Telepsychiatry Collaborative Care: Improving Access and Outcomes

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Disclosures

- Sara Haack: No relevant conflicts of interest
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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

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

C. Murray, GBD Study, Lancet 2012

Who Gets Treatment?










Wang et al., 2005

Who Gets Treatment?

No Treatment






Primary Care Provider




Mental Health Provider

Wang et al., 2005

Better screening?

- Excellent!

Better screening?

- Excellent!
- Oh, wait.

Issues of Capacity and Equity

- If psychiatrics providers saw everyone with active mental illness:

US: Urban

US: Rural

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

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.

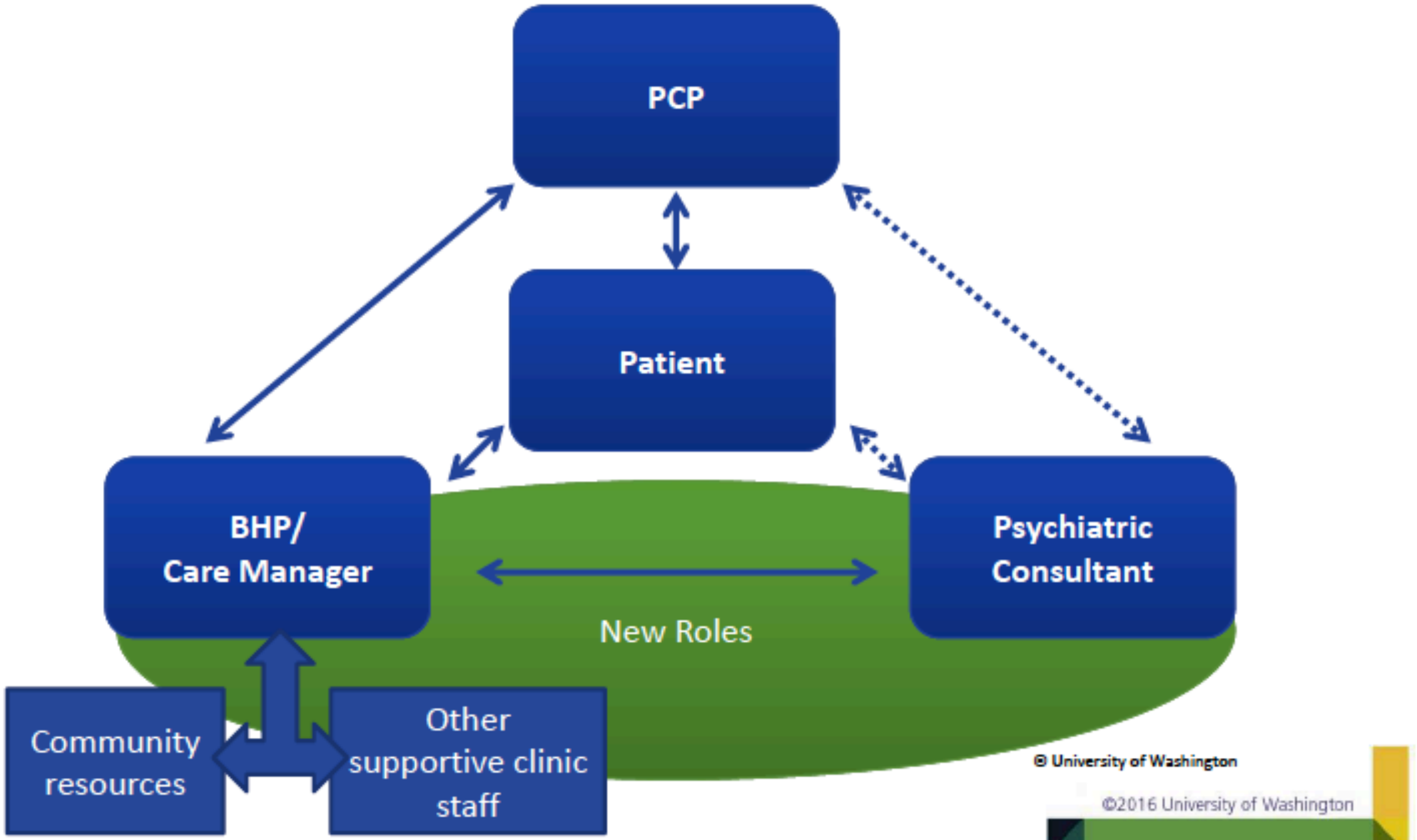
Evidence-Based Care

- 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.

Collaborative Care Team



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

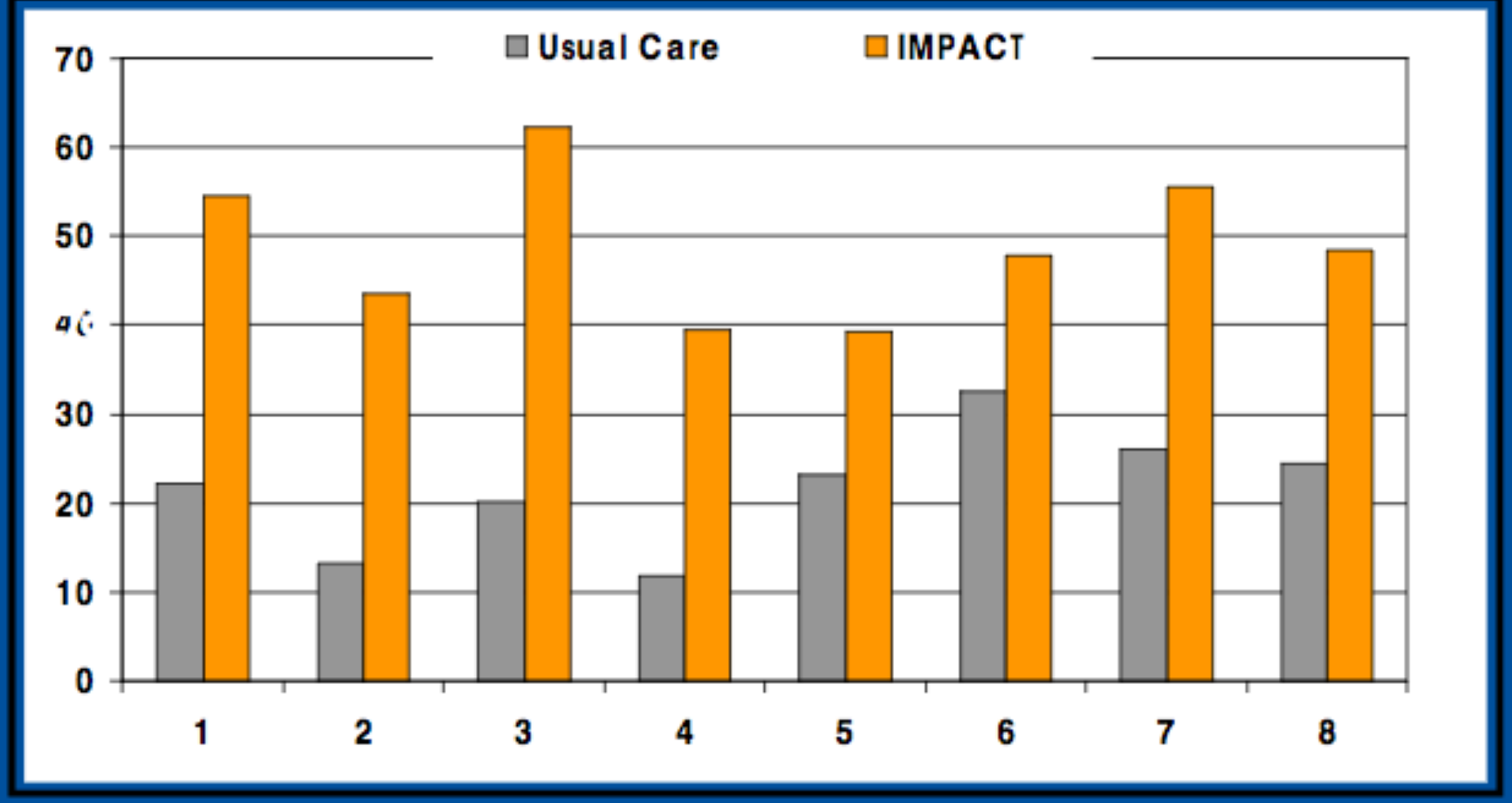
→ THE TRIPLE AIM

"I got my life back"

Findings Robust Across Diverse Health Care Organizations

TREATMENT RESPONSE

50 % or greater improvement in depression at 12 months



Unutzer, et al. *JAGS* 2003; 51:505-514

How Well Does It Work With Other Disorders?

Evidence Base Established	Emerging Evidence
• Depression - Adolescent Depression - Depression, Diabetes and Heart Disease - Depression and Cancer - Depression in Women's Health Care • Anxiety • Post Traumatic Stress Disorder • Chronic Pain • Dementia	• Substance Use Disorders • ADHD • Bipolar Disorder

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 stake holders
- 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

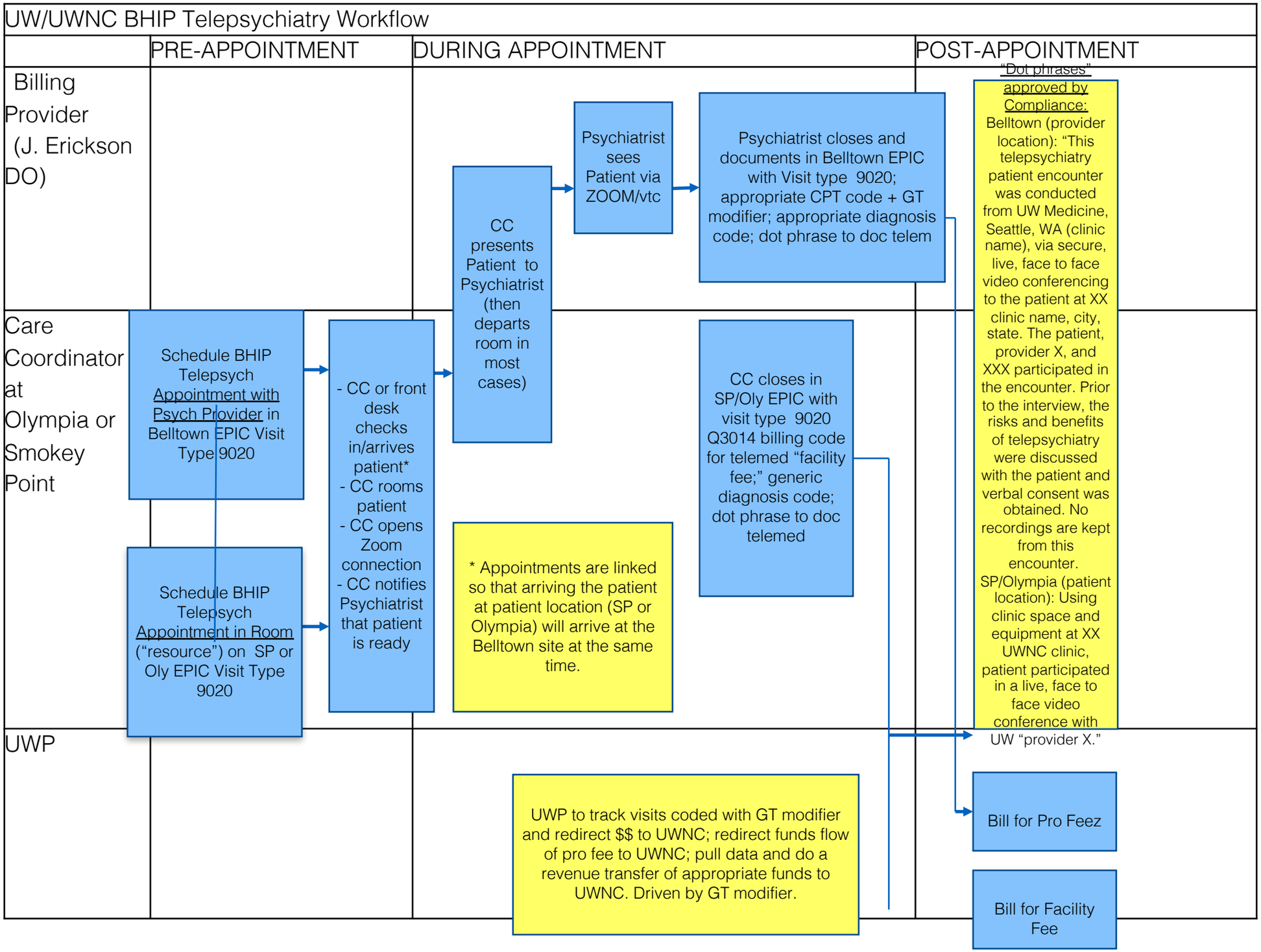
Program Numbers

- 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



Questions?