

# Achieving the Triple Aim:

**Can Collaborative Care Help Us Improve the Patient Experience, Improve Health Outcomes and Reduce Cost?**

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## DISCLOSURES

**Professor & Chair, University of Washington Department of Psychiatry and Behavioral Sciences**

**Director, AIMS Center: Advancing Integrated Mental Health Solutions**

**Adjunct Professor, Health Services; Global Health, UW School of Public Health**

### Grant funding

- National Institute of Health
- National Corporation for Community Service (Social Innovation Fund)
- Center for Medicare and Medicaid Innovation
- Department of Defense (Henry M. Jackson Foundation)
- John A. Hartford Foundation
- PCORI (Patient Centered Outcomes Research Institute)

### Contracts

- Community Health Plan of Washington, Public Health -- Seattle & King County
- New York State Department of Health

### Consultant & Advisor

- Group Health Research Institute
- Substance Abuse and Mental Health Services Administration (SAMHSA; CMHS)
- World Health Organization

### Author with Royalties

- Up To Date





# Key points

- Mental illness and substance use (behavioral health problems) are major drivers of disability & costs.
  - Fewer than half of those in need have access to effective specialty behavioral health care.
  - Effective integration of behavioral health care with primary care has several advantages:
    - Better access to care
    - Better health outcomes
    - Lower costs
- = the Triple Aim of health care reform**



# Burden of Mental Illness

**1 in 4** Americans struggle with a mental health or substance use problem at some point in their lives. No family goes untouched.

Behavioral health disorders cause **nearly 25 % of all disability worldwide**

Depression alone accounts for 10 % of health related disability.

Years Lost to Disability (YLD) from depression =

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

(Murray C et al; Global Burden of Disease ; Lancet, 2012)

For governments: high health care costs, high rates of unemployment, homelessness, and involvement in the criminal justice system.

For employers, mental health & substance use problems are

- Major drivers of absenteeism and presenteeism.
- Major drivers of health care costs



# Suicide

- One suicide every **15 minutes**
- More suicides than homicides or motor vehicle fatalities

**Tragedies that may be prevented by better access to the right care at the right time!**



# High Health Care Costs

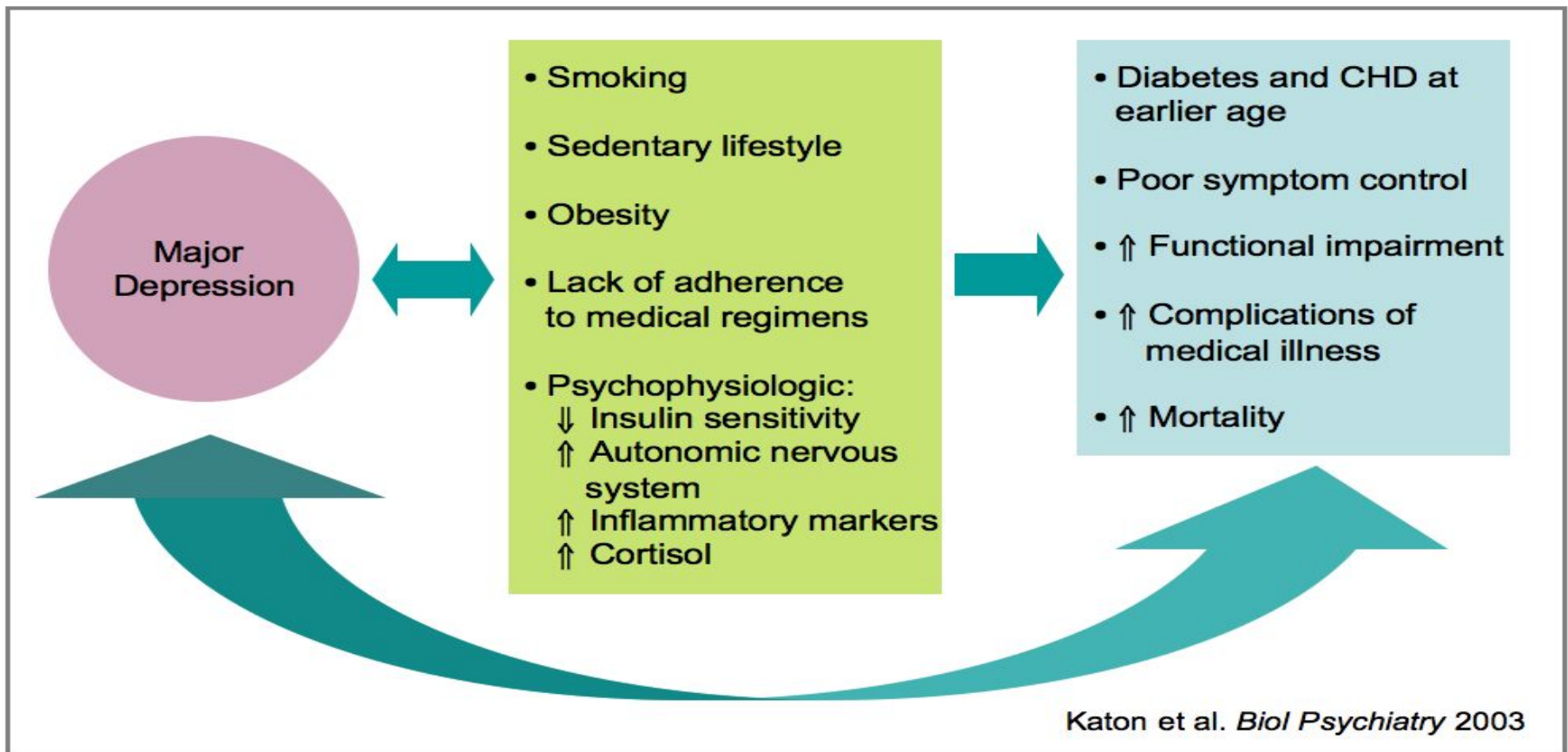
Population	% with behavioral health diagnosis	PMPM without BH diagnosis	PMPM with BH diagnosis	Increase in total PMPM with BH diagnosis
Commercial	14%	\$ 340	\$ 941	276 %
Medicare	9%	\$ 583	\$ 1429	245 %
Medicaid	21%	\$ 381	\$ 1301	341 %
<b>All insurers</b>	<b>15%</b>	<b>\$ 397</b>	<b>\$ 1085</b>	<b>273 %</b>

Mental health specialty care accounts for only 3 % of overall costs.  
More effectively integrated mental health care could save billions.

\* APA Milliman report; Melek et al; 2013

# Mental and Medical Disorders are Tightly Linked

e.g., Depression & Diabetes



# Access to Care

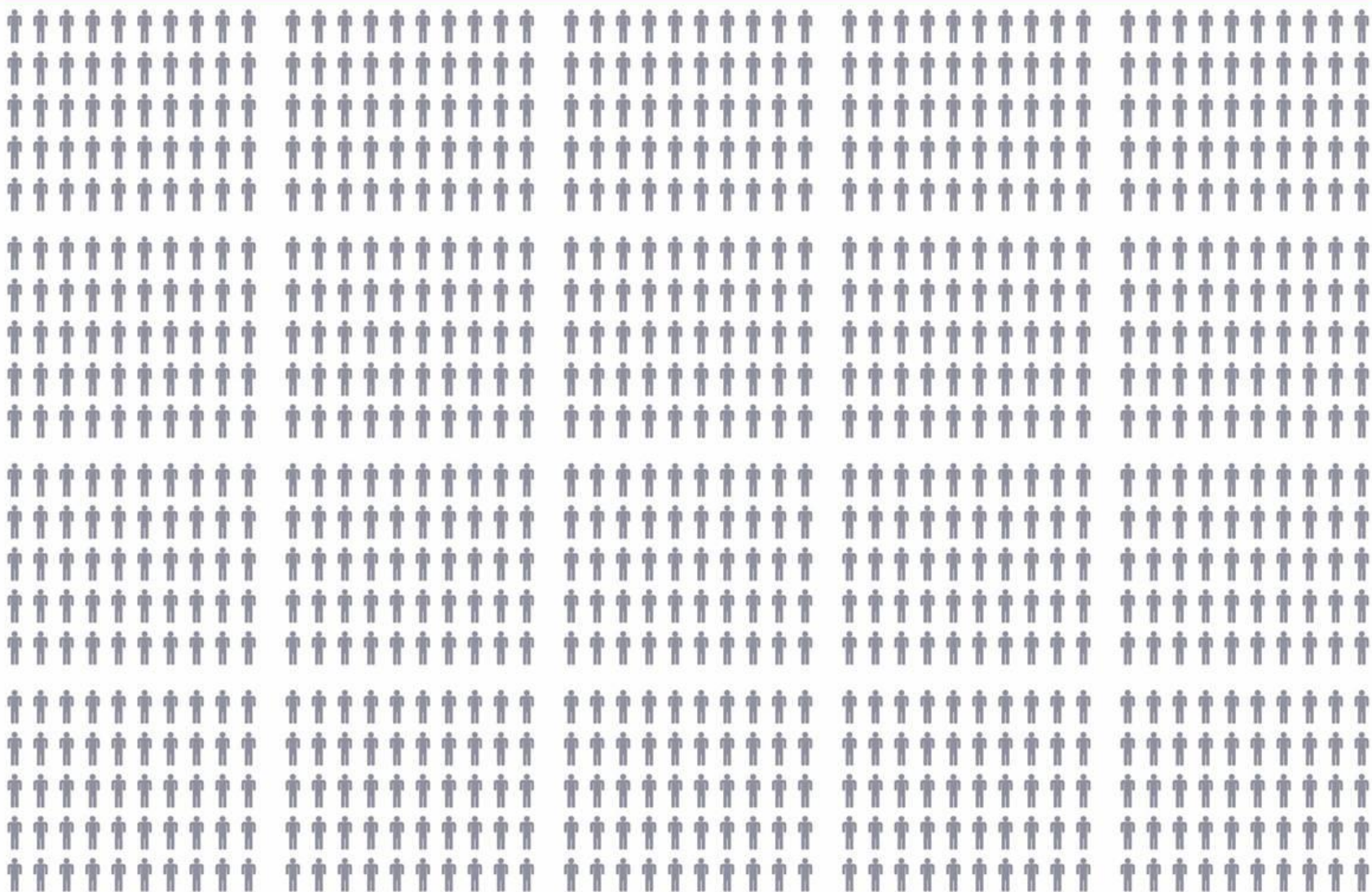
- Even with insurance, the average wait time is **25 days** to see a mental health specialist.
- **2/3** of primary care providers report poor access to mental health care for their patients.
- Only **1/10** Americans with a substance use disorder receive specialty care.



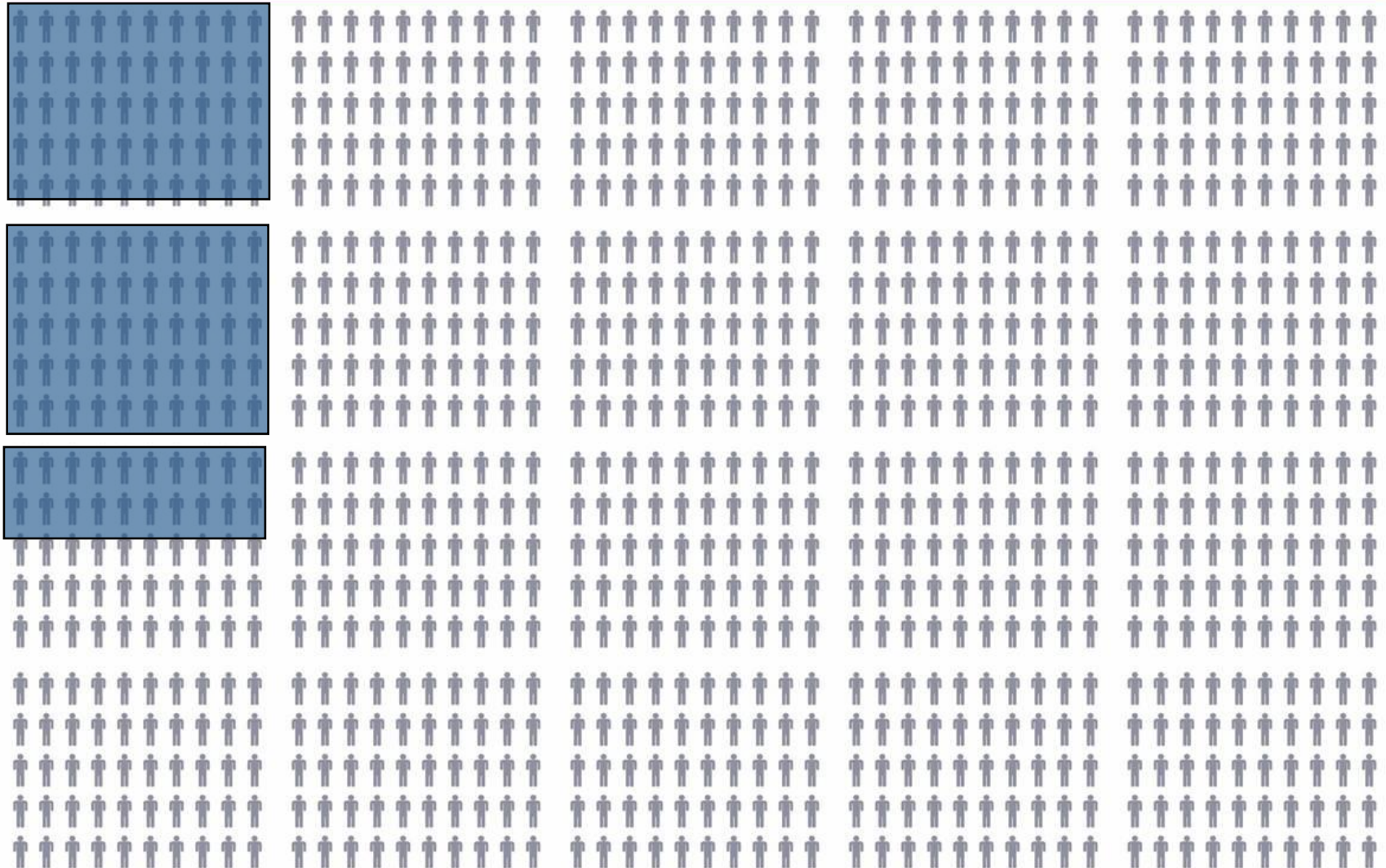
*"We couldn't get a psychiatrist, but perhaps you'd like to talk about your skin. Dr. Perry here is a dermatologist."*



# Of all people living with mental disorders

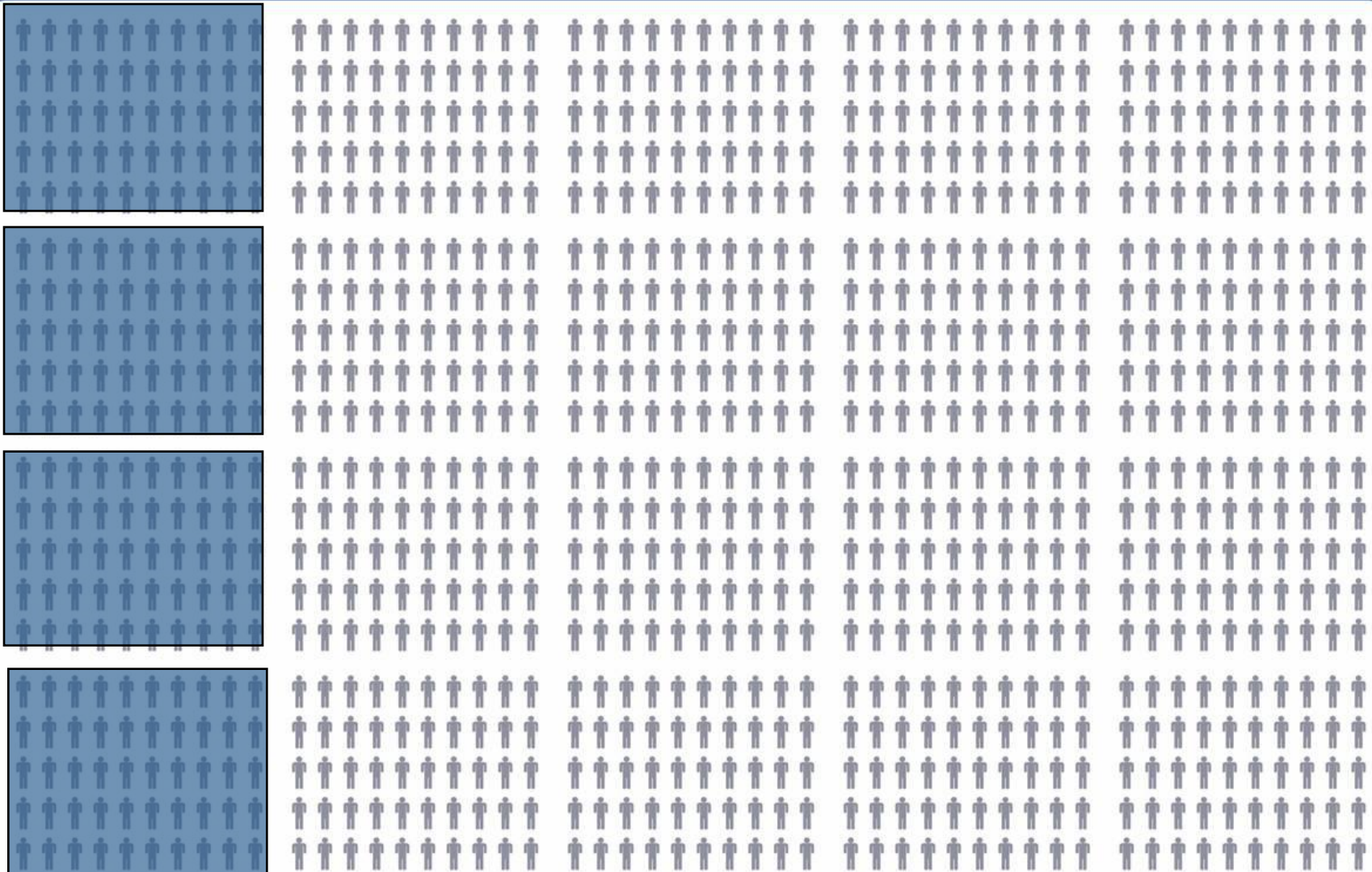


# 12% see a psychiatrist





## 20 % see any mental health specialist

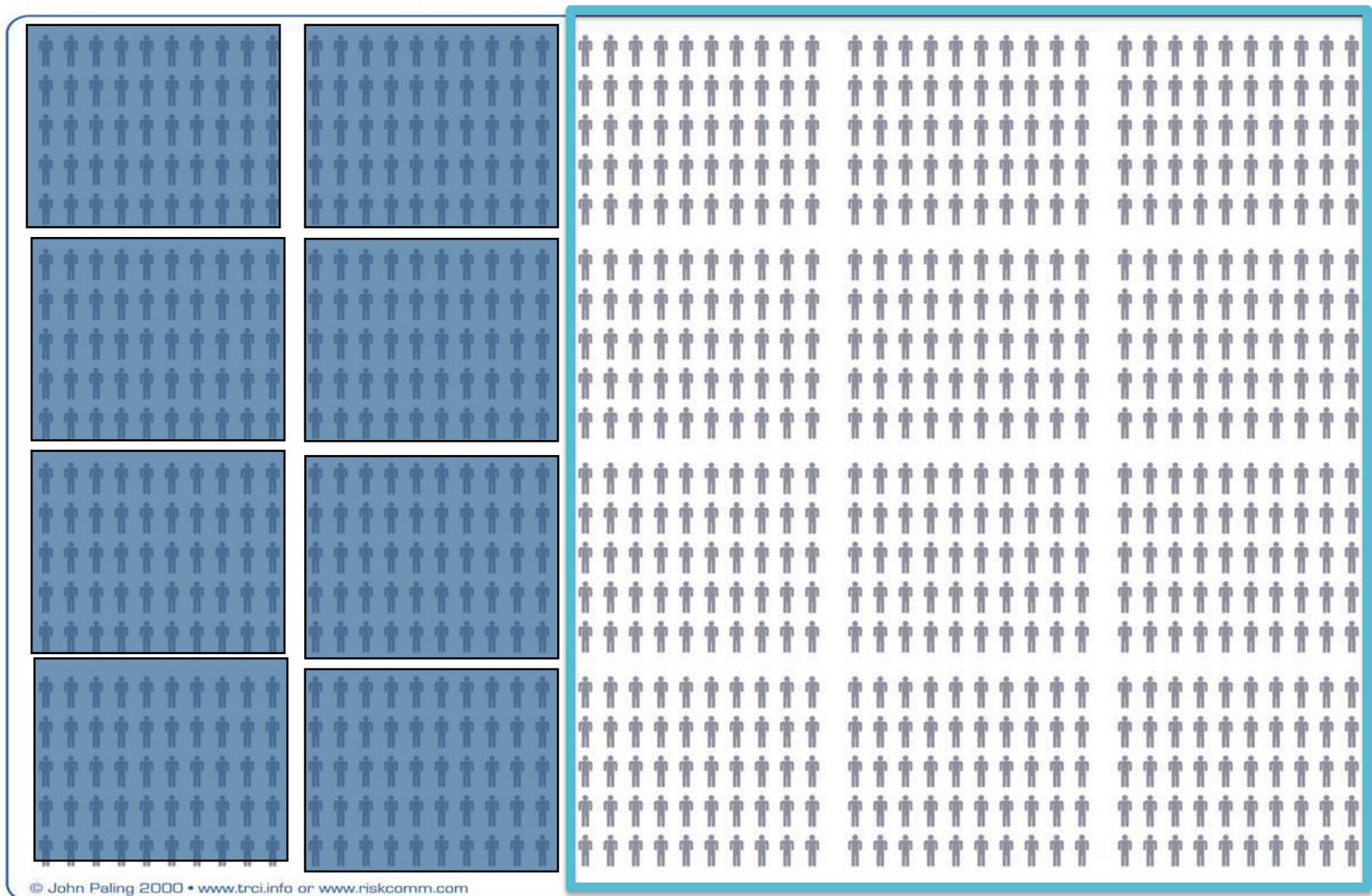


## 40 % get mental health treatment in primary care





# Most get no formal treatment.



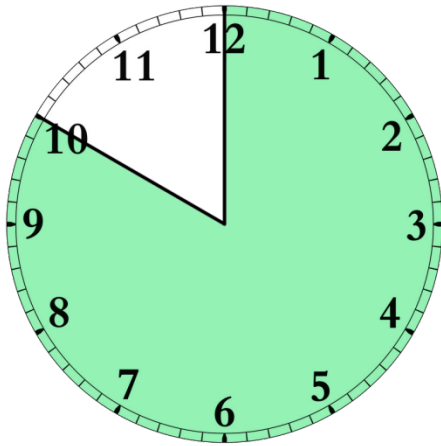


# Mental Health Workforce

- Mental health professionals are concentrated in urban areas.
- More than half of counties in US don't have a single practicing psychiatrist or psychologist

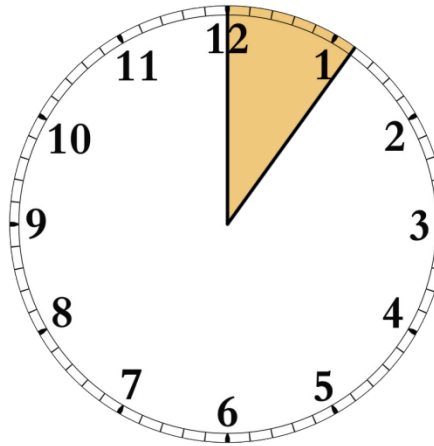
# "The 50 minute hour"

## •Ideal



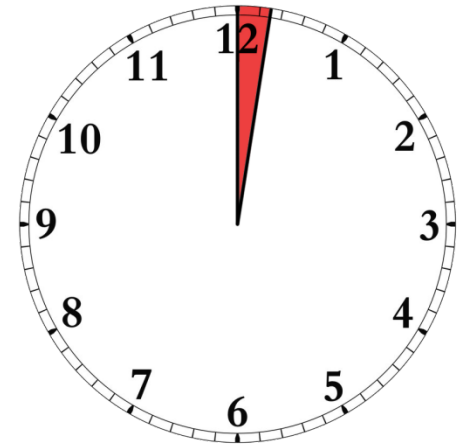
50 minutes

## •Urban US



6 minutes

## •Rural US



1.5 minutes

Assuming that 3 % of population could benefit from psychiatric care.

*Talk fast!*

# Quality of Care

- ~ 30 million people receive a prescription for a psychiatric medication in primary care each year **but only 25% improve.**
- Patients with serious mental illness **die 10 – 20 years earlier** due to poor medical care.



***“Of course you feel great. These things are loaded with antidepressants.”***





# Services are poorly coordinated





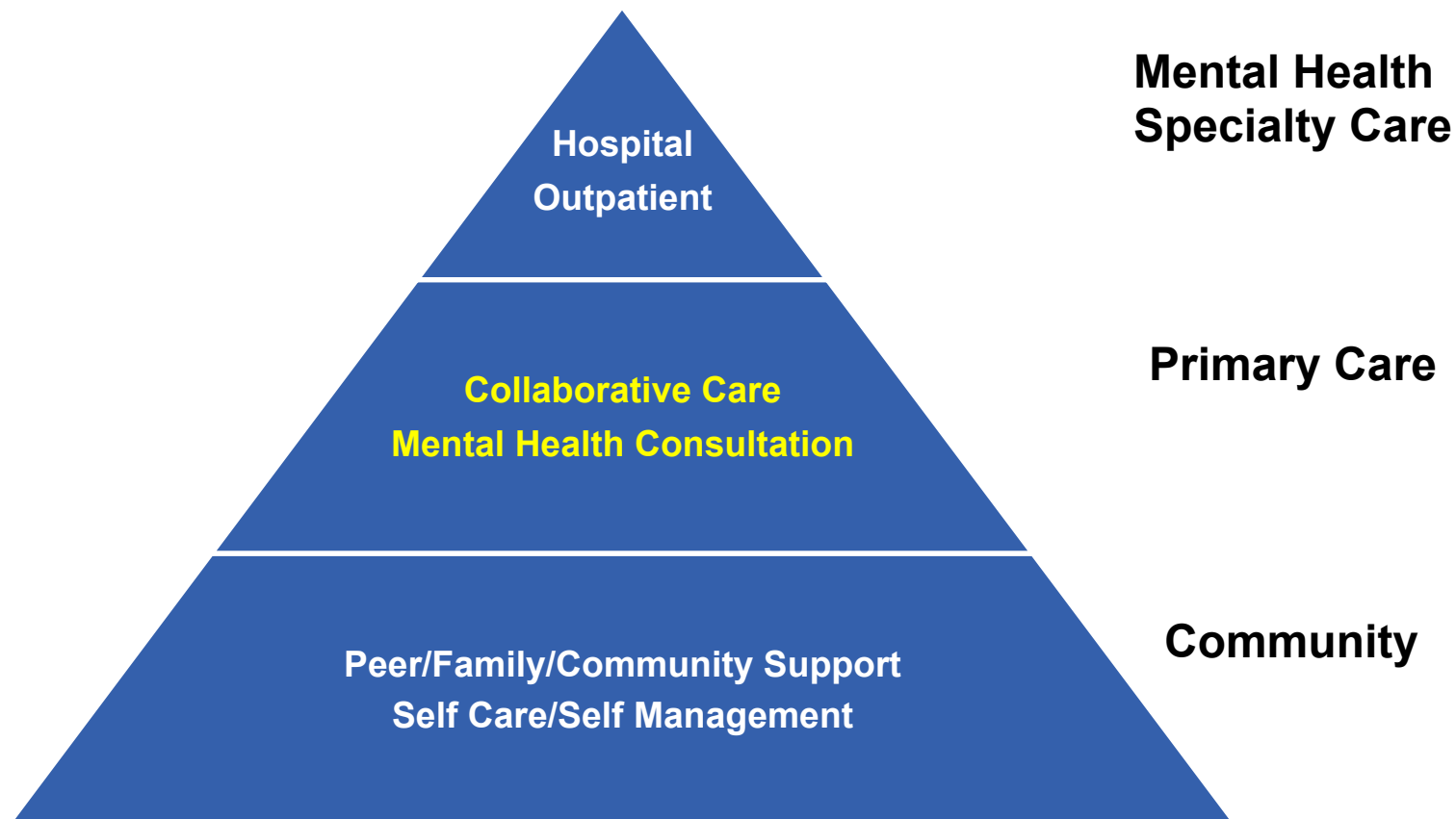
# How do we close the gap?

- **Train and retain more mental health professionals**
- **Work smarter: leverage mental health professionals through**
  - **Collaboration (e.g., primary care)**
  - **Technology**



# ***Task sharing.***

*“You have no idea how much lunch there is.”*

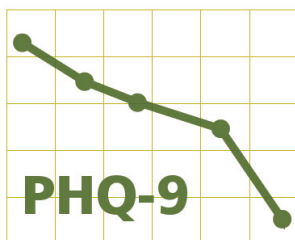


# Collaborative Care

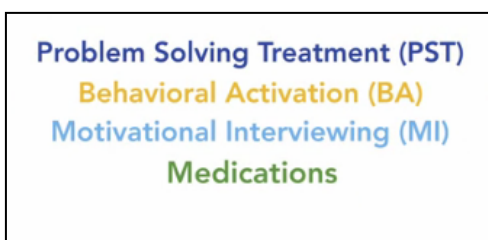


## Primary Care Practice

- Primary Care Provider
- Patient
- +
- Behavioral Health Professional
- Psychiatric Consultant



Outcome  
Measures



Treatment  
Protocols

[ACTIVE PATIENTS]						
Flags	[Patient ID]	[Name]	[Enrollment Date]	[Status]	[Initial Assessment Date]	[Progress]
	0001	Test, Test	2/8/2013	[T]	8/24/2013	
	0008	Test, Suzy	4/2/2013	[T]	5/21/2013	12
	0010	Test, Test	4/17/2012	[T]	4/25/2013	16
	0035	Test, Rgp Reminder	1/10/2013	[T]	1/10/2013	
	0038	Test Patient, Mbwcc	1/23/2014	[T]	1/23/2014	22
	0041	Test, Test	3/4/2014	[T]	3/4/2014	
	0042	Test, Test	3/7/2014	[T]	3/7/2014	

Population  
Registry



Psychiatric  
Consultation



# Evidence Base

More than **80 randomized controlled trials** have shown Collaborative Care to be more effective than usual care for common mental health conditions such as depression and anxiety.

First demonstrated in the **IMPACT Trial**



# Collaborative Care achieves The Triple Aim of health care reform

- **Better care experience**
  - Access to care
  - Satisfaction
- **Better clinical outcomes**
  - Less depression
  - Less physical pain
  - Better functioning
- **Lower health care costs**



***“I got my life back”***





# IMPACT

Evidence-based depression care

[home](#)[about](#)[implementation](#)[tools](#)[training](#)[stories](#)[news](#)[contact us](#)[register](#)

One in ten older adults  
visiting a physician  
suffers from depression

IMPACT Team Care  
doubles the effectiveness  
of depression treatment



## Quick Links

Get to the information you need by using the quick links below to some of the most popular pages.

[Evidence base for IMPACT](#)[IMPACT key components](#)[Tools \(manuals, videos, etc.\)](#)[Online training](#)[IMPACT in the media](#)[IMPACT patients' stories featured in  
The John A. Hartford Foundation's  
annual report](#)

## Success Stories from Across the Country

Read about how organizations across the US are having success with the IMPACT program. Click on the map to learn more.





# Replication studies show: the model is ‘robust’

Clinical Setting	Target Clinical Conditions	Reference
Primary Care for Adolescents	Adolescent Depression	Richardson 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 Ell et al 2010
Public sector oncology clinic	Cancer and depression	Ell et al., 2010
Women's health care clinics (IDAWN)	Depression, PTSD	Melville 2014 Katon 2014
Adult primary care	Anxiety Disorders including PTSD	Roy-Byrne et al 2012
Older adults in primary care	Arthritis and depression	Unützer et al., 2008
Primary Care / Cardiology (COPES)	Heart disease and depression	Davidson et al., 2010





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**ORIGINAL ARTICLE**

## Collaborative Care for Patients with Depression and Chronic Illnesses

Wayne J. Katon, M.D., Elizabeth H.B. Lin, M.D., M.P.H., Michael Von Korff, Sc.D., Paul Ciechanowski, M.D., M.P.H., Evette J. Ludman, Ph.D., Bessie Young, M.D., M.P.H., Do Peterson, M.S., Carolyn M. Rutter, Ph.D., Mary McGregor, M.S.N., and David McCulloch, M.D.

N Engl J Med 2010; 363:2611-2620 | [December 30, 2010](#)

### BACKGROUND

Patients with depression and poorly controlled diabetes, coronary heart disease, or both have an increased risk of adverse outcomes

### MEDIA IN THIS ARTICLE

#### FIGURE 1





***A1c***



***Blood pressure***

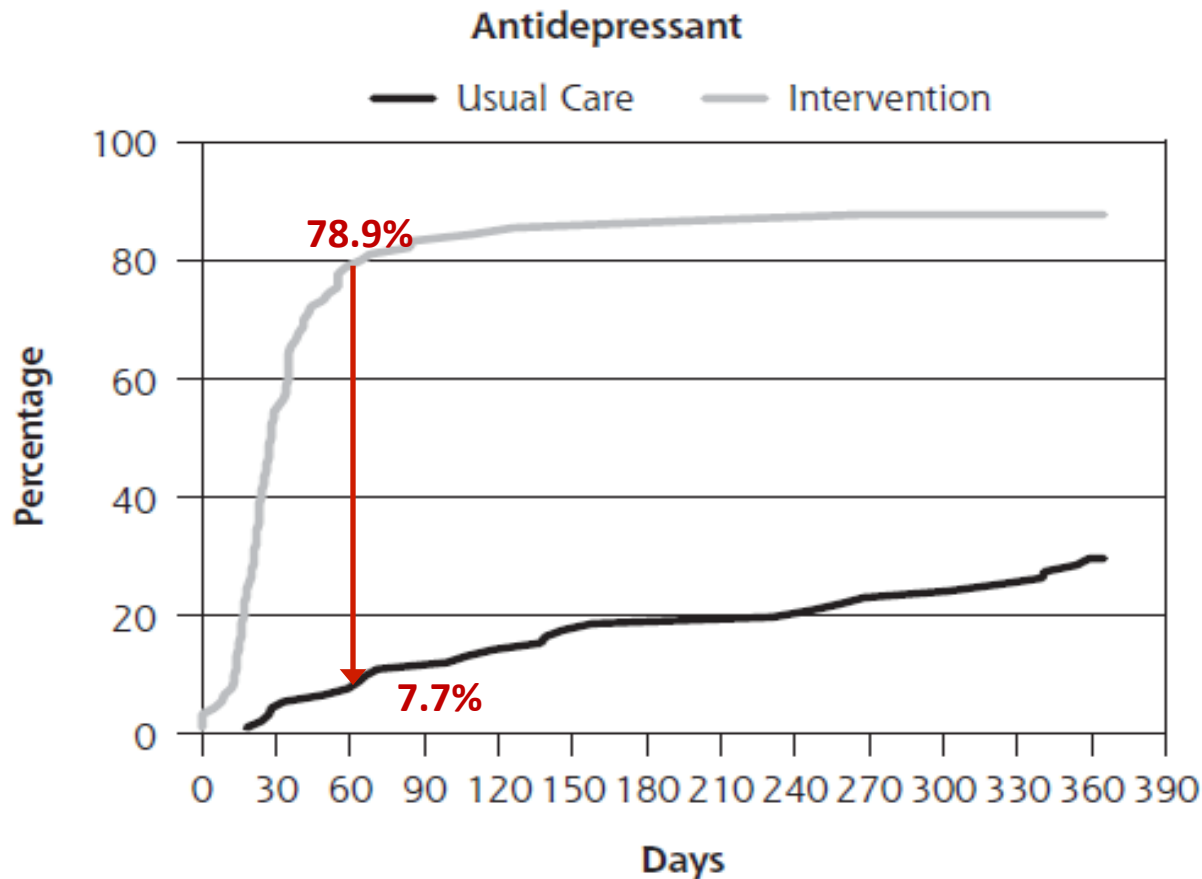


***Cholesterol (LDL)***



***Depression***

# Adjustment to antidepressant pharmacotherapy was 10 times higher in collaborative care versus usual care in the first 60 days



(Time to first treatment adjustment)



# Care Of Mental, Physical And Substance-use Syndromes\*



## COMPASS

Partnering for Mind-Body Health

Center for Medicare and Medicaid Services (CMMI)  
3 Year Innovation Grant.

Lead by Institute for Clinical Systems Improvement  
(ICSI)



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# Core Elements of COMPASS

- **Thorough Initial Evaluation & Treatment Plan**
- **Computer Registry to Track all Patients**
- **Care Manager/Coordinator**
- **Physician Consultants: Psychiatrist and PCP**
- **Treatment to Target / Intensification**
- **Regular (weekly) systematic caseload review**
- **Relapse Prevention**



# Outcomes COMPASS\*\* vs. TEAMCare RCT \*

	TEAMcare Intervention Group- 6 months*	COMPASS 10 weeks**
Depression Severity Percent Response	59%	60%
Change A1c	0.72	0.70
Change LDL	14.9	17.3
Change Systolic BP	3.8	20.4

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\*Katon WJ, NEJM 2010 Dec \*\* D. Katzelnick, MD; Mayo Clinic



# But not all integration efforts are effective

- **Approaches that don't work:**
- Screening without adequate treatment
- Referral to specialty care without close coordination
- Co-located behavioral health specialists without systematic tracking of outcomes or evidence-based treatments

Patients 'fall through the cracks' or stay on ineffective treatment for too long.





# Principles of Collaborative Care



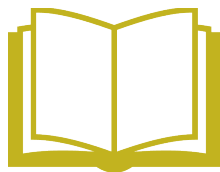
**Patient-Centered Collaboration.** Primary care and mental health providers collaborate effectively using shared care plans.



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



**Treatment to Target.** Progress is measured regularly and treatments are actively changed until clinical goals are achieved.



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



**Accountable Care.** Providers are accountable and reimbursed for quality of care and clinical outcomes, not just volume of care.

# Effective integration requires practice change





Trained over 5,000 providers

# AIMS CENTER

Advancing Integrated Mental Health Solutions



# Behavioral Health Integration Program (BHIP) at UW Medicine

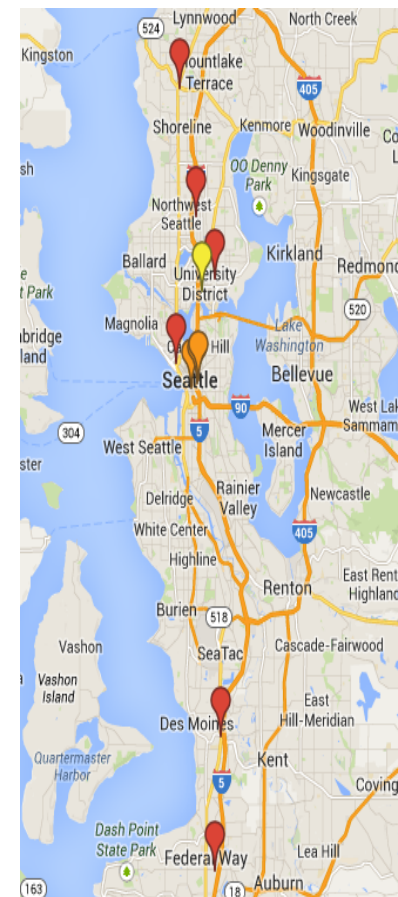
2014 APA Award of  
Distinction for  
Model Program

**20% of UW Medicine Primary Care Patients have at least one visit with a mental health diagnosis**



## 15 Participating Clinic Sites

- Harborview Medical Center (HMC):
- University of Washington Medical Center (UWMC)
- University of Washington Neighborhood Clinics (UWNC)





# UWNC Primary Care Physician

Sept 2013

*“You have no idea how helpful it is for a provider to have a resource like you in the clinic. I practiced for 16 years without it and I will never go back! You are such a great support for all of us.”*



# Wall Street Journal, Sept 2013



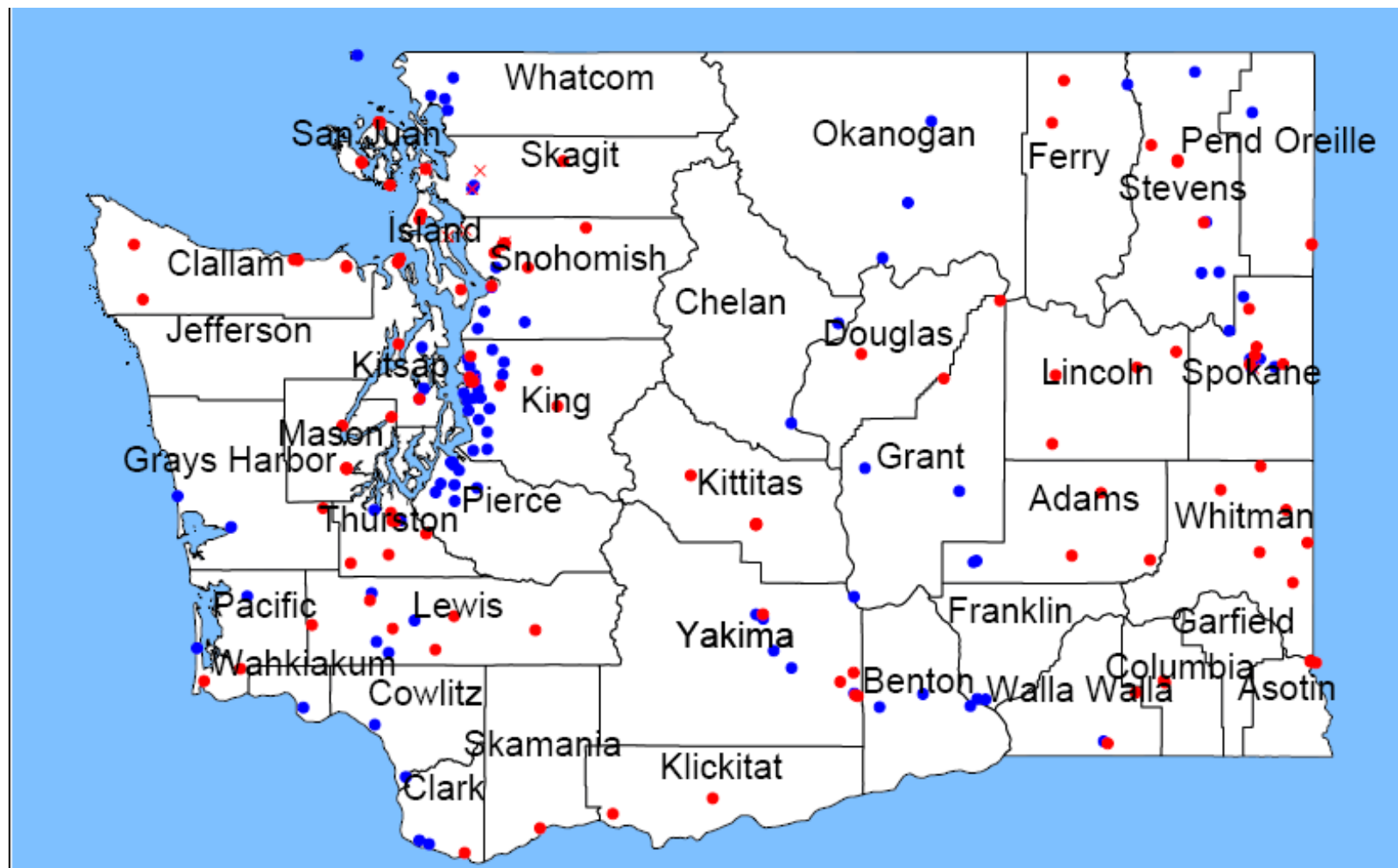


- Washington State Healthcare Authority
- Community Health Plan of Washington
- Public Health Seattle & King County

<http://integratedcare-nw.org>

# Mental Health Integration Program

> 50,000 clients served in over 150 primary care clinics





# 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

Patient | Caseload | Program | Tools | Logout

Hello, Jurgen (nutzter)

Site:   [Switch to PCP-stat](#) [Switch to Clinic-stat](#)  
 Report Created on: Wednesday, February 3, 2010, 7:02PM

CASELOAD STATISTICS L1

CO	# OF P.	CLINICAL ASSESSMENT		FOLLOW UP		LAST AVAILABLE		# ON PDS	# W/ MISSING PDS	# IN C/C	PSYCHIATRY CONSULTATION			50% IMPROVED AFTER > 10 WKS				
		#	MEAN PHQ MEAN GAD	# OF P.	MEAN # CLINIC MEAN # PHONE	MEAN PHQ MEAN GAD	# REQ'D				# W/ P/N	# W/ P/E	PHQ	GAD				
LCSW	70	68 (97%)	15.1 (n=51)	12.8 (n=52)	62 (91%)	6.7	5.5 (82%)	1.2 (18%)	11.0 (Δ=28%)	8.8 (Δ=31%)	50 (77%)	3 (4%)	0 (0%)	1 (1%)	42 (60%)	0 (0%)	19 (49%) (n=39)	16 (41%) (n=35)
LCSW	86	86 (100%)	15.9 (n=86)	14.2 (n=84)	79 (92%)	12.4	6.4 (52%)	6.0 (48%)	11.4 (Δ=28%)	10.5 (Δ=26%)	63 (79%)	2 (2%)	2 (2%)	0 (0%)	62 (72%)	0 (0%)	34 (58%) (n=50)	28 (56%) (n=50)
All	156	154 (99%)	15.6 (n=147)	13.6 (n=136)	141 (92%)	9.9	6.0 (51%)	3.9 (39%)	11.2 (Δ=28%)	9.8 (Δ=28%)	113 (76%)	5 (3%)	2 (1%)	1 (1%)	104 (67%)	0 (0%)	53 (50%) (n=89)	44 (49%) (n=89)

C/C = Continued Care Plan, P/N = Psychiatric Note, P/E = Psychiatric Evaluation

Population(s) included: ☒ GA-U ☒ Uninsured ☒ Veterans ☒ Veteran Family Members ☒ Moms ☒ Children ☒ Older Adults

Caseload summaries help manage

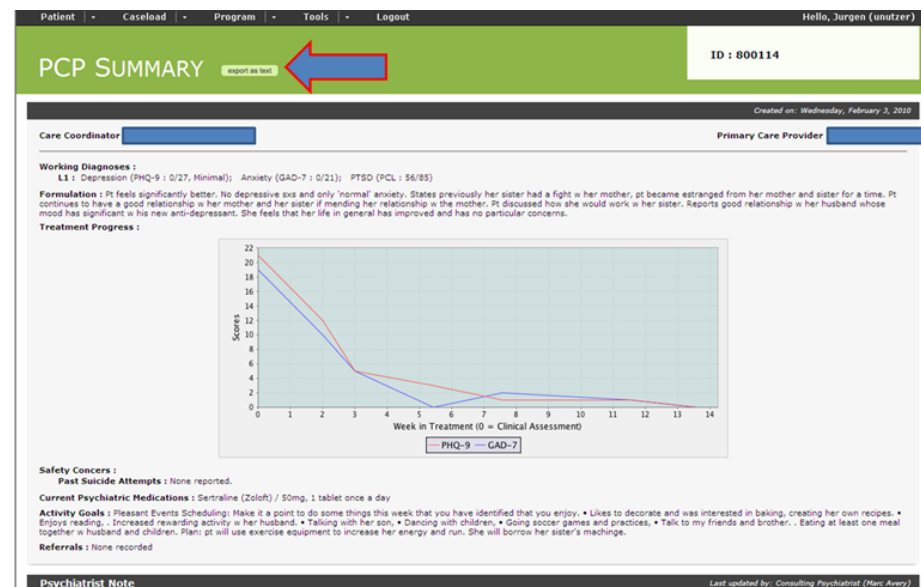
- Clinical productivity
- Quality improvement

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Caseload summaries help manage

- Clinical productivity
- Quality improvement

Licensed in 14 US states & Alberta  
Supporting care of over 100,000



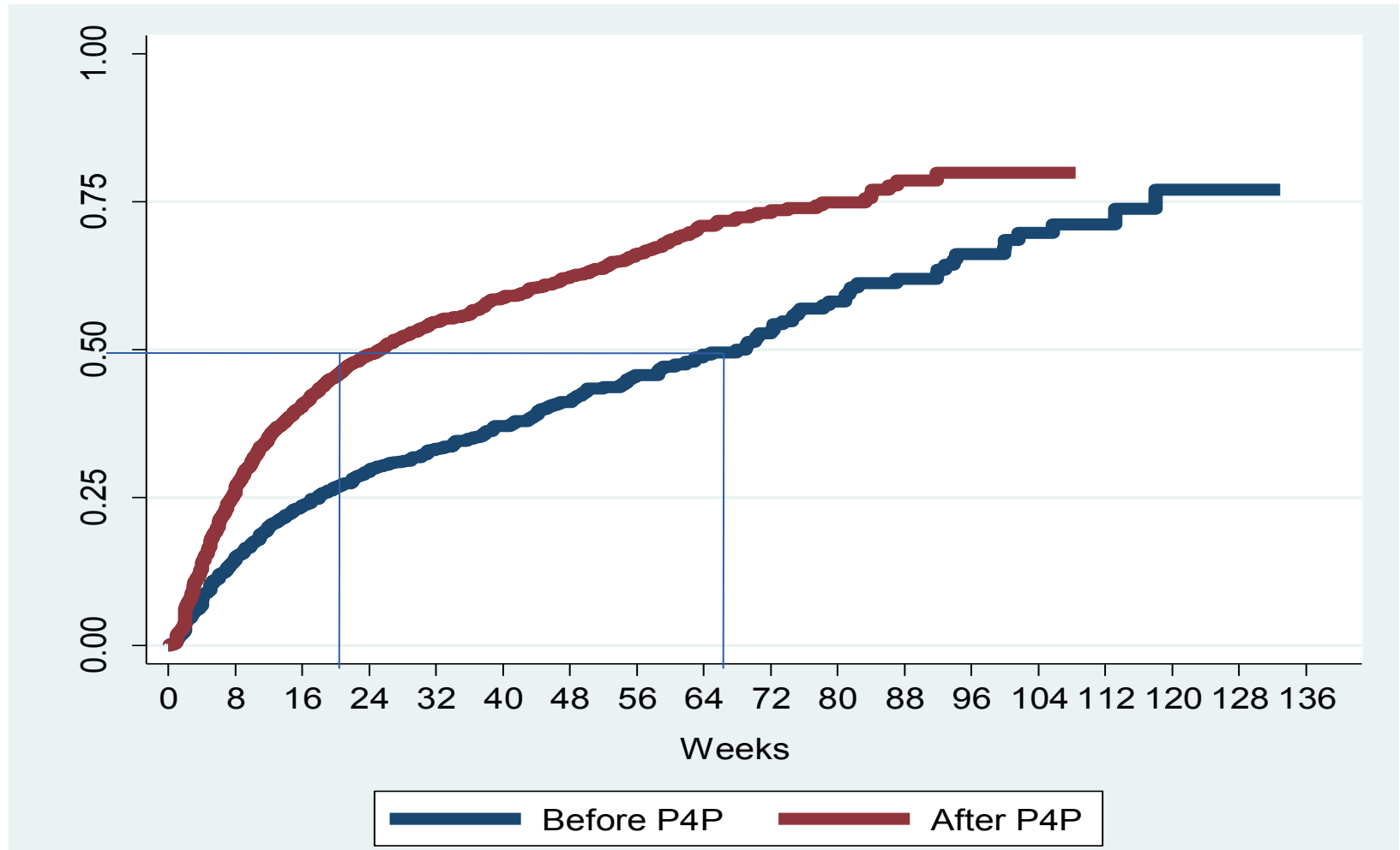


# MHIP Common Client Diagnoses

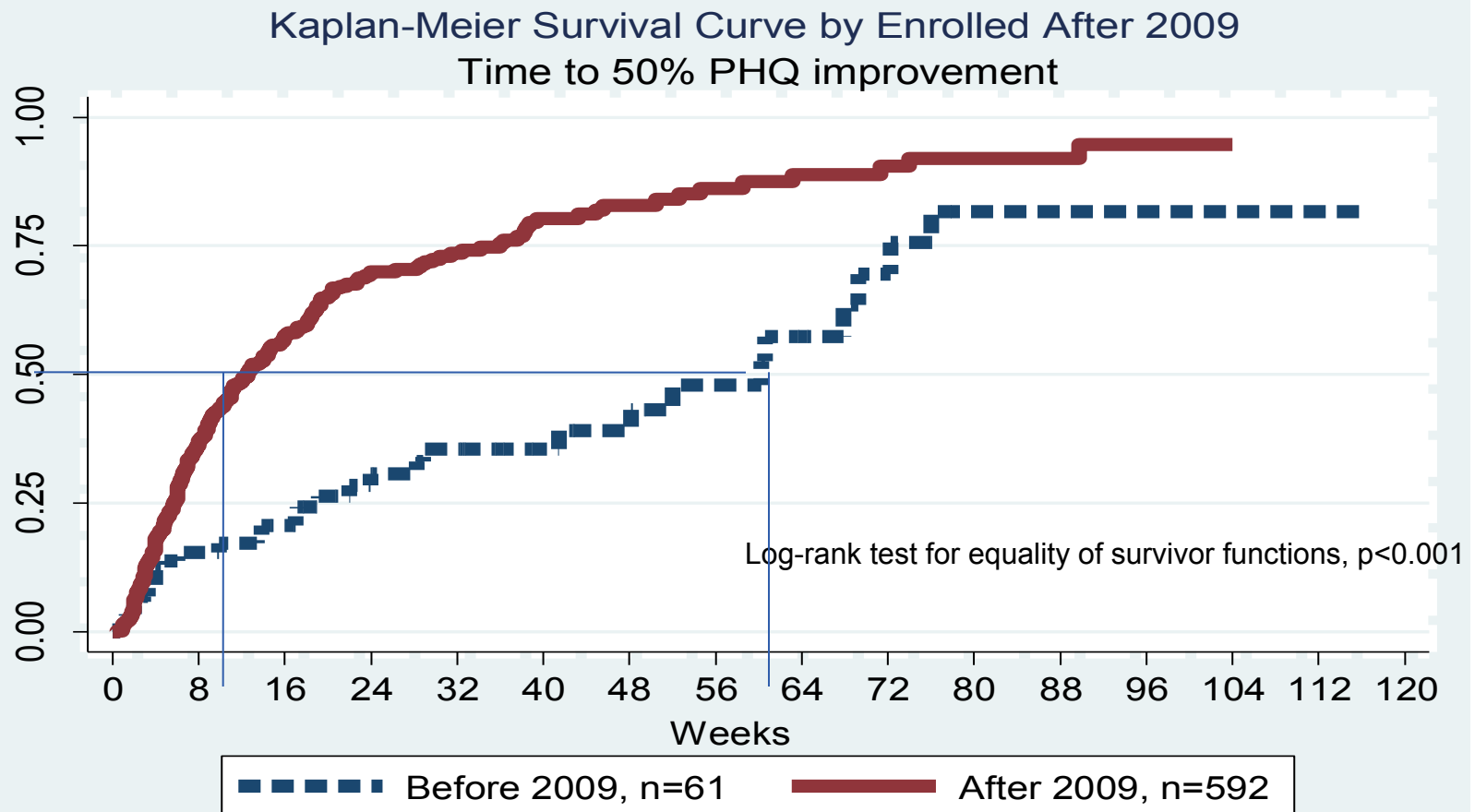
Diagnoses	%
Depression	71 %
Anxiety (GAD, Panic)	48 %
Posttraumatic Stress Disorder (PTSD)	17 %
Alcohol / Substance Abuse	17 %*
Bipolar Disorder	15 %
<b>Thoughts of Suicide</b> ... plus acute and chronic medical problems, chronic pain, substance use, prescription narcotic misuse, homelessness, unemployment, poverty.	<b>45%</b>

# MHIP: Pay for Performance initiative

## cuts median time to depression treatment response in half



# Particularly effective in high risk moms



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



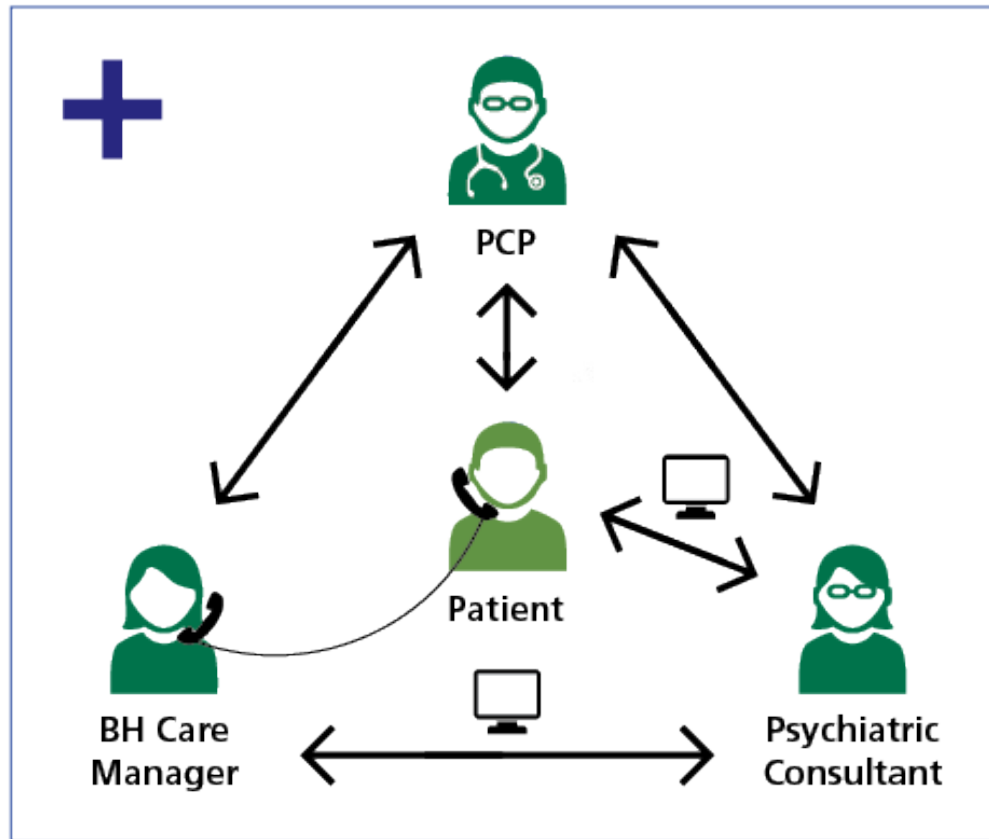
# Leverage

Psychiatrists reach many more patients:

*“I am helping so many more people than I used to see in traditional office practice.”*

*“The greatest benefit of the MHIP consultation program may be in the diagnosis and treatment of patients that aren’t even in the program.”*

# Leverage through Technology





# Task sharing with technology

## Data streams

Multimodal  
Ecologically valid  
Continuous



Cloud-based  
analytics

## Mental Health Indicator

Personalized  
Portable  
Convenient  
Discrete



## Clinical Algorithms

Evidence-based

## Provider Dashboard

Decision support  
Population-based management



NAME	AGE	GENDER	CLINICAL METRICS
John Doe	45	M	...
Jane Smith	32	F	...
...	...	...	...

## Novel interventions

Automated, or initiated by self, provider, or family  
Just-in-time  
Mobile  
Context-sensitive

## FIXING BEHAVIORAL HEALTH CARE IN AMERICA

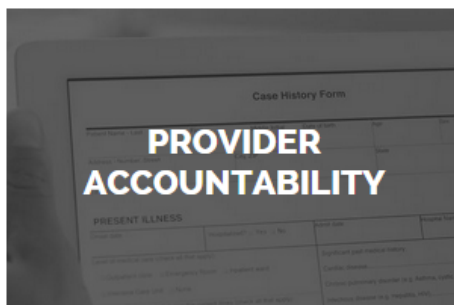
First in a series, this policy brief calls for integrating and coordinating specialty behavioral health care with the medical system in America

[LEARN MORE ABOUT THE POLICY BRIEF](#)



### OUR VISION

The Kennedy Forum is working toward lasting change in the way mental health and addictions are treated in our healthcare system, through:





# In 2015

## ACA & Medicaid expansion

- Up to 60 million Americans eligible for new or better MH coverage.
  - Strain on existing specialty mental health provider network
  - Primary care practices not sufficiently resourced to provide behavioral health care
- => patients are falling through the cracks.

## Accountable Care (ACOs)

- Patients with BH conditions have 2-3 times higher health care costs


## Patient Centered Medical Homes (PCMH) and Health Plans

- NCQA: measurement of depression screening and remission rates.

## State Medicaid Programs are working towards integrated care:


- WA State
- Fully Integrate Purchasing & Delivery of Behavioral Health and Medical Services by 2020
- Integrated Care Psychiatry Training Program at UW
- Funding for Telemedicine / Telepsychiatry

Resources: <http://aims.uw.edu>

 UNIVERSITY of WASHINGTON  
PSYCHIATRY & BEHAVIORAL SCIENCES

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"None of us is as smart as all of us"  
— Japanese Proverb

## Our Mission:

To improve the health and mental health of populations through patient-centered, integrated mental health services for individuals across the age span.



# ***Thank you***

unutzer@uw.edu

<http://uw.aims.edu>

