Advancing Collaborative, Measurement-based Care

Diane Holliday-Welsh
Operations Administrator for Behavioral Health, Essentia

Amar Kendale
Chief Product Officer, Livongo Health

Michael Schoenbaum, Ph.D.
Senior Advisor for Mental Health Services, Epidemiology and Economics, National Institute of Mental Health

Julie Sonier
President & CEO, MN Community Measurement *(Moderator)*

Michael Trangle, M.D.
Psychiatrist (retired); Past President Minnesota Psychiatric Association

Minnesota Health Action Group™
Innovating, Leading, Engaging

How Employers Can Improve Access to Effective Behavioral Care Through Measurement-based Care

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Michael Trangle, M.D.
Psychiatrist (retired); Senior Fellow, HealthPartners Institute for Research and Education; Past President Minnesota Psychiatric Association

Measurement-based Care: Research Base

The Tipping Point: Findings of a research review of 51 articles

- Virtually all randomized controlled trials with frequent and timely feedback of patient-reported symptoms to the provider during the medication management and psychotherapy encounters significantly improved outcomes.
- Outcomes improved from 20 to 60% depending on the study.
- Fortney et al. cited studies that found up to a nearly 75% difference in remission rates between patients receiving MBC and those who received usual care.

Fortney, J., et al. (2017). A Tipping Point for Measurement-Based Care. Psychiatric Services in Advance, 68(2), 179-188.

Implementing Measurement-based Care in Behavioral Health: A Review

- Review article which synthesized literature showing MBC is underused:
  - 17.9% of psychiatrists
  - 11.1% of psychologists
  - 13.9% of masters-level practitioners engage in MBC
  - as little as 5% use it every session
  - status quo in the United States, the United Kingdom & Australia as of March 2019

Cara C. Lewis et al; JAMA Psychiatry. 2019;76(3):324-335. doi:10.1001/jamapsychiatry.2018.3329

Measurement-based Care: Path Forward Recommendations

Expanding Use of Measurement-Based Care:

- Support employers and health plans in requiring health systems to use validated and quantifiable screening tools—tracking and reporting on treatment outcomes as part of standard clinical practice in order to achieve greater accountability and positive treatment outcomes.
- Measurement-based care (MBC) is necessary in all settings: primary care, emergency departments, and specialty behavioral health providers.

Specific Actions Steps:

- Request that your TPAs adopt and require standardized measures of outcomes for behavioral health disorders in their ACOs and Primary Care Medical Homes and their large Behavioral Health Providers that are part of their networks.
- Request that the major medical groups in your members' networks also adopt these measures for their ACOs, PCMHs and internal Behavioral Health Providers. Request that large Behavioral Health Providers in your members' networks adopt MBC.

Measurement-based Care: American Psychiatric Association (APA) and APA Foundation

Advancing Measurement Based Care Employers and Employer Coalitions:

- Request that health plans provide an action plan that requires providers to use standardized measurement-based tools (e.g. PHQ-9, GAD-7 and others) to guide decisions and requires them to provide aggregate-level outcomes data for employees being treated for mental health and substance use conditions.
- Inform health plans that enrollees should be screened for depression, anxiety, psychosis, bipolar disorder, suicide, and substance use and track and report on treatment outcomes. Health plans and Behavioral Health Organizations.
- Provide incentive payments and minimize administrative requirements to primary care, mental health and substance use providers who participate in network and in quality improvement programs that require the use of standardized measurement tools (e.g. PHQ-9, GAD-7 and others) at regular intervals.

Measurement-based Care: Joint Commission Standard

The Joint Commission standard was implemented on January 1, 2018 for all free-standing behavioral health accredited programs.

Standard CTS 03.01.09 – The organization assesses the outcomes of care, treatment, or services provided to the individual served.

- EP 1 – The organization uses a standardized tool or instrument to monitor the individual's progress in achieving his or her care, treatment, or service goals
- EP 2 – The organization gathers and analyzes the data generated through standardized monitoring, and the results are used to inform the goals and objectives of the individual's plan for care, treatment, or services as needed
- EP 3 – The organization evaluates the outcomes of care, treatment, or services provided to the population(s) it serves by aggregating and analyzing the data gathered through the standardized monitoring effort

Measurement-based Care: Medicare ACO

Two depression-related quality measures in the Medicare ACO Shared Savings Program are linked to payments:

- Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan (NQF 0418);
- Depression Remission at Twelve Months (NQF 0710)

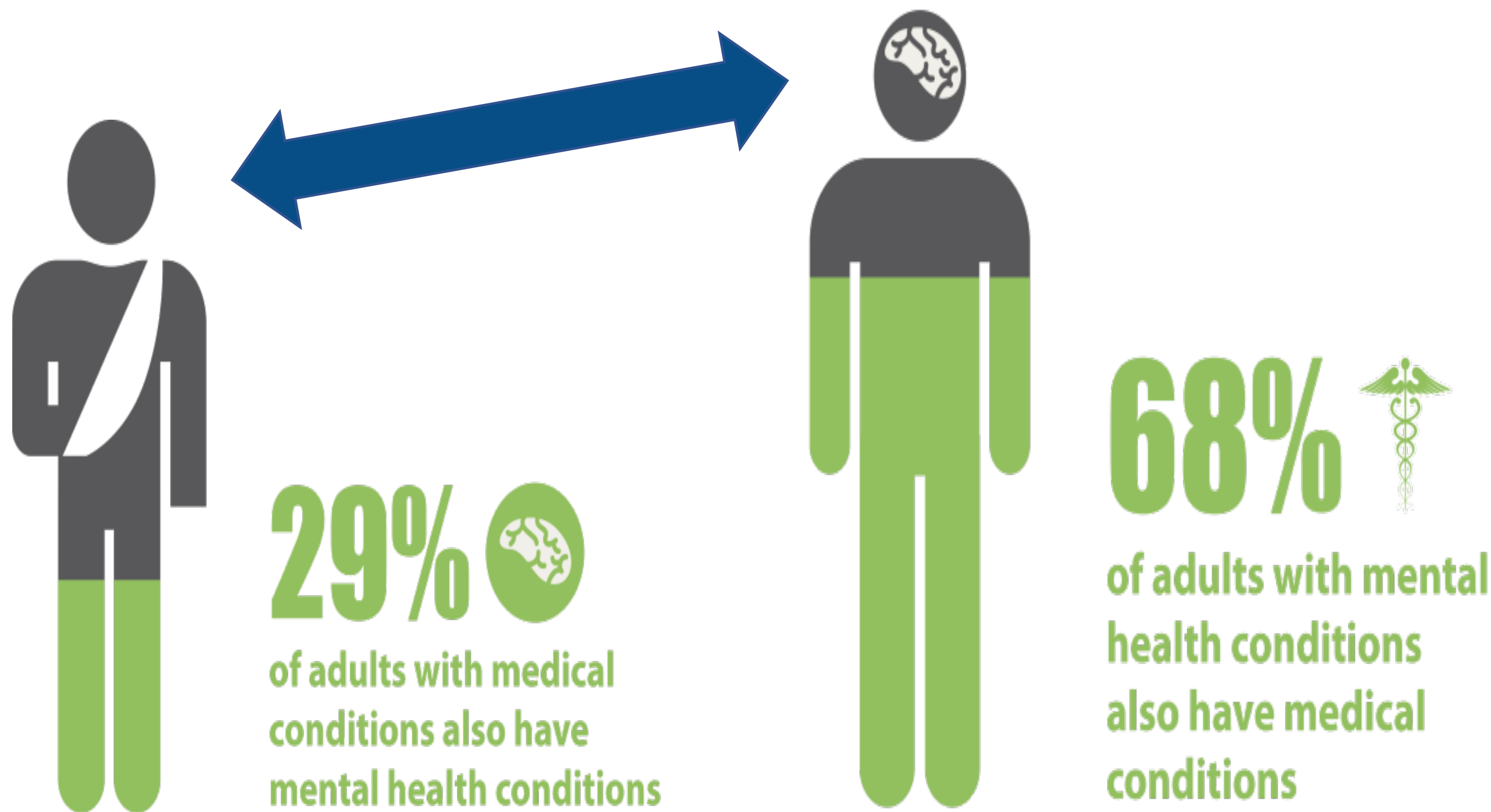
Each measure has a detailed operational definition and set of reporting requirements, with the remission measure requiring use of the PHQ-9 or PHQ-9M. In ACO payment years 2 and 3, the screening measure requires certain levels of performance in frequency of reporting relative to benchmarks, while the remission measure requires reporting only.

Measurement-based Care: Collaborative Care Codes

Requirements in Medicare and AMA Collaborative Care CPT Codes:

- 99492: Initial assessment of the patient, **including administration of validated rating scales**, with the development of an individualized treatment plan
- **Entering patient in a registry and tracking patient follow-up and progress** using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant
- 99493: Tracking patient follow-up and progress using the registry, with appropriate documentation
- Monitoring of patient outcomes using validated rating scales
- 99484: Initial assessment or follow-up monitoring, **including the use of applicable validated rating scales**

Mental Health Affects Medical Conditions and Outcomes in a BIG WAY



Physical Health Costs in the Presence of Behavioral Health Conditions

Commercial Population - 2017 Costs
Per Member Per Month

Behavioral Health Diagnosis	Physical Health Only			Behavioral Health Only			All Health
	Non-Rx Costs	Rx Costs	**Total Costs**	Non-Rx Costs	Rx Costs	**Total Costs**	**Total Costs**
None	$327	$90	**$417**	$3	$6	**$9**	**$426**
MH, Not Serious or Persistent	$765	$246	**$1,011**	$33	$65	**$98**	**$1,109**
MH, Serious and Persistent	$700	$176	**$876**	$119	$159	**$278**	**$1,154**
SUD	$980	$214	**$1,194**	$153	$73	**$226**	**$1,420**

Physical Health Conditions: Medical and Surgical
Behavioral Health Conditions: Mental Health and Substance Use Disorder
MH: Mental Health
SUD: Substance Use Disorder
Rx: Prescription Drugs

Source: Milliman Research Report -- "Potential economic impact of integrated medical - behavioral healthcare", January 2018

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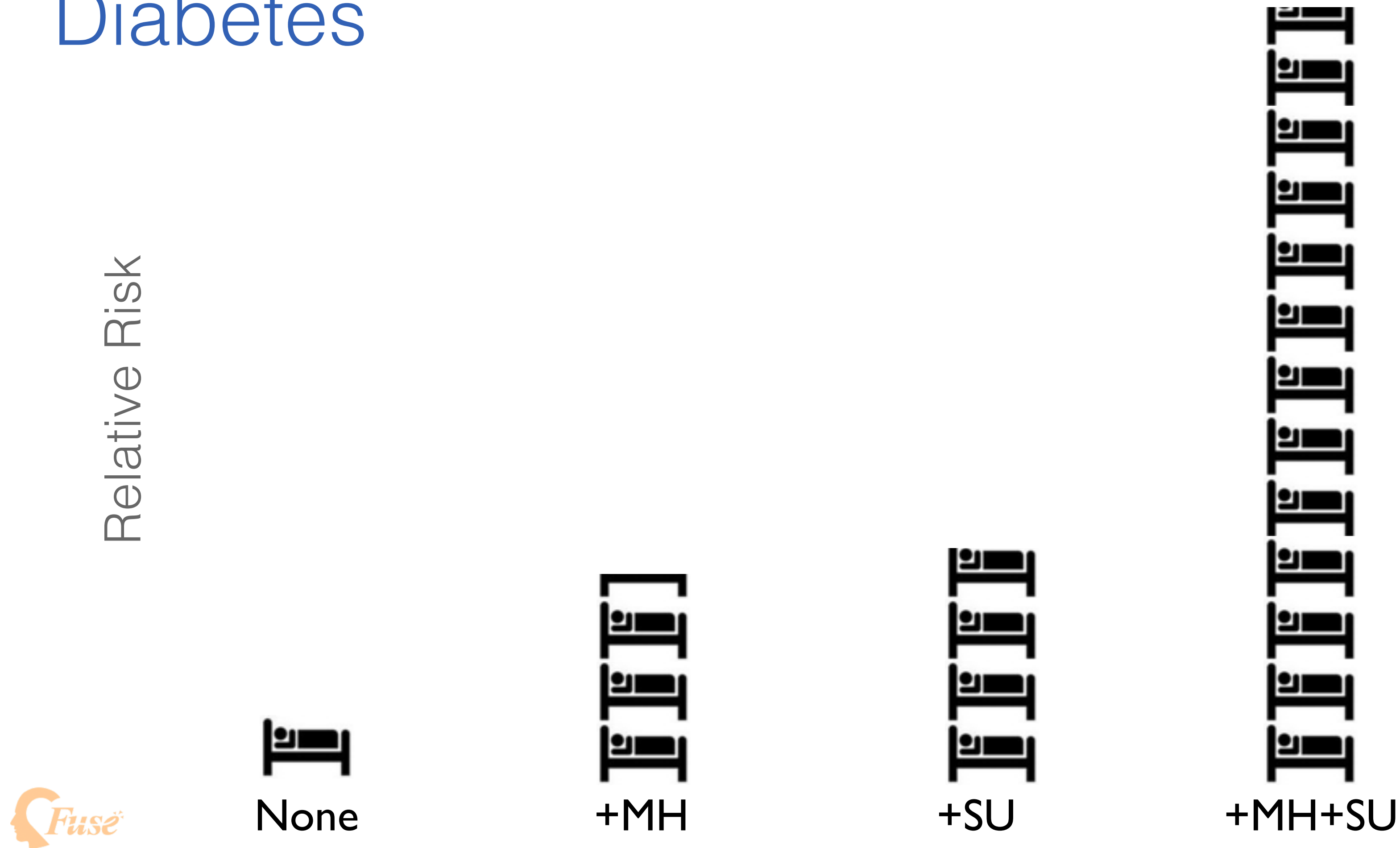
Impact of MHSUD on Medical Costs

POPULATION	% WITH BEHAVIORAL HEALTH DIAGNOSIS	PMPM WITHOUT BH DIAGNOSIS	PMPM WITH BH DIAGNOSIS	INCREASE IN TOTAL PMPM WITH BH DIAGNOSIS
Commercial	14%	$340	$941	276%
Medicare	9%	$583	$1429	245%
Medicaid	21%	$381	$1301	341%
All Insurers	15%	$397	$1085	273%

Melek S, Norris D, Paulus J: Economic Impact of Integrated Medical-Behavioral Healthcare: Implications for Psychiatry. Edited by Milliman I. Denver, CO, Prepared for American Psychiatric Association; 204. pp. 1-39.

Relative Risk of Medical Admission With & Without MH and SU Comorbidity



Source: Hilltop Institute, 2012

Fuse

Across Top 9 Chronic Conditions, Depression and Anxiety Go UNDIAGNOSED 85% of the Time.

Medical Costs per Disease State					
Chronic Medical Condition	PMPM With Behavioral Condition	PMPM Without Behavioral Condition	% Treated For Depression or Anxiety	Expected Depression or Anxiety Prevalence	% Missed
Arthritis	$871.88	$564.76	7.1%	32.3%	77.9%
Asthma	$861.99	$470.05	6.8%	60.5%	88.8%
Cancer (Malignant)	$1,180.96	$1,018.45	5.7%	39.8%	85.7%
Chronic Pain	$1,210.56	$884.70	5.9%	61.2%	90.4%
Coronary Artery	$1,305.00	$958.34	5.7%	48.2%	88.1%
Diabetes	$1,110	$828.18	5.2%	30.8%	83.2%
Heart Failure	$2,242.85	$1,888.11	7.0%	43.8%	84.1%
Hypertension	$880.33	$588.04	5.5%	30.5%	82.0%
Ischemic Stroke	$1,461.57	$1,254.68	7.7%	52.4%	85.2%

Cost Burdens from unrecognized/undiagnosed/Mental Health Cases.

Source: United Healthcare