National Behavioral Health Network
for Tobacco & Cancer Control
from NATIONAL COUNCIL FOR MENTAL WELLBEING

2023 Cancer and Mental Wellbeing Education Training Series – A Collaborative Care Approach to Delivering Population Based Integrated Psychosocial Oncology Care

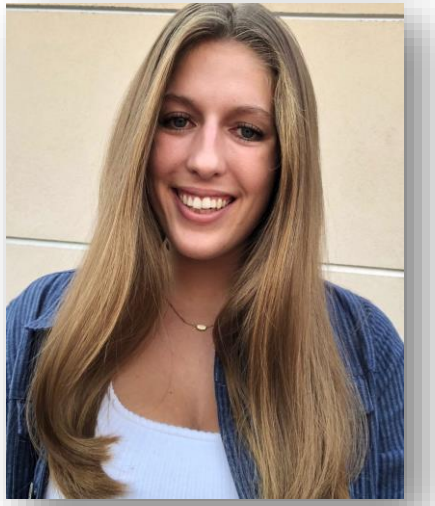
Thursday, July 6, 2023

3:00 – 4:00 pm ET

Welcome from The National Behavioral Health Network Team!

Tamanna Patel, MPH, CDP
Director

Samara Tahmid, MPH
Project Manager



Coyle Shropshire
Project Coordinator

National Behavioral Health Network
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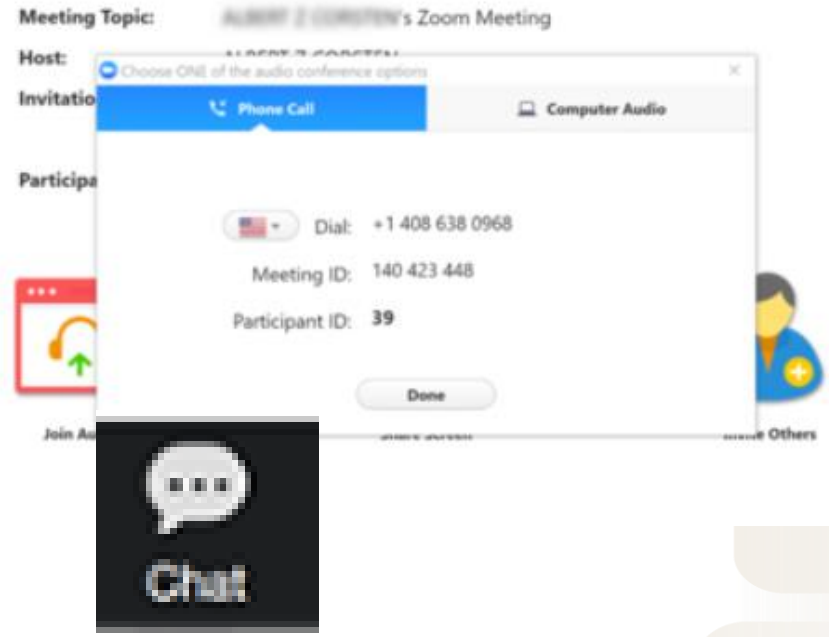
Housekeeping

This session is being recorded.

For audio access, participants can either dial into the conference line or listen through your computer speakers.

You can submit questions by typing them into the chat box or using the Q&A panel.

Closed captioning can be accessed by turning on the closed captioning feature on the zoom dashboard.



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National Behavioral Health Network for Tobacco & Cancer Control

- Jointly funded by CDC's *Office on Smoking & Health & Division of Cancer Prevention & Control*
- Provides resources and tools to help organizations reduce tobacco use and cancer among individuals experiencing mental health and substance use challenged
- 1 of 8 CDC National Networks to eliminate cancer and tobacco disparities in priority populations

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National Behavioral Health Network for Tobacco & Cancer Control from National Council for Mental Wellbeing

National Behavioral Health Network for Tobacco & Cancer Control

Learning Agenda

National Behavioral Health Network
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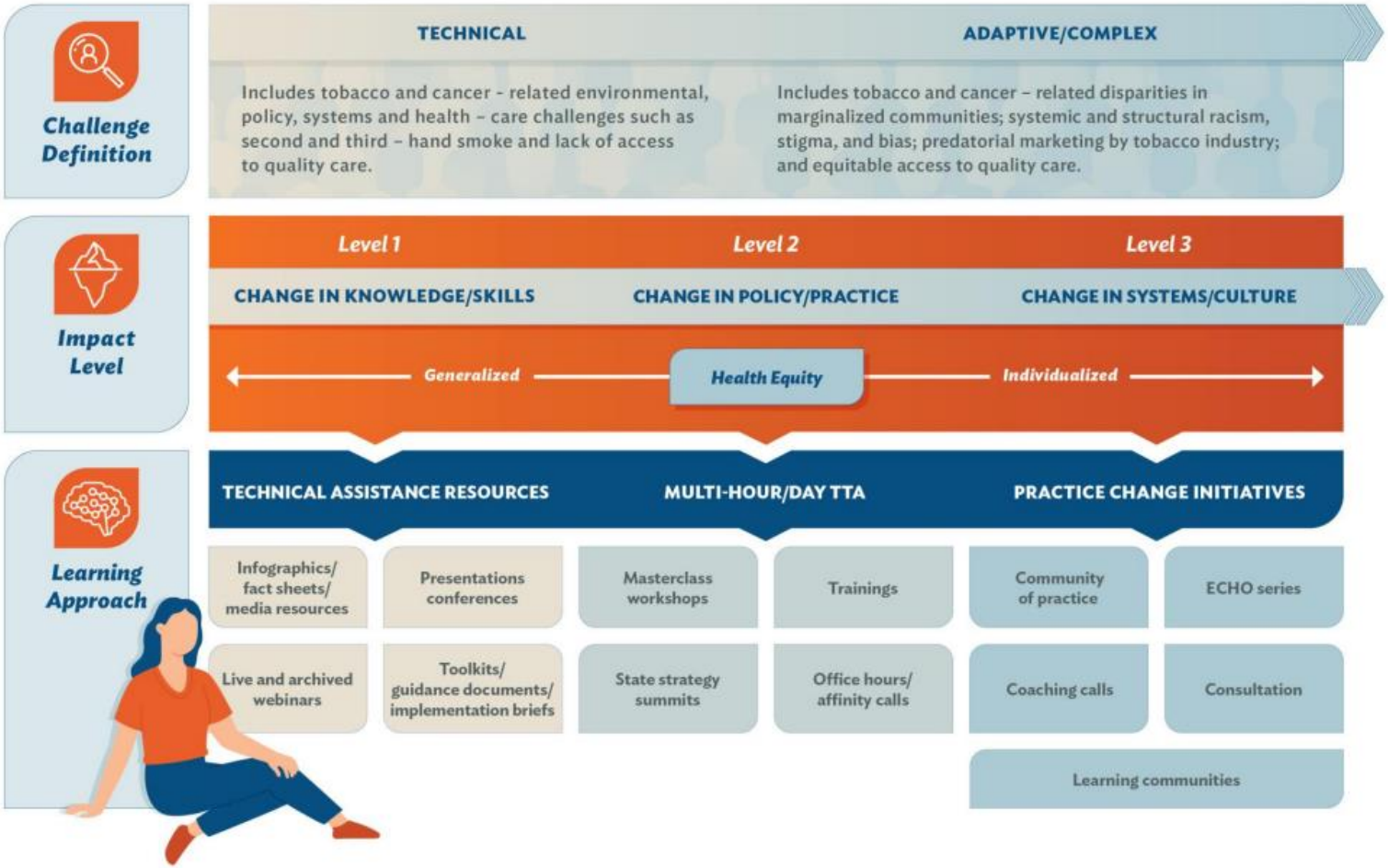

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NBHN's learning agenda is designed to advance health equity by...

- Reducing tobacco and cancer-related disparities among individuals with mental health and substance use challenges.
- Addressing social and political that influence tobacco and cancer-related disparities.
- Strengthening, supporting and mobilizing communities and partnerships in tobacco control, cancer control and behavioral health.
- Building, championing, and implementing tobacco-free policies, plans and laws.
- Improving the availability, accessibility and effectiveness for cessation and counseling services.
- Implementing trauma-informed resilience oriented prevention and cessation messaging.
- Building a diverse and skilled tobacco control, cancer control and behavioral health workforce.
- Promoting the improvement, access, and utilization of tobacco, cancer and behavioral health data.

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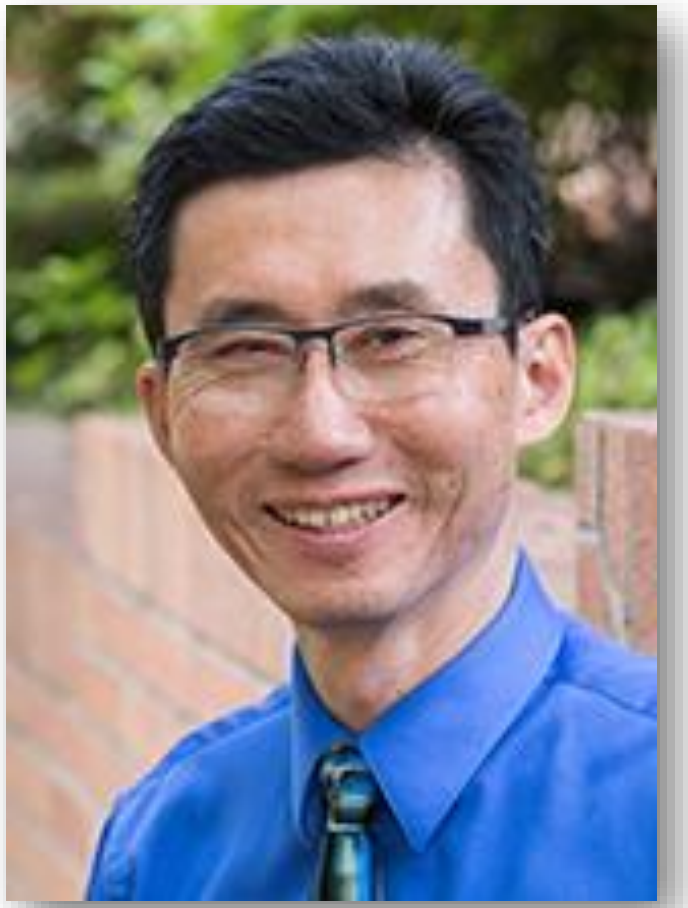
Cancer and Mental Wellbeing Education Training Series

Goal: Identify opportunities across multiple levels to address cancer-related disparities among individuals with mental health and substance use challenges.



Today's Featured Speaker

Jesse Fann, MD, MPH

Professor, Department of Psychiatry and Behavioral Sciences

Mark N Tabbutt Endowed Professorship for Education in Brain Health

Director, Clinician Scientist Training Program

Adjunct Professor, Rehabilitation Medicine and Epidemiology

University of Washington

Medical Director, Psychosocial Oncology,

Fred Hutchinson Cancer Center

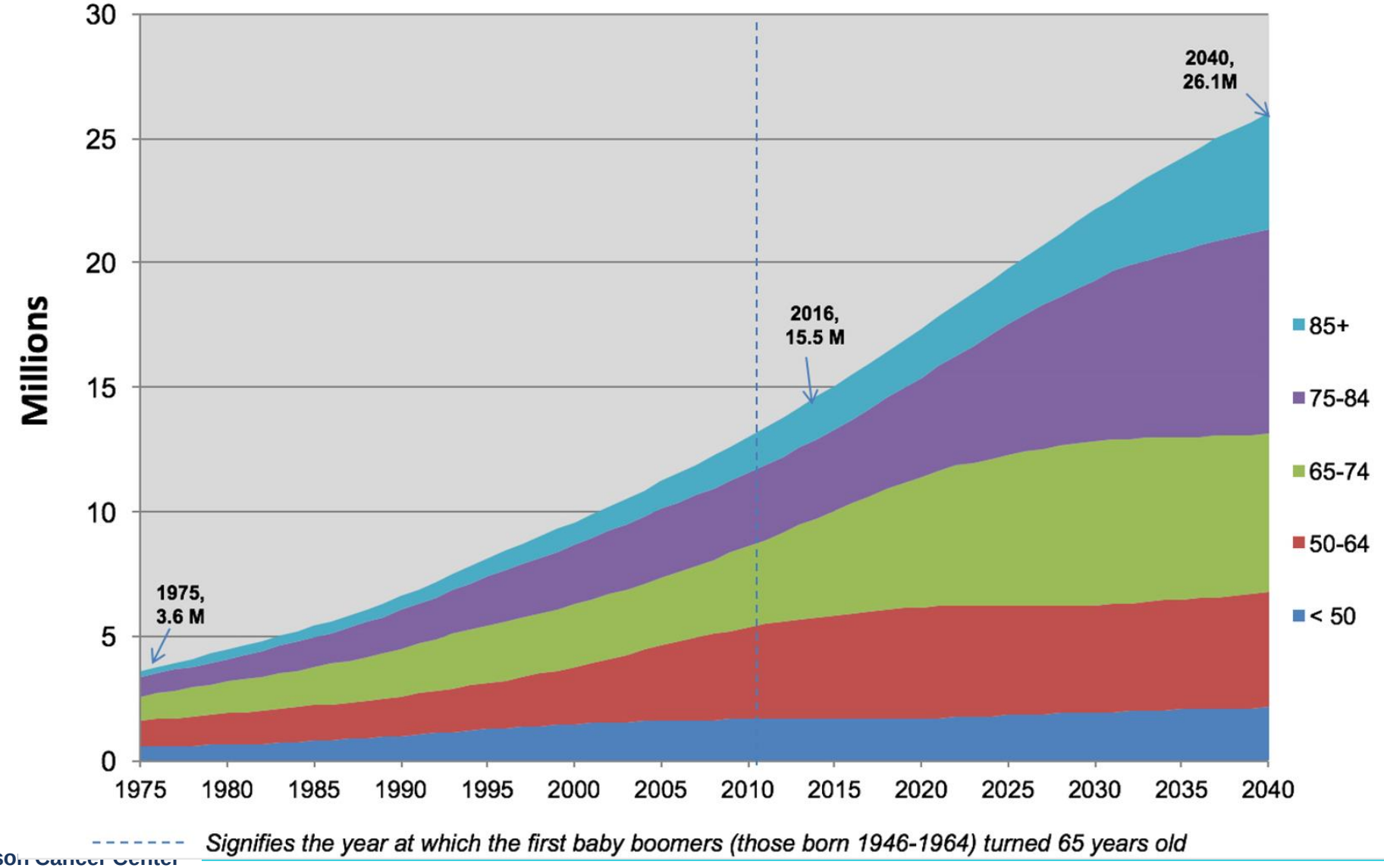
A Collaborative Care Approach to Delivering Population Based Integrated Psychosocial Oncology Care

Jesse Fann, MD, MPH
Professor, Department of Psychiatry and Behavioral Sciences
Mark N Tabbutt Endowed Professorship for Education in Brain Health
Director, Clinician Scientist Training Program
Adjunct Professor, Rehabilitation Medicine and Epidemiology
University of Washington
Medical Director, Psychosocial Oncology, Fred Hutchinson Cancer Center

Objectives

1. Examine barriers to psychosocial cancer care for individuals with mental health & substance use challenges
2. Learn how to integrate patient-centered psychosocial care into routine cancer care
3. Explore the collaborative care model as a strategy to support individuals with cancer and mental health & substance use challenges

Estimated Cancer Prevalence by Age In



Bluethmann et al, 2016

Sources / Types of Distress

(occurs on a continuum)

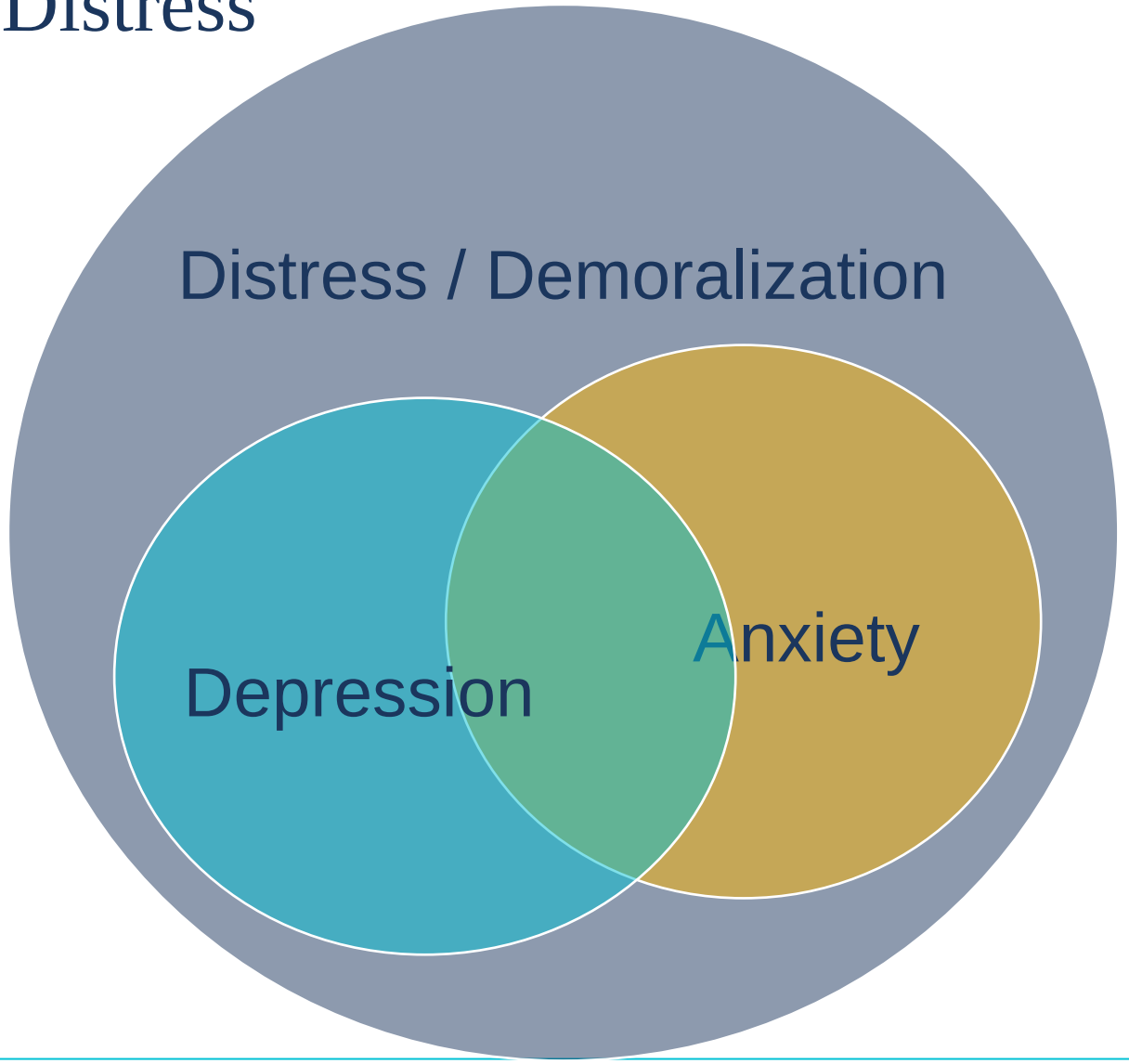
Practical

Family

Cognitive

Emotional

Financial



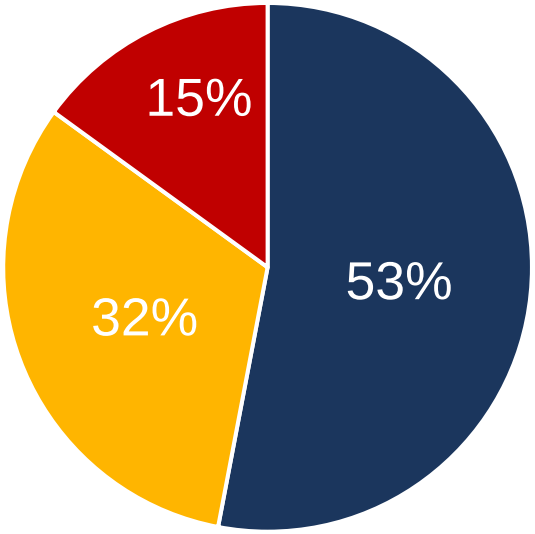
Spiritual

Social

Physical

Vocational

Mental Health Conditions & Cancer



- No disorder
- Adjustment d/o
- Major Dx

e.g., Suicidal, Major Depression, Panic Disorder, PTSD, Substance Abuse, Delirium, Dementia

Significantly increased rates of Depression & Anxiety during COVID pandemic

Derogatis et al, JAMA 1983; Pirl, Fann, Greer et al, Cancer 2014

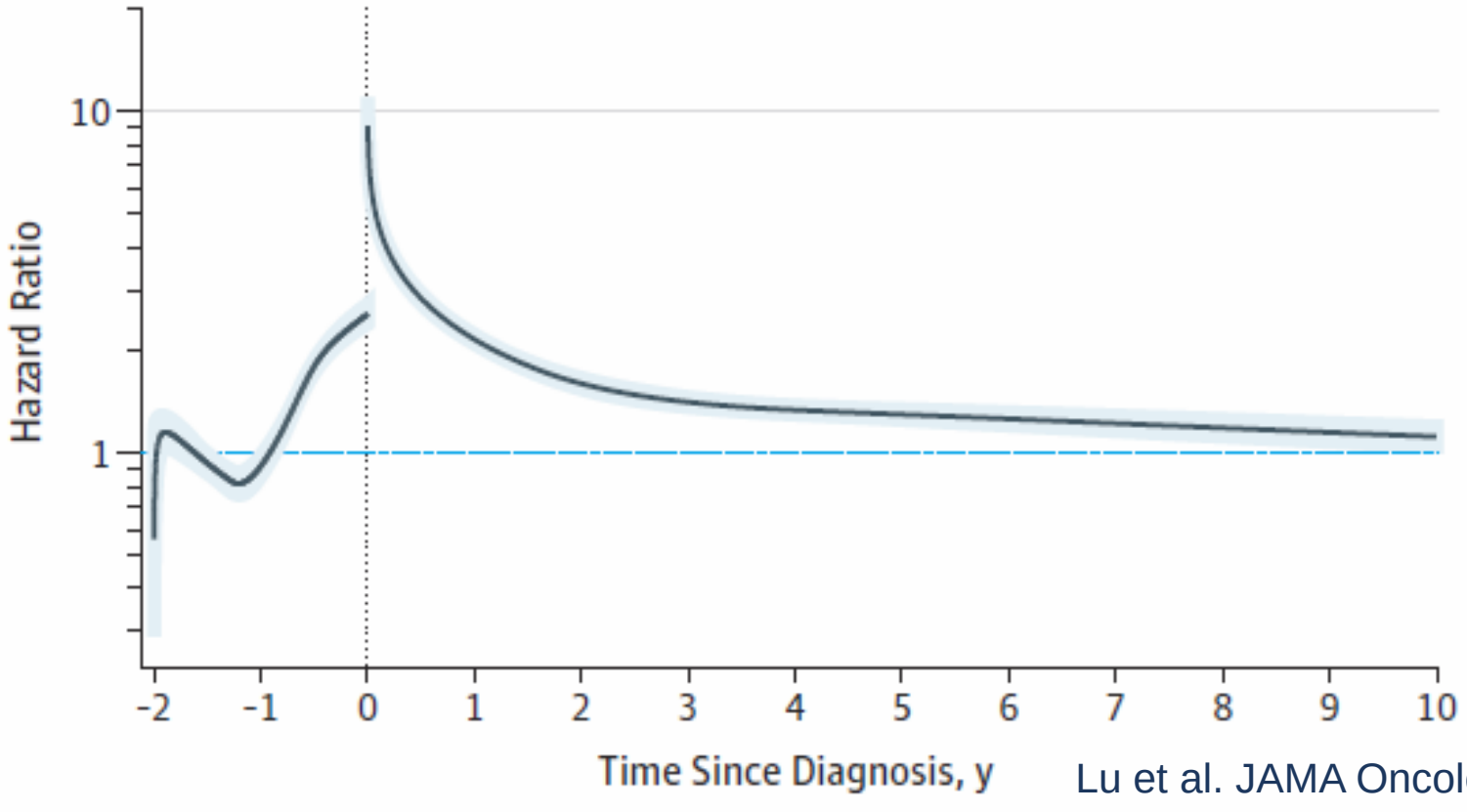
Impact of Distress

Associated with:

- Poor adherence & ability to complete cancer Tx
- Poor tolerance of aversive symptoms (e.g., nausea)
- Poor health behaviors, satisfaction with medical care
- Decreased functioning, family cohesion and QOL
- More cognitive and somatic complaints (e.g., pain, fatigue, sexual dysfunction)
- Longer hospital lengths of stay, higher health care utilization
- More frequent requests for hastened death
- Increased risk of suicide
- Higher mortality

Mental Health Conditions Before & After Cancer Dx

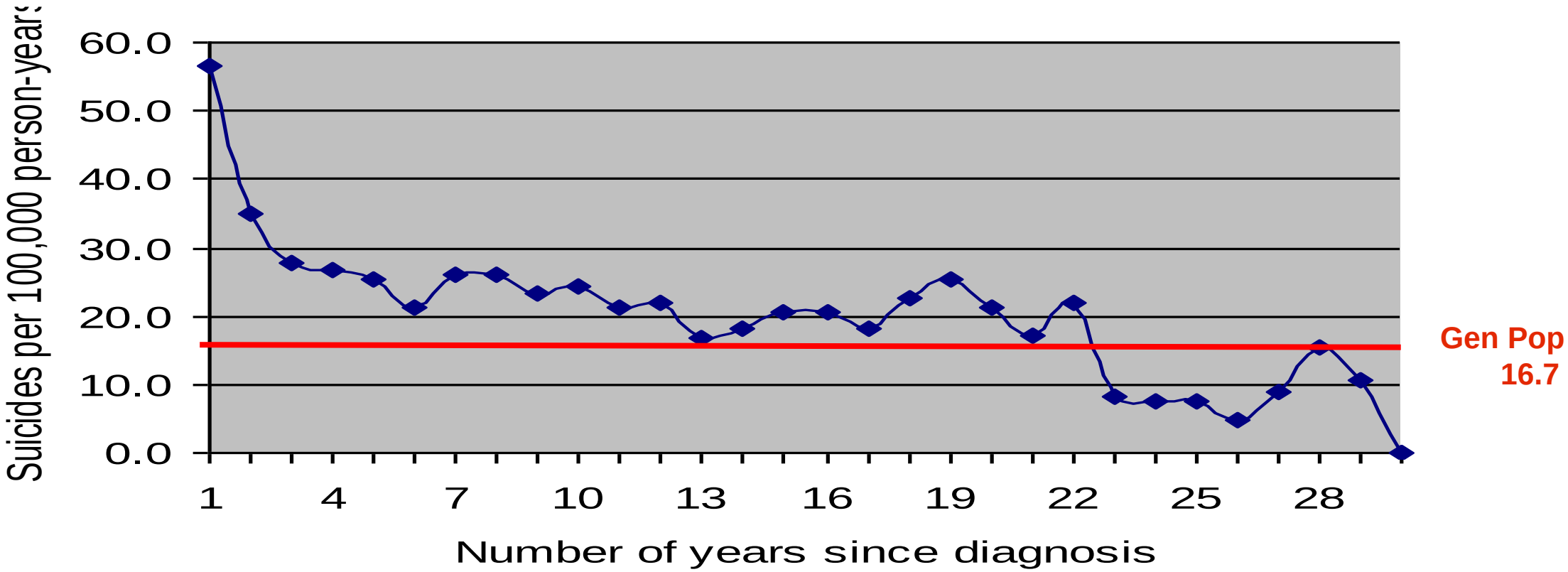
Figure 1. Hazard Ratios and 95% CIs of Depression, Anxiety, Substance Abuse, Somatoform/Conversion Disorder, and Stress Reaction/ Adjustment Disorder Before and After Cancer Diagnosis in a Matched Cohort Study in Sweden, 1999 to 2010



Lu et al. JAMA Oncology 2016

Suicide Rates after Cancer Diagnosis

People with cancer have 2x the rate of completed suicides



Misono, Weiss, Fann, et al. J Clin Oncol 2008

Suicide rates by tumor site

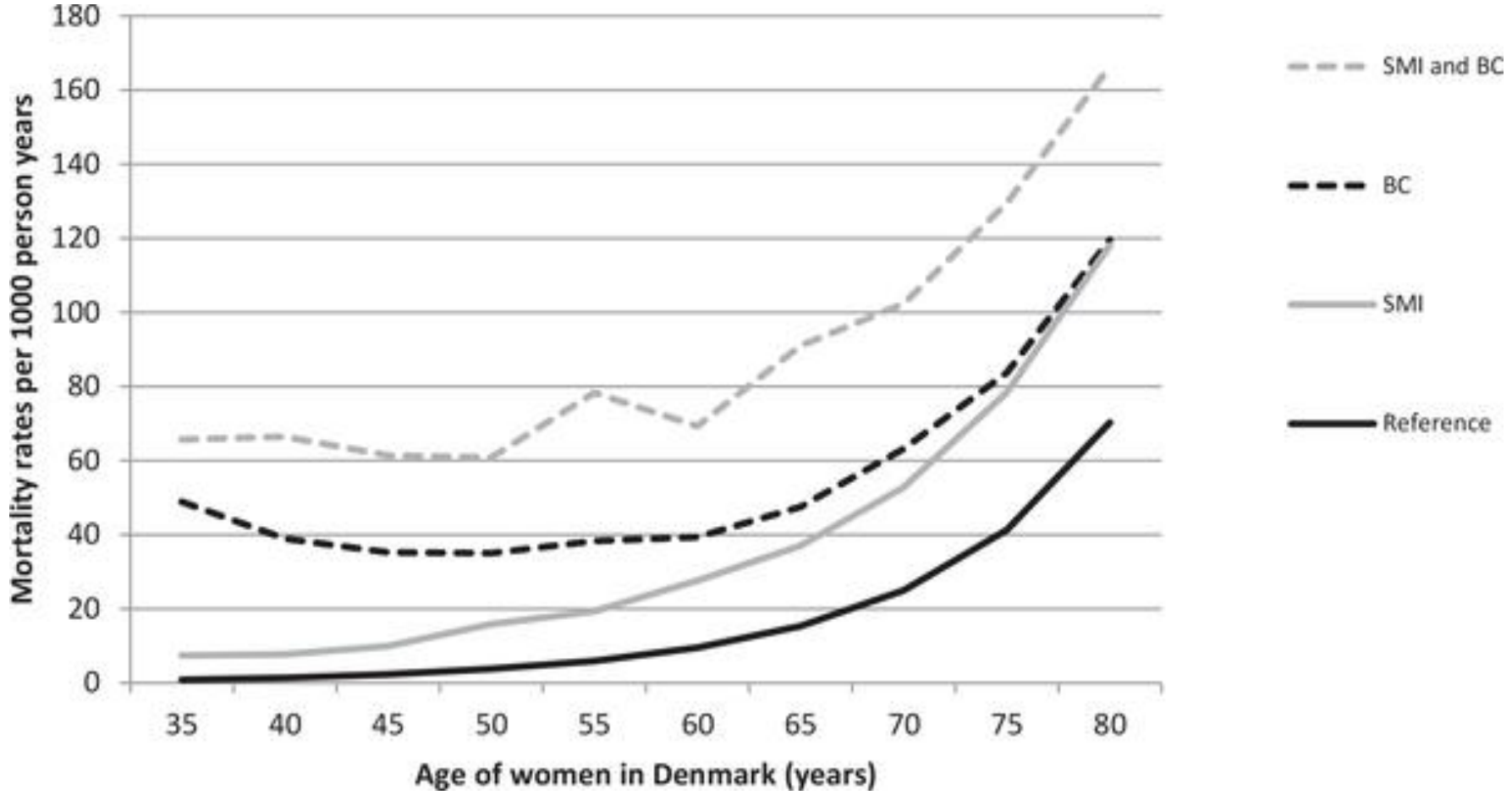
SEER Registry: 5,838 suicides / 18.6 million person-years

Group	Rate[1]	SMR[2]
US General Population	**15.8**	**1**
SEER	**32.4**	**2.06**
Lung & Bronchus	81.7	5.74
Stomach	71.7	4.68
Oral cavity & Oropharynx	53.1	3.66
Larynx	46.8	2.83

[1]Per 100,000 person-years [2]SMR=Standardized Mortality Ratio

Misono, Weiss, Fann, et al, JCO 2008

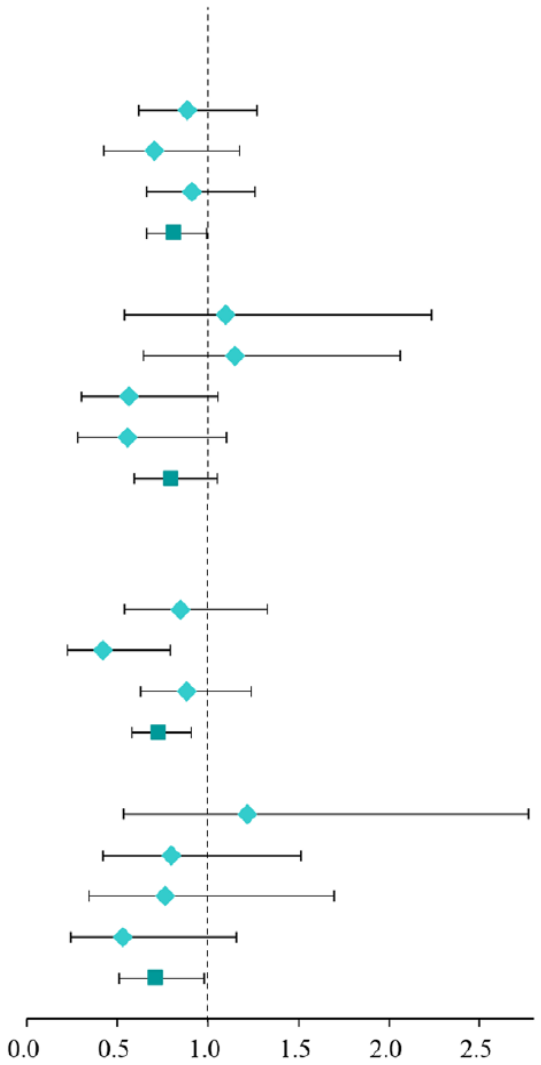
All-cause mortality rates for women with Serious Mental Illness (SMI) and Breast Cancer (Denmark, 1980–2011).



Ribe et al, PLoS One 2016

Mortality Associated with Receiving Psychiatric Tx within 30 Days from Psychiatric Dx in Cancer Pts

Variables	Adjusted hazard ratio	95% CI	*p* value
All-cause mortality			
Men			
Gastric cancer	0.88	(0.62–1.27)	.5023
Colorectal cancer	0.70	(0.42–1.17)	.1742
Lung cancer	0.91	(0.66–1.26)	.5629
Total	0.81	(0.66–0.99)	.0376
Women			
Breast cancer	1.09	(0.54–2.23)	.8054
Gastric cancer	1.15	(0.64–2.06)	.0715
Colorectal cancer	0.56	(0.30–1.05)	.6423
Lung cancer	0.55	(0.28–1.10)	.0908
Total	0.79	(0.59–1.05)	.1063
Cancer-related mortality			
Men			
Gastric cancer	0.85	(0.54–1.33)	.4719
Colorectal cancer	0.42	(0.22–0.80)	.0076
Lung cancer	0.88	(0.63–1.24)	.4723
Total	0.73	(0.58–0.91)	.0051
Women			
Breast cancer	1.22	(0.54–2.77)	.6372
Gastric cancer	0.80	(0.42–1.51)	.5077
Colorectal cancer	0.76	(0.34–1.70)	.4904
Lung cancer	0.53	(0.25–1.16)	.1123
Total	0.71	(0.51–0.98)	.0393



Korean National Health Insurance Claims Data (N=1,025,340)

Lee et al, Oncologist 2020

Antidepressant Adherence & Mortality (Nationwide Israeli cohort study)

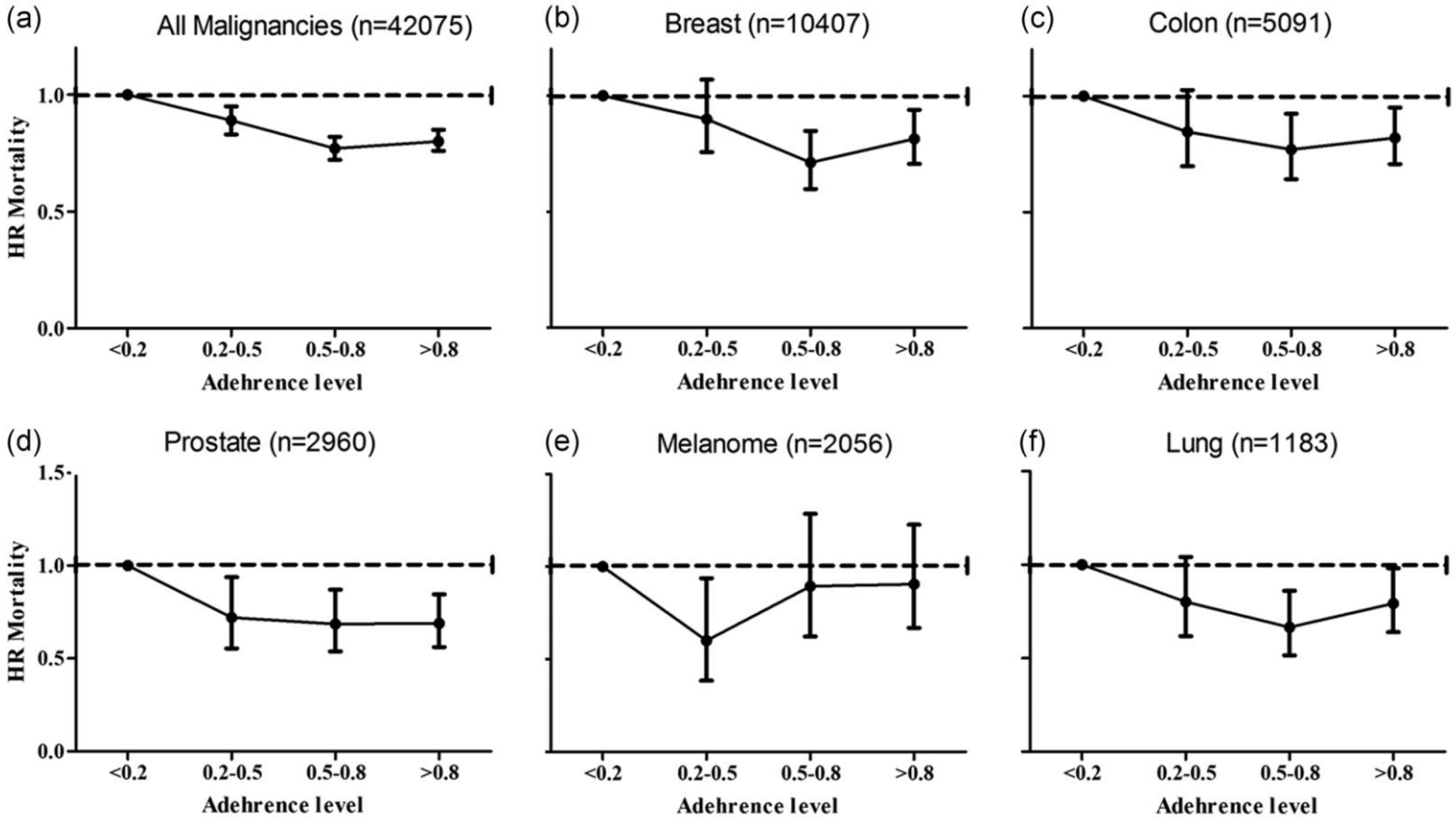


FIGURE 1 Relative hazard ratios (HR) for mortality by adherence level during 4 years follow-up. (a) All malignancies, $n = 42{,}075$). Nonadherence level (<20%) serves as the reference. The model is based on the Cox multivariate survival model adjusted for gender, age, smoking, socioeconomic status, and Charlson's comorbidity index. Each box (b–f) represents subpopulation with specific cancer type

Shoval et al, Depress Anxiety 2019

Depression and healthcare utilization in patients with cancer

- 5,055 cancer patients, 561 with depression dx.
- Depressed patients:
  - Had more annual non-MH healthcare visits
    (aRR = 1.76, 95% CI = 1.61–1.93)
  - Were 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)
- Increased ORs when comorbid with Anxiety
- More MH visits assoc. w/ lower healthcare costs

adjusting for age, gender, race/ethnicity, insurance type, medical comorbidities, length of time with cancer, and metastatic status

Mausbach et al, 2017, 2018, 2020

Screening for Distress is only the first step…

“You can’t fatten a cow by weighing it”

- Proverb

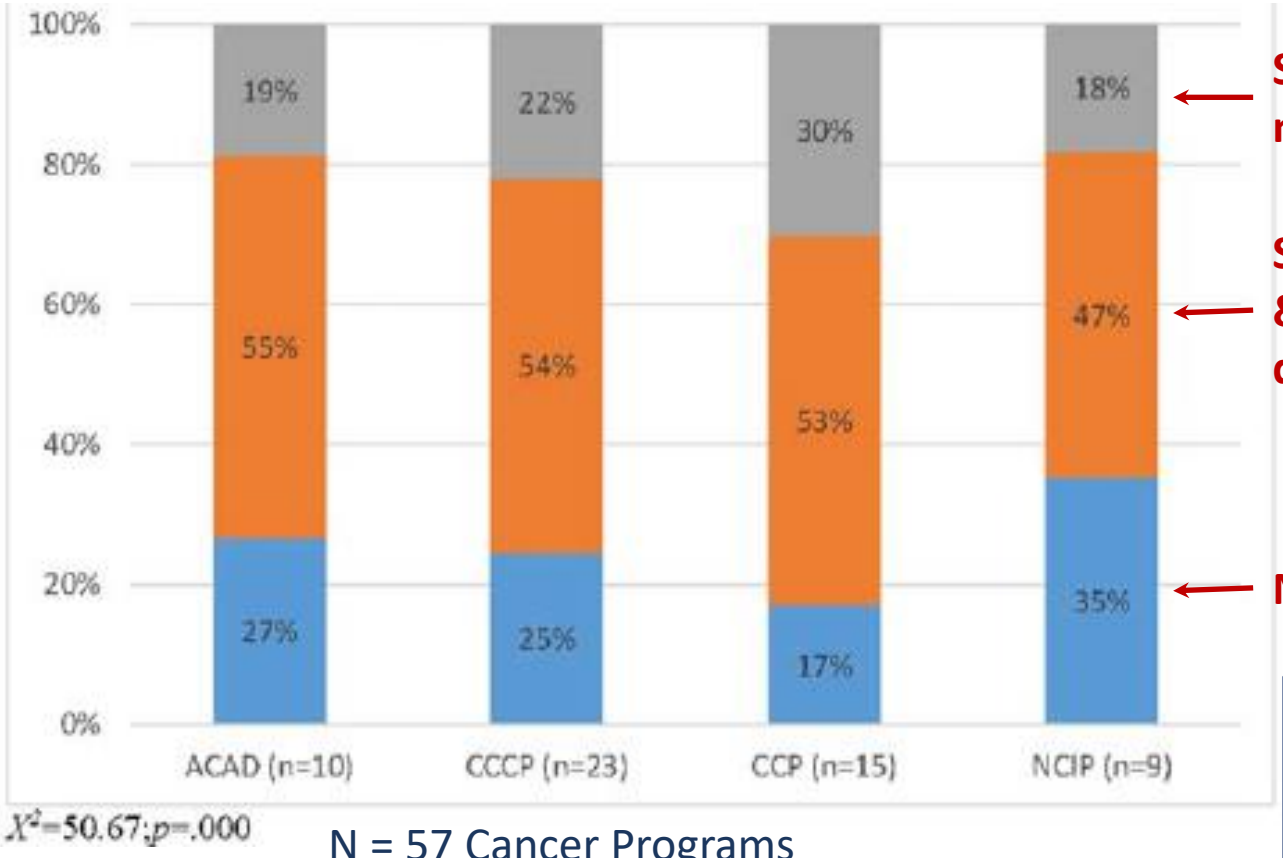
Approaches that we know *Don't Work*

- 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

Meijer et al, 2011, 2013; McCarter et al, BMJ Open 2018; Carlson et al, J Clin Oncol 2010; Hollingworth et al, J Clin Oncol 2013 ; Forsythe et al, J Clin Oncol 2013

Psychosocial Tx Plan Follow-ups, Re-evaluations, & Adjustments



Structure to manage Pts needing Tx adjustment

Systematic F/U completed & documented

No process in place

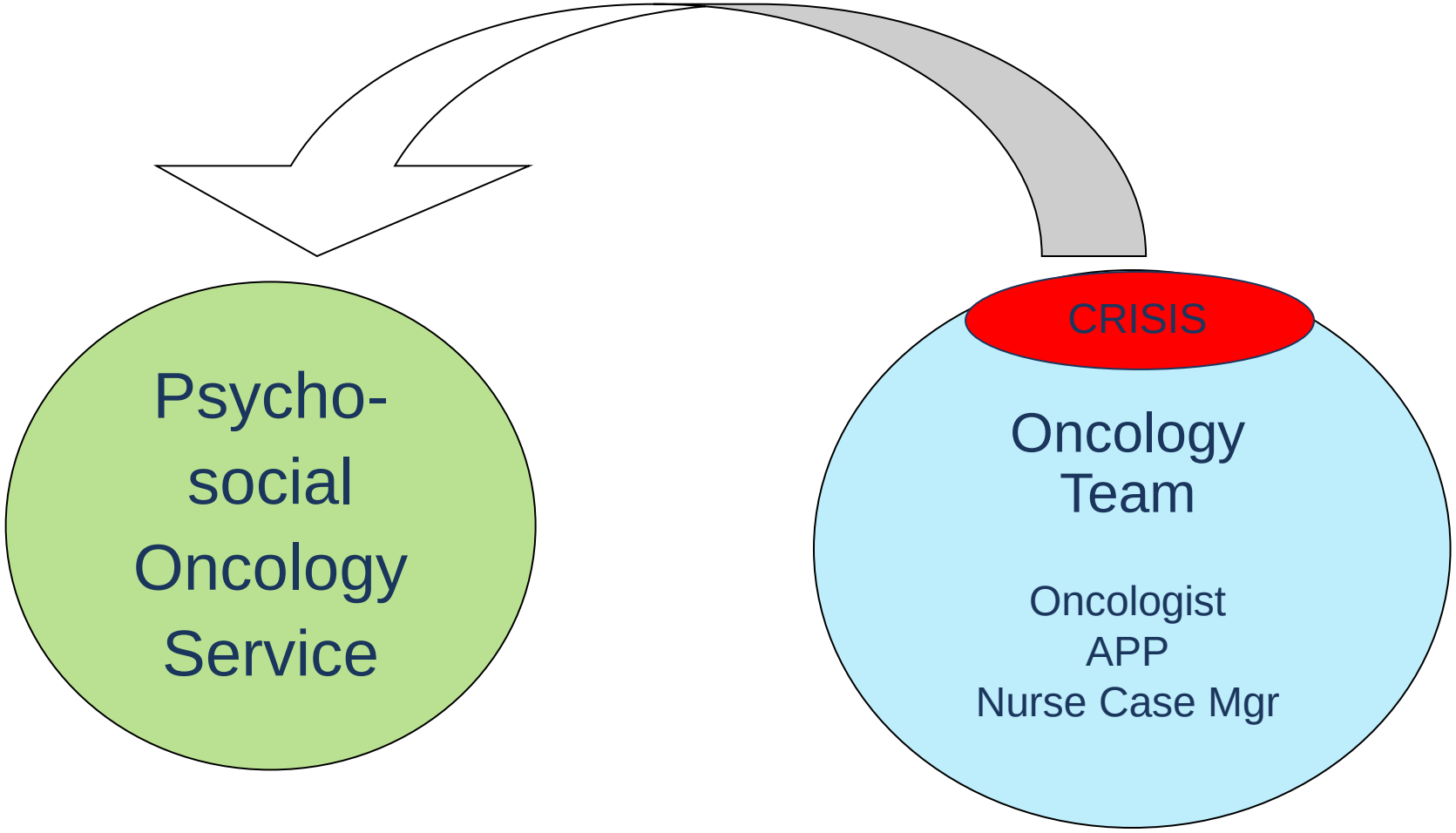
N = 57 Cancer Programs

ACAD	Academic Comprehensive Cancer Program
CCCP	Comprehensive Community Cancer Program
CCP	Community Cancer Program
NCIP	NCI-designated Program

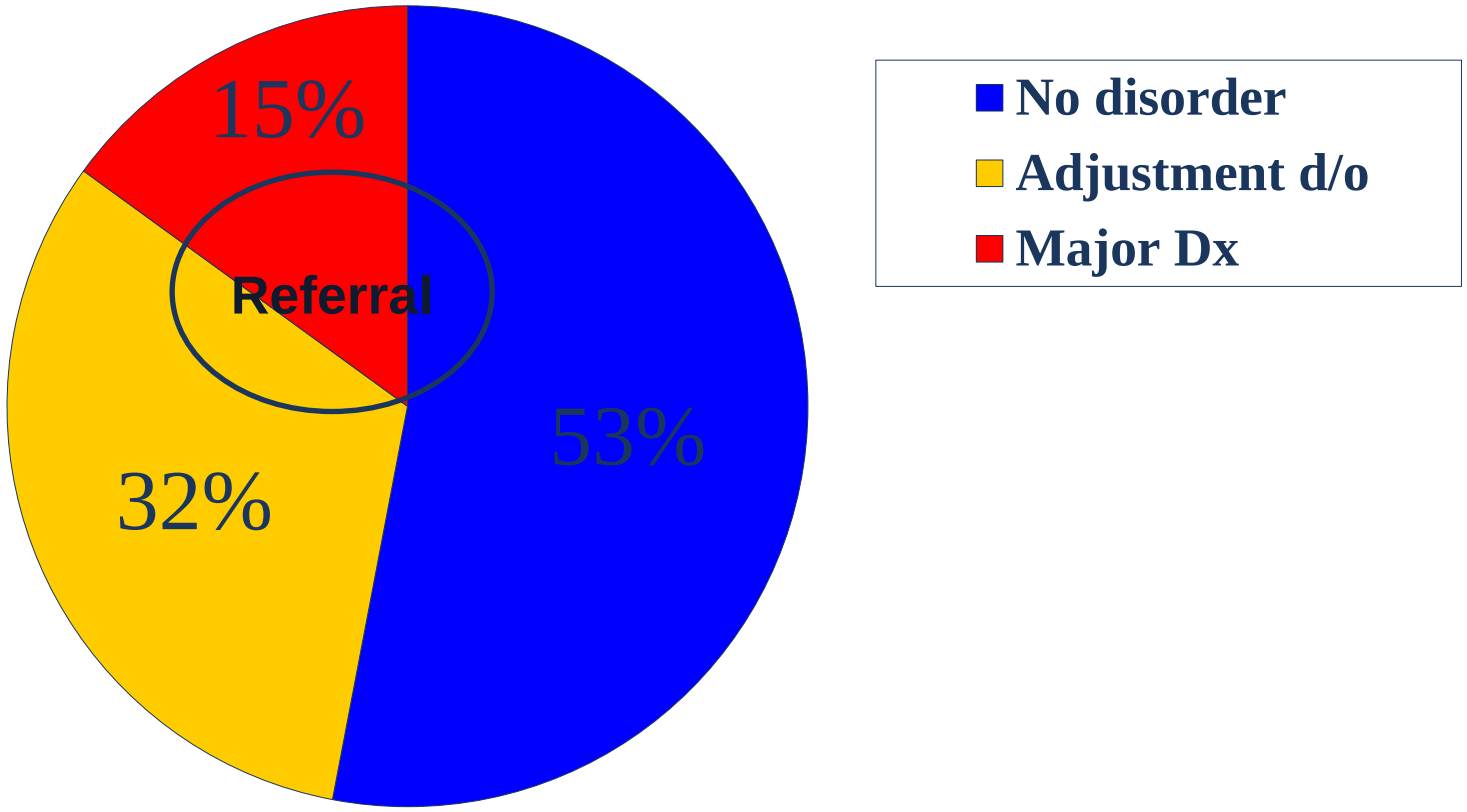
Protocol adherence assoc. w/ 18-19% fewer ED visits & hospitalizations

Zebrack et al, 2016, 2017

Traditional Referral Model



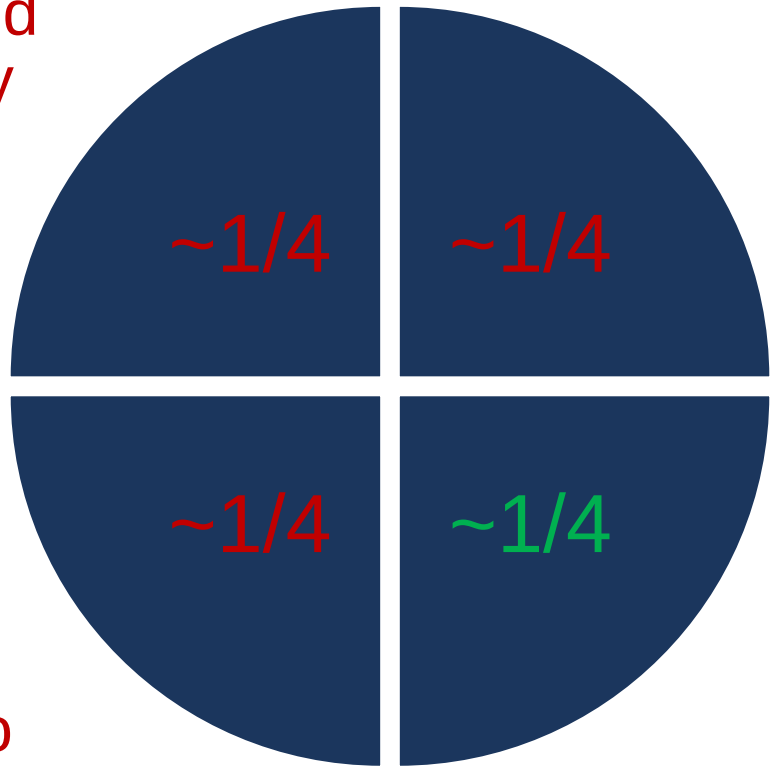
What's the Population Impact?



Derogatis et al, JAMA 1983

Limits of Traditional Referral to treat clinically significant distress

Not recognized or effectively engaged in care



Stay on ineffective treatments for too long

Drop out of treatment too early

Effectively treated

Young et al, 2001, 2008; Walker et al, 2014; Alwhaibi et al, 2017

Behavioral Health and Cancer Care

An evolving relationship

Referral / Consultative Model

- BH providers see patients in consultation ‘when needed’

Co-located Model

- BH providers see patients in oncology setting

Integrated Model

- BH providers work together to take responsibility for a caseload of patients and work closely with oncology providers

What is Collaborative Care?

It is *NOT* just…

- Co-located care
- Deciding to work closely together
- Communicating well with each other
- Copying providers on EHR notes
- Attending rounds & case conferences

Key Principles of Collaborative Care
Based on >90 Randomized Controlled Trials

Population-Based Care

- Builds on Universal Distress Screening

Patient-Centered Team Care

- Coordinated by Care Manager, focus on shared decision making

Measurement-Based, Treatment to Target

- Track outcomes & adherence, electronic registry

Evidence-Based Stepped Care

- Weekly psychiatric caseload review/consultation

Accountable Care

- Transparency, everyone is accountable

aims.uw.edu
Bao et al, 2016
Archer et al, 2012
Thota et al, 2013
Huffman et al, 2014
Beach et al, 2015

CoCM 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
  - Dementia
  - Serious Mental Illness
  - Substance abuse
  - Pain
  - Postconcussive disorder

Huffman et al, Psychosomatics 2013; Panagioti et al, JAMA Psychiatry 2016

Meta-Analysis of Collaborative Care for Depression in Cancer

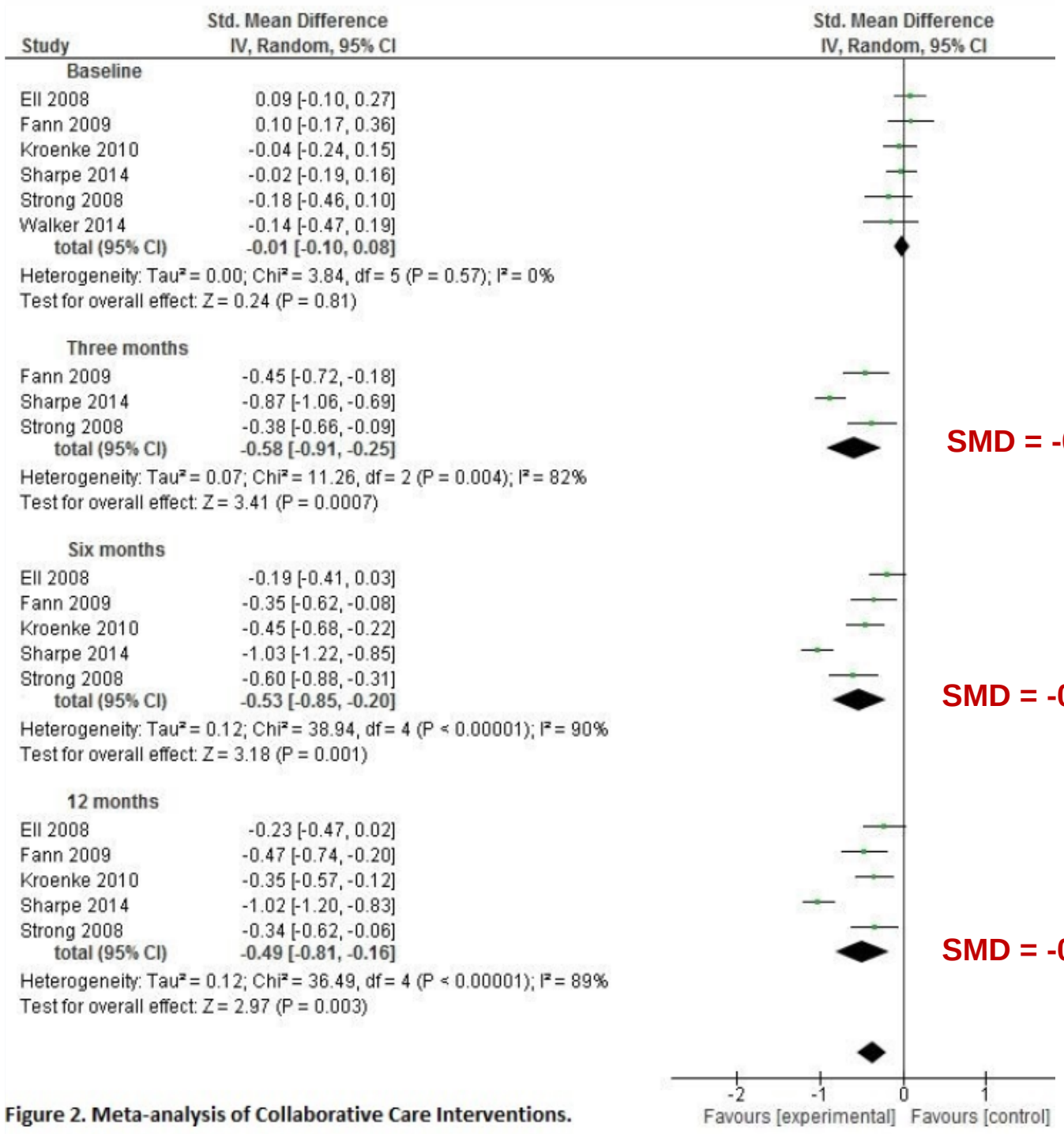


Figure 2. Meta-analysis of Collaborative Care Interventions.

SMD = -0.58

SMD = -0.53

SMD = -0.49

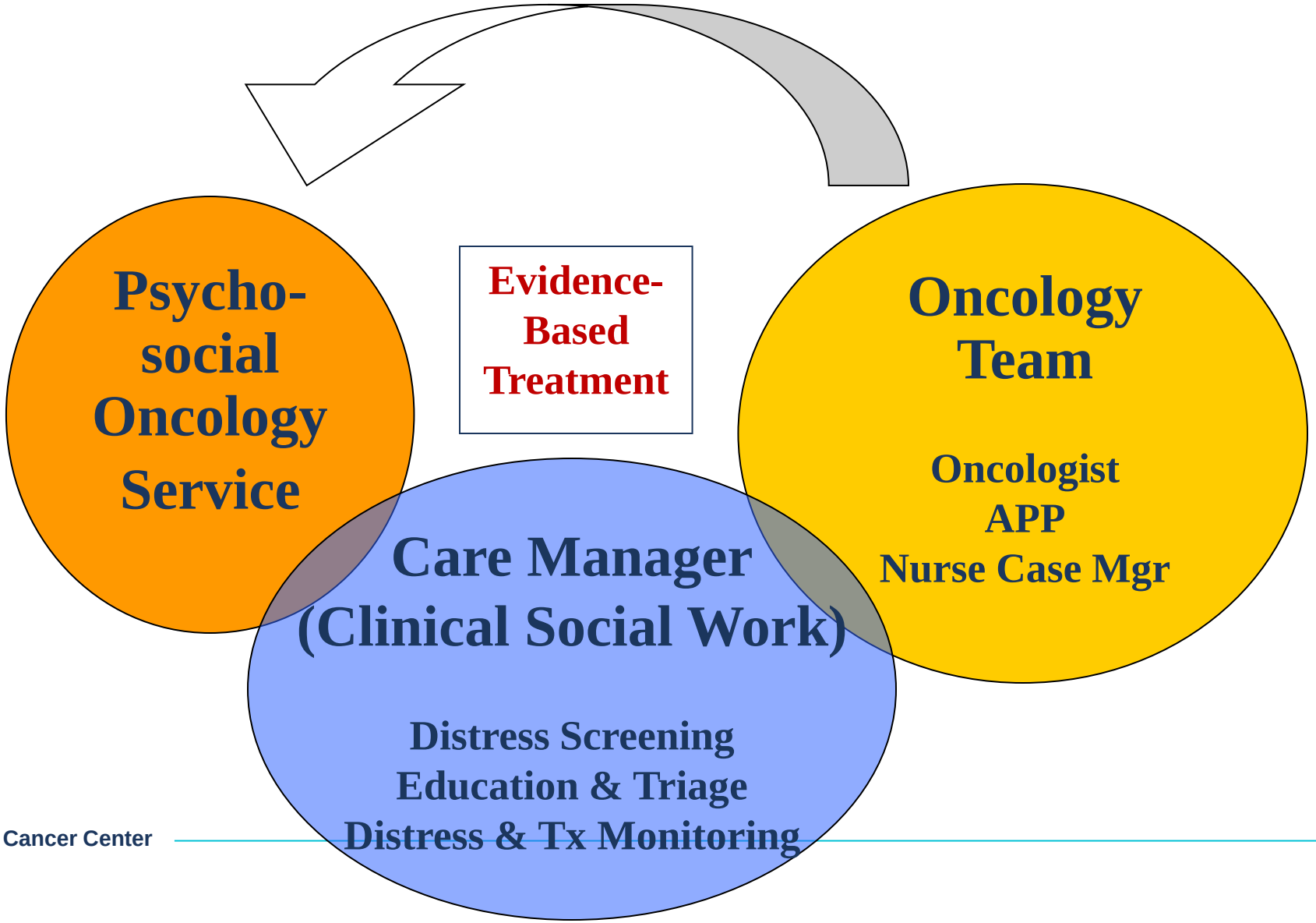
Li et al, Psycho-Oncology 2017

Department of Psychosocial Oncology

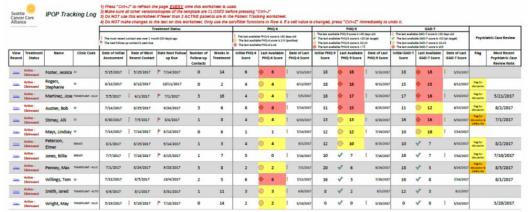
Fred Hutch Cancer Center

- **Integrated, team-based, collaborative care model -** since 2010
- **Psychiatry/Psychology**, **Social Work** and **Patient Navigation** are:
  - Critical components of the **continuum of psychosocial determinants of health**
  - Closely aligned in their goals & interventions to **decrease psychosocial distress and barriers to health**
  - Interdependent components of our **stepped care model**
  - Addresses full spectrum of **tangible needs** & **clinical needs**

Integrated Psychosocial Oncology



Integrated Psychosocial Oncology Program (IPOP)



Endorse & Facilitate Psychosocial Care

Interact as needed for complex cases

Oncology Providers

Psychiatrist / Psychologist

Patient & Caregiver

Weekly caseload review
Treatment adjustments

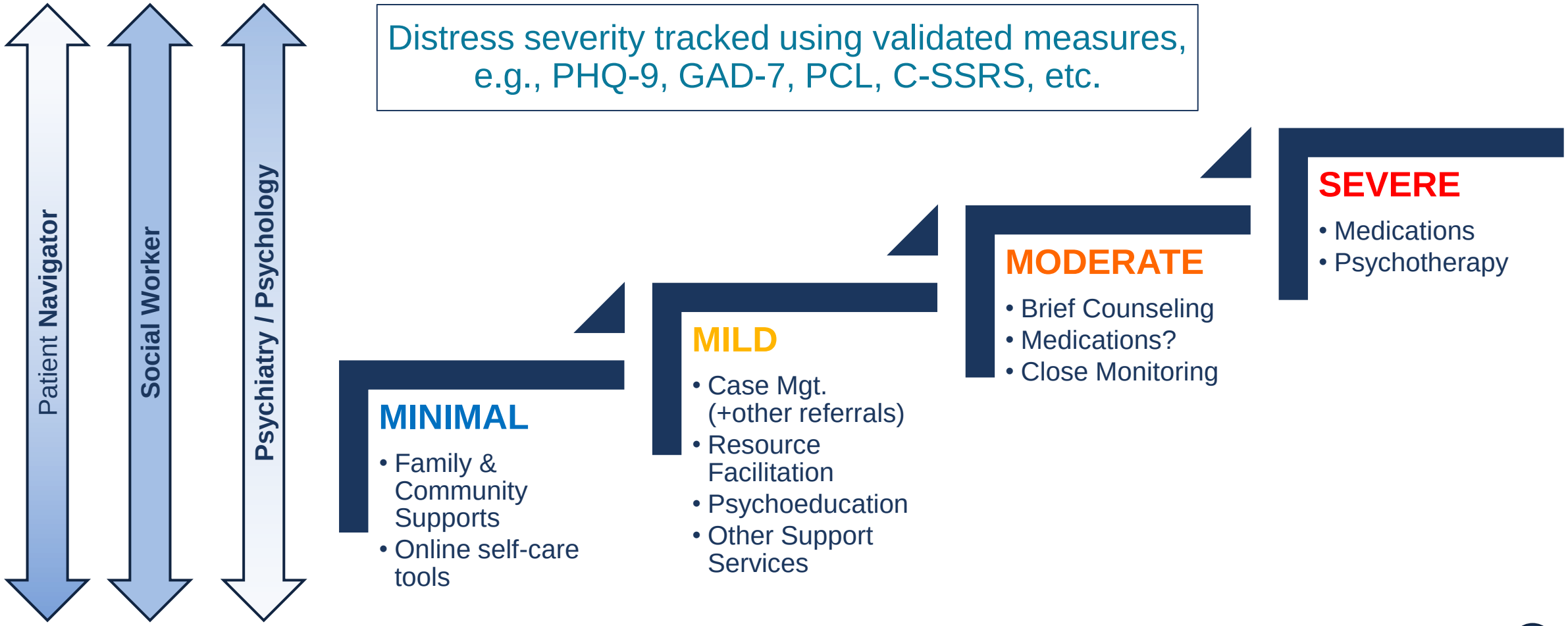
Care coordination
Feedback to Team

Engage in Care, Monitor PROs,
Motivate Tx adherence
Behavioral: Provide brief evidence-based Tx
Medical: Shared decision-making,
Monitor & Communicate Tx response

Social Worker

Fann, Ruark, Sharpe, Textbook of Psycho-Oncology 2021

Stepped Psychosocial Care



Fann, Ell, Sharpe, J Clin Oncol 2012; Courtnage, Bates, Armstrong et al, Psycho-Oncology 2020

Common Reasons for Referral

Tangible Needs: Pt Navigators

- Housing
- Transportation
- Financial assistance
- Insurance questions (partner with Patient Financial Svc.)
- Employment concerns
- Cultural concerns (need for cultural liaison between patient & oncology team)

Clinical Needs: Social Work and/or Psych

- Suicidal thoughts
- Depression, grief
- Anxiety, panic
- PTSD
- Insomnia
- Fatigue
- Cognitive deficits, confusion
- Substance use
- DWD / end of life issues
- Non-adherence
- Behavioral challenges
- Decisional capacity
- Body image / sexuality

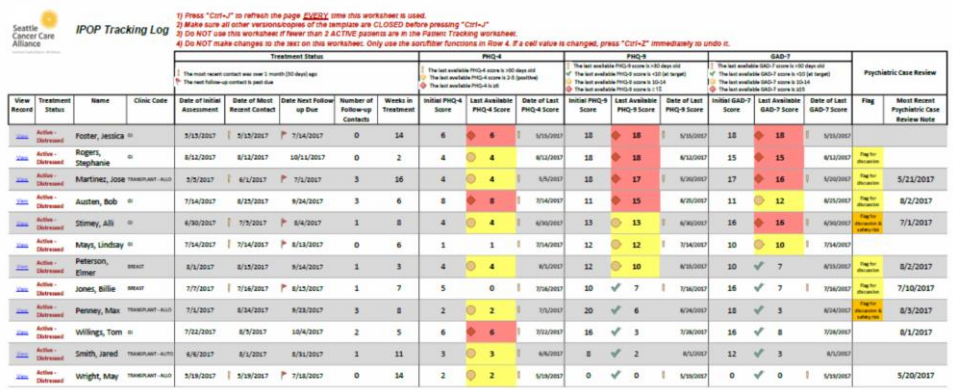
Clinical Social Work Role in Collaborative Care

- Provide brief evidence-based counseling to patients and loved ones
- Administer distress screening using validated instruments
- Support psychotropic medication management
- Care coordination for psychosocial distress/mental illness during cancer treatment
- Provide coordination for patients and providers throughout DWD process
- Refer to psychiatry or psychology for specialty mental health and substance use treatment
- Support patients considering fertility preservation
- Locate community resources to address concrete needs and refer to Fred Hutch Patient Navigators, as needed
- Staff support and Critical Incident Stress Debriefing

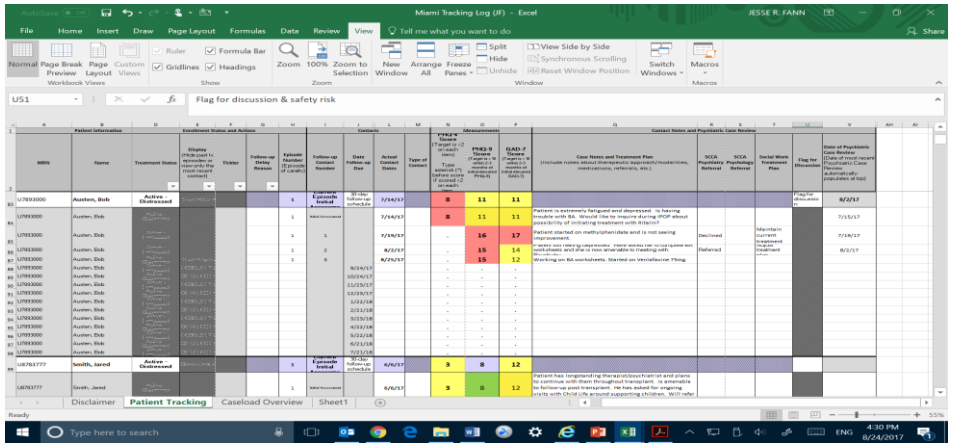
Monitor identification of distress and treatment adherence & outcomes

Care Manager Level

Caseload Overview

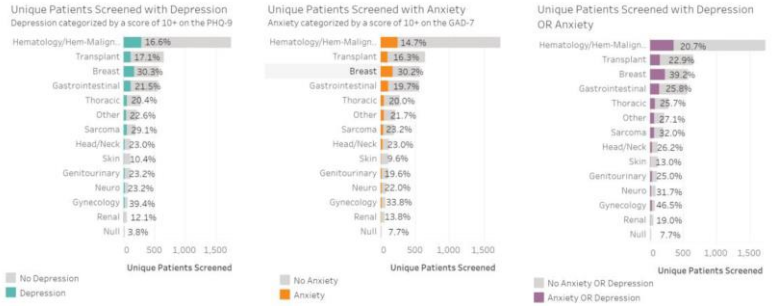


Individual Patient Tracking



Population Level

Distress Rates

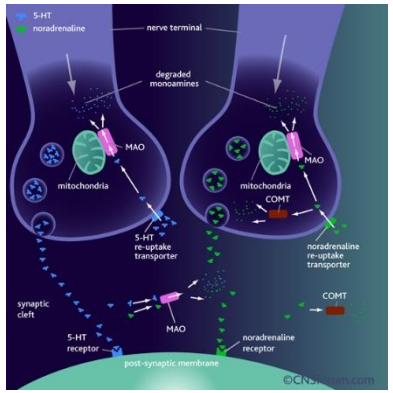


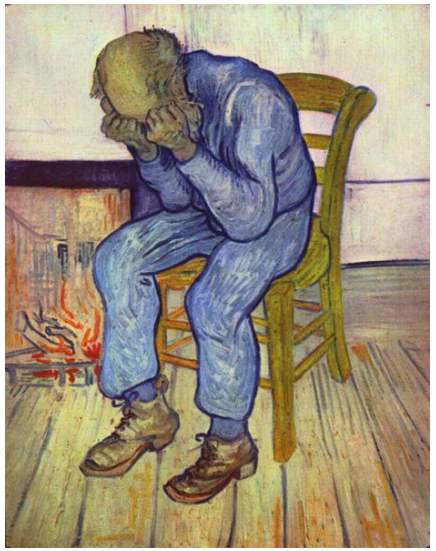
Clinical Outcomes

Tailoring Treatment

Depression/Anxiety

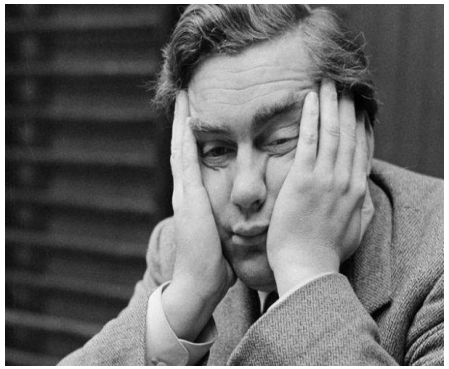
Neurobiological Factors





Cognitive Distortions

Isolation, Avoidance, Few Pleasant Activities



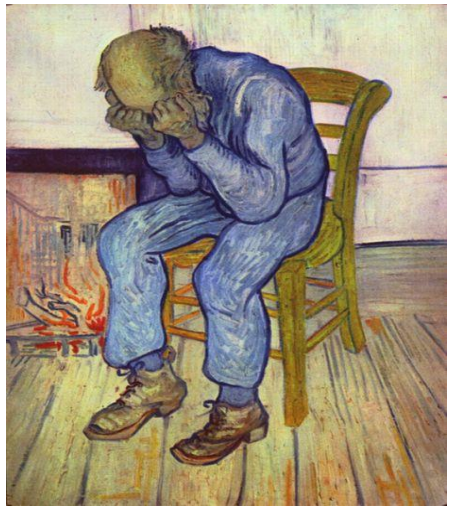
Psychosocial Adversity

Sedentary, Substances

Tailoring Treatment

Depression/Anxiety

Pharmacotherapy, Light, Neuromodulation



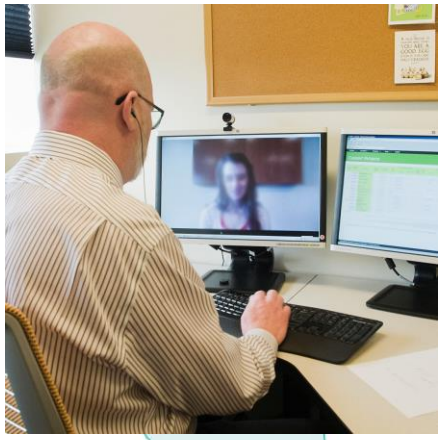
Cognitive Behavioral, Mindfulness Therapy

Behavioral Activation

Case Mgt., Social Support, Problem Solving Therapy

Motivational Interviewing, Exercise

IPOP Scalable using Telehealth



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CoCM Addresses Common Barriers

- **Effective in underserved and rural populations**
- **Increases Access & Engagement**
  - Social Workers quickly engage & assess patients
  - Psychosocial treatment gets started quickly
- **Improves Care Coordination & Follow-up**
  - Oncologists get input within hours/days vs. weeks/months
  - Electronic Tracking Log ensures monitoring of outcomes
- **Ensures Treatment Adjustments, when needed**
  - Measurement-informed treat-to-target (e.g., PHQ-9<10)
  - Make Tx recs per Clinical Practice Guidelines & Pathways
  - Psychiatrists/Psychologists focus in-person visits on the most challenging patients

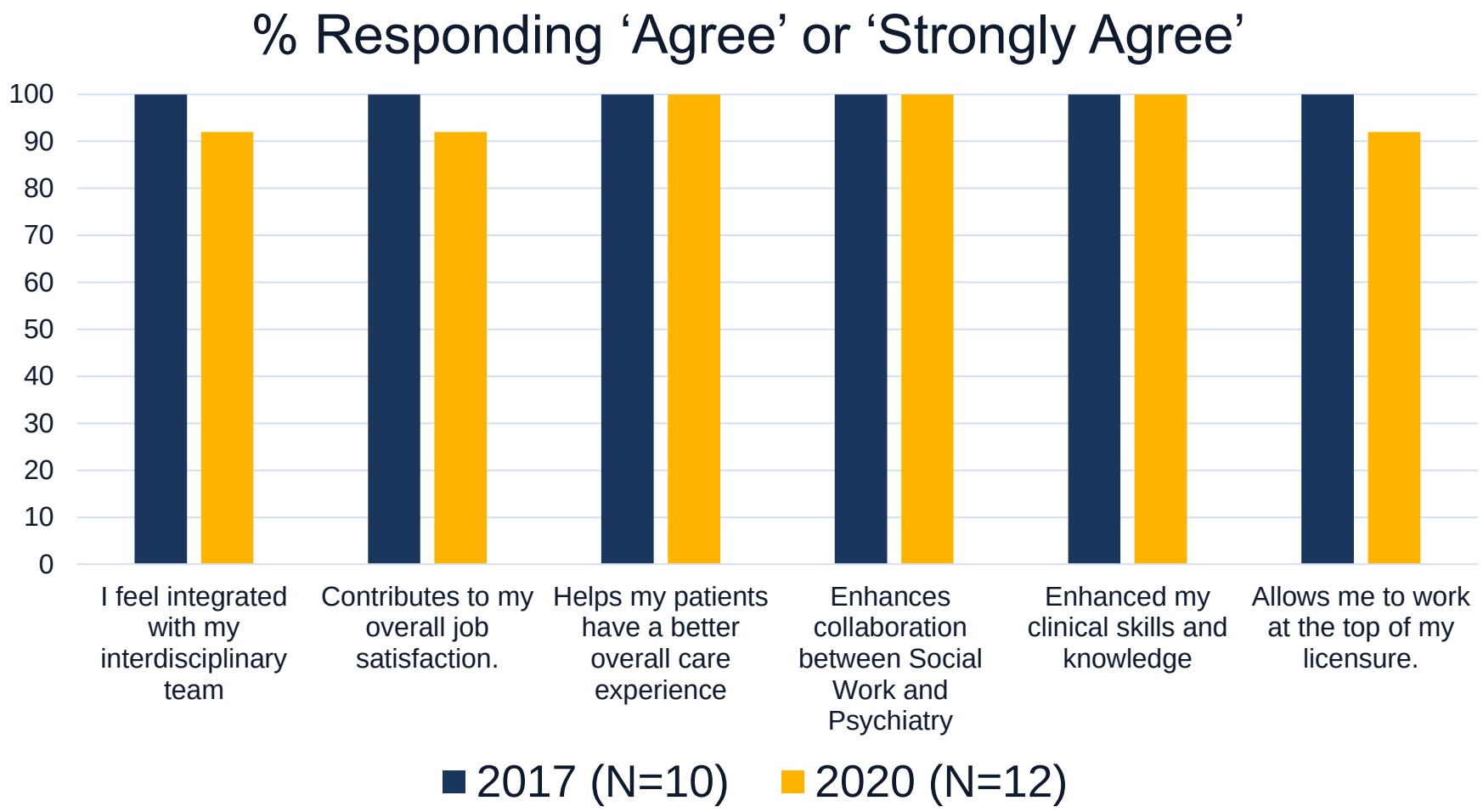
Fann, Ell, Sharpe, J Clin Oncol 2012;
Pirl, Greer, Wells-Di Gregoria et al, Psycho-Oncology 2020

CoCM is Sustainable

- **Flexible & Adaptable**
  - Enhances (vs. replaces) traditional referral model
  - Capitalizes on existing supportive care staffing
  - Can adapt to Patients' & Providers' preferences
- **Facilitates Value-based Accountable Care**
- **Cost-efficient** (Reimbursable with CPT codes)
  - Directs level of need to appropriate resources
- **Quality Improvement**
  - Consistent with QI models (e.g., Lean Six Sigma)
- **Provider Satisfaction**
  - Promotes teamwork, mutual support, & practice at top of license

Courtnage, Bates, Armstrong et al, Psycho-Oncology 2020;
Fann, Ruark, Sharpe, Textbook of Psycho-Oncology 2021

IPOP Social Work Satisfaction Survey



Courtnage, Bates, Armstrong et al, Psycho-Oncology 2020

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