

EXECUTIVE SUMMARY

COLLABORATIVE CARE IN HEALTH SYSTEMS

Competencies and Skills of Psychosomatic Medicine Psychiatrists

The rising costs of US health care drive reform (Slides 1-11)

The US spends far more of its gross domestic product (17.4%) on health care than comparable developed countries (www.ahrq.gov). The recent recession, the Affordable Care Act, and the current federal budget crisis have concentrated unprecedented pressure on our government and health care systems to reduce the costs of health care urgently.

Experts agree that true health care reform requires achieving all three primary aims: a) improved quality of care, b) better outcomes, and c) lower costs.

Health care reform demands, among other things, a change in how we pay for health care services that combines capitation with pay-for-outcomes incentives (AHRQ). For example, 30 day readmission prevention efforts are increasingly incentivized by health care payors.

Population health management has demonstrably positive impacts on health care quality and costs. Patient Centered Medical Homes and Accountable Care Organizations are organizational structures that facilitate population health. Psychiatric services provided directly in these population health systems improve quality and cost outcomes.

Ten percent of patients consume 63% of the health care dollar (Hussain and Seitz 2014). These high utilizers are usually complex patients with comorbid chronic medical and mental illness. Psychosomatic Medicine psychiatrists specialize in treating these patients. Characteristics that influence high costs in these complex patients are the presence of chronic medical and psychiatric conditions, end of life care, inpatient care, unnecessary re-admissions, medical errors, overuse of health care services, and obesity.

Primary care patients with one chronic medical condition are twice as likely to have a psychiatric illness. Primary care patients with 4 or more chronic medical conditions have five times higher rates of psychiatric illness (Barnett et al 2011). A high percentage of patients with certain types of chronic medical conditions have even higher rates of comorbid psychiatric conditions:

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|--------------------------|---------|
| - Chronic pain | 25%-50% |
| - Obesity | 40%-70% |
| - Cancer | 10%-20% |
| - Neurological disorders | 10%-20% |
| - Heart disease | 10%-30% |
| - Diabetes | 10%-30% |



Many strategies for health care reform focus on these top 10% high utilizers:

- Collaborative care
- Proactive psychiatric consultation
- Population health/chronic illness models of care
- Delirium prevention programs

Psychosomatic Medicine psychiatrists lead many of these initiatives and strategies.

Collaborative Care (Slides 12-13)

Extensive research has established that collaborative care for depression and chronic illness improves both mental and physical outcomes while saving health care costs (Katon W 2012). This research has shown reduced hospitalizations and emergency services utilization with the collaborative care intervention in the complex co-morbidly ill, among the most costly patients in any clinical practice or any health care system.

Collaborative care borrows from principles of population health, moving beyond a traditional consultative model, or even a model that co-locates psychiatric services in primary care clinics. In collaborative care, psychiatrists take responsibility for a caseload of primary care patient and work closely with PCPs and other primary care-based behavioral health providers (<http://uwaims.org>)

Primary care is the “defacto mental health system” for most patients with anxiety, depressive or alcohol/substance use disorders (Slide 14)

Twenty to forty percent of primary care patients have behavioral disorders. Seventy-five percent of patients with depression see primary care providers, but only approximately half are accurately diagnosed (Mitchell et al, The Lancet, 2009).

Primary care providers prescribe 80% of all antidepressant medications in the United States. Unfortunately, only 20-40% of patients with depression improve substantially in primary care settings over a six-month period (Schulberg et al, Arch Gen Psychiatry, 1996).

Only about half of patients referred to specialty mental health actually follow through with making an appointment (David Grembowski et al, J Gen Intern Med, 2002)

Over two thirds of primary care physicians describe marked difficulty finding mental health referrals or advice for their patients. (Cunningham PJ, Health Affairs, 2009)

Integrating behavioral care into primary care settings has strong evidence for efficacy (Slides 15-19)

There are 69 randomized, controlled trials of integrated or collaborative care versus standard depression treatment in primary care settings, which have demonstrated superior outcomes compared to usual primary care, when care is patient-centered, team-based, and collaborative (Gilbody et al, Arch Int Med 2006; Verugheze et al, Am J Prev Med 2012).



Collaborative care in health systems: Competencies and skills of Psychosomatic Medicine Psychiatrists

Collaborative care meets the Triple Aim of health reform: improving patient access, satisfaction with care, quality of care and improved outcomes at reduced costs. Improved depressive outcomes with collaborative care have been shown to persist as long as two to five years.

Several factors are associated with the superior quality and cost outcomes of collaborative care models (Verghese et al 2012, Gilbody et al 2006, Unutzer et al 2006):

- Presence of care managers to monitor adherence
- Medication dose
- Psychiatrist engagement with other team members
- Population health model
- Team care model
- Measurement based treatment to target
- Evidence-based

Collaborative care has shown improvements in different types of patients, including cancer patients, diabetic patients, and coronary artery disease patients (Katon et al 2010). Compared to traditional care, there are improvements in medical outcome measures, functional outcome measures, mental health outcome measures, and patient and provider satisfaction levels.

There is demonstrated effectiveness in both inpatient and outpatient medical settings (Unutzer et al 2008, Hussain and Seetiz 2014).

Collaborative care can be performed at-distance (e.g., telemedicine), to address supply/demand mismatches.

Psychosomatic Medicine and the “Top 10% “ (Slides 20-22)

One potential target of cost-saving efforts is the 10% of patients who consume nearly two-thirds of the health care dollar. The Agency for Healthcare Research and Quality has shown that these patients are those with multiple chronic conditions, including comorbid mental disorders, the elderly, the obese, and those whose conditions result in inpatient admissions. Recent data has shown that as the number of chronic conditions increase there is a linear increase in the percentage of patients with psychiatric comorbidity (Barnett K et al 2012)

Patients with comorbid medical and behavioral conditions account for up to half of all health care spending (Melek and Norris, Milliman Research Report, July 2008).

Psychosomatic Medicine specialists are among the few who are specifically trained in the management of these high cost patients with multiple comorbidities.

Proactive psychiatric consultation on a general medicine inpatient unit can reduce costs and improve outcomes (Desan et al 2011)



Psychosomatic medicine physicians are also well positioned to implement delirium prevention and management teams, targeting one factor that contributes to excessive and unnecessary hospital costs (Inouye S 1999).

One collaborative care program (Unutzer et al 2008) demonstrated a high level of return on investment, \$6.50 saved for every \$1.00 invested, harvested largely from decreased inpatient medical costs.

More patients are covered by one psychiatrist in collaborative care models. One psychiatrist provides input on 10-20 patients in a half day, as opposed to personally seeing 3-4 patients.

Employer costs of psychiatric disorders (Slide 23)

Average annual sick days for depression (9.9) exceed those from hypertension (5.4), back problems (7.2), diabetes (7.2) and heart disease (7.5) (Melek and Norris, Milliman Research Report, July 2008). Figures are even higher when there are medical and behavioral comorbidities.

Depressed workers have between 1.5 and 3.2 times more short-term disability days on a monthly basis than other workers (Kessler et al, 1999).

Collaborative care is associated with improved employment, personal income, and other workforce outcomes (Wang et al 2007, Schoenbaum et al 2002).

Payment for Collaborative Care (Slide 24)

Fully capitated (e.g., DoD, VA, Kaiser Permanente)

Fee for service with case rate payment for care management and psychiatric consultation/case reviews (e.g., DIAMOND initiative in Minnesota)

Payment for performance (Unutzer et al 2012)

Cuts median time to depression treatment response in half (Unutzer et al 2012)

Opportunities for reform: Psychosomatic Medicine as a resource (Slides 25-26)

Hospital systems can relatively rapidly achieve better outcomes at lower costs in three areas of opportunity:

- 1) *Reducing lengths of stay*, especially in those with limited insurance/resources such as comorbid patients (proactive CL; delirium prevention/treatment; Complexity Intervention Units);
- 2) *Reducing the use of constant observation* (an unreimbursed service with increasing use nationally)
- 3) *Reducing 30-day readmission rates* for patients with CHF, diabetes, pneumonia.

The physicians who are uniquely qualified to provide cost-effective care to patients who have comorbid medical and psychiatric disorders are Psychosomatic Medicine psychiatrists, double-boarded physicians in medicine and psychiatry, and consultation-liaison psychiatrists. These physicians have the hospital privileges, legal authority, assessment skills and prescribing skills to deliver more effective care than

other clinicians, and are well-qualified to support and lead interdisciplinary teams of professionals who provide effective evidence-based collaborative care.

Preventing Readmissions (Slide 27)

20% of Medicare beneficiaries are re-hospitalized within 30 days, 33% within 90 days. 25% of these readmissions are preventable.

Depression predicts re-hospitalization within 30 days

The Affordable Care Act and Medicare have implemented fines for early readmissions of selected chronic conditions. Depression and cognitive impairment are major contributors to early readmissions (Mitchell SE et al, 2010), and ambulatory care sensitive hospitalizations (Davydow D et al, 2013).

Integrating psychiatric care into inpatient medical services prevents readmissions.

Psychosomatic Medicine Psychiatrists have unique training and competencies that support optimal outcomes in integrated behavioral health programs (Slides 28-29)

Competencies for Psychosomatic Medicine Psychiatrists (Consensus Statement of the Academy of Psychosomatic Medicine and European Association of Psychosomatic Medicine, Psychosomatics, 2011):

- Medical expertise (training in medical settings)
- Collaboration across medical settings and disciplines
- Communication training and interpersonal skills development specific to medical-surgical settings
- Focus on meeting needs of patients and consultees
- Health advocacy
- Scholarship and research
- Professionalism

Specific skills and advantages that Psychosomatic Medicine psychiatrists bring to integrated behavioral health (Slides 30-31)

- Medical expertise
- Familiarity with psychiatric conditions as they present in medical patients
- Expertise working in outpatient medical settings
- Leadership roles in integrated behavioral health program development and implementation
- Involvement at a national level in health care reform preparedness
- Expertise in triaging patients to appropriate levels of care
- History of working closely with both primary care providers and medical and behavioral health specialists
- History of working in teams
- Familiarity with medical cultures

