Telepsychiatry Collaborative Care: Improving Access and Outcomes

By Sara Haack, MD, MPH
Jennifer Erickson, DO
Disclosures

• Sara Haack: No relevant conflicts of interest
• Jennifer Erickson: No relevant conflicts of interest
Acknowledgements

• Thank you to the University of Washington AIMS Center, especially Marc Avery and Cara Towle for their help and guidance
• Some slides courtesy of the University of Washington AIMS Center
Why Make Any Change in the Existing Psychiatric Care?
COLLABORATIVE CARE: RATIONALE AND EVIDENCE
The Challenge

Behavioral Health

- Psychiatric disorders cause
- 25% of all disability worldwide* 
- 10% of Years Lived with Disability (YLD) from depression alone 
- 3x diabetes, 10x heart disease, 40x cancer 
- In the US, one suicide every 14 minutes 
  - Ex: WA State has 2-3 suicides per day

* C. Murray, GBD Study, Lancet 2012

Health Behaviors

- Behavior determines ≈ 50% of all mortality and morbidity 
- Unhealthy behaviors are major drivers of health care costs 
- 40–50% struggle with treatment adherence 
- Employers struggle with absenteeism and presenteeism
Who Gets Treatment?

Wang et al., 2005
Who Gets Treatment?

No Treatment

Primary Care Provider

Mental Health Provider

Wang et al., 2005

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Better screening?

• Excellent!
Better screening?

- Excellent!
- Oh, wait.
Issues of Capacity and Equity

• If psychiatrics providers saw everyone with active mental illness:
In Other Words...

- Depression is common and undertreated
- Depression is costly
- Capacity: There are not enough psychiatrists
- Equity: There are especially few psychiatrists in rural, poor areas
Collaborative Care

Caseload-focused psychiatric consultation supported by a care manager

**Better access**
- PCPs get input on their patients’ behavioral health problems within a days /a 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

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Principles of Effective Integrated Behavioral Health Care

Patient Centered Care
- Team-based care: effective collaboration between PCPs and Behavioral Health Providers.

Population-Based Care
- Behavioral health patients tracked in a registry: no one ‘falls through the cracks’.

Measurement-Based Treatment to Target
- Measurable treatment goals and outcomes defined and tracked for each patient.
- Treatments are actively changed until the clinical goals are achieved.

Evidence-Based Care
- Treatments used are ‘evidence-based’.

Accountable Care
- The delivery system is accountable and reimbursed for quality of care, clinical outcomes, and patient satisfaction, not just the volume of care provided.
IMPACT: Summary

1) Improved Outcomes:
   • Less depression
   • Less physical pain
   • Better functioning
   • Higher quality of life

2) Greater patient and provider satisfaction

3) More cost-effective

“I got my life back”
Findings Robust Across Diverse Health Care Organizations

TREATMENT RESPONSE
50 % or greater improvement in depression at 12 months

Participating Organizations

Unutzer, et al. JAGS 2003; 51:505-514
# How Well Does It Work With Other Disorders?

<table>
<thead>
<tr>
<th>Evidence Base Established</th>
<th>Emerging Evidence</th>
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<tbody>
<tr>
<td>• Depression</td>
<td>• Substance Use Disorders</td>
</tr>
<tr>
<td>- Adolescent Depression</td>
<td>• ADHD</td>
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<tr>
<td>- Depression, Diabetes and Heart Disease</td>
<td>• Bipolar Disorder</td>
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<td>- Depression and Cancer</td>
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<td>- Depression in Women’s Health Care</td>
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<tr>
<td>• Anxiety</td>
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<tr>
<td>• Post Traumatic Stress Disorder</td>
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<td>• Chronic Pain</td>
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<td>• Dementia</td>
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</table>
TELEPSYCHIATRY
COLLABORATIVE CARE:
RATIONALE & EVIDENCE
Mental Health Challenges

- Capacity
  - Collaborative Care
- Equity
  - Telepsychiatry
- Capacity and Equity
  - Integrated care telepsychiatry
Telepsychiatry Models

Figure 1. Pyramid of telepsychiatry models.

Fortney et al. 2015
Collaborative Care Telepsychiatry and Patient Outcomes

- Patient Outcomes in primary care
  - Depression
    - ↑ response, remission, med adherence (Fortney et al. 2007)
    - ↑ response, remission (Fortney et al. 2013)
  - PTSD
    - ↓ PTSD, depression symptoms; ↑ psychotherapy initiation, retention (Fortney et al. 2015)
Collaborative Care Telepsychiatry and Patient Outcomes

- Patient Outcomes in specialty care
- Depression+ HIV
  - ↑ depression response, remission at 6 m; ↓ HIV symptom severity at 6 m, 12 m (Pyne et al. 2011)
Collaborative Care Telepsychiatry and Satisfaction

- Primary care
  - ↑ patient satisfaction (Fortney et al. 2007)
- Specialty care
  - high patient and provider satisfaction (Drummond et al. 2017)
Collaborative Care Telepsychiatry and Cost

• Depression in primary care
  • Clinically and cost-effective: $25,728 per QALY (Pyne et al. 2015)
  • Clinically effective but expensive: $85,624 per QALY (Pyne et al. 2010)
Summary

• Mental illness, especially depression, is common and costly
• Collaborative care telepsychiatry addresses two big challenges
  • Capacity
  • Equity
• And it achieves the Triple Aim!
UWNC & Tele-Collaborative Care

- 2 New UW Neighborhood clinic sites opened in Jan 2016
  - Smokey Point
  - Olympia
- Behavioral Health Integration Program (BHIP) started Sept 2016

Image from: http://www.wsdot.wa.gov/partners/TIO/washington.htm
Clinics

• Smokey Point
  • Care Coordinator (SW)
  • Patient Navigator
  • 7 Primary Care Providers

• Olympia
  • Care Coordinator (SW)
  • 4 Primary Care Providers
Clinic Structure

- PCP places referral to CC

- CC review referrals with psychiatrist and sorts:
  - SW services
  - Outside referral for long term Counseling/Psychiatry
  - BHIP
  - Psychiatrist Referral for Diagnosis/Management Considerations
Clinic Structure

- BHIP Referrals
  - Short term therapy and initial diagnosis made by SW
  - Case reviewed by Psychiatrist
  - Can be seen by Psychiatrist
- Psychiatric Referrals
  - Screened by SW with standard tool including scales
  - Seen by psychiatrist for 1-2 in person appointments and assessed for medications/next treatment steps
Unique Consideration for Tele-implementation

- Start up logistics
- Training care coordinators at a distance
- Clinical culture
- Complex cases
- Fewer organic shared experiences
Unique considerations: Start up logistics

- Technology
  - Proper camera, computer, and IT
- Stakeholders
  - Who is responsible for what/where?
- Billing
Unique Consideration: Distance Training

- Population health and care model
- Screening tools (PHQ-9, GAD7, others)
- Registry
- Managing the referral box
- Short term therapy support
Unique Consideration: Clinical Culture

- No two clinics are the same
- Exploring, understanding, compromising within the new system
- Managing clinic expectations
Unique Considerations: Complex Cases

- Indirect care
- Patient safety
- Limits of safe care
Unique Considerations: 
Shared Experiences

- Team building
- Ease of access to staff
Creating a Remote Presence

- Communicate with your stakeholders
- Create a shared vision with clinic site
- Check in with CC about clinic
- Curbsides with PCPs and electronic check ins
- Chart reviews based on SW screenings when appropriate
- Occasional in person visits
Summary of Considerations and Recommendations

- Communicate consistently
- Manage expectation about the program and who will do what
- Put effort into creating a virtual presence
Program Numbers

- Smokey Point
  - 190 patient referrals
  - 29 chart review for medication recommendations
  - BHIP Case Load between 8-14 patients
  - 3 inperson psychiatric assessments completed
Program Numbers

• Olympia
  • 200+ referrals
  • 40 charts reviewed for medication recommendations
  • BHIP case load 20-32
  • 10 in person psychiatric assessments completed
Clinic Next Step

• Patient to provider Telepsychiatry visits
  • 4 per site per clinic day
  • New role of the Care Coordinator
**Telepsychiatry Work Flow**

**UW/UWNC BHIP Telepsychiatry Workflow**

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<thead>
<tr>
<th></th>
<th>PRE-APPOINTMENT</th>
<th>DURING APPOINTMENT</th>
<th>POST-APPOINTMENT</th>
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<tbody>
<tr>
<td>Billing Provider</td>
<td>(J. Erickson DO)</td>
<td>Psychiatrist sees Patient via ZOOM/vtc</td>
<td>Psychiatrist closes and documents in Belltown EPIC with Visit type 9020; appropriate CPT code + GT modifier; appropriate diagnosis code; dot phrase to doc telem</td>
</tr>
<tr>
<td>Care Coordinator at Olympia or Smokey Point</td>
<td>Schedule BHIP Telepsych Appointment with Psych Provider in Belltown EPIC Visit Type 9020</td>
<td>CC presents Patient to Psychiatrist (then departs room in most cases)</td>
<td>CC closes in SP/Oly EPIC with visit type 9020 Q3014 billing code for telmed “facility fee;” generic diagnosis code; dot phrase to doc telem</td>
</tr>
<tr>
<td>UWP</td>
<td>Schedule BHIP Telepsych Appointment in Room (“resource”) on SP or Oly EPIC Visit Type 9020</td>
<td>- CC or front desk checks in/arrives patient* - CC opens Zoom connection - CC notifies Psychiatrist that patient is ready</td>
<td>* Appointments are linked so that arriving the patient at patient location (SP or Olympia) will arrive at the Belltown site at the same time.</td>
</tr>
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<td></td>
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<td>approved by Compliance; Belltown (provider location): “This telepsychiatry patient encounter was conducted from UW Medicine, Seattle, WA (clinic name), via secure, live, face to face video conferencing to the patient at XX clinic name, city, state. The patient, provider X, and XXX participated in the encounter. Prior to the interview, the risks and benefits of telepsychiatry were discussed with the patient and verbal consent was obtained. No recordings are kept from this encounter. SP/Olympia (patient location): Using clinic space and equipment at XX UWNC clinic, patient participated in a live, face to face video conference with UW &quot;provider X.&quot;</td>
</tr>
</tbody>
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**UWP to track visits coded with GT modifier and redirect $$ to UWNC: redirect funds flow of pro fee to UWNC; pull data and do a revenue transfer of appropriate funds to UWNC. Driven by GT modifier.**

**Bill for Pro Feez**

**Bill for Facility Fee**
Questions?