IMPACT
Delivering Care as a Team

IMPACT Workflow

Identify & Engage
Establish a Diagnosis
Initiate Treatment
Follow-up Care & Treat to Target
Complete Treatment & Relapse Prevention

System Level Supports

IMPACT Team Approach
Primary Care Provider

PCP oversees all aspects of patient's care.
- Introduces IMPACT team
- Diagnoses common mental disorders
- Starts & prescribes pharmacotherapy
- Makes treatment adjustment in consultation with team

Behavioral Health Care Manager

Owns the caseload of patient and coordinates integrated treatment plans. Either BH CM or psychotherapist delivers brief behavioral interventions.
- Facilitates patient engagement and behavioral health education
- Performs systematic initial and follow-up assessments; Systematically tracks treatment response
- Supports treatment plan with PCPs; Reviews challenging patients with the consulting psychiatrist weekly

Shared Care Manager

- Define / Split Care Manager tasks
- Coordinate efforts
- Keep therapist involved in care management
  - Registry can help
- Clear communication plan
- How will psychiatric consultation be handled?
Psychiatric Consultant

Supports care managers and PCPs through caseload consultation.
- Provides regular (weekly) and as needed consultation on a caseload of patients followed in primary care
- Focus on patients who are not improving clinically
- +/- In person or telemedicine consultation
- Provides education for team

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Rachel Jones

Rachel Jones is a 62 y/o woman who attends her regular check-up for hypertension and hypothyroidism. She has a past history of depression and is concerned about recent weight gain.
Checkpoint: Identify

If Rachel Jones was in your waiting room, what would happen next for Rachel using an IMPACT approach?

– How will you identify patients that need depression treatment?
– Who will administer depression screening?

Behavioral Health Measures as “Vital Signs”

Behavioral health measures are like monitoring blood pressure!

– Identify that there is a problem
– Need further assessment to understand the cause of the “abnormality”
– Help with ongoing monitoring to measure response to treatment

More to come this afternoon!

Rachel Jones

• Clinic screens all patients with HTN and diabetes for depression by giving them measures as part of the registration packet
• Vital Signs taken
  – PHQ-9 (depression): score is 16 (high)
  – GAD-7 (anxiety): GAD-7 is 5 (normal)
  – AUDIT (alcohol): AUDIT is 0 (she does not drink).
  – Other vitals normal (BP, HR)
• PCP Dr. Smith sees patient
  – Increase in BMI from 26 to 27
  – Asks about elevated PHQ-9
  – Low mood and lack of motivation for several years
  – Treated in the 90’s with amitriptyline for depression
  – Now lack of exercise and subsequent recent increase in her weight.
Checkpoint: Engage

- Dr. Smith is concerned that Rachel Jones is depressed
  - What would happen next in your clinic?
  - How will you engage patients like Rachel Jones in IMPACT?
  - How will you introduce IMPACT to patients like Rachel Jones?

Practice

- GOAL: Each person will generate PERSONALIZED introduction to IMPACT based on real role in clinic
  - Get into pairs → Each person gets 5 minutes to practice introducing IMPACT
  - Model introduction to IMPACT on worksheet
  - Partner provides feedback
  - Ideally get to do 2 “introductions”

Common Misconceptions about IMPACT

- ALL patients will be treated with medications → 10-15% never had medication in original study
- ALL patients will receive psychotherapy → Only 30% of patients in original study ever received psychotherapy
- PST is the ONLY therapy that can be used → PST is best place to start but not the only option
- PST is IMPACT → IMPACT is way of providing care
**Identify and Engage**

- Identify people who may need help
- Screen for behavioral health problems using valid measures
- Identify safety concerns
- Engage patient in integrated care program
- Introduce IMPACT

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**Provisional Diagnosis**

- Assessment by PCP, CM & Therapist
- Psychiatric Consultant Case Review
- Measures filled out by patient
- Provisional diagnosis and treatment plan

→ More to come!
Rachel Jones – Meeting the Care Manager
• PCP introduces Care Manager, Sue Black, as a member of the primary care team

Checkpoint: Establish a Diagnosis
• Dr. Smith introduces patient to Sue Black the Care manager
  – What will happen next in your clinic?
  – How will you establish a diagnosis?

Rachel Jones – Meeting the Care Manager
Sue discovers a pattern consistent with Major Depression
• Confirms that there are no acute safety concerns. No SI. No history of suicide attempts.
• Reviews that depression symptoms have been present for two years worse in last few months.
• Assesss current functioning including social isolation and that Rachel Jones is no longer riding her bike.
• Takes family history and prior treatment history.
• No symptoms of mania, trauma, anxiety or substance use.
Establish Diagnosis

- Perform Initial Assessment
- Identify & Treat Co-existing Medical Conditions
- Diagnose Behavioral Health Disorders
- Patient Education about Symptoms & Diagnosis

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System Level Supports

Rachel Jones – Meeting the Care Manager

- Describes treatment options
  - Behavioral interventions
  - Medications
- That first visit she works with Rachel Jones to:
  - Set treatment goals
  - Pleasant events scheduling to call 2 friends from her bike club in the next week
  - Provide educational material on sleep hygiene
- Rachel Jones is also interested in medication treatment
Checkpoint: Initiate Treatment

- Sue Black presents range of treatment options: Rachel Jones interested in medication
  - What happens next in your clinic?
  - Would the CM talk to the PCP or the psychiatric consultant first?
  - Would the patient need to make another appointment with PCP?
  - How will the CM track the patient’s progress to getting medication prescribed?
  - How will follow up be scheduled?

Rachel Jones – Psychiatric Consultant

- Sue and Dr. Smith want to treat with an antidepressant
- Rachel Jones reports past weight gain with SSRI but willing to try antidepressant
- Dr. Smith is unsure what to do next and has Sue call the Jane Johnson, ARNP, the psychiatric consultant
  - suggests a trial of bupropion
  - warns of potential problems with activation and insomnia
  - suggests Dr. Smith call her if she has any questions
  - inquires if there is a recent TSH
- The PCP and BHP discuss the treatment strategy with Rachel Jones and initiate treatment
  - Dr. Smith writes a prescription
  - Sue adds Rachel Jones to the registry

Communication: Care Manager and Primary Care Provider

GOAL: Efficiently communicate changes in clinical and functional status

- Specific Question / Request
- Brief history of problem
  - Baseline Clinical measures; e.g., PHQ-9 Score
  - Current Symptoms / persistent symptoms
  - Current treatment duration, effectiveness, side effects.
  - Psychiatric recommendations
PCP Discussion Template

Communication: Care Manager and Psychiatric Consultant

GOAL: Provide psychiatric expertise to team
- Through consultation
  ✓ Scheduled
  ✓ As Needed
- Education
  ✓ Integrated
  ✓ Presentations

Psychiatric Consultation Model Consultation Hour
- Brief check in
  – Changes in the clinic
  – Systems questions
- Identify patients and conduct reviews
  – Requested by CM
  – Not improved w/o note
  – Severity of presentation
  – Disengaged from care
- Wrap up
  – Confirm next consultation hour
  – Send any educational resources discussed
Consulting Psychiatrist Template

Provider to Provider Communication: How and When?

• Consider modality
  – In person
  – Staff (MA or nurse)
  – Phone
  – Fax
  – Email (careful with confidential info)
  – EMR
• Frequency
  – Scheduled
  – As needed

Planning

• Plan YOUR team communication!
• Break into small groups for each clinic and use Team Communication Planning Worksheet
  – Consider provider to provider communication
  – Consider modality
  – Consider frequency
• May need to capture which handoffs need further discussion!
Checkpoint: Initiate Treatment

• What if Rachel Jones had active suicidal ideation?
  – What would happen next in your clinic?
  – What is your clinic protocol around safety concerns?
  – Who would be involved in assessing the patient and initiating care?
  – How will follow up be scheduled?

Establishing a Clinical Safety Protocol

• Elements of a protocol
  – What is done immediately with patient?
  – Who is consulted?
  – What does follow-up look like?

• Sample Protocols
  – Project Vida
  – Peninsula Community Health Services

Initiate Treatment

• Patient Education about Recommended Treatment
• Develop Behavioral Health Treatment Plan
• Prescribe Psychotropic Medications – as indicated
• Evidence-based Psychotherapy (e.g., PST, Behavioral Activation, CBT, IPT) – as indicated
• Facilitate Referral to Specialty Care or Social Services – as indicated
Rachel Jones: Follow Up

- Sue calls Rachel Jones the following week:
  - Checks on mood
  - Asks if she made the calls to her friends
  - Assesses her for sleep and tolerance of the bupropion
  - Has her complete the PHQ-9 and the score is now 12 and records this in the registry
  - She also confirms her follow-up appointments
- During weekly caseload review with Jane Johnson, they discuss Rachel Jones and confirm plan and will continue to monitor her progress

Typical Course of Care Management: Contact Frequency

- **Active Treatment**
  - Until patient has >50% decrease in symptoms and/or PHQ-9 score under 10
  - Minimum 2 contacts per month
    - Typical during first 3-6 months of treatment
    - Mix of phone and in-person works
- **Monitoring**
  - 1 contact per month
    - After 50% decrease in PHQ / GAD (or similar) achieved
    - Monitor for ~3 months to ensure patient stable
Comparison of Contacts in Usual Care vs. IMPACT

**USUAL CARE**

- 3.5 PCP Contacts per year
- 20% - 40% treatment response/improvement

Based on HRSA report of average PCP visit rates for FQHCs

**Collaborative Care**

- 3.5 PCP Contacts per year
- 10 contacts with CM (on average)
- 2 case consultations from psychiatrist to CM/PCP (on average)
- 50% - 70% treatment response/improvement

Follow Up Care and Treat to Target

- Track Treatment Engagement & Adherence using Registry
- Reach out to Patients who are Non-adherent or Disengaged
- Track Patients’ Symptoms with Measurement Tool (e.g., PHQ-9)
- Track Medication Side Effects & Concerns
- Track Outcome of Referrals & Other Treatments
- Assess Need for Changes in Treatment
- Provide Caseload-Focused Psychiatric Consultation Focused on Non-responding Patients
- Proactively Adjust Treatment if Patients are Not Responding
- Facilitate Changes in Treatment Plan
- Provide In-Person or Telehealth Psychiatric Assessment of Challenging Patients
Typical Course of Care Management: Duration

- 6 months (average)
- Determined by clinical outcomes
  - 50%-70% of patients need at least one change in treatment to improve
  - Each change of Tx moves an additional ~20% of patients into response or remission

Complete Treatment and Provide Relapse Prevention

- Assess for Completion of Goals
- Create & Support Relapse Prevention Plan
- Communicate Plan to Team
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Provide System Level Support

- Provide Administrative Support for Program (e.g., Scheduling, Resources)
- Coordinate Communication Among Team Members / Providers
- Engage in Continuous Quality Improvement Efforts

Questions?
<table>
<thead>
<tr>
<th>Where do I go for the Afternoon?</th>
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<tbody>
<tr>
<td><strong>Care Manager and Psychotherapist Role</strong></td>
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<tr>
<td>- Describe the functions of care management</td>
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<tr>
<td>- Introduce PHQ-9 and other measures to a patient</td>
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<tr>
<td>- Describe the best use of measures</td>
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<tr>
<td>- Describe key components of differential diagnosis</td>
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<tr>
<td>- Discuss treatment options with a patient</td>
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<tr>
<td>- Understand the importance of relapse prevention planning</td>
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<tr>
<td><strong>Psychiatric Consultant and PCP Role</strong></td>
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<tr>
<td>- Understand the role of the psychiatric consultant and PCP to support care in a IMPACT care workflow.</td>
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<tr>
<td>- Practice team communication required to provide team-based care</td>
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<td>- Develop a plan to champion PCP engagement and share information from the training.</td>
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