



OCCUPATIONAL HEALTH **BEST PRACTICES**

---

WORKING TOGETHER TO KEEP PEOPLE WORKING

# Chronic Pain & Behavioral Health: Collaborative Care

ACHIEV Meeting  
July 28, 2016

---

Dawn Ehde, PhD

Professor, Rehabilitation Medicine

University of Washington

# Other Team Members

---

- Susan Campbell, MPS
  - Deb Fulton-Kehoe, PhD
  - Terri Smith-Weller, RN, MN, COHN-S
  - Kari Stephens, PhD
- *Some content was adapted from the University of Washington AIMS Center: <https://aims.uw.edu>*

# Chronic Pain & Behavioral Health Collaborative Care

---

## Target Population:

*Injured workers with pain and/or behavioral health issues – at risk for time loss and disability*

# Collaborative Care

---

- A well-established model of care that is transforming healthcare
- Adopted by WA Community Health Clinics, Veterans Administration, & other systems
- Endorsed by the Centers for Medicare & Medicaid Services
- Patient-centered
- Supports providers

<https://aims.uw.edu/collaborative-care>

# Collaborative Care Achieves the **Triple Aim**

---

1. Better patient and provider satisfaction with care
2. Better clinical outcomes
  - Doubles effectiveness of depression treatment
  - Less physical pain
  - Better functioning
  - Higher quality of life
3. Reduced health care costs

# Principles of Effective Collaborative Care

---

Patient-Centered Team Care / Collaborative

Population-Based Care

Measurement-Based Treatment to Target

Evidence-Based Care

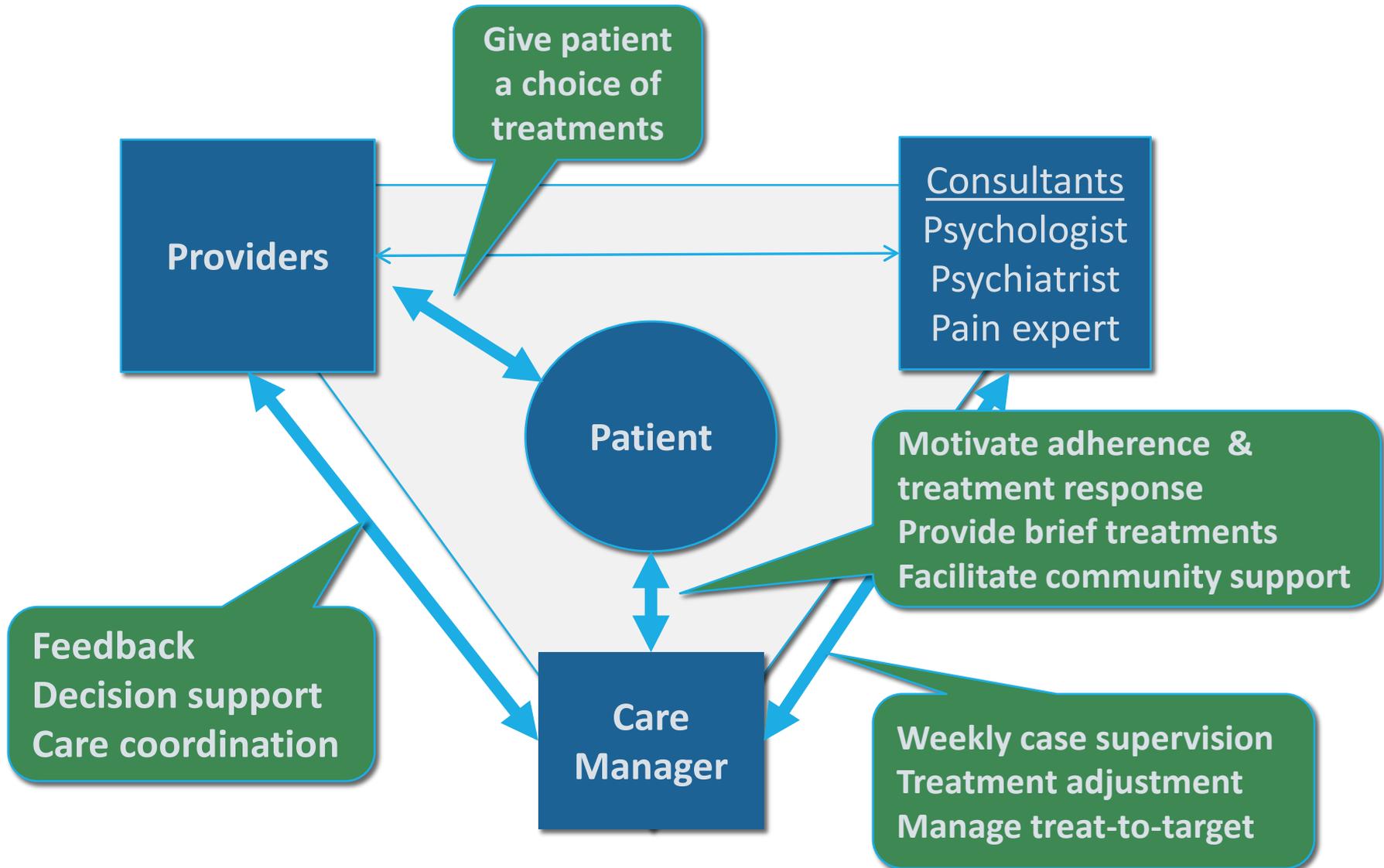
Accountable

# Patient-Centered Team Care

---

- Based on self-management
  - The patient is the most important member of the team & brings strengths & skills to the situation
  - Care includes strategies to educate, engage, & motivate patient
- Specific evidence-based treatment strategies are selected based on patient's needs, goals, & preferences

# Collaborative Care Model



# Care Plan Example

## Psychiatric/Depression

collapse update

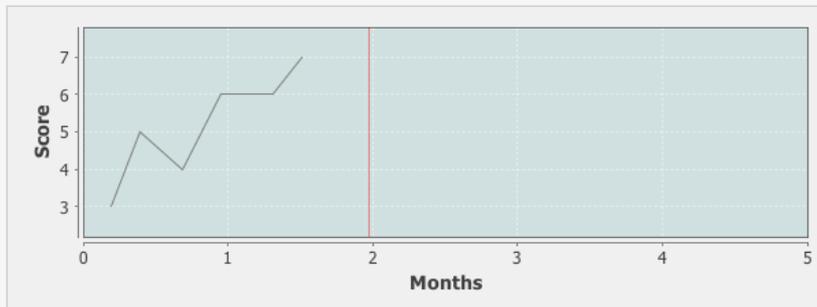
### General Information

Last updated by: Marc Avery, 10/15/2012

**Problem Category** : Psychiatric  
**Problem Subcategory** : Depression  
**Target Outcome Measurement Tool** : Basic 0-10 Scale  
**Target Outcome Measure** : 8  
**Timeframe** : 2 months  
**Date Opened** : 8/30/2012  
**Date Closed** :  
**Closed Reason** :  
**Clinical Lead** : AASuzy Hunter, CC

**Problem/Need** : "I as yelling at my children too much -- I think it really affects them."  
**Goal** : "I want to be able to talk to people without snapping at them."  
**Barriers** : "I works long hours and does not have much time for this mumbo jumbo."  
**Strengths** : "I really want to be a good Dad. If I could focus as much on that as I do on work I'd be a Superdad!"

### Measurement History



### Interventions

1

**Modality** : Patient Activity  
**Activity** : Dan is reading the behavioral activation workbook.

2

**Modality** : Counseling  
**Activity** : We are doing emotional regulation therapy during appointments.

# Population-Based Care

---

- Patients are tracked in a registry to make sure that no patient “falls through the cracks”
- Care managers reach out to patients who are not following through or improving
- Specialists guide care of all patients being followed rather than only a few
- Technology supports care

# Example: Caseload List Report

FLAGS	PATIENT ID	NAME	STA-TUS ⓘ	PHQ-9		GAD-7		CONTACTS							
				FIRST ⓘ	LAST ⓘ	FIRST ⓘ	LAST ⓘ	I/A ⓘ	F/U ⓘ	P/N ⓘ	RPP ⓘ	# SESS ⓘ	WKS SINCE I/A ⓘ		
🔔	0000033	Tester, Bethany	T	27	24	21	18	1/13/15	3/28/16	+		+	3	65	
🔔	0000006	Test, Harry	T	20	21*	19	15*	8/18/11	2/11/14	+		+	2	242	
🔔	0000029	Patient, A	T	9	19	13	16	1/5/12	4/3/16	+	1/14/12	12/3/14	+	5	222
🔔	0000012	Test, Yogi	T	18	18*	12	12*	8/1/11	2/15/12	+		+	2	245	
🔔	0000061	Demo, Drusilla	T	19	13	17	9	2/12/16	4/12/16	+		+	2	8	
🔔	0000003	Demonstration, Don	T	15	11*	12	8*	8/15/11	2/16/12	+	8/15/11	+	3	243	
🔔	0000021	Test B, Patient	T	13	9*	11	11*	1/2/12	2/23/12	+		+	3	223	
🔔	0000056	Fake, Jennifer	T	27	8*	20	20*	9/23/13	11/17/15	+		+	3	133	
🔔	0000039	Demo, Edward	T	15	4	20	3*	5/7/12	4/12/16	+		+	4	205	
🔔	0000040	Demo, Xander	RPP	24	4	19	3	6/25/12	4/4/16	+	1/5/15	7/5/15	5	198	
🔔	0000032	Demo, Harry	T	16	3*	7	2*	3/9/12	3/21/12	+	10/13/15	10/8/14	+	4	213
🔔	0000024	Demo, Frank	T	9	2*	12	6*	5/15/12	3/9/16	+		+	4	204	
🔔	0000030	Patient, B	E						+				0	0	
🔔	0000046	Demo, Anabelle	E						+				0	0	

# Reminders/Alerts: Minimizes Patients Falling Through the Cracks

[PATIENT ID]	[NAME] 	[INITIAL ASSESSMENT] 	[FOLLOW UP] 	REFERRAL 	LAST CONTACT ATTEMPT 	NEXT APPOINTMENT 
000071	Basu, Bavi		77 days overdue 			4/15/2016 3:00PM
000103	Demo, Nicole	24 days overdue 				
000039	Marks, Steve		66 days overdue 			4/15/2016 12:00PM
000047	Richards, Emily		14 days overdue 			
000046	Smith, Bob		56 days overdue 	83 days overdue 	3/28/2016	
000066	Smith, Anna		15 days overdue 	68 days overdue 	4/12/2016	4/22/2016 12:00PM
000043	Test, Charles		87 days overdue 		12/20/2015	4/30/2016 12:00PM
000062	Williams, Robert		42 days overdue 			
000048	Zhu, Hong		87 days overdue 		8/25/2014	

# Measurement-Based Treatment to Target

---

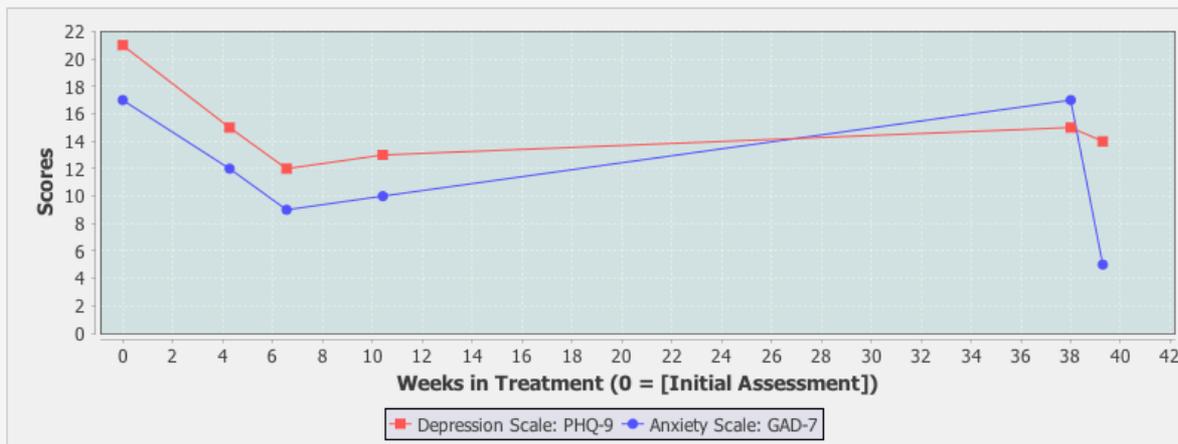
- The treatment plan lists patient's goals & outcomes to be measured
- Treatment outcomes (e.g., pain) are assessed routinely
- Treatments are adjusted or updated as needed
- Reduces inertia & use of treatments that are not achieving results

# Treatment History Report

## [Contacts]

[DATE OF CONTACT]	[CONTACT TYPE]	[WEEKS IN Tx]	[VISIT TYPE]	[PHQ-9]	[GAD-7]	[CURRENT MEDICATIONS]
4/20/2015	[Initial Assessment]	0	Clinic	21	17	Fluoxetine HCl (Prozac) 50mg
5/20/2015	[Follow Up]	4	Phone	15	12	†Fluoxetine HCl (Prozac) 50mg
7/2/2015	[Follow Up]	10	Clinic	13	10	Fluoxetine HCl (Prozac) 60mg
7/2/2015	[Psychiatric Consultation Note]	10	[Phone w/ CM]			
8/26/2015	[Relapse Prevention Plan]	18	Phone			†Fluoxetine HCl (Prozac) 60mg
1/11/2016	[Follow Up]	38	Clinic	15	17	†Fluoxetine HCl (Prozac) 60mg
1/11/2016	[Follow Up]	38	Phone			†Fluoxetine HCl (Prozac) 60mg
1/20/2016	[Follow Up]	39	Clinic	14	5	Aspirin-Hydrocodone Bitartrate (Azdone) †Fluoxetine HCl (Prozac) 60mg Prazosin HCl (Generic)

## [Patient Progress]

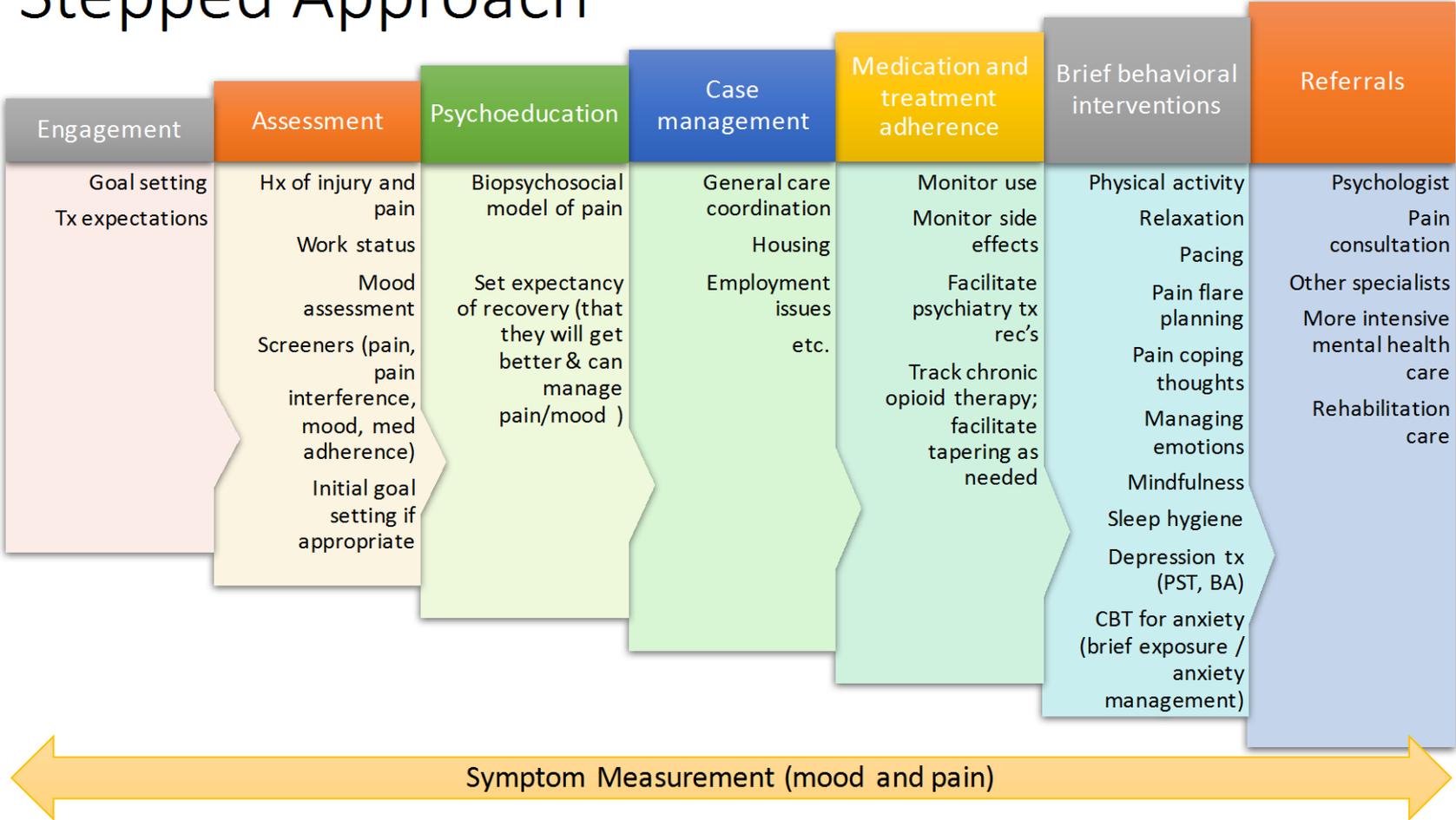


# Evidenced-Based Care

---

- Patients are offered treatment options that are supported by scientific evidence for the condition
- For chronic pain, these may include:
  - Cognitive behavioral skills training (e.g., relaxation, mindfulness)
  - Physical activity/exercise recommendations
  - Coaching on strategies for adhering to provider's recommendations
  - Medication management (including medication tapering if indicated)

# Stepped Approach



# Accountable Care

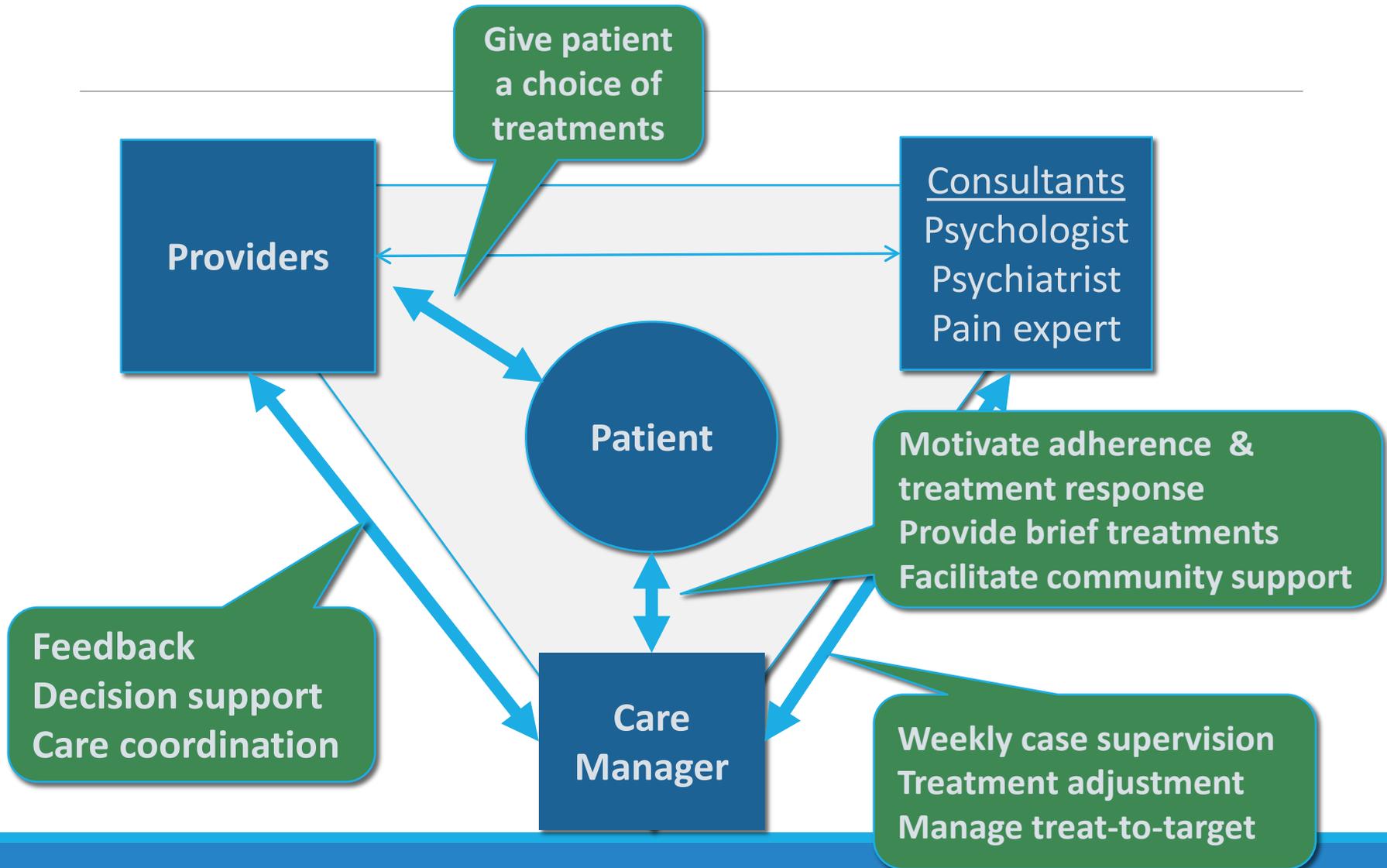
---

- Providers are accountable through measurement and panel review for quality of care and outcomes
- Systematic outcomes and care tracking facilitates accountability & maximizes the value of services provided

# Caseload Statistics Report

[CLINIC]	# OF PT.	[INITIAL ASSESSMENT]			[FOLLOW UP]				% CONTACT NOTES WITH PHQ	LAST AVAILABLE		# ON MEDS	# w/ MISSING MEDS	# IN [R/P]	[PSYCHIATRIC CONSULTATION NOTE]			DECREASED 5+ POINTS		50% IMPROVED OR < 10 AFTER > 10 WKS	
		#	MEAN PHQ	MEAN GAD	# OF PT.	MEAN #	MEAN # CLINIC	MEAN # PHONE		MEAN PHQ	MEAN GAD				# REQ'D	# w/ [P/N]	NOT IMPRV w/o [P/N]	PHQ	GAD	PHQ	GAD
Downtown Test Clinic	18	14 (78%)	16.6	9	11 (79%)	4	1.4 (34%)	1.2 (30%)	64%	10.5	7	6 (55%)	0 (0%)	2 (14%)	4 (22%)	2 (11%)	8	7 (64%)	2 (40%)	4 (67%) (n=6)	4 (67%) (n=6)
Test Clinic	76	62 (82%)	17.8	13.8	50 (81%)	2.8	1.3 (46%)	0.7 (25%)	61%	13.5	9.9	28 (56%)	1 (2%)	15 (24%)	27 (36%)	8 (11%)	34	18 (62%)	11 (65%)	13 (42%) (n=31)	11 (35%) (n=31)
All	92	74 (80%)	17.2	12.6	59 (80%)	2.7	1.2 (45%)	0.7 (26%)	64%	13.2	9.6	32 (54%)	1 (1%)	16 (22%)	31 (34%)	9 (10%)	42	23 (61%)	12 (57%)	15 (43%) (n=35)	13 (37%) (n=35)

# Examples



# Summary and Next Steps

---

- Overall aim: To provide high quality, accessible, population-based care for injured workers at risk for time loss and disability
- UW staff working with L&I and meeting regularly
- Developing a pilot
  - Requirements for a pilot site
  - Measures and evaluation
  - Assessments and triggers
- Report recommendations to L&I in 2017