

IMPACT Model of Collaborative Care

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- **None to report**

Outline

- **Information about co-presenters**
 - **Backgrounds**
 - **Experience with IMPACT and Collaborative Care**
- **Overview of IMPACT study and Collaborative Care**
- **Background on AIMS Center and their work with indigenous communities**
- **YKHC experience with Collaborative Care**
- **Implementing Collaborative Care exercise**
 - **Compare your current care model with Collaborative Care**
 - **Identify next steps to plan for clinical practice changes**

Theresa Hoeft

University of Washington



My background:

- Health Services Researcher and Health Economist with degree more broadly in Population Health
- Focus on how primary care can meet mental and emotional needs
- Also interested in how health systems address spiritual needs (e.g. around post-traumatic stress)
- Community-engaged research with primary care clinics, community, and community leaders
 - Alaska Native communities (Anchorage and Bethel area in Southwest Alaska)
 - California with several diverse communities

My experience with IMPACT and Collaborative Care:

- Graduate work on models that can address comorbid physical conditions and common mental disorders
- Fellow working with the AIMS Center from July 2013 – June 2015

Donald Desper

Yukon Kuskokwim Health Corporation

My background:

- Clinical Director of Crisis Residential Services
- Program Director of Partial Hospitalization
- Program Director of Intensive Outpatient Services
- Mental Health Liaison to Court Services
- Clinical Supervisor for Village Services

My experience with IMPACT and Collaborative Care:

- Manager of IMPACT Services with YKHC
- Integrated Care Consultant
- Behavioral Health Consultant: Integrated Care

Overview of IMPACT study and Collaborative Care

Primary Care and Mental Health

Primary Care:

- Whole patient with multiple medical & behavioral issues
- Focus on acute care & health maintenance
- Structured diagnostic procedures & outcome monitoring
- Single practitioner with limited support

Mental Health Care:

- Attention to limited subset of problems
- Focus on chronic mental disorders
- Subjective diagnostic procedures & outcome monitoring
- Multidisciplinary treatment teams & case management

Moving towards Collaborative Care

- **Worst case scenario = compete**
- **Usual situation = co-exist**
- **Helpful but not sufficient = consult (or) co-locate**
- **Ideal = collaborate effectively**

IMPACT Study



- IMPROVING MOOD -- PROMOTING ACCESS TO COLLABORATIVE TREATMENT
- 1999 – 2004
- 1,801 depressed older adults in primary care randomly assigned to IMPACT care or usual care
- 18 primary care clinics - 8 health care organizations in 5 states
 - 8 diverse health care systems
 - 450 primary care physicians

Funded by

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Collaborative Care



Primary Care Practice with Mental Health Care Manager



Outcome Measures



Treatment Protocols

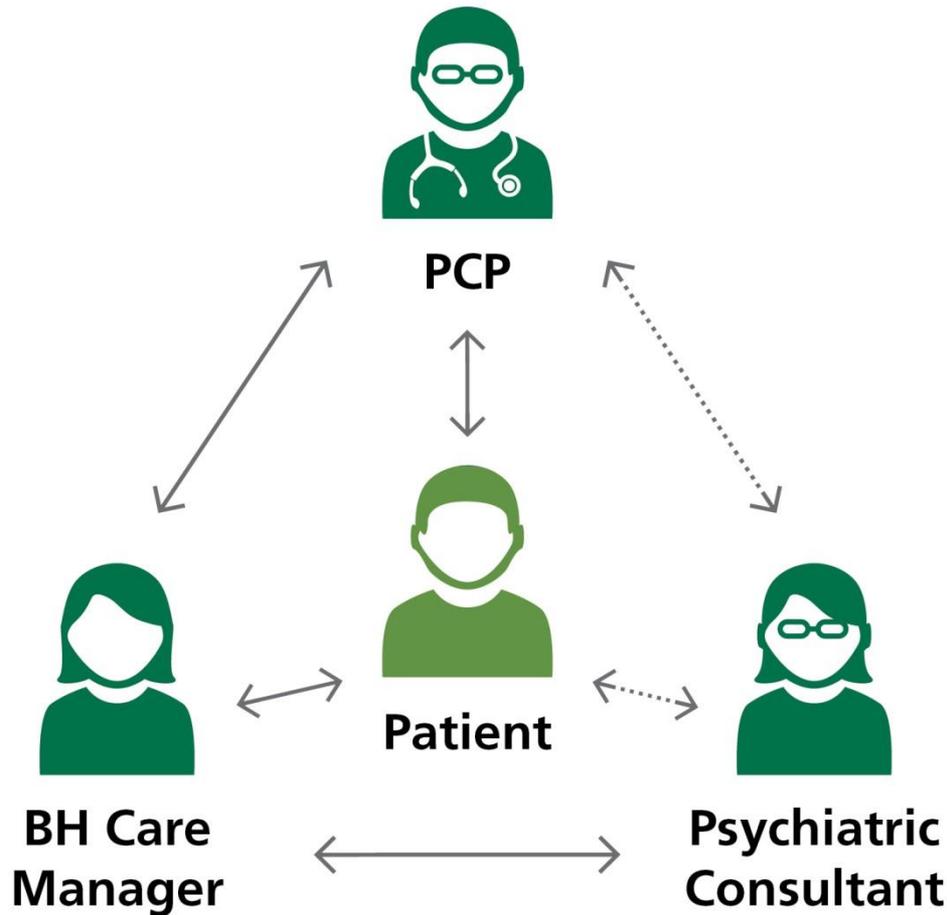


Population Registry



Psychiatric Consultation

Collaborative Care Team Structure



The **Patient** seeks help, discloses symptoms, participates and engages in treatment, and tracks symptoms.

The **PCP** identifies patients, introduces Collaborative Care, makes an initial diagnosis, and initiates treatment (prescribes medication, referral to psychotherapy, or both).

The **Behavioral Health Care Manager** engages patients, tracks patients in a registry and provides care management, brief crisis management, measurement-based treatment to target, and optional evidence-based therapy.

The **Psychiatric Consultant** provides caseload consultation (reviews patient registry), supports team assessment and treatment, and delivers optional direct evaluation (in person or televideo).



Principles of Collaborative Care



Patient-Centered Team



Population-Based



Treatment to Target



Evidence-Based



Accountable

Key components of Collaborative Care

1. Case finding / screening / patient engagement
2. Patient education / self-management support
3. Support medication treatment prescribed in primary care
 - Monitor adherence, side effects, outcomes, follow-up
 - Outcome measures (e.g., PHQ-9)
 - Tracking (e.g., registry)
4. Brief counseling (e.g., Behavioral Activation, PST-PC, IPT, CBT)
5. Psychiatric consultation / caseload supervision
6. Stepped care
 - Increase intensity as needed
 - Facilitate Mental Health Specialty as needed

Outcomes

- **Doubles effectiveness of care for depression** (Unützer et al., JAMA 2002; Psych Clin NA 2004)
- **Improves physical function** (Callahan et al., JAGS 2005; 53:367-37)
- **Reduced pain** (Lin et al., JAMA 2003)
- **Improves patient and provider satisfaction** (Unützer et al., JAMA 2002; Levine et al., Gen Hosp Psychiatry 2005)
- **Reduces health care costs** (Unützer et al., Am J Managed Care 2008)

Replication studies: 'robust' model

Clinical Setting	Target Clinical Conditions	Reference
Primary care for adolescents	Adolescent Depression	Richardson et al., 2009, 2014
Adult primary care	Depression & Diabetes Depression, Diabetes, Heart Disease	Katon et al., 2004 Katon et al., 2010
Latino patients in safety net clinics	Diabetes and depression	Gilmer et al., 2008 Elliott et al., 2010
Public sector oncology clinic	Cancer and depression	Elliott et al., 2010
Women's health care clinics (IDAWN)	Depression, PTSD	Melville et al., 2014 Katon et al., 2015
Adult primary care	Anxiety Disorders including PTSD	Roy-Byrne et al., 2012
Older adults in primary care	Arthritis and depression	Unutzer et al., 2008
Primary care / Cardiology (COPES)	Heart disease and depression	Davidson et al., 2010

AIMS Center history

2004

- After the success of the IMPACT trial, the **IMPACT Implementation Center** is created with funding from the John A. Hartford Foundation to help organizations put IMPACT (Collaborative Care) in place.

2008

- Growing evidence shows that IMPACT care not only works for depressed, older adults, but for all age groups and for many other common mental health conditions such as anxiety disorders, PTSD, and co-morbid medical conditions such as heart disease and diabetes. To acknowledge this depth of evidence and to improve the reach of Collaborative Care to other populations, the IMPACT Implementation Center **becomes the AIMS (Advancing Integrated Mental Health Solutions) Center**.

See more at: <https://aims.uw.edu/>

AIMS CENTER

Advancing Integrated
Mental Health Solutions

W UNIVERSITY OF WASHINGTON, PSYCHIATRY & BEHAVIORAL SCIENCES
DIVISION OF INTEGRATED CARE & PUBLIC HEALTH



WHO WE ARE

WHAT WE DO

COLLABORATIVE CARE

Search

EVIDENCE BASE

CORE PRINCIPLES

TEAM STRUCTURE

DOLLARS & SENSE

STORIES

RESOURCE LIBRARY

IMPLEMENTATION GUIDE

STEP 1: LAY THE FOUNDATION

STEP 2: PLAN FOR CLINICAL
PRACTICE CHANGE

STEP 3: BUILD YOUR CLINICAL
SKILLS

STEP 4: LAUNCH YOUR CARE

STEP 5: NURTURE YOUR CARE

QUICK LINKS



IMPLEMENTATION GUIDE



WELCOME TO THE COLLABORATIVE CARE IMPLEMENTATION GUIDE

This guide is an introduction to the process of implementing Collaborative Care, from the crucial first step of understanding what it is to monitoring outcomes once Collaborative Care is in place. Each step contains learning objectives along with materials to help you achieve them.

It's important to understand that implementing Collaborative Care necessitates practice change on multiple levels. It is nothing short of a new way to practice medicine and requires an openness to doing things differently. We hope this free guide helps you understand the scope of work involved and provides you with the tools you need to get started. The AIMS Center offers in-depth [coaching and training](#) that goes far beyond the contents of this guide and we encourage you to [contact us](#) to learn more.

Successful implementations

- **Have a clear vision**
 - How do we (all) know we are successful?
 - A clear vision will help guide staff and leadership through transitions and turnover
- **Engage leaders and stakeholders**
- **Build a team with complementary skills and shared accountability**
 - Acknowledge competing demands and agendas, build trust, use a problem solving attitude
- **Require adequate resources and support**
- **And a realistic focus and scope with measurable goals**
 - Start with early adopters

Additional resources

- **Free online training for Collaborative Care**
- **Stories**
- **Resource library**
 - e.g. sample job descriptions for Care Manager and Psychiatric Consultant

See more at: <https://aims.uw.edu/>

AIMS Center's work with indigenous communities

Alaska Integrated Care Initiative

- Funded by Alaska Mental Health Trust Authority
- May 2009 – December 2013
- Launched with an in-person training on IMPACT and SBIRT model for substance use
- Provided ongoing training and implementation coaching on IMPACT
- 3 health systems initially planned to implement IMPACT
 - 2 clinics expressed interest but did not launch
 - Chugachmiut clinic in Port Graham
 - SEARHC clinic in Kake
 - Chugachmiut clinic in Seward launched
 - Offered IMPACT for 1 year
 - Anchorage Neighborhood Health Center launched
 - Less than 1% of this population in IMPACT was AI / AN
 - Staff turnover became a barrier to continued implementation after 3 years of IMPACT
- Yukon-Kuskokwim Health Corporation in Bethel then expressed interest for 3 clinics
 - YKHC joined initiative after in-person training in Bethel in May 2011
 - Implementation support from the AIMS Center through May 2013
 - Some additional training provided for new staff as needed

Social Innovation Fund

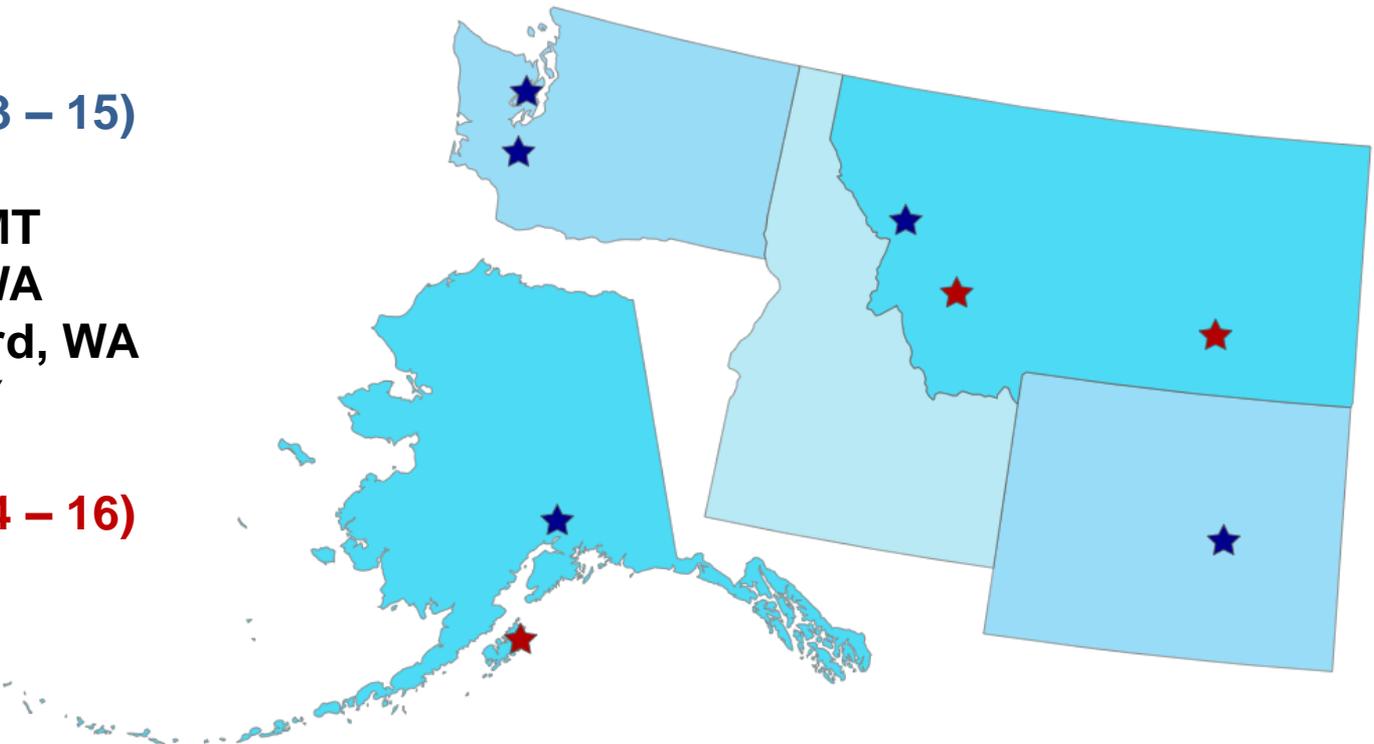
Implementing Collaborative Care in underserved areas of the WWAMI states

Cohort 1 (2013 – 15)

- Wasilla, AK
- Missoula, MT
- Chehalis, WA
- Port Orchard, WA
- Casper, WY

Cohort 2 (2014 – 16)

- Kodiak, AK
- Butte, MT
- Hardin, MT



Implementation is context specific

- Implementation support with AI / AN communities is developing
- Some insights from work so far:
 - Substance use and suicide are often a concern
 - On screening, Patient Health Questionnaire (PHQ-9) score for depression symptoms does not override clinical judgement
 - PHQ-9 is useful for screening and treatment monitoring
 - On screening however, individuals may underreport symptoms so helpful to incorporate clinical judgement when interpreting score on PHQ-9
 - Occasionally as patient – provider relationship develops PHQ-9 score may go up
- Each context is unique
 - Core Principles of Collaborative Care mix with existing health system priorities and services

YKHC experience with Collaborative Care

IMPACT

**Improving Mood-Promoting Access
to Collaborative Treatment**

Description of Need

- ▣ 70% of patients referred to Behavioral Health by Primary Provider do not attend Behavioral Health Services
- ▣ WHO- 40-60% of patients who completed suicide saw their Primary Provider within 1 month of their completed suicide
- ▣ **Depression often co-occurs with other illnesses and medical conditions.**
- ▣ Cancer: 25% of cancer patients experience depression. (National Institute of Mental Health, 2002)
- ▣ Strokes: 10-27% of post-stroke patients experience depression. (National Institute of Mental Health, 2002)
- ▣ Heart attacks: 1 in 3 heart attack survivors experience depression. (National Institute of Mental Health, 2002)
- ▣ HIV: 1 in 3 HIV patients may experience depression. (National Institute of Mental Health, 2002)
- ▣ Parkinson's Disease: 50% of Parkinson's disease patients may experience depression. (National Institute of Mental Health, 2002)
- ▣ Eating disorders: 50-75% of eating disorder patients (anorexia and bulimia) experience depression. (National Institute of Mental Health, 1999)
- ▣ Substance use: 27% of individuals with substance abuse disorders (both alcohol and other substances) experience depression. (National Institute of Mental Health, 1999)
- ▣ Diabetes: 8.5-27% of persons with diabetes experience depression. (Rosen and Amador, 1996)

STATISTICS

- ▣ 357 patients in the past year
- ▣ Patients overall exhibited a 50% reduction in symptoms
- ▣ No patient receiving IMPACT services has completed suicide
- ▣ Approximately 55 patients screened per day in 3 clinics
- ▣ Approximately 3 Regular Behavioral Health Referrals per week

IMPACT:

Principles of Collaborative Care

- ▣ Patient Centered Team Care
- ▣ Population Based Care
- ▣ Measurement Based Treatment to Target
- ▣ Evidence Based Care
- ▣ Accountable Care

Patient Centered Team Care

- ▣ Shared Care Plans
- ▣ Whole Person Care
- ▣ Communication and Coordination
- ▣ Patient Support and Empowerment
- ▣ Ready Access to Quality Care
- ▣ Autonomy

5 Principles of PCC

- ▣ Respect
- ▣ Choice and Empowerment
- ▣ Patient Involvement in Health Care Policy
- ▣ Access to Quality Care
- ▣ Support and Information

Population Based Care

- ▣ Care Team shares a defined group of patients who are tracked in a registry
- ▣ Patient and Symptom Tracking
- ▣ Mental Health Specialists provide case load focused consultation
- ▣ Reduces Inequalities in Health Care
- ▣ Primary, Secondary and Tertiary Prevention

Measurement Based Treatment to Target

- ▣ Use validated measures to identify Behavioral Health Needs
- ▣ Symptom Identification
- ▣ Identify each patient's personal goals
- ▣ Routine measurement of symptoms and goal attainment
- ▣ Constant evaluation of the Care Plan

Evidenced Based Care

- ▣ Solution Focused Brief Therapy
- ▣ Problem Solving Treatment
- ▣ Behavior Activation
- ▣ Motivational Interviewing
- ▣ Cognitive Behavioral Therapy
- ▣ Stress Inoculation

Accountable Care

- ▣ Research suggests that up to \$6 are saved in health care costs for each dollar spent on Collaborative Care, a return on investment of 6:1.
- ▣ Systematic tracking of clinical outcomes at individual and population levels facilitates accountable care and helps maximize the value of services provided.
- ▣ Collaborative Care makes efficient use of limited resources.
- ▣ Limited mental health specialty capacity (e.g., psychiatry or psychology) is effectively 'leveraged' through supporting treatment for common behavioral health conditions in primary care.
- ▣ Face-to-face psychiatric consultation focuses on patients who are not improving as expected.
- ▣ Systematic treatment to target reduces clinical inertia and helps reduce costs associated with well-intended treatments that are not achieving results (e.g., unnecessary duplication of services, emergency department or hospital visits, medications and other treatments that are not effective).

IMPACT Services

- ▣ Patient and IMPACT Team agree on treatment goals, objectives and Treatment Modality
- ▣ Treatment Goals are the overall purpose of treatment
- ▣ Objectives are measurable behaviors that indicate that treatment is effective or not effective
- ▣ Goals and Objectives are specific, individualized, measurable, timely, and realistic
- ▣ Treatment may incorporate several Treatment Modalities
- ▣ Progress toward treatment objectives is assessed weekly and Care Plans are modified as needed with consent of the patient

Assessment, Diagnosis & Consultation

- ▣ **Assessment and Diagnosis**
 - **Mental Status Exam**
 - **Behavioral Assessment/Integrated Assessment**
 - **Diagnosis**

- ▣ **Consultation**
 - **Results**
 - **Recommendations**

- ▣ **Referral**
 - **IMPACT Services**
 - **Behavioral Health**
 - **Medication Evaluation/Psychiatric Services**
 - **Involuntary Commitment**
 - **Emergency Services**

Assessment, Diagnosis & Treatment Planning

- ▣ All Patients 15 and older are asked to complete the PHQ-9
- ▣ All Patients who score 10 or above on the PHQ-9 are referred to IMPACT for follow up
- ▣ All patients who endorse suicidal ideation are referred to IMPACT and evaluated in the clinic
- ▣ Patients seen in the clinic or referred for follow up are given a MSE and asked to complete a Comprehensive Behavioral Assessment
- ▣ Upon completion of the assessment process, Patient information is provided to the Primary Provider and treatment options are agreed upon
- ▣ Treatment options are discussed with the Patient and a Care Plan is put into effect
- ▣ Weekly consultation with psychiatry or as needed
- ▣ All patient progress or lack thereof is recorded in EMR

Care Planning

- ▣ Focus on Symptom Reduction and Patient Goals
 - Treatment Goals and Patient Goals are stated in objective terms
 - Treatment objectives are stated in objective terms
 - Treatment and Patient Goal attainment are evaluated during each Patient contact
 - Barriers to completing goals/objectives are assessed
 - Ways to eliminate barriers are assessed
 - Treatment modalities are assessed
 - Care Plan is assessed and changed if progress is not exhibited

Re-Evaluation

- ▣ If progress is not exhibited within 3-4 weeks:
 - Staff with Care Team
 - Refer for medication evaluation
 - Explore alternative intervention strategies
 - Revisit commitment
 - Change care plan

In Progress at YKHC

- ▣ Comprehensive Care Plan that includes all disciplines
- ▣ Running notes
- ▣ Care Team evaluations
- ▣ Routine Evaluations of the Program
- ▣ Additional Services
- ▣ Improve patient satisfaction surveys
- ▣ Clinic Design

Implementing Collaborative Care Exercise

- **Break into small groups of about 3 people**
- **Next 5 – 10 minutes discuss:**
 - Your current practice
 - First steps you might take toward implementing Collaborative Care
- **We will come back together to discuss:**
 - Compare your current care model with Collaborative Care
 - Identify next steps to plan for clinical practice changes

Question and Answer Session