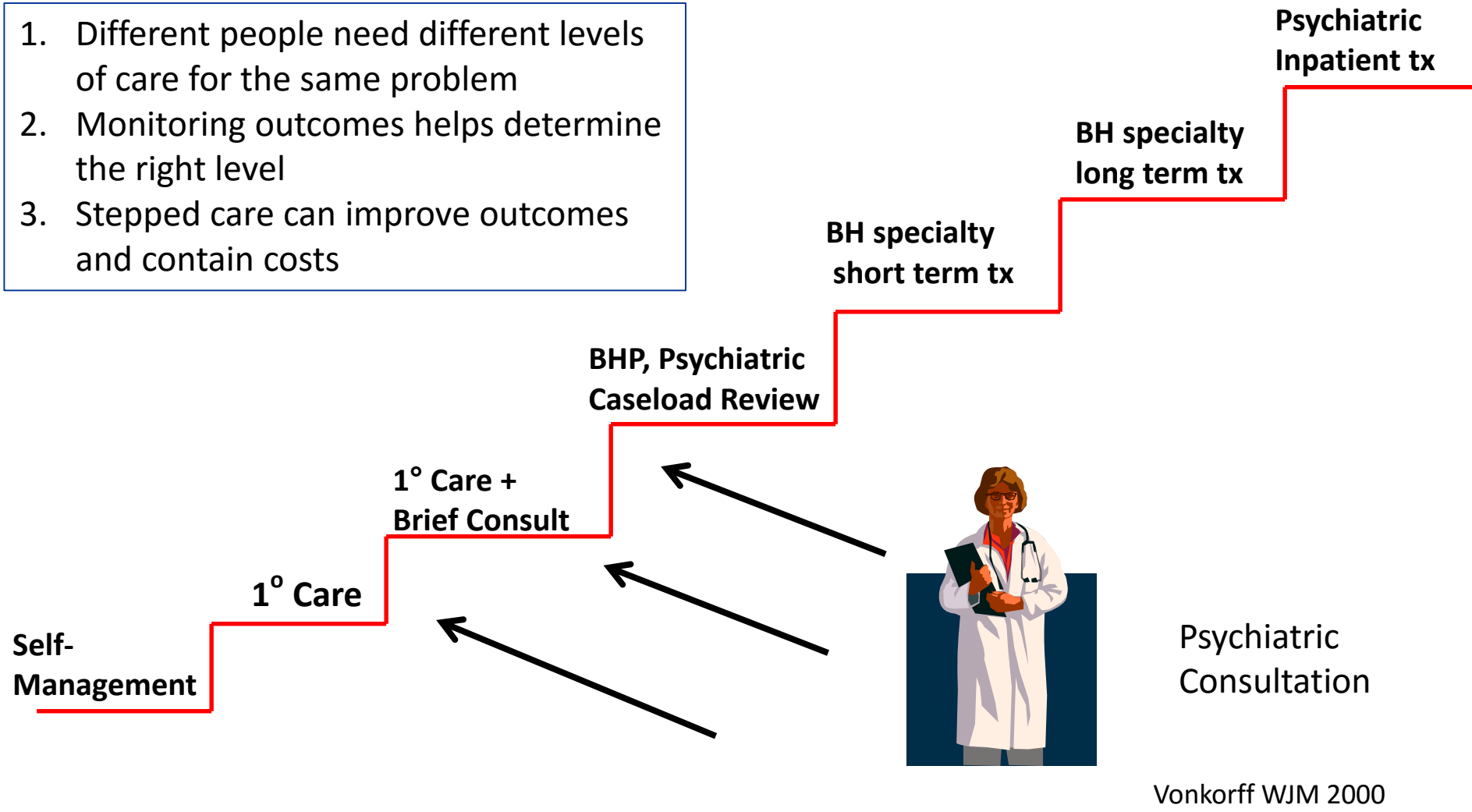
- **diabetes nurse educators**
- **Caseload supervision**
  - **Depression: psychiatrist**
  - **Diabetes and CAD: family doctor**
  - **E-Mail to diabetologist for complex cases**

Cost Savings
$600-1100/pt

Katon et al NEJM 2010, Katon et al Archives of General Psychiatry 69 (5), 2013

STEPPED CARE APPROACH

1. Different people need different levels of care for the same problem
2. Monitoring outcomes helps determine the right level
3. Stepped care can improve outcomes and contain costs



Vonkorff WJM 2000

COLLABORATIVE CARE: CORE COMPONENTS AND TASKS

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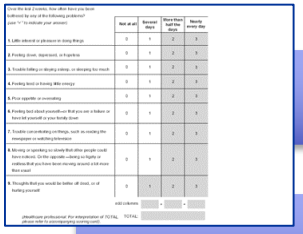

Patient Identification and Diagnosis

Engagement in Integrated Care Program

Evidence Based Treatment

Systematic Follow-up, Treatment Adjustment, Relapse Prevention

Communication, Care coordination and Referrals

Systematic Case Review and Psychiatric Consultation

Program Oversight and Quality Improvement

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PHQ-9

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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)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	✓	3
2. Feeling down, depressed, or hopeless	0	✓	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	✓	3
4. Feeling tired or having little energy	0	1	2	✓
5. Poor appetite or overeating	0	✓	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	✓	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	✓	3
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	0	1	✓	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	✓	1	2	3
add columns:		2	+ 10	+ 3
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:			15	

SAMPLE

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 – none/remission
- 5 - mild
- 10 - moderate
- 15- moderate severe
- 20 - severe

www.uspreventiveservicestaskforce.org

ROLES OF PRIMARY CARE PROVIDER

- ***IDENTIFY*** individuals who need BH support and ***ENGAGE*** them in the treatment model
- Willing to prescribe medications for behavioral health
- Collaborate and consult with BHP and Psychiatric prescriber to enhance BH Care
  - WARM HAND OFFS
- Utilize screening tools to track progress (e.g., PHQ-9)

PCPS - MUST HAVE BUY-IN

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Before Implementation	After 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	• This takes a load off my plate • This speeds me up • I always want to practice like this • I am giving better care to may 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

BHPS/CARE MANAGERS- HIRE THE RIGHT PERSON

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Who are the BHPs/CMs?

- Typically MSW, LCSW, PhD, PsyD, RN – could be MA, CHW
- Variable clinical experience
- Need brief intervention skills – BA, MI, PST, SFBT, DTS
- Health Behavior Change Experts

What makes a good BHP/CM?

- Organization
- Persistence- tenacity
- Creativity and flexibility
- Strong patient advocate
- Willingness to be interrupted
- Ability to work in a team

CAUTION:
Prefer traditional approach to therapy
Not willing to be interrupted
Timid, insecure about skills

EVIDENCE-BASED BRIEF INTERVENTIONS

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- Motivational Interviewing
- Distress Tolerance Skills
- Behavioral Activation
- Problem Solving Therapy

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EXPERTS IN BEHAVIOR CHANGE

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REGISTRIES TO TRACK PROGRESS

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Caseload Overview

			Treatment Status				PHQ-9				GAD-7				Psychiatric Consultation	
			! Indicates that the most recent contact was over 2 months (60 days) ago				✓ Indicates that the PHQ-9 score is at target (less than 5 or 50% decrease from initial score) ! Indicates that the last available PHQ-9 score is more than 30 days old				✓ Indicates that the last available GAD-7 score is at target (less than 10 or 50% decrease from initial score) ! Indicates that the last available GAD-7 score is more than 30 days old					
View Record	Treatment Status	Name	Date of Initial Assessment	Date of Most Recent Contact	Number of Follow-up Contacts	Weeks in Treatment	Initial PHQ-9 Score	Last Available PHQ-9 Score	% Change in PHQ-9 Score	Date of Last PHQ-9 Score	Initial GAD-7 Score	Last Available GAD-7 Score	% Change in GAD-7 Score	Date of Last GAD-7 Score	Flag	Most Recent Psychiatric Consultant Note
View	Active	Susan Test	9/5/2015	2/23/2016	10	26	22	14	-36%	2/23/2016	18	17	-6%	! 1/23/2016	Flag for discussion & safety risk	1/27/2016
View	Active	Albert Smith	8/13/2015	! 12/2/2015	7	29	18	17	-6%	! 12/2/2015	14	10	-29%	! 12/2/2015	Flag for discussion	
View	Active	Joe Smith	11/30/2015	2/28/2016	6	14	14	10	-29%	2/28/2016	10	✓ 6	-40%	2/28/2016	Flag for discussion	2/26/2016
View	Active	Bob Dolittle	1/5/2016	3/1/2016	3	9	21	19	-10%	3/1/2016	12	10	-17%	3/1/2016	Flag as safety risk	2/18/2016
View	Active	Nancy Fake	2/4/2016	2/4/2016	0	4	.	No Score			.	No Score				
View	RP	John Doe	9/15/2015	3/6/2016	10	25	20	✓ 2	✓ -90%	3/6/2016	14	✓ 3	✓ -79%	3/6/2016		2/20/2016

FREE UW AIMS Excel® Registry (https://aims.uw.edu/resource-library/patient-tracking-spreadsheet-example-data)

Allows proactive engagement (“no one falls through the cracks”) and treatment adjustment

PSYCHIATRY: CASELOAD CONSULTANT

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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 – may or may not implement

REGISTRIES TO TRACK: PHQ-9 MEASUREMENT TOOL

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Patient | Caseload | Program | Tools | Logout — Search Patient : — Hello, Jurgen (unutzer)

MHITS ID	Popu-lation	Date Enrolled	Sta-tus	Clinical Assessment			# of Sess-ions	Wks in Tx	Last PHQ						Continued Care Plan	Psych. Note	Psych. Eval.	Next Appt.
				Date	PHQ -9	GAD -7			Date	PHQ -9	Dep Impr	GAD -7	Anx Impr	Med				
3400027	U	3/22/2011	L1	3/22/2011	22	21	4	10	5/31/2011	19*		21*		✓		5/16/2011		
3400009	U	12/13/2010	L1	12/13/2010	24		9	24	5/12/2011	23		16		✓		5/16/2011		5/26/2011 12:30PM
3400020	U	2/9/2011	L1	2/9/2011	23	13	5	16	5/31/2011	21		17		✓		5/16/2011		6/14/2011 11:30AM
3400024	U	3/9/2011	L1	3/9/2011	24	17	5	12	5/16/2011	22		17		✓		5/2/2011		6/1/2011 2:00PM
3400010	U	12/13/2010	L1	12/13/2010	21	18	9	24	5/23/2011	12*		12*		✓		4/4/2011		6/2/2011 2:30PM
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3400017	U	1/25/2011	L1	1/25/2011	22	15	5	18	5/23/2011	17		19		✓		5/23/2011		6/2/2011 1:00PM
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3400007	U	12/8/2010	L1	12/8/2010	13	8	13	25	5/31/2011	8		2		✓		5/31/2011		6/14/2011 11:00AM
3400013	U	12/28/2010	L1	12/27/2010	19	15	9	22	5/17/2011	3		4		✓	4/19/2011	1/20/2011		6/14/2011 5:00PM
3400003	U	11/18/2010	L1	11/18/2010	22	18	10	27	5/25/2011	5*		8*		✓		5/31/2011		6/8/2011 4:30PM
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3400030	U	5/18/2011	L1	5/18/2011	22	10	1	2	5/19/2011	22*		10*				5/23/2011		
3400029	U	5/2/2011	L1	5/2/2011	24	16	3	4	5/24/2011	7		5		✓		5/16/2011		6/6/2011 8:30AM

AIMS Center: http://aims.uw.edu

MEASUREMENT-BASED CARE VERSUS STANDARD CARE FOR MAJOR DEPRESSION:

A RANDOMIZED CONTROLLED TRIAL WITH BLIND RATERS

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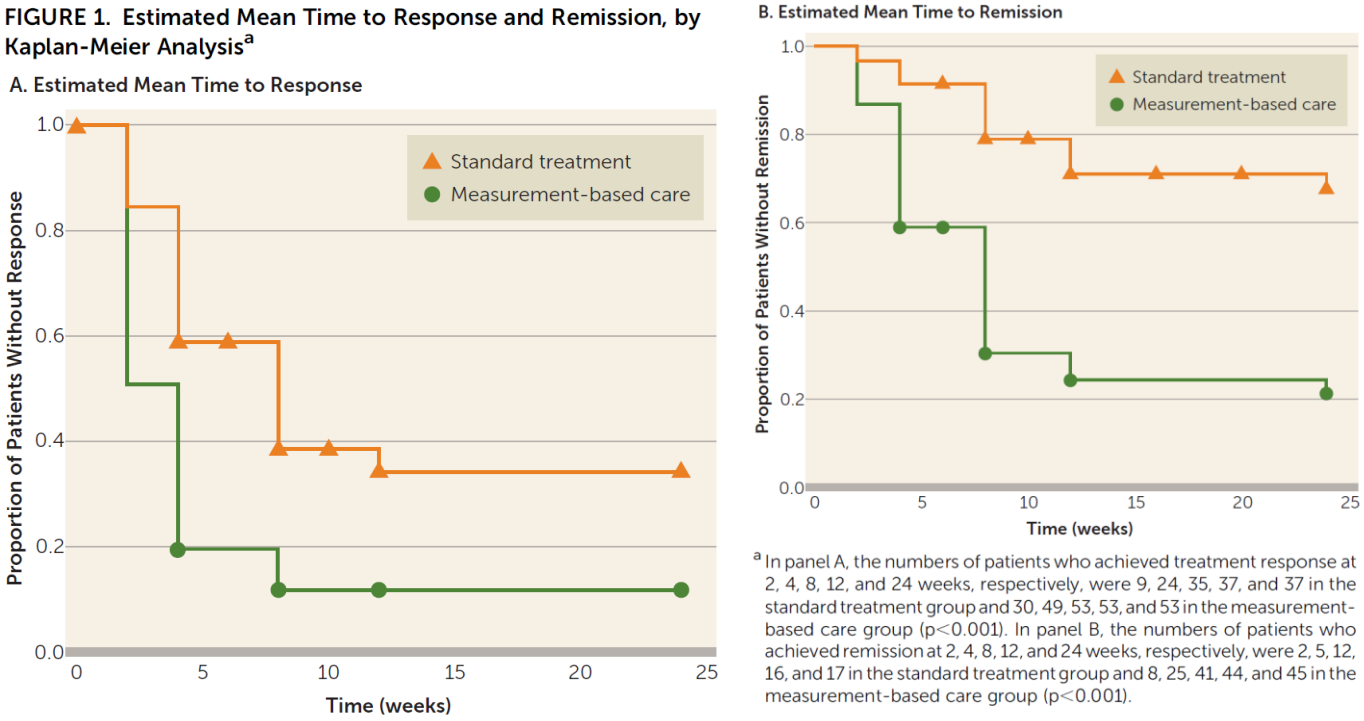
FIGURE 1. Estimated Mean Time to Response and Remission, by Kaplan-Meier Analysis[a]



[a] In panel A, the numbers of patients who achieved treatment response at 2, 4, 8, 12, and 24 weeks, respectively, were 9, 24, 35, 37, and 37 in the standard treatment group and 30, 49, 53, 53, and 53 in the measurement-based care group ($p<0.001$). In panel B, the numbers of patients who achieved remission at 2, 4, 8, 12, and 24 weeks, respectively, were 2, 5, 12, 16, and 17 in the standard treatment group and 8, 25, 41, 44, and 45 in the measurement-based care group ($p<0.001$).

- 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

Quo T, Correll, et al. American Journal of Psychiatry, 172 (10), Oct, 2015

SAMPLE CONSULTATIONS ~ 30 MIN

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REASON FOR CONSULT	DIAGNOSIS	RECOMMENDATION
Side effects from lithium	BP 1	Switch to valproic acid
SE from lisdexamfetamine	ADHD	Try another per protocol
Lithium level is 1.2	BP 1	Continue unless having side effects
Inc depression symptoms	MDNOS	TSH, if normal start lamotrigine
Poss SE from quetiapine	BP 1/PD	Decrease Seroquel to 100 mg
Paroxetine not effective	MDD	Add bupropion
Regular lamotrigine or XR?	BP 2	No difference
Side effects with citalopram	MDD	Switch to bupropion
Depression symptoms increase	BP1	Check lithium level first, maximize if low, may need to add lamotrigine
Suicidal, acute distress	PD	Safety plan, DBT referral
High doses of meds, confused	MDD	Stop hydroxyzine, reduce lorazepam, call collateral
Anxious, wants alprazolam, nipple pain	GAD	No alprazolam, increase sertraline, coping skills

PSYCHIATRISTS SUPPORTING TEAMS

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Care Manager 4

Care Manager 1

Care Manager 3

Care Manager 2

50-80 patients/caseload
2-4 hrs pscyh/week/ care manager
= a lot of patients getting care

PSYCHIATRISTS BEST SUITED FOR THIS WORK

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- Flexible – expect the unexpected
- Adaptable - child and other populations
- Willing to tolerate interruptions
- Able to manage liability concerns
- Like teaching
- Enjoy being part of a team
- Willing to lead
- **Extending psychiatric expertise to a larger population

Blessed are the flexible for they shall not get bent out of shape.

CMS CODES FOR COCM: COMING JANUARY 2017

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GPPP1/GPPP2

- 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.

PERFORMANCE MEASURES

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- **Process Measures**
  - Percent of patients screened for depression
  - Percent follow-up within 2 weeks
  - Percent not improving that received case review and psychiatric recommendations
  - Percent with recommendation implemented by PCP
  - Percent not improving referred to specialty BH
- **Outcome Measures**
  - Percent with 50% reduction PHQ-9
  - Percent to remission 6 and 12 mos (PHQ-9 < 5) – NQF 0710/0711
- **Cost/Utilization Measures**
  - ED, Inpatient, Overall healthcare cost

TWO CULTURES, ONE PATIENT

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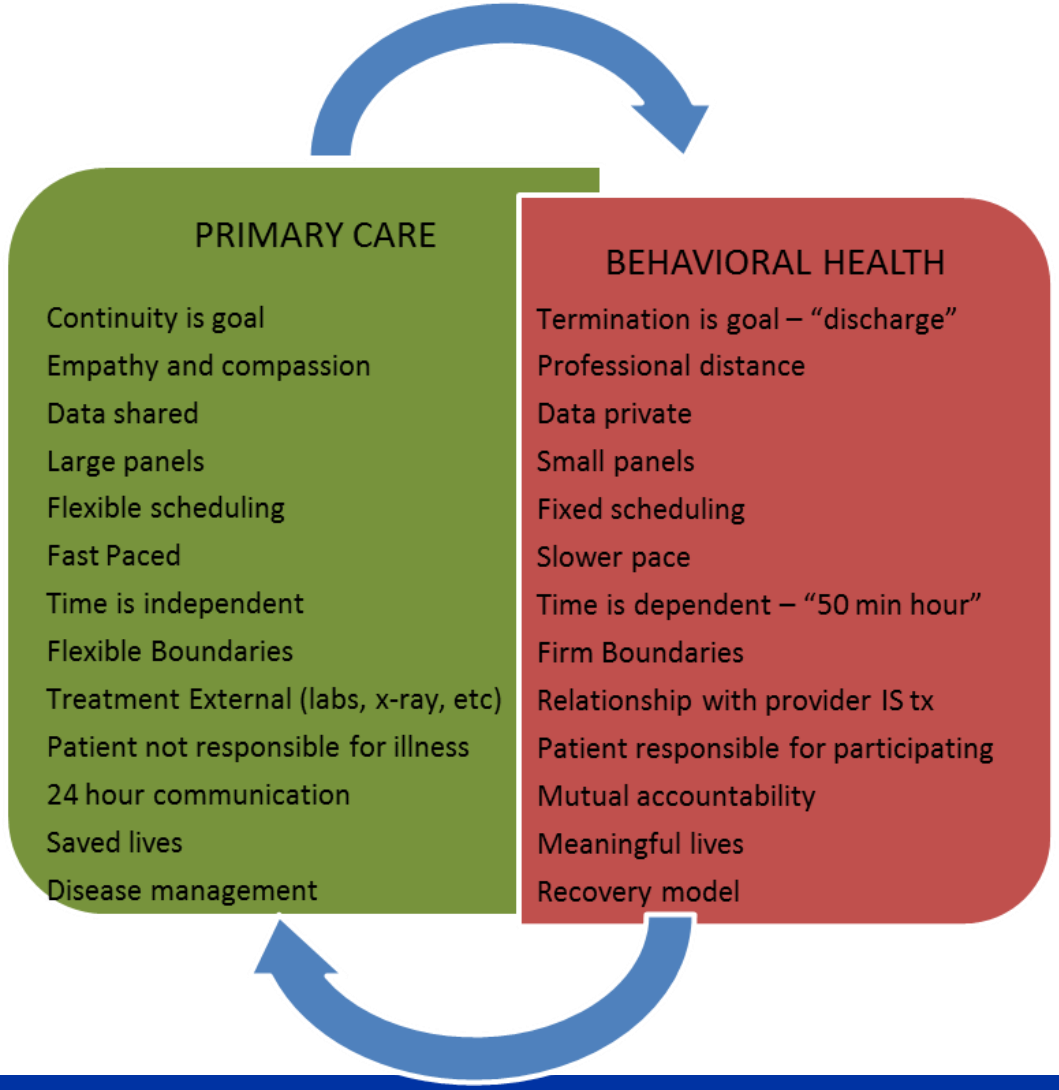
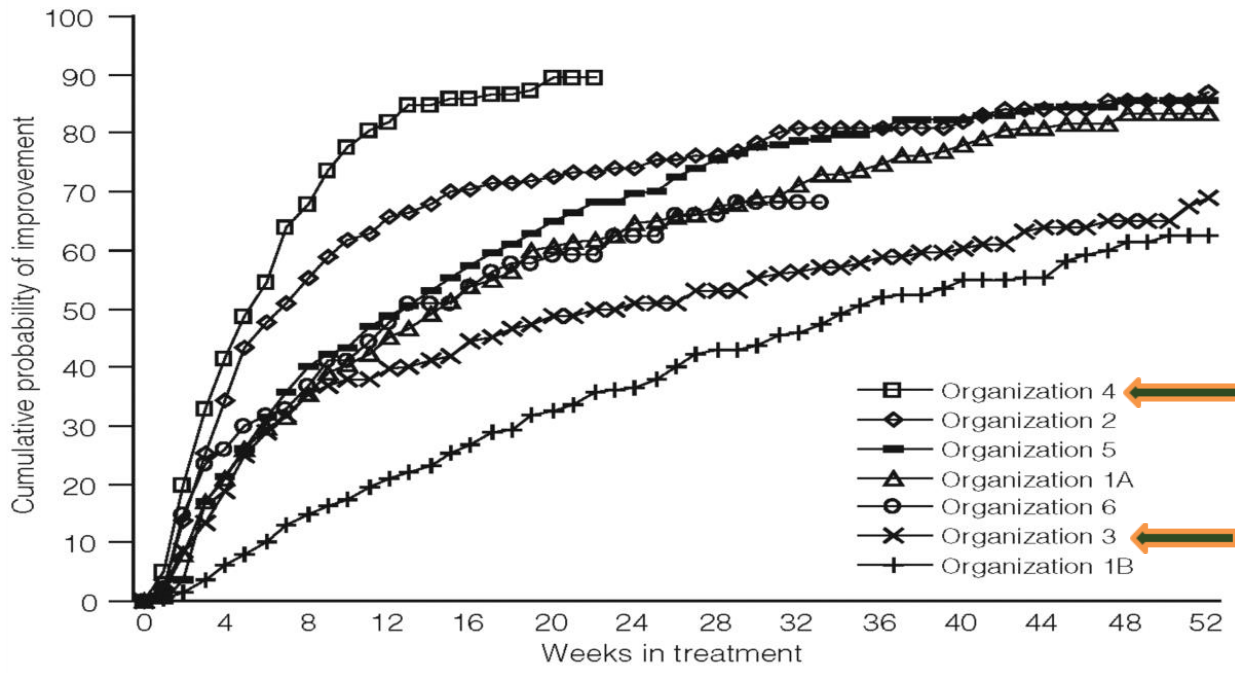


From: Implementation of Collaborative Depression Management at Community-Based Primary Care Clinics: An Evaluation

Psychiatric Services. 2011;62(9):1047-1053. doi:10.1176/appi.ps.62.9.1047

Figure 1

Estimated time elapsed between initial assessment and improvement of depression during the first year of treatment at six organizations[a]



[a] Estimates were truncated when ten or fewer patients remained in treatment at each site.

Figure Legend:

Estimated time elapsed between initial assessment and improvement of depression during the first year of treatment at six organizations

"SECRET SAUCE": TWO KEY AREAS OF EFFECTIVENESS

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Patient Activation and Engagement:

- Strong leadership support and a strong physician champion are essential for patient activation into the program.
- The more well defined and implemented the care manager role, the higher the rate of patient activation.

Patients Reaching Remission (PHQ-9 < 5):

- The more engaged a psychiatrist was and the more often in-person communication occurred, the more frequently patients experienced remission from their depression.
- The less likely a group experienced operating costs as a barrier, the more likely their patients were to experience remission.

Whitebird, et al. Am J Manag Care. 2014;20(9):699-707

"ENGAGED"

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- Do you/care managers *meet routinely with the psychiatrist* for the weekly 2 hour meetings?
- Is the psychiatrist *friendly and helpful* with your/cm review of patients in your caseload?
- Does he/she give *feedback, direction, suggestions* for both pharma and other therapeutic approaches to getting the patient to goal
- Do the *psychiatrist and PCP's ever connect*?
- If the PCP contacts the consulting psych in between the weekly sessions, does he/she typically *get back to the PCP in a timely manner?*
- Has the psychiatrist done any other types of *in-services or education sessions* for your PCPs, your care managers, and/or care teams?
- Do you have any concerns about the consulting psychiatrist working on your team?

Whitebird, et al. Am J Manag Care. 2014;20(9):699-707

RECIPE FOR SUCCESS

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- ***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, measure, measure response to treatment
  - 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

UTOPIA

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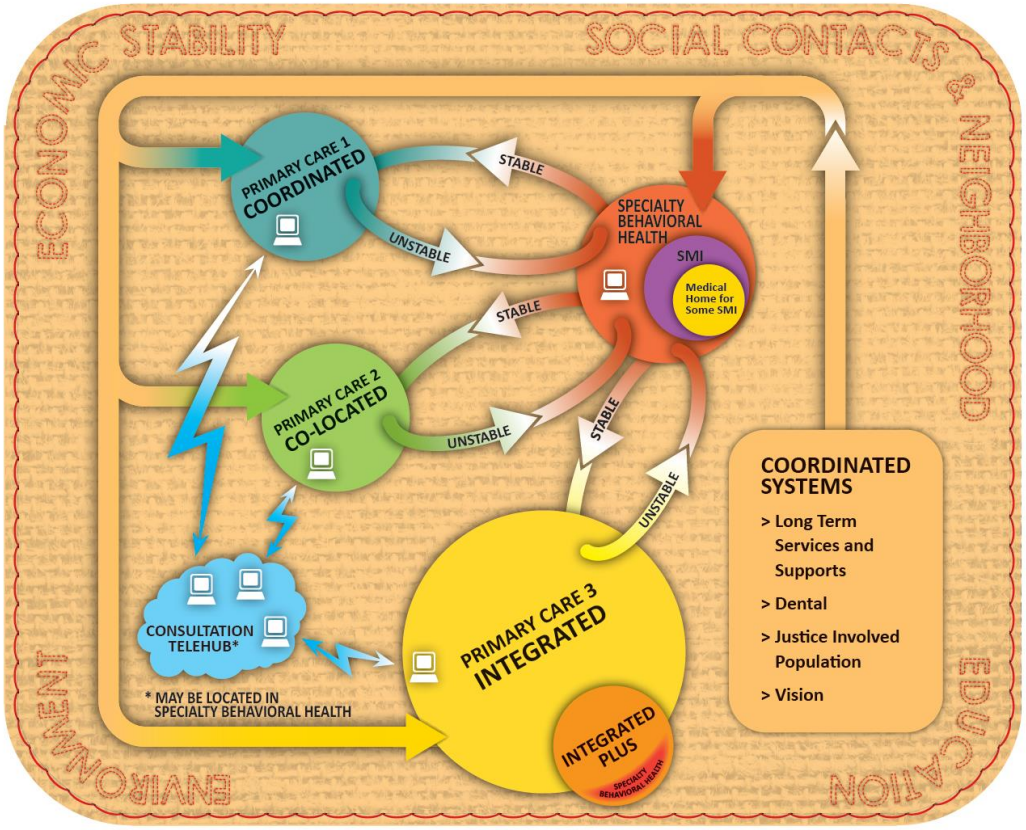
THE CYCLE OF COLLABORATIVE CARE



RESOURCES

AMERICAN PSYCHIATRIC ASSOCIATION

- IPS – DC Oct 6-9
- APA Website: www.psych.org and list serve
- AIMS Center: http://aims.uw.edu
- Center for Integrated Health Solutions: http://www.integration.samhsa.gov/
- ARHQ Integration Academy: http://integrationacademy.ahrq.gov/
- Books:
  - Integrated Care: Working at the Interface of Primary Care and Behavioral Health – edited by Lori Raney, MD
  - Integrated Care: Creating Effective Mental and PC Teams - AIMS
  - Prevention in Psychiatry – Robert McCarron and colleagues
  - Integrated Care and Psychiatry – Summergrad, Kathol

APA SAN OBJECTIVE: TRAIN, READY, CONNECT

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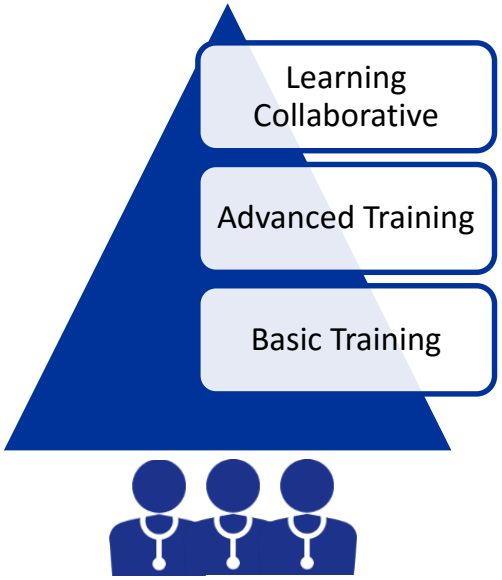
The APA SAN will train 3500 psychiatrists in collaborative care through online and live trainings; offer certificates to those who complete learning collaboratives, and connect trained psychiatrists with PTNs across the country.

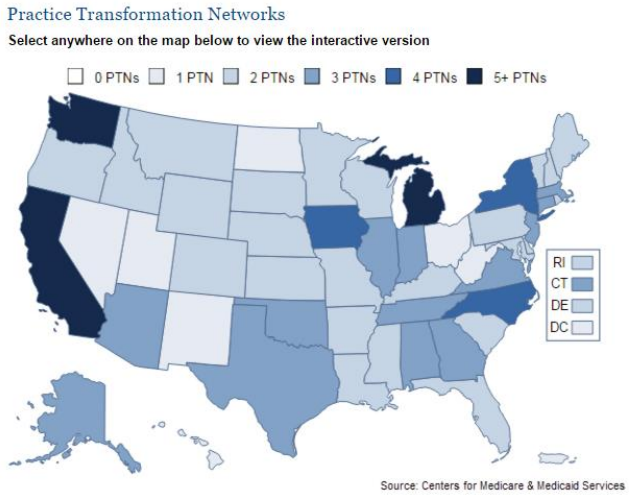
TRAIN



Psychiatrists

READY

CONNECT



GET CONNECTED

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Stay up-to-date on APA's SAN and training offerings at:

www.psychiatry.org

For more information or questions, email SAN@psych.org

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lraney@healthmanagement.com