<table>
<thead>
<tr>
<th>AMHA-USA</th>
<th>Introductions</th>
<th>INDEPENDENT PRACTICE INTEGRATED CARE</th>
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</thead>
<tbody>
<tr>
<td>- AMHA-USA is a national mutual-benefit corporation; designed as a structure for local multi-disciplinary groups of mental health professionals. - Initially the intent was to build chapters state by state, but our experience since 1995 has taught us that more localized groups can serve AMHA values more effectively.</td>
<td>- Michael Conner, Psy.D. - Micheele Dunlap, Psy.D. - David Johnson, LCSW - Martha Blake, MBA, NCPsyA - Christine Glenn, Ph.D.</td>
<td>Creating a high performance independent mental health practice network capable of providing a practice-research level of care and quality</td>
</tr>
<tr>
<td>American Mental Health Alliance (AMHA-USA) 1995 AMHA-Oregon – Portland Metro Area – formed 1996 Central Oregon – AMHA-USA members forming COMPHA Central Oregon Mental Health Professionals Alliance</td>
<td>- Mental health professionals love to process, but few of them love to “organize” - We have to talk about organization. - Organization is essential for the challenges we face!</td>
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</table>
You will leave here understanding more about health care reform and its impact on mental health practice – now and in the near future.

You will leave here understanding a model for collaboration and integration of care that meets and exceeds the intent of the Affordable Care Act.

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### Schedule

<table>
<thead>
<tr>
<th>Time</th>
<th>Event Description</th>
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<tbody>
<tr>
<td>9:30 – 10:45</td>
<td>Dave Johnson presents - health care reform overview</td>
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<tr>
<td>10:45</td>
<td>Break</td>
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<tr>
<td>11:00 – 12:00</td>
<td>Mike Crew, JD discusses legal questions concerning the structure of Independent Practice Associations.</td>
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<tr>
<td>12:00 – 1:00</td>
<td>Lunch, downstairs in the Community room.</td>
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<tr>
<td>1:00 – 3:00</td>
<td>Conner will present the Connecting Care/ IPIC model. Johnson and discussants will provide additional perspectives.</td>
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<tr>
<td>3:00-3:15</td>
<td>Break</td>
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### AMHA-USA

AMHA's mission is to develop local groups of mental health professionals that are mutually supportive, that share education and research activities and clinical consultation; groups that facilitate appropriate clinical referrals, and that support the mental health of their communities with focus on ethical concerns including client choice and privacy.

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### AMHA-OR

- Has been an active and stable Chapter of USA since its incorporation in 1996 – descriptions of its many activities and benefits can be found in the pages of a recent Therapists Directory (the 22nd AMHA-OR has published)
- The Board of AMHA-OR voted in 2012 to support AMHA-USA in its intent to create new chapters in Oregon to meet the challenges on healthcare reform.
- All AMHA-OR members are members of AMHA-USA
- AMHA-OR is moving toward revised by-laws which will allow accommodation to health care reform, IPA contracting.
AMHA-USA currently supports development of a Central Oregon Independent Practitioners Alliance by:

- Allowing individual practitioners to join at a low initial annual fee, in order to begin pilot projects that demonstrate and refine Connecting Care protocols.
- Negotiating discounts for the EMR, (billing, measurement and clinical data management systems) the group will need to gain and serve accountable care contracts.

AMHA-USA currently supports development of a Central Oregon Independent Practitioners Alliance by:

- Providing initial funding for the creation of IPA Bylaws and concomitant attorney consultation.
- Providing an electronic structure which allows simple and continuous credentialing of local group/chapter members.

AMHA-USA is willing to support development of other Oregon Chapters ... where ever there are groups of mental health professionals who want to come together in support of one another and subscribe to the Principles of AMHA.

AMHA-USA supports these principles:

- People have the right to choose their own therapists.
- Psychotherapy is a collaborative process between therapist and client in service of the client.
- Therapists shall preserve client confidentiality.
- Mental health professionals shall create an interdisciplinary community that promotes and supports competent and ethical practice.

We hope to help you adapt to Healthcare reform

It is not our objective to scare you OR to tell you what you must do.

BUT WAIT!!

- We’re getting ahead of the story!
- Many mental health professionals do not want to deal with the looming changes in health care.
- Many mental health professionals barely recognize the challenges to their current expectations for being in practice.
The Affordable Care Act is a Federal law that demands significant changes in the delivery of health care services across the board. Up until now, "a usual and customary fee" was tied to a particular procedure. Qualified providers submitted claims for services rendered and payment was made according to a contracted payment schedule.

Beginning in 2013 the "fee for service" model has begun moving toward extinction. Oregon is the lead state for the implementation of the Affordable Care Act. Governor Kitzhaber successfully petitioned the Federal government that Oregon be a test case for initiating Accountable Care, in exchange for an infusion of money to cover the shortages in the Oregon Health Plan and even more money to be the beta test for accountable care.

Haven’t we been through this before with Managed Care?

Managed care was not based on Federal Law. Managed Care was instituted by insurance companies as an attempt to control costs within the fee for service model. Managed care went out of favor largely because it restricted care and did not produce the anticipated savings and resulted in numerous, significant law suits.

Are we Toast?

What can be done to help us stay in private practice and continue to bill insurance companies for our services?
There are alternatives

IPAs, Independent Mental Health Practitioner Associations are an excellent course of action because they can give us the ability to negotiate contracts and fee structures. Since an individual practitioner cannot do this, a group, organized to meet the professional and legal requirements, is necessary to fulfill this function.

There are alternatives

Your practice can be all private pay
AMHA membership can help you with that too.

There are alternatives

Structural and Functional Model for Healthcare Reform
Mike Conner

What I will talk about
- The resistance and personal challenges when adapting to healthcare reform
- Individual vs Group vs Organizational issues
- What is Healthcare Reform to us
- Functional group or organizational model
- The technology requirements

Individual (solo) practice
- Payers want to contract with groups
- Groups will be paid more
- Out of network will still be required to use technology
What are the Challenges when Creating or Recruiting for a Group or Independent Practice Association?

First problem
- You need a group or organization of professionals that are capable of contracting with Payers

Many professionals do not join Associations – Organizations - Alliances

Why?

Why mental health professionals don’t join Associations – Alliances – Organizations?
- “I don’t see the value”
- “It is not going to get me more referrals”
- “It is an expense”
- “It won’t market my practice”
- “I’m not a joiner”
- “I’ll be fine without it”
- “I’m retiring in 5 years”
- “I don’t believe they will look out for me”
- “I don’t like some of the people involved”
- “Don’t fence me in”

An e-mail exchange part 1
On one professional list serve Conner wrote:
“I fear that we, in independent practice, have minimal advocacy or support with useful data from research that would prevent independent practice over the next 7 years from accepting an income after expenses of $30 to $40 an hour. ... I fear a tsunami of fee-for-service cuts, are coming for us.”

Part 2
The respondent wrote:
“Don’t mean to be (too) critical but: Michael, liberate yourself from the burden you carry!

Screw the data! Collect directly from your patients! What a concept! Stop worrying about Federal $, mental health economics, tsunami cuts, IPAs and all the rest of it...find enough people who will pay you out of pocket to make a decent living.”
How many people will want to pay cash?

In Multnomah county
- Population of 16+ y.o. is 591,000
- Cost of 20 therapy at $100 per session out of pocket is $2,000
- Median wage is $29,000 (that is 7% of income)
- In 2015, nearly 95% of Oregonians will have health insurance

What happens when you try to form a group or IPA?

Benefits
- Mutual referral
- Peer consultation
- Develop training
- Contracting

Problems
- Can't set the same fee
- Can't contract as a group
- Can't collectively bargain

So what happens?

Why is it so hard to get people involved?

The adaptation curve
As a social psychology model
If you believe in theories of adaptation…

What might happen?

Because practice is already difficult and it takes a lot of time

Why else do people not want to form alliances….
How do we compare to physician groups?

Let's look the structure and functional model of group medical care?

How are physician groups organized?
- Specializations: (Family, Internal, Geriatric, Oncology, General surgery, etc.)
- Practice Administration: (CEO, CFO, COO, Line Directors, Nursing, etc.)
- Organized: (IT Department, EHRs, Referral Department, Billing, etc.)
- Electronic infrastructure for coordinated and accountable care
- Similar standard for care
- Coordinated internal and external referrals

What do physicians often assume about mental health professionals?
- Know each other
- Have electronic infrastructure
- They are all licensed
- Semi-organized
- They know how to provide coordinated and accountable care
- Similar standards for care and practice

This is not true

What does mental health really look like?
What else do we know about independent mental health professionals?
- Not everyone is licensed
- They are loosely and informally organized
- They do NOT have electronic infrastructure
- A subset want to collaborate with physicians
- Many do not know how to provide coordinated and accountable care

How do we compare to hospital-based medical and mental health care?

Why should you care?

What do we know about Hospital based medical homes?
1. Hospital based medical care systems can have Integrated Behavioral Health Departments that have advantages over independent mental health professionals
2. They can assume risk (COIPA vs physician hospital alignment in Central Oregon)

What advantages?

6 Advantages
1. Centralized appointment scheduling
2. Internal referrals (Social work, Primary Care, ER, Inpatient, Neurology, etc.)
3. Interoperable EMR portals
4. Peer consultation and review
5. Progress and outcome measures
6. Electronic billing and auditing

How can we compete with that?

Should just give up?

The current mental health referral process has many problems and we can be the solution

The Referral Process is an Important Part of Providing Coordinated and Accountable Care
What are the problems with the current referral process?

Internal vs. External Referrals

- Hospital Employees
- Medicare, Medicaid
- State Health Plans, TriWest
- Commercial Insurance

External Referrals

- Independent Mental Health Practitioners

Why do physicians need to make referrals in new ways?

Because being accountable means physicians can't continue profit from treating the medical consequences of behavioral and mental health problems that are NOT being treated.

The rate of undiagnosed mental health problems in primary care is between 20 and 40% of patients.
As many as 75% of all patients who see physicians will report physical symptoms and mental health symptoms.

16 to 32% of all patients who seek medical care and describe physical problems have no physical or medical cause and in fact have an underlying mental health problem.

How can we easily and painlessly adapt?

But seriously, we need to understand the terminology.

Smart people can speak in “acronyms”.

Terminology
**Terminology**
- There is a lot of terminology in healthcare reform.
- Words like
  - RAC
  - CCO
  - AHS
  - IPAs
You have your Glossary in hand … and you are WAY ahead of the curve!

**Can we make a difference?**
The research says we can.

**Challenge**
Mental Health (or Well-being)
- I think so because…
  - The presence of any untreated mental health diagnosis increases total health care costs by a factor of 2.24
  - The total investment in behavioral and mental health services has been less than 5% of total health care.

**I also think so because…**
- 50% of mental health conditions go undiagnosed[1]
- Less than 30% of individuals in mental health treatment complete follow-up visits within a month of establishing a care plan or the prescribing of medication[1]
- Only 25% of patients referred by the PCP to specialty mental health services make the first appointment[1]
- Mental health outcomes in primary care patients are only slightly better than spontaneous recovery[1]
- 50-60% of mental health patients do not adhere to their psychoactive medications within the first 4 weeks[1]
- 50% of all mental health services are provided by PCPs[1]
- 67% of psychoactive agents are prescribed by PCPs[1]
- 80% of antidepressants are prescribed by PCPs[1]
- 92% of elderly receive mental health care from PCPs[1]

**How are behavioral & mental health services important?**
The how of why…

**DEPRESSION**
Lets look at the impact of treating and not treating depression in a timely manner
WHAT IS BOOM?

Boom is a concept associated with military personal who trigger explosive "land mines". Right of Boom is after the bomb goes off. Left of Boom is before. Prevention in health care is a left of Boom model.

How effective can we be?

Still looking at just depression

Depression: Acting Right of Boom

- Untreated depression assumes a chronic course.
- Timely diagnosis and treatment of depression (and related conditions) will greatly reduce medical care utilization...
  1. Asthma (Fewer Primary and Emergency Care visits)
  2. Rheumatoid arthritis (Improved health status)
  3. Strokes within 10 years (up to 50% rate reduction)
  4. Myocardial infarction (up to 25% rate reduction)
  5. Diabetic complications (cost reduction up to 75%)
  6. Suicide re-attempts (50% rate reduction)
  7. Over-Utilization of Emergency Services for Depression Associated Problems (cost reduction up to 25%)
  8. Over-utilization of primary care services (Cost reduction up to 25%)

BOOM – Adolescent Suicide

- Grades 8 through 12
  - 1 out of 8 children seriously consider suicide.
  - 1 out of 14 take some self-harming action 2 or more times.
  - 1 out of 10 require medical care for serious injury, overdose or poisoning.
  - The average cost for suicidal behavior in a school system with 10,000 children in grades 8 to 12 is conservatively $1,000,000.
What is Healthcare reform?

My vision…

What is Needed to Stop BOOM

- Timely Detection
- Comprehensive Screening & Effective Referral
- Preventative Care
- Coordinated Treatment
- Accountable Treatment, Process and Outcomes

What is Healthcare Reform about…?

- Finding CCOs and AHS that are willing to assume Financial Risk
- Creating systems that can deliver coordinated and accountable care (not waiting for a model to be imposed).
- The ability to adapt to what is foreseeable
Who is assuming risk?
Groups, not individuals

Organizations that Assume Risk

Private
- Accountable Hospitals System (AHS)
- Health Care System (HCS)

State
- Coordinated Care Organizations (CCO)

Federal
- Accountable Care Organizations (ACO)

Where do we fit in?

- Solo-practice (in-network and out-of-network contract provider)
- Mental Health Group Practice
- Independent Mental Health Practice Association
  - Providing integrated care aligned with a physician group
  - Providing care as a "carve-out"

What is the problem with assuming Risk?
There are NOT Enough Low Risk Clients

There are at least 8 key elements
1. Health information exchange
2. Reliable uniform screening, process and/or outcome measurement
3. Reasonable and timely patient access
4. Positive patient experience
5. Empirically supported &/or evidence based treatment
6. Improving patient well-being and physical health
7. Improving community physical and emotional health
8. Managing or at least containing cost

How do we provide Coordinated & Accountable Care?

- 1. Health information exchange
- 2. Reliable uniform screening, process and/or outcome measurement
- 3. Reasonable and timely patient access
- 4. Positive patient experience
- 5. Empirically supported &/or evidence based treatment
- 6. Improving patient well-being and physical health
- 7. Improving community physical and emotional health
- 8. Managing or at least containing cost
Yeah, but…

Many independent mental health professionals do not want to work with physicians.

Why?

5 Reasons
1. Independent private practice mental health professional want to remain independent
2. They want to practice in total privacy
3. They do not want other people controlling the services they provide
4. Many have limited training and experience working with physician groups
5. The is the M-Deity effect

There are at least 5 reasons…

5 Reasons
1. 95% of Oregonians will eventually have health insurance
2. Paper claims are coming to an end
3. Electronic records are becoming the standard for practice
4. Payers are requiring coordinated and accountable care
5. Auditing is going to increase (RACs)
6. Out-of-network providers are/will be reimbursed less
7. Payers want to contract with groups (not individuals)
8. Payers are moving from “claims-based” to “performance-based” contracts

Why do we need to adapt?

Reasons to Adapt… 8 reasons
1. 95% of Oregonians will eventually have health insurance
2. Paper claims are coming to an end
3. Electronic records are becoming the standard for practice
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Commercial insurance changing!
But isn’t healthcare reform just about the Oregon Health Plan, Medicare and Medicaid? Nope!
Commercial insurance is changing because... 6 reasons
1. Federal dollars pay for more than 50% of health care. That defines a new defensible standard for practice.
2. Employers no longer want managed care (i.e. restricted care)
3. Employers want quality care. (i.e. their money’s worth)
4. Insurance payers believe they can save money by initiating quality improvement programs.
5. CCOs can offer commercial insurance and compete with commercial payers.
6. AHSs are starting to mirror our State CCOs and Federal ACOs

It appears that the Oregon Health Authority & Blue Cross may become a giant toy death match

Steps Toward Adaptation
What is required in order to FULLY adapt and stay ahead of the wave

We must recognize emerging Standards for Practice 7 expectations
1. Screening
2. Electronic records
3. Electronic billing
4. Coordinated care
5. Continuity of care
6. Quality measures
7. Legal and ethical information exchange

There must be Quality Measures 9
1. Screening Counts, Referral counts, MHP appointments made
2. Date of referral, Date of first appointment
3. MH evaluation complete, diagnosis made, treatment plan established
4. Prognosis, Progress measures
5. Medication reconciliation
6. Coordinated care plan
7. Level of medically necessary coordination
8. Outcome measures and Effect sizes
9. Patient experience

We need to provide Coordinated & Accountable Care? 9
1. Health information exchange
2. Consistent and reliable measures
3. Uniform screening, process and outcome measurements
4. Reasonable and timely patient access
5. Positive patient experience
6. Empirically supported &/or evidence based treatment
7. Improving patient well-being and physical health
8. Improving community physical and emotional health
9. Managing or at least containing cost
Additional measures (in 5 to 10 years)

Real time reporting and measures
- Emergent, Urgent and Hospital care
- Timely access to outpatient mental health services
- Utilization rates
- Cumulative usage reports
- Populations demographics
- Approximate 180 day online re-screening using depression and anxiety subscales as outcome measure

Scary Subject
I need to introduce scary subject

SCREENING
We must understand screening that is measurable and recognizes the good work that we do.

Ultra-Brief Screenings
That means we need to understand ultra-brief screenings
And the weakness of using these things as outcome measures

PHQ-9
So called “Patient Health Questionnaire”
Originally designed as a screening for depression
9 questions
Paper and pencil
Developed by Pfizer Pharmaceuticals

PHQ-9
A PHQ-9 depression severity increases, symptom-related difficulty work days, and health care utilization increases.
A PHQ-9 score of ≥ 10 had a sensitivity of 88% and a specificity of 88% for major depression.
A PHQ-9 score of 5, 10, 15, and 20 represented mild, moderate, moderately severe, and severe depression, respectively.
Problem: PHQ-9 has a high false negative disorder.
**Patient Health Questionnaire: PHQ-9**

(Discussion & decision)
- 9 questions (paper and pencil)
- Identifies depression (as defined) and symptoms of depression (as defined) caused by other disorders and problems.
- Has 1 scale.
- Does not inform referral or treatment options, planning or decision.
- Does not support differential diagnosis.

Question: The PHQ-9 is valid. But how useful is it? Validity and usefulness are not the same thing.

---

- While DSM has been described as a “Bible” for the field, it is, at best, a dictionary, creating a set of labels and defining each.
- The strength of each of the editions of DSM has been "reliability".
- The DSM ensures that clinicians use the same terms in the same ways.
- The weakness is its "lack of validity".

Thomas R. Insel, M.D.
Director of the National Institute of Mental Health (NIMH)

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If the patient has other problems, the PHQ-9 does not identify those

Why does primary care need a more thorough screening process than the PHQ-9?

You miss all the other behavioral and mental health problems if you use the PHQ-9.

Without treatment, the people with these other problems start to become depressed, anxious, self-medicating, and unhealthy.

---

Which one of these may respond best to antidepressants?

- Depression
- Anxiety
- OCD
- Bipolar
- Psychotic disorders
- ADHD
- Violent, suicidal or self-harming
What happens if you treat these conditions with the wrong medication or refer to the wrong mental health professional?

**BooM!**

- ADHD
- Bipolar
- Anxiety
- OCD
- Psychotic disorders
- Depression
- Alcohol & Substance Misuse

What is **CONNECTING CARE**?

Connecting Care is a Model for creating High Performance Networks that can provide Practice-Research Quality Care

What is a high performance?

- Practice behavior and processes are flexible and responsive to patient needs

What is practice-research quality?

- Practice that is actively informed by measures and data analysis
- Real time information gathering and analysis

So how do we make a BOOM?

1. **Failure to diagnose** and treat depression.
2. **Over diagnosis** of depression and treating for depression (i.e. using the wrong treatment).
3. **Not treating the real problem** that is causing symptoms of depression.
4. **Medicating symptoms** caused by something else.
5. **Not screening fully** OCD, schizophrenia, bipolar, ADHD, PTSD, symptoms of life stress, sleep disorders, domestic violence, personality disorders, substance use, etc.
6. **Delaying treatment** resulting in patient self-medication, self-harming or seeking emergency services for urgent problems.

Limitations of the PHQ-9

- If the patient is only depressed, the PHQ-9 identifies only depression.
- If the patient is not depressed, then it identifies the patient is not depressed.
- If the patient has another disorder, the PHQ-9 does not identify it.
- Depression can be a consequence of other untreated disorders.
- Treating depression identified by the PHQ-9 can result in the wrong treatment.
- The PHQ-9 provides no information that can inform treatment options, planning and decision.
- Requires further diagnostic screening and interview.
- Does not support differential diagnosis.
- Does not measure other conditions.
- Given the emerging Treatment Guidelines, the high false positives have the favorable economic consequence of increased sale of "antidepressants".
- The PHQ-9 alone can contribute to "Right of Boom" costs and consequences.
- The high sensitivity and specificity scores can be misleading as they do not reflect the high false positive rates one can expect when it is used in a general clinic population.
- Note: The PHQ-9 is owned and promoted by Pfizer.
What the heck is Connecting Care?

Connecting Care consists of 3 things…

1. Independent Practice Association
2. Practice management software
3. Screening, process and outcome measurement software

What is an Independent Practice Association (IPA)?

- Corporation
- Articles of Incorporation
- By-laws
- Board of Directors
- Executive Director
- Contracting with payers
- Alignment with medical healthcare groups

IPA's in Oregon

Easy subject. There has been only ONE

Some people think TWO

OMHA & AMHA

Oregon Mental Health Association (OMHA)

- Contracted with Pacific Source
- No common electronic infrastructure
- Traditional quality measures (e.g., utilization review)
- Closed after contract was withdrawn
American Mental Health Alliance (AMHA)
- Formed to contract directly with employers
- State law prohibited direct contracting
- AMHA turned to supporting independent practice, marketing credentialed professionals, peer consultation, ethical services, privacy and choice
- Being re-Designed to contract with Insurance payers – (this does not require that all members must participate in those contracts.)

Connecting Care also consists of...
1. Independent Practice Association
2. Online Practice management software
3. Online Screening, process and outcome measurement software

What is Practice Management Software?
- Electronic Charting
- Electronic Billing
- Appointment Scheduling

Why do you need Practice Management Software?
- Insurance payers are requiring electronic billing
- Reduce the risk of an audit, fines and penalties through errors
- Make more money by reducing omissions
- You can set permission so that you can share records for your
  - a billing professional
  - a colleague

Why do you need Electronic Charting?
- Electronic charting is a high Standard of Practice
- Reduce time charting
- Security and backup of records
- Risk management
  - Audit protection
  - Legal protection
  - Licensure protection
  - HIPAA compliance
- Gather data to demonstrate quality (pay-for-performance)
- Uniform coordination of care with other professionals
- Professional Will

CarePaths practice management software
- Electronic mental health record
- Electronic practice management
- Electronic billing
- Supports auditing
- Data analysis that supports contracts with insurance payers
- eSuite (practice billing support)
- Patient portal
- Physician portal (beta testing)
**Connecting Care** consists of…

1. Independent Practice Association (Alliance & IPA)
2. Online Practice management software
3. **Online screening, process and outcome measurement delivery software**

**Why do you need screening, process and outcome measurement software?**

- To identify our patients’ needs
- To define population needs
- To inform and support diagnosis
- To support authorization of
  - intensive services
  - chronic conditions
- To demonstrate change
  - symptoms
  - behavior
  - well-being
  - Therapeutic relationship

**What is the difference between Screening, Process and Outcome Measures?**

**What is “Screening”?**

- **Screening** is the investigation of a great number of people looking for those with a particular problem or characteristic.
- Self-report questionnaires are a common tool.
- Reports by others are often as valid, or more valid, and can add incremental validity.
- Screening is NOT Diagnosis or Personality assessment

**What are process measures?**

- Questions about the process of therapy
- Usually measures that when answered over time can show a calculated Effect.

**What is an “Effect Size” and how to we measure it?**
The Effect Size of Therapy

Do you and your therapist see eye to eye?

Another type of Effect Size

Play your Effect measures and size of the effect

What are “Outcome Measures”?

• Measuring patients and helping them to change categories. (i.e. depressed or not depressed)
• Hopefully to a better category.

What is the difference between Outcomes and Effect Size?

• Effect size – is the degree to which you are making a difference (0.2, 0.5, 0.8)
• An outcomes – is the difference from a category statistically significant (0.90, 0.95, 0.97)
• Is the DSM Global Assessment of Functioning (GAF) valid?

Who likes to talk about statistics?

• Some simple concepts you need to understand

What is Validity?

• No simple answer
• But there are TWO ways to look at validity
<table>
<thead>
<tr>
<th>The first way to look at “Validity”</th>
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<tr>
<td><strong>The construction of a questionnaire</strong></td>
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<tr>
<td>• Face – Looks valid</td>
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<td>• Content – People agree that the content is valid</td>
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<td>• Concurrent – Results match something else that is valid</td>
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<td>• Predictive – What you predict will happen actually happens</td>
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<td>• Construct validity – The model predicts more than one thing consistently</td>
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<table>
<thead>
<tr>
<th>The second way to look at “Validity”</th>
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<tr>
<td><strong>Diagnostic and Agreement Statistics: Properly Classify</strong></td>
</tr>
<tr>
<td>• Sensitivity</td>
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<tr>
<td>• Specificity</td>
</tr>
<tr>
<td>• Positive prediction value</td>
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<tr>
<td>• Negative prediction value</td>
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<tr>
<td>• Hit rates</td>
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<td>• Misclassification rates</td>
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<td>• Etc…</td>
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<th>What is reliability?</th>
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<tr>
<td>• How consistent is it?</td>
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<td>• Is diagnostic interview consistent?</td>
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<tr>
<th>What is utility?</th>
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<td>• How useful is it?</td>
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<tr>
<th>Statistical Laws</th>
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<tbody>
<tr>
<td>• Nothing is valid if it is not reliable</td>
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<tr>
<td>• Nothing can be more valid than it is reliable</td>
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<tr>
<td>• 0.0 reliability means random</td>
</tr>
<tr>
<td>• 1.0 is perfect reliability</td>
</tr>
<tr>
<td>• The most reliable measures are usually 0.6 to 0.8</td>
</tr>
<tr>
<td>• The validity of something that has 0.6 reliability is no more than 0.36 (at best)</td>
</tr>
<tr>
<td>• The DSM has reliability that ranges from 0.5 to 0.7</td>
</tr>
<tr>
<td>• The validity of the DSM is between 0.25 and 0.50 (meaning it is wrong at least 50 to 75% of the time)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Talking about validity?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• If it is not reliable, it is not valid</td>
</tr>
<tr>
<td>• If it is not valid, it might still be useful.</td>
</tr>
<tr>
<td>• If it is not valid, it might also be harmful.</td>
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</table>
Trick Questions
Is the DSM a Valid Tool?
Should we use it to measure performance?
What is the DSM good for?

How valid is diagnosis

- How valid are diagnostic interviews using the DSM?

At best, diagnosis based on interview using the DSM is “invalid” 50 to 75% of the time.
And the DSM is not valid to begin with!

Why do people believe things that are not valid and not true? (i.e. lies)

- “Can a million physicians be wrong?” No.
- Bias
- “Can a billion Chinese be wrong?” Yes
- Cultural Bias

Cognitive Dissonance

- The feeling of discomfort that results from holding two conflicting beliefs.
- When there is a discrepancy between beliefs and behaviors, something must change in order to eliminate or reduce the dissonance.

Give me an example of Cognitive Dissonance?

- I was trained to believe the DSM was a valid tool and everyone is using it.
- I will get paid if I don’t use it.
- Result: Comfortable feeling

- The DSM is not valid and I should not use it
- I will NOT get paid?
- Result: I am uncomfortable

So the American Psychiatric Association, by committee declared a Washing Machine a space craft"
What if the American Psychiatric Association said “The DSM is a Washing Machine?”

If the DSM sucks…
Then what the heck should we be screening for and measuring anyway?
Hopefully not a change is diagnosis

What conditions should we screen for and measure?

<table>
<thead>
<tr>
<th>Wellness, Symptoms and Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Depression</td>
</tr>
<tr>
<td>2. Tobacco use</td>
</tr>
<tr>
<td>3. Alcohol abuse</td>
</tr>
<tr>
<td>4. Non-specific drug misuse</td>
</tr>
<tr>
<td>5. Pain</td>
</tr>
<tr>
<td>6. Life stress</td>
</tr>
<tr>
<td>7. Somatization</td>
</tr>
<tr>
<td>8. Obesity</td>
</tr>
<tr>
<td>9. Anxiety</td>
</tr>
<tr>
<td>10. Sleep disorders</td>
</tr>
<tr>
<td>11. Panic disorder</td>
</tr>
<tr>
<td>12. Suicide</td>
</tr>
<tr>
<td>13. Violence</td>
</tr>
<tr>
<td>14. Interpersonal sensitivity</td>
</tr>
<tr>
<td>15. Anger &amp; Hostility</td>
</tr>
<tr>
<td>16. Phobia</td>
</tr>
<tr>
<td>17. OCD</td>
</tr>
<tr>
<td>18. Attention &amp; Concentration</td>
</tr>
<tr>
<td>19. Hyperactivity</td>
</tr>
<tr>
<td>20. Mania</td>
</tr>
<tr>
<td>21. Bipolar disorder</td>
</tr>
<tr>
<td>22. Distrust, suspicion &amp; paranoia</td>
</tr>
<tr>
<td>23. Psychotic symptoms</td>
</tr>
<tr>
<td>24. Bulimia/Anorexia</td>
</tr>
<tr>
<td>25. Adverse Child Experiences</td>
</tr>
<tr>
<td>26. Elder abuse</td>
</tr>
</tbody>
</table>

How do we measure things?

Measures using questions (roughly categorized)
- Ultra-Brief measure (6 to 40 questions)
- Brief (90 to 140 questions)
- Comprehensive (240 questions plus)

Is there a Technology to do all this?
Connecting Care

What is it?

- AMHA (an Alliance and IPA)
- CarePaths (Total Practice Management)
- ScreeningWare (screening, process and outcomes)

Connecting Care Pilot

- Bend Memorial Clinic (100 physicians)
- Free screening to all patients
- Integrated Specialty Care

ScreeningWare

- Online screening system
- HIPAA compliant
- Generates immediate results and information for patients, mental health professionals and physicians
- Ultra-brief measures
- Comprehensive measures
- Online
- Tablets
- Smartphone (testing)

Who could we work with?

Healthcare Provider Clients

1. Family Practice
2. Internal medicine
3. Neurologists
4. Cardiologists
5. Pulmonologists
6. Endocrinologists
7. Orthopedics
8. Emergency Care
9. Urgent Care
10. Public Mental Health

What is CarePaths?
CarePaths is...
- Total practice management software
- ONC certified
- And it is $25 a month if you are an AMHA member.
- It doesn’t get any better than that.

What is ONC Certification
The Office of National Coordinator for Health Information Technology
Software is rigorously tested by an approved computer technology laboratory.

How does CarePaths Work?

Demonstration of CarePaths eRecord

What is ScreeningWare?
Disclosure

How does ScreeningWare Work?
Portals
Bend, Oregon
Portland, Oregon

New Account
1. Enters their Access Code
2. Enters basic information
3. Reads the Terms of Use
4. Clicks a button if they agree

Terms of Use Test
1. Must answer 9 questions
2. Press 'Check Answers' and Proceed
3. Correct answers demonstrate informed consent

Patient Dashboard
Patient enters their...
1. Basic information
2. Health insurance
3. Authorizations
4. Referral requests
With this information we can...
1. Calculate BMI
2. Identify local resources
3. Make referrals
4. Send reports to MDs, MHPs

Patient then...
1. Takes a screening
2. Generates a report
Summary of CONNECTING CARE

1. Comprehensive Practice Management, eRecord, Measurement and Billing Solution
2. A Practice Building Tool (generating referrals from many sources)
3. Coordinated and Accountable Care Design
4. A Risk Management System
5. Meets licensing standards, and State and Federal Regulations and Laws
6. Can be use to contract as a group with insurance payers
How am I going to adapt to health care reform?

What choices are you going to make?
Live Demonstration

www.BendHealth.com