

**Robert Lee Sutherland Seminar XV**  
**Hogg Foundation for Mental Health**

**Concurrent Session I: Paying for Integrated Care**  
Summary Notes

- I. Richard Frank
  - A. 53% of depression is treated in a primary care setting
  - B. There have been technical changes in clinical effectiveness, i.e., innovations in pharmacology and psychotherapy
  - C. Cost effectiveness of evidence-based care
    - a. Economically efficient
    - b. Usual care is quite different from evidence-based treatment
      - i. Failure to recognize depression
      - ii. Only get an extra 2 minutes when the doctor recognizes depression
  - D. What prevents integrated care
    - a. Attitudes and habits - physicians don't / can't devote extra time
    - b. Organization of physician practices
      - i. 30% are solo practices
      - ii. 20-30% are in small groups
    - c. Expensive to hire care manager
    - d. Technology is expensive too
    - e. Payment policies
      - i. Carve-outs can be an impediment
      - ii. Network problems (don't overlap)
      - iii. Medicare and other payers won't pay for same encounter
      - iv. Payers pay less attention to depression which sends a message to physicians to do the same
      - v. Plans devote less quality improvement effort / attention to depression
  - E. Renewed Improvement: Care Management
    - a. Generic chronic disease care managers
    - b. Virtual care managers
      - i. Large portion of contact by phone
    - c. Physician time
      - i. Need compelling reason to change habits
      - ii. Not always a question of money
      - iii. Carve-outs are here to stay
    - d. Quality improvement programs
      - i. Focus on depression
      - ii. Health care plans can create right incentives (financial and non-financial)
    - e. Path
      - i. Improved care management
      - ii. Longitudinal tracking
      - iii. Physician time
      - iv. Plans have role

## II. Gary Oftedahl

- A. DIAMOND care delivery
  - a. Tracking mechanism
    - i. Rating Scale (PHQ-9)
  - b. Evidence-based guidelines
    - i. Stepped-care approach
  - c. Prevention
- B. Two key roles
  - a. Care manager
  - b. Consulting psychiatrist
- C. Training program
  - a. Arm of 6 different plans
- D. Barriers
  - a. No coordination between plans
  - b. Need payment standardization (but anti-trust worries)
  - c. Cost of improved care
    - i. Need to show approach saves money
- E. Strategy: An impartial organization to engage health plans, having everyone in the same room
  - a. No one was doing well with depression so helped to bring people to the table
  - b. Phased implementation
    - i. Alleviates anxiety about cost
    - ii. Identify single methodology that all plans could pay
  - c. Got health plans to agree to a code for care management reimbursement
    - i. Because of present system, complexity of health care contracts
  - d. Problem: System pays in haphazard way
    - i. Must be done in collaborative fashion, engage those who disagree
    - ii. Move away from blindspot
    - iii. Difficult discussions about payment reform
    - iv. Diamond will fail if payment mechanism is not in place

## III. Patricia Young Brown

- A. Community health centers get beneficial Medicaid reimbursement
  - a. Since 2004, Travis County Healthcare District has provided financial support for EMerge Program (collaboration with Austin Travis County MHMR Center)
  - b. Grant request: Integration with behavioral health programs
    - i. Became mainstay
    - ii. Combination of 12 behavioral health counselors and 2 psychiatrists
      - 1. Work in community mental health centers
      - 2. Psychiatrist gives support to primary care providers (PCPs) in form of consultation/medication support
      - 3. Use of PHQ-9
      - 4. Based on national model
  - c. Funding: phased approach

- i. Started with 1 Provider
- ii. Partnership with MHMR authority
  - 1. Managed under MHMR umbrella
  - 2. Best use of local resources/funding
- iii. Behavioral health staff = MHMR employees
  - 1. Part of MHMR system
    - a. Easy flow of patients
    - b. Higher level of services needed, go to MHMR
  - 2. Have access to MHMR database
    - a. Sharing data is often difficult
- d. Established common data repository
  - i. Hospitals, PCPs, MHMR
  - ii. Single clinical record
    - 1. See how they accessed care before/after
    - 2. How often they used the clinic
- e. Intangible returns
  - i. Community health system overcrowded
  - ii. Frees up the PCPs for someone else
- f. Made case to expand the program
  - i. FQHCs (federally qualified health centers)
    - 1. Low income, other situations exacerbate depression conditions