AHCCCS Targeted Investments Program

Peds A Quality Improvement Collaborative

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Stephanie Furniss, PhD

TIP Year 5: Session #1
October 6, 2020

College of Health Solutions
Arizona State University

AHCCCS
Arizona Health Care Cost Containment System
Targeted Investments

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

Disclosures

There are no disclosures for this presentation.

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	William Riley, PhD Stephanie Furniss, PhD
12:00 PM – 12:20 PM	Collaborative Care Model: Use Case	Touchstone Behavioral Health
12:20 PM – 12:55 PM	Discussion & Q&A	All
12:55 PM – 1:00 PM	Next Steps	Kailey Love

TIP Year 5

<u>QIC Attendance:</u>

- 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

<u>Continuing Education Units:</u>

- 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

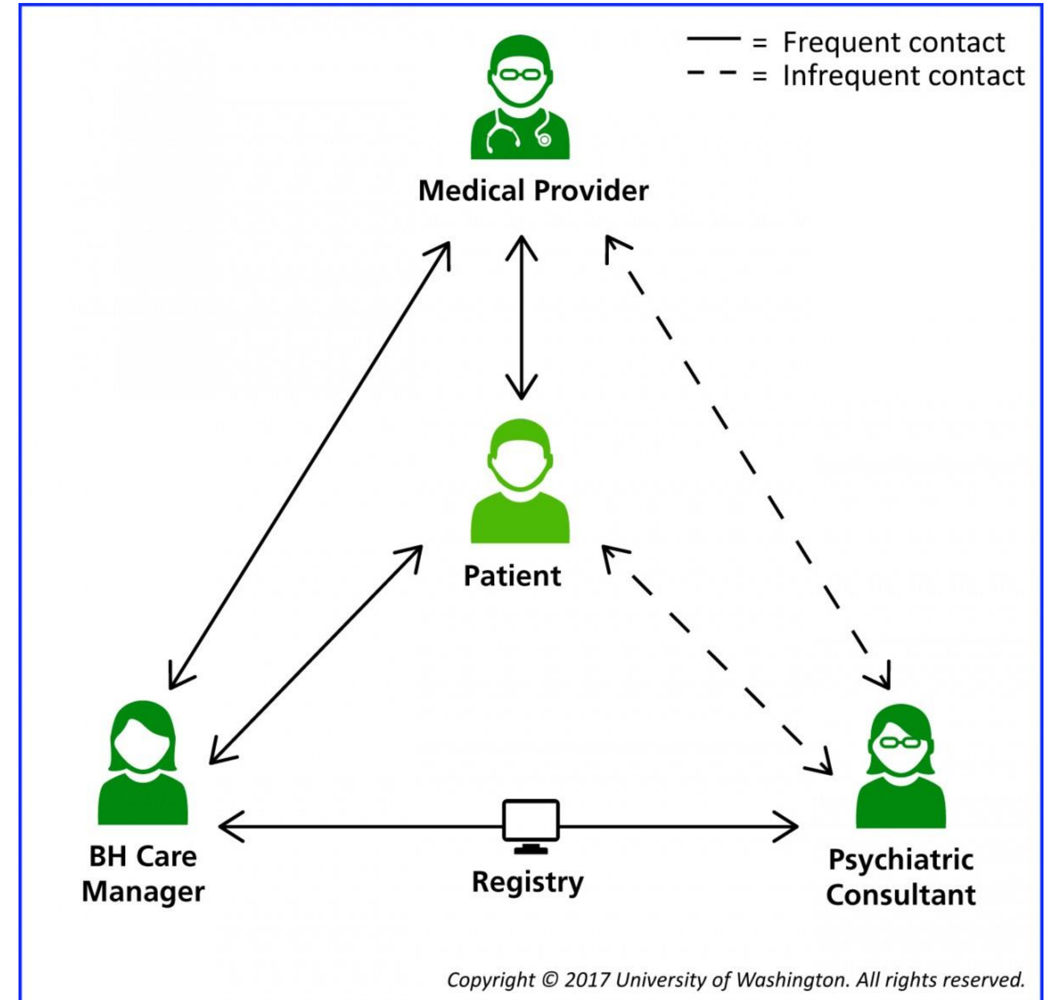
- 10% of patient visits are BH related
- Patients referred to BH often do not follow through
- Typically 30-60 days to see a psychiatric provider
- Collaborative Care Model (CoCM) reduces these barrier

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.

Touchstone Health Services

Natasha McClain, MHI
Population Health Administrator

Why Implement CoCM?

- Improve patient outcomes
- Measurement-based practice and treatment to target defined populations
- Improved efficiency and function within our healthcare system

When and How Did You Implement the CoCM?

- We haven’t fully implemented the process but are building the population health model around key concepts. Concepts are patient centeredness, front-line engagement, persistent focus, transparency and innovation.
  - Patient centeredness-focus on being the health home for all our members
  - Front-line Engagement-Ensuring our front-line staff share in our vision and feel empowered to aide in quality improvement for both staff and patients
  - Persistent Focus-remained focused on each project, detailed documentation, supportive of analytics
  - Transparency -Shared progress and open invitation for possible solutions
  - Innovation- focused on finding new and inventive ways to meet our patient needs. A willingness to think outside of the box

What were major difficulties you encountered during implementation of CoCM?

- Clinic systems and processes
  - Population health
  - Ideology and Culture
  - Patient-Centered Communication
- Organizational Structure
  - Providers
  - Competing priorities

How has CoCM improved integration of PC and BH?

- Provider and support staff education
- Reorganization of practice to meet our patient needs, (ICL (Integrated Care Liaison) role in connecting Primary and Behavioral Health)
- Defined plans and protocols in place
- Supportive information systems (work towards utilizing single EHR, collaboration with partnering org, assisting with outcome monitoring, care planning, reminders, and feedback

What are your expectations with the CoCM for staff and member outcomes?

- Professional engagement
  - Believe that this will be strengthen by the observation and communication of positive outcomes for the patients in treatment
- Regular face-to-face interaction
  - formal supervision between Care Managers and Providers. Important that these supervisions are focused on specific patients and outcomes
- Patient encounters
  - Standardized instruments for keeping track of progress, planning support, facilitating interventions when needed
- Real-Time Monitoring
  - Evaluation of consequences of new workflows and processes. (e.g., systematic monitoring of patient outcomes, feedback from patients, observation and supervision between Care Managers and Providers.

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!

UNIVERSITY OF WASHINGTON, PSYCHIATRY & BEHAVIORAL SCIENCES
DIVISION OF POPULATION HEALTH

IMPACT

AIMS CENTER
Advancing Integrated
Mental Health Solutions

WHO WE ARE
WHAT WE DO
COLLABORATIVE CARE
Search

EVIDENCE BASE
CORE PRINCIPLES
TEAM STRUCTURE
BUILDING THE BUSINESS CASE
FINANCING STRATEGIES
BEHAVIORAL INTERVENTIONS
STORIES
RESOURCE LIBRARY
CARE MANAGER ESSENTIALS
IMPLEMENTATION GUIDE

QUICK LINKS
RESOURCE LIBRARY
IMPLEMENTATION GUIDE
CARE MANAGER ESSENTIALS

COLLABORATIVE CARE

Behavioral health problems such as depression, anxiety, alcohol or substance abuse are among the most common and disabling health conditions worldwide, collectively robbing millions of their chance to lead healthy and productive lives. The good news is that there are effective treatments for most mental health conditions. The bad news is that most people in need don't receive effective care due to stigma, a shortage of mental health specialists, and lack of follow through.

Integrated care programs try to address this problem by providing both medical and mental health care in primary care and other clinical settings. Offering mental health treatments in primary care is convenient for patients, can reduce the stigma associated with treatment for mental disorders, builds on existing provider-patient relationships, and can help improve care for the millions of patients who have both medical and mental disorders. There is a wide range of integrated programs, some of which are based on evidence and some of which are not.

Collaborative care is a specific type of integrated care developed at the University of Washington that treats common mental health conditions such as depression and anxiety that require systematic follow-up due to their persistent nature. Based on principles of effective chronic illness care, collaborative care focuses on defined patient populations tracked in a registry, measurement-based practice and treatment to target. Trained primary care providers and embedded behavioral health professionals provide evidence-based medication or psychosocial treatments, supported by regular psychiatric case consultation and treatment adjustment for patients who are not improving as expected.

QUICK FACT

Only 50% of patients who receive a referral for specialty mental health care ever follow through with the referral. Among those who do, many do not have more than one visit.

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.

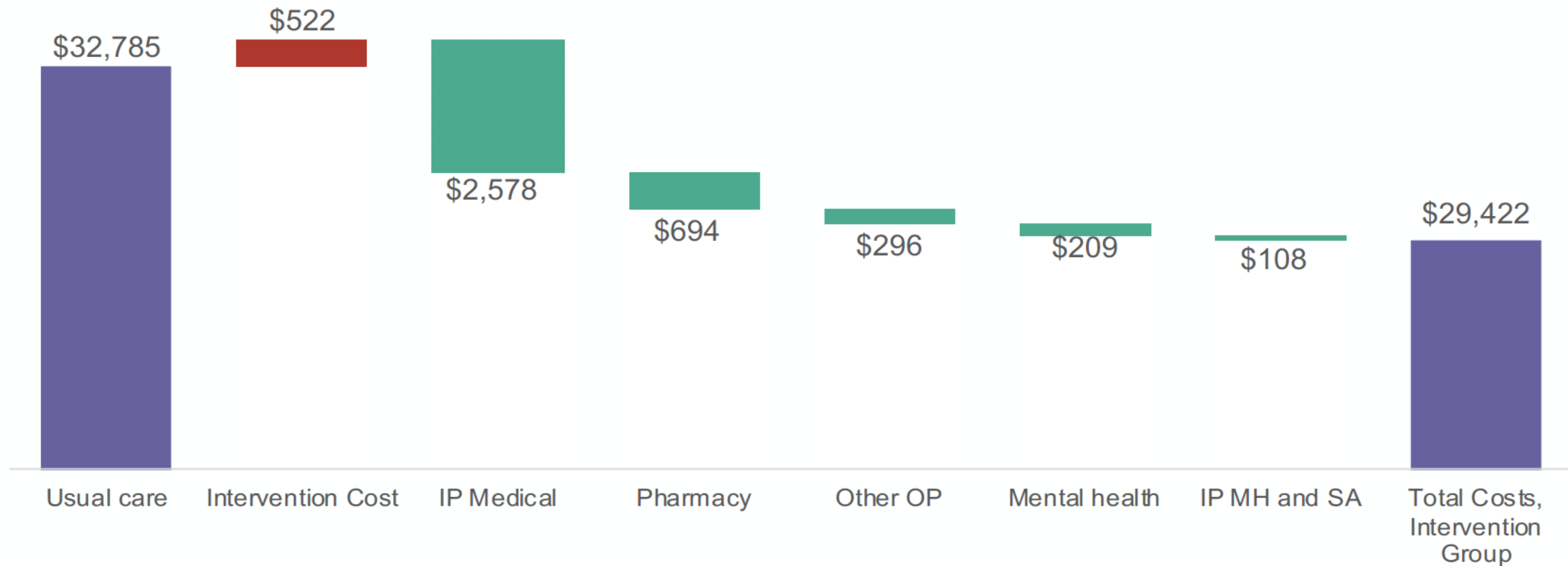
Typical Care Vs Collaborative Care

Typical Care	Collaborative Care
Little impact on physical health	Improvement in LDL, SBP and HbA1c (TEAMCare)
20% members receive BH care	>60% members receive BH care
Difficult to scale	Easy to scale with telehealth/remote services
19% efficacy PCP meds only	51% efficacy with CoCM
30-day average access to psychiatric services	Same day appointments/consults
Limited outcomes	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



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