PRESENTED BY: Angela Kypriotis

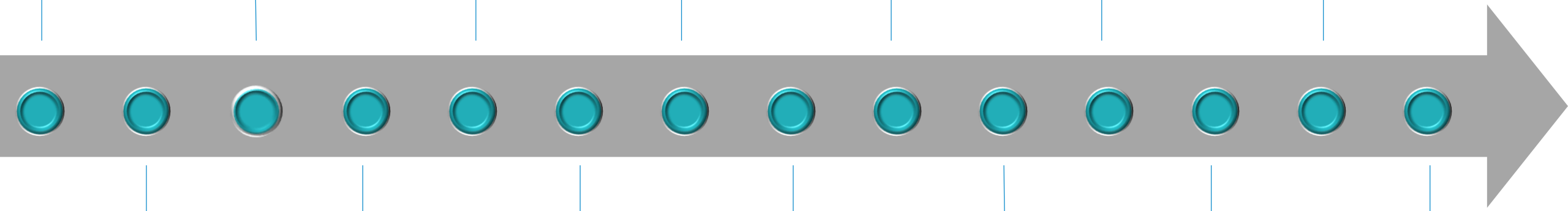
Implementation of Collaborative Care Model in Primary Care

AHN

Agenda

1. How It Started- The Vision
2. BH Integrated Care Committee
3. Choosing A Model & Choosing The Role/Credentials of BH CM
4. Measuring What We Do
3. Q&A

BHC Timeline



Sept 2015
1st BHC hired for residency

Dec 2016
2nd BHC hired for residency

Jan 2017
Hired 1st Chronic Condition BHC

Sept 2017
Primary Care redesign begins; Includes plan for BH in care team

Dec 2017
Primary Care, Psychiatry & Dept. of Medicine create BH Collaborative

Jan 2018
Hired 2nd Chronic Condition BHC

May 2018
BH Manager starts, BH workgroup formed

June 2018
Model selected, progress note submitted to EPIC, job description revised

Sept 2018
Hired 1st Specialty BHC

Nov 2018
Hired 3rd BHC in Primary Care & 3rd for Chronic Cond

Dec 2018
Hired 2nd Specialty BHC, 4th Chronic Condition, and started billing workgroup

Jan 2019
Hired 3 more BHC's in Primary Care

Feb 2019
Hired 3 more BHC's in Primary Care, 1 specialty

Mar 2019
Hired 1 more BHC in Primary Care; Recruiting 2 more, progress note expected to go live

Foundation: Support & Infrastructure

- Leadership Vision & Champions
- Assess Current State (existing staff?)
- Create BH Integration Workgroup
- Create Charter, Outline Goals
- Choose Model/Determine Minimum Qualifications
- Consider Sustainability
- Participate in AIMS monthly implementation and finance calls
- Human Resources-Create Position
- Build Medical Record To Meet Needs-ours included billing
- Hire BH Roles
- Create Orientation, Training, Supervsion Structures
- Create Learning Collaboratives

Choosing A Model
&
Role of BH CM

SAMHSA's 6 Levels of Collaboration/Integration

Table 1. Six Levels of Collaboration/Integration (Core Descriptions)

COORDINATED KEY ELEMENT: COMMUNICATION		CO LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Behavioral health, primary care and other healthcare providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:
▸▸ Have separate systems ▸▸ Communicate about cases only rarely and under compelling circumstances ▸▸ Communicate, driven by provider need ▸▸ May never meet in person ▸▸ Have limited understanding of each other's roles	▸▸ Have separate systems ▸▸ Communicate periodically about shared patients ▸▸ Communicate, driven by specific patient issues ▸▸ May meet as part of larger community ▸▸ Appreciate each other's roles as resources	▸▸ Have separate systems ▸▸ Communicate regularly about shared patients, by phone or e-mail ▸▸ Collaborate, driven by need for each other's services and more reliable referral ▸▸ Meet occasionally to discuss cases due to close proximity ▸▸ Feel part of a larger yet non-formal team	▸▸ Share some systems, like scheduling or medical records ▸▸ Communicate in person as needed ▸▸ Collaborate, driven by need for consultation and coordinated plans for difficult patients ▸▸ Have regular face-to-face interactions about some patients ▸▸ Have a basic understanding of roles and culture	▸▸ Actively seek system solutions together or develop work-a-rounds ▸▸ Communicate frequently in person ▸▸ Collaborate, driven by desire to be a member of the care team ▸▸ Have regular team meetings to discuss overall patient care and specific patient issues ▸▸ Have an in-depth understanding of roles and culture	▸▸ Have resolved most or all system issues, functioning as one integrated system ▸▸ Communicate consistently at the system, team and individual levels ▸▸ Collaborate, driven by shared concept of team care ▸▸ Have formal and informal meetings to support integrated model of care ▸▸ Have roles and cultures that blur or blend

Researching Models

COMPASS

Mental Health Integration Prog

IMPACT/Collab Care

PACT-VA

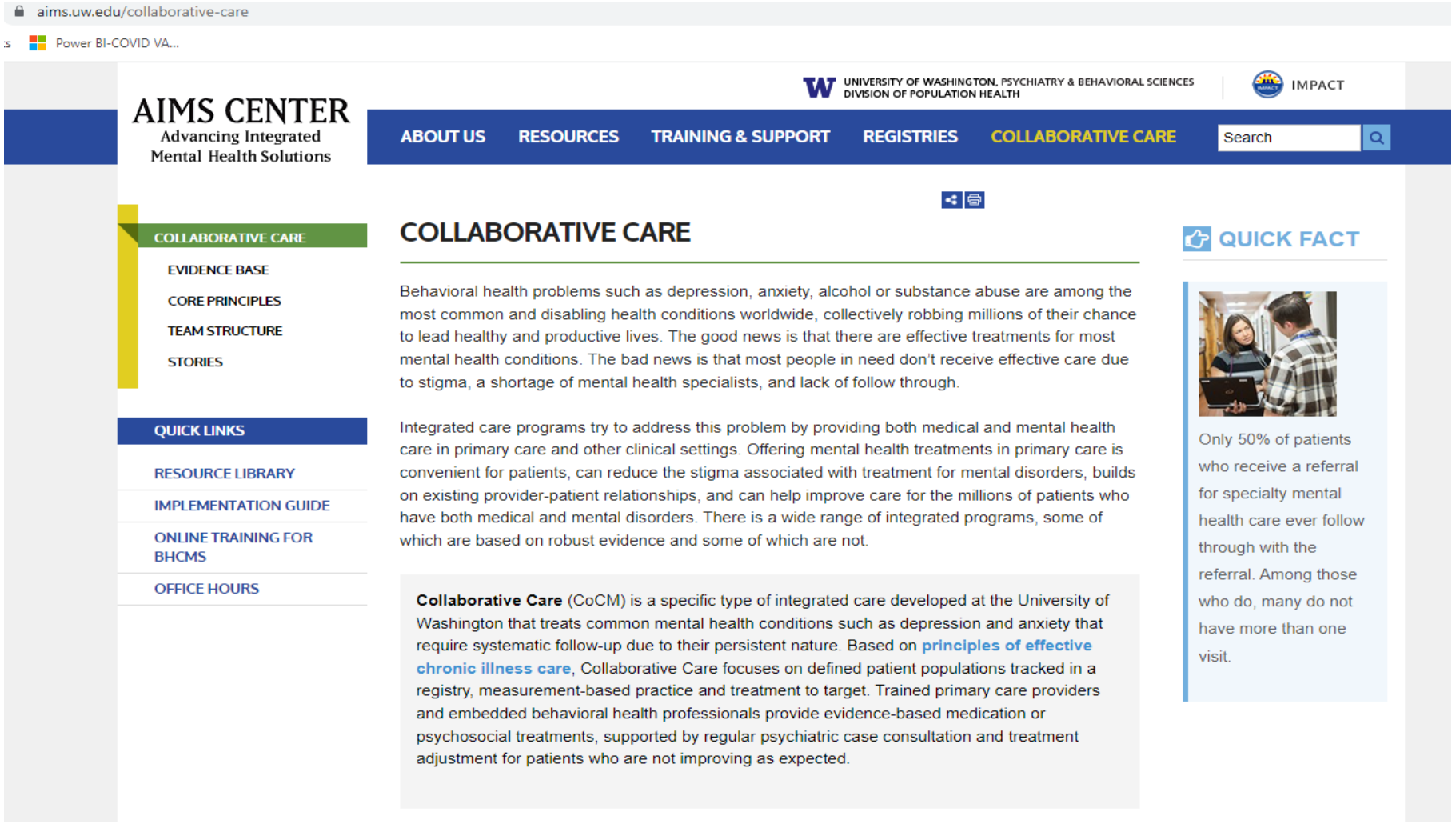
RESPECT-MIL

UC Davis Depression CM

Kaiser

TeamCare

University of Washington AIMS Center Website



AIMS Center-Principles of Effective Integrated Health Care

Five core principles define Collaborative Care and should inform every aspect of an implementation. If any one of these principles is missing, effective Collaborative Care is not being practiced. These principles, along with core components and tasks, were developed in consultation with a group of national experts in integrated behavioral health care in 2011 with support from The John A. Hartford Foundation, The Robert Wood Johnson Foundation, Agency for Healthcare Research and Quality, and California HealthCare Foundation.

Patient-Centered Team Care
Primary care and behavioral health providers collaborate effectively using shared care plans that incorporate patient goals. The ability to get both physical and mental health care at a familiar location is comfortable to patients and reduces duplicate assessments. Increased patient engagement oftentimes results in a better health care experience and improved patient outcomes.

Population-Based Care
Care team shares a defined group of patients tracked in a registry to ensure no one falls through the cracks. Practices track and reach out to patients who are not improving and mental health specialists provide caseload-focused consultation, not just ad-hoc advice. Read how to identify a behavioral health patient tracking system [1] in our Implementation Guide [2].

Measurement-Based Treatment to Target
Each patient's treatment plan clearly articulates personal goals and clinical outcomes that are routinely measured by evidence-based tools like the PHQ-9 depression scale [3]. Treatments are actively changed if patients are not improving as expected until the clinical goals are achieved. Measurement-Based Treatment to Target [4] is sometimes called Stepped Care.

Evidence-Based Care
Patients are offered treatments with credible research evidence to support their efficacy in treating the target condition. These include a variety of evidence-based psychotherapies proven to work in primary care, such as PST [5], BA and CBT, and medications. Collaborative care itself has a substantial evidence base [6] for its effectiveness, one of the few integrated care models that does.

Accountable Care
Providers are accountable and reimbursed for quality of care and clinical outcomes, not just the volume of care provided. Read more about accountability in our Financing [7] section.

Deciding on BH Role

AIMS- Univ of WA

JOB DESCRIPTION

- **Behavioral Health Care Manager Job Description**

Effective BHCMs support the PCP in their role by

- ✔ participating in diagnosis and treatment planning
- ✔ coordinating treatment
- ✔ providing proactive follow-up of treatment response
- ✔ alerting the PCP when the patient is not improving
- ✔ supporting medication management
- ✔ facilitating communication with the psychiatric consultant regarding treatment changes
- ✔ offer brief counseling (using evidence-based techniques such as motivational interviewing, behavioral activation, and **problem-solving treatment**)

Job Description

GENERAL OVERVIEW:

A BHC is a member of the core healthcare team who assists the care managers in managing overall health of their enrolled population. The BHC's goals are to help improve recognition, treatment, and management of psychosocial/behavioral problems and medical conditions in the enrolled population. The BHC provides clinical mental health consultation services within the scope of their state's professional licensure board to all patients referred by the care team. The BHC participates in the management of psychosocial aspects of chronic and acute diseases, application of behavioral principles to address lifestyle and health risk issues, consultation and co-management in the treatment of mental disorders and psychosocial issues. The BHC is the team's go-to expert for mental health and substance abuse assessment, intervention, and connection to higher levels of care for mental health and addiction services as required.

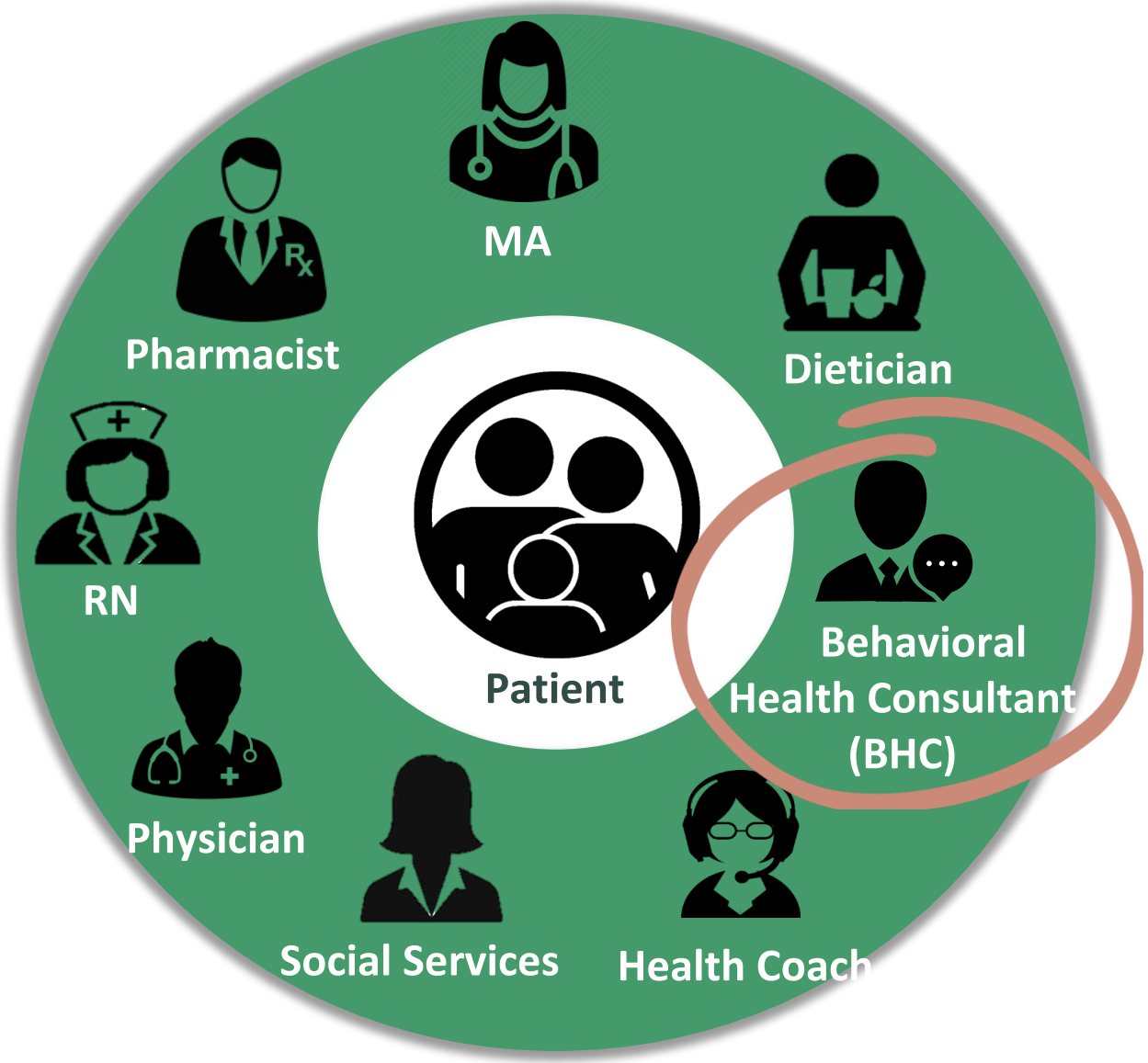
ESSENTIAL RESPONSIBILITIES:

1. Member of Care Team & Population Health Efforts
   - Acts as a core care team member to develop specific clinical pathways or best practice programs for targeted patient groups
   - Participates in practice staff meetings and trainings
   - Provides education and support on a variety of topics from behavioral health and substance abuse background, training, and expertise to multidisciplinary team members during the course of treatment planning for patients
   - Participates in daily huddles, listening for behavioral health, substance abuse, and psychosocial needs
   - Provides population based care based on registry to high risk/high need patients
   - Provides services to all enrollees (not just those with diagnosable mental disorders)
   - Participates in system-wide BHC learning collaborative
2. Effective Communicator and Change Agent
   - Promotes ongoing change efforts in the practice and within the AHN health system around mental health and substance abuse disorders
   - Documents in the same medical record as the rest of the team in a place that is easily visible by providers and other team members
   - Engages patients via telephone as well as in person
3. Clinical Interventions
   - Meets patients and providers where they are, usually the same day a patient presents in clinic providing immediate support to include assessment, intervention and referrals to higher levels of care for mental health and addiction needs when required
   - Often sees patients immediately after other team members (often in exam room or nearby consult room) and encourages patient participation in the overall treatment plan
   - Provides therapeutic counseling services appropriate to the ambulatory care environment: using 15-30 minute interventions
   - Identify functional outcomes; make recommendations that target occupational, social, and familial functioning; home activities; recreation
   - Treat patients with short term interventions based on "treat to target" approach using solution focused approaches, CBT, Motivational Interviewing and other short term counseling interventions
   - Coordinates with patient family members and other support systems (with patient permission)
   - Provide brief follow up, including relapse prevention education
   - Promote skill building to enhance psychological and physical health/sometimes in the form of groups
   - Helps patient in crisis get urgent mental health and substance abuse needs met
   - Triage and refer patients to specialty mental health and substance abuse services when appropriate (i.e. Childhood trauma, IOP, inpatient hospitalization, PTSD, psychiatry, etc.)
4. Advocacy, Outreach, Community Linkages, and Coaching
   - Advocates for patients who are perceived as difficult to work with or "non-compliant"
   - Reaches out to patients who are not engaging (usually via phone) to re-engage them in their care
   - Encourages patient to become an active participant in their own care and treatment
   - Connects patient to a variety of resources in the community related to social determinants of health

Behavioral Health Consultant

Behavioral Health Consultant (BHC)-

- **Licensed behavioral health professional who can assess and treat patients for behavioral health conditions as well as grief, adjustment to illness, behavior change related to chronic conditions, substance use, etc.**
- **Brief intervention model (6-8 sessions)**
- **Refers to higher levels of care when necessary**
- **Consults weekly with AHN Psychiatrist, liaison to PCP**



BHC

- Meets patients and providers where they are, providing **immediate support**
- Available for **“warm handoffs”**
- Helps patient in crisis get **urgent mental health** and substance abuse needs met
- Treat patients with short term interventions based on **“treat to target”** approach
- Provide brief follow up, including **relapse prevention** education
- **Triage** and refer patients to specialty mental health and substance abuse services when appropriate

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Warm Hand-offs

ID

- PCP meets with pt
- Need identified
- PCP describes members of team who have expertise in this area
- PCP asks pt permission to include BHC

Intro

- PCP brings BHC in room
- PCP introduces identified need and literally “hands off” to BHC
- PCP usually leaves the room

GO

- BHC takes some time to get to know the patient, build rapport and does an initial assessment if time permits
- BHC schedules follow up with patient
- BHC keeps PCP in the loop

Warm Handoffs

A Guide for Clinicians

What is a warm handoff?

A warm handoff is a handoff that is conducted **in person**, between two members of the health care team, **in front of the patient** (and family if present).

How do I conduct a warm handoff?

Whenever you need to share information about patient care, do it in person and in front of the patient.

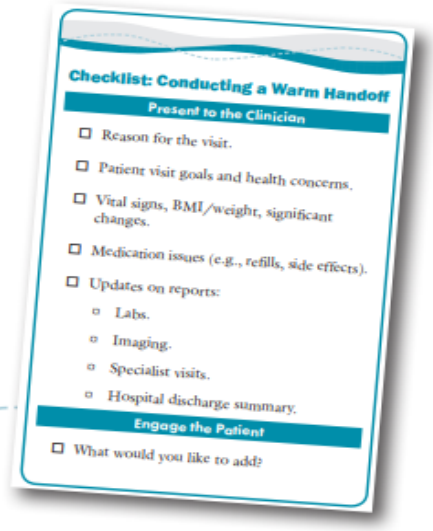
You can both give and receive warm handoffs. For example:

- After your staff has roomed the patient, the staff member can use a warm handoff to present the patient to you. A checklist is available to help with this.
- After you complete the clinical exam, you can use a warm handoff if additional patient services such as labs or immunizations are needed.
- You can use a warm handoff with extended care team members such as a diabetes educator or pharmacist and with specialists.

Why is it important?

Communication breakdowns can result in medical errors. Warm handoffs can help address communication issues and:

- Engage patients and families and encourage them to ask questions.
- Allow patients to clarify or correct the information exchanged.
- Build relationships.
- Provide a safety check.



AHRQ Agency for Healthcare Research and Quality

Guide to Patient and Family Engagement in Primary Care

CHARTER

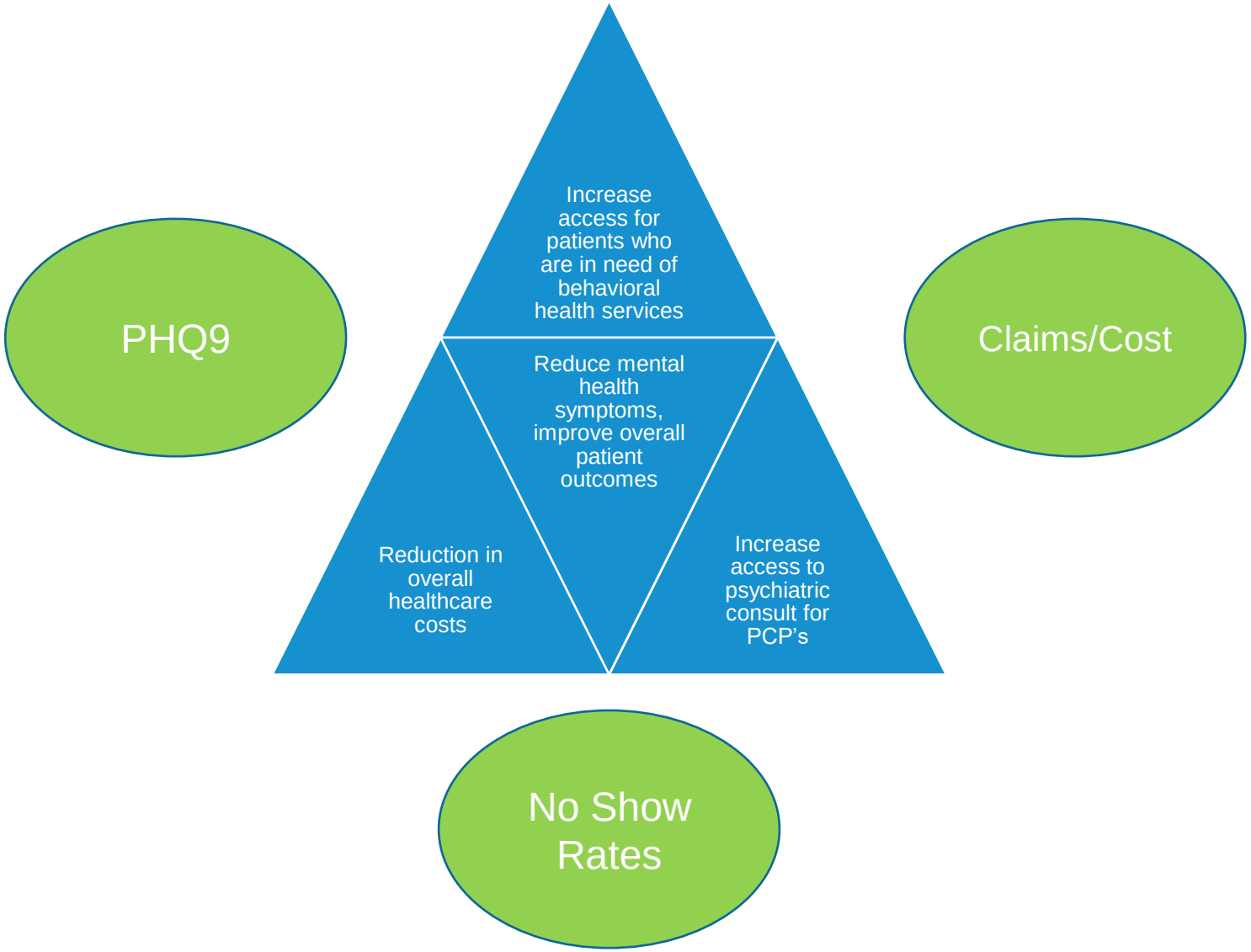
Charter-Background

Allegheny Health Network (AHN) has shown support for the Team Based Care Model based on evidence that has been proven effective in other health systems across the United States. In several ambulatory practices supportive positions have been added to include Health Coaches, RN's, and in some cases ancillary supports such as Pharmacy and Nutrition as well as Behavioral Health. Managing depression, anxiety, grief, and other mental health conditions as well as substance use disorders often fall to primary care or specialty providers when patients are not actively seeking specialized support in other parts of the community. The integration of behavioral health support on-site has become widely recognized as a successful intervention for increasing access for patients in a convenient and trusted location. This resource also gives providers the comfort of having an on-hand specialist to help manage some very complex patient populations.

Charter- Background continued

AHN plans to recruit, hire, train, and integrate Behavioral Health Consultants into additional ambulatory practices in 2019 and 2020. Staffing allocation is based on panel size, insurance type, number of patients with chronic conditions, and an assessment of vulnerable populations served. Some practices provide medication assisted treatment (MAT) for example and may require additional counseling support. The role of the BHC is based on the evidence based Collaborative Care model out of the University of Washington AIMS and is in line with the NCQA's Behavioral Health Integration model for a Patient Centered Medical Home. Additionally, in January 2018 the Center for Medicare and Medicaid Services introduced new CPT codes referred to as Psychiatric Collaborative Care Services [6] for this work and other payers are quickly following CMS to support reimbursement.

Charter-Project Goals & Outcome Measurements



Implementation

Implementation Phase I: Getting Started

Choose the Right Practice

- Practice has providers and a practice manager who are open to change and willing to be champions
- Practice is open to screening for depression- every patient, every visit
- Practice has a space for BHC in their office-can be shared space

Choose The Right Hiring Team & The Right BHC

- Interview BHC's with the practice manager and physicians. The practice voice is very important in selecting their new member
- Choose a BHC that has background and experience that is appropriate to the site's needs (ie. adults, children, specialty populations)

Create Standardized Documentation For BHC's in the EMR

- Work with IT to create standardization of documentation (BHC progress note) in the Medical Record
- Progress note includes drop downs and collectible fields in order to improve cross-system/cross-department data collection for this role

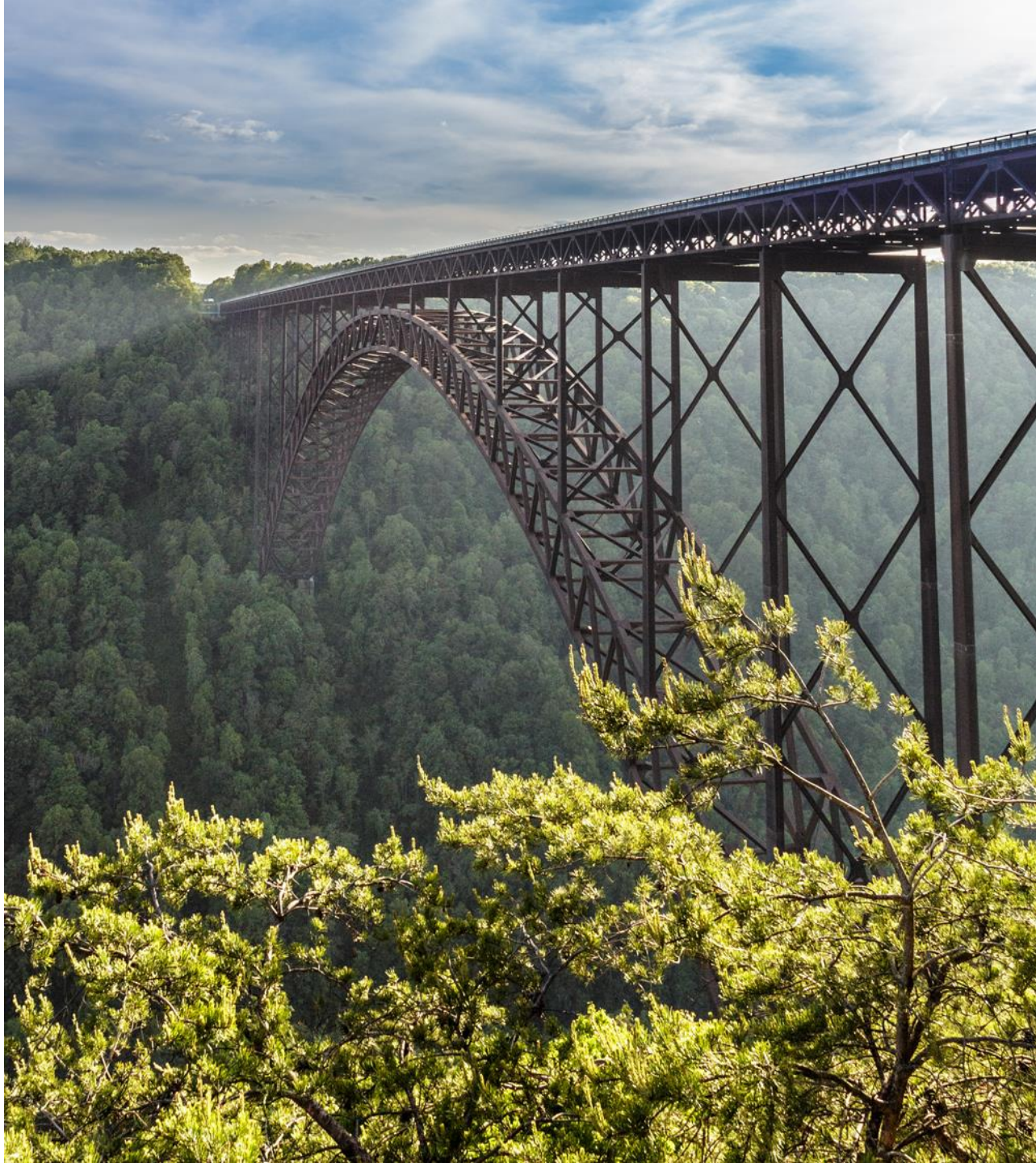
Implementation Phase II: Billing CoCM

Set Up Billing Logistics

- Establish a relationship with billing and coding team to determine what documentation needs to be in place
- Establish process for collective billing at end of each month so appropriate code(s) can be dropped (ie. Work que in EPIC)
- Provide education on new process to BHC's, practice managers, providers, billing and coding team, etc.
- Test billing for sample patients to work out any kinks
- Establish communication process for explaining services and copays to patients

Set up Psychiatric Consult Logistics

- Partner with Psychiatry Department to designate Psychiatry resource
- Establish pilot sites to test weekly psychiatry consult
- Establish process for providers to add cases to be discussed to the weekly list
- Establish process for psychiatrist to receive list and have time to review case in medical record before consult time
- Establish process for psychiatrist to document recommendations in the medical record
- Establish process for psychiatrist to be contacted outside of regular consult time for urgent needs
- Establish process for BHC to maintain registry of patients being followed



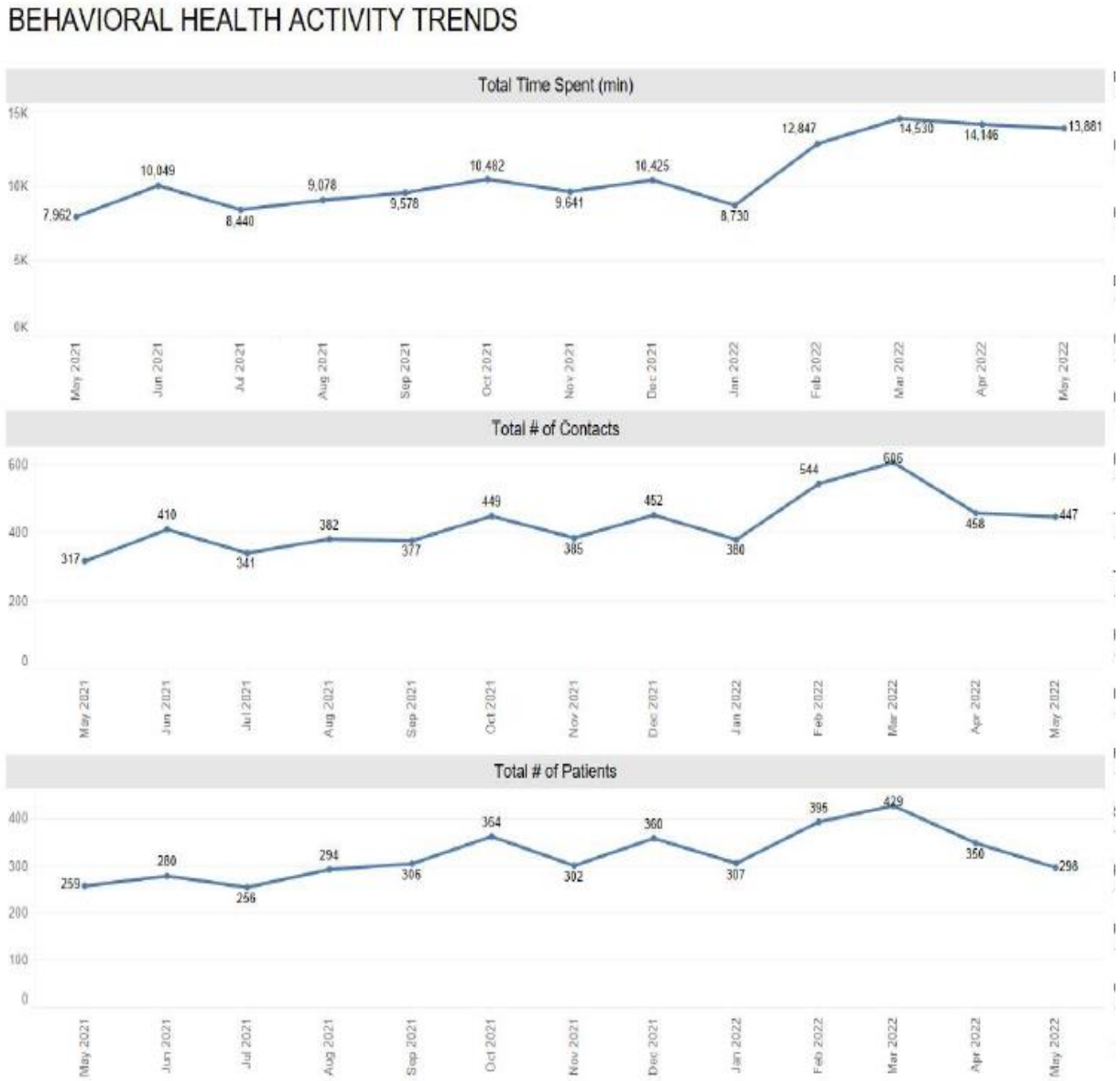
Implementation Phase III: Capturing Data & Telling The Story

Set up Reporting Logistics

- Work with IT to build reports that can be pulled as needed/or on a regular cadence from the medical record

Use Data For Decision Making and Measurement

- Use information gathered to review utilization
- Use information gathered to make adjustments to staffing
- Use information gathered to tell the story of the work that is being done
- Use information gathered to measure impact on care team
- Use information gathered to show symptom improvement and progress towards goals



Implementation Phase IV: Review, Revise, Replicate

Quality Improvement

- Use QI Process to review successes and failures, revise process, and replicate successes
- Behavioral Health Workgroup continues to meet to discuss changes in procedures and process
- Bring BHC's together monthly from various sites to continue to learn from each other
- BHC leadership team meets weekly
- BHC Leads and Supervisors provide ongoing training for existing employees and orientation training for new hires
- Continued participation in AIMS calls monthly

Training and Supervision

Training for BHC's

- Motivational Interviewing (Highmark)
- Problem Solving Therapy (AIMS)
- Stigma Reduction Training (Pitt)
- SBIRT training in 6 offices (Pitt)
- CBT-Insomnia (Stanford)
- Internal resources within AHN and within Highmark (Dept of Psychiatry, Center for Inclusion Health, Womens BH, Care Management, Regional SW)
- External Resources In Regional Pods
- Conferences- CFHA

Training Links

- **What is integrated care? (6 min)** https://www.youtube.com/watch?v=S-029Yf7AYM
- **SAMHSA-Behavioral Health Integration- whole person care (3 minutes)** https://www.youtube.com/watch?v=79-KMN6IWXk
- **Core Components of the BHC visit by Dr. Serrano (14 minutes)** https://www.youtube.com/watch?v=xmiXvRIRWFE&app=desktop
- **How to introduce your BHC to the patient (5 minutes)** https://www.youtube.com/watch?v=luTrKOeQ4ag
- **Dr. Serrano re: Follow up visits in Primary care (10 minutes)** https://www.youtube.com/watch?v=2TyTFk9p1R0
- **Behavioral Health Screening (7 minutes)** https://www.youtube.com/watch?v=qbyb-B6sv00
- **Physician started using PHQ9 in cardiology patients (4 minutes)** https://www.youtube.com/watch?v=DtQCp5350as
- **Integrated BH in PCP offices by Christiana Care, Dr. Linda Lang (3 minutes)** https://www.youtube.com/watch?v=L9_vWCh0m3Y
- **BHC Warm Handoffs** https://www.youtube.com/watch?v=iOsprxCI4bM&list=PLEfjD1Shw8jNkasGemOrgQb4cw4bWRTrV&index=100
- **A Day in the Life of a BHC, David Bauman, PsyD (18 minutes)** https://www.youtube.com/watch?v=9XfvrEaSR0U
- **Warm Hand Off Diabetes, David Bauman, PsyD** https://www.youtube.com/watch?v=JKFWsb8RtW0

Clinical and Administrative Supervision

Total Team=49

1st step: Manager for Behavioral Health, LCSW-1

2ndstep: Lead Behavioral Health Consultant, LCSW or LPC (60%/40%) (cannot have direct reports)-4

3rd step: Project Manager-1

4th step: Supervisor Behavioral Health Consultant, LCSW or LPC (60%/40%) (has direct reports)-2

- Monthly 1:1 supervision, 1 hour
- Quarterly reviews, review goals, caseloads, targets, self-care strategies, needs
- Available daily as needed by phone for consultation/emergencies
- Regional teams have monthly learning collaboratives specific to the resources in their area and clinical needs of the team

Communication With Care Team

Collaborative Family Healthcare Association (CFHA)

Dr. Serrano describes nicely the differences between a traditional therapist/patient relationship and the patient relationship with the whole care team in a primary care setting.

How do primary care behavioral health programs provide informed consent for treatment? By Dr. Neftali Serrano

- The practice of informed consent for treatment is a practice that has some parallels in medicine, usually for specialty services such as surgery, for example, but also has deep roots in the practice of specialty mental health as evidenced by the attention provided to informed consent in the American Psychological Association's ethical codes.
- The practice of informed consent in the primary care behavioral health model differs significantly from that in specialty mental health in large part due to the difference in the nature of the relationship between the patient and the behavioral health consultant versus the nature of the relationship between the patient and therapist. In the primary care behavioral health model the **behavioral health consultant is responsible first to the primary care provider and only provides services to patients as part of the primary care provider's medical team**. In other words, **whereas the therapist maintains sole ownership of the relationship with their client, the behavioral health consultant only maintains a relationship indirectly with the patient through the services of their primary care clinic**. This is why in a specialty mental health environment a therapist will begin the process of care by reviewing the parameters of treatment including risks and benefits and other particulars related to patient confidentiality and patient responsibilities.
- In the primary care behavioral health model many of these details of treatment are either the primary responsibility of the primary care provider or depending on how a clinic may function, the responsibility of the clinic administration when taking on new patients. However in primary care the standards for informed consent vary greatly, although presentation of patient rights in accordance with federal law (HIPAA) are a consistent legal standard. Therefore many primary care behavioral health practices have more fully developed their new patient registration processes to provide information relevant to the work of behavioral health consultants as part of the medical team, patient rights with respect to their treatment and ownership of confidential medical information and patient responsibilities related to payment. These are often presented to patients at the point of registration or at subsequent points in their care in paper form.
- Additionally, **behavioral health consultants routinely provide additional information related to informed consent when consulting with a patient for the first time**. This may include a brief description of their role on the medical team, limits on confidentiality, notification of documentation practices (e.g. joint record-keeping) and a description of how care is likely to proceed in collaboration with their primary care provider. In concordance with relevant ethical codes such informed consent may need to be repeated over time based on the circumstances of patient care to ensure that patients have a clear understanding of the course of their care. Generally speaking most primary care behavioral health practices do not have separate documentation of informed consent as signed in paper form similar to what occurs in specialty mental health since the relationship that the patient has is to the primary care clinic not primarily with the behavioral health consultant. However it is **good practice for such conversations to be documented by behavioral health consultants in the medical record**.
- While these practices have emerged as part of the development of the primary care behavioral health model professional ethical standards and in some cases state-based regulations have generally not kept up with practice. As such, program developers need to refer to their local regulations to determine adequate compliance.

1. For a comprehensive review of current standards of practice related to informed consent and other ethical challenges see: http://www.ncbi.nlm.nih.gov/pubmed/?term=Navigating+the+legal+and+ethical+foundations+of+informed+consent+and+confidentiality+in+integrated+primary+care
2. For a description of the American Psychological Association's ethical codes related to inform consent see: http://www.apa.org/ethics/code/index.aspx?item=6#310

BHC & Care Team Communication

- Huddles: frequency varies by office/team
- Medical Record: chats, copied on notes
- Pop-ins: quick in person chats or hallway updates
- Email
- Phone
- Psychiatric Consultant Case Reviews

Adapt to provider style

Consenting Patients

- Introduce name and title and explain role as a support providing brief intervention.
- Outline the amount of time you will be spending with the patient today and in possible future appointments.
- Discuss confidentiality (mandated reporting, documenting in medical record and team based sharing relationship).
- Briefly describe the billing process and cost sharing for appointments if they would continue to meet with you.
- Document that you had this conversation with the patient the first time you interact with them (we created a smart phrase for use in the record).

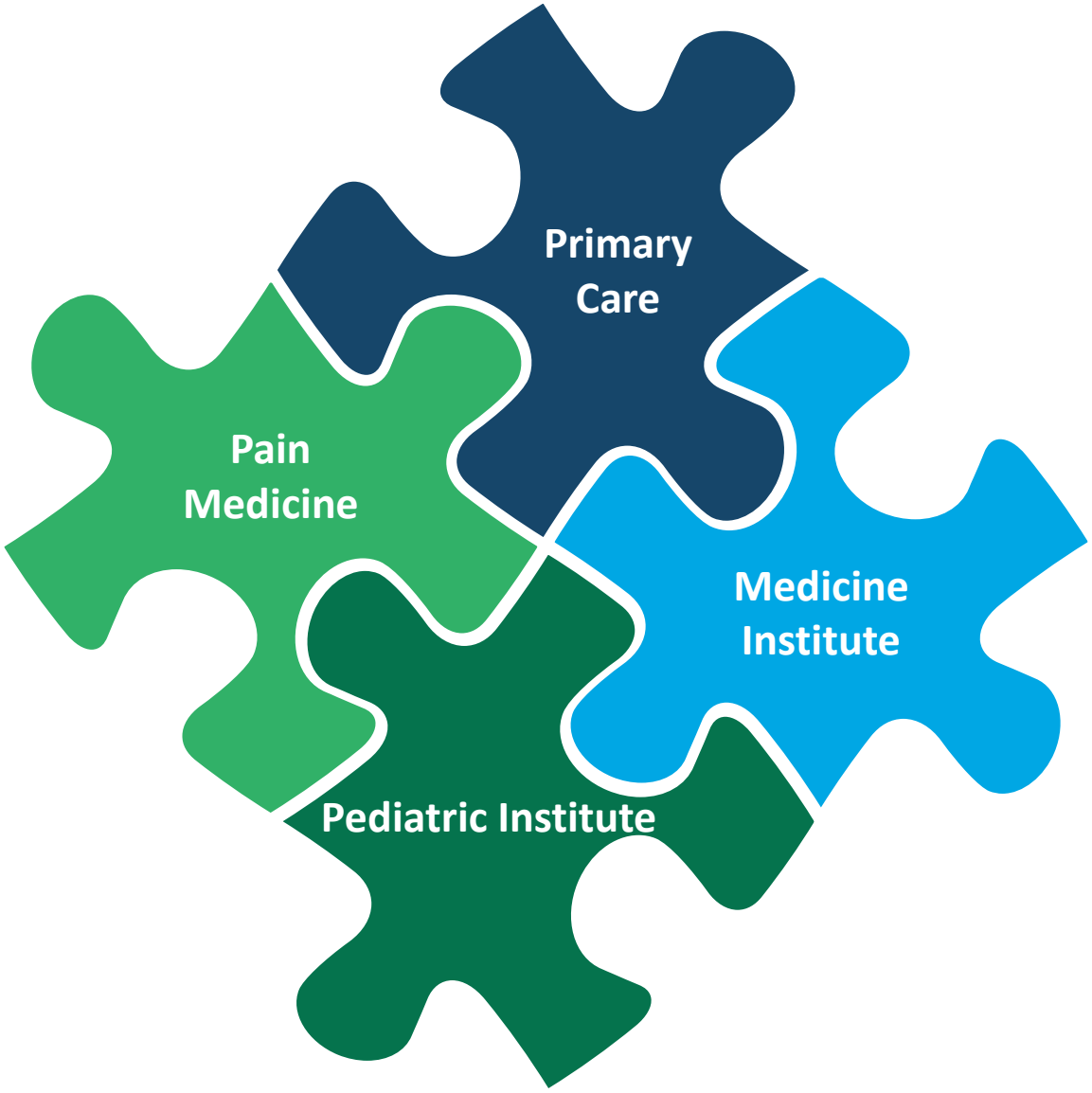
"Described to patient the team based care approach including the role of the Behavioral Health Consultant. Explained to the pt that the documentation by the BHC including behavioral health and substance abuse information will be accessible to all members of the care team. The pt verbalizes understanding of this team based care approach including the use of a shared electronic medical record."

What can PCP expect?

- FAST Access to care-same day/same week
- BHC Caseload 35-50
- Average 50-71mins/month per patient
- BHC will handle whatever the need is and will update PCP
- BHC triage and will bridge those who need higher level/specialty care while they wait (traditional therapy, psychiatric evaluation/assessment, substance use treatment, trauma or other specialized treatment)
- BHC will “treat to target” based on evidence based tools such as PHQ9/GAD7
- When BHC is not physically in office they will call patient within 2 days
- BHC will discuss with PCP when ready to discharge

Where Are We Now?

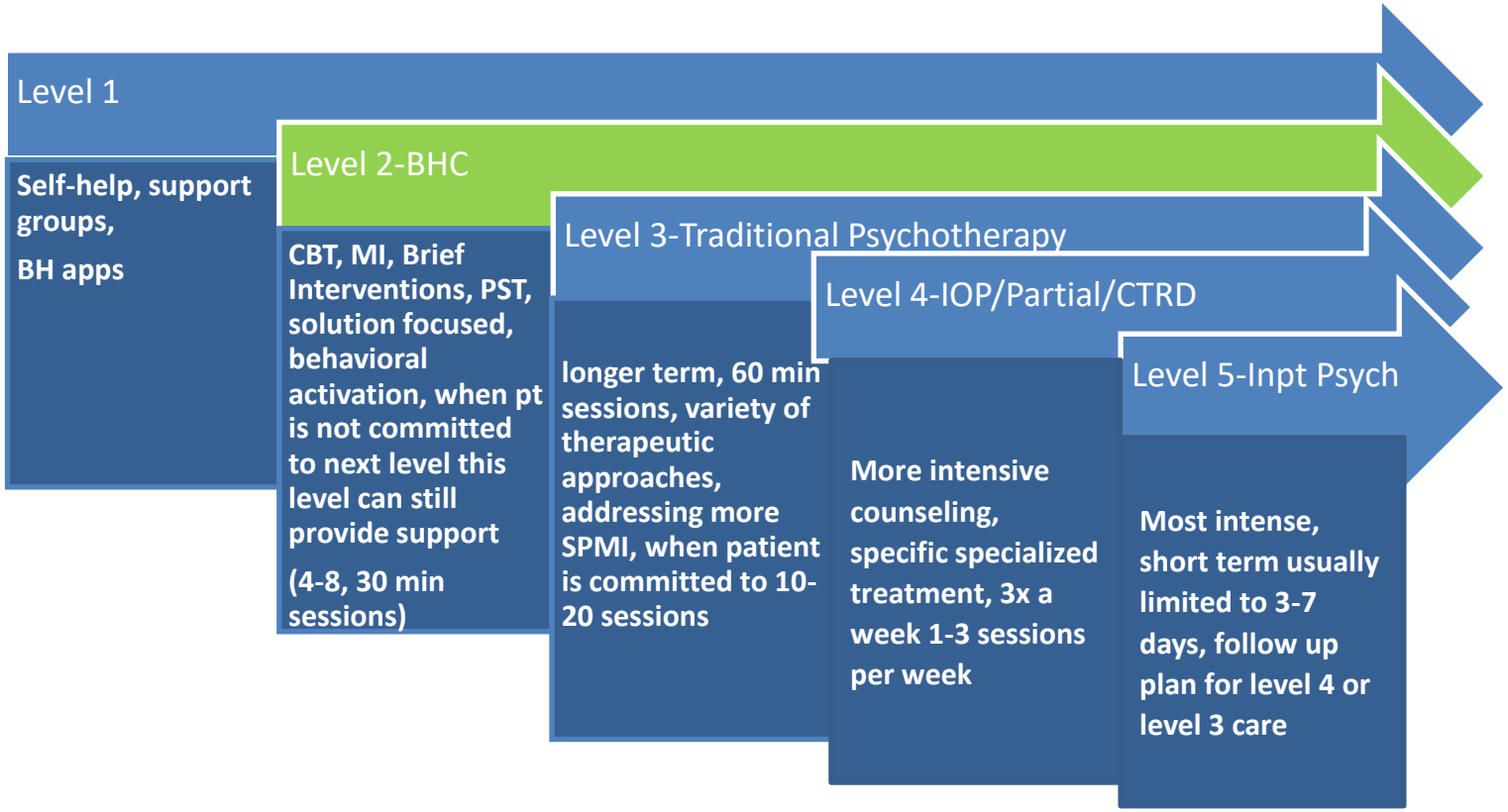
Behavioral Health and Social Services Integration



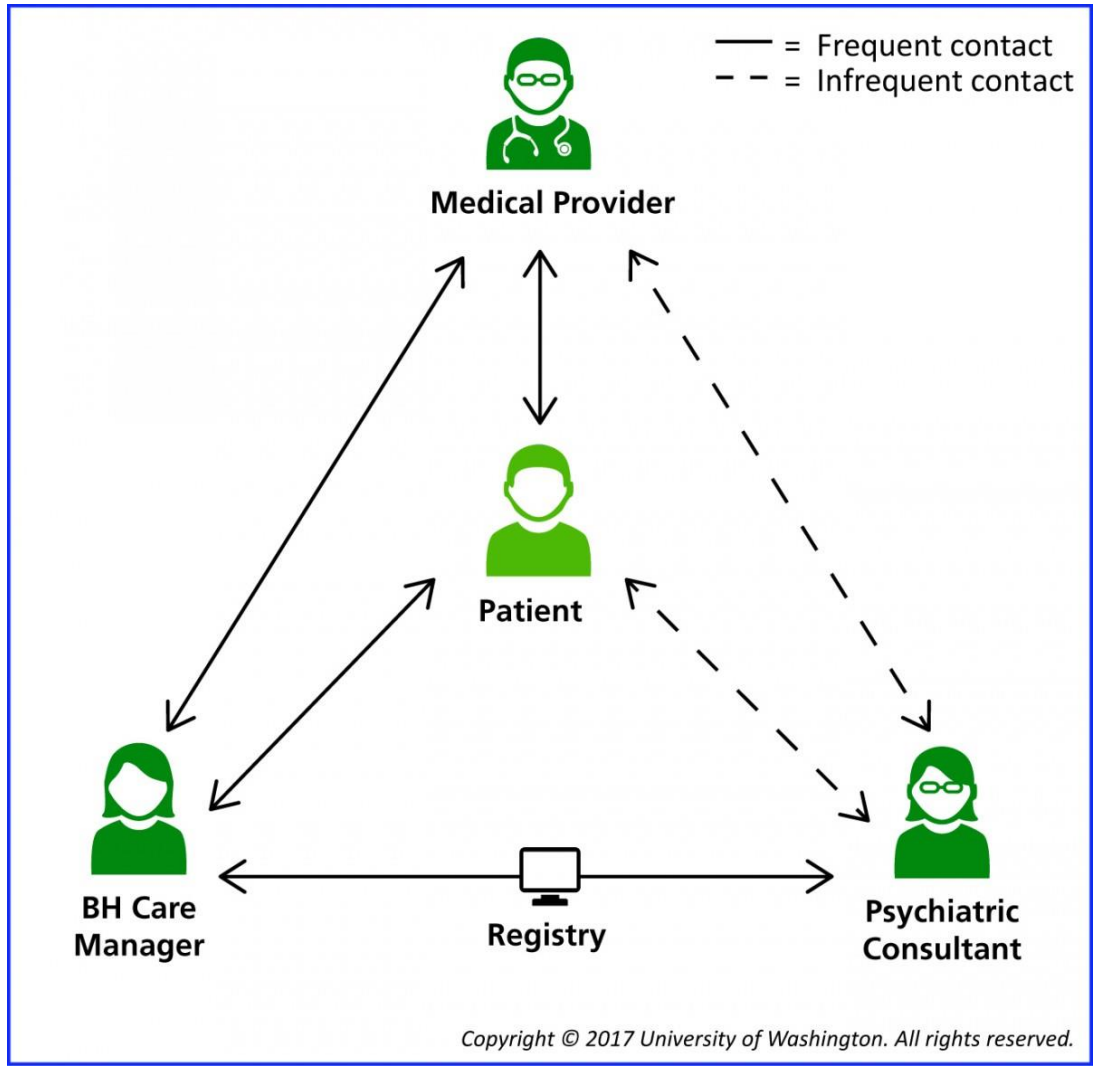
- **Primary Care (70 sites)**
  - BHC Supervisors: 2
  - BHCs: 36
  - SWs: 6
- **Medicine Institute (10 sites)**
  - BHC Supervisor: 1
  - BHCs: 6
  - Caseworkers: 3
- **Pain Medicine (6 sites)**
  - BHC Supervisor: 1
  - BHCs: 3
  - Caseworkers: 1
- **Pediatrics (4 sites)**
  - BHCs: 1
  - SWs: 1

Inter Department Collaboration

Levels of BH Care



Psychiatry Consult



- Designated weekly consult time for each BHC (who is covering between 1-3 practices)
- Discuss diagnostic questions, symptom management, treatment plans, and medications
- BHC is often the liaison between Psychiatrist and PCP: sometimes there are additional follow up questions, tools to administer, or additional patient history needed
- Psychiatrist makes recommendations to PCP
- PCP decides whether to implement recommendation
- PCP is the prescriber
- PCP can reach out to Psychiatrist anytime for follow up questions, concerns and urgent situations

Weekly Psychiatric Case Reviews

- **Criteria:** Anyone the PCP and BHC would like reviewed- could be new patient, could be discussing a previously discussed patient regarding follow up
- **How:** PCP sends BHC name, MRN and question or problem they are trying to solve for (diagnosis? medication changes? considering medication? etc.) to the BHC. BHC keeps list and sends it to psychiatric consultant the day before standing scheduled time.
- Symptom history and timeline
  - What are symptoms
  - Are symptoms worsening recently
  - What has helped symptoms
  - Any trauma history
  - Sleep disturbance and history
- Med History and timeline
  - What meds in the past
  - Have any medications helped relieve symptoms
  - Did the patient give the medication a good trial period (4-6 weeks)
- Family history of MH and meds
  - Family history of MH
  - Have any meds worked/not worked for other family members

Psychiatric Collaborative Care Billing

Psychiatric Collaborative Care Services (CoCM)

- **CMS adopted codes in 2017**

- Integrating behavioral health care with primary care (behavioral health integration or BHI) is now widely considered an effective strategy for improving outcomes for millions of Americans with mental or behavioral health conditions. Medicare makes separate payment to physicians and non-physician practitioners for BHI services they supply to beneficiaries over a calendar month service period.

- **https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf**

Psychiatric Collaborative Care Services (CoCM)

What is CoCM? This figure is a model of behavioral health integration that enhances usual primary care by adding two key services to the primary care team, particularly patients whose conditions are not improving: Care management support for patients receiving behavioral health treatment and regular psychiatric inter-specialty consultation.

A team of three individuals deliver CoCM:

1. Behavioral Health Care Manager (what we call a Behavioral Health Consultant or BHC at AHN)
2. Psychiatric Consultant
3. Treating (Billing) Practitioner

Psychiatric Collaborative Care Services (CoCM)

- **Calendar month billing (total and drop code at end of month)**

Code	
99492 (CoCM)	70 mins/calendar month-1st visit
99493 (CoCM)	60 mins/calendar month
99494 (CoCM)	Each addtl 30 mins/month
G2214 (CoCM)	30 mins/calendar month
99484* general integration	20 mins/calendar month

Psychiatric Collaborative Care Services (CoCM)

- BHC drops “dummy” miscellaneous code in charge capture in EPIC note
- Flows to special work que for this specific misc code-staffed by those who have been trained
- Billing team drops appropriate CPT code after month end/total minutes tallied
- Copays are pretty low for patients (except high deductible plans)

Evaluation

Clinical Evaluation- Patient Progress

Treat to target (and often bridging to another level of care)

- Reduction in PHQ-9 scores
- Reduction in GAD-7 scores
- Other conditions not as easy to measure
- Clinician evaluates status at discharge as one of these discreet fields
  - Did not achieve any goals
  - Partially achieved goals
  - Partially achieved goals and needed higher level of care
  - Successfully achieved most or all goals
  - Patient moved out of area
  - Patient is deceased
- Still a work in progress

Program Evaluation

- Look at Stars Scores, consider as part of transformation sometimes difficult to measure because multiple interventions happening at the same time
- Build discreet fields in medical record
- Engage data analytics team
- Build reports or dashboards for individual BHC level and department level data- allows you to look at activity level/volume and make decisions about FTE allocation to clinics
- Data analytics team can collect data, group data, look at trends, create comparison /control group, pre and post intervention (COVID time might be excluded)
- If you have access to claims that may be a good place to look
- Takes time to get large enough “N” for statistically significant results
- Takes time to show cost savings over time
- Ask providers for anecdotal feedback
- This is still a work in progress

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