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Psychiatry and Addictions Case Conference

UW Medicine | Psychiatry and Behavioral Sciences

COLLABORATIVE CARE

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APRIL 27, 2017

UW Medicine
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SPEAKER DISCLOSURES

Nothing to disclose

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GENERAL DISCLOSURES

The University of Washington School of Medicine also gratefully acknowledges receipt of educational grant support for this activity from the Washington State Legislature through the Safety-Net Hospital Assessment, working to expand access to psychiatric services throughout Washington State.

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OBJECTIVES

At the end of this presentation, participants will

1. Understand the core principles and standard workflow of Collaborative Care
2. Consider the role of the PCP in each phase of the collaborative care workflow
3. Learn about new research evidence and policy changes related to collaborative care model

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THE CHALLENGE FOR PRIMARY CARE

Behavioral health disorders cause

- 25 % of all disability worldwide[1]
  - 10 % of Years Lived with Disability (YLD) from depression alone
  - 3x diabetes,10x heart disease, 40x cancer
- In the US, one suicide every 14 minutes[2]
  - In WA, 2-3 suicides / day
- Increased complications, costs, mortality associated with chronic medical conditions[3]

Murray CJ, et al. Lancet. 2012 Dec 15;380(9859):2197-223.
https://afsp.org/about-suicide/suicide-statistics/
Katon WJ et al. Diabetes Care. 2005 Nov;28(11):2668-72

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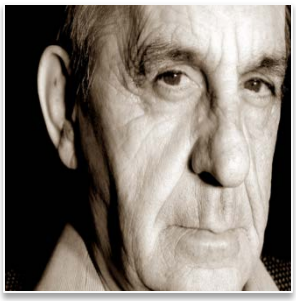
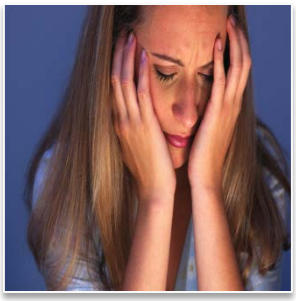
WHO GETS TREATMENT?

No Treatment






Primary Care Provider




Mental Health Provider

Wang PS et al Arch Gen Psychiatry. 2005 Jun;62(6):629-40.

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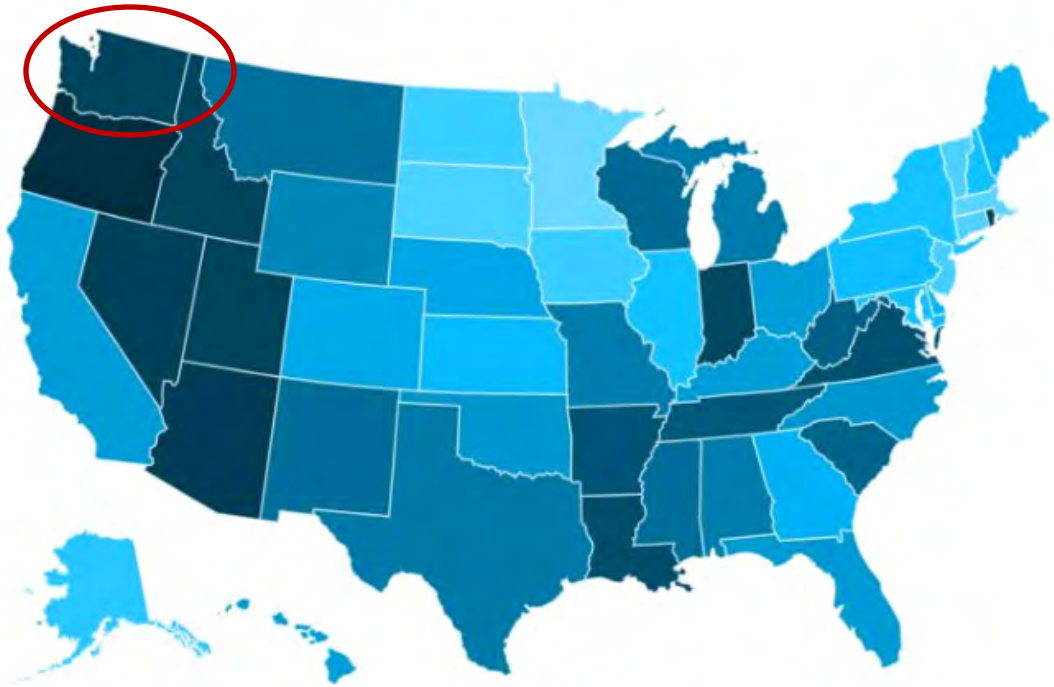
BUT WHAT ABOUT HERE?
THE STATE OF MENTAL HEALTH IN AMERICA



Rank	State
35	Mississippi
36	New Mexico
37	Wisconsin
38	South Carolina
39	West Virginia
40	Tennessee
41	Arkansas
42	Virginia
43	Louisiana
44	Indiana
45	Idaho
46	Utah
47	Washington
48	Rhode Island
49	Nevada
50	Arizona
51	Oregon

Source: Parity or Disparity: The State of Mental Health in America (2016), Mental Health America

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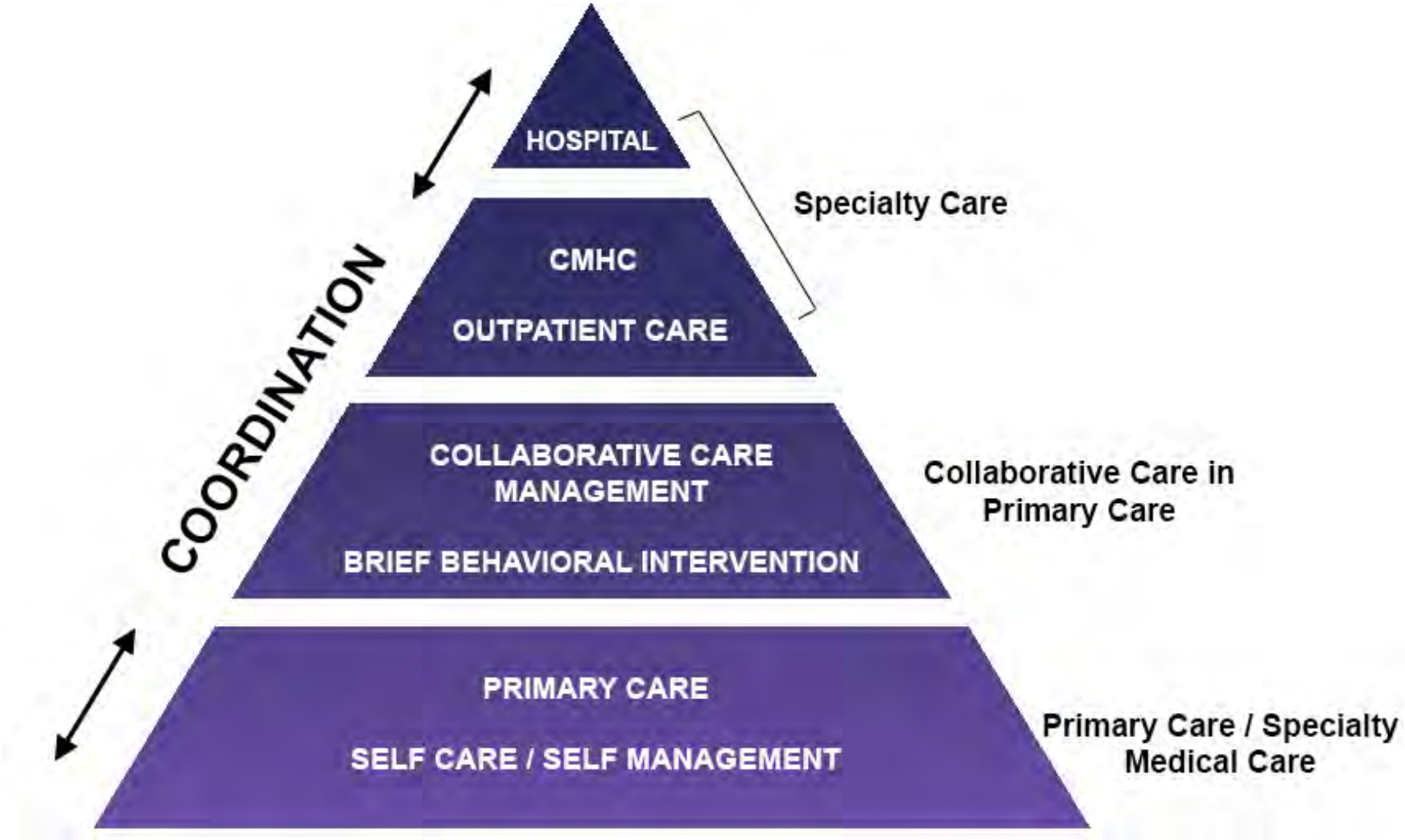
BETTER MENTAL HEALTH CARE FOR MORE PEOPLE



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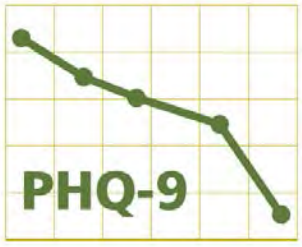
COMPONENTS OF COLLABORATIVE CARE

- Primary Care Physician
- Patient

  +
- Mental Health Care Manager
- Consulting Psychiatrist



Outcome Measures

Evidence-based Treatments

Registry

Consulting Psychiatrist

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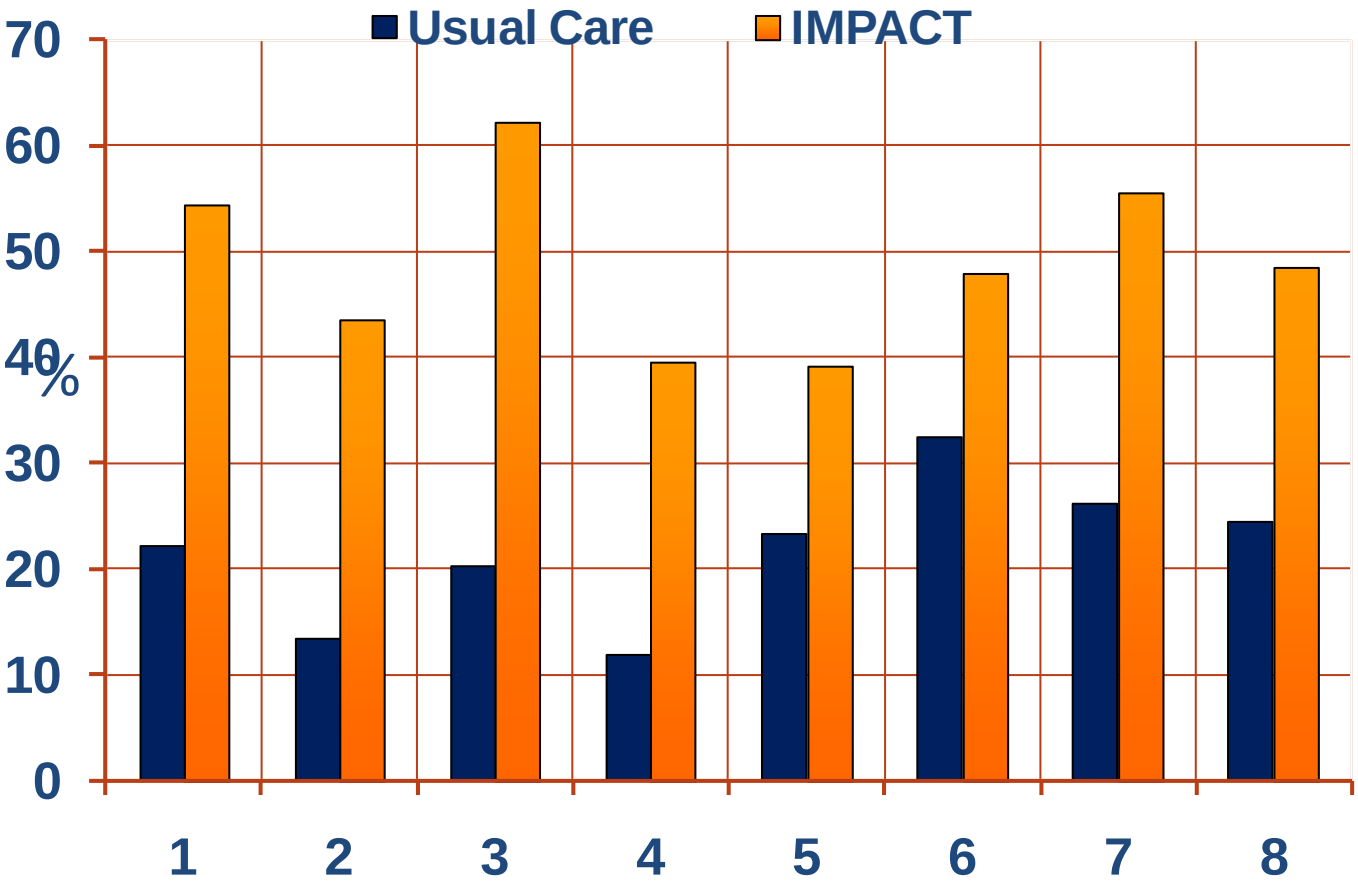
TWICE AS EFFECTIVE AS USUAL CARE

% of patients with 50 % or greater improvement in depression at 12 months



Unützer et al., JAMA 2002;

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SUMMARY: THE TRIPLE AIM

- Improved Outcomes:
  - Less depression
  - Better functioning
  - Higher quality of life
- Greater patient and provider satisfaction
- More cost-effective
  - Reduced healthcare costs: ROI $6.5 saved for $1 invested

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RESEARCH EVIDENCE

- Meta analysis of more than 80 RCT: collaborative care treatment of depression in primary care (US and Europe)—consistently more effective[1]
- In large (n= 7000) retrospective study, time to remission was 86 days for patients in Collaborative Care, compared to 614 days for usual care[2]
- Evidence for effectiveness
  - Anxiety[3]
  - PTSD[4]
  - Adolescent depression[5]
  - Ob-gyn clinics[6]
  - Depression and poorly-controlled diabetes[7]

[1]Archer, J. et al., Cochrane Database Syst Rev. 2012 Oct 17;10:CD006525; [2]Garrison GM et al J Am Board Fam Med. 2016 Jan-Feb;29(1):10-7; [3]Sullivan G, et al. Am J Psychiatry. 2013 Feb;170(2):218-25; [4]Zatzick D, et al, Arch Gen Psychiatry. 2004 May;61(5):498-506; [5]Richardson LP, et al .JAMA. 2014 Aug 27;312(8):809-16; [6]Katon W, et al. Am J Psychiatry. 2015 Jan;172(1):32-40; [7]Katon WJ, et al. N Engl J Med. 2010 Dec 30;363(27):2611-20

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CORE PRINCIPLES OF COLLABORATIVE CARE

Patient-Centered Team Care

Population-Based Care

Measurement-Based Treatment to Target

Evidence-Based Care

Accountable Care

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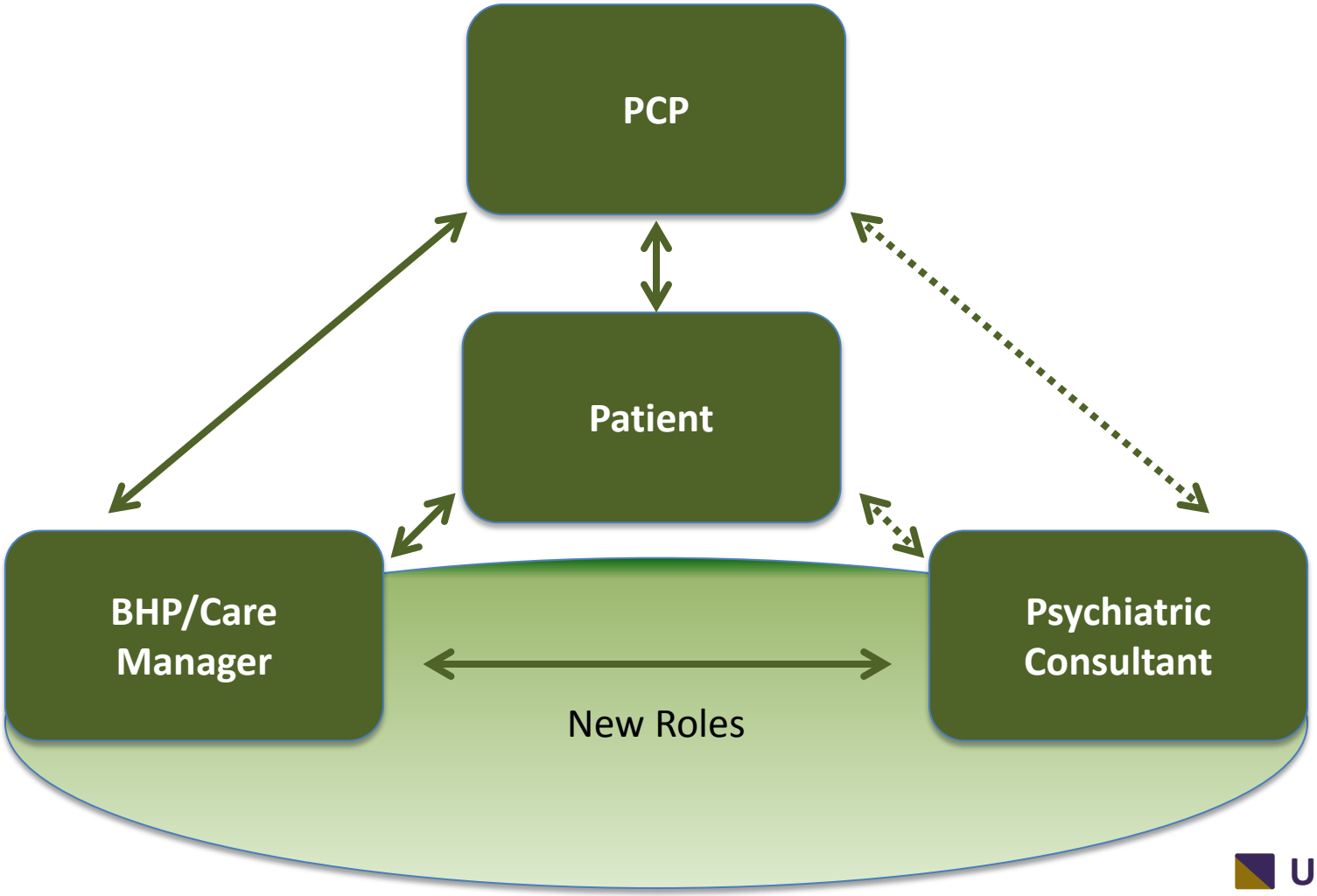
PATIENT-CENTERED TEAM CARE



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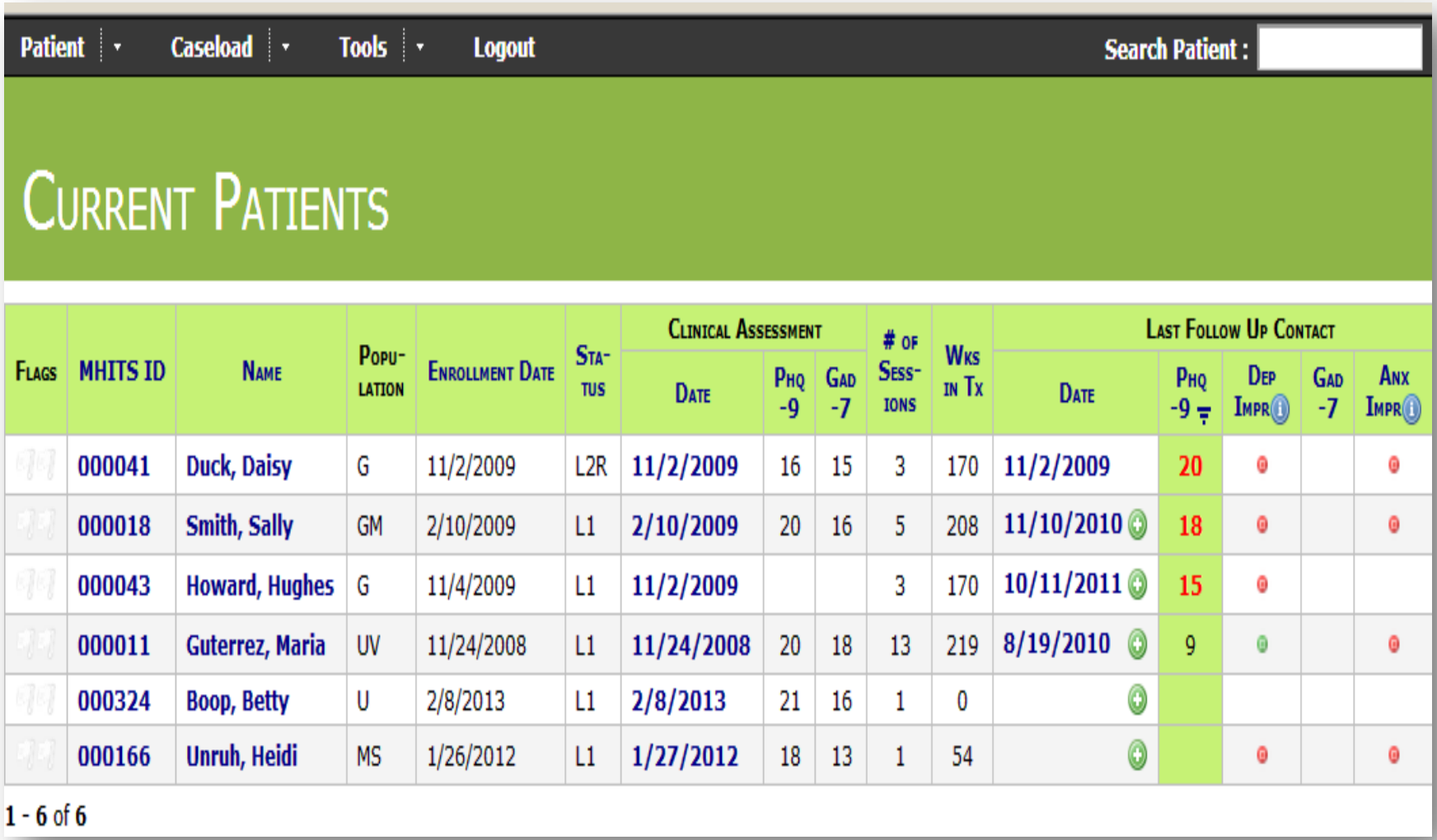
POPULATION BASED CARE



Patient | Caseload | Tools | Logout | Search Patient :

Current Patients

Flags	MHITS ID	Name	Popu-lation	Enrollment Date	Sta-tus	Clinical Assessment			# of Sess-ions	Wks in Tx	Last Follow Up Contact				
						Date	PHQ -9	GAD -7			Date	PHQ -9	Dep Impr	GAD -7	Anx Impr
	000041	Duck, Daisy	G	11/2/2009	L2R	11/2/2009	16	15	3	170	11/2/2009	20	0		0
	000018	Smith, Sally	GM	2/10/2009	L1	2/10/2009	20	16	5	208	11/10/2010	18	0		0
	000043	Howard, Hughes	G	11/4/2009	L1	11/2/2009			3	170	10/11/2011	15	0		
	000011	Guterrez, Maria	UV	11/24/2008	L1	11/24/2008	20	18	13	219	8/19/2010	9	0		0
	000324	Boop, Betty	U	2/8/2013	L1	2/8/2013	21	16	1	0					
	000166	Unruh, Heidi	MS	1/26/2012	L1	1/27/2012	18	13	1	54			0		0

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MEASUREMENT-BASED TREATMENT TO TARGET

- Measurable treatment goals defined
- Outcomes frequently monitored using validated clinical rating scales (PHQ-9, GAD-7)
- Results tracked in a registry
- Treatment frequently evaluated and adjusted until target goals achieved

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EVIDENCE-BASED TREATMENT

- Medications
  - More frequent monitoring to adjust treatment
  - Recommendations for switching/ augmentation
- Brief Behavioral Treatments
  - Behavioral Activation
    - specific, concrete plan for self-care that patient will do before the next contact.
  - Problem Solving Therapy
  - Interpersonal Therapy

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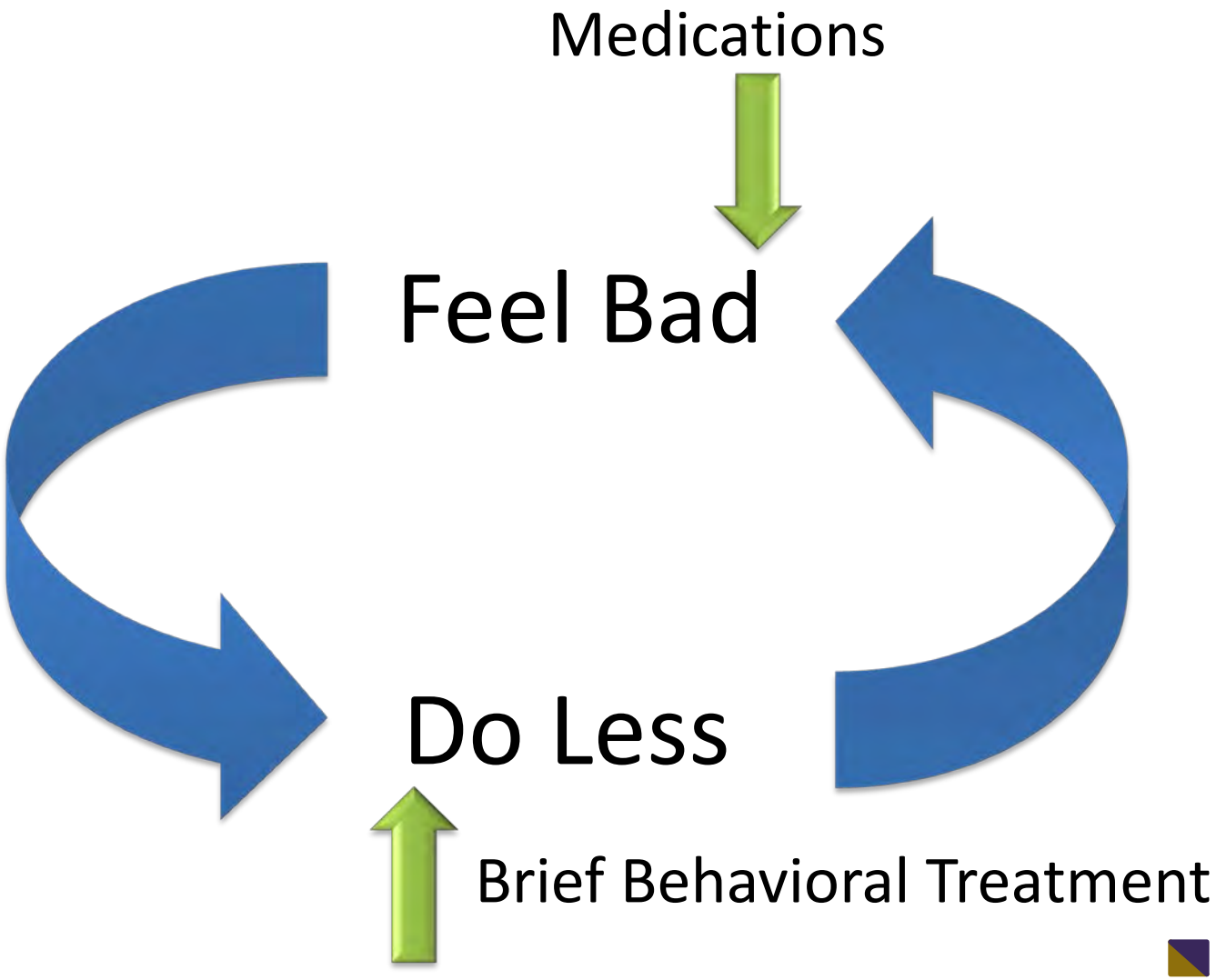
BEHAVIORAL ACTIVATION



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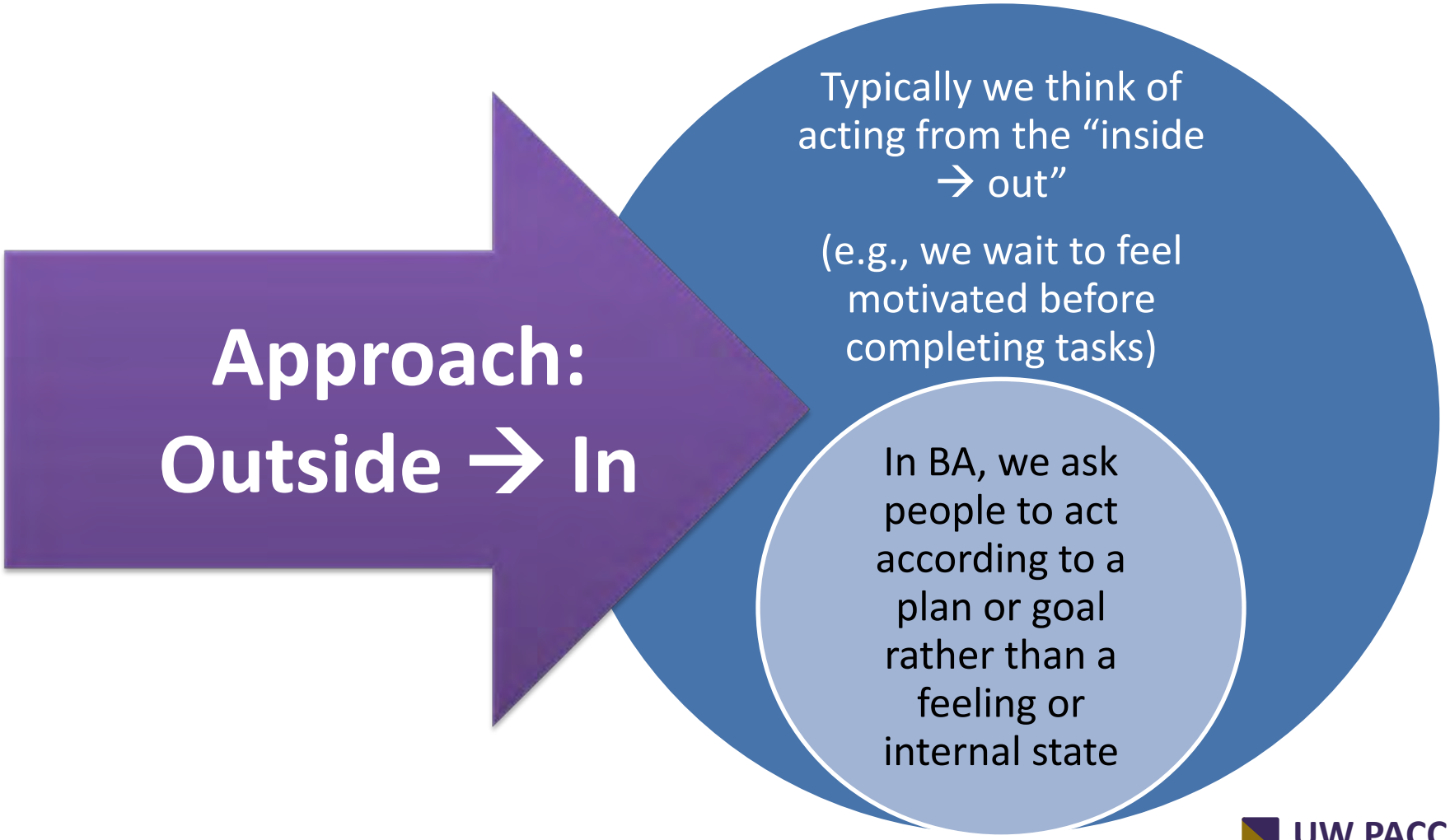
MAXIMIZING ACTIVATION



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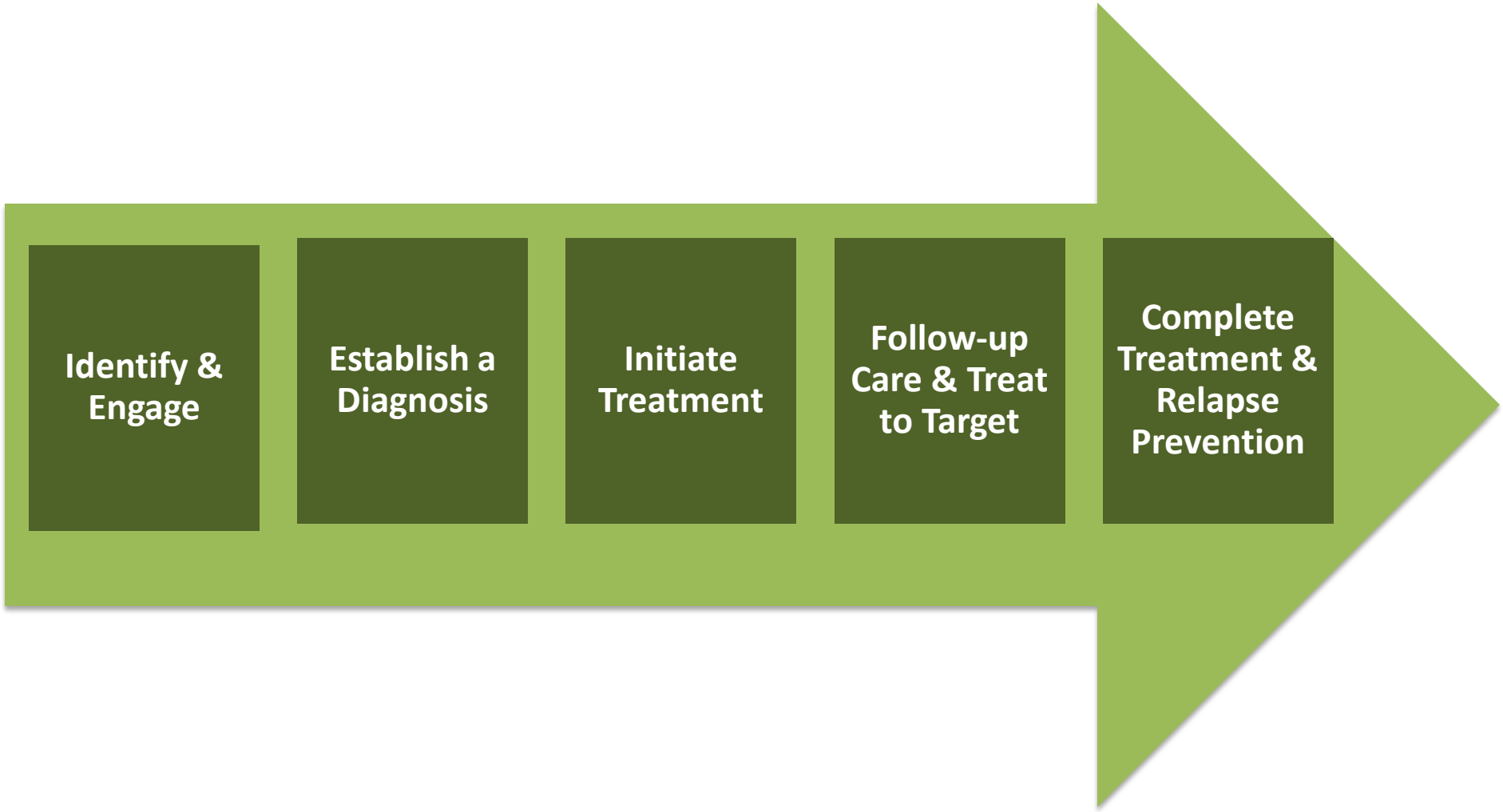
COLLABORATIVE CARE CLINICAL WORKFLOW



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BEHAVIORAL HEALTH MEASURES AS "VITAL SIGNS"

- Behavioral health measures are like monitoring blood pressure!
  - Identify that there is a problem
  - Need further assessment to understand the cause of the "abnormality"
  - Ongoing monitoring to measure response to treatment

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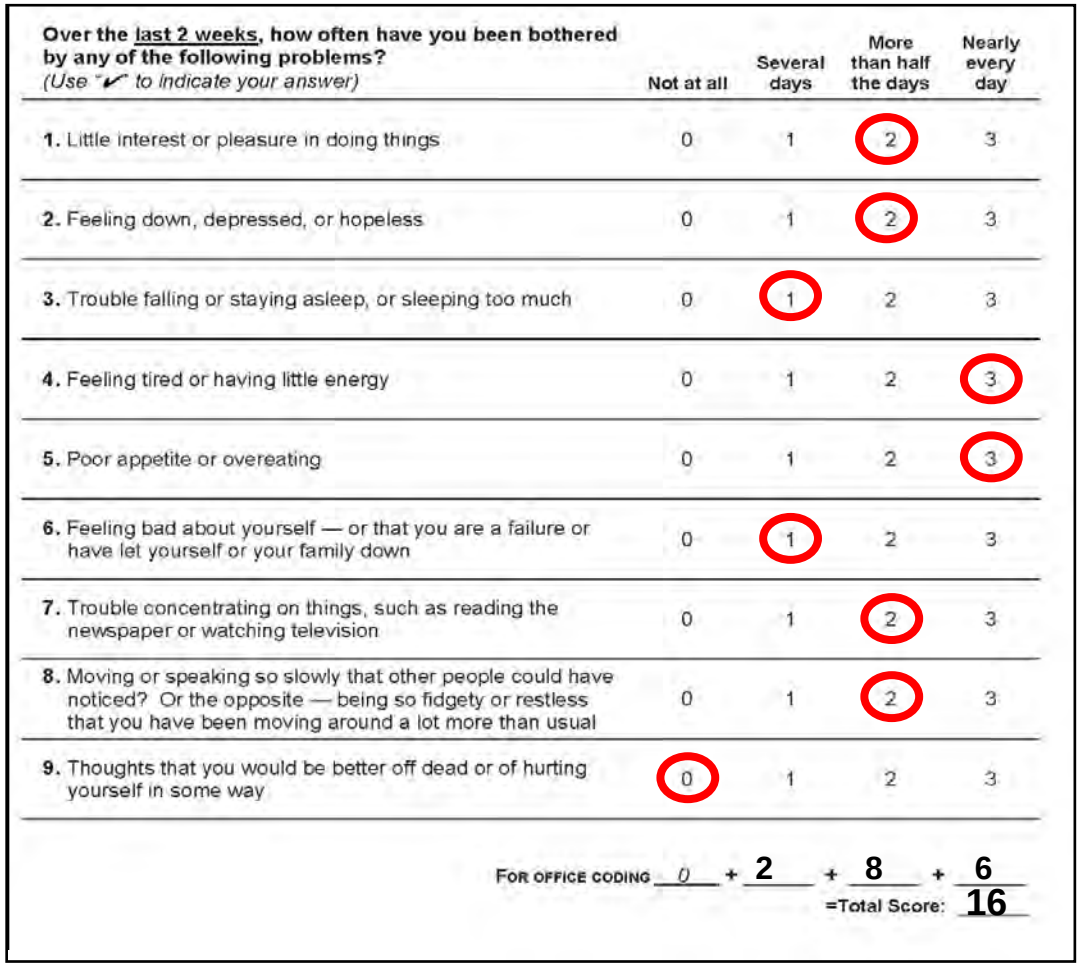
How to Score the PHQ-9



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	**2**	3
2. Feeling down, depressed, or hopeless	0	1	**2**	3
3. Trouble falling or staying asleep, or sleeping too much	0	**1**	2	3
4. Feeling tired or having little energy	0	1	2	**3**
5. Poor appetite or overeating	0	1	2	**3**
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	**1**	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	**2**	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	**2**	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	**0**	1	2	3

FOR OFFICE CODING 0 + 2 + 8 + 6
=Total Score: 16

Adapted from Kroenke K, Spitzer RL, Williams JB. The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine*, 16:606-13, 2001.

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PCP ROLE: ENGAGEMENT

- Most important ingredient for success
  - Articulation of plan and team roles critical
  - PCP recommendation powerful
- Existing relationship as foundation
- PCP sees the whole picture
- Key messages:
  - Options
  - Proactive Persistence
  - Hope

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BRIEF BEHAVIORAL TREATMENT

- Pros
  - No medication side effects
  - Alternative for poor response to medications
  - Accommodates patient who does not want medication
  - Evidence that could work with older adults who have mild cognitive impairment
    - (Areán et al., 2010, American Journal of Psychiatry; Alexopoulos et al., 2010, Archives of General Psychiatry)
- Cons
  - More time-consuming (30 min to 1 hr sessions)
  - May take longer to work
  - Staff training, mental health professionals

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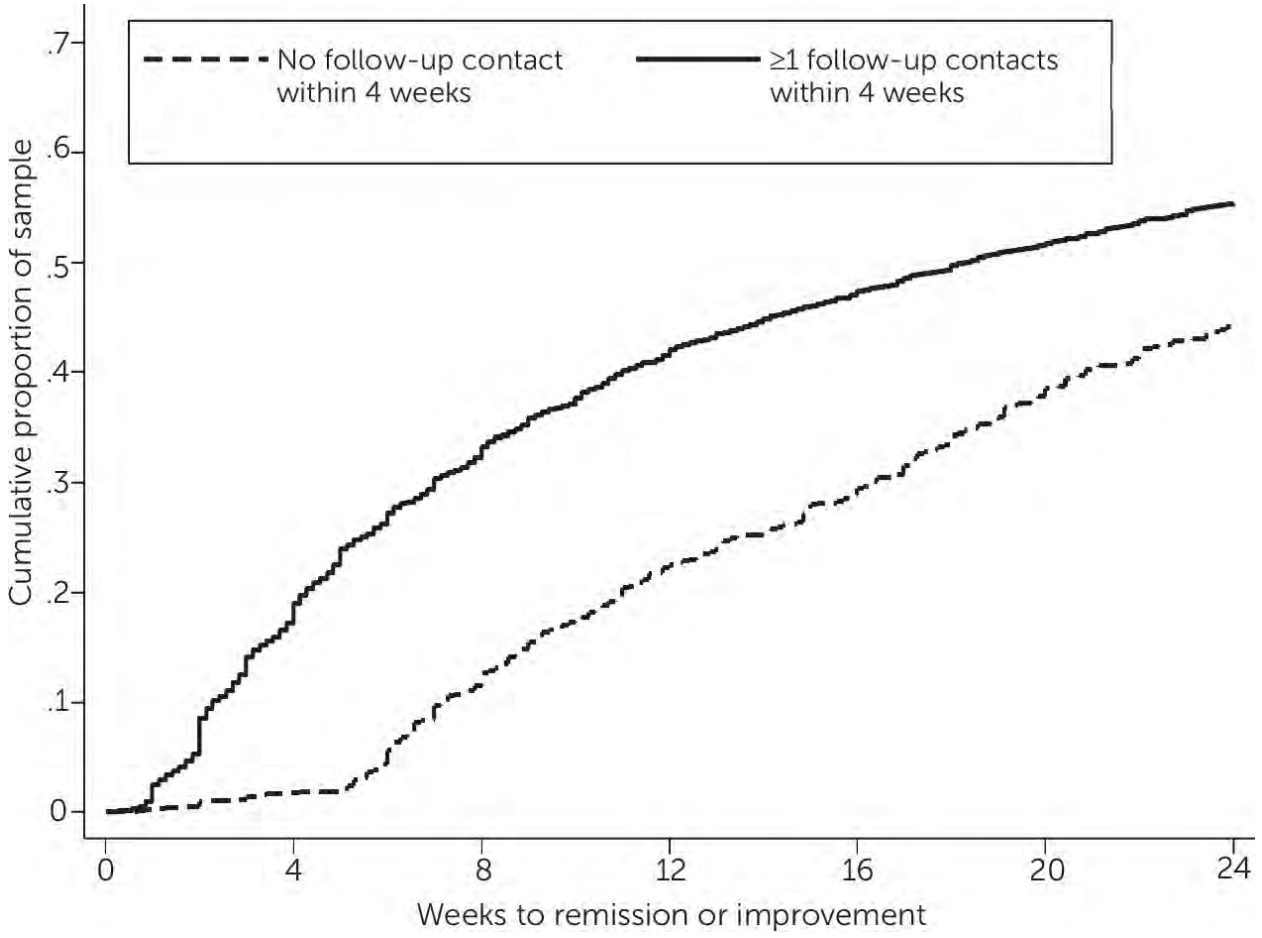
"FRONT LOADING" CARE MANAGEMENT INTERVENTIONS KEY TO IMPROVEMENT

Early intervention is key to earlier improvement



Bao, Y., Druss, B.G., Jung, H.Y., Chan, Y.F. & Unützer, J. (2015). Unpacking Collaborative Care for Depression: Examining Two Essential Tasks for Implementation. *Psychiatric Services in Advance,* doi: 10.1176/appi.ps.201400577

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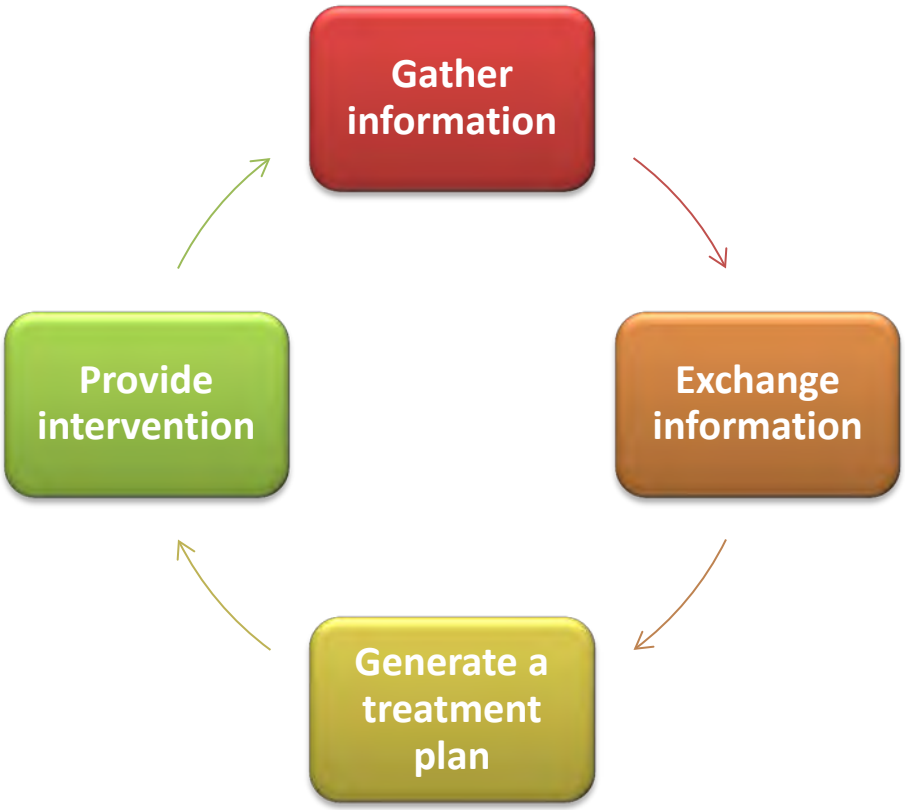
PCP ROLE: DIAGNOSIS



- Consult not always needed
- Sometimes iterative process required
- Sometimes complicated from the outset
- You typically know the patient best

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CARE MANAGER TASKS

- Engagement
- Systematic initial evaluation
  - Education about depression
- Regular follow-up contacts
  - Tracks treatment response for caseload of patients
  - Supports medication management by PCP
  - Provides brief, structured evidence-based therapy
- Reviews challenging patients with the team psychiatrist weekly
- Completes relapse prevention with patient

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SYSTEMATIC CASE REVIEW

- Weekly 60 to 90 minute meeting between CM and psychiatrist
- In-person or by phone / Zoom
- BH care manager and psychiatric consultant review caseload
- Entire caseload monitored over time (typically over a month)

Garrison GM et al. Am Board Fam Med. 2016 Jan-Feb;29(1):10-7.

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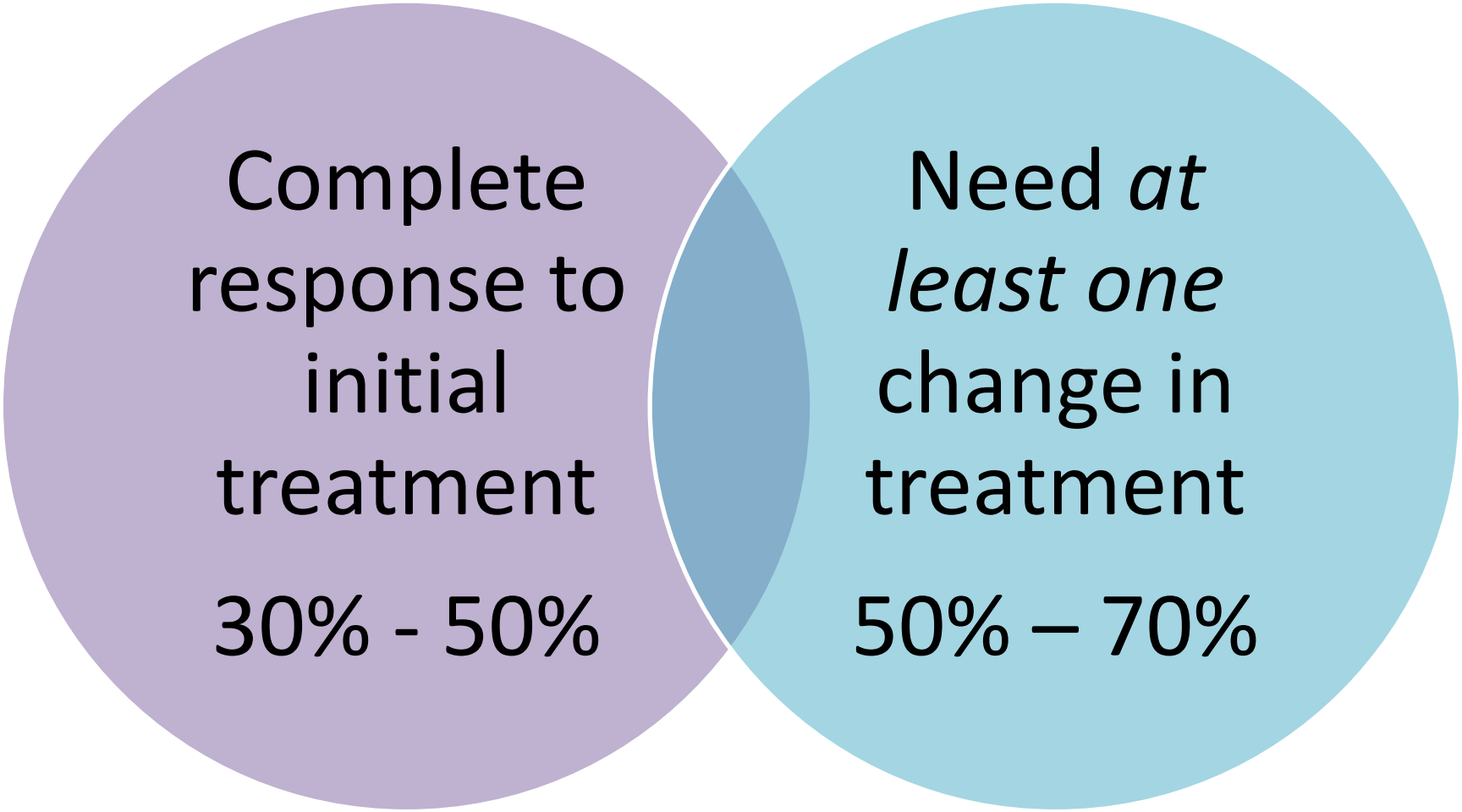
PCP ROLE: TREATMENT ADJUSTMENT



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AIMS EXCEL® PATIENT TRACKING TOOL

Patient information		Enrollment Status and Actions				Contacts				Measurements				Contact Notes and Psychiatric Case Review		
MRN	Name	Treatment Status	Display (Hide past tx episodes or view only the most recent contact)	Tickler	Episode Number	Follow-up Contact Number	Date Follow-up Due	Actual Contact Dates	Type of Contact	PHQ-9 Score (Target is <5 within 5-7 months of initial elevated PHQ-9)	% Change in PHQ-9 score (Target is -50% within 5-7 months of initial elevated PHQ-9)	GAD-7 Score (Target is <10 within 5-7 months of initial elevated GAD-7)	% Change in GAD-7 score (Target is -50% within 10 weeks of tx initiation or change)	Care Manager Contact Notes and Flag for Psychiatric Case Review (Include notes about appointment reminder calls, referrals to specialty services, etc.)		Date of Psychiatric Case Review (Date of most recent Psychiatric Case Review automatically populates at top)
1234	**Joe Smith**	Active			**2**	Current Episode Initial Assessment	2-week follow-up schedule	**3/11/16**		**15**		**14**				**3/30/16**
1234	Joe Smith				1	Initial Assessment		**8/1/15**		19	27%	12	-14%			8/20/15
1234	Joe Smith				1	1		**8/15/15**		16	7%	10	-29%			10/1/15
1234	Joe Smith				1	2		**Canceled**		12	-20%	**9**	-36%			12/1/15
1234	Joe Smith				1	3		**9/13/15**		7	**-53%**	10	-29%			3/30/16
1234	Joe Smith				1	4		**9/27/15**		**4**	**-73%**	**6**	**-57%**			
1234	Joe Smith				1	5		**10/10/15**		**4**	**-73%**	**5**	**-64%**			
1234	Joe Smith				1	6		**11/1/15**		**2**	**-87%**	**3**	**-79%**			
1234	Joe Smith				1	7		**12/2/15**		**3**	**-80%**	**1**	**-93%**			
1234	Joe Smith				2	Initial Assessment		**3/11/16**		15	0%	14	0%			
1234	Joe Smith				2	1		**3/25/16**		16	7%	12	-14%			
1234	Joe Smith			Contact due in 3 days	2	2	4/8/16			.		.				
1234	Joe Smith						4/22/16			.		.				
1234	Joe Smith						5/6/16			.		.				
1234	Joe Smith						5/20/16			.		.				
1234	Joe Smith						6/3/16			.		.				
3456	**Bob Dolittle**	Active			**1**	Current Episode Initial Assessment	2-week follow-up schedule	**3/5/16**		**23**		**17**			Flag for discussion	
3456	Bob Dolittle				1	Initial Assessment		**3/5/16**		23	0%	17	0%			
3456	Bob Dolittle				1	1		**3/20/16**		22	-4%	17	0%			
3456	Bob Dolittle			Past Due	1	2	4/3/16			.		.				
3456	Bob Dolittle						4/17/16			.		.				
3456	Bob Dolittle						5/1/16			.		.				

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AIMS EXCEL® 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 last available 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

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CMS CODES

http://aims.uw.edu/new-bhi-services-fact-sheet

BHI Code	BH CM staff time (per calendar month)	Assumed billing practitioner time
G0502 (CoCM first month)	70 minutes	30 minutes
G0503 (CoCM subsequent months)	60 minutes	26 minutes
G0504 (add on, any month)	Each additional 30 minutes	13 minutes
G0507 (general BHI)	At least 20 minute	15 minutes

Care team members:

- Treating (Billing) Practitioner: Typically PCP
- Beneficiary
- Clinical Staff (may include BH CM and consulting psychiatrist, but not required

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MEDICAID TRANSFORMATION (1115 WAIVER)

- 5-year demonstration program
- 3 initiatives to improve care
  - better address local health priorities,
  - deliver high-quality, cost-effective care that treats the whole person
  - create linkages between clinical and community-based services
- Initiative 1 builds incentives for changing care delivery
  - Bi-directional integrated care is required project

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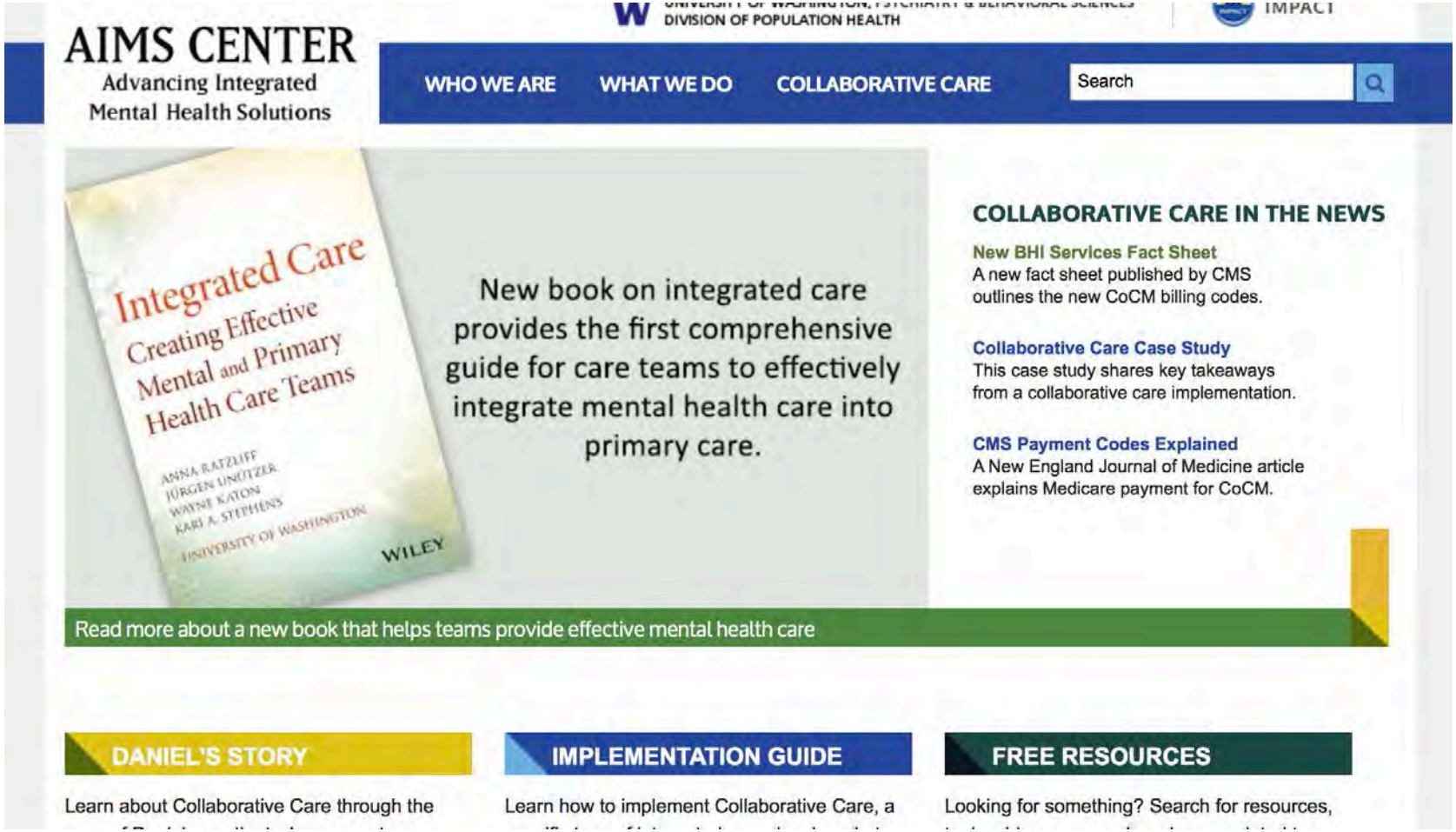
HTTP://AIMS.UW.EDU



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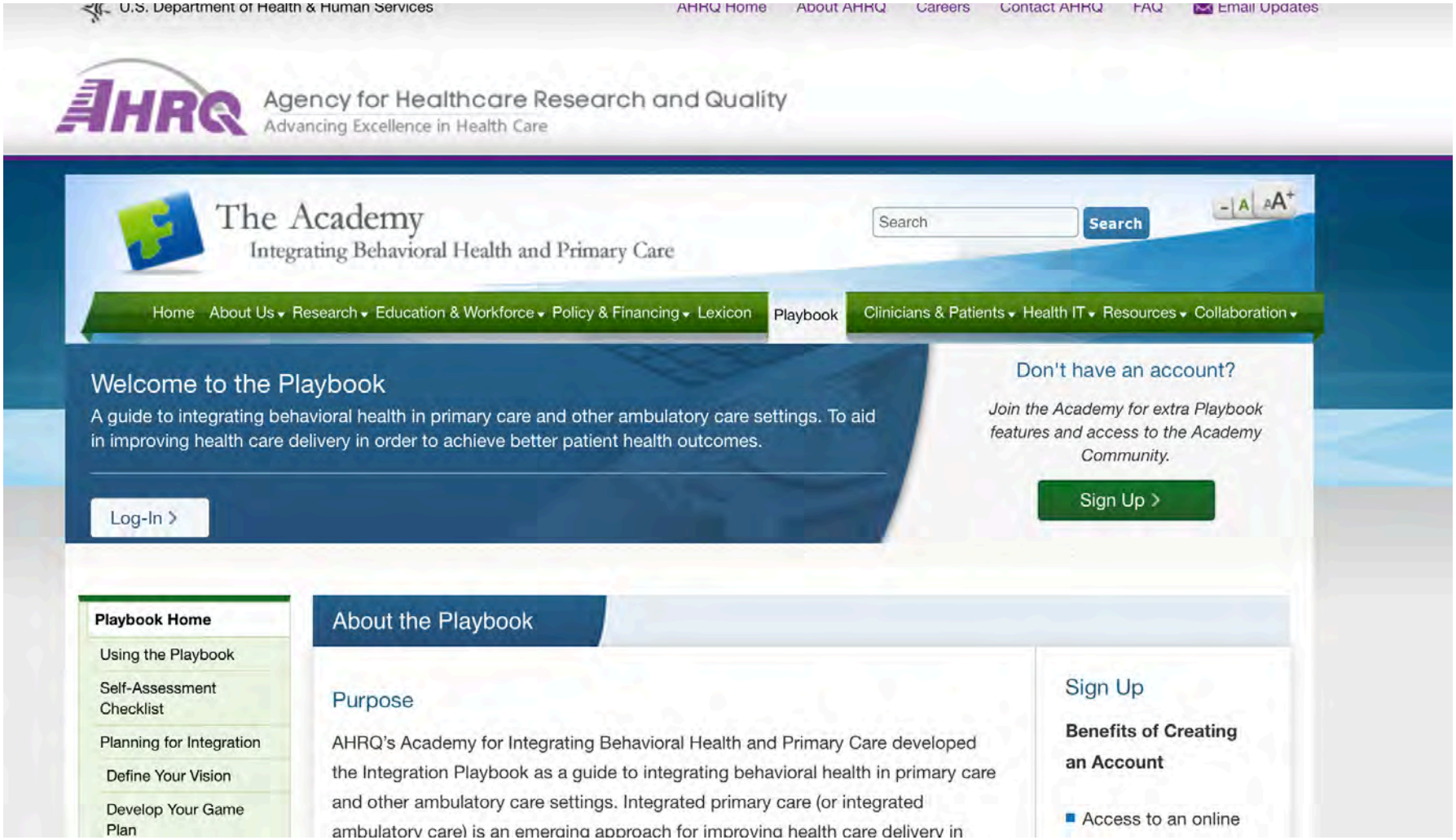

http://integrationacademy.ahrq.gov/playbook/about-playbook

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