AHCCCS Targeted Investments Program

Adult A Quality Improvement Collaborative

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Stephanie Furniss, PhD

TIP Year 5: Session #1
October 1, 2020

ASU College of Health Solutions
Arizona State University

AHCCCS Arizona Health Care Cost Containment System | Targeted Investments

ASU College of Health Solutions
Arizona State University
Center for Health Information and Research

Disclosures

Satya Sarma is a Medical Director at AHCCCS

Agenda

TIME	TOPIC	PRESENTER
11:30 AM – 11:35 AM	Overview • Agenda	Kailey Love
11:35 AM – 12:00 PM	Collaborative Care Model • Overview • Billing Codes	Satya Sarma, MD Stephanie Furniss, PhD
12:00 PM – 12:20 PM	Collaborative Care Model: Use Case	Banner University Primary Care
12:20 PM – 12:55 PM	Discussion & Q&A	All
12:55 PM – 1:00 PM	Next Steps	Kailey Love

TIP Year 5

QIC Attendance:

- There will be a total of 10 virtual quality improvement collaboratives (QICs) during TIP Year 5, which begins October 2020.
  - Two of these will occur in what remains of 2020—October and November.
  - There will be no QICs in December 2020.
  - The remaining 8 QICs will be scheduled in 2021.
  - Attendance requirements will stay the same for TIP Year 5

Continuing Education Units:

- Continuing Education Units (CEUs) for the virtual quality improvement collaboratives (QIC) will be awarded on an annual basis following the last QIC session of the calendar year.
  - For 2020, TIP participants can receive up to 12 CEU (1.5 per virtual QIC session) and will be awarded following the last virtual QIC session in November 2020.
  - For 2021, participants will have the opportunity to earn up to 12 CEUs (1.5 per virtual QIC session).

Learning Objectives

1. Describe the components of the Collaborative Care Model.
2. Analyze the role of Collaborative Care Model in healthcare integration and value-based care.
3. Identify opportunities for incorporating the Collaborative Care Model in a Primary Care and Behavioral Health practice.

Behavioral Health Integration

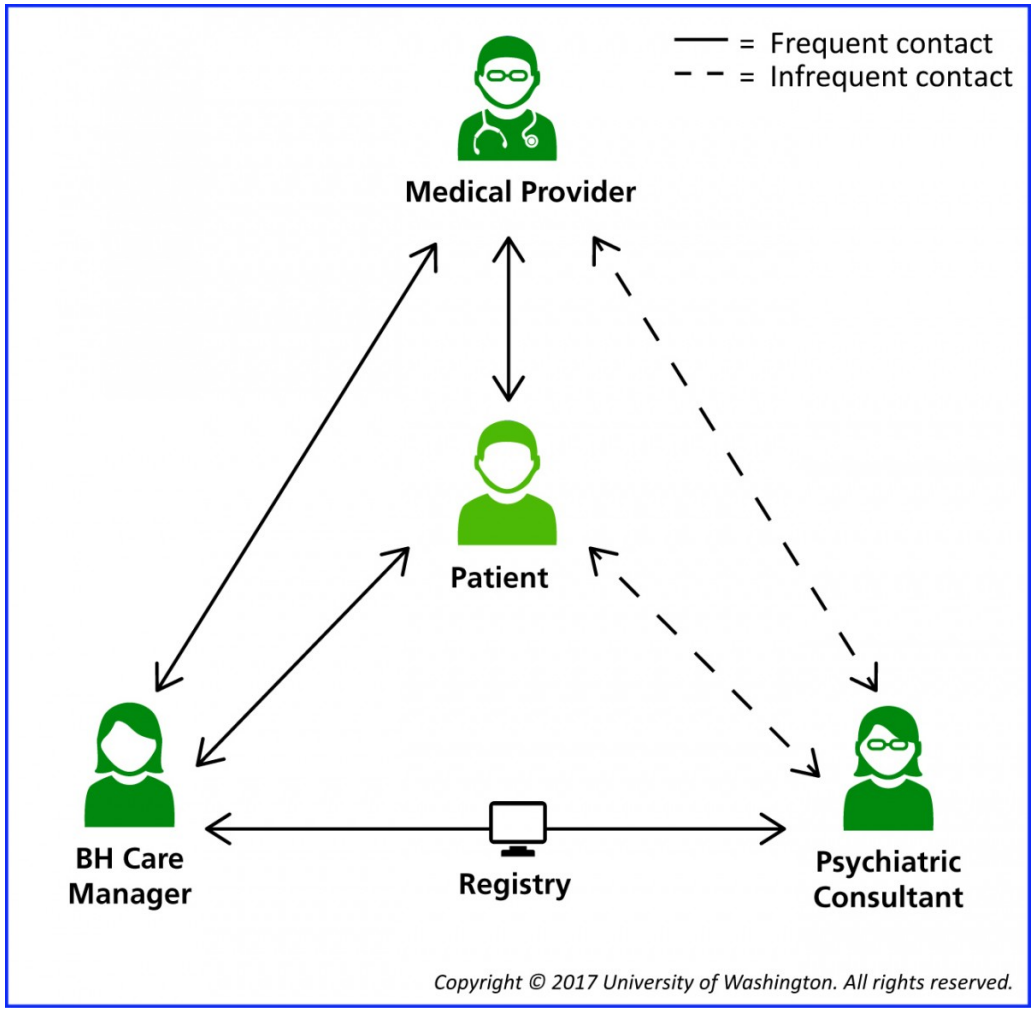
- 10% of patient visits are BH related
- Patients referred to BH often do not follow through
- Typically 30-60 days to see a psychiatric provider
- Collaborative Care Model (CoCM) reduces these barrier

Psychiatric Collaborative Care Model (CoCM)

- An approach to BHI developed at the University of Washington and shown to be effective in randomized controlled trials
- Enhances primary care with addition of two key services:
    1. Care management/therapeutic support for patients receiving behavioral health treatment
    2. Psychiatric inter-specialty consultation for the primary care team
- Services provided by a team of primary care and behavioral health specialists who each have well-defined roles

5 Core Principles

1. Patient-Centered Team Care
2. Population-Based Care
3. Measurement-Based Treatment to Target
4. Evidence-Based Care
5. Accountable Care



Source: https://aims.uw.edu/collaborative-care/team-structure

Service Components

- **Initial assessment** by the primary care team (billing practitioner and behavioral health care manager)
- **Care planning** by the primary care team, jointly with the beneficiary, with care plan revision for patients whose condition is not improving adequately. Treatment may include pharmacotherapy, psychotherapy, and/or other indicated treatments
- Behavioral health care manager performs **proactive, systematic follow-up** using validated rating scales and a registry
- **Regular case load review** with psychiatric consultant

Source: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

Why PCP's love Psychiatric Collaborative Care

- **Established Evidence Base-** CoCM has a robust evidence base of over 80 randomized controlled trials and has been shown to be the best approach to treating depression in many populations and settings.
- **Better Medical Outcomes-** CoCM is linked to better medical outcomes for patients with diabetes, cardiovascular disease, cancer, and chronic arthritis.
- **Help with Challenging Patient Cases-** Many challenging cases likely have patients with untreated or undertreated behavioral health conditions. Behavioral health providers do the follow-up and intervention tasks that a busy PCP doesn't have time to do but make a big difference for patients.
- **Faster Improvement-** A 2016 retrospective study at Mayo Clinic found that the time to depression remission was 86 days in a CoCM program while in usual care it was 614 days.
- **It Takes a Team-** CoCM has a population-based treatment to target approach utilizing a psychiatric consultant. Only 30-50% of patient have a full response to the first treatment (psychiatric medication). 50-70% require one adjustment which is why the psychiatric consultant is so crucial.

Sources: University of Washington AIMS Center; Psychosomatic Medicine, 2014; Family Community Health , 2015; Psychiatric Services, 2015

Benefits of Psychiatric Collaborative Care

- **2- 3** times increase in PMPM cost for comorbid mental health conditions. Effective integration reducing this number by **9 to 17%** with savings of 38 to 68 billion annually (Milliman)
- The **IMPACT** study suggested that up to $6.50 are saved in health care costs for every dollar spent on collaborative care, a return on investment of 6:1.
- Avg of $600 annual savings per member (over 80 clinical trials)
- **TEAMCare** study: PQH 9, HbA1c, Systolic BP, LDL all improved for patients receiving CoCM
- Lower cost than specialty BH care- caps on Utilization
- 70-80% of members won't accept referrals. Typical PCP tx with meds only= 19% Efficacy
- 24-72 hour access to psychiatric care vs 30 days
- Increased PCP satisfaction- No credentialing/contracting required
- Endorsed by APA, CMS and all Major Health Plan Partners

Source: http://aims.uw.edu/resource-library/long-term-cost-effects-collaborative-care-late-life-depression
http://us.milliman.com/uploadedFiles/insight/2018/Potential-Economic-Impact-Integrated-Healthcare.pdf

Billing Overview

- PCP is billing provider
- PCP collaborates with BH team members
- Covered by all major health plans
- Service billable by the PCP to all major health plans under current contract

CoCM Codes

BHI code	BH Care Manager or Clinical Staff Threshold Time	Assumed Billing Practitioner Time
CoCM First Month (99492)	70 minutes per calendar month	30 minutes
CoCM Subsequent Months* (99493)	60 minutes per calendar month	26 minutes
Add-On CoCM (Any month) (99494)	Each additional 30 minutes per calendar month	13 minutes

* CoCM is furnished monthly for an episode of care that ends when targeted treatment goals are met or there is failure to attain targeted treatment goals culminating in referral for direct psychiatric care, or there is a break in episode (no CoCM for 6 consecutive months).

Source: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

What about CPT 99484?

- Not a CoCM code and not included in TIP however this code is an essential component of integration
  - Allows provider to monitor progress of members seeing BH specialist
- Used to bill services furnished using other BHI models of care that include systematic assessment and monitoring using validated clinical rating scales (where applicable), behavioral health care planning (with care plan revision for patients whose condition is not improving), facilitation and coordination of behavioral health treatment, and a continuous relationship with a designated member of the care team.
- Services may be provided directly by the PCP and do not have to be furnished by a designated BH care manager or involve a psychiatric consultant

CoCM codes & FUH 7/30-day

An AHCCCS Committee in consultation with CHiR established how the CoCM services (i.e., codes 99492, 99493 and 99494) will be recognized in the TI Program.

- ***PCP measure evaluation (i.e., 7/30-day follow up after hospitalization for mental illness measures):*** CoCM codes will count as a qualified visit for numerator.
- ***PCP attribution:*** CoCM codes will not be included among E&M codes or other qualifying visit in PCP attribution process.
- ***BH measure evaluation & attribution (i.e., 7/30-day follow up after hospitalization for mental illness measures):*** In post-discharge period, CoCM codes will count as a qualified visit for numerator. In period prior to hospitalization (i.e., 90 days prior), CoCM codes will qualify the BH provider in denominator.

Collaborative Care
Banner University Primary Care

Sarah Coles, MD
Deborah Kastiel, RN BSN

WHY?

BECAUSE

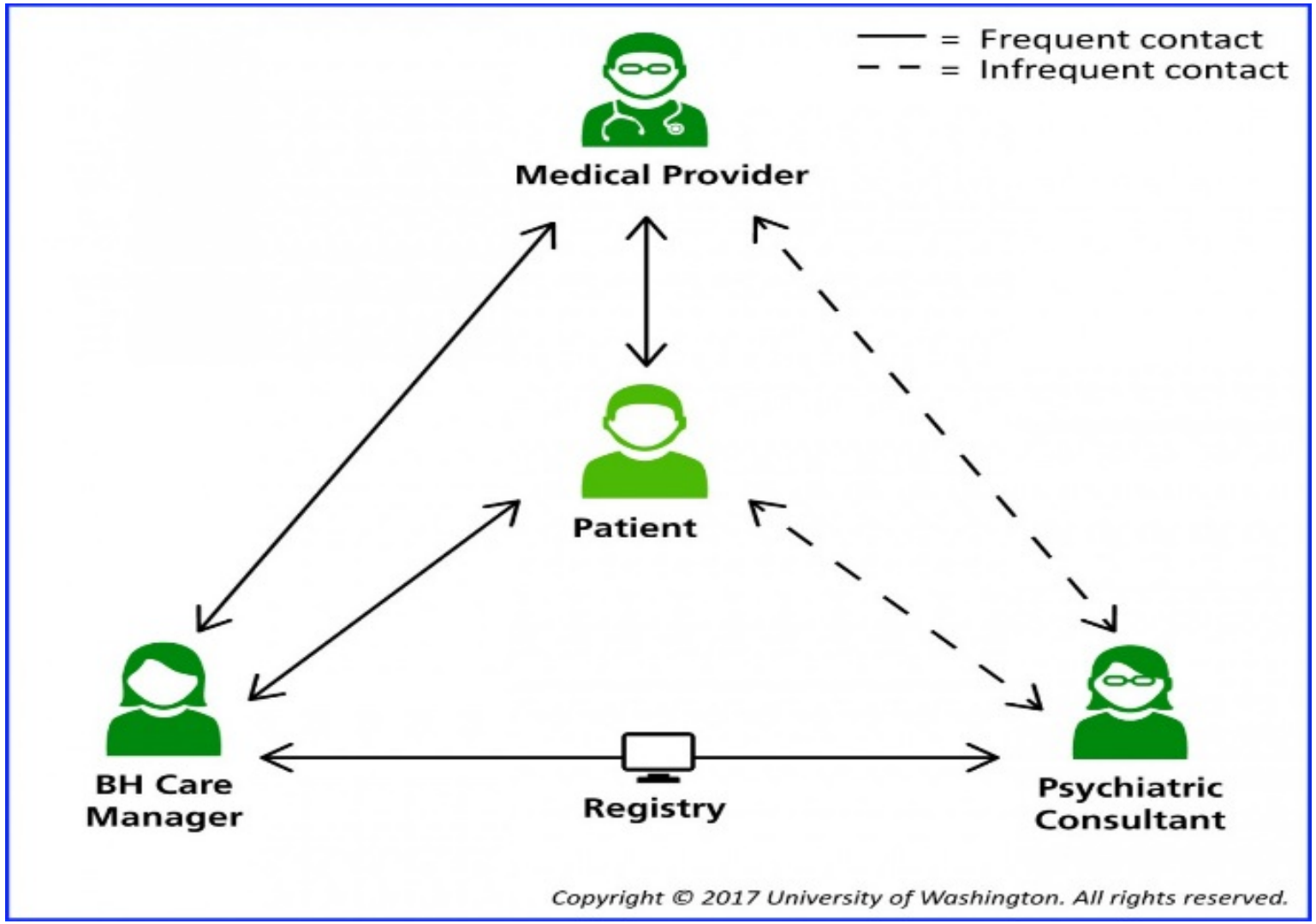
50% of patients do not follow through on a referral to a mental health provider

AND

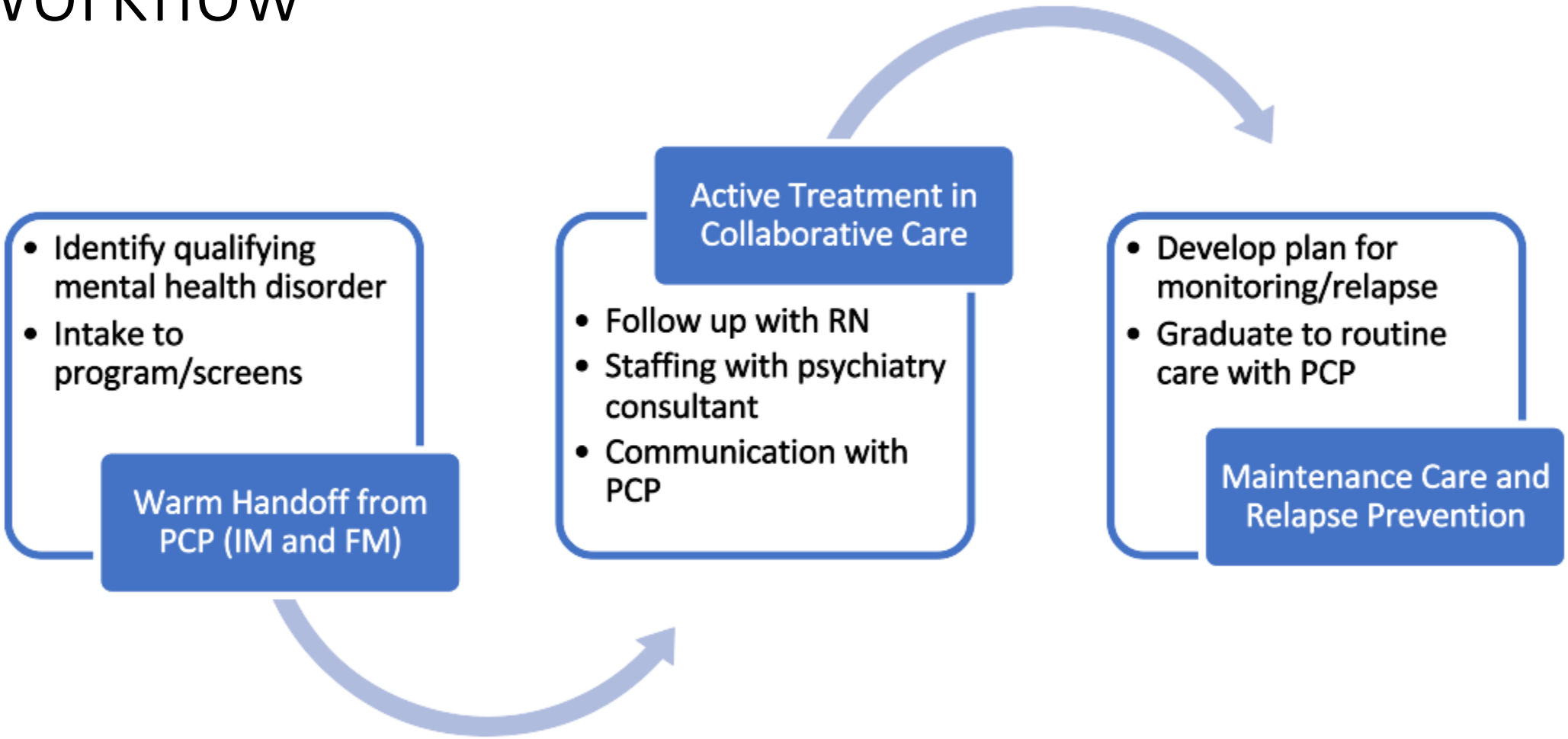
70-80% of antidepressants in the US are prescribed by PCPs

- **CDC The State of Mental Health and Aging**
- **https://www.cdc.gov/aging/agingdata/data-portal/mental-health.html**
- **Healthy People 2020 https://www.healthypeople.gov/**

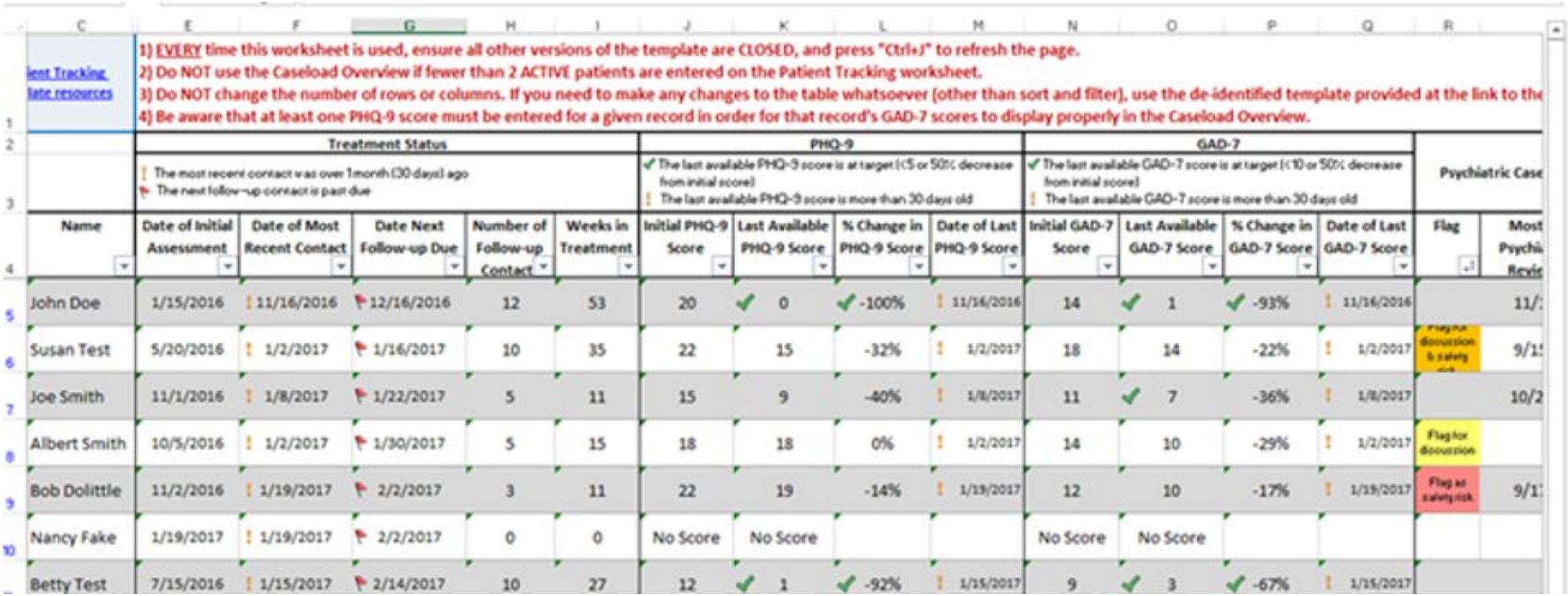
The Collaborative care Team



Workflow


Identify qualifying mental health disorder
Intake to program/screens
Warm Handoff from PCP (IM and FM)
Active Treatment in Collaborative Care
Follow up with RN
Staffing with psychiatry consultant
Communication with PCP
Develop plan for monitoring/relapse
Graduate to routine care with PCP
Maintenance Care and Relapse Prevention

Registry



	C	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	
1	ient Tracking late resources	1) EVERY time this worksheet is used, ensure all other versions of the template are CLOSED, and press "Ctrl+J" to refresh the page. 2) Do NOT use the Caseload Overview if fewer than 2 ACTIVE patients are entered on the Patient Tracking worksheet. 3) Do NOT change the number of rows or columns. If you need to make any changes to the table whatsoever (other than sort and filter), use the de-identified template provided at the link to the 4) Be aware that at least one PHQ-9 score must be entered for a given record in order for that record's GAD-7 scores to display properly in the Caseload Overview.														
2		Treatment Status					PHQ-9				GAD-7				Psychiatric Case	
3		! The most recent contact was over 1 month (30 days) ago ⚑ The next follow-up contact is past due					✓ The last available PHQ-9 score is at target (<5 or 50% decrease from initial score) ! The last available PHQ-9 score is more than 30 days old				✓ The last available GAD-7 score is at target (<10 or 50% decrease from initial score) ! The last available GAD-7 score is more than 30 days old					
4	Name	Date of Initial Assessment	Date of Most Recent Contact	Date Next Follow-up Due	Number of Follow-up Contact	Weeks in Treatment	Initial PHQ-9 Score	Last Available PHQ-9 Score	% Change in PHQ-9 Score	Date of Last PHQ-9 Score	Initial GAD-7 Score	Last Available GAD-7 Score	% Change in GAD-7 Score	Date of Last GAD-7 Score	Flag	Most Psychi Revie
5	John Doe	1/15/2016	! 11/16/2016	⚑ 12/16/2016	12	53	20	✓ 0	✓ -100%	! 11/16/2016	14	✓ 1	✓ -93%	! 11/16/2016		11/
6	Susan Test	5/20/2016	! 1/2/2017	⚑ 1/16/2017	10	35	22	15	-32%	! 1/2/2017	18	14	-22%	! 1/2/2017	Flag for discussion & safety	9/1
7	Joe Smith	11/1/2016	! 1/8/2017	⚑ 1/22/2017	5	11	15	9	-40%	! 1/8/2017	11	✓ 7	-36%	! 1/8/2017		10/2
8	Albert Smith	10/5/2016	! 1/2/2017	⚑ 1/30/2017	5	15	18	18	0%	! 1/2/2017	14	10	-29%	! 1/2/2017	Flag for discussion	
9	Bob Dolittle	11/2/2016	! 1/19/2017	⚑ 2/2/2017	3	11	22	19	-14%	! 1/19/2017	12	10	-17%	! 1/19/2017	Flag as safety risk	9/1
10	Nancy Fake	1/19/2017	! 1/19/2017	⚑ 2/2/2017	0	0	No Score	No Score			No Score	No Score				
	Betty Test	7/15/2016	! 1/15/2017	⚑ 2/14/2017	10	27	12	✓ 1	✓ -92%	! 1/15/2017	9	✓ 3	✓ -67%	! 1/15/2017		

About Us

- Sites:
  - Family Medicine Residency
    - 3 office sites in same building
    - Psychology interns with limited availability
    - Large, interprofessional practice
  - Internal Medicine Residency programs
    - 1 office site in same building as Family Medicine
    - No access to in house behavioral health
    - Large, interprofessional practice
  - Psychiatry Residency:
    - 1 office site in same building and IM and FM
    - Previously not integrated with primary care

Implementation

- Goal: Implement evidence-based program to improve behavioral health care in our primary care setting
  - Partners: IMC, FMC, and Psychiatry
- Research models
  - University of Washington AIMS Model
- Create Stakeholder Buy In:
  - PCPs, Staff, Psychiatric Consultant, Residents, Administration
- Hire Nurse Navigator
- Develop workflow
- Training
  - Rationale, Workflows, Billing and Coding, Behavioral Health Management

Implementation

- Implemented March 2018
- Frequent Team Meetings to Review
- Reinforcement of shared mission and development to culture of integrated behavioral health care
- Iterative Training
- Frequent Process Changes
  - PDSA Cycles

Benefits to Practice

Clinicians

- Increase comfort with behavioral health screening, diagnosis, and management
- Increase scope of practice
  - Support from psychiatry for more complex cases
  - Support from nurse navigator
- Office visit decompressed
- Billable service
- Improved detection of SDoH and other factors

Patients

- Remain in primary care home
- Increased touch points with patient
- Improved access to behavioral health care
- Improved behavioral health outcomes
- Possibly improved physical health outcomes
- Coordination with multiple services
  - PCP, SW, pharmacy, psychology, RD, community services

Improved Patient Outcomes as of September 2020

Family Medicine Clinic

- Mean initial PHQ 13.7 Current mean PHQ 9.6 (-30%)
- Mean initial GAD 10.4 Current mean GAD 7.1 (-32%)

Internal Medicine Clinic

- Mean initial PHQ 12.3 Current mean PHQ 6.0 (-51%)
- Mean initial GAD 12.6 Current mean GAD 6.4 (-49%)

Physical Health Outcomes

Initial Values on Enrollment

- HbA1C < 9%: 69%
  - FMC Baseline: 72.6%
- HTN Controlled (<140/90): 71%
  - FMC Baseline: 74.2%

Patient Example

- 43 yo F with bipolar disorder
- Initial Scores: 6/2018
  - A1C: >14%, GAD7 17, PHQ9 16
- Follow Up Scores: 12/2018
  - A1C: 8.1%, GAD7 2, PHQ9 4

Challenges & Making the Team Comfortable

Challenges

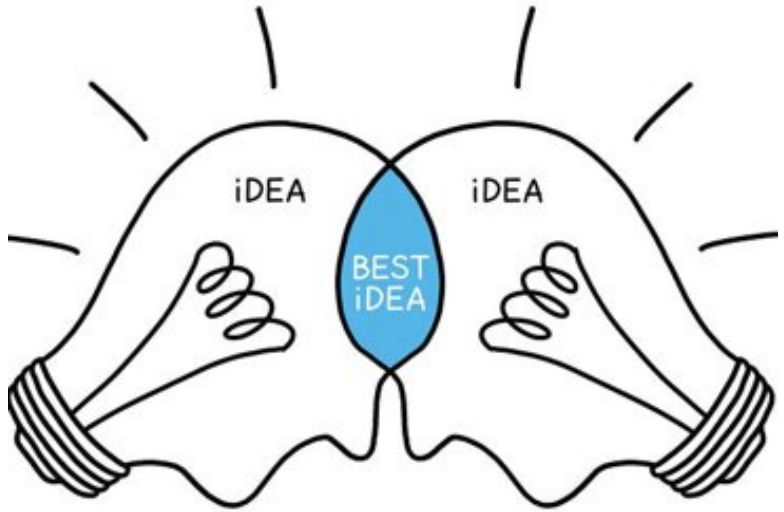
- New model of care
- Expanded scope for PCPs
- Nurse Navigator is “new” role for nursing
- Psychiatrists making recommendations with limited info
- New billing codes
- Residency clinic
- Registry integration with EHR
- Integration with Health Information Exchange

Solutions

- Education and support services
- Psychiatrist
  - Available for questions and can see patient if required
  - Consult notes educational
- Referrals are optional
  - If PCP uncomfortable, don’t refer
- Nurse navigator training
- Team Meetings: Inclusive voices and shared mission

Collaboration Across Practices

- Champion at each site involved at all stages of development and implementation
- Build workflows to accommodate all sites needs/goals
- Regular communication using agreed upon format
- Frequent touch points
- Dynamic nature of the panel



Impact on Learners

Survey of Residents and Faculty found that:

- 77% have referred to Collaborative Care
- 90% felt collaborative care keeps their patients in the primary care home
- 82% felt collaborative care was more effective than traditional care
- 91% felt collaborative care benefited their patients
- 73% felt collaborative care improved their management of mental health disorders
- 70% felt collaborative care improved their management of chronic medical conditions

Clinician Comments

- Check ins for mood during visit were definitely shortened allowing more time for other chronic issues.
- Provides a great opportunity for residents to learn how to manage more complex behavioral health problems.
- Patients seem more comfortable with engaging in mental health treatment because they get to keep their care in our clinic.
- I like that I can call a psychiatrist for advice on med management for meds that I used to just refer out.
- It has been particularly nice for more complicated patients that I may have tried to refer outside the office.
- Pt's get started on meds earlier and seeing earlier stabilization.
- I have treated severe depression, mild-moderate bipolar, and even early psychosis that I would never have started meds on before.
- Passively suicidal patient had great support and many check ins that helped her get through a very hard time without needing care outside of our office

Improved Integration

- 199 patients have received care from the Collaborative care team
- Integrated Care Plan developed with the patients
- Behavioral health goals set with the patient
- Regular communication between all disciplines: PCP, psychiatric RN, social workers, dietician, behavioral health community clinics
- Depression and anxiety screening for all patients
- SDoH assessments on all patients
- Medical conditions addressed during Collaborative Care contacts

Q&A

- Please insert any questions in the Q&A box

Next Steps

- Next Steps
  - Post-Event Survey: 2 Parts
    - Feedback Questions for TIP Year 5 QIC
    - Continuing Education Evaluation
  - Continuing Education
    - For 2020, TIP participants can receive up to 12 CEU (1.5 per virtual QIC session) and will be awarded following the last virtual QIC session in November 2020.
    - For 2021, participants will have the opportunity to earn up to 12 CEUs (1.5 per virtual QIC session) and will be awarded following the last virtual QIC session in 2021

- Questions or concerns?
  - Please contact ASU QIC team at TIPQIC@asu.edu if questions or concerns regarding performance data

Thank you!

TIPQIC@asu.edu

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Appendix

Implementation / Tools

- AIMS Center website
  - Building the business case
  - Financing Strategies
  - Job Descriptions
  - Care Manager Essentials
  - Implementation Guide
  - AIMS Caseload Tracker
  - And more!

Resources

- CMS and Medicare Learning Network. Behavioral Health Integration Services. Updated 5/2019.
- CMS. Frequently Asked Questions about Billing Medicare for Behavioral Health Integration (BHI) Services. Updated 4/17/2018.
- University of Washington AIMS Center. Collaborative Care.
  - They also have an online Resource Library
- American Psychiatric Association and Academy of Psychosomatic Medicine. Dissemination of Integrated Care Within Adult Primary Care Settings: The Collaborative Care Model. 2016.
- American Psychiatric Association. FAQs for billing the Psychiatric Collaborative Care Management (CoCM) codes (99492, 99493, 99494, and G0512 in FQHCs/RHCs) and General Behavioral Health Intervention (BHI) code (99484, and G0511 in FQHCs/RHCs). Updated 6/2019.

Typical Care Vs Collaborative Care

Typical Care

- Little impact on physical health
- 20% members receive BH care
- Difficult to scale
- 19% efficacy PCP meds only
- 30-day average access to psychiatric services
- Limited outcomes

Collaborative Care

- Improvement in LDL, SBP and HbA1c (TEAMCare)
- >60% members receive BH care
- Easy to scale with telehealth/remote services
- 51% efficacy with CoCM
- Same day appointments/consults
- Over 80 randomized clinical trials (Endorsed by CMS and all major health plans)

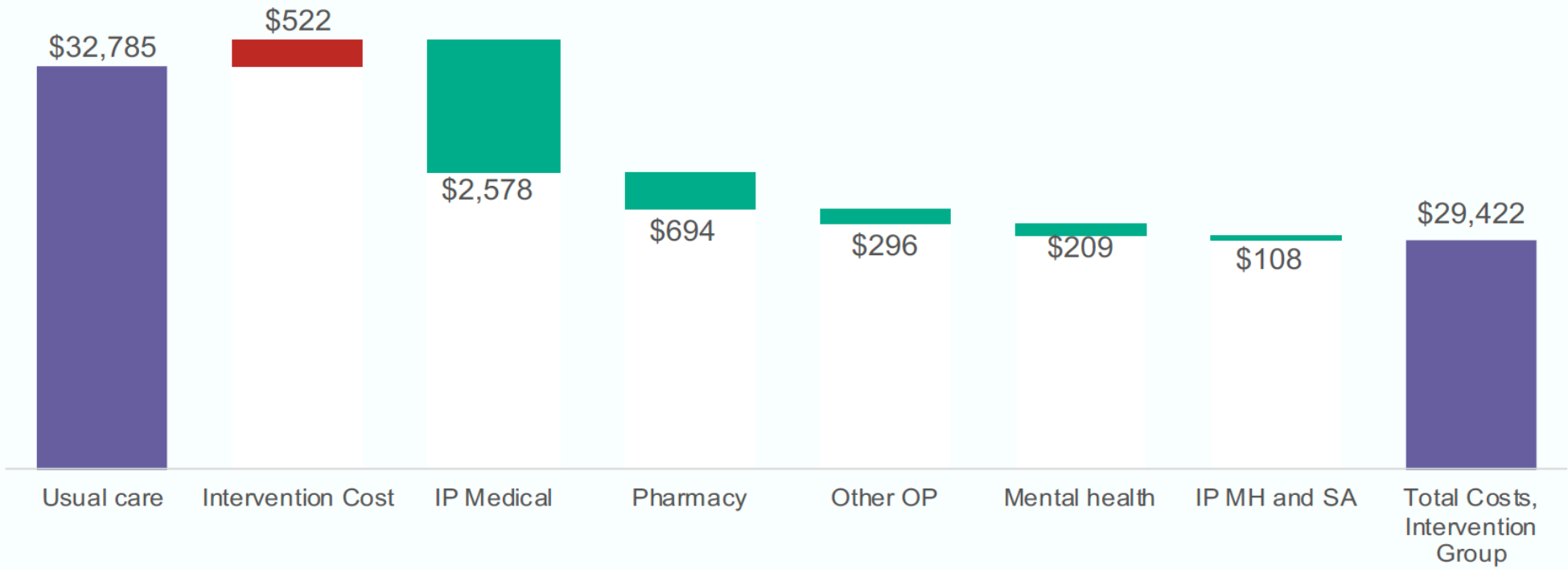
IMPACT Study

- The IMPACT study was the first large randomized controlled trial of treatment for depression
- Demonstrated that collaborative care more than doubled the effectiveness of depression treatment for older adults in primary care settings.
- Collaborative care more than doubled the effectiveness of depression treatment for older adults in primary care settings.
- At 12 months, about half of the patients receiving collaborative care reported at least a 50 percent reduction in depressive symptoms, compared with only 19 percent of those in usual care.
- Savings of $3,365 per patient (n = 272) over patients receiving usual primary care over a four-year period, even though the intervention ended after one year.

IMPACT COST DATA: 4 YEAR SAVINGS ACROSS CATEGORIES

Total Cost of Care: Intervention vs. Control

1 Year CoCM Intervention, 4 Year cost data. Older adults, randomized on positive PHQ9 (over 9)



1. Source: https://pubmed.ncbi.nlm.nih.gov/18269305/

Notes:

a. Other outpatient incl: outpatient primary care and specialty medical and surgical visits, PT/OT, urgent care, ED care, & other outpatient services

b. Data now 15 years old – all values likely higher due to inflation. Study used Medicare data, so commercial/Medicaid experience may reflect smaller cost avoidance unless targeting high risk patients