Optimizing Population Health via Telepsychiatry

10:55 AM – 11:55 AM
Steering Toward Success: Achieving Value in Whole Person Care

The Healthier Washington Practice Transformation Support Hub
Steering Toward Success: Achieving Value in Whole Person Care

Optimizing Population Health via Telepsychiatry

Cara Towle, RN MSN MA
Associate Director
UW Psychiatric Consultation & Telepsychiatry/Integrated Care Training Programs

Russell McCann, PhD
Acting Assistant Professor, University of Washington
Deputy Director, Telemental Health VA Puget Sound

With Acknowledgment: Marc Avery, MD; Jen Erickson, MD
Optimizing Population Health via Telepsychiatry

Learning Objectives:
• Describe the “nuts and bolts” of setting up telepsychiatric services.
• Identify the basics for billing telepsychiatric services.
• Recognize the evidence base behind telepsychiatry.
• Review examples of the innovative ways that telepsychiatry is being implemented to improve population health outcomes.
The State of Mental Health in Washington

(Center for Health Workforces Studies, 2016)
The State of Mental Health in Washington

- **Prevalence** – 42\textsuperscript{nd}
- **Access to care** – 24\textsuperscript{th}
- **Prevalence + Access** – 30\textsuperscript{th}

Source: [http://www.mentalhealthamerica.net/issues/ranking-states](http://www.mentalhealthamerica.net/issues/ranking-states)
How to Help Meet These Needs?
What is Telepsychiatry?
Summary (Hubley, Lynch, Schneck, Thomas, & Shore, 2016)
– Patients and providers generally satisfied
  • Providers concern > patients
– ≈ Face-to-Face (FTF)
  • Diagnosis
  • Pharmacotherapy
  • Psychotherapy
– ↓ cancellations (3.5% vs 4.8%), ↓ no shows (4.2% vs 7.8%)
– Generally ↓ cost
Nuts and Bolts: What to Use

- HIPAA Compliant Platforms
  - Zoom
  - Vidyo
  - Cisco Jabber Video
  - VSee

- Integrated EHR / Video Platforms
HIPAA/HITECH Act

- “Administrative, physical, and technical safeguards…[in context of E-PHI]”
- Business Associate Agreement (BAA) — software companies accountable, too
- Conduit is exempt… (e.g., FaceTime)
- HITECH Act gets at enforcement
Nuts and Bolts: Confidentiality Concerns

How is it different from in-person visits?
Ryan Haight Act 2008:
• Named after teenager who overdosed on prescription pain killers obtained via the Internet from a doctor he never saw.

The main rules:
• You CAN’T prescribe scheduled substances via the Internet unless...
  – You’ve seen the patient in person at least once
  – You’re covering for another doc who has seen the patient in person at least once
  – The patient is at a DEA-registered facility
  – It’s an emergency
Nuts and Bolts: Legal (State)

SB5175 & SB6519 (Washington State)

• Defines telemedicine
  – Real-time video communication

• Requires coverage, but not equal reimbursement

• Allows for credential-by-proxy

• Allows for various patient locations, including the home
Nuts and Bolts: Legal (State)

Washington State
- Telemedicine Guideline (MD2014-03)
  - Provides telemedicine information relevant to licensure and standards of care

All states have telemedicine policy
- MUST be licensed where the patient sits
- Interstate Medical Licensure Compact
  - WA signed into law in 2017
  - https://imlcc.org
- States vary...
Credentialing
• Must be credentialed at all organizations
• Expedited credentialing can be available
• Credential-by-proxy
• Credentialing for payers
Telepsychiatry Billing Basics

- Telephone vs telepsychiatry

- How to bill:

<table>
<thead>
<tr>
<th>Patient location</th>
<th>Clinic</th>
<th>Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider bills</td>
<td>CPT+GT</td>
<td>CPT+GT</td>
</tr>
<tr>
<td>Clinic bills</td>
<td>Q3014</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Telepsychiatry Billing Basics

• Medicaid & commercial payers:
  – If a service is covered when delivered in-person, it must also be covered when delivered via telemedicine.

• Medicare is tricky:
  – Only federally defined rural locations
  – Only specific CPT codes
  – Only specific practitioners
Innovative Telepsychiatry Practices
Department of Veterans Affairs

• VA Puget Sound
  – Telehealth as part of clinical practice

• Western Telemental Health Network
Extending Mental Health Care with Limited Resources

COORDINATION

UW PCAT

COLLABORATIVE CARE & PCAT

UW PACC

HOSPITAL

CMHC

COLLABORATIVE CARE MANAGEMENT

BRIEF BEHAVIORAL INTERVENTION

PRIMARY CARE

SELF CARE / SELF MANAGEMENT

Specialty Care

Collaborative Care in Primary Care

Primary Care / Specialty Medical Care
UW Psychiatry Consultation and Telepsychiatry

UW Pool of Psychiatrists

© Can Stock Photo - csp1219140
UW Psychiatry Consultation and Telepsychiatry

- **Target**: hospital-based health care providers and their patients with MH needs
- **Strategy**: consultative support by UW psychiatrists, direct assessment as needed
- **Technology**: telephone consultation, tele-video consultation with patients
- **Timeframe**: one-time or short-term
Narasimhan et. al.
“Impact of a Telepsychiatry Program at Emergency Departments Statewide on the Quality, Utilization, and Costs of Mental Health Services.”
4-year study of statewide telepsychiatry service in nonpsychiatric Eds: 9000+ patients

Telepsychiatry patients
- more likely to receive both 30- and 90-day outpt f/u,
- less likely to be admitted to hospital during the index ED visit
- .86 day reduction in inpt length of stay
- $2,336 lower costs for a 30-day inpt (not statistically different).
UW Psychiatry Consultation and Telepsychiatry

**Benefits**
- Single bed certification - WA
- Access to psychiatrists well-versed in consultative services, wide array of subspecialty expertise
- Reduced burden of recruiting, hiring, paying full-time psychiatrist
- Collaboration, support and mentoring to encourage clinicians to practice at the top of professional scope.
  - Narasimhan et al.

**Challenges:**
- Documentation
- Billing – who? credentialing with payers?
- Costs – provider-to-provider consultation not reimbursed
Evidence-based Integrated Care: Collaborative Care

PCP

Patient

BHP/Care Manager

Psychiatric Consultant

New Roles

Population Registry

Outcome Measures

Treatment Protocols

Figure used with permission from the AIMS Center, 2017

Problem Solving Treatment (PST)
Behavioral Activation (BA)
Motivational Interviewing (MI)
Medications

Table: Active Patients

<table>
<thead>
<tr>
<th>ID</th>
<th>Name</th>
<th>Age</th>
<th>Gender</th>
<th>Start Date</th>
<th>End Date</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>John</td>
<td>28</td>
<td>Male</td>
<td>6/28/2013</td>
<td>7/27/2013</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Jane</td>
<td>32</td>
<td>Female</td>
<td>6/28/2013</td>
<td>7/27/2013</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Mike</td>
<td>35</td>
<td>Male</td>
<td>6/28/2013</td>
<td>7/27/2013</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Sarah</td>
<td>29</td>
<td>Female</td>
<td>6/28/2013</td>
<td>7/27/2013</td>
<td></td>
</tr>
</tbody>
</table>

PHQ-9 Graph

Figure used with permission from the AIMS Center, 2017
Collaborative Care + Telepsychiatry

Psychiatrist can support collaborative care remotely
Collaborative Care + Telepsychiatry

• **Target**: primary care health care providers and their patients with MH needs

• **Strategy**: consultative support by UW psychiatrists, direct assessment as needed

• **Technology**: telephone consultation, tele-video consultation with patients

• **Timeframe**: ongoing patient management; goal - graduate back to PC
Collaborative Care + Telepsychiatry

Benefits

• Access to psychiatrists well-versed in consultative services, wide array of subspecialty expertise
• Reduced burden of recruiting, hiring, paying full-time psychiatrist
• Collaboration, support and mentoring to encourage clinicians to practice at the top of professional scope.
• **Client-centered Collaboration + Population-based Care + Treatment to Target + Evidence-based Care = Accountable Care**

Challenges

• **Team-based:** lots of moving parts, across distance/institutions
• Documentation – registry, shadow charts?
• Costs – provider-to-provider consultation not (yet) reimbursed
UW Psychiatry and Addictions Case Conference (UW PACC)

Case-based Consultation & Continuing Medical Education (CME)

* chronic conditions * multiple community sites * interdisciplinary team of specialists *
WHEN: Every Thursday 12:00-1:30pm PST

WHO: multi-site participant network of primary care providers, mental health or addictions providers, psychiatrists

WHAT:
* Multi-disciplinary psychiatry & addictions “tele-mentoring”
* Didactic: 20-30 minutes
* Case presentations:
  - from community clinicians
  - de-identified cases
  - interactive consultations with inter-professional panel
  - written recommendations

COST: No cost; nominal fee for CME credits

GOALS:
• Expand the mental health and addictions care capacity of health care professionals in remote, underserved areas of Washington
• Offer telehealth resource support to build the confidence and skills of providers who care for patients with mental and behavioral health conditions
• Train UW fellows to deliver a regional peer learning and support network for treating mental health and addictions

SPONSOR: UW Integrated Care Training Program, funded and supported by the Washington State Legislature through the Safety-Net Hospital Assessment, working to expand access to psychiatric services throughout the State of Washington
UW PACC

- **Target**: providers = PCPs, community providers, including psychiatrists
- **Strategy**: didactics + case-based learning; no interaction w/patient
- **Technology**: multi-site video teleconference
- **Timeframe**: one-time, sometimes follow-up
UW PACC – Year 1 CME Evaluations

- Intend to Make Practice Change
- Addressed Competencies in my Specialty
- New Ideas or Info Expect to Use
- Enhanced Current Knowledge
- Adequate Opportunity for Questions
- Objectives Met

Percentage dashboard:
- 75% to 100%
Benefits of ECHO Model

Traditional Telemedicine
- Specialist Manages Patient Remotely

ECHO Telehealth
- Specialist Supports Community-Based Clinician

"Multiplier Effect"

Patients Reached with Specialty Knowledge & Expertise

Adapted from Sanjeev Arora MD
Evidence Supporting the ECHO Model

<table>
<thead>
<tr>
<th>HCV Genotype</th>
<th>ECHO Sites</th>
<th>UNM HCV Clinic</th>
<th>Difference between ECHO Sites and UNM HCV Clinic</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>All genotypes</td>
<td>152/261 (58.2)</td>
<td>84/146 (57.5)</td>
<td>0.7 (−9.2 to 10.7)</td>
<td>0.89</td>
</tr>
<tr>
<td>Genotype 1</td>
<td>73/147 (49.7)</td>
<td>38/83 (45.8)</td>
<td>3.9 (−9.5 to 17.0)</td>
<td>0.57</td>
</tr>
<tr>
<td>Genotype 2 or 3</td>
<td>78/112 (69.6)</td>
<td>42/59 (71.2)</td>
<td>−1.5 (−15.2 to 13.3)</td>
<td>0.83</td>
</tr>
</tbody>
</table>

* The rates of sustained virologic response are not reported separately for six patients with genotype 4 or genotype 6. ECHO denotes Extension for Community Healthcare Outcomes, HCV hepatitis C virus, and UNM University of New Mexico.

- The outcomes in terms of reduced viral loads of patients treated by primary care practitioners (PCPs) were slightly better than those achieved by specialists at the University.
- The serious side effect rate was a great deal better 6.9% vs 13.7%.
- More minorities treated in ECHO group.

More Evidence Is Needed

“Project ECHO: Enthusiasm Overtakes Evidence”

• “The evidence of the benefits of ECHO appear to be far more limited than is generally understood and we are in substantial danger of making public policy decisions without adequate clinical results, much less cost-effectiveness information.”

• Skepticism about the effectiveness and generalizability of Project ECHO:
  – Concerns about limitations in the evidence base for the model
  – Challenges inherent in incorporating it into the current fee-for-service health system
  – The model is likely to function differently depending on the targeted condition and the community being served.

  Christopher Langston, Health Affairs, 2017-01-03
Challenges of the ECHO Model

• Appropriate location for vtc set up at clinic
• Getting time for community clinicians to participate
• Recruiting case presentations
  – Only two to three cases per session
• More education than clinical care
WA SB5175/HB1403

“Telehealth Reimbursement Law”

IT PASSED!!!

Doesn’t cover ECHO programs…
Challenges of the ECHO Model

Financial sustainability

- **Costs** for current model = $125-$200+k/year*
  - How many panelists? How much FTE?
  - Administrative oversight and support
  - IT equipment, software, & support
  - Frequency of sessions

- **Funding:** grants, line item in state budget, insurance companies, etc.

- **Reimbursable?** New Mexico Medicaid is reimbursing UNM at $400 per case and rural site $150 per case. L&I in Washington does pay.

*Does not include infra-structure support ("indirects")*
Proof-of-concept using transaction cost analysis to examine chronic pain management in-clinic and through UW TelePain.

<table>
<thead>
<tr>
<th>Comparison</th>
<th>In-Clinic Pain Specialist Encounter</th>
<th>UW TelePain Case Consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td> # discreet steps</td>
<td>46</td>
<td>27</td>
</tr>
<tr>
<td>Costs per patient</td>
<td>$332.89</td>
<td>$376.48</td>
</tr>
<tr>
<td>Time over which cost accrued</td>
<td>153 days</td>
<td>4 days</td>
</tr>
<tr>
<td>Time elapsed between referral and completion of initial consultation</td>
<td>72 days</td>
<td>4 days</td>
</tr>
</tbody>
</table>
GOAL

Mental Health Hero
Resources

Washington State
• WA State Department of Health
• SB5715
• SB6519

Federal
• Ryan Haight Act
• HIPAA

Professional Organizations
• American Psychiatric Association
• American Telemedicine Association
The project described was supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.