CMS proposal to change payment rates promotes coordinated care

Centers for Medicare & Medicaid Services (CMS) officials on July 7 issued a proposed change to the Physician Fee Schedule saying that the rule would transform how Medicare pays for primary care through a new focus on care management and behavioral health. The new rule emphasizes care coordination and proposes to pay for specific behavioral health services furnished using the Collaborative Care Model (CoCM). The proposed rule updates payment policies, payment rates and quality provisions for services furnished under the Medicare Physician Fee Schedule on or after Jan. 1, 2017. Officials say this year the CMS is proposing a number of new Physician Fee Schedule policies that will improve Medicare payment for those services provided by primary care physicians for patients with multiple chronic conditions, mental and behavioral health issues, and cognitive impairment or mobility-related disabilities.

The services include but are not limited to visits, surgical procedures, diagnostic tests, therapy services and specified preventive services. In addition to physicians, the fee schedule pays a variety of practitioners and entities, including nurse practitioners, physician assistants, and some other types of providers.

Bottom Line...
The new proposal demonstrates important steps to helping clinicians become involved in collaborative care with appropriate funding support.

N.Y. program sets standard in meeting behavioral needs of visually impaired

The grief that often accompanies a considerable loss of vision can result in depression and a host of other problems. When the individual also has to address another serious medical issue, it becomes critically important to provide comprehensive and coordinated care.

Few mental health provider organizations ever encounter a sufficient number of visually impaired patients to develop an expertise in meeting their needs. A striking exception to the lack of specialized behavioral health programs for this population can be found at two locations in New York City, where the nonprofit Lighthouse Guild operates a multidisciplinary program serving adults and children who have experienced loss of vision from a variety of causes.

“Vision loss is often experienced as a loss of a part of one’s self,” Goldie Dersh, Ph.D., vice president of Lighthouse Guild Behavioral Health Services, told MHW. “These life changes are really permanent. The individuals experience difficulty...”

Bottom Line...
Multidisciplinary care and close coordination with general health providers are among the foundational components of the New York–based Lighthouse Guild’s Behavioral Health Program for visually impaired individuals.
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and physical therapists, as well as radiation therapy centers and independent diagnostic testing facilities.

The proposals, said Andy Slavitt, CMS acting administrator, in a news release, “are intended to give a significant lift to the practice of primary care and to boost the time a physician can spend with their patients listening, advising and coordinating their care — both for physical and mental health. If this rule is finalized, it will put our nation’s money where its mouth is by continuing to recognize the importance of prevention, wellness, and mental health and chronic disease management.”

Care management services

CMS officials say they are proposing a number of changes to coding and payment policies under the Physician Fee Schedule. These proposals are intended to accomplish the following:

- Improve payment for care management services provided in the care of beneficiaries with behavioral health conditions (including services for substance use disorder treatment) through new coding, including three codes used to describe services furnished as part of the psychiatric CoCM and one to address behavioral health integration more broadly.
- Improve payment for cognition and functional assessment, and care planning for beneficiaries with cognitive impairment.
- The CMS is also proposing to pay for specific behavioral health services furnished using the CoCM, which has demonstrated benefits in a variety of settings, say officials. In this model, patients are cared for through a team approach, involving a primary care practitioner, behavioral health care manager and psychiatric consultant.
- Additional policies proposed in the 2017 payment rule include revisions to payment for chronic care management, including payment for new codes and for extra care management furnished by a physician or practitioner following the initiating visit for patients with multiple chronic conditions.

Push for collaborative care

“We’re encouraged [by the facilitation of appropriate payment to providers for collaborative care],” Chuck Ingoglia, senior vice president of public policy and practice improvement for the National Council for Behavioral Health, told MHW. “This will help make care more sustainable.”

Ingoglia noted that the field has been desperately trying for many years to provide integrated care. “The funding mechanisms were not there to support it,” he said. “The frustration has been that people are committed to collaborative care and there’s a tremendous amount of evidence that it works, in terms of the impact it has on health outcomes for individuals and the cost savings to the system,” Ingoglia said. “The problem is that it’s been hard to implement due to lack of funding,” he said.

The National Council gives much credit to the American Psychiatric Association (APA), said Ingoglia. “It’s been a huge priority for the APA and others on the Hill, including Sen. Andy Gardiner [R-Fla.], in supporting this,” he said.

Ingoglia added that there’s always been a gap between development and practice and payment policy. “We’re hopeful the new codes will lead to wider adaptation of collaborative care and foster more relationships between primary care and specialty behavioral health,” he said. “We expect the new CPT [Current Procedural Terminology] codes to be released next year,” said Ingoglia.

Psychologists respond

The American Psychological Association said it applauded the CMS for issuing a proposal to cover the cost of psychiatric consulting servic-
Fluoxetine best treatment for children, adolescents with MDD

Although psychological treatments are still considered the first-line treatment for depression in children and adolescents, antidepressant medications are still widely used in treating major depressive disorder (MDD) in this population amid controversy. Researchers of a new study published in The Lancet last month found that fluoxetine (Prozac, Sarafem) was statistically more significant than placebo for treating children and adolescents with MDD.

According to the study, “Comparative Efficacy and Tolerability of Antidepressants for Major Depressive Disorder in Children and Adolescents: A Network Meta-analysis,” researchers set out to compare and rank antidepressants and placebo for MDD in young people.

An estimated 3 percent of children aged 6 to 12 and about 6 percent of adolescents aged 13 to 18 have an MDD. Compared with adults, children and adolescents with major depressive disorder are still underdiagnosed and undertreated, possibly because they tend to present with rather undifferentiated depressive symptoms (e.g., irritability, aggressive behaviors and school refusal), said researchers. Consequences of depressive episodes in these patients include serious impairments in social functioning, and suicidal ideation and attempts.

Researchers also found robust

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evidence to suggest a significantly increased risk for suicidality (suicidal behavior or ideation) for young people treated with venlafaxine (Effexor, Effexor XR).

“There has to be careful monitoring of adolescents, and also children, with mental health issues,” Andrea Cipriani, Ph.D., with the Department of Psychiatry at the University of Oxford in the United Kingdom, and lead researcher, told MHW. The involvement of parents and guardians is also necessary, along with documented clinical notes, he said.

Researchers say their study provides the first comprehensive systematic review and network meta-analysis of all available double-blind randomized trials, comparing any antidepressant with placebo or another active antidepressant as oral monotherapy in the acute treatment of MDD in children and adolescents (mean age 9–18). “Future studies should understand the differences and peculiarities of major depression in young people and identify strong markers of disease and predictors of response for this disorder,” Cipriani said. “New randomized controlled studies should then adopt a superiority design and probably use fluoxetine as comparator, not just placebo.”

Methods

Researchers conducted a network meta-analysis to identify both direct and indirect evidence from relevant trials. Searches included PubMed, the Cochrane Library, PsycINFO, other sources and international registers for published and unpublished, double-blind randomized controlled trials up to May 31, 2015, for the acute treatment of MDD in children and adolescents.

They examine data from 34 previous studies involving 5,200 children and teens. Researchers included trials of 14 antidepressant treatments: amitriptyline, citalopram, clomipramine, desipramine, duloxetine, escitalopram, fluoxetine, imipramine, mirtazapine, nefazodone, nortriptyline, paroxetine, sertraline and venlafaxine. Trials recruiting participants with treatment-resistant depression, treatment duration of less than four weeks or an overall sample size of fewer than 10 patients were excluded.

Results

For efficacy, only fluoxetine was statistically more effective than placebo. In terms of tolerability, fluoxetine was the best drug (75.7 percent) and imipramine the worst (13.1 percent). Patients given imipramine, venlafaxine and duloxetine had more discontinuations due to adverse events than did those given placebo.

Researchers noted that when considering the risk-benefit profile of antidepressants in the acute treatment of MDD, these drugs do not seem to offer a clear advantage for children and adolescents. Fluoxetine is probably the best option to consider when a pharmacological treatment is indicated, said researchers. Second, venlafaxine was found to be associated with an increased risk of suicidality in the young population. Because of the absence of reliable data on suicidality for many antidepressants, the researchers could not comprehensively assess the risk of suicidality for all drugs. However, from a clinical perspective, children and adolescents taking antidepressant drugs should be closely monitored regardless of the treatment chosen, particularly at the beginning of treatment.

Clinical implications

If a current medication is working for a young person with MDD, then clinicians should not stop treatment and replace it with fluoxetine, Cipriani cautioned. “If the drug is working for individuals, they have to keep taking it,” he said. If psychiatrists or other mental health professionals have young patients with MDD and they have no information to guide their choice, such as family history, then fluoxetine may be the best treatment to start with, said Cipriani.

Other antidepressants do not seem to be suitable as routine treatment options. In the clinical care of young people with MDD, clinical guidelines recommend psychotherapy (especially cognitive behavioral therapy or interpersonal therapy) as the first-line intervention. Fluoxetine should be considered only for patients with moderate-to-severe depression (especially adolescents) who do not have access to psychotherapy (e.g., in Western or low-income and middle-income countries) or have not responded to nonpharmacological interventions, said Cipriani.

Fluoxetine is recognized by the World Health Organization, and is available around the world, he said. “You do not need to be a psychiatrist to prescribe the medication,” Cipriani said. “It can be prescribed by a practitioner or a nurse,” he said. “Fluoxetine is the most rational, evidence-based choice.”

Cipriani added, “We have a tool to treat patients. Now it’s a matter of time until we’re using it in the proper way.”

Antidepressants are not well-studied in this population, and further research on moderators of treatment effect and possible new interventions are needed, said researchers. In all these cases, however, clinicians should carefully look for the emergence or exacerbation of suicidality and balance the risk-benefit profile of antidepressants during the acute treatment phase, researchers concluded.

‘We have a tool to treat patients. Now it’s a matter of time until we’re using it in the proper way.’

Andrea Cipriani, Ph.D.
RAND: Calif. suicide prevention hotlines need more structure

Although suicide prevention hotlines in California are generally helping to prevent suicide by ensuring the immediate safety of suicidal callers, and linking those who may be at risk of suicide with appropriate and available resources, much more can be done to make them more accessible and improve the quality of their services, according to new RAND research released July 12.

In the study, “Suicide Prevention Hotlines in California: Diversity in Services, Structure, and Organization and the Potential Challenges Ahead,” RAND researchers suggest that solutions to improved prevention programs include expanding digital offerings — such as chat services and crisis-line texting — and integrating with health care services and systems. Its focus is on California, but the implications may reach far beyond, said RAND researchers.

California Mental Health Services Authority (CalMHSA) requested RAND evaluate its suicide prevention hotlines, along with a number of its other statewide prevention and early intervention (PEI) services, said Rajeev Ramchand, lead author and senior behavioral scientist at the RAND Corporation. The PEI initiatives received funding by the state’s historic voter-approved ballot proposition, known as Proposition 63 or the Mental Health Services Act, he said.

“CalMHSA administered funds to counties to create new suicide prevention hotlines or to expand existing ones,” Ramchand told MHW. “We evaluated suicide prevention hotlines, how they’re operating, how they’re structured and how they vary the care they offer.”

Some of the hotlines across the state are county-specific, others are independent agencies and still others are part of community mental health services, said Ramchand. Organizations that identify as suicide prevention hotlines may engage in a variety of activities not limited to fielding incoming crisis calls. For example, they may conduct outreach, make outgoing calls to provide follow-up support, operate “blended” call centers that receive calls from multiple types of hotlines or engage in broader professional activities.

Challenges, for the most part, are related to funding and resources, he said. “We know funding is tight,” he said. “Many of the hotlines rely on volunteers. Others provide no real standard for running the hotlines.” Callers may receive different types of care, or there’s a lack of consistency in the quality of the care, he noted. Other challenges may be related to recruiting and training a sufficient number of volunteers to answer calls to the hotline. Some hotline programs, however, are doing “great” work, he said.

Methods

The examination of suicide prevention hotlines was a three-component process. The first study, “Characteristics and Proximal Outcomes of Calls Made to Suicide Crisis Hotlines in California,” was published online in June in the Crisis: The Journal of Crisis Intervention and Suicide Prevention.

The second component was a statewide survey of California adults asking how likely they would be to use each of a series of resources if they were seeking help for suicidal thoughts. Survey participants ranked calling a crisis line fourth, with 62 percent stating that they were likely to make such a phone call. In comparison, 46 percent favored a web-based chat platform, and 43 percent said they would prefer to text a crisis line. The top-ranked preferences were seeking face-to-face help from a mental health professional (78 percent) or family and friends (17 percent).

Ramchand said researchers were not necessarily surprised by the finding that calls to crisis lines ranked fourth in the survey. “People were put in a hypothetical situation,” he said. “If you were suicidal, it made sense that they wanted real human interaction, which was their preference.” Ramchand noted that there are known challenges with access to face-to-face mental health care, but many people will still feel more comfortable accessing anonymous help over a hotline, and may want to access this care via digital-related questions.

He added, “There continues to be a shortage of mental health providers nationally, and even harder is getting timely appointments. Hotlines cannot be expected to serve as substitutes for this type of care.”

The third component is the current report. Researchers conducted silent monitoring evaluations of 10 of the 12 hotline programs funded by Proposition 63. According to the study, one of the 12 crisis centers refused to participate in the evaluation, and another was run by the county and did not provide the nec-

‘There continues to be a shortage of mental health providers nationally, and even harder is getting timely appointments. Hotlines cannot be expected to serve as substitutes for this type of care.’

Rajeev Ramchand

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essay approvals in time for re-
searchers to conduct the evaluation.

Call outcomes

On a scale of 1 to 5 (with 5 indi-
cating high levels of satisfaction), RAND raters assessed the overall level of caller satisfaction as 3.4, with very little variability across cen-
ters (range: 3.2–3.9). Caller distress
was assessed at both the beginning
and end of the call. Just under half
of callers experienced reductions in
distress, and, in most of the remain-
ing calls, there was no change.

“Our analysis found that centers
that offered crisis text and chat had,
on average, higher levels of satisfac-
tion with people on the phones,” said
Ramchand. “In addition, we found
that calls that were affiliated with the
National Suicide Prevention Lifeline
tended to reduce caller distress rela-
tive to non-NSPL affiliated calls.”

Ramchand added, “We can’t
claim that these factors cause calls to
be better, but it is interesting that
these call center characteristics are
with better calls. Nonetheless, we be-
lieve that our monitoring of calls
yielded unique insight into the type
of care that callers to hotlines receive,
and recommend that crisis centers
themselves adopt stringent quality
assurance standards and protocols to
identify opportunities to monitor and
improve the care that they provide.”

Recommendations

RAND researchers offer four rec-
ommendations that they say are par-
ticularly relevant for organizations
that operate suicide prevention hot-
lines. They noted, however, that agen-
cies and organizations that fund or
otherwise support suicide prevention
hotlines, as well as those that oversee
their operation (i.e., accrediting agen-
cies), could use these recommenda-
tions to guide or otherwise inform
funding priorities or requirements.

The recommendations are:
1. Conduct continuous quality-
   improvement activities.
2. Promote hotlines that are in-
   tegrated with health care sys-
   tems.
3. Increase the availability of
   high-quality chat and text
   services.
4. Increase referral competency
   through a statewide referral
   system, call centers with spe-
   cialized content areas or im-
   proved training for all re-
   sponders.

It’s important for organizations
and agencies running suicide preven-
tion hotlines to minimize the number
of calls that get put on hold and max-
imize the number of calls that get an-
swered, said Ramchand. For those
organizations that don’t have the ca-
pacity for Internet/chat or text por-
tals, resource-strapped centers and
entities should consider their invest-
ment in them carefully, he said. “They
don’t want to create [the aforemen-
tioned] and not have the bandwidth
to support demands,” Ramchand said.

More research is needed to esti-
mate the return on investment of
adopting new strategies to improve
care. This can be done by evaluating
new services when they are incor-
porated into existing practices or by
modeling the potential effects be-
fore adopting new services, re-
searchers concluded.

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Doing the things they did in the past.
They often feel worthless. They no
longer are enjoying activities such as
reading, or going outdoors.”

The outpatient program serves a
large number of individuals with
mood disorders and no prior history
of mental health problems prior to
experiencing the vision loss. Dersh
said the organization also treats
some visually impaired patients with
serious mental illness. These individ-
uals come in daily for services, and a
primary goal in their care involves
connecting them with supported
employment opportunities, she said.
The Lighthouse Guild program is
identified as a safety-net provider for
the seriously and persistently men-
tally ill population, she said.

Coordinated approach

The Lighthouse Guild’s behav-
ioral health program involves the ef-
forts of a multidisciplinary team that
includes psychiatrists, a neuropsy-
chologist who conducts testing for
cognitive impairment/brain injury,
clinical social workers who conduct
most of the therapeutic services, and
art therapists. Close collaboration
with a patient’s primary care physi-
cians, neurologists, endocrinologists
and other medical providers becomes
essential, says Dersh. This includes
careful selection of medication treat-
ments to make sure that they do not
interfere with the treatment of pa-
tients’ other health conditions.

“We want to make sure we don’t add
to the problem,” Dersh said.

Medical conditions such as dia-
abetes often have been the cause of a
patient’s vision loss, and the vision
loss in turn will make it more diffi-
cult for the patient to manage a
chronic illness. For example, “Now
they will have difficulty reading
medication labels,” Dersh said. She
added, “All of our patients have one
or more disabilities.”

When such patients are hospi-
talized, their stays often become ex-
ten because of the need to en-
sure that community supports are in
place for the patient prior to dis-
charge, she said.

While individual therapy is
among the services offered in the
Lighthouse Guild program, Dersh
says group therapy sessions that

‘All of our patients have one or more
disabilities.’

Goldie Dersh
help patients learn new skills from one another prove to be a critical component. There may be anxiety, for instance, surrounding a person’s decision to start using a sighted cane (white cane) in public, and if someone who has succeeded in that can help ease the others’ fear, that becomes “a great motivator” for patients, said Dersh.

She says the typical age range served in the program is 40 to 90, with a relatively even distribution by gender and a similar number of black and Latino patients (around 10 percent of the program’s patients are Caucasian). Most patients are Medicare or Medicaid beneficiaries, although several are covered by private insurance.

Lighthouse Guild operates behavioral health program sites on the Upper West Side of Manhattan and in the Greenpoint section of Brooklyn, and treats around 500 behavioral health patients each year. It also runs a 24-hour crisis call line for patients.

Ability to cope

Individuals who experience significant vision loss at some point in their lives will react in different ways depending on their life circumstances, Dersh explained. A writer or photographer likely would have a much different response from someone not as visually dependent or adept, for example.

“A lot of the coping depends on the individuals themselves, in terms of how they have dealt with issues in the past, and how they have coped with adversity,” Dersh said.

Lighthouse Guild President and CEO Alan Morse, Ph.D., commented in a news release about the importance of integrating health services for this population, stating, “We know that mental health services are a foundation of good healthcare. But, unfortunately, we also know that there is still a stigma attached to acknowledging the need for mental health services. We want people with visual impairment who are dealing with mental health issues to get to know that our Behavioral Health Program is here to help them.”

Survey finds county jails unequipped for inmates with SMI

Observing that incarceration has largely replaced hospitalization for thousands of individuals with serious mental illness in the United States, with state prisons and county jails holding as many as 10 times more of these individuals than state psychiatric hospitals, the Treatment Advocacy Center (TAC) and the Public Citizen’s Health Research Group on July 14 released a new comprehensive national survey of county sheriffs and detention officers.

The survey, “Individuals with Serious Mental Illnesses in County Jails: A Survey of Jail Staff’s Perspectives,” focused on county jails and sought to understand the point of view of front-line workers at county jails, including sheriffs, deputies and other staff who have to care for inmates with mental illness during their incarceration, said officials.

The survey notes that because individuals with serious mental illnesses are predisposed to committing minor crimes due to their illnesses, many end up detained in county jails with limited or no mental health treatment until a state hospital bed becomes available for them. Some have even been jailed in the absence of any criminal charges, the survey stated.

Methods

Researchers developed the survey instrument (a 22-item questionnaire) with input from subject matter experts and sheriffs. The questionnaire defined serious mental illnesses as including schizophrenia, bipolar disorder (manic-depressive illness) and related conditions, excluding suicidal thoughts or behavior without other symptoms, and alcohol and drug abuse in the absence of serious mental illnesses.

Survey responses were obtained Sept. 23, 2011, through Nov. 28, 2011. To identify their sample, researchers obtained a 25 percent random sample of a nationwide list of sheriff’s departments from the National Sheriffs’ Association. The survey had a response rate of 40.1 percent. The cumulative average daily inmate population across these jails during the year preceding the survey was approximately 68,000.

Slightly more than a quarter (27.8 percent) of these jails were large (averaging 251 or more inmates), 39.6 percent were medium (averaging 51–250 inmates) and 30.9 percent were small (averaging 50 inmates or fewer). Jail size was not reported by 1.7 percent of the respondents.

Key findings

The report found that:

- Three-quarters of the jails reported seeing more or far more numbers of seriously mentally ill inmates compared to five to 10 years ago.
- Segregation of inmates with serious mental illnesses was reported in 68.7 percent of the jails, particularly in those with smaller percentages of inmates who were seriously mentally ill.

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mentally ill.
• Most jails reported major problems with the seriously mentally ill inmates, including the necessity of watching them more closely for suicide, their need for additional attention, their disruption of normal jail activities, and their being abusive of, or abused by, other inmates.
• Caring for the seriously mentally ill in county jails was particularly challenging for law enforcement staff, who have limited training in dealing with these inmates. Almost half of the jails reported that only 2 percent or less of the initial training they provide to their staff and sheriff’s deputies was allotted to issues specifically dealing with seriously mentally ill inmates, and 60.4 percent reported that only two hours or less of annual training were allotted to such issues.

Recommendations
Among its recommendations, TAC suggests that inmates with serious mental illness inside jails be provided with proper mental health treatment and widespread use of assisted outpatient treatment programs. Other recommendations included:
• Implementations of prebooking diversion programs to prevent entry of mentally ill people into the justice system.
• Implementation of postbooking (jail) diversion programs to direct mentally ill people to treatment programs.
• Establishing careful intake screening for mental illnesses in jails.
• Implementation of community-based pretrial psychiatric competency evaluation and restoration for qualifying inmates.

Coming up...
The Building Blocks for Infant Mental Health Conference is being co-hosted by the Tennessee Department of Mental Health & Substance Abuse Services September 22–23 in Gallatin, Tenn. For more information, visit http://tamho.org/uploads/pdfs/2016%20IMH%20Conference/SaveTheDateIMH.pdf.

Reviewer finds N.H. officials failed to improve mental health care
The reviewer overseeing reforms outlined in a lawsuit settlement over mental health care says New Hampshire’s state and nonprofit social service agencies have left some patients untreated, the Concord Monitor reported July 11. The Valley News reported court-appointed monitor Stephen Day says the state should have plans in place by next month on growing and upgrading Assertive Community Treatment teams. Day also says the state should issue monthly progress reports on those plans. The teams provide treatment to patients with serious mental illnesses. They were supposed to improve access to services by reaching patients in their communities. Jeffrey Meyers, the state health and human services commissioner, acknowledged the shortcomings in the main areas identified by Day and said they’re committed to implementing the changes outlined in the settlement. New Hampshire reached a 2013 settlement with the federal government over inadequate community mental health services.

In case you haven’t heard...
The National Institute of Mental Health (NIMH) is enrolling youth from around the country to test the effectiveness of methylphenidate plus citalopram vs. methylphenidate plus placebo for decreasing irritability in children with severe mood dysregulation (SMD), according to an NIMH press release. Children with SMD display chronic anger, sadness or irritability, as well as hyperarousal (such as insomnia, distractibility and hyperactivity) and extreme responses to frustration (such as frequent, severe temper tantrums). Children ages 7 to 17 with SMD may be eligible to participate in this 12-to-15-week inpatient or outpatient study. At the end of the study, those who received methylphenidate plus placebo will have the opportunity to receive methylphenidate plus active citalopram if clinically appropriate. All procedures and medications associated with the research are provided at no cost to participants, and transportation expenses are reimbursed by NIMH. Schooling will be provided while on the inpatient unit or in day treatment.