Sustaining Practice Change
What does it take to prevent organizational relapse?

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Conflicts of Interest

No conflicts to report
Translation & Implementation

Translation

Efficacy to Effectiveness

Implementation

Fidelity vs. Flexibility

Maintenance vs. Sustainment

RE-AIM

Reach
Effectiveness
Adoption
Implementation

Maintenance

Dynamic Sustainability Framework (DSF)

Institutionalization

Responsive to local context

- Institutional
- Cultural
- Ecological System

Continuous quality improvement (CGI)

Stakeholder engagement

Depression Treatment

No Treatment

Primary Care

Mental Health

Why Not Just Refer?

Half don’t go

Mean # of visits = 2

Access to Depression Treatment

“We couldn’t get a psychiatrist, but perhaps you’d like to talk about your skin. Dr. Perry here is a dermatologist.”

Nearly 10% of primary care visits are depression related
Quality of Depression Treatment

... only 20% improve in primary care after 12 months of treatment

“Of course you feel great. These things are loaded with antidepressants.”
Collaborative Care
IMPACT

1,801 older adults with depression
- 8 health systems in 5 states
- 18 clinics
- Fee-for-service
- Staff model HMO
- VA clinic

Randomized Controlled Trial
- Collaborative Care for 12 months
- Usual Care

Evidence-based Treatments

Individualized treatment plan includes **one or both**

Medications
- Consultant helps PCPs expand capacity

Psychotherapy
- Modalities appropriate for primary care
  - Brief
  - Structured
  - Strong evidence
Twice as Effective

50% or greater improvement in depression at 12 months

Improved Physical Function

SF-12 Physical Function Component Score

Other Outcomes

- Less physical pain
- Higher quality of life
- Provider satisfaction
- Patient satisfaction
- Cost effective
  $6.50 : $1

## Older Adults in Community Health Centers

<table>
<thead>
<tr>
<th>Population</th>
<th>Mean baseline PHQ-9 depression score</th>
<th>Follow-up (%)</th>
<th>Mean number of primary care contacts</th>
<th>% with psychiatric consultation</th>
<th>% with significant clinical improvement (PHQ-9 reduced 50% or more)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older Adults at baseline (2008) N = 124</td>
<td>15 / 27</td>
<td>63 %</td>
<td>3</td>
<td>18 %</td>
<td>24 %</td>
</tr>
<tr>
<td>Older Adults in 2012 N = 568</td>
<td>15 / 27</td>
<td>86%</td>
<td>8</td>
<td>69 %</td>
<td>51 %</td>
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Collaborative Care Evidence

Over 100 research trials worldwide

- Depression, anxiety, PTSD
- Substance use, ADHD, bipolar 2
- Racial / ethnic minority
- Rural, low-income
- Low- and middle-income countries


Key Principles

- Population-Based Care
- Measurement-Based Treatment to Target
- Patient-Centered Collaboration
- Evidence-Based Care
- Accountable Care
Taking Effective Models to Scale

everyone wants better.
o one wants change.
Improving Depression Treatment Access and Quality

- Rural / Frontier FQHCs
- Medically Underserved
- Healthcare Provider Shortage Area
Implementation Process

1. Lay the Foundation
2. Plan For Clinical Practice Change
3. Train Your Clinical Team
4. Launch Your Care
5. Ongoing Maintenance
Roadmap for Implementation

1. Lay the Foundation
   - Ensure clinic staff watch “Introduction to IMPACT” and “Creating the Collaborative Care Team” webinars (or receive key messages from each webinar).
   - Understand the five principles of Collaborative Care and how they apply to your organization.
   - Create a vision for IMPACT at your organization with input from key stakeholders.

2. Plan For Clinical Practice Change
   - Schedule pre-launch calls with AIMS Center.
   - Complete Team Building Worksheets and create Action Plan.
   - Create Clinical Workflow chart.
   - Send Action Plan and Clinical Workflow to AIMS Center.
   - Complete CMTS registry license and identify account manager.

3. Train Your Clinical Team
   - Identify who will attend Sept 27-28, 2014 training in Seattle.
   - Complete online registration for attendees.
   - Reserve lodging and make other travel arrangements for attendees.
   - Schedule webinar and/or live Q&A for PCPs unable to attend Seattle training.
   - Ensure clinical staff offering psychotherapy as a treatment complete PST (Problem-Solving Treatment) certification following in-person training.

4. Launch Your Care
   - Select a specific date for launch and communicate this widely to all clinic staff.
   - Ensure all administrative details are in place prior to launch.
   - Begin monitoring implementation process and clinical outcomes.

5. Ongoing Maintenance
   - Block time on care manager(s) & clinical supervisor calendars for bi-monthly case call with all SIF sites.
   - Block program leadership and care manager calendars for monthly implementation technical assistance call.
   - Monitor schedule of bi-monthly topic webinars & block time for participation on calendars of relevant clinic staff.
   - Block psychiatric consultant calendar for quarterly call (all SIF psychiatric consultants and AIMS).
   - Monitor implementation process and clinical outcomes.
Pre-Launch Technical Assistance

Patient-Centered Integrated Behavioral Health Care
Principles & Tasks

About This Tool

The core principles of effective integrated behavioral health care include a patient-centered care team providing evidence-based treatments for a defined population of patients using a measurement-based treat-to-target approach.

Principles of Care

1. Patient-Centered Care
Primary care and behavioral health providers collaborate effectively using shared care plans.

2. Population-Based Care
Care team shares a defined group of patients tracked in a registry. Practices track and reach out to patients who are not improving and mental health specialists provide caseload-focused consultation, not just ad-hoc advice.

3. Measurement-Based Treatment to Target
Each patient’s treatment plan clearly articulates personal goals and clinical outcomes that are routinely measured. Treatments are adjusted if patients are not improving as expected.

4. Evidence-Based Care
Patients are offered treatments for which there is credible research evidence to support their efficacy in treating the target condition.

5. Accountable Care
Providers are accountable and reimbursed for quality care and outcomes.

Step 1: Individual Visions
Each member of the team creates a vision of their ideal future by answering the following:

- Why do we want to implement Collaborative Care? (possible motivating factors include improved health outcomes, increased patient satisfaction, increased provider satisfaction, increased employer/purchaser demand, improved performance indicators, financial incentives for quality care, cost savings, etc.)
- How does Collaborative Care complement our overall mission?
- How likely will Collaborative Care succeed in improving the health of our patients?
- What are my biggest hopes for implementing Collaborative Care?

Step 2: Vision Statement for Collaborative Care
Team members share their answers, raising discrepancies as questions and keeping the discussion open until there is final agreement. Work together to create a compelling vision statement that captures the essence of what your team is trying to accomplish. Remember, vision statements say where an organization wants to be and provides the inspiration for daily operations. Get creative! Maybe a visual shows your vision best.

Step 3: Operationalize the Vision
A subset of the team thinks about how to put the shared vision into practice, attempting to be as specific as possible. The following questions can guide you:

- What is the scope of our Collaborative Care program (number of sites, practices, providers, patients)?
- Which conditions do we want to treat?
- What target populations do we want to serve? (age, gender, languages, special needs, insurance benefits)
- What evidence-based psychotherapies are we going to practice?
- What services will we offer? What services can we refer patients to?
- How will we know if Collaborative Care is working? What should we measure?
- How will Collaborative Care feed into our existing quality improvement efforts?
- What strengths do we have to facilitate Collaborative Care? What challenges do we...
Pre-Launch Training

Web-based Didactics

Module 1: Introduction to Collaborative Care (25 minutes)
Description: The rationale and evidence base for integrated behavioral health in primary care; the Care team structure; Key principles of effective Collaborative Care.
Presentation
Slide Handout

Module 2: Key Collaborative Care Tasks (23 minutes)
Description: The team tasks of Collaborative Care; identifying and engaging patients, assessment, initiation of treatment, follow-up and tracking outcomes, relapse prevention.
Presentation
Slide Handout

Required Evaluation training materials are on the Evaluation page.

Additional role-specific materials
Module 3: The Care Manager Role (39 minutes)
Audience: Primarily the care manager(s), but the content is relevant to the entire clinical team. The care manager role may be filled by a behavioral health provider, nurse or similar professional. At some sites care manager responsibilities are shared with a community health specialist, medical assistant or similar person. This presentation is designed for everyone who will have responsibility for some or all of the care management responsibilities.
Description: The care manager role and tasks; team communication; patient engagement, treatment and outcome tracking.
Presentation
Slide Handout
Description: The short videos below each demonstrate different care management activities.
Initial Visit (09:19)
Patient Education (17:44)
Behavioral Activation (05:22)
Treatment Monitoring (05:06)
Antidepressant Education (03:56)

Module 4: The PCP Role (23 minutes)
Audience: Primarily for Primary Care Providers (PCPs), but the content is relevant to the entire clinical team.
Description: Identifying and engaging patients, prescribing medications, support from the care manager and psychiatric consultant support, depression treatment options.
Presentation
Slide Handout

Module 5: The Psychiatric Consultant Role (22 minutes)
Implementation Support Tools

- Screening & Measurement
- Team Communication
- Patient Identification & Engagement
- Relapse Prevention
- Behavioral Activation
- Supporting Medication Therapy
# Web-based Registry

## Current Patients

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<th>Date</th>
<th>PHQ-9</th>
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## Post-Launched Training

Topics delivered according to developmental stage of implementation

### Diagnosis

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### Difficult Patients

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<td>7/8/15 – Rita Haverkamp</td>
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<tr>
<td>The Difficult Patient Case Call</td>
<td>1:28:57</td>
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### Distress Tolerance

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<td>Case Presentation Form</td>
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### Engagement

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</table>
Relapse Prevention - Patient

- Personal Warning Signs
- Treatments
- Self-management
- Action Plan
# Post-Launch Coaching

## Social Innovation Fund
### IMPACT Expansion in the Rural West

**Implementation Overview: 12/29/2016**

<table>
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<tr>
<th>SITE</th>
<th>Care Mgr FTE</th>
<th>Care Mgr Type</th>
<th>Total Patients Treated</th>
<th>Active Caseload Goal Minimum</th>
<th>Active Caseload^2</th>
<th>Contact &gt;2 months</th>
<th>Active Caseload: % of Minimum</th>
<th>% &gt;24 Weeks^3</th>
<th>% Contacts w/ PHQ-9^4</th>
<th>5+ Point Decrease</th>
<th>50%+ Decrease After at Least 10 Weeks</th>
<th>Psychiatric Consultation^5</th>
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*All values are percentages.*
Stepped implementation support

Monitor
  – Patient-level clinical outcomes
  – Clinic-level processes of care

Course corrections

Tailored support
  – 1:1 phone / web
  – Onsite intensive

Goal = independent sustainability
## Demographics

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<th>n</th>
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<td>3556</td>
<td>68%</td>
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<td>Men</td>
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## Depression Outcomes

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<td><strong>Depression severity</strong> (range 0-27)</td>
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<tr>
<td>PHQ-9 at baseline</td>
<td>16.1</td>
<td>15.9, 16.2</td>
<td>5.7</td>
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<tr>
<td>PHQ-9 at last measurement</td>
<td>10.9</td>
<td>10.8, 11.1</td>
<td>7.2</td>
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<td>Change from baseline to last</td>
<td>5.1&lt;sup&gt;a,b&lt;/sup&gt;</td>
<td>4.9, 5.3</td>
<td>6.7</td>
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<tr>
<td><strong>Suicidal ideation</strong> (range 0-3)</td>
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<td>Baseline</td>
<td>0.59</td>
<td>0.57, 0.62</td>
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<td>Last measurement</td>
<td>0.35</td>
<td>0.33, 0.37</td>
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<td>Change from baseline to last</td>
<td>0.25&lt;sup&gt;a,b&lt;/sup&gt;</td>
<td>0.22, 0.27</td>
<td>0.77</td>
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</tbody>
</table>

<sup>a</sup> $P < 0.0001$

<sup>b</sup> Paired t-test
Organizational Relapse Prevention

Cohort 1
- 5 clinics
- 4 moved into sustainment

**Support** phase = 2.5 years
- Typically 12-18 months

**Sustainment** phase = 12 months
Relapse Prevention

**Patient**

Pre-Treatment
- Vision (shared decision making)
- Treatment Goals

**Organization**

Pre-Launch
- Vision (stakeholders)
- Goals
Relapse Prevention

**Patient**

**Treatment phase**
- Measurement-based treatment-to-target
- Treatment changes to meet goal(s)
- Relapse prevention plan

**Organization**

**Support phase**
- Measurement
- Adjustments
- Relapse prevention plan
Relapse Prevention

**Patient**

Maintenance phase
- Periodic measurement
- Action plan

**Organization**

Sustainment phase
- Periodic measurement
- Action plan
Method

Internal facilitation
- Group webinar
- 1 coaching session per clinic
- Coach available for consultation

Plan development
- 2 months

Presentation
- Coaches, peers
- Accountability
Dynamic Sustainability Framework (DSF)

Institutionalization

Responsive to local context
- Institutional
- Cultural
- Ecological System

Continuous quality improvement (CGI)

Stakeholder engagement

DSF - Institutionalization

Prior to Collaborative Care implementation
  - Vision
  - Roles
    - Prior implementation experience

Internal facilitation
  - Internal capacity
DSF - Responsive to Context

Institution
- Fidelity to clinical outcomes
- Processes of care = diagnostic
- Workforce considerations; training

Culture
- Fish camp
- American Indian / Alaska Native

Ecological systems
- Financing, policy changes
- Population characteristics
DSF Institution – Outcomes

Clinical Outcomes / Benchmarks
- Response ( > 40% )
- Remission ( > 25% )

Processes of Care
- Follow-up within first 4 weeks
- Case consultation with psychiatric expert

DSF Institution - Workforce

Care Manager Role
  – Shared by licensed and paraprofessional

Psychiatric Consultant
  – Psychiatric nurse practitioner
  – Shared by clinics

DSF Culture

Rural

– Fierce independence
– Self-reliance
– Stigma

American Indian / Alaska Native

– Stoicism
– Beliefs, healing interventions

DSF Ecological Context

Financing

- Staffing
- Productivity
- Workflow Optimization
- Direct Revenue
- Indirect Revenue
- Contracting
- Coding/Denials
DSF - Continuous Quality Improvement

**Measurements**
- Identify / adapt (congruent with vision)
- Benchmarks
- Warning signs

**Process**
- Leader(s)
- Frequency
- Updates

**Problem-Solving**
- Rapid testing / learning (PDSA)
DSF - Stakeholder Engagement

**Accountability**

- Patients
- Providers
- Payers
- Community partners
- Peers
## Sustainment Outcomes

<table>
<thead>
<tr>
<th></th>
<th>Support</th>
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<td>Total Number of Follow-ups</td>
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<td>&lt;0.001</td>
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<td>223 (25.3)</td>
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<td>0.032</td>
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<tr>
<td></td>
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<tr>
<td>Treatment Duration , months</td>
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<td>&lt;0.001</td>
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<td>1.8 (2.3)</td>
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<td>141 (16.0)</td>
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<td>Response</td>
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- **Remission** = PHQ-9 score under 5
- **Response** = >50% reduction in PHQ-9 score
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**Remission** = PHQ-9 score under 5  
**Response** = >50% reduction in PHQ-9 score
Qualitative Data

“It really opened up discussions to accountability... [but] that’s going to be a slow change.”

“It’s a fluid process and a constant paying attention to different areas....you get one going well then you need to go back and look at another”

“Getting our more traditional care managers out of that traditional counseling role is ongoing.”
“I’m afraid you’ve had a paradigm shift.”
Acknowledgements

Collaborators
- Jürgen Unützer, MD, MA, MPH – Principal Investigator
- Rita Haverkamp, MSN – Implementation Coach
- Joan Russo, PhD – Senior Analyst
- Rob Arao, MPH – Data Manager, Analyst

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  Social Innovation Fund

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  - Margaret A. Cargill Foundation
  - Helmsley Charitable Trust
  - Rasmussen Foundation
  - Lewis County Commissioners