AIMS CENTER
W UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

June 22, 2015

The Honorable Orrin Hatch
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Hatch and Senator Wyden,

In response to your solicitation for recommendations on ways to improve care for Medicare patients with chronic conditions, the University of Washington AIMS (Advancing Integrated Mental Health Solutions) Center strongly encourages the adoption of policies that improve and integrate behavioral health care services in primary care. Depression is among the most common chronic illnesses in the US elderly Medicare population, affecting approximately 11.5% of beneficiaries with estimated costs of about USD 65 billion annually. Strengthening behavioral health care services in primary care is critically needed for three reasons: 1) the majority of Medicare patients with chronic medical and behavioral health conditions get their care in primary care; 2) the quality of behavioral health care in primary care is substandard; and 3) effectively treating Medicare patients with behavioral health conditions offers enormous cost savings.

In response to your request for proposals that will address overall policy goals of increased care coordination, streamlining, efficiency, and stronger patient outcomes, we recommend the consideration of the **Collaborative Care Model**, which has the most robust evidence for effective integration of behavioral health care into primary care. It is a specific type of integrated care that treats common mental health and substance use conditions such as depression and anxiety in primary care settings (*please refer to our attached, previous letter dated September 30, 2013, for more information on Collaborative Care*).

In usual primary care, the treatment team has two members: the primary care provider and the patient. Collaborative Care adds two additional vital roles: a care manager (typically embedded) and a psychiatric consultant (typically engaged by phone or tele-video link). Collaborative Care is:

- *Measurement-based*, with screening and monitoring of patient-reported outcomes over time to assess treatment response;
- *Team-based*, led by a primary care provider with support from a care manager and consultation from a mental health specialist who provides treatment recommendations for patients who are not achieving clinical goals;

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- *Population-based,* whereby the care team uses a registry to monitor treatment engagement;
- *Patient-centered*, with proactive outreach to engage, activate, promote self-management and treatment adherence, and coordinate services;
- *Evidence-based,* with demonstrated cost-effectiveness in diverse practice settings and patient populations;
- *Practice-tested,* with sustained adoption in hundreds of clinics across the country;
- *Accountable* for the care provided and for continuous quality improvement to meet care goals.

The evidence behind Collaborative Care is clear and compelling. More than 80 randomized controlled trials have shown Collaborative Care to be more effective than usual care for common mental health conditions such as depression and anxiety. Collaborative Care has been further substantiated by several recent meta-analyses, including a 2012 Cochrane Summary that reviewed 79 randomized controlled trials and 24,308 patients worldwide.

The research is particularly strong for depression, as illustrated initially in the IMPACT study reported in *The Journal of the American Medical Association* in 2002. Collaborative Care more than doubled the effectiveness of depression treatment for adults aged 60 years or older in primary care settings. At 12 months, about half of the patients receiving Collaborative Care reported at least a 50 percent reduction in depressive symptoms, compared with only 19 percent of those in usual care. Evidence is increasing that Collaborative Care is an effective strategy for other mental health conditions as well, including anxiety disorders, posttraumatic stress disorder, and for co-morbid medical conditions such as heart disease, diabetes and cancer. Dr. Wayne Katon and others first reported on improved outcomes in depression and comorbid medical illnesses in *The New England Journal of Medicine* in 2010, and the eight-state CMS COMPASS study is further evaluating Collaborative Care for co-occurring mental health and medical conditions.

In the sections below, we offer our specific feedback and recommendations on the eight issue areas outlined in the May 22, 2015, letter to stakeholders:

1. Improvements to Medicare Advantage for patients living with multiple chronic conditions

Strengthening the level of integrated behavioral health services delivered through Medicare Advantage (MA) organizations will require setting new program quality improvement performance requirements. We recommend that CMS incorporate depression screening and follow up treatment into the MA Chronic Care Improvement Program. All MA organizations must conduct at least one Chronic Care Improvement Program (CCIP) each year that is focused on clinical areas of concern, with the aims of improving health outcomes and patient

satisfaction. Incorporating depression care into the CCIP will set clear expectations that MA organizations are to develop effective strategies for behavioral health integration over time.

This expectation is critically needed because the majority of Medicare patients with chronic medical and behavioral health conditions get all or most of their care in primary care, but the quality of behavioral health care in primary care is often substandard and does not lead to measureable clinical improvements. In addition, improvements are necessary because effectively treating Medicare Advantage patients with behavioral health conditions offers enormous cost savings. In a 2010 study of depressed patients with chronic medical conditions published in *The New England Journal of Medicine*, Collaborative Care was associated with a total 24-month outpatient cost savings of roughly $600 in capitated populations and $1100 savings in fee-for-service care.

2. Transformative policies that improve outcomes for patients living with chronic diseases either through modifications to the current Medicare Shared Savings ACO Program, piloted alternate payment models (APMs) currently underway at CMS, or by proposing new APM structures

Current quality data reporting is an important aspect of the Shared Savings Program. . A single measure -- depression screening and follow up -- is the only mental health measure included among the 33 current metrics.

We recommend the Shared Savings Program also include metrics that reflect depression treatment response and patient outcomes, so as to incentivize providers to adapt evidence-based strategies and focus on improved clinical outcomes for their patient population. These should align with the metrics and specifications already proposed for NQCA depression metrics in 2016, including:

- Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults
- Depression Remission, Response or Treatment Adjustment for Adolescents and Adults
- Depression Screening and Follow-up for Adolescents and Adults

3. Reforms to Medicare's current fee-for-service program that incentivize providers to coordinate care for patients living with chronic conditions

Fee-for-service (FFS) mechanisms might be created to cover the two additional interventions of Collaborative Care for depression and other common mental disorders. However, FFS payment strategies alone will not ensure accountability of providers. We will also need mechanisms to ensure providers help their patients get better and intervene in ways that are most likely to help their patients respond to treatment. We recommend

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financial strategies are considered that would tie maximum FFS payment to patient outcomes, paying for performance.

The two additional interventions that Medicare FFS program will have to cover in order to include evidence-based Collaborative Care are:

- Systematic care management and
- Consultation between primary care provider or team and a psychiatric consultant.

Systematic care management, incident to and supervised by the primary care provider (PCP), will need sufficient delivery requirements in place to drive effective treatment strategies. Components of this intervention should include functions such as: supporting the primary care team by providing patient education and brief counseling; monitoring patient progress, adverse effects, and adherence to treatment protocols (both prescription drugs and referrals to mental health specialists); and facilitating additional visits or treatment modification with the PCP.

Qualifications for the care manager will need to be carefully considered and align with states' licensure requirements and scope of practice. Collaborative Care programs typically use nurses, clinical social workers, psychologists or other mental health professionals licensed by the state to provide mental health services in this capacity.

Core interventions provided by the care manager include the following:

- The care manager facilitates consultations between the PCP and mental health specialists.
- The care manager is responsible for coordinating patient education regarding the diagnosis and helping the patient understand and select treatment options.
- The care manager coordinates an initial treatment plan with the PCP and the beneficiary.
- The care manager works with the beneficiary to help implement and support the treatment plan (including monitoring patients on medications and/or providing brief, evidence-based counseling treatments such as motivational interviewing, behavioral activation or problem-solving treatment). Care management services do not necessarily require face-to-face contact with patient.
- At the end of treatment, the care manager will work with the beneficiary to develop a relapse prevention plan.
- The care manager tracks clinical outcomes with an accepted quantifiable measure (e.g., the PHQ-9 depression assessment instrument) according to the treatment protocol outlined by the PCP, and will work with the PCP and a psychiatric consultant to change protocol in the case of lack of progress or adverse effects.

Regular, systematic consultation between primary care physician or other members of primary care team and a qualified psychiatric consultant greatly improves the level of specialty support

available in primary care. Because clinical recommendations often involve management of psychotropic medications, psychiatrists and psychiatric nurse practitioners are the two types of clinicians eligible to provide these services in most settings.

Consultation responsibilities include:

- Regular (usually weekly) reviews of a caseload of patients, with a focus on patients who are not improving as expected and treatment recommendations on those patients to the treating primary care provider (PCP);
- Recommendations, usually summarized in brief, focused written or electronic notes, including treatment recommendations, to the care manager supporting the PCP or directly to the PCP; and
- Availability for consultation to the PCP during the week by pager to answer questions about recommendations made.

The level of effort for consultants is typically two to three hours per week for each care manager's primary care caseload. This cost-effective approach leverages the skills of a psychiatric consultant, allowing them to serve a much larger population of patients than those who could be seen in traditional office-based practices. The evidence for the effectiveness of team-based consultation extends to common mental disorders such as clinical depression (e.g., major depression or dysthymic disorder) and anxiety disorders (e.g., panic disorder, posttraumatic stress disorder, social anxiety disorder, generalized anxiety disorder).

4. The effective use, coordination, and cost of prescription drugs

Antidepressants are the second most commonly prescribed medications, right after drugs to lower cholesterol. Among people 65 years or older, 14 percent use antidepressants annually for depression, anxiety, or another indication. While adherence to antidepressants is critical to realizing the effectiveness of antidepressant treatment, around 40% of Medicare managed care patients discontinue their antidepressant treatment prematurely. High out-of-pocket costs due to lack of drug coverage or high cost-sharing has been shown to decrease drug adherence in most populations, including Medicare beneficiaries using antidepressant medication.

Much of the growth of antidepressant use has been driven by a substantial increase in antidepressant prescriptions by non-psychiatrists. Each year, 30 million people receive a psychiatric medication prescription in primary care, but as few as 20% show substantial clinical improvement because many patients do not receive them in sufficient doses or for a sufficient amount of time. In 2010, antidepressant prescriptions resulted in nearly $10 billion in costs.

By including a psychiatric consultant on the care team, Collaborative Care provides primary care providers support and guidance on antidepressant and other psychiatric medication prescriptions. The psychiatric consultant is better equipped to recommend a change in

medication or dosage than the primary care provider, thereby increasing the effectiveness of prescriptions in primary care and lowering their enormous costs.

5. Ideas to effectively use or improve the use of telehealth and remote monitoring technology

More than half of counties in the US do not have a single practicing mental health professional, a problem particularly acute in rural areas. The Affordable Care Act has created new or better mental health care coverage for millions of patients, but the existing specialty mental health care system is already at, or beyond capacity. Increasing the numbers of available specialty mental health providers is challenging and would only make a small dent in the large unmet need for mental health care. The simple truth is we will never have enough mental health providers to meet the mental health needs of most Americans under a traditional model of referral to mental health specialty care.

Collaborative Care offers a way to leverage the scarce numbers of mental health professionals by engaging a psychiatric consultant via phone or tele-video link. Telemedicine-Based Collaborative Care (TBCC), an adaptation of Collaborative Care, makes further use of telehealth technologies by using off-site telephone nurse care managers as well. A recent study conducted in Federally Qualified Health Centers showed contracting with an off-site Telemedicine Based Collaborative Care team (on-site primary care provider and off-site telephone nurse care manager, telephone pharmacist, tele-psychologist and tele-psychiatrist) yielded better outcomes than implementing Collaborative Care with locally available staff. Study participants were predominantly rural, unemployed, and uninsured with numerous comorbidities and were treatment resistant.

6. Strategies to increase chronic care coordination in rural and frontier areas

Providing effective mental health care in rural areas is extremely challenging given the lack of resources, high rates of poverty, prevalence of uninsured patients, and lack of mental health professionals. Although 20 percent of Americans live in rural communities, less than 10 percent of the country's physicians practice in those areas; more than half of counties in the US do not have a single practicing mental health professional. The scarcity also may be at least partially responsible for the greater incidence of chronic health conditions such as hypertension, heart disease, and depression among rural residents.

As described under Issue Area 5 above, Collaborative Care can effectively leverage and extend the reach of psychiatrists and other mental health via phone or tele-video link. Further use of off-site Telemedicine Based Collaborative Care teams (on-site primary care provider and off-site telephone nurse care manager, telephone pharmacist, tele-psychologist and tele-psychiatrist) are feasible and effective strategies to support the work

of primary care providers in rural and frontier communities and assist them in their care.

A current grant from the Corporation for Community and National Service (Social Innovation Fund) is supporting eight primary care community clinics in rural areas of the western United States to implement Collaborative Care. The AIMS Center is testing the effectiveness of the model in terms of cost and clinical outcomes, something previously not evaluated in rural settings.

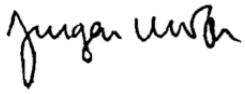
7. Options for empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with their health care providers

Because Collaborative Care takes a patient-centered approach to providing mental health care, it encourages patients to become involved in their own health care and care plan. Patient engagement is established before moving to treatment, and patient goals are tracked alongside clinical goals to personalize the treatment plan. Patients with multi-conditions (e.g. depression and diabetes) are asked which condition they want to tackle first leading to increased engagement and better outcomes. Current research is looking at how family members and community-based organizations can be incorporated into the care team, potentially giving even more control of the treatment plan to patients.

8. Ways to more effectively utilize primary care providers and care coordination teams in order to meet the goal of maximizing health care outcomes for Medicare patients living with chronic conditions.

As we have described in detail in our suggestions and recommendations, we strongly encourage the Senate Finance Committee to adopt policies that improve behavioral health care services in primary care, paving the way for implantation of effective, evidence-based models of integrated care such as Collaborative Care. Doing so would increase access to high quality behavioral health care for thousands of Medicare patients with chronic conditions.

Sincerely,



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