Collaborative Care in EOCCO

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GOBHI

Disclosure statement

In-kind financial relationship as it relates to the sponsorship of the event

Company: GOBHI/EOCCO

Relationship: Employed by GOBHI

Learning Objective

- Summarize the benefit of behavioral health integration into a PCPCH

Principles of Effective Integrated Health Care

1. Patient-Centered Team Care - Collaborative Care Primary care and behavioral health providers collaborate effectively using shared care plans. It's important to remember that colocation does NOT mean collaboration, although it can.
2. 2. Population-Based Care Care -team shares a defined group of patients tracked in a registry to ensure no one "falls through the cracks." Practices track and reach out to patients who are not improving and mental health specialists provide caseload-focused consultation, not just ad-hoc advice.
3. 3. Measurement-Based Treatment to Target -Each patient's treatment plan clearly articulates personal goals and clinical outcomes that are routinely measured. Treatments are actively changed if patients are not improving as expected until the clinical goals are achieved.
4. 4. Evidence-Based Care -Patients are offered treatments for which there is credible research evidence to support their efficacy in treating the target condition.
5. 5. Accountable Care- Providers are accountable and reimbursed for quality of care and clinical outcomes, not just the volume of care provided.

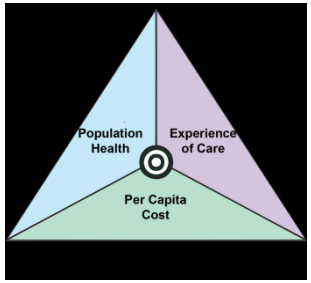
Why Behavioral Health Should be Part of the PCMH

Six Reasons *Why* Behavioral Health Should be Part of the PCMH

1. High **prevalence** of behavioral health problems in primary care
2. **High burden** of behavioral health in primary care
3. **High cost** of unmet behavioral health needs
4. **Lower cost** when behavioral health needs are met
5. **Better health** outcomes
6. **Improved satisfaction**

Triple Aim

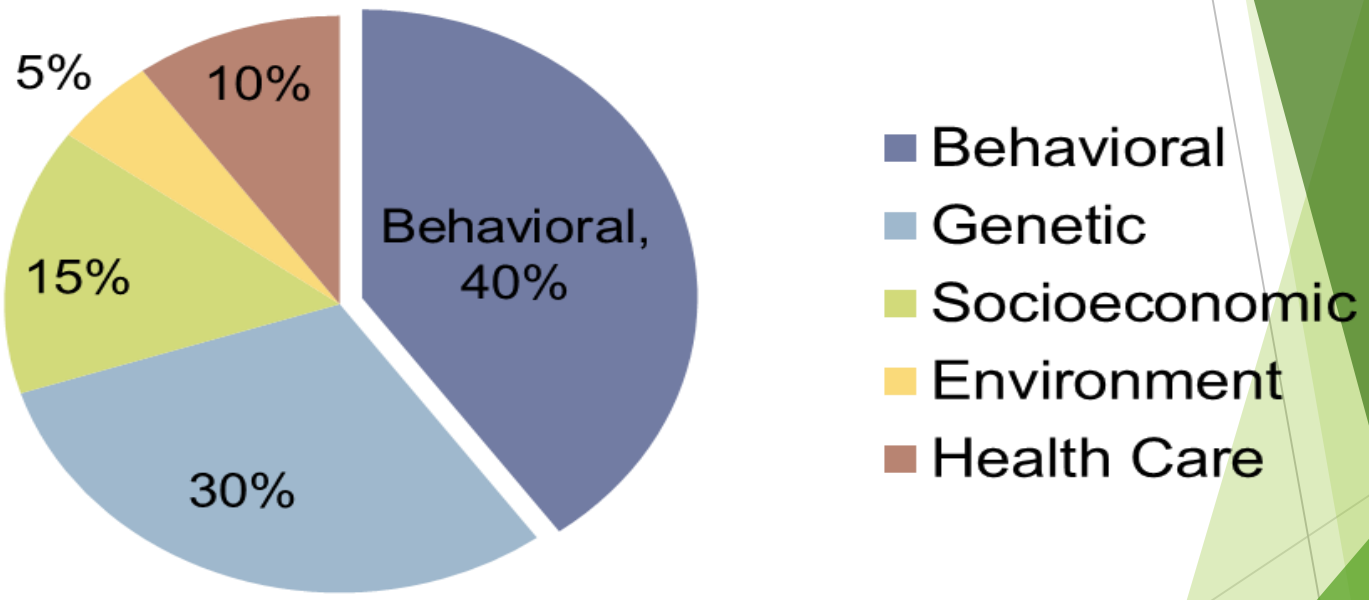
Behavioral health integration achieves the triple aim.



the map to PCMH success…

Prevalence

Leading Determinants of Overall Health are Behavioral[1,2]



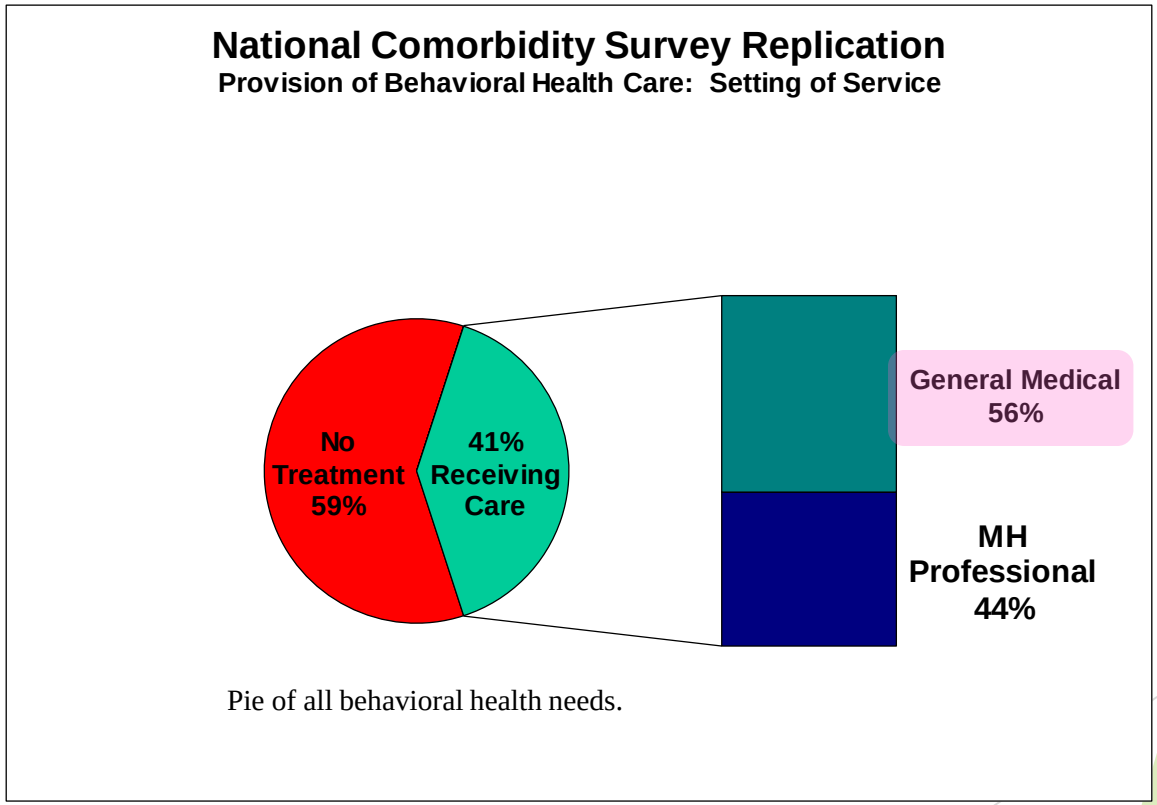
Sources: [1]McGinnis JM et al. JAMA 1993; 270:2207-12. [2]Mokdad AH, et al. JAMA 2004; 291:1230-1245.

Patient-Centered Medical Home

1.Prevalence

integrated care

Primary Care is the 'De Facto' Mental Health System



Pie of all behavioral health needs.

Wang P et al. *Arch Gen Psychiatry*, 2005: 62

Adapted from Katon, Rundell, Unützer, Academy of PSM Integrated Behavioral Health 2014

Patient-Centered Medical Home

2. Unmet Behavioral Health Needs

- **67% with a behavioral health disorder** do not get behavioral health treatment[1]
- **30-50% of referrals** to behavioral health from primary care don't make first appt[2,3]
- Two-thirds of primary care physicians reported **not being able to access** outpatient behavioral health for their patients[4] due to:
  - Shortages of mental health care providers
  - Health plan barriers
  - Lack of coverage or inadequate coverage
- **Depression goes undetected** in >50% of primary care patients[5]
- **Only 20-40% of patients improve** substantially in 6 months without specialty assistance[6]

1. Kessler et al., NEJM. 2005;352:515-23.
2. Fisher & Ransom, Arch Intern Med. 1997;6:324-333.
3. Hoge et al., JAMA. 2006;95:1023-1032.
4. Cunningham, Health Affairs. 2009; 3:w490-w501.
5. Mitchell et al. Lancet, 2009; 374:609-619.
6. Schulberg et al. Arch Gen Psych. 1996; 53:913-919

Patient-Centered Medical Home

3. High Cost of Unmet BH Needs

- Individuals with behavioral health and substance use conditions **cost 2-3 times** as much as those without[1]
- BH disorders account for **half as many disability days** as "all" physical conditions[2]
- Annual medical expenses--chronic medical & behavioral health conditions combined **cost 46% more** than those with only a chronic medical condition[3]
- **Top five conditions** driving overall health cost[4]
  1. **Depression**
  2. Obesity
  3. Arthritis
  4. Back/Neck Pain
  5. **Anxiety**

1. Milliman report to the APA, August 2013 available here.
2. Merikangas et al., Arch Gen Psychiatry. 2007;64:1180-1188
3. Original source data is the U.S. Dept of HHS the 2002 and 2003 MEPS.
4. Loeppke et al., J Occup Environ Med. 2009;51:411-428.

Patient-Centered Medical Home

4. Lower cost when BH is treated

- **Medical use decreased 15.7%** for those receiving behavioral health treatment while controls who did not get behavioral health medical use increased 12.3%[1]
- Depression treatment in primary care for those with diabetes resulted in **$896 lower** total health care cost over 24 months[2]
- Depression treatment in primary care $3,300 lower total health care cost over 48 months[3]
  - This resulted in a **return of $6.50 for every $1 spent**
- Multi-condition collaborative care for **depression** and **diabetes** saved **$594 per patient** over 24 mos.[4]

1. Chiles et al., Clinical Psychology. 1999;6:204–220.
2. Katon et al., Diabetes Care. 2006;29:265-270.
3. Unützer et al., American Journal of Managed Care 2008;14:95-100.
4. Katon et al. Arch Gen Psych, 2012:69:506-514

Patient-Centered Medical Home

4. Lower cost when BH is treated

integrated care

IMPACT Collaborative Care for **Depression** Reduces Costs

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**

$avings

Unützer et al., American Journal of Managed Care 2008;14:95-100

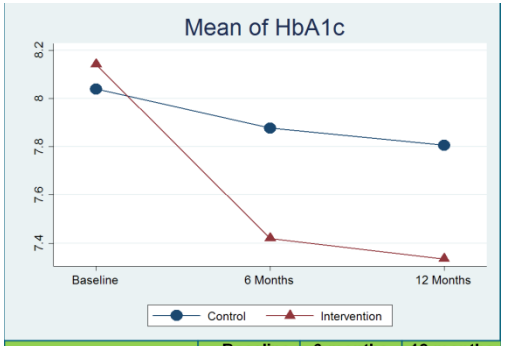
Patient-Centered Medical Home

5. Leading to Improved physical health outcomes

integrated care

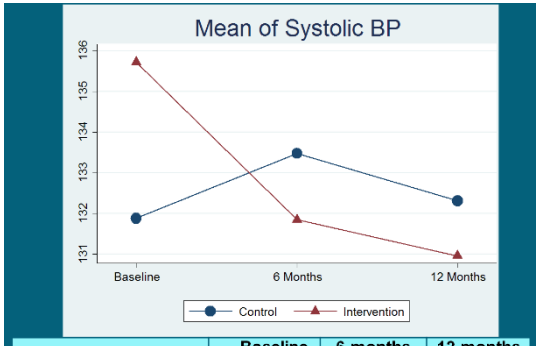
- When treated in harmony with mental health, **chronic physical health improves significantly**[1]

Improved Diabetes[1]



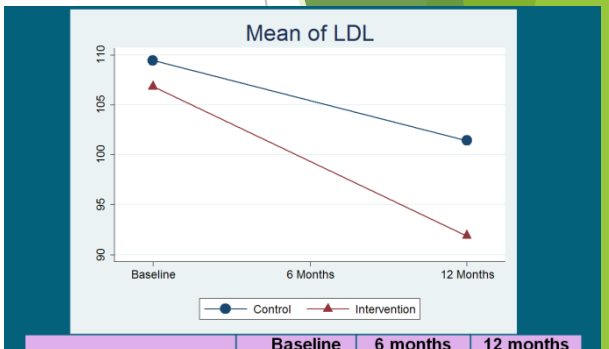
	Baseline	6 months	12 months
Intervention mean (N)	8.1 (105)	7.4 (99)	7.3 (101)
Control mean (N)	8.0 (105)	7.9 (95)	7.8 (97)

Improved BP[1]



	Baseline	6 months	12 months
Intervention mean (N)	135.7 (105)	131.9 (102)	131.0 (101)
Control mean (N)	131.9 (106)	133.5 (101)	132.3 (101)

Improved Cholesterol[1]

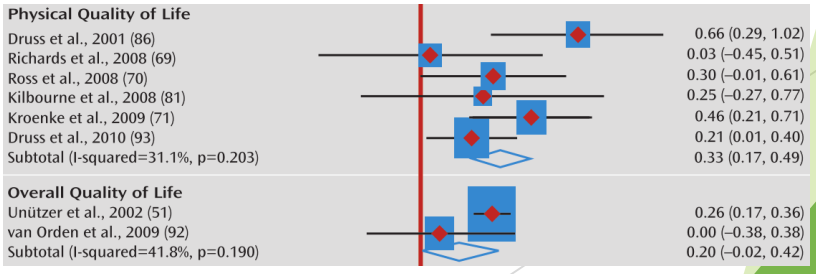


	Baseline	6 months	12 months
Intervention mean (N)	106.8 (105)	N/A	91.9 (98)
Control mean (N)	109.4 (103)	N/A	101.4 (90)

Overall **quality of life** and **physical health** improve consistently[2]

Physical health

Quality of life



1. Katon et al, NEJM, 2010:363:2611-2620
2. Woltman et al, AJP, 2012: 169:790-784

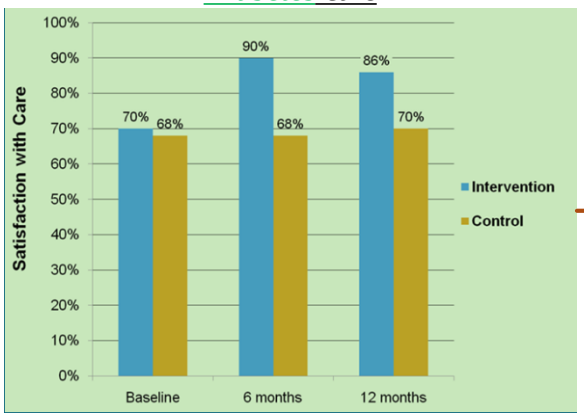
Patient-Centered Medical Home

6. Improved patient satisfaction

integrated care

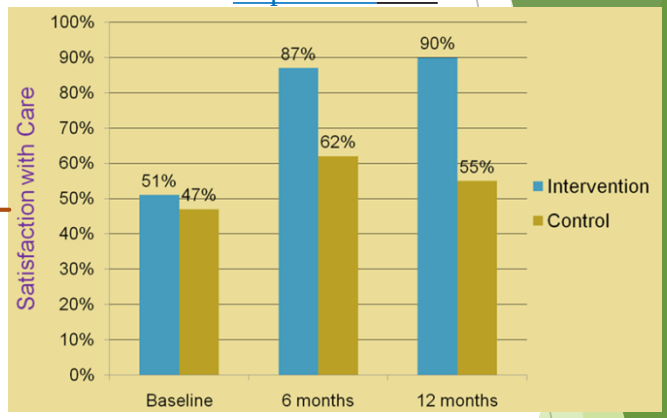
- After 12 months of care, multi-condition collaborative care **improved patient satisfaction** in depression **AND** diabetes care[1]

Diabetes care



synergy

Depression care



Patient testimonial on integrated care:

"...the staff at Marillac Clinic actually cared about what I had to say- they were there to help when I needed it - not just medical help, but counseling - and the medications needed to get well. They helped me learn how to care for myself -I understood how to accept myself from the kindness in their eyes."

Past patient of Marillac Clinic, Grand Junction, Colorado

1. Katon et al, NEJM, 2010:363:2611-2620

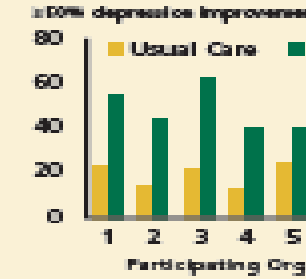
Reasons PCPs Love Collaborative Care

"I practiced for 16 years without it and I will never go back"
primary care physician, UW Neighborhood Clinic

1 Gold Standard of Depression Care

Collaborative Care is the best approach to treating depression, as proven by 79 randomized controlled trials published in a 2012 Cochrane Review. Why practice anything less?

Results of the landmar
study (1 of the 79 trial
Cochrane Review) show
Collaborative Care pati
twice as likely to exper
significant improvemen
though 70% of usual c
were prescribed an ant
by their PCP.



2 Better Medical Care

Collaborative Care has been linked to better medical outcomes for patients with diabetes, cardiovascular disease, cancer, and chronic arthritis pain.

Care has been
as a primary
ategy for fatal and
ovascular events in
ut preexisting heart

3 Access to experts

Care managers and psychiatric consultants expand the treatment options available and support the care provided by PCPs. From providing psychotherapy when clinically indicated to supporting pharmacotherapy, these experts support you as the primary clinical decision maker.

of patients have a
o the first treatment.
–70% of patients
one change in
ditional experts can

4 Help with Challenging Patients

Many of your most challenging patients likely have un-treated or under-treated mental health conditions. Care managers do the follow-up and behavioral intervention tasks a busy PCP doesn't have time for, tasks that can make a big difference for your patients.

Think co-locating a be
health specialist or han
referrals is enough? Th
The organization circle
Masters-level, co-locate
behavioral health clini
practicing within the p
clinic using a referral m
Collaborative Care still
twice as well!

5 It Takes a Team

Collaborative Care uses a population-based, treat-to-target approach similar to care for chronic medical conditions. Knowing when a proactive change in care is needed makes sure that none of your patients fall through the cracks.

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usual primary care
tial clinical
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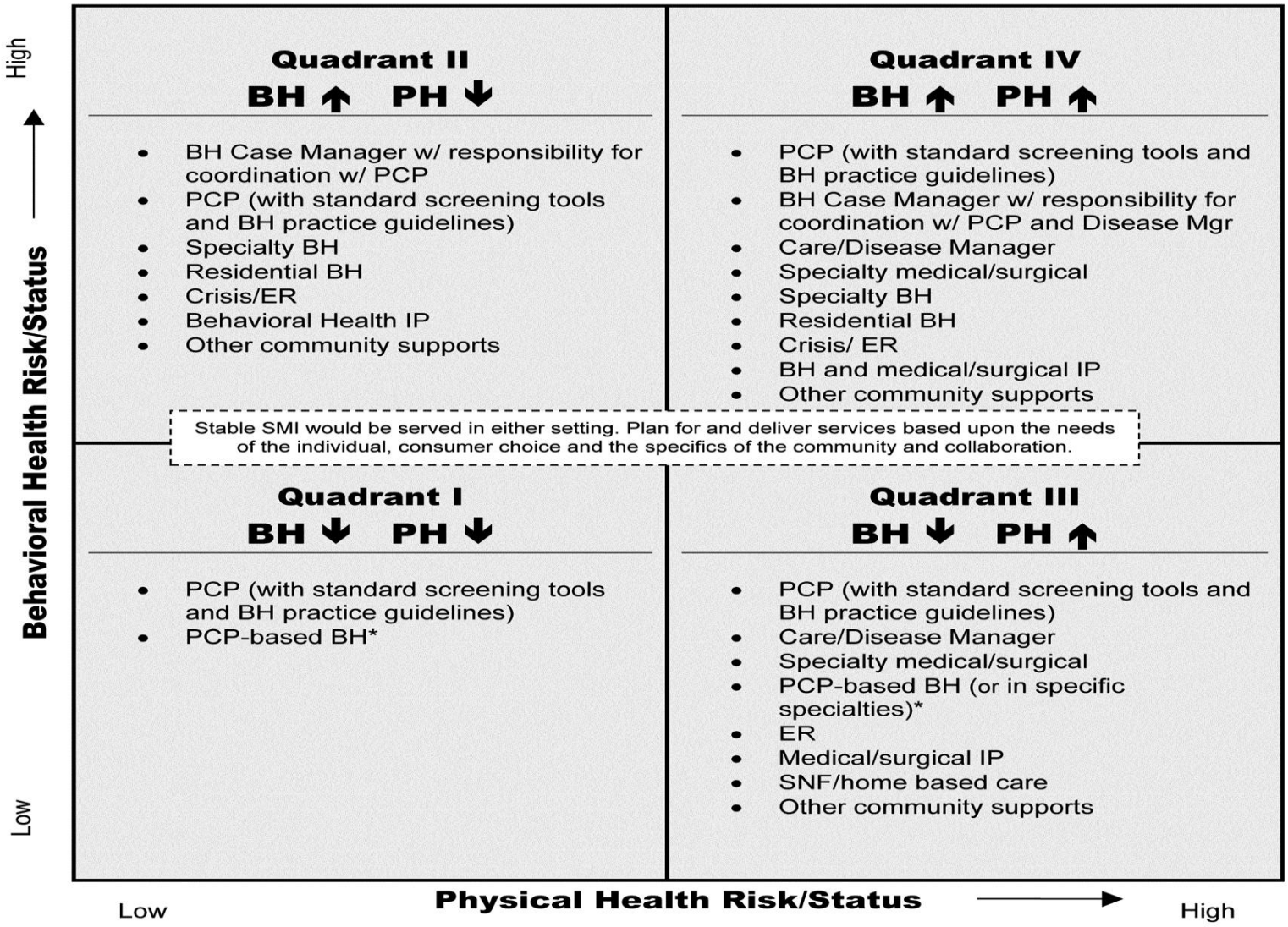
UNIVERSITY of WASHING

Review: Six Reasons *Why* Behavioral Health Should be Part of the PCMH

1. **High prevalence** of behavioral health problems in primary care
2. **High burden** of behavioral health in primary care
3. **High cost** of unmet behavioral health needs
4. **Lower cost** when behavioral health needs are met
5. **Better health** outcomes
6. **Improved satisfaction**
7. **BONUS! Collaborative care *IS* a m**

the map to PCMH success…

The Four Quadrant Clinical Integration Model



*PCP-based BH provider might work for the PCP organization, a specialty BH provider, or as an individual practitioner, is competent in both MH and SA assessment and treatment

Implementation Tasks

- Complete environmental scan
- Determine program's capacity and "filters"
- Establish administrative and clinical leadership "buy-in"
- Decide whether to rent or own BH staff
- Determine staffing pattern and BH tasks
- Define BH specialist skills

Stepped Care Levels

1. Basic education: info sharing & referral to self-help resources
2. Clinicians provide psycho-educational & motivational support
3. BH specialists use specific practice algorithms
4. Referral to external specialty or higher level BH providers

Clinical Tasks

- Triage
- Comprehensive assessment
- On-site treatment
- Referral
- Consultation
- Care monitoring & condition management
- Treatment/medication optimization
- **The key is balanced management of these tasks!**

Staffing The Model

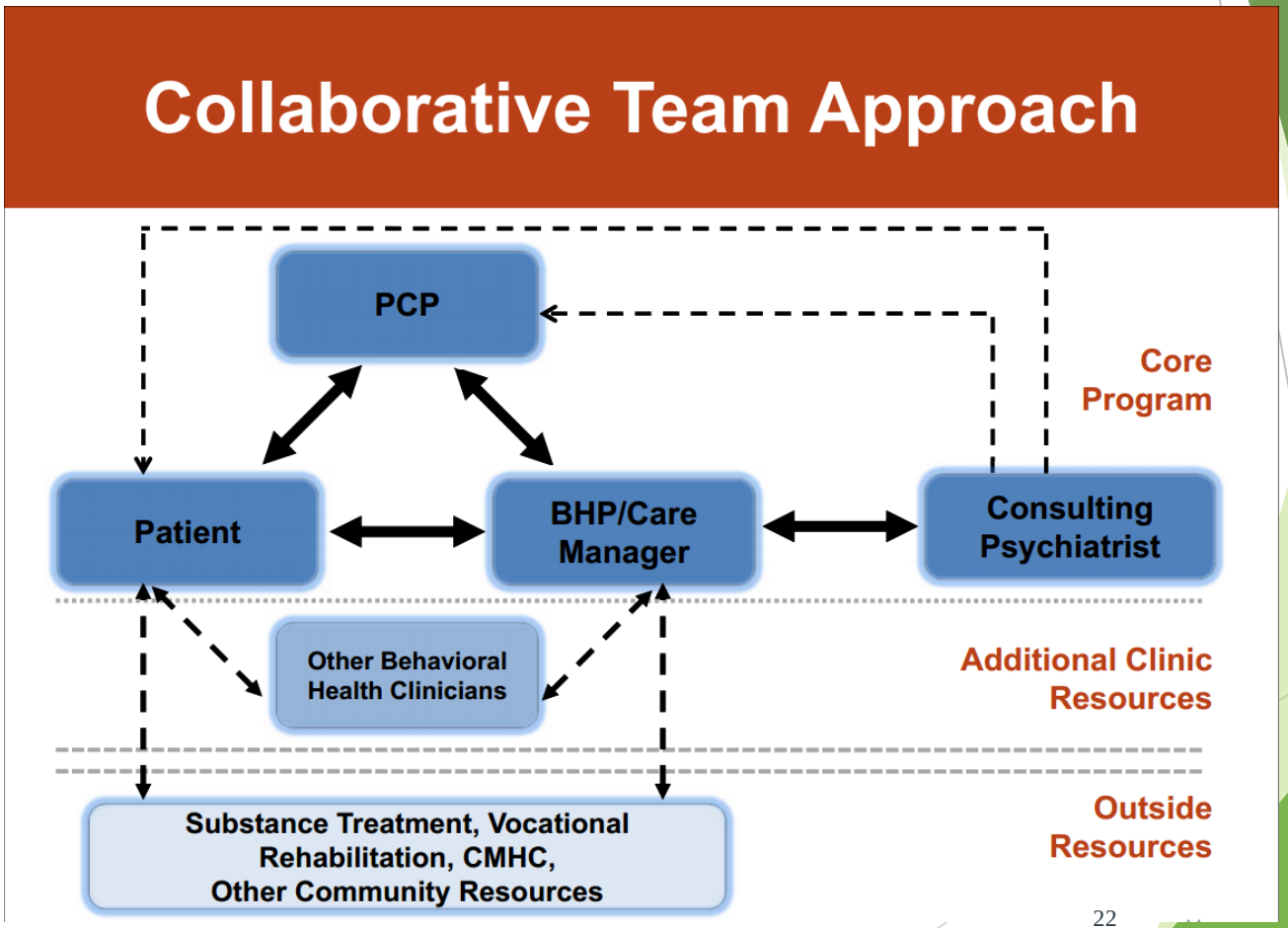
- Behavioral health professional (Masters or higher)
- Psychiatric provider (for diagnostic and tx insights, not just for meds)
- Non-BH personnel trained to provide specific support functions

Patient-Centered Medical Home

7. Collaborative care *is* a medical home

integrated care

Collaborative care *optimizes* all behavioral health resources

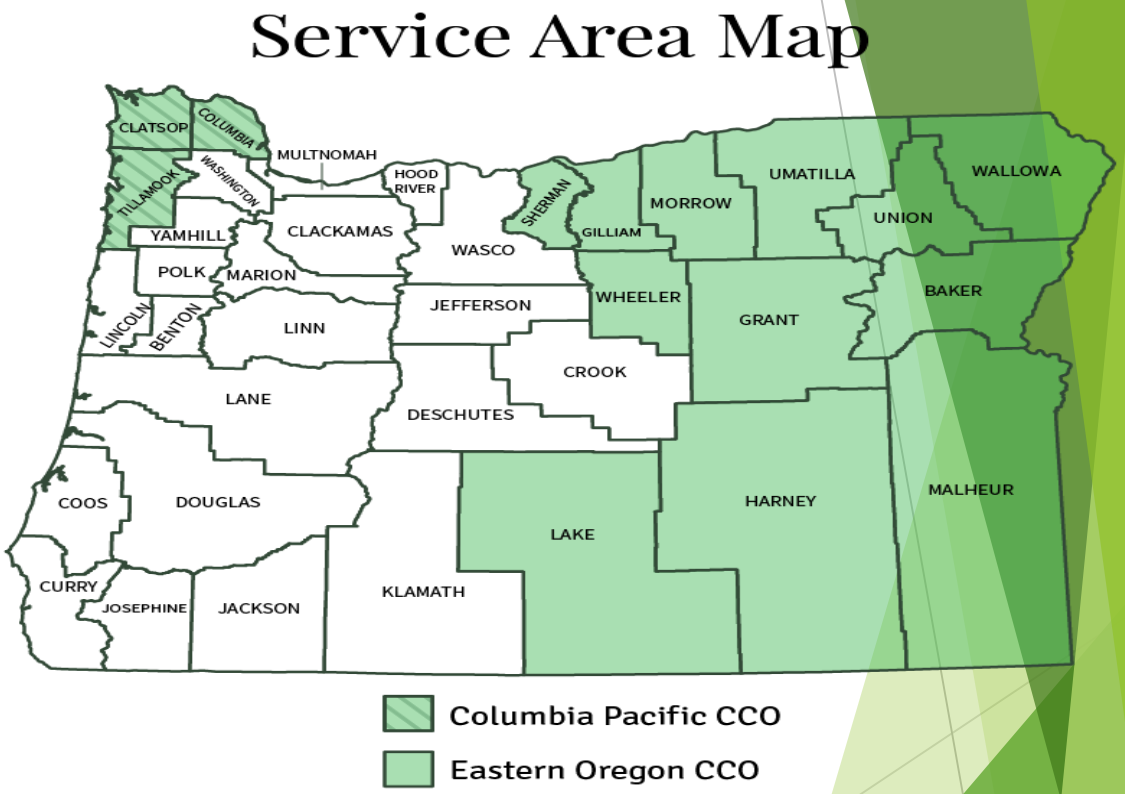


Selected Resources

- AHRQ Academy for Integrating Behavioral Health and Primary Care: http://integrationacademy.ahrq.gov/
- AIMS CENTER: http://aims.uw.edu/
- Center for Integrated Primary Care: http://www.umassmed.edu/cipc/
- Collaborative Family Healthcare Association: www.cfha.net
- Evolving Models of Behavioral Health Integration in primary Care. Milbank Memorial Fund 2010. http://www.milbank.org
- Lexicon for Behavioral Health and Primary Care Integration. AHRQ 2013: http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf
- National Alliance on Mental Illness. Integrating Mental Health & Pediatric Primary Care Resource Center: http://www.nami.org
- SAMHSA/HRSA Center for Integrated Health Solutions: http://www.integration.samhsa.gov

Sites in Action

- **Columbia River Community Health Services**: Boardman, OR (Morrow County)
- **Valley Family Health Care**: Ontario, OR (Malheur County)
- **Wallowa Valley Center for Wellness**: Enterprise, OR (Wallowa County)



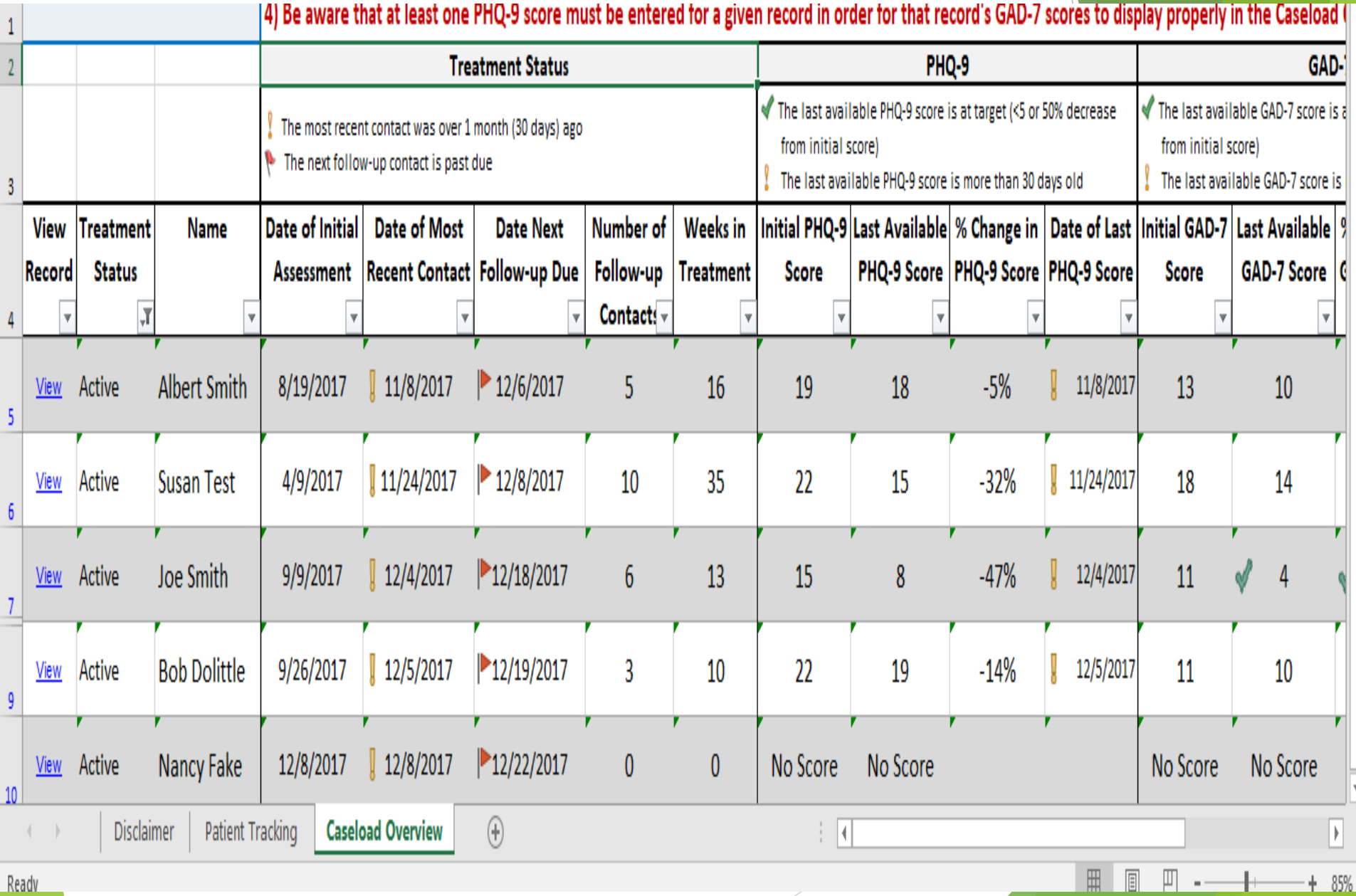
Overview of teams

- Behavioral health care managers: licensed clinical social workers, chronic care management nurse/pharmacist
- Psychiatric consultant: MD, PMHNP
- Primary care providers: between 4-6 at each site (PAs, NPs, MD/Dos)

Workflow

- Similar between sites, with slight variations
- PCP: identifies provisional diagnosis, prescribes, involved in evolution of treatment
- BH Care Managers: engages, educates, refines diagnosis, and drives treatment plan through warm handoffs from PCPs, scheduled visits (from 20-60 minutes), phone follow-up, strategically using screeners, registry management to track treatment to target
  - Use evidence based brief psychotherapy interventions in individual or group form: Problem Solving Treatment, Behavioral Activation, CBT, Interpersonal Psychotherapy, MI

Example Registry



4) Be aware that at least one PHQ-9 score must be entered for a given record in order for that record's GAD-7 scores to display properly in the Caseload

	Treatment Status						PHQ-9				GAD-	
	! The most recent contact was over 1 month (30 days) ago The next follow-up contact is past due						✓ The last available PHQ-9 score is at target (<5 or 50% decrease from initial score) ! The last available PHQ-9 score is more than 30 days old				✓ The last available GAD-7 score is a from initial score) ! The last available GAD-7 score is	
View Record	Treatment Status	Name	Date of Initial Assessment	Date of Most Recent Contact	Date Next Follow-up Due	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
View	Active	Albert Smith	8/19/2017	! 11/8/2017	12/6/2017	5	16	19	18	-5%	! 11/8/2017	13	10
View	Active	Susan Test	4/9/2017	! 11/24/2017	12/8/2017	10	35	22	15	-32%	! 11/24/2017	18	14
View	Active	Joe Smith	9/9/2017	! 12/4/2017	12/18/2017	6	13	15	8	-47%	! 12/4/2017	11	✓ 4
View	Active	Bob Dolittle	9/26/2017	! 12/5/2017	12/19/2017	3	10	22	19	-14%	! 12/5/2017	11	10
View	Active	Nancy Fake	12/8/2017	! 12/8/2017	12/22/2017	0	0	No Score	No Score			No Score	No Score

Disclaimer | Patient Tracking | Caseload Overview

Ready 85%

Workflow continued

- Psychiatric Consultant:
  - Indirect consultation: meets with BH Care Manager for 1 hour weekly to review patients on registry who:
    - Need diagnostic clarification
    - Not improving (haven't had 50% decrease in symptoms over 10-12 weeks with treatment plan already in place)
    - Difficult cases (like pregnancy, medically complex)
  - Direct consultation: sees 1-2 patients per week, if team decides necessary to guide treatment plan

The Treatment Target

- Patient Improves with 50% decrease in symptoms/PHQ9<10
  - Monitor for stability for 3 months with decrease contacts from team (about 1 contact per month)
  - Form relapse prevention plan and remove from registry's active caseload

Collaboration with Community Mental Health Program

- Some patients who do not improve will be referred to the CMHP for longer term psychotherapy, pharmacotherapy, and/or other recovery resources
- Crisis services
- Some patients at the CMHP who reach stability may be referred back to primary care

Community of Practice: Learning from other BH Care Managers

- Vidyo lunch-hour meeting 2x/month with BH Care Managers from the active sites and any others in region who would like to join
- Brief didactic material
- Opportunity to discuss and get support about work flow issues, difficult cases, etc.

Preliminary Qualitative Data from PCPs at start of CRCHS Program

- Prior to program, impression that many barriers to getting patient mental healthcare and not enough supply to meet need of these patients
- A couple months into program, impression of increasing capacity to care for mental health conditions in-clinic and in-coordination with other community providers
- Positive feedback about using screeners as diagnostic and treatment guides, as long as done before start of appointment

Behavioral Health Integration at YVFWC

Brian E. Sandoval, Psy.D.

Clinical Director, Primary Care Behavioral Health
Yakima Valley Farm Workers Clinic

PCBH Staffing

Washington
- 10 BHCs, 9 clinics

Oregon
- 6 BHCs, 5 clinics

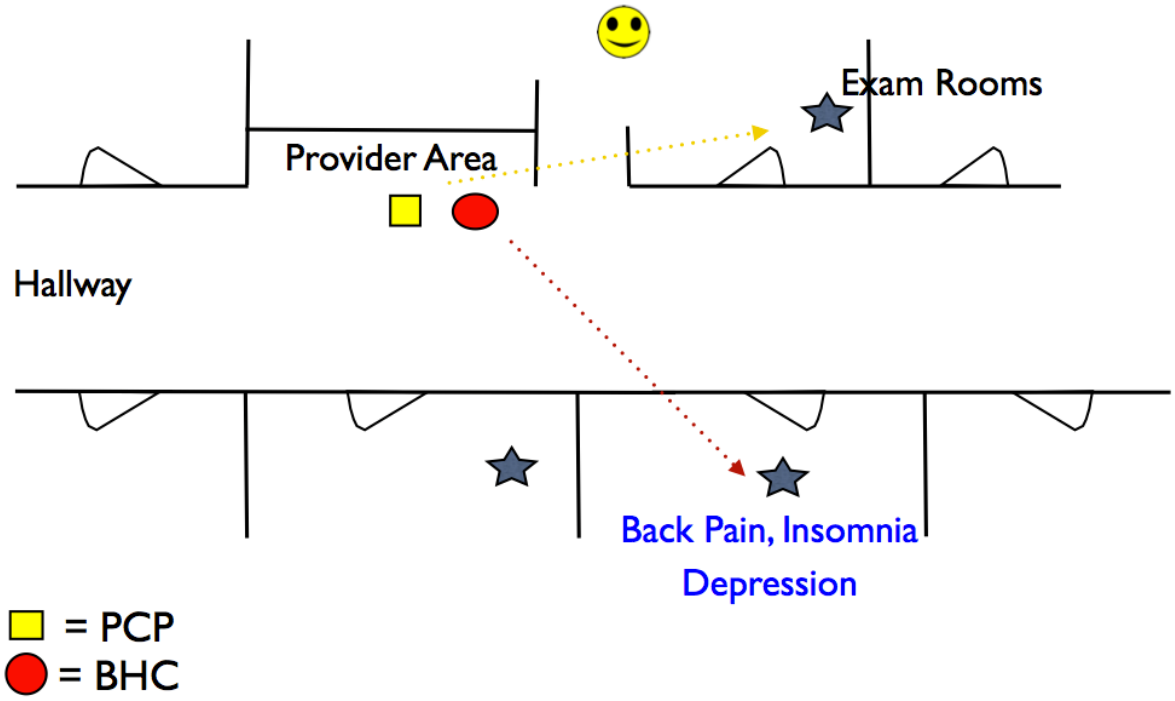
✱ = Current BHC

✱ = BHC open position

The PCBH Consultant Model

PCBH is:

- Routine Primary Care
- Part of PCMH team
- Consultative
- Result of clinical and population need



Adapted from Serrano (2009)

Key Features		
PCBH 		**CoCM** 
Horizontal Integration	**Type**	Vertical Integration
Access/Reach/ ⬇Barriers	**Function**	Care Mgmt. via Registry
PCP consult, brief visits	**Method**	Psychiatry Consult/PST
Constantly “Enrolled”/Accessible	**Duration**	Enrolled for 6 months
Enhance PC/PCMH	**Goal**	Improve Mgmt. of target condition (e.g. depression)

Year in Review: 2017 Data

Unique Patients Served:

14,891

Average Pop. Penetration:

15%

Penetration Range:

4% - 24%

			Unique Medical	Patient pentration	
CFHC GENERAL MEDICINE	**Count: 193**	**192**	4352	4.41%	*
CUTTS, JULIETTE L.	13				
REYNOLDS, NICOLE	186				
SAUERWEIN, MARK	1				
FMC GENERAL MEDICINE	**Count: 1251**	**1251**	8202	15.25%	
WILSON, LEVI	1251				
GMDC GENERAL MEDICINE	**Count: 1238**	**1238**	11259	11.00%	
BECKMANN, SARAH J.	1238				
LHC GENERAL MEDICINE	**Count: 1393**	**1393**	12308	11.32%	
BEEGHLY, JESSICA	1				
CUTTS, JULIETTE L.	68				
WHITE, LAURA J.	1349				
MFHC GENERAL MEDICINE	**Count: 1743**	**1742**	7089	24.57%	
MELENDEZ-CRUZ, CHRISTIAN	1743				
SANCHEZ, RAQUEL	1				
PP PEDIATRICS	**Count: 59**	**59**	2183	2.70%	
CUTTS, JULIETTE L.	59				
RFHC GENERAL MEDICINE	**Count: 1234**	**1233**	6893	17.89%	
BRIGGS, ELIZABETH	1174				
CUTTS, JULIETTE L.	10				
MANDEVILLE, AMY	1				
SANDOVAL, BRIAN E.	106				
SMC GENERAL MEDICINE	**Count: 1556**	**1556**	10293	15.12%	*
BEEGHLY, JESSICA	998				
CUTTS, JULIETTE L.	693				
SANDOVAL, BRIAN E.	26				
SMC BHC	8				
TMDC GENERAL MEDICINE	**Count: 1638**	**1634**	15455	10.57%	*
HAWLEY, PHILLIP B.	1025				
MCVAY, SARAH	5				
SANCHEZ, ROCIO	4				
VALENTINE, COURTNEY	865				
UCHM GENERAL MEDICINE	**Count: 1265**	**1265**	6521	19.40%	
HALLSTROM, KIRSTEN	1262				
WIARDA, NICHOLAS	14				
UCHN GENERAL MEDICINE	**Count: 1392**	**1392**	5591	24.90%	
WIARDA, NICHOLAS	1392				
YMDC GENERAL MEDICINE	**Count: 1951**	**1951**	15815	12.34%	*
HAWLEY, PHILLIP B.	14				
LEE, JESSICA	848				
MCVAY, SARAH	1337				
SANDOVAL, BRIAN E.	1				
		14891			
			Ave pentration	**15.16%**	
			Range	**4.41% - 24.57%**	

PCBH Program Metrics

- **General Productivity**
  - Goal: 10-12 FTF Visits/Day
  - **Actual: 10 visits/day**
- **Program Adoption**
  - Population Penetration (Total Unique BHC / Total Unique Medical)
  - **Goal**: End of 1st year: 5%
    Year 2-3: 7%-10%
    Year 3-4: 10%-12%
    Year 4-5: 12%-15%
    Year 6+: 20%
  - **2017 Average = 14%, Range = 11%-24%**
- **Clinical Measures**
  - PHQ9 - 44.3% improvement*
  - GAD7 - 50.3% improvement**
  - Utilization – Decrease in 2 visits/patient for highest 100 medical utilizers

*Defined as ≥ 5 points pre/post for PHQ-9 scores (Kroenke et al., 2001)

**Defined as ≥3 points pre/post for GAD-7 scores (Spitzer et al., 2006)

PRIMARY CARE BEHAVIORAL HEALTH PROGRAM

we are family

Depression Screening and Follow up (OHA/CCO/UDS)

Org Wide

	UDS Quality Measures Status Update 7-30-2017	YVFWC 2016 UDS	HRSA Benchmark	2017 UDS YTD	2017 UDS YTD	2017 UDS YTD	Variance prior month
Preventive Care							
T6B	Patients screened for depression and follow-up	36.6%	*>51%*	83.3%	83.6%	83.8%	0.2%

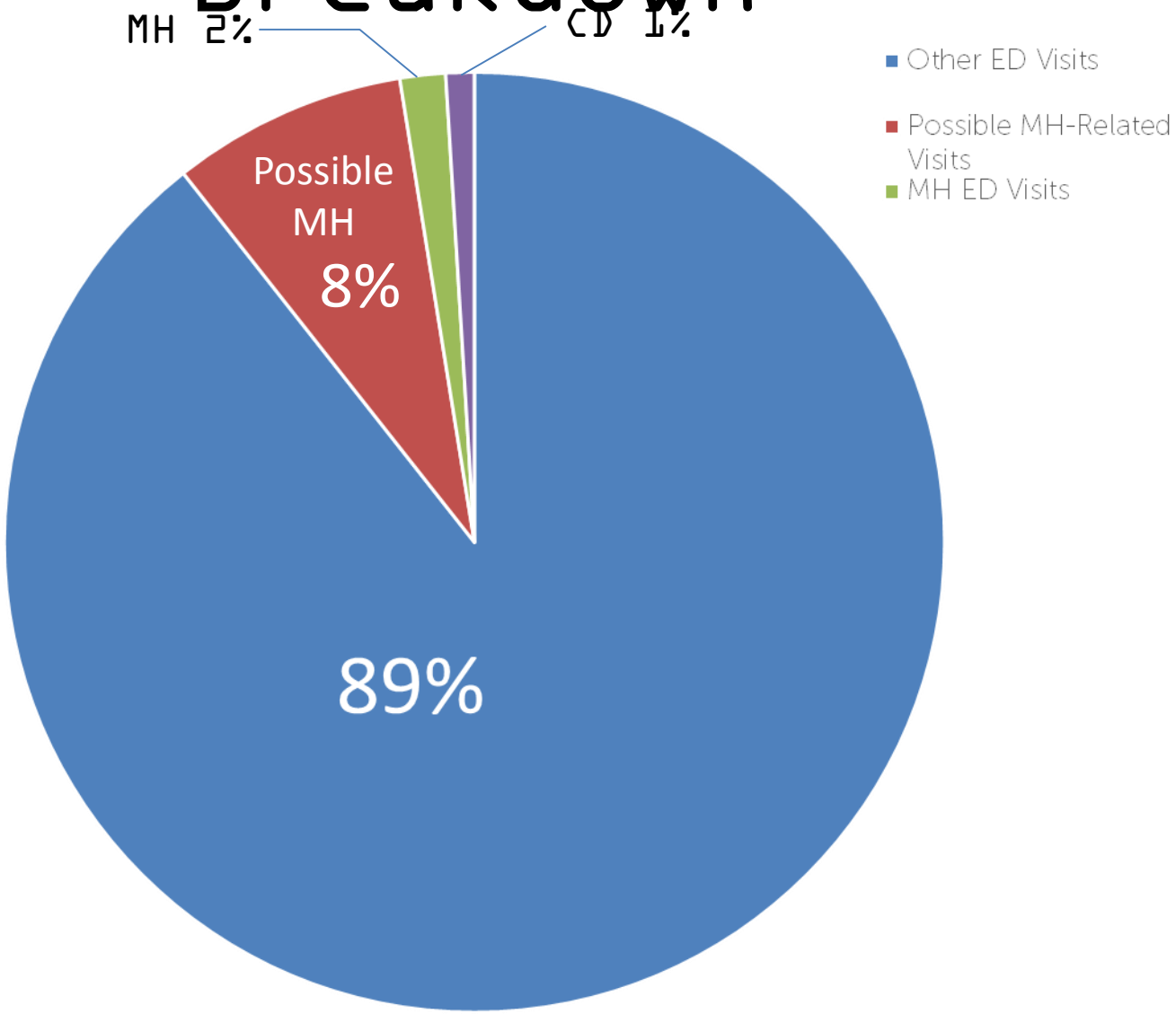
NO BHC

Clinic	Depression screening
Sunnyside Immediate Care	1.8%
Granger Immediate Care	1.9%
Pacific Peds	39.8%
Unify Community Health West Central	49.9%
Mountainview Womens Health	55.4%
Coastal Family Health Center	59.2%
Clatskanie School Based	63.3%
Mid-Valley Medicine	66.5%
Lancaster at Lancaster	67.9%
Yakima Medical-Dental Clinic	68.1%
Lancaster Family Health Center	72.7%
Community Health Center Clatskanie	73.4%
Lincoln Avenue	79.2%
Rosewood Family Health Center	79.2%
Unify Community Health on Mission	80.0%
Salud Medical Center	83.6%
Unify Community Health Northeast	83.9%
Toppenish Medical Dental	85.3%
Grandview Medical Dental Clinic	90.5%
Mirasol Family Health Center	93.5%
Family Medical Center	96.2%
Valley Vista Medical Group	97.2%
Miramar Health Center	97.4%
All YVFWC Clinics (OR & WA)	83.8%
YVFW OR Clinics (only)	82.1%
HRSA Benchmark	51.0%

ED Diagnoses

MENTAL HEALTH		
Diagnosis	**Visit Count YTD**	**Approx Annual Visits**
Anxiety D/O (e.g. Panic, GAD, PTSD)	366	732
Depression	127	254
Suicidality	95	190
Total	**588**	**1176**
CHEMICAL DEPENDENCY	**368**	**736**
SIGNS/SYMPTOMS of possible MH concern		
Unspec/Generalized Abdominal Pain	648	1296
Chest pain	551	1102
Headache	448	896
Epigastric Pain	368	736
Low back pain	276	552
Migraines	208	416
Chronic Pain	194	388
Dizziness	144	288
Palpitations/tach	103	206
Shortness of breath/Dyspnea	82	164
Insomnia	15	30
Total	**3037**	**6074**

ED Visit Reason Breakdown



Highest Utilizers of ED

Treating/tracking patients with MH conditions is paramount!

COORDINATED CARE HIGH ED UTILIZERS		
YTD ED VISITS ≥ 8	(Range 8-22, Median 9)	
N = 29		
	Count	Percentage
MH Diagnosis	25	86.2%
Seen BHC	16	55.2%
Missed opportunities	9	31.0%
No MH and seen BHC	2	6.9%

Continuing Initiatives

- Depression/SBIRT Protcols and Tracking
- ED Pilot Testing and Iteration
- TeleBHC Optimization
- Focus on Retention
- Continue to “be” primary care


NO LONGER
LOST