New roles for CL Psychiatrists

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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

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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](http://impact-uw.org)).
- MacArthur Initiative on Depression and Primary Care: RESPECT study and 3CM Model [www.depression-primarycare.org/](http://www.depression-primarycare.org/)
- HRSA Bureau of Primary Care Health Disparities Collaboratives (over 100 FQHCs) [http://www.hrsa.gov/mentalhealth/](http://www.hrsa.gov/mentalhealth/)
- RWJ Program: Depression in Primary Care—Linking Clinical and System Strategies
- CiMH [http://www.cimh.org/Initiatives/Primary-Care-BH-Integration.aspx](http://www.cimh.org/Initiatives/Primary-Care-BH-Integration.aspx)
- CAL MEND [www.calmend.org](http://www.calmend.org)
- Hogg Foundation for Mental Health Integrated Mental Health Initiative in Texas ([http://www.hogg.utexas.edu/programs_ihc.html](http://www.hogg.utexas.edu/programs_ihc.html))
- VA, US Air Force, HMOs (Group Health, Kaiser Permanente), Cherokee, Washtenaw County (WCHO)
- Patient Centered Primary Care Collaborative: [www.pcpcc.net](http://www.pcpcc.net)
- Collaborative Family Healthcare Association: [www.CFHA.net](http://www.CFHA.net)
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

National Comorbidity Survey Replication
Provision of Behavioral Health Care: Setting of Service

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

- Cancer: 10 - 20%
- Neurologic Disorders: 10 - 20%
- Smoking, obesity, physical inactivity: 40 - 70%
- Chronic Physical Pain: 25 - 50%
- Heart Disease: 10 - 30%
- Diabetes: 10 - 30%
- Chronic Physical Pain: 25 - 50%

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Moving Towards Integrated Care

IDEAL
Collaborate Effectively

A GOOD START
Co-locate Services

TYPICAL
Refer for Consultation

WORST CASE
Compete
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*
- Women's 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
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Better Physical Function

SF-12 Physical Function Component Summary Score (PCS-12)

## Long-Term Cost Savings

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

Savings


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## IMPACT Replication Studies

<table>
<thead>
<tr>
<th>Patient Population (Study Name)</th>
<th>Target Clinical conditions</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult primary care patients (Pathways)</td>
<td>Diabetes and Depression</td>
<td>Katon et al, 2004</td>
</tr>
<tr>
<td>Adult patients in safety net clinics (project Dulce; Latinos)</td>
<td>Diabetes and Depression</td>
<td>Gilmer et al, 2008</td>
</tr>
<tr>
<td>Public sector oncology clinic</td>
<td>Cancer and Depression</td>
<td>Dwight-Johnson et al, 2005</td>
</tr>
<tr>
<td>County hospital oncology clinic (Latino patients)</td>
<td>Cancer and Depression</td>
<td>Ell et al, 2008</td>
</tr>
<tr>
<td>HMO patients</td>
<td>Depression in primary care</td>
<td>Grypma et al, 2006</td>
</tr>
<tr>
<td>Adolescents in primary care</td>
<td>Adolescent Depression</td>
<td>Richardson et al, 2009</td>
</tr>
<tr>
<td>Older adults</td>
<td>Arthritis and Depression</td>
<td>Unutzer et al, 2008</td>
</tr>
<tr>
<td>Acute Coronary Syndrome patients (COPES)</td>
<td>Coronary Events and Depression</td>
<td>Davidson et al, 2010</td>
</tr>
</tbody>
</table>
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
- SAMHSA
  - National Registry of Evidence-Based Programs and Practices (NREPP)

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

The IMPACT Implementation Center conducts in-person training across the country to offer cutting-edge training. Here is information on upcoming training events:

**Upcoming Presentations and Training Events:**

- **October 2-3, 2014:** Seattle, WA
  - University of Washington/IMPACT Training Conference
  - Registration opening soon; keep checking back!

**Past Presentations and Training Events:**

- **February 20-21, 2013:** Anchorage, AK
  - Alaska Mental Health Trust

- **February 13-15, 2013:** Minneapolis, MN
  - HIEA/MN/IBM/IMPACT Training Conference

- **January 12-13, 2013:** Seattle, WA
  - Vida Europe/Atlantic Health (CAN/IMPACT Training)

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AIMS CENTER | Advancing Integrated Mental Health Solutions
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

DIAMOND

DIAMOND is one of the nation's most promising efforts to improve healthcare 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.
6-month outcomes from the first 10 implementing clinics

Moving beyond common mental disorders
Comorbidity is common in safety net populations

52 percent had substance abuse or mental illness identified
31 percent had a chronic physical condition only

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

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

Chronic Physical Condition

- Chronic Physical
  - Only 31%
  - All Three 13%

Alcohol/Drug Problem

- AOD Only 5%
- AOD + MI 3%
- MI Only 5%

Mental Illness

- Physical + MI 14%

Primary Conditions

- Chronic Physical 69%
- Mental Illness 36%
- Substance Abuse 32%

Sources: MMIS claims, TARGET service encounters, and WSP arrest records, FY 2003-04. Chronic physical and mental illness diagnosis groups derived from CDPS grouper.
A Partnership to Promote Patient-Centered Collaboration

What is MHIP?

What is MHIP? [http://integratedcare-nw.org](http://integratedcare-nw.org)

Integration & Collaboration

The Mental Health Integration Program 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)

- Helpful or Very Helpful: 70.00%
- Neutral: 20.00%
- Not Helpful: 10.00%

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MHIP: 15,000 clients served

Projectwide Weekly Accumulated Enrollment

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# Client Demographics

<table>
<thead>
<tr>
<th></th>
<th>Mean or %</th>
<th>Range across clinics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>52 %</td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>48 %</td>
<td></td>
</tr>
<tr>
<td>Mean Age</td>
<td>40</td>
<td>1-100</td>
</tr>
<tr>
<td>Challenge with Housing</td>
<td>29 %</td>
<td>3% - 52 %</td>
</tr>
<tr>
<td>Challenge with Transportation</td>
<td>21 %</td>
<td>10 % - 50 %</td>
</tr>
</tbody>
</table>
## Common Client Diagnoses (L1)

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>71 %</td>
</tr>
<tr>
<td>Anxiety</td>
<td>48 %</td>
</tr>
<tr>
<td>Posttraumatic Stress Disorder (PTSD)</td>
<td>17 %</td>
</tr>
<tr>
<td>Alcohol / Substance Abuse</td>
<td>17 %*</td>
</tr>
<tr>
<td>(likely underreported)</td>
<td></td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>15 %</td>
</tr>
</tbody>
</table>

... 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

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

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

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## Program Staffing in Diverse Clinic Settings

<table>
<thead>
<tr>
<th>Clinic Population (mental health needs)</th>
<th>% of clinic population with need for care management</th>
<th>Typical caseload size for 1 FTE Care Manager</th>
<th># of unique primary care clinic patients to justify 1 FTE CM</th>
<th>Typical personnel requirement for 1,000 unique primary care patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>FTE Care Manager</td>
</tr>
<tr>
<td>Low need (e.g., insured, employed)</td>
<td>2%</td>
<td>100</td>
<td>5000</td>
<td>0.2</td>
</tr>
<tr>
<td>Medium need (e.g., comorbid medical needs / chronic pain / substance abuse)</td>
<td>5%</td>
<td>75</td>
<td>1500</td>
<td>0.7</td>
</tr>
<tr>
<td>High need (e.g, safety-net population)*</td>
<td>15%</td>
<td>50</td>
<td>333</td>
<td>3</td>
</tr>
</tbody>
</table>
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 primary care coordinators treating MHIP patients in participating community health centers (CHCs) and care clinics.

DUTIES AND RESPONSIBILITIES

1. Provide regularly scheduled (usually weekly) caseload consultation to assigned care coordinators. 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 on the CCs' caseload.
3. Work with the assigned CCs to track and oversee their patient panels and clinical outcome-based MHITS care management tracking systems.
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
Clinics

- 6 primary care clinics serving complex safety net clients.
- Severe baseline depression & anxiety scores.
- Mature programs with high rates of engagement, follow-up, and clinical improvement.

LCSW

Caseload summaries help manage

- Clinical productivity
- Quality improvement
### Member Information

**Status:** Evaluated - Accepted into Level 1

### Working Diagnoses

1. **Depression (PHQ-9: 0/17, Minimal)**
2. **Anxiety (GAD-7: 0/21)**
3. **PTSD (PCL: 56/85)**

### Assessment

Patient (PT) feels significantly better. No depressive sx or 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

**Past Suicide Attempts:** None reported.

### Medications

1. **Sertraline (Zoloft) / 50mg**

### Other Treatment

None recorded

### 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

1 referral closed.
Preliminary Diagnoses:
- Depression (PHQ-9: 0/27, Minimal)
- Anxiety (GAD-7: 0/21)
- PTSD (PCL: 5/55)

Current Concerns: Pt feels significantly better. No depressive sx's 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 had his significant w his new anti-depressant. She feels that her life in general has improved and has no particular concerns.

Treatment Progress:

- PHQ-9
- GAD-7

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

Recent Psychiatric Medications:
- None reported

Recent Employment:
- None reported

Recent Housing:
- None reported

Future Goals:
- Pleasant Events Scheduling: Make it a point to do some things this week that you have identified that you enjoy.
- Talking with her son, Dancing with children, Going soccer games and practices, Talk to my friends and brother.
- Eating at least one meal w husband and children. Plan: pt will use exercise equipment to increase her energy and run. She will borrow her sister's machine.

Past Suicide Attempts:
- None reported

Psychiatric Note

Last updated by: Consulting Psychiatrist (Marc A)
Safety Concerns:
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. Plnt pt will use exercise equipment to increase her energy and run. She will borrow her sister’s machine.
Referrals: None recorded.

Psychiatrist Note

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, Chronic mycosis, Left renal cyst, Migraine HA.
Substance Use: ETOH: Use: social drink, every Frday 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.
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)

<table>
<thead>
<tr>
<th>% of patient population using depression care management</th>
<th>Approximate clinic population / FTE care manager</th>
<th>Cost per participant (12 months)</th>
<th>PMPM (cost per member per month)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 %</td>
<td>5,000</td>
<td>$ 750</td>
<td>$ 1.88</td>
</tr>
</tbody>
</table>
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
Effective care management program may optimize -billing by PCPs -Incident to physician billing

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Time (min)</th>
<th>Allowable Fee</th>
<th>Medicare Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>90801</td>
<td>Initial evaluation</td>
<td>N/A</td>
<td>$144.31</td>
<td>$115.45</td>
</tr>
<tr>
<td>90804</td>
<td>Counseling</td>
<td>20–30</td>
<td>$66.22</td>
<td>$33.11</td>
</tr>
<tr>
<td>90805</td>
<td>Counseling and medical evaluation and management</td>
<td>20–30</td>
<td>$72.60</td>
<td>$36.30</td>
</tr>
<tr>
<td>90806</td>
<td>Counseling</td>
<td>40–50</td>
<td>$99.09</td>
<td>$49.55</td>
</tr>
<tr>
<td>90807</td>
<td>Counseling and medical evaluation and management</td>
<td>40–50</td>
<td>$105.40</td>
<td>$52.70</td>
</tr>
<tr>
<td>90862</td>
<td>Pharmacologic management</td>
<td>N/A</td>
<td>$52.25</td>
<td>$26.13</td>
</tr>
</tbody>
</table>

**Psychiatry codes**

**General office evaluation and management codes[^c]**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Time (min)</th>
<th>Allowable Fee</th>
<th>Medicare Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>99204</td>
<td>Initial evaluation: comprehensive</td>
<td>45</td>
<td>$136.44</td>
<td>$109.15</td>
</tr>
<tr>
<td>99212</td>
<td>Straightforward follow-up</td>
<td>10</td>
<td>$37.86</td>
<td>$18.93</td>
</tr>
<tr>
<td>99213</td>
<td>Low complexity follow-up</td>
<td>15</td>
<td>$53.07</td>
<td>$26.53</td>
</tr>
<tr>
<td>99214</td>
<td>Moderate complexity follow-up</td>
<td>25</td>
<td>$82.80</td>
<td>$41.40</td>
</tr>
<tr>
<td>99215</td>
<td>Complex follow-up</td>
<td>40</td>
<td>$120.99</td>
<td>$60.49</td>
</tr>
</tbody>
</table>

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


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

HRSA Slides on BH Reimbursement in Primary Care Settings:  

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