

Caring for Our Aging Population: An Integrated Care Approach

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Learning Objectives



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- **Identify the basic concepts of Integrated Care and the rationale for team-based treatment**
 - **Describe the unique health, mental health, and substance abuse treatment needs of older adults**
 - **Describe collaborative care approaches to depression care**

Integrated Care – What is it?



-
- **Mental health and medical care providers working together to address both the physical and mental health needs of their patients.**
 - **Evidence-based, strategic framework that addresses the whole person, no matter which “door” the person enters.**
 - **Assumes that health is a shared community responsibility and can be achieved through the dissolution of barriers that result in silo-style service provision** (Mauer & Jarvis, 2010).

Integrated Care – Why do it?



The “Graying” of America

- **By the year 2025, the world’s older population (60 and older) will approach 1.2 billion.**
- **By the year 2030, 1 of every 5 people in the U.S. will be 65 or older.**
- **Older Americans will number more than 65 million**

Older Adults Have More Chronic Health Problems



- Older adults **CAN** have at least two chronic health conditions, including heart disease, cancer, and stroke and these **CAN** be exacerbated by **MODIFIABLE** health behaviors:
 - ✗ Smoking
 - ✗ Poor diet
 - ✗ Physical inactivity (Mokdad et al., 2004)
- Older adults have high levels of depression and anxiety with:
 - ✗ Obstructive pulmonary disease (Maurer et al., 2008)
 - ✗ Rheumatoid arthritis (Isik et al., 2007)
 - ✗ Type II diabetes (Grigsby et al., 2002)
- The highest rates of depression are found in those with strokes (30% to 60%), coronary artery disease (up to 44%), cancer (up to 40%), Parkinson's disease (40%), and Alzheimer's disease (20% to 40%)

(Birrer et al., 2004)

Older Adults and Alcohol



Even small amounts of alcohol can:

- Cause or create medical conditions;
- Produce unsafe medication interactions;
- Increase falls, confusion, depression, and insomnia; and
- Cause premature mortality.
- Alcohol abuse is often undetected and untreated in older adults.

(TIP #26)

Prescription Drugs and Medications



- **Older adults**
 - purchase over $\frac{3}{4}$ of all OTC medications, and often misuse them.
 - consume more prescribed and OTC medications than any other age group in the United States.
- **Prescription drug misuse and abuse is prevalent among older adults not only because more drugs are prescribed to them but because, as with alcohol, aging makes the body more vulnerable to drugs' effects.**
- **Antipsychotic drugs, which are commonly and often inappropriately prescribed to older adults with behavioral problems, leads to problematic, potentially dangerous symptoms and side effects.**

(Steinhagen, 2008)

Our Older Adults have more **RISKS** after the age of 65



-
- **Social isolation**
 - **Loss of capacity**
 - **Grief and loss**
 - **Unmarried due to death of partner or divorce**
 - **Medical illness of partner or self**
 - **Caregiving responsibilities**
 - **Depression at an earlier stage of life**

(Unutzer et al., 1999)

AND...Let's not forget about COST!



- The US Health System is the **MOST** costly in the **WORLD!**
17% of the gross domestic product (GDP) is spent on
HEALTH CARE
with estimates that this percentage will grow to nearly

20% by 2020!



Compare this to other developed
countries that spend between
9 – 11 % GDP

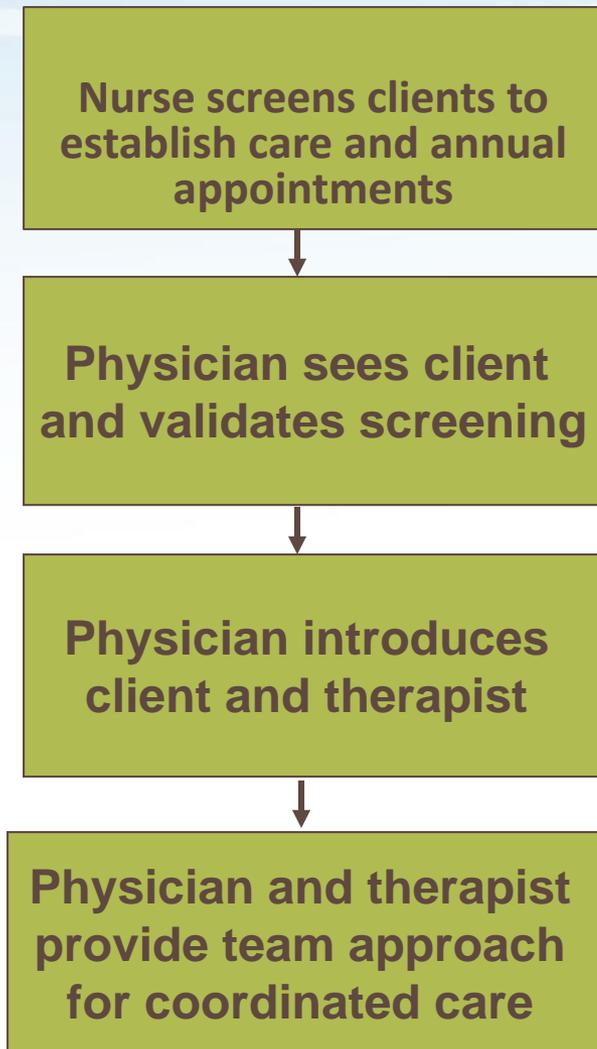
Source: National Healthcare Expenditure Projections, 2010-2020. Centers for Medicare and Medicaid Services, Office of the Act

How does Integrated Care work?



- **Medical and behavioral health providers partner to**
 - **Screen,**
 - **treat,**
 - **and follow patient's behavioral and physical conditions.**
- **The patients' entry into services drives the model:**
 - Behavioral health into the healthcare setting,**
 - Healthcare into the behavioral healthcare setting**
- **The level of integration is on a continuum -- from minimal collaboration to fully integrated, whole person care.**

Snapshot: An Integrated Care Program



Behavioral Health Services integrated with Primary Health Care:

- Screening
- Assessment
- Brief supportive counseling
- Therapy
- Case management
- Medication monitoring
- Coordinated team care

Common Goals for Integrated Healthcare



- Recognition and treatment of mental health, substance use, and medical disorders with a focus on *functioning*;
- Early detection of “at risk” clients, with the aim of preventing further mental or physical deterioration;
- Prevention of relapse or morbidity in conditions that tend to recur over time and go hand in hand;
- Prevention and management of addiction to pain medicine or tranquilizers;

There are many faces of aging...



You can not know how age
thinks...

What stories remain to be told...



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What gifts still to give...



What work remains to be done...



What wisdom remains to be taught...



What love remains to share



DEPRESSION IS A THIEF



LATE LIFE DEPRESSION



-
- Profound effects on quality of life, functioning and healthcare costs.
 - 5 million out of 31 million adults over 65 in the U.S. have significant depressive symptoms
 - Few receive specialty mental health care compared to a younger population
 - **IMPACT** – Improving Mood, Promoting Access to Collaborative Treatment
 - Designed to address the unmet needs of these older adults

IMPACT WORKS TO RESTORE... FUNCTIONING



Connection...



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And Meaning.....



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IMPACT Study Results



- **1998-2003 – 80 research studies show:**
- **Less depression**
- **Less physical pain**
- **Better functioning**
- **Higher quality of life**
- **Greater patient and provider satisfaction**
- **Cost effective**
- **Effective with minority populations**



Model Effectiveness



- **At 12 months, about half of the patients receiving IMPACT care reported at least a 50 percent reduction in depressive symptoms (19% in usual care i.e.: ANYTHING ELSE!)**
- **A survey conducted one year after IMPACT shows that the benefits of the intervention persist after 1 year and last up to 4 years**

What we are doing



- CCWNC was invited by Kate B. Reynolds Charitable Trust to apply for a grant to implement the IMPACT model
- KBR mission: serve the needy and unserved population
- 2 counties each with 1 practice
- Each practice has 3 sites
- Provide model for a 3 year period
- Pilot project to determine
 - Can we achieve the same outcomes as the studies
 - Can this model be expanded across the state
 - Is it sustainable



IMPLEMENTING THE MODEL

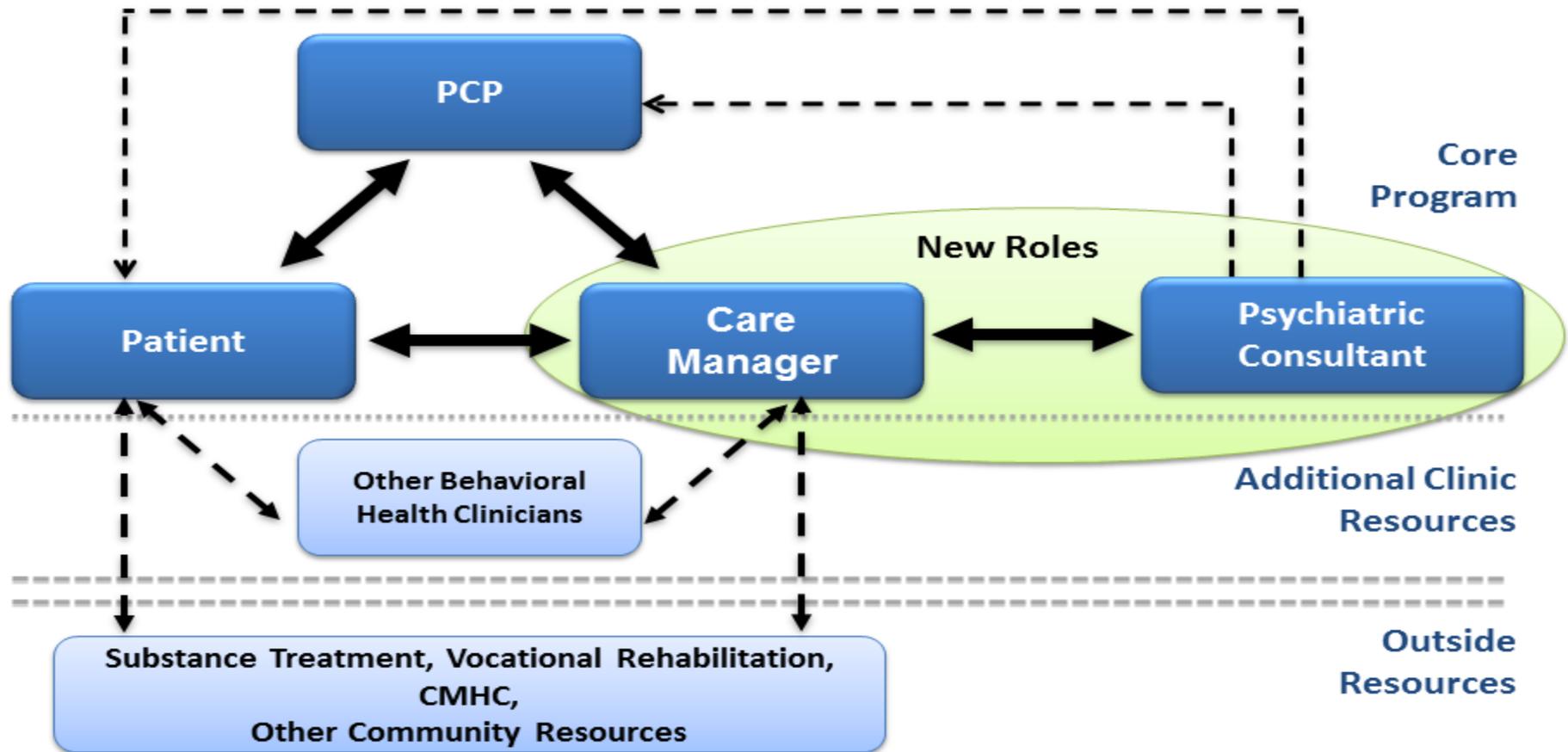


■ The Implementation Team

- Critical to success of the program
- Identified 6 months before launch date
- Comprised of key staff
- Charged with making system wide changes
 - Staff training and orientation to the model
 - Changes to the EMR to accommodate referral flow
 - Patient Education Material
 - Designate space for the ICM to meet with patients
 - Develop the work flow



Collaborative Team Approach



Work Flow

All patients
60+ are
given PHQ9
by clinical
staff/ MA



MA scores
PHQ9 &
notifies provider
of scores 10+



Provider
educates
patient about
IMPACT and
makes referral
through EMR



Work Flow



Contact with Patient is made

↳ Initial Assessment conducted

**↳ Begin treatment – Medications and/or
Therapy**

↳ Track progress in EMR and Registry

**↳ Case Review with PCP champ, Psychiatrist and
ICM for those not improving**

Registry



Impact : Database (Access 2007 - 2010) - Microsoft Access

File Home Create External Data Database Tools

View Paste Filter Refresh All Delete More Find Select Text Formatting

Menu Patient Work List hcc Table Alerts

IMPACT

31

Name

Please exit here

First Name or Partial

Last Name or Partial

Date of Birth (Not Req)

Form View Num Lock

Patient Work List



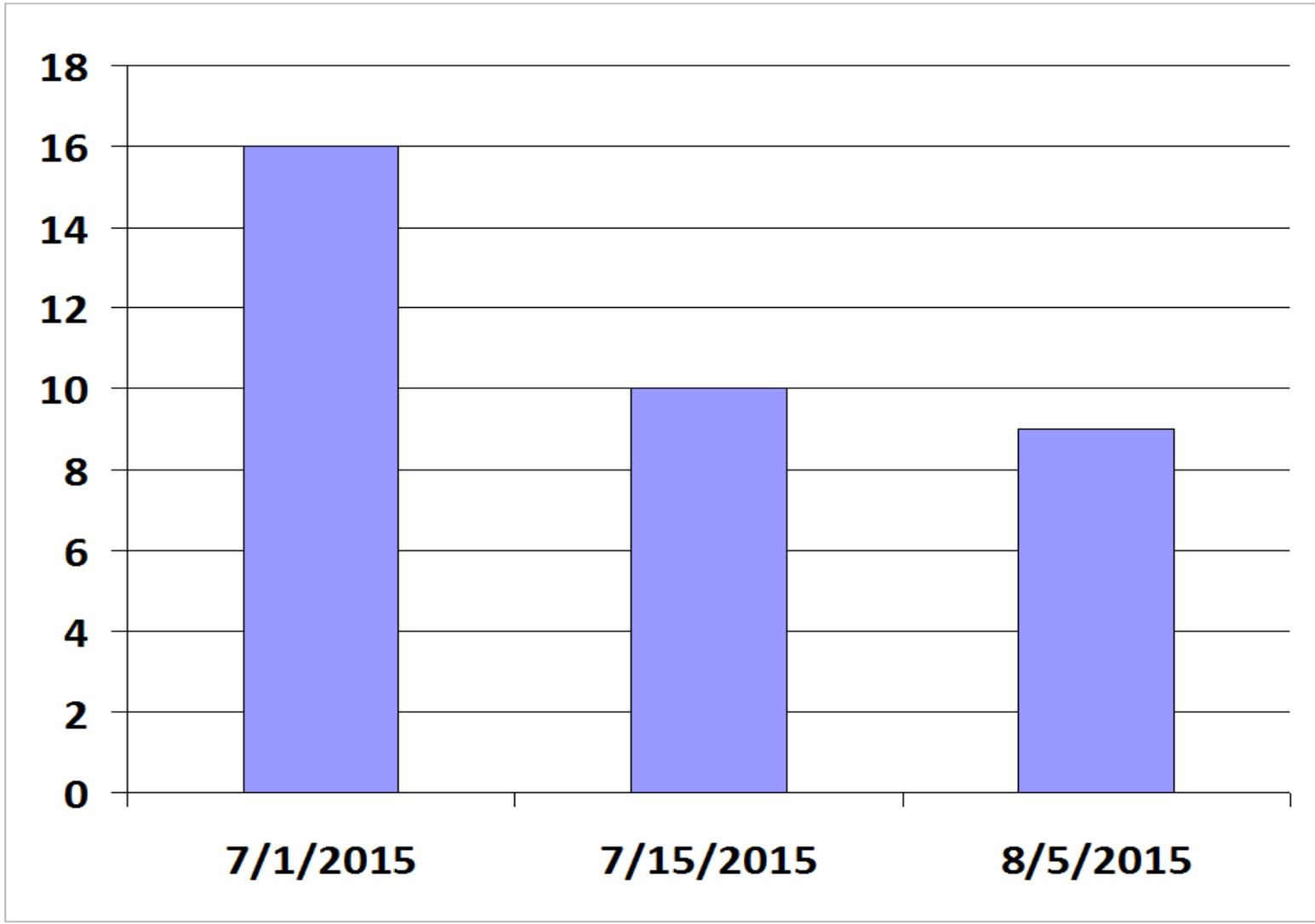
Patient Work List

Name	Age	Status	PHQ1s	NextActivit	Safety	Di	Last Act	Last Psy	PsychCol	PHQ9Di	PHQ%	Activity	LastSessio
	72	Active	11	7/25/2016		98	7/11/2016			-1	-9.1%	Session - Ph	7/11/2016
	65	RPP	16	7/28/2016		181	8/1/2016	2/18/2016	1	-13	-81.3%	Call Attemp	6/28/2016
	65	Active	14	8/4/2016		104	7/21/2016	5/19/2016	2	-8	-57.1%	Call Receive	6/14/2016
	72	RPP	18	8/4/2016		165	7/5/2016	6/23/2016	4	-2	-11.1%	Session - Fa	7/5/2016
	60	Active	17	8/4/2016		214	8/9/2016	7/21/2016	5	0	0.0%	Call Attemp	7/20/2016
	83	Active	16	8/5/2016		81	7/22/2016	7/21/2016	3	-14	-87.5%	Session - Fa	7/22/2016
	84	Active		8/8/2016		32	7/25/2016					Call Receive	
	66	Active		8/8/2016		21	8/2/2016					Call Attemp	
	59	Active		8/8/2016		40	7/25/2016	7/7/2016	1			Letter Sent	
	69	Active		8/10/2016		19	8/4/2016					Call Attemp	
	82	Active	19	8/15/2016		221	8/1/2016	7/7/2016	4	-8	-42.1%	Call Success	7/5/2016
	96	Active	12	8/17/2016		32	8/3/2016			-3	-25.0%	Initial Asses	
	77	RPP	23	8/18/2016	Jnknowr	187	7/19/2016	3/3/2016	3	-17	-73.9%	Session - Ph	7/19/2016
	77	RPP	13	8/18/2016		221	7/19/2016	5/26/2016	2	-9	-69.2%	Call Success	6/10/2016
	66	Active	17	8/18/2016		53	8/4/2016	8/4/2016	1	-15	-88.2%	Psych Consu	7/27/2016
	67	Active		8/18/2016		24	8/4/2016	8/4/2016	1			Psych Const	
	62	RPP	12	8/24/2016		136	7/25/2016	5/5/2016	2	-8	-66.7%	Call Success	7/1/2016

Report of PHQ9 for [REDACTED], Joseph

1/20/2016 4:30:42 PM

Print



Registry Functions



-
- **Tracks patient success**
 - **Makes sure patients don't fall in between the cracks**
 - **Determines clinical decision making at key milestones**
 - **Ensures that 70% of patients are receiving Psychiatric consult**
 - **Helps with oversight work load balance and referrals by team members**

Cost Effectiveness



- Average cost ~ \$580./participant
- Cost of IMPACT to an insured older population ~ \$1 /member/month (PMPM)
- Overall Health care in 4 yr period (IMPACT included) was ~ \$3,300. less

Sustainability



- **Payment reform to capitated value-based care**
 - Accountable Care Organizations: forming but data outcomes and realized savings at the practice-level are far off
 - Intermountain Study: 113, 452 Patients. NCQA influenced practices (have PCMH activities and team-based care) who also have BH integration have significantly better cost and health outcomes than those without Team-Based Care. In addition, the cost of implementation and support needed to build these routines is covered by the financial savings realized by Team-Based care.
 - Cost Effectiveness continued: Kaiser Permanente results are encouraging for value based care.



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IMPACT Service Activity	Billable Now	Billable Soon Proposed 1/1/17 (or are already billable)
Assessment face to face	Yes	Yes
Session face to face	Yes	Yes
Psych Consult - Face to Face	Yes	Yes
Session by phone	No – except CC Coding	Yes
Psych Consult - record	No	Yes
Telephone non-session CM	No	Yes
Practice encounter non- session - CM	No	Yes
Referral - CM	No	Yes
Chart Review - CM	No	Yes
No Show	No	No

Proposed
payment for
services
and new
coding by
CMS for
Medicare.
G codes
2017,
CPT 2018

CMS Proposed G Codes



-
- **GPPP1** - Initial psychiatric collaborative care management, first 70 minutes in the first calendar month.
 - **Outreach** to and **engagement** in treatment of a patient
 - **Initial assessment** review by the psychiatric consultant
 - Entering patient in a **registry/ tracking** patient follow-up and progress
 - **Weekly caseload consultation** with the psychiatric consultant
 - Provision of **brief interventions**: behavioral activation, motivational interviewing, and other focused treatment strategies.

CMS Proposed G Codes



-
- **GPPP2 - Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month .**
 - **Tracking** patient follow-up and progress **using the registry**
 - **Weekly caseload consultation** with the psychiatric consultant
 - Ongoing collaboration with and **coordination of the patient's mental health care** with the treating physician or other mental health providers
 - **Review of progress and recommendations for changes in treatment**
 - **Monitoring of patient outcomes** using validated rating scales
 - **Relapse prevention planning** with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.

CMS Proposed G Codes



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- **GPPP3** - Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month

(List separately in addition to code for primary procedure)

(Use **GPPP3** in conjunction with **GPPP1, GPPP2**)

Key Points for Success



- Importance of leadership and organizational commitment
- Integrated health care as part of the “culture” of an organization
- Orientation/Education is important for patients and clinic staff
- Registry functionality is a necessity
- Pre-screening with PHQ2 is more effective than PHQ9 to determine eligibility in older adults

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Barriers to Mental Health Treatment for Older Adults



-
- **Obstacles such as transportation and financial concerns make it less likely for older adults to be able to access mental health treatment outside of primary care.**
 - **Older adults and providers may have maladaptive beliefs about aging and mental health. (Rybarczyk et al., 2013)**
 - **Older patients are generally less likely to perceive a need for mental health care and are less likely to receive referrals for specialty mental health care (Klap et al., 2003).**