UPDATE ON COLLABORATIVE CARE IN HAWAII – 2023

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Project ECHO

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UH Tower 426

Disclosure

- I am employed by Queen's University Medical Group and work in Queen Emma Clinic
- No other financial conflicts of interest to disclose.

Collaborative Care Team

- Currently for Queen's employed and QCIPN PCP's who have signed agreement with QCIPN to share HIPPA protected info
- Currently three psychiatrists – 1-2 hours per week each, including one child and one geriatric psychiatrist, plus psych resident off and on
- 3 full-time LCSW Care Managers, plus social work assistants and SW interns
- Weekly Interdisciplinary team (IDT) meeting with each psychiatrist and care managers – both new cases and follow-ups as needed
- Psychiatrists and Care Managers have access to EPIC charts, and most PCP's are also on Epic and can share their charts.
- Care Managers follow-up with patient and PCP as needed, with less frequent calls as patient stabilizes and improves.

Collaborative Care Workflow

- PCP has patient with psychiatric problem, makes referral to “Behavioral Health Integration.”
- Consult goes to Care Manager, who contacts PCP within 1-3 days.
- Care Manager obtains history from PCP and reviews chart, then contacts patient, usually by phone or video.
- Care Manager does full psychosocial assessment, usually including PHQ-9, GAD-7, other relevant rating scales.
- Care Manager presents case to psychiatrist during weekly scheduled Inter-Disciplinary Team (IDT) meetings.
- Psychiatrist reviews chart via Epic (or scanned chart if PCP does not use Epic), generates consult note with specific recommendations and guidance for PCP.

Follow-up

- Care Managers follow-up with patient and PCP, consult with psychiatrist as needed during weekly IDT meetings
  - Track progress (anxiety and depression scales)
  - provide counseling to keep patient engaged in treatment
  - Are trained in brief psychotherapy modalities – Behavioral Activation and Motivational Interviewing
- Frequency of follow-up varies with acuity of patient's problem.
  - Reduced as patient improves and stabilizes
  - Can be increased if patient's condition worsens
- Psychiatrist can be called back in as needed, via IDT meetings or by phone if there is an urgent question.
- Patients are discharged from follow-up if:
  - Problem is stabilized or resolved (with "Relapse Prevention" plan),
  - If they don't respond to follow-up calls or decline further follow-up,
  - If they move away or die, or
  - If they escalate to direct care with community BH specialists.

Primary Care network

- We have trained 185 PCPs and APRNs, geriatricians, and neurologists in the Collaborative Care Model (~1/2 of independent primary care practices in HI).
- We cover Oahu and Big Island, and Molokai
- We have trained 6 SNFs on Oahu and Big Island.
- Active sites are using telehealth to run Interdisciplinary Team meetings.
- Close collaboration with Queen's geriatric team, especially for SNFs.

Problems managed by Collaborative Care

- The model was developed for mild to moderate psychiatric problems such as depression and anxiety.
- Not intended for psychosis, drug and alcohol abuse, dementia, major personality disorders.
- However, Hawaii has a severe lack of available psychiatrists, especially on neighbor islands and for patients with Medicaid (and Medicare).
- We want to support the PCPs, so we have been willing to apply the model to all problems, and find it is as effective as direct care for the vast majority, including the severe problems listed above.

Collaborative Care Financing Options

- Center for Medicare and Medicaid Services FFS codes:
  - CoCM team submits time/patient/month as “episode of care” to PCP.
  - PCP bills insurer with FFS “G” codes for ”episode of care.”
  - PCP charges co-pay to patient.
  - PCP uses most of payment to pay CoCM team.
  - No insurer in Hawaii has made this work yet
  - Collaborative Care programs on mainland find this billing system covers at most 80% of costs.
- Non-fee-for-service funding streams:
  - Accountable Care Organizations
  - Capitated systems
  - Grants

QCIPN Collaborative Care Financing

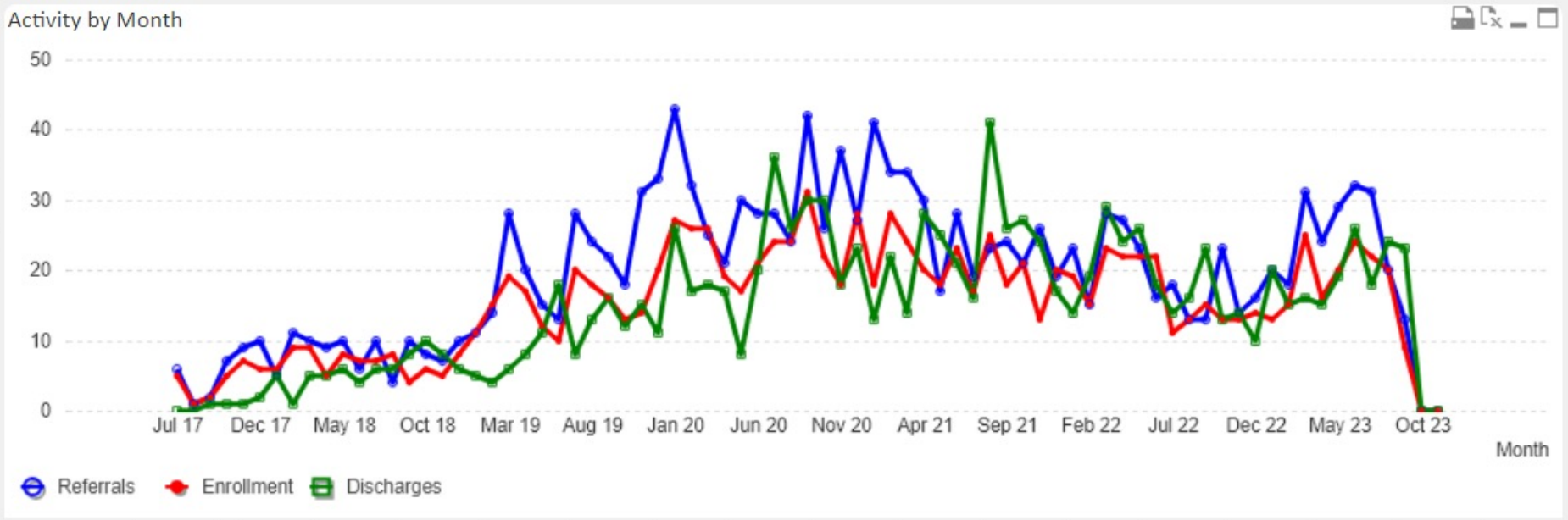
- Grants or per-case rate from most Hawaii insurers, effectively a global operating budget with all professionals paid with salaries (no FFS billing)
- Some insurers use case rate as if CMS codes were used - viable for QCIPN because no FFS saves billing and collection costs. Grants are most cost-effective financing.
- Services made available to all PCPs who are Queen's employed or affiliated by contract with QCIPN
- Program set up as community resource, no charge to PCP or patient
- Services independent of patient health insurance status
- Cost of one "module" ~ $180,000 per year:
  - 2 hours psychiatrist time, 1 FTE LCSW care manager, some admin and IT support
  - One module covers ~ 80% of mental health care needs for ~ 40-50 full-time primary care practices.

Evaluating Efficacy of Collaborative Care

- Access to care when needed?
- Patient engagement rate?
- Improvement in target symptoms (e.g. depression or anxiety)?
- Compared to direct referral to community mental health practitioner?
- Compared to co-located care (psychiatrist or other mental health professional hired within primary care practice)?
- Intangibles – with or without data on patient improvement:
  - PCP satisfaction? Caregiver satisfaction? Confidence that patient is managed appropriately?

QCIPN Collaborative Care Data Through June 2023

Activity by Month



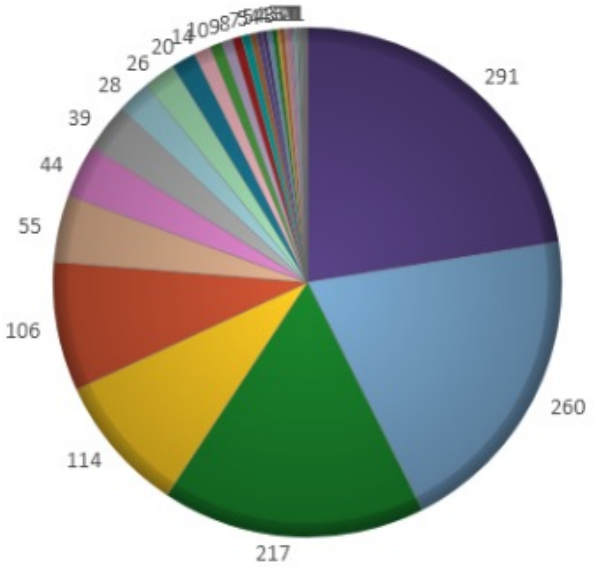
Month	Totals	2	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
Referrals	1518	3	16	18	13	13	23	14	16	20	18	31	24	29	32	31	20	13
Enrollment	1187	2	22	11	13	15	13	13	14	13	15	25	16	20	24	22	20	9
Discharges	1141	6	18	14	16	23	13	14	10	20	15	16	15	19	26	18	24	23

Total Referrals: 1518 **Total Enrollment: 1187** **Total Discharge: 1141**

Data Source: QCIPN MHI Qlikview

Primary Payor

Primary Payor



Primary Payor

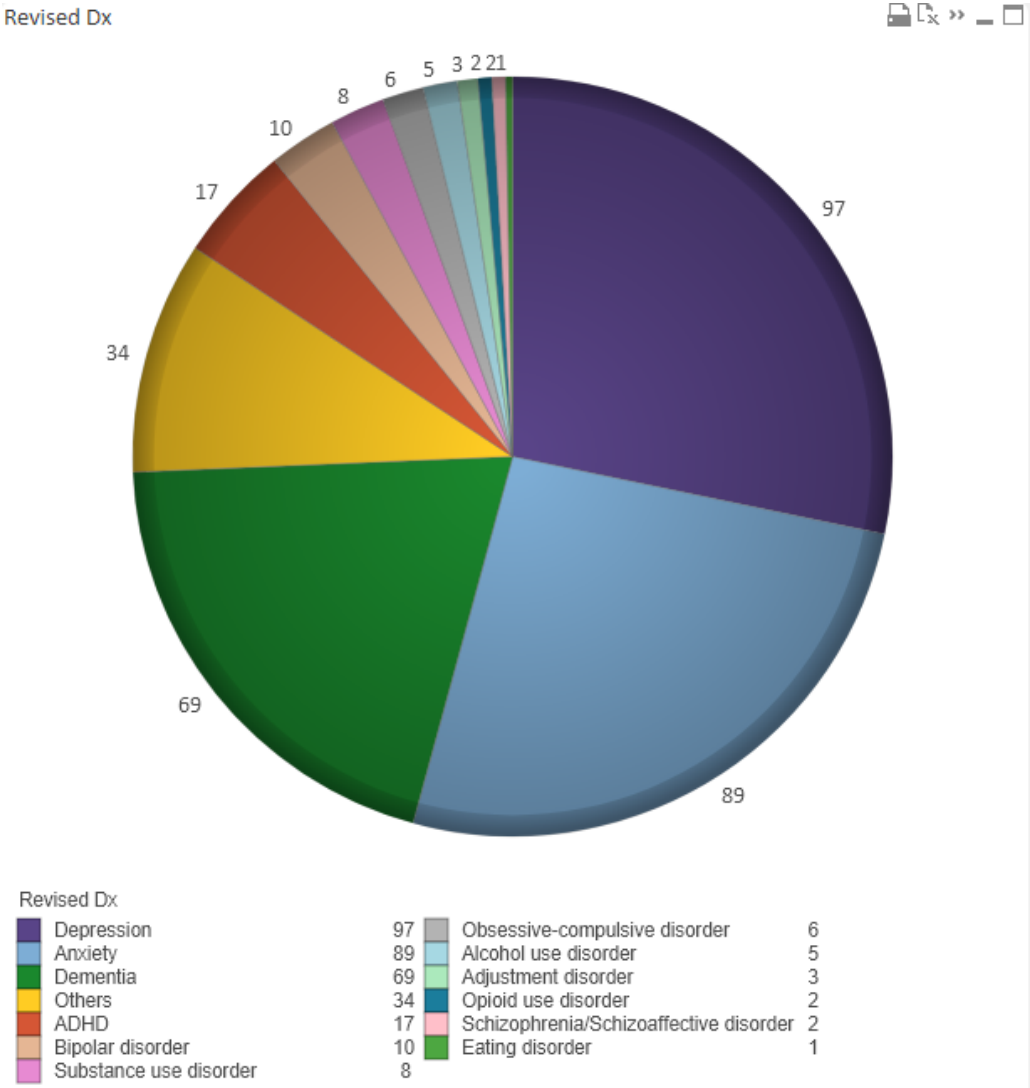
HMSA	291	OUT OF NETWORK COMM AETNA	4
MEDICARE	260	COMMERCIAL NETWORKS	4
MEDICARE PART C (MA)	217	MGH HMSA	4
QUEST INTEGRATION HMSA	114	PSWA	3
HMSA PART C (MA) 2011	106	BLUE CROSS BLUE SHIELD	3
QUEST INTEGRATION ALOHACARE	55	MGH HMSA QUEST INTEGRATION	3
TRICARE	44	VA	3
UNIV HEALTH ALLIANCE	39	CHAMPVA	2
QUEST INTEGRATION UHC	28	UNITED HEALTHCARE	2
HMSA INTERPLAN	26	QEXA UHC COMMUNITY PLAN	1
HMAA HWMG	20	KAISER OUT OF NETWORK	1
QUEST INTEGRATION OHANA	14	MGH MEDICARE PART C (MA)	1
COMMERCIAL OTHER	10	MEDICAID HAWAII	1
MEDICARE PART D DRUG COV	9	HMA	1
MDX	8	HAWAII LABORERS	1
MGH ALOHACARE QUEST INTEGRATION	7	HUMANA CHOICECARE COMMERCIAL	1
OUT OF NETWORK COMM CIGNA	5	UNITED HEALTHCARE COMMERCIAL	1
LIABILITY UNIDENTIFIED	5	KAISER SENIOR	1

Primary Payor

Primary Payor	Volume	Volume %
Total	**1295**	**100.00%**
HMSA	291	22.47%
MEDICARE	260	20.08%
MEDICARE PART C (MA)	217	16.76%
QUEST INTEGRATION HMSA	114	8.80%
HMSA PART C (MA) 2011	106	8.19%
QUEST INTEGRATION ALOHACARE	55	4.25%
TRICARE	44	3.40%
UNIV HEALTH ALLIANCE	39	3.01%
QUEST INTEGRATION UHC	28	2.16%
HMSA INTERPLAN	26	2.01%
HMAA HWMG	20	1.54%
QUEST INTEGRATION OHANA	14	1.08%
COMMERCIAL OTHER	10	0.77%
MEDICARE PART D DRUG COV	9	0.69%
MDX	8	0.62%
MGH ALOHACARE QUEST INTEGRATION	7	0.54%
LIABILITY UNIDENTIFIED	5	0.39%
OUT OF NETWORK COMM CIGNA	5	0.39%
COMMERCIAL NETWORKS	4	0.31%
MGH HMSA	4	0.31%
OUT OF NETWORK COMM AETNA	4	0.31%
BLUE CROSS BLUE SHIELD	3	0.23%
MGH HMSA QUEST INTEGRATION	3	0.23%
PSWA	3	0.23%
VA	3	0.23%
CHAMPVA	2	0.15%
UNITED HEALTHCARE	2	0.15%
HAWAII LABORERS	1	0.08%
HMA	1	0.08%
HUMANA CHOICECARE COMMERCIAL	1	0.08%
KAISER OUT OF NETWORK	1	0.08%
KAISER SENIOR	1	0.08%
MEDICAID HAWAII	1	0.08%
MGH MEDICARE PART C (MA)	1	0.08%
QEXA UHC COMMUNITY PLAN	1	0.08%
UNITED HEALTHCARE COMMERCIAL	1	0.08%

Data Source: QCIPN MHI Qlikview

Conditions 2023

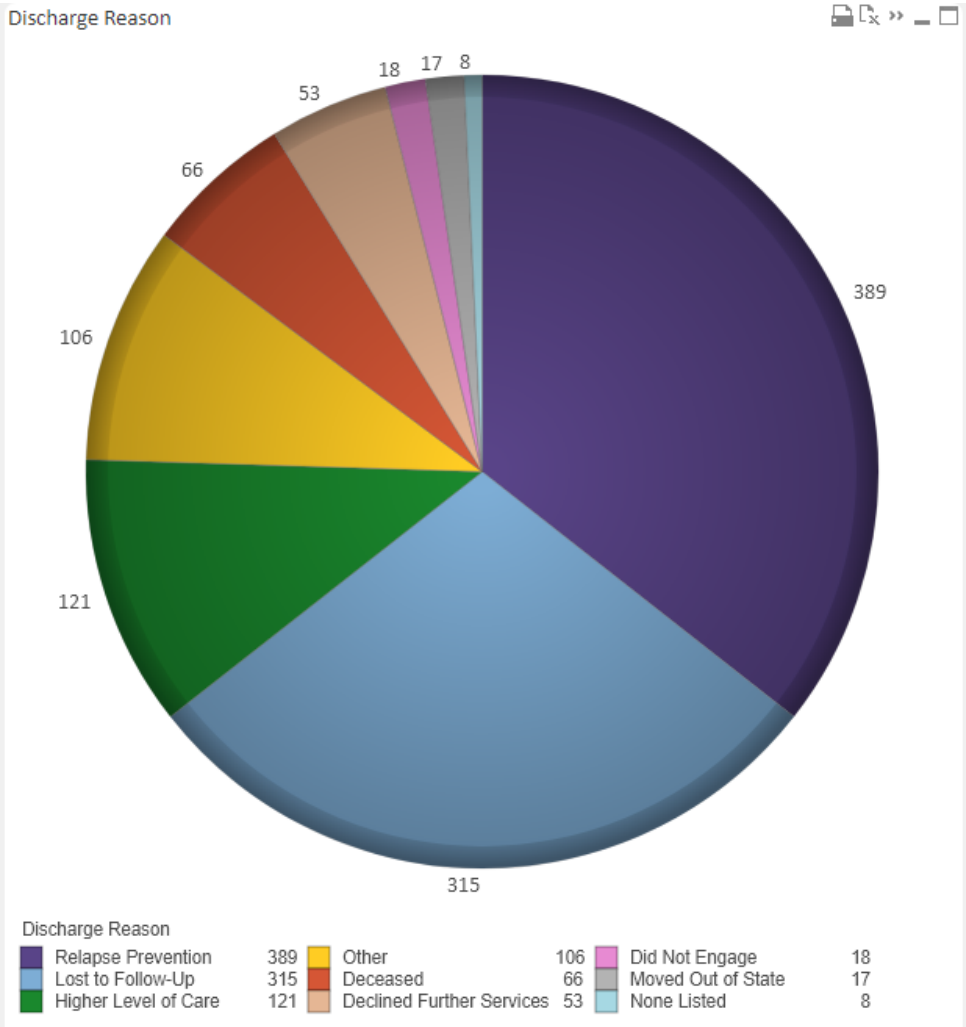


Revised Dx

Revised Dx	Volume	Volume %
Total	**229**	**100.00%**
Depression	97	28.28%
Anxiety	89	25.95%
Dementia	69	20.12%
Others	34	9.91%
ADHD	17	4.96%
Bipolar disorder	10	2.92%
Substance use disorder	8	2.33%
Obsessive-compulsive disorder	6	1.75%
Alcohol use disorder	5	1.46%
Adjustment disorder	3	0.87%
Opioid use disorder	2	0.58%
Schizophrenia/Schizoaffective disorder	2	0.58%
Eating disorder	1	0.29%

Data Source: QCIPN MHI Qlikview
Disclosures: Conditions are not mutually exclusive.

Discharge Reason



Discharge Reason

Discharge Reason	Volume	Volume %
Total	**1093**	**100.00%**
Relapse Prevention	389	35.59%
Lost to Follow-Up	315	28.82%
Higher Level of Care	121	11.07%
Other	106	9.70%
Deceased	66	6.04%
Declined Further Services	53	4.85%
Did Not Engage	18	1.65%
Moved Out of State	17	1.56%
None Listed	8	0.73%

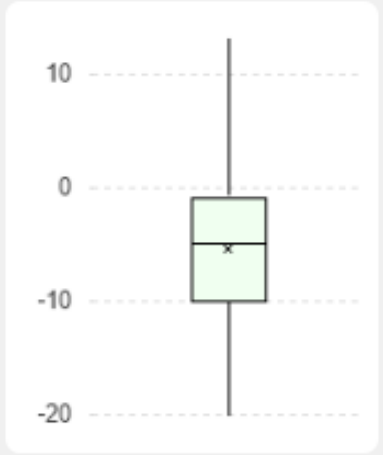
Data Source: QCIPN MHI Qlikview

PHQ9 Changes in Patients with Depression

Since Program Start

Last Enrolled** PHQ9 Change

N	244
Average	-5.5
Max	13.0
75th %ile	-1.0
Median	-5.0
25th %ile	-10.0
Min	-22.0



Has Last Enrolled Score N=244
Reached Response (>50% Change) = 104
Reached Remission (Score <5) = 95
Reached Response or Remission = 122
Average Last Enrolled Score: 8.85 (-37%)

Score at enrollment: Range: 1-25 | Average: 14.1

**Score at enrollment vs last score available during time enrolled (may still be enrolled)

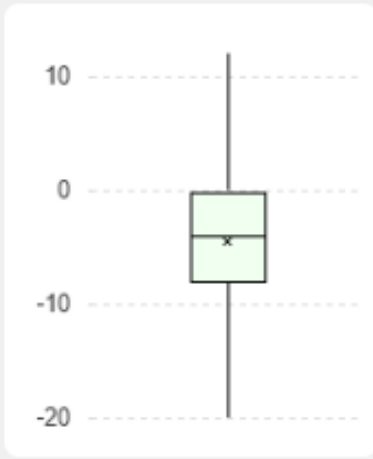
Data Source: QCIPN MHI Qlikview

GAD7 Changes in Patients with Anxiety Disorder

Since Program Start

Last Enrolled** GAD7 Change

N	218
Average	-4.5
Max	12.0
75th %ile	-0.3
Median	-4.0
25th %ile	-8.0
Min	-20.0



Has Last Enrolled Score N= 218

Reached Response (>50% Change) = 107

Reached Remission (Score <10) = 149

Reached Response or Remission = 149

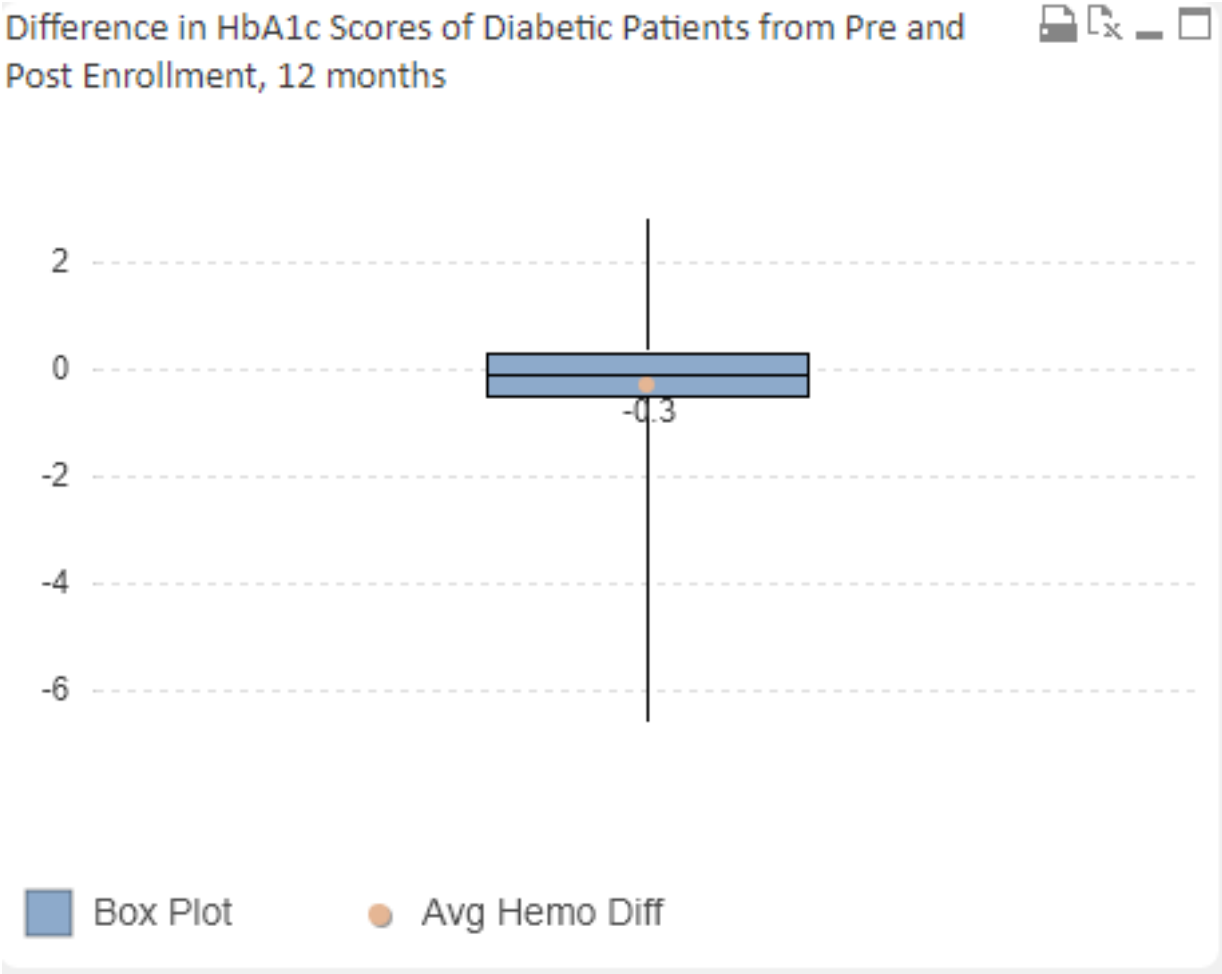
Average Last Enrolled Score = 7.45 (-35%)

Score at enrollment: Range: 1-21 | Average: 11.5

**Score at enrollment vs last score available during time enrolled (may still be enrolled)

Data Source: QCIPN MHI Qlikview

Change in HbA1c for Diabetic Patients

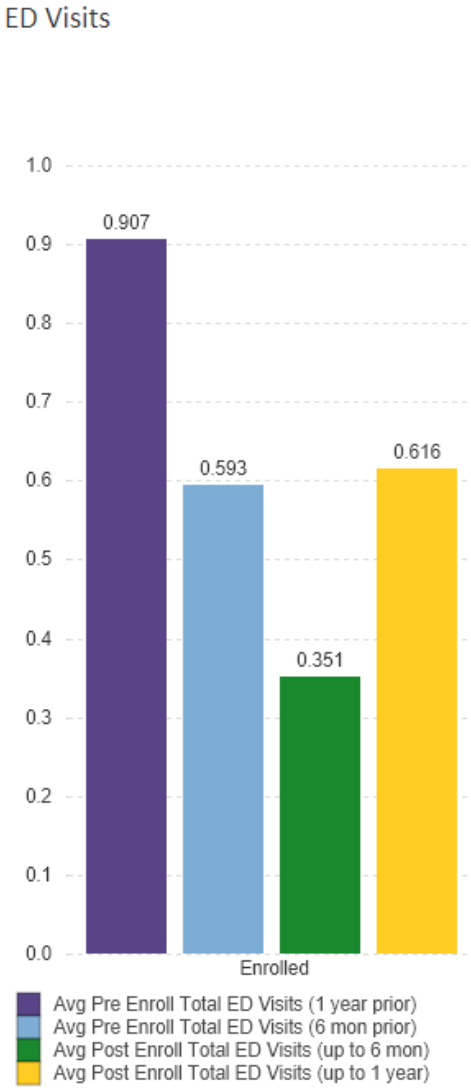


Difference in HbA1c Scores

HbA1C Difference	HbA1C Difference
N	95
Average	-0.3
Max	2.8
75th %ile	0.3
Median	-0.1
25th %ile	-0.5
Min	-6.6

Data Source: QCIPN MHI Qlikview

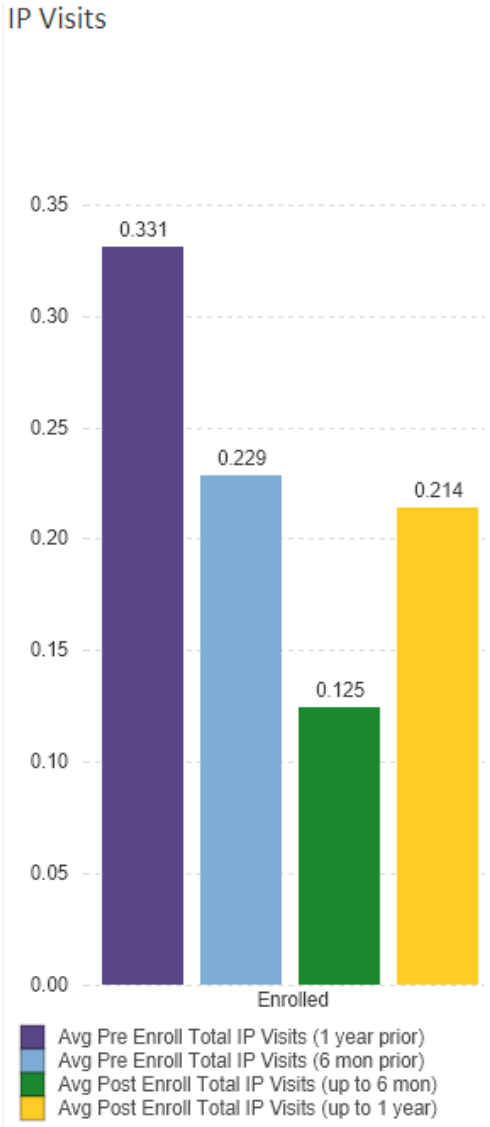
ED Visits (QHS Data Only)



N	N (> 6mo Post Enroll)	N (> 12 mo post Enroll)	Pre Enroll Total ED Visits (1 year prior)	Pre Enroll Total ED Visits (6 mon prior)	Post Enroll Total ED Visits (up to 6 mon)	Post Enroll Total ED Visits (up to 1 year)
1129	1027	947	1.02e+03	670	360	583

Data Source: QCIPN MHI Qlikview

IP Visits (QHS Data Only)



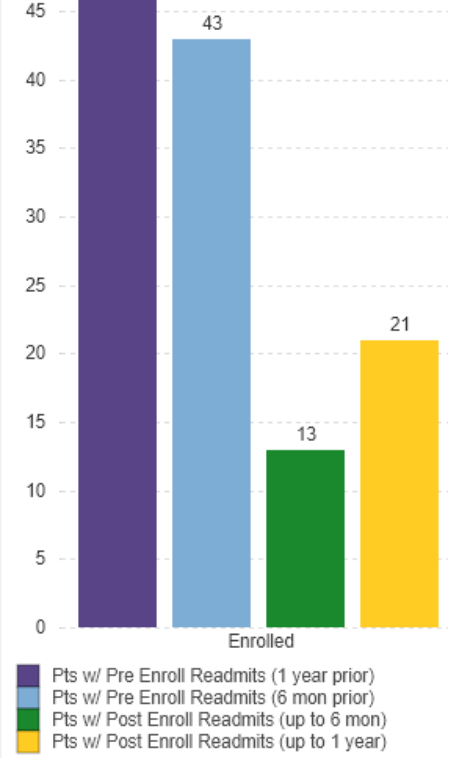
N	N (> 6mo Post Enroll)	N (> 12 mo post Enroll)	Pre Enroll Total IP Visits (1 year prior)	Pre Enroll Total IP Visits (6 mon prior)	Post Enroll Total IP Visits (up to 6 mon)	Post Enroll Total IP Visits (up to 1 year)
1129	1027	947	374	258	128	203

Data Source: QCIPN MHI Qlikview

IP Readmits (QHS Data Only)

IP Readmits

N	N (> 6mo Post Enroll)	N (> 12 mo post Enroll)	Pre Enroll Total IP Visits (1 year prior)	Pre Enroll Total IP Visits (6 mon prior)	Post Enroll Total IP Visits (up to 6 mon)	Post Enroll Total IP Visits (up to 1 year)	Pre Enroll Total Readmits (1 year prior)	Pre Enroll Total Readmits (6 mon ...	Post Enroll Total Readmits (up to 6 mon)	Post Enroll Total Readmits (up to 1 year)
1129	1027	947	374	258	128	203	74	60	15	24



Data Source: QCIPN MHI Qlikview

Primary Care Treatment of Depression

Response, Partial Response, and Nonresponse in Primary Care Treatment of Depression

Corey-Lisle, Nash et. Al. Archives of Internal Medicine, June 14, 2014

- (E) Enrolled = 688,
- (C) Completed 6-month Evaluations = 482 (70% engagement)
- (F) Dropped out/failed to engage = 206 (30%)
- (QCIPN program has 78% engagement rate.)

- Remitters: 109 (22.6% of C, 15.8% of E) (QCIPN - 40%)
- Partial responders: 152 (31.5% of C, 22.1% of E)
- Response or remission: 54% of C, 37.9% of E (QCIPN – 51% of E)
- Non-responders = 45% of C
- Failures – non-responders plus dropouts = 59% of E

Co-Located care (CoL) vs Collaborative Care Model (CoCM)

Comparison of Collaborative Care and Colocation Treatment for Patients With Clinically Significant Depression Symptoms in Primary Care.

Blackmore et. al. Psychiatric Services. Nov 2018.

- Primary care patients with PHQ-9 ≥ 10
- Engagement in study: 43% - 240/541 patients
  - (118 CoCM, 122 CoL)
- Outcome - reduction in PHQ-9 scores at 12 weeks:
  - CoL: 14%↓ in PHQ-9
  - CoCM: 33%↓ in PHQ-9

(QCIPN: 38%↓ in PHQ-9)

Beyond Psychiatry

- Collaborative Care greatly enhances efficacy of primary care – PCPs report increasing confidence in managing psychiatric problems knowing they have expert backup if they have any questions
- Psychiatric problems become much less stressful
  - Care Manager gathers full history and provides frequent patient contact,
  - Expert psychiatric advice enables PCP to know they are “doing the right thing” for their patients.
- Collaborative Care Model is applicable to any specialty consultation that does not require an imminent procedure
- Preliminary discussions with neurology, managing congenital heart disease, complex endocrine problems, and UHA’s “Medical Yurt” model for complex cases.

Questions?

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