Collaborative Care in Health Systems

Competencies and Skills of Psychosomatic Medicine Psychiatrists

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ACADEMY OF PSYCHOSOMATIC MEDICINE
Psychiatrists Providing Collaborative Care for Physical and Mental Health
Game Changers

The rising costs of US health care drive reform

Source: Organization for Economic Co-operation and Development

Per capita health care spending, 2006

$ at PPP*

2006 R²=0.88

Per capita GDP ($)

* Purchasing power parity.
** Estimated Spending According to Wealth.
Source: Organization for Economic Co-operation and Development (OECD)
Game Changers

- Health care systems of all sizes will survive if they provide the triple aims of health care reform:
  - Better quality care
  - Better outcomes
  - Lower costs
Game Changers

- Health care reform demands a change in how health care systems are paid for services

- Shift from fee-for-service to:
  - Population-based care
  - Capitation systems
  - Pay for outcomes
Game Changers

- Population Management
  - Patient Centered Medical Homes (PCMHs)
  - Accountable Care Organizations (ACOs)
    - Primary care and medical specialty systems and hospitals will work together often as single governing units using EMR and registries
    - ACOs will share financial savings in medical costs with the federal government for the population they are responsible for
  - 30 day re-admission prevention
Short-term Targets

- 10% of patients consume 63% of the health care dollar
  - “Complex patients”
  - Comorbid chronic medical and mental illness
  - High utilizers

- Psychosomatic Medicine physicians specialize in treating many of these patients

Short-term Targets

- Integrating psychiatric and medical care improves inpatient and outpatient outcomes:
  - Long-term care admissions
  - Re-admissions
  - Health costs/utilization


Who are the Top 10%?

Primary care patients with 1 chronic medical condition have 2x higher rates of psychiatric illness

Primary care patients with 4 or more chronic medical conditions have 5x higher rates of psychiatric illness
Health Complexity Requires Individualized Physical and Mental Condition Care Integration

Patient Type

Acute Illness

Chronic or Serious Illness

High Complexity: Physical & mental health co-morbidities

100 % of Patients

% of Costs

Low 1/3

Medium 1/3

High 1/3

Adapted from Meier DE, J Pall Med, 7:119-134, 2004
Essentials of Effective Care

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

Percentage with comorbid behavioral condition

Patient-centered care?
Short-term Targets

- Strategies for reform focusing on top 10%:
  - Chronic illness model
  - Registries of high utilizers
    - Hot Spotter Teams to reduce costs
  - Proactive psychiatric consultation reduces
    - Length of stay
    - Transfers
    - Early readmissions
  - Delirium prevention programs

- Psychosomatic Medicine physicians lead these initiatives

Collaborative Care

Psychiatric conditions are *already mostly treated in primary care*

- 20-40% of primary care patients have behavioral care needs
- Up to 80% of antidepressants are prescribed by primary care physicians
- 75% of patients with depression see primary care providers
- Depression goes undetected in >50% of primary care patients
- Only 20-40% of patients improve substantially in 6 months without specialty assistance
- Only about half of patients referred to specialty mental health actually follow through

Collaborative Care

- Behavioral conditions drive total health care costs
- Integrated models of care increase value for patients, PCPs, & payors
  - Remission (patient)
  - Capacity and quality (PCP)
  - Behavioral care and medical cost reductions (payor)
  - Especially when co-morbid conditions exist (e.g., diabetes and depression)
  - Effective in both inpatient and outpatient settings


Psychiatry and Primary Care

An evolving relationship:

Consultative Model
• Psychiatrists sees patients in consultation in his/her office – away from primary care

Co-located Model
• Psychiatrist sees patients in primary care

Collaborative Model
• Psychiatrists takes responsibility for a caseload of primary care patients and works closely with PCPs and other primary care-based behavioral health providers

http://uwaims.org
Evidence to Support Collaborative Care

- 69 randomized studies of collaborative vs usual depression treatment in primary care
  - Meta-analysis Gilbody et al, Arch Internal Med, 2006
  - Outcomes improved as long as 2 to 5 years

- Consistently more effective than usual care
  - Effect size related to
    - Presence of care managers to monitor adherence
    - Medication dose
    - Psychiatrist engagement with PCPs and caseload supervision of care coordinators

Effective Care Models

Patient Centered Team Care / Collaborative
- Effective collaboration requires more than physical co-location

Population-Based
- Patients tracked in a registry: no one falls through the cracks

Measurement-Based Treatment to Target
- Treatments are actively changed until the clinical goals are achieved

Evidence-Based
- Treatments used are evidence-based

Accountable
- Providers are accountable and reimbursed for quality of care and clinical outcomes, not just the volume of care provided
Collaborative Care for Patients with Depression or Anxiety and Chronic Illness

- Improved medical, mental health, financial, satisfaction and functional outcome measures compared with usual care
- Collaborative care effectively treats depression in
  - Cancer patients
    - Improvements in fatigue, depression, and anxiety levels
  - Coronary artery disease patients
    - Improvements in prognosis, depression, and satisfaction
  - Diabetes patients
    - Improvements in mortality, diabetes control, functioning

Rollan et al: Telephone-delivered collaborative care for treating postCABG depression: randomized controlled trial. JAMA 2009;301:2095-2103
http://www.thelancet.com/themed/depression-and-cancer
Ell K et al: Collaborative care management of major depression among low income, predominantly Hispanic subjects with diabetes. Diabetes Care 2010; 33:706-713
Bogner HR et al: Diabetes, depression and death: a randomized controlled trial of a depression treatment program for older adults based in primary care. Diabetes Care 2007; 30:3005-3010

Academy of Psychosomatic Medicine
Collaborative Care Reduces Health Care Costs

- Depression increases health care costs 50-100%
- Collaborative care is more cost-effective than usual care, especially in patients with medical disorders
  - Katon et al; Diabetes Care 2008; 31:1155-1159
  - Katon et al; Arch Gen Psychiatry 2002; 59:1098-1104
- Long-term cost savings observed in inpatient and outpatient implementations
  - Unutzer et al; Am J Managed Care 2008; 14:95-100
  - Reiss-Brennan B; J Healthcare Management 2010: 55:97-113
Effectiveness of Collaborative Care

- Less depression and anxiety
- Less physical pain
- Better functioning
- Higher quality of life
- Greater patient and provider satisfaction
- More cost-effective care
- Can be performed at-distance to address supply/demand
IMPACT reduces health care costs
ROI: $ 6.5 saved / $ 1 invested

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<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>
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<td>29,422</td>
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Collaborative Care

Caseload-focused psychiatric consultation supported by a care manager

Better Access
- PCPs get input on their patients’ behavioral health problems within a day/week versus months
- Focuses in-person visits on the most challenging patients

Regular Communication
- Psychiatrist has regular (weekly) meetings with a care manager
- Reviews all patients who are not improving and makes treatment recommendations

More patients covered by one psychiatrist
- Psychiatrist provides input on 10 – 20 patients in a half day as opposed to 3-4 patients

“Shaping over time”
- Multiple brief consultations
- More opportunity to ‘correct the course’ if patients are not improving

http://uwaims.org
Pay-for-Performance Based Quality Improvement Cuts Median Time to Depression Treatment Response in Half

Estimated Cumulative Probability

Weeks

Before P4P  After P4P

Collaborative Care and Employment/Workforce Participation

- Depression and anxiety disorders reduce productivity and effective workforce participation

- Collaborative care is associated with improved employment, personal income, and other workforce outcomes
  - Schoenbaum et al. Health Services Research 2002; 37:1145-58
Payment for Collaborative Care

- 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 can improve quality and outcomes of care
  - Unutzer et al, Am J Public Health 2012
Psychosomatic Medicine Strategies Provide Value

Roles, Competencies and Skills of Psychosomatic Medicine Psychiatrists

ACADEMY OF PSYCHOSOMATIC MEDICINE
Psychiatrists Providing Collaborative Care for Physical and Mental Health
Clinical Outcomes and Cost Drivers

- Psychosomatic medicine physicians are trained to identify and manage key contributing factors to high costs:
  - Lack of adherence
  - Mental illness
  - High risks for delirium and extended inpatient stays
  - High risks for early re-hospitalization
Re-hospitalization

- 20% of Medicare beneficiaries are re-hospitalized within 30 days, 33% within 90 days (1/4 are preventable)
- Depression predicts re-hospitalization within 30 days
- Estimated $12 billion in Medicare costs are due to preventable hospitalization
  - Medicare will reduce payments to hospitals with an excess of readmissions
- Integrating psychiatric care into inpatient medical services prevents re-hospitalization

Hussain and Seitz 2014
Davydow D et al, J Gen Intern Med 2013
Mitchell SE et al, 2010
Psychosomatic Medicine Psychiatrists Have Unique Skills

- Physicians—medical degrees and comprehensive training
- Medical expertise beyond the scope of general psychiatrists
- Training and experience with the most frequent psychiatric conditions in primary care
- Expertise working in outpatient and inpatient medical settings
- Expertise in primary care integration settings and in high utilizers
- Experience with working closely with primary care physicians and specialists in clinics and hospitals
- Experience with working on collaborative teams
- Familiar with medical-surgical cultures
Psychosomatic Medicine Competencies

- Psychosomatic Medicine Psychiatrists' unique skills make them ideal resources for implementing and executing integrated and collaborative care in:
  - Primary care
  - Specialty care
  - Inpatient medical surgical settings

- Academy of Psychosomatic Medicine Scope of Practice and Competencies
  - Medical expertise
  - Collaboration across settings/disciplines
  - Communication and interpersonal skills
  - Effectiveness for patients and consultees
  - Health advocacy
  - Scholarship and research

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Strategies Provide Value: Psychosomatic Medicine

- Collaborative Care
- Proactive Consultation
- Delirium Prevention
- Hot Spotter Teams
- Complexity Intervention Units
- Patients with Chronic Medical Conditions
Who Makes Reform Happen?

The Role of Psychosomatic Medicine specialists:

- Leaders in research on integrated care
  - Cost-effectiveness research
- Experts in identifying psychiatric illness complicating chronic medical conditions
- Experts in integrating psychiatric care into medical care and triaging patients to appropriate level of mental health care
- Experts in system change for integrated care
- Experts in improving patient outcomes through comprehensive care