Southern California Regional Implementation & Improvement Science Webinar Series

Welcome to the Webinar

Karen Coleman, PhD
Research Scientist II
Southern California Permanente Medical Group

"Thoughts about the Implementation of an Evidence-Based Approach to Collaborative Care in Patients with Depression and Cardiovascular Disease"

1. Everyone will be in listen-only mode, until Q&A.
2. To be able to speak, you must enter your *Audio Pin – do so by pressing #PIN#*
3. If you are unable to find the *Audio Pin*, or don't want to talk, feel free to type in your questions in the box to the right.
4. Any additional questions? Please email them to abmartinez@mednet.ucla.edu or isankare@mednet.ucla.edu.

The webinar will begin shortly.

At the end, please take 2 minutes to complete a brief evaluation.

Thoughts about the Implementation of an Evidence-Based Approach to Collaborative Care in Patients with Depression and Cardiovascular Disease.

Karen J. Coleman, PhD
Research Scientist, Department of Research and Evaluation
Kaiser Permanente Southern California

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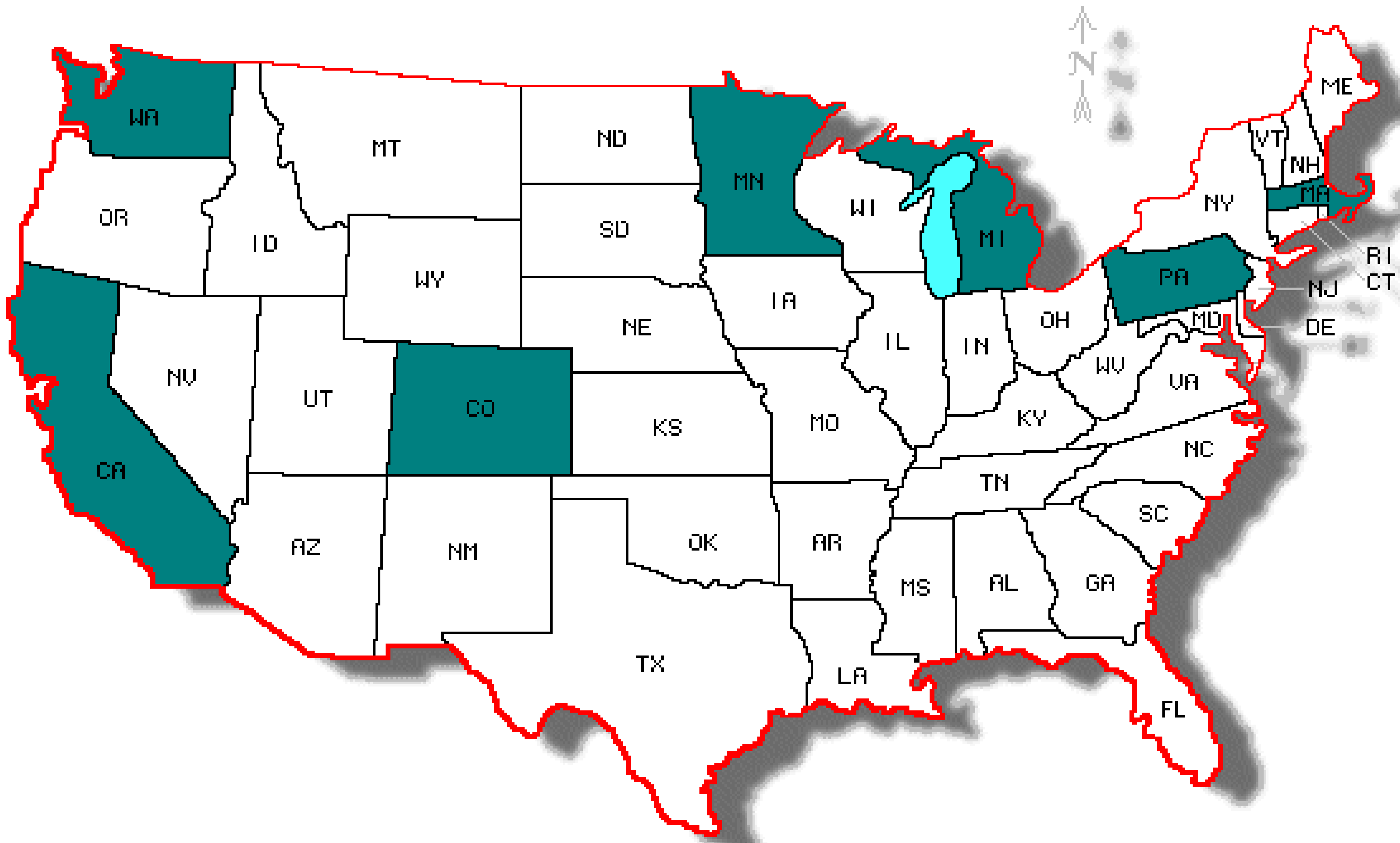
Care Of Mental, Physical And Substance-use Syndromes (COMPASS)

- COMPASS is a three-year initiative funded by Centers for Medicare and Medicaid Services (CMS) Healthcare Innovation Challenge
- Implementation of innovative care strategies – not primarily a research project
- Objectives of CMS Innovation Challenge:
  - Lower cost of care for people enrolled in government programs like Medicare and Medicaid
  - Engage broad set of partners to test new delivery models
  - Identify new models of workforce development to create jobs
  - Leverage existing models to improve patient care quickly
- Goals
  - Achieve depression improvement and/or remission in 40% of patients
  - Improve diabetes control rates by 20%
  - Decrease hospitalizations and emergency department visits



COMPASS Consortium Partners

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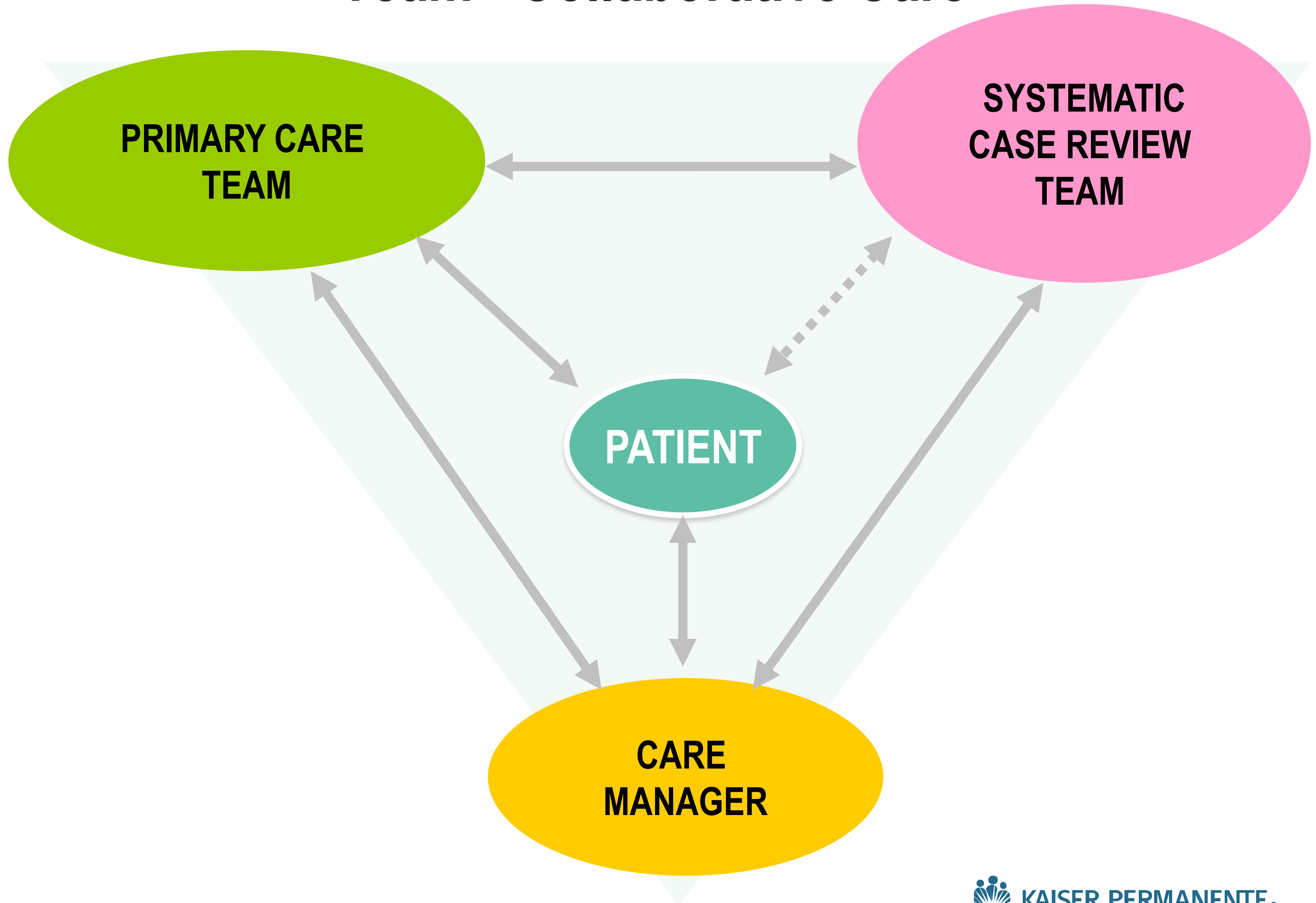
COMPASS Intervention Partners

- Multi-stakeholder Health Care Collaborative (Mi-CCSI)
- Mount Auburn Cambridge IPA , MA (MACIPA)
- Pittsburgh Regional Health Initiative (PRHI)
- Kaiser Permanente Colorado (KPCO)
- Community Health Plan of Washington (CHPW)
- Institute for Clinical Systems Improvement (ICSI)
- Kaiser Permanente Southern California (KPSC)
- Mayo Health System (MAYO)

Team - Collaborative Care



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Required Treatment Components

- Every new patient is reviewed by the Systematic Case Review (SCR) team
- Patients not responding to treatment are reviewed by the SCR thereafter
- Every patient should have a contact (phone or in person) from a care manager once per month (minimum)
- Evaluate depression symptoms at every contact
- Treat-to-Target guidelines are followed to achieve goals of depression improvement/remission and diabetes control (aggressive medication management and behavior change efforts)
- HbA1c assessed every 6 weeks while adjustments in treatment are made
- Treatment phase is a minimum of 6 months followed by 6 months of maintenance
- Discharge should be accompanied by a Relapse Prevention Plan
- Therapy should NOT be provided – only Behavioral Activation and Problem Solving "Therapy" to address behavior change
- Psychiatry, endocrinology, social medicine, and other specialty care is coordinated – patients are not refused treatment unless there is serious illness

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Kaiser Southern California Site Characteristics

- **Site 1**
  - Located in the Inland Empire with a large Hispanic population and high rates obesity and chronic illness
  - 1.5 FTE Physician Assistants and 0.5 FTE Registered Nurse
  - 5 – 10 Diabetes Care Managers (already in place) who are closely linked to PAs but not devoted to COMPASS patients
  - PAs primarily handle depression care and coordinate closely with diabetes care managers
  - PAs order all medications with approval from primary care physician
- **Site 2**
  - Located in Los Angeles metro area with large multilingual, transient population
  - 1.0 FTE Registered Nurse and 0.5 Licensed Social Worker
  - 5 – 10 Diabetes Care Managers (already in place) linkage is diffuse
  - Nurses primarily handle diabetes care with depression care in mild cases and LCSW handles moderate to severe depression
  - Do not have the ability to order medication and depend heavily on the primary care physicians and psychiatrists

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Kaiser Southern California Site Characteristics

- **Site 3**
  - Located in the Coastal Areas of LA county (Long Beach) with high African American population
  - 1.25 FTE Licensed Social Workers (LCSW)
  - 0.5 FTE Registered Nurses (RN) [Diabetes Care Managers]
  - LCSWs only do depression and Nurses only do diabetes although they are somewhat cross-trained and closely coordinate work
  - Do not have the ability to order medication and depend heavily on the primary care physicians and psychiatrists
- **Site 4**
  - Located in San Diego county with extremely diverse population, primarily Hispanic
  - 2.0 FTE Physician Assistants
  - PAs exclusively handle both depression and diabetes
  - PAs order all medications with approval from primary care physician

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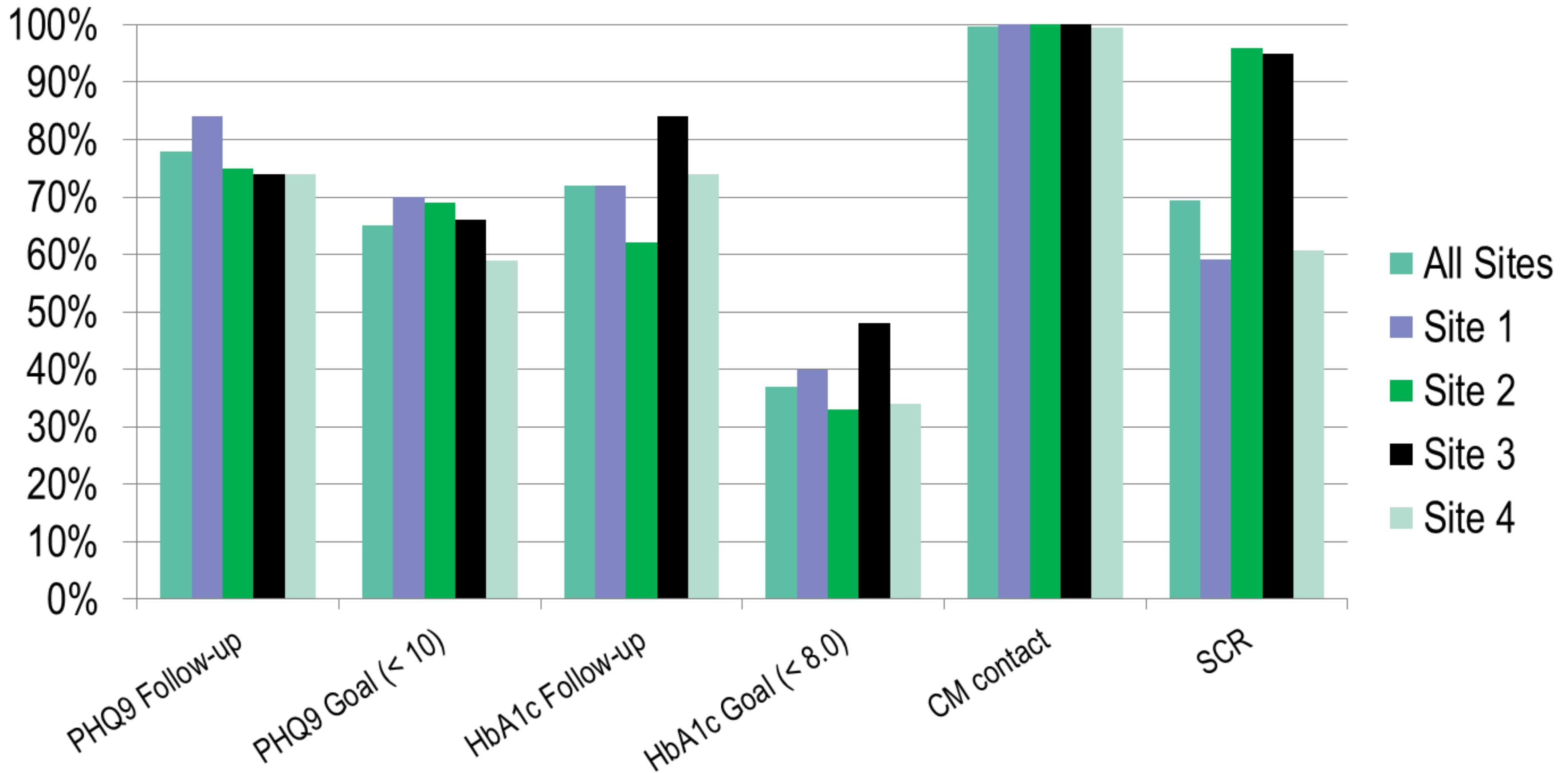
	ALL Sites	Site 1	Site 2	Site 3	Site 4
Patients	416	137	72	39	168
% Male	34%	39%	29%	15%	36%
Age in years	61 ± 11	62 ± 11	62 ± 11	58 ± 12	60 ± 11
% ≥ 65 years old	42%	45%	43%	36%	40%
% < $75,000 year	69%	71%	72%	71%	67%
% ≤ High School	50%	59%	46%	53%	44%
INSURANCE STATUS					
% Medicare	47%	55%	47%	44%	42%
% Medicaid	17%	21%	18%	13%	14%
% Commercial	61%	56%	60%	69%	63%
% Other	55%	53%	42%	49%	63%
RACE/ETHNICITY					
% White	31%	29%	25%	21%	39%
% Black	16%	18%	13%	49%	9%
% Hispanic	44%	47%	54%	31%	41%
% Other/Missing	8%	6%	8%	0%	11%
% Spanish	18%	20%	33%	10%	13%
% High Comorbidities	82%	88%	82%	74%	80%

Implementation and Outcomes



PHQ9 = patient health questionnaire; HbA1c = hemoglobin A1c; CM = care manager; SCR = systematic case review

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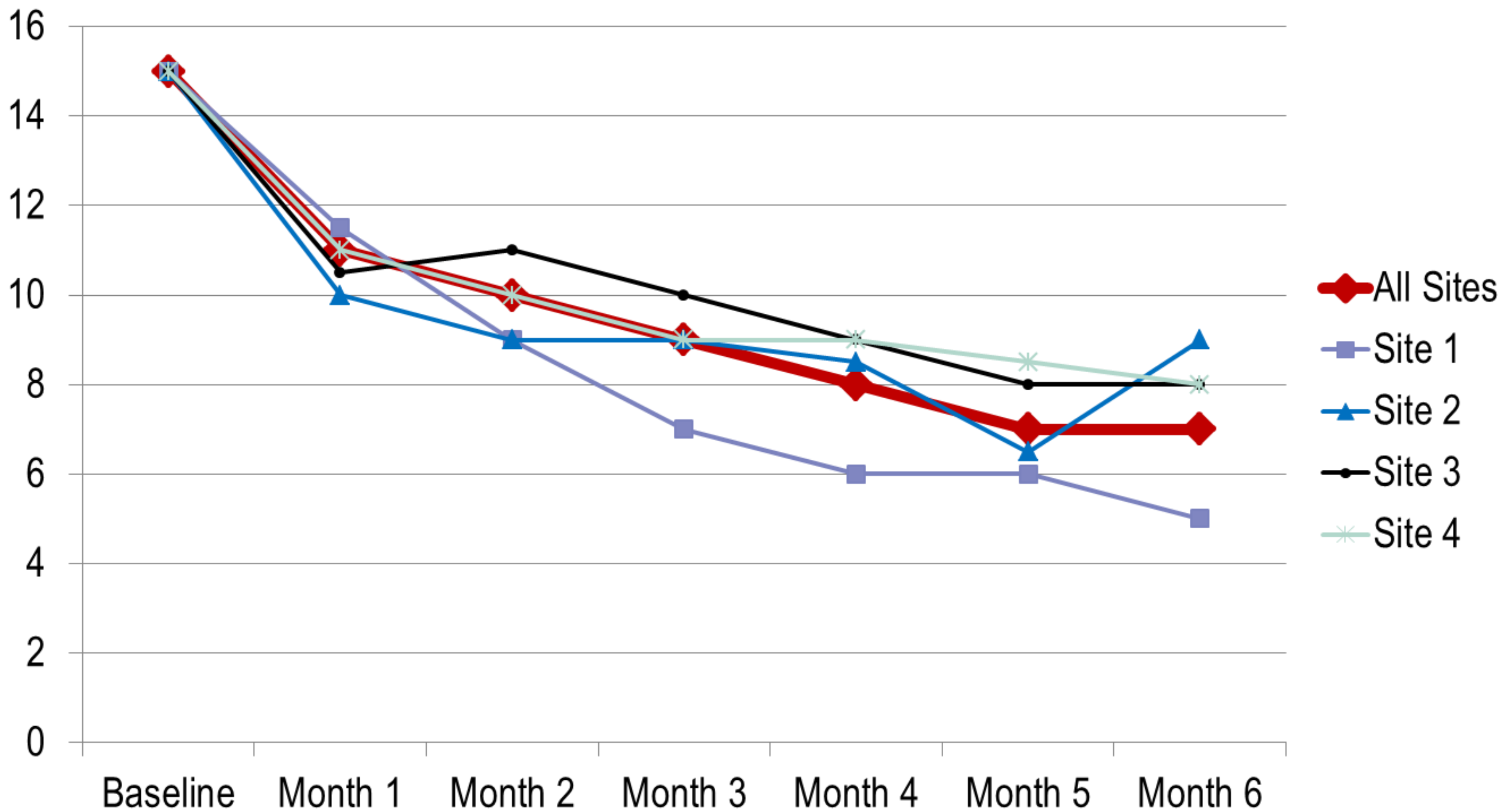

average change overall – 7.56 (-8.23,-6.88); $p < .001$; n = 323

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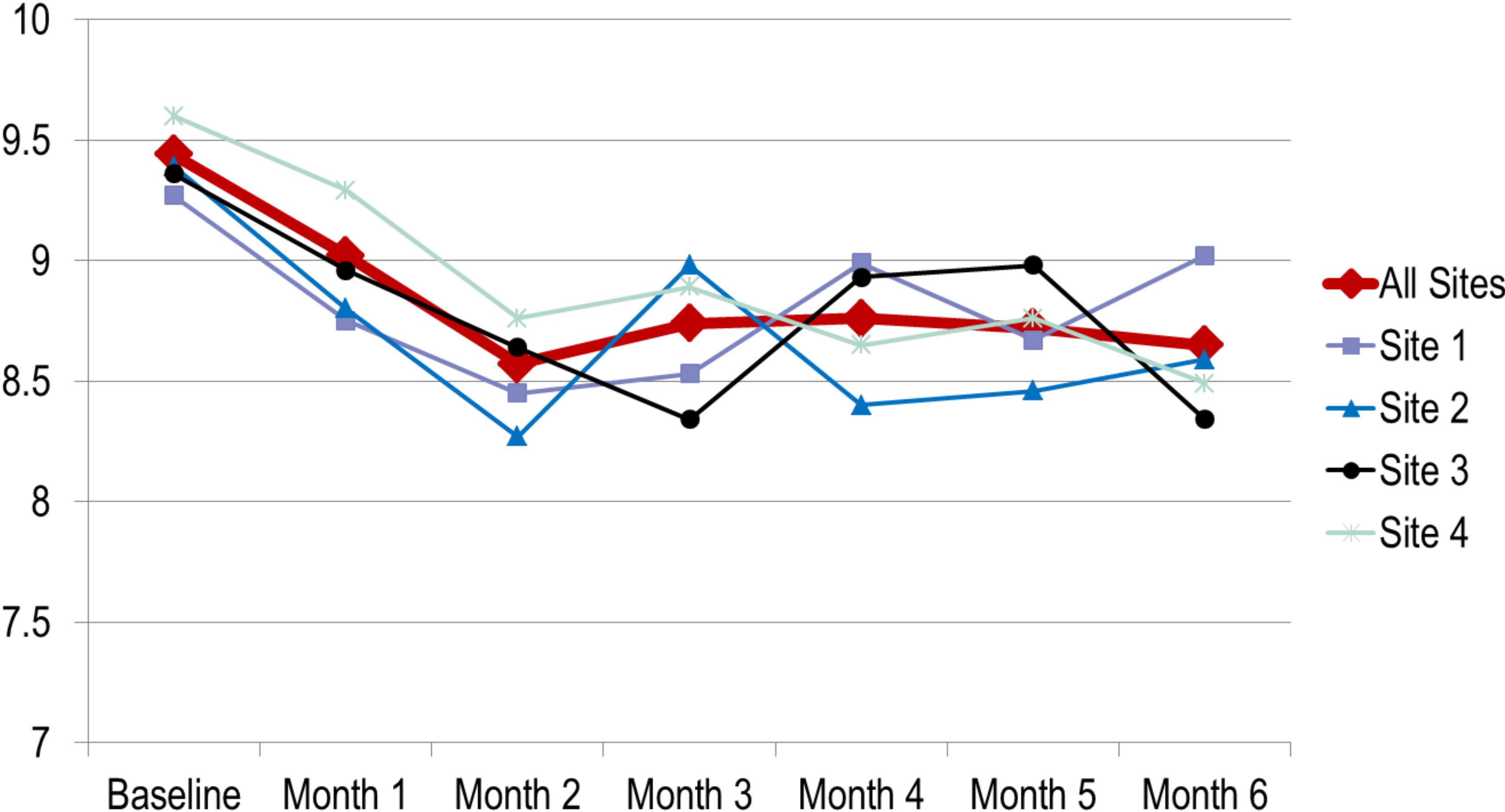
HBA1c for Diabetics



average change overall – 0.56 (-0.75,-0.36); $p < .001$; n = 273

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Successes and Barriers

- Successes
  - Care managers are able to manage larger panels of complex patients and prevent the use of more expensive ER and inpatient services
  - Consulting physicians and psychiatrists are integrated into resources available for care managers
  - Psychiatry, addiction medicine, and social medicine are seen as specialty care much like endocrinology and cardiology and are not outside the scope of primary care treatment
  - Patients who otherwise would not receive treatment are responding to care
- Barriers (specific to KPSC)
  - Layered COMPASS onto existing care management systems that are specialized by condition leading to many scope of practice concerns
  - Care managers not cross-trained to handle multiple needs
  - Competing demands of large healthcare organization
  - Expensive short term – full time care manager panel 75 - 100 patients; treatment at least 6 – 12 months