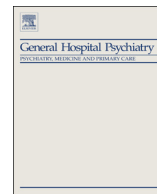




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## General Hospital Psychiatry

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## Letter to the Editor

**Response to “Impact of a national collaborative care initiative for patients with depression and diabetes or cardiovascular disease”<sup>☆</sup>***To the Editor:*

In the recent publication by Rossom et al., the authors demonstrated that collaborative care programs for depression and chronic disease can be established outside of clinical trials in a diverse set of health care systems and depression remission can be achieved [1]. However, their population was primarily white (69%) patients on Medicare (48%) or commercial insurance (28%). The literature suggests the prevalence of depression is higher among Medicaid recipients (20%) than the general public (13%) [2,3], while minority populations are less likely to receive necessary mental health care [4,5]. Incorporating these marginalized populations would strengthen the evidence provided by Rossom et al. As the country's largest safety-net health care system, NYC Health + Hospitals successfully implemented a collaborative care program outside of a clinical trial setting for a Medicaid (65%) and uninsured (25%) population in which English is not the primary language (~60%).

Under New York State Hospital–Medical Home Demonstration Program [6], we established a collaborative care for depression program in 2014 based on the IMPACT model [7]. Our program provides care for patients with moderate to severe depression, or depression and a co-occurring chronic condition, in primary care clinics in 11 hospitals and 6 community health centers [8]. We implemented universal PHQ9 depression screening at every primary care visit as a part of the vital signs, and referred eligible patients who screened positive to our program.

Using a patient registry, we produce patient lists and data tools to help our 17 sites prioritize outreach, track progress and design treatment workflows. We continuously monitor clinical improvement (PHQ9 < 10 or 50% reduction from baseline for individuals enrolled ≥ 70 days; target 50%), and evaluate how we care for patients that do not improve (Fig. 1). Among patients enrolled ≥ 70 days that do not improve, we help sites evaluate their psychiatric consultation rate (target 75%), and change in treatment rate (target 75%). We were able to exceed 2 of 3 targets by sharing data with site teams in 2015 and a 2016 system-wide depression performance improvement project. However, we found that sustaining such progress can be challenging, especially in a resource poor environment. In the face of staffing shortages and competing performance improvement priorities, our institution-wide improvement rate hovered around our target 50%. However, we do see variations across the sites. For example, in Q4 2016 our improvement rates ranged from 13% to 73%. Overall, sufficient and engaged staffing is a key to program successes at the institution and site levels.

<sup>☆</sup> Response to the following article: Rossom RC, Solber LI, Magnan S, Crain AL, Beck A, Coleman KJ, et al. Impact of a national collaborative care initiative for patients with depression and diabetes or cardiovascular disease. *General Hospital Psychiatry* 2017; 44: 77–85.

Both the literature [9] and Rossom et al. [1] highlight the challenge of financing these programs outside of clinical trials. In April of 2015, we began to bill for our Medicaid patients actively engaged in care through the NYS Medicaid Collaborative Care Program, with billing bundled monthly. It was extremely challenging to develop and implement novel billing workflows across the enterprise as all staff were impacted, from clinical to administrative, and we are still working to maximize revenue. Centers for Medicare and Medicaid Services has created new reimbursement opportunities in 2017 with four new billing codes to allow payment to physicians for Behavioral Integration Services for Medicare beneficiaries [10]. These new regulations may have great value to the programs featured in Rossom et al. and those looking to create collaborative care programs. We look forward to the ongoing conversation around sustainability, especially in underserved populations, as we all strive to improve the health and well-being of our patients.

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Kathleen S. Tatem, M.P.H.\*  
Remle Newton-Dame, M.P.H.  
Jessica Black, M.S.W., M.P.H.  
Jesse Singer, D.O., M.P.H.

Office of Population Health, OneCity Health, NYC Health + Hospitals,  
199 Water Street, New York, NY 10038, United States

\*Corresponding author.

E-mail address: [tatemk@nychhc.org](mailto:tatemk@nychhc.org) (K.S. Tatem).

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Letter to the Editor

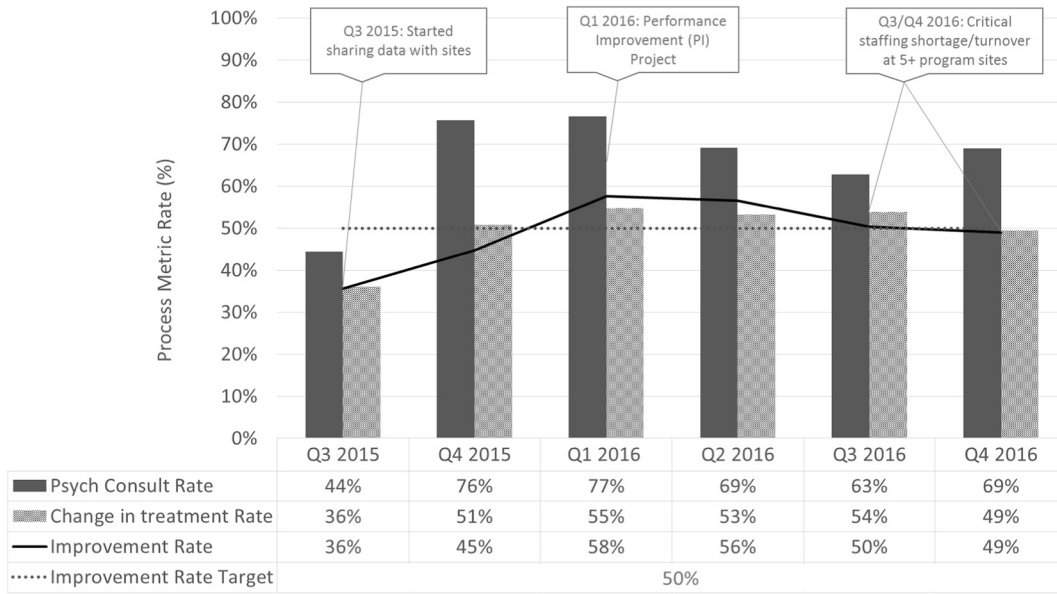


Fig. 1. 2015–16 quarterly metrics for individuals enrolled in NYC Health + Hospitals Collaborative Care for Depression Program.