Life Goals Collaborative Care

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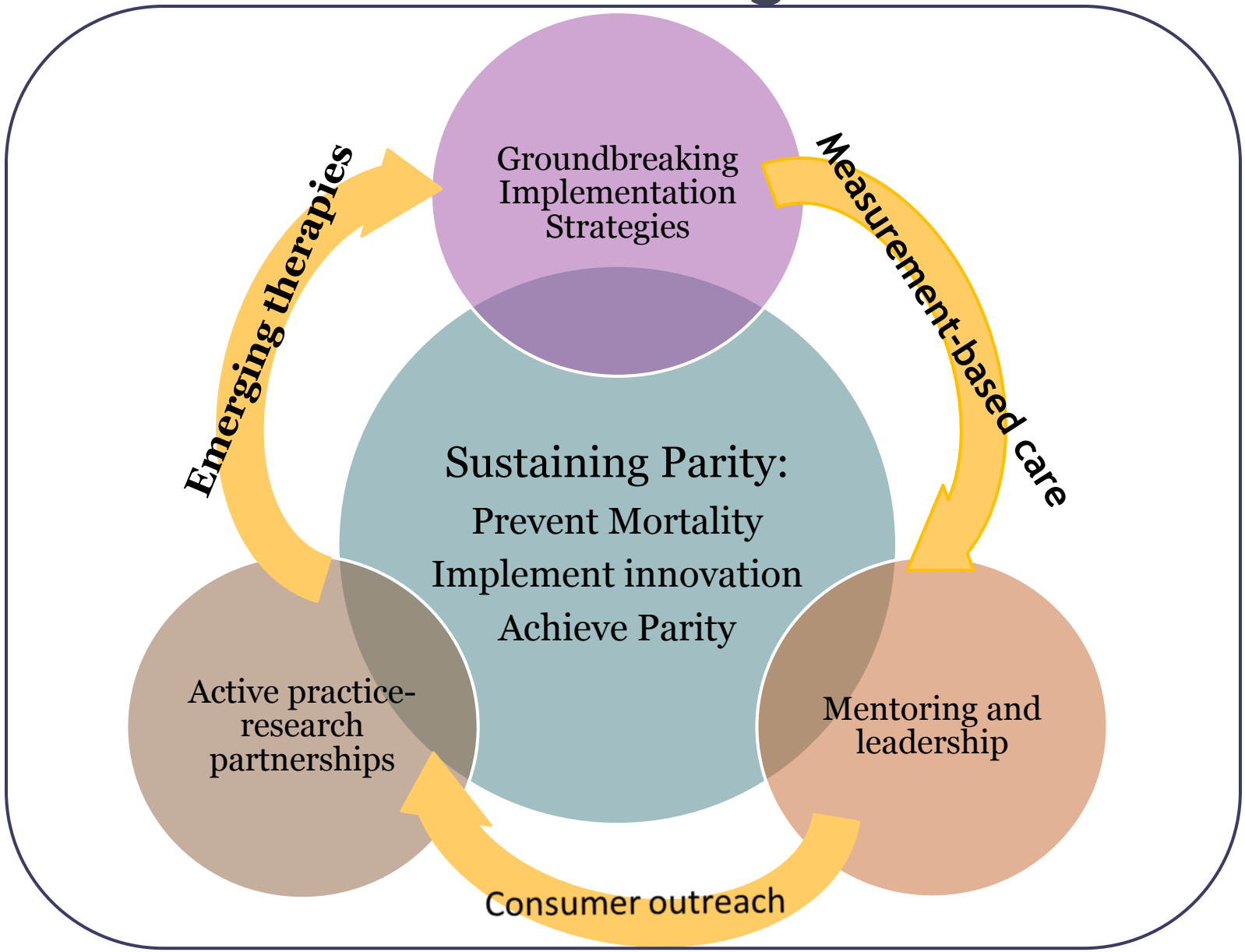
COMPASS
Collaborative Mental Health Program for Achieving Sustainable Systems

Life Goals
Collaborative Care

COMPASS Program



Background to Life Goals Collaborative Care and Overview of the Evidence

Mental Disorders & Poor Outcomes

- 15-25 years potential life lost
- Top 10 - WHO global burden of disease
- Homelessness, incarceration
- Co-occurring conditions common
  - Medical: 33% >=3 medical conditions
  - Cardiovascular disease (CVD) leading cause of death

Manic-Depressive Disorder: Co-Occurring Conditions

- Psychiatric
  - Substance disorder: 35-40%
  - Anxiety disorder: 35-45%
  - Any current: 55-60% (2+: 20-30%)
- Medical
  - Metabolic syndrome: 20-47%
  - Hypertension: 33%
  - Hepatitis C: 16%
  - Any current: 80%

Mental Disorders and Cardiovascular Disease

- *Most common cause of mortality*
- The risk factors are multi-factorial:
  - **Behavioral** (diet, exercise)
  - **Systemic** (access to care, coordination, continuity of care)
  - **Treatment** (atypical antipsychotics)
- **Obesity** and **insulin insensitivity** drive CVD risk

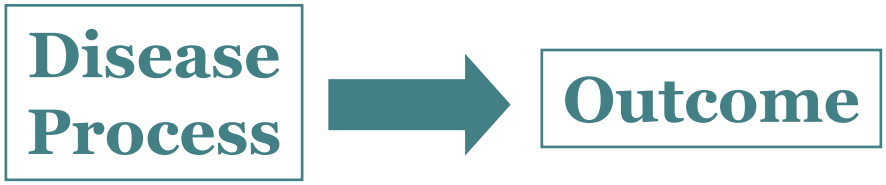
  → Hypertension, hyperlipidemia, diabetes

  → "Metabolic syndrome"

Focus on Bipolar Disorder: Unique Risk Factors

Episode	Challenges
Manic/pre-manic	Binge eating Unstable social behavior, risky behaviors Substance use Injury
Depressive	Sedentary lifestyle, overeating Suicidal ideation Anxiety
Psychoses	Hallucinations, violence/injury Tobacco use
Euthymic	Non-adherence

Mental Disorders Outcome: Over-Simplified



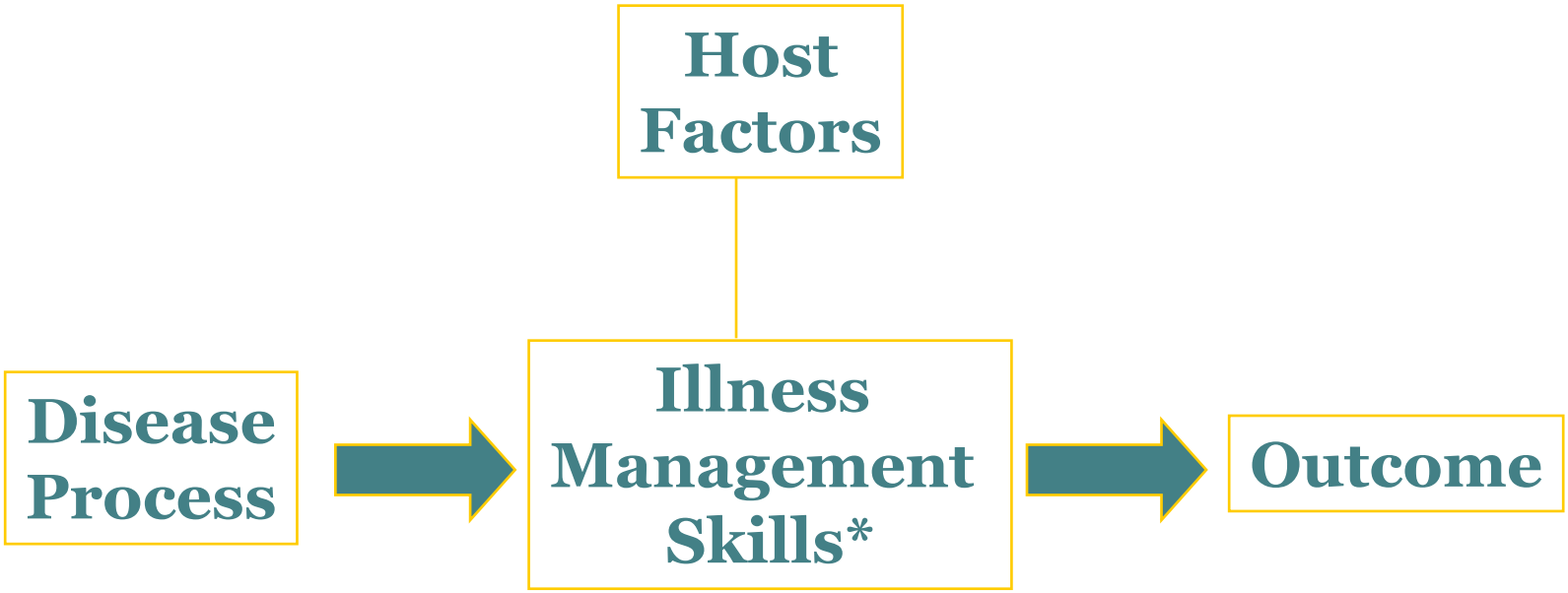
Some Ugly Statistics on Adherence

- Antipsychotics:
  - 20-89% (Dolder 2002)
  - SGA = FGA (Cabeza 2000)
  - 73% d/c within 2 years, half in 4 months (Lieberman 2006)
- Mood Stabilizers:
  - 46% partial, 21% fully non-adherent
  - Lithium ~ Anticonvulsants (Sajatovic 2007)

Some More Ugly Statistics on Adherence

- Antidepressants:
  - 7-44% drop-out (Riolo & Weston, 2008)
  - SRIs ~ TCAs (Cochrane Collaboration, #)
- Anti-Anxiety Agents:
  - 25-37% d/c (Keane 2005; Goethe 2007)
  - 31% adequate treatment (Fernandez 2006)
- Medical:
  - 62% adherence to short-term Rx
  - 54-57% adherence to long-term Rx (Sackett, 1979)

Mental Disorders: The Real World



* "…the ability of a person to:
- cope with his or her illness and
- participate actively in treatment."

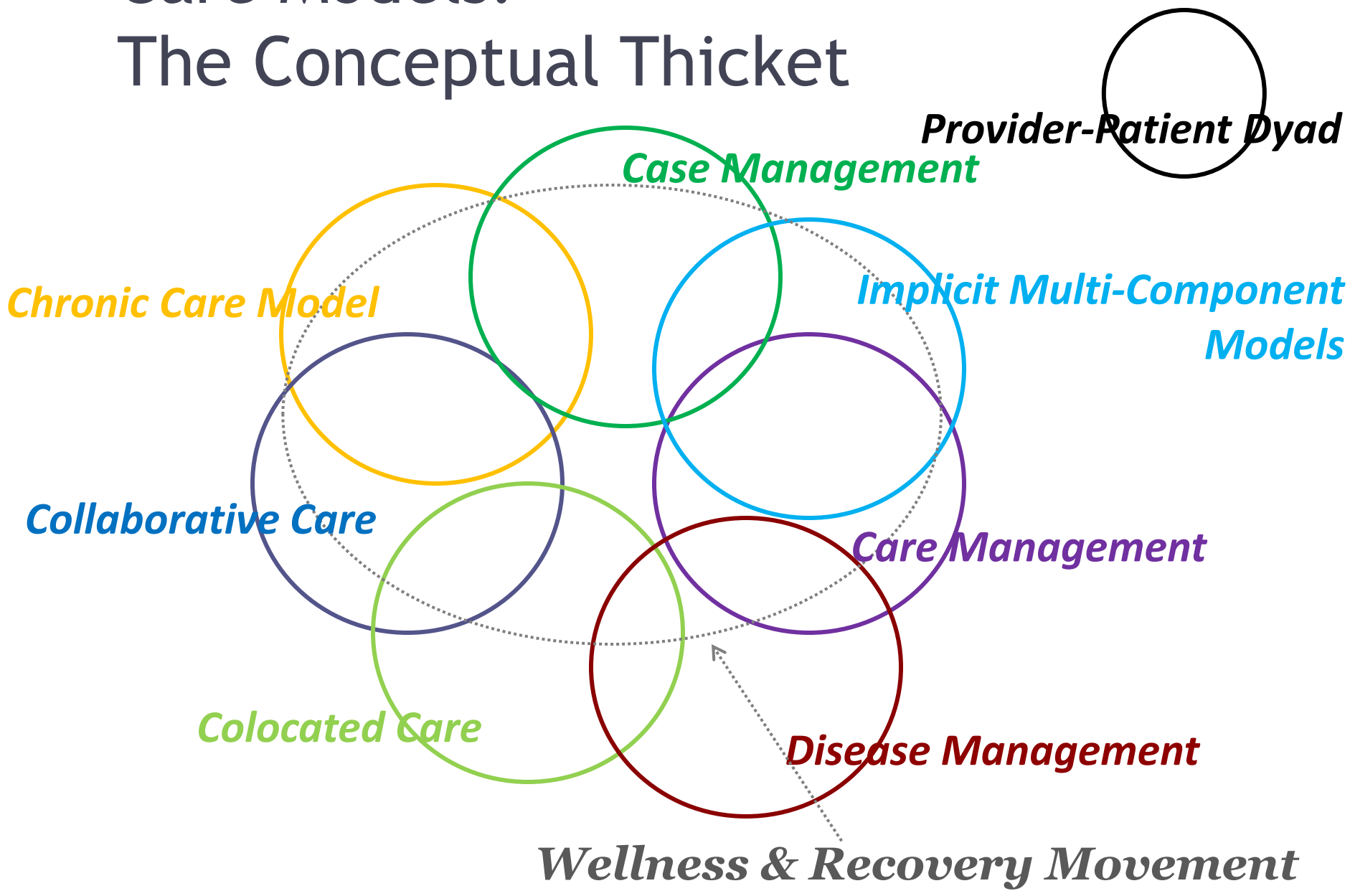
Bauer MS, McBride L. *Structured Group Psychotherapy for Bipolar Disorder: The Life Goals Program, 2nd Edition* (Springer, 2003)

Why a *Psychosocial* Component for Mental Disorders?

To supplement (not replace) medical-model treatment:

- Compliance is low—about 50% adequate
- Address independent determinants of disease outcome (stressors, comorbidities)
- Poor social role function and quality of life
  - Only 1/3 return to pre-morbid function & 1/3 rated poor
  - Depression ← → Functional status
  - No change with the Modern (Psychopharm) Era

Care Models: The Conceptual Thicket



Defining Collaborative/Chronic Care Models

- Goal: Evidence-based, anticipatory, continuous, collaborative care
- CCM Elements:
  - Practice redesign
  - Patient self-management support
  - Expert systems (on-site consult, guidelines)
  - Information systems
  - Community linkages

Chronic Care Models: Evidence

- RCTs show benefit in:
  - Multiple chronic medical illnesses
  - Frail elderly
  - Depression treated in primary care

- But for serious, chronic *mental* illness?

Roots of Chronic Care Models for Serious Mental Illness

- Lithium Clinics
  - Finerty 1973, Runyan 1973
  - Fieve 1975

    →Expert care plus: continuity, education
- Primary care
  - Starfield 1973

    →Coordination & longitudinal care
- Chronic Care Models (CCMs)
  - Wagner & Von Korff 1996
  - Life Goals Collaborative Care

Roots of Life Goals Collaborative Care

- Expert consultation with patients, providers & academic experts
- Lorig Chronic Disease Self-Mgt. Groups
- Motivational Interviewing
  - Spirit
  - Techniques (e.g., decisional balance)
- Psychoeducation
- CBT (C<u>B</u>T)

Evidence for Life Goals Collaborative Care

(Bauer et al. 2006; Simon et al. 2006; Kilbourne et al. 2008)

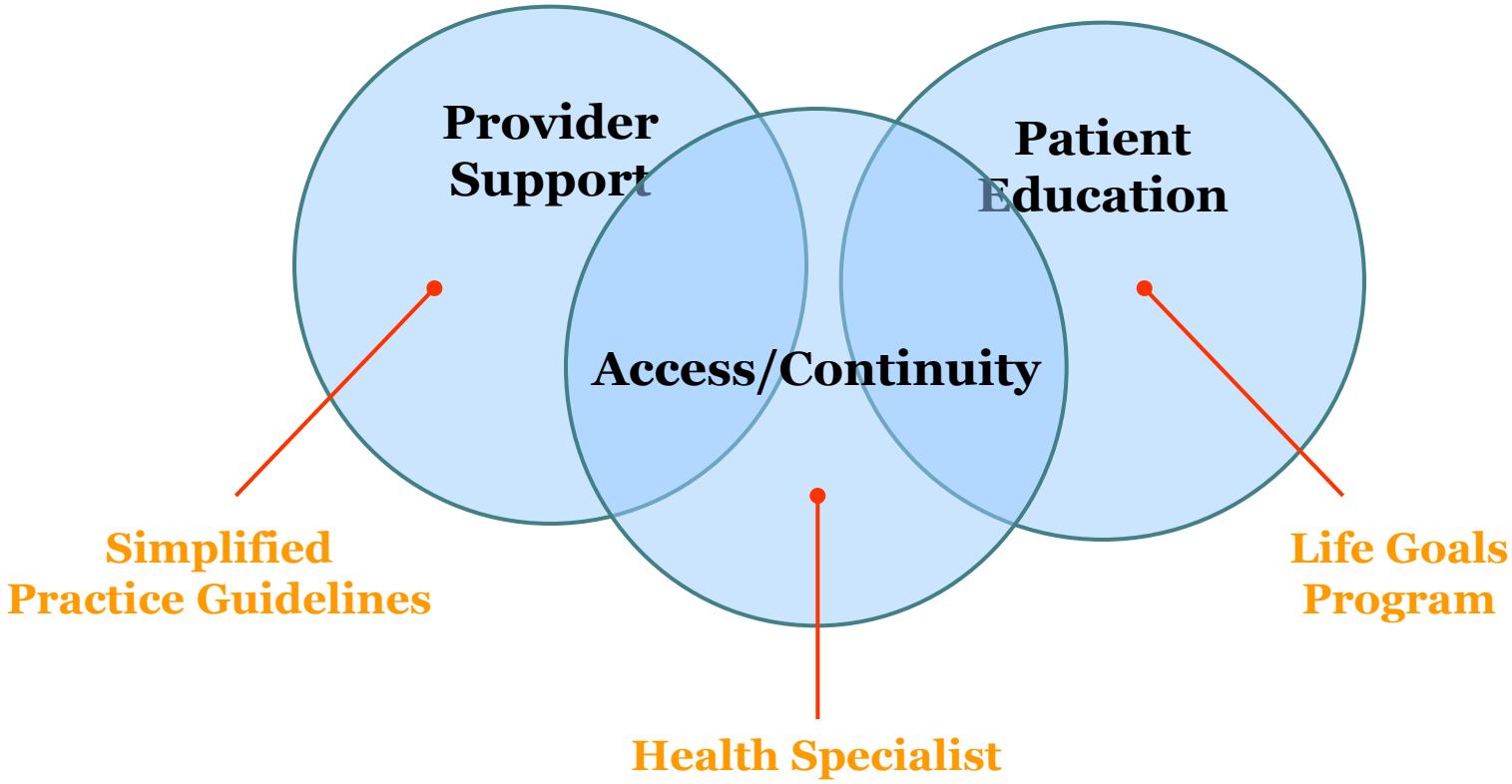
In three randomized controlled trials, Life Goals:

- Reduced overall affective, manic symptoms
- Improved overall social role function
- Improved mental, physical HRQOL
- Improved participant satisfaction
- Was shown to have minimal to zero net cost

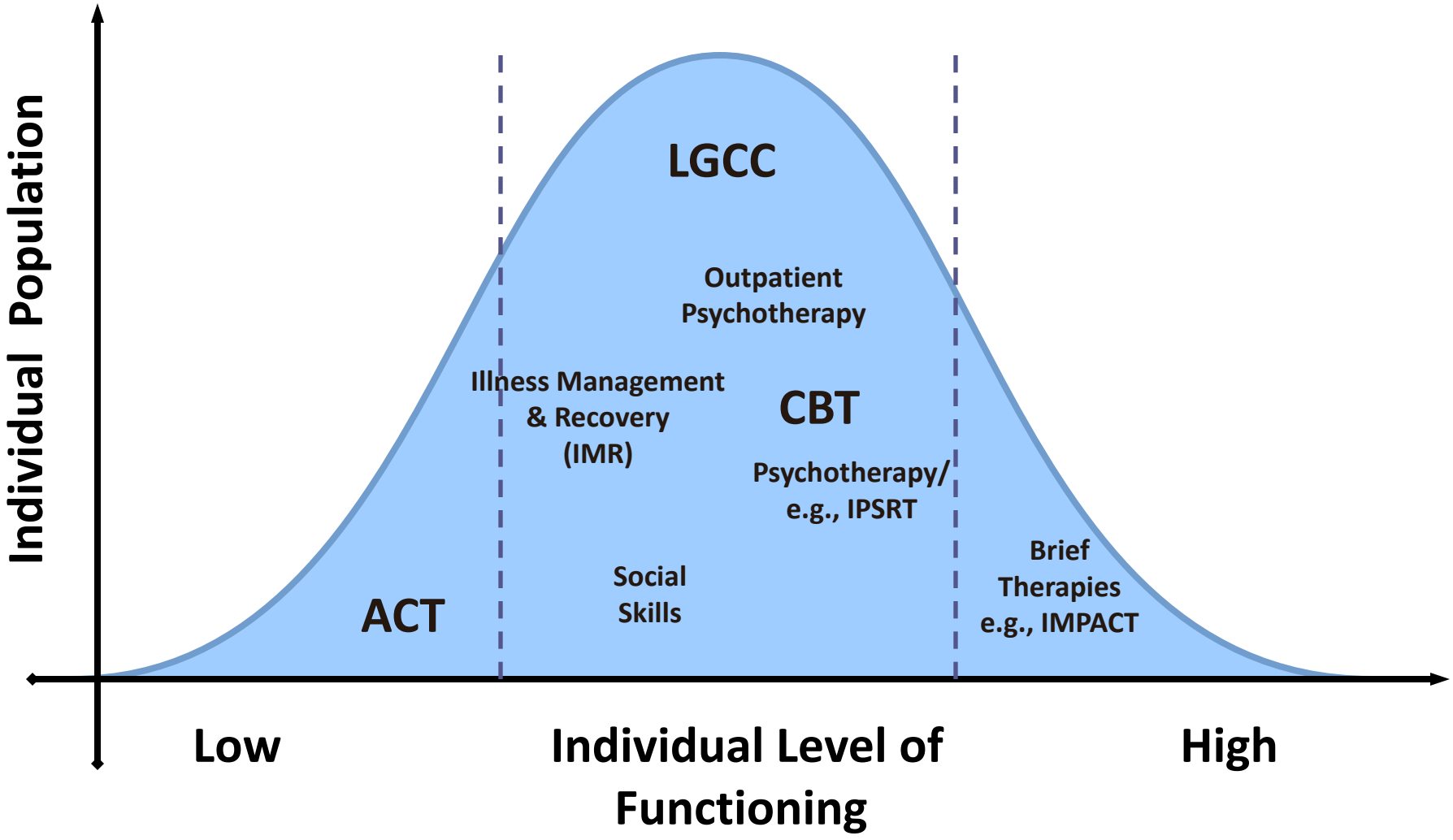
LGCC Development

1992-96:	Expert/consumer consults & program development
1997-2004: Bauer)	**VA Cooperative Study #430** (11-site, 3-yr RCT, PI:
1998-2003:	NIMH RO1 (Washington, 4-site, 2-yr RCT, PI: Simon)
2006:	2nd Generation RCT (CIVIC-2→CVD risk; PI: Kilbourne)
2008-present: Studies:	Implementation / Adaptation / Dissemination
	SMAHRT, Achieving Wellness, ROCC
	Emphasis on CVD risk, depressive episodes
2008:	*Consumer Workbook* published- expanded, multi-functional workbook for providers & consumers
2009:	LGCC Training Programs and ongoing implementation
2010-present:	Expanded LGCC: web-based, cross-diagnosis, telehealth, health home models (e.g., Aetna, GCCMH, WCHO, VA)

Life Goals Collaborative Care

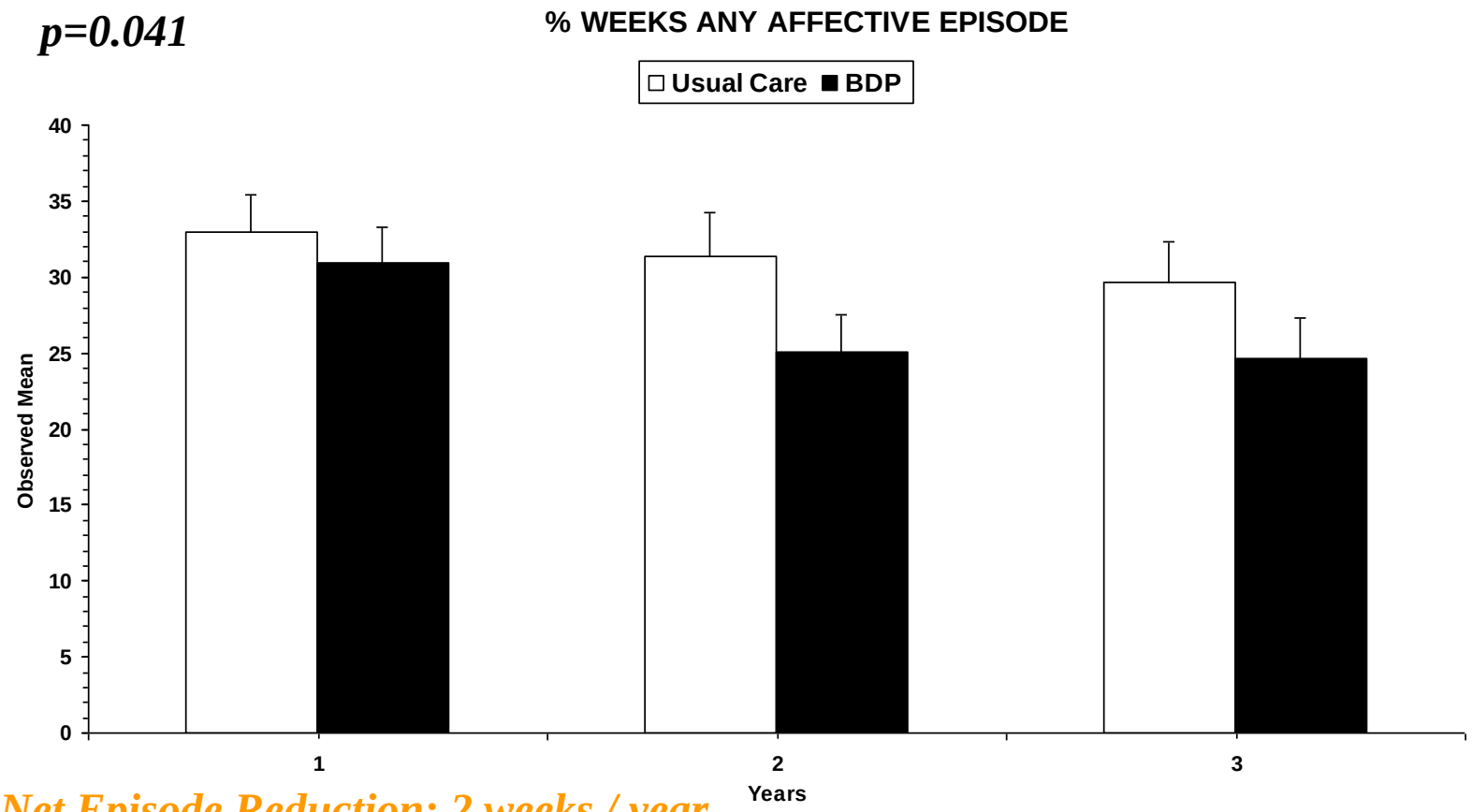


LGCC Proposed Population



VA CSP #430: Syndromal Outcome: % Weeks in Any Episode

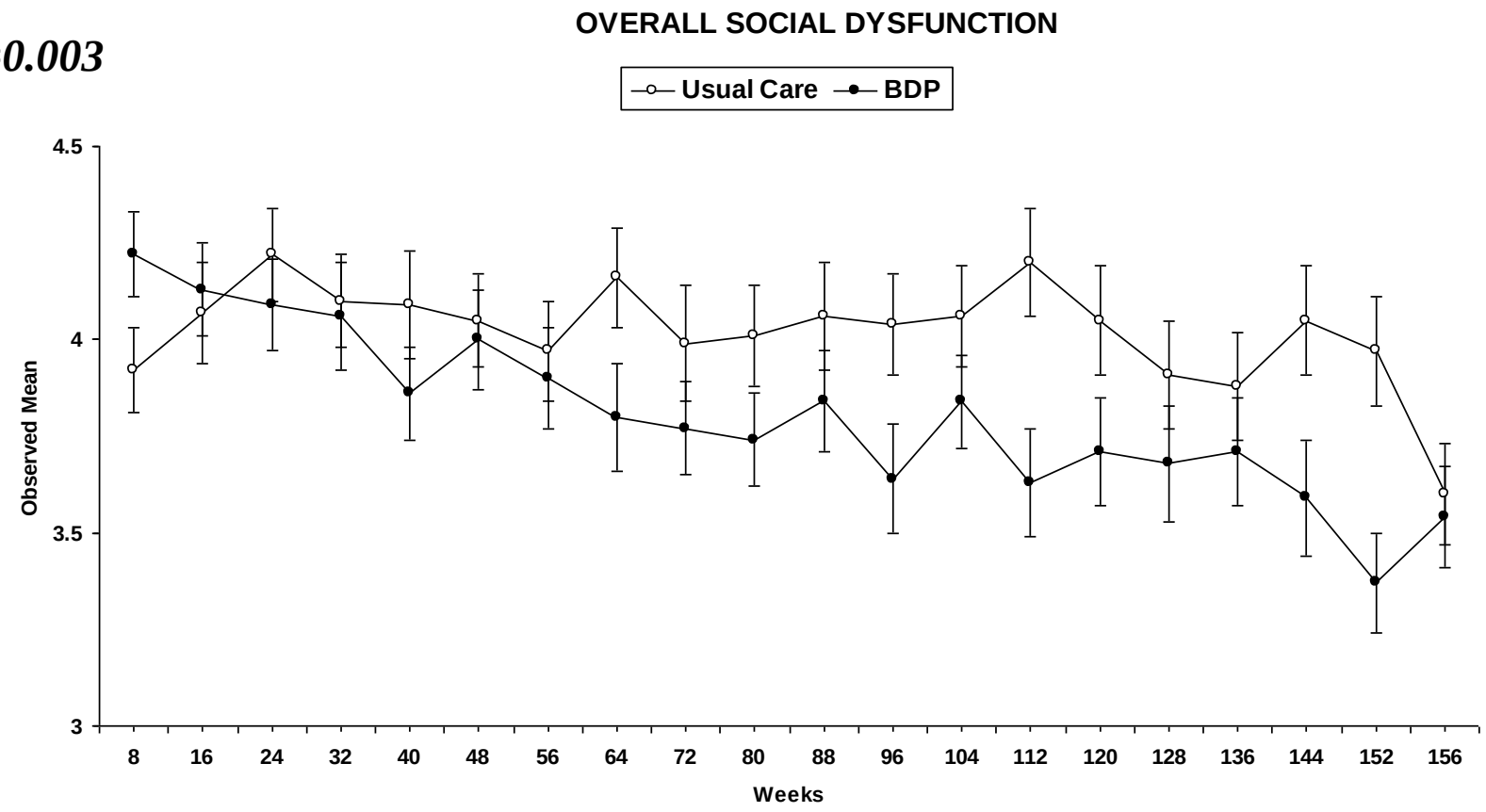
p=0.041



Net Episode Reduction: 2 weeks / year

VA CSP #430: Changes in Dysfunction

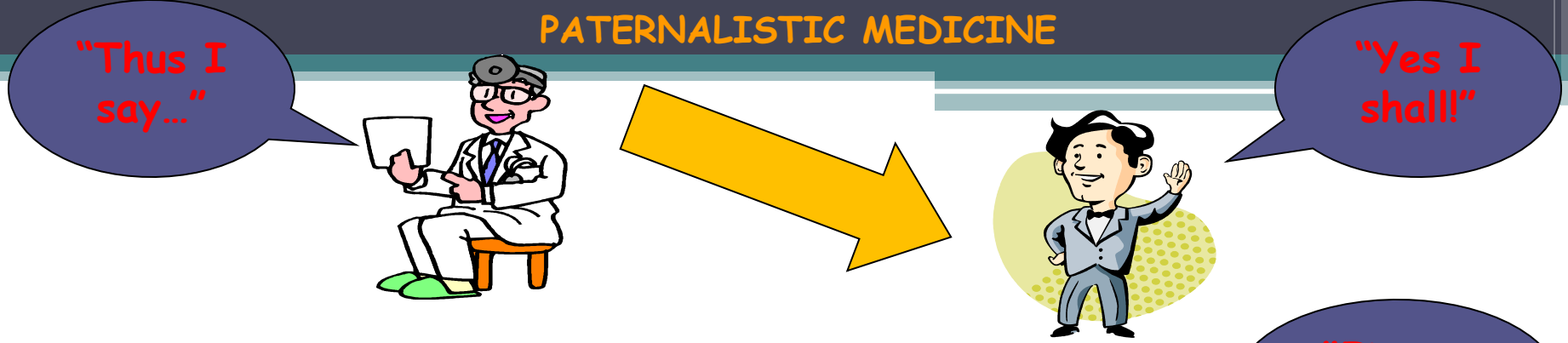
p=0.003



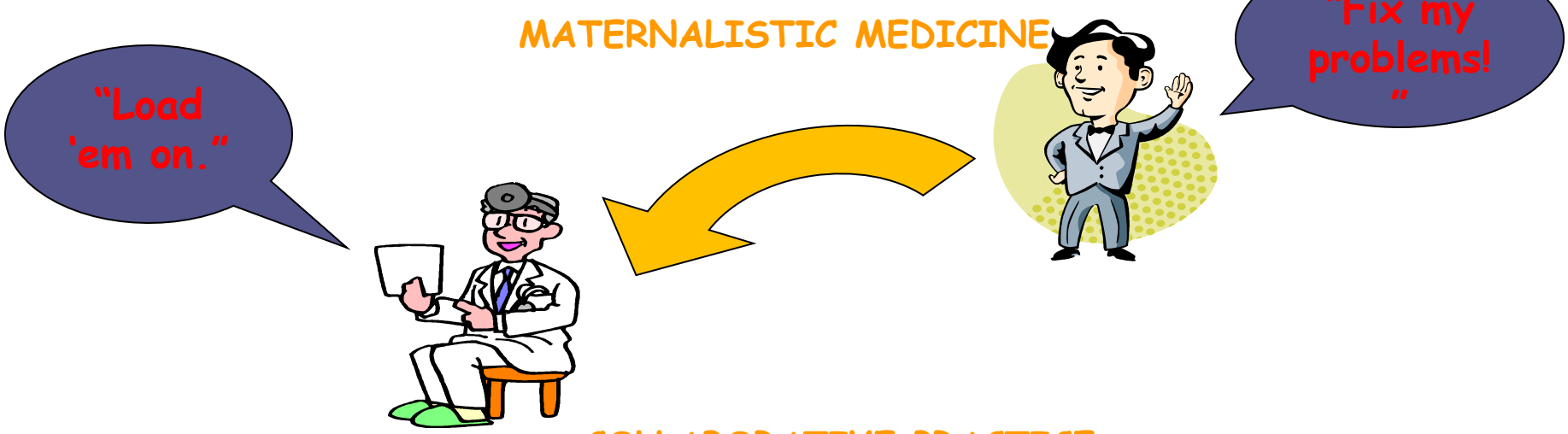
LGCC: 6-Month Physical Outcomes

	Beta (95% CI)	F	P-value	d
SF-12 PCS	**2.5 (0.5, 4.9)**	**2.01**	**0.04**	**0.32**
SF-12 MCS	1.6 (-0.7, 3.8)	1.36	0.17	0.20

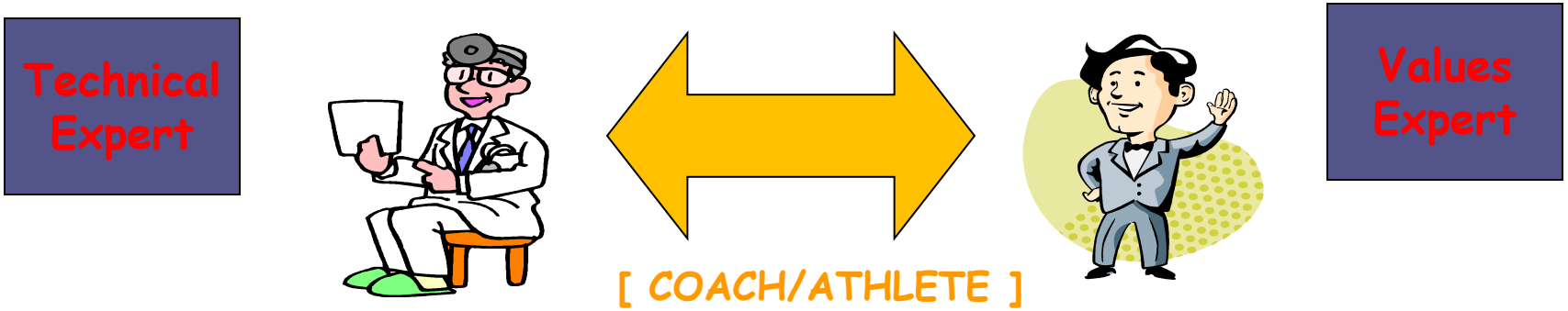
PATERNALISTIC MEDICINE



MATERNALISTIC MEDICINE



COLLABORATIVE PRACTICE



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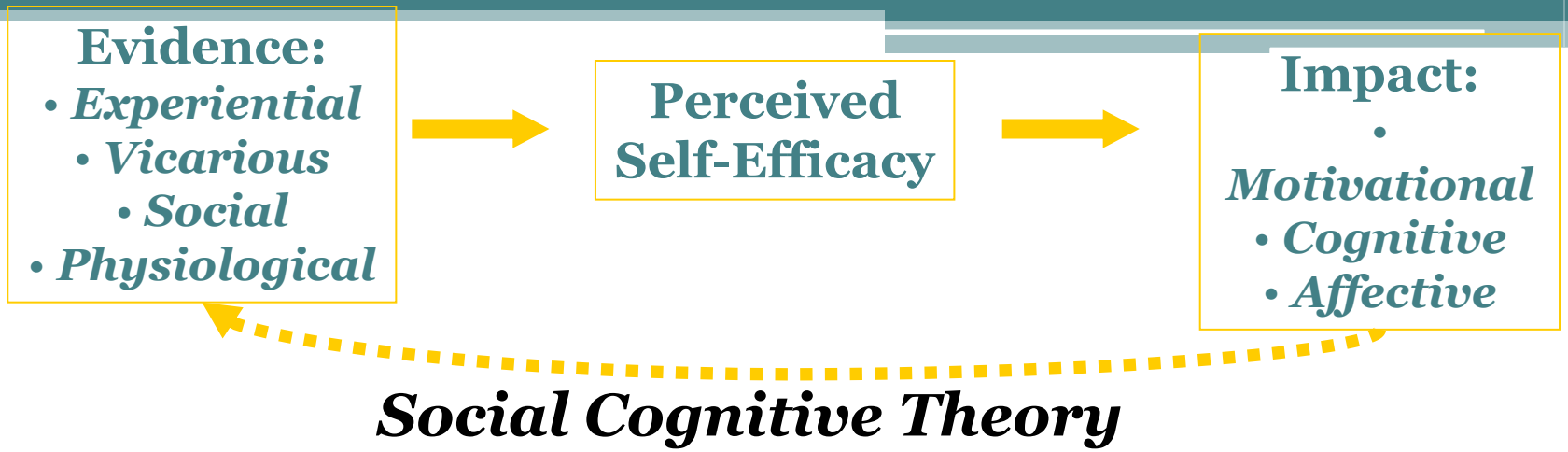
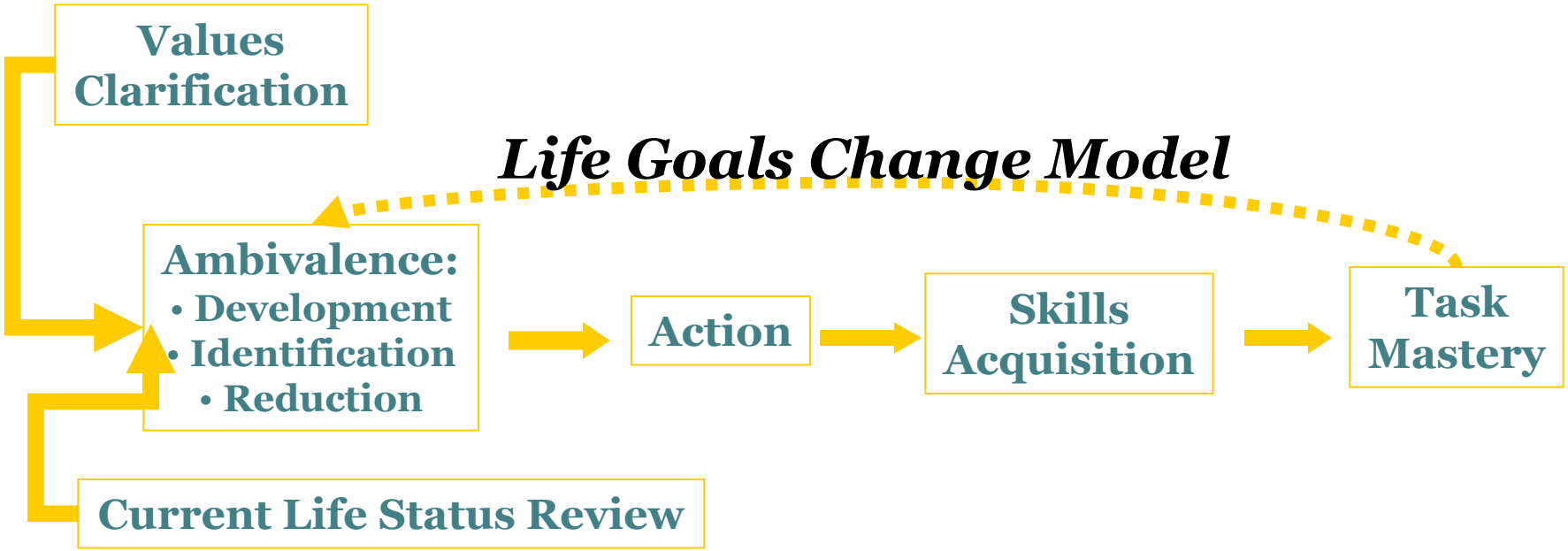


Social Cognitive Theory



Life Goals Change Model

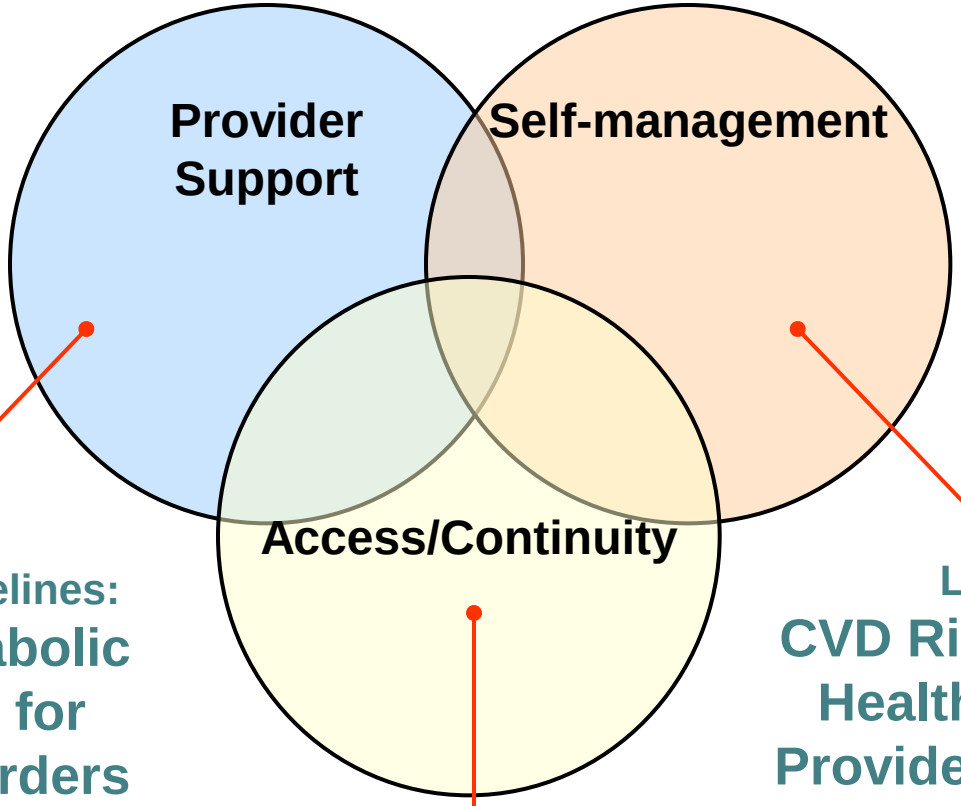
Life Goals in the Mitten

Achieving Wellness through Effective and Sustainable Organizations for Mental Health (AWESOME)

- Pilot RCT of Life Goals Collaborative Care compared to usual care in Towner, Ellsworth Clinics (2008-2010)
- Outcomes: CVD risk factors, mood symptoms, disability
- PI: Amy Kilbourne, PhD (R34 MH 74509); Health Specialist: Julia Clogston, MSW; Program Coordinator: Kristina Nord, MSW

Life Goals Collaborative Care:

AWESOME: *Enhanced to address medical (CVD) risk factors*



Practice Guidelines:
CVD & metabolic syndrome for mental disorders

Life Goals:
CVD Risk, Symptoms
Healthy Behaviors
Provider Engagement

Care management (Health Specialist):
Registry tracking (Symptoms, QOL, functioning)
General Medical Provider Liaison

LGCC Self-Management

Four Life Goals sessions- led by Health Specialist:

- Mood disorder facts; handling stigma
- Personal goals- behavioral change
- Active discussions re: symptom management
  - Personal Symptom Profile
  - Early warning signs; triggers
  - Coping responses
- Collaborative care
  - Provider engagement, communication tips

LGCC Group Sessions

- Four 2-hour sessions
  - Depends on the population and agency limitations (time, space issues, symptom severity)
  - 2-12 participants (5-8 is ideal)
- Group is semi-directive
  - Well "guided"
  - Not a process group
- Manual, evidenced-based approach
  - Use abbreviated workbook adapted from *OBD* for most group exercises

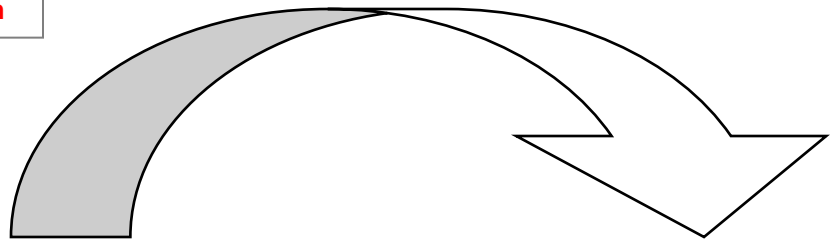
Spirit: Motivational Interviewing for Health Behavior Change

- **Brief Motivational Interviewing** (MI)
  - Collaborative and individual driven
  - Avoids confrontation
  - Empowers by helping people recognize problems and identify their own solutions for change
  - Aims to increase self-efficacy, value-driven decisions, enhance group/individual discussions, and develop action plans that are mindful to contextual barriers

Life Goals Collaborative Care: *The* Individual's Experience

Session 1
- Self management & Collaborative Care
- Understanding Bipolar Disorder
- Identifying Core Values
- Bipolar Disorder & Wellness

Session 3
- Depression overview and symptoms
- Triggers to depressive episodes
- "What's Your Experience"?
- Action plan for depression



WEEK ONE | WEEK TWO | WEEK THREE | WEEK FOUR | SIX MONTH FOLLOW UP WITH HEALTH SPECIALIST

Session 2
- Mania overview & symptoms
- Triggers to manic episodes
- "What's Your Experience"?
- Action plan for mania

Session 4
- Your Wellness Plan
- Building and Strengthening Collaboration of Care
- Relapse Prevention

Following the session work, the Health Specialist will initiate contact with the indnvidual at agreed upon monthly scheduled times, for 10-15 minute intervals for the following:

✓Assist with wellness goals
✓Review medications
✓Collaborate on care
✓Assist with mood monitoring
✓Review of lessons learned

Care Management

- Health Specialist (HS) relays concerns/progress to providers
  - Refills
  - Symptoms and side effects (e.g., weight gain, CVD risk)
  - Medical record documentation
- Cue providers if no improvement
- Crisis intervention
- Tracking progress
- Supplement, not replace providers

Decision Support

- Health Specialist provides information on BD and co-occurring conditions to providers where appropriate
- Serves as information resource for special topics (e.g., cardiometabolic management, comorbidities)
- Community resources

AWESOME: Participant Characteristics

- Demographics (N=65)
  - Mean age =45 (SD=13)
  - 61% female
  - 19% minority
  - 54% smoke
  - 27% substance use disorder
- CVD risk
  - 53% Hypertension
  - 68% hyperlipidemia
  - 19% diabetes diagnosis

AWESOME: Baseline CVD Risk Factors

N=65	Mean	SD
Systolic BP, mmHg	133.9	19.7
Diastolic BP, mmHg	85.1	11.1
Total cholesterol, mg/dL	216	37
BMI, kg/m^2	**35.2**	**7.3**
Waist circumference, inches	**45.0**	**6.0**
Framingham Score (10-Yr CVD risk)		
<10 %	48.4%	
10-20%	42.2%	
>20%	9.4%	

AWESOME 12-Month Outcomes

Repeated Measures Analysis

LGCC vs. Usual Care	Beta	95% CI	F	P
BMI	-4.1	-7.7 to -.5	2.3	.03
Waist circumference	-4.9	-7.7 to -2.0	3.5	.005
Disability (WHO-DAS)	-4.7	-8.1 to -1.4	-2.8	.002
Well-being	4.3	1.5 to 7.2	3.1	.005
Depressive symptoms	-2.7	-4.9 to -.5	-2.5	.02

Summary

- Substantial CVD risk
- LGCC may reduce CVD risk in bipolar disorder
- *Cross-diagnosis* LGCC developed for mood disorders, SMI
- How to implement/sustain?

Life Goals Collaborative Care
Some Implementation Issues

Domain	CCM Component	*And now to implement in the real world…*
Consumer	Self-Management Skills	*What are population needs?* *How to deliver?* *Who delivers?* *How reimbursed?*
Provider	Decision Support	*Whose guidelines?* *How provided?* *How incentivized?*
System	Delivery System Redesign	*What type of Care Manager?* *Where do they work?* *How do they interface?*
	Clinical Information System	*Level of IT support* *Opportunities* *Limitations* *Barriers*

Implementing LGCC: Training Providers (Insel, 2009)

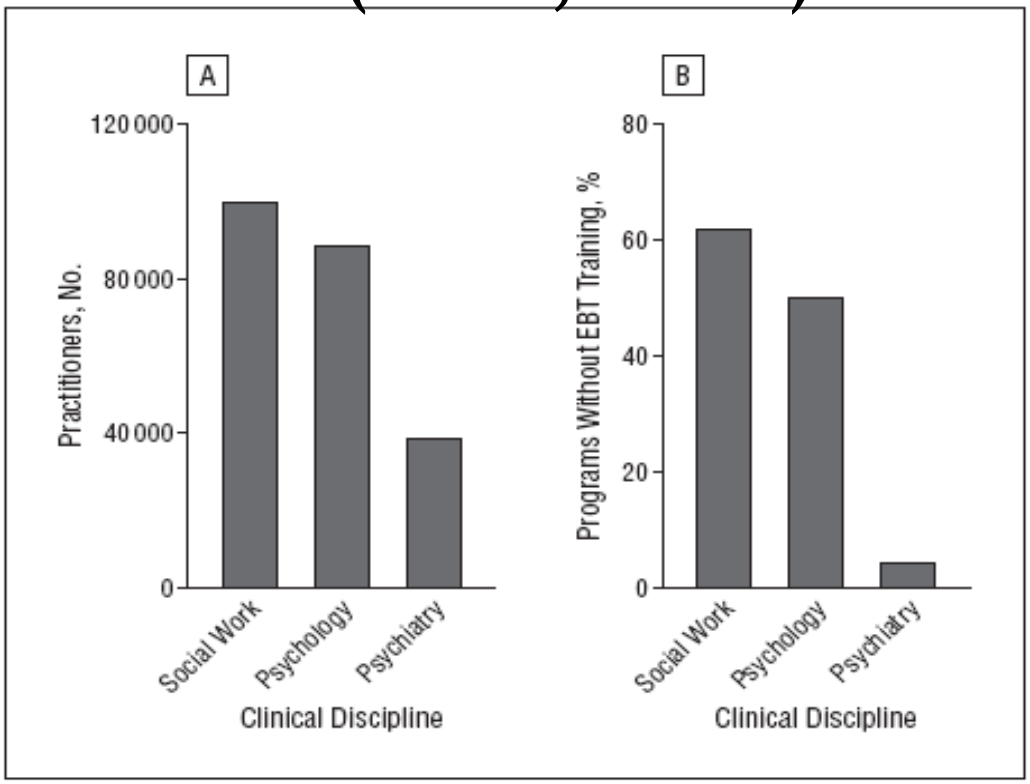


Figure 4. Much of the psychotherapy workforce is not trained to provide evidence-based treatments. A, The number of practitioners within mental health–related clinical disciplines in the United States.[42] B, The percentage of mental health–related clinical training programs that do not require gold standard training (both didactic and clinical supervision) in any evidence-based psychotherapies. More than 50% of psychology and social work programs do not require gold standard training in any evidence-based psychotherapies. Psychology data include both PhD and PsyD training programs.[43] EBT indicates evidence-based therapy.

Recovery Oriented Collaborative Care (ROCC) (R01MH79994)

- Goal: implement and evaluate dissemination of LGCC in community practice
- Close the research-to-practice gap in mental health services
- Effective, practical behavioral interventions exist
- Programs not disseminated in real world
  - Many toolkits not specific enough
  - Trainings are expensive
  - Technical assistance (TA) unspecified
- Technology transfer strategies needed
  - User-friendly with technical support

ROCC Goals

- Apply CDC's Replicating Effective Programs (REP) framework to implement LGCC
- Implement LGCC using REP test effects of "REP Plus" (customized facilitated implementation) or standard REP process
- Return-on-investment (fidelity, outcomes, acceptance, cost-effectiveness)
- Future dissemination model for psychosocial interventions

REP Conceptual Framework: Technology Transfer for Implementation

Pre-implementation

Identification of Problem

Identifying appropriate intervention

Package intervention

Dissemination

Further diffusion of training., TA across sites

Sustainability

REP was developed by Centers for Disease Control in 1996 to rapidly translate HIV prevention programs to community-based settings. Over 14 HIV prevention and treatment interventions have been packaged and disseminated (Neumann et al. 2000)

ROCC Collaborators

University of Michigan:
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Mark Bauer, MD

Columbia University:
Harold Pincus, MD

CDC:
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ROCC Sites

Washtenaw County Health Organization/Continuous Support Treatment Services-Ellsworth	*Ann Arbor, MI*
Packard Health	*Ann Arbor, MI*
Genesee County Community Mental Health	*Flint, MI*
Mental Health Center of Denver	*Denver, CO*
Community Reach	*Thornton, CO*

LGCC Core Elements

CCM Domain	Core Elements	Menu Option Examples
Self Management	-- 4 Group Sessions --Mental disorder facts --Setting personal goals --Active discussions of symptom coping strategies --Provider engagement and communication tips	Make-up sessions – phone or in-person Family involvement
Care Management	--Ongoing contacts to reinforce lessons from self-management (1 per month) --Provider contacts (cues) --Crisis management --Ongoing wellness monitoring --Community resources	Crisis intervention protocols Provider communication preferences Link to existing services
Decision Support	Summary information, treatment and health issues (e.g. cardiometabolic risk monitoring	Mode of delivery

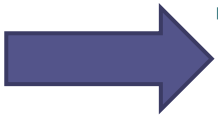
Technical Assistance

- Post implementation technical assistance to problem solve barriers to:
  - Logistics (space, time, access)
  - Recruitment
  - Staff uptake
  - Participant issues
  - Clinic integration
- ***Organizational and financial barriers also discussed***

ROCC: Expanded REP (REP+)

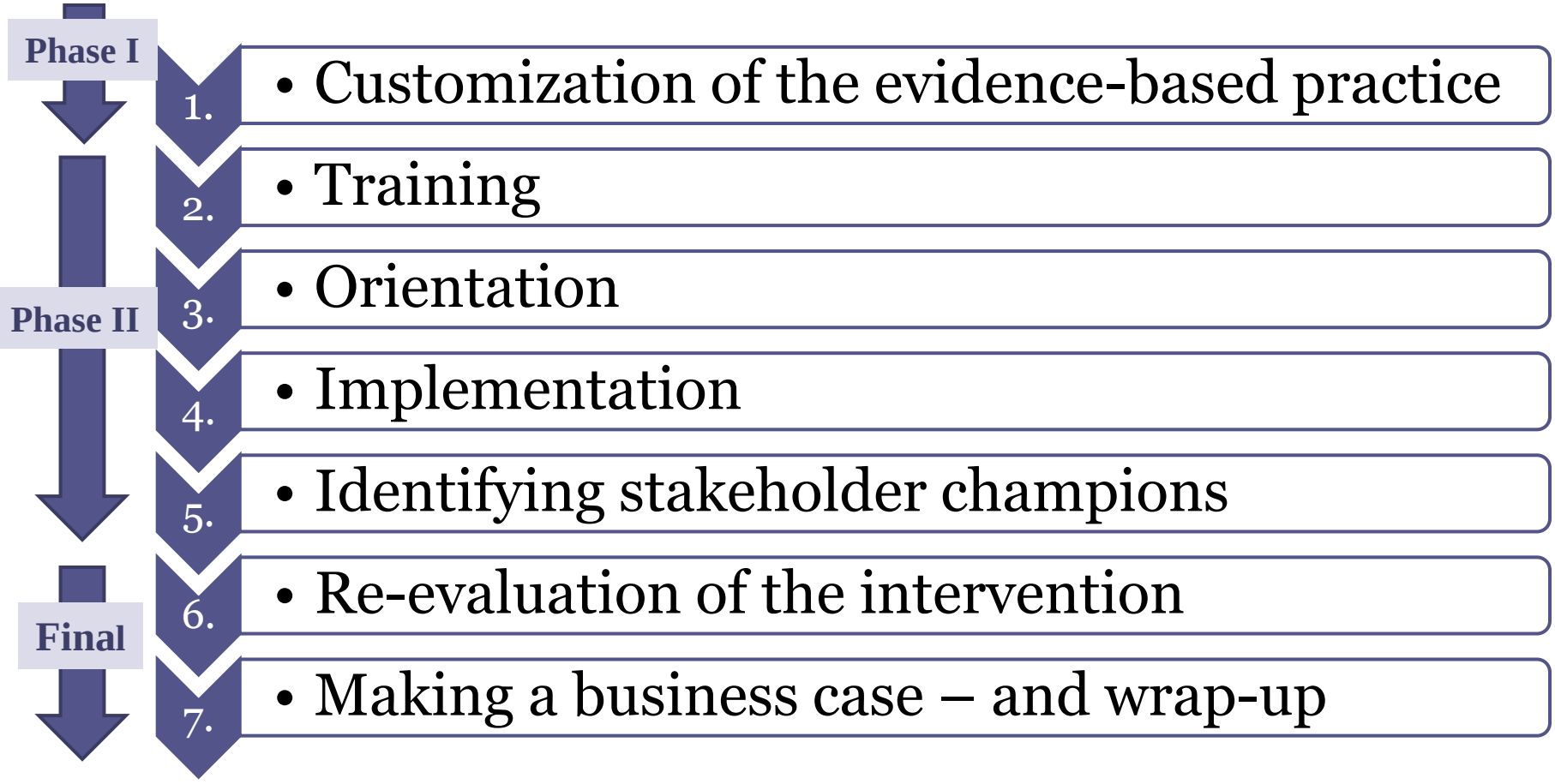
Phase I Activities: Customization of Life Goals Collaborative Care

- Feedback panel of persons receiving services(CSTS)
- Organizational needs assessment by CSTS/Packard administration
- Staff interviews (case managers, prescribers, supervisors, administration)



- Customized workbooks for people enrolled
- Consideration for logistical barriers (phone follow-ups, meeting people in the community)
- Creation of a packaged, user friendly guide to implementing LGCC at CSTS and Packard

Expanded REP+ Implementation Model



ROCC Preliminary Data

- 73 participants enrolled at CSTS
- 55 participants enrolled at Packard

- TOTAL across all sites: 367

ROCC Preliminary Data

	Packard (N=49)	CSTS (N=62)	Genesee (N=68)
Visited ER in the last 6 months	**32%**	25%	44%
Hospitalized in last 6 months	**16%**	34%	30%
Current smoker	**64%**	37%	78%
Hypertension	**30%**	30%	38%
Dyslipidemia	**46%**	45%	50%
Arthritis or chronic pain	**39%**	58%	63%

ROCC Preliminary Data

	Packard (N=49)	CSTS (N=62)	Genesee (N=68)
PHQ 9 ≥ 10	**70%**	65%	60%
ISS Depression	**8.6±6.7**	7.0±5.1	7.9±6.5
ISS Activation	**19.8±13.4**	18.4±12.7	23.0±12.7
PTSD	**41%**	33%	48%
SF-12 MCS	**31.9±9.3**	33.4±7.1	32.8±8.4
SF-12 PCS	**37.2±8.1**	36.6±6.9	36.0±7.9
Substance use in last 6 months	**28%**	18%	32%
Hazardous drinking	**26%**	6%	14%

Future Directions

- Life Goals Collaborative Care: Primary Care (FQHCS in Colorado, Michigan sites)
- Life Goals SMI, Collaboration with Genesee County, VA
- REP+ Toolkit for Evidence-based Integrated Care Practices

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