UW Medicine
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Behavioral Health Care When Americans Need It:
Ensuring Parity and Care Integration

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Chairman Wyden and Ranking Member Crapo, thank you for conducting the hearing today entitled, "*Behavioral Health Care When Americans Need It: Ensuring Parity and Care Integration*."

My name is Dr. Anna D. Ratzliff. I am a psychiatrist and Professor in the Department of Psychiatry and Behavioral Sciences at the University of Washington where I am a national expert on the Collaborative Care Model and specifically, on training teams to implement and deliver mental health treatment in primary care settings. I have developed additional expertise in suicide prevention training, mental health workforce development, adult learning best practices, and mentorship. I am the Director of the UW Psychiatry Resident Training Program at UW Medicine, Co-Director of the AIMS Center (Advancing Integrated Mental Health Solutions) and Director of the UW Integrated Care Training Program for residents and fellows. As a member of the American Psychiatric Association (APA), I have partnered closely with the APA to disseminate and promote improved access to care through behavioral health delivery in primary care settings or integrated care and to advocate for policies that would support deployment of this model more broadly.

I thank you for having me here today to address the myriad issues surrounding the state of our nation's mental health.

I sit here before you today because the COVID-19 pandemic continues to exacerbate mental health conditions, including substance use disorders (MH/SUD). Data show that COVID-19 has impacted almost every single aspect of our lives, from job security to health equity, health outcomes and beyond. Though, as we near the particularly grim number of losing a million Americans to the pandemic, being a part of this panel here today makes me hopeful that Congress and our nation will do the difficult work of addressing the MH/SUD pandemic that we are facing.

Before I get into the policy recommendations of my testimony, it is important to stress that as psychiatrists, we often see patients who cannot advocate for themselves. As such, it is our professional responsibility to speak for our patients by promoting policies that help them get access to lifesaving care. I will reference a handful of my patients in my testimony here today along with the many ways that Congress can help promote policies to improve access to help patients like mine.

These policies include incentivizing the integration of behavioral healthcare into primary care, addressing health equity, and increasing access to telehealth. Championing evidence-based policies that ensure that our patients receive the mental health and substance use disorder care that they need will save lives and reduce overall health costs. I will detail these policy proposals throughout my testimony below.

Integration of Behavioral Health and Primary Care

As we continue to build our workforce pipeline and as our healthcare system moves toward value-based integrated care, the most promising near-term and immediate strategy for providing prevention, early intervention and timely treatment of mental illness and substance use disorders is the implementation of evidence-based integrated care models using a population-based approach. **The Collaborative Care Model (CoCM)** is a specific model of integrated care developed at the University of Washington to treat common and persistent mental health conditions such as depression and anxiety. **The CoCM is an evidence-based integrated care model with over 90 validated studies to show its effectiveness and has been recognized by the Centers for Medicare and Medicaid Services (CMS) with specific billing codes introduced in 2017**. This approach provides MH/SUD treatment in a primary care office through consultation between a primary care clinician (PCP) working collaboratively with a psychiatric consultant and a behavioral health care manager to manage the clinical care of behavioral health patient caseloads.

One of my patients, Daniel, who has given me permission to share his story, represents the advantages of integrated behavioral health care, specifically the CoCM, as an access point to care. Daniel struggled with untreated mental health symptoms in young adulthood, eventually leading to a suicide attempt. He sought treatment in primary care and at his first visit with his new PCP, she recognized that he was struggling with mental health symptoms and referred him to a behavioral health care manger whose office was just down the hall. Daniel's PCP was able to walk with him to meet the behavioral health provider that day and to schedule an intake appointment the same week. As the psychiatric consultant, I was able to review his case within a few days during my regular meeting with the behavioral health care manager. This consultation was conducted using telepsychiatry since my office was not located in the primary care setting and allowed me to review multiple patients at that clinic in the time I would normally only be able to see one patient. We were able to determine his diagnosis, and I provided recommendations for medications for the primary care provider to prescribe and behavioral treatments, like behavioral activation, for the behavioral health care manager to deliver when she met with Daniel about every other week. Within weeks, he was feeling better, and he enrolled in local community college. He eventually was able to successfully complete his training to become a medical assistant. This example is important because Daniel said that he never would have sought mental healthcare if it had not been so seamless, especially when it was early in his treatment. His mother feels that this access saved his life.

Though Daniel's is just one story, the CoCM is population-based, facilitating treatment for many more patients, and dramatically improving patient access in comparison to integrated models that use one-to-one care. This innovative model allows patients to receive behavioral health care through their PCPs, often alleviating the need for referrals, which frequently take months and too often result in patients receiving no care. This is especially important as studies slow only 50% of patients who receive a referral for specialty mental health care ever follow through with the referral. Among those who do, many do not have more than one visit.

Implementation of the CoCM is a critical strategy to quickly improve access for patients by extending the current workforce, especially given the shortage of all mental health clinicians. This evidence-based model of integrated care allows for the early diagnosis and intervention of mental health conditions in the primary care setting and is proven to prevent emergency room visits and/or hospitalizations. **More widespread use of the model can help to alleviate a portion of the current psychiatric workforce shortage** by leveraging the expertise of the psychiatric consultant to be able to provide treatment recommendations to the PCP on a panel of patients, generally 60-80 patients, in as little as 1-2 hours a week. This is possible because the CoCM is a team-based approach in which the psychiatric consultant prioritizes their attention only to the patients that need their expertise. Given the ability for the psychiatric consultant to provide treatment recommendations to the PCP on multiple patients versus seeing these patients 1:1, the CoCM is a superior model for improving access to MH/SUD care quickly and more effectively to a broader population versus colocation models of integrated care.

Further, the CoCM uses measurement-based care, which means that the patient's progress is tracked regularly, and treatment is adjusted if clinically indicated**.** This means that practices can easily identify patients that are getting better and patients who may need to access more intensive services, strategically allocating resources so that each patient is able to receive just the right amount of care.

Serving Rural Communities

In my work supporting clinics to implement integrated care, I have had the opportunity to work to adapt this model to serve rural communities. I partnered with one of our Washington rural access hospitals that had an active primary care clinic. In this setting, the clinic employed a behavioral health care manager who could work closely with a psychiatric consultant located at UW Medicine on the other side of the state. This approach allowed patients to receive care without fear of stigma and to avoid spending potentially hours in the car to travel to a behavioral health prescriber. With our partnership, the primary care providers also felt better supported to deliver appropriate MH/SUD care to their communities. This example demonstrates the power of integrated care to leverage scarce psychiatric expertise to serve all our communities.

These stories from my practice show that the CoCM can work in discrete exemplar settings. However, the data on the model's effectiveness show more broadly that implementing the CoCM can more than double the chance that a patient will have a meaningful response to MH/SUD treatment. In addition, studies show that the CoCM can improve access to care for patients in rural or underserved areas. Because consultations between the team members can be provided remotely, the model addresses the uneven distribution of the mental health workforce and leverages the scarce psychiatric workforce.

Addressing Health Equity

In my role as a psychiatric consultant, I have had the opportunity to work with a primary care clinic that provided culturally and linguistically appropriate healthcare to a population in which six out of seven patients were Black, Indigenous, People of Color (BIPOC). In this clinic, I worked with a woman who had recently had her second child and developed post-partum depression. She was able to meet with her behavioral health care manager, was diagnosed with major depressive disorder and was able to work with the CoCM team members to choose the best treatment for her from a range of evidence-based options from medications prescribed by the primary care provider to brief behavioral interventions delivered by the behavioral health care manager. All of these treatments were immediately available without any need for a referral. For this patient, evidence-based therapy was her preferred treatment and an approach that was more culturally acceptable to her. The team was able to monitor her symptoms in response to treatment to make sure that she got better.

This example is consistent with studies that compared depression outcomes in BIPOC and white patients who received treatment with the Collaborative Care Model, with results showing either equivalent or significantly better outcomes for BIPOC patients. This makes the CoCM an important strategy to improve behavioral health equity.

Financial Considerations

Expanding the use of the CoCM can also help reduce health care costs. The CoCM is currently being implemented in many large health care systems and practices, and is also reimbursed by Medicare, most private insurers, and numerous state Medicaid programs. According to the University of Washington AIMS Center, long term analyses of the CoCM have demonstrated that every $1 spent on CoCM saves $6.50 in health care costs -- a return on investment of over six to one. In this research, the healthcare savings came from across all categories, including inpatient/outpatient medical, inpatient/outpatient psychiatry, and pharmacy. Though implementing the CoCM makes sense from the perspective of expanded access, improved outcomes, and long-term financial savings, unfortunately, the requisite start-up costs have proven to be a barrier to its adoption by many primary care practices. Implementing the CoCM requires up-front investments by primary care offices to upgrade their electronic medical records, hire behavioral health care managers, etc.

Policy Considerations

In my role as the AIMS Center Co-Director, I have worked to implement the Collaborative Care Model at hundreds of clinics nationally and internationally. I have also partnered closely with the APA to deliver training and technical assistance as part of a large four-year project in which we trained approximately 10% of US psychiatrists in the skills needed to deliver Collaborative Care. This work in settings across the US has informed the specific recommendations outlined below. **I encourage the Committee to consider the following policy recommendations that the APA has outlined to further the adoption of the CoCM:**

- Fund primary care offices to assist with the implementation of the Collaborative Care Model.

- Eliminate the patient cost-sharing requirement under Medicare to remove an additional barrier to care for Medicare beneficiaries. Practices that have implemented the CoCM have seen patient attrition because of the cost-sharing requirements despite patients reporting benefits of the CoCM model.
- Increase the current reimbursement for CPT codes for the CoCM to more appropriately reflect the value and benefits of services and care being provided to patients with MH/SUD needs and to incentivize primary care to invest in the model that has proven health care savings.

Telehealth

I have learned in my clinical experiences, telehealth is an important strategy to increase access to general psychiatric care and also supports and complements integrated care. I want to acknowledge and express my appreciation of how the rapid expansion of telepsychiatry authorized by Congress and the last two Administrations has significantly enhanced patient access to care. In the practices that I currently support, I have seen numerous examples of patients with mental health disorders continuing to access much needed therapy and medications and patients with opiate-use disorder being able to continue to receive medications that have been demonstrated to save lives. As the pandemic evolves, many patients continue to receive care via telehealth who otherwise may not have initially received or continued care if telehealth were not available. The progress we have made in reaching more patients through telehealth and coordinating care with other systems of support has been a literal lifeline for our patients.

Prior to COVID-19, substance use disorders and co-occurring mental health services were exempt from geographic and site of service restrictions under Medicare, but mental health treatment services alone were not. At the end of 2020, Congress took the important step of permanently waiving these restrictions for mental health. However, Congress also passed requirements for patients receiving care via telehealth to have an in-person evaluation with their mental health provider within the six-month period prior to their first telehealth visit and at subsequent periods as required by the Secretary. This arbitrary requirement, which does not apply to those with SUDs or co-occurring MH/SUDs who see their clinicians via telehealth, creates an unnecessary and difficult barrier to needed care for Medicare patients with a mental health diagnosis. Whether a patient needs to be seen in person is a clinical decision that should be made together by a patient and their clinician at the appropriate time.

Policy Considerations

I encourage the Committee to consider the following policy recommendations, endorsed by the APA, that would address the current challenges with access to telehealth services for behavioral healthcare needs:

- Remove the six month in-person requirement for mental health treatment to ensure that mental health and substance use disorder services furnished via telehealth are treated equally.

- Expand telehealth flexibilities afforded to providers under the COVID-19 Public Health Emergency, including lifting of site of service and geographic restrictions as well as allowing for the use of audio-only telehealth services when clinically appropriate or when no other alternative exists.

Closing

In closing, I want to reiterate how encouraged I am by the bipartisan, bicameral support we're seeing from Congress and in particular this Committee regarding addressing our most pressing mental health and substance use disorder needs. I thank you for extending to me the opportunity to testify before you here today and look forward to both hearing my colleagues on the panel testify and to answering each of your questions.