IMPACT Training
Part 1
Evidence-based
Integrated Mental
Health Care
2011 CBHC Annual
Conference
October 1, 2011

AIMS Center
http://uwaims.org

Jürgen Unützer, MD, MPH, MA
Disclosure

IMPACT Training at
2011 CBHC Annual Conference

Today
8:00-9:30am: IMPACT Training Part 1
Overview of Evidence-based Integrated Mental Health Care
10:00-11:30am: IMPACT Training Part 2
Population-based Stepped Care Approaches to Integrated Mental Health Care
2:30-4:00pm: IMPACT Training Part 3
Implementing Evidence-based Integrated Mental Health Care

IMPACT Training Materials

Available on the 2011 CBHC Annual Conference Website:
http://www.cbhc.org/annual-conference/

Or visit:
http://impact-UW.org/
Integrated Care: Improving Patient Outcomes with a Team Approach

Mental Disorders are Rarely the Only Health Problem

Why Primary Care?
- Patient Centered Care
- Improved Access

Health Care Reform will dramatically expand Medicaid coverage

Dually Eligible in Washington State
- Behavioral health conditions are highly prevalent, especially among working-age disabled duals
- The prevalence of behavioral health conditions is likely to be underestimated because we have not yet integrated Medicare medical claims

Primary Care is the ‘De Facto’ Mental Health System

Alcohol/Drug Treatment Need (FY 2008-09)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Total</th>
<th>Adult NC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol/Drug Treatment Need</td>
<td>4,212</td>
<td>1,964</td>
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Mental Health Diagnosis (FY 2008-09)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Total</th>
<th>Adult NC</th>
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</thead>
<tbody>
<tr>
<td>Mental Illness Diagnosis</td>
<td>95,453</td>
<td>38,319</td>
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<tr>
<td>Psychosis</td>
<td>16,517</td>
<td>6,271</td>
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<tr>
<td>Depression</td>
<td>13,007</td>
<td>4,979</td>
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<tr>
<td>Delirium and Dementia</td>
<td>12,248</td>
<td>2,371</td>
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</table>

Mental Health Medication (FY 2008-09)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Total</th>
<th>Adult NC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antidepressants</td>
<td>17,819</td>
<td>12,506</td>
</tr>
<tr>
<td>Antipsychotics</td>
<td>5,015</td>
<td>1,504</td>
</tr>
</tbody>
</table>

Mentally CCMI medical risk threshold (FY 2008-09)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Total</th>
<th>Adult NC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>12,012</td>
<td>7,319</td>
</tr>
</tbody>
</table>

Smoking, Obesity, Physical Inactivity

- Chronic Physical Pain 25-50%
- Cancer 10-20%
- Neurologic Disorders 10-20%
- Mental Health / Substance Abuse 10-20%
- Heart Disease 10-30%
- Diabetes 10-30%
- Smoking, Obesity, Physical Inactivity 40-70%

Chronic Physical Pain 25-50%
Cancer 10-20%
Neurologic Disorders 10-20%
Mental Health / Substance Abuse 10-20%
Heart Disease 10-30%
Diabetes 10-30%
Smoking, Obesity, Physical Inactivity 40-70%

Mental Health / Substance Abuse

Heart Disease

Diabetes

Smoking, Obesity, Physical Inactivity

Cancer

Neurologic Disorders

Chronic Physical Pain

Dually Eligible in Washington State

- Alcohol/Drug Treatment Need
- Mental Health Diagnosis
- Mental Health Medication
- Mentally CCMI medical risk threshold

Primary Care is the ‘De Facto’ Mental Health System

Integrated Care: Improving Patient Outcomes with a Team Approach

Why Primary Care?

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Health Care Reform will dramatically expand Medicaid coverage

Dually Eligible in Washington State

Primary Care is the ‘De Facto’ Mental Health System
66% of PCPs Report Poor Access to Mental Health Care for Their Patients

Cunningham PJ, Health Affairs, 2009;28(3)490-501

Life of a Busy PCP

- Large patient panels (1,500 – 2,000)
- 20-30 short (15-20 min) encounters / day
- “Everything comes at me.”
- How to cope?
  - Need to focus
  - Diagnose and treat ‘over time’
  - Need practical solutions, effective communication / help

Limits of our Current System

Few clients with behavioral health problems receive effective treatment

- ~ 25% are not recognized or effectively engaged in care
- ~ 25% drop out of treatment too early
- ~ 25% stay on ineffective treatments for too long

Patient-Centered Care?

“Don’t you guys talk to each other?”
Collaboration is NOT a natural state.

CMS: Driving Healthcare System Transformation

Un-managed | Coordinated Care | Patient Centered

- Fee For Service
  - Inpatient focus
  - Inpatient care
  - Low Reimbursement
  - Poor Access and Quality
  - Little oversight
  - No organized networks
  - Focus on paying claims
  - Little Medical Management

- Accountable Care
  - Integrated Care delivery
  - Aligned incentives
  - Linked by HIT

- Integrated Provider Networks
  - Benefit
  - Focus on cost avoidance and quality performance
  - Care management
  - Transparent Performance Management

- Integrated Health
  - Patient Centered
    - Personalized Health Care
    - Production and delivery of health care
    - Patient and provider interaction
    - Information focus
    - Aligned self care management
    - E-health capable
  - Accountable Care Organizations
  - Meaningful use of Health IT

Paul McGann, MD. Acting CMO. CMS. 2/25/2011
We are beyond the ‘tipping point’

Select Integrated Care Initiatives

- 25 years of NIMH Research on Collaborative Care [www.nimh.nih.gov]
- AHRQ Integration Academy
- MacArthur Initiative on Depression and Primary Care: RESPECT study and 3CM Model [www.depressionprimarycare.org]
- HRSA Bureau of Primary Care Health Disparities Collaboratives (over 100 FQHCs) [http://www.hrsa.gov/mentalhealth]
- RAP Program: Depression in Primary Care—Linking Clinical and System Strategies
- NCCBH Collaborative Care Learning Collaboratives [http://www.thenationalcouncil.org]
- California Endowment: Integrated Behavioral Health Program (IBHP) [http://www.ibhp.org]
- CIIM: [http://www.clinc.org/Initiative/Primary-Care-BH-Integration.aspx]
- CAL: [www.calnosed.org]
- Hogg Foundation for Mental Health Integrated Mental Health Initiative in Texas [http://www.hogg.utexas.edu/programs_ihc.html]
- REACH: [Project in New Orleans: [http://reachnola.org/]
- VA, US Air Force, HMOs (Group Health, Kaiser Permanente), Cherokees, Washoe County
- Patient Centered Primary Care Collaborative: [www.pcpcc.net]
- Collaborative Family Healthcare Association [www.CFHA.net]
- AAFP's National Research Network [www.aafp.org/nrn/ccrn]
- UCI Health: [www.cimh.org/Initiatives/Primary-Care-BH-Integration.aspx]
- CAL MEND [www.calmend.org]
- Hogg Foundation for Mental Health Integrated Mental Health Initiative in Texas [http://www.hogg.utexas.edu/programs_ihc.html]
- REACH: [Project in New Orleans: [http://reachnola.org/]
- VA, US Air Force, HMOs (Group Health, Kaiser Permanente), Cherokees, Washoe County
- Patient Centered Primary Care Collaborative: [www.pcpcc.net]
- Collaborative Family Healthcare Association [www.CFHA.net]
- AAFP's National Research Network [www.aafp.org/nrn/ccrn]

Evidence-based Solutions for Integrated Care

The Evidence for Collaborative Care

Over 40 Randomized Controlled Trials for Depression: Gilbody S. et al., Archives of Internal Medicine; Dec 2006
- 37 trials of collaborative care for depression in primary care (US and Europe)
- CC consistently more effective than usual care

Since 2006, several additional RCTs in new populations and for other common mental disorders (e.g., CALM study for anxiety disorders, PTSD)

The IMPACT Study

Funded by John A. Hartford Foundation
California Healthcare Foundation

IMPACT Study

1998 – 2003
1,801 depressed adults
18 primary care clinics –
- 8 health care organizations in 5 states
  - Diverse health care systems
    - Urban & semi-rural settings
    - Capitated (HMO & VA) & fee-for-service
  - 450 primary care providers

IMPACT Study Methods

Design:
- 1,801 depressed adults randomly assigned to IMPACT or to Care as Usual

Usual Care:
- Primary care or referral to specialty mental health

IMPACT Care:
- Collaborative / stepped care disease management program for depression in primary care
  - Offered for up to 12 months

Analyses:
- Independent assessments of health outcomes and costs for 24 months. Intent to treat analyses

Unützer et al., J Med Care. 2001; 49(5):785-99
### Case Example

‘Mr. T’

### Team-based Care

**Patient**
- Chooses treatment in consultation with provider(s):
  - Antidepressant and / or brief psychotherapy

**Primary Care Provider (PCP)**
- Refers; prescribes antidepressant medications
+ Depression Care Manager
+ Consulting Psychiatrist

### IMPACT Team Care Model

**Effective Collaboration**
- Prepared, Pro-active Practice Team
- Informed, Activated Patient

**Practice Support**

### IMPACT Treatment Protocol

1. Assessment and Education
2. Behavioral Activation / Pleasant Events Scheduling
   AND
3. a) Antidepressant Medication
   - Usually an SSRI or other newer antidepressant
   OR
   b) Problem-Solving Treatment in Primary Care (PST-PC)
   - 6-8 individual sessions followed by monthly group maintenance sessions
4. Maintenance and Relapse Prevention Plan for patients in remission

### Stepped Care

- Systematic follow-up & outcomes tracking
  - Patient Health Questionnaire (PHQ-9)
    - The “cheap suit”
- Treatment adjustment as needed
  - Based on clinical outcomes
  - According to evidence-based algorithm
  - In consultation with team psychiatrist

### IMPACT Findings Robust Across Diverse Organizations

- 50% or greater improvement in depression at 12 months
- Treatment adjustment as needed
- Based on clinical outcomes
- According to evidence-based algorithm
- In consultation with team psychiatrist

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Unutzer et al., JAMA, 2002
Psych Clin N America, 2004

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IMPACT Training for 2011 CBHC Annual Conference

10/1/2011
IMPACT Care Benefits Ethnic Minority Populations

50% or greater improvement in depression at 12 months

- White: 43% IMPACT, 10% Usual Care
- Black: 94% IMPACT, 25% Usual Care
- Latino: 42% IMPACT, 14% Usual Care

Areán et al., Medical Care, 2005

IMPACT Summary

- Less depression (IMPACT doubles effectiveness of usual care)
- Less physical pain
- Better functioning
- Higher quality of life
- Greater patient and provider satisfaction
- Effective with minorities
- Cost effective

Unützer et al., JAMA, 2002; Psych Clin N America, 2004

Fewer Thoughts of Suicide

% patients with suicidal thoughts

- IMPACT
- Usual Care

Unützer et al., JAGS, 2006

Co-Location is NOT Integration

50% or greater improvement in depression at 12 months

Participating Organizations

Unützer et al., JAMA, 2002; Psych Clin N America, 2004

Case Example

‘Mr. T’ - II

The Value of a Team Approach

Photo credit: J. Lott, Seattle Times

“I got my life back”
“None of us is as smart as all of us”

Effective teamwork is key to success

– Different professionals (nurses, social workers, psychologists, licensed counselors, and medical assistants) work together to support primary care providers with evidence-based care

– Psychiatric caseload review / consultation provides important back-up to primary care based care management programs

Primary Care Provider – I

– Oversees all aspects of patient’s care
– Diagnoses common mental disorders
  – Brief screeners: (e.g., PHQ-9, MDQ, GAD-7)
– Starts & prescribes pharmacotherapy
– Introduces collaborative care team and care manager
– Consults with care manager and team psychiatrists and makes treatment adjustments as needed.

Care Manager – I

– Supports and collaborates closely with PCPs managing patients in primary care
– Facilitates patient engagement and education
– Performs systematic initial and follow-up assessments. Systematically tracks treatment response
– Supports medication management by PCPs

Care Manager – II

– Provides brief, evidence-based counseling (e.g., behavioral activation, PST-PC) or refers to other providers for counseling services
– Reviews challenging patients with the consulting psychiatrist weekly
– Facilitates referrals to other services (e.g., substance abuse treatment, specialty care and community resources) as needed
– Prepares client for relapse prevention

Psychiatric Consultant

Supports care managers and PCPs

– Provides regular (weekly) and as needed caseload review and consultation on a caseload of patients in primary care,
  – focusing on patients who are not improving clinically
– In person or telemedicine consultation or referral for complex patients
– Provides education and training for primary care-based providers

Other Mental Health Professionals

Available in some clinics

– behavioral health specialists / psychotherapists / CD counselors / clinical social workers / clinical psychologists
– Incorporated in team care model and ‘shared clinical workflow’
**Principles for patient-centered integrated behavioral health care**

**Principles of care:**
1. Patient centered collaborative care
2. Population-based care: keep patients from ‘falling through the cracks’
3. Measurement-based practice and treatment to target: provide care that works
4. Pay for performance: pay for value, not volume

**Tasks for patient-centered integrated behavioral health care**

**Specific Tasks:**
1. Patient Identification and Diagnosis
2. Treatment Engagement and Initiation
3. Follow-up and Treatment Adjustment
4. Communication and care coordination
5. Systematic case review and psychiatric consultation
6. Referrals
7. Relapse prevention
8. Administrative support
9. Clinical support
10. Quality improvement

**Replication Studies**

<table>
<thead>
<tr>
<th>Patient Population (Study Name)</th>
<th>Target Clinical Conditions</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult primary care patients</td>
<td>Diabetes and depression</td>
<td>Katon et al., 2004</td>
</tr>
<tr>
<td>Adult patients in safety net clinics</td>
<td>Diabetes and depression</td>
<td>Gilmer et al., 2008</td>
</tr>
<tr>
<td>Adult patients in safety net clinics</td>
<td>Diabetes and depression</td>
<td>Ell et al., 2010</td>
</tr>
<tr>
<td>Public sector oncology clinic</td>
<td>Cancer and depression</td>
<td>Dwight-Johnson et al., 2005</td>
</tr>
<tr>
<td>HMO patients</td>
<td>Depression in primary care</td>
<td>Guptha et al., 2006</td>
</tr>
<tr>
<td>Adolescents in primary care</td>
<td>Adolescent depression</td>
<td>Richardson et al., 2009</td>
</tr>
<tr>
<td>Older adults</td>
<td>Arthritis and depression</td>
<td>Unutzer et al., 2008</td>
</tr>
<tr>
<td>Acute coronary syndrome patients (COPES)</td>
<td>Coronary events and depression</td>
<td>Davidson et al., 2010</td>
</tr>
</tbody>
</table>

**Evidence for Integrated Care for Anxiety and PTSD**

Several studies show Collaborative Care more effective than usual care for
- Panic Disorder
  - Roy-Byrne, Katon et al.
  - Multiple Anxiety Disorders (CALM Study)
    - Roy-Byrne, Craske, Sullivan, Stein, et al.
- PTSD
  - Zatzick et al.

**Greater Remission Rates in Panic Disorder**

![Graph showing remission rates in panic disorder](image)

*p<.05*
Some Lessons

1) ‘None of us are as smart as all of us’
   PCP, Care Manager, Consulting Psychiatrist

2) Co-location is NOT sufficient
   Successful integration requires
   - Clinical, operational, and financial integration
   - A shared workflow and shared, measurable goals

3) Initial treatments are rarely sufficient. Several changes in treatment are often necessary
   - Outcomes tracking.
   - Measurement based stepped care
   - Consultation for clients who are not improving as expected.

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Tasks for patient-centered integrated behavioral health care

Specific Tasks:
1. Patient Identification and Diagnosis
2. Treatment Engagement and Initiation
3. Follow-up and Treatment Adjustment
4. Communication and care coordination
5. Systematic case review and psychiatric consultation
6. Referrals
7. Relapse prevention
8. Administrative support
9. Clinical support
10. Quality improvement
**Population-focused**

Public health approach; making sure no one ‘falls through the cracks’
Assume responsibility for an entire population of clients
Pro-active vs. Re-active
The clients who no-show may need the most attention

**Measurement-based Stepped Care**

Core symptoms can be measured
– Like blood pressure
Measurement gives information to clients and providers
– Offers a target for treatment
– How will we know if we are getting there?
– Treatment changes more proactive, frequent

**Care Manager: Core Skills**

Actively engages the patient in therapeutic alliance
Conducts initial assessment and follow-up visits using standard assessments and symptom scales (e.g., PHQ-9)
Provides patient education and reviews goals and expectations of treatment
Elicits treatment preferences
Encourages treatment adherence
Supports medication management by Primary Care Provider
Provides brief, structured counseling / psychotherapy (behavioral activation, PST-PC) or referral for psychotherapy

**Care Manager: Core Skills**

Coordinates care
– Consults with team psychiatrist
– Collaborates closely with patient’s primary care provider (PCP)
– Facilitates referrals to specialty care community resources

**Care Managers Support the Patient’s PCP**

Few PCPs have the time & support necessary to:
– Fully educate and support patients in treatment
– Closely monitor treatment & make adjustments in treatment when needed

Care Managers:
– Support treatments initiated by PCP
– Provide education and brief, structured counseling
– Refer to other resources (e.g., substance abuse counseling, psychotherapy, social work)
– Facilitate consultation by a mental health specialist (e.g., psychiatrist) as needed

**Communication with PCPs**

Clarify preferred method of communication
– In person
– Phone
– Fax
– Email (careful with confidential information)

Communicate changes in patient’s clinical and functional status
– Prioritize which changes need to be brought to the attention of the PCP
– Maintain enough contact so that they remember who you are, but no so much that they see you as a pest
Key Elements to Include When Talking to PCP

Baseline Clinical measures
– e.g., PHQ-9 Score

Current Symptoms
– Symptoms that aren’t improving

Length of time on current treatments

Problematic side effects

Care Manager: The Facilitating Presence

Actively engages the patient in a therapeutic alliance by:
– Eliciting concerns
– Providing information
– Clarifying preferences
– Encouraging informed decision-making
– Conveying hopefulness
– Teaching skills
– Monitoring progress
– Reinforcing self-management

Screening and Symptom Tracking

Depression: Patient Health Questionnaire (PHQ-9)

Assists with depression diagnosis

Tracks 9 core symptoms of depression over time

Easy to use

Patients become familiar with it

Can be done over the phone

A good teaching tool
PHQ-9: How to Administer

In-Person
– Especially initially
– Facilitates assessment AND teaching about depression

Self-administered

PHQ-9: How to Score

PHQ-9: How to Score

Understanding the PHQ-9 Score

Score | Severity
--- | ---
0 – 4 | No Depression
5 – 9 | Mild Depression
10 – 14 | Moderate Depression
≥ 15 | Severe Depression

Screening for Anxiety Disorders: “Have you had...”

• Sudden unexpected anxiety or physical symptoms when no one around (PD)
• Worry, tense, anxious more days than not for 6 months (GAD)
• Anxiety and avoidance in social situations (SAD)
• Recurrent intrusive recollections of trauma or avoidance of trauma reminders (PTSD)

The Generalized Anxiety Disorder (GAD)-7 Scale

Scoring the GAD-7

Score | Severity
--- | ---
0-5 | Mild Anxiety
6-10 | Moderate Anxiety
11-15 | Moderately Severe Anxiety
16-21 | Severe Anxiety


Kroenke K et al., Ann Intern Med. 2007;146:317-325

Ann Intern Med. 2007;146:317-325
Initial Visit

Assessment
Education
Discuss treatment options / plans
Coordinate care with PCP
Start initial treatment plan
Arrange follow-up contact
  – In person or by phone
  – In one week or earlier
Document initial visit

Patient Engagement

PCP introduction
Warm handoff
Call immediately
Flyers
Not “program”
More work than patient
Don’t give up
Tracking

Discussing Mental Health Diagnosis with Patient

“Don’t argue” about whether or not patient has mental illness → focus on symptoms and symptom resolution
  – Give hope!
  – “You don’t have to feel this way”
  – “This can be treated”
Educate patient about treatment in primary care
  – To reduce resistance from stigma
  – Depression as a medical condition
  – We have effective treatments for this

Address Attitudes & Beliefs About Depression

Patients often know little about depression or anxiety disorders
Many may feel like they should “handle it themselves”
  – About 60% of people aged 65 and older believe it is “normal” for people to get depressed as they age
Patient Education – Depression

Depression affects the body, behavior, and thinking
*Physical symptoms may be the most apparent*

The ‘cycle of depression model’
Depression can almost always be treated with antidepressant medications or psychotherapy
Recovery from depression is the rule, not the exception
*...but relapse is common if treatment discontinued*

Minor tranquilizers, drugs, and alcohol can make depression worse, not better

The ‘Cycle of Depression’

<table>
<thead>
<tr>
<th>STRESSORS</th>
<th>THOUGHTS &amp; FEELINGS</th>
<th>PHYSICAL PROBLEMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Illness</td>
<td>Negative thoughts</td>
<td>Poor sleep</td>
</tr>
<tr>
<td>Family Problems</td>
<td>Low self esteem</td>
<td>Pain</td>
</tr>
<tr>
<td>Work Problems</td>
<td>Sadness</td>
<td>Low Energy</td>
</tr>
<tr>
<td></td>
<td>Hopelessness</td>
<td>Poor concentration</td>
</tr>
</tbody>
</table>

Behavior
Social Withdrawal
Decreased activities
Decreased productivity

Talking with Caregivers About Depression

Patient education materials (booklets, videos) can aid caregivers in recognizing depression symptoms
Caregivers may have a better view of the patient’s mood and behavior changes over time

Anxiety

- Stress responses are ‘normal’ reactions
- Anxiety is often ‘experienced’ in your body
- Anxiety can be a normal reaction that has become too intense or is triggered at times when it is not really needed

Anxiety Cycle

- Physical symptoms (e.g., sweaty, shaking)
- Thoughts of: dying, going crazy, losing control; danger and catastrophes; being negatively judged by others
- Avoidance and escape behaviors

Treatment Planning

Patient, PCP & Care Manager all involved in making the treatment plan
Treatment plans are ‘individualized’ because patients differ in
- Medical comorbidity
- Psychiatric comorbidity
- Prior history of depression and treatment
- Current treatments
- Treatment preferences
- Treatment response
Treatment Expectancies?

OUTCOME EXPECTANCY:
Is treatment going to work?

SELF-EFFICACY EXPECTANCY:
Can I help myself get better?

Follow-Up Contacts

Weekly or every other week during acute treatment phase
- In person or by telephone to evaluate depression severity (PHQ-9) / treatment response

Initial focus on
- Adherence to medications
- Discuss side effects
- Follow-up on activation and PST plans

Later focus on
- Complete resolution of symptoms and restoration of functioning
- Long term treatment adherence

Using the Telephone

Under utilized tool
- Check up on adherence to medications
- Check in about side effects to medications
- Check in on behavioral activation
- Check in on symptoms after in remission

Client-centered approach
- Convenient
- Pro-active

Why Track Outcomes

Facilitate treatment planning and adjustment (know when it’s time to change)
- Avoid Patients staying on ineffective treatments for too long

Know when to refer for consultation / get help
- Example: Blood Pressure

Systematic Outcome Tracking
Remember: Most Patients Will Need Treatment Adjustments

Over 30 – 50% of patients will have a complete response to initial treatment

50 – 70% will require at least one change in treatment to get better

Tracking Systems

Tracking is an essential function of IMPACT … and all effective chronic care programs

– Can be accomplished in many different ways
– Each has pros/cons

Paper Tracking

Electronic Medical Records

Can track ‘key information’

– Visits
– Medications
– Consultations
– Outcome measures (e.g., PHQ-9)

EMR example from Institute for Family Health
(Virna Little, PsyD, LCSW-R, SAP)
How Can a Registry Help?

- Keep track of all clients so no one “falls through the cracks”
  - Up to date client contact information
  - Referral for services
- Tells us who needs additional attention
  - Clients who are not following up
  - Clients who are not improving
  - Reminders for clinicians & Managers
  - Customized caseload reports
- Facilitates communication, mental health specialty consultation, and care coordination

Facilitate Consultation

- Establish set schedule for psychiatrist caseload consultations and in person consultations / visits
- Facilitate communication between PCPs and consulting psychiatrists
Seek Consultation with Psychiatrist when Patient...

- Is severely depressed (PHQ-9 score ≥20)
- Fails to respond to treatment
- Has complicating mental health diagnosis, such as personality disorder or substance abuse
- Is bipolar or psychotic
- Has current substance dependence
- Is suicidal or homicidal

Discussing Treatment Adjustment with the PCP

PCPs may be more receptive to suggested treatment adjustments if you can say:

- “the consulting psychiatrist, Dr. ___ suggests that we consider…”

Key Principles of Medication Therapy

Most Patients Need Treatment Adjustments

Over 30 – 50% of patients will have a complete response to initial treatment

50 – 70% will require at least one change in treatment to get better
Using Antidepressants

Key principles

– Use antidepressants, not minor tranquilizers / benzodiazepine for depression and most anxiety disorders
– Use adequate doses for an adequate amount of time
– Start slow and work with side effects but titrate to an effective dose as needed
– Change medication if not effective
  • Usually after 8 – 10 weeks

FDA-Approved Antidepressants

Serotonin Reuptake Inhibitors (SSRIs)
fluoxetine (Prozac), paroxetine (Paxil), citalopram (Celexa), escitalopram (Lexapro), sertraline (Zoloft), fluvoxamine (Luvox)

Newer Antidepressants (atypical)
buproprion SR (Wellbutrin), mirtazapine (Remeron), venlafaxine XR (Effexor), desvenlafaxine (Pristiq), duloxetine (Cymbalta)

Tricyclics (TCAs)
secondary amines: nortriptyline, desipramine
tertiary amines: imipramine, doxepin, amitriptyline

Not recommended for older adults

Serotonin Reuptake Inhibitors (SSRIs)

Common side effects in all SSRIs (>10 %): GI distress (nausea, diarrhea), insomnia, restlessness, agitation, fine tremor, headache, dizziness, sexual dysfunction.

* mg

<table>
<thead>
<tr>
<th>Drug name</th>
<th>Unit doses</th>
<th>Therapeutic dose</th>
<th>Usual dose</th>
<th>Starting dose</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fluoxetine</td>
<td>10, 20</td>
<td>10-60</td>
<td>20</td>
<td>10 daily</td>
<td>Long half-life</td>
</tr>
<tr>
<td>Sertraline</td>
<td>50, 100</td>
<td>25-200</td>
<td>50-100</td>
<td>25 daily</td>
<td></td>
</tr>
<tr>
<td>Citalopram</td>
<td>20, 40</td>
<td>10-40</td>
<td>20</td>
<td>10 daily</td>
<td>Few drug interactions</td>
</tr>
<tr>
<td>Escitalopram</td>
<td>5, 10, 20</td>
<td>10-20</td>
<td>10</td>
<td>10 daily</td>
<td>Few drug interactions</td>
</tr>
<tr>
<td>Paroxetine</td>
<td>10, 20, 30, 40</td>
<td>10-50</td>
<td>20-30</td>
<td>10 daily</td>
<td>Dry mouth, constipation</td>
</tr>
</tbody>
</table>

SNRI side effects: GI distress (nausea, diarrhea), insomnia, restlessness, agitation, fine tremor, headache, dizziness, sexual dysfunction, decreased appetite, sexual dysfunction.

Small risk of elevation of blood pressure at higher doses => check BP.

* mg

<table>
<thead>
<tr>
<th>Drug name</th>
<th>Unit doses</th>
<th>Therapeutic dose</th>
<th>Usual dose</th>
<th>Starting dose</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Venlafaxine</td>
<td>25, 75, 100</td>
<td>75, 150</td>
<td>12.5-150 bid</td>
<td>25-100 bid</td>
<td>25 daily</td>
</tr>
<tr>
<td>Comment</td>
<td>Once daily dosing with XR preparation.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Desvenlafaxine
(no generic)

<table>
<thead>
<tr>
<th>Drug name</th>
<th>Unit doses</th>
<th>Therapeutic dose</th>
<th>Usual dose</th>
<th>Starting dose</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desvenlafaxine</td>
<td>50 – 100</td>
<td>50</td>
<td>50 daily</td>
<td>50 daily</td>
<td></td>
</tr>
</tbody>
</table>

Comments
Active metabolite of venlafaxine; similar side effect profile.

New Antidepressants: SNRIs

SNRI side effects: GI distress (nausea, diarrhea), insomnia, restlessness, agitation, fine tremor, headache, dizziness, sexual dysfunction, decreased appetite, sexual dysfunction.

Small risk of elevation of blood pressure at higher doses => check BP.

* mg

<table>
<thead>
<tr>
<th>Drug name</th>
<th>Unit doses</th>
<th>Therapeutic dose</th>
<th>Usual dose</th>
<th>Starting dose</th>
<th>Comments</th>
</tr>
</thead>
</table>
| Duloxetine | 20, 30, 60 | 40-60 daily | 40-60 daily | 30 daily | Nausea, dry mouth, constipation, decreased appetite, fatigue, sweating, sexual dysfunction. Enteric coated. DO NOT break tablets!
**Mirtazapine**

<table>
<thead>
<tr>
<th>Drug name</th>
<th>Unit doses</th>
<th>Therapeutic dose</th>
<th>Usual dose</th>
<th>Starting dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mirtazapine</td>
<td>15, 30</td>
<td>15-45 qhs</td>
<td>15-30 qhs</td>
<td>7.5 -15 qhs</td>
</tr>
</tbody>
</table>

**Comments**
- Sedation, weight gain.
- Minimal sexual side effects.
- May help with anxiety / nausea.


**Bupropion**

<table>
<thead>
<tr>
<th>Drug name</th>
<th>Unit doses</th>
<th>Therapeutic dose</th>
<th>Usual dose</th>
<th>Starting dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bupropion</td>
<td>75,100</td>
<td>75-150 tid</td>
<td>75-150 tid</td>
<td>75 daily</td>
</tr>
<tr>
<td>SR 100, 150</td>
<td>100-200 bid (SR)</td>
<td>100-200 bid (SR)</td>
<td>100 daily (SR)</td>
<td></td>
</tr>
<tr>
<td>XL 150, 300</td>
<td>150-450 daily (XL)</td>
<td>150-300 daily (XL)</td>
<td>150 daily (XL)</td>
<td></td>
</tr>
</tbody>
</table>

**Comments**
- TID dosing with regular preparation.
- BID dosing with SR. Daily dosing with XL.
- Insomnia, agitation, tremor.
- Anorexia; no weight gain.
- Risk of seizures at high doses.
- Minimal sexual side effects.
- Perhaps less mania induction in bipolars
- Not good for anxiety.


**Secondary Amine Tricyclics (TCAs)**

**Common side effects in all TCAs (>10 %):**
- arrhythmias (particularly with pre-existing conduction defects), dry mouth, constipation, blurry vision, orthostatic hypotension, and weight gain.

<table>
<thead>
<tr>
<th>Drug name</th>
<th>Unit doses</th>
<th>Therapeutic dose</th>
<th>Usual dose</th>
<th>Starting dose</th>
<th>Side effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nortriptyline</td>
<td>10, 25, 50, 75</td>
<td>40-150</td>
<td>50-100</td>
<td>10 qhs</td>
<td>Weakness/fatigue</td>
</tr>
<tr>
<td>Desipramine</td>
<td>10, 25, 50, 75, 100, 150</td>
<td>75-200</td>
<td>100-200</td>
<td>25 daily</td>
<td>Tachycardia, insomnia, agitation</td>
</tr>
</tbody>
</table>


**Choosing Antidepressants**

- Prior treatment history in patient/family members
- Patient preferences
- Expertise of prescribing provider
- Side effect profile
- Safety in overdose
  - 10 days of a TCA can be a lethal overdose
- Availability and costs
- Drug-drug interactions


**When and How to Stop Antidepressants?**

- Treat all adults for 4-9 months after initial response
- Treat those at high risk for relapse for 2 years or longer. Some may need lifetime treatment
- Maintenance treatment should be at full dose
- Make a relapse prevention plan
- Taper antidepressants slowly to avoid discontinuation syndrome


**Depression is a Chronic Disease**

- 15 years after recovery, *85% of patients have experienced a recurrence*

---

*Mueller TI et al., Am J Psychiatry, 1999*
*Keller MB et al., JAMA, 1983*
Maintenance Therapy on Basis of Episodes

Problems Early in Treatment
Nonadherence
Medical and psychiatric comorbidity
Side effects
Unmasking bipolar disorder
Activation and suicidal ideation
Incomplete response

General Office Strategies for Optimizing Adherence
Provide rationale for use
Careful attention to side-effects (see below)
Counter demoralization
Address fear of dependence and loss of control
Enlist family/spousal support
Address concerns in relation to patient’s or significant other’s prior experience with medication
Increase contact with brief phone check-ins
Specific instructions (take regardless of symptom change, don’t stop on own)
Use symptom scale (e.g., PHQ-9)

Is Patient at Maximum Therapeutic Dosage?*

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fluoxetine</td>
<td>60mg</td>
</tr>
<tr>
<td>Paroxetine</td>
<td>60mg</td>
</tr>
<tr>
<td>Escitalopram</td>
<td>20mg</td>
</tr>
<tr>
<td>Citalopram</td>
<td>60mg</td>
</tr>
<tr>
<td>Sertraline</td>
<td>200mg</td>
</tr>
<tr>
<td>Venlafaxine</td>
<td>300mg</td>
</tr>
<tr>
<td>Desvenlafaxine</td>
<td>100mg</td>
</tr>
<tr>
<td>Duloxetine</td>
<td>60mg</td>
</tr>
<tr>
<td>Bupropion SR</td>
<td>450mg</td>
</tr>
<tr>
<td>Mirtazapine</td>
<td>60mg</td>
</tr>
<tr>
<td>Nortriptyline</td>
<td>150mg  (check serum level)</td>
</tr>
<tr>
<td>Despramine</td>
<td>300mg  (check serum level)</td>
</tr>
</tbody>
</table>

*Consider titrating to these doses unless patient does not tolerate them ‘maximum doses’ due to side effects.

Managing Side Effects
Consult with pharmacist / team psychiatrist
Are side effects ‘physical’ or ‘psychological’?
Short term strategies
Wait and support (e.g., GI side effects of SSRIs)
Adjust medication timing (e.g., take sedating meds at bedtime)
Consider temporary dose reduction
Treat side effects (if drug effective)
Change to a different antidepressant
Change to or add PST-PC
Common Side Effects

Short term:
- GI upset / nausea
- Jitteriness / restlessness / insomnia
- Sedation / fatigue

Long term:
- Sexual dysfunction (up to 33%)
- Weight gain (5 to 10%)

Orgasmic Dysfunction

25 – 33% of SSRI-treated patients

Change to
- Bupropion
- Mirtazapine

Augment
- Bupropion SR 100mg PO BID
- Buspirone 15mg PO BID to 30mg PO BID

Weight Gain

5 to 10% of SSRI treated patients

Rx – Bupropion, Fluoxetine

Drug-Drug Interactions

Antidepressants are metabolized by the P450 isoenzyme system in the liver. They can
- change blood levels of other drugs that are metabolized by the same hepatic enzymes
- displace other protein-bound drugs

Rule of thumb: if a patient is on a drug with a narrow therapeutic window (e.g., digoxin, warfarin, theophylline, antiarrhythmics, lithium, TCAs, anticonvulsants), check a serum level of that drug when a steady state of the antidepressant is reached or if there are side effects

Consult pharmacist

Good Reasons to Stop a Medication

Intolerable side effects
Dangerous interactions with necessary medications
The medication was not indicated to start with (e.g., bipolar depression)
Medication has been at maximum therapeutic dose without improvement for 4-8 weeks

What if Patients Don’t Improve?

Is the patient adhering to treatment?
Is the dose high enough?
- See max dose guidelines
Is the diagnosis correct?
- ? Bipolar depression
- ? Medical conditions (hypothyroidism, sleep apnea, pain)
- ? Meds: steroids, interferon, hormones
- ? Withdrawal: stimulants, anxiolytics
Are there untreated comorbid conditions / life stressors?
Antidepressant Summary

There are over 30 FDA-approved antidepressants
- Each is effective in ~40 – 50% of patients
- It may take several trials until an effective medication is identified
- Patients need support during this time (work with care manager)

If medications are not effective after 8 – 10 weeks at a therapeutic dose
- Is patient taking medication as prescribed?
- Consider substance abuse, bipolar disorder, anxiety disorders, cognitive impairment. Ask every patient about suicidal ideation
- Consult with team psychiatrist and change treatment (medications, other somatic treatments, psychotherapy)

Care Manager Role in Supporting Medication Therapy

Support Manager Role in Supporting Medication Therapy

Supporting Medication Therapy

Become familiar with commonly used antidepressant and other psychotropic medications and medication doses
Provide basic patient education about medications commonly prescribed in primary care
Support medication adherence
Know when treatment is ‘not working’ and alert the rest of the team to facilitate a change

Supporting Medication Therapy

Help patients and providers identify...
- Potentially inadequate doses
- Ineffective treatment (e.g., persistent symptoms after adequate duration of medication trial)
- Side effects
Facilitate patient-provider (e.g., PCP) communication about medications
Consult with PCP and team psychiatrist about medication questions

Patient Education About Antidepressants

Key messages
How do these medications work?
By restoring a chemical imbalance in the brain
There are many options (over 30 available medications)

Anticipate
Patient concerns about medications
Side effects (these can be managed)
Problems with adherence

Reinforce
Need for continuation or maintenance treatment to prevent relapse even after the patient feels better

Antidepressant Adherence

Key messages:
- Take medication daily
- Wait 2-4 weeks for effect
- Side effects can occur, but often resolve in 1-2 weeks
- Keep taking medication even if better
- Check with MD before stopping
- Not addicting

Lin EH., Arch Gen Psychiatry 1995;52:87
Psychotherapy for Depression in Primary Care

- CBT, IPT, Psychodynamic
- Behavioral Activation / Activity Scheduling
- Problem Solving Treatment

Behavioral Activation

Objectives:

- Reduce depression by gradually increasing engagement in pleasant and enjoyable activities that are patient/client identified
- Help patients re-engage pleasant activities and learn new ways of dealing with distress

Behavioral Activation

Depression $\rightarrow$ inactivity and withdrawal

$\Rightarrow$ Downward cycle of doing less and feeling worse

- Awareness of this pattern can help some patients understand the purpose and benefit of behavioral activation
Activity Scheduling

Feel Bad

Do Less

Social / physical activities tend to be most potent mood boosters
Treatment will also focus on increasing daily pleasant events

Reasons for Change in Activity

Some additional reasons:
- Inactivity due to loss of function, i.e. vision problems, mobility problems
- Loss of partner
- Pain
- Lack of interest
- Move to new facility or location
- YOUR ideas?

Behavioral Activation

Goals:
- Re-establish routines
- Distract from problems or unpleasant events
- Increase positively reinforcing experiences
- Reduce avoidant patterns
- Increase critical thinking
- Decrease negative emotional response

Some strategies:
- Review pleasant activities for ideas
  - Things that used to be 'pleasant' in the past
  - Consider new activities
- List activities and rate them for mastery and pleasure
- Choose and schedule a daily pleasant activity
- Mentally rehearse the selected activity
- Identify potential barriers (feasibility, realistic activities)

Make a Specific Plan with Patient

The more detailed the plan the more likely it is to be followed

In the plan consider:
- Date or days of the week
- What time of day
- How long
- With whom
- Other aspects that need to be planned

Follow-up

Normalize that this is a self experiment – learn from any results
Review all tasks
Praise success – ask about how the activity affects their mood
Discuss things that didn’t work
  - What obstacles got in the way?
  - Maybe we picked the wrong activity?
  - What might work better?
Set new goals and continue successful ones
Video Clip:
Behavioral Activation

Relapse Prevention & Maintenance Treatment

After patient is ‘in remission’ from acute episode
Make a relapse prevention plan
Follow the patient with monthly contacts
   – Usually by telephone calls
   – Individual OR in a maintenance group
Bring patient back in for further evaluation if symptoms recur

IMPACT Training
Part 3
Implementing Evidence-based Integrated Mental Health Care

The Evidence for Collaborative Care

Over 40 Randomized Controlled Trials for Depression: Gilbody S. et al., Archives of Internal Medicine; Dec 2006
   – 37 trials of collaborative care for depression in primary care (US and Europe)
   – CC consistently more effective than usual care

Since 2006, several additional RCTs in new populations and for other common mental disorders (e.g., CALM study for anxiety disorders, PTSD)
IMPACT Team Care Model

Effective Collaboration

Prepared, Pro-active Practice Team

Informed, Activated Patient

Practice Support

Research Evidence is Not Enough

Over 50 peer reviewed publications... but

Publications in JAMA, BMJ, and NEJM do not guarantee uptake and practice change in the real world.

Implementers need a lot more...

“It is one thing to say with the prophet Amos, ‘Let justice roll down like mighty waters,’ and quite another to work out the irrigation system.”

William Sloane Coffin, Social activist and clergyman

From Research to Practice:
Implementation Experience

Over 4,500 Providers Trained in IMPACT Care

Over 4,500 Providers Trained in IMPACT Care... 

~ 600 clinics

Integrated Mental Health (IMH) Program Implementation Process

The process begins with a clinical leader who identifies a need for a program. The leader then prepares a business plan, which is reviewed by the Executive Committee. The plan is then approved by the Board of Directors. The program is then implemented, with ongoing evaluation and feedback from the clients. The process is continuous, with adjustments made as needed.
Building the IMPACT Team

Tasks for patient-centered integrated behavioral health care

Specific Tasks:
1. Patient Identification and Diagnosis
2. Treatment Engagement and Initiation
3. Follow-up and Treatment Adjustment
4. Communication and care coordination
5. Systematic case review and psychiatric consultation
6. Referrals
7. Relapse prevention
8. Administrative support
9. Clinical support
10. Quality improvement

Evidence-Based ‘Team Care’ for Depression

<table>
<thead>
<tr>
<th>TWO PROCESSES</th>
<th>TWO NEW ‘TEAM MEMBERS’</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Care Manager</td>
</tr>
<tr>
<td>1. Systematic diagnosis and outcomes tracking</td>
<td>- Patient education / self management support</td>
</tr>
<tr>
<td></td>
<td>- Close follow-up to make sure pts don’t ‘fall through the cracks’</td>
</tr>
<tr>
<td>2. Stepped Care</td>
<td>- Support anti-depressant Rx by PCP</td>
</tr>
<tr>
<td></td>
<td>- Brief counseling (behavioral activation, PST-PC, CBT, IPT)</td>
</tr>
<tr>
<td></td>
<td>- Facilitate treatment change / referral to mental health</td>
</tr>
<tr>
<td>2a. Change treatment according to evidence-based algorithm if patient is not improving</td>
<td>- Consultation focused on patients not improving as expected</td>
</tr>
<tr>
<td>2b. Relapse prevention once patient is improved</td>
<td>- Recommendations for additional treatment / referral according to evidence-based guidelines</td>
</tr>
</tbody>
</table>

Building the Collaborative Care Team

Six steps in team building process:
1. Assessment with Individual Staff Members
2. Identify Gaps, Duplicate Services & Training Needs
3. Create Customized Integrated Behavioral Health Care Work-Flow
4. Generate Implementation Plan & Timeline
5. Train Staff
6. Track program Outcomes & Adjust as necessary

Building the Collaborative Care Team

Three worksheets to support team building process:
1. Staff Self-Assessment
2. Task Summary by Staff Member
3. Team Building Summary & Change Plan
IMPACT Team: Care Manager

- Hire new staff vs. re-deploy existing staff
- Split duties between higher and lower skilled staff?
  - e.g., psychologist and medical assistant
- Types of behavioral health care managers: nurses, social workers, counselors, ARNPs, psychologists, etc.
- Caseload / number of care managers needed

IMPACT Team: Psychiatric Consultant

- Hire new vs. re-deploy
- In-house vs. external consultant
- In-person or telemedicine
- Responsibility for caseload of patients
- Approximately 0.1 FTE psychiatric consultant time for each 1 FTE care manager

IMPACT Team: PCP

- How will PCP work with care manager?
- How will PCP ‘sell’ the team approach to patients?
- Access to consulting psychiatrist?
- How will PCP work with psychiatric consultant and other mental health staff?

IMPACT Team: Manager

- Keep track of outcomes and adjust program as needed
  - Patient engagement and clinical outcomes
- Integrate care manager and consulting psychiatrist into existing clinic staff, space, and ‘flow’
  - ‘Private’ space to see patients
  - Time (“this is a real job”)
- Access to computer, EMR, charts
Workforce Issues

In general and especially in rural areas

- Challenges finding qualified mental health providers
  - Care managers, therapists trained in evidence-based treatments, consulting psychiatrists (especially child psychiatrists)
  - Few providers are trained in effective ‘team-care’ which requires effective collaboration and ‘handoffs’

Primary care providers

- Are overextended and can be difficult to engage
- Have to learn to use care managers effectively

Primary care-based mental health providers

- Do not all embrace the collaborative / care management model
- May see themselves as co-located therapists or more traditional social workers and not work closely with PCPs and consulting psychiatrists

Consulting psychiatrists

- May not be familiar / comfortable with the caseload and population-focused consultation model
- Telemedicine consultation can be helpful

“Your Care Team Template”

Combine with other patient educational materials

Customize template –

- Insert staff photos and contact information
- Put assessment tool (PHQ-9) on back
- Make into tri-fold brochure and include other general information for patients

Training

Overall program

Specific Skills
e.g., Behavioral Activation; PST
- Didactic
- Case Supervision

Web-based Training

- Videos of key care management skills
- http://impact-uw.org

Case-based Supervision / Consultation

Implementation Consultation
Training

Trained over 4,500 providers in nearly 600 clinics

Practice Change is Hard

“You are asking me to … change the oil while driving the car.” … rebuild the airplane in mid-air.”

Need Effective Implementation Support

Implementing Collaborative Care

Shared Vision
- How will we know success?
- Shared, measurable outcomes
  - e.g., # and % of populations screened, treated, improved
Engaged leaders & stakeholders
- Clinic leaders & administration
- PCPs, care managers, psychiatry, other mental health providers
Clinical & operational integration
- Functioning teams, communication, and handoffs
  - Clear about ‘shared workflow’ & roles of various team members
Adequate resources
- Personnel, IT support, funding
Proactive problem solving re-barriers & competing demands
- Minimize complexity, PDCA

Examples of large-scale implementations

- Kaiser Permanente
- DOD (RESPECT-MIL)
- VA
- DIAMOND
- Washington State MHIP

Kaiser Permanente
San Diego, California
IMPACT Dissemination at Kaiser Permanente

KPSC in IMPACT Study
– (~ 280 participants in 1 clinic)
KPSC in San Diego after IMPACT
– (2 clinics; Grypma et al, 2005)
KPSC Depression Initiative (Dreskin)
– 12 regional medical centers serving 3 million members – over 40,000 in depression care management

Kaiser Permanente of Southern California

– Pilot Study
  • Compare 284 clients in ‘adapted program’ with 140 usual care patients and 140 intervention patients in the IMPACT study (Grypma et al, 2006)

– Dissemination
  • Implemented core components of program in 10 regional medical centers

KPSC – San Diego ‘After IMPACT’

Fewer care manager contacts

IMPACT Remains Effective

≥ 50% drop in PHQ-9 depression scores

IMPACT Post-Study

IMPACT Post-Study

IMPACT Remains Effective

IMPACT Remains Effective

IMPACT Remains Effective

Lower Total Health Care Costs

Case Study - II: Mental Health Integration Program (MHIP)

• Funded by State of Washington and Seattle King County Public Health (SKCPH)
• Administered by Community Health Plan of Washington and SKCPH in partnership with over 100 Community Health Centers and UW AIMS Center
• Initiated in 2008 in Western WA; expanded state-wide in 2009

http://integratedcare-nw.org
MHIP Target Populations

State-wide: unemployed adults with short term disability due to mental health / substance abuse problems (Disability Lifeline Program)

King County: high risk mothers and their children, uninsured adults, older adults, Veterans and their family members

Program Staffing in Diverse Clinic Settings

<table>
<thead>
<tr>
<th>Clinic Population (mental health needs)</th>
<th>% of clinic population with need for care management</th>
<th>Typical caseload sizes for 1 FTE Care Manager</th>
<th># of unique primary care clinic patients to justify 1 FTE CM</th>
<th>Typical personnel requirement for 1,000 unique primary care patients FTE Care Manager / FTE Psychiatrist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low need (e.g., insured, unemployed)</td>
<td>2%</td>
<td>100</td>
<td>5000</td>
<td>0.2 / 0.05 (2 hrs / week)</td>
</tr>
<tr>
<td>Medium need (e.g., comorbid medical needs / chronic pain / substance abuse)</td>
<td>5%</td>
<td>75</td>
<td>1500</td>
<td>0.7 / 0.07 (3 hrs / week)</td>
</tr>
<tr>
<td>High need (e.g., safety-net population)</td>
<td>15%</td>
<td>50</td>
<td>333</td>
<td>3 / 0.3 (12 hrs / week)</td>
</tr>
</tbody>
</table>

MHIP for Behavioral Health Mental Health Integration Program

Job Description: University of Washington Consulting Psychologist

Mental Health Integration Program (MHIP)

Primary Care Provider supported by Behavioral Health Care Coordinator

Practice Support

Informed, Active Patient

Collaborative Care

Outcome Measurement

Referral to and coordination with specialty behavioral health care providers

Provider Training and Support

Low need (e.g., insured, unemployed) 2% 100 5000 0.2 0.05 (2 hrs / week)

Medium need (e.g., comorbid medical needs / chronic pain / substance abuse) 5% 75 1500 0.7 0.07 (3 hrs / week)

High need (e.g., safety-net population) 15% 50 333 3 0.3 (12 hrs / week)
Care Management Tracking System (CMTS)

Web-based. In use in MHIP program and several other collaborative care programs in Minnesota, Texas, and Alberta, Canada.

Registry function
- Prevents patients from ‘falling through the cracks’

Care management functions
- Structured templates facilitate efficient / effective clinical encounters
- Individual and caseload summaries facilitate
  - measurement-based practice / treatment to target
  - efficient psychiatric consultation on challenging patients
- systematic quality improvement

Caseload summaries help manage
- Clinical productivity
- Quality improvement
MHIP client Demographics

<table>
<thead>
<tr>
<th></th>
<th>Mean or %</th>
<th>Range across clinics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>52 %</td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>48 %</td>
<td></td>
</tr>
<tr>
<td>Mean Age</td>
<td>40</td>
<td>1-100</td>
</tr>
<tr>
<td>Challenge with Housing</td>
<td>29 %</td>
<td>3% - 52 %</td>
</tr>
<tr>
<td>Challenge with Transportation</td>
<td>21 %</td>
<td>10%- 50 %</td>
</tr>
</tbody>
</table>

Clinical Diagnoses

<table>
<thead>
<tr>
<th></th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>71 %</td>
</tr>
<tr>
<td>Anxiety (GAD, Panic)</td>
<td>48 %</td>
</tr>
<tr>
<td>Posttraumatic Stress Disorder (PTSD)</td>
<td>17 %</td>
</tr>
<tr>
<td>Alcohol / Substance Abuse</td>
<td>17 %*</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>15 %</td>
</tr>
<tr>
<td>Thoughts of Suicide</td>
<td>45 %</td>
</tr>
</tbody>
</table>

MHIP client Demographics - Clinical Diagnoses

Sample Community Health Center

<table>
<thead>
<tr>
<th>Population</th>
<th>Mean baseline PHQ-9 depression score (0-27)</th>
<th>Follow-up (%)</th>
<th>Mean number of care coordinator contacts</th>
<th>% with psych consultation</th>
<th>% with significant clinical improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability Lifeline</td>
<td>16.7</td>
<td>92 %</td>
<td>8</td>
<td>69 %</td>
<td>43 %</td>
</tr>
<tr>
<td>Uninsured</td>
<td>15.8</td>
<td>83 %</td>
<td>8</td>
<td>59 %</td>
<td>50 %</td>
</tr>
<tr>
<td>Older Adults</td>
<td>15.3</td>
<td>92 %</td>
<td>8</td>
<td>55 %</td>
<td>43 %</td>
</tr>
<tr>
<td>Vets &amp; Family</td>
<td>15.5</td>
<td>92 %</td>
<td>7</td>
<td>54 %</td>
<td>53 %</td>
</tr>
<tr>
<td>High risk Mothers</td>
<td>15.4</td>
<td>81 %</td>
<td>7</td>
<td>50 %</td>
<td>60 %</td>
</tr>
</tbody>
</table>

Systematic Quality Improvement

Team building and implementation support
Provider training and ongoing support
Weekly caseload-based psychiatric review
Outcomes-based Feedback and QI
Pay-for-performance program (P4P)
  - Initiated in 2009
  - 25 % of payment depends on meeting quality indicators

Other policy relevant outcomes

Comparison of DL clients with mental health needs in counties with and without the MHIP program in 2008 and 2009.
Outcomes examined:
  - homelessness
  - arrest rates

CHAMMP; Jan 27, 2011;

Pay-for-performance-based quality improvement cuts median time to depression treatment response in half.
Lower increases in homelessness in clients receiving MHIP during difficult economic times.

Reduced arrest rates* in clients receiving MHIP

Over 20,000 safety-net clients served
- Large, 'real world' implementation of collaborative care
- When well implemented, clinical outcomes can match those in RCTs with safety net populations
- Safer communities and less homelessness
Systematic quality improvement with a P4P component can
- Improve health outcomes
- Close the gap between research and practice

**Chronic Pain**

20 – 30% of younger and 60 – 80% of older adults report pain on a daily basis

Chronic pain involves:
- Suffering: physical and emotional
- Disability, activity & work limitations
- Lower quality of life
15% of those with chronic pain say they cannot work because of it

**Pain ↔ Depression**

Bidirectional Relationship
Depression and Pain Have Combined Effects

Depression with pain causes more functional limitations and economic burden than depression alone.

Pain with depression predicts greater functional impairment than pain alone.

But: Pain Impedes Improvements in Depression

Managing Persistent Pain

Establish a diagnosis
Educate patient
  – All pain is ‘real’
Focus on functional impairment
  – What does the pain keep you from doing?
  – How do you cope with this?
Encourage
  – Regular physical activity
  – Adequate trials of analgesic medications
    • “How bad does the pain need to be?”
Consult
  – Orthopedics, Rheumatology, PT/OT
  – Coordinate care with all providers

Stepped Care

Systematic outcomes tracking
  – Patient Health Questionnaire (PHQ-9)
  – Brief Pain Inventory
Treatment adjustment as needed
  – Based on clinical outcomes
  – According to evidence-based algorithm
  – In consultation with psychiatrist and PCP

IMPACT DP: Treatment Protocol

1) Education
2) Behavioral Activation / Pleasant events scheduling
3) (a) Antidepressant medication
   Usually an SNRI or other newer antidepressant
   (b) Analgesic medications
      Acetaminophen, NSAIDs, opioids
4) Problem-Solving Treatment in Primary Care (PST-PC) 6 to 8 sessions
Pain Medications

- Acetaminophen
- Non-steroidal anti-inflammatory drugs (NSAIDs)
  - Aspirin, NSAIDs
- Antidepressants
- Opioids
- Adjuvant medications
  - Anticonvulsants
  - Stimulants
  - Antidepressants

How to Use Pain Medications

- Use / change one drug at a time
- Careful with total daily dose
  - Acetaminophen or ibuprofen may be taken OTC but also contained in many prescription drugs
- Start low but go to target doses
- Give adequate trial
- Scheduled rather than PRN ("as needed") dosing. Take medications before pain gets bad.
- Manage side effects
- Change treatment if no effect after 10 to 14 days at target dose
- Combine medications and other treatments if only partial response

Referral to Physical Therapy

- Assess current activity level, gait, strength, fitness, preferences
- Create individualized physical activity plans
  - Preserve or restore range of motion / flexibility
  - Increase aerobic conditioning
  - Increase muscle strength / endurance
  - Include physical activities into daily life
- Be aware of physical deconditioning
  - > gradual increase in frequency and intensity (pacing)
- Pay attention to rewards and positive reinforcers
- Address fears and concerns about physical activity
- Osteoarthritis
  - Non weight-bearing exercise: walking, warm-water pool exercise

Other Treatments to Consider

- Relaxation / Meditation / Guided Imagery
- Electrical counter-stimulation (TENS)
- Acupuncture
- Nerve blocks or infiltrations
- Neurosurgical procedures
- Orthopedic (e.g., hip, knee, or shoulder replacement)

Clinical Outcomes

Patient Comments

"I thought I was going to have to live with this for the rest of my life," "this program helped me get my life back on track," and "this program saved my life."

CM described as "helpful" and "easy to talk to." "It was so good to talk with someone who knows what you are struggling with." "[The CM] knew what she was talking about." "Pain is one thing but depression is a personal matter and [the CM] was easier to talk to than my doctor." "[The CM] took the time to listen to my problems." "had more time to talk about how to use the medicines than the doctors do." and "stuck with me through several medications until we found one that worked for my pain." "[The CM] helped me negotiate with my surgeon about my knee replacement."

"[The CM] got very concrete and practical with me about what I should try between now and next time I saw her sort of like giving me homework and checking up on it the next time I would see her." "It’s one thing to say ‘get some exercise’ and another thing to get specific about what to do, where, with whom, how often, and for how long." "[The CM] made me focus and keep on track." "More doctors should be aware of these small helpful things."
Clinical Outcomes - II

Pain-related interference reduced in all areas examined including:
- General activity
- Mood
- Walking ability
- Work
- Relationships with others
- Sleep
- Enjoyment in life

IMPACT Value Proposition

Improved care for depression can
- Lower depression
  - Twice as effective as care as usual
  - Improve physical & social functioning
- Improve patient and provider satisfaction
- Improve cost-effectiveness of care
- Reduce overall health care costs long-term
- Improved total revenue under certain circumstances
  - (e.g., under HCC coding in Medicare Advantage)

Financing IMPACT Care

No One Size Fits All…
- Different Settings
- Different Payment Mechanisms
- Different Opportunities, Challenges, Questions

IMPACT Program Costs

Cost components
- Care manager time and salary
  - 75 - 100 active cases for each FTE CM
- Consulting psychiatrist time
  - 0.1 FTE for each FTE CM
- Program materials
  - Educational video / brochure
- +30% overhead

$ 750 per participant for 12 months of care*

*(IMPACT costs adjusted to 2010 dollars)

IMPACT Costs Per Insured Beneficiary (PMPM)

<table>
<thead>
<tr>
<th>% of patient population using depression care management</th>
<th>Approximate clinic population / FTE care manager</th>
<th>Cost per participant (12 months)</th>
<th>PMPM (cost per member per month)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 %</td>
<td>5,000</td>
<td>$ 750</td>
<td>$ 1.88</td>
</tr>
</tbody>
</table>

Program Staffing in Diverse Clinic Settings

<table>
<thead>
<tr>
<th>Population (extent of mental health needs)</th>
<th>% of clinic population with need for mental health care management</th>
<th>FTE Care Manager</th>
<th>FTE Psychiatrist**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low need (e.g., insured, employed)</td>
<td>2%</td>
<td>0.2</td>
<td>0.05</td>
</tr>
<tr>
<td>Medical need (e.g., medically ill, elderly, physical disability)</td>
<td>5%</td>
<td>0.7</td>
<td>0.07</td>
</tr>
<tr>
<td>High need (e.g., safety-net population with high mental health, substance abuse and social service needs)</td>
<td>15%</td>
<td>5.8</td>
<td>0.3</td>
</tr>
</tbody>
</table>

* Needs can be approximated by % and % of clinic population with ICD diagnoses of mental disorders and / or prescription of psychotropic medications.
** Usually, 0.1 FTE psychiatric consultant time is required for 1 FTE care manager. If clinics or populations covered are small, a minimum of 2 hours / week is needed.
Costs Are ‘Front-Loaded’

Monthly Care Manager Contacts in IMPACT

http://impact-uw.org

Thank you!

UW AMS Center:  
Diane Powers, Manager  
powersd@uw.edu

IMPACT Implementation Center:  
Kitty Christensen, Manager  
kchriste@uw.edu