

**Community Care Collaborative**  
**Integrated Behavioral Health Intervention for Chronic Disease Management**  
**307459301.2.3 Pass 3**

**Provider:** The Community Care Collaborative (CCC) is a new multi-institution, multi-provider, integrated delivery system. Launched in April 2012 by Central Health, Travis County's Healthcare District, and the Seton Healthcare Family, Central Texas' largest hospital system, this 501(c)3 will integrate safety net providers in Travis County in a ACO-like model. Patients will receive navigated, patient-centered care that will lead to better health outcomes, increased satisfaction with the system, efficient delivery of services, and lower costs.

**Intervention(s):** Through this project, the CCC will develop a care management approach specific to individuals dually diagnosed with diabetes and clinical depression. A care team will help these patients address and manage their dual diagnoses by providing treatment for their depression while addressing their diabetes. Patients will interact regularly with a care manager, and the care team will engage in a physician-led weekly case review. Patient progress also will be tracked via a disease management registry. In conjunction with the fourteen other DSRIP projects that build critical infrastructure, expand access to care, and ensure that patients receive the right services in the right place at the right time, this DSRIP will lead to better clinical outcomes for the patient, less reliance on acute and emergency care, and lowered costs of care for the indigent care system in Travis County.

**Need for the project:** Depression was the most prevalent mental health condition among low-income Travis County residents and when a co-occurring medical condition was observed, diabetes was one of the medical conditions observed. Indeed, depression is twice as prevalent among persons with diabetes as it is among persons without diabetes. The undiagnosed and untreated presence of depression significantly worsens the outcome or prognosis of a variety of illnesses and disease and increases the annual cost of care by 33% (Pettersen, S.M., Phillips, R.L., Basemore, A.L., et al. (2008). "Why there must be room for mental health in the medical home", American Family Physician, 77(6): 757).

**Target population:** The CCC's covered population will initially be around 50,000 persons under 200% of the Federal Poverty Level. All of these patients will be affected by the implementation of PCMH model. In addition, all patients who come into contact with the CCC's provider network, regardless of payor, will benefit from more patient-centered care. This includes thousands of low-income uninsured and Medicaid patients. This project specifically targets CCC patients who are dually diagnosed with diabetes and depression.

**Category 1 or 2 expected patient benefits:** This project will provide integrated treatment for approximately 1,500 CCC patients dually diagnosed with diabetes and clinical depression. Using a care-team approach, patients are expected to have improvements on clinical depression and diabetes measures.

**Category 3 outcomes:**

Approval for Category 3 outcomes is still pending.

**Title of Project:** Integrated Behavioral Health Intervention for Chronic Disease Management

**Project Option:** 2.19.1 Innovation and Redesign/Develop Care Management Function that integrates primary and behavioral health needs of individuals/Design, implement, and evaluate care management programs and that integrate primary and behavioral health needs of individual patients

**RHP Project Identification Number:** 307459301.2.3 Pass 3

**Performing Provider Name:** Community Care Collaborative

**Performing Provider TPI:** 307459301

### ***Project Description***

The Community Care Collaborative (CCC) is a 501(c)3 public-private partnership that will redesign the Travis County indigent healthcare delivery system. The CCC was created in 2012 by Central Health, the taxpayer-funded Travis County Healthcare District, and the Seton Healthcare Family, Travis County's largest hospital system. Austin Travis County Integral Care, the designated provider of community-based behavioral health and development disorder services for Travis County, has also recently joined the CCC as a partner. The CCC's overarching goal is to provide high quality, cost effective, patient centered care that improves health outcomes for its targeted population. The CCC, through its contracted provider network, will initially serve a defined patient population of 50,000 uninsured individuals at or below 200% of the Federal Poverty Level and who meet other established eligibility requirements.

The operational objectives of the CCC are to create effective coordination between providers across the continuum of care; increase and integrate capabilities of providers' Electronic Health Record (EHR) and the system's Health Information Exchange; and aligns payments with outcomes, rather than outputs. With significant public investment in the transformation of the indigent healthcare system, the CCC will develop and implement accountable care organization (ACO) and patient-centered medical home principles by establishing a strong, comprehensive primary care base, collective responsibility for care of patients across the delivery continuum, payments linked to quality improvements, and reliable and progressively stronger performance measurement and reporting.

**The Integrated Behavioral Health Intervention for Chronic Disease Management Project** will provide integrated treatment for approximately 1,500 patients with co-occurring clinical depression and diabetes. This project aims to improve these patients' dual diagnoses by implementing integrated care practices to treat these two diseases. These patients will benefit from a robust care protocol as described in this project, but also the fourteen other DSRIP projects that the CCC is proposing. These fourteen projects are:

- Chronic Care Management Project
- Patient Centered Medical Homes
- Disease Management Registry
- Expanded Hours at Community Clinics
- Mobile Clinics to Underserved Areas
- Dental Care Expansion
- Gastroenterology in Community Clinics
- Pulmonology in Community Clinic
- Telepsychiatry in Community Clinics
- Pregnancy Planning
- Community Paramedic Navigator Project
- STI & HIV Screening and Treatment & Referrals
- Comprehensive Patient Navigation
- Centering Pregnancy

This project uses a care team consisting of a primary care physician, mental health providers, and a care manager to provide care management to a targeted population of patients with co-occurring clinical depression and diabetes; one of the target population for the Community Care Collaborative. In this project, patients will receive treatment for their depression. Successful control and treatment of chronic conditions like diabetes requires major lifestyles changes and often involves adherence to complicated medical regimens. When a patient is depressed, effecting such health changes and maintaining treatment compliance can be even more difficult.

Patients with diabetes will be referred to a behavioral health specialist who will assess the person for clinical depression. Those also diagnosed with clinical depression will receive a treatment protocol specifically designed for co-occurring diabetes and mental health conditions. It is expected that patients who are able to properly manage their depression through therapy and learn self-care skills are able to better control their diabetes. Patients will interact regularly with their care manager either in-person through the patient's medical home, or via telephone conferencing. While the patient interacts with only the care manager on a regular basis, the entire care team plays an integral part in the patient's care via regular case reviews and physician monitoring of the patient's health. Patients will have access to specialty care as needed. To keep track of patients' health through the program and to make changes to patient care as needed, their clinical measurements will be assessed regularly and entered into a disease management registry.

### ***Project Goals***

- By the end of 5 years, this project aims to provide services to approximately 1,500 patients dually diagnosed with clinical depression and diabetes
- Patients will receive support to increase medical compliance, improve health outcomes, and increase their self-reported quality of life.

### ***Challenges or Issues Faced by the Performing Provider***

The performing provider acknowledges some of the challenges associated with implementing this project such as clinicians in the primary care setting with training in identifying depression, and behavioral health clinicians with specific training in treating depression. An additional challenge is ensuring consistent implementation of the program across all of its different network providers.

### ***How the Project Addresses those Challenges***

To address the experience and skills of behavioral health providers, training in evidence-based behavioral strategies such as motivational interviewing, behavioral activation, and systematic problem-solving will be provided. Care team members will be hired with competitive salaries to ensure that access to providers does not limit success in the program.

The CCC will use the learning collaborative as a forum to discuss patient engagement, program implementation and outcomes. These regular meetings will help ensure consistency in program implementation across sites and providers.

### ***How the Project is Related to RHP Goals***

The project aligns with the following RHP Goals:

Goal 2: Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting.

Goal 3: Improve the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems.

Goal 4: Bolster individual and population health by improving chronic disease management.

Goal 6: Expand access to behavioral health services to ensure timely, effective treatment that minimizes the use of crises services and promotes recovery.

Goal 7: Improves the patient experience of care by increasing the quality of care and patient safety.

---

## **Starting Point/Baseline**

### ***Baseline Data***

This is a new program for the CCC; no one is enrolled in this program.

### ***Time Period for Baseline***

N/A

---

## **Rationale**

### ***Reason for Selection of Project Options and Components***

Depression was the most prevalent mental health condition among low-income Travis County residents and when a co-occurring medical condition was observed, diabetes was one of the co-occurring medical conditions observed (Region 7 Community Needs Assessment). Indeed, depression is twice as prevalent among persons with diabetes than it is among persons without diabetes (Anderson et al, The prevalence of comorbid depression in adults with diabetes: a meta-analysis. Diabetes Care. 2001 Jun;24(6):1069-78). The undiagnosed and untreated presence of depression both increases the risk of developing certain chronic conditions, such as diabetes, as well as significantly worsening the outcome or the prognosis of a variety of illnesses and diseases. However, the treatment of depression appears to be associated with improved glycemic control (Lustman, P., Freedland, K., Griffith, L.S., & Clouse, R.E. (1998), "Predicting response to cognitive behavior therapy of depression in type 2 diabetes". General Hospital Psychiatry, Sep 20(5):302-6).

Furthermore, there is an economic impact of co-morbidity; the cost of unmet care for individuals with diabetes increases from \$4,172 annual for those without a mental health condition, to \$5,559 annual for those with a mental health condition; a 33% annual increase in cost (Pettersson, S.M., Phillips, R.L., Bazemore, A.W., et al. (2008), "Why there must be room for mental health in the medical home". American Family Physician, Mar 15;77(6):757).

Research indicates that collaborative care between behavioral and medical practitioners, combined with a brief, focused model of intervention to assist with adherence to prescribed medication regimens, results in significantly improved outcomes for patients with depression, diabetes and coronary heart disease (Katon, Lin, et al., (2012). Collaborative care for patients with depression and chronic illnesses. New England Journal of Medicine, 363(27)).

Option 2.19.1 includes eight required components which will be addressed by the CCC in its implementation:

a) Conduct data matching to identify individuals dually diagnosed with diabetes and depression.

- b) Review chronic care management best practices such as Wagner's Chronic Care Model and select practices compatible with organizational readiness for adoption and implementation.
- c) Identification of BH case managers and disease care managers to receive assignment of these individuals.
- d) Develop protocols for coordinating care; identify community resources and services available for supporting people with co-occurring disorders.
- e) Identify and implement specific disease management guidelines for high prevalence disorders, e.g. cardiovascular disease, diabetes, depression, asthma. In the case of the CCC, diabetes will be the chief disease addressed by this project.
- f) Train staff in protocols and guidelines.
- g) Develop registries to track client outcomes.
- h) Review the intervention(s) impact on quality of care and integration of care and identify "lessons learned," opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.

Since this is a new project for the CCC, the initial years of the program will focus on project planning, including reviewing chronic care management best practices for treating co-occurring diabetes and depression in the literature, from local network of providers (2.19.1.b) and developing the practice model, and identifying and hiring care managers (2.19.1.c) who will oversee the care management of the target population. An evaluation of promising practice models for diabetes and clinical depression (2.19.1.e) will help the project team to develop the protocols for coordinating care, including identifying community resources to support positive outcomes (2.19.1.d) and to train hired staff on the protocols (2.19.1.f). The protocols and practices developed in this project will fold into and help inform the larger CCC Chronic Care Management Model Protocol project which addresses a larger number of patients with a greater diversity of chronic disease diagnoses.

The target population will be identified based on referral by primary care physicians (PCP). The initial years of the program will be used to refine the recruiting process.

Eventually, patient data will be captured in the CCC's Disease Management Registry project but prior to its rollout, DY2 will be used to establish methods of tracking patient data over time 2.19.1(g).

Project developers, along with practitioners will engage in the Region's learning collaborative to collaborate with other participants on how to increase patient engagement, review the program's impact on quality of care, integration of care, and identify "lessons learned" to improve the program (2.19.1.h).

### ***Reason for Selection of Milestones/Metrics***

The milestones and metrics were chosen because they best represent the sequence of effective project implementation. Demonstration Years 2 and 3 focus on program planning and development to ensure that the best care management protocols are identified and properly implemented so that by the end of DY3, the first set of program participants will begin receiving integrated care for their co-occurring diabetes and depression. By DY4, an even larger number of patients are expected to be included in the program.

### ***Unique Community Need Identification Number***

CN.4 Inadequate access to behavioral health care

CN.6 Inadequate services throughout the continuum of care for individuals with behavioral health issues such as screening, outpatient treatment, and integrated care

CN.7 Lack of coordination of care across: settings of care, multiple conditions, physical and behavioral health

CN.9 High rates of chronic disease such as cardiovascular disease, and rising rates of diabetes

CN.10 Many residents in Region 7 have multiple chronic conditions

CN.15 Additive and costly impact of co-occurring mental health, substance use, and medical conditions

### ***How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative***

This project is a new initiative for the performing provider. While providers in the network do engage in integrated care, this project specifically focuses on individuals with clinical depression and diabetes. This program uses a unique pathway to improve a chronic physical health condition via depression management.

### ***Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS)***

None

### ***Related Category 3 Outcome Measure(s)***

---

#### ***Category 3 Outcome Measures(s) Selected***

Category 3 Outcome Measure selection is still pending.

### ***Relationship to Other RHP Projects***

---

#### ***How Project Supports, Reinforces, Enables Other Projects***

The CCC's 15 projects are all interrelated and will provide high quality, cost effective, patient centered care that improves health outcomes for its targeted population. The CCC projects most closely related to Integrated Behavioral Health Intervention for Targeted Chronic Disease Patients are outlined below.

#### ***List of Related Category 1 & 2 Projects (RHP Project ID Number)***

307459301.2.1: Primary Care Medical Home

307459301.1.1: Disease Management Registry

307459301.2.2: Chronic Care Management Model  
307459301.1.8: Telepsychiatry Services in Federally Qualified Primary Health Clinic  
137265806.1.1: Psychiatric Emergency Department  
137265806.2.4: Behavioral Health Navigation  
307459301.1.3: Mobile Primary Care

***List of Related Category 4 Projects (RHP Project ID Number)***

RD-1.2 Potentially Preventable Admissions – Diabetes Admission Rate  
RD-1.3 Potentially Preventable Admissions – Behavioral Health and Substance Abuse Admission Rate  
RD-2.2 30-Day Readmissions – Diabetes: 30-Day Readmissions  
RD-2.3 30-Day Readmissions – Behavioral Health and Substance Abuse: 30-Day Readmissions

**Relationship to Other Performing Providers' Projects in the RHP**

---

***List of Other Providers in the RHP that are Proposing Similar Projects***

133542405.2.1: Integrate Primary and Behavioral Health Care Services  
133542405.2.5: Implementation of Chronic Disease Prevention/ Management Models  
126844305.2.4: Primary Care / Behavioral Health Care Integration Clinic – Caldwell County  
186599001.2.2: Chronic Care Management – Pediatrics  
133340307.2.1: Hays County Mental Health Center Integrated Care  
201320302.2.2: Expansion of Community Diabetes Project  
137265806.2.4: Behavioral Health Assessment and Resource Navigation  
137265806.2.9: Adult diabetes inpatient chronic care management

**Plan for Learning Collaborative**

---

***Plan for Participating in RHP-wide Learning Collaborative for Similar Projects***

RHP 7's performing providers, IGT entities, and anchor recognize the importance of learning from each others' implementation experiences and will make regular efforts to share ideas and solve problems. Region-wide, anchor-led meetings will be held at least annually and will offer an opportunity to share, listen, and learn what providers have encountered while implementing their DSRIP projects. RHP 7 envisions continuing the regular, anchor-led calls that are open to all performing providers and IGT entities, as launched during plan development. These calls have brought value to the process, and will be continued on a schedule that will be helpful throughout the waiver period. Further, the region will continue to use its website ([www.texasregion7rhp.net](http://www.texasregion7rhp.net)) to share information, updates and best practices as has been done during this first waiver year. As useful, Central Health, as RHP 7's anchor, will foster the development of topical learning collaborative - smaller meetings as the annual regional summit - that will bring together all levels of stakeholders who are involved in DSRIP projects that share common goals, outcomes, themes or approaches. This multi-pronged approach should allow for continuous improvement of regional projects, which will in turn better serve RHP 7's low-income population and transform its healthcare delivery system.

## Project Valuation

---

### *Approach for Valuing Project*

In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the “ripple effect” the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.