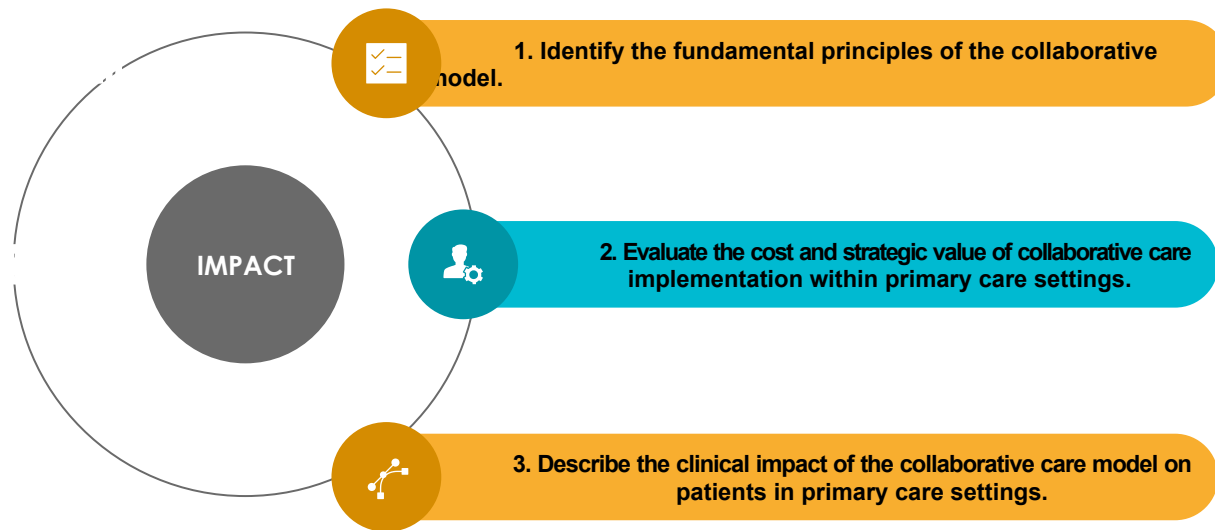


Catch Them Early & Don't Let Them Linger:

Changing the Trajectory of Depression, Anxiety, and
Substance Use through Collaborative Care

Lora Peppard, PhD, DNP, PMHNP-BC & Rebecca A. Bates, DNP, FNP-C

Objectives



Problem

Nationwide

- Between 2013-2016, 8.1% of adults in the U.S. experienced symptoms of depression during a 2-week period.
- 80% of those individuals reporting difficulty with home, work, or social activities because of the symptoms of depression.
- Less than 50% of individuals seeking care for depression will make an initial appointment with a mental health provider.
- 45% of individuals who complete suicide had a recent primary care visit in the past month.

Free Clinic

- Eligibility criteria: 200% or below the federal poverty level, uninsured, live in the county, adult ages 18-64 years
- Clinic receives no federal or state funding
- Addresses: Lack of access to care and case management

Collaborative Care

Overview

- Behavioral health integration model for primary care setting
- >80 RCTs evidence base
- Treatment team: patient, primary care provider, care manager, and psychiatric consultant
- Evidence-based treatment plans may include medication, psychotherapy, or both
- Target treatment goal for most patients would be a 50% reduction in PHQ-9 or PHQ-9<5
- Ongoing evaluations
 - Regular intervals, typically every two to four weeks
 - Completed by the care manager or primary care provider
 - Assess disease acuity over time
- Population health tracked and managed through patient care registry

Collaborative Care Fundamentals

Patient-Centered Team Care

- Effective collaboration
- Shared care plans with patient goals
- One-stop care
- Increased patient engagement

Population-Based Care

- Defined group of patients
- Tracked in a registry
- Outreach if not improving
- Focused consultation

Measurement-Based Treatment to Target

- Clinical outcomes routinely measured by evidence-based tools
- Treatment changed if no improvement or goals not achieved

Evidence-Based Care

- Treatments with credible research evidence for target condition
- Proven modalities for primary care

Accountable Care

- Providers accountable and reimbursed for quality of care & clinical outcomes, not just volume

Settings

Free Clinic

PROFILE

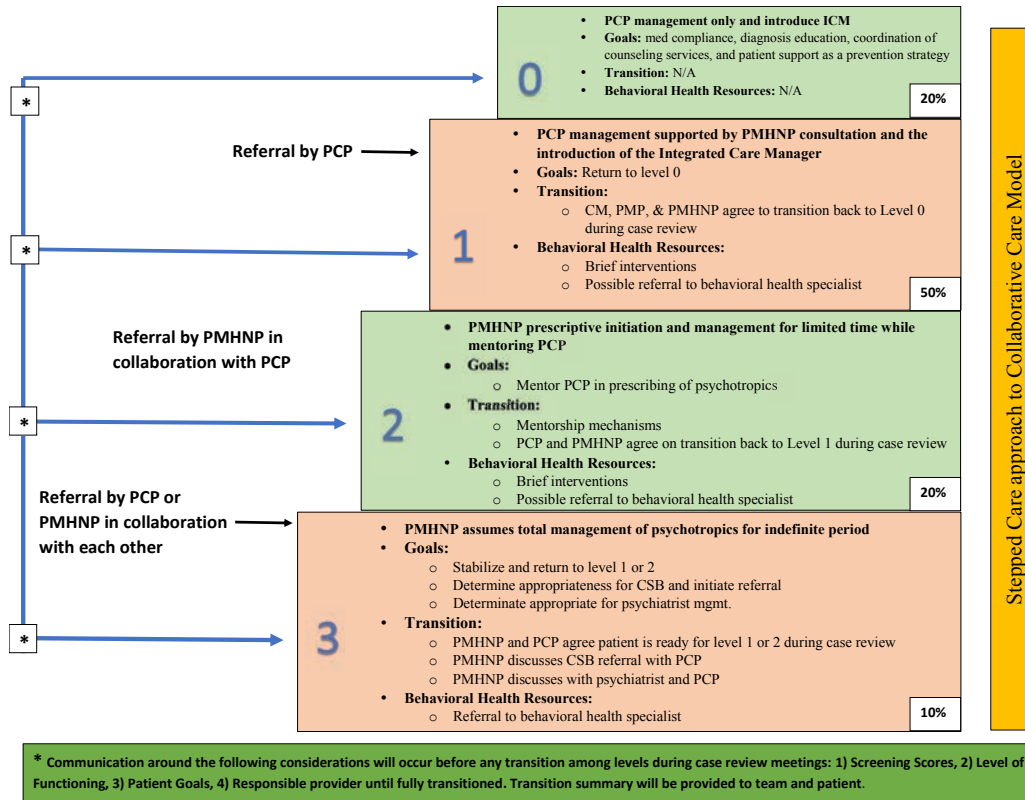
- Staffed by 13 paid staff/providers, 160 volunteers
- More than 1500 patients
- Provides \$8 of care for every \$1 spent

Student Health Center

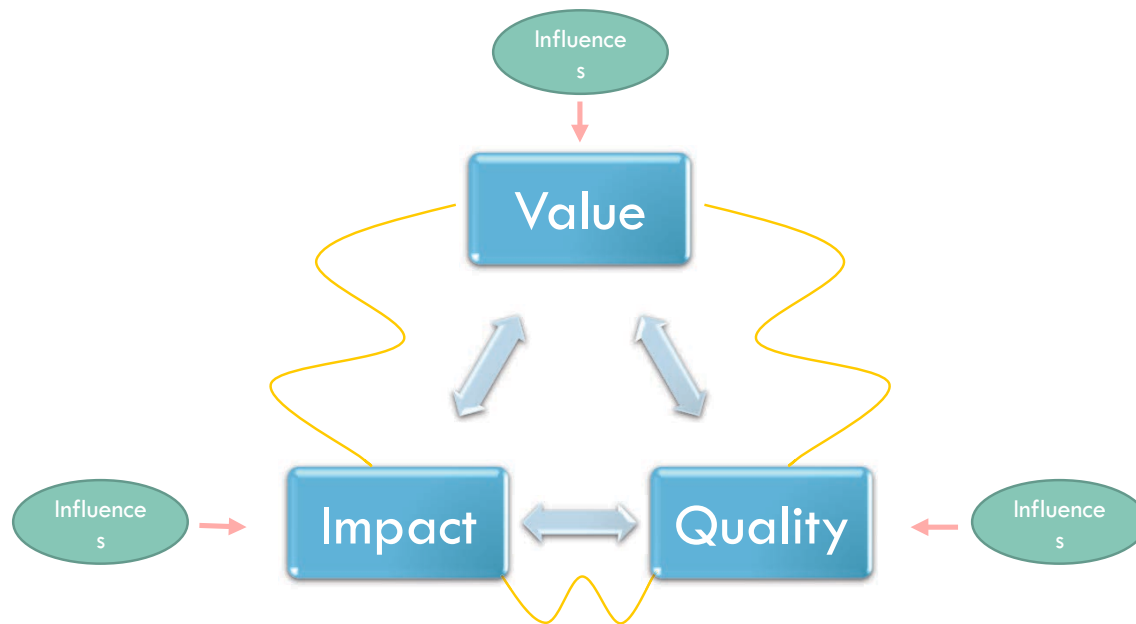
PROFILE

- Staffed by paid staff clinicians, nurses, and administrative staff
- Patient population is any enrolled university student (37,000+)
- United Healthcare

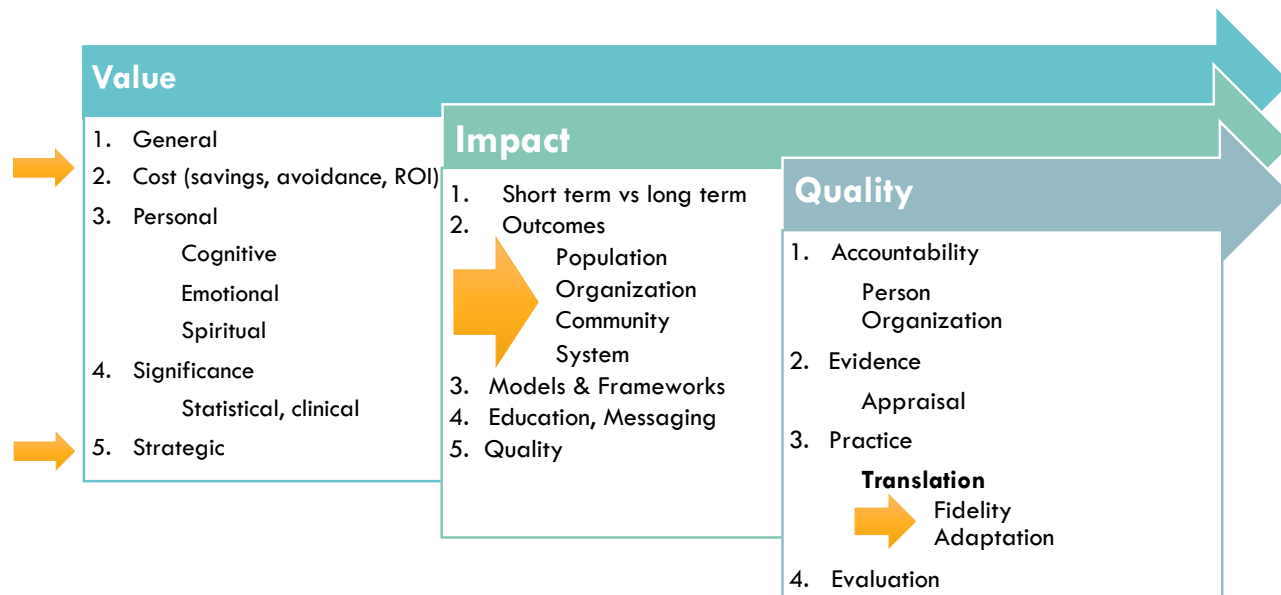
Stepped Care Framework



VIQ



VIQ



Cost Analysis

Return on Investment

$$\text{ROI} = \frac{(\text{Current Value of Investment} - \text{Cost of Investment})}{\text{Cost of Investment}}$$

$$\text{ROI} = \frac{(\text{Revenue} - \text{Implementation Cost})}{\text{Implementation Cost}}$$

Revenue

Medicare CPT Payment Summary 2019

CPT	Description	Payment/PT (Non-Facilities) Primary Care Settings	Payment/Pt (Fac) Hospitals and Facilities
99492	Initial psych care management, 70 min/month – CoCM	\$162.18	\$90.46
99493	Subsequent psych care management, 60 min/month – CoCM	\$129.38	\$81.81
99494	Initial/subsequent psych care management, additional 30 min CoCM	\$67.03	\$43.97
99484	Care mgmt. services, min 20 min – General BHI services	\$48.65	\$32.80

Revenue

Initial Intake Revenue

CPT	Description	Payment/PT (Non-Facilities) Primary Care Settings	# of patients seen over first year	Total Revenue from Intakes
99492	Initial psychiatric care management, 70 min/month	\$162.18	133	\$21,569.94

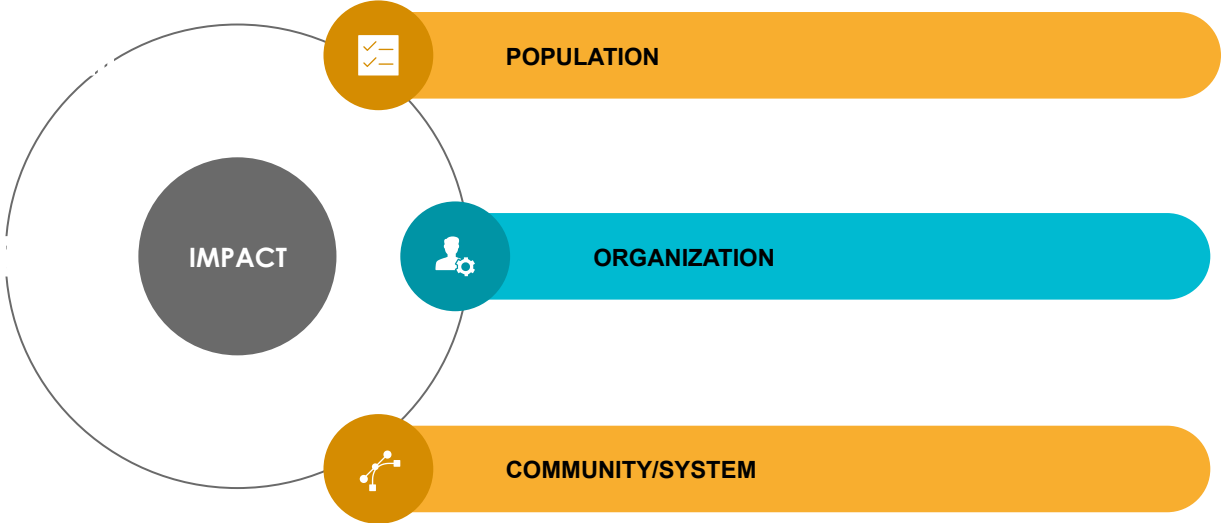
Strategic Value

Organization & Community

One Stop Shop

- › Enhanced ability to screen & treat in primary care
- › Decreased wait time for access to services
- › Decreased burden on Community Services Boards and other community resources
- › Improved team communication
- › Competitive Value
- › Patient & Provider Satisfaction
- › Offer Hope

Impact



Impact

Patient Outcomes

1. Successful Enrollment and Engagement in Care
2. Improved Continuity in Care
3. Supports full collaboration in a transformed/merged integrated practice

Examples:

- Flagged patients who were about to run out of medications or stopped abruptly
- Increased contacts (not just during therapy)
- Improvements in depression, anxiety, and chronic disease management

Quality

Fidelity

MORE THAN JUST AN ETHICAL PRINCIPAL

- › The degree of exactness with which something is copied or reproduced
- › Supports reproducibility of outcomes
- › Consistent process for ensuring fidelity should be in place
 - › Adherence to principles of CoCM
 - › PDSA
 - › CQI

Discussion

Adaptation

Existing Resources

- › LSW
- › Students

Substance Use

Systematic Follow-up

- › SBIRT
- › DAST, AUDIT

System of Care

Stepped Care

- › PCBH – first layer
- › CoCM – infrastructure for behavioral health integration
- › SBIRT infusion into infrastructure
 - › Expansion of care manager role
 - › Consider training medical providers to deliver BI

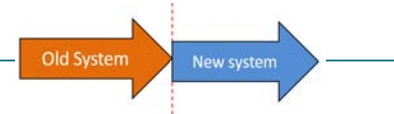
Sustainability

Free Clinic

Strategy

- › Value - ROI common language
- › Impact – translate outcomes into meaningful language for audience
 - › Relate outcomes to experiences of audience
 - › Establish protocols and policies including training in CoCM for all staff
 - › Improved interprofessional practice resulting from frequent team meetings
 - › Use language familiar to Board, no fancy terminology
 - › Describe outcomes in terms of larger picture (chronic disease or co-morbidities)

Practice Transformation



SHAPE Framework

	Concepts	Considerations
S	Sustainability & Systems	<ul style="list-style-type: none">• Buy-in, Champions• Reimbursement• Where EBPs fits into the big picture (organization and community)
H	Harness Potential	<ul style="list-style-type: none">• Meet them where they are at• Training• Communication• Expectations of change process
A	Approach	<ul style="list-style-type: none">• Model choice• EBP choices• Roles
P	Process	<ul style="list-style-type: none">• Clinical work flow• Data
E	Evaluation	<ul style="list-style-type: none">• CQI• All levels (system, process, skill)• Selection of measures to demonstrate impact



Thank You

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