Integrating Healthcare Through Population Health Management

Joseph Parks, M.D.
National Council Behavioral Health Medical Director

Today’s Moderators
Madhana Pandian
Coordinator
Deann Jepson, M.S.
Co-facilitator

Slides for today’s webinar will be available on the CIHS website:
www.integration.samhsa.gov
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Disclaimer: The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA), or the U.S. Department of Health and Human Services (HHS).

Setting the Stage
Dr. Joe Parks
National Council Behavioral Health Medical Director
**Setting the Stage**

John Kern, MD  
Clinical Professor of Psychiatry and Behavioral Sciences at University of Washington

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**Behavior Change is not easy**

“My New Year’s resolution is to lose thirty-eight thousand pounds.”

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**Katon on relationship between DM and depression**

- Smoking
- Sedentary lifestyle
- Obesity
- Lack of adherence to medical regimen
- Psychophysiological
  - Insulin sensitivity
  - Autonomic nervous system
- Inflammatory markers
- Cortisol

- Diabetes and CHD at earlier age
- Poor symptom control
- Functional impairment
- Complications of medical illness
- Mortality

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**Collaborative Care as approach to depression in primary care**

Basic principles
- Population-Based Care
- Measurement-Based Treatment to Target
- Patient-Centered Collaboration
- Evidence-Based Care

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**COLLABORATIVE CARE TEAM**

PCP  
BHP/Care Manager  
Patient  
Psychiatric Consultant

New Roles
Primary Care Provider

Behavioral Health Provider / Care Manager has two functions

Psychiatric Consultant Role

Screening processes

Getting buy-in from staff

PHQ-9 above 10

AIM for remission

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Biopsychosocial treatment

Evidence-based meds
- Don’t wait to start meds if they are indicated – clinical inertia can really delay access to effective treatment.

Evidence based psychosocial treatment
- Behavioral Activation
- Problem-solving therapy

Use of registry

Who is not getting better
Who is slipping through cracks
Don’t obsess waiting for the perfect tool
Should also be used for physical monitoring

Collaboration Care Network in the TEAMcare intervention

PC in MH registry
Training behavioral health staff in Collaborative Care – sources of material:
AIMS center website: aams.uw.edu
Center for Integrated Health Solutions web page

Establishing Policies and Procedures

Starts with buy-in from the top
Systematizing:
- Screening – front desk has to be involved
- Flow to get screening result to the PCP in a digestible form
- Double entry into registry – has to be done by someone.
- Registry review and outreach – has to be done by someone.
- PCP involvement – may require persuasion / engagement – they need to know when hired.
- Money for psychiatric consultation.

An example from AIMS:
An instrument for Assessing Gaps in care process:

ENGAGING THE PCP: "WHY AM I DOING THIS?"

These patients are already your patients. They are not going away. We can help with everyday workflow, shorten long appointments, reduce arguments about controlled substances... We have your back! Can help with chronic disease outcomes, IMPROVE YOUR METRICS!

SECRET SAUCE

Frequent early contact
Unutzer et al, American Journal of Public Health Vol. 102, No. 6, pp. e41 - e45, 2012

Treatment to target

Questions?
Learning Sessions

May 23, 12 noon – 1 p.m. ET
Presenter: Joseph Parks, M.D.
Interactions of Depression and Diabetes – Impacts on Treatment and Outcomes

June 15, 2 – 3 p.m. ET
Presenter: Katie Stuckmeyer
Metabolic/Diabetic Screening and Strategies to Improve Treatment Adherence

July 28, 2 – 3 p.m. ET
Presenter: Jeff Capobianco, Ph.D., LLP
Strategies to Maintain Gains, Support Momentum, and Sustain Adoption of the Innovation

Report Out

August 15
2 – 3:30 p.m. ET
5 x 5 presentations

Learn how Innovations Community participants are:

✓ Progressing toward goals
✓ Sustaining momentum, improving interventions, and garnering positive gains
✓ Establishing best practice models across the organization

Next Steps:

Continue to:

• work on your plan’s action steps with your team,
• meet with your coach on a regular basis, and
• provide status updates.

If you haven’t done so already...

• schedule a call with your coach, and
• send a copy of your workplan to your coach.

Resources

Diabetes Management
• http://www.integration.samhsa.gov/health-wellness/wellness-strategies#diabetes

Collaboration & Teamwork
• http://www.integration.samhsa.gov/workforce/collaboration-and-teamwork

Depression Screening Tools
• http://www.integration.samhsa.gov/clinical-practice/screening-tools#depression

Depression and Diabetes in Marginalized Communities: Spotlight Hispanic Community
• http://www.integration.samhsa.gov/workforce/Diabetes_Depression_in_the_HispanicLatino_Community.pdf

Benefits of Integrating Diabetes and Depression Care Study

Thank you for joining us today. Please take a moment to provide your feedback by completing the survey at the end of today’s webinar.

If you have additional questions/comments, please send them to:
Joe Parks – joep@thenationalcouncil.org
Deann Jepson – djepson@ahpnet.com
Madhana Pandian – madhanap@thenationalcouncil.org