MidAtlantic Path Forward
CoCM Friday Lunch Series

- Share experiences implementing/sustaining collaborative care programs
- Virtual sessions - 12-1pm ET – recorded, shared on MAPF website
  - 2 presentations
    - 15-20 minutes, followed by Q&A
    - Representing organizations with diverse profiles
- Focus
  - Implementation - funding, process, workflows, training, etc.
  - Sustainability
  - Barriers, solutions, lessons learned

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Sylvan C Herman Foundation Inc

PATH FORWARD

Focus: a few scalable, high -impact reforms to improve access to MHSUD care

AMERICAN PSYCHIATRIC ASSOCIATION

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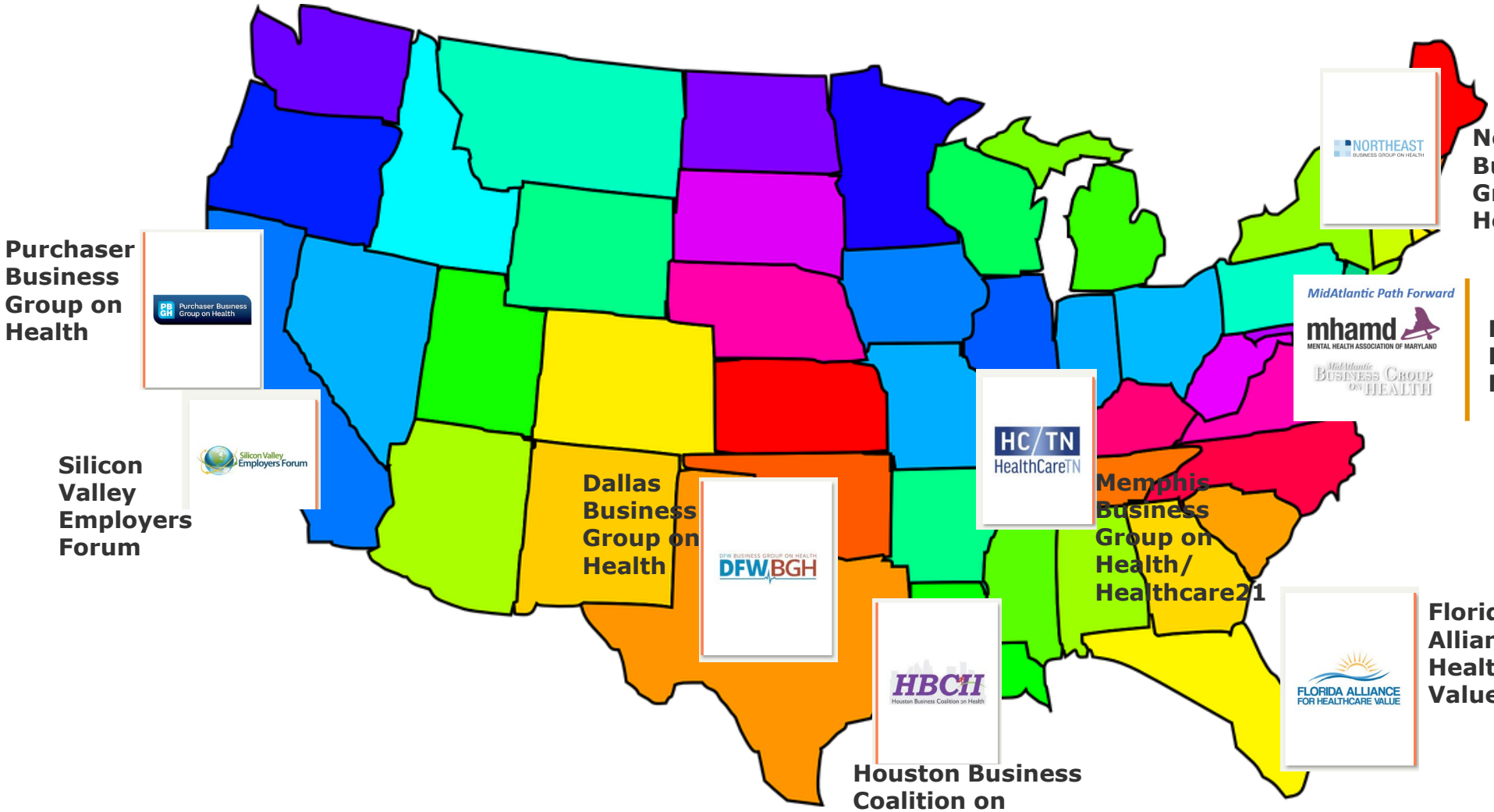
The Jed Foundation

MEADOWS MENTAL HEALTH POLICY INSTITUTE

National Alliance of Healthcare Purchaser Coalitions
Driving Health, Equity and Value

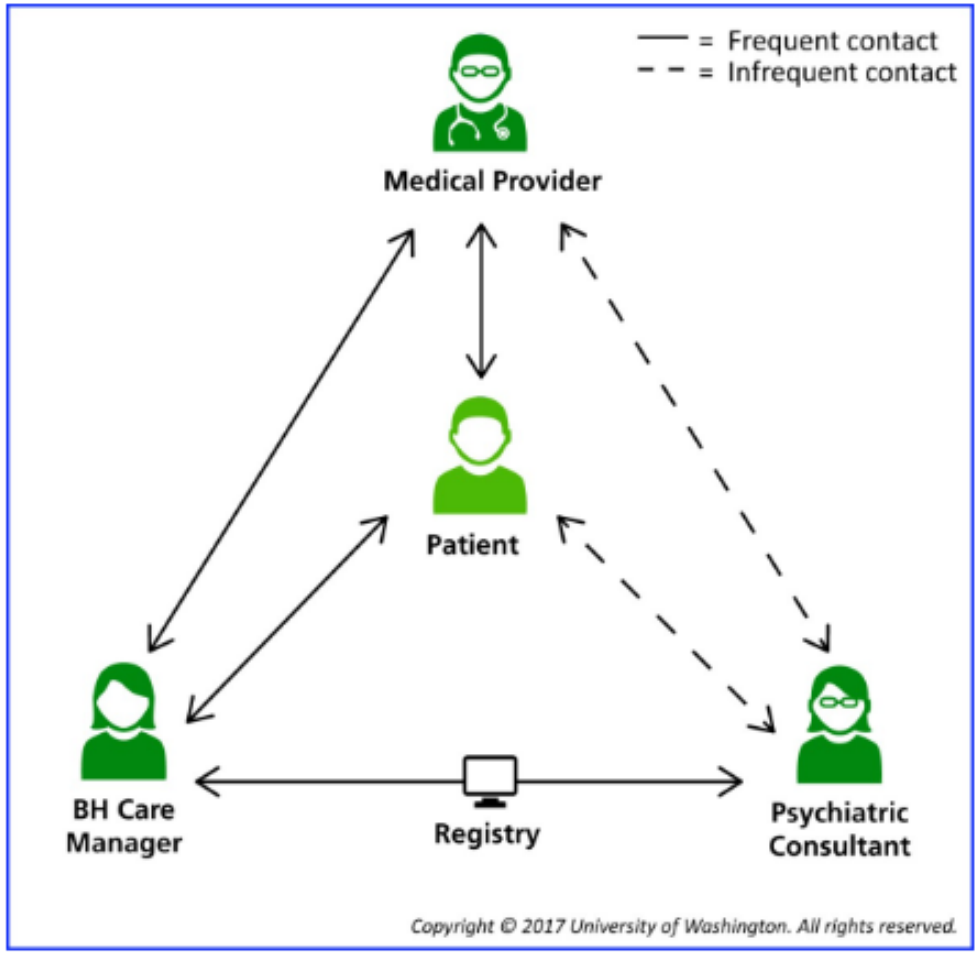
REGIONAL IMPLEMENTATION PARTNERS



The Collaborative Care Model

PCP maintains treatment responsibility for patient

Evidence-based medication or psychosocial treatments



Case consultation, treatment adjustment for patients not improving as expected

Today's Presenters

Patricia deSa, MS

Patricia deSa is a Director for the National Mental Health & Addiction Care Program for Kaiser Permanente (KP) based in Oakland, CA.

In her leadership role, Patricia has oversight for the implementation, spread and scale of clinical care delivery programs in mental health and addiction, including but not limited to suicide prevention, feedback-informed care, primary care integration, alcohol screening and follow-up, opioid overdose prevention, and harm reduction. For the past 10+ years she has partnered with each of KP's eight regions and the University of Washington AIMS Center to establish full-fidelity Collaborative Care Management (CoCM) programs to effectively treat patients with moderate depression and anxiety. Her work to advance CoCM has had a strong focus on centering equitable care practices, integrating social health screening and follow-up, and leveraging digital adjuncts to care. In the addiction medicine space, Patricia collaborates with clinicians and subject matter experts to develop and execute a harm reduction for opioid use disorder. The three-pronged strategy includes overdose prevention, culturally responsive anti-stigma education and training, and peer recovery support.

Patricia earned her Bachelor of Arts degree from the University of California, Santa Cruz in Santa Cruz, CA and her Master of Science degree in exercise physiology from Ithaca College in Ithaca, NY. She has also earned a Distinguished Toastmaster award and designation from Toastmasters International after completing robust programs in communication and leadership. She recently graduated from the Strategic Leadership Program co-led by Kaiser Permanente and Cornell University.

Today's Presenters

Hani Talebi, PhD LSSP

Dr. Hani Talebi is the Chief Clinical Officer and Senior Vice President of Health Systems Integration at the Meadows Mental Health Policy Institute. Prior to joining Meadows, Dr. Talebi was the Director of Pediatric Psychology at Dell Children's Medical Center in Austin, Texas. A dually licensed psychologist and licensed specialist in school psychology, Dr. Talebi is an affiliate faculty member in the UT Austin Dell Medical School Department of Psychiatry and Behavioral Sciences and courtesy affiliate faculty in the Department of Pediatrics. Additionally, he is the 2024 President of the Texas Psychological Association.

In his role at the Meadows Institute, Dr. Talebi's work focuses on advancing collaborative care and measurement-based care in primary care and health system settings. With more than 25 years of clinical experience, he has served in a variety of roles including Director of Psychological Services at Del Valle Independent School District, Director of Clinical Programming in various community mental health centers, and as a clinical/consultative leader in the private sector. Dr. Talebi's administrative efforts at the juncture of the medical and mental health models have resulted in innovative program development, various quality improvement initiatives and fiscally sustainable service provision platforms across milieus.

Closing Remarks

Thank you!

The Collaborative Care Journey at Kaiser Permanente (KP)

Patricia deSa, MS

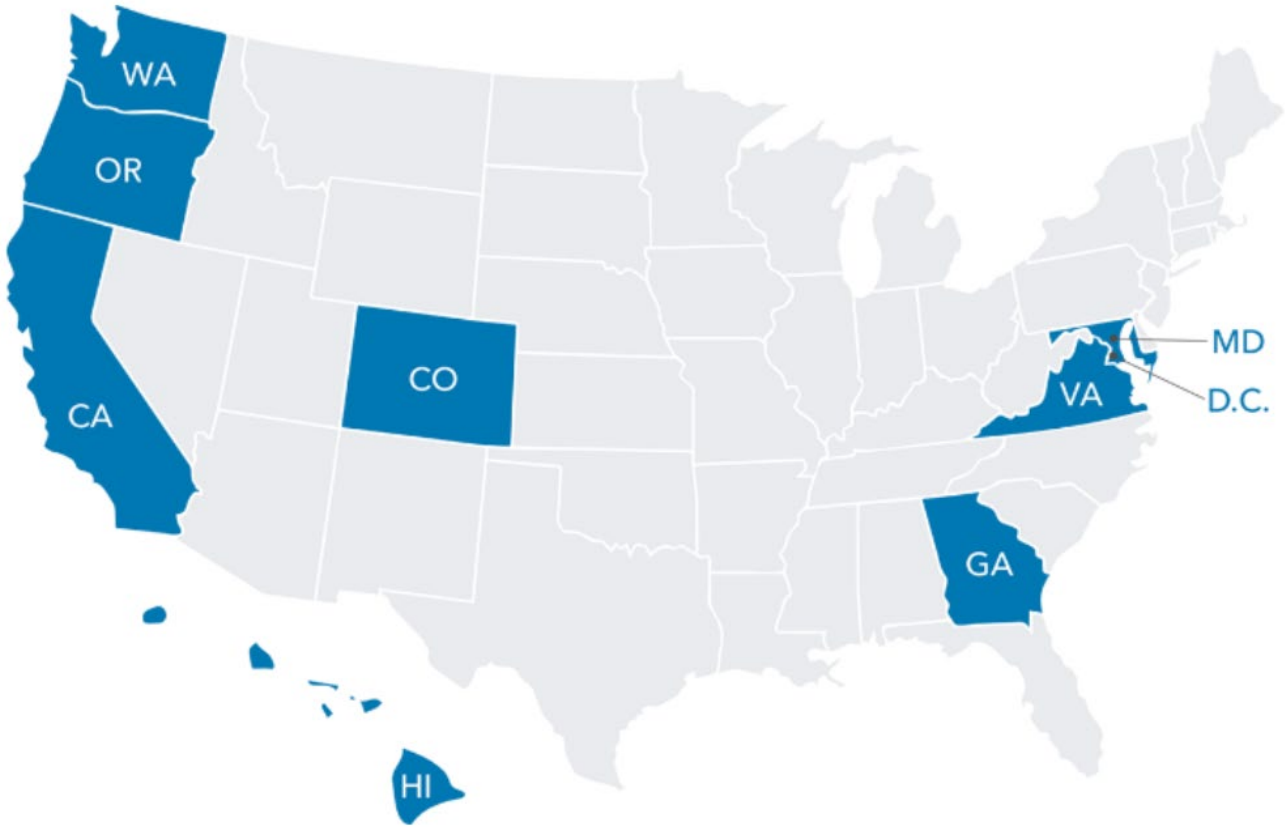
Director, National Mental Health, Wellness & Addiction Care

Implementation Lead, National Collaborative Care Management

Disclaimer

No conflicts of interest to disclose.

Kaiser Permanente at a Glance
(about.kaiserpermanente.org)



Founded
1945

Headquarters
Oakland, Calif.

Members
12.5M

Hospitals
40

Medical offices[1]
618

Physicians[2]
24,605

Nurses[3]
73,618

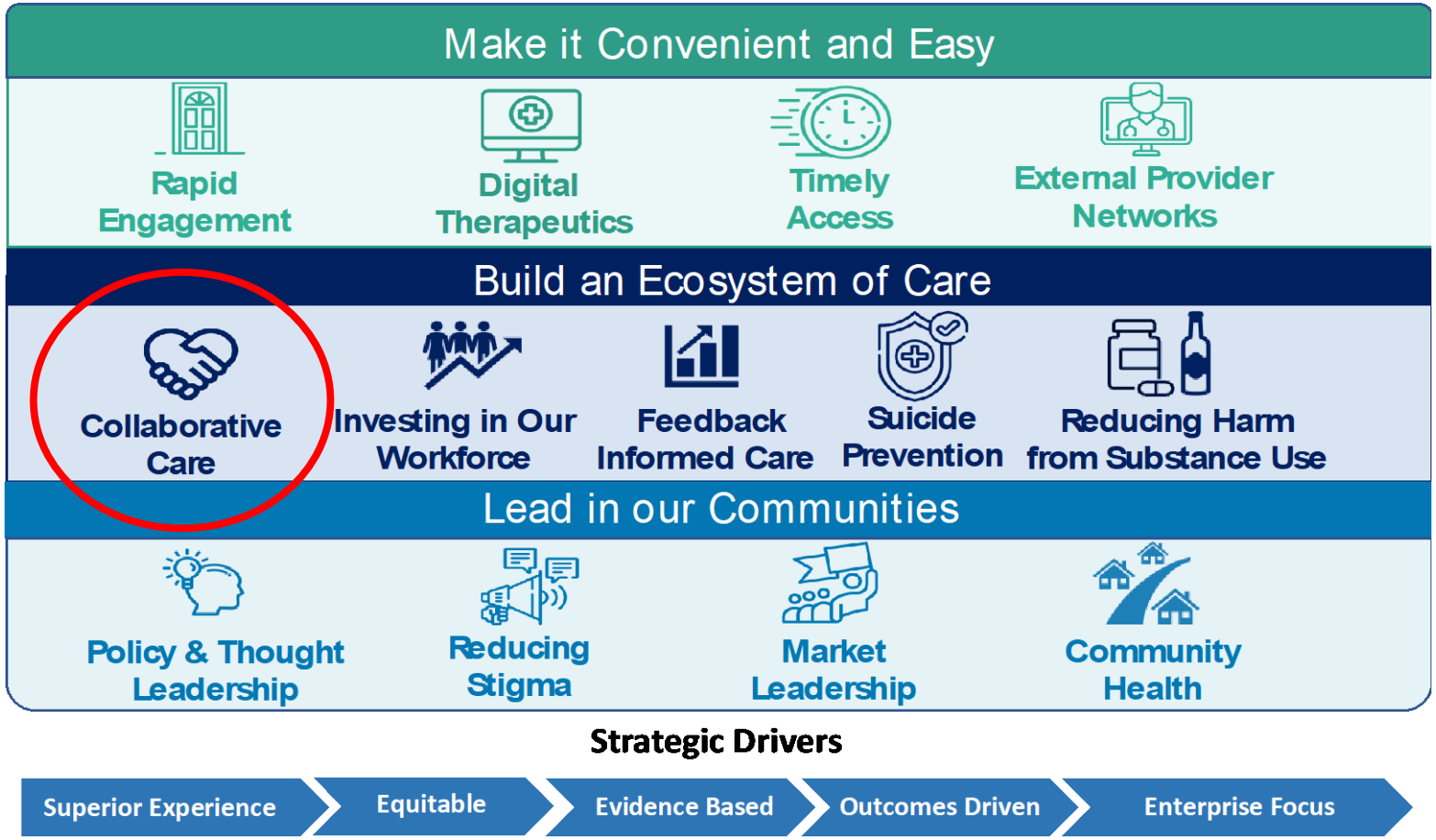
Employees+
235,785

Mission: **Kaiser Permanente exists to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve.**

1,2,3,* Data as of December 2023

KP's National Mental Health, Wellness, and Addiction Care Program

Our vision: Anyone, at any time, in any place, can achieve mental well-being and recovery from addiction.



Early Research: Two KP sites participated in the original IMPACT trial

Original Contribution

FREE

December 11, 2002

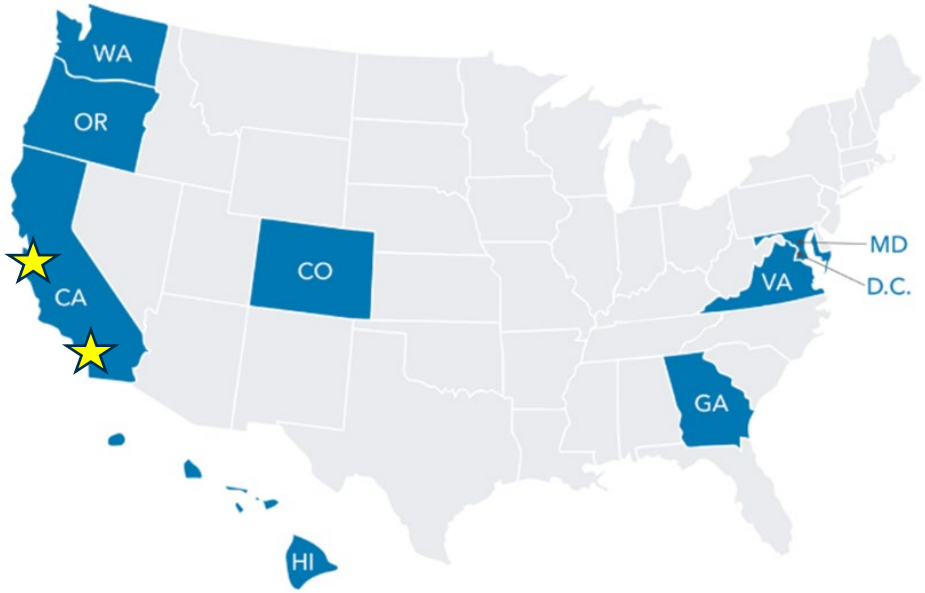
Collaborative Care Management of Late-Life Depression in the Primary Care Setting

A Randomized Controlled Trial

Jürgen Unützer, MD, MPH; Wayne Katon, MD; Christopher M. Callahan, MD; et al

Author Affiliations

JAMA. 2002;288(22):2836-2845. doi:10.1001/jama.288.22.2836

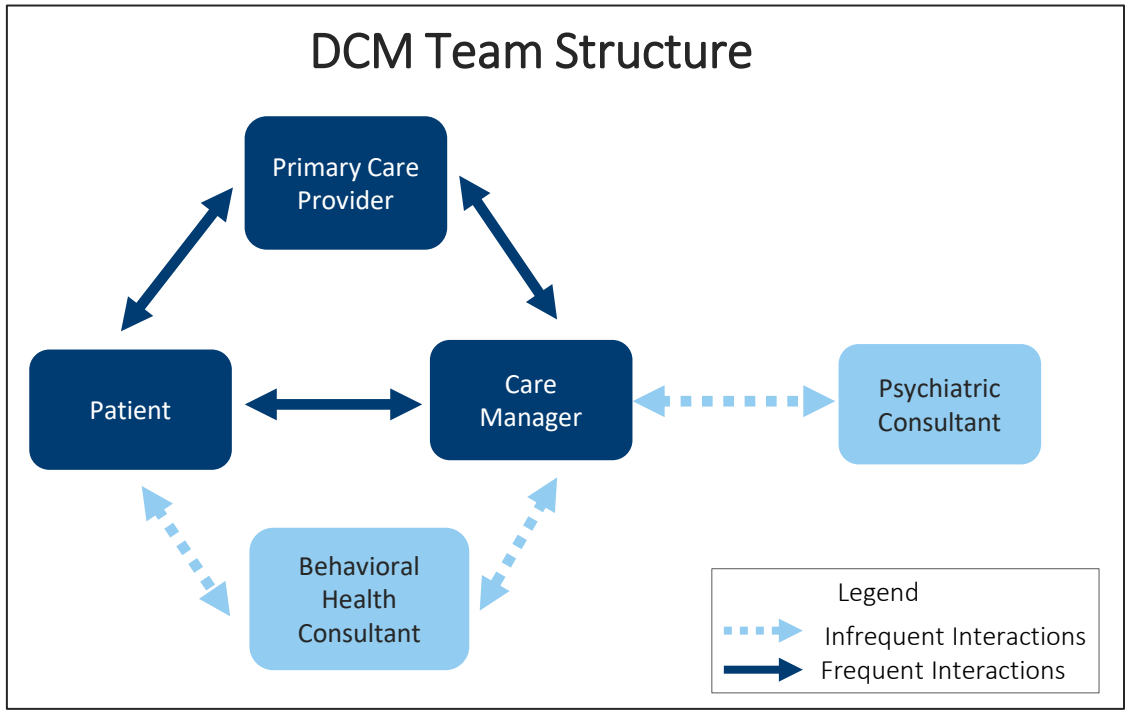


The 2011 KP-Colorado pilot of Depression Care Management

Why?

- **Address high prevalence** of mental health concerns in Primary Care
- **Improve Outcomes:** depression severity, CVD risk factors (LDL, HbA1C, hypertension)
- **Increase** patient satisfaction, functional status, and quality of life
- **Decrease** avoidable utilization, ER & hospital admissions
- **Increase** access to mental health care
- **Meet and exceed standards** for quality (HEDIS AMM)
- ***It's the right thing to do!***

KP Colorado's Depression Care Management Model



- **Target population:** 18+, new depression diagnoses, new medication start
- **BH Care Managers:** Registered Nurses
- **Modality:** Telephone-based (no cost)
- **Intervention:** Medication management, brief interventions
- Minimum 4 clinical encounters with an average program length of 3-6 months

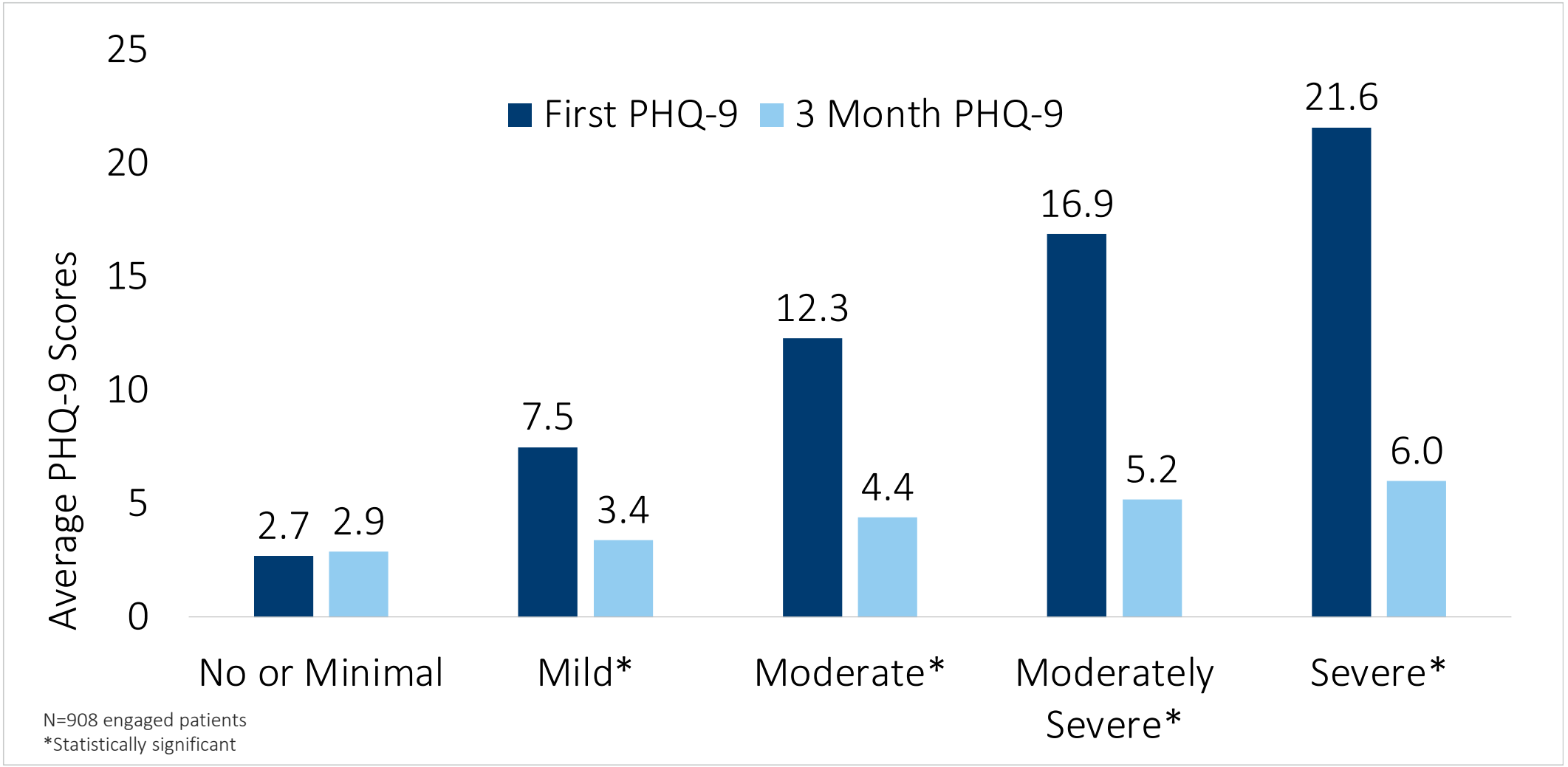
Encounter 1
1-3 days after med start

Encounter 2
2 weeks after med start
PHQ-9

Encounter 3
4 weeks after med start or increase
PHQ-9

Encounter 4
4 weeks after Encounter 3
PHQ9

KP Colorado 2015 DCM Evaluation: PHQ9 Scores for Engaged Participants



N=908 engaged patients
*Statistically significant

Positive Member and Clinician Response

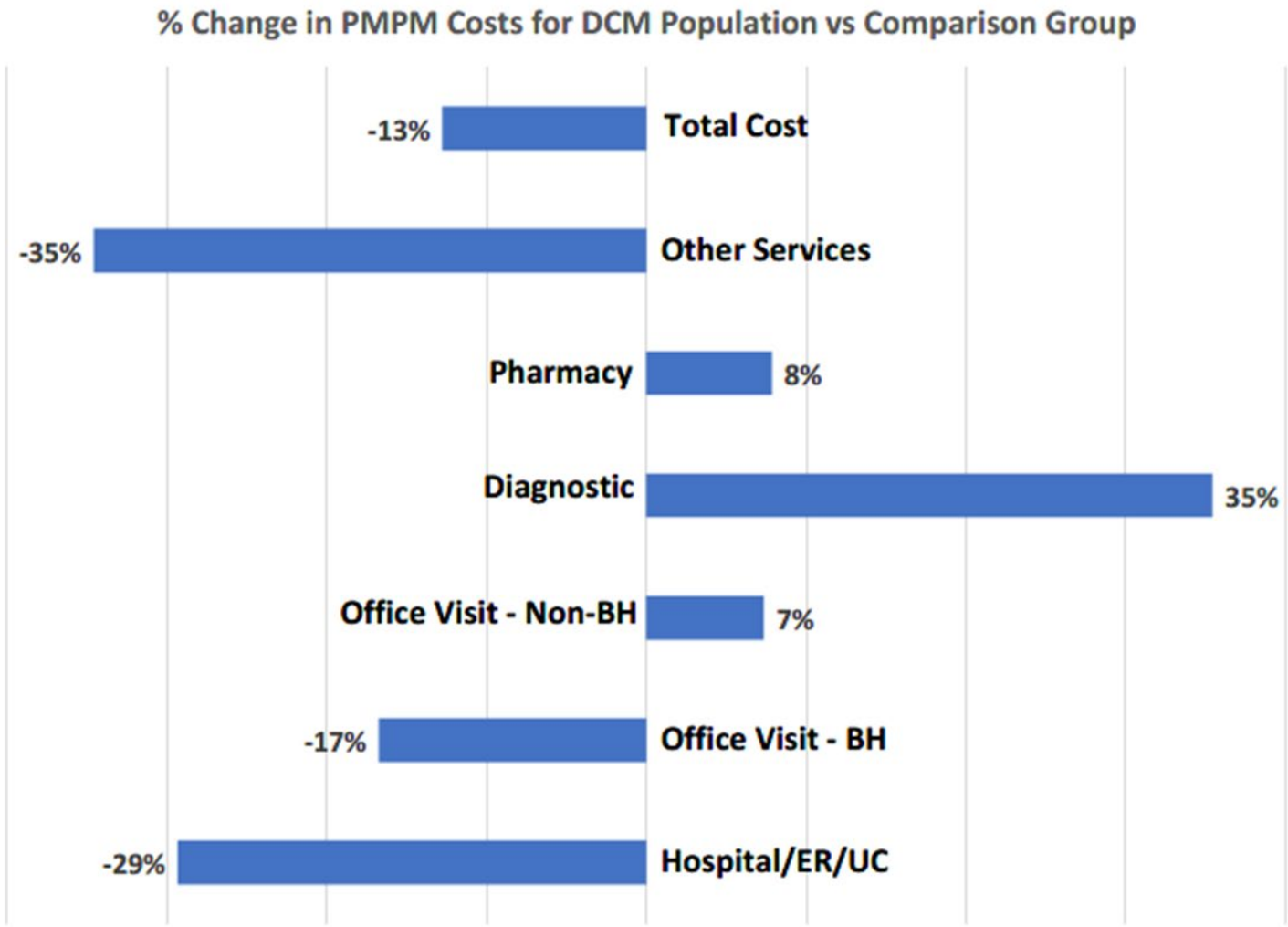
"My primary doctor made me feel good and cared for, but **my nurse really made me feel important.** Like she actually was invested in my progress and how my medication was working."

– KP member

"This program has proved really helpful to provide that support to patients and **get them feeling better relatively quickly in a way that's pretty cost-effective**. We're able to work with a large number of people with just a few care managers and that frees up the providers to be working with folks on their other medical issues."

– BH Care Manager

KP Colorado DCM 2015 Cost Analysis

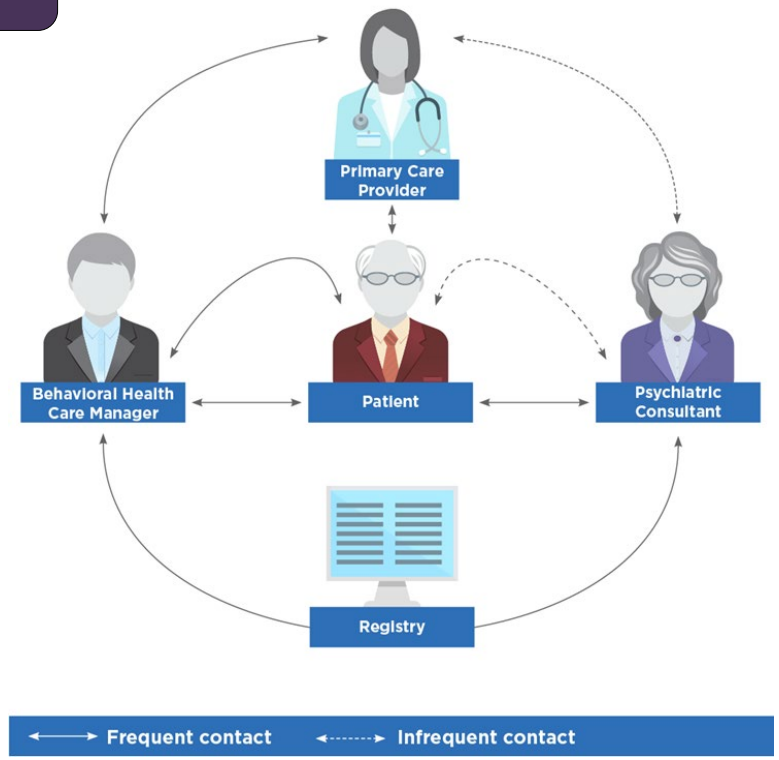


Continuing the Journey: A *National* Depression Care Management Program

2015 - 2021

Depression Care Management

- **(18+) New Diagnosis**
- **Depression**
- **Moderate to Moderately Severe**
- **Medication Only**
- **RN**



Why?

- Further evidence of effectiveness (~80 RCTs)
- Evidence of reduced costs
- New HEDIS metrics for depression (DSF, DMS, DRR)
- Aligned with KP Medicare and Quality goals
- Improved access
- ***It's the right thing to do!***

Leadership Support

- Medicare Accountable Leads
- Permanente Physician Quality Leaders
- Health Plan Vice Presidents of Quality
- National Mental Health & Wellness Executive and Physician Leadership

How we expanded Depression Care Management Across the Enterprise

1. Dedicated national **implementation, analytic, and clinical leads.**
2. **Implementation playbook** with a step-by-step guide for implementing the KP Colorado model
3. **Learning collaborative** that shared resources, best practices and innovations
4. **Member and clinician interviews** to understand what was working and what could be improved.
5. **National metrics dashboard** that included process and outcomes: initiation, engagement, response, remission
6. **Performance improvement** project in two regions focused on improving engagement rates

What we learned

Leadership support was key at the national and local levels

For members that completed the program, **outcomes were consistent with literature**

Primary Care physician endorsement was key to patient initiation and engagement

Patients found the program to be **seamless and supportive**

Virtual program made care more accessible and satisfying

Positive Member and Clinician Response

"The response is very rapid and very assuring. I feel like there's **someone supervising and helping me through it.**"

– KP member

"There are patients that have said that they **wouldn't seek mental health support if we hadn't reached out.** That's something that I found to be very rewarding and is working well."

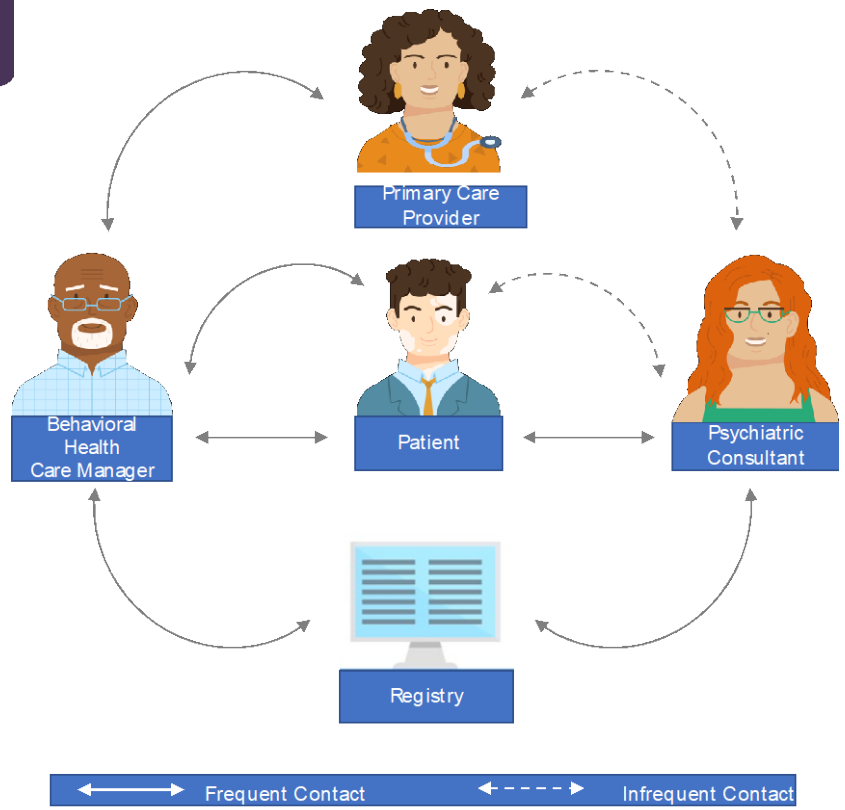
– BH Care Manager

Continuing the Journey: Expansion from DCM to Collaborative Care

2021 – present

Collaborative Care Model

- (18+) New **and Existing Diagnoses**
- Depression **and Anxiety**
- Moderate to Moderately Severe
- Medication **and Counseling**
- RN, **LCSW, PhD, PharmD, coaches, etc.**



Why?

- Increased demand for mental health services
- Further evidence (90+ RCTs)
  - Significantly better treatment outcomes (2x) compared to usual care.
  - Reduces total cost of care (6:1 ROI).
  - Effective for youth and adults
- Alleviates outcomes disparities in minority and underserved populations.
- ***It's the right thing to do!***

Leadership Support

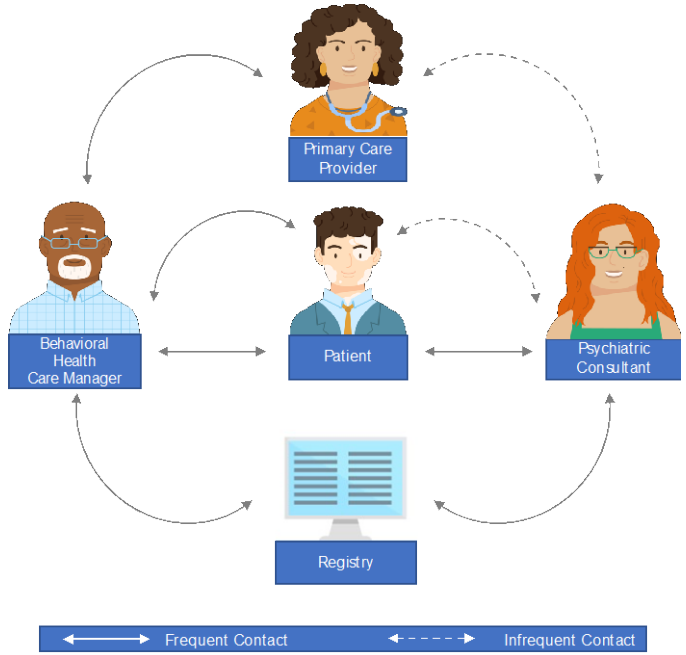
- Executive Medical Directors
- Health Plan Presidents
- Medicare Leads
- Primary Care Physician Leaders
- National Mental Health Physician and Executive Leadership

Continuing the Journey: Collaborative Care Management

2021 – present

STRONG EMPHASIS ON HIGH FIDELITY AND THE 5 ESSENTIAL COMPONENTS

- 01. PATIENT-CENTERED TEAM CARE
- 02. POPULATION-BASED CARE
- 03. MEASUREMENT-BASED TREAT TO TARGET
- 04. EVIDENCE-BASED CARE
- 05. ACCOUNTABLE CARE



Enhancements (not in all regions)

- Adolescents (13+) and OB/GYN patients included in target population

- Clinical pharmacist
- Care manager support staff
- Virtual care clinician

- Social health screening
- Weighted priority

- Social health referrals
- Integration of health and wellness resources including digital tools

Positive Member and Clinician Response

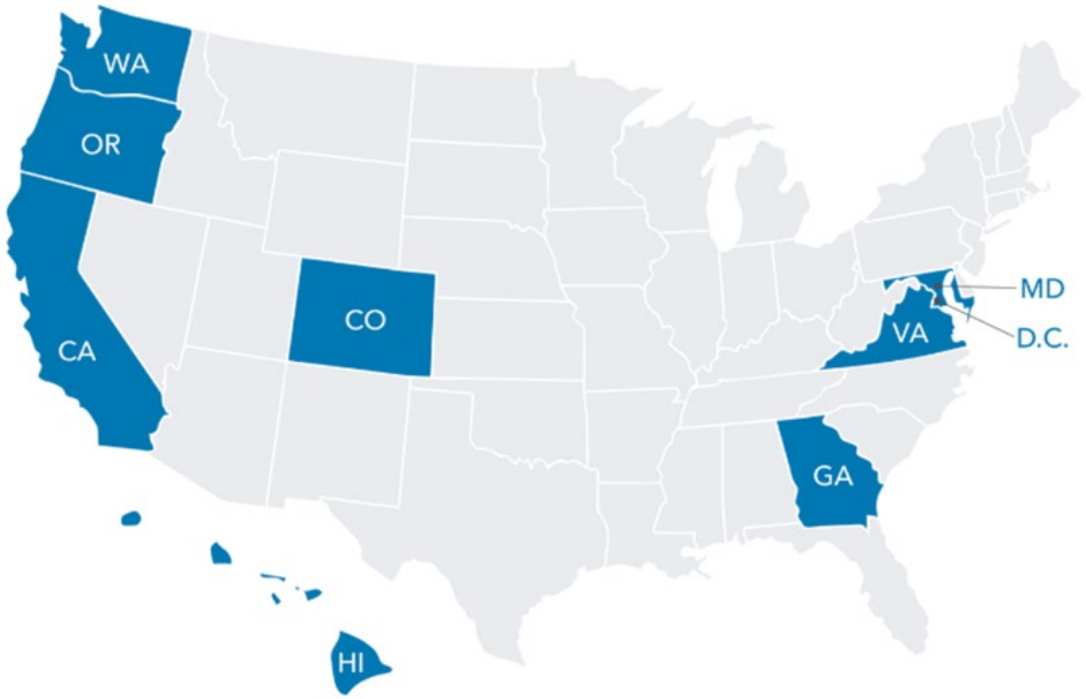
"Teamwork was very important. I would say **everybody worked together**…I felt that [the team] had a sense of urgency to help the patient."

– KP member

"We've had other members who have just not found usual care comfortable: Perhaps having to drive to a different site to meet with the therapist when they felt they needed support acutely. **We're able to identify patients in the middle of a doctor's appointment**, with their primary care provider. They're able to initiate our brief behavioral interventions or counseling within the program."

– Psychiatric Consultant

How's it going



Launched and expanded in 7 (of 8) regions; 8th region pending

01. Successes

- Partnership with UW AIMS: Toolkit, coaching, training
- Community of Practice: to share successes and resources
- Cost model to support business cases for expansion
- Member and clinician testimonials/satisfaction
- Primary care champions

02. Challenges

- Additional resources/FTE
- Building up caseloads
- Confusion with other integrated models
- Technical issues with registries

03. On the Horizon

- Internal training capability
- National measurement dashboard with disaggregation
- Expansion to other departments including OB/GYN

Positive Member and Clinician Response

"I tell everybody about this awesome program that Kaiser has. Everything that this program has come to offer has been amazing. I think just **having that support and knowing that somebody is there that understands** what you're going through is a huge, huge thing for me."

– KP Member

"It's the **one stop shop for all your mental health needs**. It'll make sure not only that you know the medication adjustments and steps are sorted out with the patient in mind, but also making sure that they're plugged into whatever else they need. So, it's really like autopilot. And if [members] qualify it, I'd say by all means recommend it, because it seems like a **win-win for everybody**."

– Virtual Care Physician

Questions?

CoCM Implementation with Texas A&M University

Mid-Atlantic Path Forward Collaborative Care Webinar Series

May 10th, 2024

MEADOWS
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POLICY INSTITUTE

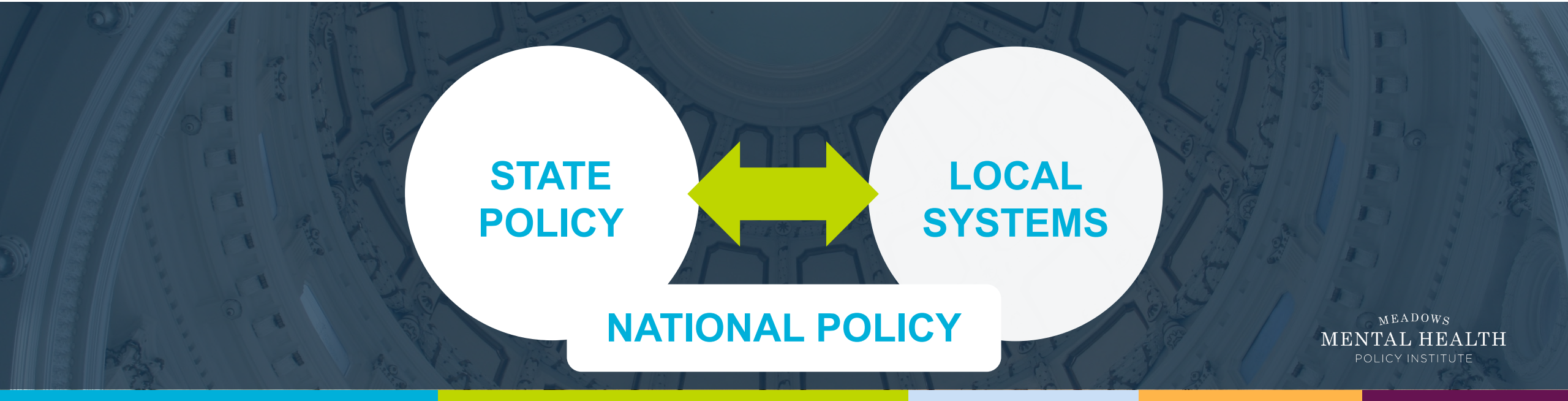
DISCLOSURE STATEMENT

Dr. Talebi has no actual or potential conflict of interest in relation to the content of this program/presentation.

Vision, Mission, Core Change Strategy

Vision: We envision Texas to be the national leader in treating people with mental health needs.

Mission Statement: Independent and nonpartisan, the Meadows Mental Health Policy Institute works at the intersection of policy and programs to create equitable systemic changes so all people in Texas, the nation, and the world can obtain the health care they need.



MEADOWS MENTAL HEALTH POLICY INSTITUTE

Our Unique Value: Intersection of Policy & Programs

STATE AND NATIONAL POLICY

Shape mental health policy

Enact mental health policy

Extract lessons learned and proof points

SOLUTIONS

Develop, implement, scale, and finance evidence-based solutions in local, state, and national systems

OUR VALUES

Collaboration and partnership | Data-driven and evidence-based | Innovation | Nonpartisanship | Stewardship

MEADOWS MENTAL HEALTH POLICY INSTITUTE

Texas A&M – University Health Center

CoCM Implementation

Practice Description and Location

Texas A&M University is located in College Station, Texas

University Health Services (UHS) is the on-campus healthcare provider for students attending Texas A&M University.

All currently enrolled Texas A&M students are eligible to be seen by UHS after they have paid the student health center fee and university advancement fee for the appropriate semester.

Texas A&M University

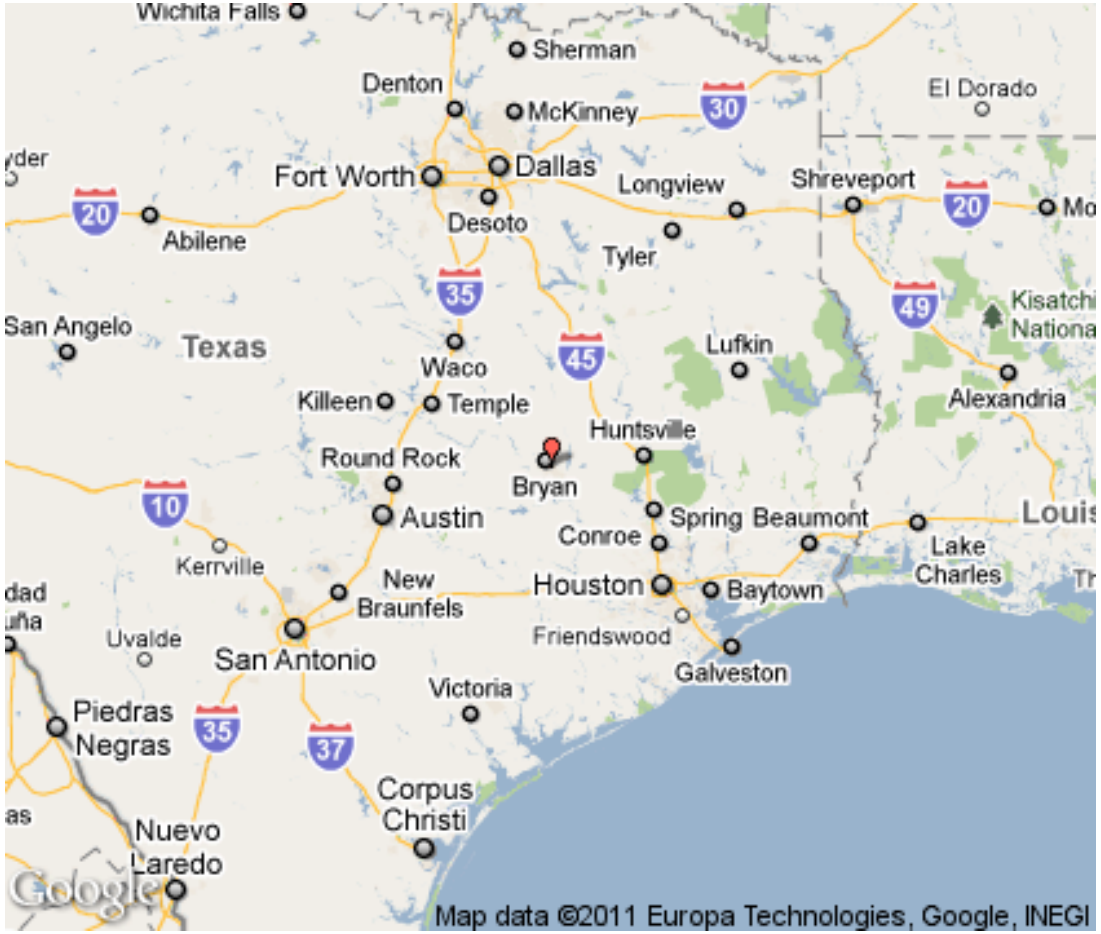
Location: College Station, Texas – population ~124,000

Surrounding Region: Brazos County, Texas – population ~242,000

Regional Mental Health Providers: Mental Health Provider Ratio (Brazos County) – 780:1; Texas – 690:1; United States – 340:1

Proximity to Closest Major Population Centers: Houston, Texas (95 miles, ~1.5 hours); Austin, Texas (107 miles, ~2 hours)

Other Notable Practice Facts: Texas A&M is one of the first universities nationally to implement CoCM through their student health clinic as a service for their student population.



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Texas A&M University – Staffing

Physicians: 8 (and ~16 resident physicians rotating through the UHS)

Advanced Practice Providers: 17 (not all FT)

BHCM: 1 (LCSW); in process of hiring another BHCM

Treatment Population Age Group: 16-75 (majority 18-24 yo)

Student population: 77,491 students enrolled: 60,729 undergraduate students; 16,762 graduate students

Training: Summer in-person, breakout groups, regular meetings in advance, APA training for BHCM, Psych Consultant and PCP (BHCM training now ~$350).

CoCM Caseloads: around 40 aiming to average 12–16-week enrollment. Maintenance phase = continuing prescription through UHS and 1-2x month check-ins (aiming to average 3 months in maintenance phase).

Psychiatric Consultancy: The psych NP from the counseling center is the psych consultant. This was great when students were higher acuity as they moved right into her care (as a specialty provider). Initial challenge was related to tracking which students were in CoCM v. stepped-up care and how best to oversee their well-being over time.

Texas A&M University – Program Start-Up

Texas A&M contacted the Meadows Institute and directly solicited our CoCM implementation technical assistance support.

Executive leadership support was exceptional. The University Health Service was eager to innovate scalable evidence-based programming in light of the mental health crisis, their massive student population, and relative below-standard outcomes over time.

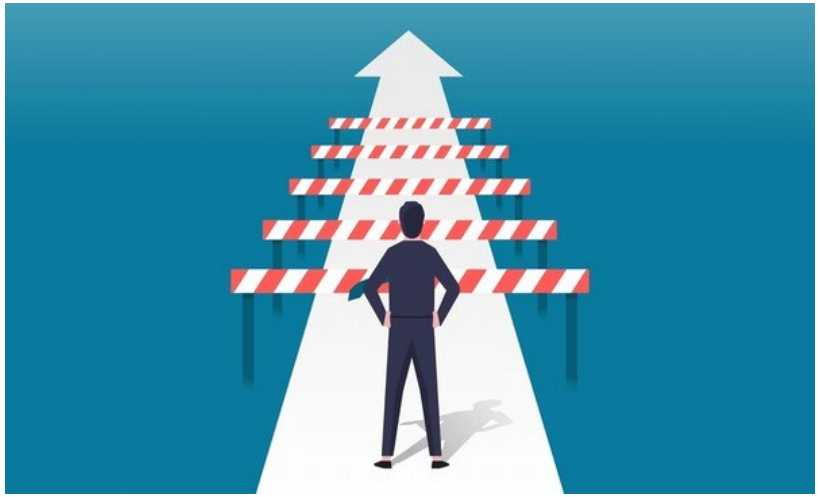
Implementation and start-up facilitators:

- Buy-in across campus service sites
- Executive leadership-driven without primary focus on near-term reimbursement
- Amazing physician champions who had already been providing mental/behavioral health support
- Comprehensive in-person training during the summer with all relevant personnel and domain-specific breakout groups
- Coordinated implementation with other campus leaders/departments (e.g., campus police, university counseling center, registrar, athletics department, etc.)

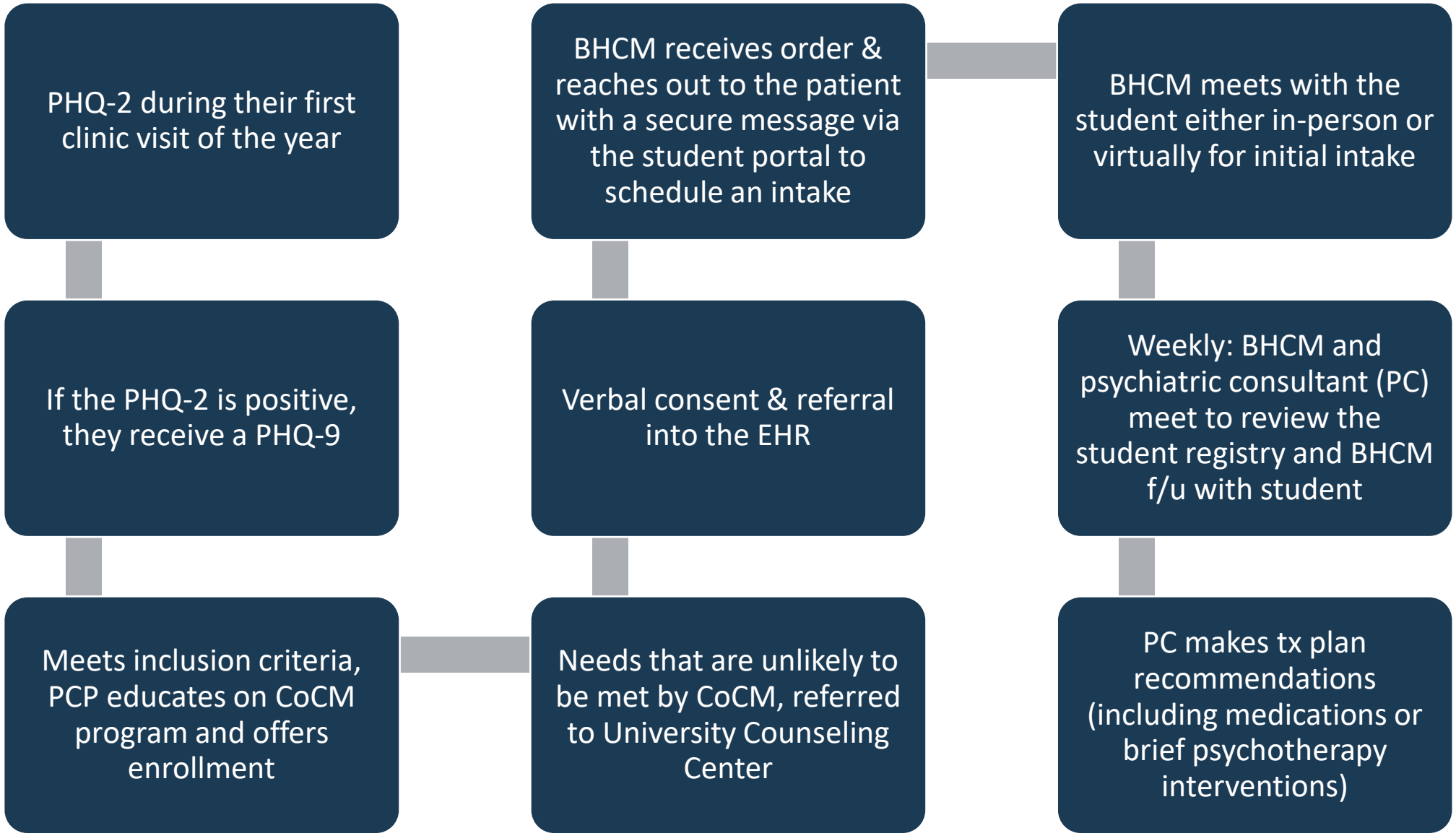
Texas A&M University – Program Start-Up

Implementation challenges:

- Historical failure with ’integrated care’ at University Health Service
- Another ‘change’ amidst so many new faces and initiatives
- TAY population – consent, confidentiality, and family v. student insurance
- Such a busy site that scheduling meetings during the school year for technical assistance related to program maintenance and optimization was difficult
- Calendar school year – ensuring continuity of care in summer for meds, service provision, etc.
- Interdigitation of university counseling center, university health services, crisis services, etc. (who went where, when, and coordination of stepped up/down care with associated student information)

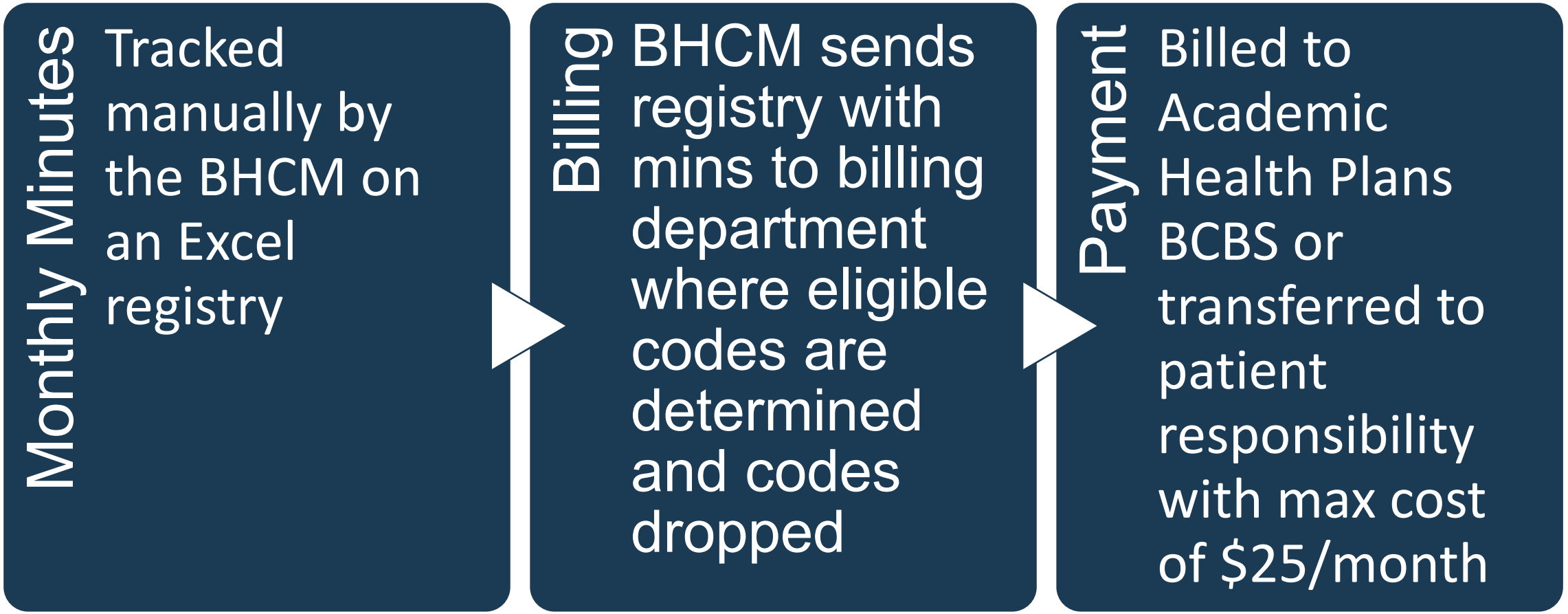


Clinical Workflow



Billing Workflow

Payers Reimbursing for Collaborative Care (CoCM): Texas A&M is contracted with Academic Health Plans through Blue Cross Blue Shield (BCBS). BCBS is reimbursing for CoCM services; all other payers are out of network.



Texas A&M University – Clinical Workflow

Workflow Challenges & Solutions

Challenge	Solution
Explanation of CoCM to students	Co-crafted scripting, added to EHR
Student financial responsibility	Billing one-pager for students, $25 max out-of-pocket per month enrolled in CoCM
Student engagement	Customized outreach workflow including messaging through secure student portal (most used modality by students)
Time tracking	Built time-capture into EHR
Alignment and coordination relative to treatment plan	Treatment plan sent to PCP as an “open note.” PCP receives, reviews, adds plan (e.g., Lexapro 5 mg called in to pharmacy by PCP) and closes note…which then auto-sends alert to original sender (e.g., BHCM)

Utilization (CoCM and MBC)

8/15/23 – 3/6/24 (~less than 6 months)

143 students referred to UHS CoCM Program

Treated:

142 enrolled (automatically for tracking)

48 Unresponsive (7 were initially in treatment)

- 37 had a PHQ-9 of 9 or higher.
- 41 had at least 2 documented PHQ9 scores.

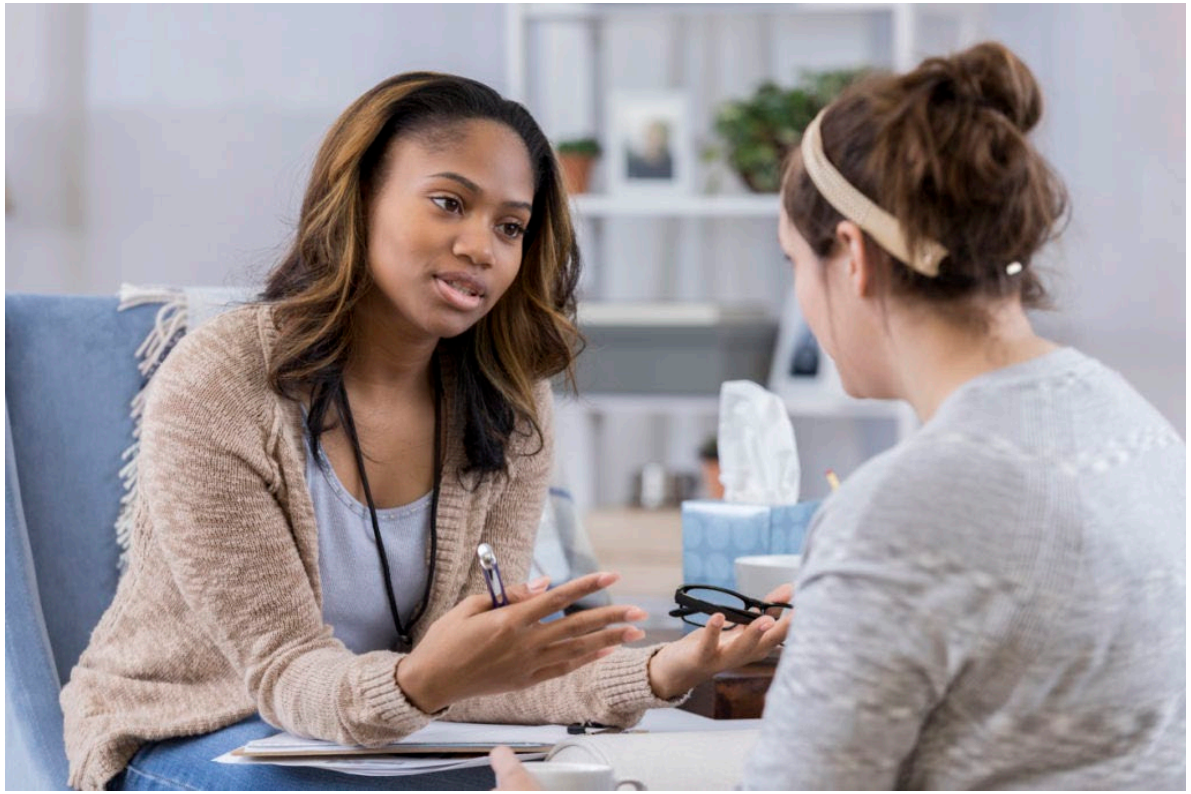
32 Declined (15 were initially in treatment)

- 20 had a PHQ-9 of 9 or higher.
- 6 had at least 2 documented PHQ9 scores.

Utilization (CoCM and MBC)

27 not enrolled due to graduating or being treated by specialty care provider.

- 23 had a PHQ-9 of 9 or higher.
- 24 had at least 2 documented PHQ-9 scores.



4 Awaiting intake

- 4 had a PHQ-9 of 9 or higher.
- 4 had at least 2 documented PHQ-9 scores.

Actively engaging in treatment

- 31 enrolled & active in CoCM
  - 26 had a PHQ-9 of 9 or higher.
  - 31 had at least 2 documented PHQ-9 scores.

*Remission: 4 of actively enrolled are in relapse & prevention

- 2 achieved a reduction of 50% reduction in PHQ-9 score.
- 2 achieve a reduction in PHQ-9 to below 5.

Overall Impression of CoCM Program

Dr. Tiffany Skaggs, Senior Director of Primary Care and Specialty Medical Care, reports: “We have found Collaborative Care to be an effective way to coordinate care management, psychiatric expertise, counseling, and primary care into a seamless delivery system for the patients we serve.”

Next Steps

- Comprehensive data collection regarding referrals, clinical outcomes, and fiscal sustainability
- Identify and address root cause(es) of unresponsive students and those who decline CoCM services
- Optimize coordination of care across (a) service provision sites on campus and (b) intra-/inter-state providers overseeing student care during summer
- Fine-tune clinical workflows, especially around seasonal ebbs and flows
- Expand CoCM program with additional BHCMs
- Improve billing workflows, where possible
- Secure additional funding source to offset monthly co-pays for financially disadvantaged students
- Determine feasibility of summer CoCM bridge program

Q&A

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Questions

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Chief Clinical Officer, SVP Health Systems Integration
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Thank You!

For more information visit mmhpi.org.

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CENTER FOR JUSTICE AND HEALTH