1. Local Care Unit: UMass Memorial Health Care
   Primary Care Psychiatry Initiative:
   Optimizing Behavioral Health Resource Utilization and
   Standardizing Medication Management

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3. LCU overview

UMass Memorial Health Care is the largest not-for-profit health care system in Central
Massachusetts with 1,500 physicians and 12,500 employees. Approximately 250
Primary Care Physicians provide services to 15,000 Harvard Pilgrim Health Care
members.

Our comprehensive network of care includes a three-campus academic medical center,
four member community hospitals, affiliated community hospitals, outpatient clinics,
community-based physician practices, long-term care facilities, and home health,
hospice, rehabilitation and mental health services. UMass Memorial is dedicated to
promoting health and wellness in the community.

As the clinical partner of the University of Massachusetts Medical School, our physicians
have access to the latest clinical trials and cutting-edge technology providing our patients
with quality and compassionate health care.

4. Brief Project Description

The UMass Memorial project group focused on developing a collaborative care model for
the treatment of depression between adult primary care physicians and the department of
psychiatry outpatient department. Physicians in the local care unit had been previously
involved with grant supported projects that introduced them to the use of standardized
screening tools, care management assistance, and the use of treatment algorithms in the
treatment of depression in the primary care setting. In this project, we attempted to
establish telephonic care coordination with patients screening positive for depression,
consultative feedback to practitioners, and access to psychiatric consultation and referral
as indicated.

5. Key Project Components

   A. Initial focus groups
      • Project leaders met with primary care physicians representing four
        practices and 62 providers to review their previous experiences with
        depression treatment and their recommendations regarding the new
        project. Providers were identified as all personnel who scheduled
        visits in the practice and included attendings, NPs and residents.
Survey data was collected on a sample of practitioners

B. Development of a modified screening tool
   • Provider feedback indicated dissatisfaction with the PHQ-9 as a routine screening tool, citing form fatigue in patients and support staff burdens
   • PHQ-2 reviewed and implemented as part of a two-step screen

C. Development of a telephonic care management team
   • Project coordinator recruited and oriented an RNCS, a LICSW and a third bicultural Spanish speaking LMHC.
   • Reimbursement method established on a per case basis

D. Development of psychiatric consultation team
   • Project director routinely reviewed cases with coordinator
   • Two additional psychiatrists with significant consulting experience to primary care practices recruited to serve as available consultants for patients identified in this project

E. Implementation phase
   • Four practices identified to participate in the project
     i. A small community based suburban practice
     ii. A hospital based ambulatory clinic in general medicine
     iii. A hospital based clinic in family medicine
     iv. A hospital based clinic in family medicine with some on-site psychological services
   • Practices were encouraged to utilize two step tool to routinely screen patients at annual visits and to assess cases of concern. Referrals of patients of concern were accepted with or without a completed screening
   • Project coordinator maintained data registry on referred patients
   • Attempts were made to contact all referred patients
     i. Patients were offered basic education about depression and treatment, PHQ-9 scores were confirmed, side effects monitored and patients were encouraged to follow-up with treatment
     ii. Attempts were made to contact the patient four times; within a week of their encounter with their PCP; at four weeks; at 8 weeks; and at 12 weeks.
   • Information was fed back to the PCP, including PHQ-9 scores, patient concerns, recommendations for medication adjustments, and concerns regarding the need for referral.
   • Assistance with referrals for specialty care or consultation was carried out based on either provider or patient request

F. Closure phase
   • Participating practices are in the process of being queried about their use of the project
   • The department of psychiatry is continuing to offer on a limited basis services to patients already enrolled in the telephonic care coordination
• Staffing for continued services on a limited basis is being reviewed

6. Key Project Outcomes to date
   a. Distribution of PHQ-9 scores over a five month period.
      Total screens received: 1067
      963 with PHQ-9 score less than 8
      104 with PHQ-9 score at 9 or greater
         19 of these already with psychiatrist care
         7 suffered from other disorders than depression
         3 referred for treatment
         38 entered care coordination program
         37 remaining patients did not enter care coordination
            8 of these refused at PCP
            3 in counseling
            19 not interested after call from coordinator
   b. Patients using care coordination
      • Of the 38 patients entering care coordination, 32 were on medications
         and 20 were still on medications for at least 3 months.
      • Of the patients using care coordination the mean improvement was 6
         points on the PHQ-9 scale (range of improvement -2 to +23). Suicide
         scores on a 3 point scale (from none=0 to 3=everyday) decreased from
         a mean of 0.6 to 0.2.
      • Comparison of the 38 patients accepting care coordination as
         compared to the 37 patients who refused, indicated:
         o Acceptors more likely to be on medications (32/38 versus
            25/37 for refusers)
         o Acceptors more likely to report chronic course by PHQ-9
            (28/38 for acceptors versus 16/37 for refusers)
         o Acceptors more likely to endorse extreme or severe functional
            impairment (24/38 for acceptors versus 8/37 for refusers)
         o Acceptors more likely to endorse suicidal ideation (mean
            suicidality score of 0.6 versus 0.4 for refusers on 3 point scale)
   c. Utilization. 31 of the 62 practitioners referred patients to the care coordination
      program. Use of the program’s services varied among the four targeted
      practices. In part, this reflected lower use at sites with resident physicians and
      part-time staff. All sites at a minimum used the program to help follow identified
      depressed patients, and two of the four used it to more broadly assist with tracking
      screenings.

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d. Feedback from primary care providers:

- Providers expressed concern from the outset of introducing changes that could not be sustained past the study period citing competing demands, patient fatigue with multiple screening demands and staff morale issues related to implementing process changes. They appreciated efforts to take these concerns into account when developing this project.
- There was positive feedback concerning the use of a two-step screening tool as opposed to the PHQ-9 as a screen. Two sites felt that they could readily incorporate a simple form into their routine practice and that this helped with patient compliance and reduced form fatigue.
- There were “no surprises” about the screening tool identifying patients that they would not have identified in their patient exams.
- Care coordination was viewed as a helpful option for many depressed patients as they saw the contact as positive.
- Care coordination for referral help was viewed as positive.
- Providers did not use the PHQ-9 scores provided by the care coordinator in making treatment decisions.
- Providers generally wanted help with referral to specialist care as opposed to consultation when concerns arose.

Commentary:

A number of collaborative care models have been proposed that offer systematic care of depressed patients in primary care settings and demonstrate superior outcomes over a defined study period. During the short time frame of this project, we offered and encouraged the use of all the key elements of these models: the use of screening tools, the provision of clinical decision support and expert consultation, assistance with the administering of a standardized follow-up assessment tool, telephonic care coordination, maintenance of a data registry and support of patients by trained professionals and assistance with referral. We found that with the financial assistance of the grant, we could rapidly develop a program based on existing models, recruit staff and establish a referral process.
Providers tended to accept interventions that they viewed as immediately helpful to their patients and their practice, i.e., telephonic support was welcomed by patients and assistance with referral was welcomed by providers. They did not either readily utilize or endorse processes that have been demonstrated to improve overall results through the standardization of assessment measurements; despite significant effort to provide help obtaining PHQ-9 scores this information did not readily inform their practices, although it did assist care coordinators in monitoring care. Medication usage in patients in care coordination generally conformed to established guidelines, but given the short study period we could not assess usage beyond the acute phase of treatment.

Dissemination and continuance of collaborative care models has often required ongoing financial incentives and continuing top-down reinforcement, despite the accumulating evidence suggesting their value in improving outcomes. In this effort, we approached providers with a “bottom-up” effort to implement these systematic interventions. This current effort suggested that enjoining our primary care practices in this collaborative and open manner could readily lead to the implementation of meaningful interventions that provided readily demonstrable benefit to provider and patient. A platform for further incremental efforts to establish more systematic approaches was established. Buy-in from practitioners varied widely, but we anticipate that a sustained effort with the support of early adopters could improve use.

Implementation of standardized assessments in the hope that the PHQ-9 could become an analog to other measurements in the management of chronic diseases (e.g., blood pressure readings, HgbA1C) did not occur in this project. Practitioners did not perceive the results as particularly helpful in either screening patients or tracking their progress. Further simplification of the assessment process, incentives and education for the use of the tool, and improvements in the informatics related to the provision of data on patients individually and collectively, may help with adoption.

7. Identify which goals were not achieved
   We were not able to utilize the Medventive registry for decision support. We did maintain a data registry on spreadsheet and provide timely feedback to providers by email and/or phone.

8. Plans for extending and sustaining achievements beyond the grant year
   a. We will continue providing care coordination for all patients enrolled in the program for the acute phase of treatment (approximately three months)
   b. We will review the possibility for maintaining telephonic care coordination activity in our outpatient psychiatry department. While we cannot maintain a registry of all screens, it may be feasible to focus on patients scoring positive for depression and their primary care providers requesting care coordination.
   c. The department of psychiatry is planning a broader effort to provide consultative services to primary care providers and this may include specific depression interventions. The department would be working with government and third party payers to sustain this effort. We are in the process of developing a program in elder mental health which may incorporate aspects of this collaborative care model.
d. Relationships remain important in developing good care—this project has been extremely helpful in bringing psychiatry and primary care staff together to work on common goals. We anticipate this continuing.

9. Lessons Learned/Words of Wisdom

Ongoing debate within the mental health field concerns the relative merits of specific techniques such as manualized therapies and algorithm based care, versus the value of non-specific factors in treatment, such as provider empathy and patient expectancy. Empirical outcomes research suggests that both the development of specific techniques and attention to so-called “non-specific” or common factors can improve results. The focus of depression treatment in primary care has been directed at the introduction of systematic approaches with less attention paid to their impact on patients and providers in terms of the quality of their relationships, motivation, and morale. While evidence for adherence to specified and systematic interventions can improve short term outcomes in research settings, the relevance of these findings to long term outcomes in routine settings remains unclear. Dissemination and continuance of these comprehensive and relatively expensive models has proven difficult.

Based in part on our department’s experience in developing collaborative models with pediatricians, we began this endeavor with a customer orientation toward primary care providers. We also assumed that the pursuit of specific interventions and the promotion of non-specific factors in care, need not be inherently at cross purposes; that we could improve adherence to guideline based care and enhance providers’ interest and attentiveness to their depressed patients. Obviously, in this pilot effort we could not offer well-validated conclusions about these assumptions. We did find that with modest resources, we could cull from well-developed collaborative care models, many helpful components that could be readily adapted to routine treatment sites. While there was significant resistance to the systematization of screening and assessment, practices and patients could be more readily engaged in joining in interventions that were immediately seen as helpful—supportive telephonic interventions for sicker patients and help with referral and care coordination for primary care providers. In addition, we established a platform for communication, continuous quality improvement, and care coordination between primary care providers and a specialist clinic.

Payers may want to consider reimbursement for telephonic care coordination for patients with depression being treated in primary care settings. To maximize the impact of this intervention we would consider that coordinators hired from local specialty practices and clinics, unlike those sponsored by insurers, would more readily stimulate referral, consultation and improved communication between providers and specialists. In addition, telephonic care coordination should be a reasonable substitute for visits in HEDIS measures, improving practitioner buy-in and patient satisfaction. Of interest, in this project, patients reporting more chronic and severe illness tended to self-triage to the more intensive care coordination offering. The use of the PHQ-9 or similar scales as a tool in the monitoring of a chronic illness, may require similar levels of infrastructure support, information system integration and reimbursement as
ordering a lab test—while our care coordinators made PHQ-9 results readily available, there use by providers was limited.