Getting Started with Collaborative Care: Working All Aspects of the Four Quadrant Model

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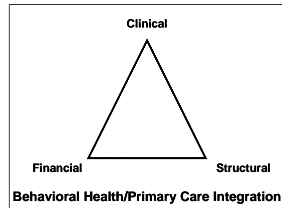
- **Communication** exists when each clinician caring for the patient shares needed clinical information about the patient to other clinicians also treating the patient
- **Collaboration** is multidimensional, requiring:
  - A shared understanding of goals and roles
  - Effective communication
  - Shared decision making
- **Care coordination** is the outcome of effective collaboration and corresponds to clinical integration
- **Clinical integration** is the extent to which patient care services are coordinated across people, functions, activities, and sites over time so as to maximize the value of services delivered to patients

Elements of BH Integration

- Financial or structural integration does not assure clinical integration
- Clinical integration helps us focus on what consumers need
- Public sector efforts focused on financial integration (carve-ins) have had limited success
- Clinical integration requires financial and structural supports in order to be successful
- Public sector financing is a major barrier to achieving clinical integration in most settings
- Washtenaw County and Cherokee Health are outstanding examples of attending to all aspects of integration

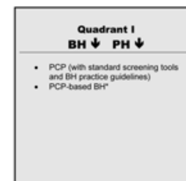


The NCCBH Four Quadrant Integration Model

- Organize our understanding of the many differing approaches—there is no single method of integration
- Think about the needs of the population and appropriate targeting of services
- Clarify the respective roles of PCP and BH providers, depending on the needs of the person being served
- Identify the system tools and clinician skill and knowledge sets needed and how they vary by subpopulation
- Population based for system planning, services should be consumer-centered

Quadrant I

- Low BH/low physical health complexity and risk
- BH services in primary care
- BH staff on site
  - Consultant to PCPs
  - Assessment and triage
  - Brief services
  - Referral to specialty BH
  - Referral to community resources
- BH staff competent in both MH and SA



Quadrant II

- High BH/low physical health complexity and risk
- BH services in specialty BH system
- BH case manager assures access to primary care
- BH case manager coordinates with PCP via established protocol
- BH staff competent in both MH and SA

Quadrant II
BH ↑ PH ↓

- BH Case Manager w/ responsibility for coordination w/ PCP
- PCP (with standard screening tools and BH practice guidelines)
- Specialty BH
- Residential BH
- Crisis/ER
- Behavioral Health IP
- Other community supports

Quadrant III

- Low BH/high physical health complexity and risk
- Served in the primary/specialty healthcare system with BH staff on site
  - Consultant to PCPs
  - Assessment and triage
  - Brief services
  - Referral to specialty BH
  - Referral to community resources
- BH clinician as physician extender and health educator regarding chronic health conditions
- BH staff competent in both MH and SA

Quadrant III
BH ↓ PH ↑

- PCP (with standard screening tools and BH practice guidelines)
- Care/Disease Manager
- Specialty medical/surgical
- PCP-based BH (or in specific specialties)*
- ER
- Medical/surgical IP
- SNF/home based care
- Other community supports

Quadrant IV

- High BH/high physical health complexity and risk
- Served in both specialty BH and primary care/specialty systems
- BH case manager works with all other healthcare providers, especially disease management care managers (e.g diabetes) to assure coordination via an established protocol
- BH staff competent in both MH and SA

Quadrant IV
BH ↑ PH ↑

- PCP (with standard screening tools and BH practice guidelines)
- BH Case Manager w/ responsibility for coordination w/ PCP and Disease Mgr
- Care/Disease Manager
- Specialty medical/surgical
- Specialty BH
- Residential BH
- Crisis/ ER
- BH and medical/surgical IP
- Other community supports

Application to Various Populations

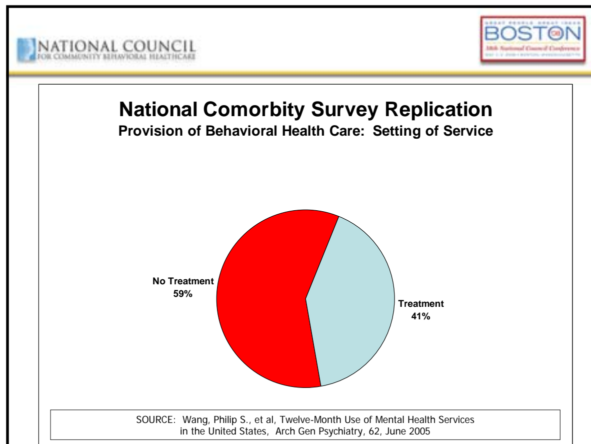
- Service components vary for each quadrant—this example is for adults
- Service components would vary for children, older adults
- Service components would vary for ethnic and minority populations (language and cultural competence)
- Service components would vary for rural settings, regional markets

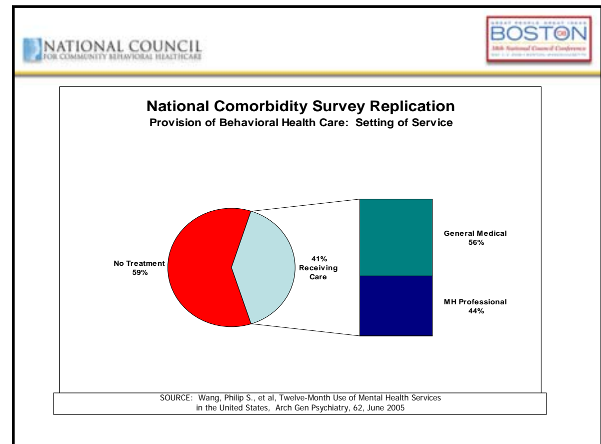
Population Prevalence

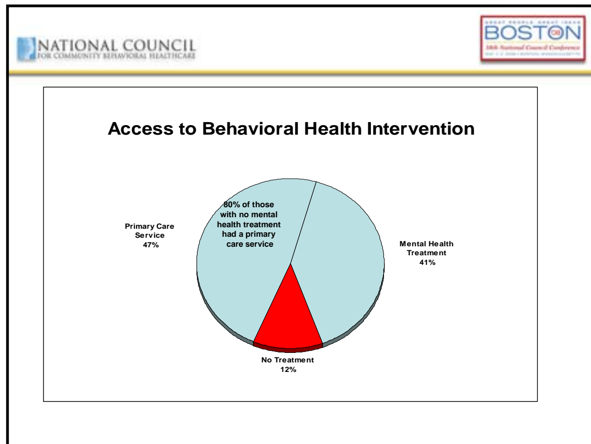
- Medicaid Mental Health managed care penetration targets were set at 10% in the early 90s, based on a 7% rate in the commercial population—this has influenced financing levels for the public mental health system
- Emerging data suggests much higher prevalence in the Medicaid, General Assistance and uninsured populations and inability of the public mental health system to serve these populations

National Comorbidity Survey Replication

- The National Comorbidity Survey Replication (NCS-R) is a household survey taken every 10 years
- Did not include homeless and institutionalized populations, or clinically complex disorders such as schizophrenia—likely that the prevalence rates are underestimates
- 26% of the general population reported symptoms sufficient for diagnosing a mental disorder in the past 12 months
- *Mental disorders gain the strongest foothold in youth: 50% of all cases start by age 14; 75% by age 24*
- Disorder severity: 22% of the 12-month cases were classified as serious, 37.3% moderate and 40.4% mild
- Thanks to Dennis Freeman of Cherokee, who prepared the following NCS graphic presentation slides







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Morbidity and Mortality Among People with Serious Mental Illness

- According to a 2006 report from the National Association of State Mental Health Program Directors (NASMHPD), persons with serious mental illness (SMI) are now dying 25 years earlier than the general population
- While suicide and injury account for about 30-40% of excess mortality, 60% of premature deaths in persons with schizophrenia are due to medical conditions such as cardiovascular, pulmonary and infectious diseases

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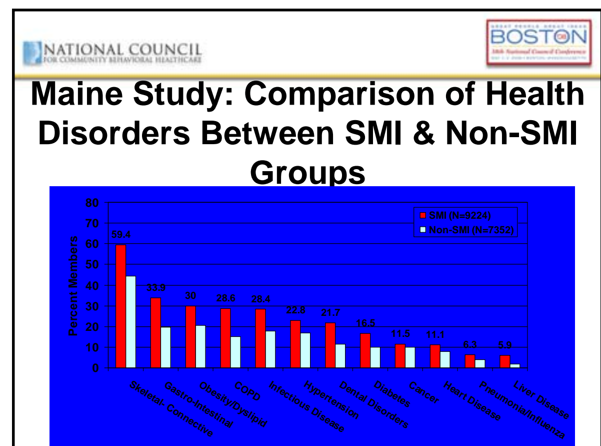
Morbidity and Mortality

- **Impact of medications**
- **Lack of access to healthcare**
- **Higher rates of modifiable risk factors:**
  - Smoking
  - Alcohol consumption
  - Poor nutrition / obesity
  - Lack of exercise
  - “Unsafe” sexual behavior
  - IV drug use
  - Residence in group care facilities and homeless shelters
- **Vulnerability due to higher rates of:**
  - Homelessness
  - Victimization / trauma
  - Unemployment
  - Poverty
  - Incarceration
  - Social isolation



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Comparison of Metabolic Syndrome and Individual Criterion Prevalence in Fasting SMI Subjects and Matched General Population Subjects

	Males		Females	
	SMI N=509	Gen.Pop. N=509	SMI N=180	Gen.Pop. N=180
Metabolic Syndrome Prevalence	36.0%	19.7%	51.6%	25.1%
Waist Circumference Criterion	35.5%	24.8%	76.3%	57.0%
Triglyceride Criterion	50.7%	32.1%	42.3%	19.6%
HDL Criterion	48.9%	31.9%	63.3%	36.3%
BP Criterion	47.2%	31.1%	46.9%	26.8%
Glucose Criterion	14.1%	14.2%	21.7%	11.2%

CATIE source for SMI data
NHANESIII source for general population data
Meyer et al., Presented at APA annual meeting, May 21-26, 2005.
McEvoy JP et al. *Schizophr Res.* 2005;(August 29).

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CATIE Study

- At baseline:
  - 88% of subjects who had dyslipidemia
  - 62.4% of subjects who had hypertension
  - 30.2% of subjects who had diabetes

WERE NOT RECEIVING TREATMENT FOR THESE CONDITIONS

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Implications for Collaborative Care

- Safety net populations generally obtain healthcare from safety net providers
- Many hard-to-engage populations are also found with safety net providers, and may not accept referrals to specialty MH/SA services (e.g., elderly, ethnic/language groups)
- Brief CBT and care management interventions in primary care, along with medications, have been shown to be effective with populations not requiring specialty MH/SA services
- Mental health centers have responsibility to address the health care status of their patients. There are promising models for providing primary care services in specialty MH/SA settings

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Implications for Collaborative Care

- Public mental health systems are frequently under-funded to serve their target populations (for both numbers of people and amount of service), much less populations that are not SMI/SED
- Many states are reducing coverage of the uninsured in their public mental health systems
- Medicaid and uninsured (safety net) populations may have higher levels of MH/SA prevalence than the general population
- These safety net populations may also have higher utilization rates of ER and other healthcare services which shows up as medical system costs
- The barriers to financing MH in primary care appear to be replicated for financing primary care in MH

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About the Money

- HRSA PIN 2004-5 clarifies that Medicaid agencies are required to reimburse FQHCs and RHCs for behavioral health services provided by physicians, physicians assistants, nurse practitioners, clinical psychologists, and clinical social workers—but there has been little action at the state level, especially in managed care states
- CPT codes for BH services in primary care (for a physical health diagnosis) have been adopted by Medicare, but little action by commercial insurers or Medicaid agencies—a few states adopted these as the method for implementing PIN 2004-05

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The Money: Pilot Projects

- Aetna Depression Management is a pilot program in ***Pennsylvania, New Jersey, Maryland, Virginia,*** the ***District of Columbia, Oklahoma*** and ***Texas***
- Provides financial support for the same service components proven in the IMPACT trials, identified in the RWJF sites and being tested in state Medicaid pilot sites (MA, NC):
  - Screening
  - Care management
  - Psychiatric consultation (principally by telephone)
- These service components are otherwise missing from public and private sector billing codes and financing policy EXCEPT IN….

The Money: Minnesota IMPACT Model

- Minnesota DIAMOND Initiative- a project of Institute for Clinical Systems Improvement (ICSI)
- Pilot designed by medical groups, hospitals, health plans (private and Medicaid), purchasers /employers and patients
- Training for proven best practice model of care
- Care management fee for evidence-based care
  - Use of a registry for tracking and follow-up
  - Use of evidence-based guidelines for treatment modification and enhancement
  - Care manager role to make frequent contacts with a patient
  - Weekly consultation for CM with DIAMOND psychiatrist to review and discuss the case load of patients with depression

The Money and the Business Model

- Financial models (FFS, case rates, global payments) are critical to selection of business models-how does Medicaid reimburse for care?
- In one FFS state, for psychiatric medication service 90862
  - A university medical center clinic is reimbursed $12.50 via fee-for-service (FFS) Medicaid
  - The same visit at a community mental health center would be reimbursed $39.92 FFS
  - At a FQHC, the visit with a psychiatrist would be reimbursed at $80-88 (variable due to quarterly recalculated cost basis)
- In a FFS and managed care nearby state, for 90862
  - A university medical center clinic is reimbursed $19.53 via fee-for-service (FFS) Medicaid
  - The same visit at a community mental health center would be reimbursed $210.87 FFS
  - At a FQHC, the visit with a psychiatrist would be reimbursed at $66.82-$155.64 (variable due to quarterly recalculated cost basis)

Q I and Q III Business Models—Who Owns the Staff?

- Placed staff: CMHC places staff on site
- Joint Venture: Common shared cost or grant
- Service contract: Primary care "purchases" BH services like lab or physical therapy [note that a barrier may be malpractice coverage]
- Primary care staff: BH clinicians are hired and supervised by primary care clinic
- In any circumstance, need to assess workload and productivity drivers
- In any circumstance, need to build relationship between primary care and specialty BH system

Q I and Q III Business Models—Who Owns the Staff?

- It has been said that the service contract or "rental" model cannot be implemented in FQHCs that are covered by the Federal Tort Claims Act for malpractice—however, the "rental" agreement with a mental health center can be put in place as long as the mental health center provides the malpractice coverage (and includes that in costing the service)
- In some states, Medicaid will not reimburse for services provided by MFTs in FQHCs, even if the same state will pay for licensed MFTs in community mental health agencies

Q I and III Business Models

	In PHC as Primary Healthcare Provider	In FQHC/RHC as BH Practitioner (PIN 2004-05 option)	As CMHC BH Practitioner Providing Services Located in PHC
Diagnosis	Physical	Psychiatric * or Physical	Psychiatric *
Authority	PCP	BH Practitioner or PCP	BH Practitioner
Billing under	PCP bundled services 99201-5, 11-15 series 99078 educational services-group 99401-4, 11-12 prevention interventions 0108 & 0109 for diabetes	MH benefit * 90804-29 series, individual 90853,57 group 90846-49 family 99150-5 codes as come on line Or, Health benefit 96000 series	MH benefit * 90804-29 series, individual 90853,57 group 90846-49 family 99150-5 codes as come on line
Documentation	In PHC medical chart	In RHC medical chart	CMHC records
Liability	PHC / BHP	RHC/ BHP	CMHC / BHP
Payments to	PHC	RHC	CMHC *Based on Dyer, NCCBH Conference 03*

Integrating Care In Washtenaw County, Michigan

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History of the Washtenaw Community Health Organization (WCHO)

- Initial Discussions – 1997
  - Threat of competitive, managed care bid in the State
  - Desire to be proactively creating something
  - Contacted a private hospital system and the University of Michigan
- WCHO created by change in law – May 2000
  - Eliminated the CMH Board as we knew it
  - Created a new, joint Policy Board with broader responsibilities
  - Appointed an Executive Director
  - CMH Program, Substance Abuse Coordinating Agency, Primary Care Policy Oversight

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WCHO Vision

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WCHO Financial Arrangements

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WCHO Administrative Arrangements

- WCHO operates on a 5.5% administrative rate including Health Services Access and 24/7 Psychiatric Emergency Services (~53 staff)
- Financing for Integrated Initiatives
  - Data Warehouse – State of Michigan/WCHO
  - Nurse Practitioner Clinics – BCBS/M – Local funds
  - PCP Clinics – WCHO based on number of existing consumers currently at the clinic; clinic to bill for services (Psychiatrist, BH as able to reimburse)
  - Grants
- Integrated Initiatives Coordinator
- WCHO has dollars and policy making responsibilities
- Research – Outcomes and Evaluation Committee

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Thoughts on Getting Started

Keys from Washtenaw County

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Source	Minimal Collaboration	Basic Collaboration from a Distance	Basic Collaboration On-Site	Close Collaboration/Partly Integrated	Fully Integrated
Doherty, McDaniel &Baird (1995)	-Separate systems -Separate facilities -Communication is rare -Little appreciation of each other's "Nobody knows my name" Who are you?	-Separate systems -Separate facilities -Periodic focused communication; most written -View each other as outside resources -Little understanding of each others' culture or sharing of influence "I help your consumers"	-Separate systems -Same facilities -Regular commun., occasionally face-to-face -Some appreciation of each others role and general sense of large picture -Mental Health usually has more influence "I am your consultant'	-Some shared systems -Same facilities -Face-to-Face consultation; coordinated treatment plans -Basic appreciation of each others role and cultures -Collaborative routines difficult; time &operation barriers -Influence sharing "We are a team in the care of consumers"	-Shared systems and facilities in seamless bio-psychosocial web -Consumers & providers have same expectations of system(s) -In-depth appreciation of roles and culture -Collaborative routines are regular and smooth -Conscious influence sharing based on situation and expertise "Together we teach others how to be a team in care of consumers and design a care system

- Keys to The Rolling Start
  - Identify low hanging fruit and begin
  - Have basic agreements; improve as you go – add the bells and whistles later
  - Always work with the consumer in mind
  - Start small and grow

The Services In Washtenaw County

Clinics and Model

- Integrated Clinics in Washtenaw County
  - Homeless Shelter
  - Free standing Not-For Profits (2)
    - FQHC Look-Alike
    - Adolescent Clinic (Ages 12-20)
  - Academic Medicine Clinics (2)
    - Pediatric Clinic
    - General Medicine Clinic
  - Private, For-Profit Hospital System (2)
    - Completely indigent clinic
    - Internal Medicine Clinic

Integrated Services and the Four Quadrant Model – Washtenaw County

Quadrant 1

- Low BH/low physical health complexity and risk
- BH services in primary care
- BH staff on site
  - Consultant to PCPs
  - Assessment and triage
  - Brief services
  - Referral to specialty BH
  - Referral to community resources
- BH staff competent in both MH and SA

Washtenaw Initiatives

- Psychiatrist 5 hours/ week for consultation
- PCP prescribing
- Disease Management

Integrated Services and the Four Quadrant Model – Washtenaw County

- **Quadrant II – High BH/Low PH**
  - BH Case Manager w/responsibility for coordination w/PCP
  - PCP with consultation
  - Specialty BH
  - Residential BH
  - Crisis/ER
  - Behavioral Health IP
  - Other Community Supports
- **Current Washtenaw Initiatives**
  - Mental Health Professional at primary care clinic w/psychiatric consultation
  - Nurse Practitioner Clinics at CMH site
  - Encompass/Care Web
  - Personal Health Record
- **Future Initiatives**
  - Expansion to other clinics
  - Expand NP clinics

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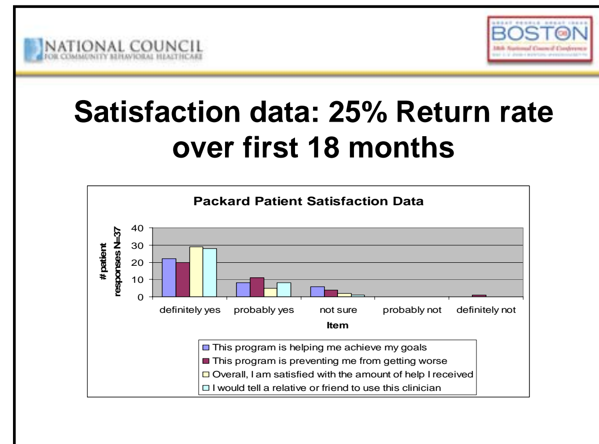
Packard MSW Visits: First 18 Months

Month: April, May, June, July, Aug, Sept, Oct, Nov, Dec, 5-Jan, 5-Feb, 5-Mar, 5-Apr, 5-May, 5-Jun, 5-Jul, 5-Aug, 5-Sep

Total appts | Therapy sessions | New Evals | N/S cancel

Packard Psychiatric Visits first 18 months

Satisfaction data: 25% Return rate over first 18 months

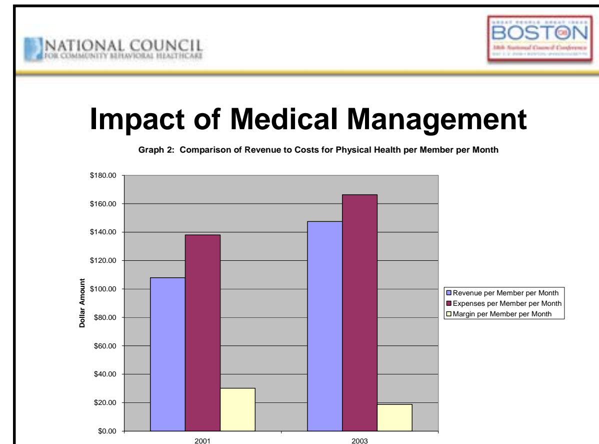


Integrated Services and the Four Quadrant Model – Washtenaw County

- **Quadrant III – Low BH/High PH**
  - PCP with screening tools
  - Care/Disease Management
  - Specialty Med/Surg
  - PCP based- BH
  - ER
- **Current Washtenaw Initiatives**
  - Psychiatric Consultation
  - Care Web
  - Medical Management Center with Care Navigators for UMHS
- **Future Washtenaw Initiatives**
  - Expand Medical Management to all physicians and clinics in the County

Used with Permission - Mauer
2003

Impact of Medical Management

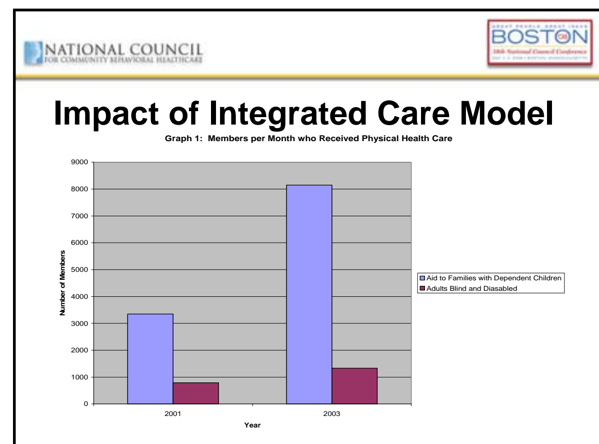


Integrating Services and the Four Quadrant Model – Washtenaw County

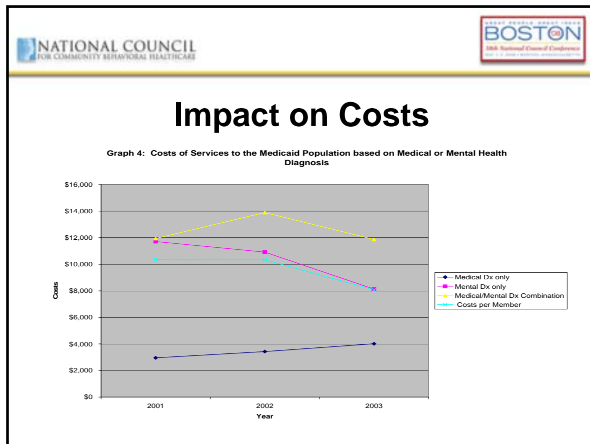
- **Quadrant IV**
- High BH/high physical health complexity and risk
- Served in both specialty BH and primary care/specialty systems
- BH case manager works with all other healthcare providers, especially disease management care managers (e.g diabetes) to assure coordination via an established protocol
- BH staff competent in both MH and SA

- **Washtenaw Initiatives**
  - NP at CMH Sites
  - Medical Management
  - Case Management
  - Disease Management at CMH
    - Diabetes Registry
    - Smoking Cessation Programs
  - Health Risk Appraisal
  - Electronic Interfaces
  - Psychiatrist and MH Professional in Primary Care

Impact of Integrated Care Model



Impact on Costs



WCHO Organizational Structures – Information Technology

- **Care Web** – integrated medical record at University of Michigan Health System with MH information added; available to all PCP's and CMH Psychiatrists and Nurse Practitioners; affirmative participation by consumers
- **Encompass** – new CMH electronic record with full web-based management system for providers to see authorizations and provide claims electronically
- **Data Warehouse** – integrated data set that includes mental health, substance abuse and primary care utilization data; refreshed nightly

Issues WCHO Faced/If we had it to do over…

- Learn to politely not accept "No" for an answer
- Reluctance from all levels and all sides
- Acknowledge the time and energy this type of work takes
- Keys to success
  - Support from the highest levels in each parent corporation; at the University we report to the Executive Vice President for Medical Affairs
  - Relationship(s) between implementing parties
  - Commitment to the vision

Primary Care Clinic	Return on Investment (Financial Costs)				
All are not-for-profit clinics that serve safety net patients	Behavioral Health Providers	FY 2006-07 full year mental health staff cost	FY 2006- 07 full year budgeted cost off-sets*	Variance	FY 2006-07 Projected Savings for CMH **
Clinic #1: 4 M.D.s; 2 nurse practitioners;1 physician assistants; 1nutritionist Serves all ages	1.FTE MSW .10 FTE Psychiatrist .10 FTE Admin 3rd year operation	$97,040	$98,967	$1,927	$48,608
Clinic #2: Homeless Health Clinic (adults) 2 half time nurse practitioners; volunteer MDs and health providers	.30 FTE Psychiatrist .10 FTE admin 2nd year operation	$78,608	$52,576	($26,032)	None; expect 33% shortfall in this program
Clinic #3: University Based Clinic Serves all ages 6 family MDs; 1 nurse practitioner; 4 pediatric MDs + training site	.10 FTE Psychiatrist .10 FTE Admin (FTE MSW planned in 2007) 1st year operation	$35,459	$25,770	($9,689)	$48,608
Clinic #4: Clinic serves ages 12-20 and their children 2.5 M.D.s; 1 nurse practitioner; 2 nutritionists	1.FTE MSW .10 FTE University Psychiatrist*** .10 FTE Admin 7 months operation	$71,516	$24,806	($46,710)	$30,380
Clinic #5: 2 MDs Safety-net Clinic, arm of local private hospital	1.FTE MSW .10 FTE Psychiatrist .10 FTE Admin 5 months operation	$88,218	$44,627	($43,591)	$60,760

National Council Collaboration Resources

- Thanks to researchers and to presenters at the 2003-2007 National Council Conferences for their materials, which have been integrated into the preceding discussion
- Visit http://www.thenationalcouncil.org/
  - Background Paper / EBP Paper
  - **Finance, Policy and Integration of Services**
  - State Assessment Tool
  - List Serve
  - Learning Community
- See also www.nasmhpd.org for **Morbidity And Mortality In People With Serious Mental Illness**

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