AHCCCS Targeted Investments Program

Peds B Quality Improvement Collaborative

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TIP Year 5: Session #1
October 28, 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 Neil Robbins, PhD
12:00 PM – 12:20 PM	Collaborative Care Model: Use Case	Healing Hearts
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

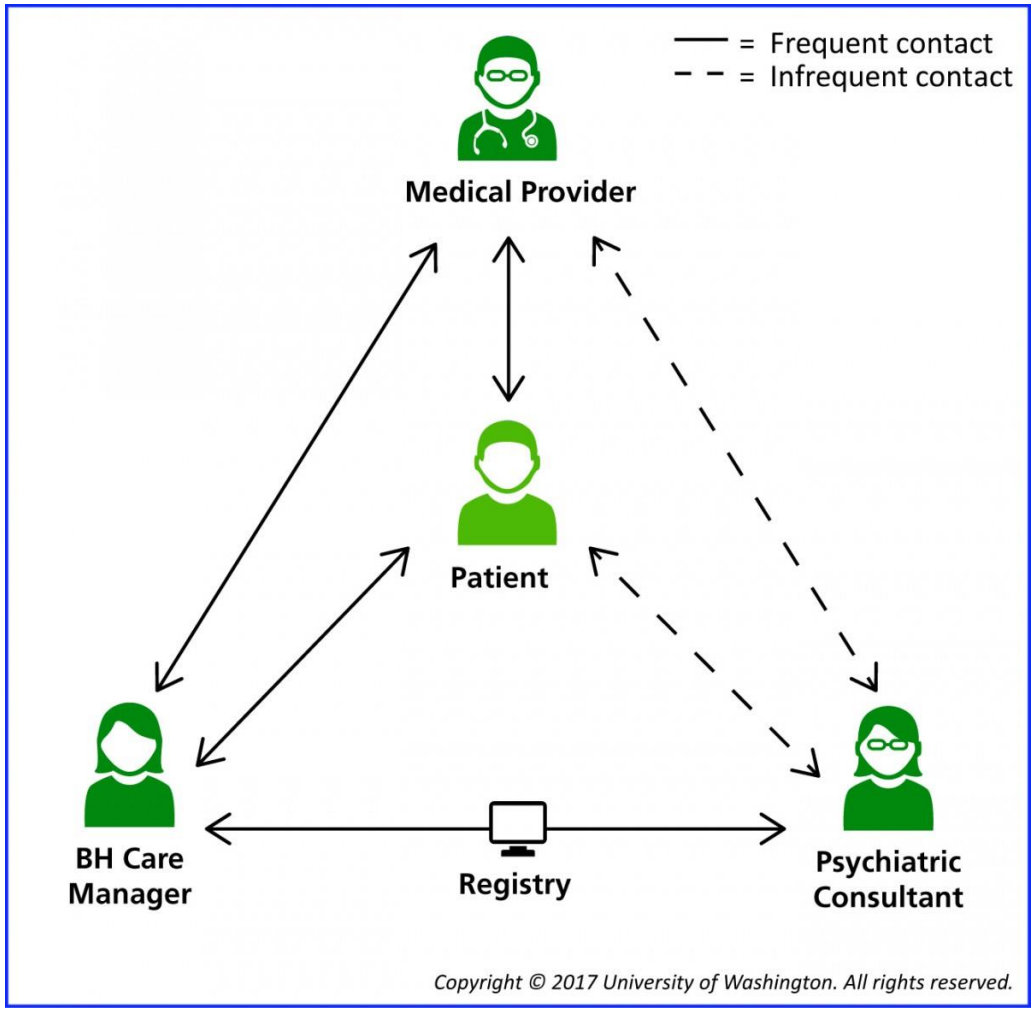
- 10% of patient visits are BH related
- Patients referred to BH often do not follow through
- Typically 30-60 days to see a psychiatric provider
- Collaborative Care Model (CoCM) reduces these barrier

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 at Healing Hearts Pediatrics

Elizabeth McKenna, MD

Collaborative Care Model

The Need

- Increased numbers of patients and parents with mental health conditions, such as anxiety, depression, behavior concerns, developmental concerns such as autism, and others, which have affected their growth and overall well being.

The Problem

- Difficult to refer patients to mental behavioral health professionals that take their insurance, are available at the times they need, and in a location that works for them.
- Oftentimes by the time an available professional is found the immediate need has past or the condition has exacerbated.

The Solution

- Hire a mental health professional that can be at our office and can be consulted and see the patient when they are in the office with the mental health problem.

Initial Implementation

The Beginning

- Cielo Mohapatra, with a Bachelor of Science in Clinical Psychology and Masters in Psychology with an Emphasis in Industrial and Organizational Psychology (MSIOP) joined us January 7, 2019. Cielo, in addition, is Spanish speaking, which helps our patient population which is approximately 35% Spanish speaking.

Initial Integration

- Initially, the intent was for Cielo to use her extraordinarily empathic and communicative skills to help all of our patients who were in need of in office counseling.
- However, with participation in and time and organization needed for the TI program, we had to limit her numbers of patients to our high risk AHCCS patients, which we deemed as those with depression and autism.

How We Started

- We have three offices with five physicians, two Nurse Practitioners, and two Physician assistants. Initially, we limited Cielo to see the patients of the two owners who had the highest numbers of high-risk patients, Dr. Khurana, with the majority of AHCCCS patients with autism, and Dr, McKenna, with the majority of AHCCCS patients with anxiety and depression.

Currently

- After the changing of the TI measures, and the organizing of behavioral health integration was completed, we opened up the availability of Cielo so that she is available to see patients of all providers and see patients with private insurance as well as AHCCCS patients.
- She is available at each of our locations on different days. If a provider has a patient that needs help, and Cielo is not at that office on that day, then a follow up visit is arranged in a short time frame for the patient to return to see that provider or another provider and Cielo on a day and particular office that she will be at.

CoCM at Healing Hearts

How has Collaborative Care helped our practice?

- Having Cielo, has fulfilled a need that our practice has had for many years; helping our patients who are having mental health problems, that we can support, but do not have the time or expertise to truly manage.
- Oftentimes, we have patients who look to us as their medical doctor to fix their medical problems and hesitate to go into fully what has been affecting them psychologically or in their lives.
- At times, this is because they are concerned there is not enough time in the visit, which is true, but other times it is because they see we have a relationship with the parent that has been built over years, and hesitate to disclose concerns because they do not want it discussed with the parent. Cielo is able to take the time needed to discuss problems with both the patient as well as the parent.
- Oftentimes, issues that she has discovered, and the seriousness of the patient's condition will lead us to start a medication, such as fluoxetine or sertraline ,when we might not have or might have waited.

Improved Experience for Members & Outcomes

How has Collaborative Care helped improve the experiences for our members and outcomes?

- When we have a patient who is going through a mental health crisis, Cielo is able to immediately talk with that patient, and identify what is going on and help them make a plan to alleviate their pain and difficult feelings . We have had suicidal, extremely anxious and depressed patients, and others who Cielo has been able to help open up about what is causing them distress and help them feel better.
- Cielo has a talent for listening and communicating in a safe way so that patients want to confide in her what is causing them pain, and often just by doing that, they are helped to feel better. Oftentimes, with the help of antidepressants that we prescribe at the same visit, a major mental health crisis is averted.
- Cielo is able to give many of our patient's handouts and resources of things that they can do at home to continue their healing. With an expertise in mindfulness, Cielo is also able to teach techniques that our patients can practice to alleviate symptoms of anxiety and depression.
- Cielo is also able to refer patients to community mental health professionals, counselors, psychologists, substance abuse specialists, and others, for ongoing therapy and help. She, with the help of our referral specialist can refer to mental and behavioral health professionals that are appropriate for the patient as well as take their insurance.

Difficulties

- Due to insurance constraints, and the requirement of Cielo to have additional certification training , Cielo is only able to see patients at the time of them being seen by the provider, not on her own. This is billed by the provider as psychiatric collaborative care and her title is care manager.
- In addition, because Cielo is at different offices on different days, there are times when a patient or parent is having an immediate need for mental health need, but Cielo is unavailable to help them at that particular time.
- Also, with the increased numbers of patients in need of counseling or resources, there may be days when multiple providers have patients that need her help at the same time, and Cielo is unable to see each patient at the same time. Sometimes patients and families are able to wait, but sometimes they are not.

Improved Integration

How has the Collaborative Care Model improved the integration of primary care and behavioral health?

- Adverse Childhood Experiences can adversely affect children affecting their mental health, and in the long run, their physical health.
- Having a Care Manager who is able to counsel and provide behavioral health resources to our patients when they are coming in for their well child check or sick office visit is crucial to us to be able to fulfill all the needs of our patients, both medical and mental. We can help our patients address issues when they happen and teach them valuable ways to be able to handle situations and their emotions, so that they in the long run will have a happier and healthier life.

Future of CoCM at HHP

- We will be having counselors from a community behavioral health organization collocate at two of our sites so that we can refer AHCCCS patients for therapy and help, even if we are not at the office . They will be able to see patients at times convenient for them, not just at the time of the medical visit. This will allow patients to receive help in a familiar location where patients feel safe and secure.
- Our intention in the future is to have a counselor who will be able to see our private insurance or self pay patients as well.

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

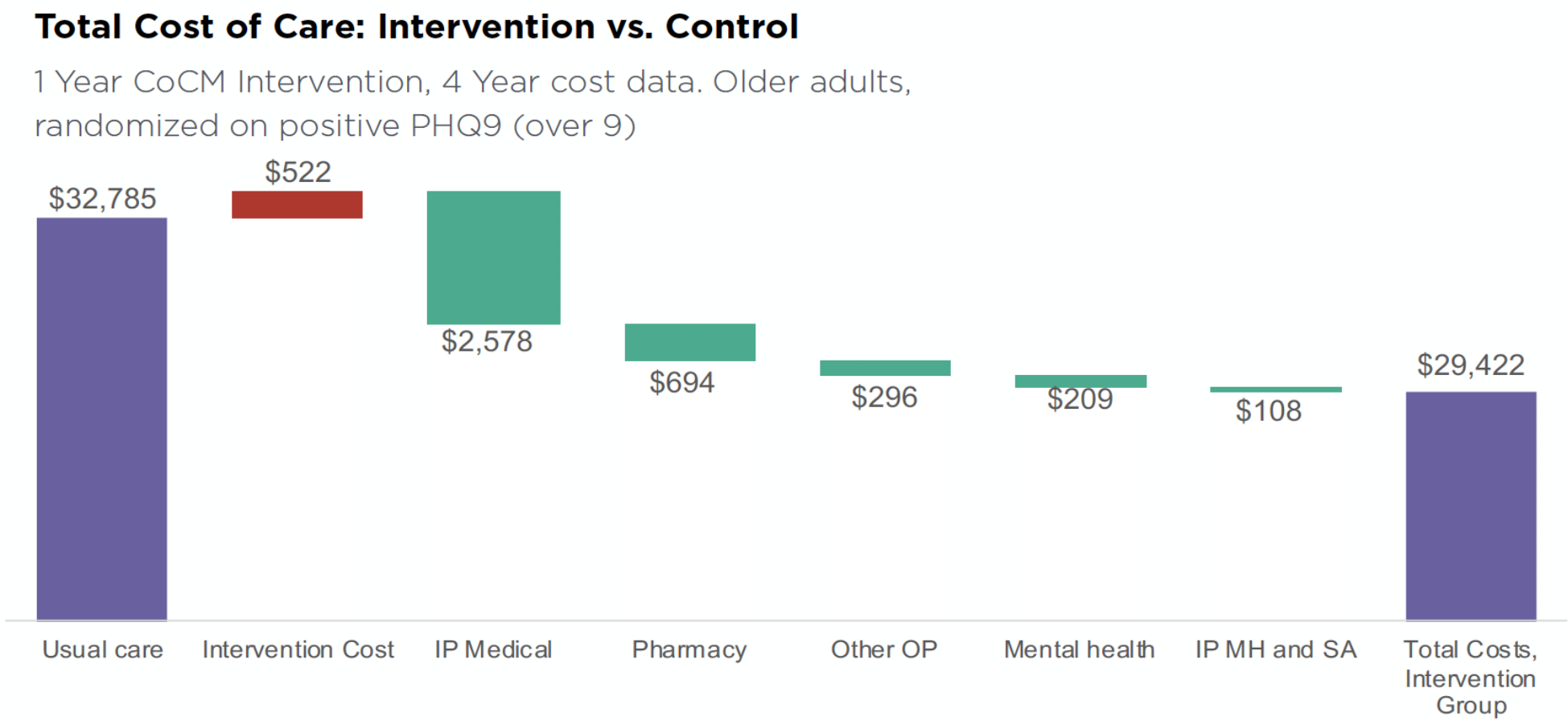
Collaborative Care

- 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



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