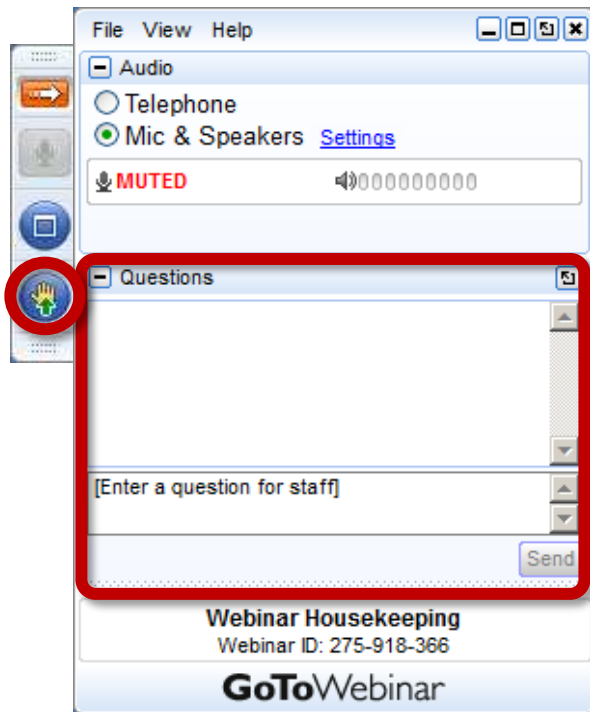# COLLABORATIVE CARE

An Evidence Based Model for
Primary Care

Virna Little, PsyD, LCSW-R, SAP, CCM
Laura Leone, MSSW, LMSW

Housekeeping

How to join the webinar?

GoToWebinar INSTRUCTIONS:
Join the webinar:
https://attendee.gotowebinar.com/register/240 6284886346984450

Call in using your telephone: +1 (914) 614-3221
Access Code: 984-704-099
Audio PIN: Shown after joining the meeting
2

To ask a question: Enter your unique Audio PIN so we can mute/unmute your line when necessary **OR** type it into the Q&A pod.

Technical difficulties? Call Citrix Tech Support at 888-585-9008

NATIONAL COUNCIL
FOR BEHAVIORAL HEALTH
MENTAL HEALTH FIRST AID

@NATIONALCOUNCIL

Upcoming Webinars

- **Implementing Collaborative Care Part 2:**
  - Wednesday June 20th 2:00-3:30pm MST
  - 2:00-2:30pm (for CFOs, CEOs, billing) *a deep dive into sustainability*
  - 2:30-3:30pm (for Behavioral Care Managers) *evidence-based practices PST & BA*

- **Suicide Safer Care**
  - Tuesday July 17th 1:30-3:00pm MST

Objectives

- Provide an comprehensive overview of the model of Collaborative Care
- Provide more detailed information on developing a plan for implementation of Collaborative Care in a primary care setting
- Provide overview of billing and coding for Collaborative Care

Why Implement Collaborative Care

1. **Access**

   Increase ability for your patients to access mental health services
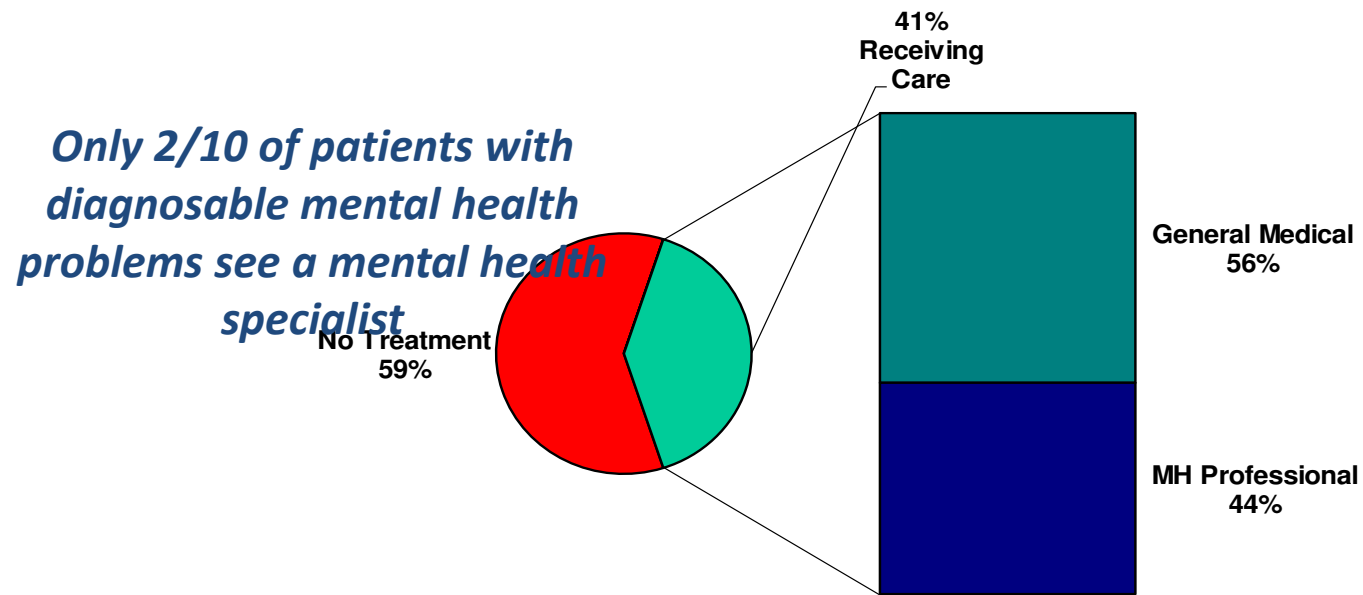
2. **Patient-Centered**

   Cares for patients where they receive care-your practice ! One patient care team

3. **Effectiveness**

   Better clinical outcomes

Primary Care & Mental Health

National Comorbidity Survey Replication
Provision of Behavioral Health Care: Setting of Service

Only 2/10 of patients with diagnosable mental health problems see a mental health specialist

41% Receiving Care

No Treatment 59%

General Medical 56%

MH Professional 44%

Wang P et al., Twelve-Month Use of Mental Health Services in the United States, *Arch Gen Psychiatry*, 62, June 2005

Depression Care

- 1/10 see psychiatrist
- 4/10 receive treatment in primary care
- 30 Million people receive antidepressant Rx
  - But only 20% improve
- 2/3 of Primary Care Providers report poor access to mental health for their patients
- Primary Care is the **de facto treatment setting** for most patients with common mental health conditions like depression and anxiety
- 70% of all antidepressant prescriptions in the United States are written by a primary care provider

What DOES work?

Collaborative Care is more **effective** than care as usual (over 80 randomized controlled trials)

- Gilbody S. et al. *Archives of Internal Medicine*; Dec 2006
- Thota AB, et al. Community Preventive Services Task Force. *Am J Prev Med.* May 2012;42(5):521-524.
- Archer J, et al. Cochrane Collaborative. Oct 17, 2012.: 79 RCTs with a total of 24,308 patients

Collaborative Care also more **cost-effective**

- Gilbody et al. BJ Psychiatry 2006; 189:297-308.
- Unutzer et al. Am J Managed Care 2008; 14:95-100.
- Glied S et al. MCRR 2010; 67:251-274.

The Collaborative Care Model

What is it?

- An integrated care model that uses a care team of primary and behavioral health care providers to treat mental health conditions such as depression, anxiety, and substance abuse in primary care settings.

Why is it important?

- Despite the prevalence of mental health conditions such as depression, anxiety, and substance abuse, many people – especially low-income individuals - do not receive effective care.

Project IMPACT

- **I**mproving **M**ood- **P**roviding **A**ccess to **C**ollaborative **T**reatment
  - Primary and behavioral health care services are integrated into the primary care setting to treat depression in patients.

  - IMPACT study
    - 1998-2003
    - 1,801 older adults from 18 primary care clinics across U.S.
    - ½ randomly assigned IMPACT model/Collaborative Care
    - Found that Collaborative Care more than DOUBLED the effectiveness of depression treatment in primary care settings.
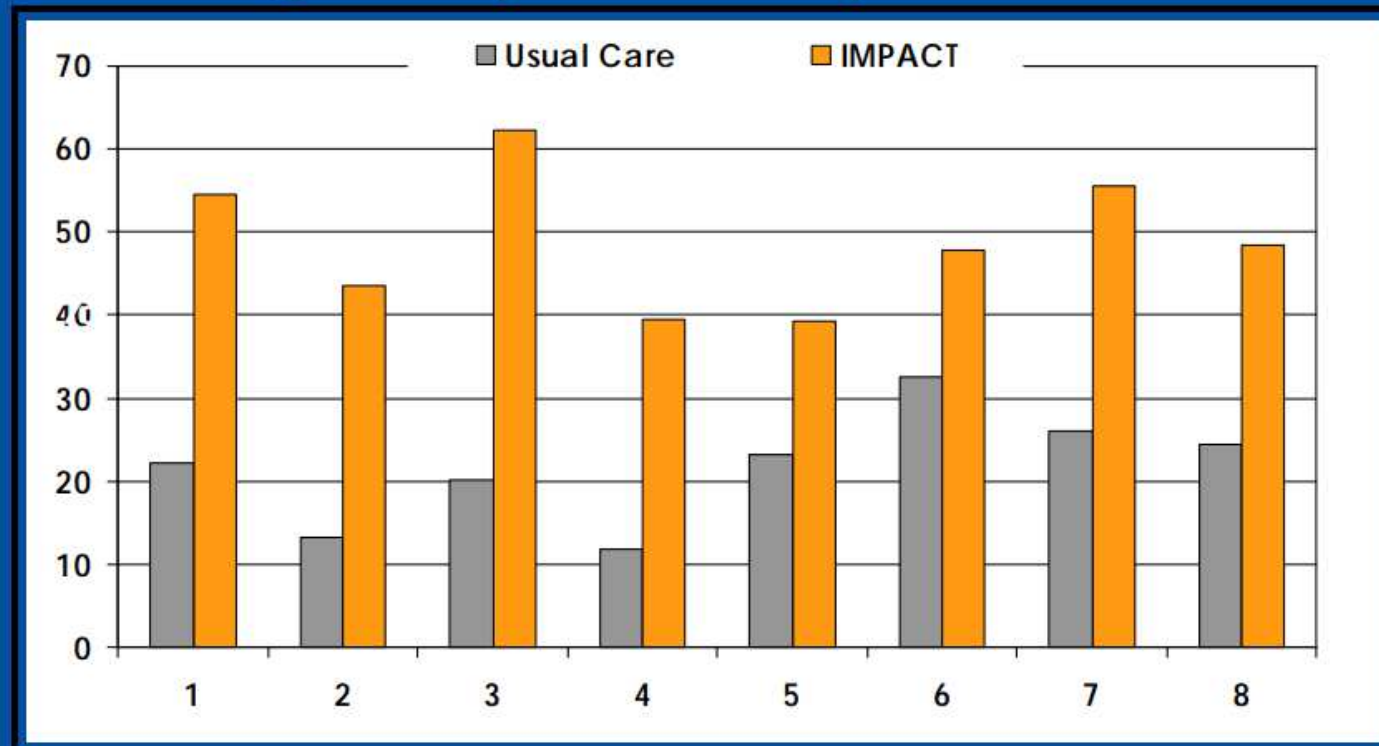   - Highly cost-effective

    http://aims.uw.edu/impact-improving-mood-promoting-access-collaborative-treatment/

Project IMPACT- Study Outcomes

IMPACT: Summary

- Less depression
  - IMPACT more than doubles effectiveness of usual care
- Less physical pain
- Better functioning
- Higher quality of life
- Greater patient and provider satisfaction
- More cost-effective

"I got my life back"
THE TRIPLE AIM

5 Core Components of Collaborative Care

1 • Patient-Centered Team

2 • Population Based Care
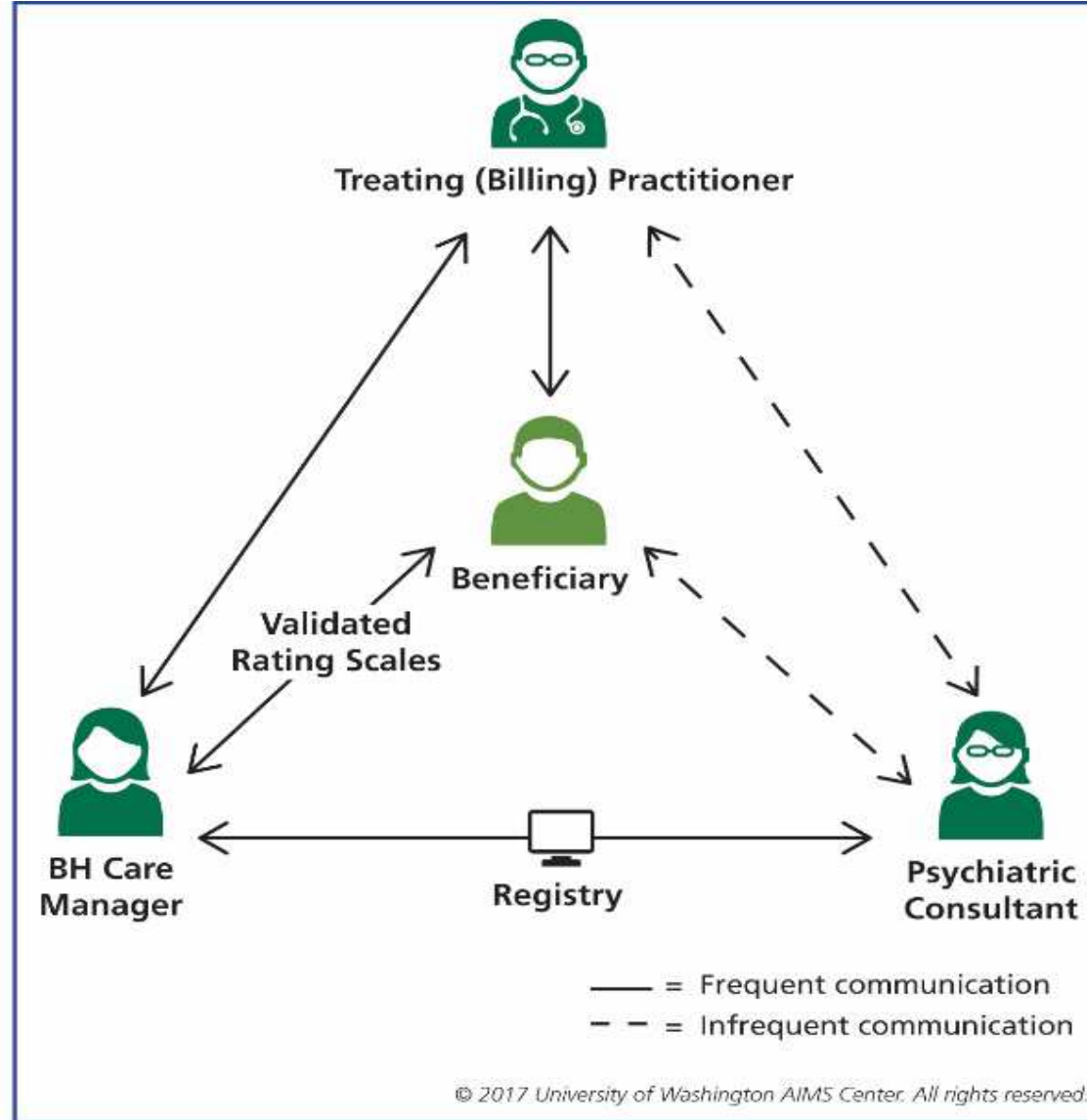
3 • Measurement-based "Treatment to Target"

4 • Evidence-based care

5 • Accountable Care

Patient-Centered Team

Treating (Billing) Practitioner

Beneficiary

Validated Rating Scales

BH Care Manager

Registry

Psychiatric Consultant

—— = Frequent communication
– – – = Infrequent communication

© 2017 University of Washington AIMS Center. All rights reserved.

Patient-Centered Team

Care Manager

- Behavioral health professional
- Coordinates overall team effort and communication
- Psychotherapy when needed

Primary Care Provider

- Makes initial assessment
- Facilitates Warm hand-off
- Starts Treatment

Psychiatric Consultant

- Supports PCP and care manager in diagnosis, treatment plan, and treatment change recommendations

Patient

- The patient is an integral part of the care team and active participant in treatment

IMPACT Model

Behavioral Health Care Manager

- Supports and collaborates closely with PCPs managing patients in primary care
- Facilitates patient engagement and education
- Systematically tracks treatment response
- Supports medication management by PCPs
- Provide brief, evidence-based therapeutic interventions
- Reviews cases with psychiatric consultant
- Facilitates referrals as needed
- Creates relapse prevention plan

IMPACT Model

Who are Care Managers?

- Common: MSW, LCSW, MA/MS Counselor, LMFT

Characteristics of Effective Care Managers

- Able to engage patients **and** providers
- Flexible and open to new ways of practicing
- Adaptable to primary care culture and workflows
- Values working in a collaborative team
- Organized and able to track entire population of patients
- Strong advocate for changing treatment until patient improved
- Persistent and consistent

Other Considerations for the Care Manager

- Role and priorities

- Setting up initial case load

IMPACT Model

- Psychiatric Consultant
  - Provides weekly consultation
  - Reviews cases for patients who are not improving as expected
  - Provides treatment recommendations and proposes changes to treatment plan
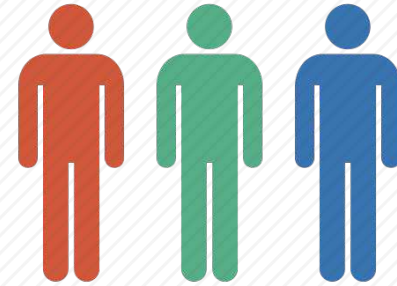 - Provides consultation for diagnostic concerns

IMPACT Model

- ## Primary Care Provider
  - Oversees all aspects of patient's care
  - Establishes diagnosis
  - Starts and prescribes pharmacotherapy
  - Introduces Collaborative Care team and Care Manager
  - Collaborates with Care Manager and Psychiatric Consultant to make treatment adjustments as needed

Population-Based Care

- A defined group of patients is tracked in a registry

- Registry Functions
  - Track and manage caseloads
  - Facilitate the delivery of evidence-based care for specific conditions

- Care team uses registry to track patients & identify those who are not showing improvement

- Ensures that patients do not "fall through the cracks"

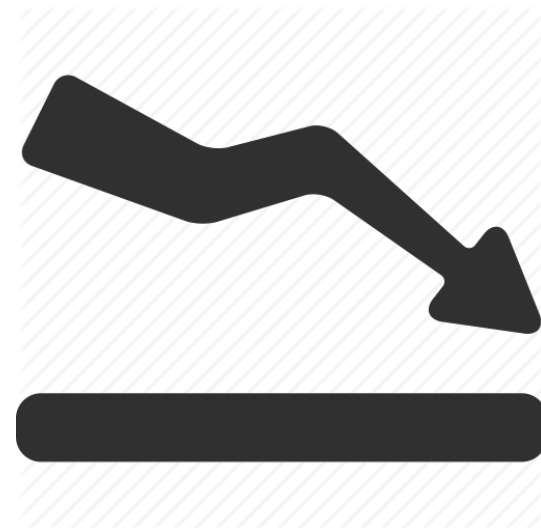# Measurement-based Treatment to Target

- **Treatment Plan**
  – Developed by the Care Team
    - Reflects the patient's goals and clinical outcomes
  – Clinical outcomes routinely measured
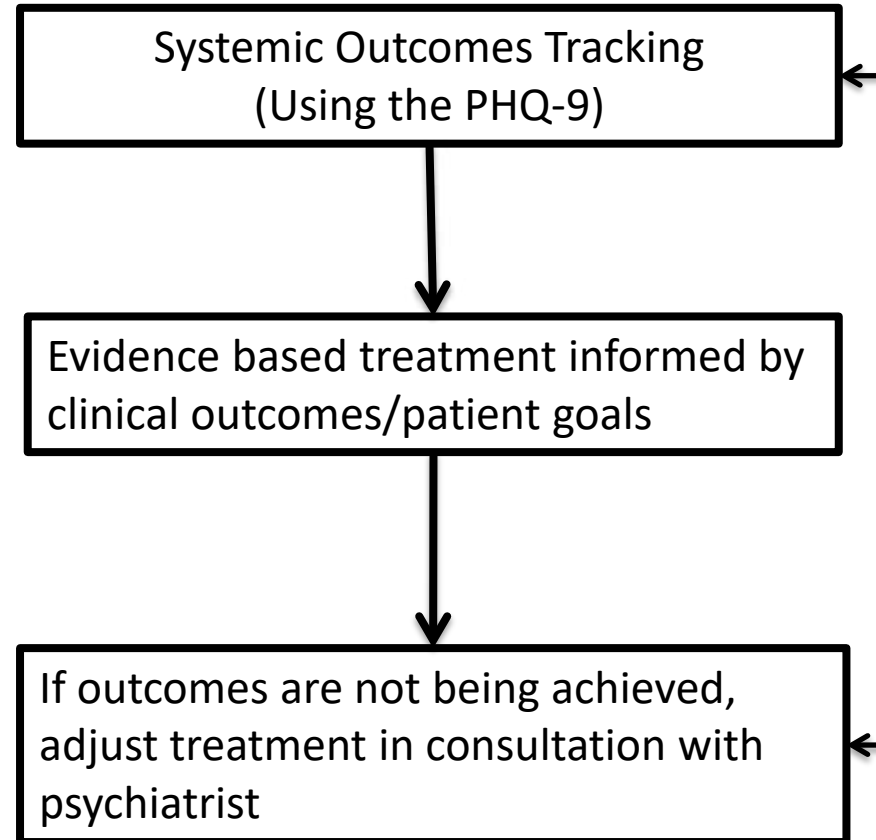 – Flexible treatment options to increase access

- **Treatment to target**
  – Treatments are actively changed until the clinical goals identified in the treatment plan are achieved
  – Clinical outcomes measured by evidence-based tools such as the PHQ-9 and the GAD-7.

IMPACT Model: Outcome Measurement

- Patients are screened before and throughout treatment by the care team

- Depression/Anxiety symptoms are actively monitored by Care Manager

  - Treatment Target:
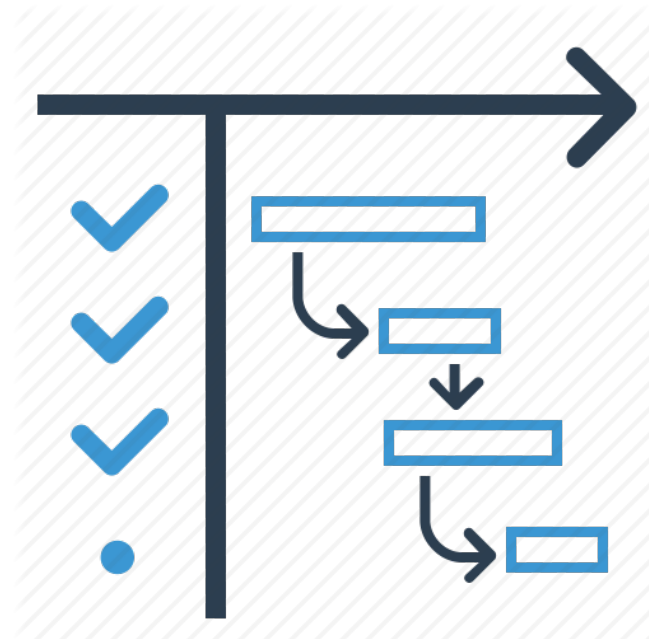   - 50% reduction in symptoms within 10-12 weeks

IMPACT Model: Stepped Care

Systemic Outcomes Tracking
(Using the PHQ-9)

Evidence based treatment informed by clinical outcomes/patient goals

If outcomes are not being achieved, adjust treatment in consultation with psychiatrist

Stepped Care

- Most patients will need treatment adjustments
  - Only 30-50% of patients will have a complete response to initial treatment
  - 50-70% will require at least one change in treatment to improve
  - Combat "clinical inertia"

Evidence-Based Care

Common Evidence-based treatments used in collaborative care include:

- Problem-Solving Treatment

- Behavioral Activation

- Cognitive Behavioral Therapy

- Interpersonal Therapy

- Medications

- Collaborative Care itself is an evidence-based model

Accountable Care

- Reimbursement is determined by the clinical outcomes outlined in the treatment plan

- This holds providers accountable for offering high-quality, effective, patient-centered care

- Team-based approach increases accountability

Technology

- Shared access by all members of care team

- Tracking can be done through the Electronic Medical Record, as long as it performs core registry functions

- Care Management Tracking System (CMTS)
  - Developed by AIMS Center
  - Alerts clinicians when a patient is not improving/ has not been seen
  - Facilitates measurement-based treatment to target
  - Assists with Accountable Care
  - Supplies reports for clinical leadership to monitor progress toward goals
  - Excel Tracker

Workflows

- Most common is PHQ2 or 3 in " triage" process
- PCP reviews total score if positive provides decision support
- Any patient on medications………
- Dedicated person as BHCM
- All can do warm hand offs – nursing and pcp etc.
- Think about and develop screening algorithm
- Workflows should not be specific with scores or other diagnosis

Sustainability

Psychiatric Collaborative Care Model (CoCM)

- Integrating behavioral health care with primary care ("behavioral health integration" or "BHI") is widely considered an effective strategy for improving outcomes for millions of Americans with mental or behavioral health conditions.

- As of 2017, Medicare makes separate payments to physicians and non-physician practitioners for BHI services they furnish to beneficiaries over a calendar month service period. FQHC's included in 2018!

- There are 3 Medicare billing codes to bill for monthly services furnished using the Collaborative Care Model (and 1 for general BHI)

- Most third party/ commercial payers are recognizing these codes

BHI Coding Summary

BHI Code	Behavioral Health Care Manager or Clinical Staff Threshold Time	Activities Include:
CoCM First Month (G0502) (CPT 99492)	First 70 minutes per calendar month	• Initial Assessment • Outreach/engagement • Entering patients in registry • Psychiatric consultation • Brief intervention
CoCM Subsequent Months (GO503) (CPT 99493)	60 minutes per calendar month	• Tracking + Follow-up • Caseload Review • Collaboration of care team • Brief intervention • Ongoing screening/monitoring • Relapse Prevention Planning
Add-on CoCM (Any month) (G0504) (CPT 99494)	Each additional 30 minutes per calendar month	• Same as Above
General BHI (G0507) (CPT 99484)	At least 20 minutes per calendar month	• Assessment + Follow-up • Treatment/care planning • Facilitating and coordinating treatment • Continuity of care

AMERICAN PSYCHIATRIC ASSOCIATION

AIMS CENTER
UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

Staffing and Service Delivery

Workbook Template Updated 05/02/2017

Input	= User-entered value
Calculation	= Calculated field (not editable)
Benchmark	= Suggested benchmark (editable)
Linked Information	= Information copied from another cell

STAFFING

Hours per week per 1.0 FTE at your organization

Team Member	FTE	Total Hours per Week	Suggested Hours per Week (Based on 40:3 ratio)
Care Manager		0.0	
Psychiatric Consultant		0.0	

WEEKLY TIME AND EFFORT ALLOCATION AND SERVICE UNIT GENERATION: CARE MANAGER

Total Care Manager Hours per Week

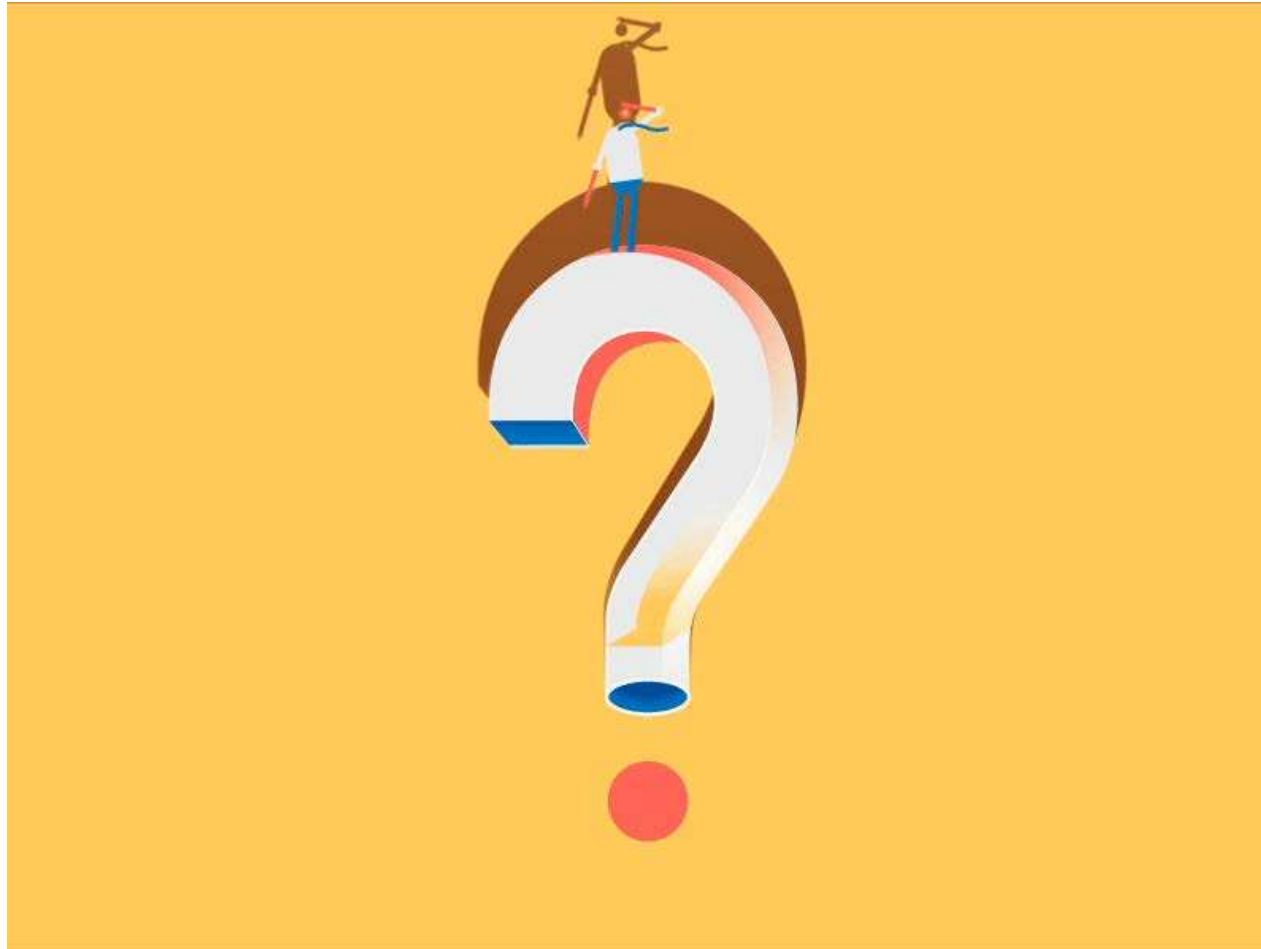| Care Management Service Category	Percentage (%) of Total Hours per Week	Hours per Week	Service Units Generated	Hours per Service Unit	
Reimbursable Direct Care Services					
Direct Treatment: Assessment Visit				*0.75*	Avg. length of assessment visit
Direct Treatment: Ongoing Visits				*0.50*	Avg. length of ongoing visits
Group Treatment				*0.25*	Avg. length of group visit divided by
***Subtotal:** Reimbursable Direct Care Services*					Avg. # of participants
Non-Reimbursable Direct Care Services					
Warm Connection (Non-Billable)				*0.25*	Avg. length of warm connection
Care Management Telephonic Services				*0.25*	Avg. length of phone calls
***Subtotal:** Non-Reimbursable Direct Care Services*					
Indirect Care Coordination and Administrative Tasks					
Charting					
Registry Management					
Psychiatric Consultation					
Team Communication					
Other (Clinical Supervision, Staff Meetings, Training, etc.)					
***Subtotal:** Indirect Care Coordination and Administrative Tasks*					
Unassigned Time [Target = 0%]	❌ 100.0%	(Green checkmark indicates value is at target)			

Common Questions

- What professional can be a BHCM ?
- What is the average caseload ?
- What is the average length of care ?
- Can I also bill individual treatment ?
- What are the best ways to manage process billing ?
- Is my case rate adjusted for Np's or geography ?
- What are some clinical outcome measures?
- What counts as provider time and how is it documented ?

Questions from the Chat Box?

NATIONAL COUNCIL
FOR BEHAVIORAL HEALTH
MENTAL HEALTH FIRST AID

@NATIONALCOUNCIL

Virnalittle@msn.com

LauraL@TheNationalCouncil.org