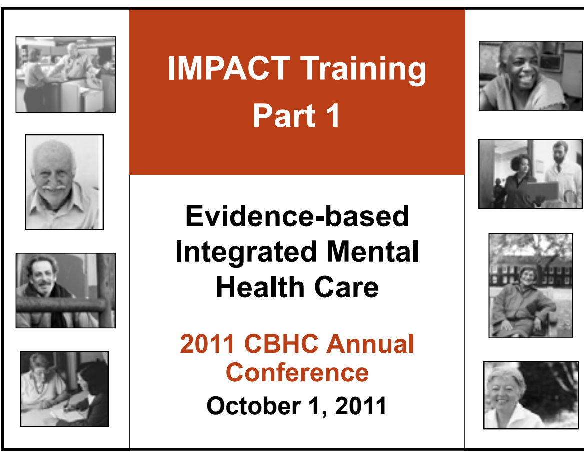
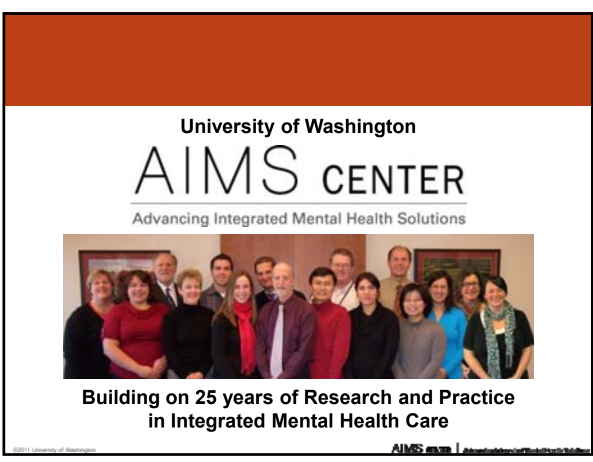
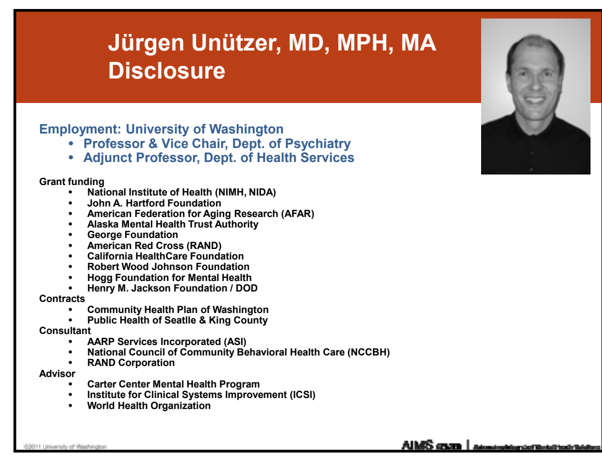






IMPACT Training at 2011 CBHC Annual Conference

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/

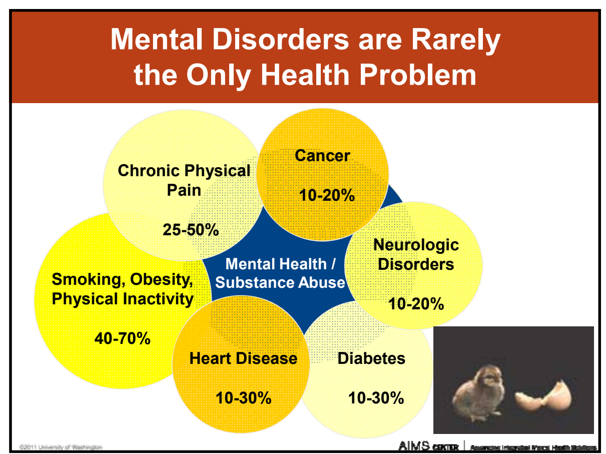
Or visit:

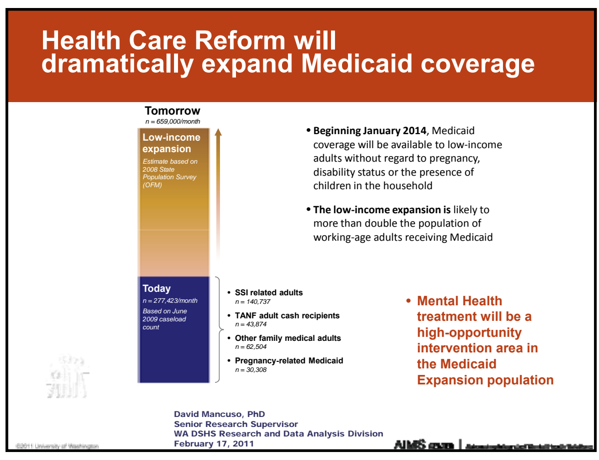
http://impact-uw.org/

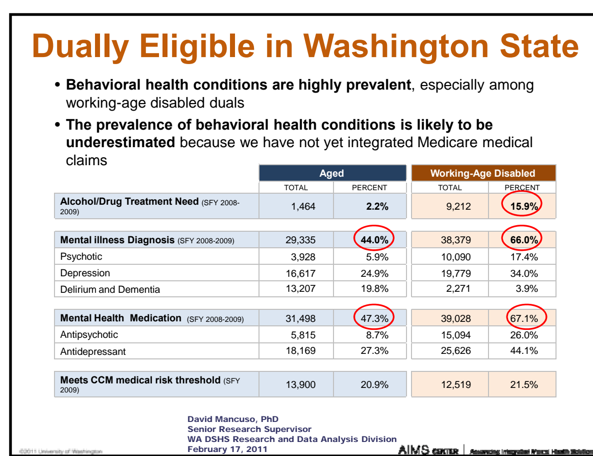
Integrated Care: Improving Patient Outcomes with a Team Approach

Why Primary Care?

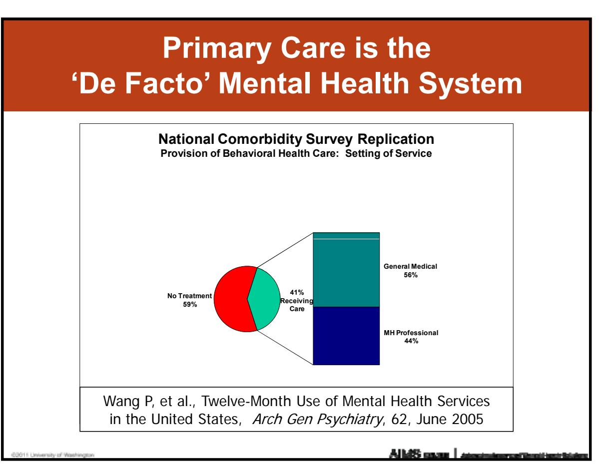
- Patient Centered Care
- Improved Access

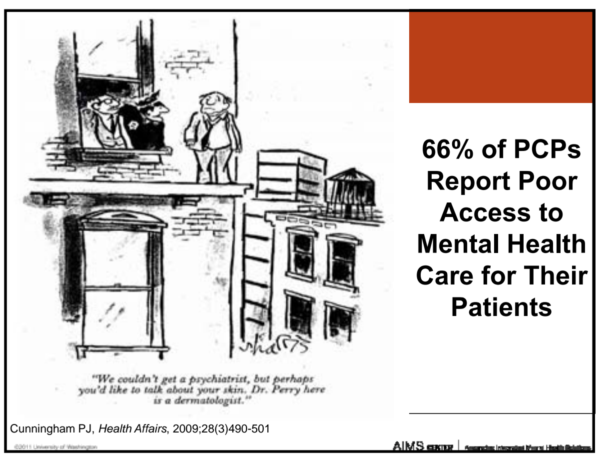






	Aged		Working-Age Disabled	
	TOTAL	PERCENT	TOTAL	PERCENT
Alcohol/Drug Treatment Need (SFY 2008-2009)	1,464	**2.2%**	9,212	**15.9%**
Mental illness Diagnosis (SFY 2008-2009)	29,335	**44.0%**	38,379	**66.0%**
Psychotic	3,928	5.9%	10,090	17.4%
Depression	16,617	24.9%	19,779	34.0%
Delirium and Dementia	13,207	19.8%	2,271	3.9%
Mental Health Medication (SFY 2008-2009)	31,498	47.3%	39,028	67.1%
Antipsychotic	5,815	8.7%	15,094	26.0%
Antidepressant	18,169	27.3%	25,626	44.1%
Meets CCM medical risk threshold (SFY 2009)	13,900	20.9%	12,519	21.5%





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

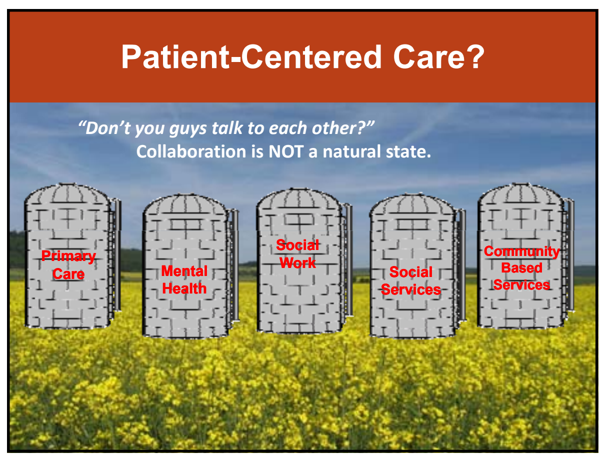
- Large patient panels (1,500 – 2,000)
- 20-30 short (15-20 min) encounters / day
- "Everything comes at me."
- How to cope?
  - Need to focus
  - Diagnose and treat 'over time'
  - Need practical solutions, effective communication / help

Limits of our Current System

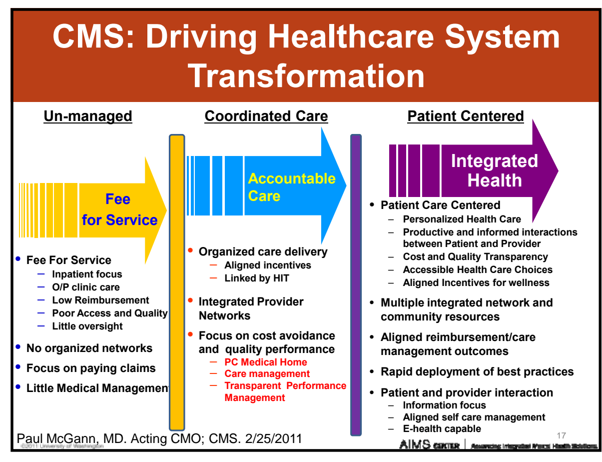
Few clients with behavioral health problems receive effective treatment

~ 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?



CMS: Driving Healthcare System Transformation



Paul McGann, MD. Acting CMO; CMS. 2/25/2011

- **Patient Centered Medical Homes**
- **Accountable Care Organizations**
- **Meaningful use of Health IT**

We are *beyond the 'tipping point'*
Select Integrated Care Initiatives

- 25 years of NIMH Research on Collaborative Care *www.nimh.nih.gov*
- John A. Hartford Foundation: IMPACT Program (http://impact-uw.org).
- AHRQ Integration Academy
- MacArthur Initiative on Depression and Primary Care: RESPECT study and 3CM Model *www.depression-primarycare.org/*
- HRSA Bureau of Primary Care Health Disparities Collaboratives (over 100 FQHCs) http://www.hrsa.gov/mentalhealth/
- RWJ Program: Depression in Primary Care—Linking Clinical and System Strategies
- NCCBH Collaborative Care Learning Collaboratives http://www.thenationalcouncil.org/
- California Endowment : Integrated Behavioral Health Project (IBPB) http://www.ibhp.org/
- CiMH http://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-NOLA Project in New Orleans http://*reachnola.org/*
- VA, US Air Force, HMOs (Group Health, Kaiser Permanente), Cherokee, Washtenaw County (WCHO)
- 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
- National Business Group on Health: *"An Employer's Guide to Behavioral Health Services"*:www.businessgrouphealth.org/benefitstopics/topics/purchasers/fullguide.pdf

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., *Med Care*, 2001; 39(8):785-99

Case Example

‘Mr. T’

Team-based Care

Patient

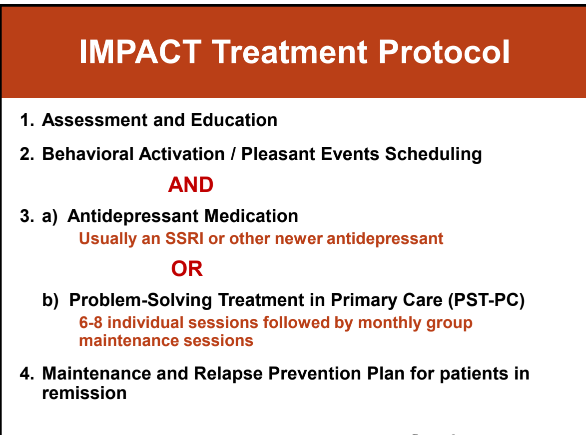
- Chooses treatment in consultation with provider(s):
  - Antidepressant and / or brief psychotherapy

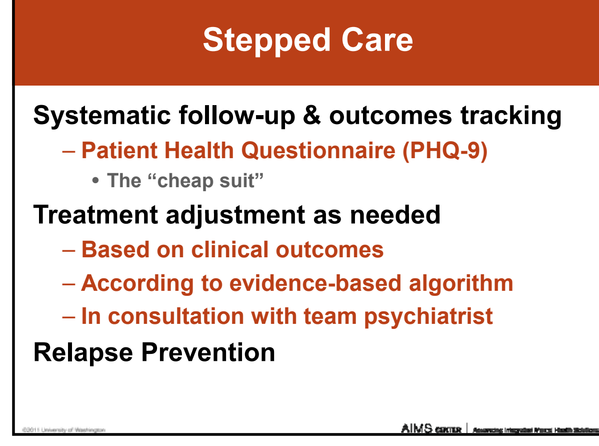
Primary Care Provider (PCP)

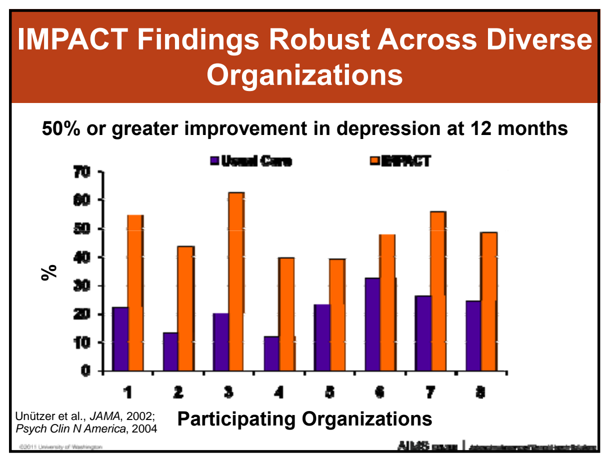
- Refers; prescribes antidepressant medications

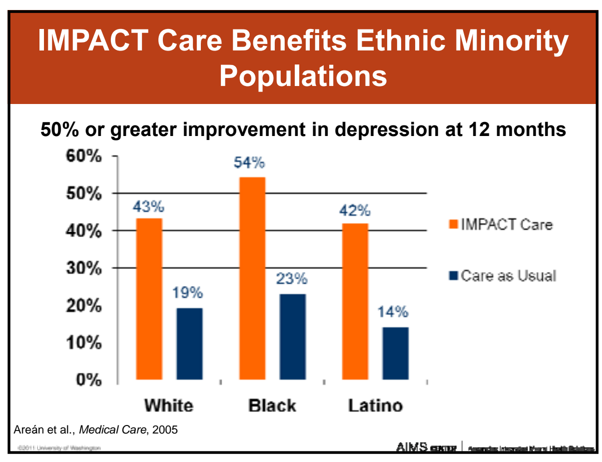
+ Depression Care Manager

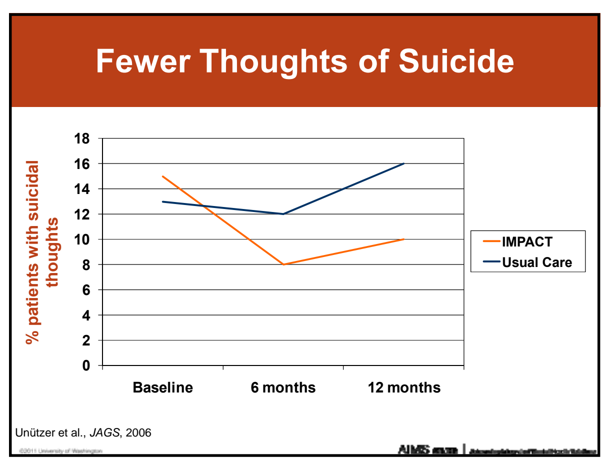
+ Consulting Psychiatrist

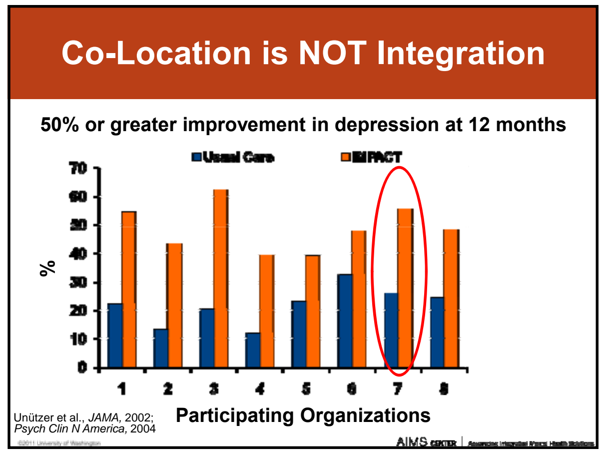


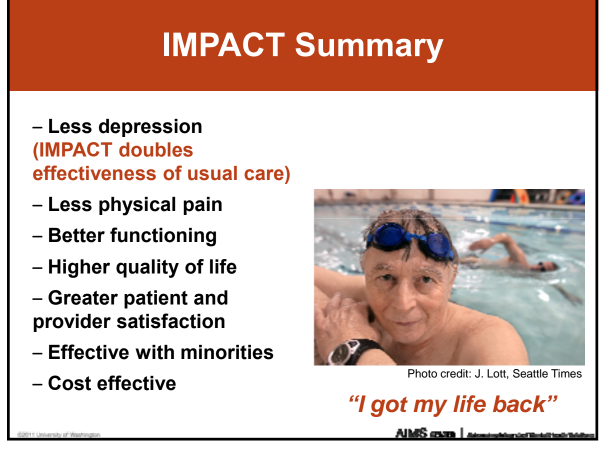


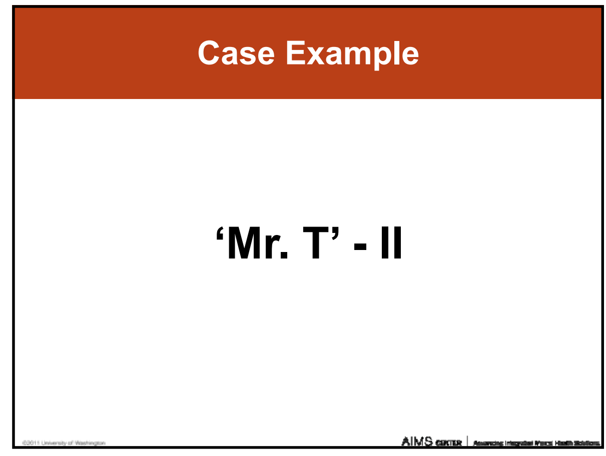


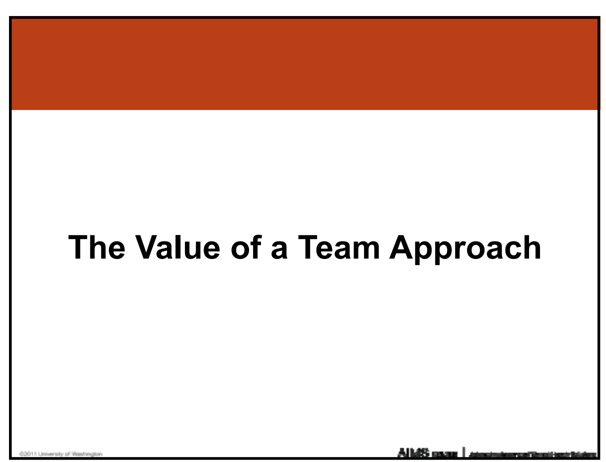

IMPACT Care Benefits Ethnic Minority Populations
50% or greater improvement in depression at 12 months
60%
50%
40%
30%
20%
10%
0%
43%
19%
54%
23%
42%
14%
White
Black
Latino
IMPACT Care
Care as Usual
Areán et al., Medical Care, 2005


Fewer Thoughts of Suicide
% patients with suicidal thoughts
18
16
14
12
10
8
6
4
2
0
Baseline
6 months
12 months
IMPACT
Usual Care
Unützer et al., JAGS, 2006


Co-Location is NOT Integration
50% or greater improvement in depression at 12 months
Usual Care
IMPACT
%
70
60
50
40
30
20
10
0
1
2
3
4
5
6
7
8
Participating Organizations
Unützer et al., JAMA, 2002; Psych Clin N America, 2004


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
Photo credit: J. Lott, Seattle Times
"I got my life back"


Case Example
'Mr. T' - II


The Value of a Team Approach

"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

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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

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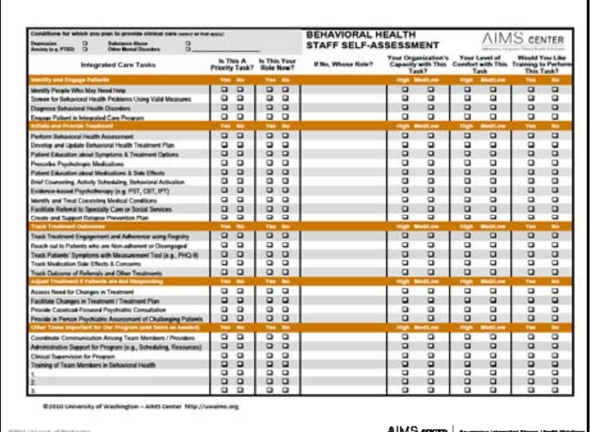

BEHAVIORAL HEALTH STAFF SELF-ASSESSMENT — AIMS CENTER

Conditions for which you plan to provide clinical care (select all that apply)
Depression ☐ Anxiety (e.g. PTSD) ☐ Substance Abuse ☐ Other Mental Disorders ☐ ____________

Integrated Care Tasks	Is This A Priority Task?		Is This Your Role Now?		If No, Whose Role?	Your Organization's Capacity with This Task?		Your Level of Comfort with This Task		Would You Like Training to Perform This Task?	
Identify and Engage Patients	Yes	No	Yes	No		High	Med/Low	High	Med/Low	Yes	No
Identify People Who May Need Help	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Screen for Behavioral Health Problems Using Valid Measures	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Diagnose Behavioral Health Disorders	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Engage Patient in Integrated Care Program	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Initiate and Provide Treatment	Yes	No	Yes	No		High	Med/Low	High	Med/Low	Yes	No
Perform Behavioral Health Assessment	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Develop and Update Behavioral Health Treatment Plan	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Patient Education about Symptoms & Treatment Options	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Prescribe Psychotropic Medications	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Patient Education about Medications & Side Effects	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Brief Counseling, Activity Scheduling, Behavioral Activation	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Evidence-based Psychotherapy (e.g. PST, CBT, IPT)	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Identify and Treat Coexisting Medical Conditions	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Facilitate Referral to Specialty Care or Social Services	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Create and Support Relapse Prevention Plan	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Track Treatment Outcomes	Yes	No	Yes	No		High	Med/Low	High	Med/Low	Yes	No
Track Treatment Engagement and Adherence using Registry	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Reach out to Patients who are Non-adherent or Disengaged	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Track Patients' Symptoms with Measurement Tool (e.g., PHQ-9)	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Track Medication Side Effects & Concerns	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Track Outcome of Referrals and Other Treatments	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Adjust Treatment if Patients are Not Responding	Yes	No	Yes	No		High	Med/Low	High	Med/Low	Yes	No
Assess Need for Changes in Treatment	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Facilitate Changes in Treatment / Treatment Plan	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Provide Caseload-Focused Psychiatric Consultation	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Provide in Person Psychiatric Assessment of Challenging Patients	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Other Tasks Important for Our Program (add tasks as needed)	Yes	No	Yes	No		High	Med/Low	High	Med/Low	Yes	No
Coordinate Communication Among Team Members / Providers	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Administrative Support for Program (e.g., Scheduling, Resources)	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Clinical Supervision for Program	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Training of Team Members in Behavioral Health	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
1.	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
2.	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
3.	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐

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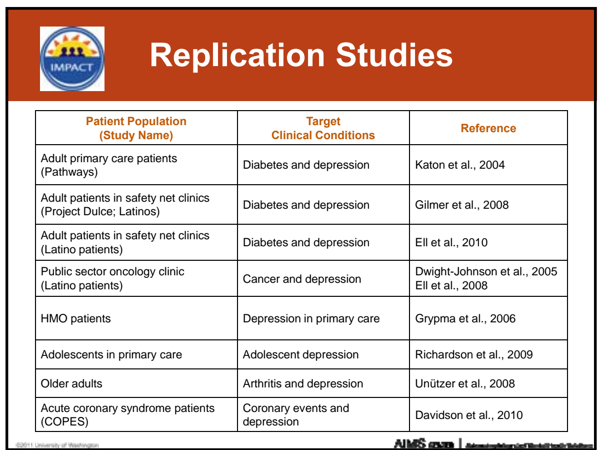

Replication Studies

Patient Population (Study Name)	Target Clinical Conditions	Reference
Adult primary care patients (Pathways)	Diabetes and depression	Katon et al., 2004
Adult patients in safety net clinics (Project Dulce; Latinos)	Diabetes and depression	Gilmer et al., 2008
Adult patients in safety net clinics (Latino patients)	Diabetes and depression	Ell et al., 2010
Public sector oncology clinic (Latino patients)	Cancer and depression	Dwight-Johnson et al., 2005 Ell et al., 2008
HMO patients	Depression in primary care	Grypma et al., 2006
Adolescents in primary care	Adolescent depression	Richardson et al., 2009
Older adults	Arthritis and depression	Unützer et al., 2008
Acute coronary syndrome patients (COPES)	Coronary events and depression	Davidson et al., 2010

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.

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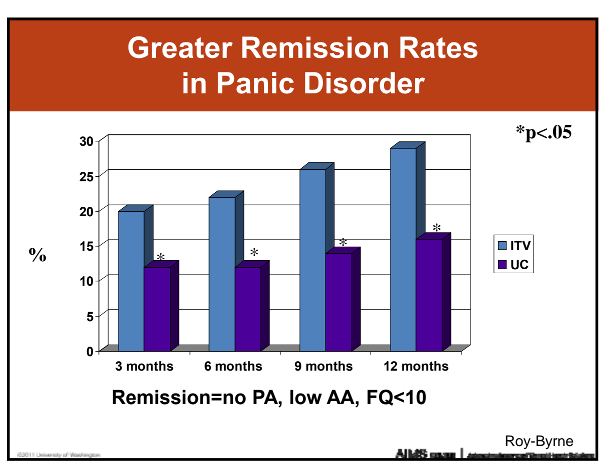

Some Lessons

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, measureable 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.

IMPACT Training at 2011 CBHC Annual Conference

Today

8:00-9:30am: IMPACT Training Part 1
Overview of Evidence-based Integrated Mental Health Care

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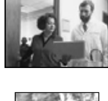
IMPACT Training Part 2

Population-based Stepped Care Approaches to Integrated Mental Health Care



IMPACT Team Care Model

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

Effective Integrated Care

Team Approach
- Medical and mental health providers
- Real team collaboration: not co-location / 'parallel play'

Population-focused
- Registry to make sure patients don't fall through the cracks

Stepped Care
- Treatment to target
- Stepped care

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

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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

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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

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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

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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

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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

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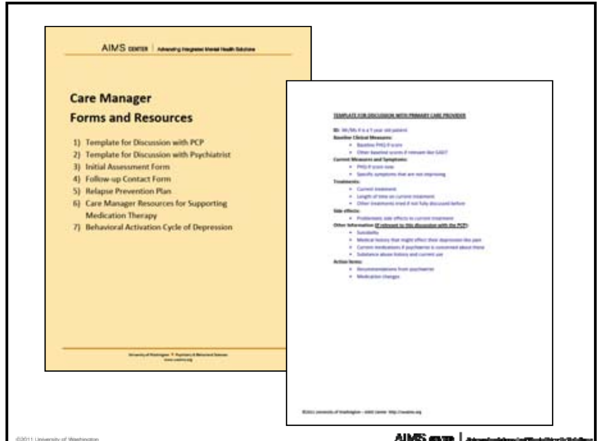
Key Elements to Include When Talking to PCP

- Baseline Clinical measures
  - e.g., PHQ-9 Score
- Current Symptoms
  - Symptoms that aren't improving
- Length of time on current treatments
- Problematic side effects



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Care Manager
Forms and Resources

1) Template for Discussion with PCP
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6) Care Manager Resources for Supporting Medication Therapy
7) Behavioral Activation Cycle of Depression

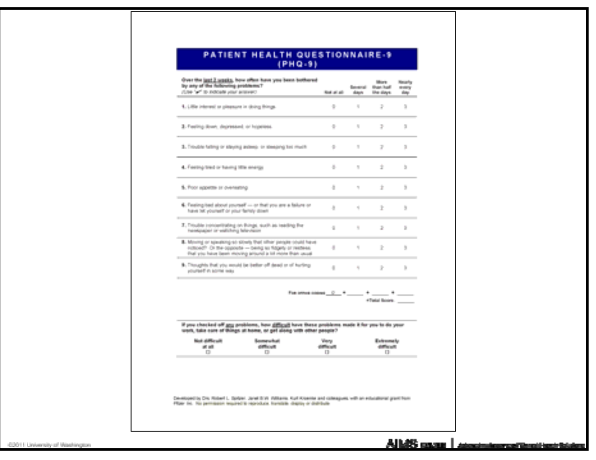
Care Manager: The Facilitating Presence

- 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

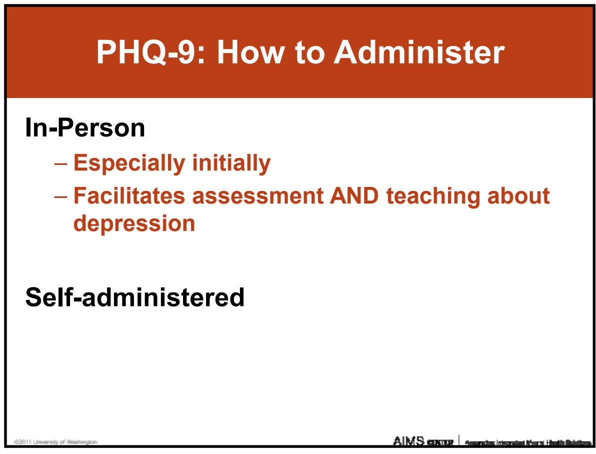


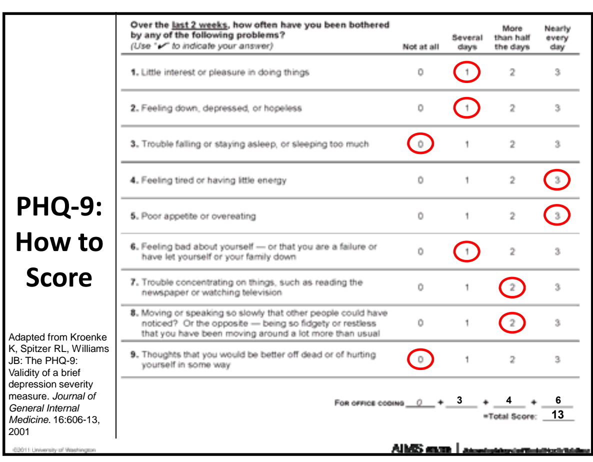
PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?	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

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐





PHQ-9: How to Score

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 + 3 + 4 + 6
=Total Score: 13

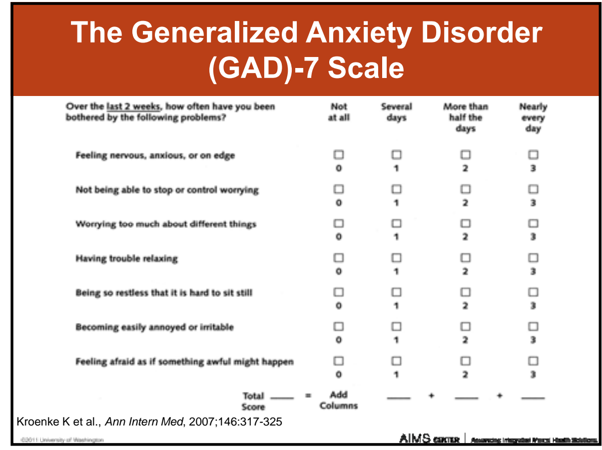
Adapted from Kroenke K, Spitzer RL, Williams JB: The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine*. 16:606-13, 2001

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)

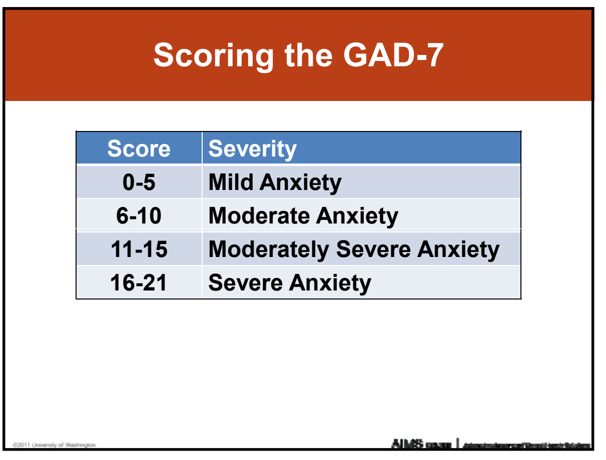


The Generalized Anxiety Disorder (GAD)-7 Scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious, or on edge	☐ 0	☐ 1	☐ 2	☐ 3
Not being able to stop or control worrying	☐ 0	☐ 1	☐ 2	☐ 3
Worrying too much about different things	☐ 0	☐ 1	☐ 2	☐ 3
Having trouble relaxing	☐ 0	☐ 1	☐ 2	☐ 3
Being so restless that it is hard to sit still	☐ 0	☐ 1	☐ 2	☐ 3
Becoming easily annoyed or irritable	☐ 0	☐ 1	☐ 2	☐ 3
Feeling afraid as if something awful might happen	☐ 0	☐ 1	☐ 2	☐ 3

Total Score ____ = Add Columns ____ + ____ + ____

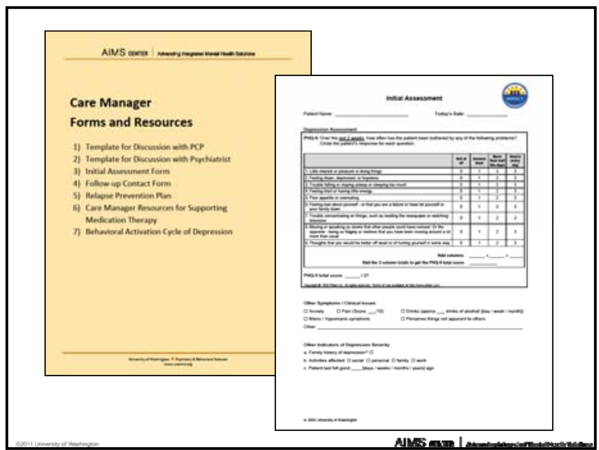
Kroenke K et al., *Ann Intern Med*, 2007;146:317-325



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

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

Video Clip: Initial Visit

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

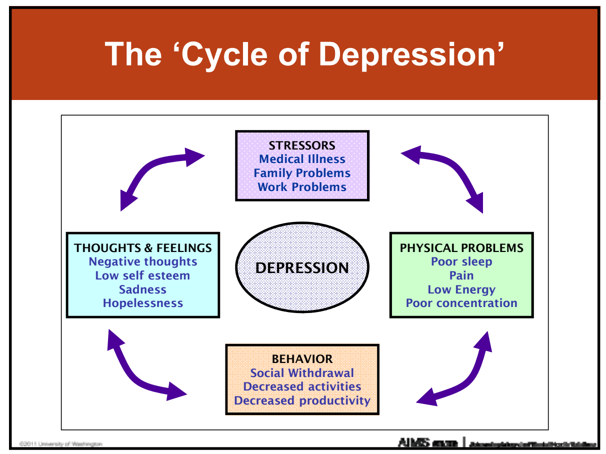
The 'cycle of depression model'

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'

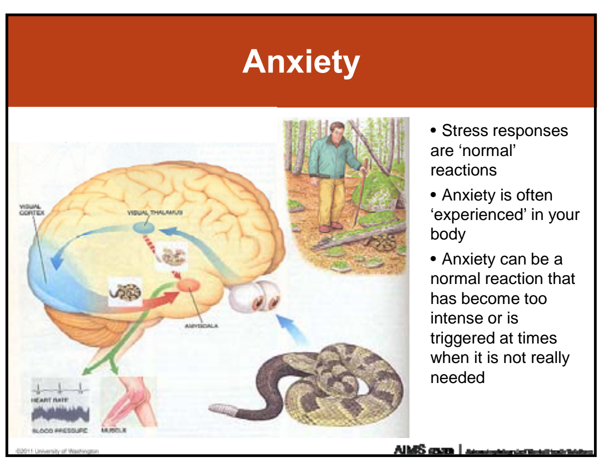


Talking with Caregivers About Depression

Patient education materials (booklets, videos) can aid caregivers in recognizing depression symptoms

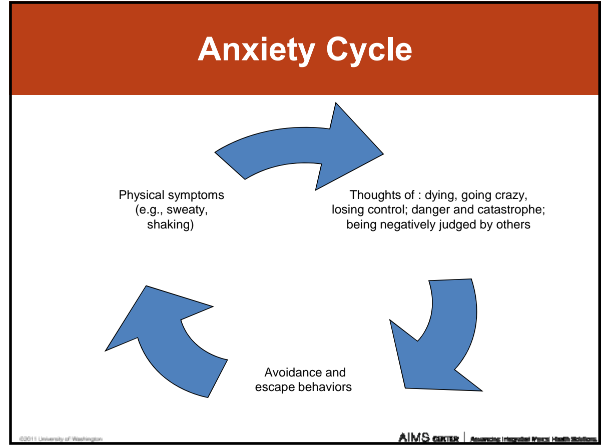
Caregivers may have a better view of the patient's mood and behavior *changes* over time

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



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?

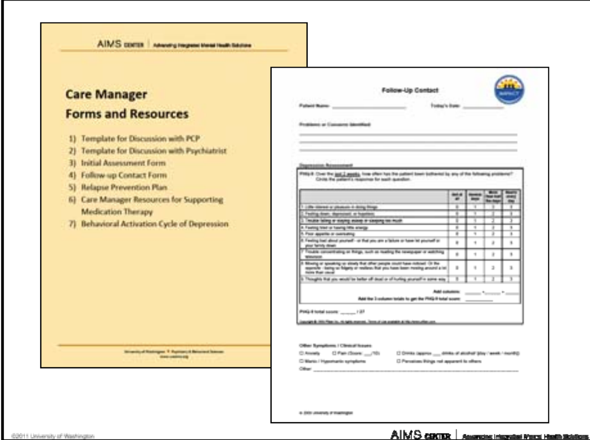
SELF-EFFICACY EXPECTANCY:
can I help myself get better?

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 mediations
- 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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Follow-Up Contact

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

Systematic Outcome Tracking

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

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

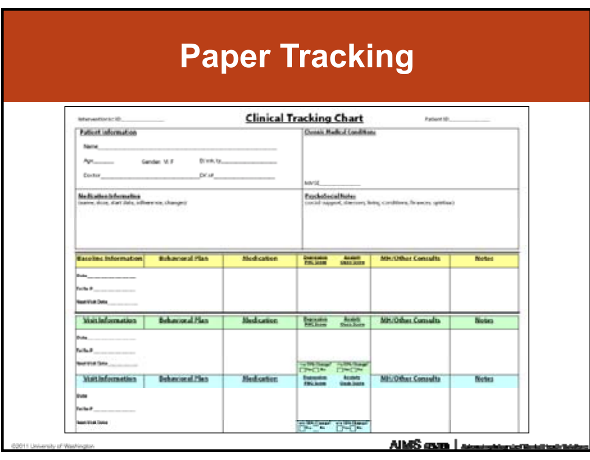
Video Clip:
Treatment Monitoring with PHQ-9

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



Excel® Tracking

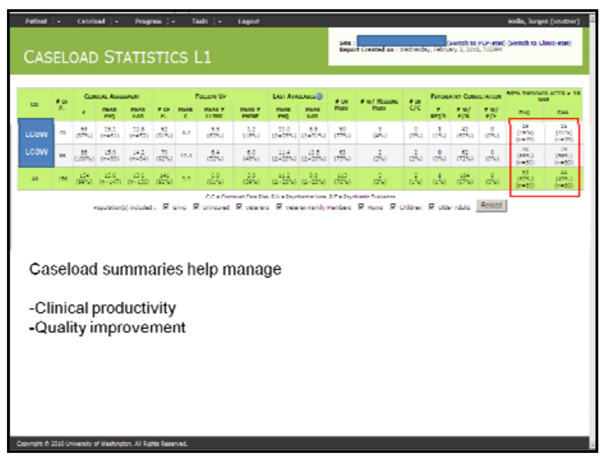
Electronic Medical Records

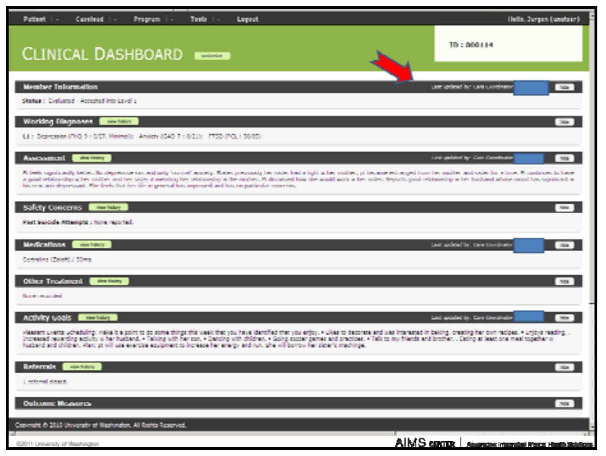
Can track 'key information'

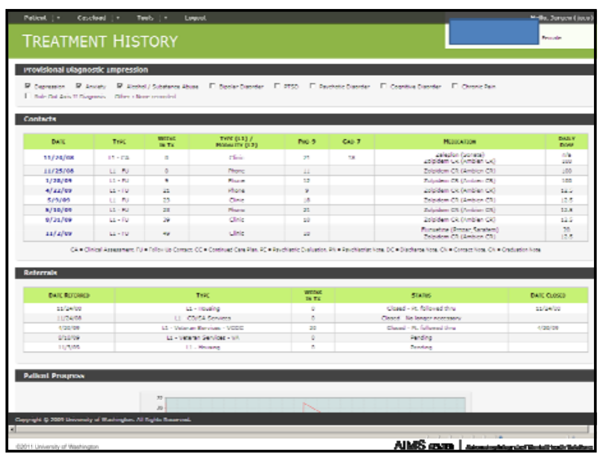
- Visits
- Medications
- Consultations
- Outcome measures (e.g., PHQ-9)

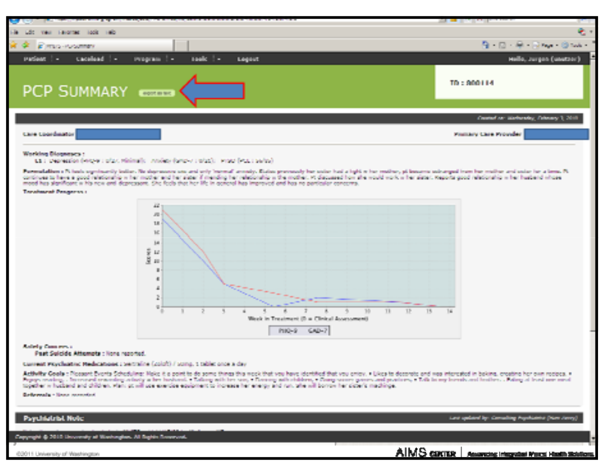
EMR example from Institute for Family Health (Virna Little, PsyD, LCSW-R, SAP)

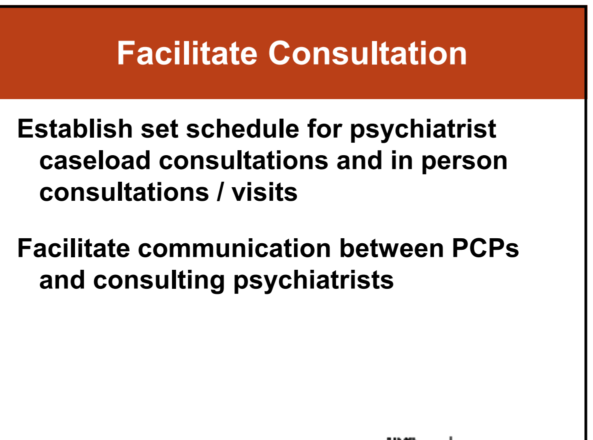
How Can a Registry Help?
Keep track of all clients so no one "falls through the cracks"
– Up to date client contact information
– Referral for services
Tells us who needs additional attention
– Clients who are not following up
– Clients who are not improving
– Reminders for clinicians & Managers
– Customized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


CASELOAD STATISTICS L1
Caseload summaries help manage
-Clinical productivity
-Quality improvement


CLINICAL DASHBOARD

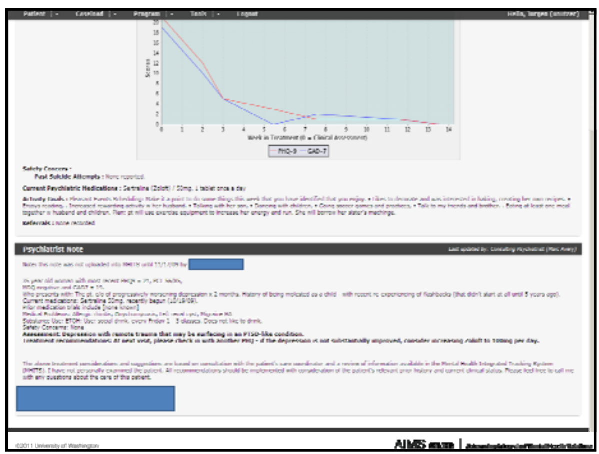

TREATMENT HISTORY

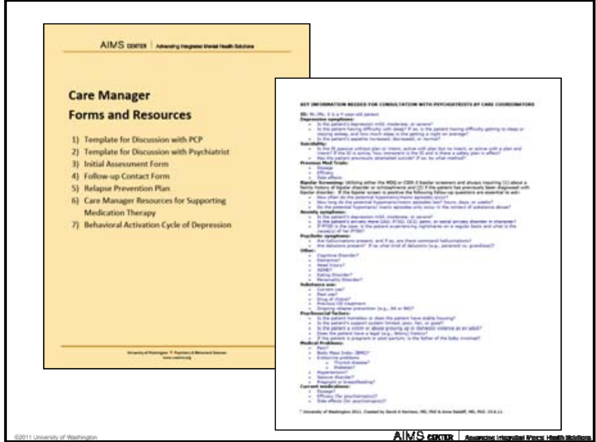

PCP SUMMARY

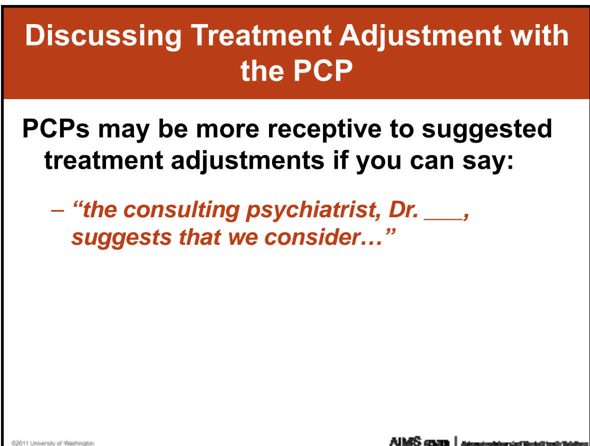

Facilitate Consultation
Establish set schedule for psychiatrist caseload consultations and in person consultations / visits
Facilitate communication between PCPs and consulting psychiatrists

Seek Consultation with Psychiatrist when Patient…

- Is severely depression (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

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FDA-Approved Antidepressants

Serotonin Reuptake Inhibitors (SSRIs)

fluoxetine (Prozac), paroxetine (Paxil), citalopram (Celexa), escitalopram (Lexapro), sertraline (Zoloft), fluvoxamine (Luvox)

Newer Antidepressants (atypical)

bupropion 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

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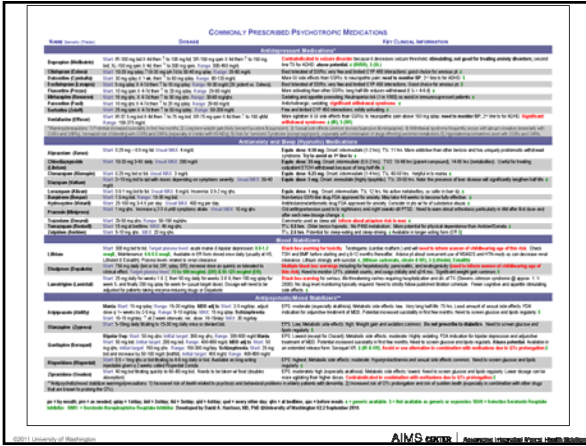
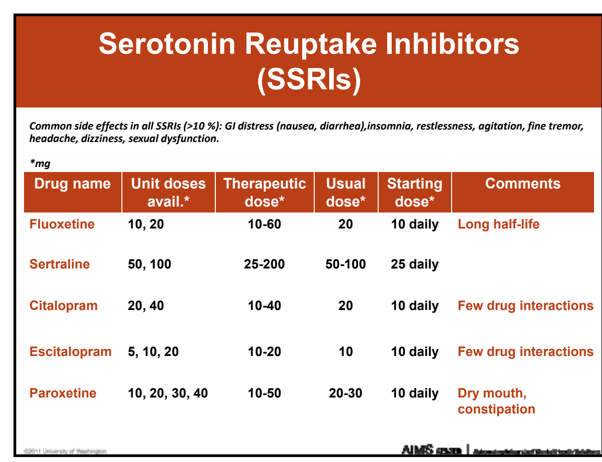


Commonly Prescribed Psychotropic Medications

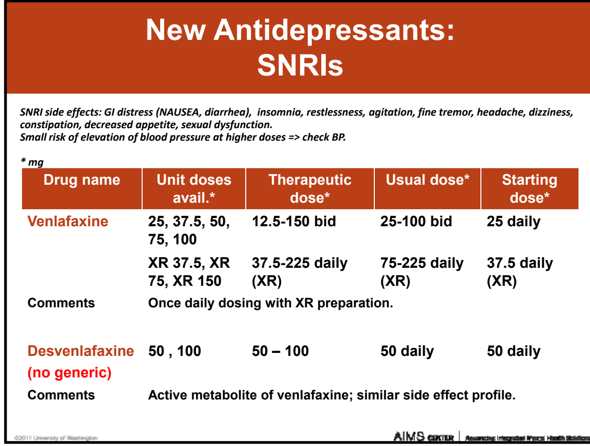


Serotonin Reuptake Inhibitors (SSRIs)

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

**mg*

Drug name	Unit doses avail.*	Therapeutic dose*	Usual dose*	Starting dose*	Comments
Fluoxetine	10, 20	10-60	20	10 daily	Long half-life
Sertraline	50, 100	25-200	50-100	25 daily	
Citalopram	20, 40	10-40	20	10 daily	Few drug interactions
Escitalopram	5, 10, 20	10-20	10	10 daily	Few drug interactions
Paroxetine	10, 20, 30, 40	10-50	20-30	10 daily	Dry mouth, constipation

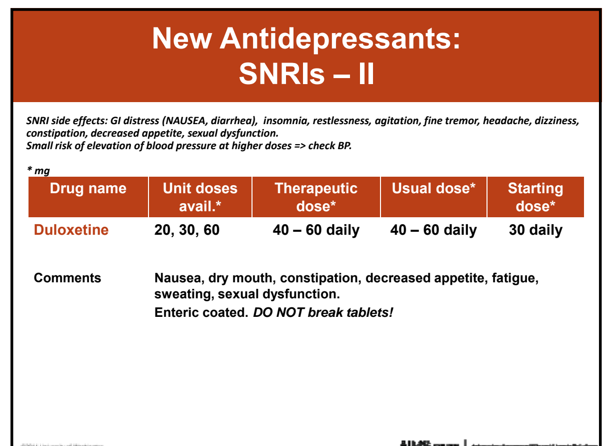


New Antidepressants: SNRIs

SNRI side effects: GI distress (NAUSEA, diarrhea), insomnia, restlessness, agitation, fine tremor, headache, dizziness, constipation, decreased appetite, sexual dysfunction.
Small risk of elevation of blood pressure at higher doses => check BP.

** mg*

Drug name	Unit doses avail.*	Therapeutic dose*	Usual dose*	Starting dose*
Venlafaxine	25, 37.5, 50, 75, 100	12.5-150 bid	25-100 bid	25 daily
	XR 37.5, XR 75, XR 150	37.5-225 daily (XR)	75-225 daily (XR)	37.5 daily (XR)
Comments	Once daily dosing with XR preparation.			
Desvenlafaxine (no generic)	50 , 100	50 – 100	50 daily	50 daily
Comments	Active metabolite of venlafaxine; similar side effect profile.			

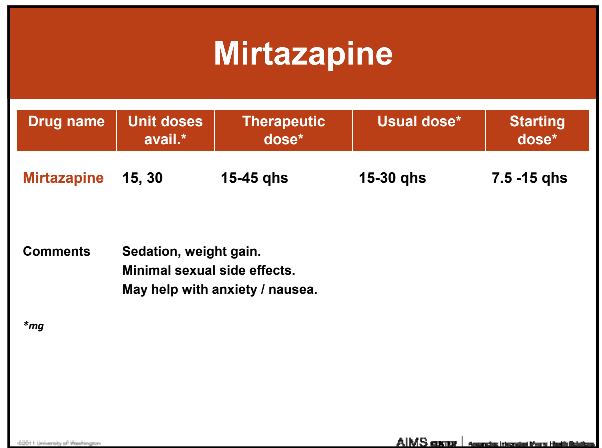


New Antidepressants: SNRIs – II

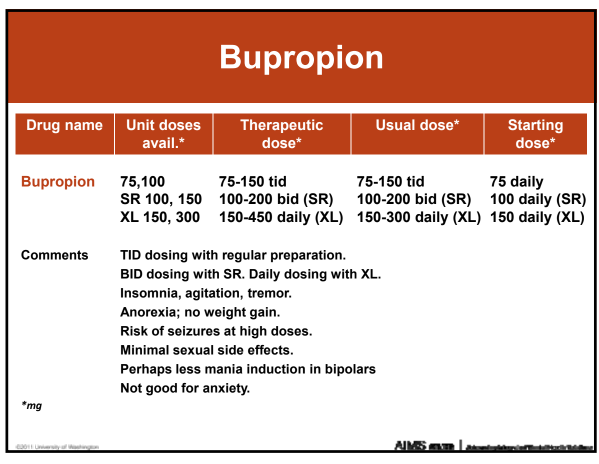
SNRI side effects: GI distress (NAUSEA, diarrhea), insomnia, restlessness, agitation, fine tremor, headache, dizziness, constipation, decreased appetite, sexual dysfunction.
Small risk of elevation of blood pressure at higher doses => check BP.

** mg*

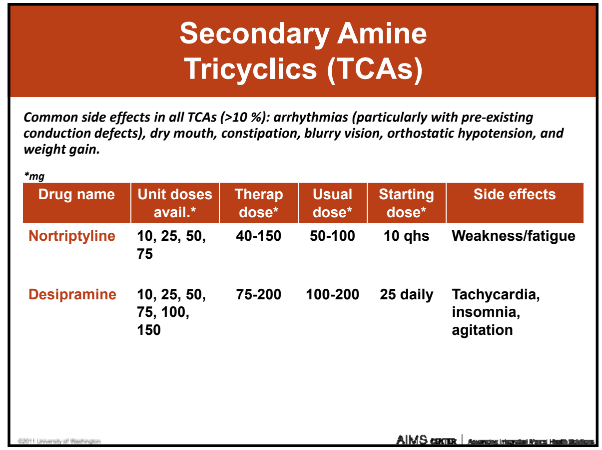
Drug name	Unit doses avail.*	Therapeutic dose*	Usual dose*	Starting dose*
Duloxetine	20, 30, 60	40 – 60 daily	40 – 60 daily	30 daily
Comments	Nausea, dry mouth, constipation, decreased appetite, fatigue, sweating, sexual dysfunction. Enteric coated. *DO NOT break tablets!*			



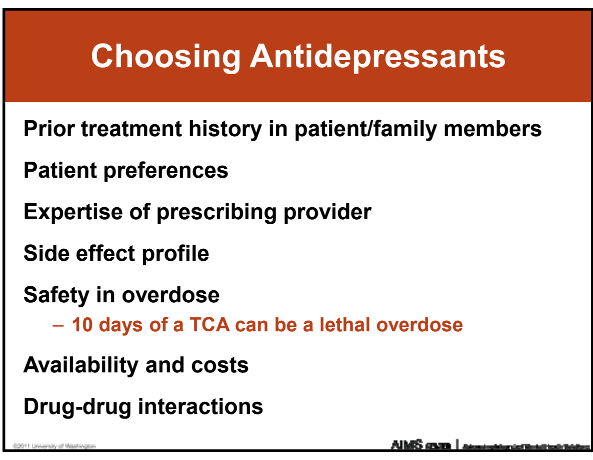
Drug name	Unit doses avail.*	Therapeutic dose*	Usual dose*	Starting dose*
Mirtazapine	15, 30	15-45 qhs	15-30 qhs	7.5 -15 qhs



Drug name	Unit doses avail.*	Therapeutic dose*	Usual dose*	Starting dose*
Bupropion	75,100 SR 100, 150 XL 150, 300	75-150 tid 100-200 bid (SR) 150-450 daily (XL)	75-150 tid 100-200 bid (SR) 150-300 daily (XL)	75 daily 100 daily (SR) 150 daily (XL)



Drug name	Unit doses avail.*	Therap dose*	Usual dose*	Starting dose*	Side effects
Nortriptyline	10, 25, 50, 75	40-150	50-100	10 qhs	Weakness/fatigue
Desipramine	10, 25, 50, 75, 100, 150	75-200	100-200	25 daily	Tachycardia, insomnia, agitation



When and How to Stop Antidepressants?

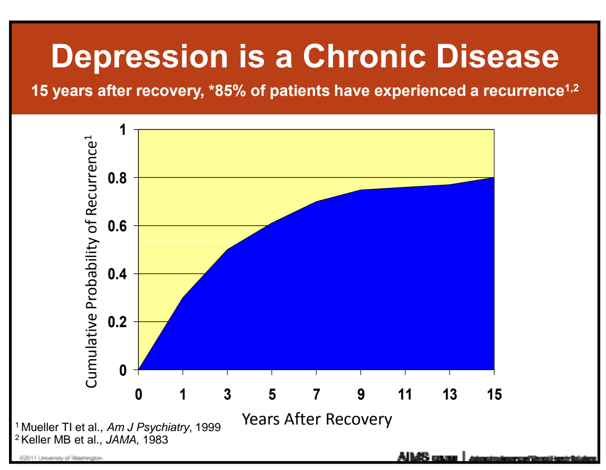
Treat all adults for 4-9 months after initial response

Treat those at high risk for relapse for 2 years or longer. Some may need lifetime treatment

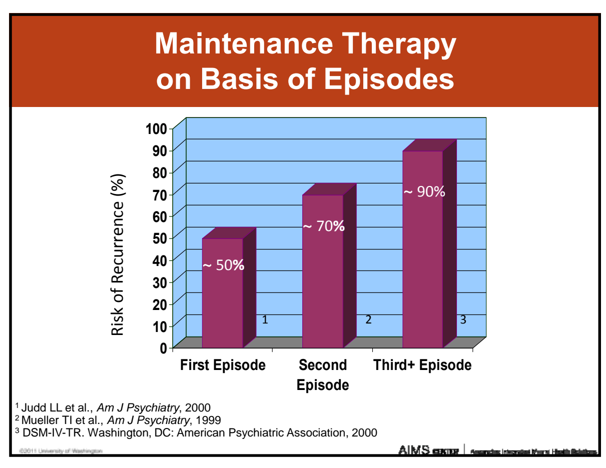
Maintenance treatment should be at full dose

Make a relapse prevention plan

Taper antidepressants slowly to avoid discontinuation syndrome



Maintenance Therapy on Basis of Episodes



[1] Judd LL et al., *Am J Psychiatry*, 2000
[2] Mueller TI et al., *Am J Psychiatry*, 1999
[3] DSM-IV-TR. Washington, DC: American Psychiatric Association, 2000

Problems Early in Treatment

- Nonadherence
- Medical and psychiatric comorbidity
- Side effects
- Unmasking bipolar disorder
- Activation and suicidal ideation
- Incomplete response

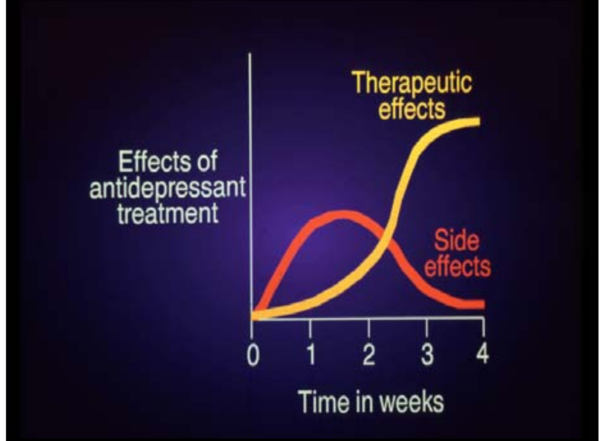
General Office Strategies for Optimizing Adherence

- 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?*

Fluoxetine	60mg
Paroxetine	60mg
Escitalopram	20mg
Citalopram	60mg
Sertraline	200mg
Venlafaxine	300mg
Desvenlafaxine	100mg
Duloxetine	60mg
Bupropion SR	450mg
Mirtazapine	60mg
Nortriptyline	150mg (check serum level)
Despramine	300mg (check serum level)

*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%)

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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

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Weight Gain

5 to 10% of SSRI treated patients

Rx – Bupropion, Fluoxetine

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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

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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

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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?

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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)

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Care Manager Role in Supporting Medication Therapy

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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

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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

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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

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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., *Med Care* 1995;33:67

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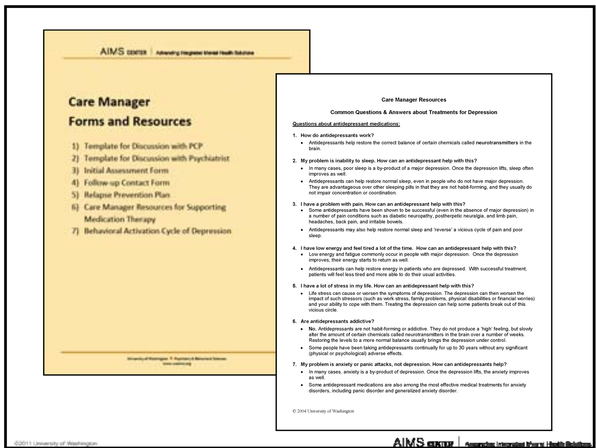

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Care Manager
Forms and Resources

1) Template for Discussion with PCP
2) Template for Discussion with Psychiatrist
3) Initial Assessment Form
4) Follow-up Contact Form
5) Relapse Prevention Plan
6) Care Manager Resources for Supporting Medication Therapy
7) Behavioral Activation Cycle of Depression

Care Manager Resources

Common Questions & Answers about Treatments for Depression

Questions about antidepressant medications:

1. **How do antidepressants work?**
   - Antidepressants help restore the correct balance of certain chemicals called **neurotransmitters** in the brain.
2. **My problem is inability to sleep. How can an antidepressant help with this?**
   - In many cases, poor sleep is a by-product of a major depression. Once the depression lifts, sleep often improves as well.
   - Antidepressants can help restore normal sleep, even in people who do not have major depression. They are advantageous over other sleeping pills in that they are not habit-forming, and they usually do not impair concentration or coordination.
3. **I have a problem with pain. How can an antidepressant help with this?**
   - Some antidepressants have been shown to be successful (even in the absence of major depression) in a number of pain conditions such as diabetic neuropathy, postherpetic neuralgia, and limb pain, headaches, back pain, and irritable bowels.
   - Antidepressants may also help restore normal sleep and 'reverse' a vicious cycle of pain and poor sleep.
4. **I have low energy and feel tired a lot of the time. How can an antidepressant help with this?**
   - Low energy and fatigue commonly occur in people with major depression. Once the depression improves, their energy starts to return as well.
   - Antidepressants can help restore energy in patients who are depressed. With successful treatment, patients will feel less tired and more able to do their usual activities.
5. **I have a lot of stress in my life. How can an antidepressant help with this?**
   - Life stress can cause or worsen the symptoms of depression. The depression can then worsen the impact of such stressors (such as work stress, family problems, physical disabilities or financial worries) and your ability to cope with them. Treating the depression can help some patients break out of this vicious circle.
6. **Are antidepressants addictive?**
   - **No.** Antidepressants are not habit-forming or addictive. They do not produce a 'high' feeling, but slowly alter the amount of certain chemicals called neurotransmitters in the brain over a number of weeks. Restoring the levels to a more normal balance usually brings the depression under control.
   - Some people have been taking antidepressants continually for up to 30 years without any significant (physical or psychological) adverse effects.
7. **My problem is anxiety or panic attacks, not depression. How can antidepressants help?**
   - In many cases, anxiety is a by-product of depression. Once the depression lifts, the anxiety improves as well.
   - Some antidepressant medications are also among the most effective medical treatments for anxiety disorders, including panic disorder and generalized anxiety disorder.

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Evidence-based Non-medication Treatments

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

Physical Activity

Social Interaction

Pleasant Events

Behavioral Activation

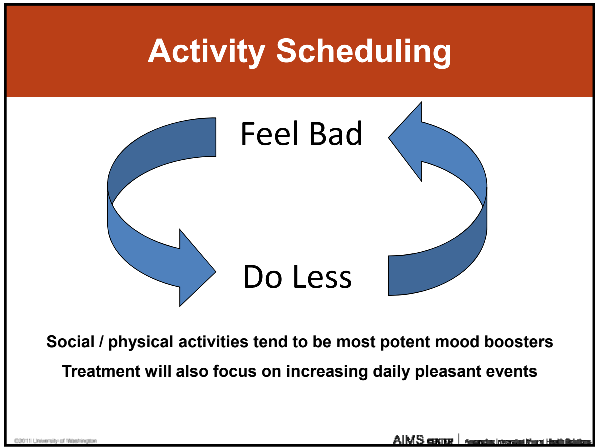
Depression → inactivity and withdrawal

=

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



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

Behavioral Activation

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

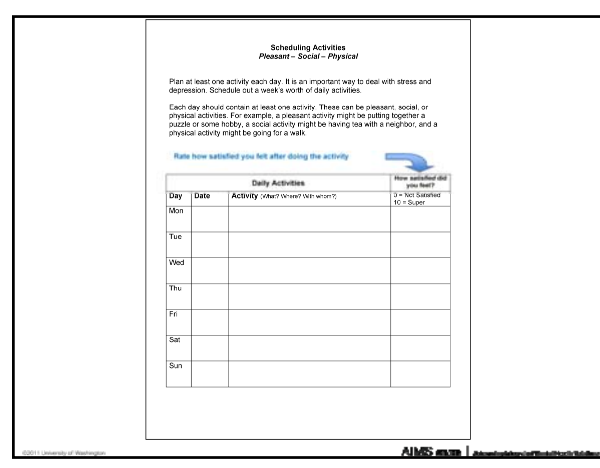
Review all tasks

Praise success – ask about how the activity effects 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



Scheduling Activities
Pleasant – Social – Physical

Plan at least one activity each day. It is an important way to deal with stress and depression. Schedule out a week's worth of daily activities.

Each day should contain at least one activity. These can be pleasant, social, or physical activities. For example, a pleasant activity might be putting together a puzzle or some hobby, a social activity might be having tea with a neighbor, and a physical activity might be going for a walk.

Rate how satisfied you felt after doing the activity

Daily Activities			How satisfied did you feel?
Day	**Date**	**Activity** (What? Where? With whom?)	0 = Not Satisfied 10 = Super
Mon			
Tue			
Wed			
Thu			
Fri			
Sat			
Sun			

Relapse Prevention & Maintenance Treatment

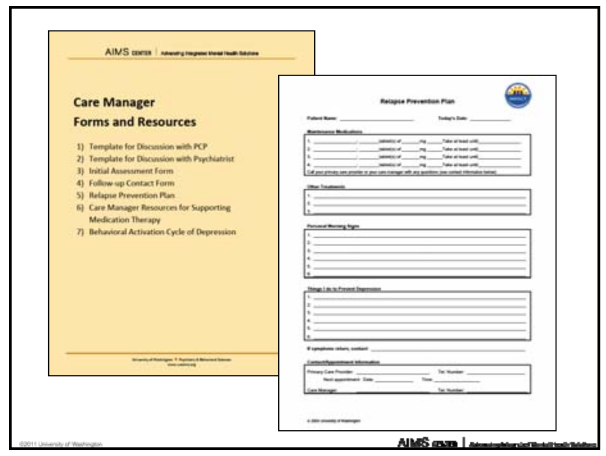
After patient is 'in remission' from acute episode

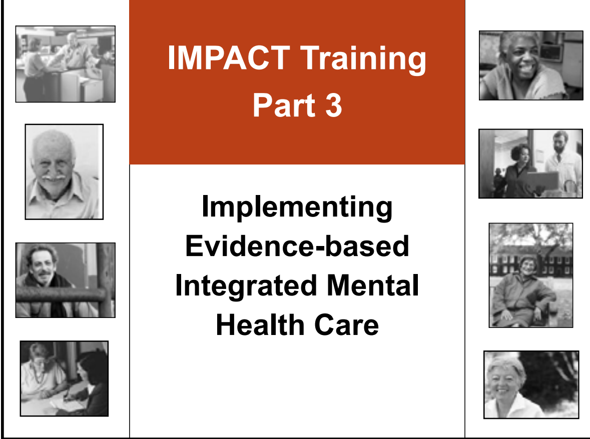
Make a relapse prevention plan

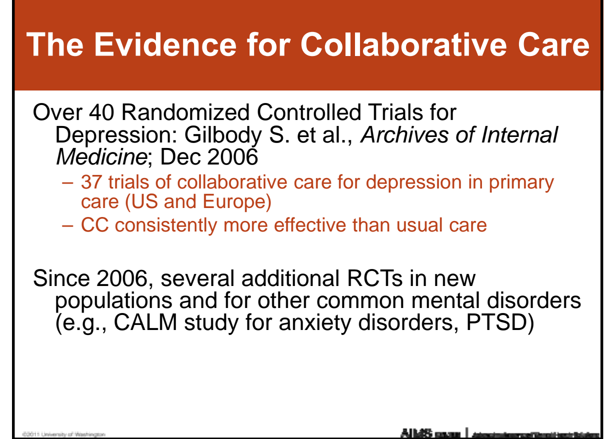
Follow the patient with monthly contacts

- Usually by telephone calls
- Individual OR in a maintenance group

Bring patient back in for further evaluation if symptoms recur







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…

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"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

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From Research to Practice:

Implementation Experience

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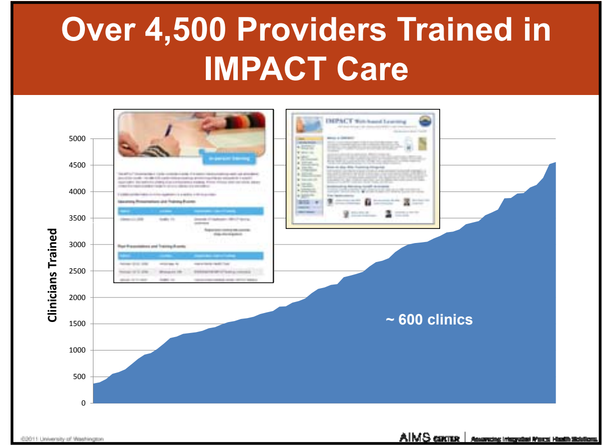

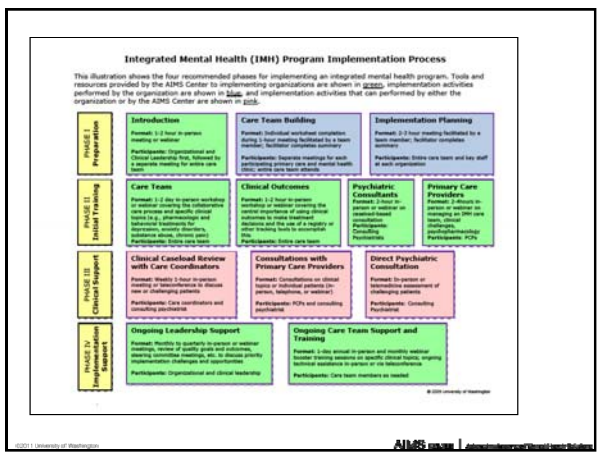

Building the IMPACT Team

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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

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Evidence-Based 'Team Care' for Depression

TWO PROCESSES	TWO NEW 'TEAM MEMBERS'	
	Care Manager	Consulting Psychiatrist
1. Systematic diagnosis and outcomes tracking e.g., PHQ-9 to facilitate diagnosis and track depression outcomes	- Patient education / self management support - Close follow-up to make sure pts don't 'fall through the cracks'	- Caseload consultation for care manager and PCP (population-based) - Diagnostic consultation on difficult cases
2. Stepped Care a) Change treatment according to evidence-based algorithm if patient is not improving b) Relapse prevention once patient is improved	- Support anti-depressant Rx by PCP - Brief counseling (behavioral activation, PST-PC, CBT, IPT) - Facilitate treatment change / referral to mental health - Relapse prevention	- Consultation focused on patients not improving as expected - Recommendations for additional treatment / referral according to evidence-based guidelines

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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**

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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**

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BEHAVIORAL HEALTH STAFF SELF-ASSESSMENT — AIMS CENTER

Conditions for which you plan to provide clinical care (select all that apply)
Depression ☐ Substance Abuse ☐
Anxiety (e.g. PTSD) ☐ Other Mental Disorders ☐ ____

Integrated Care Tasks	Is This A Priority Task?		Is This Your Role Now?		If No, Whose Role?	Your Organization's Capacity with This Task?		Your Level of Comfort with This Task		Would You Like Training to Perform This Task?	
Identify and Engage Patients	Yes	No	Yes	No		High	Med/Low	High	Med/Low	Yes	No
Identify People Who May Need Help	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Screen for Behavioral Health Problems Using Valid Measures	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Diagnose Behavioral Health Disorders	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Engage Patient in Integrated Care Program	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Initiate and Provide Treatment	Yes	No	Yes	No		High	Med/Low	High	Med/Low	Yes	No
Perform Behavioral Health Assessment	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Develop and Update Behavioral Health Treatment Plan	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Patient Education about Symptoms & Treatment Options	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Prescribe Psychotropic Medications	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Patient Education about Medications & Side Effects	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Brief Counseling, Activity Scheduling, Behavioral Activation	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Evidence-based Psychotherapy (e.g. PST, CBT, IPT)	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Identify and Treat Coexisting Medical Conditions	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Facilitate Referral to Specialty Care or Social Services	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Create and Support Relapse Prevention Plan	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Track Treatment Outcomes	Yes	No	Yes	No		High	Med/Low	High	Med/Low	Yes	No
Track Treatment Engagement and Adherence using Registry	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Reach out to Patients who are Non-adherent or Disengaged	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Track Patients' Symptoms with Measurement Tool (e.g., PHQ-9)	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Track Medication Side Effects & Concerns	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Track Outcome of Referrals and Other Treatments	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Adjust Treatment if Patients are Not Responding	Yes	No	Yes	No		High	Med/Low	High	Med/Low	Yes	No
Assess Need for Changes in Treatment	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Facilitate Changes in Treatment / Treatment Plan	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Provide Caseload-Focused Psychiatric Consultation	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Provide in Person Psychiatric Assessment of Challenging Patients	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Other Tasks Important for Our Program (add tasks as needed)	Yes	No	Yes	No		High	Med/Low	High	Med/Low	Yes	No
Coordinate Communication Among Team Members / Providers	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Administrative Support for Program (e.g., Scheduling, Resources)	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Clinical Supervision for Program	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
Training of Team Members in Behavioral Health	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
1.	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
2.	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
3.	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐

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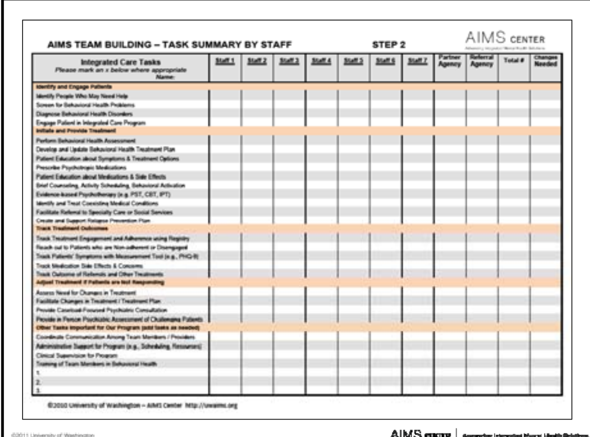

AIMS TEAM BUILDING – TASK SUMMARY BY STAFF STEP 2 AIMS CENTER

Integrated Care Tasks *Please mark an x below where appropriate* *Name:*	Staff 1	Staff 2	Staff 3	Staff 4	Staff 5	Staff 6	Staff 7	Partner Agency	Referral Agency	Total #	Changes Needed
Identify and Engage Patients											
Identify People Who May Need Help											
Screen for Behavioral Health Problems											
Diagnose Behavioral Health Disorders											
Engage Patient in Integrated Care Program											
Initiate and Provide Treatment											
Perform Behavioral Health Assessment											
Develop and Update Behavioral Health Treatment Plan											
Patient Education about Symptoms & Treatment Options											
Prescribe Psychotropic Medications											
Patient Education about Medications & Side Effects											
Brief Counseling, Activity Scheduling, Behavioral Activation											
Evidence-based Psychotherapy (e.g. PST, CBT, IPT)											
Identify and Treat Coexisting Medical Conditions											
Facilitate Referral to Specialty Care or Social Services											
Create and Support Relapse Prevention Plan											
Track Treatment Outcomes											
Track Treatment Engagement and Adherence using Registry											
Reach out to Patients who are Non-adherent or Disengaged											
Track Patients' Symptoms with Measurement Tool (e.g., PHQ-9)											
Track Medication Side Effects & Concerns											
Track Outcome of Referrals and Other Treatments											
Adjust Treatment if Patients are Not Responding											
Assess Need for Changes in Treatment											
Facilitate Changes in Treatment / Treatment Plan											
Provide Caseload-Focused Psychiatric Consultation											
Provide in Person Psychiatric Assessment of Challenging Patients											
Other Tasks Important for Our Program (add tasks as needed)											
Coordinate Communication Among Team Members / Providers											
Administrative Support for Program (e.g., Scheduling, Resources)											
Clinical Supervision for Program											
Training of Team Members in Behavioral Health											
1.											
2.											
3.											

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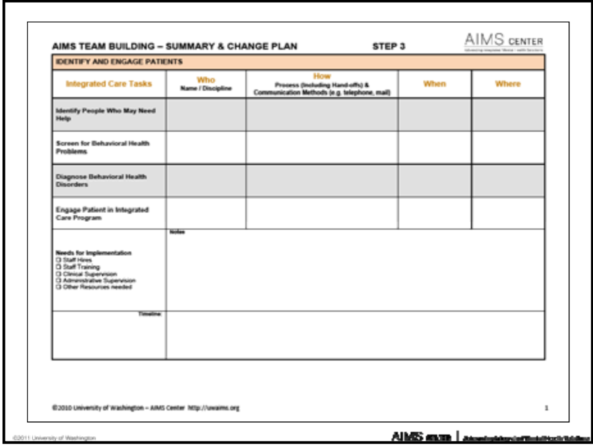

AIMS TEAM BUILDING – SUMMARY & CHANGE PLAN STEP 3 AIMS CENTER

IDENTIFY AND ENGAGE PATIENTS				
Integrated Care Tasks	Who Name / Discipline	How Process (including Hand-offs) & Communication Methods (e.g. telephone, mail)	When	Where
Identify People Who May Need Help				
Screen for Behavioral Health Problems				
Diagnose Behavioral Health Disorders				
Engage Patient in Integrated Care Program				
Needs for Implementation ❑ Staff Hires ❑ Staff Training ❑ Clinical Supervision ❑ Administrative Supervision ❑ Other Resources needed	Notes			
Timeline:				

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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'

Workforce Issues

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

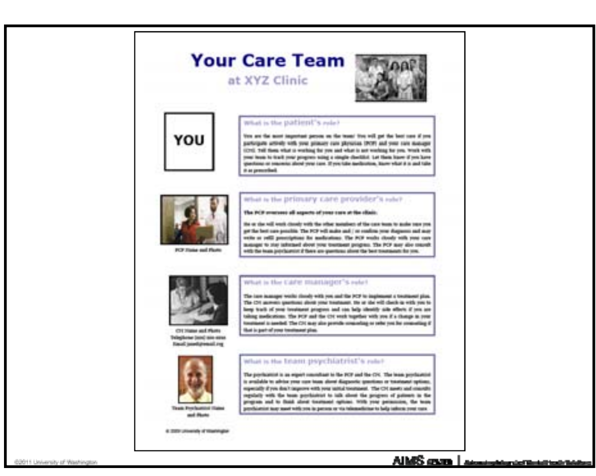
- May not be familiar / comfortable with the caseload and population-focused consultation model
- Telemedicine consultation can be helpful

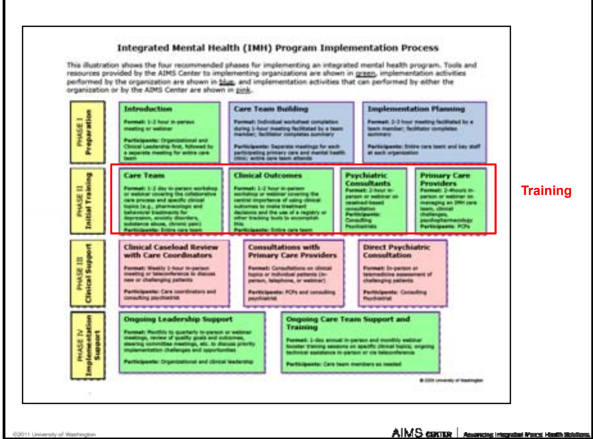
"Your Care Team Template"

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

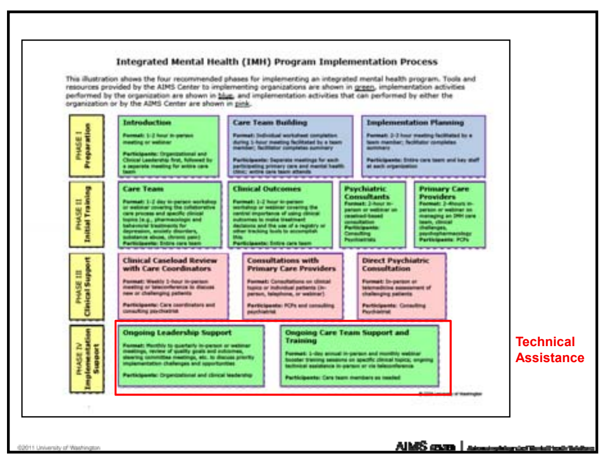
- Didactic
- Case Supervision

Web-based Training

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

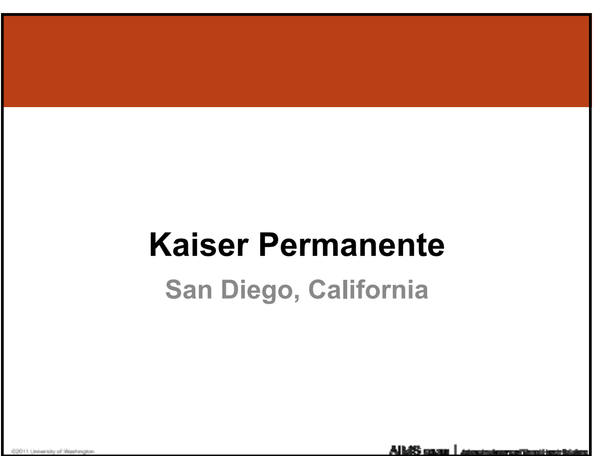
Case-based Supervision / Consultation

Implementation Consultation



Examples of large-scale Implementations

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



IMPACT Dissemination at Kaiser Permanente

KPSC in IMPACT Study
- (~ 280 participants in 1 clinic)

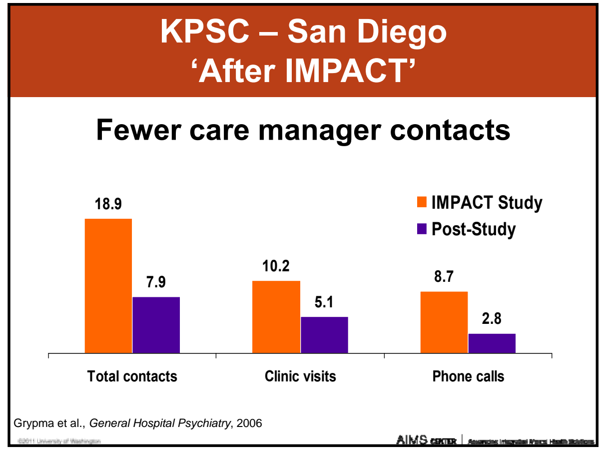
KPSC in San Diego after IMPACT
- (2 clinics; Grypma et al, 2005)

KPSC Depression Initiative (Dreskin)
- 12 regional medical centers serving 3 million members – over 40,000 in depression care management

Kaiser Permanente of Southern California

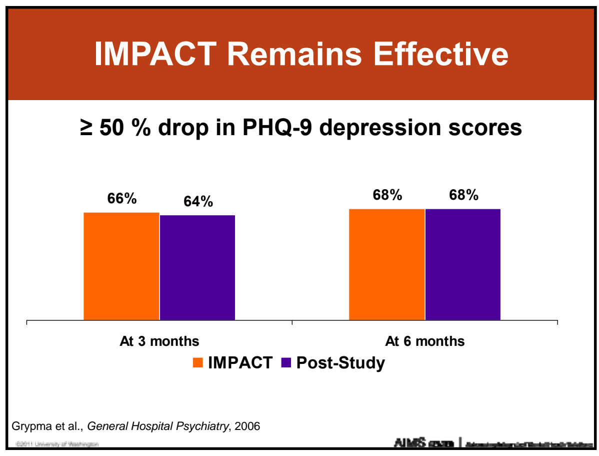
- Pilot Study
  - Compare 284 clients in 'adapted program' with 140 usual care patients and 140 intervention patients in the IMPACT study (Grypma et al, 2006)
- Dissemination
  - Implemented core components of program in 10 regional medical centers

KPSC – San Diego 'After IMPACT'



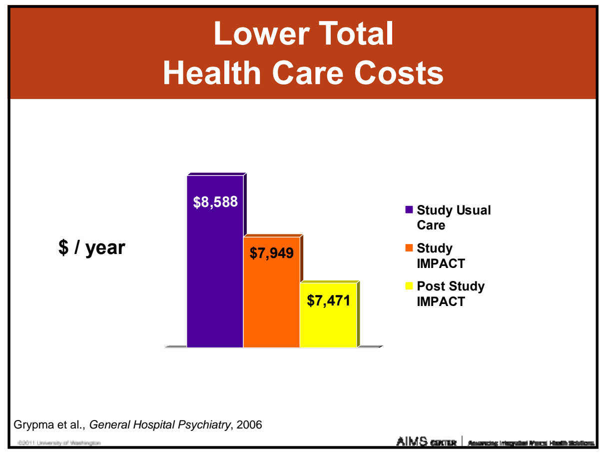
Grypma et al., *General Hospital Psychiatry*, 2006

IMPACT Remains Effective



Grypma et al., *General Hospital Psychiatry*, 2006

Lower Total Health Care Costs

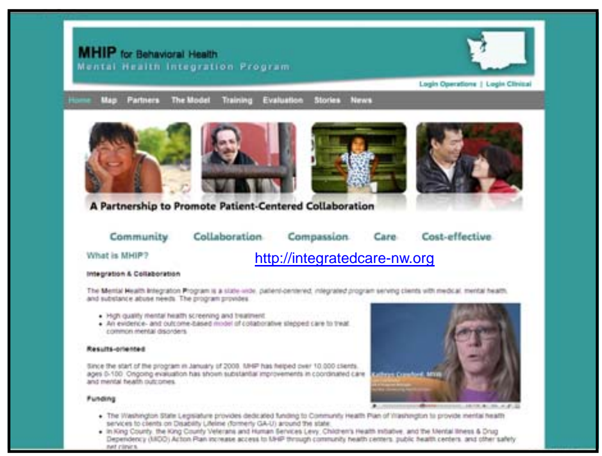


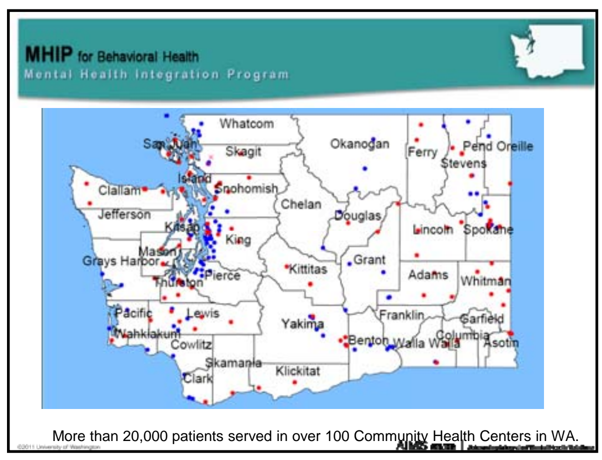
Grypma et al., *General Hospital Psychiatry*, 2006

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





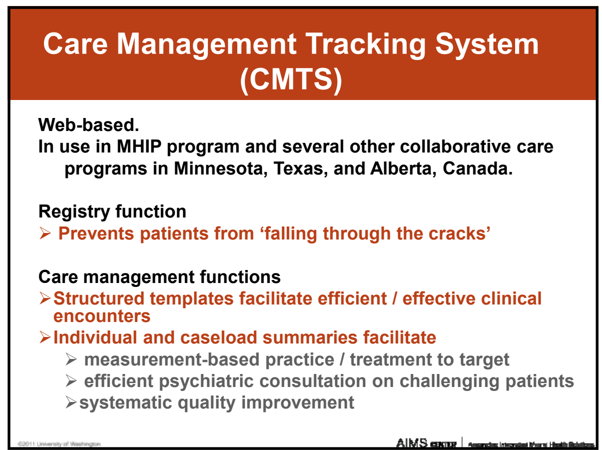
MHIP Target Populations

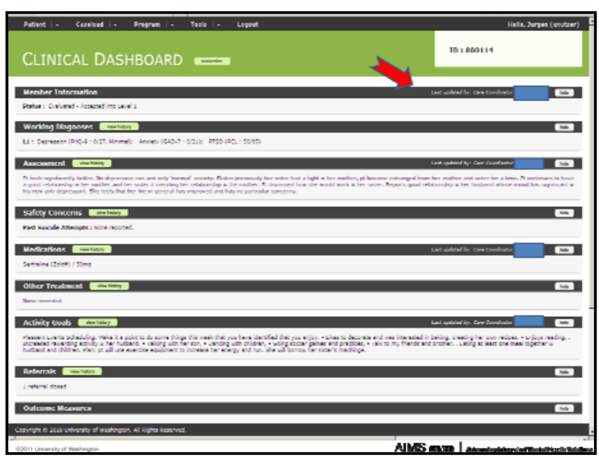
State-wide: unemployed adults with short term disability due to mental health / substance abuse problems (Disability Lifeline Program)

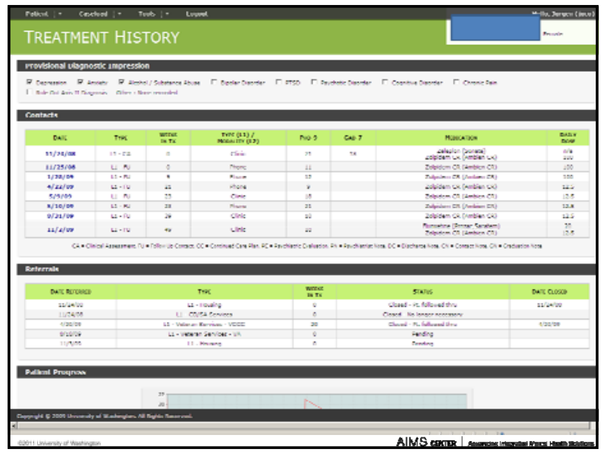
King County: high risk mothers and their children, uninsured adults, older adults, Veterans and their family members

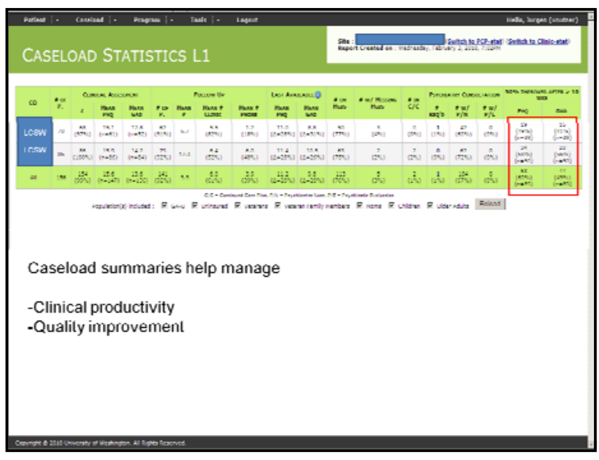
Program Staffing in Diverse Clinic Settings

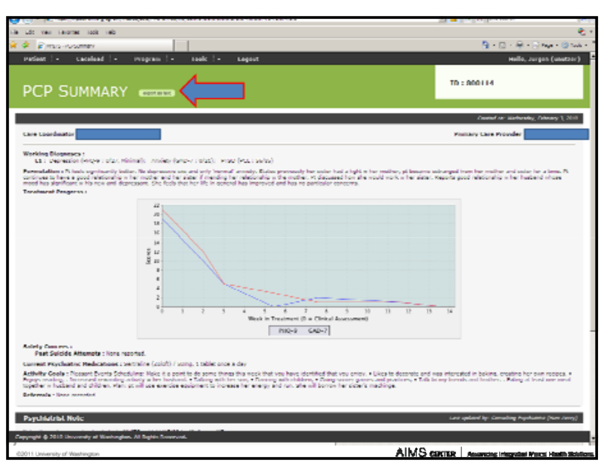
Clinic Population (mental health needs)	% of clinic population with need for care management	Typical caseload size for 1 FTE Care Manager	# of unique primary care clinic patients to justify 1 FTE CM	Typical personnel requirement for 1,000 unique primary care patients	
				FTE Care Manager	FTE Psychiatrist**
Low need (e.g., insured, employed)	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)

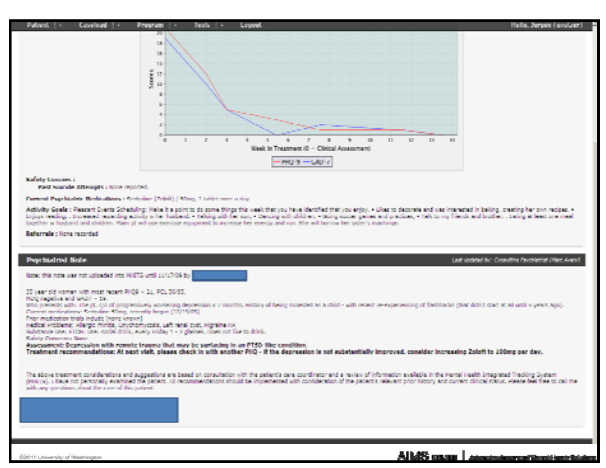

Care Management Tracking System (CMTS)
Web-based.
In use in MHIP program and several other collaborative care programs in Minnesota, Texas, and Alberta, Canada.
Registry function
➢ Prevents patients from 'falling through the cracks'
Care management functions
➢Structured templates facilitate efficient / effective clinical encounters
➢Individual and caseload summaries facilitate
➢ measurement-based practice / treatment to target
➢ efficient psychiatric consultation on challenging patients
➢systematic quality improvement


CLINICAL DASHBOARD


TREATMENT HISTORY


CASELOAD STATISTICS L1
Caseload summaries help manage
-Clinical productivity
-Quality improvement


PCP SUMMARY



MHIP client Demographics

	Mean or %	Range across clinics
Men	52 %	
Women	48 %	
Mean Age	40	1-100
Challenge with Housing	29 %	3% - 52 %
Challenge with Transportation	21 %	10 %- 50 %

Clinical Diagnoses

Diagnoses	%
Depression	71 %
Anxiety (GAD, Panic)	48 %
Posttraumatic Stress Disorder (PTSD)	17 %
Alcohol / Substance Abuse	17 %*
Bipolar Disorder	15 %
Thoughts of Suicide	45 %

… plus acute and chronic medical problems, chronic pain, substance use, prescription narcotic misuse, homelessness, unemployment, poverty, ….

Sample Community Health Center
(6 clinics; over 2,000 clients served)

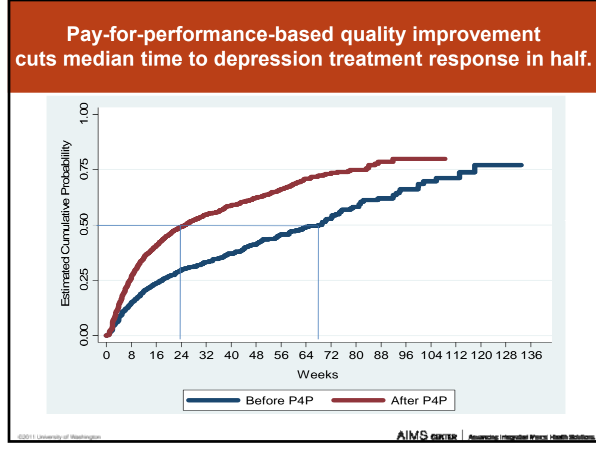
Population	Mean baseline PHQ-9 depression score (0-27)	Follow-up (%)	Mean number of care coordinator contacts	% with psych consultation	% with significant clinical improvement
Disability Lifeline	16.7	92 %	8	69 %	43 %
Uninsured	15.8	83 %	8	59 %	50 %
Older Adults	15.3	92 %	8	55 %	43 %
Vets & Family	15.5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

Data from Care Management Tracking System (CMTS): http://uwaims.org

Systematic Quality Improvement

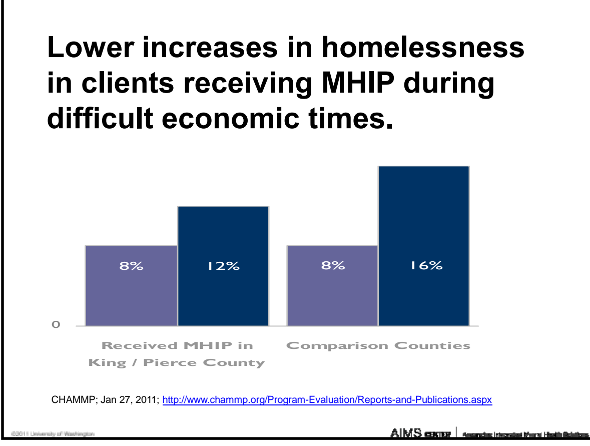
- Team building and implementation support
- Provider training and ongoing support
- Weekly caseload-based psychiatric review
- Outcomes-based Feedback and QI
- Pay-for-performance program (P4P)
  - Initiated in 2009
  - 25 % of payment depends on meeting quality indicators

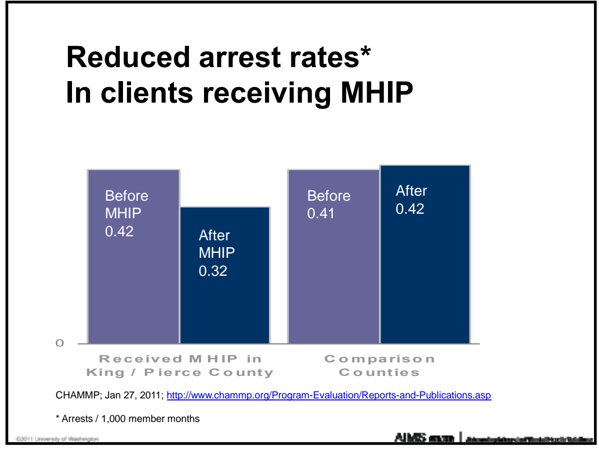
Pay-for-performance-based quality improvement cuts median time to depression treatment response in half.

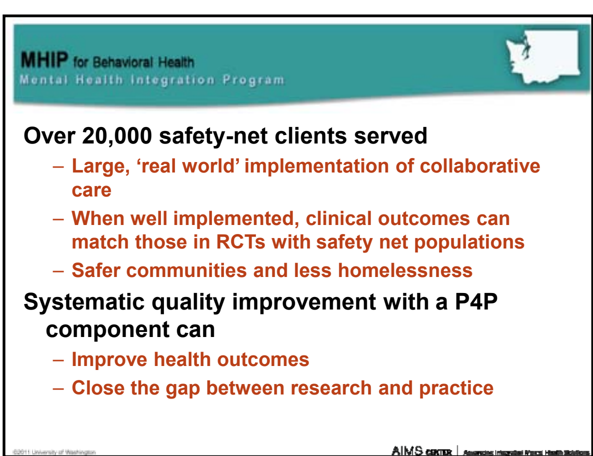


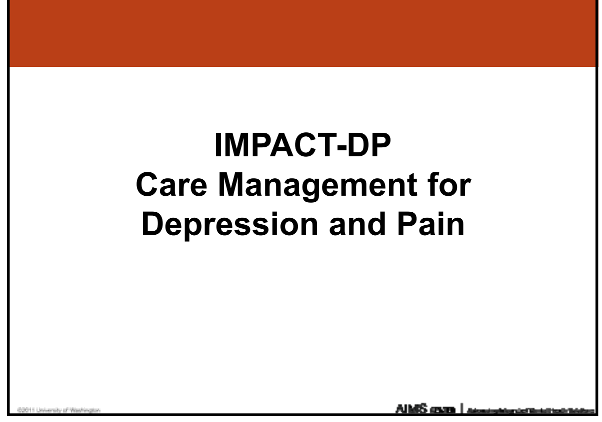
Other policy relevant outcomes

- 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; http://www.chammp.org/Program-Evaluation/Reports-and-Publications.aspx









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

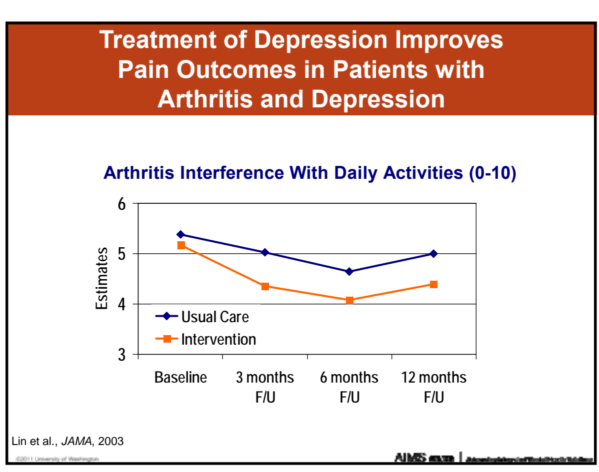
Depression and Pain Have Combined Effects

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

Pain with depression predicts greater functional impairment than pain alone

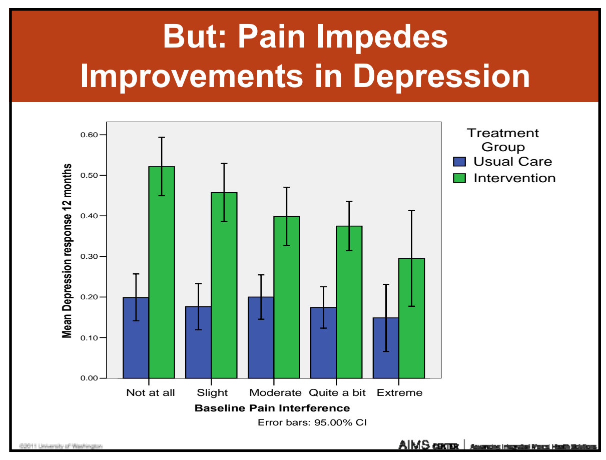
!

Treatment of Depression Improves Pain Outcomes in Patients with Arthritis and Depression

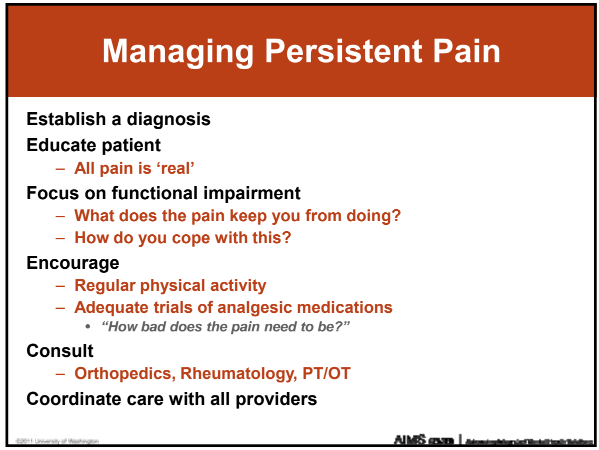


Lin et al., *JAMA*, 2003

But: Pain Impedes Improvements in Depression



Managing Persistent Pain



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

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

Pain Medications

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

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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

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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

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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)

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Clinical Outcomes

	IMPACT-DP (N=13)		
Variables	Baseline Mean(SD)	6 Month Mean(SD)	Standardized Effect Size
Depression Severity: HSCL-20 (0-4)	1.78 (0.56)	1.06 (0.59)	1.27
Depression Severity: PHQ-9 (0-27)	13.46 (5.09)	6.31 (5.39)	1.40
Depression Self Efficacy (0-10)	5.28 (2.16)	6.95 (2.13)	-0.77
Pain Intensity (0-10)	5.67 (1.69)	4.18 (1.98)	0.88
Total body areas with pain (0-10)	5.46 (1.98)	3.62 (2.40)	0.93
Pain Interference (0-10)	4.91 (1.75)	3.49 (2.14)	0.81
8 meter walk test (seconds)	12.07 (2.65)	10.34 (1.57)	0.66
Transfer test (seconds)	11.93 (4.66)	9.81 (3.02)	0.46

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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."

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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

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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)

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Financing IMPACT Care

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

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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)

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IMPACT Costs Per Insured Beneficiary (PMPM)

% of patient population using depression care management	Approximate clinic population / FTE care manager	Cost per participant (12 months)	PMPM (cost per member per month)
3 %	5,000	$ 750	$ 1.88

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Program Staffing in Diverse Clinic Settings

Population (severity of mental health needs)	% of clinic population with need for mental health care management	Typical caseload size for 1 FTE Care Manager	# of unique primary care clinic patients to justify 1 FTE CM	Typical Personnel Requirement for 1,000 unique primary care patients	
				FTE Care Manager	FTE Psychiatrist**
Low need (e.g., insured, employed)	2%	100	5000	0.2	0.05 (2 hrs / week)
Medium need (e.g., medically ill, elderly, some comorbid chronic pain / substance abuse)	5%	75	1500	0.7	0.07 (3 hrs / week)
High need (e.g, safety-net population with high mental health, substance abuse, and social service needs)*	15%	50	333	3	0.3 (12 hrs / week)

* 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.

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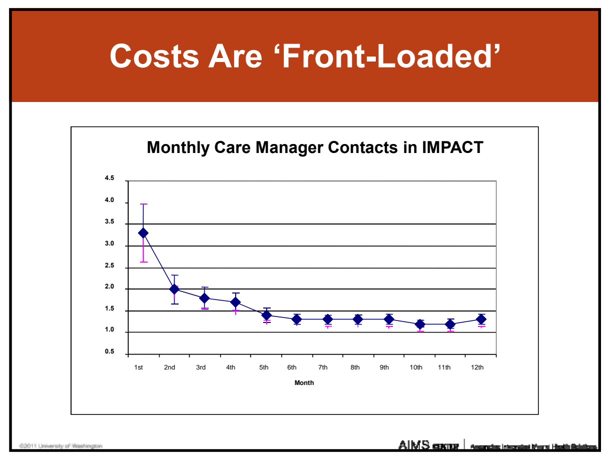
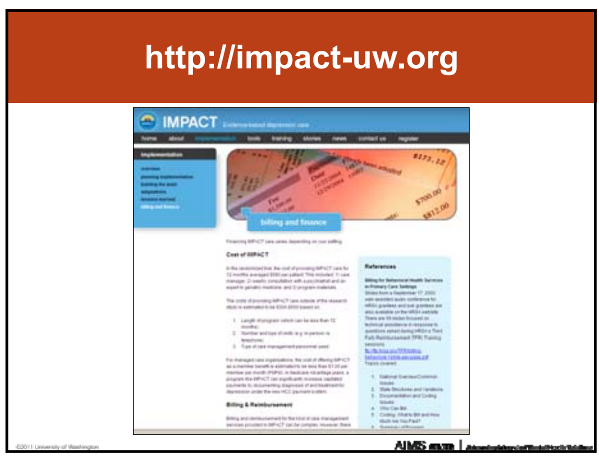
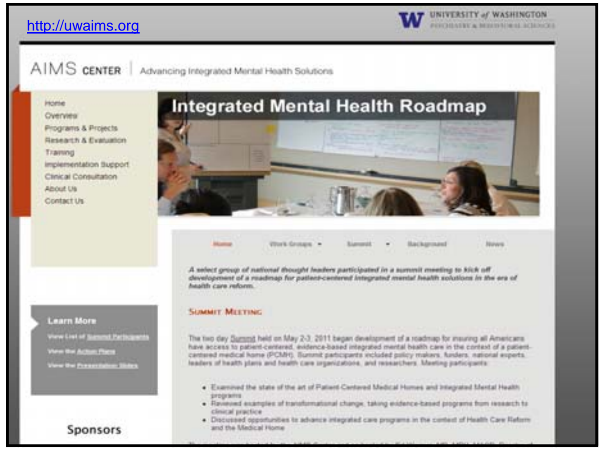

Costs Are 'Front-Loaded'
Monthly Care Manager Contacts in IMPACT
4.5
4.0
3.5
3.0
2.5
2.0
1.5
1.0
0.5
1st
2nd
3rd
4th
5th
6th
7th
8th
9th
10th
11th
12th
Month


http://impact-uw.org
IMPACT
billing and finance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IMPACT Implementation Center:
Kitty Christensen, Manager
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