Collaborative Care Approaches to Fixing Behavioral Health Care in America

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## Mental Health Costs

<table>
<thead>
<tr>
<th>POPULATION</th>
<th>% WITH BEHAVIORAL HEALTH DIAGNOSIS</th>
<th>PMPM WITHOUT BH DIAGNOSIS</th>
<th>PMPM WITH BH DIAGNOSIS</th>
<th>INCREASE IN TOTAL PMPM WITH BH DIAGNOSIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td>14%</td>
<td>$340</td>
<td>$941</td>
<td>276%</td>
</tr>
<tr>
<td>Medicare</td>
<td>9%</td>
<td>$583</td>
<td>$1429</td>
<td>245%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>21%</td>
<td>$381</td>
<td>$1301</td>
<td>341%</td>
</tr>
<tr>
<td>All Insurers</td>
<td>15%</td>
<td>$397</td>
<td>$1085</td>
<td>273%</td>
</tr>
</tbody>
</table>

Integrated Care

• Improves *access* for patients
  – Nearby primary care clinic
  – More timely appointments
  – Less stigmatizing
  – Lower out-of-pocket costs

• Increases *capacity* of mental health providers
  – Consultation
  – Collaboration
  – Leverages scarce mental health resources
Not All Integration Efforts Are Effective

• Most models of integrated care are not evidence based

• Some models of integrated care are known *NOT to work*:
  – PCP education
  – Screening (without adequate systems in place to ensure accurate dx & tx)
  – *Co-located* behavioral health specialists without systematic tracking of outcomes or evidence-based treatments
  – Disease management without direct collaboration with PCP
Core Principals of Collaborative Care

- **Team-based** - lead by a PCP with support from a care manager and consultation from a psychiatrist who provides treatment recommendations for patients who are not achieving clinical goals
- **Population-based** - whereby a registry is used to monitor treatment adherence and drop out
- **Measurement-based** - monitoring of patient-reported outcomes over time to assess treatment response
- **Patient-centered** - proactive outreach to engage, activate, promote self-management and treatment adherence, and coordinate services
- **Evidence-based** - demonstrated cost-effectiveness in diverse practice settings and patient populations
- **Practice-tested** - with sustained adoption in hundreds of clinics across the country
Using a Registry is Important!

• Registries help care managers to more easily manage a caseload of patients:
  – Identify patients who may be disengaged, falling through the cracks
  – Track outcomes over time so to evaluate response to treatment and prioritize patients for psychiatric case review:
    • Who is newly enrolled on your caseload?
    • Who is not improving as expected?
Collaborative Care - Cochrane Review

• 79 randomized controlled trials
  – 24,308 enrolled patients

• Compared to usual care (screening, referral etc.)
  – ↑ Response and remission rates
  – ↑ Quality of life
  – ↑ Patient satisfaction
  – ↓ Costs over the long run

• Results are consistent across populations
  – Stages of life
    • Adolescents → Adults → Older Adults
  – Minorities
  – Diagnoses
    • Depression
    • Anxiety
    • SUD

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What About Small Primary Care Practices And Non-integrated Health Systems?
Collaborative Care Is Practice-Tested

- **COMPASS**
  - Medicare and Medicaid
  - 7 states
  - 4,000 patients

- **DIAMOND**
  - Commercial Insurance
  - Minnesota
  - 12,000 patients

- **MHIP**
  - Medicaid
  - Washington State
  - 55,000 patients

- **Department of Veterans Affairs - PC-MHI**
  - Fixed Budget
  - Nationwide
  - 1,000,000 patients
Stepped Model of Integrated Behavioral Health Care

1. Primary care provider (PCP) provides first-line treatment
2. PCP receives ad-hoc consultation, usually from an off-site mental health specialist
3. PCP supported by brief intervention from on-site behavioral health consultant
4. PCP supported by a collaborative care team with systematic treatment to target
5. Referral to mental health specialty care
2016 Issue Brief on Collaborative Care

- Detailed overview of Collaborative Care and summary of the key issues
- Provides guidance and recommendations for implementation of Collaborative Care

New Book Focuses on Building Effective Integrated Care Teams

- Refine clinical approaches used in primary care
- Learn integrated care best practices
- Gain practical implementation skills
- Increase access, improve outcomes, lower costs

Available for purchase at Wiley.com and Amazon
AIMS Center Training at a Glance

https://aims.uw.edu/

Pre-Launch Training
- Focuses on building foundational knowledge around the evidence-base and key components of Collaborative Care and team roles
- 1.5 to 2 hours of time required, depending on role
- Delivered as self-paced online learning modules
- Typically completed 1 month prior to in-person training

In-Person Clinician Training
- Focuses on building skills that are critical to teams delivering care in a new way, such as:
  - Effective team communication
  - Identifying common implementation challenges
  - Brief behavioral interventions
  - The Care Manager’s Role
- Emphasis on experiential, active learning
- 1-2 days of time required, depending on role
- We recommend that this training occur within 1-2 weeks before launching care

Post-Launch Coaching/Technical Assistance
- Focuses on coaching/technical assistance for care managers and psychiatric consultants
- On-going distance learning
- Monthly 60 to 90 minute webinars & case calls for care managers
- Webinar topics for care managers include:
  - patient engagement
  - treating to target & follow-up
  - relapse prevention
  - working with difficult patients
- Monthly and/or quarterly case calls for psychiatric consultants, with an emphasis on the weekly systematic case review process

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Performance Metrics For Collaborative Care

- **2016 USPS Task Force Recommendations**
  - Depression screening in general population
    - If adequate systems in place to ensure accurate dx & tx

- **2016 Medicare Consensus Core Set: ACO & PCMH Measures**
  - Depression remission
    - PHQ9 less than 5 @ 12 months
  - Depression response
    - PHQ9 decrease by greater than 50% @ 12 months

- **2017 NCQA HEDIS Depression Metrics**
  - Monitor Patient Outcomes Following Depression Diagnosis
    - PHQ9 for adults
    - PHQA for adolescents
  - Depression remission
    - PHQ less than 5 within 5-7 months of evaluated PHQ
  - Depression response
    - PHQ decrease by greater than 50% within 5-7 months of evaluated PHQ
Reimbursement For Collaborative Care

• AMA CPT Board
  – Approved 3-Code Structure in Feb 2016

• CMS
  – G Codes proposed for 2017 Physicians’ Fee Schedule

• NY and WA Medicaid Collaborative Care Program
  – Monthly case rate for eligible beneficiaries bundles payment for care management and psychiatric case review
  – Pay for performance withhold

• Accountable Care Organizations
  – NCQA HEDIS depression metrics driving value based purchasing ACOs
    • Boeing: UW ACO at risk for poor response/remission rates
Thank you!