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Sent: Monday, November 14, 2022 12:09 PM
To: MCC@ahrq.hhs.gov
Cc: Poonam.Pardasaney@ahrq.hhs.gov; clarkeross10@comcast.net; Laura Groshong <lwgroshong@comcast.net>; Sally Raphel <smraphel@gmail.com>
Subject: Response to RFI on Person-Centered Care Planning for MCC

Mr. Pardasany,

Please find attached our response to the AHRQ RFI On Person-Centered Care Planning for Multiple Chronic Conditions.

Should you have questions or seek further information, please do not hesitate to be in touch.

With best regards,

NHMH - No Health without Mental Health

American Association on Health & Disability

Clinical Social Workers Association

International Society for Psychiatric Mental Health Nurses

Lakeshore Foundation

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TO: Agency for Healthcare Research and Quality (AHRQ), HHS

FROM: NHMH – No Health w/o Mental Health
American Association on Health & Disability
Clinical Social Workers Association
International Society for Psychiatric Mental Health Nurses
Lakeshore Foundation

DATE: November 14, 2022

RE: AHRQ RFI on Person-Centered Care Planning for Multiple Chronic Conditions (MCC)

(Introductory Note: This comment responds to AHRQ's 9/16/22 RFI for public comment on comprehensive, longitudinal, person-centered care planning for persons at risk or living with multiple chronic conditions (MCC). Within the MCC category, we include:
-- persons living with co-occurring mental illness and chronic medical conditions,
-- persons living with co-occurring mental illness and substance use disorders,
-- persons with co-occurring mental health and intellectual and other development disabilities,
-- persons with co-occurring mental health/substance use conditions and disabilities, and
-- persons with complex health and social needs.
Data from mainly federal projects, and from largely federally-supported academic studies, on persons with the above co-occurring disorders, are available upon request).

A.ACCELERATION, IMPLEMENTATION, SCALING AND SPREAD OF PROVEN MCC INTERVENTIONS:

At the outset we stress that our country urgently needs a national healthcare system that is much better at delivering proven effective evidence-based treatments to patients at the primary point of care. It is unacceptable that it currently takes **17 years** to translate research findings to clinical care (U.S. National Center for Biotechnology Information https://www.ncbi.nim.nih.gov/pmc/articles/PMC3241518/). This deficiency in our health system must be addressed even more so as we grapple with a national mental health/addiction crisis, and experience massive healthcare costs for multiple chronic conditions. We can no longer afford to wait two decades for proven research findings to reach patient interventions in the clinic.

B. THE TEAMcare INTERVENTION FOR MULTIPLE CHRONIC CONDITIONS:

Research over the past 10-15 years has established that the TEAMcare intervention is a demonstrated effective intervention for MCC that to date remains far from routine clinical care. We urge AHRQ and its federal health partners to address this implementation deficiency on a priority basis.

TEAMcare is an integrated multi-condition collaborative care program for chronic medical and behavioral conditions (diabetes, cardiovascular disease, depression) published in 2010 (*NEJM* 2010;363-:2611-20) and confirmed in follow-on studies. This despite the fact that TEAMcare's target patient population, highly complex patients with co-occurring conditions, is the same patient group that represents Medicare and Medicaid's highest-cost users. (Milliman, 2018). Health claims data show chronic medical conditions significantly increase patient's total healthcare cost, plus adding a mental health condition d*oubles* total cost, and adding a further substance use condition, *quadruples* the total cost (Ibid).

What does TEAMcare specifically do? TEAMCare is care management intervention that integrates collaborative depression care with systematic chronic medical illness care and treat-to-target interventions designed to improve multi-conditions of diabetes, depression and coronary heart disease. Fundamentals of the TEAMcare intervention are:

* consistent patient-centered care focus,
* collaborative goal setting between patient and care team,
* practical, tailored, collaborative care planning, and
* limited, targeted patient educational materials.

While the TEAMcare intervention targets people with depression, diabetes and heart disease, it may also be well suited to people with diabetes and heart disease and no co-occurring depression. Even for patients without depression, a patient-centered, treat-to-target focus appears to help facilitate an organized, collaborative, and practical approach to care. *The well-researched and studied TEAMcare intervention thus has the potential to be widely adopted as a practical approach to managing multiple co-occurring chronic diseases, medical and behavioral.*

The TEAMcare intervention has a solid foundation in science and medicine. It builds on the 2002 Chronic Care Model (Bodenheimer, T. Wagner, E.H. et al, Improving Primary Care for Patients with Chronic Illness, *JAMA* 2002;288(14): 1775-9), an organizing framework for improving chronic illness care at both the individual and population levels, and which is based on the assumption that improvement in chronic care requires an approach that incorporates <u>patient</u> and <u>provider</u> and <u>system-level</u> interventions. The Chronic Care Model has become the dominant model for the patient-centered medical home. The Chronic Care Model has 4 key components:

* patient self-management supports,
* effective shared clinical health information systems,
* care delivery system redesign, and
* clinician decision supports.

The TEAMcare intervention additionally builds on the Collaborative Care Model, a specific type of integrated mental health/substance use care program itself derived from the Chronic Care Model, and developed by Dr. Wayne Katon and colleagues at the University of Washington. Collaborative care aims to improve access to evidence-based mental health treatments for primary care patients. Its 4 core elements are: team-driven, population-focused, measurement-guided and evidence-based. It is notable that collaborative care is not a 'one size fits all' approach, rather must be adapted and blended for use in

diverse types of health systems and practices found across the U.S., while still be able to implement the core elements.

TEAMcare represents the gold standard for a multi-disciplinary team management of co-occurring medical and psychological illnesses. (McGregor, M., Lin, Katon, An Integrated Multi-Condition Collaborative Care Program for Chronic Medical Conditions and Depression, *Ambulatory Care Management* 2011;34: 152-62). We urge HHS to make implementation, scale and spread of the TEAMcare intervention a national healthcare services delivery priority.

C.TEAMcare's CARE PLANNING APPROACH:

The TEAMcare intervention breaks new ground in clinical care planning, ensuring that:

* care plans are individually tailored to patients, and stress patient control and choices,
* mental health/substance use strategies and life-style changes consistently reviewed updated,
* treatment goals (e.g. PHQ-9, HbA1c, SBP and lipid levels) are clear, and shared by the care manager, primary care physician and patient, and regularly reviewed,
* collaborative self-monitoring goals for tracking progress are clearly defined,
* medical regimen and EHR medication lists reflect what the patient is actually taking, and
* treat-to-target focus with clinicians and patients adjusting medications and therapies until treatment goals are reached.

D. TEAMcare TEAM ROLES AND TASKS:

The TEAMcare team consists of the patient/family, a care manager, the patient's primary care physician (PCP) and the PCP's care team, and the TEAMcare consultants, medical and behavioral. Patients targeted for this intervention have two or more chronic conditions including depression, diabetes and coronary heart disease.

TEAMcare care managers clinicians had full access to the primary care site's EHR, since the EHR was deemed an essential communications tool. The care managers received training on depression management and behavioral strategies as well as training in glycemic, blood pressure and lipid control. TEAMcare's treat-to-target focus meant that the care managers were expected to help patients and their PCPs frequently adjust medications until treatment goals were reached. Consistent change was expected until the patient reached their individual treatment goals.

Studies show the care manager's role in the TEAMcare intervention is a pivotal one. For most care managers, this work was different from all their previous experience. Principal differences were:

* a treat-to-target focus with focused algorithm for care with medication adjustment plans,
* care manager, patient and consultants' accountability for goals,
* focus on evidence-based interventions,
* weekly systematic patient caseload review with consultants, care manager, care team,
* integrated multi-condition disease management focus rather than a single disease, high cost,

or utilization focus, and

* focus on patient-centered care, i.e. explicit patient control over goals, educational materials and interventions chosen.

The TEAMcare clinician consultants provided weekly patient caseload review with the care managers. In some cases consultants might be psychiatrists, psychologists, internists, family medicine physicians, diabetologists and/or cardiologists, all available when required.

E. TEAMcare APPROACH TO SELF-CARE STRATEGIES:

Patient self-care focused on medication adherence and self-monitoring. Many patients had a variety of conditions that could be monitored at home, such as blood pressure improvement for hypertension. Patients with diabetes received blood glucose meters for monitoring at home.

Tellingly, one of the hardest self-care behaviors for many of the TEAMcare patients to identify was a pleasurable activity. Care managers often used a list of pleasurable activities to help people review fun activities they might try before the next visit. For patients with a goal to quit smoking care managers asked about their readiness to quit at most visits. If patients were interested in further discussion, care managers used motivation techniques to encourage patient behavior change. Physical activity was recommended and usually including patients receiving verbal reinforcement and expression of the care team's pride in their performance. For physically inactive patients, care managers checked for readiness to change and discussed simple, practical plans for beginning exercise.

When patients achieved their goals, a relapse prevention plan was crafted with the patient. At the end of the intervention, EHR notes were written to the PCP describing he patient's initial and ending clinical status and self-care plans. The relapse prevention plan was also included in the EHR.

The care management team developed a care management tracking system to operationalize key parts of systematic chronic illness care, such as proactive monitoring of outcomes, alerts for patients lost to follow-up, and highlighting patient who had not achieved their target goals. Every week, care managers captured the most current patient outcomes. A weekly clinical summary sheet displayed the illness parameters for each patient.

F. THE CMMI "COMPASS" SPREAD PROJECT:

The 2012-2015 CMS/CMMI "COMPASS" (Care of Mental, Physical and Substance Use Syndromes) spread project confirmed TEAMcare's status as the gold standard for multi-condition integrated care, while also revealing potential areas for future research (Rossom R.C., et al Impact of a national collaborative care initiative for patients with depression and diabetes or cardiovascular disease, *Gen Hosp Psychiatry* (2016) 2016.05.006). The COMPASS results were both consistent with their initial goals, *and less powerful than the initial 2010 TEAMcare trial.*

The COMPASS initiative aimed to implement multi-State, widespread implementation of the TEAMcare intervention on a scale not previously achieved. It included 10 healthcare organizations with 18 medical groups and 172 clinics across 8 states to provide care for patients with depression and diabetes and/or cardiovascular disease. Intervention components included care management, a care management tracking system, systematic case reviews, ways to interface with primary care teams, ongoing training and quality improvement activities, evaluations of health outcomes including patient-reported outcomes, and satisfaction and sustainability plans. The TEAMcare intervention was modified by most COMPASS clinic sites to conform to their own clinical practice guidelines.

A key finding of the COMPASS project was the great variability in outcomes across clinic sites in terms of depression outcomes, general medical health outcomes, and satisfaction ratings. There was significant site outcomes variability not only among different medical/health system groups, but also *within* individual groups/health systems, clearly an important subject for future research.

Another finding was that vigorous adherence to weekly systematic caseload review, plus more time allowed to care managers to do their care coordination work, and greater training for care managers, especially in the areas of patient self-care and self-management techniques, such as motivational interviewing, behavioral activation, and problem-solving, all of these items appeared to be key components for improved outcomes.

In sum, the COMPASS spread project further confirmed the promise of the 2010 TEAMcare trial intervention, as well as highlighting ongoing challenges of clinically implementing an intensive intervention for highly complex patients. On the one hand, the COMPASS outcomes showed the potential of this intervention to meet the Triple Aim via wider distribution. On the other hand, despite a specific and intensive intervention, the COMPASS improvements were relatively modest -- fewer than half of patients had depression response, fewer than one-quarter reached depression remission, and fewer than one-quarter reached diabetes goals.

H. RECOMMENDATIONS FOR NEXT STEPS

We urge HHS to make the implementation, scale and spread of the TEAMcare intervention for comprehensive, person-centered, longitudinal care for people with multiple co-occurring chronic conditions, a national health services delivery priority. The past 15 years have demonstrated that TEAMcare is a highly successful clinical care intervention for multi-condition chronic care for highly complex patients. Further CMMI initiatives have shown that implementation and dissemination of the TEAMcare intervention across multiple domains and health systems has the potential to provide even further benefits for hard to reach, hard to engage complex patients greatly in need of this intensive, multi-condition, multi-disciplinary care.

We also highly recommend that HHS work to ensure that our country has a healthcare system better at delivering known evidence-based treatments, such as TEAMcare, in a timely manner, to patients at the clinical care level.

Best regards,

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