



Care Coordination for Behavioral Health Problems in Primary Care Settings; How Far Can We Stretch This Approach?

Chair: Mark Williams MD

Speakers: Akuh Adaji MBBS PhD, Angela Mattson D.N.P, M.S., R.N., NE-BC

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EDUCATIONAL OBJECTIVES

- Describe the basic components of care coordination based on current evidence and where the evidence is strongest
 - Presenter: Akuh Adaji
- Provide examples of implementation of two of these models
 - Presenter: Mark Williams
- Practical challenges for implementation and ideas on solutions
 - Presenter: Angela Mattson
- Develop an argument for care coordination to bring to your own work environment
 - Mark Williams and Angela Mattson

Disclosures

- Mark Williams
 - National Education Institute
 - Acupera
- Akuh Adaji, MD
 - None
- Angela Mattson, D.N.P, M.S., R.N., NE-BC
 - None
- No off label medications



Why Do We Need Care Coordination?



Majority of Patients Not Treated

Comparing survey data

- NCS – 1990-1992
- NCSR – 2001-2003

Of all US patients with MH disorder (2001-2003)

- Receiving any treatment **32.9%**
- Rate of treatment growing fastest in Gen Med
 - General Medicine - increased 2.59 times
 - Psychiatric Services – increased 2.17 times
 - Kessler et al. NEJM, June 16, 2005

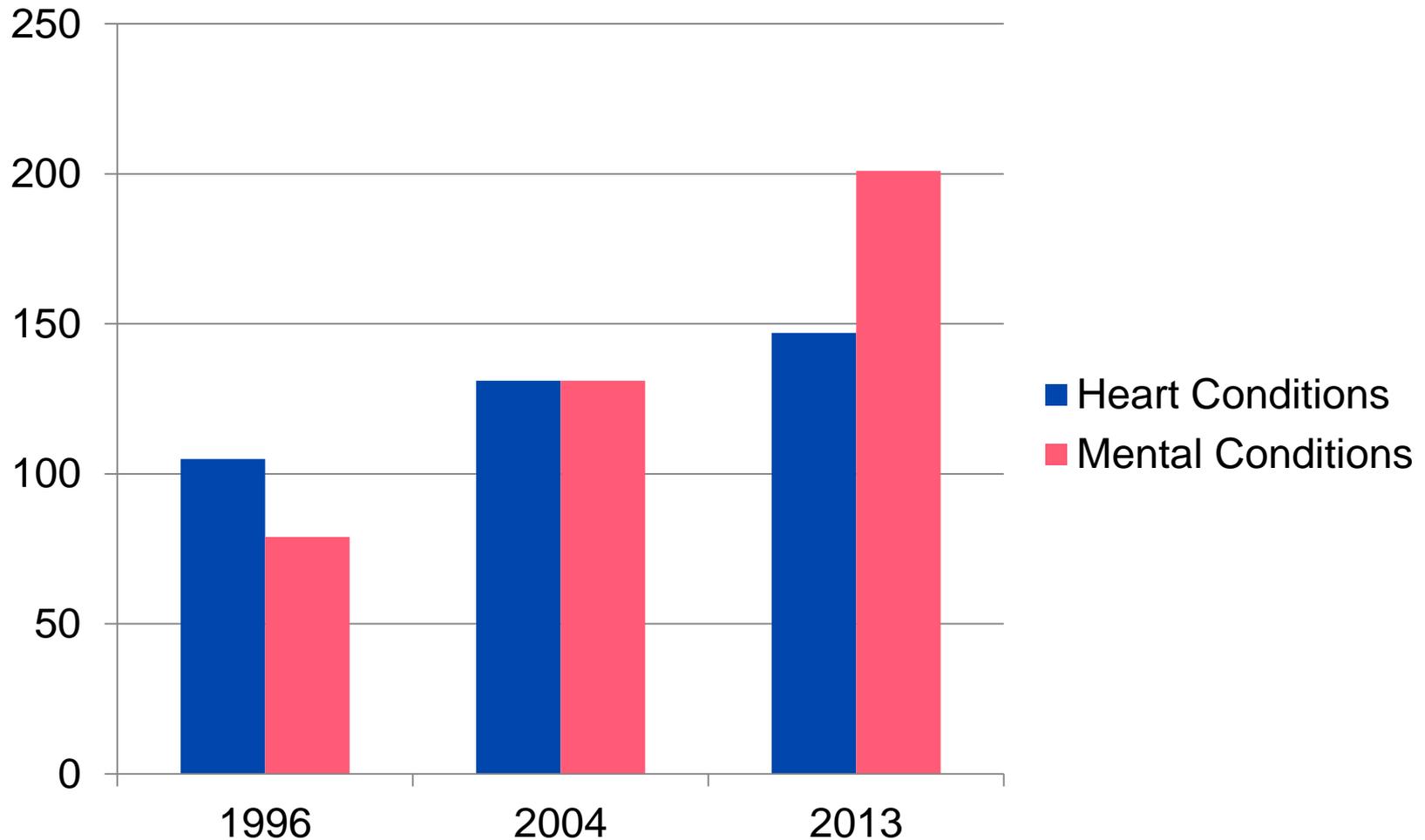
Not Enough Psychiatrists



- Psychiatry resources in USA
 - 2,600 more psychiatrists needed now to eliminate shortages
 - Based on ratio of 1:30,000 (<http://www.hrsa.gov/shortage/>)
 - Aging group – nearly 55% of current psychiatrists are 55 or older
 - Compared with 37.6% of all MDs
 - Medical students going into psychiatry
 - 4% of graduating seniors

Mental Health Conditions Most Costly Medical Condition in US at 201 billion

2013 data from National Health Expenditure Accounts



Cost Savings With Effective Integration:

Milliman American Psychiatric Association Report – April 2014

Figure 1: Projected Healthcare Cost Savings Through Effective Integration (National, 2012)

Payer Type	Annual Cost Impact of Integration
Commercial	\$15.8-\$31.6 billion
Medicare	\$3.3-\$6.7 billion
Medicaid	\$7.1-\$9.9 billion
Total	\$26.3-\$48.3 billion

- Most of savings in medical area since medical costs for treating those patients with chronic medical and comorbid mental health/substance use disorder (MH/SUD) conditions can be **2-3 times higher**.
- <http://www.psych.org/practice/professional-interests/integrated-care/integrated-care-reconnecting-the-brain-and-the-body>



Objective One

Describe the basic components of care coordination based on current evidence and where the evidence is strongest

Definitions

Illustration: A family tree of related terms used in behavioral health and primary care integration

See glossary for details and additional definitions

Integrated Care

Tightly integrated, on-site teamwork with unified care plan as a standard approach to care for designated populations. Connotes organizational integration involving social & other services. "Attitudes" of integration: 1) Integrated treatments, 2) integrated program structure; 3) integrated system of programs, and 4) integrated payments. (Based on SAMHSA)

Patient-Centered Care

"The experience (to the extent the informed, individual patient desires it) of transparency, individualization, recognition, respect, dignity, and choice in all matters, without exception, related to one's person, circumstances, and relationships in health care"—or "nothing about me without me" (Berwick, 2011).

Coordinated Care

The organization of patient care activities between two or more participants (including the patient) involved in care, to facilitate appropriate delivery of healthcare services. Organizing care involves the marshalling of personnel and other resources needed to carry out required care activities, and often managed by the exchange of information among participants responsible for different aspects of care" (AHRQ, 2007).

Shared Care

Predominately Canadian usage—PC & MH professionals (typically psychiatrists) working together in shared system and record, maintaining 1 treatment plan addressing all patient health needs. (Kates et al, 1996; Kelly et al, 2011)

Collaborative Care

A general term for ongoing working relationships between clinicians, rather than a specific product or service (Doherty, McDaniel & Baird, 1996). Providers combine perspectives and skills to understand and identify problems and treatments, continually revising as needed to hit goals, e.g. in collaborative care of depression (Unützer et al, 2002)

Co-located Care

BH and PC providers (i.e. physicians, NP's) delivering care in same practice. This denotes shared space to one extent or another, not a specific service or kind of collaboration. (adapted from Blount, 2003)

Integrated Primary Care or Primary Care Behavioral Health

Combines medical & BH services for problems patients bring to primary care, including stress-linked physical symptoms, health behaviors, MH or SA disorders. For any problem, they have come to the right place—"no wrong door" (Blount). BH professional used as a consultant to PC colleagues (Sabin & Borus, 2009; Haas & deGruy, 2004; Robinson & Reiter, 2007; Hunter et al, 2009).

Behavioral Health Care

An umbrella term for care that addresses any behavioral problems bearing on health, including MH and SA conditions, stress-linked physical symptoms, patient activation and health behaviors. The job of all kinds of care settings, and done by clinicians and health coaches of various disciplines or training.

Patient-Centered Medical Home

An approach to comprehensive primary care for children, youth and adults—a setting that facilitates partnerships between patients and their personal physicians, and when appropriate, the patient's family. Emphasizes care of populations, team care, whole person care—including behavioral health, care coordination, information tools and business models needed to sustain the work. The goal is health, patient experience, and reduced cost. (Joint Principles of PCMH, 2007).

Mental Health Care

Care to help people with mental illnesses (or at risk)—to suffer less emotional pain and disability—and live healthier, longer, more productive lives. Done by a variety of caregivers in diverse public and private settings such as specialty MH, general medical, human services, and voluntary support networks. (Adapted from SAMHSA)

Substance Abuse Care

Services, treatments, and supports to help people with addictions and substance abuse problems suffer less emotional pain, family and vocational disturbance, physical risks—and live healthier, longer, more productive lives. Done in specialty SA, general medical, human services, voluntary support networks, e.g. 12-step programs and peer counselors. (Adapted from SAMHSA)

Primary Care

Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. (Institute of Medicine, 1994)

Thanks to Benjamin Miller and Jürgen Unützer for advice on organizing this illustration

General Definition of Care Coordination

“Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient.”

- Agency for Healthcare Research and Quality definition

Essential Elements of Care Coordination

- Team driven care
- Population focused care
- Measurement guided care
- Evidence based care
- Challenges:
 - Involvement of the patient?
 - Allows many different models in practice
 - Which ones get results?

Models

- Metaanalysis data
 - Not all outcomes are consistently possible
 - Not all types of patient problems are covered with an evidence based model
- Management of adult depression
 - IMPACT trial
- Spreading to complex patients with medical issues
 - TEAMcare trial

Evidence For Care Coordination

- Cochrane review involving 79 Randomized Controlled Trials involving 24,308 patients worldwide
- Depression outcomes for adults
 - Short-term (6m) RR 1.32 (1.22 - 1.43)
 - Medium-term (7-12m) RR 1.31 (1.17 - 1.48)
 - Long-term (13-24m) RR 1.29 (1.18 - 1.41)
 - Very long term (25 m +) RR 1.12 (0.98 – 1.27)*
- Anxiety outcomes for adults
 - Short-term RR 1.50 (1.21 - 1.87)
 - Medium-term RR 1.41 (1.18 - 1.69)
 - Long-term RR 1.26 (1.11 - 1.42)
 - Very long term unavailable

- Archer J, et all Cochrane vol. 10, 2012

Example: IMPACT



IMPACT Study Methods

Design: Multi-center randomized control trial: Participants randomly assigned to IMPACT or Care as Usual

Intervention: Collaborative care program for late-life depression

- depression care manager in primary care
- proactive follow-up
- antidepressant medications or PST-PC
- expert consultation / back-up

Unützer et al, *Med Care* 2001; 39(8):785-99

IMPACT Study Methods (con't)



Participants: 1,801 older adults with SCID diagnoses of major depression/ dysthymia from 18 primary care clinics / 8 diverse health care systems in 5 states. 400 primary care providers

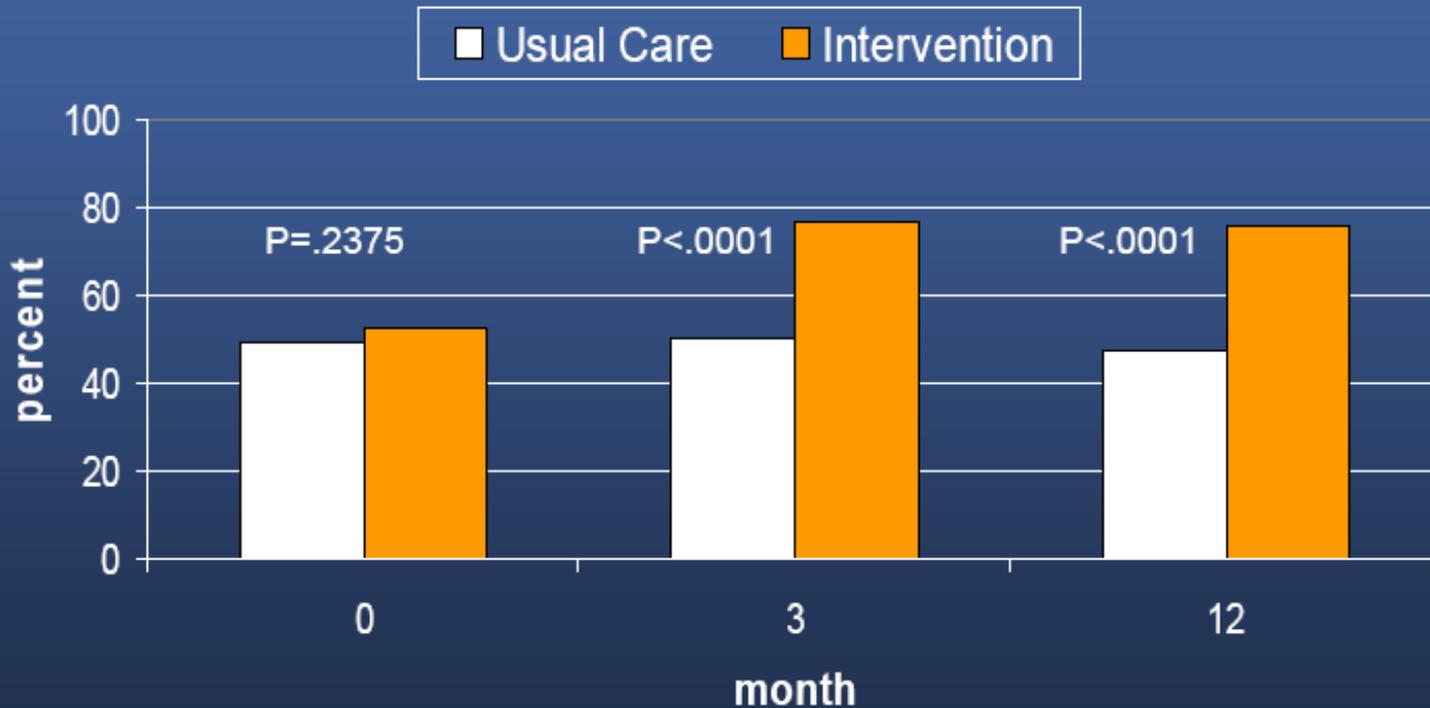
Duration: 12 month intervention; 2 year follow-up

Outcomes: quality of care, satisfaction with care, depression severity, functioning, quality of life.

Unützer et al, *Med Care* 2001; 39(8):785-99

Satisfaction

Satisfaction with Depression Care (% Excellent, Very Good)

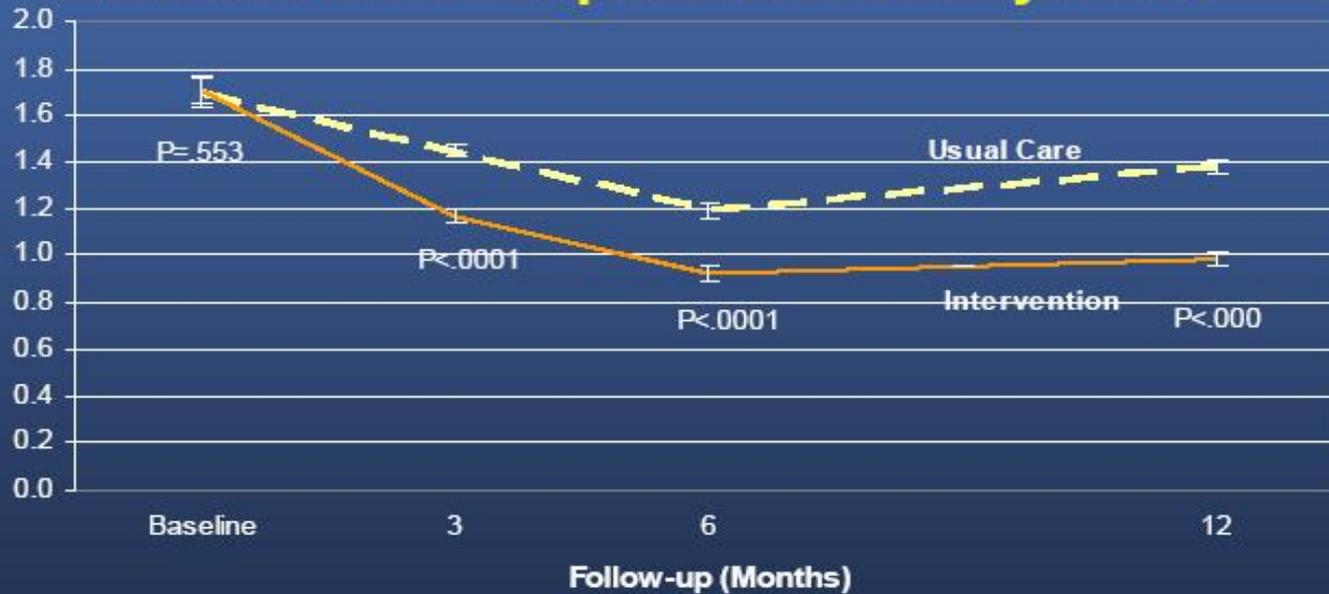


Unützer et al, JAMA 2002; 288:2836-2845

Efficacy



Mean HSCL-20 Depression Severity Score

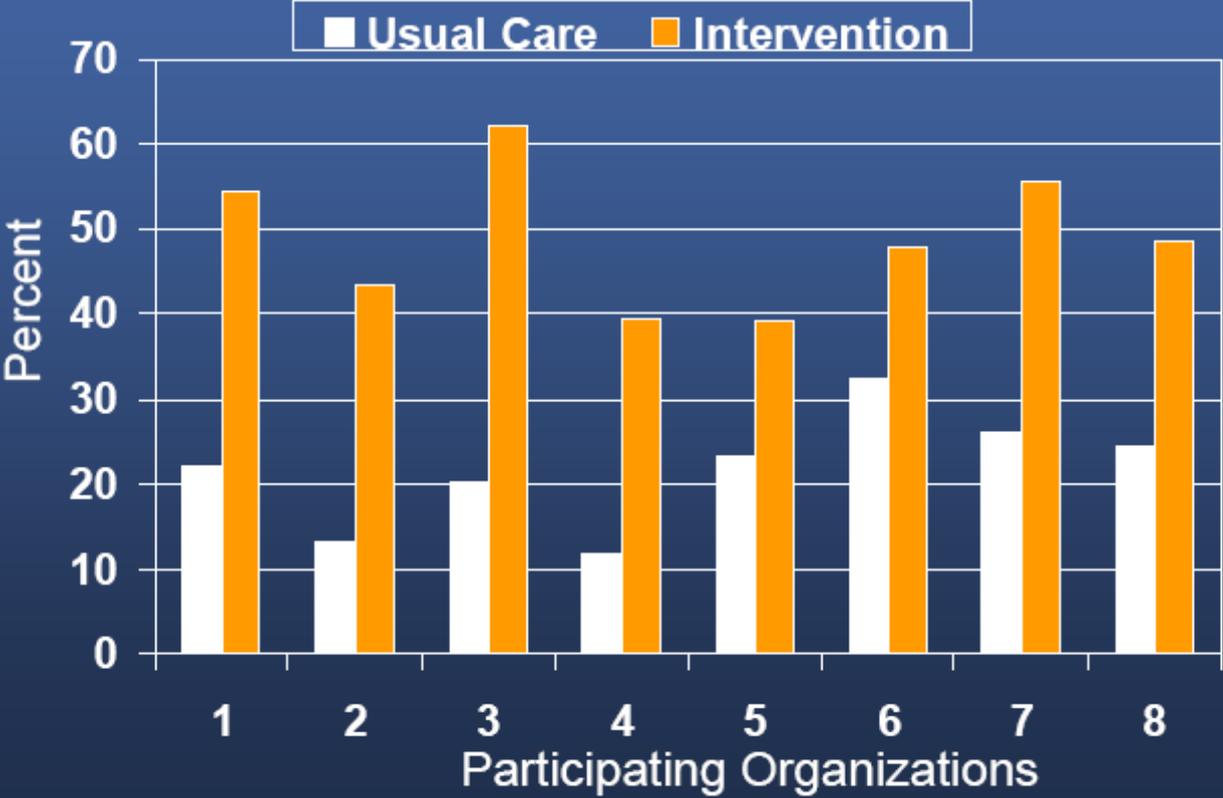


JAMA 2002; 288:2836-2845

Effective in Many Systems of Care

Findings Robust Across Diverse Health Care Organizations

(>= 50 % reduction in depression from baseline at 12 months)

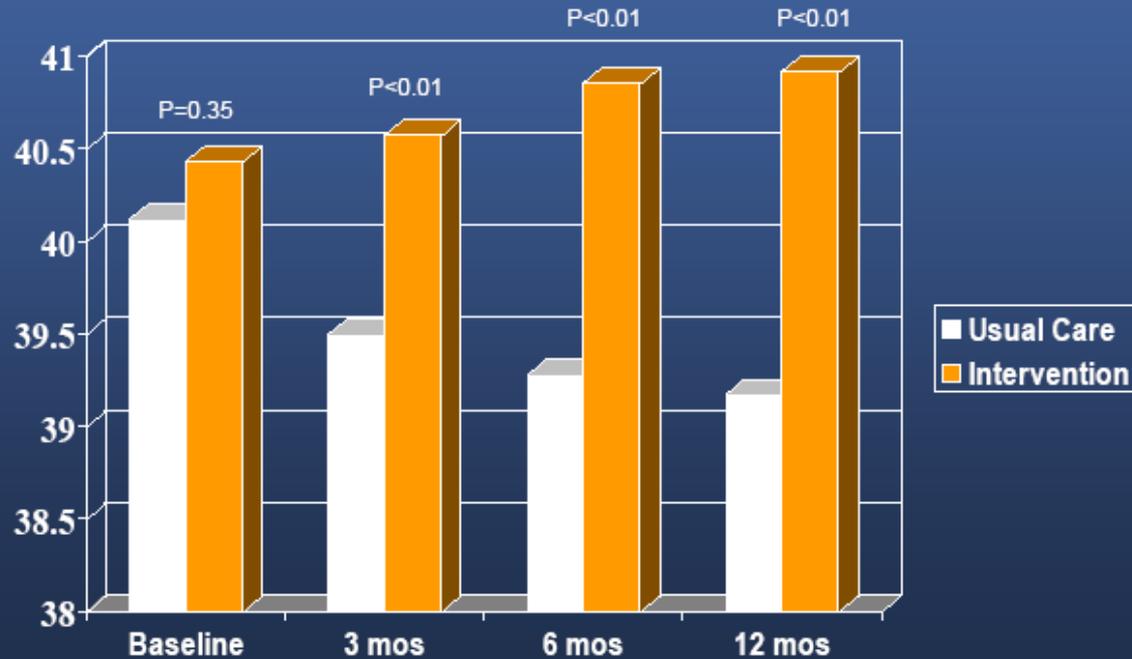


Benefits Beyond Mental Health...

Better Physical Function



PCS-12



Callahan et al, JAGS; 53:367-373

Long Term for IMPACT

- Benefits persist for 2 years
 - 12 months after completion of intervention
 - 16% intervention vs 10% controls in remission
 - 34% intervention vs 23% controls with 50% drop from baseline depression score

IMPACT Only Addresses Depression

Patients often have more than one chronic illness

TEAMCare: Methods

Design: A single-blind, randomized, controlled trial in 14 primary care clinics in an integrated health care system in Washington State

Intervention: medically supervised nurse, working with each patient's primary care physician, provided guideline-based, collaborative care management, with the goal of controlling risk factors associated with multiple diseases.

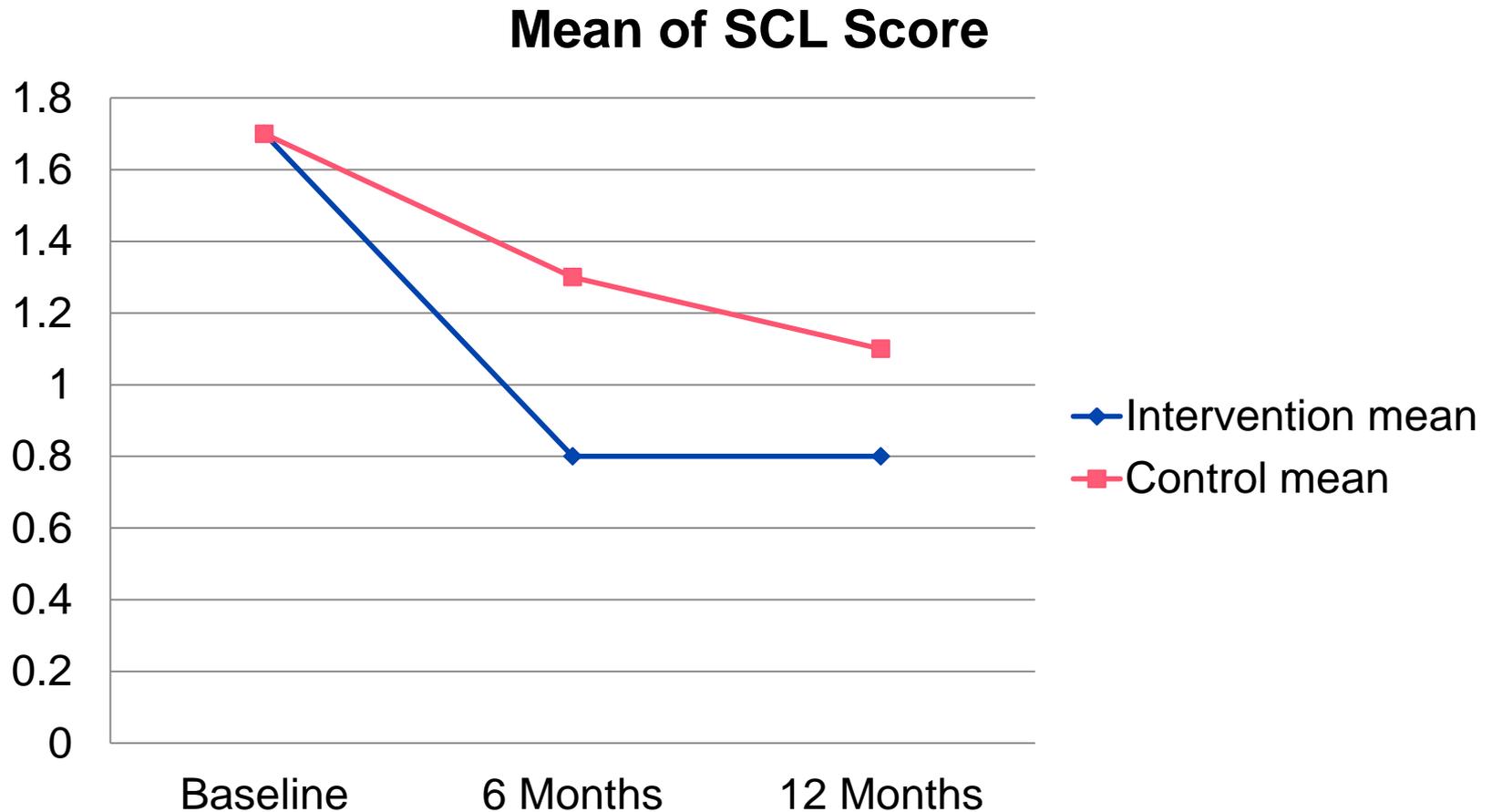
TEAMCare Study Methods *(continued)*

Participants: 214 participants (106 in the intervention group and 108 in the usual-care group) with poorly controlled diabetes, coronary heart disease, or both and coexisting depression.

Duration: 12 month intervention

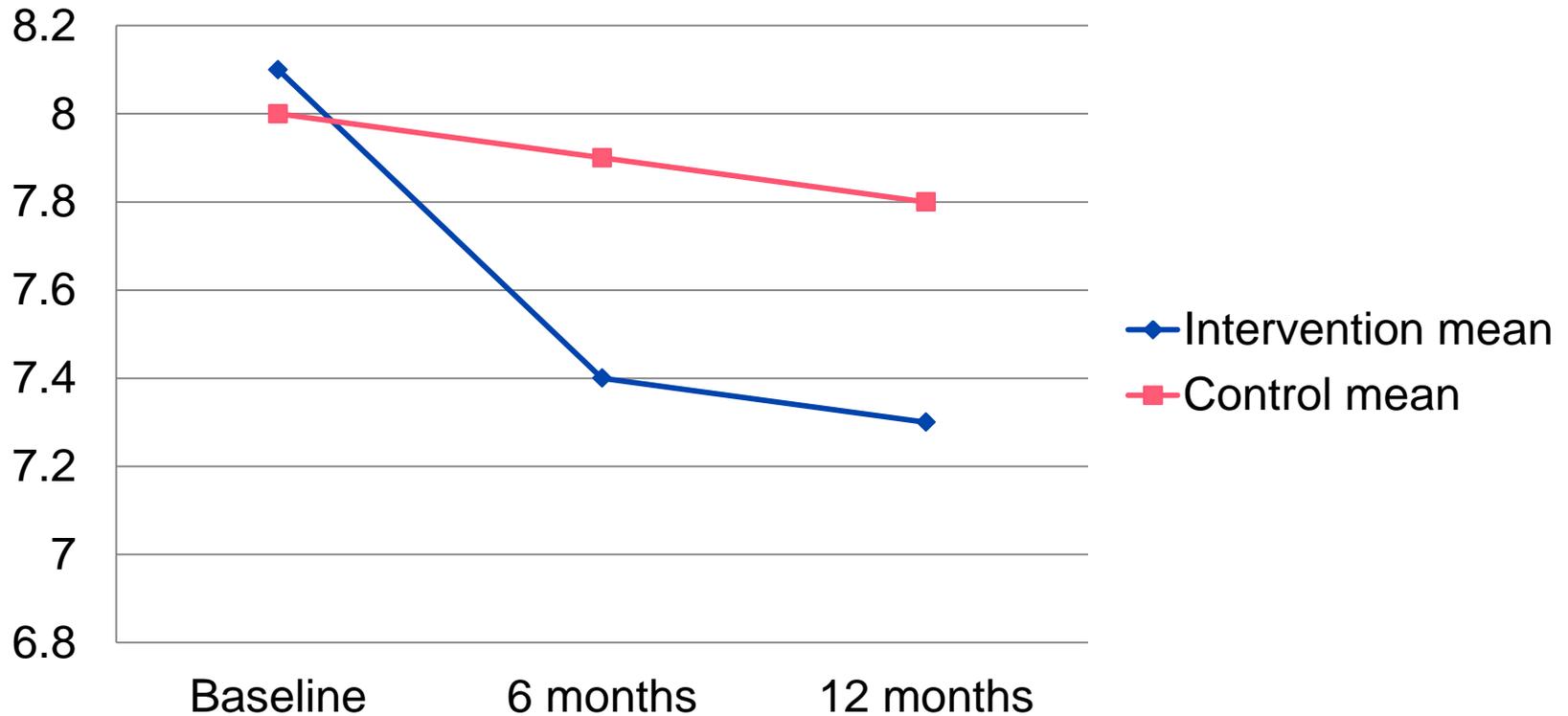
Outcomes: Simultaneous modeling of HbA1c, LDL, and systolic BP and Symptom Checklist–20 (SCL-20) depression outcomes at 12 months; satisfaction with care, quality of life, adherence to diet and exercise regimens, health care costs

Depression Outcomes



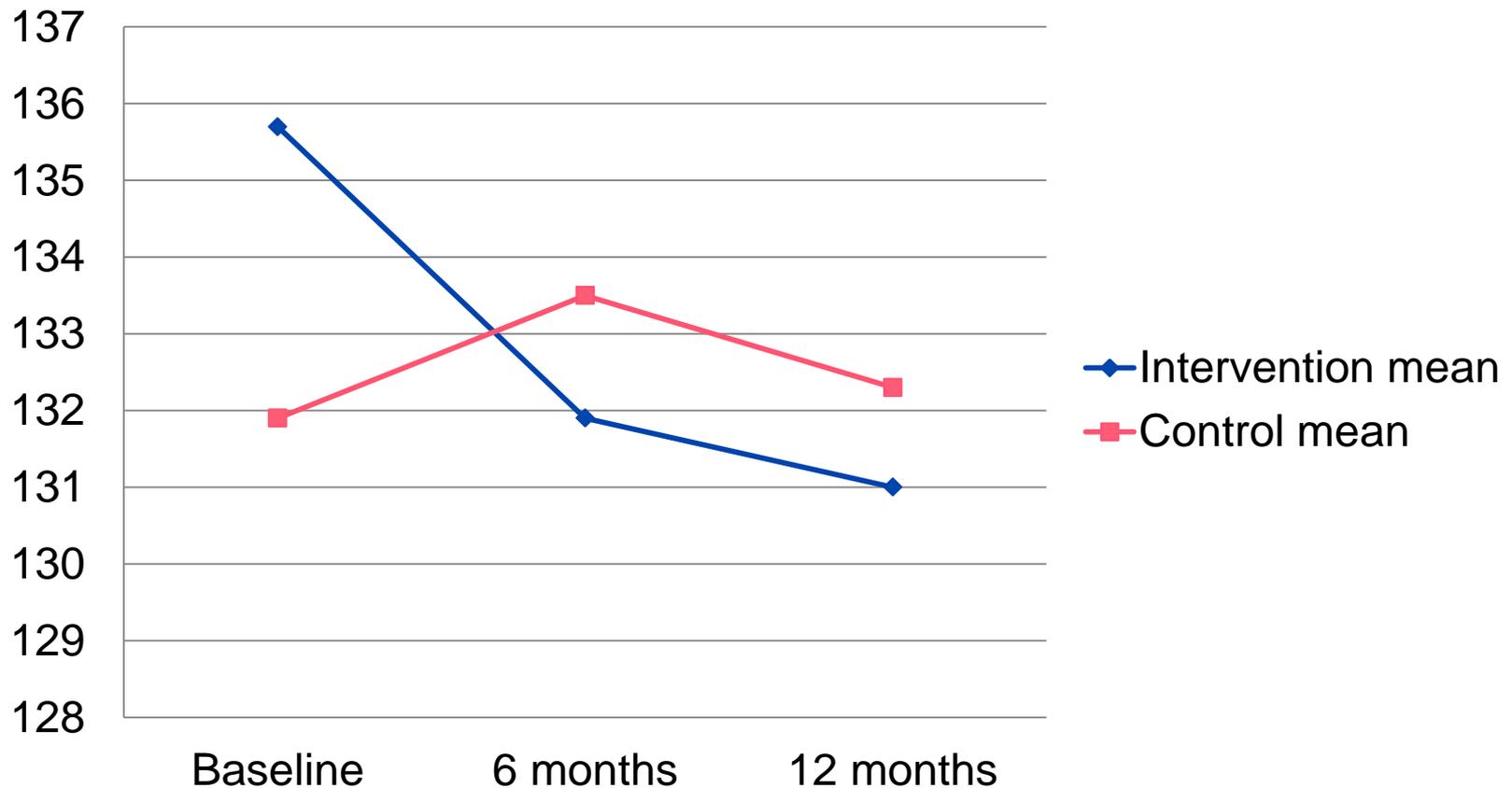
Diabetes (HbA1c) Outcomes

Mean of HbA1c



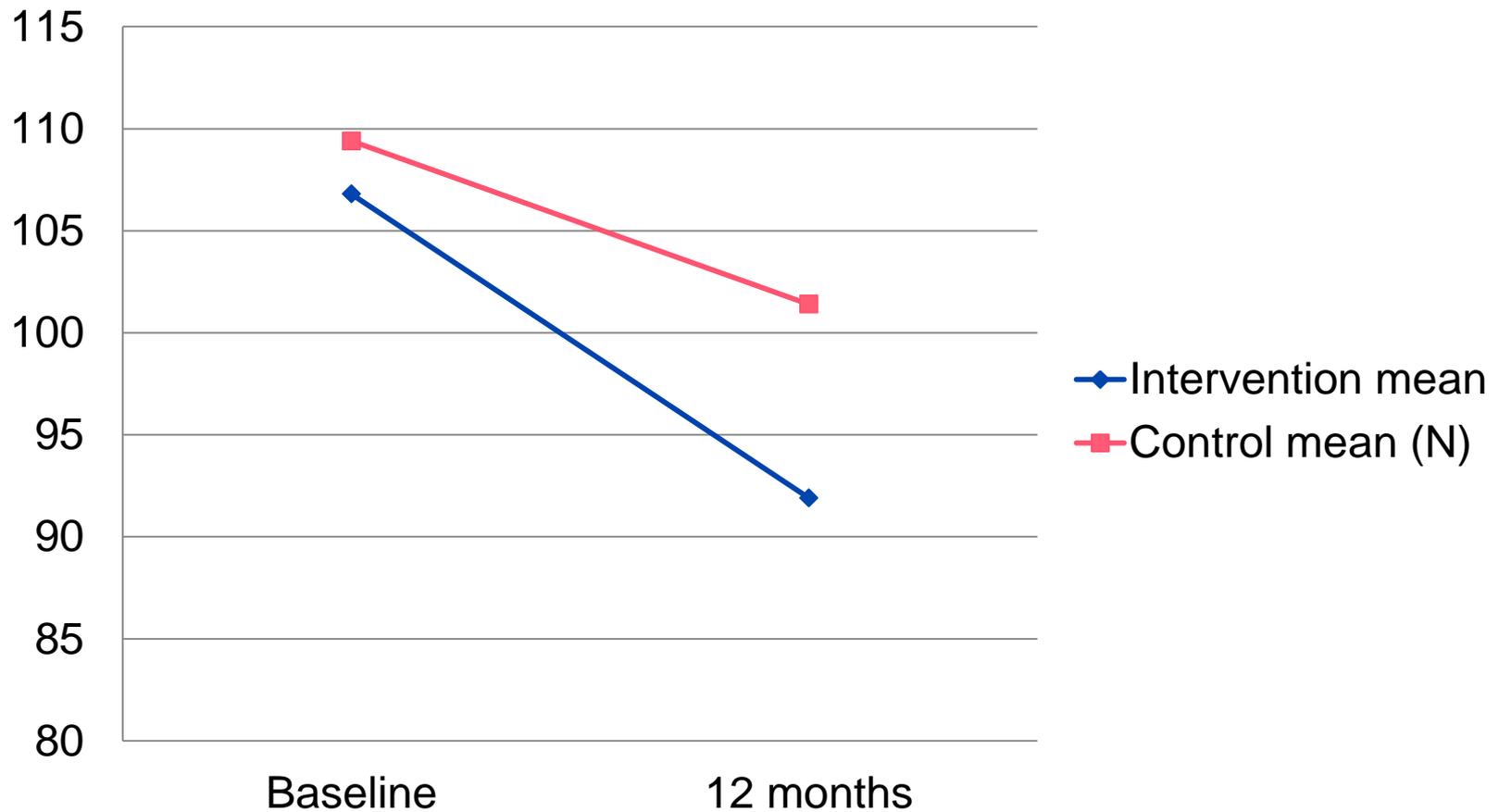
Blood Pressure Outcomes (Systolic BP)

Mean of Systolic BP

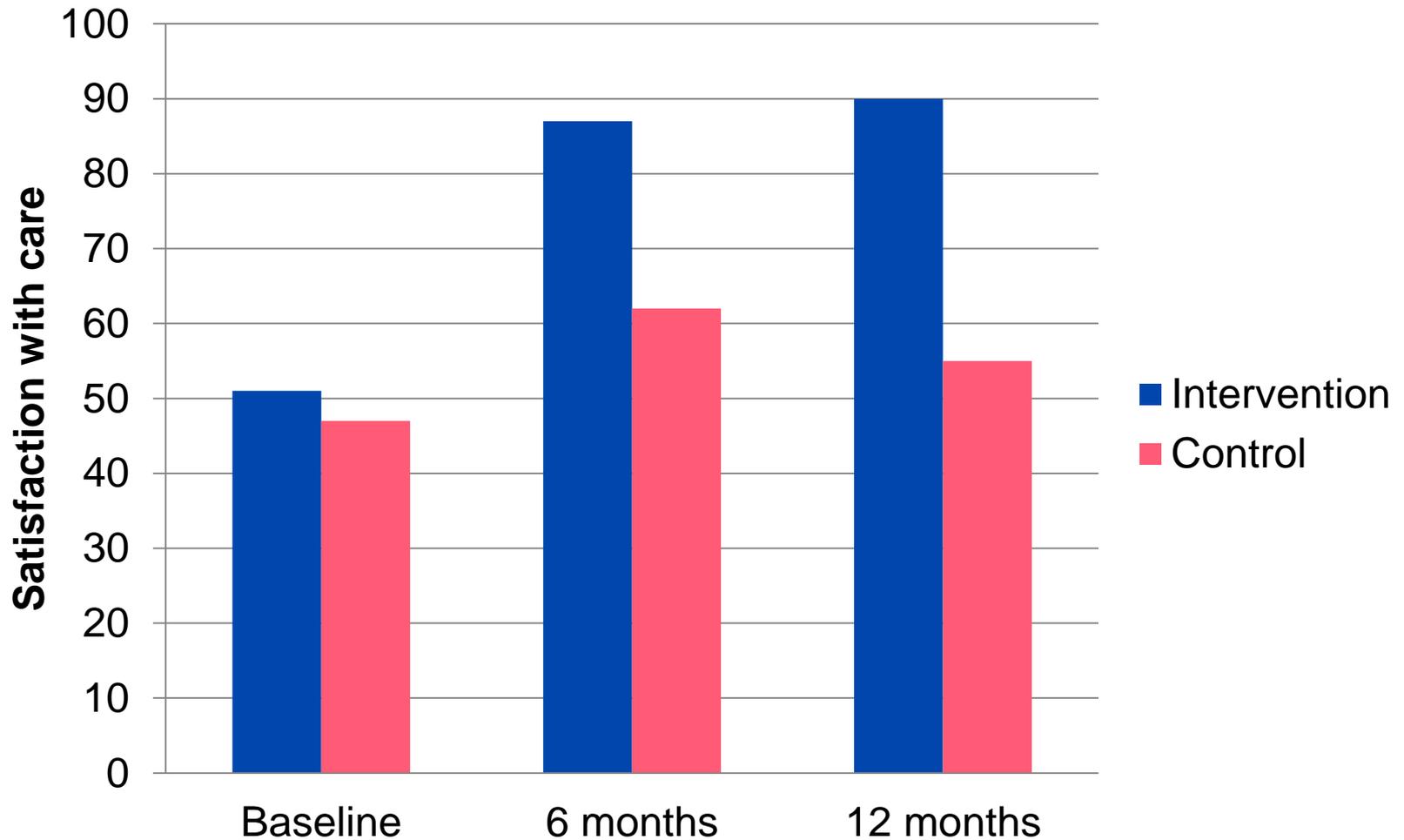


Lipid Outcomes (LDL)

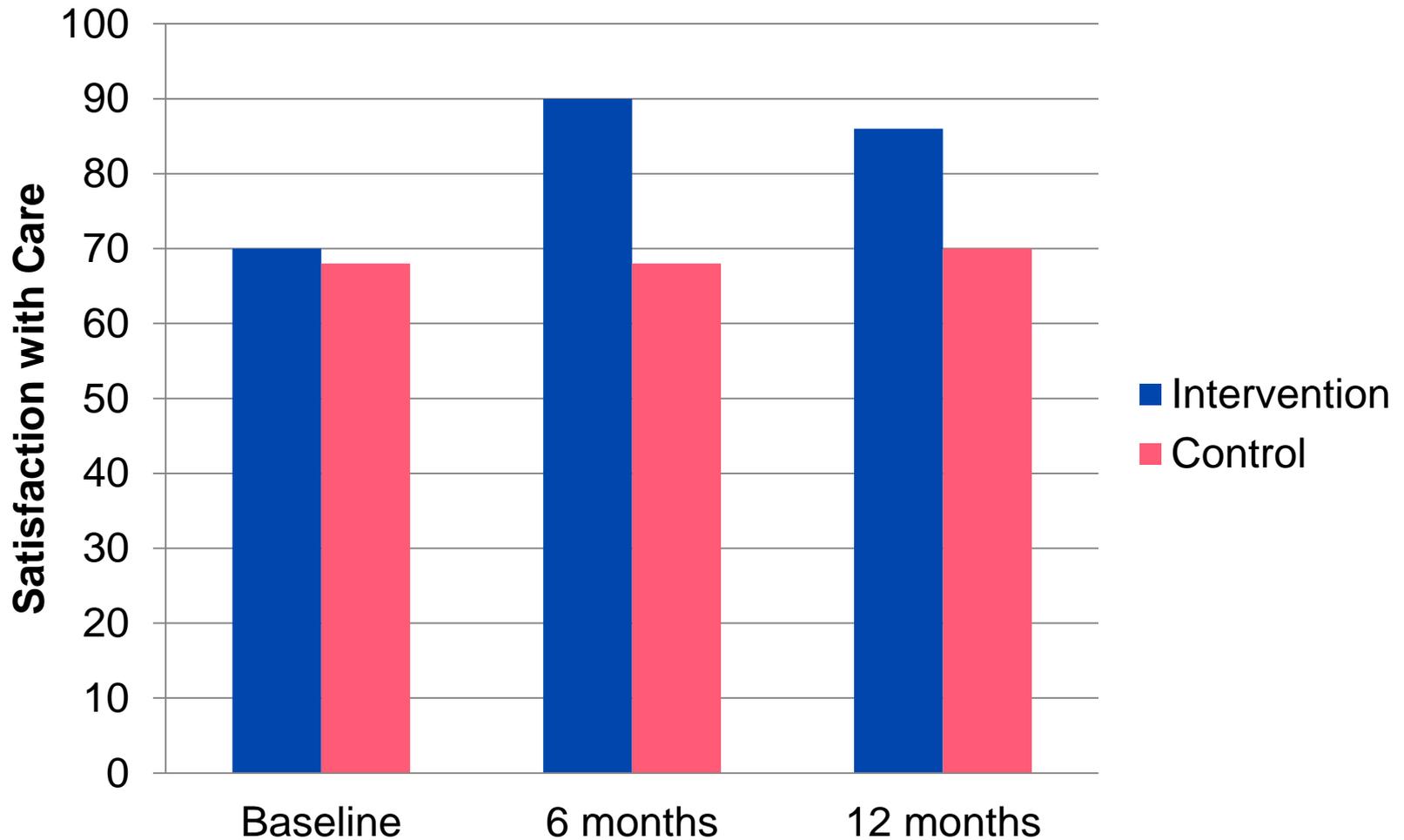
Mean of LDL



Satisfaction with Care of Depression



Satisfaction with Care of Diabetes and/or CHD



How do these trials translate in real practices?

Objective Two:



Provide examples of implementation of two of these models

- **IMPACT** → **DIAMOND**
 - The challenge of fidelity
- **TEAMcare** → **COMPASS**
 - Preserving a chronic care focus



IMPACT
Integrated Care



- Depression Initiative Across Minnesota, Offering a New Direction (2008-2012)
 - Modeled after collaborative care work (Katon and Unutzer).
 - Created by the Institute for Clinical Systems Improvement (ICSI)



ICSI

INSTITUTE FOR CLINICAL
SYSTEMS IMPROVEMENT



Transforming Health Care Through Collaboration

Bring together providers, payers, patients, and
purchasers to improve care
based on **evidence** and **innovation**.

- 60 member organizations
- 9,000 physicians
- 7 sponsoring health plans

Components of DIAMOND/IMPACT

A measurement tool – PHQ9

A care coordinator (RN)

- Collect data and keep up on progress
- Motivational interviewing and problem solving
- Link patient with services

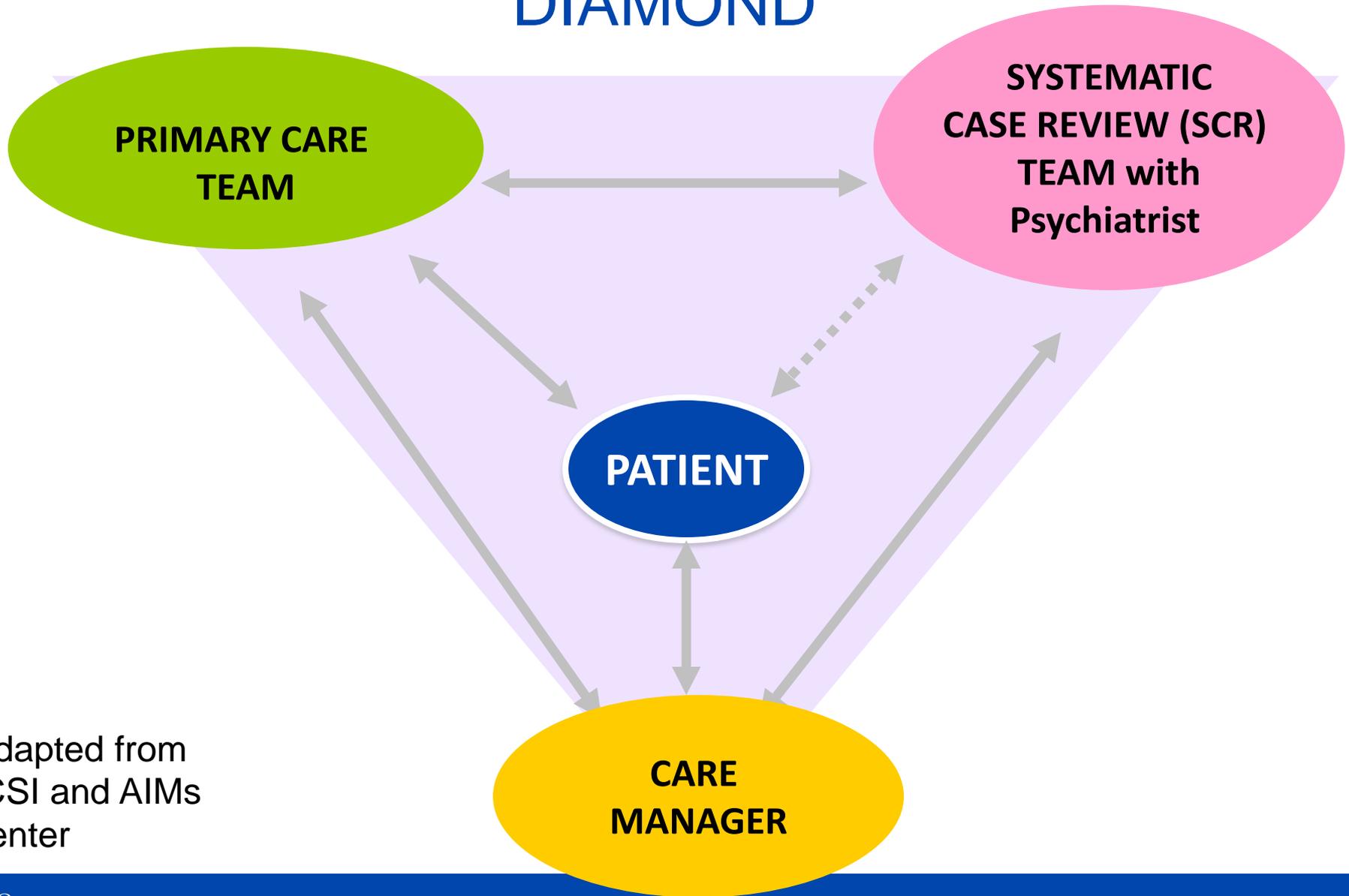
Registry

- to track population-based outcomes

Psychiatrist

- Review caseload weekly, treat to target
- Send all recommendations to GP

DIAMOND



Adapted from
ICSI and AIMs
center

From a Patient/Provider perspective

- Any primary care patient meeting criteria
 - Age \geq 18
 - Score on PHQ-9 of 10 or more (not bipolar)
 - PCP diagnosed dysthymia or major depression
- Introduced to DIAMOND care manager
 - Screen - alcoholism, anxiety, bipolar disorder
 - Clinical scenario gathered + past history
- Weekly systematic case review with psychiatry
- PCP writes all prescriptions, patient management
- Care manager tracks to see if suggestions worked

Secret of Success of this Model – Weekly Data Review on Population of Patients

Demo - Patient Stats (31)

Patient						Initial Asmnt	Contacts			Last F/U w/ PHQ-9
Clinic #	Name	Location	CM	PCP	Activation Date	PHQ	# All	# Clinic	# Phone	PHQ
-	-	Baldwin PCIM	jjm07	eet05	2013-10-09	23	2	2	0	22
-	-	Baldwin PCIM	jjm07	m08911	2013-05-30	16	16	0	16	20
-	-	Baldwin Fam Med	jjm07	gmg03	2012-12-12	14	19	1	18	18
-	-	Baldwin PCIM	jjm07	dgb04	2013-08-22	13	9	1	8	17
-	-	Baldwin Fam Med	jjm07	mrm3455	2013-05-28	20	11	1	10	16
-	-	Baldwin PCIM	jjm07	law02		15	2	1	1	15
-	-	Baldwin Fam Med	jjm07	dmk03		19	0	0	0	15
-	-	Baldwin Fam Med	jjm07	m007860		16	1	1	0	14
-	-	Baldwin Fam Med	jjm07	kjs24		14	1	1	0	14
-	-	Baldwin Fam Med	jjm07	jw f01	2013-09-04	14	10	1	9	14
-	-	Baldwin Fam Med	jjm07	m059414	2013-07-11	17	5	2	3	13
-	-	Baldwin Fam Med	jjm07	m059414	2013-06-24	22	7	2	5	12
-	-	Baldwin Fam Med	jjm07	jwb04	2013-08-07	23	8	0	8	12
-	-	Baldwin Fam Med	jjm07	mah08		12	0	0	0	12
-	-	Baldwin Fam Med	jjm07	msh01	2013-10-14	12	3	1	2	11
-	-	Baldwin PCIM	jjm07	mrn0733	2013-10-08	17	2	0	2	11
-	-	Baldwin Fam Med	jjm07	jw f01	2013-09-20	25	7	1	6	11
-	-	Baldwin Fam Med	jjm07	m106418		17	2	1	1	11
-	-	Baldwin Fam Med	jjm07	m070121		19	4	0	4	11
-	-	Baldwin Fam Med	jjm07	svs04		10	0	0	0	10
-	-	Baldwin Fam Med	jjm07	m059414	2013-09-18	13	8	4	4	10
-	-	Baldwin Fam Med	jjm07	m007860	2013-09-18	15	4	1	3	9
-	-	Baldwin Fam Med	jjm07	jw f01	2013-10-17	10	2	2	0	9
-	-	Baldwin Fam Med	jjm07	bainj	2013-08-12	16	13	1	12	8
-	-	Baldwin Fam Med	jjm07	m070121	2013-02-14	11	19	1	18	6
-	-	Baldwin Fam Med	jjm07	m059414	2012-12-17	16	14	2	12	5
-	-	Baldwin PCIM	jjm07	bjao7	2013-08-19	15	6	1	5	4
-	-	Baldwin PCIM	jjm07	mri4215	2013-05-21	18	22	1	21	3
-	-	Baldwin Fam Med	jjm07	jab35	2013-07-30	10	10	1	9	3
-	-	Baldwin Fam Med	jjm07	m049546	2013-09-09	11	5	4	1	2
-	-	Baldwin Fam Med	jjm07	rds03	2013-09-25	15	3	1	2	2



A simple column sorting tool lets the supervising physician sort by patients with (in this example) a PHQ-9 of 10 or more to make sure to review them all and make suggestions.

Collaborative Care (DIAMOND) Better than Practice as Usual at 3 & 6 months

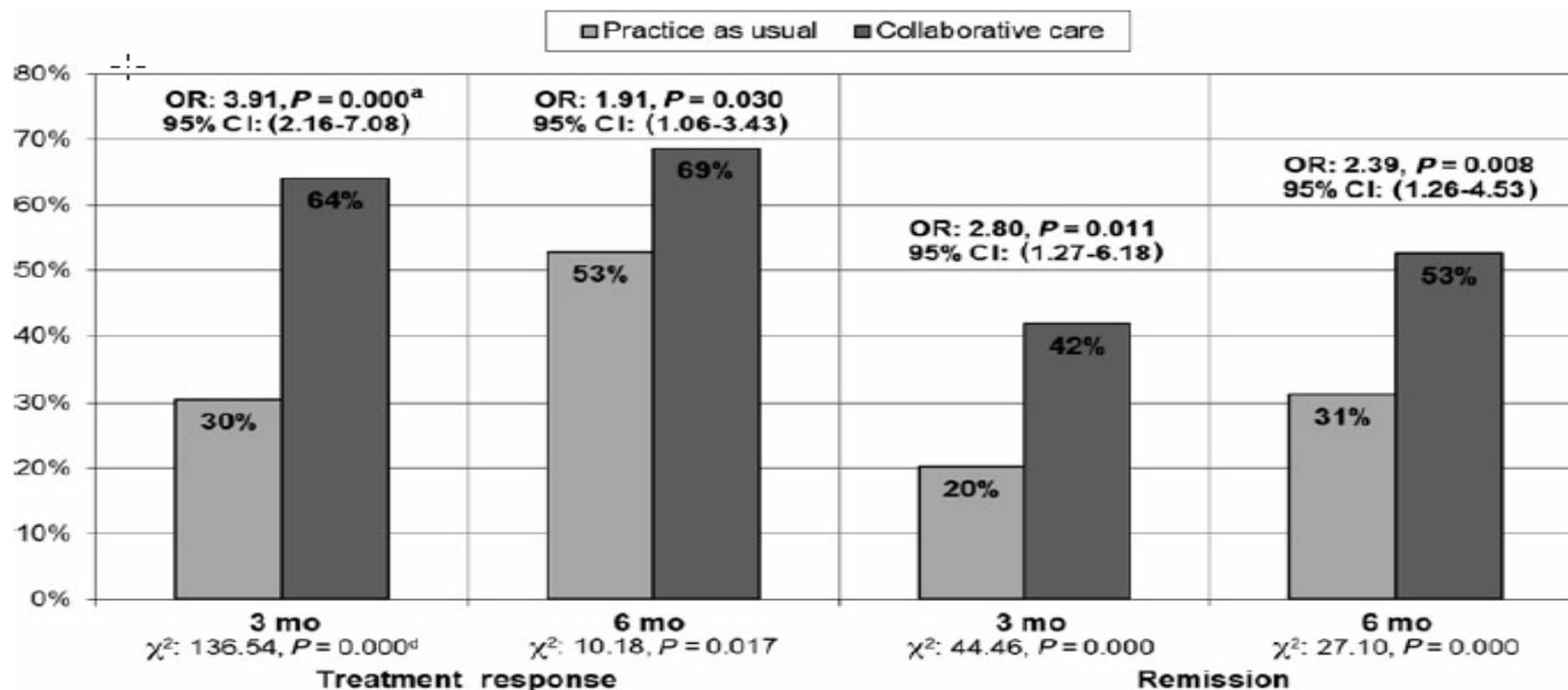


Figure 1. Adjusted rates of treatment response and remission at 3 month and 6 months, by treatment group. Rates are postestimation predictions from logistic regression models, controlling for age and sex, with clustering by clinical site. ^aAdjusted odds ratios for effect of collaborative care versus practice as usual, from logistic regression models. ^bAll treatment group effects are significant at $P < .05$. ^cChi-square statistics for logistic regression models. OR indicates odds ratio; CI, confidence interval

Patient and Provider Level Outcomes

- High patient satisfaction
 - Many testimonials
 - Qualitative research showing positive results
- Access
 - Improved from weeks to one week for input from a specialist
- Providers
 - PCP providers high satisfaction

Larger DIAMOND Study Negative Results...?

- DIAMOND versus Usual Care
 - DIAMOND patients received more services and had higher satisfaction with their care.
 - Depression remission rates were not significantly different between any of the groups with a remission rate of around 33-36% for all.

- Solberg 2015 Annals of Family medicine vol. 13(5)

Why?

- Study is flawed?
 - Robust Design
 - Stepped wedge randomized controlled trial
- Fidelity concerns?
 - ICSI had no power to ensure fidelity to evidence-based model
 - Mayo patients not included in the study
 - Higher attention to fidelity at Mayo
 - Mayo had some advantages

COMPASS (2012-2015)



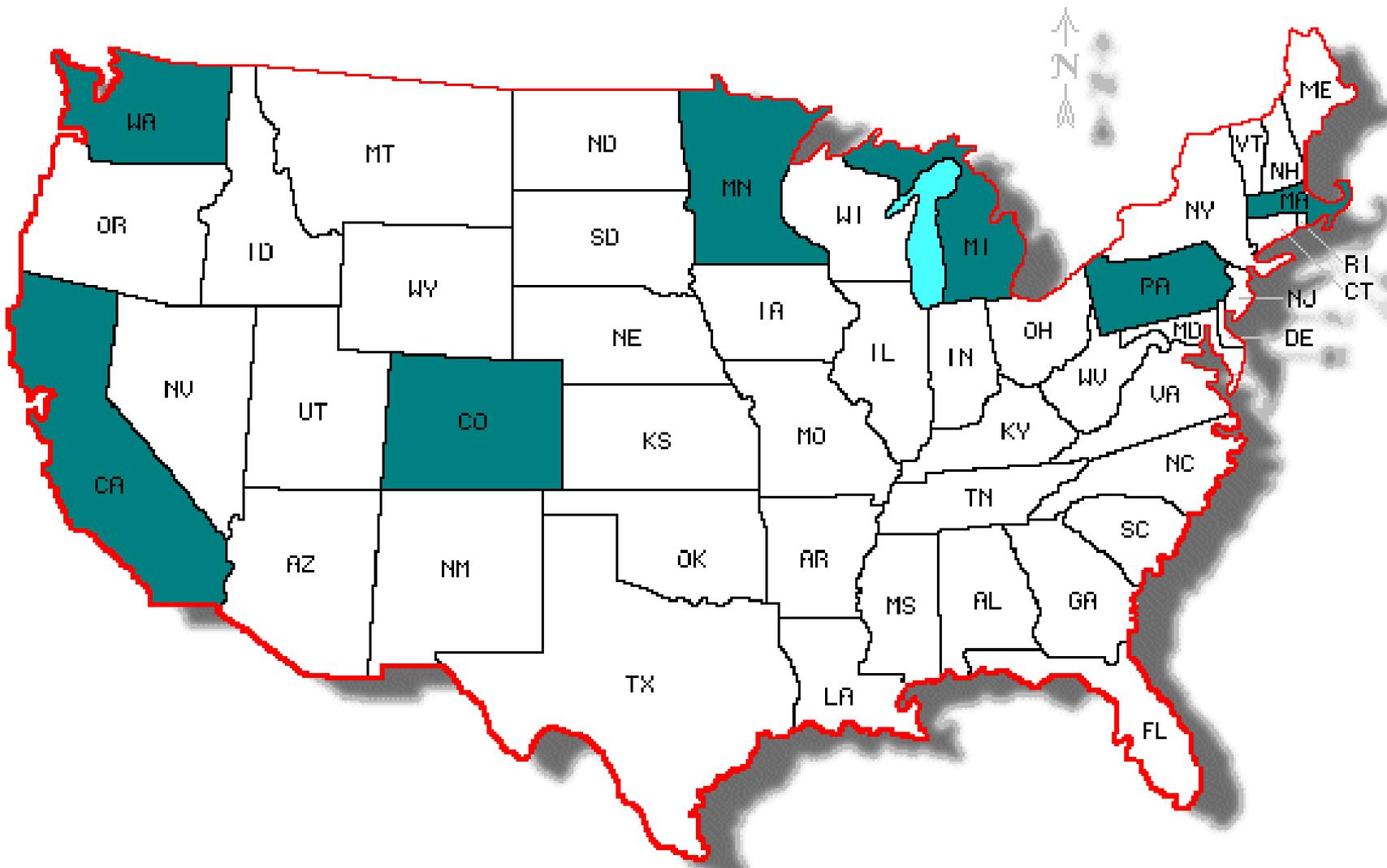
COMPASS
Partnering for Mind-Body Health

- A 3-year grant from **CMS** (Center for Medicare and Medicaid studies) to implement a well researched model of care for patients with diabetes, cardiovascular disease and depression in primary care clinics and study if this evidence-based model can be sustained in the real world.
- Primary grant awardee was ICSI
 - Adapted TEAMcare and implemented in eight several states
 - Mayo implemented in ten primary care sites
 - Two academic centers – Rochester and Florida
 - Eight rural family medicine clinics in Minnesota

Supported by Cooperative Agreement

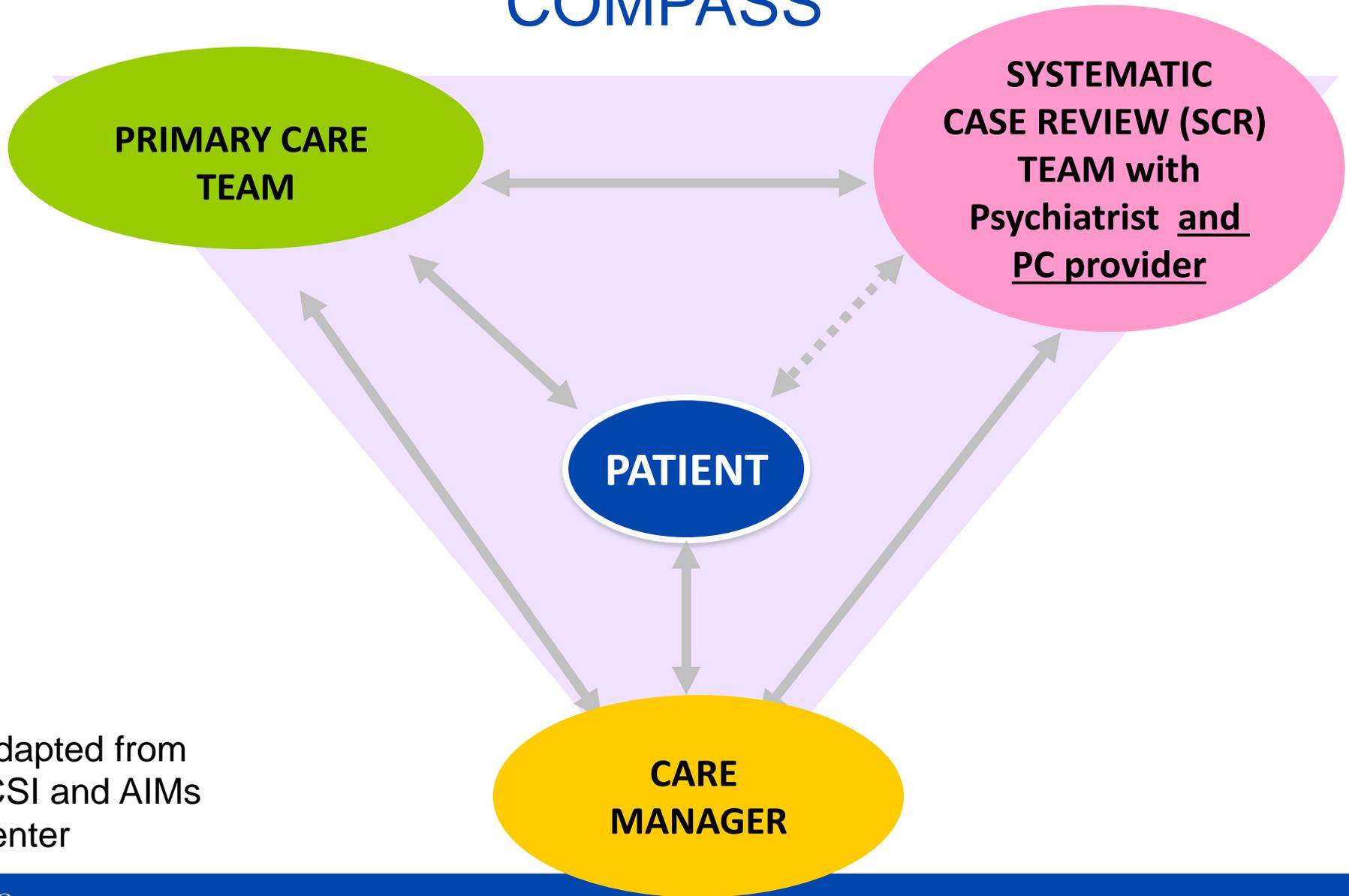
The project described in this slide set was supported by Cooperative Agreement Number 1C1CMS331048-01-00 from the Department of Health and Human Services, Centers for Medicare & Medicaid Services.

- Its contents are solely the responsibility of the authors and have not been approved by the Department of Health and Human Services, Centers for Medicare & Medicaid Services.



COMPASS Consortium Partners

COMPASS



Adapted from
ICSI and AIMs
center

Patient Demographics

Diabetes and Depression

Diagnosis	A1: Total Patients
Dep & DM	45.80%
Dep,DM & HD	32.93%
Dep & HD	13.73%
Depression	4.06%
-	2.17%
Diabetes	0.60%
DM & HD	0.48%
Heart Dz	0.13%
Diab & HD	0.08%
Other	0.03%
Total	100.00%

Majority government insurance

Insurance	A1: Total Patients
MCaid FFS	9.05%
MCaid Prepay	9.73%
MCare FFS	25.67%
MCare Prepay	21.54%
Dual	4.48%
Commercial	27.34%
Self Pay	1.94%
-	0.25%
Total	100.00%

Preliminary Comparison of Clinical Outcomes

COMPASS at Mayo and TEAMcare Randomized Trial

	TEAMcare Intervention Group- 6 months* n=105	Mayo COMPASS 6-11 months n=591	TEAMcare Intervention Group- 12 months* n=105	Mayo COMPASS 12 months or greater n=591
Depression Severity Percent Response >=50 % decrease	59%	47%	60%	53%
Change A1c**	-0.72	-0.825	-0.81	-0.89
Change LDL**		-6.3	-14.9	-10.5
Change Systolic BP**	-3.8	-6.4	-4.7	-4.0

*Katon W. [N Engl J Med.](#) 2010 Dec 30;363(27):2611-20

** Includes all patients with baseline A1C, LDL and Systolic BP.

COMPASS Overall Outcomes

Summary for 4000 patients

	Outcome Goals	Analytic Outcomes
Depression	Improve control for 40% of patients	61% have shown significant improvement (decrease in PHQ9 by 5 points or a PHQ9 of less than 10)
Diabetes	Improve control rates by 20%	23% absolute improvement in patients with a HgbA1c <8
Hypertension	Improve control rates by 20%	58% of those who entered with uncontrolled hypertension have blood pressure in control



Challenges With COMPASS at Mayo

- Blocking MD time for SCR when no reimbursement
 - Fee-for-service world
- Narrow inclusion
 - What about other mental health problems?
 - Can someone only have depression?
 - What about COPD, chronic pain, etc.
- Social barriers to care
- Drift towards acute care
 - Another service on top of everything else

Merging Our Models at Mayo

- Care coordination models
 - DIAMOND
 - COMPASS
 - Adult Care Coordination (medical only)
 - Each with different tracking systems
- Spreading a plan over clinics in five states
- Seeking a single model that can be adapted to local settings



OBJECTIVE 3

Practical challenges for implementation and ideas on solutions

Practical Realities – Who Do We Treat?

- Patient population
 - Those most costly?
 - Those identified by providers as most needy?
 - Using criteria from a researched model?
 - Rising risk or most complex?
 - Patient engagement
- Suggestions
 - Balance practical needs and desired outcomes
 - Financial outcomes
 - Take time, data, and social service help
 - Electronic risk identifiers are not always useful
 - Work to make criteria simple and clear
 - Work to consider psychosocial and functional factors

Practical Realities – Care Coordinators

- Selecting Care Coordinators
 - Role
 - Clinical experience
 - Personality
 - Tolerance of ambiguity
 - Relationship building
 - Coaching approach
- Suggestions:
 - Seek out experience with chronic conditions
 - Spend time developing interview questions
 - Consider an interprofessional interview panel

Practical Realities - Training



- Training Care Coordinators
 - Initial orientation
 - Ongoing learning needs
 - Varying experiences
 - Population approach
 - Connections across continuum of care
- Suggestions
 - Systematic case reviews = teaching opportunity
 - Continuously build upon skills
 - Provide educational opportunities
 - Monitor patient interactions to allow for feedback
 - Interprofessional observations and communication

Practical Realities - Outcomes

- Defining and Monitoring Outcomes
 - Clinical and administrative differences
 - Data abstraction and timeliness of data
 - Multiple stakeholders
 - Data sources and multiple registries
- Suggestions
 - Ideally same data at point of care as when reviewing program
 - Data helps us improve our care of patients vs. data is used to criticize my work

Practical Realities – the SCR

- Weekly systematic case review
 - Drift towards acute care
 - The forgotten patient
 - Treat to target
 - Tough to keep going without support
 - Documentation in record?
- Suggestions
 - Central to the model – no treat to target otherwise
 - Housekeeping - who enters, all are reviewed, discharges
 - Registry needed to track changes
 - Primary care role sometimes harder

What Happens Without Supervisory Sessions?

- Entry of patients
 - PCP pressures care coordinators into taking patients
 - Do all of them benefit?
- Interventions
 - Depended on finding time with each PCP to discuss their patients – burnout of care coordinators, takes longer to treat to target...
 - No peer review, harder to standardize approach
- Discharge
 - Providers advocate to keep patients in care coordination (some over 3 years).

Practical Realities – Physicians

- Physician issues
 - Comfort with giving recommendations
 - Comfort receiving recommendations
 - Avoiding taking over the patient
 - Teaching role
 - Approach to data
- Suggestions
 - Supervisory role needs support – not right for all
 - Primary care provider remains in charge of patient
 - Communication with primary team
 - Teaching role and healthy use of data

Practical Realities – Administration

- Administrative needs
 - Care coordinators
 - Centralized vs decentralized
 - Site specific vs health system
 - Standardization and case load
 - Physicians involved in care coordination
 - Loss of income?
- Suggestions
 - Communication and time
 - Cross coverage means standardizing
 - Create venues for ongoing discussion and understanding

Practical Realities – Getting Going

- Organizational support
 - Buy-in
 - Champions
 - Accountability
 - Evolving model
 - Reimbursement model
- Suggestions
 - Stories are useful in early stages especially
 - Different issues depending on stakeholders
 - Ideally your data system gathers outcomes as you go
 - Care Coordinators need to be able to sell the program

Practical Realities – Controversies

- Care coordination
 - Must reduce high cost care
 - How well trained are medical providers to manage cost?
 - Works for all complex patients?
 - Data available on some complex patients
 - How to connect with other programs?
 - Care coordination from insurance side
 - Community resources?
 - How much can care coordination impact social barriers to health?

Critical Components Versus Innovation

- Care coordinators – RN?
- Registry – Can't we use our EMR?
- Systematic case reviews – Do they have to be weekly? Are they needed?
- Consulting psychiatrist – How about an advance practice RN?
- Complex care specialist – I know my own patients!
- Entrance and graduation criteria – how important?



OBJECTIVE 4

- Develop an argument for care coordination to bring to your own work environment.
- Williams/Mattson

Making a Case – Depends on the Audience

- **Administrators:** Quality, efficiency, cost
 - Quality measurements increasingly important for contracts
 - Minnesota Health Scores
 - Medicare Access and Chip Reauthorization Act (2015) or MACRA
 - Overall goal to link payment with quality
 - Efficiency –increase access, satisfaction
 - Cost – shared risk contracts

Options for Payment to Clinic

- Salaried, ACO and capitated systems
 - VA, Kaiser
 - Focus on access, reduced cost
- Mixed settings
 - Care management fee
 - PCP bill fee for service
- Fee for service
 - Case rate for care management
 - Bill for components of care management

Upcoming Payment: CMS update 2016

- Specific coverage for
 - Psychiatric Collaborative Care Management Services
 - Coding to support payments to psychiatrists for consultative services that they provide to primary care physicians in the collaborative care model (CoCM).
 - Codes to be adopted in 2017

Psychiatry – Outcomes, Opportunity

- Outcomes – already reviewed
- Team – much less isolating and less burnout
- How will I be paid?
 - Salaried or contracted time to PC clinic
 - Grants or special programs supporting psychiatry
 - Direct patient assessment
- Liability?

Psychiatry Concern: Liability

- Care coordination support
 - Responsibility remains with the primary care provider
 - No prescriptions written unless the patient is actually seen by the psychiatrist
 - Liability felt to be similar to curbside for any specialty (e.g. review of EKG)
 - As compared to traditional direct care
 - Closer follow up involving a team
 - Measurement based
 - Increased ability to catch a patient in trouble

Making the Business Case

- Nursing Administration
 - Specialty for nurses
 - Increased autonomy
 - Ongoing learning
- Patients
 - Contact in a confusing health system
 - Describe better outcomes
 - Opportunity to link patient goals with health goals



THANKS TO OUR IBH TEAM!!!!!!

QUESTIONS/COMMENTS?