Hello, the time is now seven PM Eastern, the official start time for today's broadcast. The topic today is Providing and Financing New Evidence-based Behavioral Health Approaches in Primary Care. Now without further ado I would like to turn things over to your host Stacy Hull, behavioral task lead for Alliant Quality. Stacy, the floor is yours.

Thank you. Good evening everyone. I would like to thank you for participating in Alliant Quality’s learning and action network event tonight, and for your continued commitment to provide quality health care. Before we get started, I would like to remind you that in addition to the monthly Quickinars, Alliant is available to provide free personalized technical assistance to you and your staff. We can assist with training on process flow, motivational interviewing, and behavioral health resource coordination just to name a few. I invite you to take advantage of these services and reach out to us. I would like to remind you that the depression codes you see on the screen, as well as the alcohol screening codes on the next screen, are both Medicare reimbursable codes. We invite you to utilize these codes in your practice.

At this time, I would like to share some information about our speaker. Dr. Lori Raney is a board-certified psychiatrist and principal with Health Management Associates in Denver, Colorado. She is considered a leading authority on the collaborative care model, and a bi-directional integrational primary care and behavioral health. She is the editor of a book, Integrated Care: Working at the Interface of Primary Care and Behavioral Health. She is a master trainer for the American Psychiatric Association’s Transforming Clinical Practice Grants to train 3,500 psychiatrists in the collaborative care model. Dr. Raney served 15 years as the medical director of a community mental health center, where she fostered the development of a full range of evidence-based services. During her tenure, she led efforts to implement the collaborative care model in diverse primary care locations, tribal clinics, and school-based health centers. Please enjoy the expert advice of Dr. Lori Raney.

Thank you for the invitation to be here today. This is certainly a topic near and dear to my heart and there are new billing codes that came out for Medicare about two months ago and we are going to focus on the evidence base of integrated care and also new financial financing opportunities for that model. Just real quickly this should not be news to anyone on this call but there are some serious problems with patients getting to behavioral health providers. If you have 10 patients that have been diagnosed with behavioral health conditions, six of them receive no treatment. About, little more than two actually get their care from a primary care provider and a little less than two actually from a mental health provider. The 60% is a huge problem, lots of reasons why people don’t get care and in the primary care settings one of the issues is it is very difficult for primary care providers to provide adequate treatment much of that is because of training issues, so what we saw and actually the Wang study only about 20% of the care was considered to be minimally effective and again that is as much about training issues but also about measurement and being comfortable with the medications.

So when we start talking about Collaborative Care we start talking about integrating care and what we are really talking about is there is a sweet spot for this and treating mild to moderate mental illness as a primary care study and not necessarily about treating the most severe patients in terms of bipolar disorders or schizophrenia or (inaudible) disorder. The sweet spot for this model for doing this work is actually in the treatment of mild to moderate mental illness and one of the things it can do if we do it successfully is really keep people from moving along this triangle and their illness actually getting worse because it has gone untreated.
So let us talk a little bit about what the Collaborative Care model is and why it may differ other models of integrating care that you might be used to. A lot of things are called integrated care - having a psychiatrist come share an office in the clinic, having a social worker come to a co-located psychotherapy, having a psychologist kind of be there and available, go in and out of exam rooms and kind of address anything that is going on. Collaborative Care is much more specific than that and has a very robust evidence base because it adds two things that you do not tend to see. One is there is a concept of measurement-based care and you treat the target just like you would diabetes or anything else. You really go for a specific target and I will show you in a minute and it’s population-based care. When you do population-based care you really do have to track who your patients are and you have to have a data tool like a registry in order to be able to really be accountable. If you do all these things you could be accountable to your Medicare ACO and other payers and let me show you how that goes.

On the Collaborative Care team what you do is you add two new people, the behavioral health provider and a care manager. These are the same person in the field you'll hear people talk about BHPs, you will hear people talk about the care management role. I guess at some point I will just call them behavioral care manager so I can blend the two words. But you are adding this person who tends to be a psychologist, social worker, a licensed professional counselor and you are adding that person to the team and then you are also adding a consulting psychiatric provider who can be a psychiatrist, psychiatric nurse practitioner or psychiatric physician’s assistant; those of the three categories you will see later that are important to the code, so that is what we are adding to the traditional PCP MA nursing patient sort of triad. There can be other behavioral health folks in the clinic, alcohol and substance use counselors, other folks, but the key folks here are the addition of this behavioral health person and the consulting psychiatric provider.

What it looks like in the clinic now is we really work hard to get patients activated around their illness but you can see in this slide the gal in red is a social worker, she is right there at the elbow of the PCP if possible although some of this is now being done electronically through tablets and telemedicine. They are able to talk about the patients you see in the background, really right there to start the behavioral health treatment for the patient and then behind that is an enormous amount of practice support. Using this measurement-based treatment to target we’re going to talk about the PHQ-9 in a minute readily available psychiatric consultation, that’s me and my cell phone if a PCP calls I answer the phone and help them out. Using the registry there is an example of the registry and then providing training. The evidence base for this model is incredibly robust. There are over 80 randomized controlled trials now. This original study was an older adult and there is now the full range of age ranges including children and we have ADHD studies, adolescent depression studies, we have depression, we have got anxiety, we have studies in payer populations, Medicare populations, rural areas, urban areas, safety net clinics, African-Americans, Latina patients, Asian patients. There is just an incredibly robust evidence base and the other thing we have in this model is an ROI return on investment and the original impact study four years down the road the return on investment was about six dollars for every dollar spent. Now remember that is a robust study with lots of money. So I would not expect necessarily that ROI but certainly an opportunity to do a pretty well with this model.

The whole process starts with validated screen and measurement tools. You heard Dr. Mims talk about reimbursement around depression screening certainly something very much encouraged in primary care. This is the PHQ-9, the most used now in both research and in primary care, and it is literally the nine (inaudible) symptoms of depression rated from not at all to really happening most days. The cut off point for let’s do something now about this is a score of 10 or above and that is considered moderate depression between five and nine we are calling that kind of a mild depression just some watchful
waiting, and certainly 15 and above we have got moderate to severe depression. Less than five is considered remission so when I was talking earlier about treat the target for psychiatrists, for all of us the Holy Grail in behavioral health is really remission of symptoms if we can get there. Certainly in depression and anxiety, so I am always pushing and trying to get the PHQ-9 score below five, and that is extremely important for this model and what we are trying to do. In this particular patient you can see has a PHQ-9 of 15 and that means we will get activated, get that person into this model and begin to move. One of the most important people in this model is definitely the primary care provider whose job is to engage the patient and pitch the project, the program, the care to the patient and how they do that is extremely important and we have scripts for PCPs to help them because if they start off with this is a behavioral health condition I think you need to see a therapist I will refer you down the hall, you can certainly get resistance from the patients.

When they connect with this behavioral care manager there are some very specific things that need to be done in order to reach the evidence-based in order to reach these outcomes in the ROI. The first is these behavioral health folks are doing evidence-based brief interventions proven to work in primary care and most of us are familiar with motivational interviewing but there are things like behavioral activation, problem-solving therapy, solution focused brief therapy using teaching patients deep breathing as a distress tolerant skills that are very effective. The other thing that is really core in this model is this frequent persistent follow-up so what this little study right here shows is that patients get two or more contacts from this behavioral health person in a month, dramatic, dramatic in terms of quickness to respond and how well they do overall. So this is actually something that is now crucial to the model and this Bao study really helped show us that this needs to happen.

Some forms of integrated care, this does not happen and hence we don't really get to see the evidence base. What is also happening at these frequent persistent follow-ups, is multiple times repeating PHQ-9 or the GAD-7 if this is an anxiety disorder, so we are not doing this as much as once a week, once every two weeks now and then doing the PHQ-9. This is not once a year, it’s not twice a year, it’s every single visit, every single contact repeating the PHQ-9, which is very valid for this purpose.

The next thing that the behavioral care manager is doing is placing this data in a tracking tool called a registry and this is a free registry, you can download from the aims website and you can see both the PHQ-9 and the GAD-7 here and you can see the initial scores of 22, 18, 14 in the column on the left. You can see the last available score patients are either getting better or they are not and then the percent drops. A clinically significant reduction in PHQ-9 in particular, and GAD-7 is a 50% or more reduction in symptoms and as I mentioned earlier remission is a PHQ-9 less than five and you can see the patient at the bottom has a PHQ-9 of two they are now in remission. You can also see the person before that kind of fell through the cracks, and there is no score and something’s happened and if we are going to be accountable for the population, maybe that group in your ACO, you need to have a way to track that person. A psychiatric consultant is doing two things. They’re doing curbside consultations, answering the phone when you call and they are doing a weekly caseload review where they sit down and they go through this registry and really just focusing on the patients who are not getting better and making recommendations.

Now there are specific performance measures that you can be held accountable for in your clinic. We are seeing a lot of this now in Medicaid ACO’s, depression remission at six and 12 months are now a standard quality measure. But as I mentioned before that 50% reduction in PHQ-9 is considered a clinically significant response. That’s a NQF, also National Quality Forum, quality measure but the
percent reaching remission has really, is becoming a bit of a gold standard and remission is tough with depression. It is difficult disorder to treat so we have to be careful.

There's also very specific process measures, repeating of the PHQ-9, having the registry, the weekly caseload review, the two contacts or more by this care manager; these are all process measures that we are now learning absolutely lead to the robust evidence-based and performance that we have with this model. You can also do patient satisfaction, and what we are seeing with PCPs is pretty incredible provider satisfaction. Also functional measures, and of course, cost and utilization. The cultures of primary care and behavioral health are quite different so we have to have some strategy, some things that we can do to overcome some of these cultural differences. There is a really nice study that shows what does it really take to make this model work? And specific things are really that strong PCP champion, at least one PCP in the clinic who is very excited about this model, really willing to do things differently but also an engaged psychiatric provider. If this person is working with the clinic, reviewing that registry, really working and doing support for that clinic, we really see really robust outcomes.

So there is sort of the process measures, the key, sort of core principles that we talked about, measurement-based care and population-based care but then there are these process of care tasks that two or more contacts a month, tracking repeatedly measuring and then this review.

And then the last thing that I went over was these intangible factors I guess we could say. The strong leadership support, that PCP champion. The role of the care manager. You don’t have them off doing social work. They are not off doing transportation and housing and those sorts of things, they are really engaged in those behavioral strategies and just really knowing that you have that buy-in and those things are difficult to get. You really have to have people within your clinic who understand these barriers, who understand the potential pitfalls and what might happen and really have a mechanism to work around and real people skills, real excitement to help make this work so if you put all of these things together that I have been talking about, this is kind of a summary slide where I bring together the core principles, those process of care tasks and as I call it sometimes squishy stuff in between, the people part of this.

This is kind of your recipe for success in an integrated care model. Now let us go a little bit to financing because this is kind of the bugaboo of integrated care, has been for years. There is a lot of stuff that goes on that is not billable. These brief interventions, sometimes they are too brief to bill, and if the patient does not have a diagnosis, maybe huddled in the morning, the hallway conversations that you saw going on between social worker and the primary care provider, kind of that warm handoff. Call in the psychiatric provider and getting some recommendation on what to do, calling patients, repeating these rating scales on the phone. Now you heard earlier there is some depression screening that can be paid for if you are into this 15 minutes of screening but this is more repeating these measurement scales over and over again often on the phone, having team meetings where you are bringing primary care and behavioral health together and you sit down and maybe talking about complex patients, maybe just talking about your model and what is working and what does not. And all that time the care manager spends with the registry and the registry is practically their organizing document of the day; it tells them who to call, who to follow up with and who needs to be talked about with the psychiatrist and who needs any additional follow-up. So these tend to be the things that cannot be coded, cannot be billed, so we say in the field what works, cannot be coded. Many of these are those core principles and those core tasks that I just talked about.
What has happened recently and again this is sort of what we are very excited about, is beginning January first, CMS came out with new -- and you can see these are cheat codes for right now. These will be 99 permanent codes, CPT codes effective January 1, 2018. That is because CMS updates the physician B schedule every two years.

CMS is so interested in this model, getting picked up. Remember most CPT codes start with Medicare, so Medicare is where you can bill these right now. They were so interested and excited about getting this on the street and they came up with codes that can actually be billed effective January 1 of this year.

And so let me just kind of go through these codes. What I want you to notice is these codes go right down the evidence-base, the previous 20 slides that I showed, these are the tasks that you must do on a monthly basis to bill these codes. This code is billed once a month by the primary care provider. The primary care provider then uses the resources from this code to hire this behavioral care manager and to hire for the psychiatric time. So the code is billed by the PCP not by the psychiatrist, not by the social worker, it is billed by the PCP. In the first month the G0502, this is up to 70 minutes of a time spent working with the patient so a little higher than the G0503 which is subsequent months. Where there is about 60 minutes, maximum of 60 minutes, considered for this code. Now as you guys know with Medicare when you get halfway there you can actually go ahead and bill the code.

So in the first month if it is thirty-six minutes, the second month if it’s 31 minutes of work by this care manager and psychiatrist, then the PCP can go ahead and bill the code the minute they hit that. There are some specifics around this, we don’t have time to discuss right now but a couple of things have to be an initiating visit by that PCP and at least verbal consent that is documented in the chart not so much signed consent. And the patients do have their standard Medicare co-pay of 20% unless they have some kind of Medigap insurance so that is just kind of a starter of some of the background stuff. But look at what is required. Outreach and engagement by this behavioral health provider, remember those two contacts a month that I talked about earlier? Initial assessment and then continuing the use of these validated rating scales that you must have a registry and you must track the patient progress, once a week typically, you sit down with the psychiatric consultant and review those patients who are not getting better and then doing these brief interventions I talked about earlier.

That is what is expected of the team. In order for you to be able to bill these codes. And you have to meet the minute requirements. There is an extra code, G0504 if you spend an extra 20 minutes or more with patient during that month let’s say the patient was suicidal or something of that nature and more time is needed, you can actually bill an additional $66 under this code. We are very excited about these codes. Very watchful about clinics that are beginning to implement them and helping people overcome any barriers in terms of this implementation.

Okay, that kind of wraps that up and I would love to entertain questions or comments.

Before we get started with some additional questions, I have one, if you don’t mind Dr. Raney. I am thinking I am a primary care clinician, and smaller rural town, I’m assuming that the collaborative psychiatrist does not need to be located nearby, but are there some parameters on who can fulfill that role as the collaborating psychiatrist? Do I have to have a contract with them? Do I have -- do they have to be within my state? And how would I go about finding them?

Yes, so there are -- they do not have to be on site. Most of these are remote. If you look at Washington state almost all the psychiatrists are in Seattle and beaming out to 200 to 300 primary care clinics across,
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especially very rural, Eastern Washington. They can be a psychiatrist, psychiatric nurse practitioner or psychiatric PA. They cannot be a prescribing psychologist. They cannot be just a standard psychologist. It has to be someone who can prescribe medication. What the PCP does is contract with the psychiatrist, usually 1.5 -2 hours per care manager with the full caseload. Full caseload tends to be 60-80 patients on that registry. So that kind of helps you think about what might that cost be in terms of that psychiatrist.

And then the APA like you mentioned earlier, training 3,500 psychiatrists to do this work in their all -- after they do the training they are very eager in your state to find training sites. We now have lists of psychiatrists all over the country who have been trained to do this. We are also looking at what it would be like for the psychiatrist to do these registry reviews across state lines. A little bit of a grey area legally but sometimes considered peer to peer consultation. Which is usually allowed in most states. That is a little bit of a grey area for us right now.

So I would contact the national association to find someone locally? For you to work with?

Yes, and I can help you guys look at that. The American Psychiatric Association has that list. They also have a great training for PCPs, two modules on their APA website. American Psychiatric Association website. I could help direct you guys do that because I'm one of the master trainers and I am sure I have trained people in your states already.

Thank you, very much.

Dr. Raney, we have a question submitted by chat. Thank you for the presentation. How are these new codes being promoted or disseminated to providers, and how can we help get the word out?

Yes, they are so new. What we are finding is a lot of primary care providers do not know about them. I've been working in Colorado in their regional Medicare organization that covers multiple Western states and they said it just takes time. They are waiting for additional guidance from CMS which came out last week, the APA is promoting it, we're trying to get AAFP and other organizations to promote it. But it takes some time and typically these more regional Medicare organizations are responsible for training and notification of all the new codes. I don't know who does that in your area but everything from knee replacements on, there lots of new codes that come out and your regional Medicare organizations are responsible for disseminating those codes. But I would say any chance you get, any website, any newsletter whatever it is, let us get the word out there.

Thank you. I will turn it over now to Stacy Hull.

Dr. Ciechanowski will present on integrating care for the whole person, collaborative teams for behavioral health and medical conditions. Thank you again for joining us and if we can be of assistance, please reach out. Have a great night.