Multi-Condition Case Consultation for Whole Person Care

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Steering Toward Success: Achieving Value in Whole Person Care

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The Healthier Washington Practice Transformation Support Hub

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Steering Toward Success:
Achieving Value in Whole Person Care

Multi-Condition Case Consultation for Whole Person Care

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Learning Objectives

- Recognize the evidence base for the multi-condition case consultation model
- Describe how to conduct a multi-condition case consultation in a primary care and Behavioral Health setting
- Identify the challenges, opportunities and best practices of implementing this model
- Review examples of a multi-condition case consultation in both a BH and PC setting
- Identify the process to develop a multi-condition case consultation model

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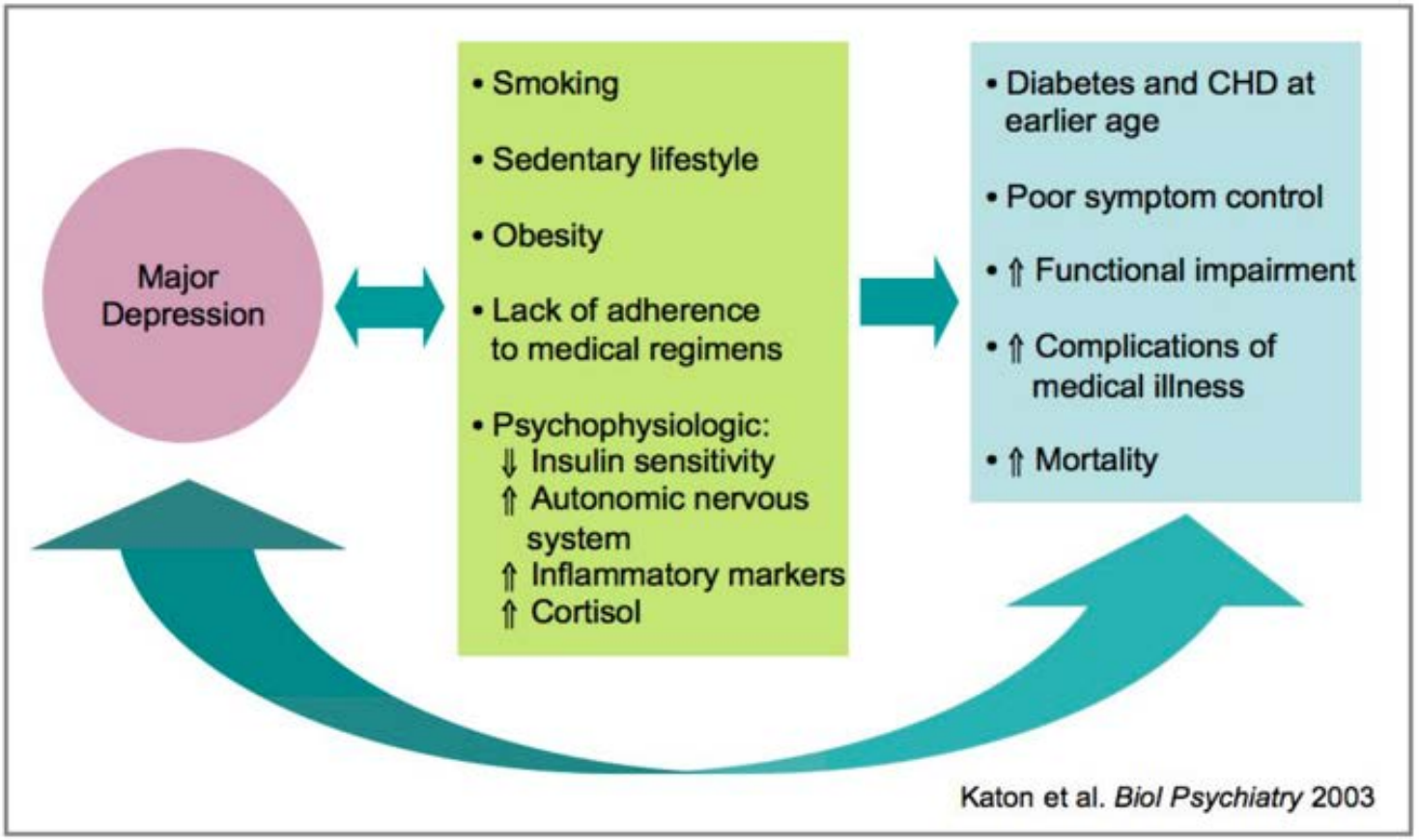
Background

- Linkage between depression, chronic illness
- Addressing co-morbidities effectively
- Use of team-based care

Adverse Bi-Directional Interaction Between Depression, Diabetes and CHD



Source: http://www.mhinnovation.net/innovations/teamcare.

Poor outcomes in CVD and Diabetes in safety net populations

Medicaid enrollees with diabetes:

- Almost 20% also have a mental health diagnosis;
- More likely to have poorer quality of diabetes care
- Increased risk of ambulatory care sensitive hospitalizations

Diabetes patients with co-morbid depression :

- Have poorer self-care
- Almost two-fold higher medical costs
- More likely to develop complications
- 50% increased risk of 5-year mortality when compared to patients with diabetes alone

Source: Chwastiak et al, *General Hospital Psychiatry*.44 (2017) 10–15.

What Didn't Work

In previous trials involving high-risk Medicare patients with diabetes, heart disease, or both, **nurse care-management interventions did not improve patient outcomes.**

Source: Peikes D, Chen A et al. *Journal of the American Medical Association*. 2009;301:603-18.

Integration Strategy: TEAMcare

TEAMcare is about "natural clusters" of illnesses that are:

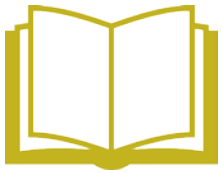
- Highly comorbid
- Have poor outcomes when they co-occur
- Have similar guideline management recommendations
  - e.g., diabetes and cardiovascular heart disease

Core Principles of Collaborative Care

Team-Based and Patient-Centered
Primary care and behavioral health providers collaborate effectively, using shared care plans.

Measurement-Based Treatment to Target
Measurable treatment goals clearly defined and tracked for every patient. Treatments are actively changed until clinical goals are achieved.

Population-Based Care
A defined group of clients is tracked in a registry so that no one "falls through the cracks."



Evidence-Based Care
Providers use treatments that have research evidence for effectiveness.

Used with Permission. Source: *http://aims.uw.edu/collaborative-care/principles-collaborative-care*.

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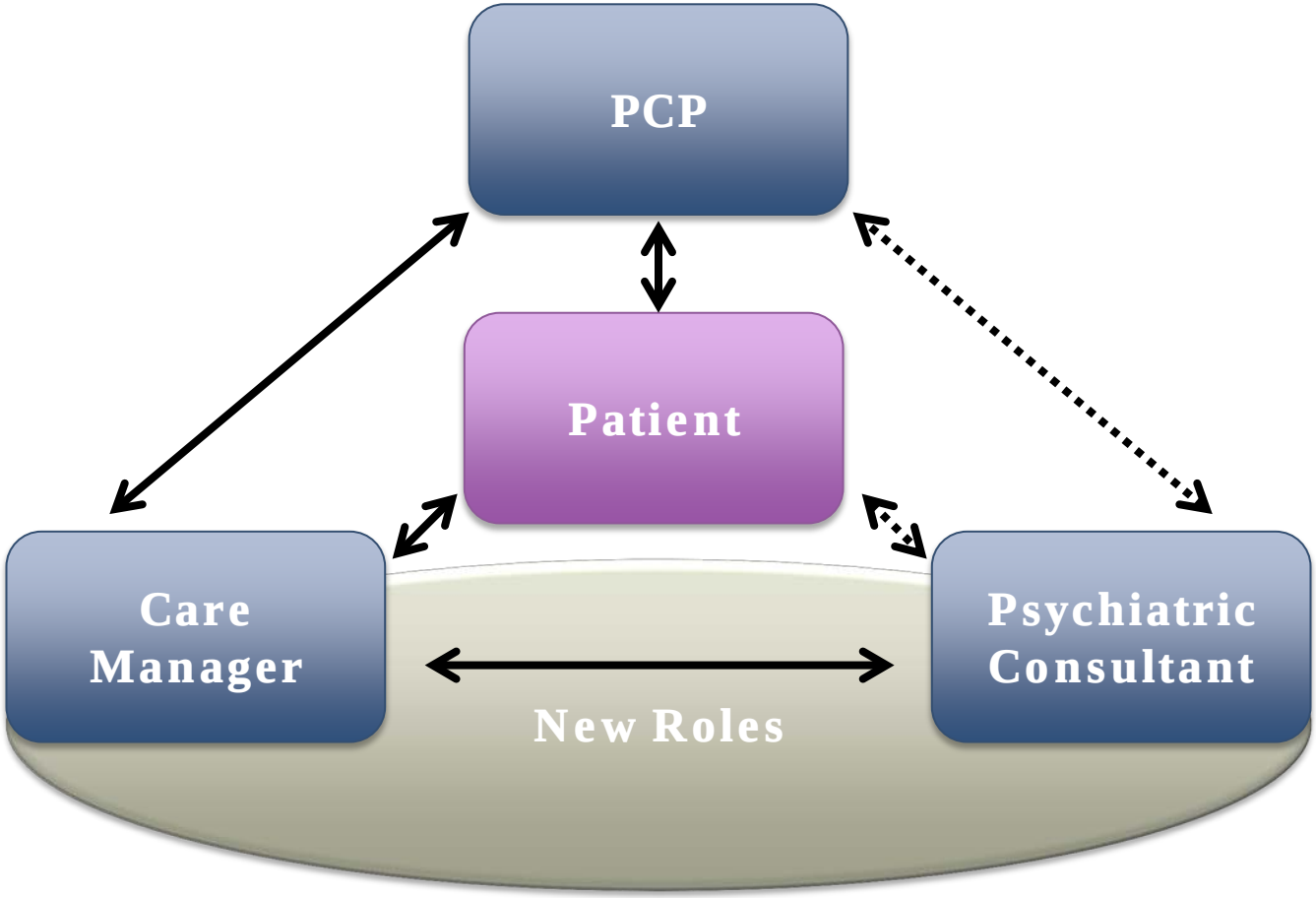
Collaborative Care Team Structure



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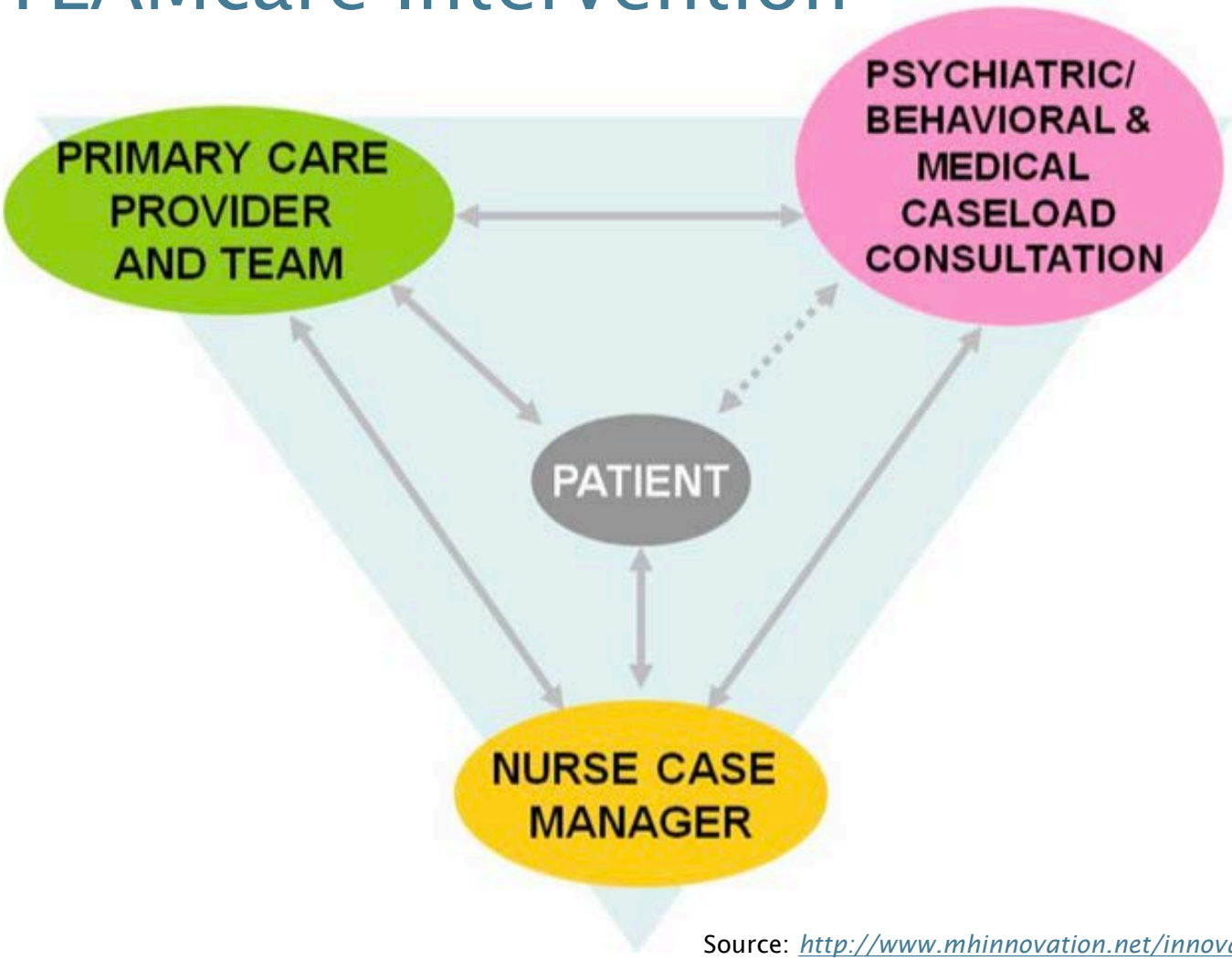
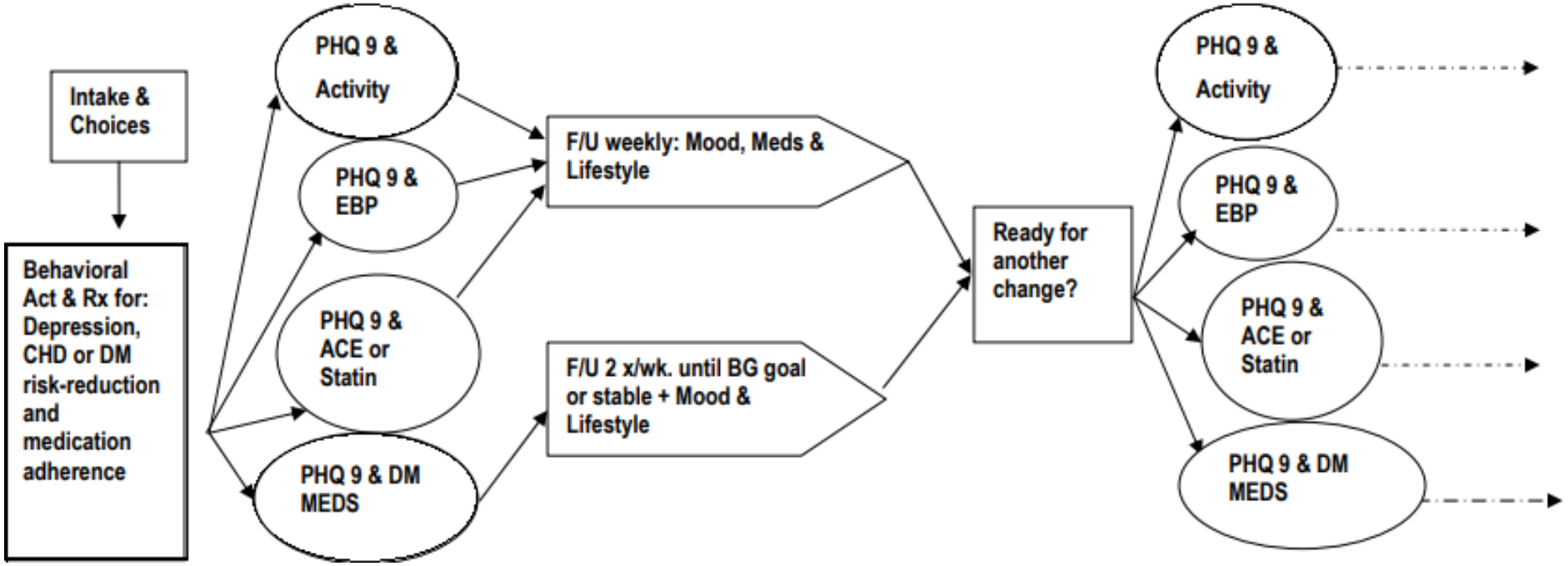
Collaborative Care Network in TEAMcare Intervention



Source: *http://www.mhinnovation.net/innovations/teamcare*.

TEAMcare Intervention Timeline



Source: *http://www.mhinnovation.net/innovations/teamcare*.

TEAMcare Research and Evidence

- Improved depression outcomes, HbA1c, LDL and systolic blood pressure, compared to usual care
- Improved function and quality of life:
  - Reduced cost of care $594/patient.
  - Cost savings of $1,773 per quality-of-life year (QALY)
  - $20,000 per QALY is the threshold for recommending rapid dissemination of an intervention to health care systems

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Large-Scale Disseminations

- Williams and Katzelnick[1]:
  - "Would we ever fail to use a drug that was as effective as collaborative care?"
- COMPASS
  - Funded by CMMI to disseminate TEAMcare model
  - Includes systematic case review
  - Results:
    - 24% depression remission, 16% depression response.
    - 23% achieved HbA1c <8.0%
    - 58% of pts achieved HTN control
    - Variability of implementation and outcomes across sites.

[1]Source: Katzelnick DJ and Williams MD. *Psychiatric Services*. 2015. 66(9) 904-906.

Challenges and Barriers

- Should collaborative care focus on a single disease or on multiple diseases?
- Should the same care coordinator address mental illnesses and chronic general medical illnesses?
- Do we need "specialty care coordinators" with extra skills?
- Is in-person coordination necessary, or can it be done via phone?

Lessons Learned: Opportunities for Improvement

What would be targets for BHA's for Multi-Condition Case Consultation programs?

- Meeting needs of primary care partner?
  - Pain / Addiction?
- Using these structures to address chronic metabolic illness in SMI populations?

Other Conditions with Multi-condition Collaborative Care Approach

Cancer

- Strong V, Waters R, et al. Management of depression for people with cancer (SMaRT oncology 1): a randomised trial. *Lancet* 2008;372(9632):4048.
- Ell K, Xie B, Quon B, et al. Randomized controlled trial of collaborative care management of depression among low-income patients with cancer. *Journal of Clinical Oncology*. 2008;26(27):4488-4496.
- Fann, J. R. Fan, M. Y.Unützer, J. Improving primary care for older adults with cancer and depression. *Journal of General Internal Medicine*. 2009: 24 Suppl 2: S417-24.

Pain

- Dobscha SK, Corson K, Perrin NA, et al. Collaborative care for chronic pain in primary care: a cluster randomized trial. *Journal of the American Medical Association*. 2009;301(12):1242-1252.
- Kroenke K, Bair MJ, Damush TM, et al. Optimized antidepressant therapy and pain self-management in primary care patients with depression and musculoskeletal pain: a randomized controlled trial. *Journal of the American Medical Association*. 2009;301(20):2099-2110.

Dementia

- Callahan CM, Boustani MA, Unverzagt FW, et al. Effectiveness of collaborative care for older adults with Alzheimer disease in primary care: a randomized controlled trial. *Journal of the American Medical Association*. 2006 May 10;295(18):2148-57.

TEAMcare Resources

- TEAMcare Intervention Manual available at: http://www.mhinnovation.net/sites/default/files/downloads/innovation/tools/TEAMcare-Intervention-Manual-2011-09-06.pdf

- Supplement to: Katon WJ, Lin EHB, Von Korff M, et al. Collaborative care for patients with depression and chronic illnesses. N Engl J Med 2010;363:2611-20. Available at: http://www.nejm.org/doi/suppl/10.1056/NEJMoa1003955/suppl_file/nejmoa1003955_appendix.pdf

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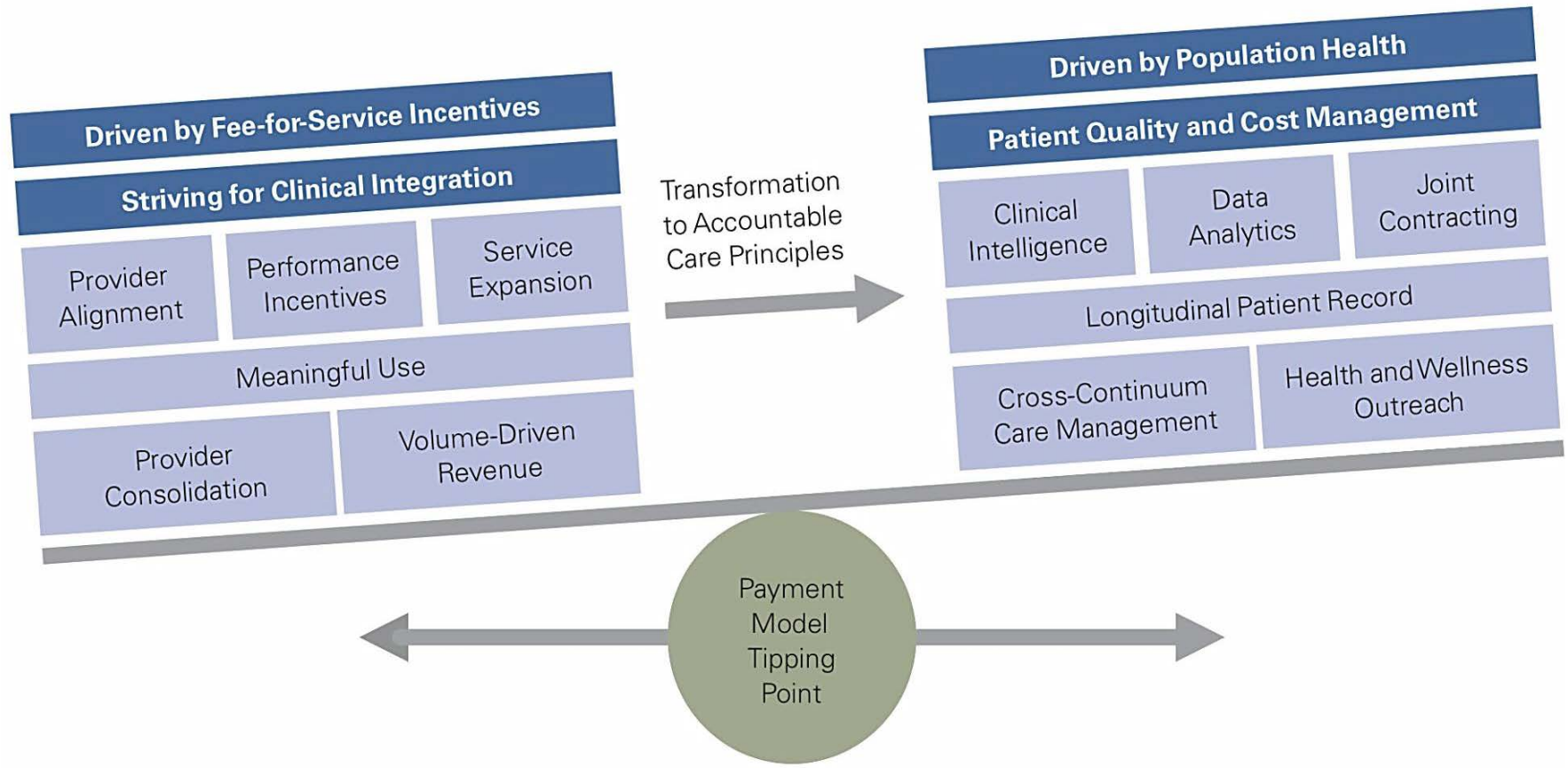
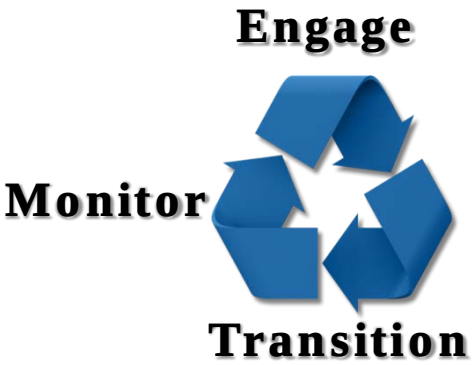
Background – What We Were Facing



Background – Health Services Under Accountable Care



- **Care management**
  - Enhanced care services
    - Complex care management and collaborative care
- **Medical management**
  - Gather data, analyze SMG clinical performance of our Tier 1 at risk populations
- **Patient engagement and outreach**
  - Transitions of care calls for patients discharged from acute care and ED admissions
  - Outreach for AWV, gap closures, HCCs
  - Health Navigation

Integration Strategies

- Embed RN CCM in primary care based on volume
  - Goal to have each RN embedded in 2 clinics, a primary and secondary
- Patient engagement Staff paired with RNs
  - Goal to provide link to community resources
- Transition of care RNs would also refer potential cases to complex care managers

Integration Strategies

- 31 Primary care clinics - 300,000 patients
- Collaborative care clinical rounds is every week in a virtual setting, staffed with two teams
- Teams consist of:
  - Complex care manager RN
  - Pharmacist
  - Psychiatrist
  - Diabetic educator
  - PCP representative
  - Health navigator
  - Patient care coordinator
  - Manager of care management

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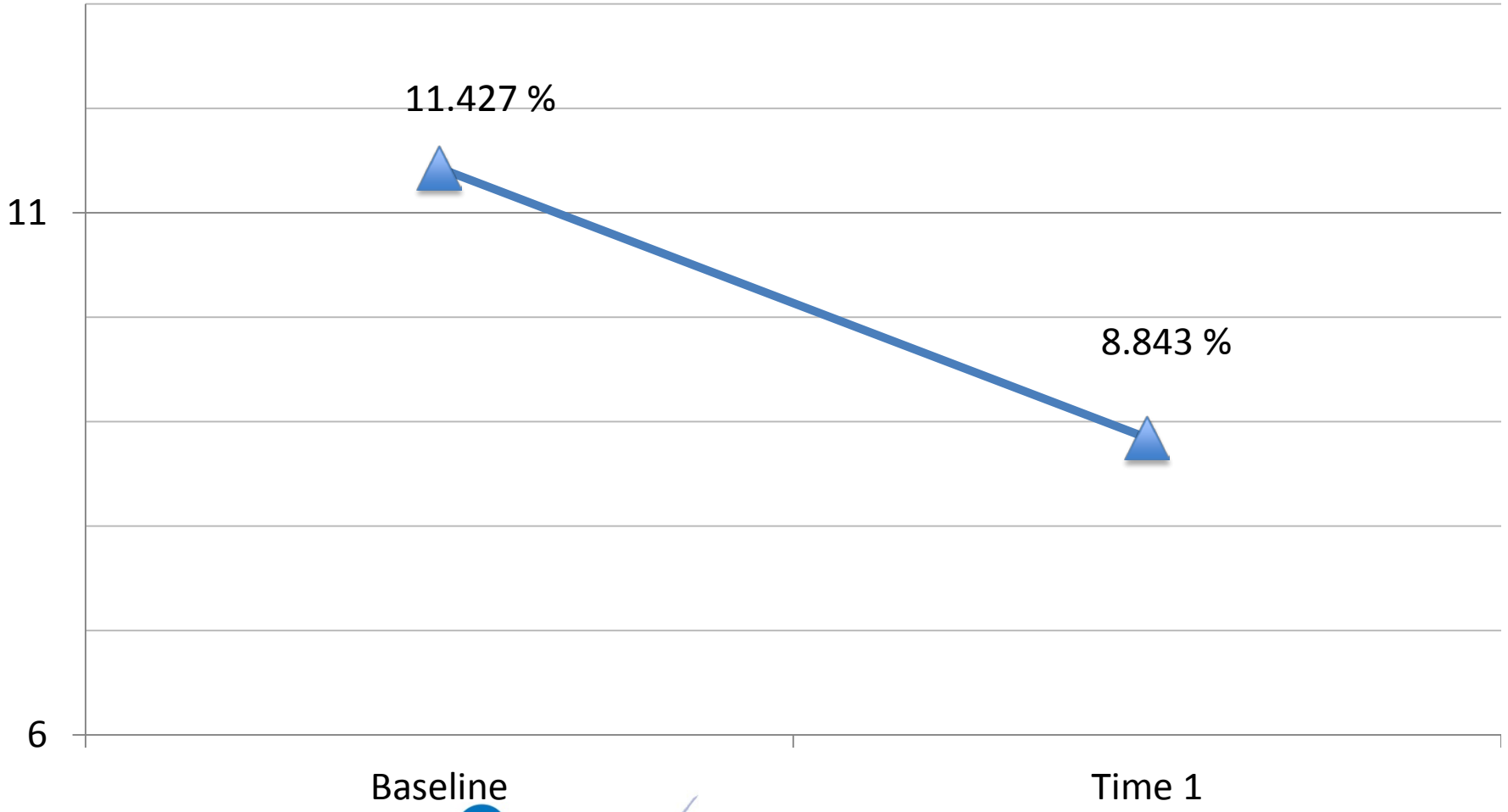
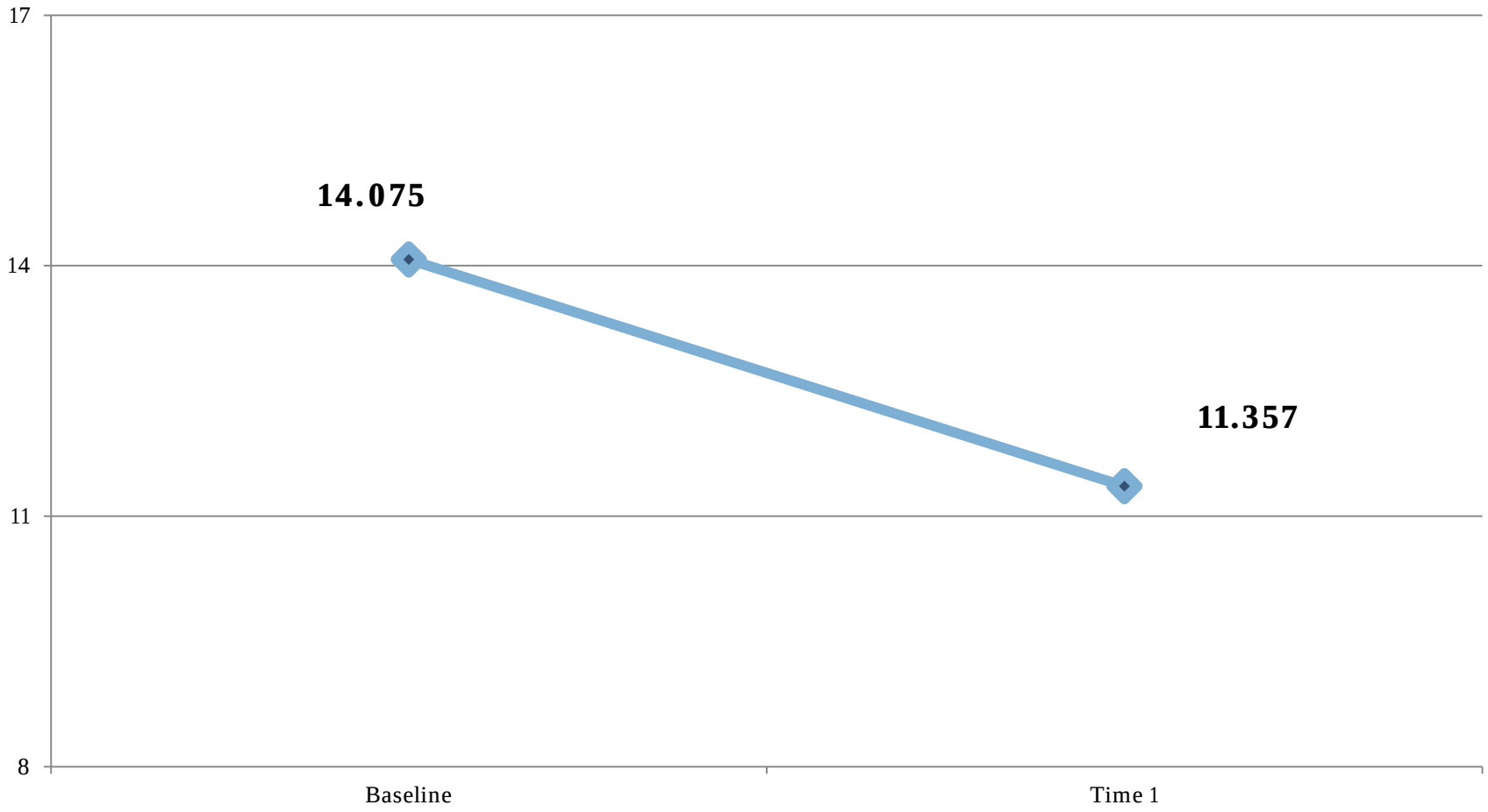
Success Stories – 2016 A1C N = 61 Graduates + Active (mean 14.1 weeks)



Success Stories – 2016 PHQ-9 N = 61,Graduates + Active (mean 14.1 weeks)



Challenges and Barriers

- Data, data, data
  - Registries, documentation, reporting
- Clear expectations - why are you setting up and developing a collaborative team? Engagement
  - Patients get tired of weekly PHQ-9's
  - Growing concern around PHQ-9 response bias
- Scalability

Lessons Learned: Opportunities for Improvement

- General model is good
  - Remember the patient
- Remember the tools
  - PHQ-9, decisional balance, patient engagement and activation, advocacy
- For our system the model needed to live with care management
- Role clarification
  - Reduce confusion on who is lead on which populations (pre, newly dx, chronic)

Future Planning: Next Steps

- Set Annual Enrollment Targets
- Engage more primary care providers
- Investigate Creating Regional Collaborative Care Clinical Rounds
- Investigate Telehealth Collaborative Care Clinical Rounds
- Continue to gather clinical outcomes

Q & A

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