Integrating the Response to Mental Disorders and other Chronic Diseases in Health Care Systems

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AIMS CENTER

Advancing Integrated Mental Health Solutions

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Disclosures

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- **Professor & Vice Chair, School of Medicine; Dept. of Psychiatry and Behavioral Sciences**
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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**
- **NAVOS**
- **Institute for Clinical Systems Improvement (ICSI)**
- **Mathematica / Center for Healthcare Strategies**

Division of Integrated Care and Public Health

AIMS CENTER

Advancing Integrated Mental Health Solutions

20 years of Research and Practice in Integrated Mental Health Care

Gulbenkian Platform Report Sept 2013

- Mental disorders share common features with other chronic diseases.
- The principles and practices for successful management are often the same.
- The main challenge in the future is not so much to further demonstrate the utility of chronic disease management models, but rather to bring them to scale.

Global Burden of Disease 2010

C. Murray et al, Lancet 2012

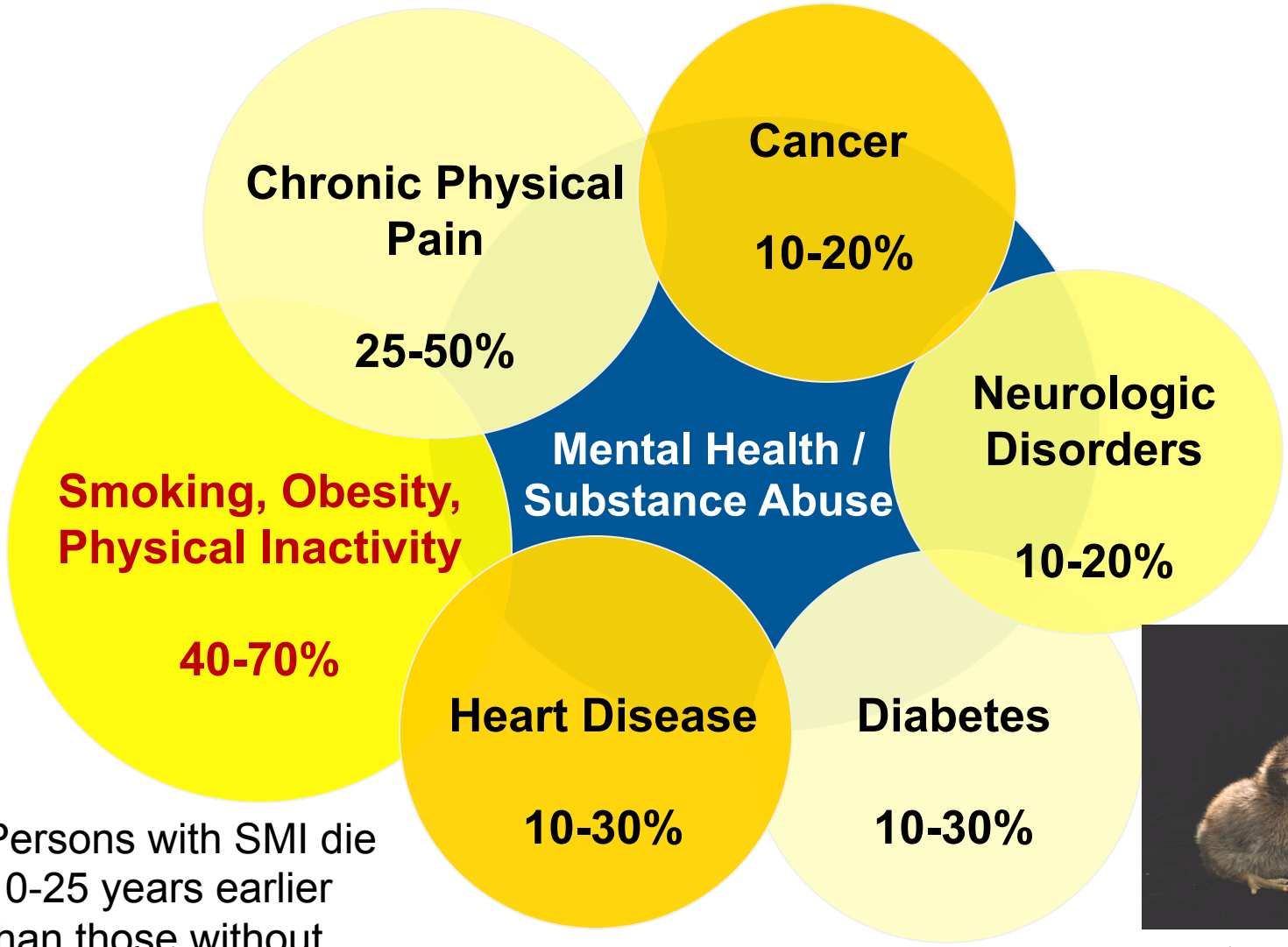
MH / SU disorders account for 23 % of Years Lived with Disability (YLD) worldwide.

Depression alone ~ 10 % of YLD s

YLD from depression is

- 3x diabetes;
- 8 x heart disease
- 40 x cancer

Mental Disorders are Rarely the Only Health Problem



Persons with SMI die 10-25 years earlier than those without.

Mental Disorders contribute to

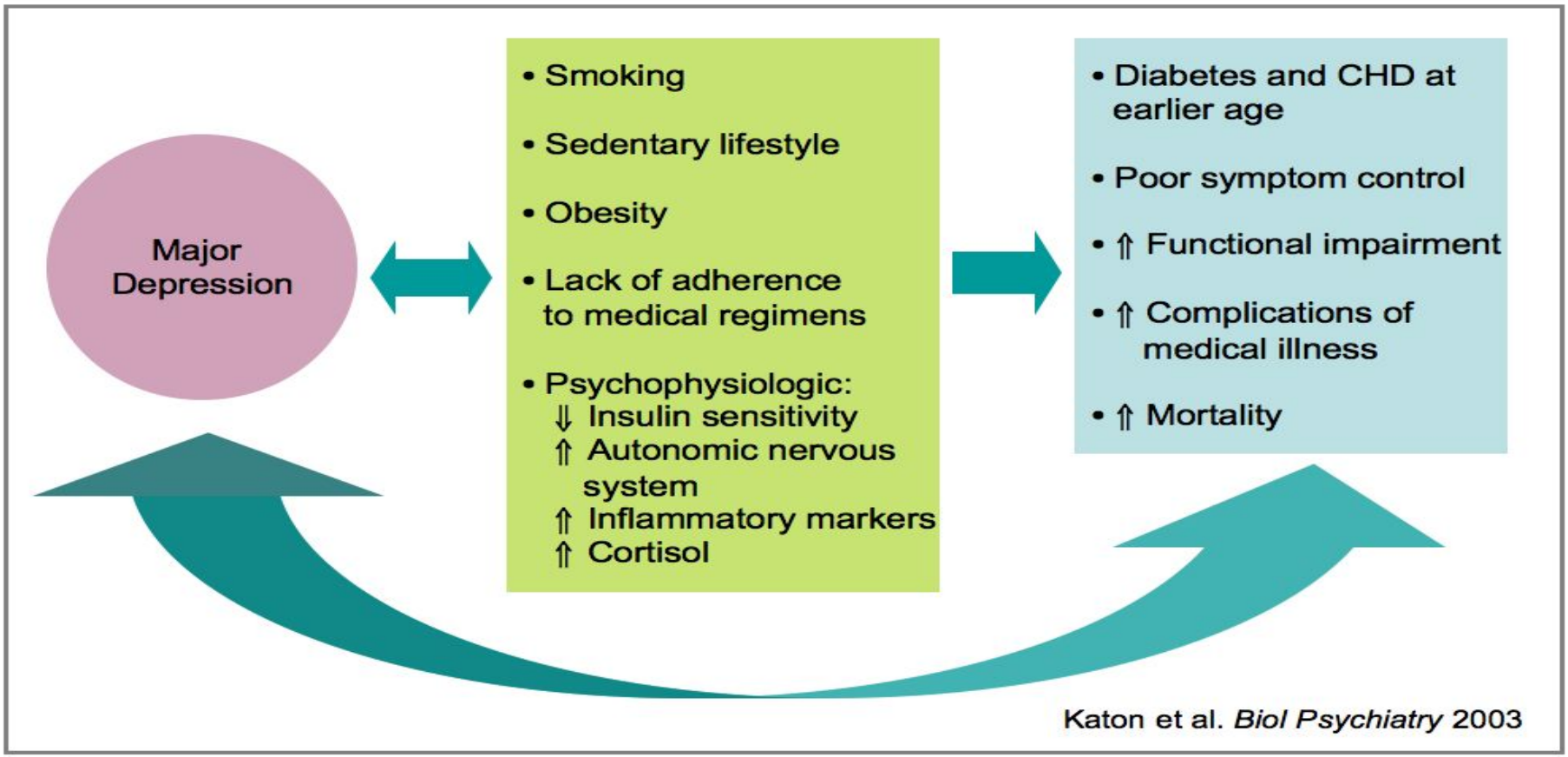
Mortality from

- self harm (depression; one suicide every 15 min)
- interpersonal violence (substance abuse)
- injuries (substance abuse)

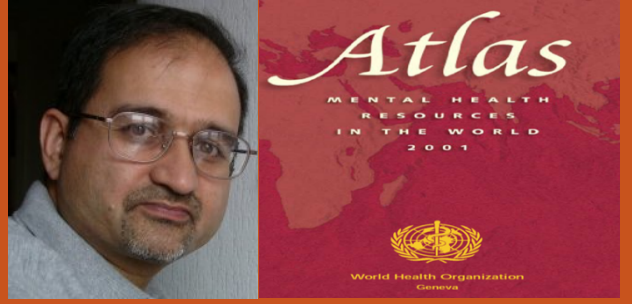
Morbidity and mortality associated with chronic medical disorders

- diabetes
- heart disease

Depression and Diabetes

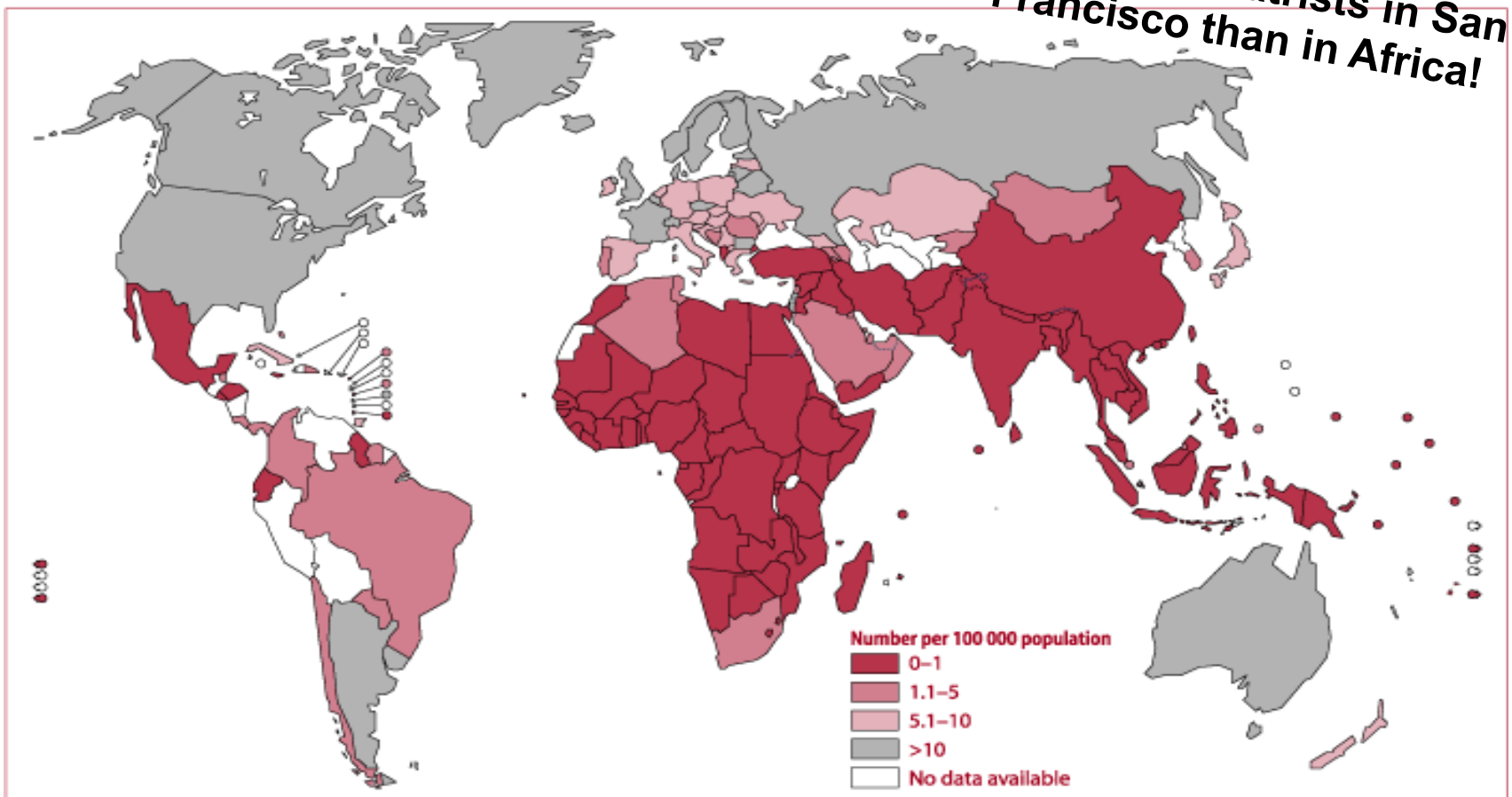


We will never have enough mental health specialists



More psychiatrists in San Francisco than in Africa!

Figure 4.4 Number of psychiatrists per 100 000 population, 2000[a]

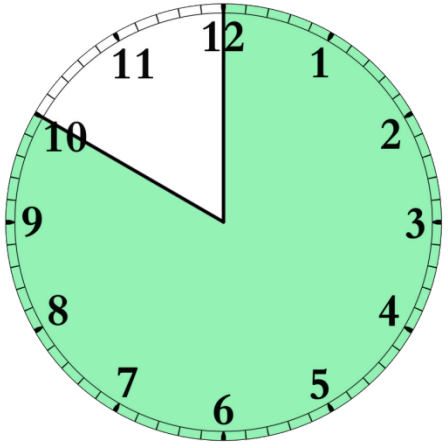


[a] Based on information from 177 Member States.

Source: *Mental health resources in the world. Initial results of Project Atlas* (2001). Geneva, World Health Organization.

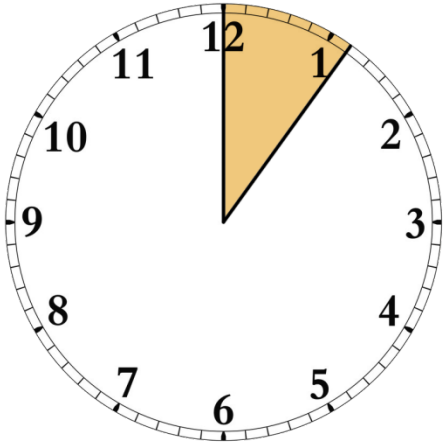
US :Psychiatrist Time / Week

Ideal



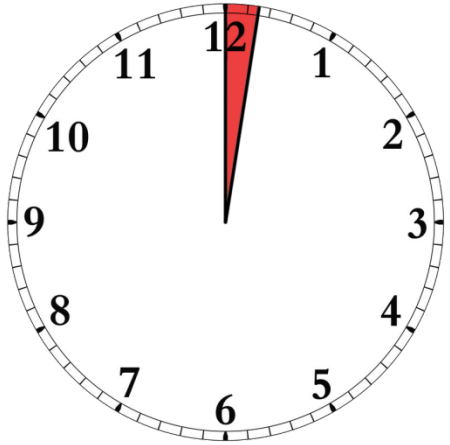
50 minutes

United States: Urban



6 minutes

United States: Rural



1.5 minutes

Talk fast!

Psychiatry Workforce

Population Served	Population / FTE Psychiatrist	Psychiatrist time available for each patient per month*
UK	25,000	6 min
China	70,000	2 min
Africa	500,000	20 sec
Kenya	900,000	10 sec
Nigeria	1,800,000	5 sec

* Assuming psychiatrist sees patients for 30 hours / week and 3 % of population need mental health services.

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.

IMPACT
Collaborative Care Model

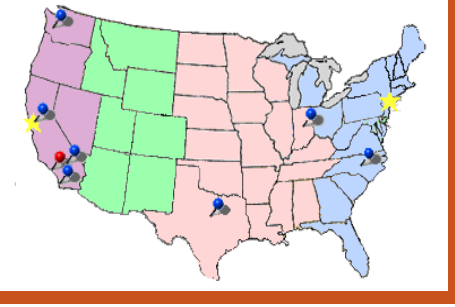
Primary Care Practice with Mental Health Care Manager

Outcome Measures

Treatment Protocols

Population Registry

Psychiatric Consultation



IMPACT Study

RCT with 1,801 depressed adults in 18 primary care clinics in 5 states

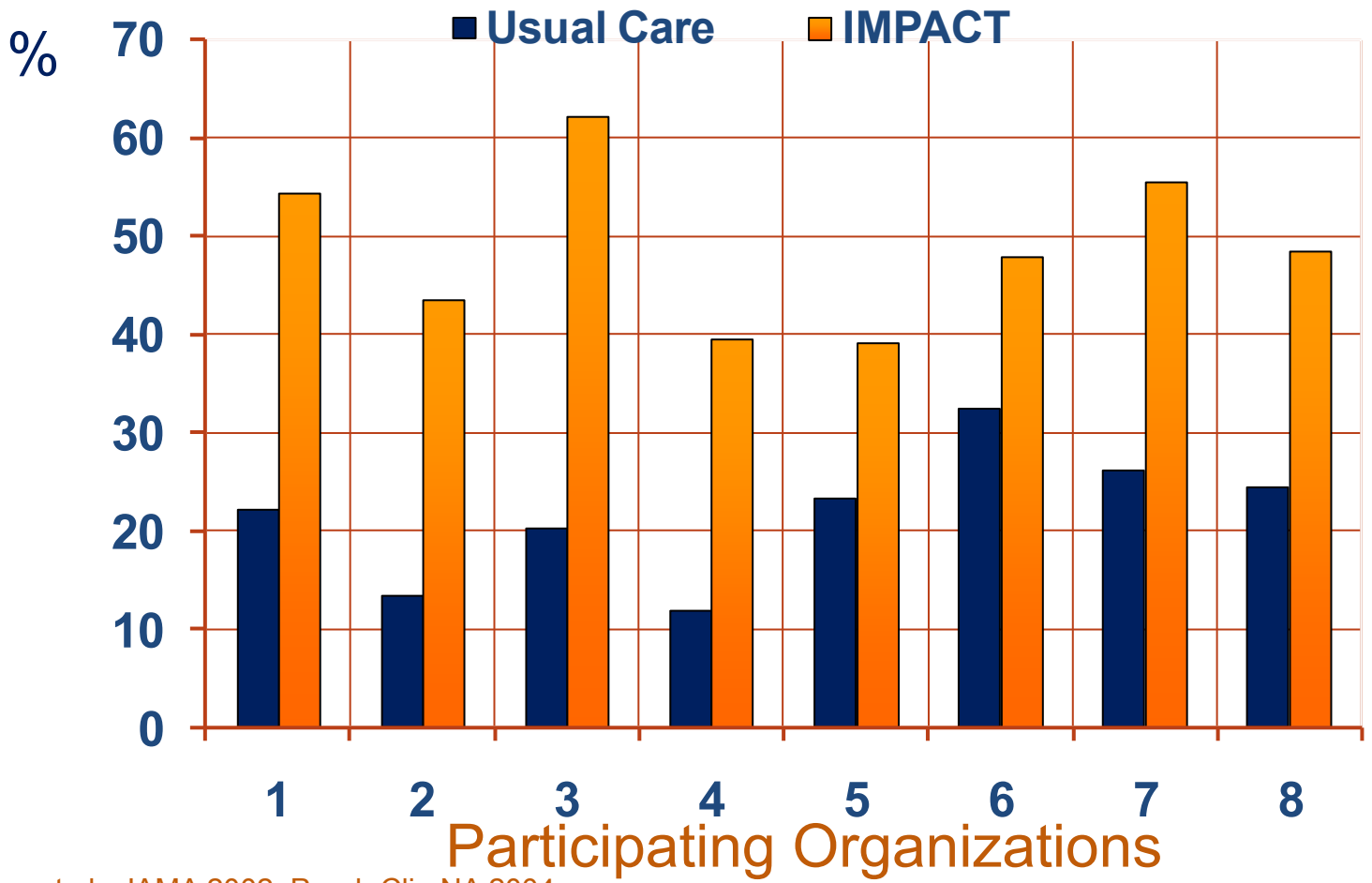
Usual care or Collaborative Care

Collaborative Care Program based on model of Chronic Illness Care (Wagner et al)

24 month independent follow-up

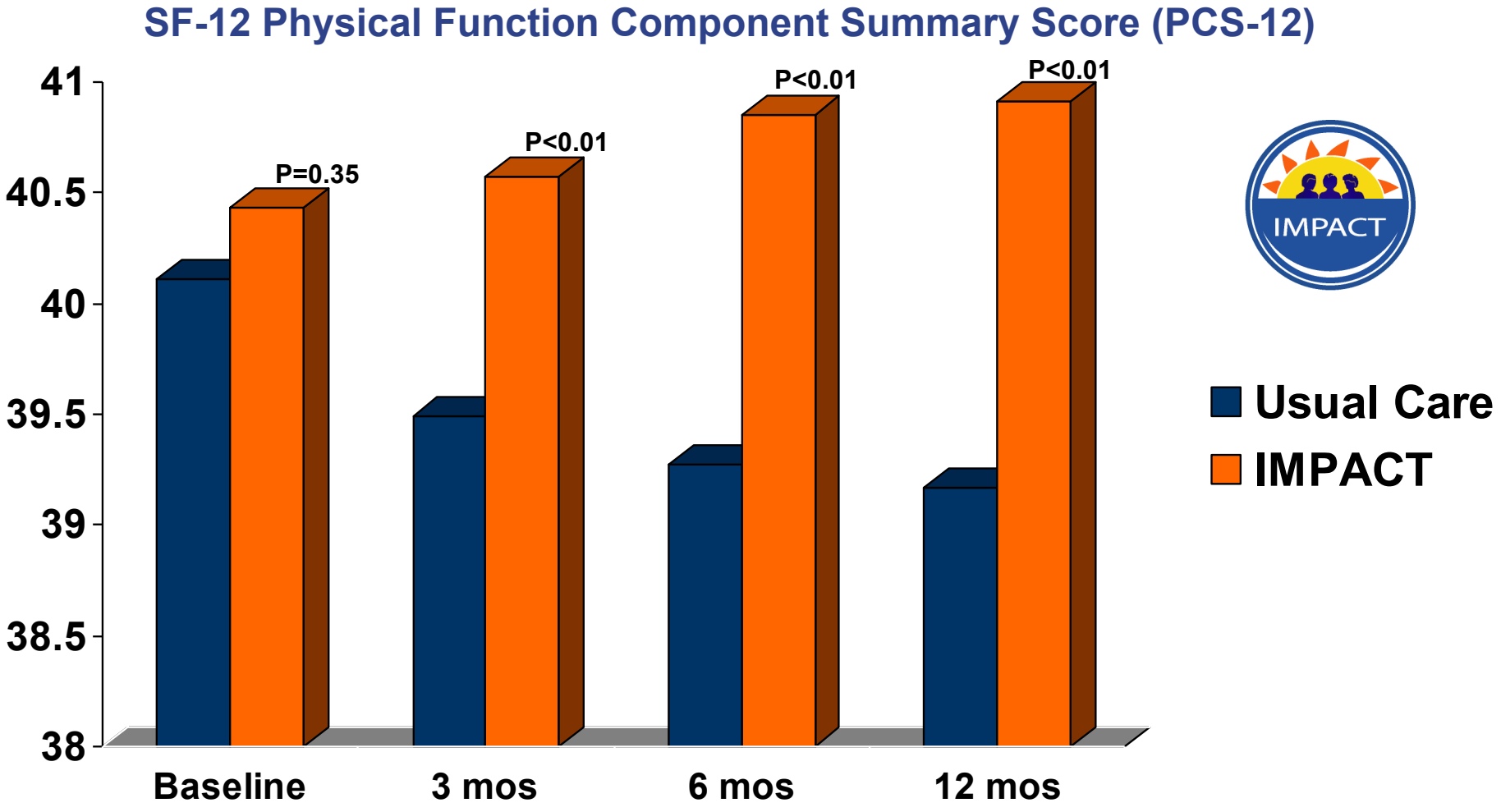
IMPACT doubles effectiveness of care for depression

50 % or greater improvement in depression at 12 months



Unützer et al., JAMA 2002; Psych Clin NA 2004

… and improves physical function



Callahan et al., *JAGS* 2005; 53:367-373

Evidence for Collaborative Care

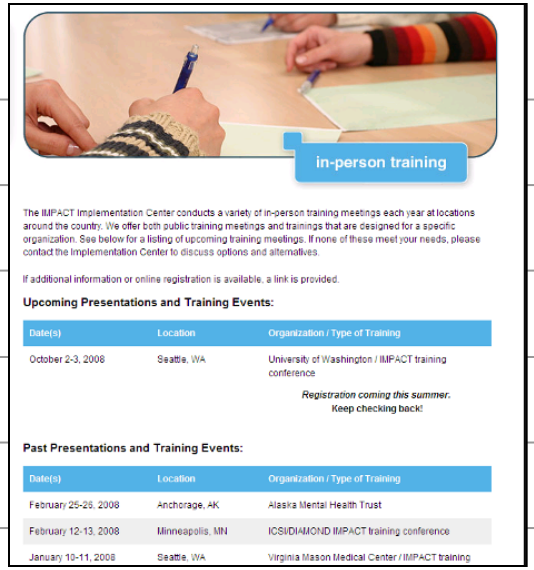
Collaborative Care is more effective and more cost effective than care as usual.

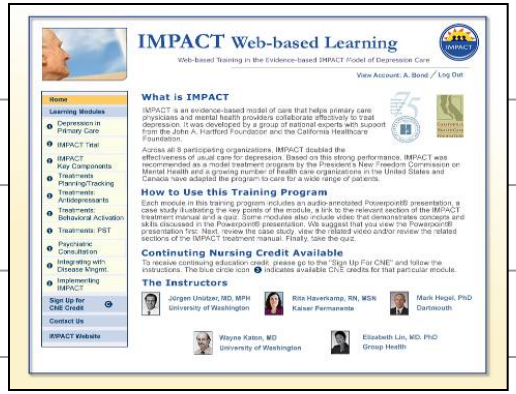
-79 RCTs (2012 Cochrane metaanalysis)

Interventions are particularly effective in underresourced communities / populations

Taking effective models to scale

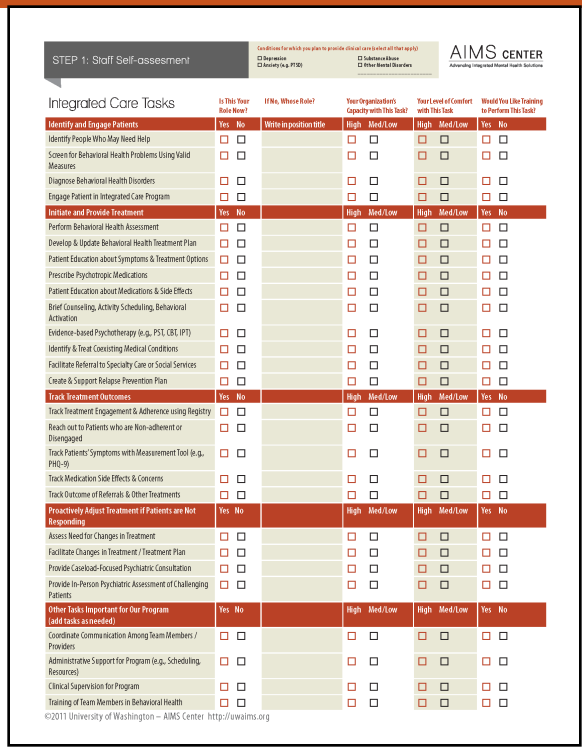
UW AIMS Center: Translating from Research to Practice





4-step Team Building Process

- **Based on experience with over 500 implementers**
- **Customizable**
- **Creates a functional workflow that fits local resources**
- **http://uwaims.org**



STEP 1: Staff Self-assesment

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

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Integrated Care Tasks	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	Write in position title	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		High Med/Low	High Med/Low	Yes No
Perform Behavioral Health Assessment	☐ ☐		☐ ☐	☐ ☐	☐ ☐
Develop & 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 & Treat Coexisting Medical Conditions	☐ ☐		☐ ☐	☐ ☐	☐ ☐
Facilitate Referral to Specialty Care or Social Services	☐ ☐		☐ ☐	☐ ☐	☐ ☐
Create & Support Relapse Prevention Plan	☐ ☐		☐ ☐	☐ ☐	☐ ☐
Track Treatment Outcomes	Yes No		High Med/Low	High Med/Low	Yes No
Track Treatment Engagement & 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 & Other Treatments	☐ ☐		☐ ☐	☐ ☐	☐ ☐
Proactively Adjust Treatment if Patients are Not Responding	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		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	☐ ☐		☐ ☐	☐ ☐	☐ ☐

Washington State: MHIP

MHIP for Behavioral Health
Mental Health Integration Program

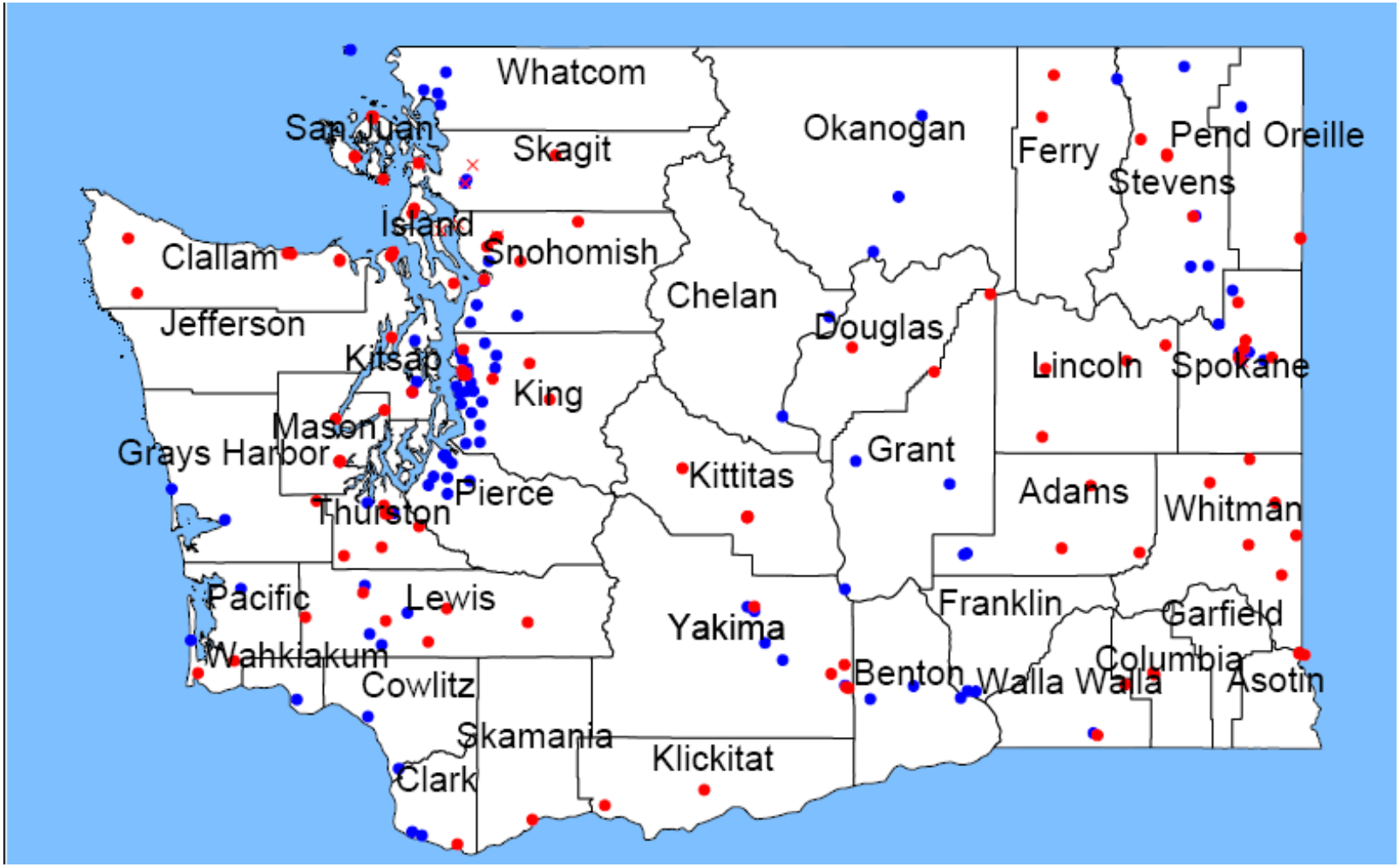
- State of Washington
- Public Health Seattle & King County (PHSKC).
- Community Health Plan of Washington

in partnership with the UW AIMS Center

- http://integratedcare-nw.org

Mental Health Integration Program

> 35,000 clients served … 4 FTE psychiatrists

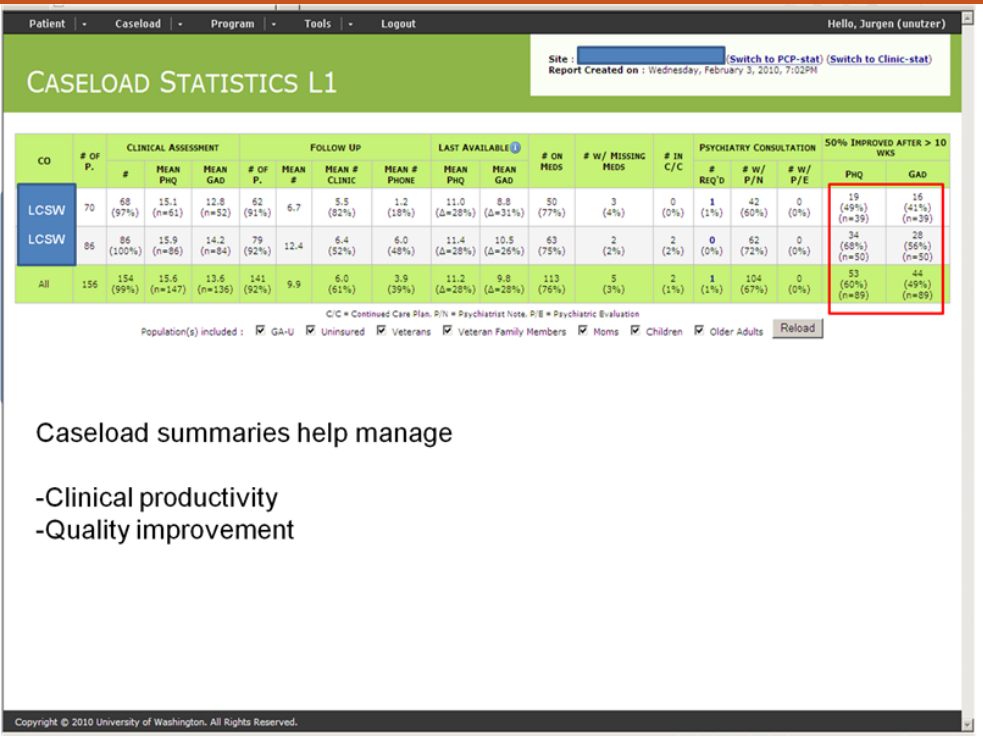


Collaborative Care effectively 'leverages' a psychiatrist to reach more people

	Office Based Private Practice	Mental health center (Psychiatrist supports MH specialty team)	Collaborative Care (Psychiatrist Supports Primary Care based Team)
Typical caseload over 12 months*	100 – 300	100 – 500	1000 – 3000
Patient contacts / case reviews over 12 months**	1500 - 2000	1500 – 2000	3000 – 5000
Total population covered***	1,500 –10,000	3,000 – 15,000	30,000 – 100,000

Assumptions:
* Typical caseload turns over once / year
**1 FTE psychiatrist sees patients 30 hours / week
*** 3 % of population has need for mental health services in any given year

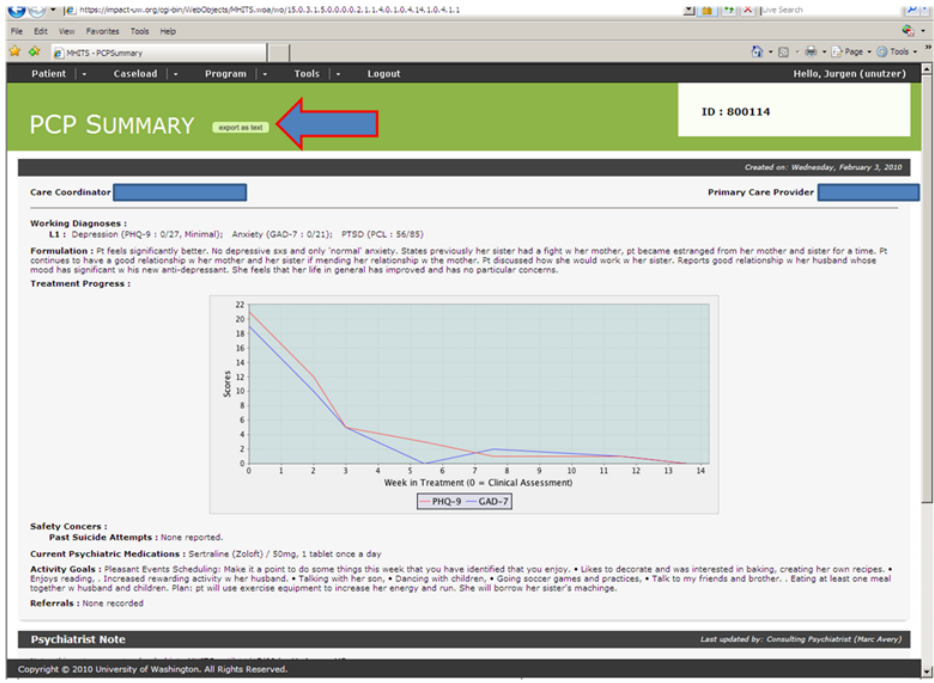
Care Management Tracking System (CMTS©)



Caseload summaries help manage

-Clinical productivity
-Quality improvement

- Access from anywhere.
- Population-based.
- Keeps track of 'caseloads'.
- Structured workflow.
- Facilitates consultation.
- Allows research on highly representative populations



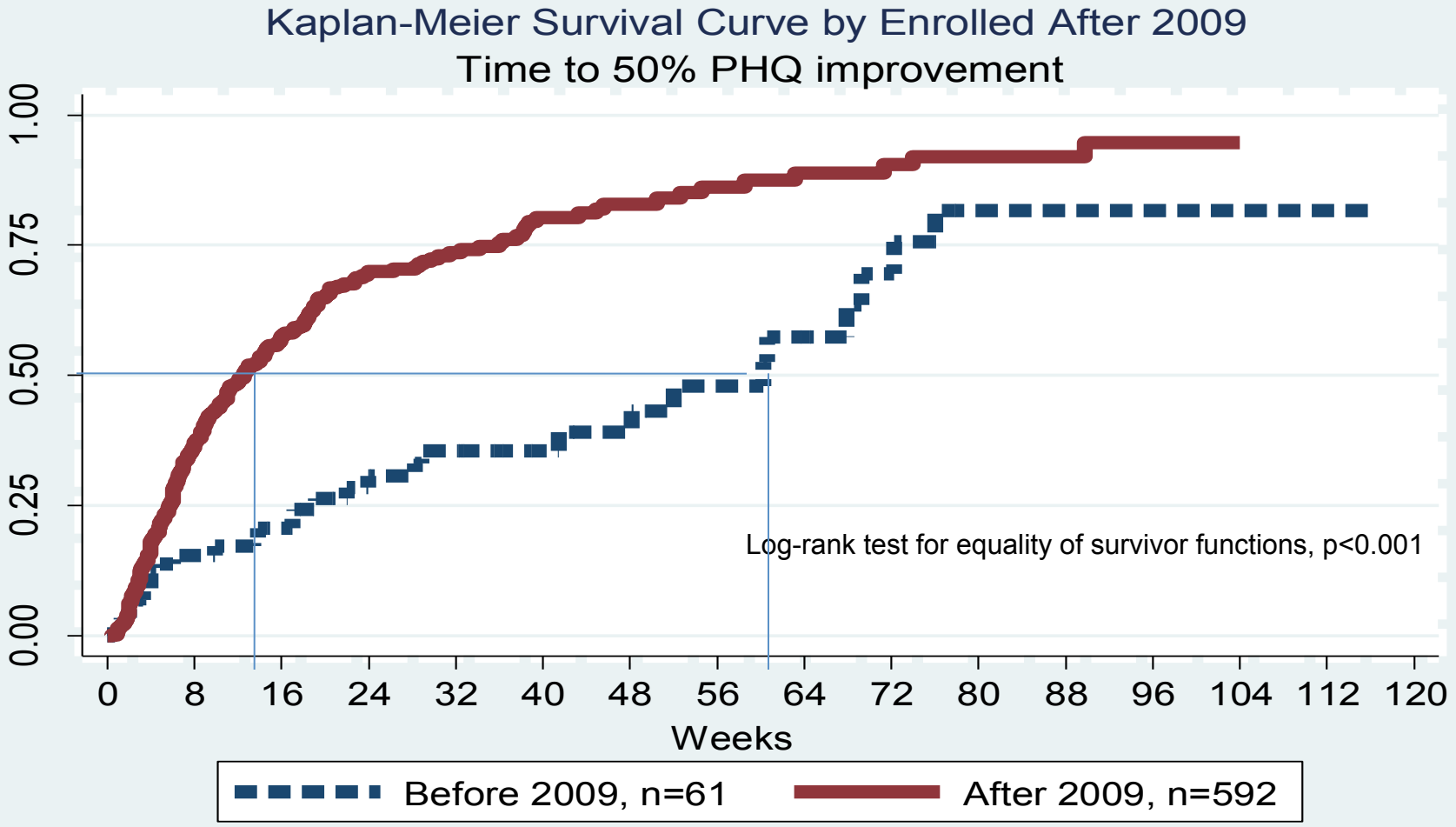
- Used in 14 US states (& Alberta)
- Supporting care of over 80,000 patients..

MHIP Common Client Diagnoses

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

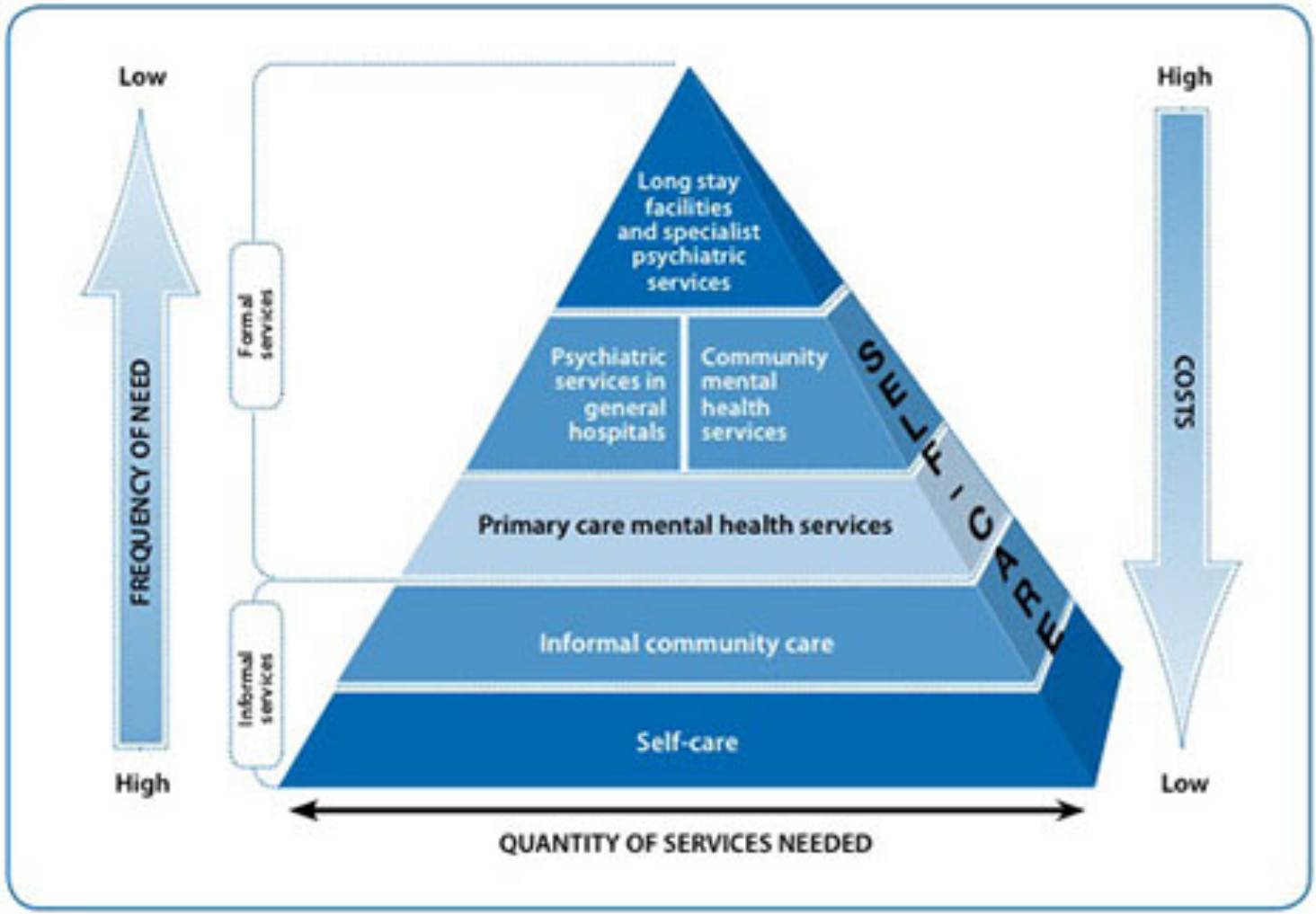
… plus acute and chronic medical problems, chronic pain, substance use, prescription narcotic misuse, homelessness, unemployment, poverty, ….

Collaborative Care for Depression in High Risk Moms



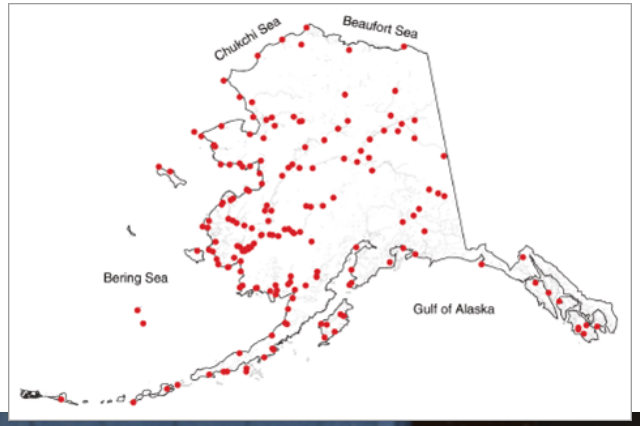
Among Mom Population (African American, Asian, Latino & White) with baseline PHQ9>=10 (n=653)

WHO Service Pyramid - Task Shifting



Rural Alaska

Rural villages without direct access to mental health specialty care and high rates of depression, alcoholism, and suicide.



The TRUST

The Alaska Mental Health Trust Authority

New Orleans, LA – 2005
… after Hurican Katrina

REACH NOLA

Working with community based health workers to address severe mental health crisis after Hurricane Katrina.

Questions about Task Shifting

- Who can do what ?
  - Patients, family members, community / lay health workers, faith-based and traditional healers, nonspecialist health staff (e.g., nurses), social workers, medical staff
  - Tele-health and other technology
- What kind of training, support, and supervision are needed?
- How can we best leverage limited specialty expertise?
- When does the model break down?
- What are the risks?

Principles of Effective Integrated Care

Integration and Collaboration

- Collaboration is more than co-location.

Population-Based Care

- Public Health Approach: patients tracked in a registry so that no one ‘falls through the cracks’.

Evidence-Based Care

- Use evidence-based treatments.

Measurement-Based Treatment to Target

- Treatments are actively changed until goals are achieved.

Thank you.

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