

TRANSCRIPT OF AUDIO FILE:

MEDICAL MONITORING IN BEHAVIORAL HEALTH - THE ROLE OF THE PSYCHIATRIC MEDICAL TEAM - 6-30-15

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BEGIN TRANSCRIPT:

MODERATOR, SARAH STEVERMAN: Good afternoon, everyone, and welcome to the SAMHSA-HRSA Center for Integrated Health Solutions Webinar, "Medical Monitoring in the CMHC: The Role of the Psychiatric Medical Team." My name is Sarah Steverman, a Consultant at the SAMHSA-HRSA Center for Integrated Health Solutions at the National Council for Behavioral Health, and your moderator for today's webinar.

As you may know, the SAMHSA-HRSA CIHS promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance abuse conditions, whether they are seen in specialty behavioral health or primary care provider setting. In addition to national webinars designed to help providers integrate care, the Center is continually hosting practical tools and resources through CIHS websites, providing direct phone consultation to providers and stakeholder groups, and directly working with SAMHSA, primary, and behavioral healthcare integration, grantees, and HRSA-funded health centers. [00:01:18]

Today we are pleased to be hosting this webinar in partnership with the American Psychiatric Association. Thanks to the APA for their collaboration and planning this event, and welcome to APA members participating today. Thank you for joining us.

Before I introduce your speakers for today's webinar, I have a few household, housekeeping items. Today's webinar is being recorded and all participants will be kept in listen-only mode. You can only listen through your computer, so I hope that you all are on, and your speakers are on. Questions may be submitted throughout the webinar by typing your questions in the box on the right-hand side of your screen. That will send it to us speakers and organizers. I encourage you to submit your questions, if you have them, and we'll answer as many questions as time allows. If at any point during the webinar you experience technical difficulties, please call Tech Support at 888-204-5477. [00:02:21]

(pause) The webinar slides are currently posted online at www.integration.samhsa.gov under the webinar section. Lastly, at the end of the webinar, please take a moment to provide your feedback by completing a short survey.

On today's webinar, our speakers will be presenting about how psychiatric providers can effectively monitor for medical conditions. You will learn about the problem of chronic conditions for individuals with mental health and substance use conditions, what providers can be doing to address it, and organizational considerations to implement medical monitoring processes in your center. [00:03:12]

To begin, before I introduce our speakers, we have a poll question that we want to pose to the participants. In your CMHC or primary and behavioral health integrated practice, do you have a structure in place to obtain vital signs BEFORE a client is seen by the psychiatric provider? Your options are: 1) Yes; 2) Yes, but it doesn't always happen; 3) No, we don't have a process; 4) I don't know, I'm not sure if we have a process; 5) Or if you're not affiliated with a provider, you can check that box there. Rose (ph), if you can launch the poll, we'll give you all a few moments to answer this question.

[pause 00:03:55 to 00:04:20)

All right. It looks like... many of you, 33%, have a process; about 17% of you have a process, but it doesn't always happen; 15.6% of you do not have a process; and 10% of you aren't quite sure. Looks like about 26% of you are not with a specific provider organization. That's good information for our speakers to have as we move forward on the event.

Speaking of our speakers, I want to introduce them now. First off, we have Dr. Benjamin G. Druss. He is the first Rosalynn Carter Chair in Mental Health at Emory University. Dr. Druss is working to build linkages between mental health, general medical health, and public health. He works closely with the Carter Center Mental Health Program, where he is a member of the Mental Health Task Force and the Journalism Advisory Board. At Emory, he directs the Center for Behavioral Health Policy Studies at the Rollins School of Health Policy and Management. [00:05:31]

We also have with us Dr. Lori Raney. She is the Chair of APA's Workgroup on Integrated Care. She is going to be beginning a position of a principle at Health Management Associates in Denver, Colorado shortly, having just served for 15 years as Medical Director of Axis Health System, implementing the collaborative care model in diverse primary care locations, including an FQHC, rural health centers, tribal clinics, and school-based health centers. She is also a private consultant with Collaborative Care Consulting.

Lastly, certainly not least, we have Bob Krumwied. He is the President/CEO of the Regional Mental Health Center, overseeing two locations in the Calumet region of Indiana, the South Lakes Center for Mental Health, and the Tri-City Mental Health Center, which merged under his leadership in 2009. Prior to moving to the Calumet region of Indiana, Bob was with the Indiana Department of Mental Health, and he holds a Masters of Health Administration from the Indiana School of Medicine. [00:06:34]

We're really thankful to have all three of you speakers with us today, and I'm going to start off by introducing Dr. Druss, who is going to lay the landscape of what we know. Then we'll move on to Dr. Raney to discuss some more on-the-ground clinical and administrative processes that you can put in place in your own CMHC. So, Dr. Druss, I'm going to turn it over to you.

DR. BENJAMIN DRUSS: Thanks so much, Sarah. I was excited to hear that there are something like a thousand of you who are out there today, attending the webinar. You know, that really reflects something so important in our field, about how this issue of the health status of populations treated in mental health safety-net settings, as well as people with mental diagnoses who are treated in general health safety-net settings, how that's just become so compelling to the field, and how many people now are really engaged in this effort to address this huge public health problem. [00:07:55]

So what I'm going to do is just start off by framing the issues for Lori and Bob, who are then going to kind of get into some of the practicalities of how to actually do this. To start, I want to have you look at this slide. This is from a recent meta-analysis (ph) that looked at the problem of excess mortality in populations with mental illnesses. What this study found was what the field has known for a long time, but has just become kind of clearer and clearer, which is, there is a two-fold elevated chance of mortality. Having a mental illness is associated with doubling the risk of mortality, of ten years of potential life lost, just having a mental illness. Then, something closer to 20 or 25 years for people with mental illnesses treated in the public mental health sector. [00:09:03]

If you add up that burden across the prevalence of mental illness across the world, you find that mental illness is responsible for something like 14% of all of the deaths seen worldwide. So it's just a huge public health burden, with a lot of the problem, at a population level, being medical illness, particularly cardiovascular disease. That's what you'll be hearing a lot about today, but also conditions like cancer (and of course, screening for cancer is very important as well), diabetes, and other medical problems.

So, what I next want to show you is a slide presenting some results from a recent, very large study that was done in the U.K. about cardiovascular risk in serious mental illness. The first thing that is interesting about the study (it's called the Primrose Study), is that it actually found that predicting cardiovascular risk in the populations that we serve is a little bit different from predicting it in general medical populations. There are specific issues you have to be thinking about, over and above the typical risk factors. [00:10:28]

So one of the things I'm going to be talking about today, and you're going to be hearing about, is antipsychotic use. This is, of course, something that's very important to the field, and here, I just want you to note that actually, there are risks across all antipsychotics, including both first and second generation. Second, of course, smoking is a huge burden. Lori is going to be talking a little bit about that more. Probably the single biggest contributor to excess mortality in the populations that we treat. There are extraordinarily high levels of smoking, as anyone who has worked in community mental health knows, something like 70% of populations with serious mental health, treated in public sector settings smoke.

Then there is this issue, which we really can't forget about in our population, which is social deprivation. People with serious mental illness, in general, of course people treated in safety-net settings, in particular, are poor. This is, you know, as you're thinking as clinicians about what you can do, you have to keep in mind people's social circumstances: the fact that they may, it may be harder for them to engage in healthier lifestyles, to get good access to medical care, to, you know, get access to healthy food and exercise. So these are some of the factors that are important for us to be thinking about, and they are some of the ones that you'll be hearing more about during the course of the different speakers today. [00:12:07]

So, what I want to talk about then is what, at kind of a high-level, what you, as clinicians, as health administrators, as leaders in community mental health need to be thinking about. The first issue, which I just alluded to before, is the fact that we do need to be taking a look at the treatments that we provide and try to minimize the harm that we're doing. Of course as, you know, the treatments, like antipsychotic medications, are very important at reducing the morbidity on the mental health side for serious mental illnesses, but they also come with adverse side effects. (pause) I am looking, I just see... I'm hoping that you guys can see the slides. I'm seeing some questions about the slides. So feel free to send me something, if there is anything that I need to be doing. [00:13:10]

In any case, there is a very good literature showing that it's possible to switch from higher-risk antipsychotic medications to lower-risk antipsychotic medications. In particular, there is a very good literature looking at switching from Olanzapine, which is one of the worst offenders in terms of weight gain, to medications like Aripiprazole and Ziprasidone. (pause) All right. So, that's sort of the first thing, is we need to be looking at what we're doing, try to minimize the harm of the treatments that we're providing.

Screening, right. So, this is the focus of today's talk. Screening is necessary, but of course, not sufficient. But it's the first step in being able to think about providing good quality care and interventions to reduce the medical burden in this population. So, it's been about ten years since the American Psychiatric Association and the American Diabetes Association jointly published guidelines on screening recommendations for patients with serious mental illness. These have been updated and are now actually increasingly becoming the standards of care. [00:14:39]

These are some new standards developed by the National Committee for Quality Assurance that are also, have been put forth by the National Quality Forum, and give you some of the kind of examples of what we're talking about with screening. In particular, these are measures that are going to, the managed care plans are going to be judged on and Medicaid plans held accountable to.

So, for instance, cardiovascular health screening for people with schizophrenia or bipolar disorder on antipsychotic medications, and here cardiovascular health screening means serum cholesterol. So people with serious mental illness on antipsychotic medications should, at the very minimum, have cholesterols drawn. You'll be hearing about, you know, more detailed other recommendations and what they should be getting as well. [00:15:44]

They should also be having diabetes screening, and that means glucose or hemoglobin A1C. Then for people who have schizophrenia and established cardiovascular disease, they should also be having cardiovascular monitoring. So they should be having serum cholesterols, as well as other kinds of basic screenings like BMI. Then they should also be having, people with diabetes and schizophrenia should be having their hemoglobin A1C monitored regularly.

So these are new standards, they are things that are likely already, you're already seeing within your organizations, but that increasingly implant in larger groups, like accountable care organizations, where plans are being judged by quality, you're going to see them being judged by the quality of their screening and monitoring of medical problems in this population. [00:16:50]

So as I mentioned, you know, screening is the first step, but it's not enough for people who are at elevated risk, which is pretty much all of the patients that we serve. We should be thinking about trying to get them more engaged in their care, more activated as patients, both around things like physical activity and also diet. One strategy that works very well for this is goal setting. It's called "Action Planning," and it involves helping patients to set goals, short-term goals, that are reasonable, behavior-specific, and very specific, and that they believe that they can achieve. It should be something that they can achieve in the next week. Then, if they have a confidence level that they're going to be able to achieve it, and when they do achieve it, then you set a next goal. So these are sort of basic strategies for changing health behaviors like diet and physical activity. [00:18:05]

So, beyond counseling, there is an increasing amount of work that is being done around what are the sorts and scope of medical services that should be provided, either by mental health providers or in specialty mental health settings. Many of you are already practicing in integrated care settings. This may mean that you have a mid-level provider who is working there, who is providing basic, you know, prescribing primary care needs. Some of you may be mental health providers, either psychiatrists who may even be prescribing medications like Metformin for common medical conditions, or you may be part of care plans that are providing that treatment.

So this is something that we need to be increasingly, as mental health providers, increasingly literate in. At the very minimum, we need to understand different medical problems, medications, and increasingly, we're going to be involved in making sure that the patients get what they need. [00:19:24]

So finally, I want to briefly talk about the issue of leadership. This is a very important space now in public mental health settings, where psychiatrists are increasingly taking leadership roles as medical directors in trying to drive this process forward, of getting patients screened, and getting them the medical care that they need. But it's not only psychiatrists. We're going to be hearing about other community mental health settings, and this is something that, at the highest levels, we really need to be thinking about, really driving these systems changes that we're seeing in community mental health settings.

So here, finally, I'm just outlining some of the things that I think that every psychiatrist, really any public mental health provider, is going to need to be thinking about. We're going to need to

be able to think in terms of populations. A lot of what's happened over the last five years with the Affordable Care Act is shifting towards, from kind of thinking about problems one patient at a time to looking across whole populations. We're going to need to use data as part of that process to improve practice. So we're going to be hearing about using registries, keeping track of patients metabolic problems, their, you know say, hemoglobin A1C's, and really targeting treatment to the people who aren't getting better, changing things when they're not reaching their target goals. [00:21:15]

As I mentioned, we need, at a minimum, to be, to have literacy in mental health issues. We have to know what an abnormal lab value looks like, we have to know the most common, basic medications and common medical problems, so that we can at least participate in the whole care plans of our patients. Finally, we need to understand that what patients care about, at the end of the day, is their level of functioning. That includes not only thinking about their medical and mental health symptoms, but thinking about where those symptoms are fitting in their broader lives. I think that's something that is going to be, as we think towards next visions of integration, we're really going to need to be thinking about these broader circles of how we can help patients to improve their functioning and move towards recovery. So those are my comments, and I'll hand it over to Lori Raney, then. Thank you. [00:22:25]

DR. LORI RANEY: Thank you, Ben, for laying that framework. I'm pleased to see there is a pretty good group out there that's already starting the metabolic monitoring process. I think this is extremely important in being a 21st Century community mental health center. For those of you that are interested in certified community behavioral health centers, and being a center of excellence, and in doing integrated care, it's going to be really important that you develop these workflows and processes to make sure that you are taking care of the medical needs of the SMI population in particular.

My story sort of starts with working on the Navajo Indian reservation back in the 90s, and working with some of the older medications that were around at the time. When I came to Durango, Colorado to begin working at a community mental health center, I had access to, our patients had access to a plethora of drugs that had come out in the 90s, including Olanzapine and Quetiapine and Risperidone, and a lot of the medications that have been associated with some of the metabolic side effects. [00:23:43]

One of the first things that we did in our center was... I sort of noticed my patients were gaining weight and got, I went down to Wal-Mart, bought a scale, brought it in the office, everyone thought it was kind of strange to have it there in 2001, 2002 when I went to purchase it. From there, over time, over the last 15 years, we've really developed a monitoring program that I want to share with you, sort of show you where we've come, over time.

So in the community mental health center that I work in, we've sort of developed a Standards of Care, based on national guidelines, and just based on what made common sense as physicians. The first is that all patients, all visits; we're really focused on cardiovascular risk, as Dr. Druss mentioned earlier. That is a major driver of mortality in these patients, followed by infectious diseases, cancers, those sorts of things. But we were really focused on that. I like to use the mnemonic CHODS—Cholesterol, Hypertension, Obesity, Diabetes, Smoking. It's kind of my

way of remembering the five risk factors for cardiovascular disease, and then thinking about how we work that into the monitoring of our patients. [00:25:02]

So happens when you walk into our community mental health center is, we have a team ready to gather certain parameters. So all patients, all visits; everyone gets a BMI, which is a Body Mass Index. They have their blood pressure taken, and they fill out a Review of Systems. I'll show you that form in just a minute. That's everybody that comes in.

With patients that are on specific medications; you'll hear us medical folks talking about SGA's, which are Second Generation Antipsychotics. Dr. Druss just mentioned a few of those. But there are also some other medicines, like Lithium and Depakote and Tegretol. For each of these medications, we are getting baseline and annual labs, in addition to the BMI and the blood pressure for these patients.

For all patients, with serious mental illness, we're really focusing on making sure they have an annual physical exam, or at least some contact with primary care. I'm going to show you how some of those standards are now being required in Colorado. Then we have quite the focus on Tobacco Cessation, or Nicotine Cessation at this point. As Dr. Druss mentioned in his slide from the Primrose Study, regardless of what's happened with medications, new medications, things that have happened on the market, at the end of the day, tobacco takes a decade of life. [00:26:28]

So in your center, if there is a particular project, a particular quality improvement project you want to think about, a tobacco cessation should clearly be at the top of your list. We actually have nicotine replacement therapy available on-site and free to patients, and purchase it and have protocols. I'll show you a little bit more about that in a few minutes. So these are sort of the standards that we set up.

Now there is more that we could do, and I know that there is going to be an upcoming webinar on viral hepatitis. There are Hepatitis B, Hepatitis C, HIV, cancer screenings; there are other things that our medical teams can also begin to look at. This is sort of where we are currently, and we are looking at the other things we need to be doing, to think about the person's overall medical care.

So our first step is sort of routine screening, finding these patients, who are we going to screen, what are we going to screen for. This graph here should be familiar to many of you. It came out in 2004, really in response to what I was seeing also, which was patients were gaining weight, their cholesterol was going up, some of them were developing diabetes. In 2004, American Psychiatric Association and the Diabetes Association came out with guidelines for screening for patients who were on Second Generation Antipsychotics. This really forms the basis of what most of us do, in terms of tracking and screening at this point. [00:28:06]

Once we sort of figured out what we needed to do, we had to develop a tracking system. This is a simple Excel Spreadsheet that we developed. We've tweaked it and done some different things with it over time to meet sort of changing requirements in our system. We took this and we call it, in our organization, "The Purple Sheet." It was an interesting move back to using paper, although you could very much leave this in Excel and enter the information. It's unfortunate, most of the

electronic health records that we have, they really don't have a tracking system for this, or at least the ones that I'm familiar with. It can also even be difficult in an ambulatory, a primary care system.

But we developed this form and we use it as patients come in. What you can see is, there are Baseline and Annual Evaluations. We look at blood pressure, we have a specific group of labs that we look at, you can see that I have a column, doesn't have an arrow, that's last appointment with the primary care provider, and then tobacco status. Are they a smoker or not, and then did we give anything out, any nicotine replacement, or anything at that visit. This form is handed to me by the medical assistant at each visit, and she's filled this in ahead of time, she's letting me know what's been done, what needs to be done. This is a very easy way for me to take a quick glance, and know where this patient is, and what they need. [00:29:41]

The other form that we developed was a lab form. It was really, we put this actually in what we call Panels, which is very much what primary care does. You can lump together a group of labs to make this simple. So there is a group here called Lithium Labs, there is a group called Second Generation Antipsychotic Labs, and also for other medications. So you can just check that off at this point, and not have to go through a long list and, you know, select different things. It also helps us be consistent in our standards, in our medical team, about exactly what we want drawn for each medication, each treatment, based on existing evidence-based protocols.

So we developed this lab panel to go with our Purple Sheet. What I want to make sure everyone is aware of is, about a year or so ago, it became very clear to us that we really no longer need to get fasting labs. This is taking that APA/ADA Guideline now and changing it for non-fasting labs. What happened was, the cardiology group changed the recommendations for cholesterol monitoring, and hemoglobin A1C's have become more the gold standard for evaluating patients for diabetes or changes in the hemoglobin A1C, even in a pre-diabetes condition. [00:31:12]

So it's no longer necessary to have the patients fast. As many people know, who do this work, it is very, very difficult to get our patients to fast, to not have a cup of coffee with some sugar or a donut on their way to the lab. So I really want to stress, as part of this talk, that if your medical staff isn't familiar with this (and there is an article here that they can take a look at), that you no longer need to do fasting labs. If you have a phlebotomist in your office and those lab services, you can actually get this done while the patient is in the office, any time of day. It doesn't really matter.

One of the problem we've had for years is the medical staff, they were following the guidelines, were ordering the labs, and in our notes, what it will say is, "Patient did not follow up with getting the labs done." So that's been a problem for us for years. It's now, for the last year, really been resolved by this ability now to get labs. Here is some cut offs, in terms of the values now that you're looking at in this screening. So that was, that's been really nice for the field. [00:32:18]

The next form that we developed was one for Review of Systems. I'm guessing that many of you are now quite familiar with this, because in, I think in January 2013, psychiatry went to E&M coding. The old codes for medication management are no longer in use, and one of the things

you have to do in the coding system is a Review of Systems. So this is one. There are lots of these out there. I'm guessing you guys are using them.

But at each visit, the patient fills this form out and then that ROS can be used for your E&M coding, which we're actually going to talk a little bit more about later. So when the patient comes in, they're getting their vitals taken, the staff is reviewing them for which labs they've had, and they're getting an ROS form done. They filled this out themselves, and then all of that is ready at the time of the psychiatric appointment. [00:33:20]

Now, as we think about the workflow, this is not something that I'm asking my psychiatric team to do. They are pressured for time, I know there has been a lot of discussion about, you know, "Do the medical staff need 15 minute appointments, 20 minute appointments, 30 minute appointments, what do these follow-ups look like?" There is a lot going on during these appointments. I remember, in the old days when I first bought blood pressure cuffs, I remember putting them in the psychiatrist rooms and trying to talk with the patient while they're trying to shrug their arm into a blood pressure cuff. It doesn't work very well, and we don't, there's not enough time to do that in that session.

We need to be a lot more like primary care, and think like primary care in our medical clinics, because we very much have a very ill population of patients who deserve this extra step, in terms of preparing them for their doctor's appointments. So this is my medical assistant, her name is Jamie. She's been helping me develop this program over the years. What she will do is get the vitals on the patients. She gets their weight, BMI, enters all of this information into this pink sheet for me, and then it's ready at the time of the patient appointment. [00:35:36]

Now, depending on the kind of electronic health records you have, we have a dashboard on ours. So she is entering these vitals directly into our electronic health record. She's able to, we're able to actually kind of take a look over time at how things are changing for this patient. I think even on this one, you can see the BMI is going up a little bit, blood pressure is going up over time, and you can use this dashboard to discuss these results with these patients. You could also give out like this formula for good health that I have here. I have the reference for it at the bottom. You can give patient information out at the time you're doing that.

This is certainly, as Dr. Druss mentioned, part of the psychiatric provider's work, is to really think about, "How do we counsel patients?" There is nothing like a graph, and just sort of thinking with a patient about what there might be, what they might be doing. Actually, I had a graph like this and was talking with a patient. It turns out, we found out that he had increased his consumption of Dr. Pepper, and we wondered if maybe that had something to do with the rise, the increase in his BMI. So it's really nice to be able, if you have a structure in your EMR, to actually use dashboards to discuss this information with your patients. [00:35:58]

So then what happened after we set all of this stuff in place, we've been cruising and doing this for, you know, since 2002, 2003 now, is this year, Colorado Medicaid came out with a Key Performance Indicator. This ties back to that NQS Standard that Dr. Druss mentioned earlier. So now (and this is verified by claims data), you must have evidence of at least one test of glucose monitoring in all patients on second generation antipsychotics. Medicaid, of course, has a

database of not only the medications you prescribed that were paid for with Medicaid funding, but they also have a list of codes that coincide with glucose monitoring. Basically this year, it's a withhold of funds until we can prove that, like with claims data, that we reach these specific targets. So this is the first time we've ever had this occur, and we were ready. We had a system in place, and we were ready to go. [00:37:00]

The other thing that was added to this list is all patients seen in our center with a mental health diagnosis, which is everybody, has to have some evidence by claims data that they've had some contact with a medical provider outside of our system. So, our standard is, they need to have a physical exam once a year if they have a serious mental illness, but state-wide, it's some contact with mental health. So the, you know, the payers caught up with us, and now they're really saying, "We want to see some value for the money. We want to see some evidence that you really are paying close attention," because the studies of the mortality gap came out in 2006. I'm not sure we've done a whole lot to move the dial on that, and we really need to step up what we're doing and how we're doing it.

I want to touch on, just real quickly, on tobacco use. Dr. Druss mentioned this also. A recent article in Psychiatric Services, you know, it's a call to all of behavior health. For some reason in behavioral health, we don't ask patients about tobacco use, even though it is responsible or linked to 50% of the deaths in our population of patients. So, you know, we're not sure why this is. Is it an education issue? Is there reluctance? Do we feel hopeless about it? You know, what's really going on with behavioral health and psychiatric staff in particular around tobacco cessation? [00:38:32]

You can see, this is a picture, this is the bowl of nicotine replacement treatments that I keep on my desk. I think, in the old days, we had a basket of condoms on our desk, now I have a basket of nicotine replacement. Actually, we should probably have a basket of both. But we really need to think about, and really strongly focus on counseling around this and prescribing the medications for Varenicline, Bupropion, a lot of new studies out last year about their safety in these populations, and combining the prescription medications for tobacco cessation with the nicotine replacement. So you can have a patch on and be taking Varenicline. That's fine. There is evidence to show that that actually is very beneficial, we really need to work on tobacco cessation. Psychiatrists have a major role to play in that.

Just to tag on to that, the APA has an initiative now called PUFFS – Psychiatry Undertaking Freedom From Smoking. There is a current survey of psychiatrists doing this work going on, they're trying to look at training needs, a position statement, what further research needs to happen. So it's a pretty exciting time with psychiatrists really thinking about how they can help with tobacco cessation. [00:39:52]

I want to end with Evaluation and Management Coding. One of the things that happens when we begin to do much more of the medical monitoring as a psychiatric provider team is that we can show in our documentation how to support 99213, 99214 and even 99215 billing codes, because we are doing so much more. We're doing vital signs, we're doing a review of systems... In the data points, we're ordering and reviewing labs and in problem points, it's no longer, "This person has schizophrenia and they're stable." It now includes, "This person has schizophrenia

and they're stable, but their hemoglobin A1C is rising, we need to do something about it. Their BMI is increasing, we need to do something about it." Each of these are problem points, and they add to the complexity of that visit. So as we address, as medical staff and as we should, the medical conditions of our patients, we're also adding to the complexity coding. [00:40:58]

I want you to think about that as you hear from Bob in the next presentation about, you know, "What's the associated cost of helping make this more like primary care, and actually having those staff to help with the monitoring?" So, you know, to me this is something I've worked quite a bit with my staff, is to show them how all that medical monitoring really does play into the coding.

You know, Dr. Druss mentioned this, you know, the piece about psychiatric staff beginning to possibly do some of the early treatment. Many of us are beginning to give Metformin as the hemoglobin A1C's are rising. We're thinking about giving statins for high cholesterol, Lisinopril and Hydrochlorothiazide for, you know, hypertension. We're really going to need the work of this team to make sure appropriate monitoring is going on at the time of these visits. It's not okay to prescribe these meds, and not be getting the appropriate labs, monitoring blood pressures, those sorts of things. [00:42:08]

So I really encourage you to work within your system to set up a way of doing this monitoring in a very systematic way. I think it would be really interesting to see, you know, six months from now, if we changed the results of the survey a bit, so that we really see that we've got, you know, close to a 100% of community mental health centers really do want to do a great job addressing the physical health of their patients and have set these monitoring systems in place. Thank you.

MODERATOR: Thank you so much, Dr. Raney, and thank you, Dr. Druss. We are going to take about ten minutes here and answer some questions. So if you have a question for us, go ahead and enter it into the box on the bottom of your screen. We will get to as many as possible, and then we are going to have a little time at the end, about 20 minutes at the end. So please go ahead and do that. [00:43:14]

Many of you asked for the forms that Dr. Raney showed. We will be able to have PDF copies of those up on the CIHS website. So we'll post those and we'll be sure that those of you in attendance are able to have access to those. So, thank you, Dr. Raney, for being willing to share those. I know that those useful tools, practical tools are really useful for many in trying to figure this all out and get this started in your own setting. I'm going to pose a few questions to Dr. Druss and Dr. Raney. Please, as I said, go ahead and continue to submit them as you have them.

One question that we had, a few of you, you both mentioned tobacco smoking as a main interest, and an area where you need to be monitoring and asking, and trying to get folks into cessation programs or treatment. There was a question about marijuana, and whether or not that... Dr. Raney, you're in Colorado, so it's legal now. So, I was just wondering if that's something that has been added to your portfolio, if that's something that you all are considering as a risk factor as well? [00:44:36]

DR. RANEY: Well, in Colorado, I mean, everywhere I've worked, even before cannabis became legal in the state, it's always, it's heavily used by many of our patients, you know, even before the legislation. But when I think of the, you know, the decade of life lost due to tobacco use, I'm not necessarily thinking about cannabis as part of that smoking. I'm really talking about tobacco and the addictive properties, physiological addictive properties of nicotine.

MODERATOR: Okay, thank you.

DR. DRUSS: Yeah, and I'd just add, I think obviously substance use is a huge piece of what we're talking about, not only cannabis but you know, when you're talking integration and screening, and it should be part of routine practice. So you know, I think it's a really good point, and I think, you know again, the patients we serve are at risk for all kinds of comorbid substance use, including cannabis. [00:45:43]

MODERATOR: Exactly. Good. What about nutrition as a... You mentioned the, your patient, Dr. Raney, who was, who you realized was increasing his Dr. Pepper intake. But what place does nutrition, nutrition counseling, lifestyle interventions, what role does that take versus, you know, just monitoring and potentially looking at blood pressure medications and that sort of things as treatment?

DR. RANEY: Ben, you want to start?

DR. DRUSS: Yeah. I mean, most guidelines for general populations recommend starting with dietary interventions for, you know, problems like early diabetes. So it's very, you know, it's really important. It's, you know, Lori may want to speak to sort of some practical approaches, but I think that, you know, the key thing is helping patients to... be able to do more cooking on their own, avoid fast food when they can, you know, begin to kind of incorporate affordable healthy food into their diets. [00:47:04]

DR. RANEY: Yeah, I agree. I think nutrition and exercise and tobacco cessation; I mean, those three come before, you know... I would hope we could go there before we needed to give any medications for blood pressure or diabetes. Unfortunately, those things, as we all know, are hard. I know the PBHCI grantees have seen this, health behavior change is difficult, but it's well worth the effort. Small amounts of weight loss and starting an exercise program, even if you're not losing significant amounts of weight, can still be cardio, metabolically friendly and helpful to patients. So I spend a lot of time talking about diet, the DASH Diet is a really nice reference to give people.

I talk about small goals for exercise, even if it's just around the block. I want to make sure people have a pair of shoes they can wear, they can actually walk in. Then, you know, trying to see if we can get scholarships to the Rec Center, if we can. It is, it's where you start with these health issues. That, and switching meds. If they're on a medication like Olanzapine, that's really causing a problem, how can I get them onto something else. So the switching and the lifestyle modification are big priorities for me. [00:48:31]

MODERATOR: Thank you. We have a couple questions about this, actually. At what point are you, whether, I guess whether you're in an integrated setting or you have some sort of collaborative relationship with a primary care provider; at what point do you, Dr. Raney (or your recommendations, Dr. Druss) recommend kind of transferring the, or communicating about those emerging metabolic issues with the primary care providers? Do you generally handle these issues in house, or what is your relationship with the primary care team in trying to address some of these issues?

DR. RANEY: Well, I'm in a situation where I'm quite lucky, because the primary care team is right there next to my office. So if I have a patient with, if I get some abnormal labs back, I can walk over to the primary care provider's office, have her take a look at them. She'll look at it and just help me decide what I might be able to do, and then decide whether or not she needs to see that patient. So I may start a medication and then, but she continues that, because she then sees them two weeks later for a visit, and a physical, and to follow up on an abnormal hemoglobin A1C or an abnormal blood pressure. I've got the luxury of a very close partnership with primary care, because we have primary care pretty much integrated throughout our organization. [00:50:16]

For people who don't, though, I think it's very important that you work to connect your patients with primary care every chance you get. We know that folks can be really reluctant to go, that there is, you know, lack of a perceived need, that you need this treatment. So we have to think, you know, where along that line we are, in terms of a patient who refuses to go across town to see a primary care provider, and how serious the issue is that we've just screened for, and found to be positive, and then where we might intervene. So, you know, my answer is, I get them connected to primary care as soon as possible, but I'm pretty lucky on that side, because we've decided to fully integrate our care.

DR. DRUSS: Yeah, I'd second that. It's a very, obviously it's a very local kind of question. It depends on what you have access to, with regards to primary care. But you know, develop those relationships. If you don't have an on-site, develop relationships with the community providers and communicate in any way that you can. [00:51:27]

MODERATOR: Absolutely. On that same issue, if you are a community mental health center that doesn't have in-house primary care providers and you want to get this started, you imagine that psychiatrists, obviously, know the side effects and know about metabolic testing and that sort of thing, but you know, if you have a psychiatrist who only comes in a few days a week and the rest of the staff are social workers and psychologists and others; do you have any recommendations for kind of learning this? I mean, there seems like there is a bit of learning curve when you've been, you've been working on behavioral health issues and not thinking, necessarily about some of the medical concerns. [00:52:24]

DR. RANEY: Well, I think there is definitely a role for your psychiatric providers in helping bring up the health literacy of your non-medical staff. I mean, you can do, you can have a "Lunch and Learn" while your psychiatrist is there and say, "Hey, tell me what you know about hypertension.. Tell me what you know about diabetes." For your psychiatric team, it might be a little bit of a refresher for us to go look up a few things, but we learned how to treat all of these

things when we were in medical school and residency. We may need to brush up on it a little bit, but I think there is a role for every...

I think everyone in the clinic should know about these common disorders that lead to, you know, early death. Everyone can talk about tobacco cessation. Maybe a social worker has a patient who's smoking, and walks over to the psychiatrist the day that they are there and says, "Hey, you know, Mr. Jones is really interested in quitting. I heard there is this medicine called Bupropion or Varenicline or Nicotine replacement. Can we get some of that and help him? I think he's ready." I mean, those are the kinds of things that I think would be really nice if your non-medical staff had that level of knowledge, and could partner with the psychiatric team around what might be helpful. [00:53:50]

I think it's very important that your non-medical staff know about lifestyle intervention. Most people know that exercise is good and certain diets are healthier, like low fat, low-sugar. But I think it's important that everyone you know, have kind of a similar knowledge base about what that looks like. You could ask your psychiatric provider to provide that over lunch, you could ask a nurse practitioner, primary care provider in the community to come in and do some Lunch and Learns with your staff. You know, whatever those connections are. It's actually kind of nice to connect with primary care in your community and say, "Hey, could you guys come over and do, you know, lunchtime session for our therapists?" Maybe have your psychiatrist and a PCP do that together over lunch.

But I strongly encourage everyone, though. In our center, our therapists take, do BMI's and blood pressures on all their therapy patients. That's how much we've ingrained that idea in them, that the physical healthcare is important. You set up a vitals stand. Let everybody use it, including your therapists. [00:54:54]

DR. DRUSS: Yeah. And the other group, in particular, to really think about are care managers. If you have care managers who are, you know, dealing with the social and mental health issues, they're a group to really target for cross-training, because they'll be the ones, you know, maybe even more than the psychiatrists, they'll be the ones who will really be tracking patients and making sure that they're getting what they need.

MODERATOR: Great! Thank you so much. We are going to stop the questions now. We have lots more in the queue, and I hope that you will continue to send them. But for right now, I'd like to turn it over to Bob Krumwied from the Regional Mental Health Center in Indiana. He is going to, Bob is going to discuss how it works on the ground and how he pays for it, and how he's implemented this in his community mental health centers. Then we will head back to more questions with all three of our presenters. So, Bob, I'm going to turn it over to you now. Thank you so much. [00:56:10]

DR. BOB KRUMWIED: Thanks, no problem, except that I've been cut off the phone twice, so if I disappear, it's not my fault, honest! I'm keeping my hands off the phone, it's just not working! First of all, I'd like to cover a little bit about why we do this, at Regional Mental Health Center.

About six years ago, our Medical Director... we're real fortunate in that Dr. Kern, our Medical Director, has bought into this really and fully, in terms of spending a lot of time trying to work out the interface between physical health and behavioral health with our client population. I also had a real strong interest in doing this, but for mostly for economic reasons, because I do believe that we have to help bend the cost curve. You know, when I was, in the early 80s, they were predicting that by the year 2000, healthcare costs would be 20% of GNP. Fortunately, it never got quite that high, but it's now at 17.4, it's kind of a stalemate, kind of stagnated for the last three or four years. But all predictions are that it's going to take another big jump now with the Affordable Care Act, and kind of the pent-up (ph) demand for healthcare that we'll probably experience in the next two or three years. [00:57:30]

So there is going to be even more pressure for us to try and truncate the cost of healthcare without giving up the quality of what we've gotten used to. All the evidence clearly identifies that behavioral health is a meaningful tool in terms of helping to bend that cost curve. You've all seen all of the statistics around the interface between behavioral health and primary care, and how treating both issues concurrently drops the overall cost. I won't bore you with some of that.

But what was interesting to me was, I thought I'd have a really difficult time selling this to my board, because they're largely lawyers, accountants, school teachers, a couple of practitioners, and quite a few consumers. But frankly, most of the time, they just kind of, they kind of nod and they only get nervous when I've got some red ink on my balance sheet, because that's something they can relate to. [00:58:33]

So I was kind of surprised when they really, from the outset, bought into this. We're very comfortable with this kind of going out on a limb and using some of our stored assets to kind of jump out in front of the curve on this thing and to spend some money and to develop a strong interest in terms of integrating primary and behavioral health care. We kind of jumped into this thing headfirst into the deep end of the pool. But when I thought back on it, and when I talked to one of the board members, it was just pretty obvious. This was a tangible item they could deal with.

As much as they're concerned with my folks who have significant behavioral health issues (and we have several primary consumers on the board, too), it's still a difficult thing for them to deal with, on a day-to-day basis. It's still kind of... it isn't commonly shared across all the population as to what exactly behavioral health is, and how much of it is physical, and how much of it caused by other issues. But when we start talking about primary care, it's a tangible item, it's something that we all kind of relate to. It's also, really kind of a neat thing for my board to identify a collective sense of responsibility for. We finally have something to measure, we can measure what's going on with blood pressure, we can measure what's going on with BMI. We can show gains on that, and indeed, we did. It's really kind of impressive. [01:00:01]

The second thing is, my board, like everybody else in the universe (including me, it seems, although I'm in denial), is getting older. You know, one of the things that has been brought right to the forefront recently is the escalating cost of healthcare, as it relates to the general GNP and also as we get older, just is taking up more and more of our resources. They estimate now that if you're 55 years old, the amount of Social Security benefit you're going to get after 65 is almost

equal to, and will soon surpass, the total healthcare cost that you experience in your life. So that's kind of a spooky scenario for folks as they get into their retirement years.

I want to give you a little bit of an overview of what Regional Mental Health Center is, because it isn't quite the typical mental health center, but it's close enough. We treat, we draw our clients from a geographic population, there is about 490,000 people in it. We treat 11,000 people a year for behavioral health issues. About 3,500 of those folks are kind of traditional, seriously mental ill folks, but we've also got 5,500 (or almost half the folks we treat) are also treated by an agency psychiatrist or an external psychiatrist. [00:01:25]

One of the things we discover in getting into this was that folks at both ends of the curve, you know, the folks that were coming in for some sort of acute care kind of issue in the behavioral health side and those who are most seriously ill actually had their primary care needs attended to the best. At the low end of the spectrum, it was because they were in a group home or a residential facility, where we could make sure that they got to their appointments, had their appointments made, took care of their physical healthcare. Of course, on the other end of the spectrum, we had the really high-functioning folks, who frankly, typically, started out in the primary care system and got a referral to us. But that only covered about 80% of our clients; I'm sorry, about 20% of our clients. So 80% of our clients just really didn't have their primary care needs attended to.

So we embarked on trying to blend this more. We started off with one of the SAMHSA Integrated Care Grants and the results we got were really phenomenal, phenomenal enough that the board got excited again. I got excited for only probably the second time in the 20 years of my career, around our ability to really have an impact on what was going on, you know, the functioning of the health of our clients in general. [01:02:42]

We started off with... well, we can start off there... Just to go on with this, we have a total staff of around 390 folks, total budget of about \$35 million. We also happen to have 12 psychiatrists. So for a mental health center our size, and for a mental health center in our state, we have more psychiatrists than, we have more psychiatric help than the typical mental health center in this state. Our total cost, as it relates to the psychiatry and some of the core integrated care staff that we have associated with it, is roughly 3.7%; I'm sorry, \$3.7 million, or it's about 10% of our total cost.

The integrated care piece, which includes three RN's, two medical assistants, and three case managers, covers about 2% of our total cost. It's around \$600,000. But we also have an extension of this in our group homes, where we have medical assistants in each of our group homes, keeping track of some of these measures on an interim basis, because a lot of our folks in the group homes only see a psychiatrist maybe once every two or three months. What we found was, we really needed to stay on top of this with these folks. They responded to our keeping track of the measures, and being able to show them concretely the success they were having in changing some of the lifestyle issues that we were working with them on. [01:04:12]

We also have a really big case management group here of around 25 folks. We started early on modestly moving them from case management into care management, and we're being much

more aggressive with it now. But it's still a work in progress. One of the things we do engage in now is much more shared data between departments, and much more shared data between community providers and us, in terms of what's going on with our clients, where they stand in terms of their current health status.

We are working now with local hospitals to see if we can't... our electronic records are, can't actually talk to each other, at least that's the theory. So we're working with our local hospital systems to see if we can't get some indicators that will trigger for us an event, where one of our clients shows up in the Emergency Room, or is admitted into the hospital, and vice versa. We'll give feedback back to the primary care provider when one of their clients has an acute exacerbation of their mental illness and ends up in our in-patient unit or calling our crisis line. [01:05:21]

So the communication is a burgeoning piece of our business that we're real excited about and actually making some progress on, which is new, in my career. But we had been moving towards, from case management to care management. It's been a slow... costly... not really costly, it's been a slow movement in terms of the culture shift that's required by that. My care managers feel like they have enough to do with case management, so... But when we have given them the opportunity to take a look at measuring some of the indicators that the physicians here have talked about, they seem to get excited. This is something new for them.

One of the phenomena we've always had in this business is a lot of turnover, especially among our case management staff, because it's so frustrating. These folks work with the clients day in and day out. They don't see the movement that our clients make. I see it, because I only see them once a month, once a quarter. It's phenomenal the improvement we make with these clients! But now that we're taking a look at the physical health needs, too, they also have something really concrete that they can lay their hands on, and then they get excited when somebody drops a fair amount of weight, or gets their diabetes under control for a prolonged period of time. It's kind of fun for them. [01:06:42]

One of the issues we had was, it was really difficult to get our clients to follow up with primary care, even if we held their hand and tried to get them to the appointments. We had lots of folks falling between the rocks here. So we went ahead and put in an application and were successful in terms of getting an FQHC, which is another set of cultural changes for us. So we both (ph) have an FQHC that we operate, but we're also engaged with a couple of local FQHC's and have therapy staff co-located there. So that's helped a bunch.

Our board was very comfortable, in terms of putting our money where our mouth was (or is). Like I said, they invested in putting medical assistance in group homes, we're investing in terms of training for our case management staff and helping them become care managers. Most importantly, at a management level, we're integrating the management of these staff, where when we started out, medical assistance was pretty much the purview of the psychiatric staff, and there wasn't a lot of intervention or integration between the two. [01:07:52]

Our care managers are right now doing a lot of the (and will do a lot more in the future), are doing a lot of the measurements, and keeping track, and moving forward of these physical

markers to the psychiatric staff. So we're in the process of blending the management of these folks, which we think will bear a lot of fruit in terms of continued improvement.

The hard part for this is, you know, I don't know that I can tell you how we pay for it, because right now, we don't pay for it well. But what we do see on the horizon is a lot of opportunities for reimbursement. I think they are more than just opportunities. I think it's an unavoidable prophecy that we're going to see reimbursement for a lot of these integrated services that we have.

In Indiana, we're working on mental health medical homes, but frankly our Department of Medicaid Policy and Planning is so overwhelmed with the recent expansion of Medicaid under the Affordable Care Act, it's tough for them to do some of the peripheral things. And yet they still carve out time to work on the standards, to bring the mental health centers into the fold, in terms of crafting those kind of standards, and still we verbally are committed to, at some point in the near future, developing an episodal (ph) rate that we can get paid for for some of these services. [01:09:27]

The opportunities that are now with the FQHC's, Federal Qualified Health Clinics, who now seems to, you know, fully embrace behavioral healthcare. They give the FQHC's that have existed for a long time a fair amount of money to help bring behavioral healthcare into their settings. They also, you know, have kind of opened up a wee bit, and we're evidence of that in terms of letting community mental health centers, who can demonstrate the capacity, participate in operating an FQHC. So that's a really neat change for our particular community and for a couple of other communities in the state of Indiana that were taken advantage of.

We do believe that a unique Medicaid rate in Indiana is on the horizon here, and it's on the horizon for a couple of reasons. One is we have a total, we have a managed care system in Indiana for Medicaid. The managed care organizations clearly understand that while they can show some gains early on, in terms of their tenure as a managed care organization, if those gains will eventually run out, they're going to have to look a little deeper to continue to provide savings without jeopardizing the quality of care. They also recognize that if they can't keep providing savings and good outcomes, they're short for this world. [01:10:46]

So they're engaging more and more with us in the community mental health center network, in terms of putting their toes in the water around how we might help them achieve some of their healthcare needs, or health cost reduction needs, and also how again, from taking care of both these issues concomitantly is going to drive their total cost down as we move forward. We're slowly blending roles while we wait for all of this to happen, but I have to tell you, there is a whole bunch of motivation here, in terms of working on this, both in terms of our clinical staff on the behavioral health side and on the medical side. I see a whole lot of energy, both at my board level, at the community level. Our clients love this a lot, and the medical staff seems to embrace it, too. So, we're really encouraged for the future. [01:11:44]

MODERATOR: (pause) Thank you so much, Bob for sharing your experience in Indiana. Before we move on to the rest of our questions, and I encourage you to be entering those into the question box, we wanted to ask one more poll question, and that is: As a result of this webinar,

do you have plans to establish medical monitoring procedures at your CMHC or primary and behavioral health integrated practice? For those of you who are, who have not done this yet, we're interested in knowing whether or not this is something that you're planning to explore.

So the first response is 1) Yes, we are already in the planning stages; 2) Yes, I will bring this back to the team, meaning I'm not sure that it's going to fly, but I'd like it to happen in our center; 3) Maybe, you're contemplating it, it's a possibility; 4) No, I don't think it's good for us right now, it's not feasible now; 5) For those of you who already have medical monitoring, you can click that next box; or 6) If you're not affiliated with a provider, let us know that. [01:13:09]

So, as a result of this webinar, do you have plans to establish medical monitoring procedures at your CMHC or primary and behavioral health integrated practice? You can answer the poll now, and we'll give you another... minute or two before we close the poll. (pause) Let's see. It looks like... about evenly split, about 21% yes, they're definitely going to move forward, about 20% are hopeful that they can, you can start thinking about it. Let's see here... many of you of course are not with providers. (pause) A small number of you are contemplating it, 7% are saying, "Maybe." I'm heartened to see that only .6% said, "No," that you're not going to explore this. Again, 28.6% of you already have medical monitoring, so that's excellent. [01:14:29]

Thank you for answering that poll question. That's helpful to us, as we move forward with thinking about materials for APA members, DHS, and National Council members, and just also considering what else we want to leave you with today. So thank you for answering those questions, that poll question.

We are going to move on to some more questions. Please, if you haven't asked a question that is burning, you're burning to ask, you're waiting to ask, please submit that into the question box and we will try to get to it. We do have a lot of questions that we're going to try to get to, but I want everyone to have an opportunity.

One question that we had, and we'll give Bob a break here. He discussed his billing (ph), and how he has sort of started to try to pay for it. Lori, the question came in about your medical assistant, how you paid for her time. Can you let us know, Dr. Raney, how you paid to begin this process, and have your medical assistant doing your monitoring for vitals? [01:15:47]

DR. RANEY: Well, Colorado is a capitated behavioral health Medicaid state. So we get a certain amount of money per member per month for patients, and then we can decide how we want to spend it. So it's not like I have to have some fee for service or some other billing mechanism in place. Like Bob was saying, you know, we knew this was the right thing to do. What I did initially was, I had an RN in one of the positions, and I took that RN position, when she left, and converted it into two medical assistant positions for roughly the same cost.

So I mean, there is also this thinking in your organizations about, you know, who needs to be doing this vital signs monitoring? Who can get the labs? Does it necessarily have to be maybe someone at an RN level of licensure, but could be someone else? So you know, just like in a primary care clinic, the person that bills for the service is the doctor, the primary care provider.

It's not the medical assistant who takes the vitals when you go to your primary care office. It's the kind of billing the doctor can do around the complexity of that visit. [01:17:04]

So I would challenge folks to think about if we're doing E&M coding, and we've got complicated patients, and we're gathering data, you can actually bill a higher E&M code as you sort of go through the process of thinking about all the different things you're really doing. We're not giving ourselves enough credit for how complex our patients are, and how much the medical monitoring influences that complexity. So I'd really encourage people to think about whether or not some E&M coding training or thoughtfulness around that might be helpful in your organization.

We've just found this medical monitoring. We had a training the other day, and it's pretty easy to reach a 99214, we just hadn't really realized that. So it's not necessary, to answer your question, it's not paying for the MA's time, it's billing for the psychiatric provider's time with your complexity codes. [01:18:02]

MODERATOR: Okay, great. Bob, what... you discussed (inaudible) care managers and another, and a kind of diverse provider staff. Do you consider use of peer support specialists (and Dr. Druss, this is something that you probably have thought about as well as you, Dr. Raney), but have you, Bob, have you used peer support in implementing your medical monitoring?

DR. KRUMWIED: You know, we have. But frankly, the role of peer support in our case is just one of encouragement of folks to participate. It's gone quite a ways to help, but we anticipate in the future it will go a lot further, because some of the lifestyle groups that we initiate, we think will be more readily and easily received in a peer support setting than they are in our clinical setting. [01:19:12]

MODERATOR: Excellent.

DR. DRUSS: Yeah, I mean, I'd agree. I think there is a lot of interest in the peer community, as well as in the public mental health sector, in expanding the roles of peers. There is, you know, something like 10,000 certified peer specialists, and the number is growing every day. I think it's, you know, it's the same thing as for other of the sorts of workforce issues that we're talking about, which is, you just have to be, as you think about taking people with less medical training moving them into more medicalized roles, you just have to be careful about making sure that people, you know, have some training on the front end.

I know that, you know, there are certification processes that are out there, they are largely around, as Bob said, kind of helping people with goal setting. They're not as medicalized in terms of, you know, kind of, you know, around things like getting, you know, labs or adjusting medications. I just, I think that, you know, the key thing is just to sort of look at who is providing the services, look at their training, look at the supervision, and then, you know, come up with the best solution. I think that, you know, there is a lot of interest, and I think there is a lot of potential for peers certainly to help as part of the process. [01:20:48]

DR. RANEY: And we have peers in our clubhouse, who are doing everything from walking groups to getting folks over to the swimming pool. They've just been great in helping get people activated to move, to do some physical exercise.

MODERATOR: That's excellent. More on the treatment, or on the activation side rather than on the actual monitoring side. But that's equally important, yeah. The question, getting back to billing and how to pay for this, and some of the complexities of monitoring within a behavioral health setting. For those who are in states with behavioral health carve-out, are there any complexities about billing for medical monitoring services, or medical monitoring interventions, or medical treatment for these issues when the provider is operating within a carve-out, the carve-out situation, where they're billing to the behavioral health carve-out? [01:22:08]

DR. RANEY: You know, it's not a problem for us in Colorado. I've heard of some problems maybe in California, and especially if some of the primary care providers try to order Metformin or Lisinopril for blood pressure, or something of that nature, that sometimes even those have been rejected because they're not considered, you know, part of the global Medicaid or other budget. I would say, if you work in a state that has that going on, you have a lot of work to do, you know, politically, within that state. But I have heard some, I have heard of that. I don't know, Bob, what it's like in your state. I don't know if you guys have a carve-out or not.

DR. KRUMWIED: No, we don't. (Dr. Raney affirms) So I can't really... No, we don't. I couldn't answer that. [01:23:06]

DR. RANEY: (pause) I mean, we're being asked to do it by Colorado Medicaid. We have to show evidence that we are doing it, with our new KPI's. So I would say that, we just haven't had a problem with it, and are actually expected to do it. It should be the norm, that that's one of the things you should be following on your patients should be the hemoglobin A1C, or BMI, or something else reflective of the NQF or other standards, like Dr. Druss was talking about earlier. That's true integration that we're doing all of it.

MODERATOR: Right, right. So if you're finding that your Medicaid, your state's Medicaid's plan is a barrier, perhaps going to the Medicaid folks and discussing it would be a good next step. I would think that they would be... you know, open to discussing a solution, if that's a barrier, which I think some of the participants on the line suspect that it might be a bit of a barrier. [01:24:22]

Have you had any issues, Dr. Raney, or I guess Bob as well, on the frontlines of any medical liability issues with psychiatric providers who are working outside of, who, you know, haven't prescribed medications for anything other than psychiatric illnesses in quite some time. Have there been any malpractice concerns, or costs that have come from kind of what is seen as going outside the scope. Obviously, it's not. We know that it's not. But, going outside the scope of what psychiatrists have traditionally seen as their bailiwick.

DR. RANEY: Yeah, I mean there is a lot of concern about that in the field. The American Psychiatric Association is actually doing quite a bit to address that right now. As I said earlier, we were all taught in medical school and residency how to treat these disorders. So the question

becomes, “At what point is this, does this move out of scope, or really move out of your comfort level?” [01:25:38]

So what the APA is doing, they have a new position statement on the role of the psychiatrist in the medical monitoring of their patients that basically says “with the appropriate refresher course training.” The other thing that a lot of us do is, we have PCP’s that we can call and consult on patients and provide us with backup for prescribing these medications. So the thought around this, and we’ve consulted with attorneys and we have a position paper on it, is to really, if you’ve got an M.D. or N.P. or P.A. behind your name, you’ve done a lot of this training already.

It’s really getting that additional training, refresh your skills, learn how to do it, and then have that consultation with it. We’re putting together, we’ve got a specific training course called “Primary Care Skills for Psychiatrists.” We’ve been offering it for about four years now. We have great attendance, we’re doing some pre- and post-tests, we’re doing this on-line. There is actually a new textbook out from American Psychiatric Publishing that Robert McCarron and his colleagues put together. It is a huge movement now in the American Psychiatric Association to bring psychiatrists up to speed, to get our level of, as Dr. Druss showed the slide, of getting our level of health literacy back up to where it needs to be to take care of a very medically ill (in addition to psychiatrically ill) population of patients. Ben, I don’t know if you have any other thoughts about that from your APA work. [01:27:11]

DR. DRUSS: No, I would just second everything that you said, Lori. I think we’re... you know, it’s an area in which we’re... you know, there is... We’re increasingly recognizing that the liability associated with doing things may be no worse (chuckles) than the liability associated, you know, if our patients are having adverse medical problems and we’re not doing things. We just need to be doing it in a way that is, you know, performing the services in a way with, that’s appropriate, and evidence based, and that has proper supervision.

DR. RANEY: I think that’s a great way to... Oh, go ahead.

MODERATOR: You can end this. I have a couple remarks, but I thought that was a good way to end our Q&A. We have about two minutes left. I do hope that people on-line are compelled to look into this, either continue with their planning, reach out for more information from CIHS or the APA. I do have up on the screen a few resources. The consensus statement, the American Diabetes Association, American Psychiatric Association Consensus Statement from 2004, that’s what that first bullet point, and a few other resources that I thought would be useful. [01:28:39]

Again, we will post to the CIHS website Dr. Raney’s forms that you can use as models. So we appreciate that from her. If you have any questions, you can let us know at integration@thenationalcouncil.org or the presenters, their contact information is here. So we appreciate them. That is all the time that we have for today, and there will be a recording and a transcription of the webinar available on the Center for Integrated Health Solutions website, so please look out for that.

Once you exit the webinar, you will be asked to complete a short survey. So please be sure to offer your feedback on today’s webinar. Your input is really important to us, and informs the

development of future CIHS webinars. So please, be sure to fill that out when you complete the webinar today.

I would like to extend a huge thank you to our presenters, Ben Druss, Lori Raney, and Bob Krumwied for joining us today. I'd also like to thank the APA for their partnership for today's event. Thank you all for participating in our webinar. We hope you'll please stay tuned for more CIHS webinars and other resources from CIHS, coming out in the near future. Have a great afternoon! I appreciate you all being with us today. Thank you.

[01:30:10]

END TRANSCRIPT