Training in Integrated Care

The American Psychiatric Association

In Collaboration with

The Washington Psychiatric Society

And

The Career, Leadership and Mentorship Group

The Cosmos Club, Gold Room
Washington, DC, Saturday April 8th, 2017

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Dear Colleagues,

Welcome to the Integrated Care training program, an American Psychiatric Association, Washington Psychiatric Society, and Career Leadership and Mentorship Collaborative.

This innovative program led by Dr. John Kern of the University of Washington will take place at the Cosmos Club, on Saturday, April 8, 2017. Continental breakfast will be served from 800 to 830 am and the program will take place from 830 am to 1230 pm. We, in the Washington Psychiatric Society are very pleased to partner with the APA in this initiative as it was our WPS and Area 3 Council that initiated the idea of Enhancing Primary Care and Psychiatric Medicine Collaboration through an Action Paper (AP) in 2008. That AP led to the subsequent Position Statement of 2010 on the same subject then the APA Position Statement on Integrated Care of 2016 and the current program.

We intend to follow up this training program with a similar one done for our primary care physician colleagues in Washington, DC. After this latter program we will organize a joint meeting of WPS members and DC Primary Care colleagues who completed the Integrated Care training and explore how we can enhance our collaboration utilizing this model. Please let us know if you would be interested in participating also in this follow up joint meeting. Thank you.

Best wishes,

Joseph P. Collins, Jr., MD
President, WPS

Eliot Sorel, MD
Chair, Founder, CLM

Applying the Integrated Care Approach: ***Practical Skills for the Psychiatric Consultant***
Agenda
4/8/2017

	WHO	Timing		
Welcome **Collaborative Care Questions** **APA TCPI Grant** **Overview of Integrated Care** - Daniel's Story - - Introduction to Collaborative Care – Collaborative Care 101 –	**Eliot Sorel, M.D.** **John Kern, M.D.** **Kristin Kroeger** **Paul Rosen, M.D.** **John Kern, M.D.**	**60**	**8:30 am**	**9:30 am**
Exercise 1: Principles in Practice –	**John Kern, M.D.**	**10**	**9:30 am**	**9:40 am**
Practical Collaborative Care Consultation Skills Assessment	**John Kern, M.D.**	**20**	**9:40 am**	**10:00 am**
Break		**10**	**10:00 am**	**10:10 am**
Exercise 2: Practice Case Reviews	**John Kern, M.D.**	**30**	**10:10 am**	**10:40 am**
Practical Collaborative Care Consultation Skills Treatment	**John Kern, M.D.**	**15**	**10:40 am**	**10:55 am**
Exercise 3: Registry Practice	**John Kern, M.D.**	**25**	**10:55 am**	**11:20 am**
Advanced Collaborative Care Skills -	**John Kern, M.D.**	**20**	**11:20 am**	**11:40 am**
Payment	**John Kern M.D.**	**10**	**11:40 am**	**11:50 am**
Next Steps and APA resources	**Kristin Kroeger**	**10**	**11:50 am**	**12:00 pm**
Q&A	**John Kern, M.D.**	**30**	**12:00 pm**	**12:30 pm**

Overall Desired Outcomes

By the end of this training, participants will know, recognize, apply, reflect on, and appreciate:

- A general history of integrated care models, including co-located care, BH, consultant, and Collaborative Care
- The workflow differences between traditional psychiatry and psychiatric consultation in Collaborative Care
- Differences between common presentations in primary care and in a typical psychiatry practice
- How initiating treatment as part of a team is different than doing it alone
- What a registry is and how it is used to facilitate treating-to-target and setting personal targets; How the use of a registry differs from current practice
- Measurement and treatment to target follow-up can be done in individual practice even if not practicing Collaborative Care
- The role of the accountability principle in team functioning
- The application Collaborative Care guiding principles to own work in psychiatry ;Setting personal goals for incorporating principles into own practice
- The goals of the Transforming Clinical Practice Initiative and the APA Support and Alignment Network

Brief Bios

Paul Rosen, MD is the Medical Officer for the Transforming Clinical Practice Initiative . At CMS, he serves in the Center for Clinical Standards and Quality (CCSQ) in the Quality Improvement and Innovation Group (QIIG).

Dr. Rosen was named "One of the First 100 Innovators" by the U.S. Federal Government Agency for Healthcare Research and Quality for his work on patient-physician communication. He is a TEDx speaker and has appeared on Sirius XM on the Business of Health Care show and on the Relentless Health Value podcast to discuss the patient experience movement. Dr. Rosen is a pediatric rheumatologist at Nemours Children's Health System. He is an Associate Professor of Pediatrics at Sidney Kimmel Medical College at Thomas Jefferson University. He holds a masters of public health degree from Harvard University and a Masters of Medical Management degree from Carnegie Mellon University.

John Kern, MD is Clinical Professor at University of Washington School of Medicine, Department of Psychiatry and Behavioral Sciences, appointed November 2016. Prior to this he was for 22 years Chief Medical Officer at Regional Mental Health Center in Merrillville, IN. He received his bachelor's degree in psychology from the University of Michigan in 1980, MD from Wayne State University School of Medicine in 1985, and completed residency at the Department of Psychiatry and Behavioral Sciences at Northwestern University Medical School in 1989. He has been board-certified by the American Board of Psychiatry and Neurology since 1991.

Dr. Kern served as Medical Director and Chief Medical Officer at Southlake Center and Regional Mental Health Center since 1994, where he was responsible for all medical services, and all intensive psychiatric, addictions and emergency programs, as well as directing all programs integrating behavioral health and primary care, areas in which Regional has been long recognized as a national leader. He initiated and ran a Collaborative Care program providing mental health services to a partner FQHC, North Shore Health Systems, since March 2007, supervising over 5000 visits per year. A plan to provide care in the FQHC site for bipolar disorder has now seen over 900 patients.

Dr. Kern was also the project director for a now-completed Cohort 2 SAMHSA Primary Care Behavioral Health Care Initiative Grant, with primary care and support services in Northwest Indiana sites, with the goal of improving medical outcomes for individuals with severe mental illness. Ongoing pursuit of integration of care led to a successful application for a Federally Qualified Health Center grant in 2013, and Dr. Kern served for 2 years as the founding Chief Medical Officer for this organization.

After 27 years, Dr. Kern left Regional Mental Health Center to focus on training and implementation of the Collaborative Care Model at the University of Washington.

Kristin Kroeger is the APA's Chief of Policy, Programs & Partnerships. Her primary role at the APA is to oversee coordination of all policies and programs in APA as well as build working relationships with all allied and external partners that affect the field of psychiatry. Ms. Kroeger has worked in the mental health arena for 22 years and before her work at the APA she worked with APA's allied organization, the American Academy of Child and Adolescent Psychiatry (AACAP). For 18 years she served as the Deputy Executive Director and Director of Government Affairs and Clinical Practice. She wore many hats, including setting internal and external policy with leadership and members, advocating to members of Congress and federal agencies, as well as working with leadership and staff to ensure they built stronger relationships with allied pediatric medical organizations and consumer organizations. Prior to working at AACAP, Ms. Kroeger worked for the National Alliance on Mental Illness.

Eliot Sorel, MD is an innovative global health leader, educator, health systems performance expert, and a practicing physician.

- At the George Washington University, in Washington, DC, Dr. Sorel is a Senior Scholar in the Center of Healthcare Innovations and Policy Research in the School of Medicine, the lead physician teaching *Global Delivery – Health Systems* and *Global Mental Health*. He is Clinical Professor of Global Health, Health Policy & Management and of Psychiatry & Behavioral Sciences. He is founder & chair of the Youth Democracy Forum at the Elliott School of International Affairs.
- A practicing physician, Dr. Sorel works collaboratively with primary care and public health colleagues. The innovative, *total health* approach, a primary care,

mental health & public health collaborative integrated model was initiated by Dr. Sorel in 2013 as a means of enhancing quality, access, and sustainability of care particularly as pertains to comorbid, non-communicable diseases that lead in the global burden of disease and disability. He was sworn-in by Mayor Muriel Bowser as a member of the District of Columbia Health Exchange Information Policy Board on March 17th 2016. He chairs the Global Mental Health Mentees' and Mentors' Network.

- He initiated and led the clinical public health research project on *Depression & Comorbidity in Primary Care* in China, India, Iran, Romania & Slovenia and the *Global health systems performance* comparisons between Africa, Asia/Pacific, Europe and the Americas.
- Dr. Sorel coauthored the APA Statement on Integrated Care and the WPA Bucharest Statement on Integrated Care & Collaborative Care. He co-chaired the scientific committee of the WPA International Congress on *Primary Care Mental Health: Innovations & Transdisciplinarity* at the Palace of Parliament in Bucharest, ROMANIA, 24-27 June 2015, accessible at www.wpa2015bucharest.org.
- He is a member of the Oversight Committee of the US Health Disparities Transdisciplinary Collaborative Center at the Satcher Health Leadership Institute with a focus on Non-communicable diseases in Region 4 of the United States.
- *21st Century Global Mental Health* is the most recent of seven books edited by Dr. Sorel. His most recent publication is *Translating Scientific Evidence into Global Health Policy.*
- Dr. Sorel was honored with *Doctor Honoris Causa* by Carol Davila Medical University and by the Politehnica University of Bucharest, Romania in October 2009 and in June 2014, respectively.
- The President of Romania decorated Dr. Sorel with the *Star of Romania Order of Commander* in January 2004.

Position Statement on Integrated Care

Approved by the Board of Trustees, July 2016
Approved by the Assembly, May 2016

"Policy documents are approved by the APA Assembly and Board of Trustees. . . These are . . . position statements that define APA official policy on specific subjects. . ." – *APA Operations Manual*

Issue: The American Psychiatric Association (APA) recognizes the well documented impact of untreated behavioral health conditions on outcomes, total healthcare expenditures and the patient care experience. Enhancing healthcare quality, access and value, including psychiatric services, requires employing new models of care with organized, proactive approaches to individuals' and populations' health. Patients with behavioral health conditions present in all sectors of the health care system and the APA can provide vital input in designing evidence-based approaches that provide comprehensive, high quality health care to the populations they serve while judiciously allocating precious healthcare resources.

It is the position of the APA that:

- Five Core Principles of Effective Integrated Care[1] are founded in the Wagner Chronic Care Model[2] and should serve as a guide for implementing and designing programs:

1. Team-Based: Care is patient-centered and provided by teams using shared care plans. Effective teams in the primary care setting include at a minimum primary care providers, behavioral care managers and psychiatric consultants. Careful attention to cultural differences and change management are crucial to success.
2. Population-Based: Patient populations are defined in advance, screened and triaged for targeted illnesses and/or health complexity, tracked in databases (referred to as registries), and followed for adherence and response to treatment. Caseloads are regularly reviewed for patients who have not followed-up and those who continue to have significant symptoms.
3. Measurement-Based treatment to target: Outcomes are regularly measured using patient and illness-specific assessment tools (standardized when possible) and treatment adjustments made when improvement is not occurring. This is an iterative process until health stabilizes at a desired level (treatment to target).

4. Evidence-Based: Treatments with evidence of effectiveness are used first, including evidence-based brief psychosocial interventions and/or pharmaco therapy proven to work in the primary care setting, followed by secondary and tertiary interventions if the initial treatment is ineffective.
5. Accountability and Quality Improvement: Systems adopting the above elements track quality of care and outcome measures that allow for quality improvement and accountability during implementation and ongoing practice.

- In the Primary Care setting, the APA recognizes a model of integrated care known as the *Collaborative Care Model* (CoCM) as the most effective approach with demonstrated positive outcomes and cost containment across different mental health diagnoses and treatment locations[3]. This model enables enhanced access to the available psychiatric workforce to provide more optimal care outside of traditional psychiatric settings. There are other practice tested approaches that have merit but currently have a more limited research base. Utilization of blended models with adaptation to local practice conditions is common and may eventually merge with the CoCM model.
- In Critical Care/Medical/Surgical settings, the APA supports the use of evidence-based models of care to improve total health outcomes, reduce admissions, readmissions, and lengths of medical/surgical hospitalization, and to promote health stabilization in inpatients with medical complexity.
- In the Public Mental Health sector, the APA will advocate aggressively for efforts to develop effective models to address the physical health disease burden and subsequent 20-30 year mortality gap experienced by psychiatric patients with serious mental illnesses ("reverse integration"). Successful models are emerging that include nurse care managers and an emphasis on health behavior change in a behavioral health home setting. There is a responsibility to monitor and address chronic medical conditions associated with mental illness and psychotropic medications. The APA will support the efforts of psychiatrists to utilize their full range of medical training to oversee the total health needs of patients.

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[1] http://aims.uw.edu

[2] Wagner EH, Austin BT, Von Korff M: Organizing care for patients with chronic illness. Milbank Q 1996; 74:511–544

[3] Archer J, Bower P, Gilbody S, et al: Collaborative care for depression and anxiety problems. Cochrane Database Syst Rev 2012;10:CD006525

- The APA must be at the forefront of supporting the development of best practices in integrated care. Psychiatrists utilize unique skills among behavioral health professionals, including knowledge about the interaction of medical and behavioral conditions. This approach supports effective patient-centered care and the ability to successfully treat psychiatric symptoms in the face of comorbid medical/surgical conditions. As a result, the APA will marshal its resources in education, research and advocacy to prepare psychiatrists for new roles in providing patient-centered outcome changing integrated health care.
- The APA will work with relevant payer, stakeholder and health systems to find sustainable reimbursement strategies, consistent with the requirements of Mental Health Parity and Addiction Equity Act (MHPAEA), for the essential processes and functions of evidence-based models of integrated care services including quality outcomes, timely access, and related performance measures.

Author(s): Lori Raney, MD and Eliot Sorel, MD (primary); APA Workgroup on Integrated Care and Council on Healthcare Systems and Financing

Psychiatry & Primary Care Integration Across the Lifespan
POSITION STATEMENT

Approved by the Board of Trustees, September 2010
Approved by the Assembly, May 2010

"Policy documents are approved by the APA Assembly – *APA Operations Manual.*

- Access to and payment for clinically appropriate services provided by psychiatrists should be included as an essential feature in medical/health home initiatives.
- Parity of benefits design for beneficiaries as well as parity in payment for all physicians, particularly psychiatric that does not discriminate by location of service or diagnosis should be provided.
- Psychiatrists should have choices of participation in a new health system, such as fully integrated clinicians and/or managers of the system, as collaborative care partners, and as consultants to it.
- The exact financial formula for these choices should be negotiated such that it is compatible with parity and nondiscrimination regarding both psychiatric patients and psychiatric physicians.

Authors: Eliot Sorel, M.D., Anita Everett, M.D. Roger Peele, M.D., Catherine May., M.D., Michael Houston, M.D., Hind Benjelloun, M.D., Kayla Pope, M.D.; and consultant, Jack Mcintyre, M.D.

ACTION PAPER

Subject: Enhancing Primary Care, Psychiatric Medicine Collaboration

Intent: Have the American Psychiatric Association champion, together with Primary Care and other specialty medical organizations, a new framework for enhanced collaboration and integration between primary care and psychiatric medicine at educational, clinical, research, and health policy levels.

Problem:

- Mental disorders are highly prevalent in primary care, 26% in outpatient, and 30-60 % in inpatient settings in the US
- 50% of disorders start by age 14 and 75% by age 24
- There are also high levels of comorbidity with cardiovascular disorders, cerebral vascular accidents, cancer, diabetes, other
- Primary care physicians deliver 22.8% and psychiatrists 12.3 % of psychiatric care in the United States (35.1 % aggregate)
- More than 60% of mental health care in the US delivered by non-physicians, of variable quality
- Only 41% of Americans who need psychiatric care, receive that care
- Only 1/3 of those receive minimally adequate care (4 meds visits and 8 counseling sessions/year)
- There is minimal collaboration and integration of primary care and psychiatric medicine contributing to
- Diminishing ***access*** and ***quality*** of psychiatric and primary care and contributing to rising health care ***costs***

Resolved that:

The Council on Psychosomatic Medicine, -with comments from the Council on Health Care Systems and Financing, Council on Quality Care, Council on Children Adolescents and Their Families, APIRE, and OMNA-, will develop a new framework of collaboration and integration of psychiatric medicine and primary care at educational, clinical, research and health policy levels

Authors:

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Implementation:

1. To The Council on Psychosomatic Medicine, for expedited implementation with an interim report to the Assembly by November 2008, final report to the Board in December 2008, implementation spring, summer 2009
2. To be tracked by Recorder

Endorsed:

1. Area III, February 24th 2008
2. Washington Psychiatric Society, March 10th, 2008
3. Area II, March 29th, 2008

Cost: **$20,000.00**

APA Mission: Advocating for our patients and the profession; Advancing scientific knowledge

Keywords: ***Primary care, psychiatric medicine, new framework, collaboration, integration***