New roles for CL Psychiatrists

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AIMS CENTER
Advancing Integrated Mental Health Solutions

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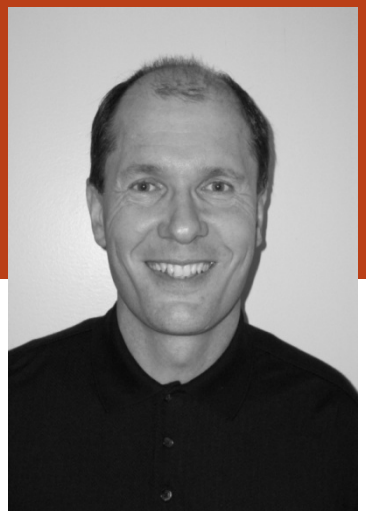
Disclosure



Employment: University of Washington

- Professor & Vice Chair, Dept. of Psychiatry
- Adjunct Professor, Dept. of Health Services

Grant funding

- National Institute of Health (NIMH, NIDA)
- John A. Hartford Foundation
- American Federation for Aging Research (AFAR)
- Alaska Mental Health Trust Authority
- George Foundation
- American Red Cross (RAND)
- California HealthCare Foundation
- Robert Wood Johnson Foundation
- Hogg Foundation for Mental Health
- Henry M. Jackson Foundation / DOD

Contracts

- Community Health Plan of Washington
- King County Department of Public Health

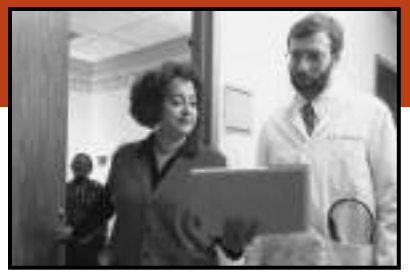
Consultant

- AARP Services Incorporated (ASI)
- National Council of Community Behavioral Health Care (NCCBH)
- RAND Corporation

Advisor

- Carter Center Mental Health Program
- Institute for Clinical Systems Improvement (ICSI)

updated April 2010



University of Washington

AIMS CENTER

Advancing Integrated Mental Health Solutions

Building on 25 years of Research and Practice in Integrated Mental Health Care

Overview

New roles for CL Psychiatrists

- Collaborative care vs ‘co-located’ care
- Outpatient CL Psychiatry
- Consultation & caseload-based supervision
- Financing
- Job descriptions

Integrated Mental Health Care

'Beyond the Tipping Point'

- **25 years of NIMH Research on Collaborative Care** *www.**nimh**.nih.gov*
- **John A. Hartford Foundation: IMPACT Program (http://impact-uw.org).**
- **MacArthur Initiative on Depression and Primary Care: RESPECT study and 3CM Model** *www.**depression**-primarycare.org/*
- **HRSA Bureau of Primary Care Health Disparities Collaboratives (over 100 FQHCs) http://www.hrsa.gov/mentalhealth/**
- **RWJ Program: Depression in Primary Care—Linking Clinical and System Strategies**
- **NCCBH Collaborative Care Learning Collaboratives http://www.thenationalcouncil.org/**
- **California Endowment : Integrated Behavioral Health Project (IBPB) http://www.ibhp.org/**
- **CiMH http://www.cimh.org/Initiatives/Primary-Care-BH-Integration.aspx**
- **CAL MEND** *www.**calmend**.org*
- **Hogg Foundation for Mental Health Integrated Mental Health Initiative in Texas (http://***www.**hogg**.utexas.edu/programs_ihc.html***)**
- **REACH-NOLA Project in New Orleans http://***reachnola**.org/*
- **VA, US Air Force, HMOs (Group Health, Kaiser Permanente), Cherokee, Washtenaw County (WCHO)**
- **Patient Centered Primary Care Collaborative: www.pcpcc.net**
- **Collaborative Family Healthcare Association: www.CFHA.net**
- **AAFP's National Research Network www.aafp.org/nrn/ccrn**
- **National Business Group on Health: *"An Employer's Guide to Behavioral Health Services"*:www.businessgrouphealth.org/benefitstopics/topics/purchasers/fullguide.pdf**

The Case for Integration

- Mental health in primary care:

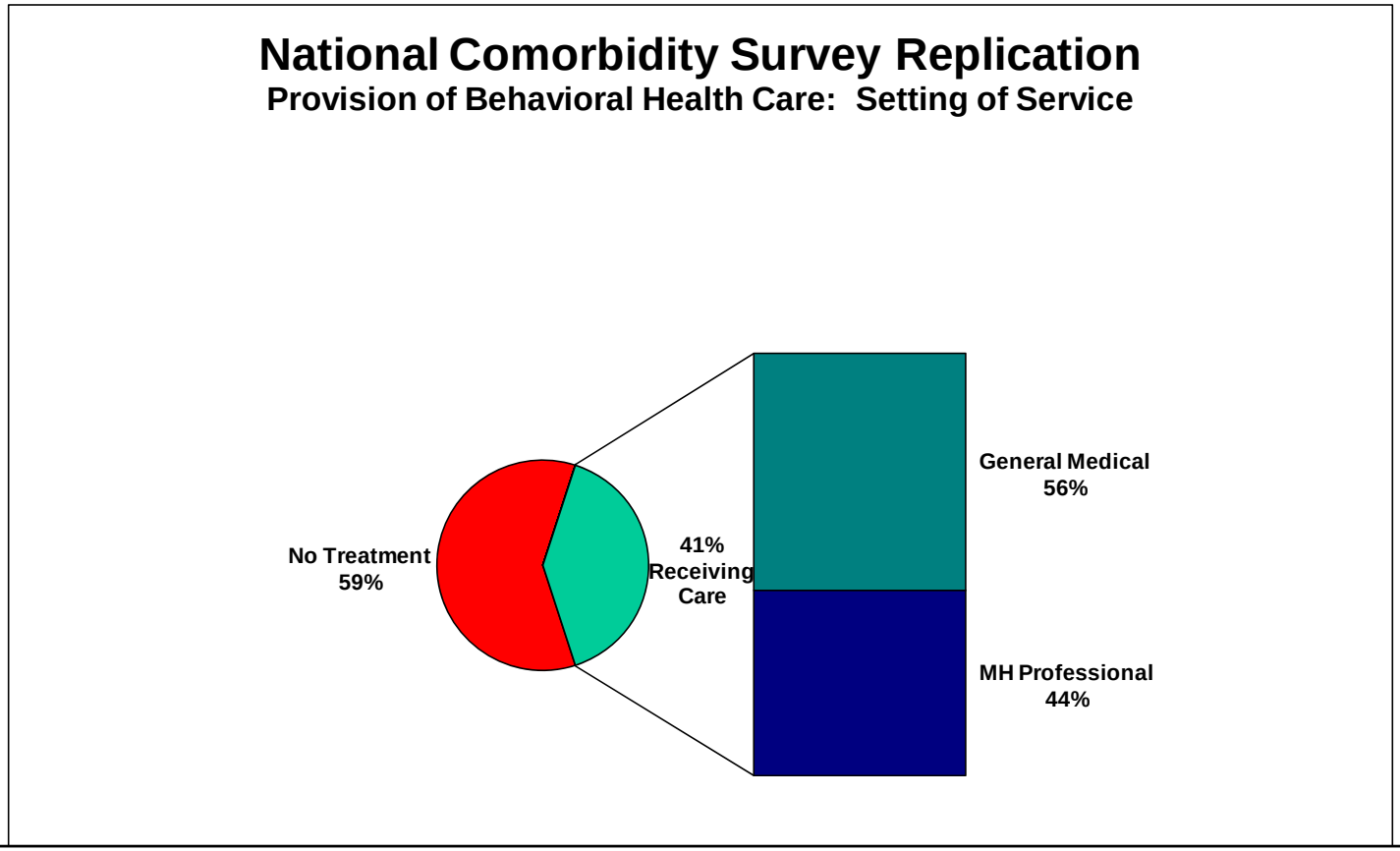
  Primary care is where the patients are.

  PC is the 'de facto' health care system for common mental disorders.

- Medical care in mental health care settings:

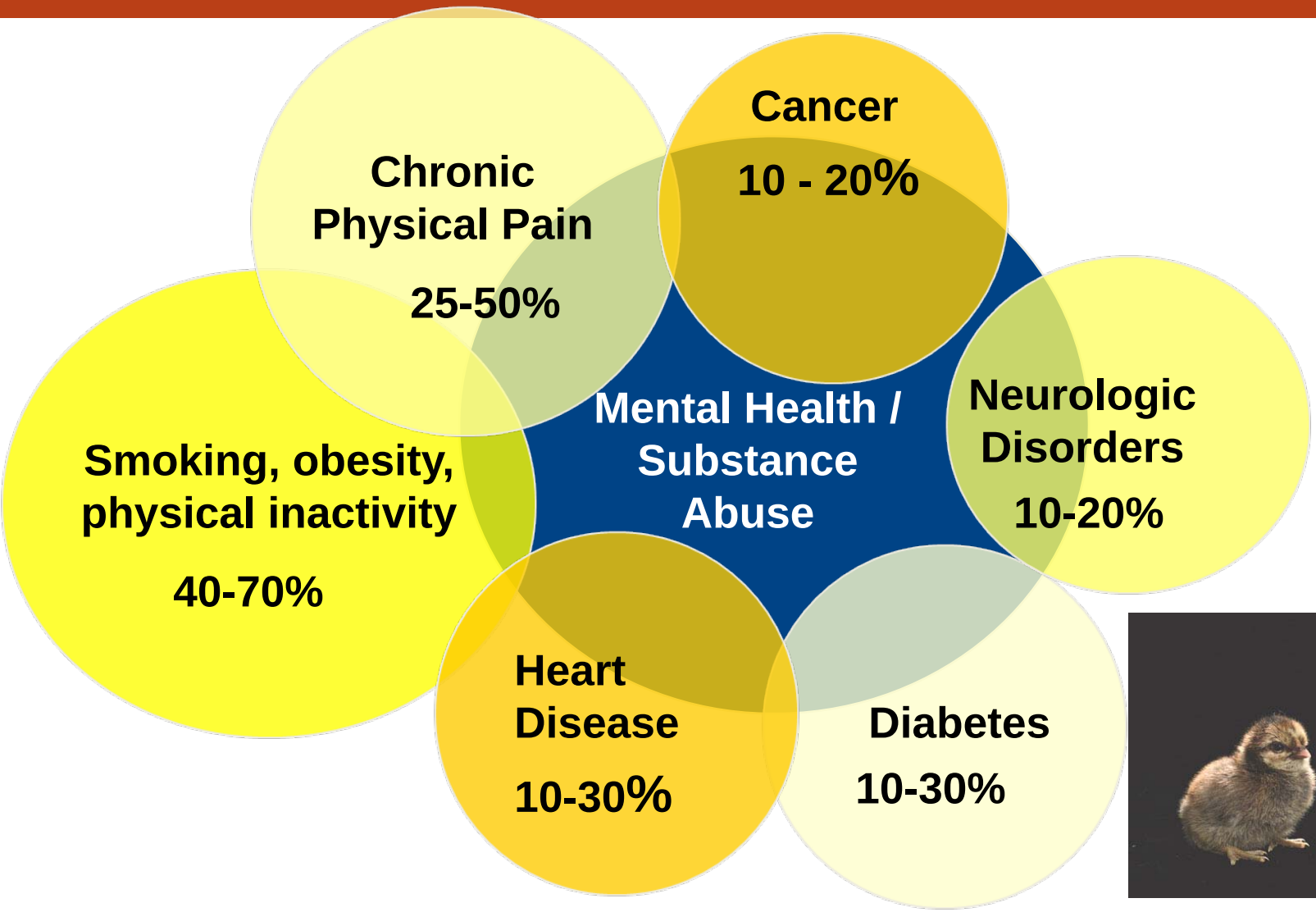
  Patients with severe mental disorders (SMI) receive poor medical care and die on average 25 years earlier than those without SMI.

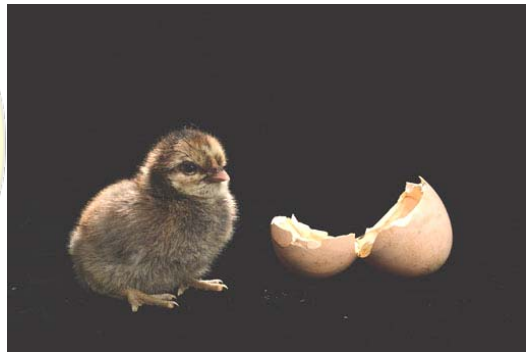
Primary Care is the 'de facto' mental health system



Wang, Philip S., et al, Twelve-Month Use of Mental Health Services in the United States, Arch Gen Psychiatry, 62, June 2005

Mental Disorders are Rarely the only Health Problem





Moving Towards Integrated Care

Roles for Psychiatrists

Traditional Consultation

- Limited access
  - 66 % of PCPs say they have poor access
- PCPs experience psychiatry consultation as a ‘black box’ (little feedback)
- Expensive:
  - all MH visits require full intakes, often leaving little time and energy for follow-up or ‘curbside consultation’.
- Works best for one-time or acute issues that don’t need follow-up.

But 66% of PCPs Report Poor Access to Mental Health Care for Their Patients

"We couldn't get a psychiatrist, but perhaps you'd like to talk about your skin. Dr. Perry here is a dermatologist."

Cunningham PJ, Health Affairs 2009;28(3)490-501

Liaison / co-location

- Psychiatrist comes to primary care.
- Fewer no shows – but this is still a problem.
- Opportunity for interaction / curbside consultations
- Better communication (often same chart) and better ‘transfers’ back to primary care.

BUT:

- Not available in many settings (e.g., rural).
- Access still problematic: new slots fill up quickly; little capacity for follow-up.
- Limited ability to make sure recommendations are carried out.

Outpatient Liaison Psychiatry at UW Medicine

University of Washington Medical Center (UWMC):

- Family Medicine*
- General Internal Medicine*
- Womens' Clinic*

UWMC Specialty clinics that provide primary care and / or serve patient populations with significant behavioral health care needs:

- Diabetes Care Center*
- MICC*
- Neurology Clinic*
- MS Clinic
- Virology
- Seattle Cancer Care Alliance*
- Pain Center*
- Transplant Clinic(s)*

Harborview Medical Center (HMC):

- Adult Medicine*
- Family Medicine*
- Pioneer Square*
- International Clinic*
- Pediatrics Clinic

HMC Specialty clinics that provide primary care and / or serve patient populations with significant behavioral health care needs

- Madison Clinic (HIV)*
- Rehabilitation Medicine Clinic*
- Neurology Clinic/Epilepsy Clinic
- Hepatitis-Liver Clinic
- Chronic Fatigue Clinic*
- Pediatrics Clinic
- Woman's Clinic
- Senior care Clinic*

UWPN Neighborhood Primary Care Clinics (7)*

Hall Health Student Health Center *

Collaborative Care

- **Effective multidisciplinary practice**

  Shared workflows with PCP, care manager, and consulting psychiatrist

- **Efficient use of limited resources**

  Psychiatry focuses on patients who are not improving / challenging.

- **Population-focus**

  Planned, caseload-focused care (vs) 'Psychiatric Urgent Care'

- **Measurement-based care**

  Systematic use of evidence-based treatments guided by clinical outcomes.

  'Treatment to target' … similar to good care for diabetes or hypertension.

Psychiatry in Collaborative Care

- Psychiatrist works closely with a care manager who manages a caseload of patients in a primary care clinic
- Indirect consults are majority with fewer direct patient visits
  - Can provide input on 10-20 patients in a half day as opposed to 3-4 patients in other two models.
- Better access and more patients covered by one Psychiatrist
- Patients get input on their mental health condition in a week versus 2-3 months in other two models.

The IMPACT Study

(1,801 participants in 18 clinics / 5 states)

http://impact-uw.org

Funded by
John A. Hartford Foundation
California Healthcare Foundation
Robert Wood Johnson Foundation
Hogg Foundation for Mental Health

Integrated Mental Health Care

PCP supported by Behavioral Health Care Manager

Effective Collaboration

Practice Support

Informed, Active Patient

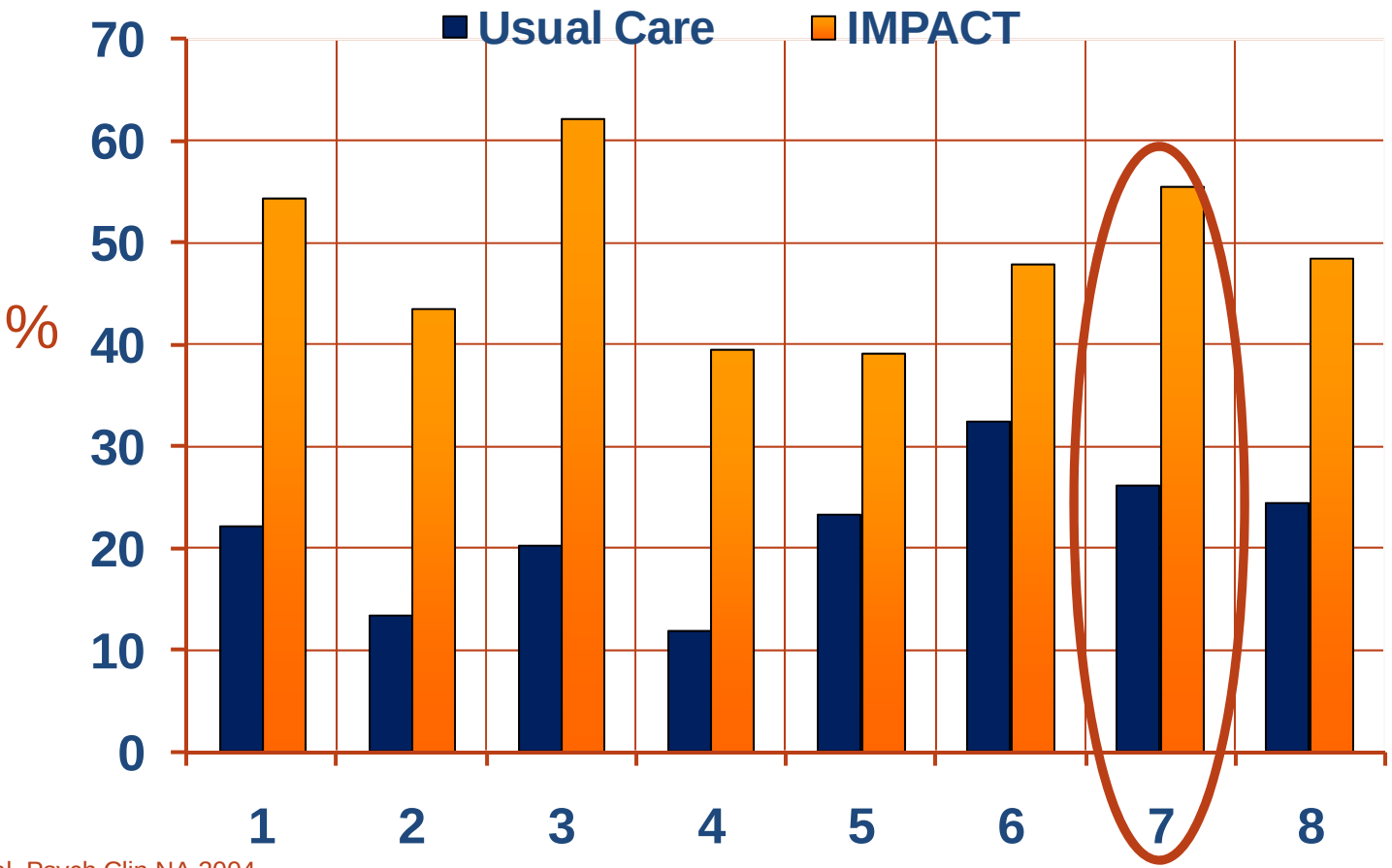
Measurement

Caseload-focused psychiatric consultation

Training

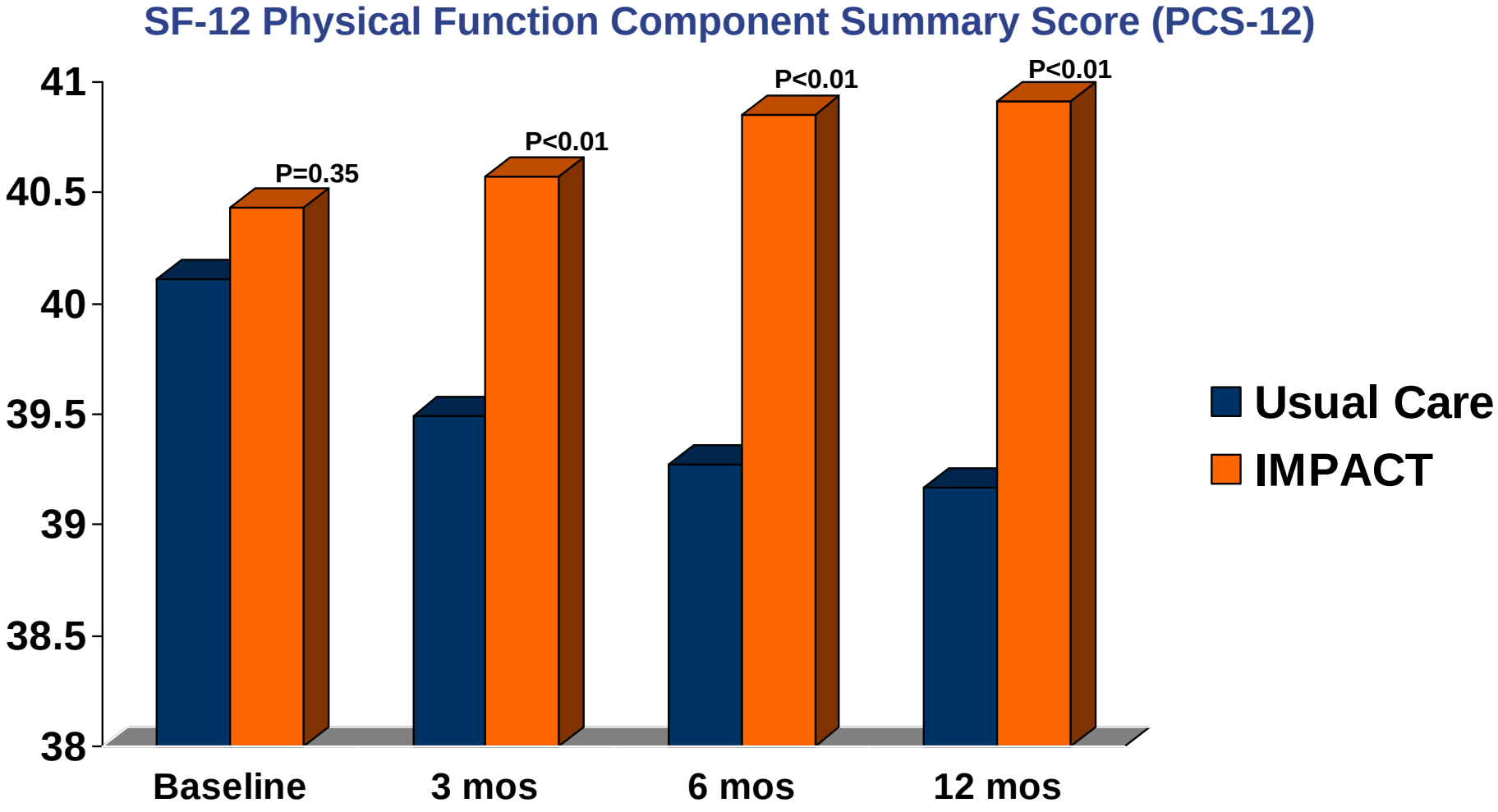
IMPACT Doubles Effectiveness of Care for Depression

50 % or greater improvement in depression at 12 months



Unutzer et al, Psych Clin NA 2004

Better Physical Function



Callahan et al, *JAGS* 2005; 53:367-373.

Long-Term Cost Savings

Cost Category	4-year costs in $	Intervention group cost in $	Usual care group cost in $	Difference in $
IMPACT program cost		522	0	522
Outpatient mental health costs	661	558	767	-210
Pharmacy costs	7,284	6,942	7,636	-694
Other outpatient costs	14,306	14,160	14,456	-296
Inpatient medical costs	8,452	7,179	9,757	-2578
Inpatient mental health / substance abuse costs	114	61	169	-108
Total health care cost	**31,082**	29,422	32,785	**-$3363**

Savings

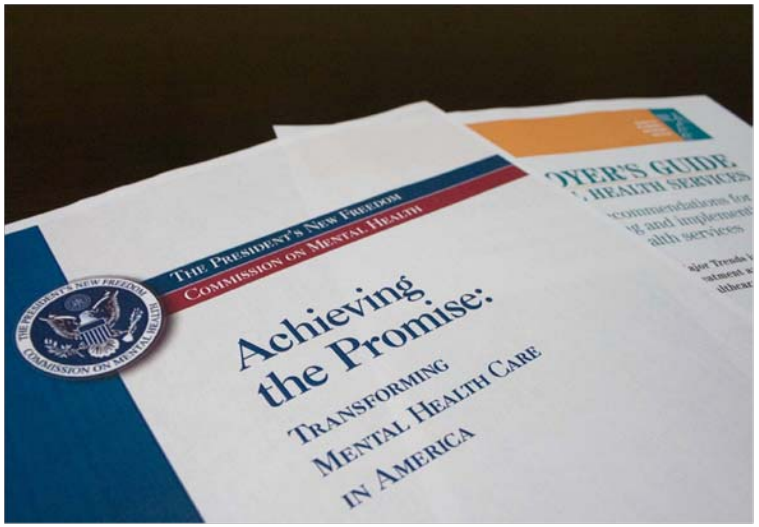
Unützer et al. *Am J Managed Care 2008*.

IMPACT Replication Studies

Patient Population (Study Name)	Target Clinical conditions	Reference
Adult primary care patients (Pathways)	Diabetes and Depression	Katon et al, 2004
Adult patients in safety net clinics (project Dulce; Latinos)	Diabetes and Depression	Gilmer et al, 2008
Public sector oncology clinic	Cancer and Depression	Dwight-Johnson et al, 2005
County hospital oncology clinic (Latino patients)	Cancer and Depression	Ell et al, 2008
HMO patients	Depression in primary care	Grypma et al, 2006
Adolescents in primary care	Adolescent Depression	Richardson et al, 2009
Older adults	Arthritis and Depression	Unutzer et al, 2008
Acute Coronary Syndrome patients (COPES)	Coronary Events and Depression	Davidson et al, 2010

Endorsements for Collaborative Care

- Presidents New Freedom Commission on Mental Health
- IOM Report
- National Business Group on Health
- CDC consensus Panel
- Annapolis Coalition
- Partnership to Fight Chronic Disease
- AHRQ Report (2009)
- SAMHSA
  - National Registry of Evidence-Based Programs and Practices (NREPP)



~ 4,000 providers trained in evidence-based integrated care

DIAMOND Initiative

Depression Improvement Across Minnesota: a New Direction

- Institute for Clinical Systems Improvement (ICSI)
- 9 health plans in Minnesota
  - Monthly billing code for evidence-based depression care management in primary care includes psychiatric consultation
    - Primary Care clinics purchase consultation
  - Regular reporting of depression outcomes to ICSI and Minnesota Community Measurement
- 25 medical groups with ~ 90 primary care clinics

Health Care Redesign

Member Login
Username
Password
Remember me
GO

Baskets of Care
Diagnostic Imaging
DIAMOND
DIAMOND FAQs for Patients
DIAMOND White Paper
Clinics Involved with DIAMOND
Lower Health Care Costs
Depression Care Tool Kit
DIAMOND Bibliography
DIAMOND Videos
DIAMOND Patient Testimonials
NIMH Grant to HealthPartners
DIAMOND Media Coverage
DIAMOND Fact Sheet
Health Care Home
Palliative Care

Home / Health Care Redesign / DIAMOND

DIAMOND

DIAMOND is one of the nation's most promising efforts to improve health care for people with depression because it changes the way care is delivered and how it is paid for. Through ICSI, medical groups, health plans, employers and patients collaborated to develop a better, evidenced-based model for managing depression.

DIAMOND FAQs for Patients
This document describes DIAMOND, how care is delivered, patient eligibility, and ICSI's role in the initiative.

DIAMOND White Paper
This document addresses why depression care has been deficient to date and how DIAMOND provides an evidence-based model to generate better patient results.

Clinics Involved with DIAMOND
Medical groups and their clinics currently offering or planning to offer DIAMOND.

Lower Health Care Costs
The cost effectiveness of collaborative care models, including DIAMOND, for treating patients with depression are detailed in this section.

Depression Care Tool Kit
This kit is for non-DIAMOND groups and is comprised of a set of tools, scripts, and other supporting documents to assist organizations in the coordination and management of depression care.

DIAMOND Bibliography
Annotated bibliography describing the evidence around the collaborative care model for depression.

DIAMOND Videos
Watch some videos from patients, physicians, care managers, psychiatrists and health plan representatives involved in the DIAMOND program.

DIAMOND Patient Testimonials
Patients share their thoughts on the DIAMOND program.

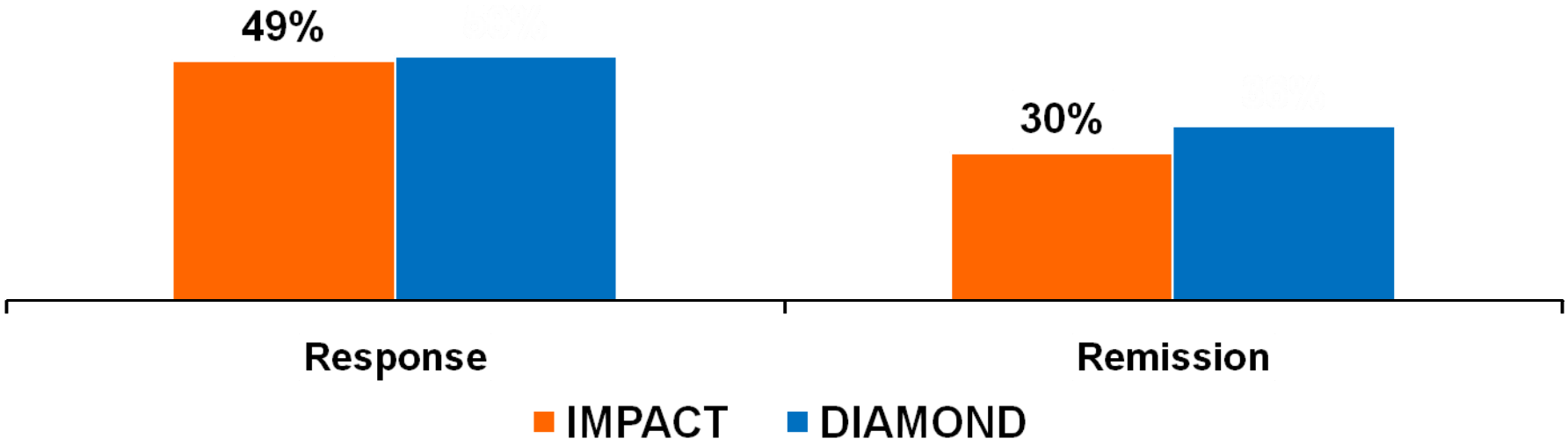
NIMH Grant to HealthPartners
The National Institute of Mental Health has provided HealthPartners Research Foundation with a $3 million, five-year grant to evaluate DIAMOND.

DIAMOND Media Coverage

DIAMOND Fact Sheet
A brief summary of the DIAMOND program for treating patients with depression.

DIAMOND

6-month outcomes from the first 10 implementing clinics



Korsen & Pietruszewski, *J Clin Psychol Med Settings*, 2009.

Moving beyond common mental disorders

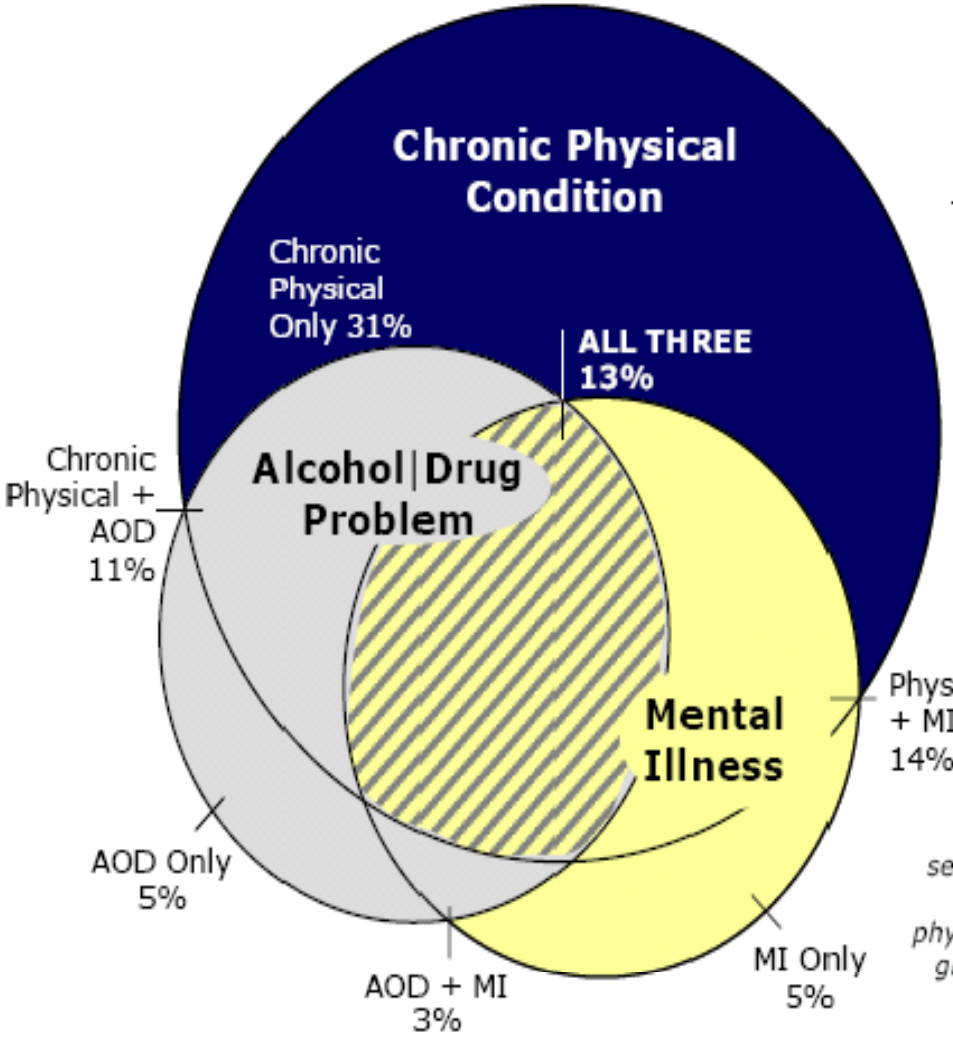
Comorbidity is common
in safety net populations

DSHS | ***GA-U Clients: Challenges and Opportunities August 2006***

Co-occurring Diagnoses and the GA-U Population

52 percent had **substance abuse** or **mental illness** identified

31 percent had a **chronic physical condition** only

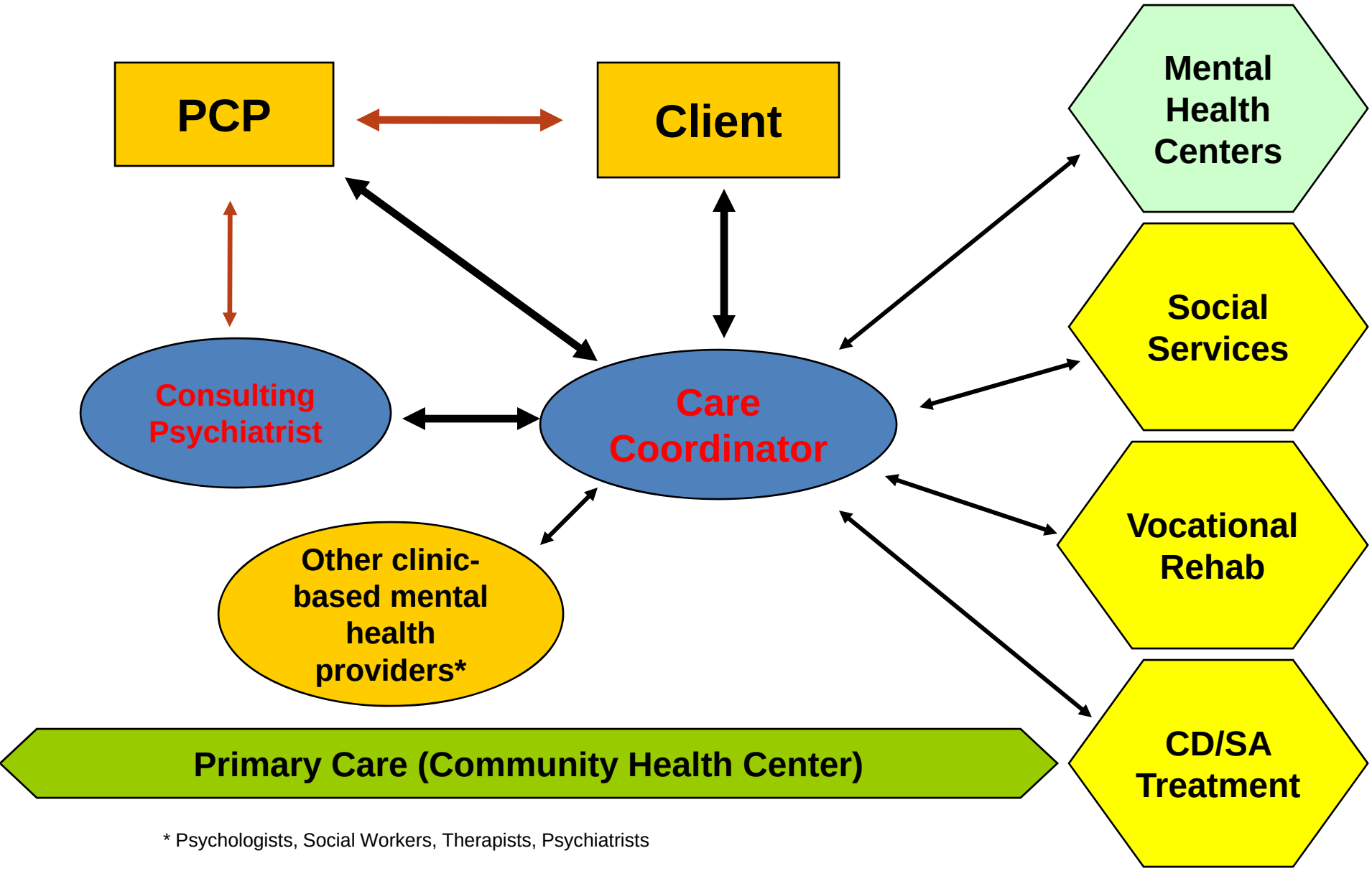


PRIMARY CONDITIONS	
Chronic Physical	69%
Mental Illness	36%
Substance Abuse	32%

… plus acute and chronic medical problems, chronic pain, substance use, prescription narcotic misuse, homelessness, unemployment, poverty, ….

SOURCES: MMIS claims, TARGET service encounters, and WSP arrest records, FY 2003-04. Chronic physical and mental illness diagnosis groups derived from CDPS grouper

WA State MHIP Program



* Psychologists, Social Workers, Therapists, Psychiatrists

MHIP for Behavioral Health
Mental Health Integration Program

Login Operations | Login Clinical

Home Map Partners The Model Training Evaluation Stories News




A Partnership to Promote Patient-Centered Collaboration

Community Collaboration Compassion Care Cost-effective

What is MHIP?

http://integratedcare-nw.org

Integration & Collaboration

The **M**ental **H**ealth **I**ntegration **P**rogram is a state-wide, *patient-centered, integrated program* serving clients with medical, mental health, and substance abuse needs. The program provides:

- High quality mental health screening and treatment
- An evidence- and outcome-based model of collaborative stepped care to treat common mental disorders

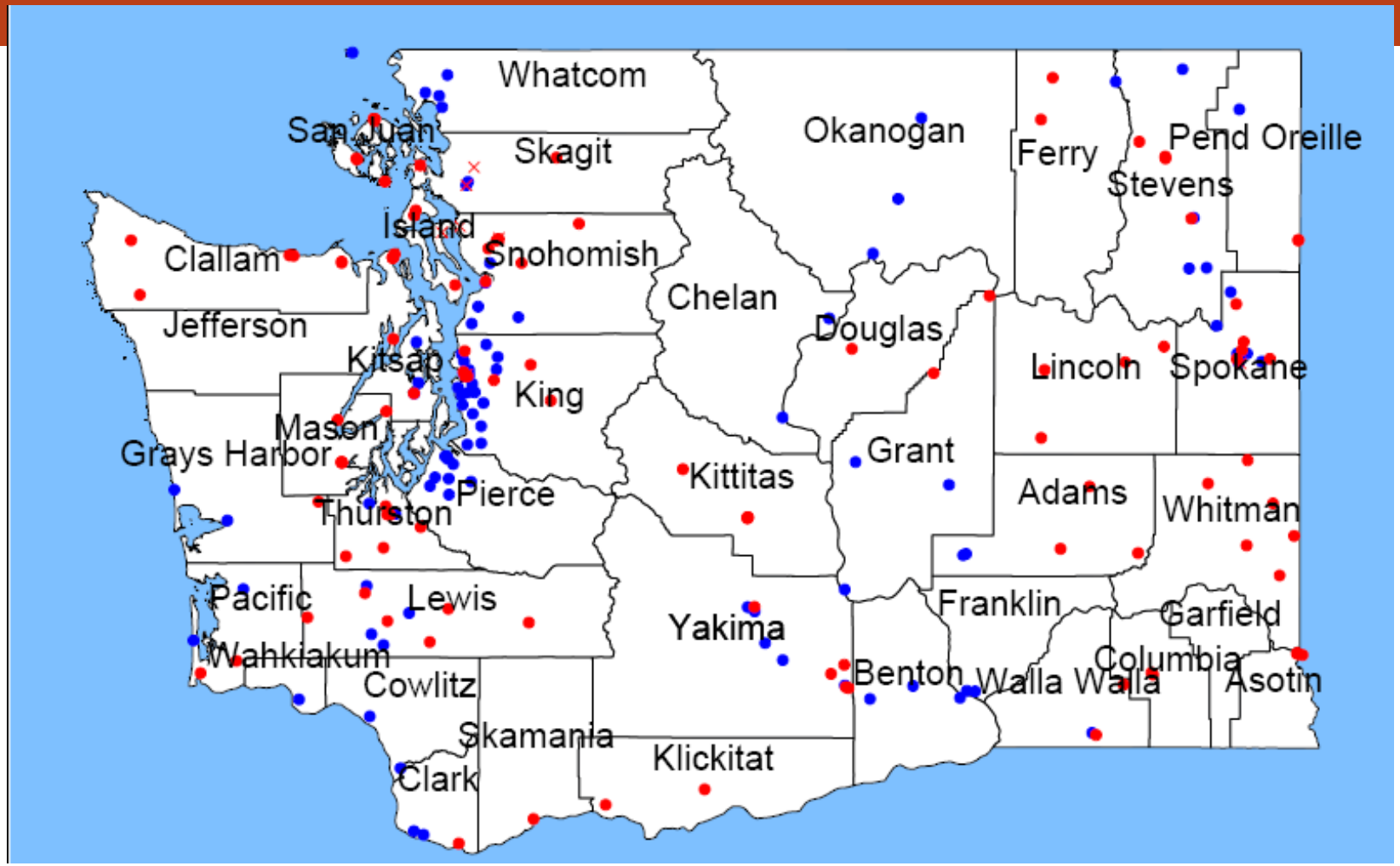
Results-oriented

Since the start of the program in January of 2008, MHIP has helped over 10,000 clients, ages 0-100. Ongoing evaluation has shown substantial improvements in coordinated care and mental health outcomes.

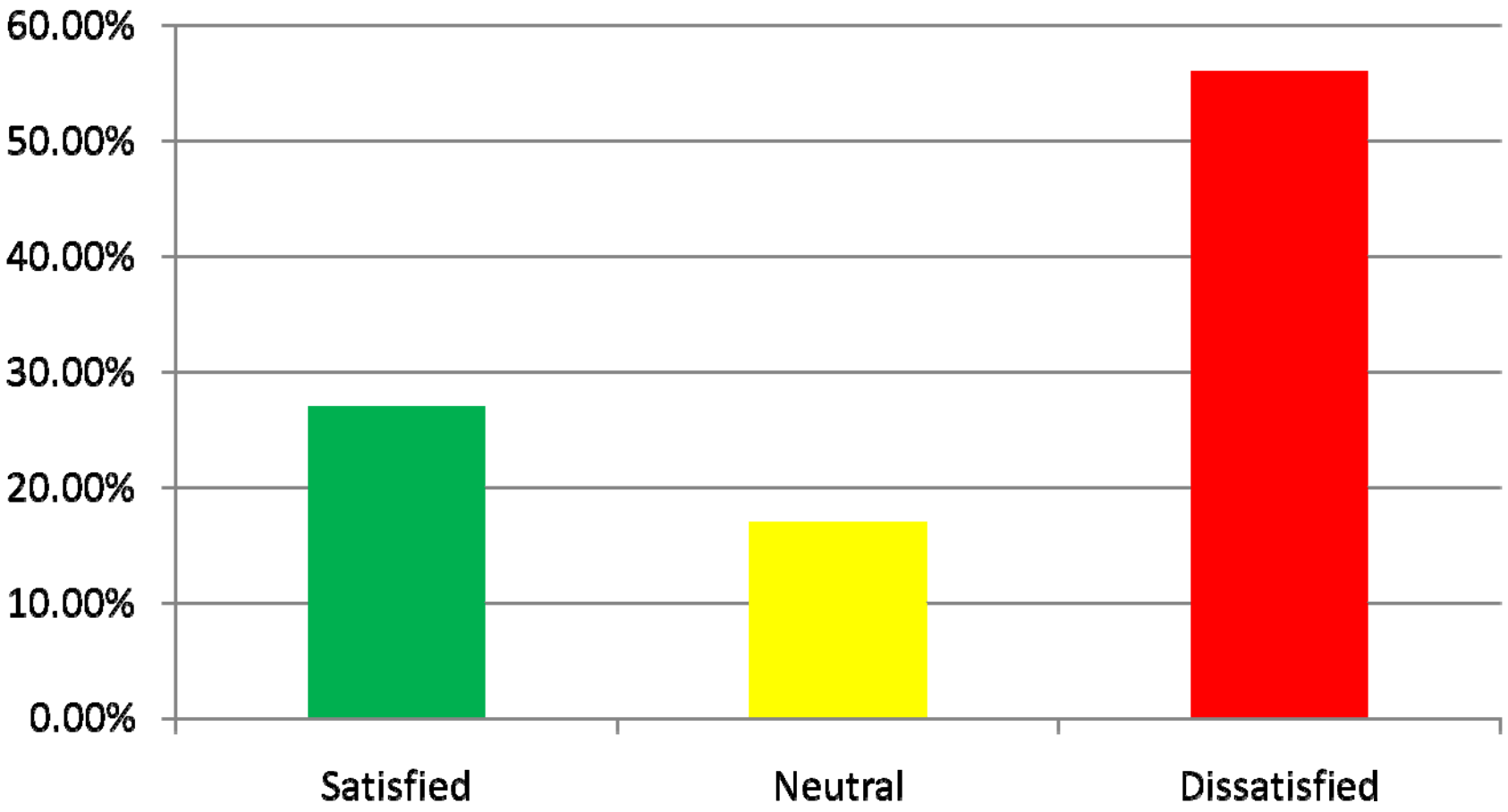
Funding

- The Washington State Legislature provides dedicated funding to Community Health Plan of Washington to provide mental health services to clients on Disability Lifeline (formerly GA-U) around the state;
- In King County, the King County Veterans and Human Services Levy, Children's Health Initiative, and the Mental Illness & Drug Dependency (MIDD) Action Plan increase access to MHIP through community health centers, public health centers, and other safety net clinics.

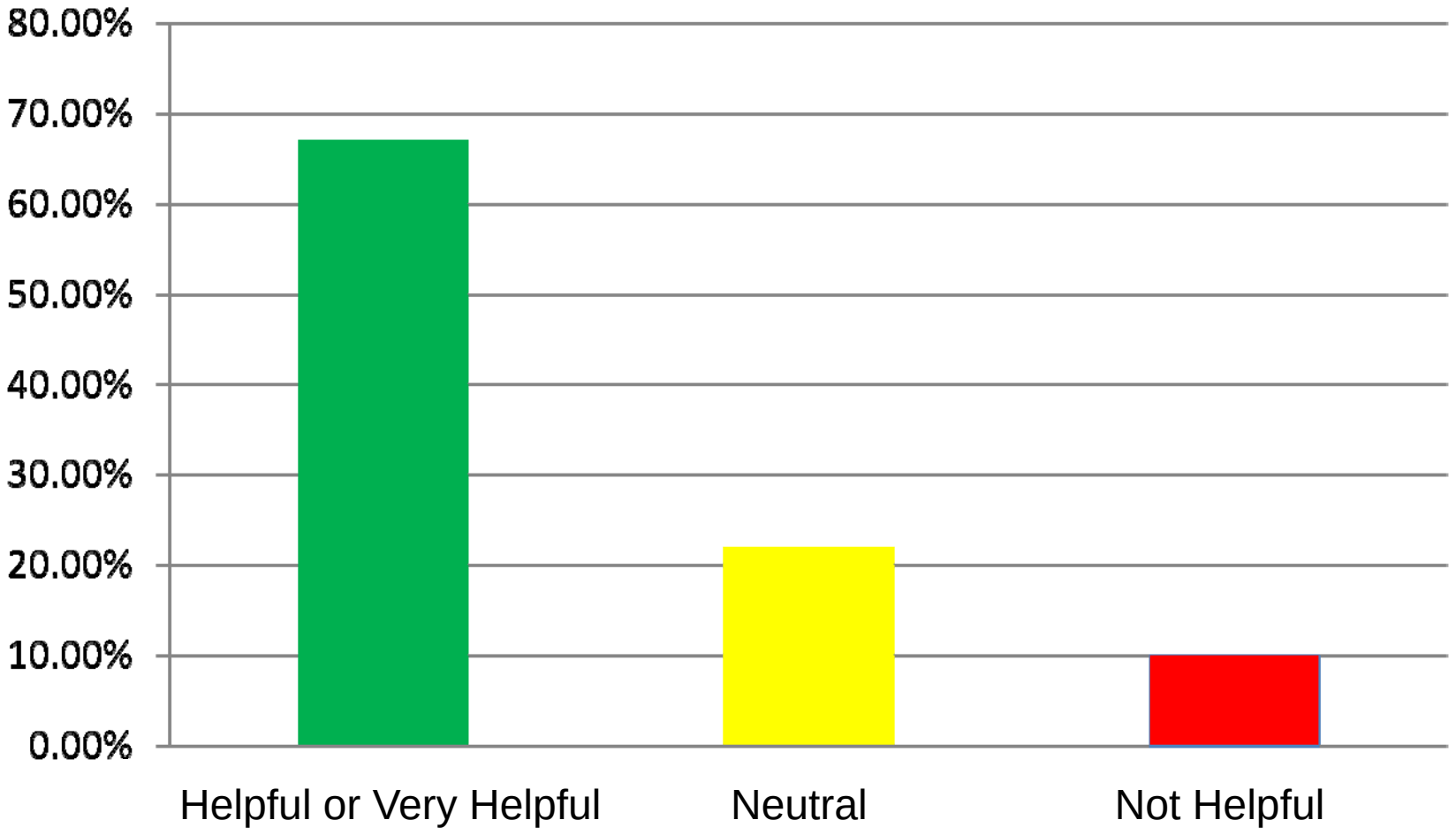
MHIP across Washington State



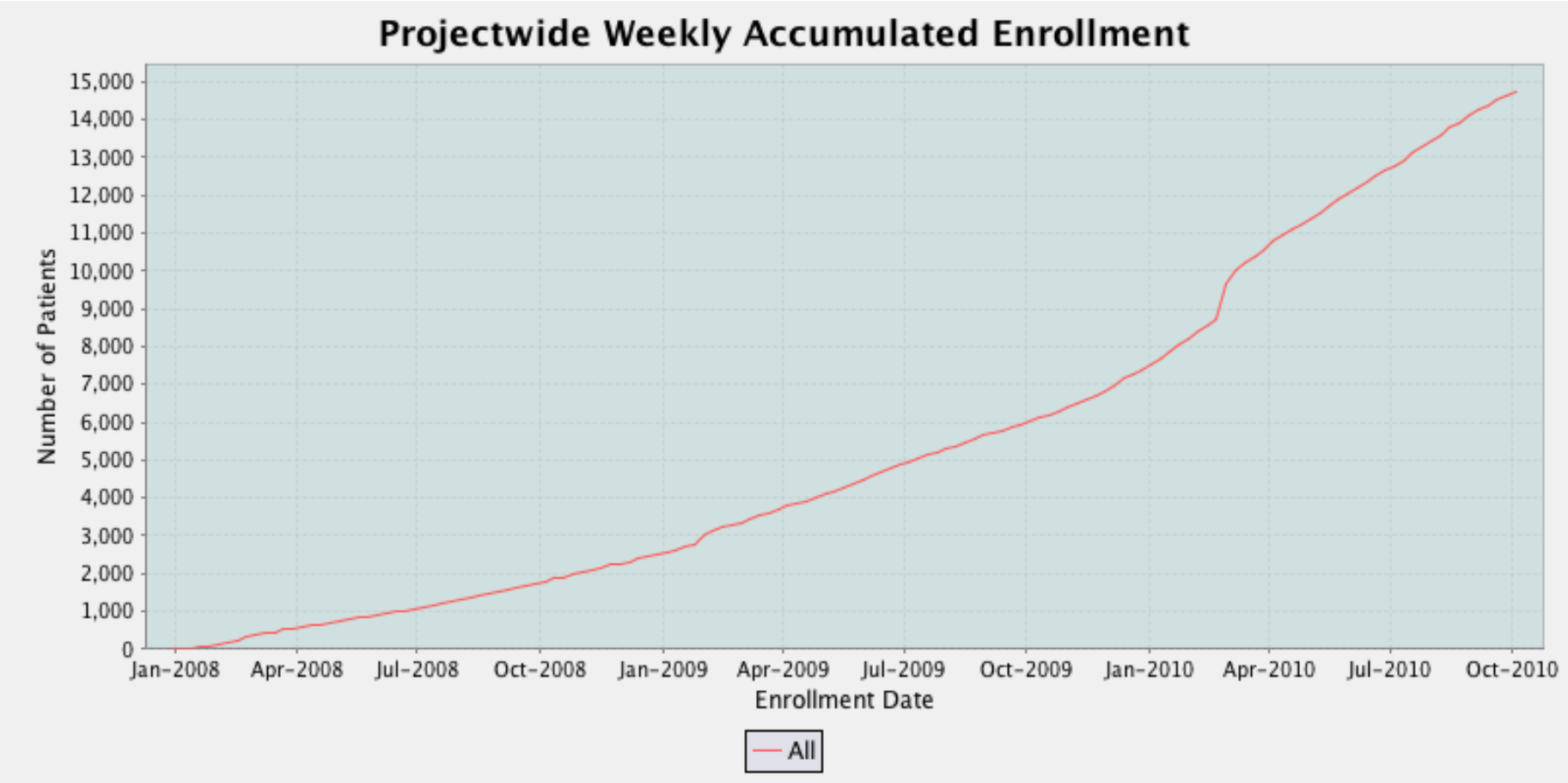
PCP satisfaction with resources available to treat MH for patients not in MHIP (n=48)



PCP Satisfaction with MHIP Psychiatric Consultation (n=48)



MHIP: 15,000 clients served



Client Demographics

	Mean or %	Range across clinics
Men	52 %	
Women	48 %	
Mean Age	40	1-100
Challenge with Housing	29 %	3% - 52 %
Challenge with Transportation	21 %	10 %- 50 %

Common Client Diagnoses (L1)

Diagnoses	%
Depression	71 %
Anxiety	48 %
Posttraumatic Stress Disorder (PTSD)	17 %
Alcohol / Substance Abuse	17 %* (likely underreported)
Bipolar Disorder	15 %

… plus acute and chronic medical problems, chronic pain, substance use, prescription narcotic misuse, homelessness, unemployment, poverty, ….

Thoughts of suicide

45 % of clients report thoughts of death or suicide on PHQ-9 depression screen

- **10 % (~ 1,500 clients to date) report being bothered by such thoughts most days of the week.**
- **10 % of L1 clients have records of 'active safety concerns' (e.g., history of prior suicide attempt)**

MHIP Clinic Example

Population	Mean baseline PHQ-9 depression score (0-27)	Follow-up (%)	Mean number of contacts	% with psych consultation	% with significant clinical improvement
DL (GA-U)	17.0	96 %	12.7	82%	50 %
Uninsured	17.0	93 %	10.6	90%	53 %
Older Adults	16.0	92 %	14.3	89%	54 %

Successful Implementation

1) Systematic assessment of needs and resources
   a) Treatment ‘volume’: visit diagnoses and Rx data
   b) Current staffing and workflows
2) Systematic Team building process
   a) Four-step team building process / worksheets
   b) Job descriptions
3) Staff Training and Implementation Support
   a) Established training program / materials
   b) Psychiatric Consultation
4) Web-based registry: ‘real time’ process and clinical outcomes data

Integrated Care Team Building Process

Conditions for which you plan to provide clinical care (select all that apply)

Depression ❑ Substance Abuse ❑
Anxiety (e.g. PTSD) ❑ Other Mental Disorders ❑ _____

BEHAVIORAL HEALTH STAFF SELF-ASSESSMENT

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Integrated Care Tasks	Is This A Priority Task?		Is This Your Role Now?		If No, Whose Role?	Your Organization's Capacity with This Task?		Your Level of Comfort with This Task		Would You Like Training to Perform This Task?	
Identify and Engage Patients	Yes	No	Yes	No		High	Med/Low	High	Med/Low	Yes	No
Identify People Who May Need Help	❑	❑	❑	❑		❑	❑	❑	❑	❑	❑
Screen for Behavioral Health Problems Using Valid Measures	❑	❑	❑	❑		❑	❑	❑	❑	❑	❑
Diagnose Behavioral Health Disorders	❑	❑	❑	❑		❑	❑	❑	❑	❑	❑
Engage Patient in Integrated Care Program	❑	❑	❑	❑		❑	❑	❑	❑	❑	❑
Initiate and Provide Treatment	Yes	No	Yes	No		High	Med/Low	High	Med/Low	Yes	No
Perform Behavioral Health Assessment	❑	❑	❑	❑		❑	❑	❑	❑	❑	❑
Develop and Update Behavioral Health Treatment Plan	❑	❑	❑	❑		❑	❑	❑	❑	❑	❑
Patient Education about Symptoms & Treatment Options	❑	❑	❑	❑		❑	❑	❑	❑	❑	❑
Prescribe Psychotropic Medications	❑	❑	❑	❑		❑	❑	❑	❑	❑	❑
Patient Education about Medications & Side Effects	❑	❑	❑	❑		❑	❑	❑	❑	❑	❑
Brief Counseling, Activity Scheduling, Behavioral Activation	❑	❑	❑	❑		❑	❑	❑	❑	❑	❑
Evidence-based Psychotherapy (e.g. PST, CBT, IPT)	❑	❑	❑	❑		❑	❑	❑	❑	❑	❑
Identify and Treat Coexisting Medical Conditions	❑	❑	❑	❑		❑	❑	❑	❑	❑	❑
Facilitate Referral to Specialty Care or Social Services	❑	❑	❑	❑		❑	❑	❑	❑	❑	❑
Create and Support Relapse Prevention Plan	❑	❑	❑	❑		❑	❑	❑	❑	❑	❑
Track Treatment Outcomes	Yes	No	Yes	No		High	Med/Low	High	Med/Low	Yes	No
Track Treatment Engagement and Adherence using Registry	❑	❑	❑	❑		❑	❑	❑	❑	❑	❑
Reach out to Patients who are Non-adherent or Disengaged	❑	❑	❑	❑		❑	❑	❑	❑	❑	❑
Track Patients' Symptoms with Measurement Tool (e.g., PHQ-9)	❑	❑	❑	❑		❑	❑	❑	❑	❑	❑
Track Medication Side Effects & Concerns	❑	❑	❑	❑		❑	❑	❑	❑	❑	❑
Track Outcome of Referrals and Other Treatments	❑	❑	❑	❑		❑	❑	❑	❑	❑	❑
Adjust Treatment if Patients are Not Responding	Yes	No	Yes	No		High	Med/Low	High	Med/Low	Yes	No
Assess Need for Changes in Treatment	❑	❑	❑	❑		❑	❑	❑	❑	❑	❑
Facilitate Changes in Treatment / Treatment Plan as needed	❑	❑	❑	❑		❑	❑	❑	❑	❑	❑
Provide Caseload-Focused Psychiatric Consultation	❑	❑	❑	❑		❑	❑	❑	❑	❑	❑
Provide in Person Psychiatric Assessment of Challenging Patients	❑	❑	❑	❑		❑	❑	❑	❑	❑	❑
Other Tasks Important for Our Program (add tasks as needed)	Yes	No	Yes	No		High	Med/Low	High	Med/Low	Yes	No
Coordinate Communication Among All Team Members / Providers	❑	❑	❑	❑		❑	❑	❑	❑	❑	❑
Administrative Support for Program (e.g., Scheduling, Resources)	❑	❑	❑	❑		❑	❑	❑	❑	❑	❑
Clinical Supervision for Program	❑	❑	❑	❑		❑	❑	❑	❑	❑	❑
Training of Team Members in Behavioral Health	❑	❑	❑	❑		❑	❑	❑	❑	❑	❑
1.	❑	❑	❑	❑		❑	❑	❑	❑	❑	❑
2.	❑	❑	❑	❑		❑	❑	❑	❑	❑	❑
3.	❑	❑	❑	❑		❑	❑	❑	❑	❑	❑

Program Staffing in Diverse Clinic Settings

Clinic Population (mental health needs)	% of clinic population with need for care management	Typical caseload size for 1 FTE Care Manager	# of unique primary care clinic patients to justify 1 FTE CM	Typical personnel requirement for 1,000 unique primary care patients	
				FTE Care Manager	FTE Psychiatrist**
Low need (e.g., insured, employed)	2%	100	5000	0.2	0.05 (2 hrs / week)
Medium need (e.g., comorbid medical needs / chronic pain / substance abuse)	5%	75	1500	0.7	0.07 (3 hrs / week)
High need (e.g, safety-net population)*	15%	50	333	3	0.3 (12 hrs / week)

MHIP for Behavioral Health
Mental Health Integration Program

Job Description: University of Washington Consulting Psyc
Mental Health Integration Program (MHIP)

JOB SUMMARY

The consulting psychiatrist is responsible for supporting mental health care provided by prima
and care coordinators treating MHIP patients in participating community health centers (CHCs
care clinics.

DUTIES AND RESPONSIBILITIES

1. Provide regularly scheduled (usually weekly) caseload consultation to assigned care coordi
   These consultations will primarily focus on patients who are new to treatment or who are
   expected.
2. Provide telephonic consultation to primary care physicians (PCPs) as requested, focusing o
   CCs caseload.
3. Work with the assigned CCs to track and oversee their patient panels and clinical outcome
   based MHITS care management tracking system.

UW Web-based Care Management Tracking System (CMTS)

Supports efficient and effective behavioral health workflows

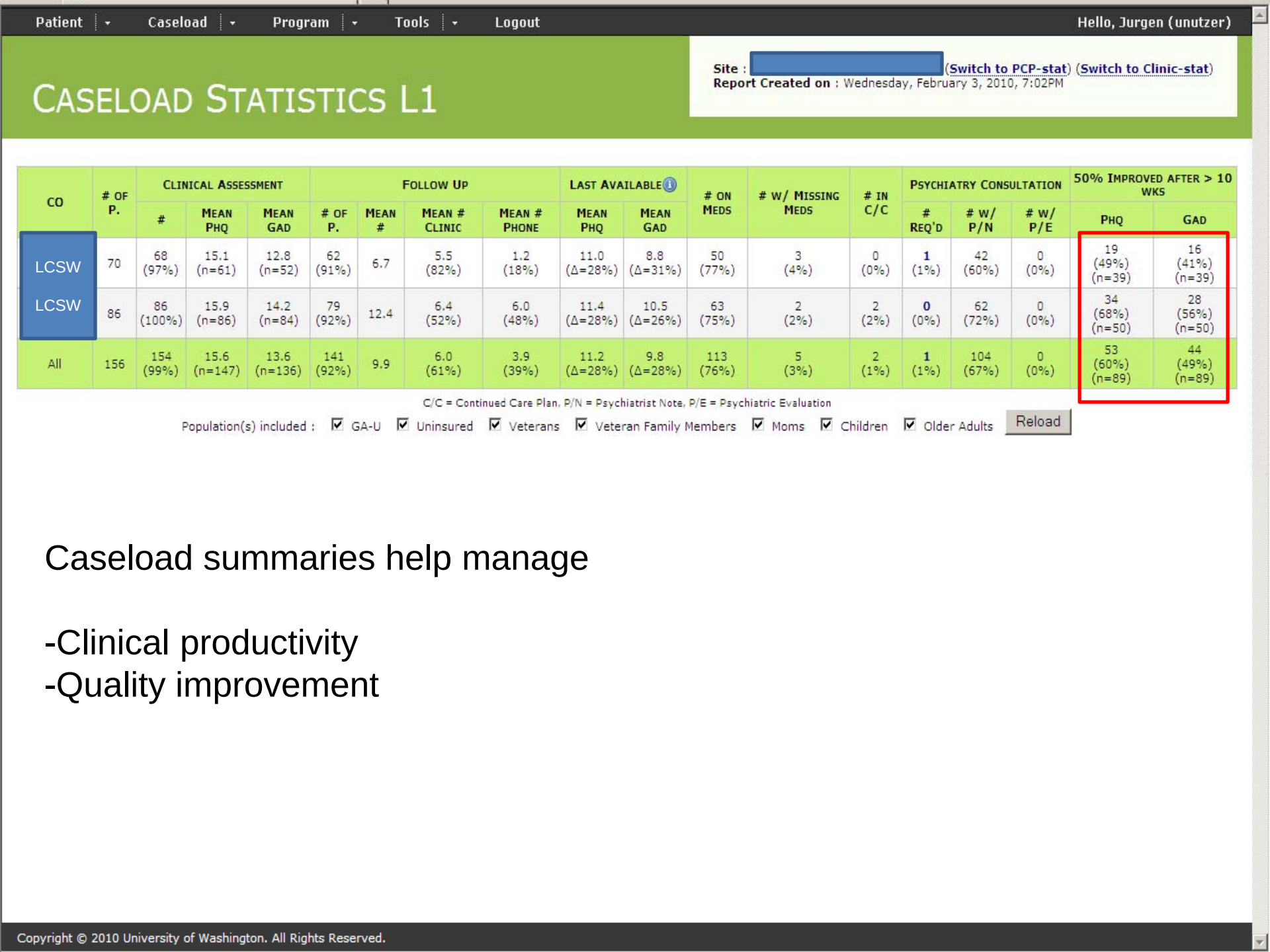
In use in WA State MHIP program and in 8 other major behavioral health integration programs in Minnesota, Texas, and Canada

Registry function

- prevents patients from ‘falling through the cracks’

Care management functions

- Structured templates facilitate efficient sessions
- Individual and caseload reports facilitate
  - measurement-based care / treatment to target
  - efficient psychiatric consultation on challenging



Caseload summaries help manage

-Clinical productivity
-Quality improvement

CLINICAL DASHBOARD

customize

ID : 800114

Member Information

Last updated by: Care Coordinator [redacted] hide

Status : Evaluated - Accepted into Level 1

Working Diagnoses

view history hide

L1 : Depression (PHQ-9 : 0/27, Minimal); Anxiety (GAD-7 : 0/21); PTSD (PCL : 56/85)

Assessment

view history *Last updated by: Care Coordinator* [redacted] hide

Pt feels significantly better. No depressive sxs and only 'normal' anxiety. States previously her sister had a fight w her mother, pt became estranged from her mother and sister for a time. Pt continues to have a good relationship w her mother and her sister if mending her relationship w the mother. Pt discussed how she would work w her sister. Reports good relationship w her husband whose mood has significant w his new anti-depressant. She feels that her life in general has improved and has no particular concerns.

Safety Concerns

view history hide

Past Suicide Attempts : None reported.

Medications

view history *Last updated by: Care Coordinator* [redacted] hide

Sertraline (Zoloft) / 50mg

Other Treatment

view history hide

None recorded

Activity Goals

view history *Last updated by: Care Coordinator* [redacted] hide

Pleasant Events Scheduling: Make it a point to do some things this week that you have identified that you enjoy. • Likes to decorate and was interested in baking, creating her own recipes. • Enjoys reading, . Increased rewarding activity w her husband. • Talking with her son, • Dancing with children, • Going soccer games and practices, • Talk to my friends and brother. . Eating at least one meal together w husband and children. Plan: pt will use exercise equipment to increase her energy and run. She will borrow her sister's machinge.

Referrals

view history hide

1 referral closed.

Outcome Measures

hide

CP SUMMARY

export as text

ID : 800114

Created on: Wednesday, February 3,

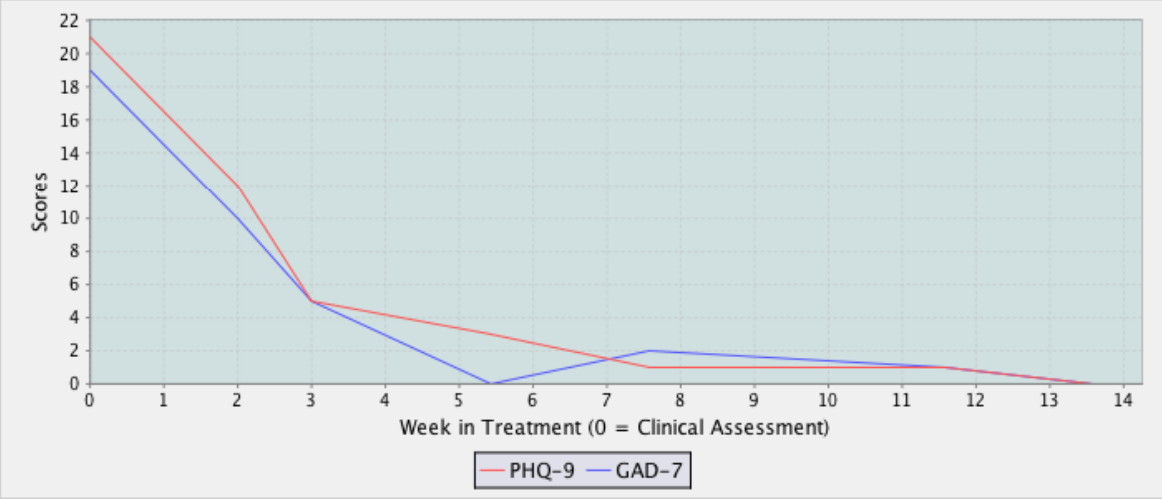
e Coordinator [redacted] **Primary Care Provider** [redacted]

rking Diagnoses :

L1 : Depression (PHQ-9 : 0/27, Minimal); Anxiety (GAD-7 : 0/21); PTSD (PCL : 56/85)

rmulation : Pt feels significantly better. No depressive sxs and only 'normal' anxiety. States previously her sister had a fight w her mother, pt became estranged from her mother and sister for a time. P tinues to have a good relationship w her mother and her sister if mending her relationship w the mother. Pt discussed how she would work w her sister. Reports good relationship w her husband whose od has significant w his new anti-depressant. She feels that her life in general has improved and has no particular concerns.

eatment Progress :



fety Concers :

Past Suicide Attempts : None reported.

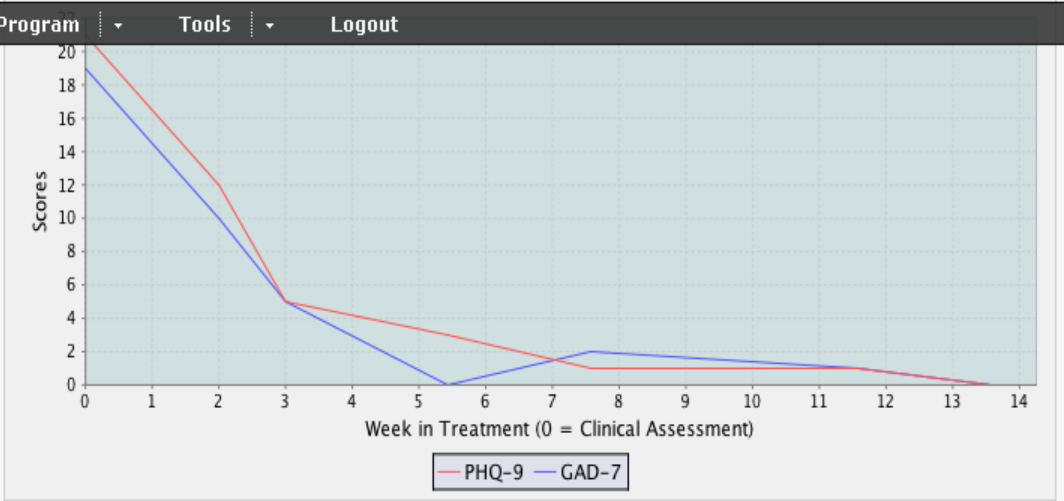
rrent Psychiatric Medications : Sertraline (Zoloft) / 50mg, 1 tablet once a day

ivity Goals : Pleasant Events Scheduling: Make it a point to do some things this week that you have identified that you enjoy. • Likes to decorate and was interested in baking, creating her own recipes. oys reading, . Increased rewarding activity w her husband. • Talking with her son, • Dancing with children, • Going soccer games and practices, • Talk to my friends and brother. . Eating at least one mea ether w husband and children. Plan: pt will use exercise equipment to increase her energy and run. She will borrow her sister's machinge.

ferrals : None recorded

ychiatrist Note

Last updated by: Consulting Psychiatrist (Marc Av



Safety Concers :

Past Suicide Attempts : None reported.

Current Psychiatric Medications : Sertraline (Zoloft) / 50mg, 1 tablet once a day

Activity Goals : Pleasant Events Scheduling: Make it a point to do some things this week that you have identified that you enjoy. • Likes to decorate and was interested in baking, creating her own recipes. • Enjoys reading, . Increased rewarding activity w her husband. • Talking with her son, • Dancing with children, • Going soccer games and practices, • Talk to my friends and brother. . Eating at least one meal together w husband and children. Plan: pt will use exercise equipment to increase her energy and run. She will borrow her sister's machinge.

Referrals : None recorded

Psychiatrist Note

Last updated by: Consulting Psychiatrist ([redacted]

[redacted]

35 year old woman with most recent PHQ9 = 21, PCL 56/85,
MDQ negative and GAD7 = 19.
Who presents with: The pt. c/o of progressively worsening depression x 2 months. History of being molested as a child - with recent re-experiencing of flashbacks (that didn't start at all until 5 years ago).
Current medications: Sertraline 50mg, recently begun (10/19/09).
Prior medication trials include [none known]
Medical Problems: Allergic rhinitis, Onychomycosis, Left renal cyst, Migraine HA
Substance Use: ETOH: Use: social drink, every Friday 1 - 3 glasses. Does not like to drink.
Safety Concerns: None
Assessment: Depression with remote trauma that may be surfacing in an PTSD-like condition.
Treatment recommendations: At next visit, please check in with another PHQ - if the depression is not substantially improved, consider increasing Zoloft to 100mg per day.

The above treatment considerations and suggestions are based on consultation with the patient's care coordinator and a review of information available in the Mental Health Integrated Tracking System (MHITS). I have not personally examined the patient. All recommendations should be implemented with consideration of the patient's relevant prior history and current clinical status. Please feel free to call me with any questions about the care of this patient.

[redacted]

Program Financing: 'no one size fits all'

- **Different Settings**
- **Different Payment Mechanisms**
- **Different Opportunities, Challenges, Questions**

Start-up Costs

Cost categories

- Program Leadership and Coordination
- Hiring & Training PCP, CM, Psychiatrist
- Support for practice change and change in workflows
- Support for Billing, Registry, EHR / IT

Costs vary based on size of program and experience with practice change / implementation

- Range from $5,000 (small clinic) to $100,000 (large medical group with multiple clinics)

Similar to comparable quality improvement programs

IMPACT Operating Costs

Cost components

- Care manager time and salary
  - 75 - 100 active cases for each FTE CM
- Consulting psychiatrist time
  - 0.1 FTE for each FTE CM
- Program materials
  - Educational video / brochure
- +30% overhead

$ 750 per participant for 12 months of care*

*(IMPACT costs adjusted to 2010 dollars)

IMPACT Costs Per Insured Beneficiary (PMPM)

% of patient population using depression care management	Approximate clinic population / FTE care manager	Cost per participant (12 months)	PMPM (cost per member per month)
3 %	5,000	$ 750	$ 1.88

Financing IMPACT Care

7 funding mechanisms for depression care management

- **Practice-based, fee-for-service**
- **Practice-based, health plan contract**
- **Global capitation**
- **Flexible infrastructure support**
- **Health-plan-based**
- **Third-party-based under contract to health plan**
- **Hybrid models**

Bachman et al, Gen Hospital Psychiatry 2006

Examples

- **Capitated (HMOs)**
  - Mental Health and Pharmacy Benefit carved-in (KP, GHC, VA) vs. carved-out
- **Case Rate**
  - DIAMOND Program in Minnesota
- **P4P**
  - Mental Health Integration Program in WA (MHIP)
- **Fee For Service**
  - Reimbursement rules vary by insurer, provider

FFS Billing
Goldberg & Oxman, 2004

Table 1. American Medical Association CPT Codes and Medicare Fee Schedule for Depression-Relevant Diagnosis and Management[a,b]

Code	Description	Time (min)	Allowable Fee	Medicare Payment
Psychiatry codes				
90801	Initial evaluation	N/A	$144.31	$115.45
90804	Counseling	20–30	$66.22	$33.11
90805	Counseling and medical evaluation and management	20–30	$72.60	$36.30
90806	Counseling	40–50	$99.09	$49.55
90807	Counseling and medical evaluation and management	40–50	$105.40	$52.70
90862	Pharmacologic management	N/A	$52.25	$26.13
General office evaluation and management codes[c]				
99204	Initial evaluation: comprehensive	45	$136.44	$109.15
99212	Straightforward follow-up	10	$37.86	$18.93
99213	Low complexity follow-up	15	$53.07	$26.53
99214	Moderate complexity follow-up	25	$82.80	$41.40
99215	Complex follow-up	40	$120.99	$60.49

[a]Data from the American Medical Association.[4]
[b]Medicare fees are regional. Listed fees in this table are for Rhode Island; other states will vary.
[c]Time is the controlling factor when counseling comprises > 50% of the visit.
Abbreviations: CPT = Current Procedural Terminology, N/A = not applicable.

Effective care management program may optimize

-billing by PCPs

-Incident to physician billing

Medicare Does Pay For

Two Visits on the same day

Incident too visits

Behavioral health providers in health centers

Medicare Does NOT Pay For

- **Excluded services**
- **Not medically necessary services**
- **Services denied as bundled or included in basic allowance of another service**
- **Claims denied as “unprocessable”**

CPT Codes for Behavioral Health Services in Primary Care

96151 – Re-assessment – 15 minutes

96152 – Health and Behavior Intervention – each 15 minutes face-to-face with patient

96153 – Group (2 or more patients)

96154 – Family (with patient present)

96155 – Family (without patient present)

96151 – Re-assessment – 15 minutes

96152 – Health and Behavior Intervention – each 15 minutes face-to-face with patient

96153 – Group (2 or more patients)

96154 – Family (with patient present)

96155 – Family (without patient present)

Health and Behavior Codes

- **Most insurance companies covers for 96150**
  - **Some on contract**
  - **Some as part of initiatives**
  - **Listed for use with smoking cessation, sbirt**
- **Some insurance companies might require a pre-authorization**

Other CPT Codes

- Interdisciplinary team conferences (99366, 99367 and 99368)may be used to support team conferences that address complex co-morbidities
- Alcohol Screening and Brief Intervention (99408 and 99409)
- But all of these codes need to be adopted by Medicaid agencies and commercial plans, in order to bill against them—for example, only a handful of state Medicaid agencies have implemented the SBI codes

Medicaid Reimbursement

- In many states BH is carved out
- Contractual arrangements and eligible providers vary
- Biggest documentation / coding problems in BH relate to 'medical necessity',
  - esp. with 'incident to' services / billing
  - Integral part of physician's professional practice
  - Generally not itemized separately on bill
  - Commonly furnished in physician's office or clinic
  - Furnished under physician's direct personal supervision
- E&M (992xx) and Therapy (908xx) cannot be billed on same day to some Medicaid programs

HRSA Medicaid Guide, 2003

	E&M	Initial Assessment	Psychotherapy	Behavioral Assessment
Codes?	New: 99201 thru 99205 Est'd: 99211 thru 99215	90801 Insight 90802 Interactive	90804 20 90805 90806 90807 90808 90809 80 Min.	96150 thru 96155
Where?	Medical Office or other O/P Facility	Behavior Health Office or other O/P Facility	Behavior Health Office or other O/P Facility	Behavior Health Office or other O/P Facility
What?	Medical Visit that can include Counseling 10 10 60 Min. 40 Min.	Psychiatric Diagnostic Interview Exam Interactive Dx. Interv. Using play Equip., etc.	Individual Psychoth. Insight Oriented Face-to-Face W/patient Individual Psychoth. w/ medical mgmt.	Used to identify the psychological, behavioral, emotional cognitive and social factors important to physical health. Patients not diagnosed with mental illness.
Who?	Physician, NP, Other Medical Clinicians	Psychiatrist, LCSW, CP, NP, Other (Payer criteria)	All	Clinical Psychologist, NP, Other for Medicare
Service Emphasis	Medical	Behavioral Health Initial Assessment	On-going Individual Psychotherapy	Biopsychosocial factors important to Physical Health problems and treatments

Medicare Advantage

Hierarchical Condition Category (HCC) Payment Methodology

- HCC Code 55 (Depression) adds ~ $300 to monthly payment for typical Medicare Advantage patient
- Additional revenue can easily outweigh the typical program cost of ~ $1.88 PMPM

Reimbursing Medical Home

- **Fee-for-service**
  - Face to face services
- **Per-member/per-month management fee**
  - Medicaid
- **Quality incentive**
  - Pay for performance fee
  - HMOs
- **Oversight**
  - Essential to the ultimate success of patient centered medical systems of care

References

Bachman J, Pincus H, Houtsinger JK, Unützer J. Funding Mechanisms for depression care management: opportunities and challenges. *General Hospital Psychiatry*. 2006; 28: 278-288.

Goldberg RJ, Oxman TE. Billing for the Evaluation and Treatment of Adult Depression by the Primary Care Physician. *Prim Care Companion J Clin Psychiatry*. 2004; 6(1):21-26.

National Council for Community Behavioral Healthcare:
http://www.thenationalcouncil.org/

HRSA Slides on BH Reimbursement in Primary Care Settings:
ftp://ftp.hrsa.gov/TPR/billing-behavioral-1slide-per-page.pdf

HRSA Provider Reimbursement Technical Assistance Materials:
http://www.hrsa.gov/reimbursement/TA-materials.htm

Additional Resources

SAMHSA Report on Reimbursement of Mental Health Services in Primary Care Settings:
http://download.ncadi.samhsa.gov/ken/pdf/SMA08-4324/SMA08-4324.pdf

Mental Health and Substance Abuse Procedure Codes:
http://hipaa.samhsa.gov/hipaacodes2.htm

Examples of State Billing Codes for Mental Health Services:
http://hipaa.samhsa.gov/pdf/Table_MH_Codes_Payers.pdf

Patient Centered Medical Home website:
http://www.pcmh.ahrq.gov

Additional Resources provided by Shelagh Smith, SAMHSA


Thank You
http://uwaims.org