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The Collaborative Care Model: How to Integrate Behavioral Health into Your Practice

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Collaborators

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More resources available at:
https://dchealth.dc.gov/dcrx

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Course Overview

- This course provides providers with information and tools to integrate behavioral health care practices into their practice using the Collaborative Care Model.
- This module will be a lecture style format with knowledge check questions at the end of the presentation.
- In order to receive completion credit, you must receive a passing score on the knowledge checks and complete the evaluation.
- This module will be approximately 1 hour in length for viewing and completion of the evaluation.
- This module is approved for 1 hour of CME.

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  The views expressed by Dr. Holloway are those of the advisor, working in a private capacity, and do not reflect the official policy of the Department of Defense (DoD), Uniformed Services University of the Health Sciences, and/or the United States Government.

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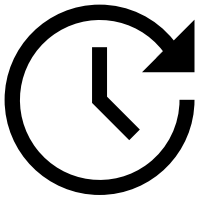
Conflict of Interest

- The instructor and advisors have no conflicts of interest to declare.

Anti-discrimination Policy

- The **instructor and advisors** have agreed to our anti-discrimination policy that prohibits the inclusion of discriminatory language, graphics, or references on the basis of race, gender identity, age, color, national origin, physical or mental disability, or religion.

Important Information



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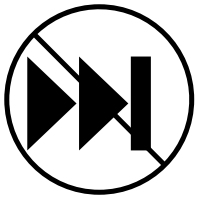

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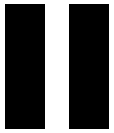

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Learning Objectives

- Develop an understanding of behavioral health and primary care integration
- Describe the rationale for Integrated Care
- Compare the different models of Integrated Care
- Name the five principles of the Collaborative Care Model
- Describe the evidence supporting the Collaborative Care Model
- Tailor and apply learned concepts to support implementation of Integrated Care

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Learning Objectives	Slides
Develop an understanding of behavioral health and primary care integration	5-8
Describe the rationale for Integrated Care	9-11, 14-19
Compare the different models of Integrated Care	20-23
Name the five principles of the Collaborative Care Model	33-44
Describe the evidence supporting the Collaborative Care Model	25-32
Tailor and apply learned concepts to support implementation of Integrated Care	46-60
Resources: for further education on Integrated Care	61-63

WHAT IS BEHAVIORAL HEALTH AND PRIMARY CARE INTEGRATION?

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Key Definitions

- Mental Health vs Behavioral Health
  - Mental health = emotional, psychological and social well-being
  - Behavioral health = behaviors and actions that impact physical and mental well-being
  - Behavioral health often used as a “umbrella” term

- Integrated Care vs Integrated Behavioral Health Care
  - NOT the same as Integrative Medicine
  - Integrated Care = collaboration between health professionals to provide treatment to patients and improve overall well-being
  - Integrated Behavioral Health Care = integration of behavioral health services within general and/or specialty medical services
  - Integrated Care often used blanket term to refer to Integrated Behavioral Health Care

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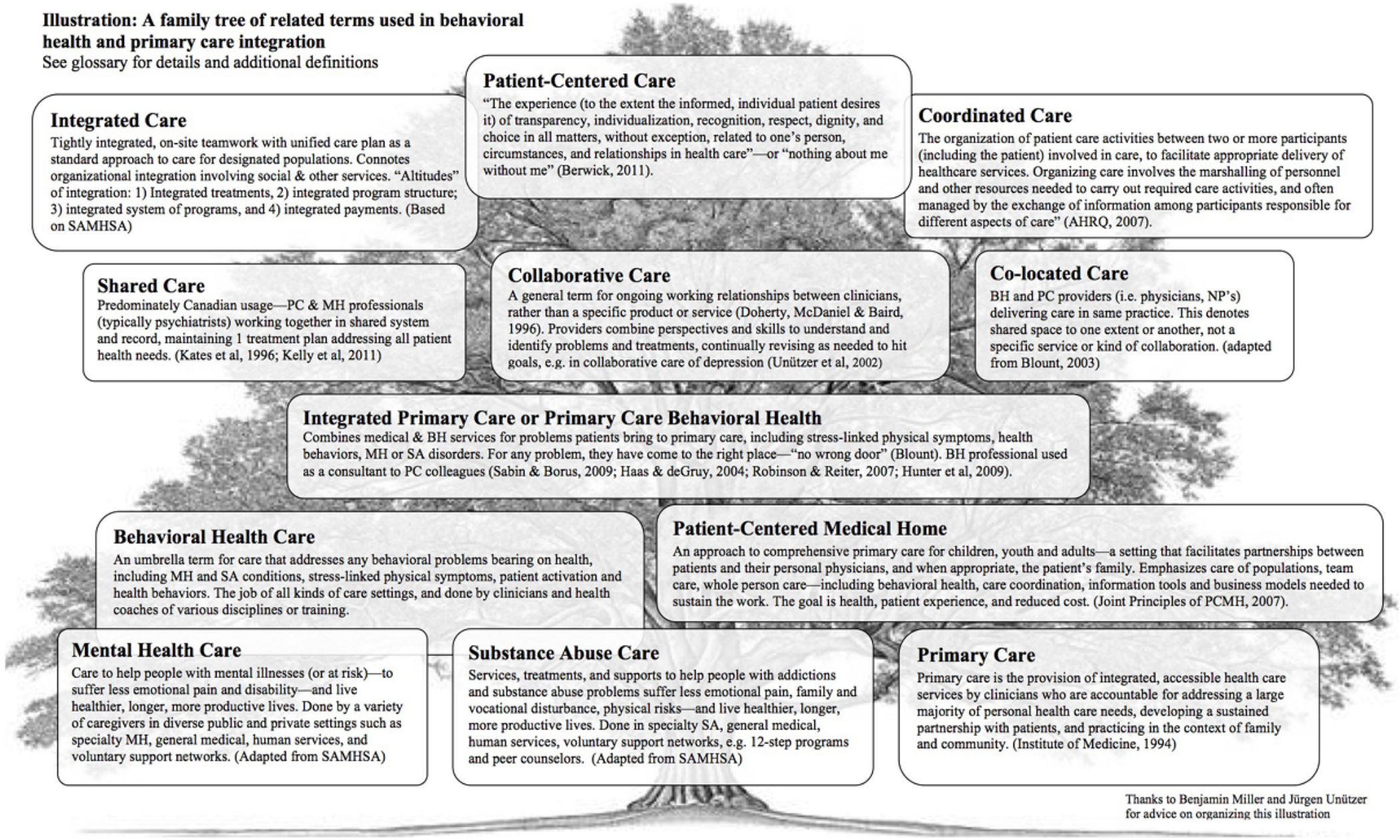
Sources: Centers for Disease Control, American Psychiatric Association, American Healthcare Research and Quality

Illustration: A family tree of related terms used in behavioral health and primary care integration
See glossary for details and additional definitions



Patient-Centered Care
"The experience (to the extent the informed, individual patient desires it) of transparency, individualization, recognition, respect, dignity, and choice in all matters, without exception, related to one's person, circumstances, and relationships in health care"—or "nothing about me without me" (Berwick, 2011).

Integrated Care
Tightly integrated, on-site teamwork with unified care plan as a standard approach to care for designated populations. Connotes organizational integration involving social & other services. "Altitudes" of integration: 1) Integrated treatments, 2) integrated program structure; 3) integrated system of programs, and 4) integrated payments. (Based on SAMHSA)

Coordinated Care
The organization of patient care activities between two or more participants (including the patient) involved in care, to facilitate appropriate delivery of healthcare services. Organizing care involves the marshalling of personnel and other resources needed to carry out required care activities, and often managed by the exchange of information among participants responsible for different aspects of care" (AHRQ, 2007).

Shared Care
Predominately Canadian usage—PC & MH professionals (typically psychiatrists) working together in shared system and record, maintaining 1 treatment plan addressing all patient health needs. (Kates et al, 1996; Kelly et al, 2011)

Collaborative Care
A general term for ongoing working relationships between clinicians, rather than a specific product or service (Doherty, McDaniel & Baird, 1996). Providers combine perspectives and skills to understand and identify problems and treatments, continually revising as needed to hit goals, e.g. in collaborative care of depression (Unützer et al, 2002)

Co-located Care
BH and PC providers (i.e. physicians, NP's) delivering care in same practice. This denotes shared space to one extent or another, not a specific service or kind of collaboration. (adapted from Blount, 2003)

Integrated Primary Care or Primary Care Behavioral Health
Combines medical & BH services for problems patients bring to primary care, including stress-linked physical symptoms, health behaviors, MH or SA disorders. For any problem, they have come to the right place—"no wrong door" (Blount). BH professional used as a consultant to PC colleagues (Sabin & Borus, 2009; Haas & deGruy, 2004; Robinson & Reiter, 2007; Hunter et al, 2009).

Behavioral Health Care
An umbrella term for care that addresses any behavioral problems bearing on health, including MH and SA conditions, stress-linked physical symptoms, patient activation and health behaviors. The job of all kinds of care settings, and done by clinicians and health coaches of various disciplines or training.

Patient-Centered Medical Home
An approach to comprehensive primary care for children, youth and adults—a setting that facilitates partnerships between patients and their personal physicians, and when appropriate, the patient's family. Emphasizes care of populations, team care, whole person care—including behavioral health, care coordination, information tools and business models needed to sustain the work. The goal is health, patient experience, and reduced cost. (Joint Principles of PCMH, 2007).

Mental Health Care
Care to help people with mental illnesses (or at risk)—to suffer less emotional pain and disability—and live healthier, longer, more productive lives. Done by a variety of caregivers in diverse public and private settings such as specialty MH, general medical, human services, and voluntary support networks. (Adapted from SAMHSA)

Substance Abuse Care
Services, treatments, and supports to help people with addictions and substance abuse problems suffer less emotional pain, family and vocational disturbance, physical risks—and live healthier, longer, more productive lives. Done in specialty SA, general medical, human services, voluntary support networks, e.g. 12-step programs and peer counselors. (Adapted from SAMHSA)

Primary Care
Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. (Institute of Medicine, 1994)

Thanks to Benjamin Miller and Jürgen Unützer for advice on organizing this illustration

Peek and the National Integration Academy Council, 2013.

Integrated Behavioral Health Care

The care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population

-Academy of Health Research and Quality, 2013

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Recognizing the Impact of Mental Health

1 in 5 U.S. adults experience mental illness each year

1 in 20 U.S. adults experience serious mental illness each year

1 in 6 U.S. youth aged 6-17 experience a mental health disorder each year

50% of all lifetime mental illness begins by age 14, and 75% by age 24

Suicide is the **2nd leading** cause of death among people aged 10-34

Among the 52.9 million U.S. adults with mental illness, *less than half* received mental health services in the past year

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Data from CDC, NIMH and select sources: https://www.nami.org/mhstats

Role of Primary Care in Mental Health Care

- An estimated 60% of mental health care delivery occurs in the primary care setting
- 79% of antidepressant prescriptions are written by providers who are not mental health care providers
- Among persons who have attempted suicide:
  - 64% visited a health care provider within 4 weeks before the attempt
  - 38% visited a health care provider within the previous week

Park, Zarate, 2019

"PCPs have become the gateway to the mental health system for many patients by screening for mental health problems."

About 2/3 of PCPs reported that they could not get outpatient mental health services for patients – a rate that was at least twice a high as that for other services

Cunningham et al. 2009

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Case Example

- 67-year-old patient with history of diabetes, hypertension, and depression presents to the primary care office for annual wellness visit
- Patient reports the following: trouble sleeping, feeling down, having difficulty concentrating, and lack of interest to engage in regular hobbies
- Patient is unemployed (recently laid off) and therefore financially stressed
- Patient reports increased conflict with spouse and increased social isolation
- You observe the patient appears withdrawn and tearful during the visit
- Vitals for the visit are 145/92 with a notable increase in weight from last visit; lab work reveals HbA1C of 10

Consider Your Practice

What is your clinical approach?

What will you do for management?

What other services are available to your patient, either in your clinic or in your community?

What is your follow up plan?

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Who Gets Treatment?

No Treatment






Primary Care Provider


Mental Health Provider


Wang et al., 2005

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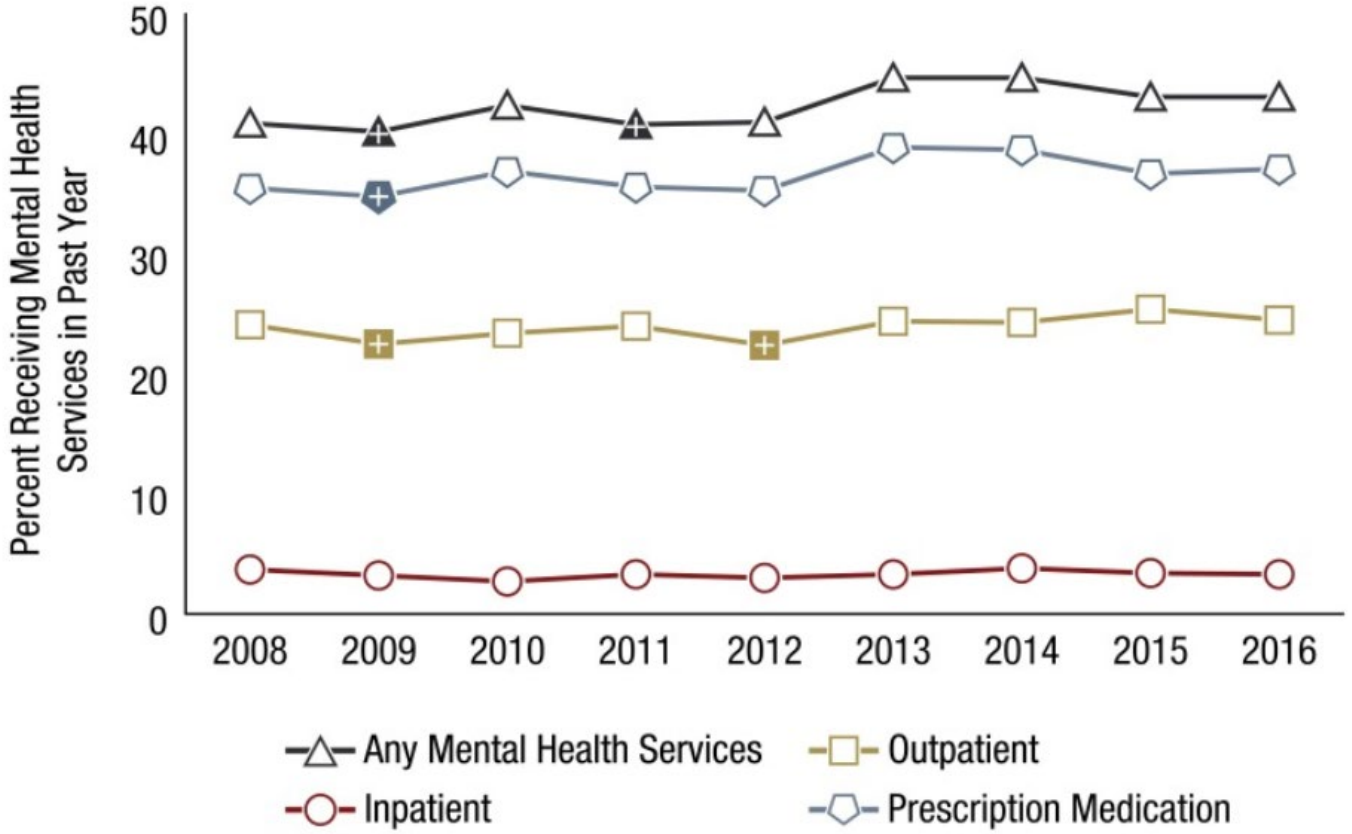
Mental Health Treatment Among Adults, Data from 2016 National Survey on Drug Use and Health

Type of Mental Health Services Received in the Past Year among Adults Aged 18 or Older with Past Year Mental Illness: Percentages, 2008–2016



Among 44.7 million adults with mental illness, **43.1%** (19.2 million) received mental health services in the past year

Park-Lee et al., 2018

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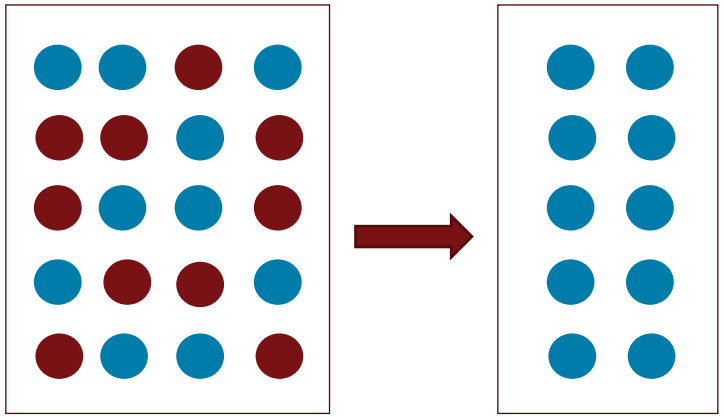
Why Not Just Refer?

Patient Factors

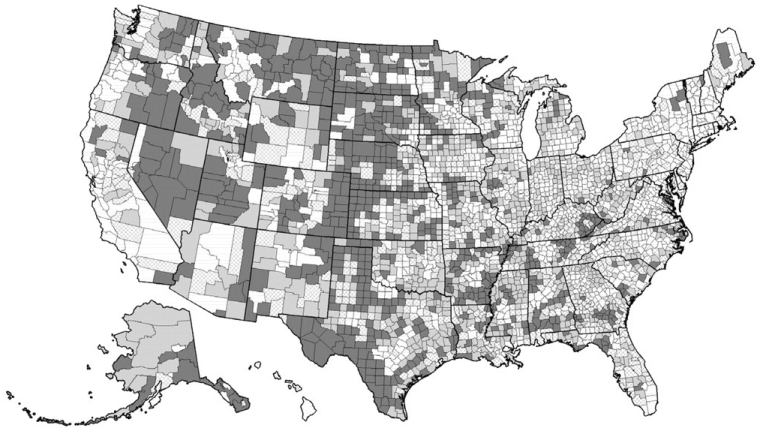
- Half of those referred do not follow through
- Mean # of visits = 2



Grembowski, Martin et al., 2002
Simon, Ding et al., 2012

Provider Factors

- 1 in 5: unmet need for non-prescribers
- 96% unmet need for prescribers



Thomas KC et al., 2009

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WHY DO INTEGRATED CARE?

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Rationale for Integrating Mental Health into Primary Care
The burden of mental health disorders is great
Mental and physical health problems are interwoven
The treatment gap for mental disorders is enormous
Primary care for mental health enhances access
Primary care for mental health promotes respect of human rights
Primary care for mental health is affordable and cost effective
Primary care for mental health generates good outcomes

World Health Organization and Wonca 2008

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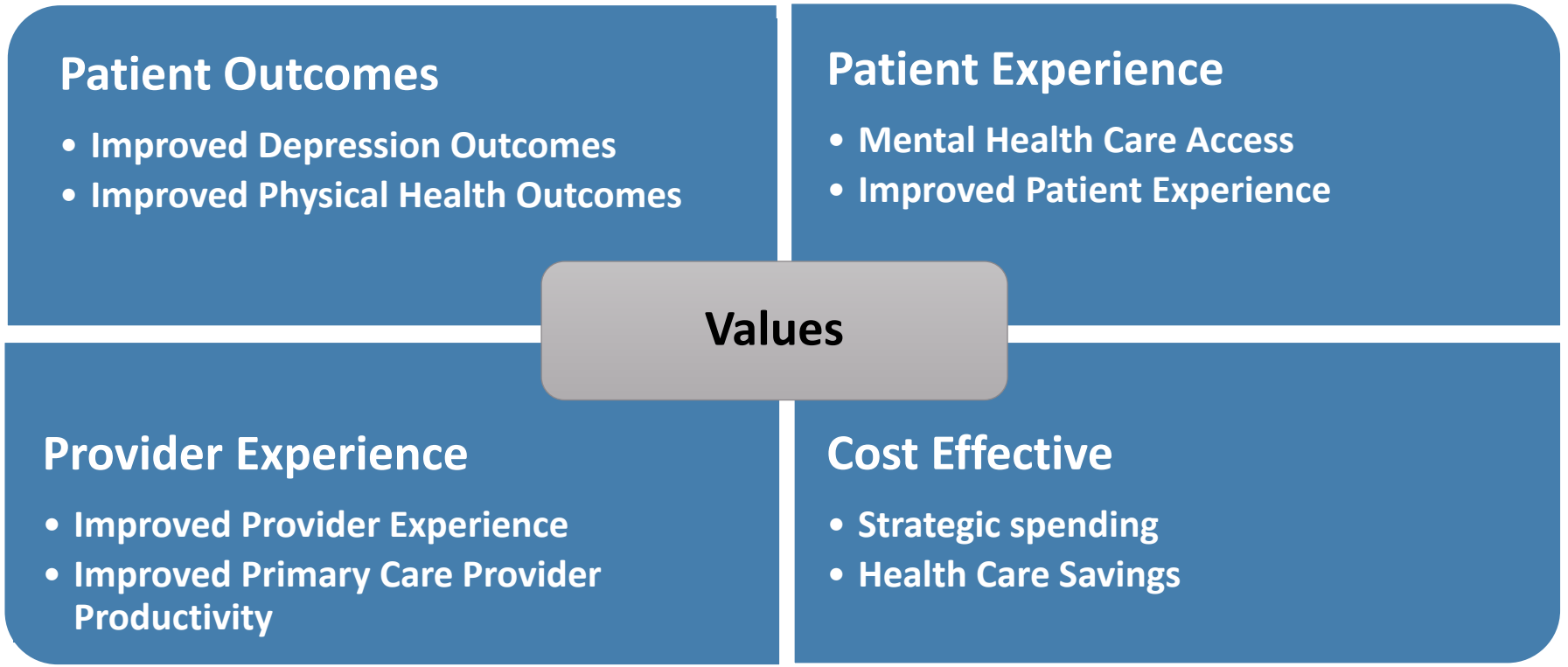
Why Integrated Care?

The Quadruple Aim defines value from different stakeholder perspectives



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MODELS OF INTEGRATED CARE

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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

https://www.thenationalcouncil.org/wp-content/uploads/2020/01/CIHS_Framework_Final_charts.pdf?daf=375ateTbd56

Continuum of Integrated Behavioral Health Care

Coordinated Care	Co-Located Care	Integrated Care
Minimal collaboration, separate facilities	Some collaboration, same shared facility/space	Full collaboration, shared space, system-level integration
Separate screening and assessment protocols, separate treatment plans	Agree on screening practices, separate plans with some sharing of info	Population-based screening, standardized practices
Patient's physical and mental health treated separately	Symptoms treated separately but at same clinical site	Whole person care provided by whole team

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Models of Integrated Care - Examples

- Tele-behavioral Health Model of Care: examples could be a referral to a tele-behavioral health team or Collaborative Care with tele-psychiatry (Fortney et al., 2013, 2021)

- Primary Care Behavioral Health Model: Behavioral Health Consultants (BHC) have brief and time limited sessions that are solution-focused and goal is to provide tangible behavioral skills to improve daily function. (Reiter et al., 2018)

- Collaborative Care Model: team-based care provided by PCP, Behavioral Health Care Manager and psychiatric consultant, following set of core principles to deliver effective mental health care in primary care setting

Consider Essential Elements of Integration

Leadership & Organizational Commitment	• Leaders that are willing to allocate resources to the developmental process, including the time needed for cultural shifts, changes to practice, and team process
Team Development	• Providers are given clear expectations regarding team-based care, roles, and responsibilities
Team Process	• The team continuously reexamines team functioning and dynamics as the team grows
Team Outcomes	• Integrated teams track and monitor patients' treatment through objective measures

https://www.thenationalcouncil.org/wp-content/uploads/2021/04/Essential_Elements_of_an_Integrated_Team.pdf

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INTRODUCTION TO THE COLLABORATIVE CARE MODEL

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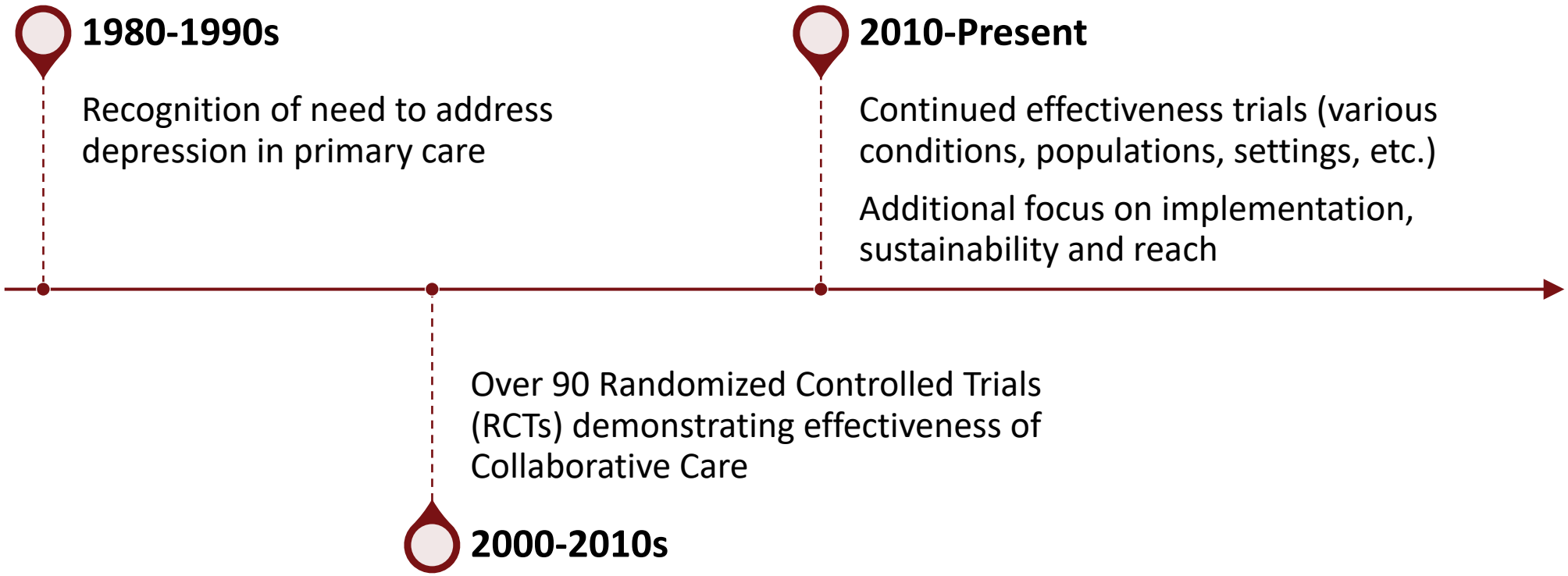
History and Evidence Base for Collaborative Care



Evidence Base for Collaborative Care

- Over 90 Randomized Controlled Trials (RCTs)
  - Cochrane meta-analysis for Collaborative Care for depression in primary care
  - **Consistently more effective than usual care**

- Advancing Integrated Mental Health Solutions (AIMS) Center
  - Dissemination and implementation center for Collaborative Care
  - Information on evidence-base as well as resource library and other tools
  - https://aims.uw.edu/

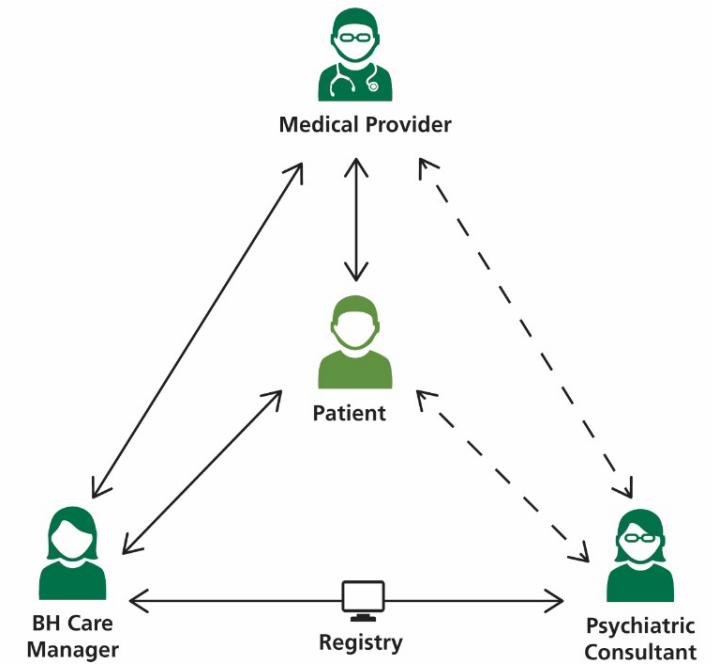
Summary of Evidence Base for Collaborative Care

Psychiatric disorders	Co-morbid Conditions	Populations	Settings
• Depression • Anxiety • Bipolar Disorder • Post-Traumatic Stress Disorder • Substance Use Disorders • Dementia • ADHD in children	• Diabetes • Heart Disease • Cancer • Chronic Pain • HIV	• Older Adults • Racial and Ethnic Minorities • Safety-net/Under-resourced • High-risk Mothers • Adolescents	• Primary Care • Telehealth • Safety-net/Under-resourced • Rural • Women's Health

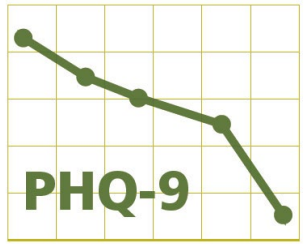
For more information: https://aims.uw.edu/collaborative-care/evidence-base-cocm

Collaborative Care Model (CoCM): IMPACT Study

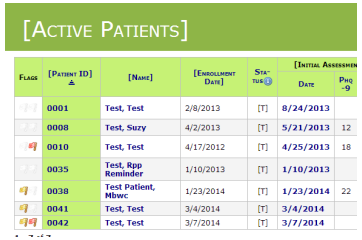
Prepared, Pro-active Practice Team



Informed, Active Patient



Outcome Measures



Flags	[Patient ID]	[Name]	[Enrollment Date]	Status	[Initial Assessment] Date	PHQ-9
	0001	Test, Test	2/8/2013	[T]	8/24/2013	
	0008	Test, Suzy	4/2/2013	[T]	5/21/2013	12
	0010	Test, Test	4/17/2012	[T]	4/25/2013	18
	0035	Test, Rpp Reminder	1/10/2013	[T]	1/10/2013	
	0038	Test Patient, Mbwc	1/23/2014	[T]	1/23/2014	22
	0041	Test, Test	3/4/2014	[T]	3/4/2014	
	0042	Test, Test	3/7/2014	[T]	3/7/2014	

Population Registry

Treatment Protocols

Psychiatric Consultation

Unützer et al. 2002

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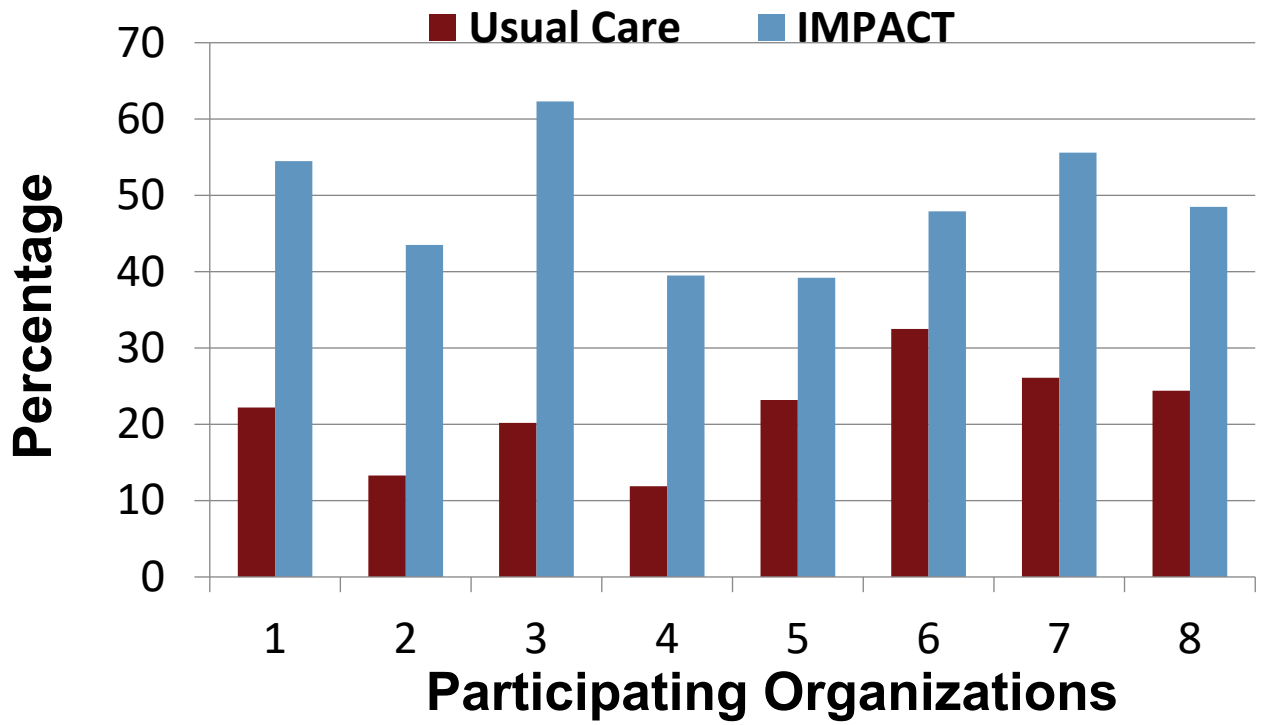
Twice as Many People Improve

50% or greater improvement in depression at 12 months



Unützer et al., 2002, 2004

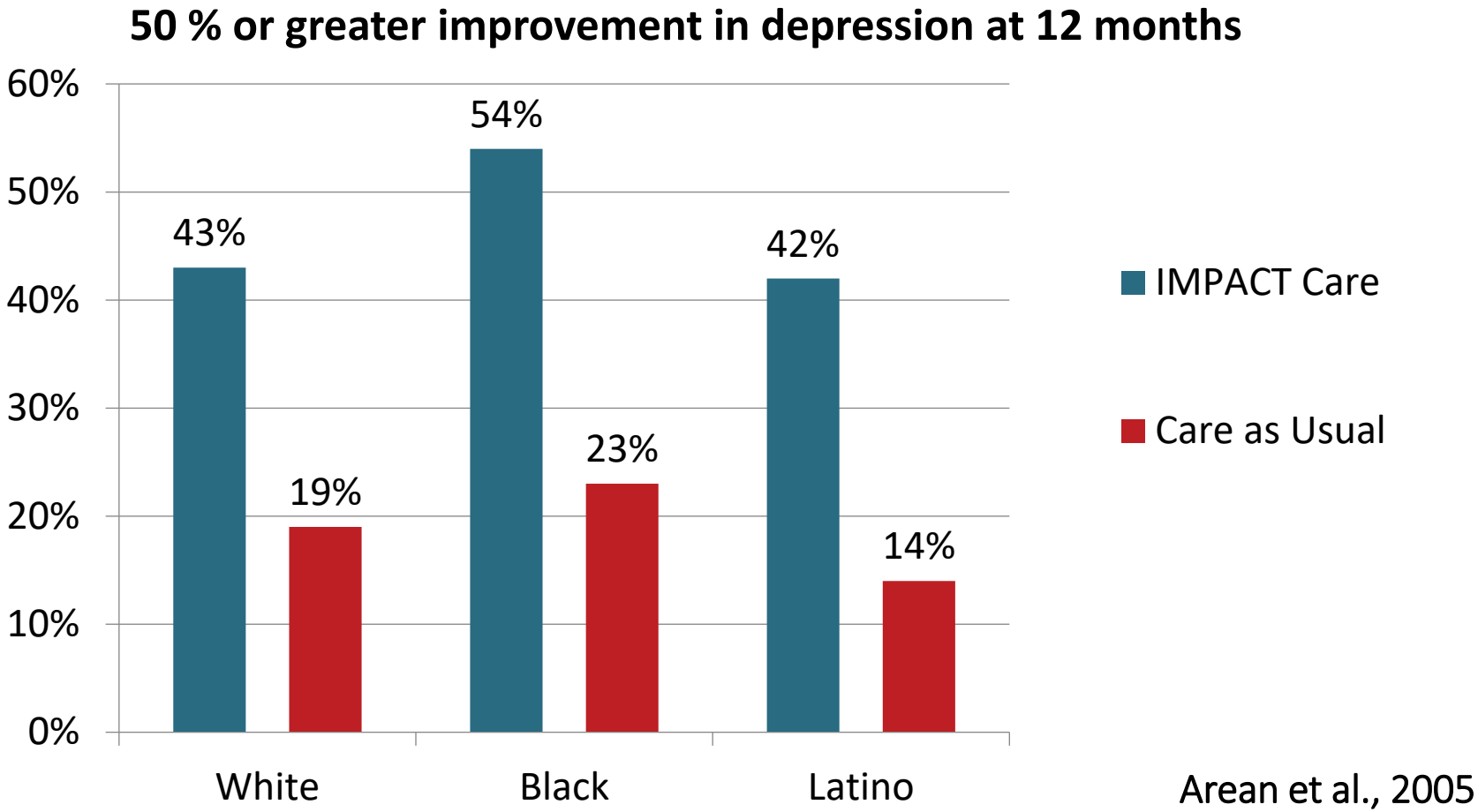
IMPACT: Summary

- Improved Outcomes
  - Less depression
  - Less physical pain
  - Better functioning
  - Higher quality of life
- Greater patient and provider satisfaction
- Reduced healthcare costs

"I got my life back"

THE TRIPLE/QUADRUPLE AIM

Collaborative Care for Disparity Populations



Arean et al., 2005

For more evidence treating racial and ethnic groups with Collaborative Care:
https://aims.uw.edu/sites/default/files/4%20Evidence%20Base_Racial%20Ethnic%20Groups.pdf

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Principles of Collaborative Care

Population-Based Care

Measurement-Based Treatment to Target

Patient-Centered Collaboration

Evidence-Based Care

Accountable Care

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Principle: Population-Based Care

Caseload Overview

Tx Status

PHQ-9 tracking

GAD-7 tracking

Psych Consult

			Treatment Status				PHQ-9				GAD-7				Psychiatric Consultation	
			! Indicates that the most recent contact was over 2 months (60 days) ago				✓ Indicates that the last available PHQ-9 score is at target (less than 5 or 50% decrease from initial score) ! Indicates that the last available PHQ-9 score is more than 30 days old				✓ Indicates that the last available GAD-7 score is at target (less than 10 or 50% decrease from initial score) ! Indicates that the last available GAD-7 score is more than 30 days old					
View Record	Treatment Status	Name	Date of Initial Assessment	Date of Most Recent Contact	Number of Follow-up Contacts	Weeks in Treatment	Initial PHQ-9 Score	Last Available PHQ-9 Score	% Change in PHQ-9 Score	Date of Last PHQ-9 Score	Initial GAD-7 Score	Last Available GAD-7 Score	% Change in GAD-7 Score	Date of Last GAD-7 Score	Flag	Most Recent Psychiatric Consultant Note
View	Active	Susan Test	9/5/2015	2/23/2016	10	26	22	14	-36%	2/23/2016	18	17	-6%	! 1/23/2016	Flag for discussion & safety risk	1/27/2016
View	Active	Albert Smith	8/13/2015	! 12/2/2015	7	29	18	17	-6%	! 12/2/2015	14	10	-29%	! 12/2/2015	Flag for discussion	
View	Active	Joe Smith	11/30/2015	2/28/2016	6	14	14	10	-29%	2/28/2016	10	✓ 6	-40%	2/28/2016	Flag for discussion	2/26/2016
View	Active	Bob Dolittle	1/5/2016	3/1/2016	3	9	21	19	-10%	3/1/2016	12	10	-17%	3/1/2016	Flag as safety risk	2/18/2016
View	Active	Nancy Fake	2/4/2016	2/4/2016	0	4	.	No Score			.	No Score				
View	RP	John Doe	9/15/2015	3/6/2016	10	25	20	✓ 2	✓ -90%	3/6/2016	14	✓ 3	✓ -79%	3/6/2016		2/20/2016

FREE UW AIMS Registry (https://aims.uw.edu/resource-library/patient-tracking-spreadsheet-example-data)

Allows proactive engagement and timely treatment adjustment, so "**no one falls through the cracks**"

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Principle: Measurement Based Treatment to Target

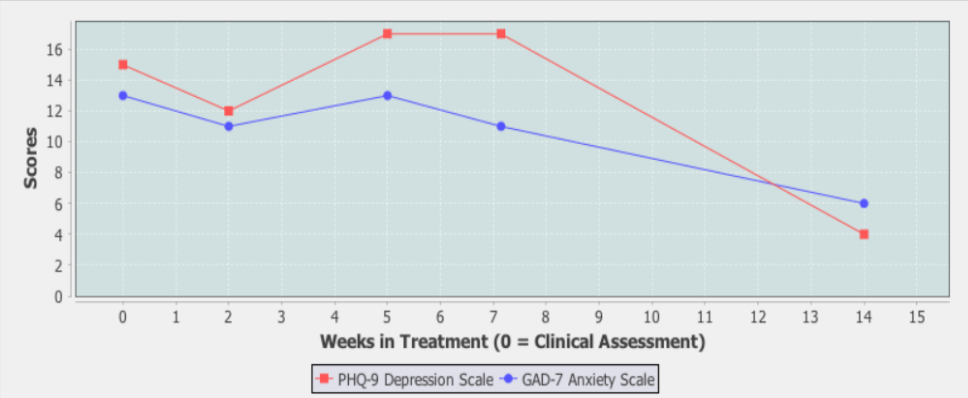
Patient | Caseload | Program | Tools | Search Name or MHITS ID | Hello, Anna (aratzliff) | Help | Logou

Date of Contact	Contact Type	Weeks in Tx	Visit Type	PHQ-9	GAD-7	Bipolar Screen	PTSD Screen	Current Medications
1/19/2016	Clinical Assessment	0	Clinic	15	13	√	√	
1/29/2016	Psychiatric Consultation Note	1	Phone w/ CC					
2/2/2016	Follow Up Contact	2	Clinic	12	11			
2/5/2016	Follow Up Contact	2	Phone					
2/10/2016	Psychiatric Consultation Note	3	Phone w/ CC					
2/10/2016	Psychiatric Consultation Note	3	Phone w/ CC					
2/23/2016	Follow Up Contact	5	Clinic	17	13			Fluoxetine HCl (Prozac) 10mg
3/9/2016	Follow Up Contact	7	Clinic	17	11			Fluoxetine HCl (Prozac) 20mg
3/18/2016	Follow Up Contact	8	Phone					†Fluoxetine HCl (Prozac) 20mg
4/26/2016	Follow Up Contact	14	Clinic	4	6			†Fluoxetine HCl (Prozac) 20mg

Collateral Contacts

Date of Contact	Name	Role	Agency	Contact Information
No Records Found				

Patient Progress



- Regular use of behavioral health measures to track response to treatment
- Use of psychiatric providers to help intensify treatment
- Stepped care makes efficient use of behavioral health resources

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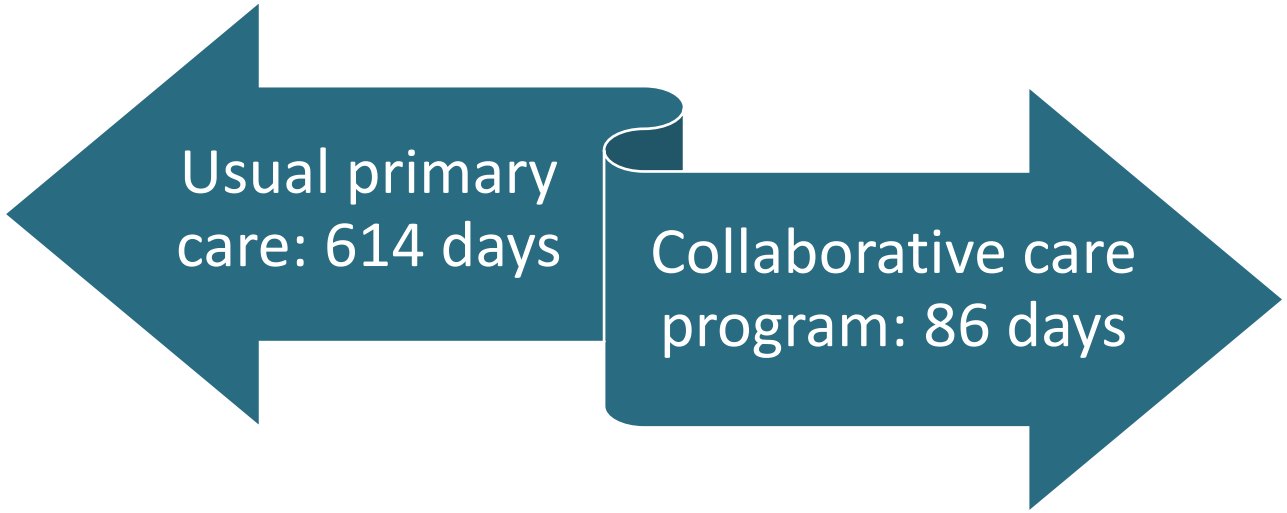
Treatment to Target Drives Early Improvement

In a recent retrospective study (2008 – 2013) of over 7,000 patients:

Time to remission for depression



Garrison et al., 2016

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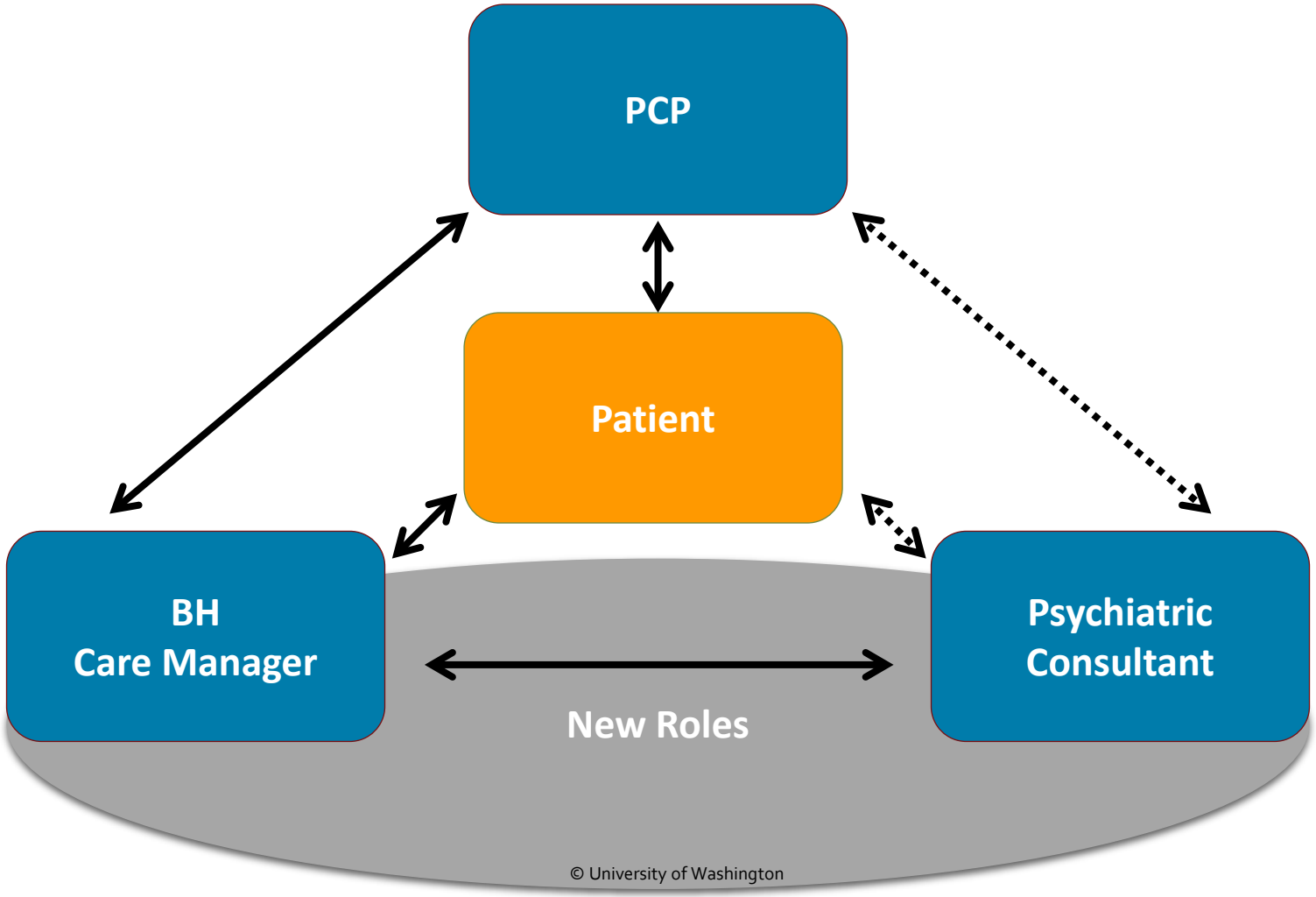
Principle: Patient Centered Collaboration



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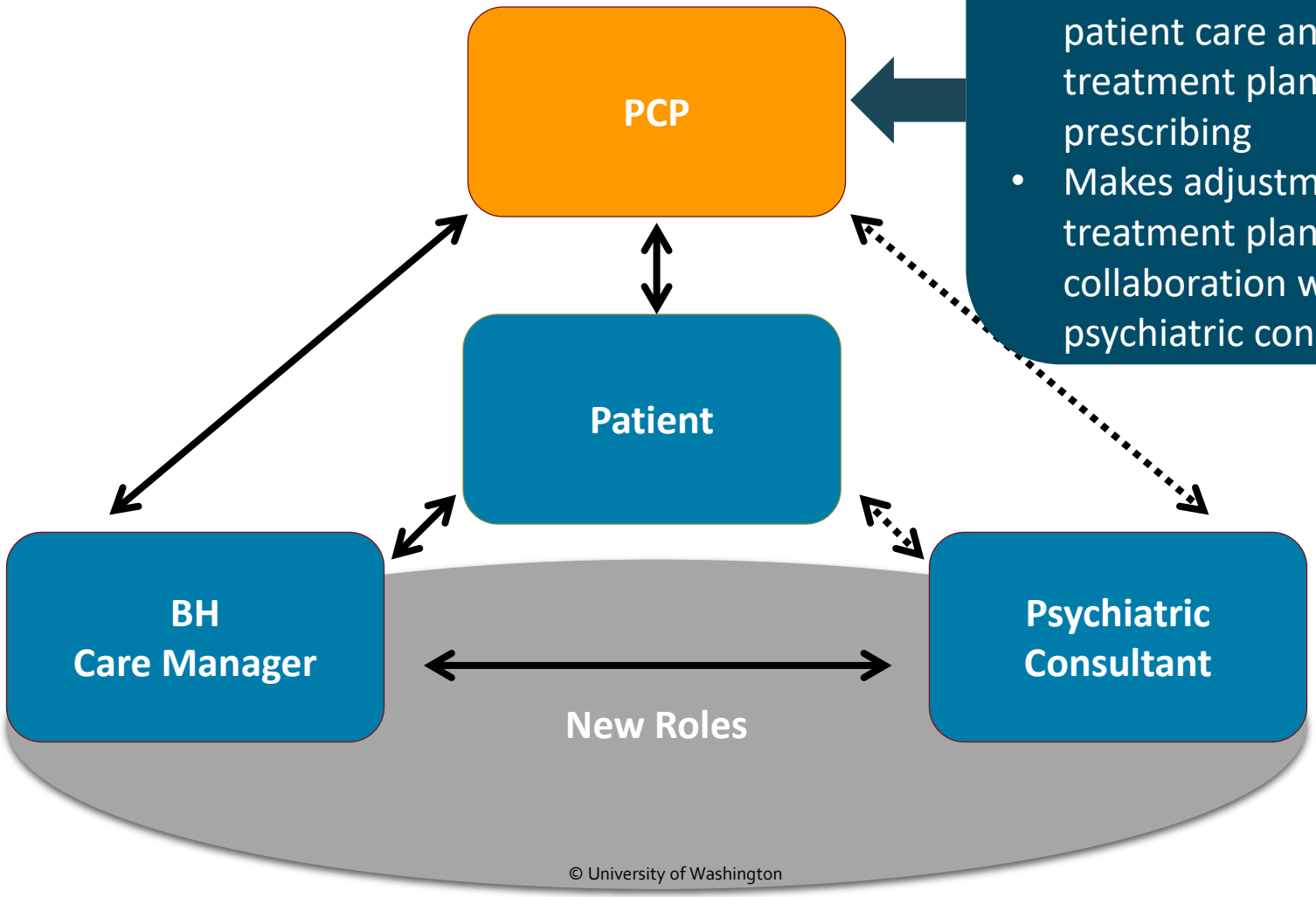
Primary Care Provider

- Identifies the patients
- Introduces the collaborative care model and team
- Oversees all aspects of the patient care and enacts the treatment plan, including prescribing
- Makes adjustment to treatment plan, in collaboration with BHCM and psychiatric consultant



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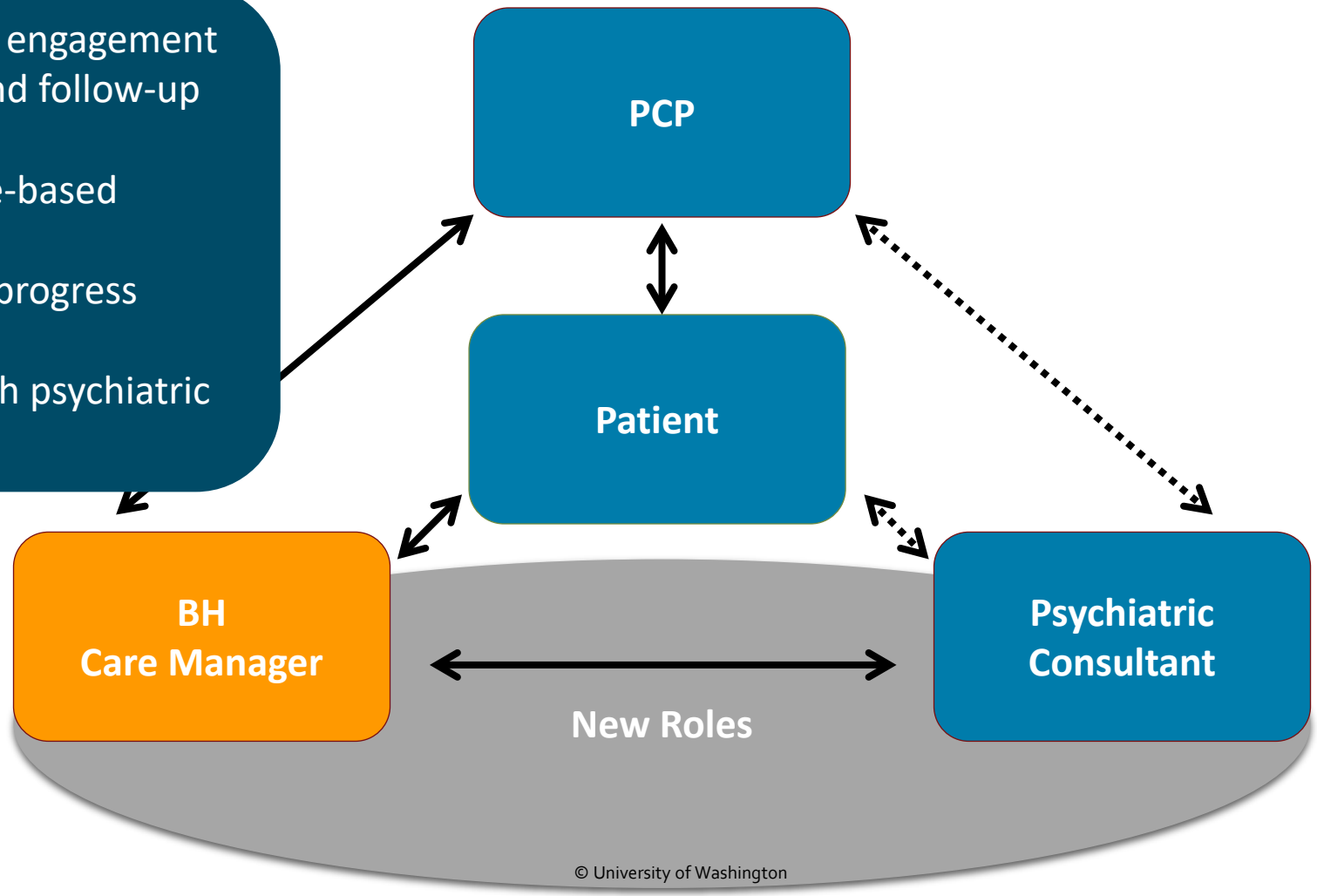
Behavioral Health Care Manager (BHCM)

- Facilitates patient engagement
- Performs initial and follow-up assessments
- Provides evidence-based therapies
- Tracks treatment progress
- Supports PCPs
- Reviews cases with psychiatric consultant



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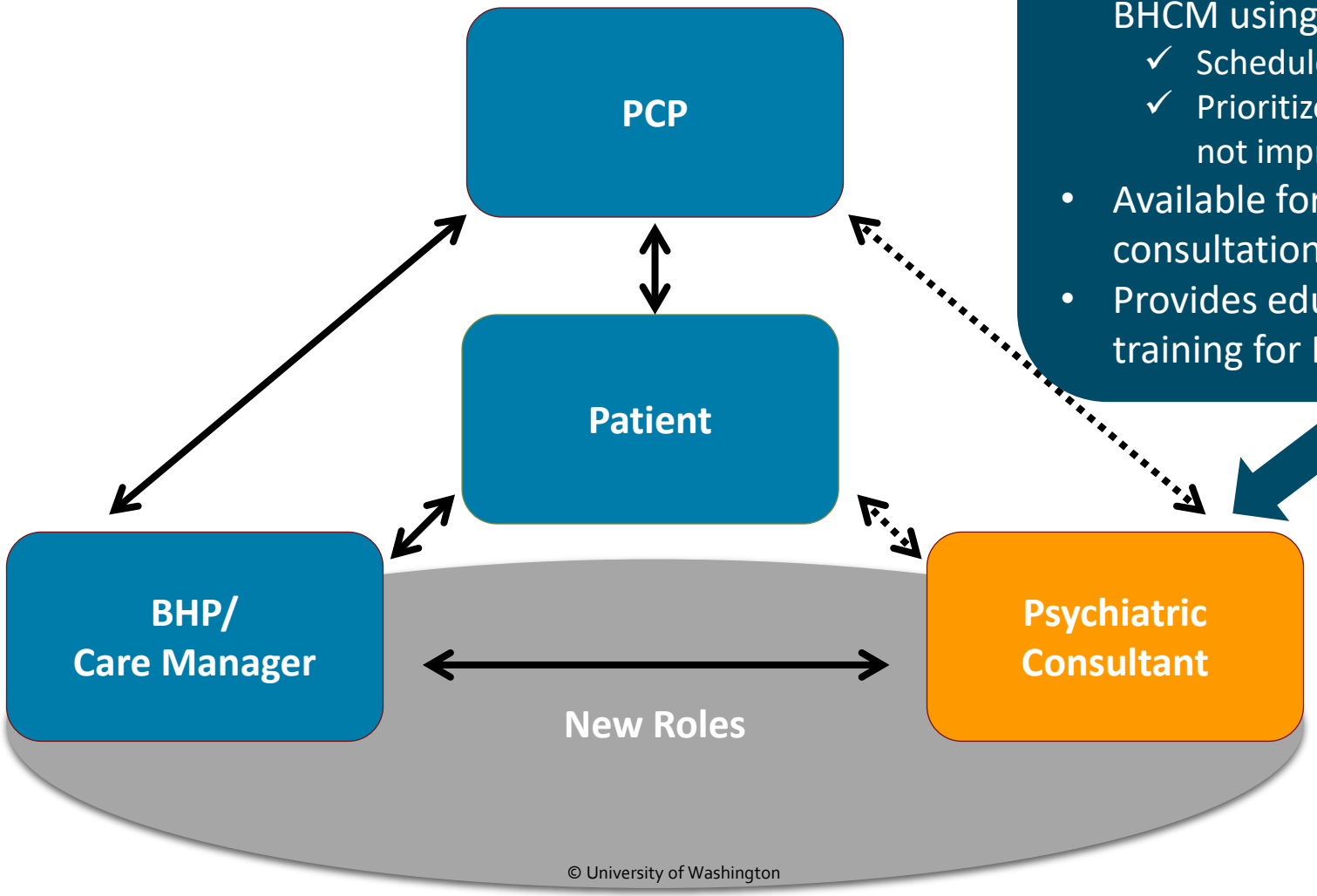
Psychiatric Consultant



- Supports PCP and BHCM
- Review cases with the BHCM using the registry
  - ✓ Scheduled (ideally weekly)
  - ✓ Prioritize patients that are not improving
- Available for curbside consultations
- Provides education and training for PCPs/BHCM

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Leveraging Scarce Psychiatric Resources

Larger population reach → through team-based care

Larger geographic reach → through telehealth

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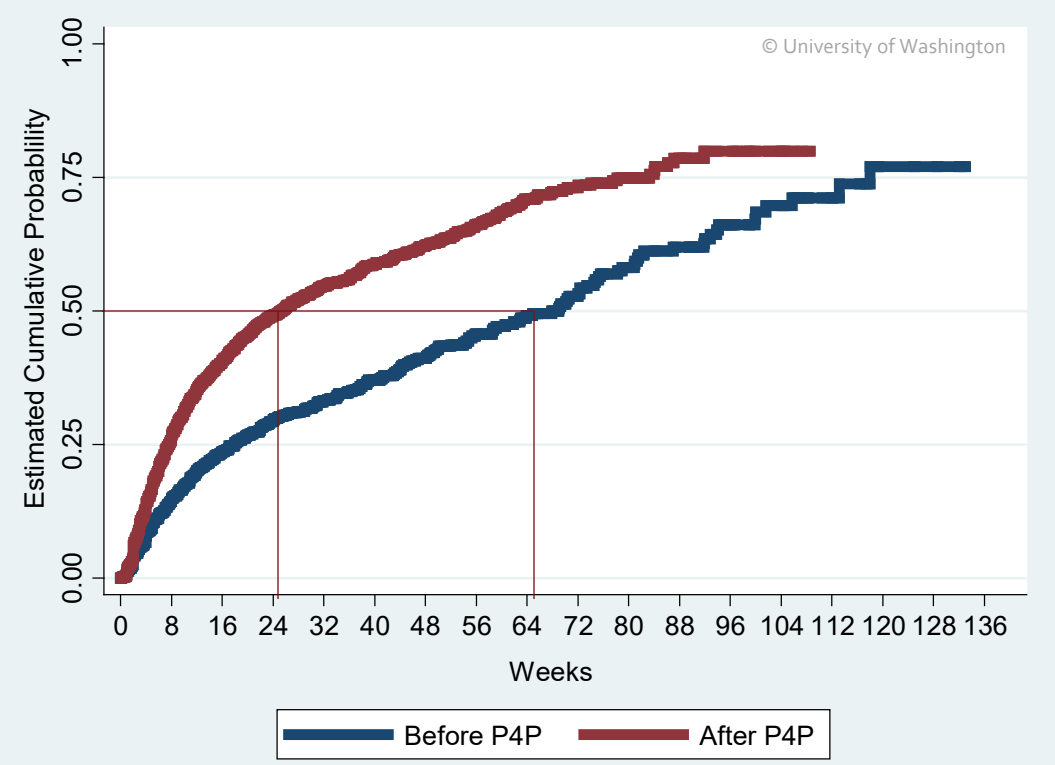
Principle: Evidence-Based Treatment

Principle: Accountable Care

Accountability in Practice

- Pay for performance on process measures
  - Complete initial assessment
  - Meet with psychiatric consultant
  - At least 2 visits per month for % of caseload
- Cut median time to depression treatment response **in half**



Unützer et al., 2012

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Principles of Collaborative Care

Population-Based Care

Measurement-Based Treatment to Target

Patient-Centered Collaboration

Evidence-Based Care

Accountable Care

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Case Example: How Would a Collaborative Care Approach Improve the Care of This Patient?

Interdisciplinary team addressing both behavioral health and health concerns collaboratively

Shared system and shared records amongst clinical providers

BH Care Manager providing evidence-based therapies

Psychiatric consultant reviewing case and providing recommendations

Tracking of progress with regular planned follow up

Proactive adjustment of treatment plan

Relapse prevention planning

Moving Towards Collaborative Care

Incorporate principles into your care

- Effective screening workflows
- Patient-centered goals
- Focused tracking on a defined population (using a registry)
- Measurement-based treatment to target for that population (using behavioral health measures)
- Consistent use of evidence-based treatment
- Accountability to measuring outcomes, especially improvement, satisfaction and cost

Screening and Identifying Patients

- Early recognition and treatment of behavioral health disorders:
  - Prevent complications
  - Improve outcomes and quality of life
  - Reduce health care costs

U.S. Preventive Services Task Force (USPSTF) recommends screening adults for depression

- Examples of Screening Tools/Measures Validated for use in Primary Care:
  - Depression: PHQ-2/PHQ-9
  - Anxiety: GAD-7
  - Alcohol: Audit-C

Screening rates are low, one estimate of depression screening in primary care was 4.2%
-Akincigil, Matthews, 2017

- Screening workflows:
  - Can be done by patient (also via EMR patient portal)
  - Or done by PCP or PCP delegate (e.g., MA, nurse)

IMPLEMENTATION AND FINANCING

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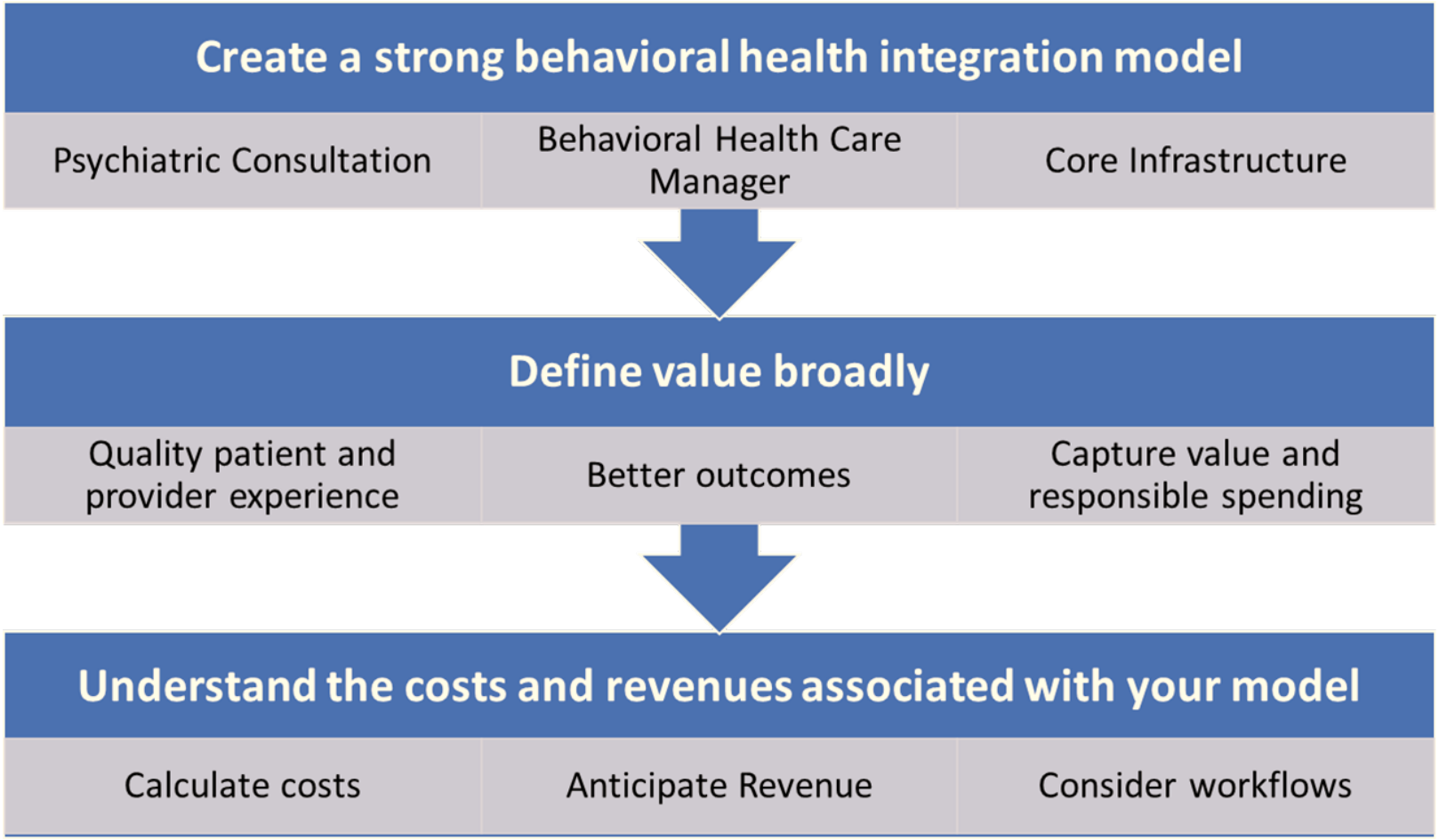
How to Approach Implementation



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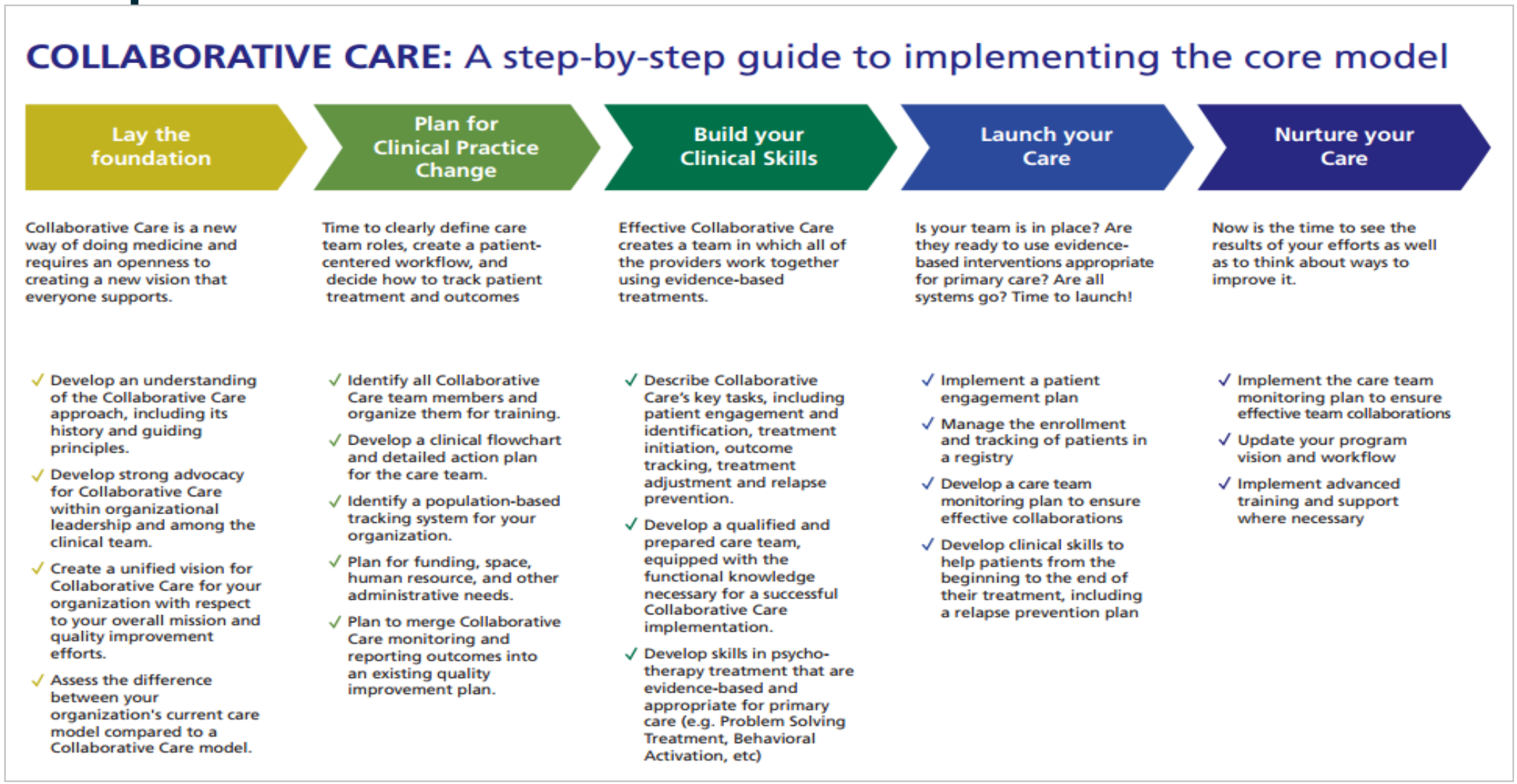
Step 1: Select a Behavioral Health Integration Model

Considerations:

- Population and clinic needs
- Understand pro/cons of each model and potential limitations
- Can be complementary, not necessarily in competition

Implementation Tools and Resources



https://aims.uw.edu/training-support/implementation-support

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Step 2: Define Value of Behavioral Health Integration

- Mental Health Care Access
- Improved Patient Experience
- Improved Provider Experience
- Improved Primary Care Provider Productivity
- High Quality of Care
- Improved Patient Outcomes
- New Funding Opportunities
- Health Care Savings

Step 3: Create a Financial Model

Initial Costs of Practice Change:

- provider and administrator time to plan for change
- care team training costs and time/workforce development
- development of registry
- workflow planning (e.g. incorporating screening), billing optimization

Ongoing Care Delivery Costs:

- care manager time
- psychiatric consultant time
- administration time and overhead (including continuous quality improvement efforts)

Financing Overview for Collaborative Care

- "Traditional" fee-for-service CPT codes
  - Health and Behavior, psychotherapy, screening, SBIRT, etc.
  - Licensure and setting requirements often vary by payor
    - Usually needs to be independently licensed behavioral health provider

- Behavioral Health Integration (Collaborative Care) codes
  - Bundled payment for the Collaborative Care team, billed under the treating medical provider
  - Licensure and setting requirements may vary between payors

Required Activities for Collaborative Care Code Billing

- ✓Engagement and assessment using validated measures, resulting in a treatment plan
- ✓Weekly caseload review with psychiatric consultant and treatment modifications as needed for individual patients
- ✓Use of registry to track visits and outcomes
- ✓Ongoing collaboration with PCP and other treating providers
- ✓Provision of brief Evidence-Based Treatments
- ✓Outcome monitoring using validated scales
- ✓Relapse Prevention Planning in preparation for discharge

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

	Traditional CPT Codes	Collaborative Care Codes*
Patient must provide consent?	No	Yes, and informed of potential of cost-share
Who is involved in care?	Patient and BH provider	PCP, BHCM, Psychiatric consultant
What type of provider?	Independently licensed BH provider (depends on payor)	BHCM does not need to be licensed, but must have specialized BH education or training**
What services are included?	Face-to face or Telehealth (with current COVID PHE)	Face to face care, as well as phone/video calls, care coordination b/w team and other BH providers, caseload review and consultation, and managing registry
Limitations/exceptions	-Limited to sessions 16 min or more -May have limited # of sessions per year based on payor	-Min <16 can be still be added to accumulated total for the month -BHCM and psych provider can ALSO bill additional CPT codes (just cannot double bill for same service)

*there are specific codes for FQHC/RHC billing **requirements vary based on payor

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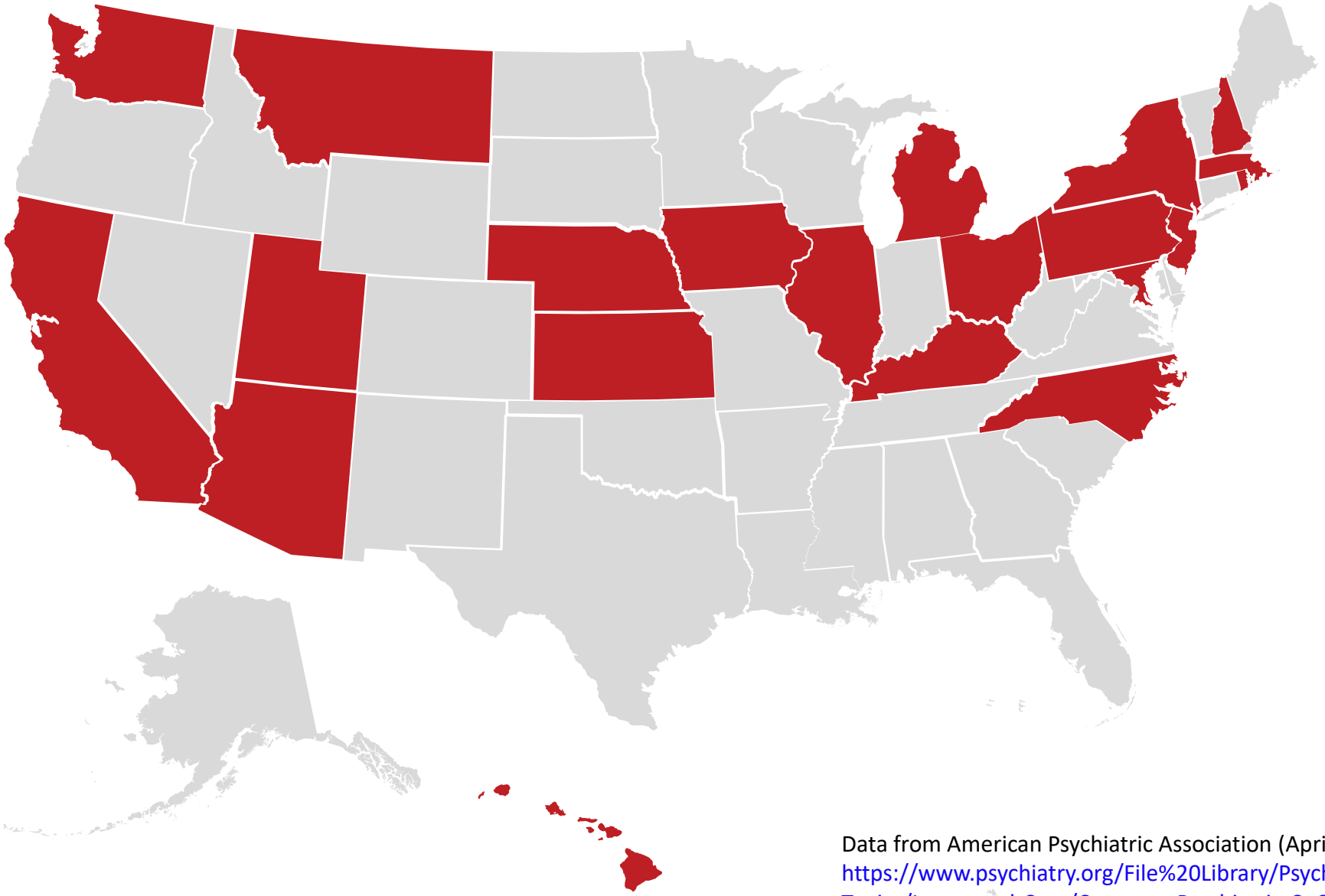
	Traditional CPT Codes	Collaborative Care Codes
How is it billed?	• Billed per visit • Billed under BH provider	• Billed per calendar month • Accumulation of minutes spent over the month (*only time of the BH Care manager counts) • Billed under medical provider as “incident to” under “general supervision”
Who receives payment?	• BH provider	• PCP
What payors are paying for these codes?	• Medicare • Medicaid • Most private insurances	• Medicare and most Medicare Advantage • Increasing number of private payors • Increasing number of state Medicaid plans (but some don’t pay for general Behavioral Health Integration codes)

https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/get-paid

Medicaid Programs That Cover Collaborative Care Code Billing



Data from American Psychiatric Association (April 2021):
https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Professional-Topics/Integrated-Care/Coverage-Psychiatric-CoCM-Codes-Payers.pdf

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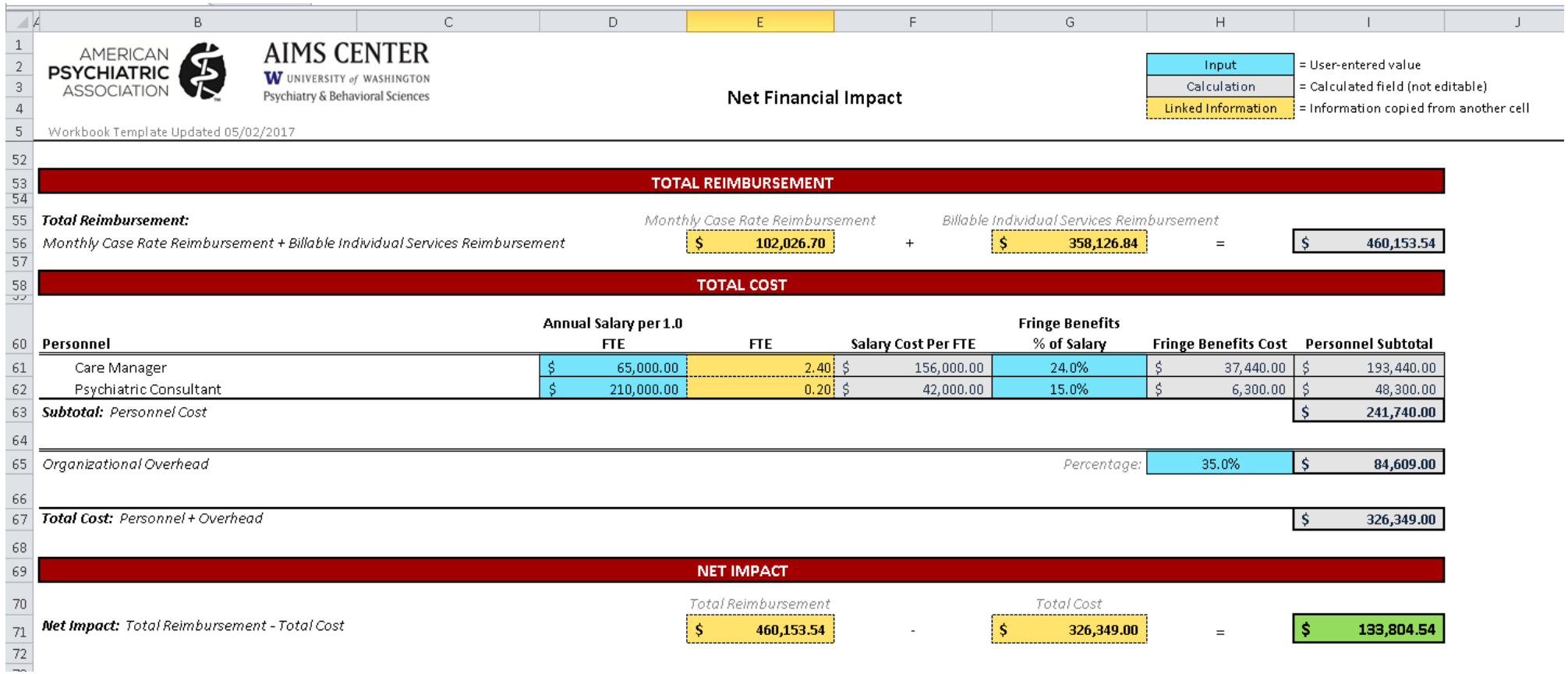
Billing Strategies

- Traditional CPT codes only
- Collaborative Care billing codes only
- A mix of both!

- Choosing a strategy will depend on:
  - Type of clinic and payor mix
  - Qualifications/licensure of BH Care Manager
  - What services are reimbursable in your state

Financial Modeling Tool Available!



AMERICAN PSYCHIATRIC ASSOCIATION

AIMS CENTER
UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

Workbook Template Updated 05/02/2017

Net Financial Impact

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

TOTAL REIMBURSEMENT

Total Reimbursement:
Monthly Case Rate Reimbursement + Billable Individual Services Reimbursement

Monthly Case Rate Reimbursement		*Billable Individual Services Reimbursement*		
$ 102,026.70	+	$ 358,126.84	=	$ 460,153.54

TOTAL COST

Personnel	Annual Salary per 1.0 FTE	FTE	Salary Cost Per FTE	Fringe Benefits % of Salary	Fringe Benefits Cost	Personnel Subtotal
Care Manager	$ 65,000.00	2.40	$ 156,000.00	24.0%	$ 37,440.00	$ 193,440.00
Psychiatric Consultant	$ 210,000.00	0.20	$ 42,000.00	15.0%	$ 6,300.00	$ 48,300.00
Subtotal: *Personnel Cost*						$ 241,740.00

Organizational Overhead	*Percentage:*	35.0%	$ 84,609.00
Total Cost: *Personnel + Overhead*			$ 326,349.00

NET IMPACT

Net Impact: *Total Reimbursement - Total Cost*

Total Reimbursement		*Total Cost*		
$ 460,153.54	-	$ 326,349.00	=	$ 133,804.54

https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/implement

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RESOURCES

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Resources

- AIMS Center:
  - http://aims.uw.edu/
- American Psychiatric Association (APA) Integrated Care:
  - Training:

    https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care
  - Coverage: https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Professional-Topics/Integrated-Care/Coverage-Psychiatric-CoCM-Codes-Payers.pdf
- National Council for Mental Wellbeing: Center for Excellence for Integrated Health Solutions
  - https://www.thenationalcouncil.org/program/center-of-excellence/
- Agency for Healthcare Research and Quality Academy
  - https://integrationacademy.ahrq.gov/

AIMS Center Office Hours

FREE opportunity to attend VIRTUAL office hours to get help with implementing and financing Collaborative Care

- Implementation Office Hours:
  - Third Thursday of every month 10-11am PST via Zoom
- Finance Office Hours:
  - First Wednesday of every month 9-10am PST via Zoom

Link for more info: https://aims.uw.edu/what-we-do/office-hours

KNOWLEDGE CHECKS

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Knowledge Check #1

In the United States, what is the number of adults living with a mental illness?

A. One in 5
B. One in 10
C. One in 50
D. One in 100

Knowledge Check #2

Which of the following statements about screening patients for mental health conditions is FALSE:

A. U.S. Preventive Services Task Force (USPSTF) recommends screening adults for depression

B. Screening rates for common behavioral health conditions (such as depression) are high in the primary care setting

C. Screening can provide early detection and treatment for mental and substance use disorders

D. Screening can help reduce health care costs

Knowledge Check #3

A primary care clinic has an embedded psychiatrist that is physically located within the clinic that provides direct consultation services for patients. This is an example of which type of Integrated Care model?

A. Traditional consultation model
B. Co-located model
C. Coordinated model
D. Collaborative Care model

Knowledge Check #4

True or False, the IMPACT trial demonstrated twice as many people improved in the Collaborative Care model compared to usual care?

A. True

B. False

Knowledge Check #5

Which of the following statements about Collaborative Care (CoCM) are true?

A. CoCM can enhance treatment for patients with cancer, diabetes, cardiovascular disease, or HIV, among other physical conditions.

B. CoCM interventions improve outcomes in safety net clinics and FQHCs, OB/GYN clinics, and rural care settings.

C. Disparities in access to quality treatment for depression experienced by racial and/or ethnic minority groups can be alleviated with CoCM.

D. All of the above statements are true.

Knowledge Check #6

The use of a patient registry supports which of the following core principles of the Collaborative Care Model? (can choose more than one)

A. Patient-centered collaboration
B. Evidence-based care
C. Population-based care
D. Measurement-based treatment to target

Knowledge Check #7

Which of the following should be the first step when considering whether to implement Integrated Care?

A. Choose a model
B. Consider financial implications
C. Consider workflow changes/development
D. Understand the needs of your organization and clinic population

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