Collaborative Care: Bring Behavioral Health Home

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Leisa Bailey, MD, FAAFP

Family Physician, Bailey Family Practice, Bonifay, Florida

Dr. Bailey is a 1987 graduate of Baylor College of Medicine, Houston, Texas, and completed her family medicine residency at Eglin Air Force Base (AFB) in Florida. After serving as an Air Force physician in Operation Desert Storm, she opened a private practice in the rural community of Bonifay, Florida, where she has been for more than 25 years. She practices a full spectrum of family medicine, including obstetrics, pediatrics, geriatrics, inpatient care, and emergency medicine. Several years ago, she began the process of practice transformation. It has evolved into a team approach with a robust chronic care program, group visits, and, more recently, a fully integrated behavioral health program that includes onsite mental health counselors and an integrative collaborative care team.
Grace Wagstaff
Performance Coach and Mindfulness Advocate, Troy, Alabama

A native of Bonifay, Florida, Bailey earned a bachelor's degree in theatre and a master's degree in clinical mental health counseling from Troy University in Alabama. She is a performance coach, an award-winning actress, and a mindfulness advocate. She is passionate about helping others and believes deeply in the power of kindness.

Diane Little, APRN
Psychiatric Consultant, Collaborative Care Program, Bailey Family Practice, Bonifay, Florida

Little is a psychiatric nurse practitioner who earned her Bachelor of Science (BS) degree at Florida State University in Tallahassee. She worked at the Life Management Center in Bonifay, Florida, for many years before returning to earn her master’s degree in psychiatric nursing at University of South Alabama, Mobile. For several years, she worked as a psychiatric nurse practitioner at Bailey Family Practice, followed by a position at the COPE Center in Defuniak Springs, Florida. After a successful career at the COPE Center, she recently retired from full-time practice and is currently providing consulting services to Bailey Family Practice. She is also an active volunteer in her church’s jail ministry and the director of a free medical clinic in her community.
Learning Objectives

1. Describe the value of comprehensive and coordinated care for both the patient and the practice.

2. Develop a plan for identifying and collaborating with highly utilized specialists and care entities.

3. Identify opportunities and methods for integrating behavioral health into the primary care practices.
Why Integrate Behavioral Health?

Because it’s what we do…

• More than 8% of adults older than 20 years of age report having significant depression during any given 2-week period.
• More than 20% of people older than 60 years of age experience some type of mental health concern.
• In 2016, the AAFP and USPS Task Force recommended screening for depression in the general adult population, including pregnant and postpartum women.
• They clarified this recommendation with the following statement: "Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment and appropriate follow-up," the groups said.
It’s a vicious cycle…

- Patients with chronic medical conditions are more likely to develop depression and/or anxiety.
- Patients with depression, anxiety, and other mental health conditions are more likely to develop chronic medical conditions.
- Chronic medical conditions closely linked with mental illness include diabetes, coronary artery disease, cerebrovascular disease, cancer, obesity, and Parkinson’s.
- It is next to impossible to get chronic illnesses under good control when mental health issues are not treated and controlled.

Levels of Behavioral Health Integration

- Level 1: Minimal Collaboration
- Level 2: Basic Collaboration at a Distance
- Level 3: Basic Collaboration On-site
- Level 4: Close Collaboration in a PARTLY INTEGRATED system
- Level 5: Close Collaboration in a FULLY INTEGRATED system
Poll Question 1

In your practice, what is your highest level of behavioral health integration?

A. Minimal collaboration
B. Basic collaboration at a distance
C. Basic collaboration on-site
D. Close collaboration in a partly-integrated system
E. Close collaboration in a fully-integrated system

CMS Models for Behavioral Health Integration

<table>
<thead>
<tr>
<th>General Behavioral Health Integration (BHI)</th>
<th>Collaborative Care Management (CoCM)</th>
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<tbody>
<tr>
<td>• Can be implemented using existing clinical staff.</td>
<td>• Team includes treating practitioner, behavioral health care manager, and a psychiatric consultant.</td>
</tr>
<tr>
<td>• Requires 20 minutes of time per month.</td>
<td>• Requires 60 minutes of time per month.</td>
</tr>
<tr>
<td>• Chronic Care Management for Behavioral Health</td>
<td>• Billing Codes: 99492, 99493, 99494</td>
</tr>
<tr>
<td>• Billing Code 99484</td>
<td>• Reimbursement: $162, $129, $67</td>
</tr>
<tr>
<td>• Reimbursement: $48.65 per month.</td>
<td></td>
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</table>
Requirements of Both BHI and CoCM

- An initiating visit, unless patient has been seen in the last year. This is billed separately.
- General Supervision: Services can be provided by your staff when you are not in the office.
- Consent, written, or verbal documented in medical record.
- Ongoing involvement by the treating practitioner (that’s you) and a designated member of your team.

What is Collaborative Care Management (CoCM) ?

A model of behavioral health integration that enhances “usual” primary care by adding 2 key services:

- Care management support for patients receiving behavioral health treatment
- Regular psychiatric inter-specialty consultation to the primary care team, particularly regarding patients whose conditions are not improving
Putting Together a Collaborative Care Team

1. **Team Leader**: the treating practitioner
2. **Team Worker Bee**: the collaborative care manager
3. **Team Adviser**: the psychiatric consultant
4. **Team Purpose**: the patient/beneficiary

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**Team Leader**
Treating/Billing Practitioner

**Qualifications:**
- Physician
- Nurse Practitioner
- Physician Assistant
- Certified Nurse Specialist
- Certified Nurse Midwife
Poll Question 2

In Collaborative Care Management, the behavioral health care manager must be a licensed mental health professional or a nurse with special training in mental health.

A. TRUE
B. FALSE

Team Worker-Bee
Behavioral Health Care Manager

Qualifications:
• An individual with formalized education or specialized training in behavioral health (psychology, counseling, social work, nursing)
• Works under the oversight of the billing practitioner
• Non-nurse individuals do not require a license, but certainly may have one.
Poll Question 3

In the CMS Collaborative Care Management Model (CoCM), the psychiatric consultant must be a psychiatrist who is certified to bill Medicare independently.

A. TRUE
B. FALSE

Team Adviser
Psychiatric Consultant

Qualifications:
- A medical professional trained in psychiatry and qualified to prescribe the full range of medications
- Psychiatrist or Psychiatric Nurse Practitioner
- Does NOT have to be able to bill Medicare independently
Team Purpose
Patient/Beneficiary

Any patient with a behavioral health diagnosis which the treating practitioner feels would benefit from Collaborative Care Management

Diagnoses Appropriate for CoCM

- Depressive disorders
- Bipolar disorders
- Substance use disorders
- Grief reactions
- PTSD
- ADD/ADHD

- Anxiety
- Adjustment disorders
- Autism disorders
- Somatization disorders
- Eating disorders
- And others…
WORKFLOW
Day-to-day Operations

ENGAGEMENT

• Referral
• Consent
• Warm Hand-off
First Month’s Tasks

• Initial psychiatric evaluation
• Administration of validated rating scales
• Creation of a care plan
• Entry into a registry
• Initial staffing with psychiatric consultant
• 70 minute time requirement

Ongoing Monthly Tasks

• Review of medication compliance and side effects
• Brief behavioral health interventions such as problem-solving therapy (PST), behavioral activation (BA), and cognitive behavioral therapy (CBT)
• Administration of evidenced based tools and entry into the registry
• Weekly review with Psych Consultant when needed
• May occur via telephone but must be available for face-to-face or after-hours if needed
Psychiatric Consultant Staffing

• Occurs weekly by phone or in person
• Includes review of all new patients
• Includes review of existing patients who are not improving
• Recommendations on fine-tuning diagnoses and medications
• Medication side effects management
• Relapse Prevention Advice

Communication

• This will make or break your CoCM program.
• Very important to utilize EMR to communicate recommendations from psychiatric consultant back to treating provider.
• Chronic Care Manager also is involved in our communication loop.
• We utilize a running monthly Behavioral Health Note that can be accessed, reviewed, and added to by the treating practitioner, behavioral health care manager, psychiatric consultant, and chronic care manager.
What is a Registry?

- A disease registry is a tool for tracking the clinical care and outcomes of a defined patient population. Most disease registries are used to support care management for groups of patients with one or more chronic diseases, such by means of diabetes, coronary artery disease, or asthma.

- A registry can be as simple as an in-office spreadsheet to track progress in similar groups of patients or as complex as a national registry that tracks large populations of patients.

Screenshot of a portion of an EMR generated REGISTRY
Billing Collaborative Care

<table>
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<tr>
<th>CMS CoCM and BHI procedure codes/billing</th>
<th>RHC and FQHC procedure codes/billing</th>
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<tbody>
<tr>
<td>• 99492 Initial Psych Care Management, 70 min $162.18</td>
<td>• G0512 Psychiatric CoCM (70 min initial month and 60 min subsequent months) $145.96</td>
</tr>
<tr>
<td>• 99493 Subsequent Psych Care Management, 60 min/month $129.38</td>
<td>• G0511 General Care Management Services (20 min per month) $67.03</td>
</tr>
<tr>
<td>• 99494 Initial/Subsequent Psych Care Management, additional 30 min $67.03 (this code may only be billed twice per month)</td>
<td>• No add-on billing allowed</td>
</tr>
<tr>
<td>• 99484 General BHI, 20 min $48.65</td>
<td>• Include behavioral health diagnoses when billing.</td>
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Business Model of CoCM per 20 enrolled patients

**COSTS:**
- Behavioral Health Care Manager: $20-$40/hour, assume 24 billable hours($460-$960)
- Psychiatric Consultant: $100-$300/hour, assume 1 hour per 10 patients ($200-$600)
- Total: $660-$1560 per month

**Revenue and Profit:**
- 2 new patients: $324
- 18 established patients: $2322
- 8 30 minute add-ons: $536
- Total Revenue: $3182
- Monthly Profit: $1622-$2522
- Benefit to patients: Priceless
In case you count work RVUs…

- 99484 General BHI 0.61 wRVUs
- 99492 Initial CoCM 1.70 wRVUs
- 99493 Subsequent CoCM 1.53 wRVUs
- 99494 Initial/Subs each additional 30 min 0.82 wRVUs

Practice Recommendations

- Regularly screen for depression and substance use disorders in your practice utilizing validated rating scales and annual wellness visits.
- Consider elevating your level of behavioral health integration, by enhancing communication with behavioral health professionals or by co-locating behavioral health in your practice.
- Consider adding general Behavioral Health Integration (BHI) to your practice utilizing existing clinical staff.
- Consider contracting with a psychiatric consultant in order to implement Collaborative Care Management (CoCM) in your practice.
Valuable Resources


• University of Washington AIMS Center (everything you need to start your own program): https://aims.uw.edu/collaborative-care

• PESI (a good resource for online and in-person training for behavioral health care managers): https://www.pesi.com

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Questions