Contextualizing Care Coordination within a changing Health Care Environment

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University of Washington
CCC Learning Session 4
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Disclosures

Employment: University of Washington
- Professor & Chair, School of Medicine; Dept. of Psychiatry and Behavioral Sciences
  - Director, Division of Integrated Care and Public Health
  - Director, AIMS Center: Advancing Integrated Mental Health Solutions
- Adjunct Professor, School of Public Health: Depts. of Health Services and Global Health

Grant funding (current & recent)
- National Institute of Health (NIMH, NIDA, AHRQ, NLM)
- National Corporation for Community Service (Social Innovation Fund)
- Center for Medicare and Medicaid Innovation (CMMI)
- Department of Defense (Henry M. Jackson Foundation)
- American Federation for Aging Research (AFAR)
- John A. Hartford Foundation
- Alaska Mental Health Trust Authority
- George Foundation
- American Red Cross (RAND)
- California HealthCare Foundation
- Robert Wood Johnson Foundation
- Hogg Foundation for Mental Health

Contracts (current & recent)
- Community Health Plan of Washington, Public Health of Seattle & King County
- Washington State Healthcare Authority
- California Institute of Mental Health
- Los Angeles County, Santa Clara County, Ventura County, Alameda County
- New York State Department of Health
- Institute for Clinical Systems Improvement (ICSI)
- Mathematica / Center for Healthcare Strategies

Consultant (current)
- National Council of Community Behavioral Health Care (NCCBH)
- AARP Services Incorporated (ASI)
- University of Colorado
- Group Health Research Institute

Advisor (current & recent)
- Carter Center Mental Health Program
- World Health Organization
Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (1948).
Psychiatric disorders cause 25% of all disability worldwide. (C. Murray, GBD Study, Lancet 2012)

10% of Years Lived with Disability (YLD) from depression alone. 3x diabetes, 10x heart disease, 40x cancer

In the US, one suicide every 14 minutes. In WA, 2-3 suicides / day.

No family goes untouched.

Behavior determines ~50% of all mortality and morbidity.

Unhealthy behaviors are major drivers of health care costs.

40–50% struggle with treatment adherence.

Employers struggle with absenteeism and presenteeism.

Vision: Mental health is an important part of health and mental health care becomes an integral and effective component of all health care.
How many of these people with mental health concerns will see a mental health provider?

Wang P, et al., Twelve-Month Use of Mental Health Services in the United States, Arch Gen Psychiatry, 62, June 2005
How good is current depression care?

Fewer than 2/10 see a psychiatrist or psychologist.

5/10 receive treatment in primary care

~ 30 million receive an antidepressant Rx in primary care

BUT only 25% improve

“Of course you feel great. These things are loaded with antidepressants.”
2/3 of PCPs report poor access to mental health services for their patients.

“We couldn’t get a psychiatrist, but perhaps you’d like to talk about your skin. Dr. Perry here is a dermatologist.”

Cunningham PJ, Health Affairs, 2009;28(3)490-501
Where are the Psychiatrists?

US: 40,000 psychiatrists largely in urban areas

WA: urban: 612 psychiatrists (14/100,000)
   rural: 58 psychiatrists (4/100,000)

(Baldwin LM et al, 2006)
Available Psychiatrist Time / Week

Ideal

50 minutes

United States:
Urban

6 minutes

United States:
Rural

1.5 minutes

Talk fast!
Figure 4.4 Number of psychiatrists per 100,000 population, 2000

More psychiatrists in San Francisco than in Africa!
How do we close the gap?

Train more specialists?

Work harder?

Work smarter!

Leverage mental health specialists more effectively

- partnerships (e.g., primary care)
- technology (e.g., telemedicine)
Building more effective care models.
Is there a better way?
Yes - Collaborative Care!

http://aims.uw.edu/daniels-story-introduction-collaborative-care
Principle 1: Patient Centered Team Care Care

- PCP
- Patient
- BH Care Manager
- Psychiatric Consultant

Core Program

New Roles
Principle 2: Population Based Treatment

<table>
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<tr>
<th>Flags</th>
<th>MHITS ID</th>
<th>POPULATION</th>
<th>ENROLLMENT DATE</th>
<th>STATUS</th>
<th>CLINICAL ASSESSMENT</th>
<th>LA FOLLO UP CONTACT</th>
<th>PHQ-9</th>
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Care Management Tracking System (CMTS©)

- Access from anywhere.
- Population-based.
- Supports effective care.
- Keeps track of ‘caseloads’.
- Facilitates consultation.
- Allows research on highly representative populations.

Caseload summaries help manage
- Clinical productivity
- Quality improvement

- Licensed by UW C4C
- 21 licenses
- 14 US states (& Alberta)
- Supporting care of over 80,000.
Principle 3:
Measurement Based Treatment To Target
Principle 4: Evidence-Based Treatment
STAR-D Summary

Level 1: Citalopram
~30% in remission

Level 2: Switch or Augmentation
~50% in remission

Level 3: Switch or Augmentation
~60% in remission

Level 4: Stop meds and start new
~70% in remission

Rush, 2007
Principle 5: Accountable Care

Numerators & Denominators
MHIP: > 35,000 clients served across Washington State

2008
Pilot initiated in King & Pierce Counties

2009
Expanded state-wide to over 100 CHCs and 30 CMHCs

- Funded by State of Washington and Public Health Seattle & King County (PHSKC)
- Administered by Community Health Plan of Washington and PHSKC in partnership with the UW AIMS Center
### MHIP Common Client Diagnoses

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th>%</th>
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<tr>
<td>Depression</td>
<td>71%</td>
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<tr>
<td>Anxiety (GAD, Panic)</td>
<td>48%</td>
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<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>
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</tbody>
</table>

... plus acute and chronic medical problems, chronic pain, substance use, prescription narcotic misuse, homelessness, unemployment, poverty, ...
Pay-for-performance cuts median time to depression treatment response in half.

Unützer et al. 2012.
MHIP High-Risk Mothers Program

% of Population with Depression Improvement

- All: 55%
- Latina: 65%
- White: 50%
- Black: 40%
- Asian: 50%
Performance Improvement

Kaplan-Meier Survival Curve by Enrolled After 2009
Time to 50% PHQ improvement

Log-rank test for equality of survivor functions, p<0.001

Among Mom Population (African American, Asian, Latino & White) with baseline PHQ9>=10 (n=653)

Before 2009, n=61
After 2009, n=592
Daniel’s Mom

“I believe it it’s made all the difference for him.”
Menu of Inspiration Options

- **Patient Centered Team**
  - Use patient centered goals.
  - Communication with other providers.

- **Population Based Care**
  - Use screeners regularly.
  - Track patient goals regularly.
  - Use a registry.
  - Lead efforts for implementation.

- **Measurement-Based Treatment to Target**
  - Track patient outcomes.
  - Set a practice improvement goal.
  - Participate in continuing ed.
  - Form a learning collaborative.

- **Evidence-Based Treatment**
  - Track patient outcomes.
  - Set a practice improvement goal.

- **Accountable Care**
  - Use a registry.
  - Lead efforts for implementation.
  - Participate in continuing ed.
  - Form a learning collaborative.
IMPACT Study

RCT of Collaborative Care for Depression

- Largest depression treatment trial to date
  - 1,801 depressed older adults
  - ~ 4 chronic medical conditions
  - 8 health care organizations in 5 states,
  - 18 primary care clinics, 450 PCPs

- Patients randomly assigned to Collaborative Care or Usual Care

- Independent blind assessments of health outcomes and costs for 24 months.

(Unutzer et al, Medical Care 2001, JAMA 2002).
IMPACT doubles effectiveness of care for depression

50 % or greater improvement in depression at 12 months

Unützer et al., JAMA 2002; Psych Clin NA 2004
IMPACT improves physical function

SF-12 Physical Function Component Summary Score (PCS-12)

Callahan et al., JAGS 2005; 53:367-373
## IMPACT reduces health care costs

**ROI:** $6.5 saved / $1 invested

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

Unützer et al., *Am J Managed Care 2008.*
1) Improved Outcomes:
   • Less depression
   • Less physical pain
   • Better functioning
   • Higher quality of life

2) Greater patient and provider satisfaction

3) More cost-effective

“I got my life back”
Replication studies: the model is ‘robust’

<table>
<thead>
<tr>
<th>Patient Population</th>
<th>Target Clinical Conditions</th>
<th>Reference</th>
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</thead>
<tbody>
<tr>
<td>Adult primary care patients (Pathways)</td>
<td>Diabetes and depression</td>
<td>Katon et al., 2004</td>
</tr>
<tr>
<td>Adult patients in safety net clinics (Project Dulce; Latinos)</td>
<td>Diabetes and depression</td>
<td>Gilmer et al., 2008</td>
</tr>
<tr>
<td>Adult patients in safety net clinics (Latino patients)</td>
<td>Diabetes and depression</td>
<td>Ell et al., 2010</td>
</tr>
<tr>
<td>Public sector oncology clinic (Latino patients)</td>
<td>Cancer and depression</td>
<td>Dwight-Johnson et al., 2005</td>
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<td>Ell et al., 2008</td>
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<tr>
<td>Health Maintenance Organization</td>
<td>Depression in primary care</td>
<td>Grypma et al., 2006</td>
</tr>
<tr>
<td>Adolescents in primary care</td>
<td>Adolescent depression</td>
<td>Richardson et al., 2009, 2014</td>
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<tr>
<td>Older adults</td>
<td>Arthritis and depression</td>
<td>Unützer 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>
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<tr>
<td>Women with depression</td>
<td>Women’s health / OB</td>
<td>Melville et al, 2014</td>
</tr>
</tbody>
</table>
Alaska Native Tribal Health Care

Rural villages without direct access to mental health specialty care and high rates of depression, alcoholism, and suicide.
New Orleans, LA – 2005
... after Hurican Katrina

REACH NOLA
Working with community based health workers to address severe mental health crisis after Hurricane Katrina.
Why provide primary care to mental health populations?

• High rates of physical illness in severely mentally ill
• Premature mortality
• Low quality of medical care to patients with mental illness
• High expense of physically ill with mental illness
• Access problems
Programs generally contain three major components:

- Primary Care Service
- Care Management and Tracking
- Health Behavior Change
Multi-Condition Collaborative Care
TEAMcare Inclusion Criteria

Evidence via automated date (ICD-9) of having diabetes and/or coronary artery disease (CAD)

Evidence of poor disease control

- HbA$_1c$ $\geq$ 8.5%
- blood pressure $>$ 140/90 mmHg
- LDL $>$ 130 mg/dL

PHQ-9 $\geq$ 10
Concurrent Treatment

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

Depression
HbA1c
SBP
LDL

All Improved!

COST SAVINGS: $600 - $1,100 per patient
Taking effective models to scale

everyone wants better.
no one wants change.
Health care environment 2014

- ACA / Medicaid expansion:
  Up to 60 million with new or improved MH benefits
- Reform of the WA state mental health system:
  HCA: Health and MH purchasing fully integrated by 2020
- Accountable Care
  Mental health quality measures at population level: P
  PHQ-9: screening & remission of depression.
Mental-Health Care at the Doctor’s Office
Providers Take Integrated Approach, With Patient Numbers Set to Jump Under New Law and Psychiatrists in Short Supply

By MELINDA BECK

Seattle psychiatrist Anna Ratzlaff oversees mental-health care for nearly 500 patients—most of whom she will never meet.

As the consulting psychiatrist for four primary care practices, Dr. Ratzlaff confers weekly with 10 care managers who follow the patients closely, provide counseling and chart their progress in electronic registries. She helps devise treatment plans and suggests changes for those who aren’t improving.

“I get to touch so many more lives than I would if I were seeing these patients in person,” she said.

Dr. Ratzlaff’s practice is part of a burgeoning effort to integrate psychiatric care into primary care offices.

Body and Mind
Who needs, gets, gives care
25% of U.S. adults experience a mental-health issue in a given year
60% of them receive no treatment
68% of adults with a mental-health disorder have at least one medical condition
29% of those with a medical condition have a mental-health issue
50% of care for mental-health disorders is delivered by primary-care providers
80% of visits to family physicians involve stress-related symptoms

Source: National Alliance on Mental Illness, National Comorbidity Survey

Dr. Thomas Golightly with patient Magali King, who...
"I’m afraid you’ve had a paradigm shift."
UW AIMS Center: Translating from Research to Practice

5,000 providers trained in ~ 1,000 clinics
- Health policy & payment change
- Practice change
Stepped Care Approach

1° Care

Self-Management

1° Care + BHP

Psychiatric consult (Face-to-face)

BH specialty short term tx

BH specialty long term tx

Psychiatric Inpatient tx

Psychiatric Consultation
Opportunities

FQHCs
(8,000 clinics serving > 20 Million)
Primary Mental Health Care
Prevention
- 3.5 visits / year

CMHCs
~ 35 visits / year
Two Cultures, One Patient

**PRIMARY CARE**
- Continuity is goal
- Empathy and compassion
- Data shared
- Large panels
- Flexible scheduling
- Fast Paced
- Time is independent
- Flexible Boundaries
- Treatment External (labs, x-ray, etc)
- Patient not responsible for illness
- 24 hour communication
- Saved lives
- Disease management

**BEHAVIORAL HEALTH**
- Termination is goal – “discharge”
- Professional distance
- Data private
- Small panels
- Fixed scheduling
- Slower pace
- Time is dependent – “50 min hour”
- Firm Boundaries
- Relationship with provider IS tx
- Patient responsible for participating
- Mutual accountability
- Meaningful lives
- Recovery model

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Effective Implementation: 9 Factors

Table 1. Factors Considered Important for Implementation of DIAMOND

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<tr>
<th>Ranking</th>
<th>Implementation Factor</th>
<th>Definition</th>
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<td>1</td>
<td>Operating costs of DIAMOND not seen as a barrier</td>
<td>The clinic has adequate coverage or other financial resources for most patients to be able to afford the extra operational costs.</td>
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<tr>
<td>2</td>
<td>Engaged psychiatrist</td>
<td>The consulting psychiatrist is responsive to the care manager and to all patients, especially those not improving.</td>
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<tr>
<td>3</td>
<td>Primary care provider (PCP) “buy-in”</td>
<td>Most clinicians in the clinic support the program and refer patients to it.</td>
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<tr>
<td>4</td>
<td>Strong care manager</td>
<td>The care manager is seen as the right person for this job and works well in the clinic setting.</td>
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<tr>
<td>5</td>
<td>Warm handoff</td>
<td>Referrals from clinicians to the care manager are usually conducted face-to-face rather than through indirect means.</td>
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<tr>
<td>6</td>
<td>Strong top leadership support</td>
<td>Clinic and medical group leaders are committed and support the care model.</td>
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<tr>
<td>7</td>
<td>Strong PCP champion</td>
<td>There is a PCP in the clinic who actively promotes and supports the project.</td>
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<tr>
<td>8</td>
<td>Care manager role well defined and implemented</td>
<td>The care manager job description is well defined, with appropriate time, support, and a dedicated space.</td>
</tr>
<tr>
<td>9</td>
<td>Care manager on-site and accessible</td>
<td>The care manager is present and visible in the clinic and is available for referrals and patient care problems.</td>
</tr>
</tbody>
</table>

DIAMOND indicates Depression Improvement Across Minnesota—Offering a New Direction.
Behavioral Health Implementation Guide

Patient-Centered Care for the Safety Net

The Safety Net Medical Home Initiative was a national Patient-Centered Medical Home (PCMH) demonstration to help 55 primary care safety net sites become high-performing medical homes and improve quality, efficiency and patient experience. Learn more about the initiative.

The initiative created a framework for PCMH transformation and published a library of resources and tools to help practices implement the PCMH Model of Care. Access our PCMH materials.

The latest additions to our collection of resources address integrating behavioral healthcare services into the primary care setting. Visit the Behavioral Health Integration page to learn more.

www.safetynetmedicalhome.org
Resources

APA Website: www.psych.org and list serve ksanders@psych.org
AIMS Center: http://aims.uw.edu
Center for Integrated Health Solutions: http://www.integration.samhsa.gov/
ARHQ Integration Academy: http://integrationacademy.ahrq.gov/
IBHP Partners in Care Toolkit 2013: www.ibhp.org
Books/E-books:
  - Integrated Care: Working at the Interface of Primary Care and Behavioral Health – edited by Lori Raney, MD
  - Prevention in Psychiatry – Robert McCarron and colleagues
  - AIMS – Team-Based Care
Thank you.