Implementing the Collaborative Care Model to Deliver Population-based Psychosocial Oncology Care

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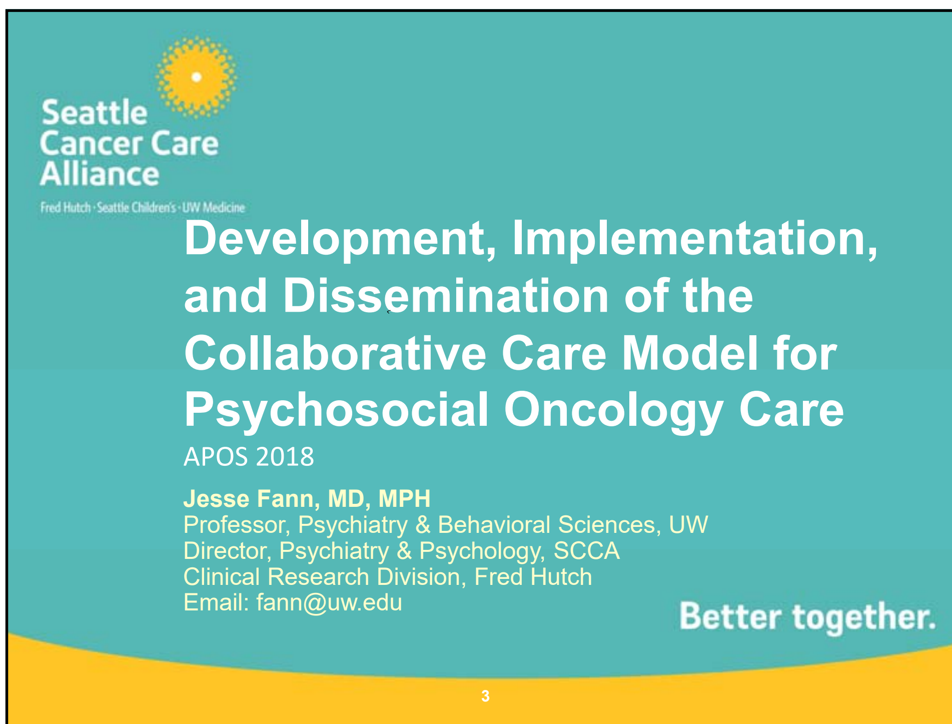
Symposium Objectives

- Provide information to assist cancer programs of all types interested in implementing collaborative care by featuring four program directors with unique experiences in implementing the model at their cancer centers.



APOS 2018

Disclosure: Jesse Fann, MD MPH

Research Funding	NIH, PCORI, VHA, DHHS	
Consulting		Quartet Health

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- Apply the core components of collaborative care
- Identify strategies and tools to overcome potential challenges.

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- Jen Sexton, MD
- Mitch Levy, MD
- Catherine Howe, MD, PhD
- Julia Ruark, MD, MPH
- Laurel Pellegrino, MD
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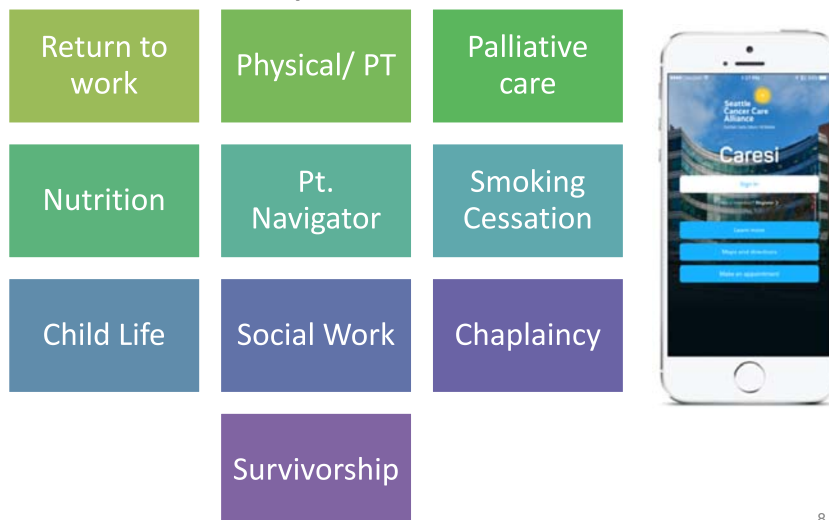
- Chris Jackson, MS
- Lauren Bruck

Funding from The Mary Gates Foundation

Supportive Cancer Care Questionnaire

(Baseline, q2-months, End of Tx)



Screening is only the first step…

"You can't fatten a cow by weighing it."

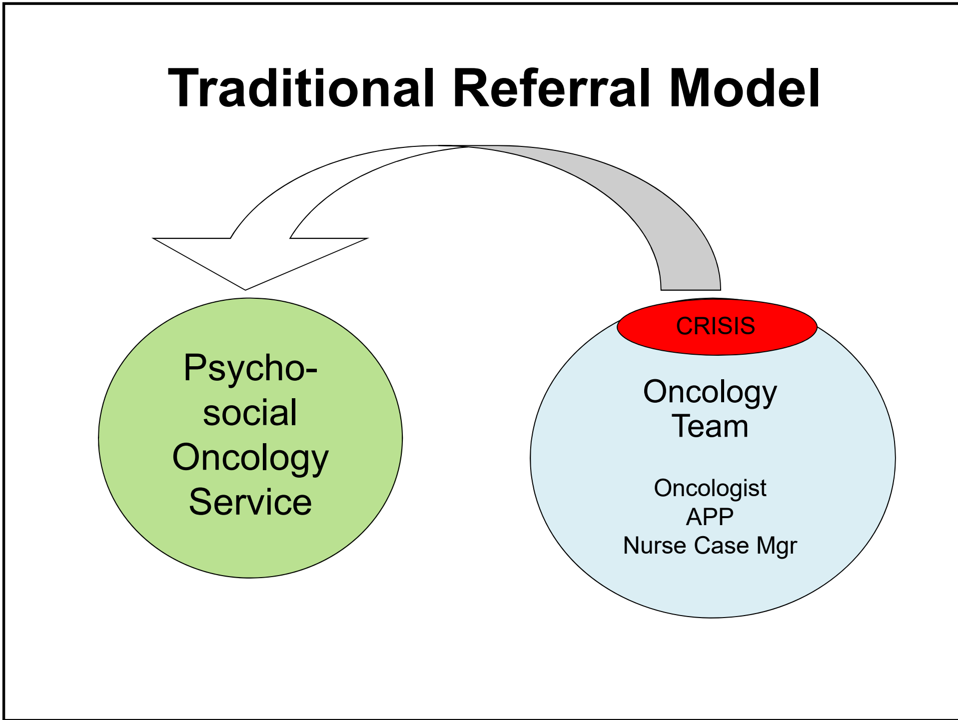
Proverb

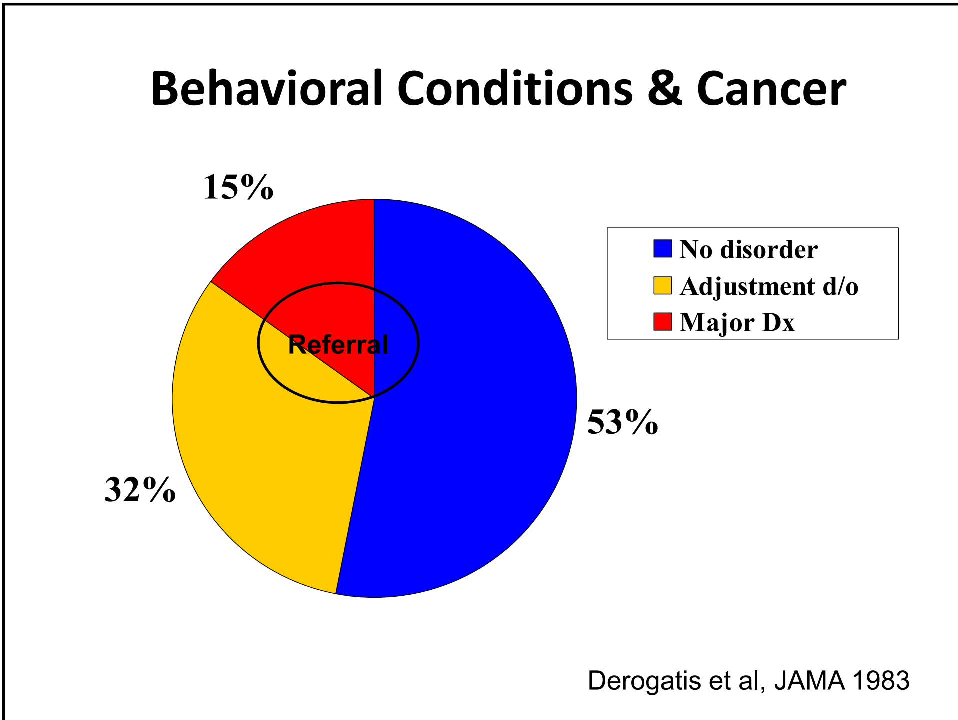
Approaches that we know ***Don't Work***

- Screening without a system to ensure access to evidence-based treatment
- Referral to specialty care without close coordination and follow-up
- Co-location of behavioral health specialists without a system for tracking outcomes and treatment adjustments

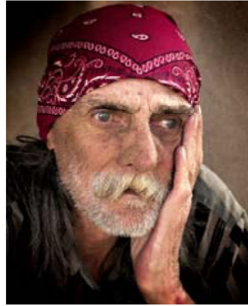
Patients 'fall through the cracks' or stay on ineffective treatments for too long

Carlson et al, J Clin Oncol 2010; Hollingworth et al, J Clin Oncol 2013


Traditional Referral Model
Psycho-
social
Oncology
Service
CRISIS
Oncology
Team
Oncologist
APP
Nurse Case Mgr


Behavioral Conditions & Cancer
15%
Referral
53%
32%
No disorder
Adjustment d/o
Major Dx
Derogatis et al, JAMA 1983

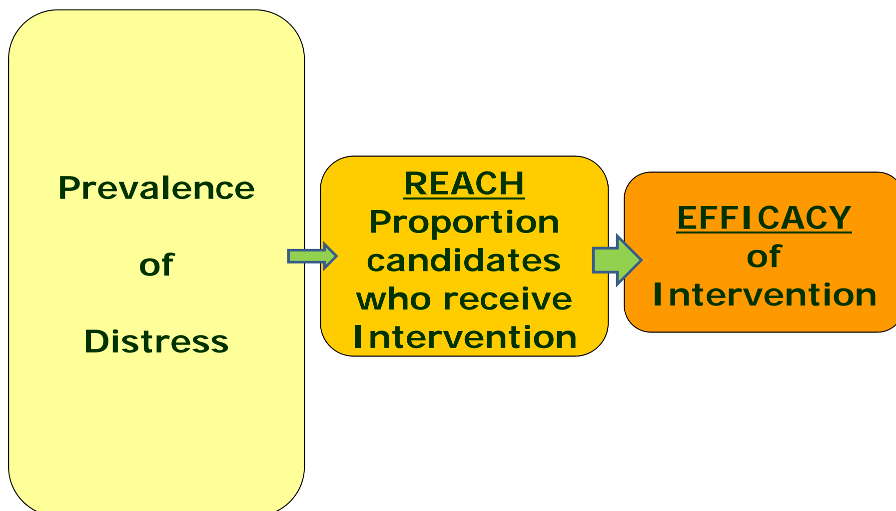
Limits of Traditional Referral

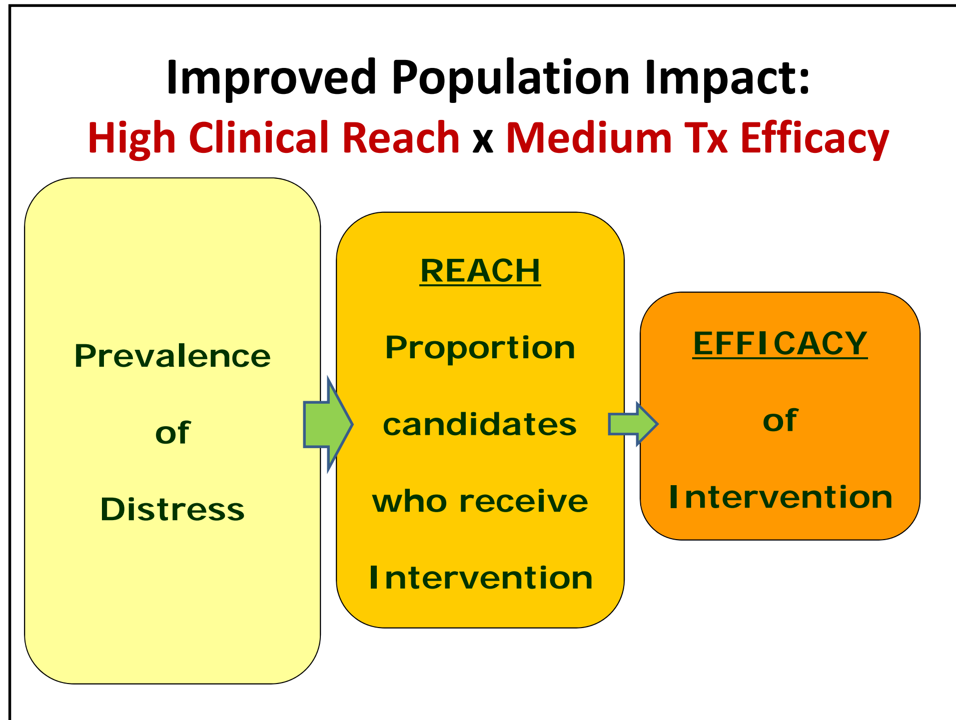


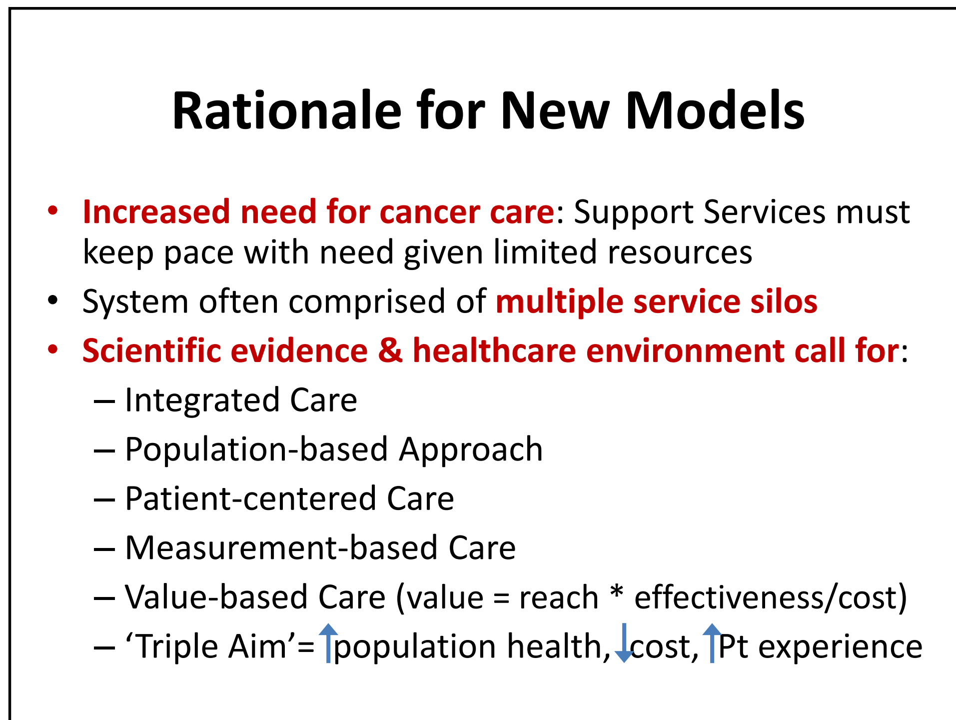
- ~ 1/4 not recognized or effectively engaged in care
- ~ 1/4 drop out of treatment too early
- ~ 1/4 stay on ineffective treatments for too long
- ~ 1/4 effectively treated

Minimal Population Impact:

Low Clinical Reach x High Tx Efficacy




Improved Population Impact:
High Clinical Reach x Medium Tx Efficacy
Prevalence of Distress
REACH
Proportion candidates who receive Intervention
EFFICACY
of Intervention


Rationale for New Models
Increased need for cancer care: Support Services must keep pace with need given limited resources
System often comprised of multiple service silos
Scientific evidence & healthcare environment call for:
– Integrated Care
– Population-based Approach
– Patient-centered Care
– Measurement-based Care
– Value-based Care (value = reach * effectiveness/cost)
– 'Triple Aim'= ↑population health, ↓cost, ↑Pt experience

Key Principles of Collaborative Care

Based on >80 Randomized Controlled Trials

Population-Based Care

– Builds on Universal Distress Screening

Patient-Centered Team Care

– Coordinated by Care Manager, focus on Pt preference

Measurement-Based, Treatment to Target

– Track outcomes & adherence, electronic registry

Evidence-Based Stepped Care

– Weekly caseload review/supervision

Accountable Care

– Transparency, everyone is accountable

aims.uw.edu
Archer et al, 2012
Thota et al, 2013
Huffman et al, 2014
Beach et al, 2015

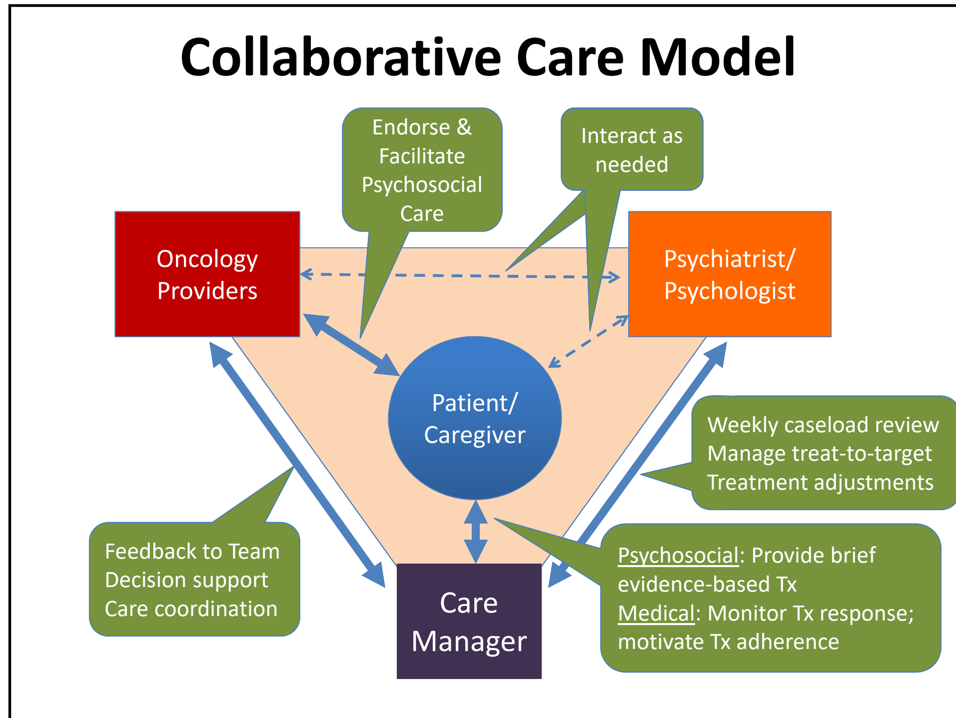
Components of Collaborative Care

Electronic Patient Registry / Decision Support Tool

On-Site Care Coordinator

Weekly Caseload Review/Supervision

Systematic Use of Validated Screening and Outcome Tools



CC Addresses Common Barriers to Care

- **Access & Engagement**
  - Care managers embedded in oncology clinics
  - Care managers quickly engage & assess patients
  - Psychosocial treatment gets started quickly
- **Care coordination & follow-up**
  - Oncologists get input on their patients' psychosocial problems within hours/days vs. weeks/months
  - Electronic Tracking Log ensures monitoring of clinical outcomes

CC Addresses Common Barriers to Care

- **Treatment adjustments**
  - Weekly Caseload Review with Psychiatrists/ Psychologists & Care Managers
    - Track outcomes using validated measures
    - Make Tx recs per Clinical Practice Guidelines / Pathways
  - Psychiatrists/Psychologists focus in-person visits on the most challenging patients

CC is Sustainable

- **Flexible & Adaptable**
  - Enhances (vs. replaces) traditional referral model
  - Capitalizes on existing supportive care staffing models (e.g., social work)
  - Various specialties can be trained as care managers
  - Can adapt to
    - Patients' Tx preferences
    - Providers' practice preferences (e.g., prescribing)
  - Scalable using Telehealth
- **Facilitates Value-based Accountable Care**
  - Population-based, measurement-based, improves patient satisfaction

CC is Sustainable

- **Cost-efficient**
  - Shown to be cost-effective in RCTs
  - Directs level of need to appropriate resources
  - New CMS billing codes
- **Quality Improvement**
  - Consistent with QI models (e.g., CPI, lean)
- **Provider Satisfaction**
  - Promotes teamwork, mutual support, & practice at top of license
  - trainee education & experience in integrated care

CC Evidence Base

- **Medical settings**
  - Primary care - Maternal care
  - Oncology - Adolescent medicine
  - Cardiology - Pain / Fibromyalgia
  - Diabetes care - Multiple Sclerosis
  - HIV - Brain / Spinal Cord Injury
- **Conditions**
  - Depression - Serious Mental Illness
  - Anxiety - Substance abuse
  - PTSD - Pain
  - Bipolar disorder - Postconcussive disorder

Huffman et al, Psychosomatics 2013

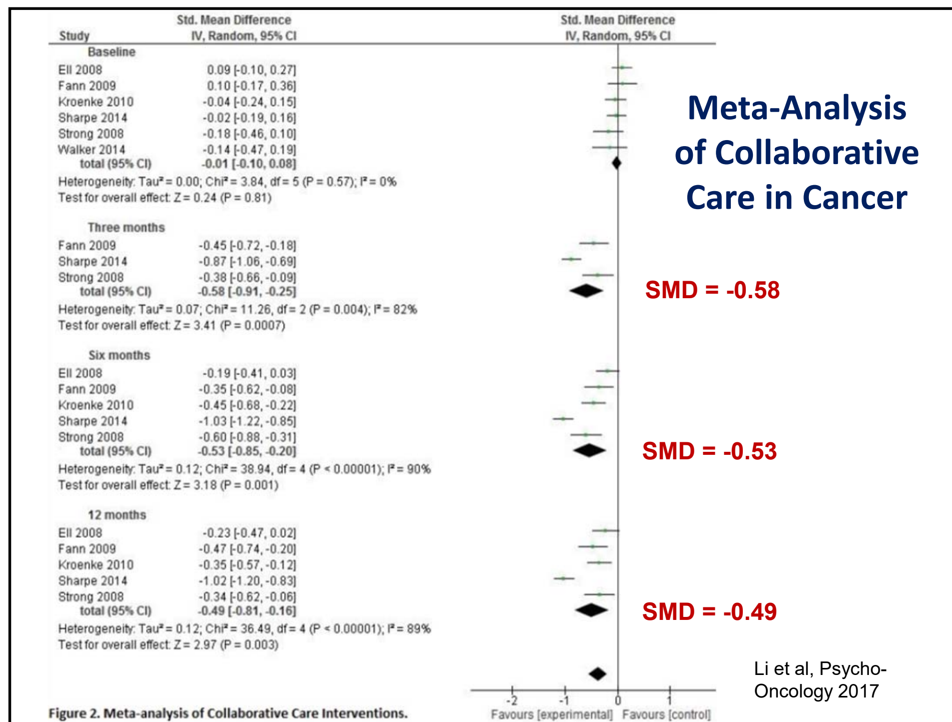


Figure 2. Meta-analysis of Collaborative Care Interventions.

- Sharpe M, Walker J, Holm Hansen C, et al. Integrated collaborative care for comorbid major depression in patients with cancer (SMaRT Oncology-2). Lancet 384:1099-108, 2014.
  - **British multi-site general cancer population**
- Walker J, Hansen CH, Martin P, et al. Integrated collaborative care for major depression comorbid with a poor prognosis cancer (SMaRT Oncology-3). Lancet Oncol 15:1168-76, 2014.
  - **British multi-site lung cancer population**
- Ell K, Xie B, Quon B, Quinn DI, Dwight-Johnson M, Lee PJ. Randomized controlled trial of collaborative care management of depression among low-income patients with cancer. J Clin Oncol 26:4488-4496, 2008.
  - **Low-income, mostly female, Hispanic at a county cancer clinic**
- Fann JR, Fan MY, Unutzer J. Improving primary care for older adults with cancer and depression. Journal of General Internal Medicine 24(Suppl 2):417–424, 2009
  - **Elderly cancer patients treated in primary care**
- Kroenke K, Theobald D, Wu J, et al: Effect of telecare management on **pain and depression** in patients with cancer: A randomized trial. JAMA 304:163-171, 2010
  - **16 community based oncology practices using Telehealth**
- Steel JL, Geller DA, Kim KH, et al: Web-based collaborative care intervention to manage **cancer-related symptoms in the palliative care setting**. Cancer 2016
  - **Improved dep, pain, fatigue, QOL in patients and stress, dep in caregivers**

Integrated Psychosocial Oncology Program (IPOP)

Inpatients

150 adult oncology beds (20 transplant)

40 pediatric oncology beds

SCCA Outpatients

~8,000 new patient Tx episodes per year

>80,000 clinic visits per year

Timeline of Implementation of Integrated Psychosocial Oncology Program

- **2001** SCCA opens
  Collaborative Care model introduced
- **2009** Proposed IPOP model to leadership
  SW/Psychiatry/Psychology Partnership
  Negotiated increased staffing
- **2010-2011** Piloted IPOP
- **2011** Presented results to Med Exec Comm.
- **2011-2013** Implement & roll out IPOP
  - Presented scientific evidence & rationale to each SCCA clinic
  - Continuous Process Improvement QI initiative
  - Universal screening mandate & implementation
  - Published *JCO 2012* paper & *Psycho-Oncology 2015* textbook chapter on Integrated Collaborative Care

Conclusions: IPOP Pilot

IPOP was associated with:

- Streamlined psychosocial care, allowing limited specialty mental health resources to be available to more people
- Ability to direct more intensive services to patients with highest need
- Early detection and collaborative management of diverse psychosocial needs
- Enhanced tracking of psychosocial and behavioral outcomes and treatment adjustments
- Improved patient and provider satisfaction

Integrating Psychosocial Care Into Cancer Services

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JOURNAL OF CLINICAL ONCOLOGY

REVIEW ARTICLE

Integrating Psychosocial Care Into Cancer Services

Jesse R. Fann, Kathleen Ell, and Michael Sharpe

Jesse R. Fann, Fred Hutchinson Cancer Research Center, University of Washington, Seattle, WA; Kathleen Ell, School of Social Work, University of Southern California, Los Angeles, CA; and Michael Sharpe, University of Oxford, Oxford, United Kingdom.

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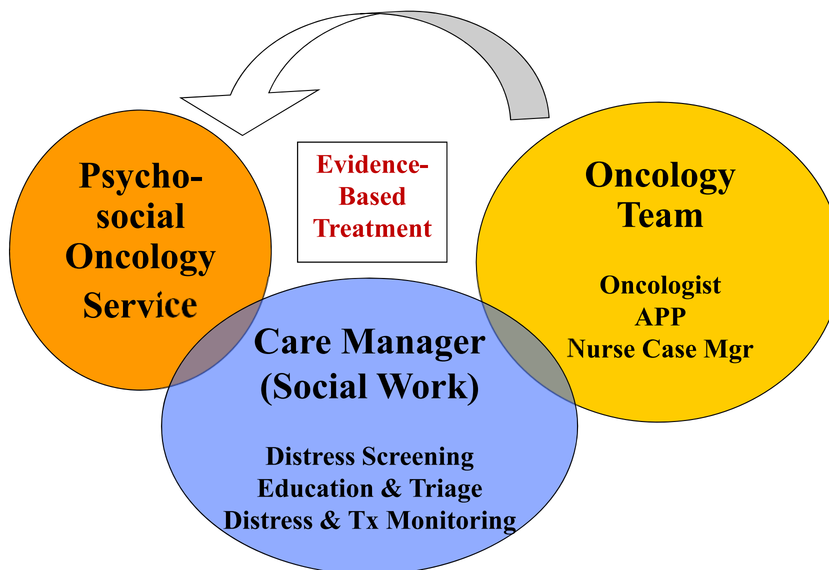
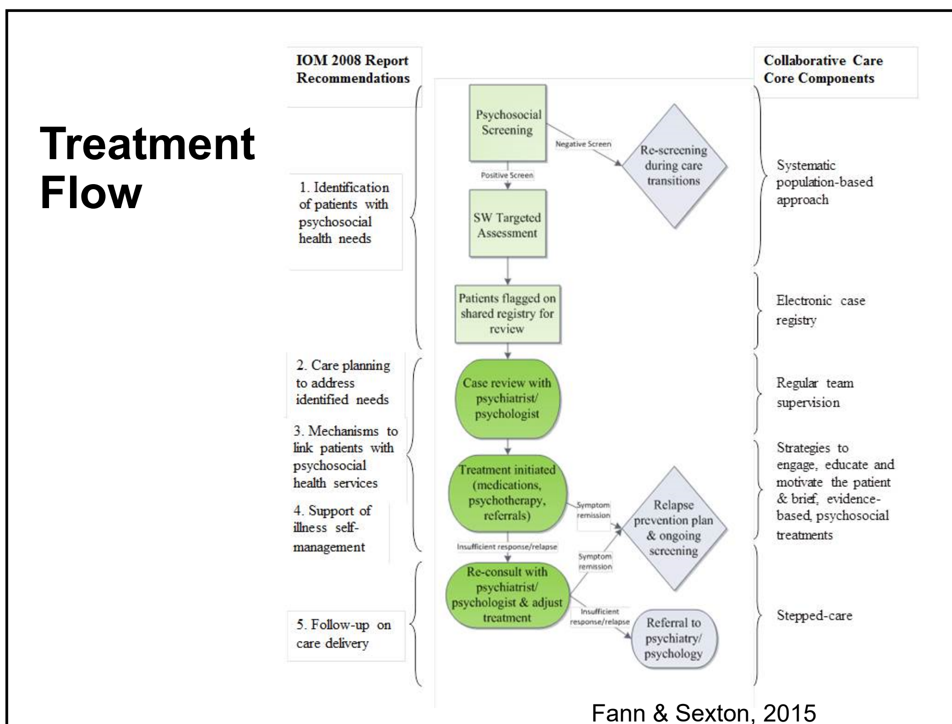
A B S T R A C T

Despite substantial evidence that patients with cancer commonly have significant psychosocial problems, for which we have evidence-based treatments, many patients still do not receive adequate psychosocial care. This means that we risk prolonging life without adequately addressing the quality of that life. There are many challenges to improving the current situation, the major one of which is organizational. Many cancer centers lack a system of psychosocial care that is integrated with the cancer care of the patient. Psychosocial care encompasses a range of problems (emotional, social, palliative, and logistical). The integration must occur with the cancer care of the patient at all stages (from screening to palliative care) and across all clinical sites of care (inpatient and outpatient cancer services as well as primary care). In this article, we consider the challenges we face if we are to provide such integrated psychosocial services. We focus on the collaborative care service model. This model comprises systematic identification of need, integrated delivery of care by care managers, appropriate specialist supervision, and the stepping of care based on systematic measurement of outcomes. Several trials of this approach to the management of depression in patients with cancer have found it to be both feasible to deliver and effective. It provides a model for services to meet other psychosocial needs. We conclude by proposing the key components of an integrated psychosocial service that could be implemented now and by considering what we need to do next if we are to succeed in providing better and more comprehensive care to our patients.

J Clin Oncol 30:1178-1186. © 2012 by American Society of Clinical Oncology

Integrated Psychosocial Oncology




Treatment Flow
IOM 2008 Report Recommendations
Collaborative Care Core Components
1. Identification of patients with psychosocial health needs
2. Care planning to address identified needs
3. Mechanisms to link patients with psychosocial health services
4. Support of illness self-management
5. Follow-up on care delivery
Psychosocial Screening
Negative Screen
Re-screening during care transitions
Positive Screen
SW Targeted Assessment
Patients flagged on shared registry for review
Case review with psychiatrist/ psychologist
Treatment initiated (medications, psychotherapy, referrals)
Symptom remission
Relapse prevention plan & ongoing screening
Insufficient response/relapse
Symptom remission
Re-consult with psychiatrist/ psychologist & adjust treatment
Insufficient response/relapse
Referral to psychiatry/ psychology
Systematic population-based approach
Electronic case registry
Regular team supervision
Strategies to engage, educate and motivate the patient & brief, evidence-based, psychosocial treatments
Stepped-care
Fann & Sexton, 2015

Stepped Psychosocial Care
SEVERE
Medications
Psychotherapy
MODERATE
Brief Counseling
Medications?
Close Monitoring
MILD
Medical team
SW, Spiritual, Complimentary Supports
NORMAL
Family & Community Supports

IPOP Tracking Log

(not actual patients shown)

'Caseload Overview'

Seattle Cancer Care Alliance

IPOP Tracking Log

1) Press "Ctrl+J" to refresh the page EVERY time this worksheet is used.
2) Make sure all other versions/copies of the template are CLOSED before pressing "Ctrl+J"
3) Do NOT use this worksheet if fewer than 2 ACTIVE patients are in the Patient Tracking worksheet.
4) Do NOT make changes to the text on this worksheet. Only use the sort/filter functions in Row 4. If a cell value is changed, press "Ctrl+Z" immediately to undo it.

Treatment Status: The most recent contact was over 1 month (30 days) ago; The next follow-up contact is past due

PHQ-4: The last available PHQ-4 score is >30 days old; The last available PHQ-4 score is 3-5 (positive); The last available PHQ-4 is ≥6

PHQ-9: The last available PHQ-9 score is >30 days old; The last available PHQ-9 score is <10 (at target); The last available PHQ-9 score is 10-14; The last available PHQ-9 score is ≥15

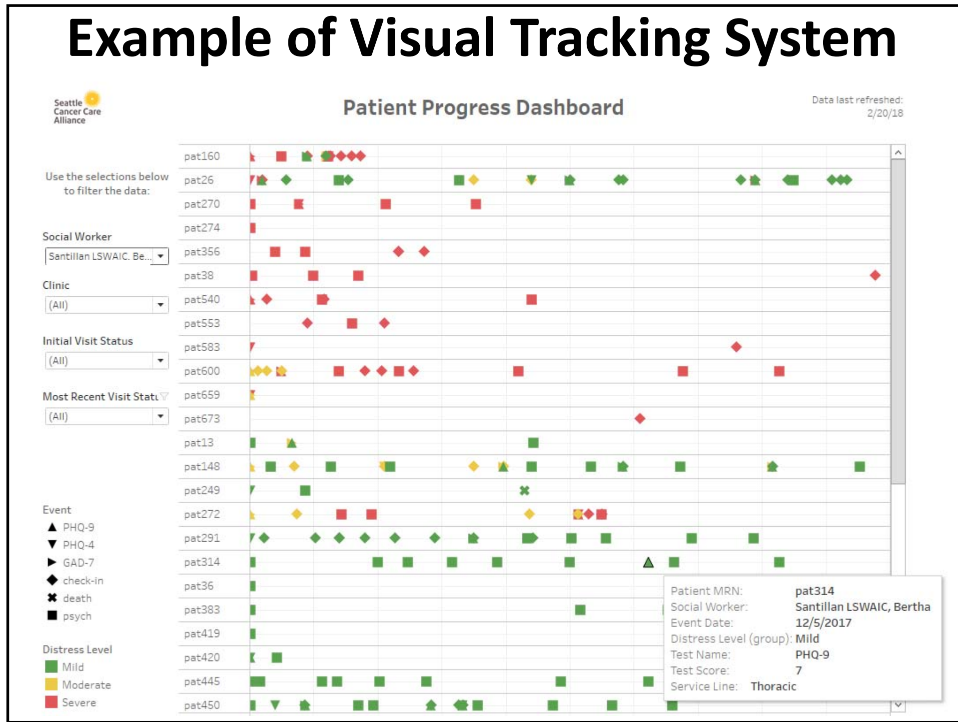
GAD-7: The last available GAD-7 score is >30 days old; The last available GAD-7 score is <10 (at target); The last available GAD-7 score is 10-14; The last available GAD-7 score is ≥15

				Treatment Status					PHQ-4			PHQ-9			GAD-7			Psychiatric Case Review	
View Record	Treatment Status	Name	Clinic Code	Date of Initial Assessment	Date of Most Recent Contact	Date Next Follow up Due	Number of Follow-up Contacts	Weeks in Treatment	Initial PHQ-4 Score	Last Available PHQ-4 Score	Date of Last PHQ-4 Score	Initial PHQ-9 Score	Last Available PHQ-9 Score	Date of Last PHQ-9 Score	Initial GAD-7 Score	Last Available GAD-7 Score	Date of Last GAD-7 Score	Flag	Most Recent Psychiatric Case Review Note
View	Active - Distressed	Foster, Jessica	GI	5/15/2017	5/15/2017	7/14/2017	0	14	6	6	5/15/2017	18	18	5/15/2017	18	18	5/15/2017		
View	Active - Distressed	Rogers, Stephanie	GI	8/12/2017	8/12/2017	10/11/2017	0	2	4	4	8/12/2017	18	18	8/12/2017	15	15	8/12/2017	Flag for discussion	
View	Active - Distressed	Martinez, Jose	TRANSPLANT - ALLO	5/5/2017	6/1/2017	7/1/2017	3	16	4	4	5/5/2017	18	17	5/20/2017	17	16	5/20/2017	Flag for discussion	5/21/2017
View	Active - Distressed	Austen, Bob	GI	7/14/2017	8/25/2017	9/24/2017	3	6	8	8	7/14/2017	11	15	8/25/2017	11	12	8/25/2017	Flag for discussion	8/2/2017
View	Active - Distressed	Stimey, Alli	GI	6/30/2017	7/5/2017	8/4/2017	1	8	4	4	6/30/2017	13	13	6/30/2017	16	16	6/30/2017	Flag for discussion & safety risk	7/1/2017
View	Active - Distressed	Mays, Lindsay	GI	7/14/2017	7/14/2017	8/13/2017	0	6	1	1	7/14/2017	12	12	7/14/2017	10	10	7/14/2017		
View	Active - Distressed	Peterson, Elmer	BREAST	8/1/2017	8/15/2017	9/14/2017	1	3	4	4	8/1/2017	12	10	8/15/2017	10	7	8/15/2017	Flag for discussion	8/2/2017
View	Active - Distressed	Jones, Billie	BREAST	7/7/2017	7/16/2017	8/15/2017	1	7	5	0	7/16/2017	10	7	7/16/2017	16	7	7/16/2017	Flag for discussion	7/10/2017
View	Active - Distressed	Penney, Max	TRANSPLANT - ALLO	7/1/2017	8/24/2017	9/23/2017	3	8	2	2	7/1/2017	20	6	8/24/2017	18	3	8/24/2017	Flag for discussion & safety risk	8/3/2017
View	Active - Distressed	Willings, Tom	GI	7/22/2017	8/5/2017	10/4/2017	2	5	6	6	7/22/2017	16	3	7/28/2017	16	8	7/28/2017		8/1/2017
View	Active - Distressed	Smith, Jared	TRANSPLANT - AUTO	6/6/2017	8/1/2017	8/31/2017	1	11	3	3	6/6/2017	8	2	8/1/2017	12	3	8/1/2017		
View	Active - Distressed	Wright, May	TRANSPLANT - ALLO	5/19/2017	5/19/2017	7/18/2017	0	14	2	2	5/19/2017	0	0	5/19/2017	0	0	5/19/2017		5/20/2017

IPOP Tracking Log

(not actual patients shown)

'Individual Patient Tracking'



IPOP Training Modules*

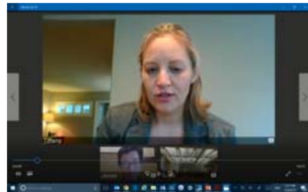
Background	Integrated, Population-based, Collaborative Care
Process	Shared Workflow/Clinical Pathways Screening & Assessment Tools Mental Status Exam/Using DSM Outcomes Tracking Caseload Reviews Clinical Presentations Communication w/ Medical Teams
Interventions	Brief Behavioral Interventions Pharmacotherapy
Conditions	Psychosocial conditions in cancer

*Provided free CE Credit

Fann & Sexton, 2015

IPOP Training Modules (cont.)

Psychosocial Conditions
- Distress
- Depression
- Suicidal ideation
- Anxiety, PTSD, OCD
- Insomnia
- Pain/Fatigue
- Substance abuse
- Cognitive impairment
- Delirium

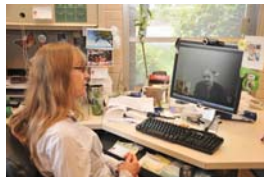


Brief Interventions
- Psychoeduction
- Diaphragmatic breathing
- Progressive muscle relaxation
- Mindfulness meditation
- Cognitive behavioral strategies
- Behavioral Activation
- Problem Solving Therapy
- Motivational Interviewing
- Distress tolerance (DBT)

- Pharmacotherapy principles

Fann & Sexton, 2015

Expansion to SCCA Network Sites



Feasible through use of Telehealth

Other Enhancements to Increase Coordination & Scalability

- **Integration of other support services into IPOP**
- **Trainees**
  - 4 Psychiatry R3/4 residents
  - 2 fellows (Consultation-Liaison, Addictions)
  - Potential Psychology resident
- **Front desk hands out PHQ/GAD at check-in**
- **EMR integration of outcome measures**
  - Universal screening (q2mos), IPOP, Pall Care, etc.
- **Streamlining process for transitioning Pts who have completed treatment into community**

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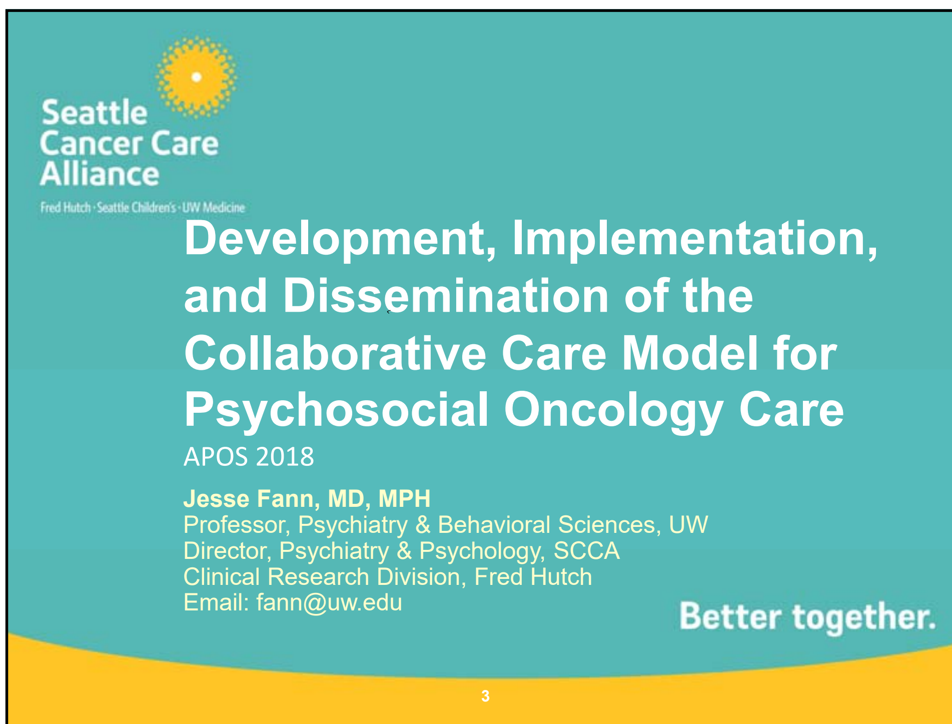

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Supportive Cancer Care Questionnaire

(Baseline, q2-months, End of Tx)

Screening is only the first step…

"You can't fatten a cow by weighing it."

Proverb

Approaches that we know ***Don't Work***

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- **Referral** to specialty care without close **coordination** and **follow-up**
- **Co-location** of behavioral health specialists without **a system for tracking outcomes** and **treatment adjustments**

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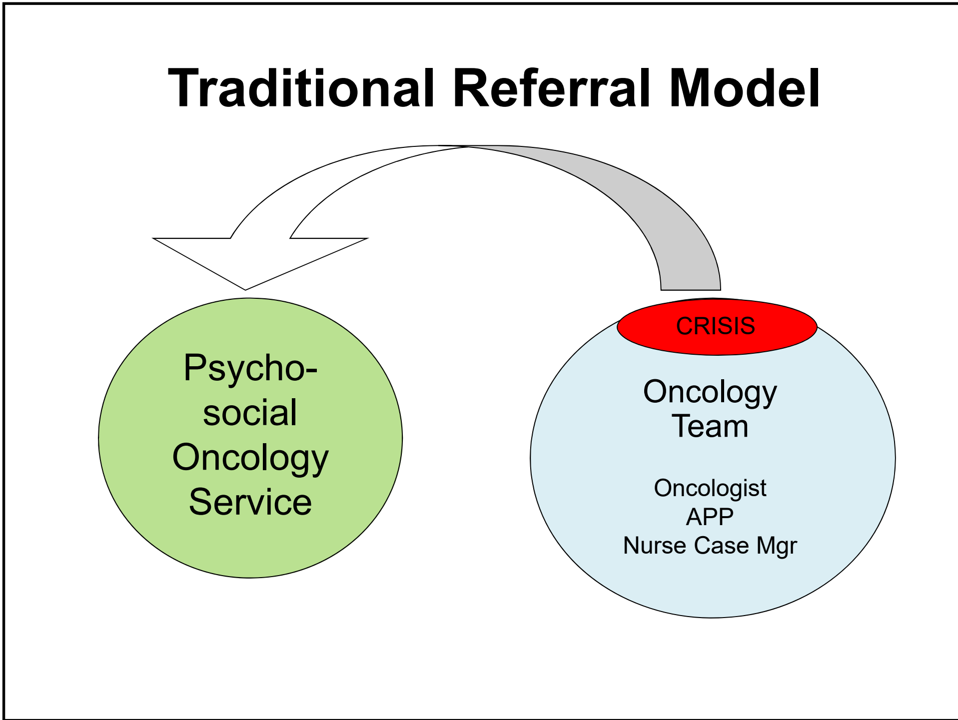
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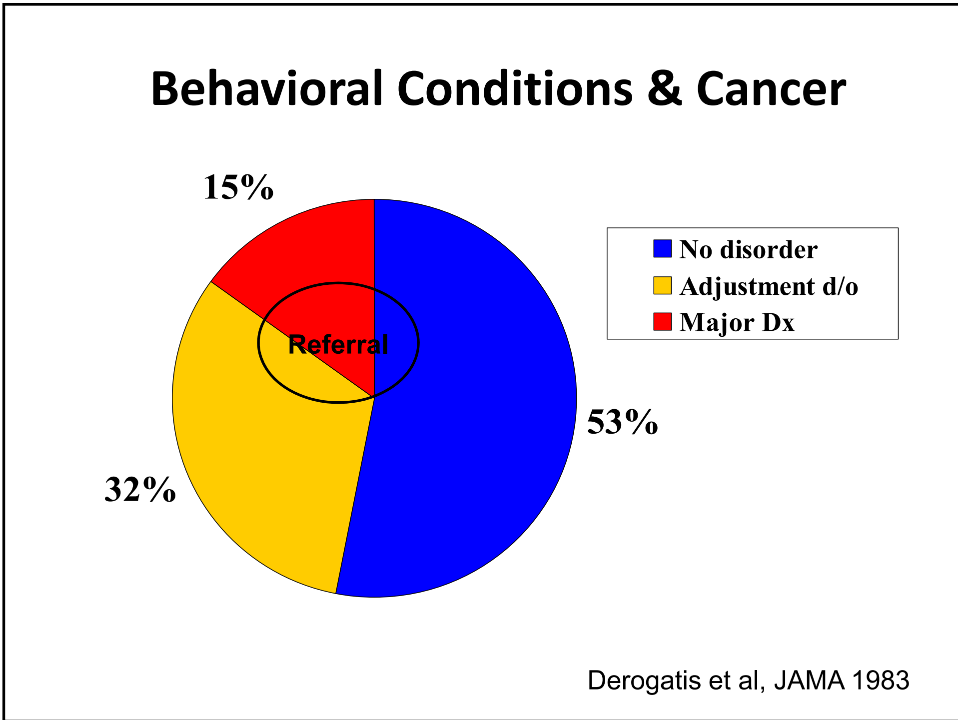
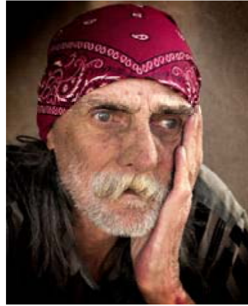
Psycho-
social
Oncology
Service
CRISIS
Oncology
Team
Oncologist
APP
Nurse Case Mgr

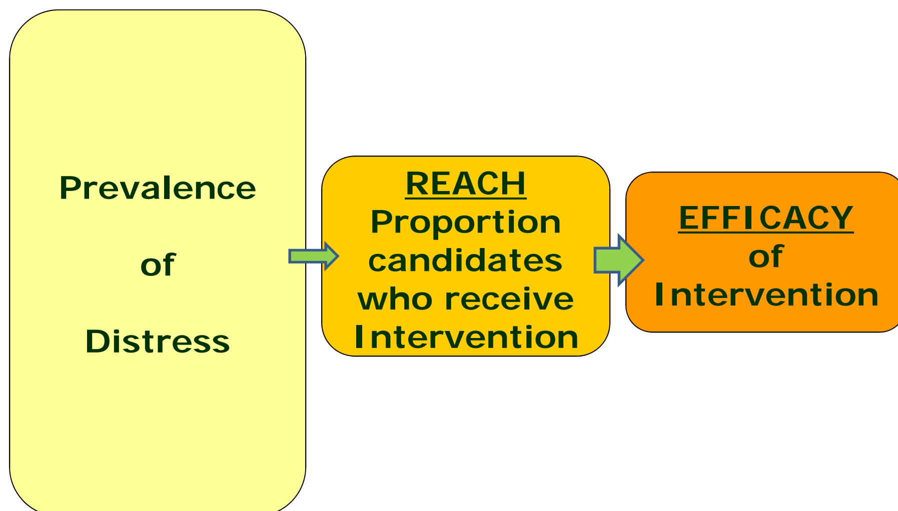

Behavioral Conditions & Cancer
15%
53%
32%
Referral
No disorder
Adjustment d/o
Major Dx
Derogatis et al, JAMA 1983

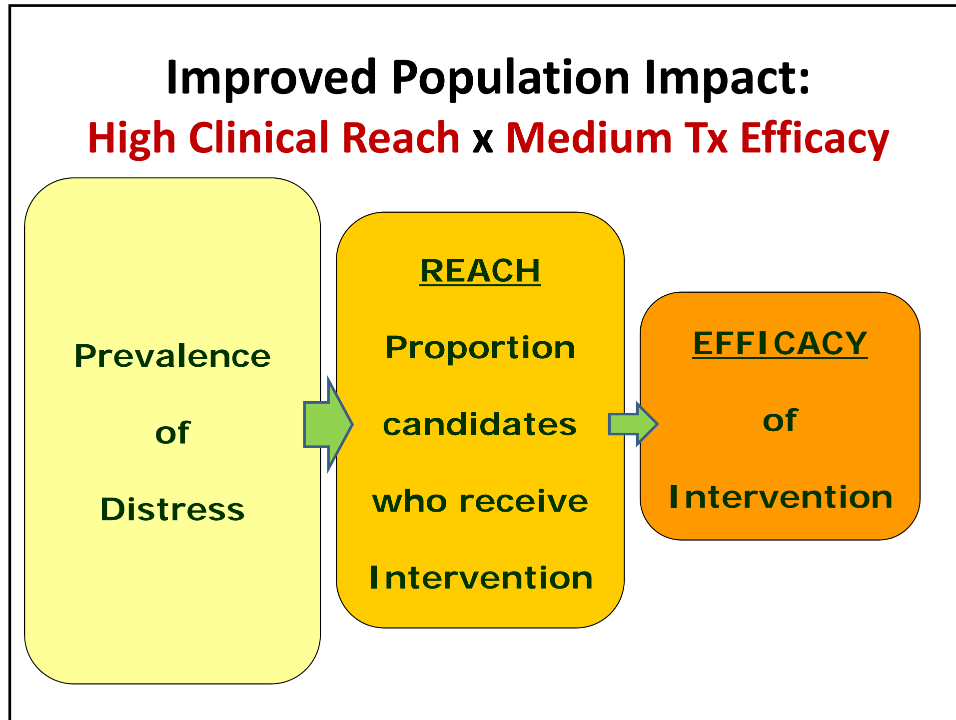
Limits of Traditional Referral

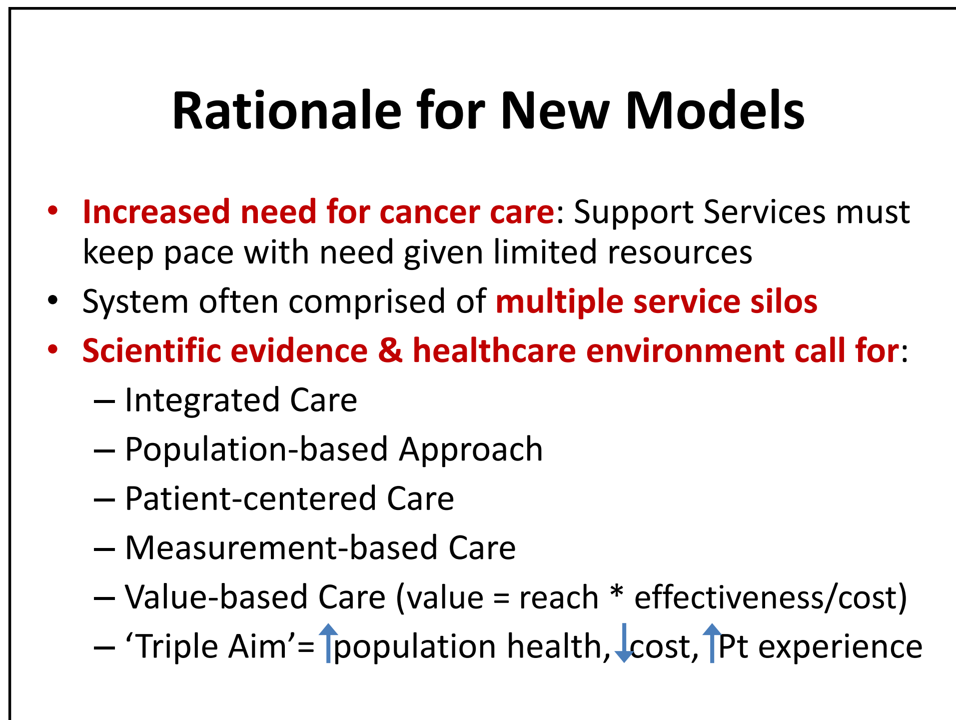


- ~ 1/4 not recognized or effectively engaged in care
- ~ 1/4 drop out of treatment too early
- ~ 1/4 stay on ineffective treatments for too long
- ~ 1/4 effectively treated

Minimal Population Impact: Low Clinical Reach x High Tx Efficacy




Improved Population Impact:
High Clinical Reach x Medium Tx Efficacy
Prevalence of Distress
REACH
Proportion candidates who receive Intervention
EFFICACY
of Intervention


Rationale for New Models
Increased need for cancer care: Support Services must keep pace with need given limited resources
System often comprised of multiple service silos
Scientific evidence & healthcare environment call for:
– Integrated Care
– Population-based Approach
– Patient-centered Care
– Measurement-based Care
– Value-based Care (value = reach * effectiveness/cost)
– 'Triple Aim'= ↑population health, ↓cost, ↑Pt experience

Key Principles of Collaborative Care

Based on >80 Randomized Controlled Trials

Population-Based Care

– Builds on Universal Distress Screening

Patient-Centered Team Care

– Coordinated by Care Manager, focus on Pt preference

Measurement-Based, Treatment to Target

– Track outcomes & adherence, electronic registry

Evidence-Based Stepped Care

– Weekly caseload review/supervision

Accountable Care

– Transparency, everyone is accountable

aims.uw.edu
Archer et al, 2012
Thota et al, 2013
Huffman et al, 2014
Beach et al, 2015

Components of Collaborative Care

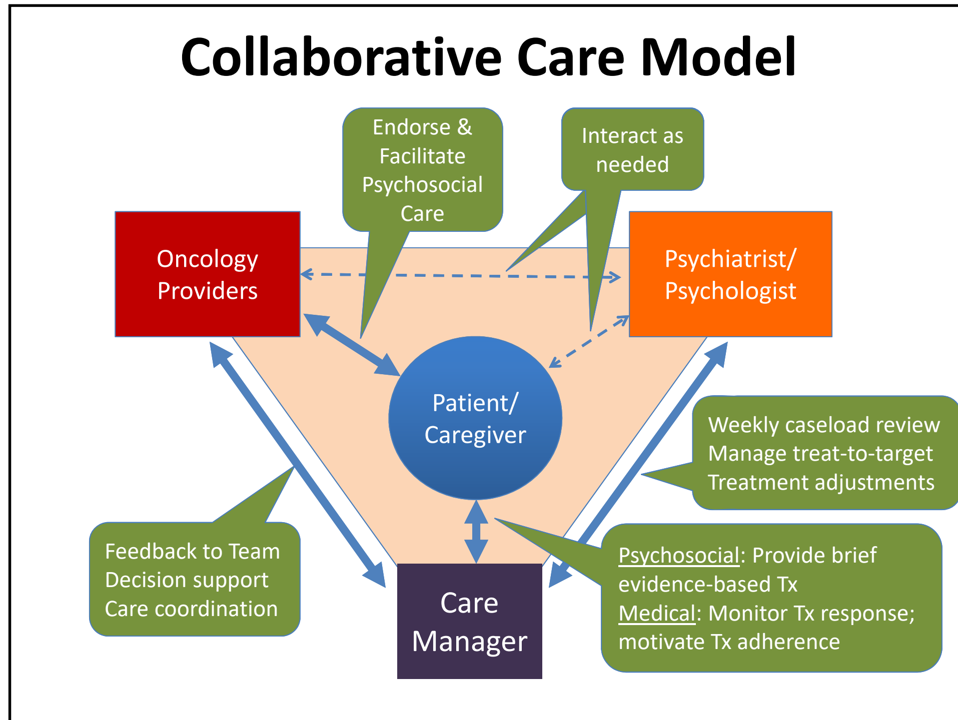
Electronic Patient Registry / Decision Support Tool

On-Site Care Coordinator

Weekly Caseload Review/Supervision

Systematic Use of Validated Screening and Outcome Tools

Collaborative Care Model



CC Addresses Common Barriers to Care

- **Access & Engagement**
  - Care managers embedded in oncology clinics
  - Care managers quickly engage & assess patients
  - Psychosocial treatment gets started quickly
- **Care coordination & follow-up**
  - Oncologists get input on their patients' psychosocial problems within hours/days vs. weeks/months
  - Electronic Tracking Log ensures monitoring of clinical outcomes

CC Addresses Common Barriers to Care

- **Treatment adjustments**
  - Weekly Caseload Review with Psychiatrists/ Psychologists & Care Managers
    - Track outcomes using validated measures
    - Make Tx recs per Clinical Practice Guidelines / Pathways
  - Psychiatrists/Psychologists focus in-person visits on the most challenging patients

CC is Sustainable

- **Flexible & Adaptable**
  - Enhances (vs. replaces) traditional referral model
  - Capitalizes on existing supportive care staffing models (e.g., social work)
  - Various specialties can be trained as care managers
  - Can adapt to
    - Patients' Tx preferences
    - Providers' practice preferences (e.g., prescribing)
  - Scalable using Telehealth
- **Facilitates Value-based Accountable Care**
  - Population-based, measurement-based, improves patient satisfaction

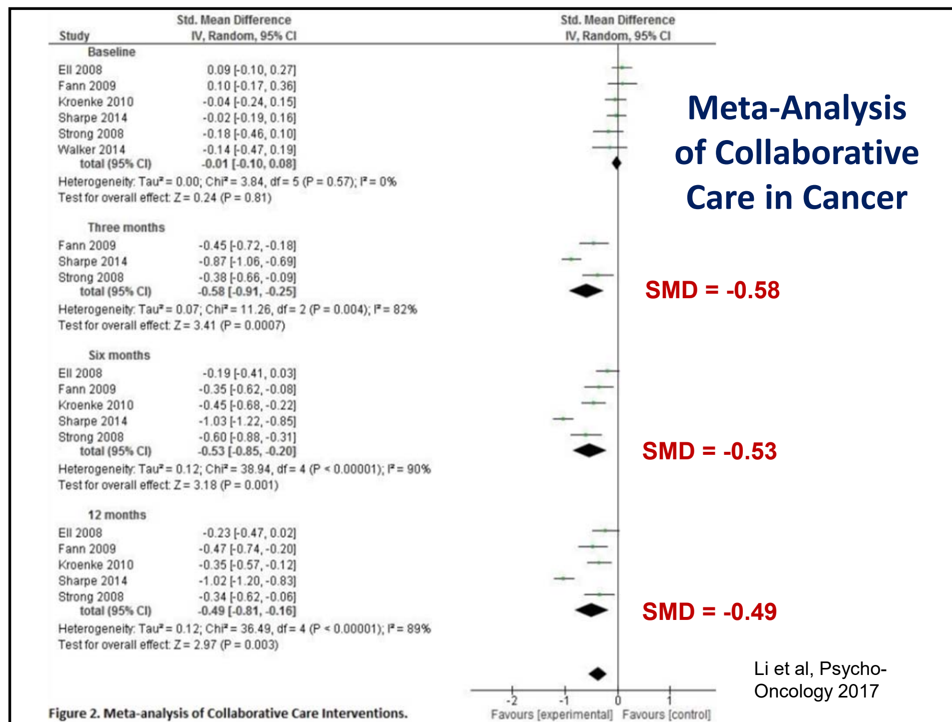
CC is Sustainable

- **Cost-efficient**
  - Shown to be cost-effective in RCTs
  - Directs level of need to appropriate resources
  - New CMS billing codes
- **Quality Improvement**
  - Consistent with QI models (e.g., CPI, lean)
- **Provider Satisfaction**
  - Promotes teamwork, mutual support, & practice at top of license
  - trainee education & experience in integrated care

CC Evidence Base

- **Medical settings**
  - Primary care
  - Oncology
  - Cardiology
  - Diabetes care
  - HIV
  - Maternal care
  - Adolescent medicine
  - Pain / Fibromyalgia
  - Multiple Sclerosis
  - Brain / Spinal Cord Injury
- **Conditions**
  - Depression
  - Anxiety
  - PTSD
  - Bipolar disorder
  - Serious Mental Illness
  - Substance abuse
  - Pain
  - Postconcussive disorder

Huffman et al, Psychosomatics 2013



- Sharpe M, Walker J, Holm Hansen C, et al. Integrated collaborative care for comorbid major depression in patients with cancer (SMaRT Oncology-2). Lancet 384:1099-108, 2014.
  - **British multi-site general cancer population**
- Walker J, Hansen CH, Martin P, et al. Integrated collaborative care for major depression comorbid with a poor prognosis cancer (SMaRT Oncology-3). Lancet Oncol 15:1168-76, 2014.
  - **British multi-site lung cancer population**
- Ell K, Xie B, Quon B, Quinn DI, Dwight-Johnson M, Lee PJ. Randomized controlled trial of collaborative care management of depression among low-income patients with cancer. J Clin Oncol 26:4488-4496, 2008.
  - **Low-income, mostly female, Hispanic at a county cancer clinic**
- Fann JR, Fan MY, Unutzer J. Improving primary care for older adults with cancer and depression. Journal of General Internal Medicine 24(Suppl 2):417–424, 2009
  - **Elderly cancer patients treated in primary care**
- Kroenke K, Theobald D, Wu J, et al: Effect of telecare management on **pain and depression** in patients with cancer: A randomized trial. JAMA 304:163-171, 2010
  - **16 community based oncology practices using Telehealth**
- Steel JL, Geller DA, Kim KH, et al: Web-based collaborative care intervention to manage **cancer-related symptoms in the palliative care setting**. Cancer 2016
  - **Improved dep, pain, fatigue, QOL in patients and stress, dep in caregivers**

Integrated Psychosocial Oncology Program (IPOP)

Inpatients

150 adult oncology beds (20 transplant)

40 pediatric oncology beds

SCCA Outpatients

~8,000 new patient Tx episodes per year

>80,000 clinic visits per year

Timeline of Implementation of Integrated Psychosocial Oncology Program

- **2001** SCCA opens
  Collaborative Care model introduced
- **2009** Proposed IPOP model to leadership
  SW/Psychiatry/Psychology Partnership
  Negotiated increased staffing
- **2010-2011** Piloted IPOP
- **2011** Presented results to Med Exec Comm.
- **2011-2013** Implement & roll out IPOP
  - Presented scientific evidence & rationale to each SCCA clinic
  - Continuous Process Improvement QI initiative
  - Universal screening mandate & implementation
  - Published *JCO 2012* paper & *Psycho-Oncology 2015* textbook chapter on Integrated Collaborative Care

Conclusions: IPOP Pilot

IPOP was associated with:

- Streamlined psychosocial care, allowing limited specialty mental health resources to be available to more people
- Ability to direct more intensive services to patients with highest need
- Early detection and collaborative management of diverse psychosocial needs
- Enhanced tracking of psychosocial and behavioral outcomes and treatment adjustments
- Improved patient and provider satisfaction

Integrating Psychosocial Care Into Cancer Services

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JOURNAL OF CLINICAL ONCOLOGY

REVIEW ARTICLE

Integrating Psychosocial Care Into Cancer Services

Jesse R. Fann, Kathleen Ell, and Michael Sharpe

Jesse R. Fann, Fred Hutchinson Cancer Research Center, University of Washington, Seattle, WA; Kathleen Ell, School of Social Work, University of Southern California, Los Angeles, CA; and Michael Sharpe, University of Oxford, Oxford, United Kingdom.

Submitted September 22, 2011; accepted January 10, 2012; published online ahead of print at www.jco.org on March 12, 2012.

Authors' disclosures of potential conflicts of interest and author contributions are found at the end of this article.

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0732-183X/12/3011-1178/$20.00

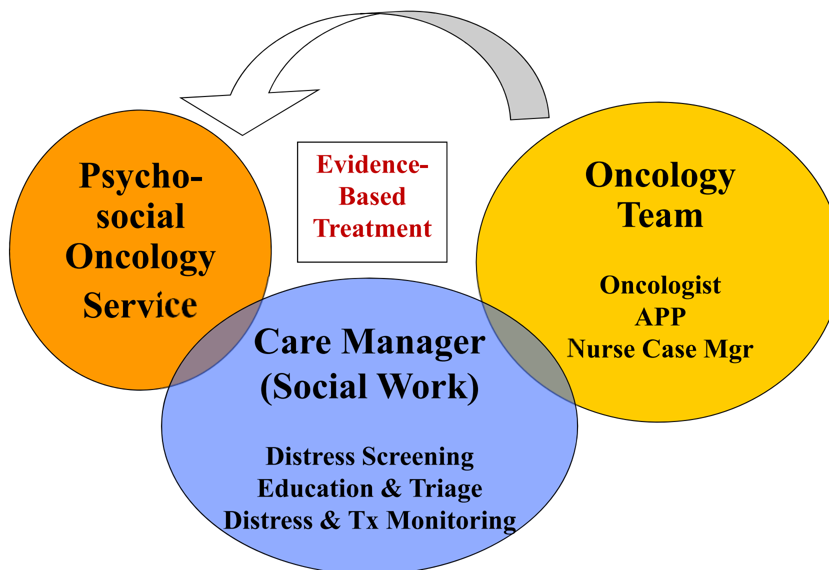
DOI: 10.1200/JCO.2011.39.7398

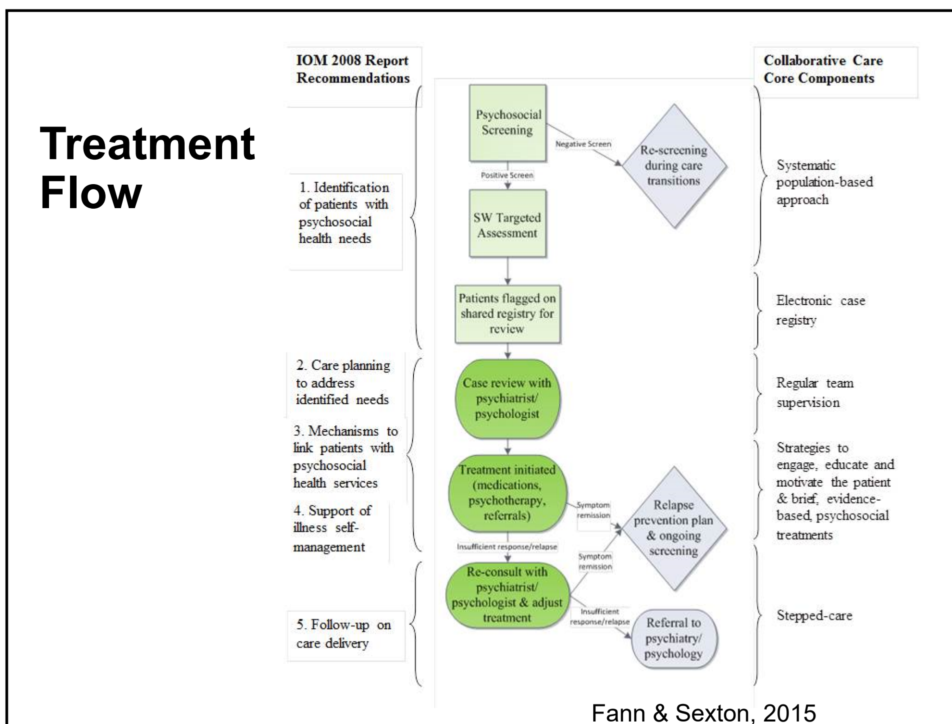
A B S T R A C T

Despite substantial evidence that patients with cancer commonly have significant psychosocial problems, for which we have evidence-based treatments, many patients still do not receive adequate psychosocial care. This means that we risk prolonging life without adequately addressing the quality of that life. There are many challenges to improving the current situation, the major one of which is organizational. Many cancer centers lack a system of psychosocial care that is integrated with the cancer care of the patient. Psychosocial care encompasses a range of problems (emotional, social, palliative, and logistical). The integration must occur with the cancer care of the patient at all stages (from screening to palliative care) and across all clinical sites of care (inpatient and outpatient cancer services as well as primary care). In this article, we consider the challenges we face if we are to provide such integrated psychosocial services. We focus on the collaborative care service model. This model comprises systematic identification of need, integrated delivery of care by care managers, appropriate specialist supervision, and the stepping of care based on systematic measurement of outcomes. Several trials of this approach to the management of depression in patients with cancer have found it to be both feasible to deliver and effective. It provides a model for services to meet other psychosocial needs. We conclude by proposing the key components of an integrated psychosocial service that could be implemented now and by considering what we need to do next if we are to succeed in providing better and more comprehensive care to our patients.

J Clin Oncol 30:1178-1186. © 2012 by American Society of Clinical Oncology

Integrated Psychosocial Oncology




Treatment Flow
IOM 2008 Report Recommendations
1. Identification of patients with psychosocial health needs
2. Care planning to address identified needs
3. Mechanisms to link patients with psychosocial health services
4. Support of illness self-management
5. Follow-up on care delivery
Psychosocial Screening
Negative Screen
Re-screening during care transitions
Positive Screen
SW Targeted Assessment
Patients flagged on shared registry for review
Case review with psychiatrist/ psychologist
Treatment initiated (medications, psychotherapy, referrals)
Symptom remission
Relapse prevention plan & ongoing screening
Insufficient response/relapse
Symptom remission
Re-consult with psychiatrist/ psychologist & adjust treatment
Insufficient response/relapse
Referral to psychiatry/ psychology
Collaborative Care Core Components
Systematic population-based approach
Electronic case registry
Regular team supervision
Strategies to engage, educate and motivate the patient & brief, evidence-based, psychosocial treatments
Stepped-care
Fann & Sexton, 2015

Stepped Psychosocial Care
SEVERE
Medications
Psychotherapy
MODERATE
Brief Counseling
Medications?
Close Monitoring
MILD
Medical team
SW, Spiritual, Complimentary Supports
NORMAL
Family & Community Supports

IPOP Tracking Log

(not actual patients shown)

'Caseload Overview'

Seattle Cancer Care Alliance

IPOP Tracking Log

1) Press "Ctrl+J" to refresh the page EVERY time this worksheet is used.
2) Make sure all other versions/copies of the template are CLOSED before pressing "Ctrl+J"
3) Do NOT use this worksheet if fewer than 2 ACTIVE patients are in the Patient Tracking worksheet.
4) Do NOT make changes to the text on this worksheet. Only use the sort/filter functions in Row 4. If a cell value is changed, press "Ctrl+Z" immediately to undo it.

				Treatment Status					PHQ-4			PHQ-9			GAD-7			Psychiatric Case Review	
				The most recent contact was over 1 month (30 days) ago; The next follow-up contact is past due					The last available PHQ-4 score is >30 days old; The last available PHQ-4 score is 3-5 (positive); The last available PHQ-4 is ≥6			The last available PHQ-9 score is >30 days old; The last available PHQ-9 score is <10 (at target); The last available PHQ-9 score is 10-14; The last available PHQ-9 score is ≥15			The last available GAD-7 score is >30 days old; The last available GAD-7 score is <10 (at target); The last available GAD-7 score is 10-14; The last available GAD-7 score is ≥15				
View Record	Treatment Status	Name	Clinic Code	Date of Initial Assessment	Date of Most Recent Contact	Date Next Follow-up Due	Number of Follow-up Contacts	Weeks in Treatment	Initial PHQ-4 Score	Last Available PHQ-4 Score	Date of Last PHQ-4 Score	Initial PHQ-9 Score	Last Available PHQ-9 Score	Date of Last PHQ-9 Score	Initial GAD-7 Score	Last Available GAD-7 Score	Date of Last GAD-7 Score	Flag	Most Recent Psychiatric Case Review Note
View	Active - Distressed	Foster, Jessica	GI	5/15/2017	5/15/2017	7/14/2017	0	14	6	6	5/15/2017	18	18	5/15/2017	18	18	5/15/2017		
View	Active - Distressed	Rogers, Stephanie	GI	8/12/2017	8/12/2017	10/11/2017	0	2	4	4	8/12/2017	18	18	8/12/2017	15	15	8/12/2017	Flag for discussion	
View	Active - Distressed	Martinez, Jose	TRANSPLANT - ALLO	5/5/2017	6/1/2017	7/1/2017	3	16	4	4	5/5/2017	18	17	5/20/2017	17	16	5/20/2017	Flag for discussion	5/21/2017
View	Active - Distressed	Austen, Bob	GI	7/14/2017	8/25/2017	9/24/2017	3	6	8	8	7/14/2017	11	15	8/25/2017	11	12	8/25/2017	Flag for discussion	8/2/2017
View	Active - Distressed	Stimey, Alli	GI	6/30/2017	7/5/2017	8/4/2017	1	8	4	4	6/30/2017	13	13	6/30/2017	16	16	6/30/2017	Flag for discussion & safety risk	7/1/2017
View	Active - Distressed	Mays, Lindsay	GI	7/14/2017	7/14/2017	8/13/2017	0	6	1	1	7/14/2017	12	12	7/14/2017	10	10	7/14/2017		
View	Active - Distressed	Peterson, Elmer	BREAST	8/1/2017	8/15/2017	9/14/2017	1	3	4	4	8/1/2017	12	10	8/15/2017	10	7	8/15/2017	Flag for discussion	8/2/2017
View	Active - Distressed	Jones, Billie	BREAST	7/7/2017	7/16/2017	8/15/2017	1	7	5	0	7/16/2017	10	7	7/16/2017	16	7	7/16/2017	Flag for discussion	7/10/2017
View	Active - Distressed	Penney, Max	TRANSPLANT - ALLO	7/1/2017	8/24/2017	9/23/2017	3	8	2	2	7/1/2017	20	6	8/24/2017	18	3	8/24/2017	Flag for discussion & safety risk	8/3/2017
View	Active - Distressed	Willings, Tom	GI	7/22/2017	8/5/2017	10/4/2017	2	5	6	6	7/22/2017	16	3	7/28/2017	16	8	7/28/2017		8/1/2017
View	Active - Distressed	Smith, Jared	TRANSPLANT - AUTO	6/6/2017	8/1/2017	8/31/2017	1	11	3	3	6/6/2017	8	2	8/1/2017	12	3	8/1/2017		
View	Active - Distressed	Wright, May	TRANSPLANT - ALLO	5/19/2017	5/19/2017	7/18/2017	0	14	2	2	5/19/2017	0	0	5/19/2017	0	0	5/19/2017		5/20/2017

IPOP Tracking Log

(not actual patients shown)

'Individual Patient Tracking'

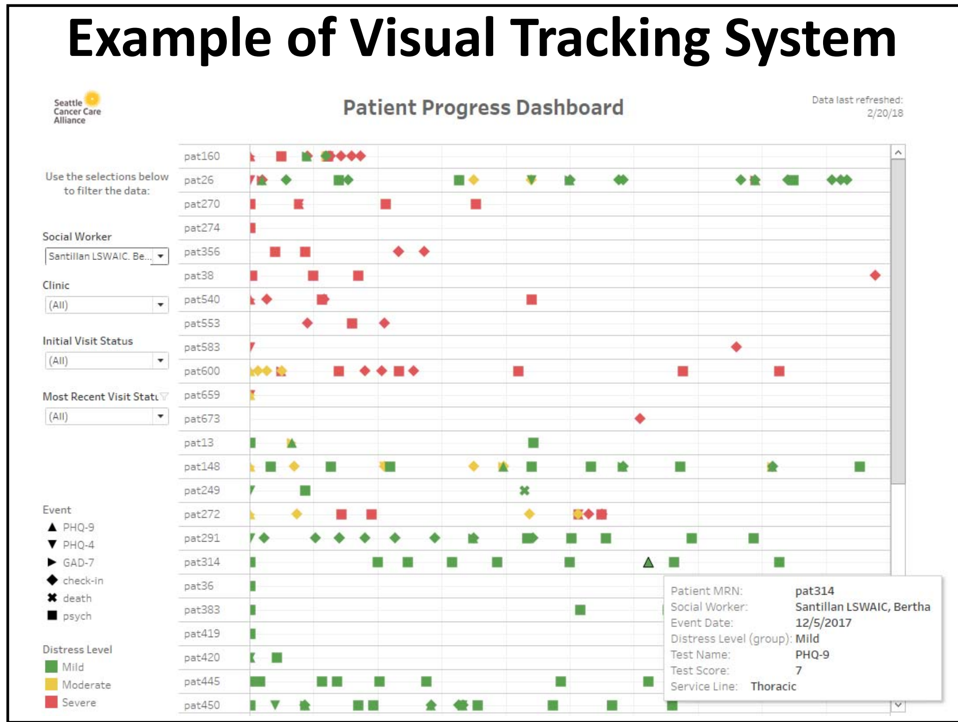
Miami Tracking Log (JF) - Excel

File Home Insert Draw Page Layout Formulas Data Review View

Flag for discussion & safety risk

Disclaimer | Patient Tracking | Caseload Overview | Sheet1

Example of Visual Tracking System



IPOP Training Modules*

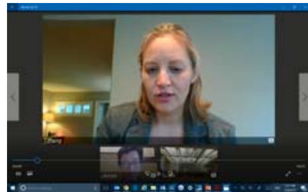
Background	Integrated, Population-based, Collaborative Care
Process	Shared Workflow/Clinical Pathways Screening & Assessment Tools Mental Status Exam/Using DSM Outcomes Tracking Caseload Reviews Clinical Presentations Communication w/ Medical Teams
Interventions	Brief Behavioral Interventions Pharmacotherapy
Conditions	Psychosocial conditions in cancer

*Provided free CE Credit

Fann & Sexton, 2015

IPOP Training Modules (cont.)

Psychosocial Conditions
- Distress
- Depression
- Suicidal ideation
- Anxiety, PTSD, OCD
- Insomnia
- Pain/Fatigue
- Substance abuse
- Cognitive impairment
- Delirium



Brief Interventions
- Psychoeduction
- Diaphragmatic breathing
- Progressive muscle relaxation
- Mindfulness meditation
- Cognitive behavioral strategies
- Behavioral Activation
- Problem Solving Therapy
- Motivational Interviewing
- Distress tolerance (DBT)

- Pharmacotherapy principles

Fann & Sexton, 2015

Expansion to SCCA Network Sites

Feasible through use of Telehealth

Other Enhancements to Increase Coordination & Scalability

- **Integration of other support services into IPOP**
- **Trainees**
  - 4 Psychiatry R3/4 residents
  - 2 fellows (Consultation-Liaison, Addictions)
  - Potential Psychology resident
- **Front desk hands out PHQ/GAD at check-in**
- **EMR integration of outcome measures**
  - Universal screening (q2mos), IPOP, Pall Care, etc.
- **Streamlining process for transitioning Pts who have completed treatment into community**

Implementing Innovative Care Models

Scott A. Irwin, MD, PhD & ***TEAM***

Director Supportive Care Services
Professor of Psychiatry and Behavioral Neurosciences

Samuel Oschin Comprehensive Cancer Institute
Department of Psychiatry and Behavioral Neurosciences

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Goals

- Excellence in providing value to patients / families / care teams and health system
- Monthly screening / wide-net / most distressing issues / important triage points
- Real-time registry / risk stratification with medical record data (e.g., ED visits / hospitalizations)
- Real time monitoring by / triage to / intervention by appropriate staff (e.g., social work, nutrition, palliative care)
- Care management rounds
- Tracking of impact on care, quality, and cost

Experience over last 4 years at two institutions

UC San Diego Moores Cancer Center:

- Referral Based Psychiatry & Psychology Services
- Moved from Patient-Centered to Clinic-Centered
- Added “Wellbeing” Screening
- Were Moving Towards Collaborative Care

Screening Development Phase . . .

- Attended NCI sponsored workshop: "Implementing Comprehensive Biopsychosocial Screening"
- Identified Key Stake Holders
- Formed Transdiciplinary Wellbeing Subcommittee
  - Met weekly
- Developed the tool and coordinated Spanish translation
- Compiled educational materials for patients and providers

. . . Development Phase

- Developed Process
  - Integration into EMR
  - Timing
  - Automation
  - Assessment / Triage Responsibility
- Developed Staff Training w/ Staff Champions
- Took 3 months

Implementation Phase

- Trained staff in tool administration, assessment, and documentation
- Triage rests with nursing
- Piloted in two clinics, one being Quality Director's, with champion support
- Added one to two clinics per month
- Gathered feedback and did rapid cycle improvement throughout process
- Took 6 months for 12 teams plus infusion center (all of medical oncology)
- Requests from surgical oncology to expand

15 Item Wellbeing Screening Tool

"Distress" screening mandated by QOPI, NCCN, and CoC

"Start a conversation" tool

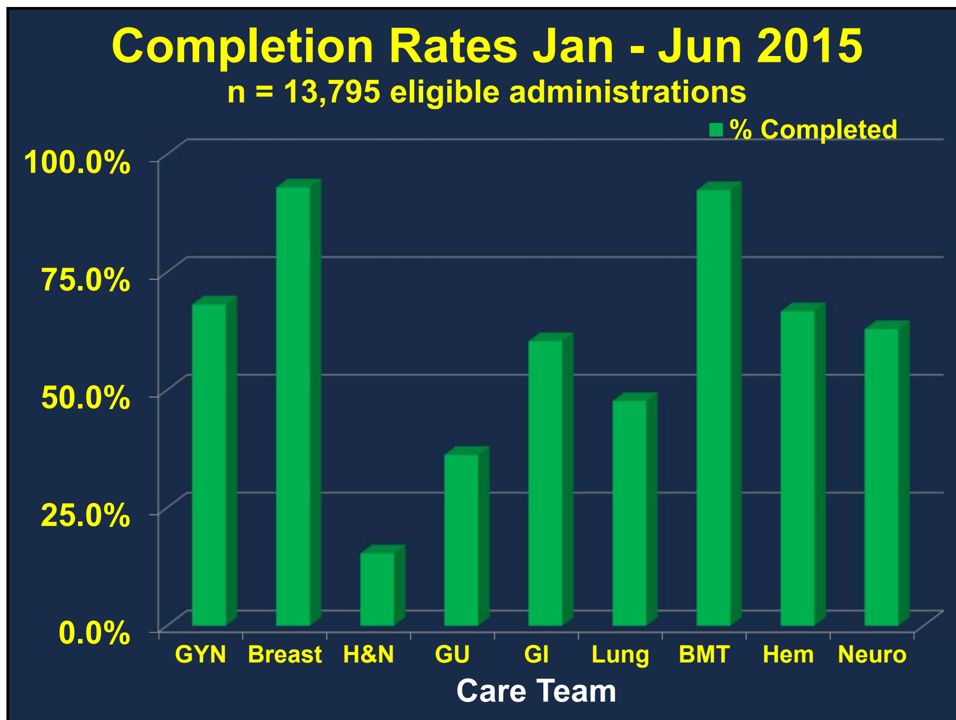
0 - 3 Scale of 15 most common concerns

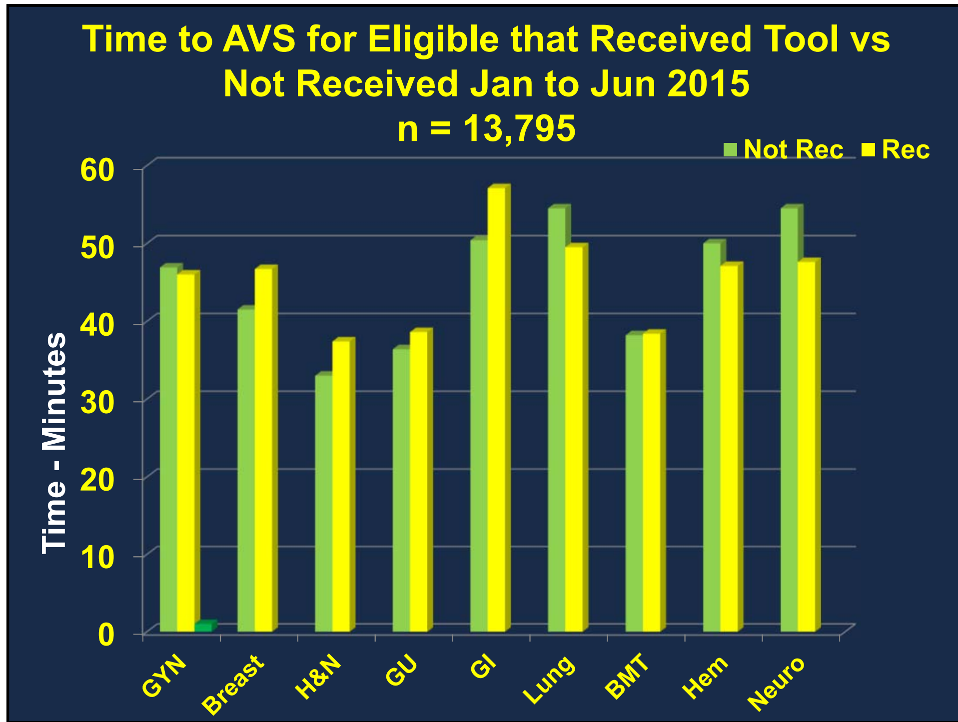
Given no more than every 7 days

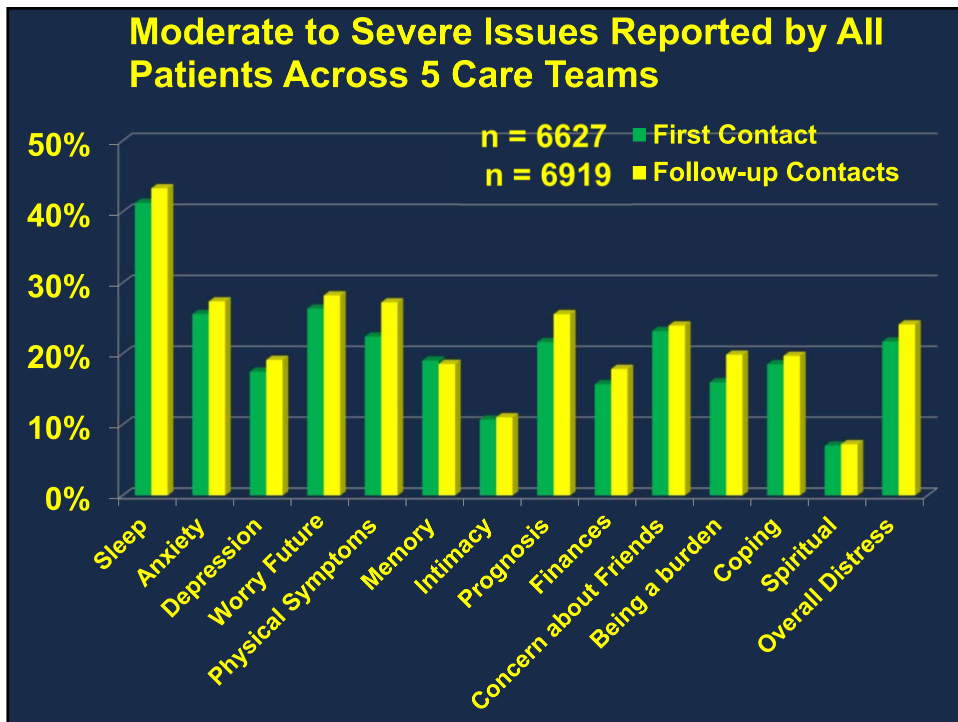
Patients can request educational materials or to speak with someone or decline screening

Outcome Monitoring

- Chart audits of nursing documentation
- Scale characteristics
- Data monitoring / Reporting




Time to AVS for Eligible that Received Tool vs Not Received Jan to Jun 2015
n = 13,795
Not Rec
Rec
Time - Minutes
60
50
40
30
20
10
0
GYN
Breast
H&N
GU
GI
Lung
BMT
Hem
Neuro


Moderate to Severe Issues Reported by All Patients Across 5 Care Teams
n = 6627
First Contact
n = 6919
Follow-up Contacts
50%
40%
30%
20%
10%
0%
Sleep
Anxiety
Depression
Worry Future
Physical Symptoms
Memory
Intimacy
Prognosis
Finances
Concern about Friends
Being a burden
Coping
Spiritual
Overall Distress

Research Outcomes:

Value of Supportive Care

Depression and healthcare service utilization in patients with cancer

- 5055 cancer patients, 561 with depression
- Depressed patients had significantly more:
  - Annual healthcare visits (aRR = 1.76, 95% CI = 1.61–1.93)
    - Non-mental health
    - 14 more visits to oncologist
  - More likely to have an
    - ED visit (OR = 2.45; 95% CI = 1.97–3.04),
    - Hospitalization (OR = 1.81; 95% CI = 1.49–2.20)
    - 30-day readmission (OR = 2.03; 95% CI = 1.48–2.79)

Mausbach & Irwin, Psycho-Oncology, 26:1133, 2017

Healthcare Costs of Depression in Patients Diagnosed with Cancer

- 2,051 depressed vs 11,182 non-depressed patients with cancer
- Depressed cancer patients: total annual healthcare charges that were 129% higher (B = 0.83; p < 0.001).
  - Estimated mean charges of $260,657 compared to $113,971
    - Ambulatory care
    - Emergency department charges
    - Hospital charges

Mausbach & Irwin, Psycho-Oncology, submitted

Association of Mental Health Visits and Annual Healthcare Costs in Patients with Cancer and Major Depressive Disorder

- 182 individuals with cancer and comorbid major depressive disorder
- Among patients receiving at least one mental health visit (N = 56), (mean (± SD) of 11.6 (10.4))
  - 126 (68.5%) receiving no mental health visits
- For year following cancer dx, significant association between number of mental health visits and annual healthcare charges (exp(B) = 0.972, 95% CI = 0.947-0.997; P = .028)
- Model-based estimates of total annual healthcare costs were $152,328 for patients receiving no mental health visits vs $108,143 for patients receiving the sample-based mean of 12 mental health visits
  - = About 2.8% decrease in cost per MH visit

Mausbach & Irwin, Psycho-Oncology, submitted

Future Steps

- Implement electronic data collection / entry and make use of electronic outreach
- Consultation / training with the U of W team
- Implement collaborative stepped care / tracking / risk stratification / triage / care management
- Move to Los Angeles?

Cedars-Sinai Samuel Oschin Comprehensive Cancer Institute:

Broad Range of Services

Outreach and Referral Based

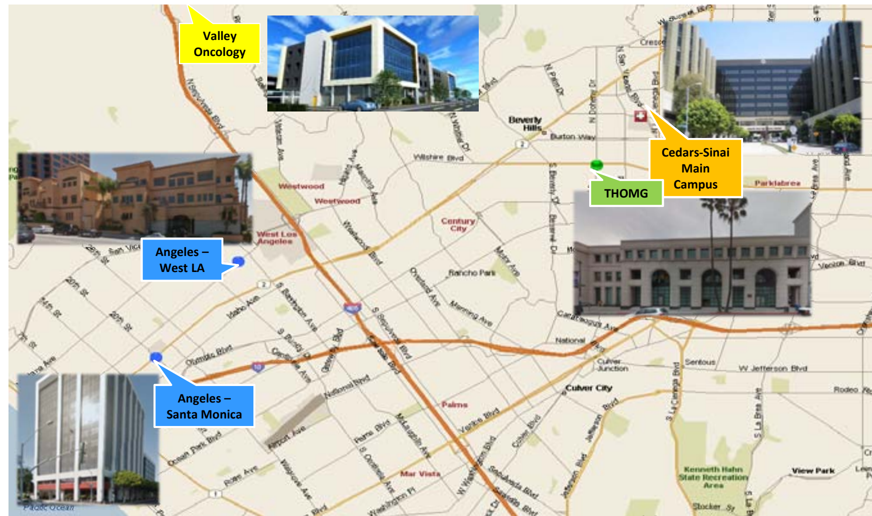
Consolidating and Expanding Screening

Moving Towards Collaborative Care

Cedars-Sinai Medical Center

- One of the largest not-for-profit medical centers in the western United States with 886 licensed beds
- More than 10,200 full-time employees, 2,100 physicians on medical staff, 2,800 nurses and more than 2,800 volunteers
- In FY2013 more than 7,000 babies delivered, 32,000 operating room procedures, 85,000 emergency department visits, 49,000 admissions and 630,000 outpatient visits

Oncology Sites of Care



CSMC Cancer Volumes

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
TOTAL ANALYTIC CANCER CASES (Cases diagnosed and/or part or all of the first course of treatment was given at CSMC and/or OCC. This is the first planned treatment given prior to progression or recurrence of the cancer.)	3602	3536	3490	3424	3494	3641	3703	3666	3679	3922
TOTAL NON-ANALYTIC CANCER CASES (Cases first seen at CSMC and/or OCC with progression or recurrence of the cancer.)	723	581	936	1012	940	1064	1131	1023	1048	1565
TOTAL CANCER CASES	4325	4117	4426	4436	4434	4707	4834	4689	4727	5487

> 30,000 Visits / year to Cancer Center alone

Largest Market Share in LA County Despite 3 NCI-Designated Centers

Data Source: Cancer Registry

CEDARS-SINAI's ONCOLOGY SUPPORTIVE CARE SERVICES, CONTEXT & RELATIONSHIPS

Upon arrival:

- Dieticians and SW attempt to see all infusion /rad onc
  - Many fall through cracks
- Rest of team referral based
- iPad Screening in two clinics
  - One didn't like it, did paper distress thermometer as well
  - Other did it at time that was not clinically relevant
  - No integration into EMR
  - Data not in real time
  - High rates of false positives
- Attempts to integrate to EMR for real-time useful registry based / risk stratified data still in process 2 years later

Embark Upon Collaborative Care Model Training

- Cancer Center and Psychiatry leadership buy-in
- Jesse / Tiffany visit with team and administrators
- Training of SW group by teleconference
- Implementation in limbo
  - Staff turn over
  - Stakeholder buy-in
  - Lack of IT support
    - Now changing
- Jesse regular check-ins, encouragement to implement in a clinic or two without EHR support

Barriers

- "We already do this"
- "We are not broken and don't want to be fixed"
- Don't want to change model, role, or work
- Don't need psychologists
- Don't want manual data entry work
- Concern about scrutiny
- Worried about increased work
- 2 years short time for culture change
- Leadership buy-in
- IT – Progress yesterday!

Improve Access and Visibility

- Care-team service orientation
- Cover more clinic time vs infusion
- Attend care team meetings
- Develop dashboards
- More outreach presentations
- More cross talk among other "supportive" teams at Cedars
  - Social Work
  - Palliative Medicine

Wins

- New referral process
- SW want brief intervention training
- Interest in objective outcomes
- Interest in transferring to more "clinical" role
- Screening implementation

PSYCHOSOCIAL DISTRESS SCREENING at the Cancer Center, and beyond

Intermediate State (Start February 2018)

- Move toward unified screening tool
  - ESAS-R
    - Available for entry in CS-Link flow sheet
    - Immediate Provider feedback on areas of distress
    - Able to graph, track, insert into notes, and create reports for regulatory and internal purposes
- Extend screening to more care teams
  - 1st Pilot Feb 2018
    - Supportive Care Services Providers every visit
    - GI Clinics at least every 30 days
    - GU Clinics at least every 30 days

CEDARS-SINAI

. . . PSYCHOSOCIAL DISTRESS SCREENING at the Cancer Center, and beyond . . .

- Screening (when not done at any visit by any provider within 30 days of current visit)
  - Clinic PSR's will look at next day's schedule
    - Flag those due for ESAS-R
  - CNA
    - Hand paper copy to patient in waiting room or upon rooming
    - Enter in to CS-link flowsheet
    - Leave paper copy in room with patient for nurse/NP/Physician review
  - Nurse/Navigator
    - Reviews (Can review last several in flow sheet or by graphing)
    - Can use smartphrase to document in nursing documentation
    - Alerts MD/NP to any areas of moderate to severe distress (> 3)
    - Leave paper copy in room for physician/NP review
  - SW reviews all ESAS-Rs with psychosocial item scores > 3

CEDARS-SINAI

. . . PSYCHOSOCIAL DISTRESS SCREENING at the Cancer Center, and beyond . . .

- Documentation
  - Nurse/Navigator/NP/MD
    - Can pull in last 3 results to visit notes via smart phrase
- Intervention
  - Nurse/Navigator/NP/MD
    - Alert team social worker to any psychosocial, psychological, psychiatric needs
      - Non-urgent – inbasket message
      - Urgent – by phone/text
  - NP/MD
    - Need to document intervention and/or referral (can be below smartphrase or in A/P of note)
      - Watch and wait is acceptable, as long as follow-up time stated
      - Any referrals to Supportive Care Services or other
      - Any medication or non-medication interventions
      - Follow-up

. . . ESAS-R Flowsheet . . .

11/27/2017 visit with Irwin, Scott A, MD for FOLLOW UP - 1 MO F/U *8LF

BMT Form

SIGNED & HELD ORDERS
Orders
Release Orders
Held/Pended Orders

TREATMENT ORDERS
Plan Summary
Treatment Plan
Supportive Plan 1
Radiation Therap...

BMT
MOB/Pre-Transpl...

RESEARCH
Research Treatm...
Research Support...
Research Schedu...

ASSESSMENTS/SCREENINGS
ESAS
CAGE
PHQ-9
PHQ-2
Karnofsky/Lansky

EPISODE
Episodes

ESAS - Edmonton Symptom Assessment System

Time taken: 0818 11/27/2017

Responsible Create Note

Edmonton Symptom Assessment System

Item	Options	Previous
Pain	0=No pain, 1=One, 2=Two, 3=Three, 4=Four, 5=Five, 6=Six, 7=Seven, 8=Eight, 9=Nine, 10=Wors...	7=Seven taken 1 month ago
Tiredness	0=Not tired, 1=One, 2=Two, 3=Three, 4=Four, 5=Five, 6=Six, 7=Seven, 8=Eight, 9=Nine, 10=Worst ...	7=Seven taken 1 month ago
Drowsiness	0=Not dro..., 1=One, 2=Two, 3=Three, 4=Four, 5=Five, 6=Six, 7=Seven, 8=Eight, 9=Nine, 10=Worst ...	7=Seven taken 1 month ago
Nausea	0=Not na..., 1=One, 2=Two, 3=Three, 4=Four, 5=Five, 6=Six, 7=Seven, 8=Eight, 9=Nine, 10=Worst...	7=Seven taken 1 month ago
Lack of appetite	0=Best ap..., 1=One, 2=Two, 3=Three, 4=Four, 5=Five, 6=Six, 7=Seven, 8=Eight, 9=Nine, 10=Worst ...	5=Five taken 1 month ago
Shortness of Breath	0=No shortn..., 1=One, 2=Two, 3=Three, 4=Four, 5=Five, 6=Six, 7=Seven, 8=Eight, 9=Nine, 10=Worst po...	0=No shortness of breath taken 1 month ago
Depression	0=Not dep..., 1=One, 2=Two, 3=Three, 4=Four, 5=Five, 6=Six, 7=Seven, 8=Eight, 9=Nine, 10=Worst ...	7=Seven taken 1 month ago
Anxiety	0=Not an..., 1=One, 2=Two, 3=Three, 4=Four, 5=Five, 6=Six, 7=Seven, 8=Eight, 9=Nine, 10=Worst...	8=Eight taken 1 month ago
Wellbeing	0=Best feelin..., 1=One, 2=Two, 3=Three, 4=Four, 5=Five, 6=Six, 7=Seven, 8=Eight, 9=Nine, 10=Worst po...	6=Six taken 1 month ago
Other	0=No othe..., 1=One, 2=Two, 3=Three, 4=Four, 5=Five, 6=Six, 7=Seven, 8=Eight, 9=Nine, 10=Worst ...	5=Five taken 1 month ago
Respondent	Patient, Caregiver, Caregiver-assisted	Patient taken 1 month ago
ESAS Total Score		59 (calculated) taken 1 month ago

Restore Close Cancel

. . . ESAS-R Smart Phrases . . .

Smart phrase: .ESAS

Example of how looks in note:

Edmonton Symptom Assessment System (ESAS):

The severity at the time of assessment of each symptom is rated from 0 to 10 on a numerical scale; with 0 meaning that the symptom is absent and 10 that it is the worst possible severity.

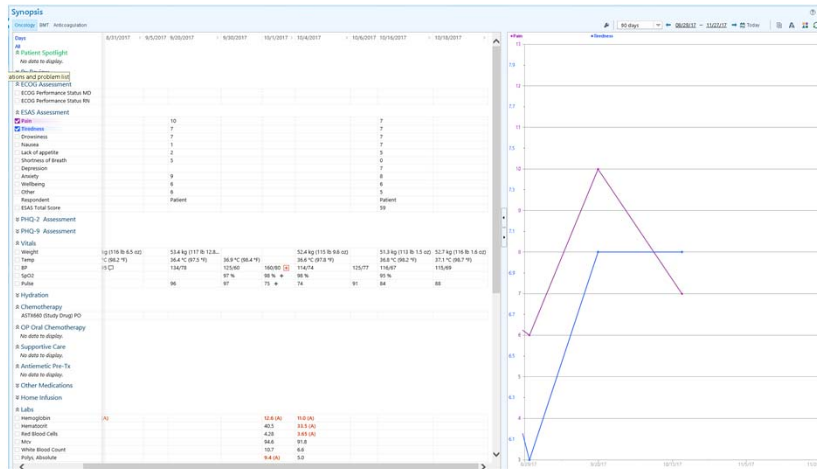
Pain: No pain
Tiredness: Four
Nausea: Not nauseated
Depression: Four
Anxiety: Three
Drowsiness: Not drowsy
Lack of appetite: Best appetite
Wellbeing: Four
Shortness of Breath: No shortness of breath
Other: Two
Respondent: Patient
ESAS Total Score: 17

Smart phrase: .ESASLAST3X

ESAS Score	12/21/2017	1/26/2018	1/26/2018
Pain	0	3	4
Tiredness	1	3	4
Drowsiness	2	3	4
Nausea	3	3	4
Lack of appetite	4	3	4
Shortness of Breath	5	3	4
Depression	6	3	4
Anxiety	7	3	4
Wellbeing	8	3	4
Other	9	3	4
Respondent	Patient	Patient	Patient
ESAS Total Score	45	30	40

. . . ESAS-R Synopsis

- Can graph individual or all items
- Can copy and paste graph into notes



Future State

- Integration with electronic entry + Patient Portal + Registry
  - Expanded screening tool
  - Move from clinic flow to check-in flow, with automatic data entry to CS-link via tablet device
  - Immediate provider and patient feedback on areas of distress
  - Provide Educational materials for the patients and families
  - Allow for Supportive Care real time-tracking, triage, and outreach via CS-Link registry
  - Ability to track outcomes and costs
- Extend to other Oncology Enterprise sites
  - Staffing
  - Electronic / Tele / Video Care Capabilities

Summary

- Distress Screening is required by our accreditation bodies
- Goals are to:
  - Detect patterns of distress and services needs
  - Serve as ***BASIS*** for:
    - Excellence in providing population based value to patients / families / care teams and health system
    - Use of evidence based tools
    - Targeting limited professional resources via stepped care
    - Improving care coordination and collaboration
    - Providing real time feedback on clinical outcomes
    - Improve patient and family cancer, symptom, and psychosocial-spiritual outcomes

QUESTIONS?

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T.A.N.A.S.
H.H.W.W.

Updated 4/9/2018

Implementing Collaborative Care: Sylvester Comprehensive Cancer Center University of Miami

William Pirl, MD, MPH

Associate Director, Sylvester Comprehensive Cancer Center
Cancer Support Services
Miller School of Medicine, University of Miami

Disclosures

- No financial disclosures

Miami

- 4th largest urban area in the US
- Population > 5.5 million
- Richest city in US and 7th in world
- 10% non-Hispanic white
- 50% residents born outside US
- 70% households do not speak English at home
- Cultural pluralism, not melting pot

University of Miami

- Founded in 1925
- 16 schools and programs with over 16,000 students
- Miller School of Medicine founded in 1952
  - Jackson Memorial Hospital
  - Holtz Children's Hospital
  - UHealth System
    - University of Miami Hospital
    - Sylvester Comprehensive Cancer Center
    - Bascom Palmer Eye Institute

Sylvester Comprehensive Cancer Center

- Opened as Comprehensive Cancer Center in 1992
- Over 500,000 total square feet distributed across 7 locations
- ~6,000 new patients/year
- 40 inpatient beds with 19 specialized Stem Cell Transplant beds and 7 ICU capable beds
- Although free-standing cancer center, matrix organizational structure
- Applying for NCI designation in 2019

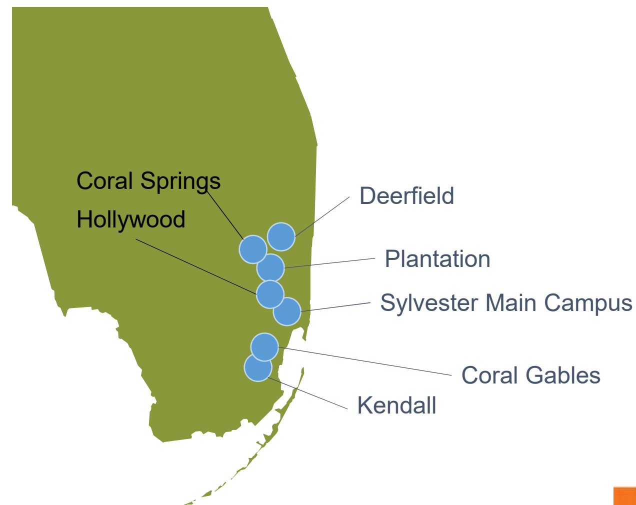
Psychosocial Clinical Services

- Psychiatry (2.2 FTE)
- Psychology (2.5 FTE)

- Oncology Social Work (13 FTE)

Challenges in Providing Psychosocial Care

- Volume
- Geography
- Cultural



Implementation Plan

- Partner with Oncology Social Work
- Hire oncology social worker as program coordinator
- Plan to pilot at one of satellites
- Consulting
- Ethnographic phase
- Pilot
- Training oncology social work (simultaneous with pilot)
- Plan to roll out to all sites within next year

Partner with Oncology Social Work

- Lisa Merheb, MSW, LCSW

Program Coordinator

- Kathleen Russell, MSW, PhD

Pilot Site: Deerfield Beach

- Already had full-time social worker
- Psychiatry 3 days a week
- Organized into multidisciplinary clinics
- Frequent requests/complaints about access

Consulting

- September 2016
  - 2-day visit from Jesse Fann, MD and Ailey Armstrong, MSW of Seattle Cancer Care Alliance
    - Grand rounds
    - Meetings with leadership
    - Trainings with oncology social work
    - Implementation materials
- September 2017
  - Follow-up visit with oncology social work from Tiffany Courtnage, MSW of Seattle Cancer Care Alliance

Ethnographic Phase

- Relationship building
- Observing clinic flow
- Docking into distress screening structure
- Enhancing screening
- Developing procedures and educating staff

Ethnographic Phase

- Relationship building

Relationship Building

Relationship Building

Relationship Building

"I know who you are and don't need to meet you. This isn't going to work and you won't be here very long."

Cultural Shift

- Collaborative care = distress screening = waste of time
- Role of oncology social work
  - Traditionally case management
  - Psychiatrists only mental health clinicians
  - Analogy with NPs
- Demonstration

Ethnographic Phase

- Relationship building

- Docking into distress screening structure

Docking into Distress Screening Structure

- Discovered that rates of screening were poor
- Navigators might be most strategic
- Spent time focusing on screening

Ethnographic Phase

- Relationship building

- Docking into distress screening structure
- Enhancing screening

Enhancing Screening

- Planned to shift from Distress Thermometer to PHQ-4
- Developed screening form that could also be built into EPIC

Enhancing Screening

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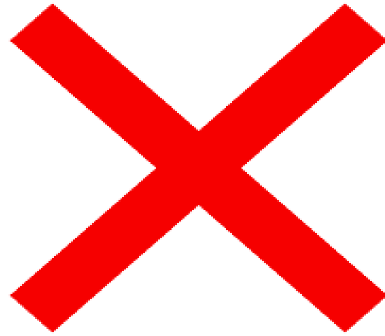

UHealth
UNIVERSITY OF MIAMI
HEALTH SYSTEM
Merging University of Miami Hospital, Sylvester Comprehensive Cancer Center, and Bascom Palmer Eye Institute into one entity with a single license

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UNIVERSITY OF MIAMI
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Merging University of Miami Hospital, Sylvester Comprehensive Cancer Center, and Bascom Palmer Eye Institute into one entity with a single license
HARMONIZATION

Ethnographic Phase

- Relationship building
- Docking into distress screening structure
- Enhancing screening
- Developing procedures and educating staff

Developing Procedures

- Screening: Distress Thermometer
- Kathleen reviews all forms, contacts patients
- Initial evaluations scheduled, patients tracked
- Weekly meeting with psychiatrist (me) to discuss cases
- Oncologists and nurses still wanted to make referrals
- Oncologists preferred med recommendations as message from psychiatrist through EPIC

Pilot Experience

- 15% of screened enter into collaborative care treatment
- Providers have learned roles and referrals
- Direct referrals bulk of patients
- Patients appreciate screening follow up
- Decrease in complaints about psychiatry access
- Less medication recommendations than expected, still need on-site psychiatry

Pilot Experience

- 15% of screened enter into collaborative care treatment
- Providers have learned roles and referrals
- Direct referrals bulk of patients
- Patients appreciate screening follow up
- Decrease in complaints about psychiatry access
- Less medication recommendations than expected, still need on-site psychiatry
- Kathleen now has a full-time office with a window

Pilot Feedback

- *"We appreciate and know the value of your service at a facility as dynamic and busy as Deerfield Beach."*
- *"Your services are incredibly beneficial for our patients and staff! It has filled a vert important gap in our care."*

FINANCIAL LOSSES

FINANCIAL LOSSES
LEADERSHIP TURN OVER

FINANCIAL LOSSES
LEADERSHIP TURN OVER AND OVER

FINANCIAL LOSSES
HURRICANE
LEADERSHIP TURN OVER AND OVER

FINANCIAL LOSSES
HURRICANE
LEADERSHIP TURN OVER AND OVER
HOLIDAY PARTIES BANNED

Cancer Center Leadership's Response

- "Blown away by presentation"
- Asked for 2 FTE of bachelor's level resource specialists
  - Received 0.5 FTE
  - Model CMS billing to justify more positions

Current Activities

- Deerfield Beach collaborative care "pilot" on-going
  - Deerfield Beach has grown to be half as big as main campus
- Still training oncology social work at other sites
  - Twice monthly educational program with time to practice skills
  - Internal culture shift

Summary

- Collaborative care might be best solution to care across multiple satellite sites
- Be an ethnographer
- If you can get something up and running, everyone will love it

Questions

Thank you

Sylvester Comprehensive Cancer Center
Collaborative Care Implementation Team

Kathleen Russell, MSW, PhD

Lisa Merheb, MSW

Cristina Pozo-Kaderman, PhD

Angela Pino-Olier, RN, MBA, DNP

A COLLABORATIVE CARE MODEL FOR DEPRESSION CARE IN ONCOLOGY:

From research to practice

Michael Sharpe MD
Jane Walker PhD
Josephine Fielding MB

Acknowledgements and Disclosures

- Dr Jane Walker and research staff in Edinburgh and Oxford and NHS Staff and patients in participating cancer services
- Research funding from Cancer Research UK and National Institute of Health Research UK. No other disclosures
- Clinical team in Oxford Cancer Centre and clinical funding from Oxford University Hospitals NHS Foundation Trust and Macmillan Cancer Relief

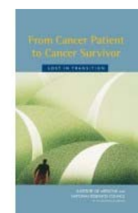
Why major depression matters for people with cancer

- Makes it harder to tolerate cancer treatment
- Has a major negative effect on symptoms and quality of life
- Impedes return to normal life
- May result in suicide

Why is treatment for major depression is inadequate?

- Depression is not identified
  - ‘Don’t ask don’t tell’
  - Depression is ‘understandable’

- Depression is not treated
  - Poor acceptance by patient
  - Inadequate treatment by clinicians



Research to improve the identification and treatment of major depression

Developing and evaluating a collaborative care model

Identifying major depression: Symptom monitoring service (SMS)

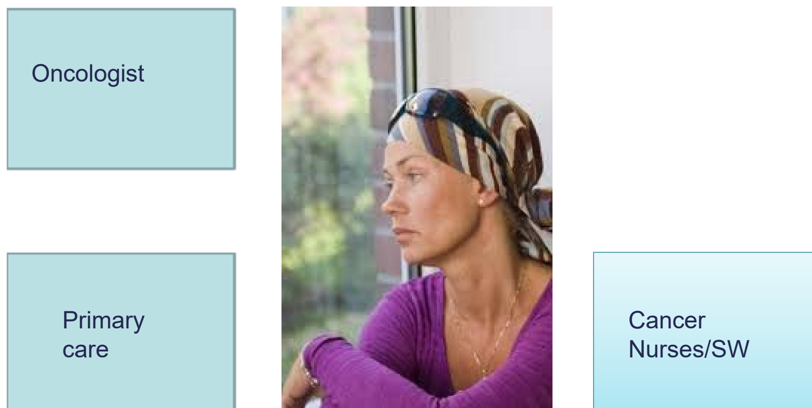
- Patient administered PHQ8 questionnaire in the cancer clinic

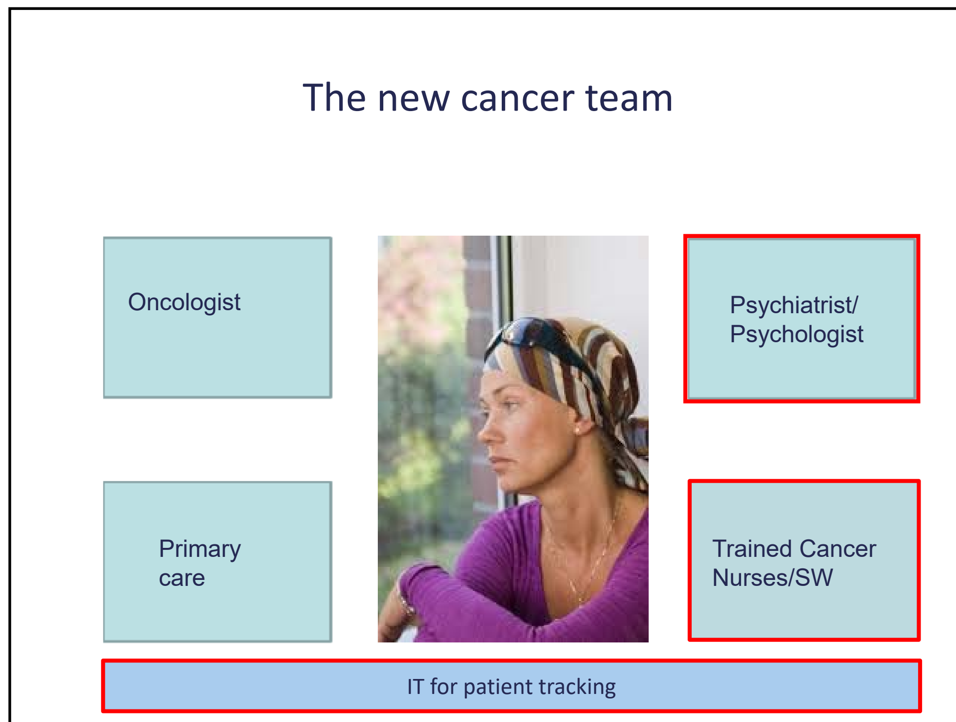
- Interview administered diagnostic assessment for major depression

Treating major depression: Depression Care for People with Cancer (DCPC)

- Team-based treatment
- Trained cancer nurses (SW)
- Supervised by psychiatrist (psychologist)
- Provides both pharmacological and psychological treatment
- Delivered as part of cancer care

The current cancer team





Implementing the research findings in practice

Experience in the Oxford Cancer Centre:

An implementation study

Oxford University Hospitals Cancer Centre

Methods

- A contemporaneous log
- In depth interviews
- Evaluation of quantitative outcomes
- Benchmarking against trials

Background

- Very limited psychosocial service
  - Psychiatry for emergencies
  - Charity funded counselling service
  - Half a day a week of a CBT therapist

- Local enthusiasm for better
  - Academic psychiatrists MS & JW
  - Some of the hospital directors
  - A national charity

Preparation

- Sharing the published data – publications and policy
- Gaining support from the oncologists - presentations
- Getting 'buy-in' from the hospital management - connections
- Identifying funding from hospital and charity - selling

Getting started

- Recruiting suitable staff – recruiting and selecting
- Finding suitable team accommodation – hard negotiating
- Providing training for the new team – need time and expertise
- Underpinning IT – clear specification and EPR compatibility

Establishing the service in routine care

- How fast to expand – select clinics and patient types
- How best to fit in with oncology clinics – not obstructing
- How to gain acceptance as a core part of care – prove it
- How to ensure team sustainability - regular refresh sessions

Where we are now

- Screening
  - Most clinics
  - Accepted but limited help from clinic staff
- Treating
  - Team recruited (0.5 psychiatry and 3.0 nurse/OT)
  - Team trained and treating patients
- Outstanding
  - Bespoke IT
  - Full integration into care

Clinician comments on the new service

- *"And sometimes if you don't know what to do about a problem, you ignore it. I think this is giving us a way of beginning to address the problems that if we're honest we, we all know they've been there, we've just not known what to do"*
- *"I think putting a face to it and taking any sort of taboo out of it, that we're all there for the same common goal, otherwise, you know, afterwards you've got to do a referral letter and it just takes longer and you lose the impetus"*

Patient comments on the new service

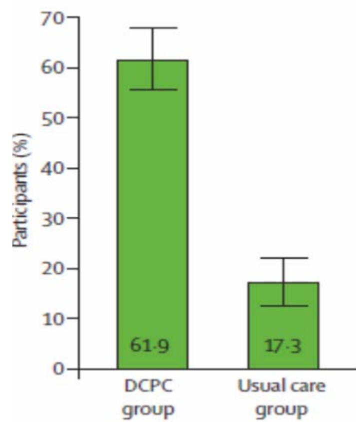
- *"I was definitely floundering on the rocks, so it was good to have somebody to reach out, grab hold of me."*
- *"I didn't want to just sit there and talk about how I feel because a lot of the time it was "not great", so having the structure, was really important, for me*
- *"I think it's a really good service, I think it fits really well with the other treatment, you know all the physical treatments, I think it's really important"*

Thank you

www.oxfordpsychologicalmedicine.org

www.thelancet.com/depression-and-cancer

SMaRT Oncology-2 findings



Absolute difference = 45%
(95% CI: 37% to 53%)

Odds ratio: 8.5
(95% CI: 5.5 to 13.4)

NNT: 2.2

SES: 1.1

p<0.001