Collaborative Care Model (CoCM) and Primary Care Behavioral Health Model (PCBH)

Creating Access, Impacting Populations, and Strengthening the Healthcare Team

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- PCBH program started in 2006
- Program has grown to include the following in 2023
  - 0.75 FTE consulting psychiatrist, Dr. Julie Nielsen-Witkovsky
  - 10.5 FTE Behavioral Health Consultants (psychologists and social workers)
  - 2.0 FTE Behavioral Health Care Coordinators

- January 2023 started CoCM project planning meetings in collaboration with WPHCA and CFHA

- August 2023 Go-Live for CoCM services and billing
- Integrated behavioral health services provided at 3 primary care clinics in Madison, WI

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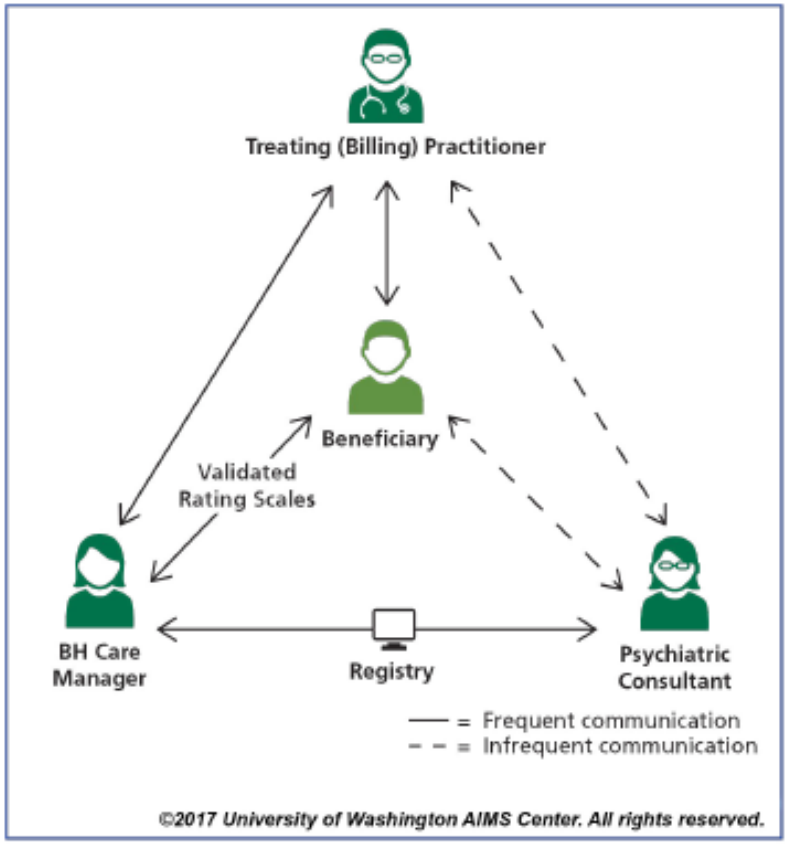
Collaborative Care Model (CoCM)

Community Health Center providers should submit claims with procedure code G0512 to be reimbursed at the PPS rate

PSYCHIATRIC COLLABORATIVE CARE SERVICES (COCM)

CPT codes 99492, 99493, and 99494 are used to bill for monthly services furnished using the Psychiatric Collaborative Care Model (CoCM), an approach to BHI shown to improve outcomes in multiple studies.

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



CARE TEAM MEMBERS

- **Treating (Billing) Practitioner** – A physician and/or non-physician practitioner (PA, NP, CNS, CNM); typically primary care, but may be of another specialty (e.g., cardiology, oncology)
- **Behavioral Health Care Manager** – A designated individual with formal education or specialized training in behavioral health (including social work, nursing, or psychology), working under the oversight and direction of the billing practitioner
- **Psychiatric Consultant** – A medical professional trained in psychiatry and qualified to prescribe the full range of medications
- **Beneficiary** – The beneficiary is a member of the care team

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Collaborative Care Model (CoCM)

General BHI (CPT code 99484) has not yet been approved by DHS.

However, we have learned that there is active planning for implementation/approval over the next 6-12 months.

The General BHI code is for use to bill monthly services delivered using Behavioral Health Integration (BHI) models of care other than CoCM that also include service elements such as:

- Systematic assessment and monitoring
- Care plan revision for patients whose condition isn't improving adequately
- Continuous relationship with an appointed care team member

CPT code 99484 is used to report models of care that don't involve a psychiatric consultant, or an appointed behavioral health care manager, although these personnel may deliver General BHI services.

General BHI Service Parts

- Initial assessment, including administering applicable validated rating scales
- Systematic assessment and monitoring, using applicable validated clinical rating scales
- The primary care team's joint care planning with the patient, with care plan revision for patients whose condition isn't improving
- Facilitation and coordination of behavioral health treatment

Continuous relationship with an appointed member of the care team

Collaborative Care Model (CoCM)

Patient-Centered Care

Effective collaboration between BHCCs and PCPs, incorporating patient goals into the treatment plan

Measurement-Based Treatment to Target

Measurable treatment goals and outcomes defined and tracked for each patient (PHQ-9/GAD-7)

Treatments are actively changed until the clinical goals are achieved

Population - Based Care

- Defined and tracked patient population to ensure no one falls through the cracks

Evidence-Based Care

- Treatments are based on evidence

Accountable Care

- Providers are accountable and reimbursed for quality of care and clinical outcomes

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CoCM: Role of the PCP

Identifies and Engages:

- Introduces CoCM to patient
- Obtains informed consent
- Initiates warm handoff to behavioral health care manager

- *At Access given we already have a robust PCBH program the PCP simply refers to the BHC team and we assess for appropriateness of engagement with CoCM program*

Responsible for:

- Works with care team and patient to develop a treatment plan
- Works with care team to implement treatment and make treatment adjustments
- Prescribes medications, as needed*
- Addresses safety concerns
- Monitors physical health and potential medication interactions

The PCP also continues to oversee all aspects of the patient's care, including medication management.

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CoCM: Role of the Psychiatric Consultant

Responsible for:

- Supports the PCP and BH care manager in treating patients
- Meets weekly with care manager, focusing treatment planning for patients that have not improved at least 50% after 10-12 weeks
- Psychiatrist does not typically see the patient or prescribe medications in CoCM
- Available for ad-hoc consultations as needed

Skills:

- Make recommendations to PCP to enhance care without seeing the patient directly
- Ability to educate/share knowledge related to psychotropic management
- Create a treatment plan with limited information to support population health

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CoCM: Role of the Behavioral Health Care Manager

- *At Access the care manager is referred to as Behavioral Health Care Coordinator (BHCC)*

Coordinates the overall effort of the treatment team and ensures effective communication among team members

- Engages the psychiatrist to provide advice to the patient's provider, and based on the final decision of the provider shares the treatment plan with the patient
- Between provider visits, regular medication monitoring and psychoeducation
- Offers brief behavioral health interventions (using evidence-based techniques such as motivational interviewing, behavioral activation, and problem-solving treatment)
- Co-creates the relapse prevention plan with the patient
- Participates in systematic case review; Close collaboration with the provider and psychiatric consultant
- Supports the PCP by providing proactive follow-up of treatment response, alerting the PCP when the patient is not improving, supporting medication management, and facilitating communication with the psychiatric consultant regarding treatment changes

Identifying Eligible Patients: Inclusion Criteria

- Identified by PCP/BHC team for possible referral to CoCM program
  - Referral to the Behavioral Health Care Coordinator to reach out to provide overview and obtain verbal consent for engagement
- Use of registries for patients identified as having diagnosis of depression or anxiety

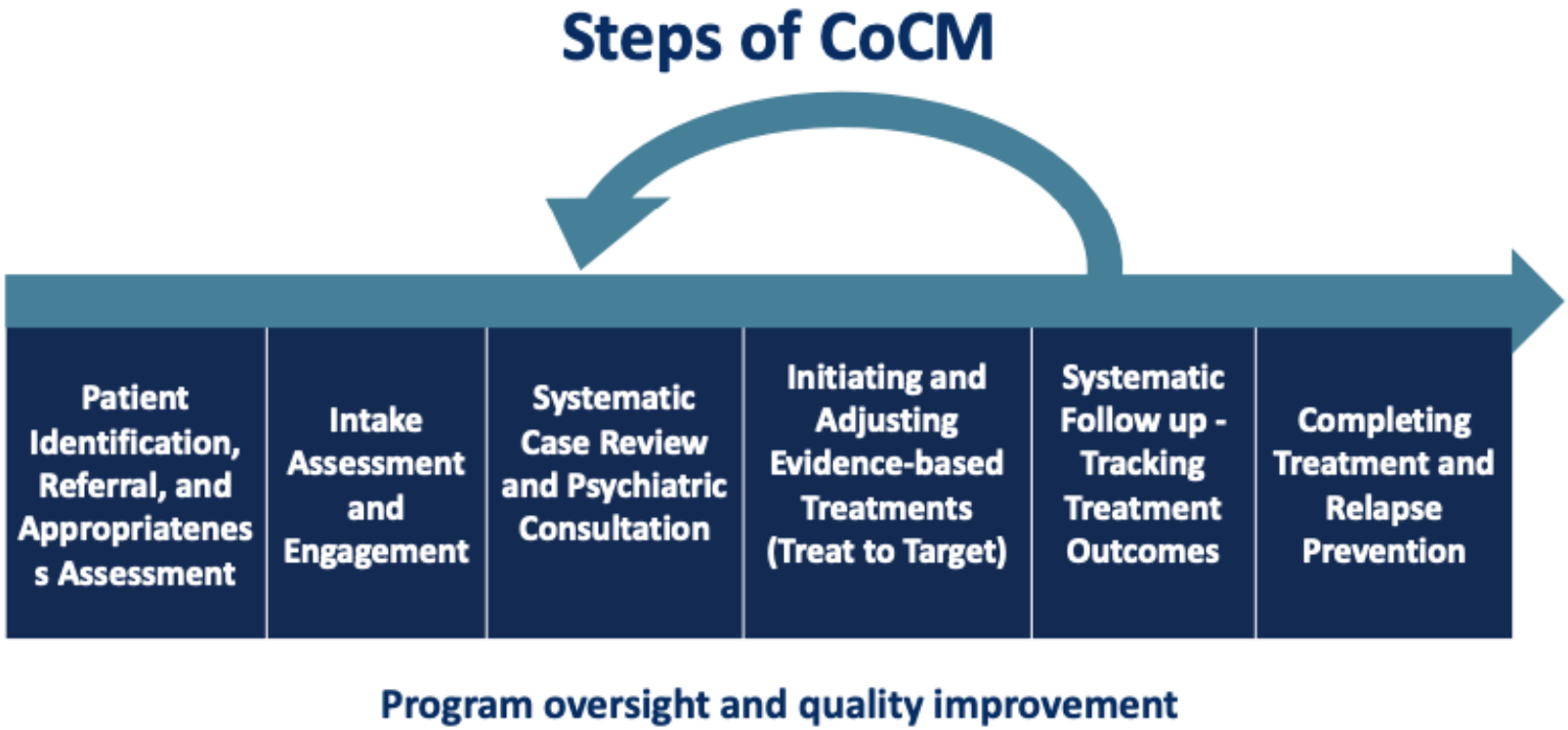
Defining the target population:

PHQ-9 and/or GAD-7 of 10 or more

Diagnosis of depression and/or anxiety on problem list

Just started on a new antidepressant, or regimen was changed by medical provider

CoCM Process



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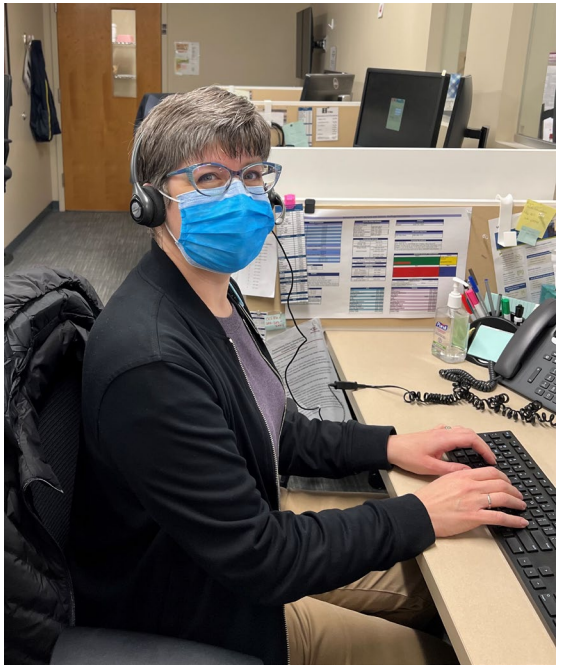
Primary Care Behavioral Health Model (PCBH)



"The PCBH model is a team-based primary care approach to managing behavioral health problems and biopsychosocially influenced health conditions. The model's main goal is to enhance the primary care team's ability to manage and treat such problems/conditions, with resulting improvements in primary care services for the entire clinic population. The model incorporates into the primary care team a behavioral health consultant (BHC), sometimes referred to as a behavioral health clinician, to extend and support the primary care provider (PCP) and team. The BHC works as a generalist and an educator who provides high volume services that are accessible, team-based, and a routine part of primary care."

(Reiter, Dobmeyer & Hunter, 2018)

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G

Generalist: the BHC is "open to all" and sees a variety of presenting concerns including mental health, substance use disorders, preventive medicine, health and behavior changes, etc; across a lifespan.

A

Accessible: Available in real time to support the patient experience and support the PCP via warm handoffs and curbside consults, targeted contacts 15-30 minutes, schedule set up to support same day access.

T

Team-Based: BHC goal to maximize effectiveness of PCP, support care team communication, flexibly contributing to the team.

H

High Productivity: BHCs typically see 8-14 patients per day, population health focus, development of clinical pathways-depression screening/intervening, SBIRT.

E

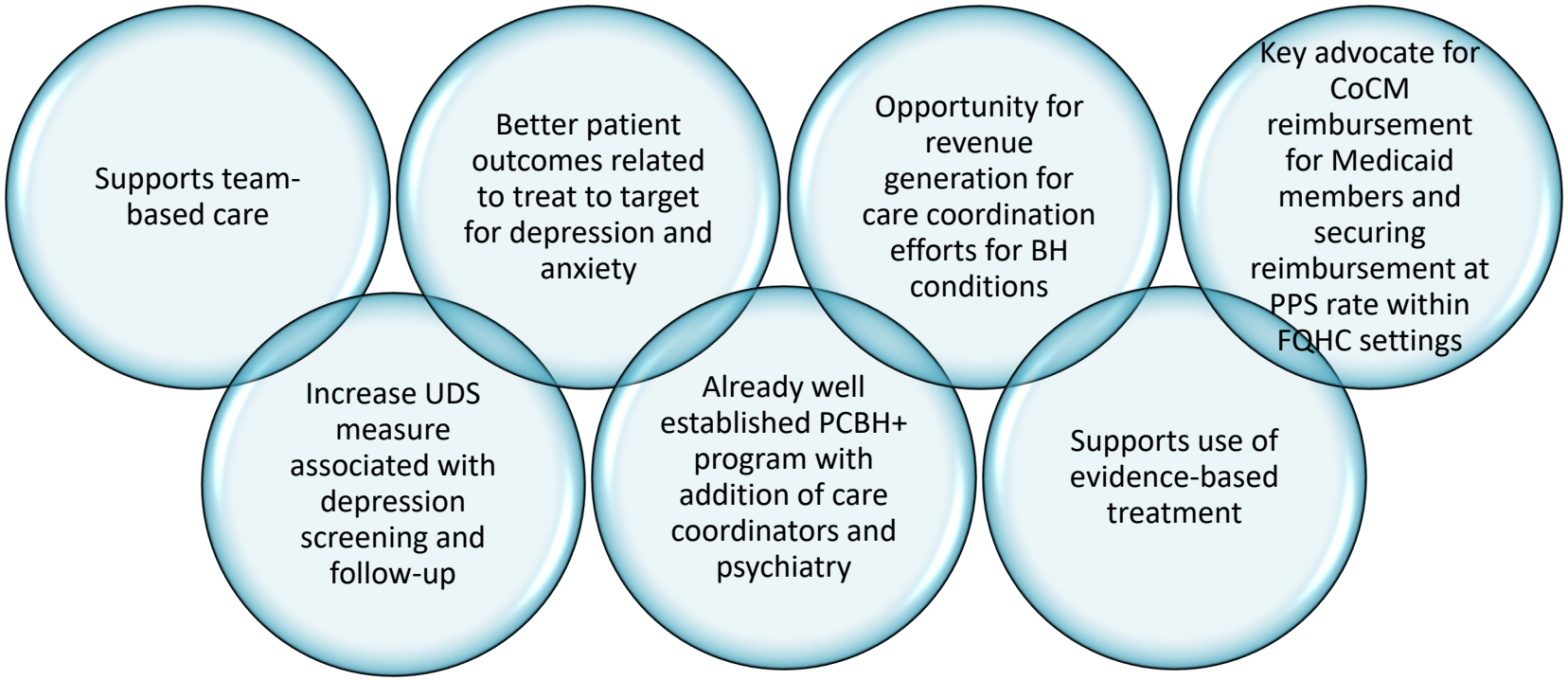
Educator: BHCs share knowledge to support the education of the entire care team related to biopsychosocial functioning and communication.

R

Routine: Develop BHC as routine part of primary care to support improving health of the primary care population.

(Reiter, Dobmeyer & Hunter, 2018)

Why Pursue CoCM at Access?



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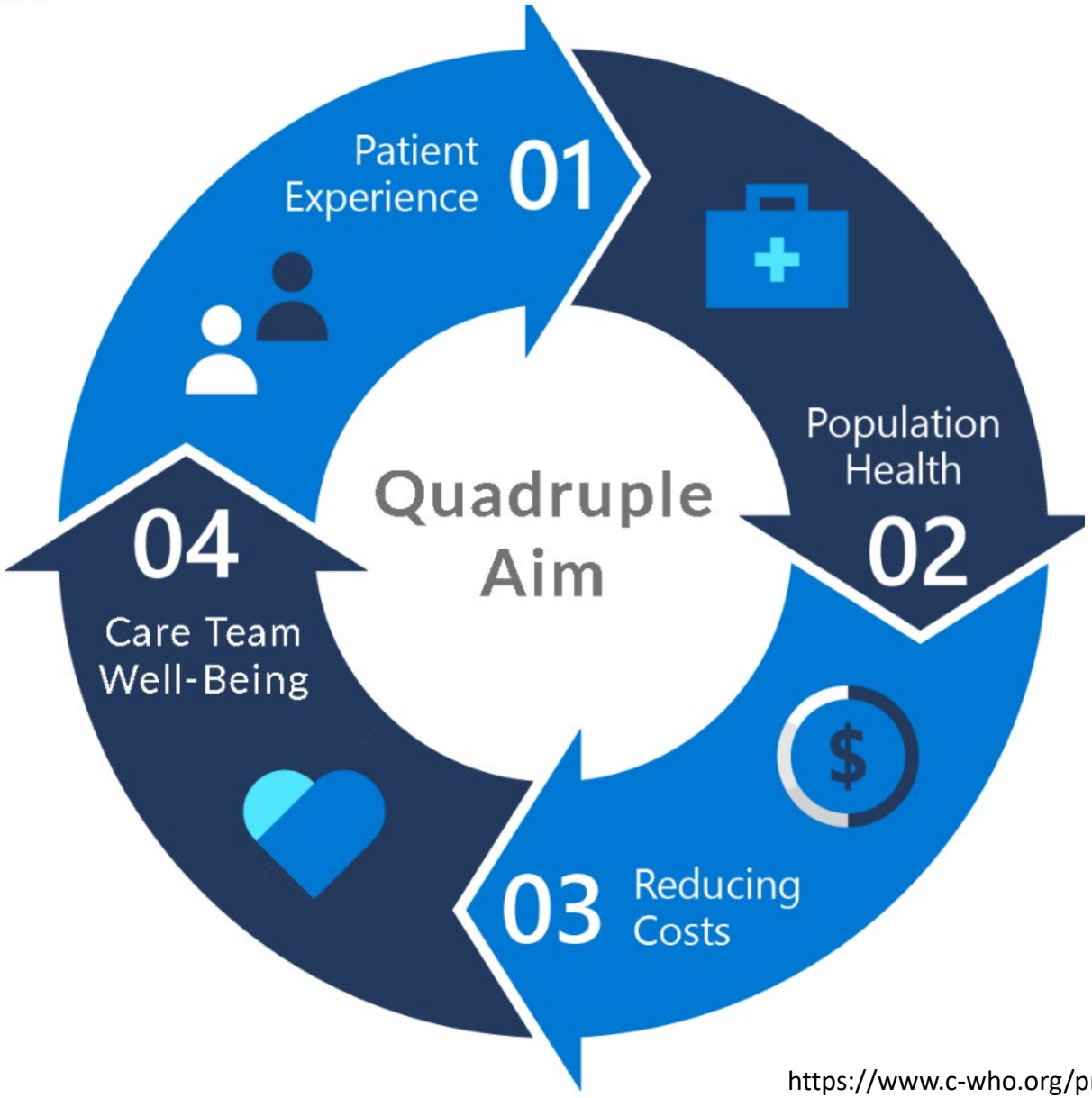

https://www.c-who.org/practice-based-research-2/

Benefits of CoCM & PCBH Models

Benefits of Blending CoCM & PCBH Models

- Harnessing the impact of both CoCM and PCBH to promote population health and provide comprehensive biopsychosocial approach to care
  - The PCBH approach is that of a generalist in which we are open to seeing any and all BH conditions across a lifespan. This ensures access to needed services to the population we serve
  - The addition of CoCM to our current BH service offerings allows us to better support our patients with specific, defined behavioral health conditions of depression and anxiety with a systematic process that is registry driven to provide increased support and outreach for engagement in treatment and stepped care

- By blending CoCM and PCBH we can have the greatest impact on populations to promote wellness

- Ability to focus on broad range of individual and family health needs while also having systematic way to follow patients with defined mental health conditions and treat to target

American Psychological Association Center for Psychology and Health; **Behavioral Health Services in Primary Care:** An Essential Component of Integrated Care

https://www.apa.org/health/behavioral-health-services-primary-care.pdf

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CoCM Planning at Access

- June 2022 WI DHS provided Forward Health Update related to reimbursement for CoCM codes for WI Medicaid
  - 2022-25: Collaborative Care Model Policy
  - 2022-40: Collaborative Care Model and New Billing Procedure for Community Health Centers

CoCM Planning at Access

- Work group involving WPHCA, CFHA, Access staff/leaders
- Collaboration with UW Health (shared EHR and billing/coding revenue cycle)
- Developing project scope and work plan
  - Core project team with Access staff and project management support

Work Plan

B	C	D	F	G	H
COCM Services	**Target date: August 15, 2023**				**Access Community Health Centers**
Last Updated: 8/18/2023 by Kay					
Function/Task	**Person Responsible**	**Due Date**	**Status**	**Indicator**	**Updates**
Workflows/Processes/Procedures					
Meeting with UW and CFHA to discuss how UW has incoporated this work	CFHA	January 30, 2023	Completed	●	IT/Epic build, consent, registry, workflows, billing codes and process. Meeting scheduled for 1/30/2023. How are the automating this to not have to manually drop charges? How do you talk to patients about this program? Can you share smart phrases and tools used for this program?
Identify target population/inclusion criteria and treatement targets			Completed	●	Starting with 2 for each BHCC to understand time and impact.
Establish workflow for COCM work	Team	October 1, 2023	In process	●	Draft workflows are ready for implementation. Will continue to tweak and adjust as we go. There are still a couple workflows that need to be reviewed.
Claify which staff will do which roles in the workflow	Team	August 1, 2023	Completed	●	
Establish evaluation criteria for pilot			Not started	●	BHC's will manage the implementation
Identfy steps for implementation of workflow	Beth/Ashley	August 1, 2023	Completed	●	
IS/Epic Build					
Identify tools/build used by UW	CFHA	February 1, 2023	Completed	●	Meeting scheduled for 1/30/23. Kay also meeting with Tracy on 1/6 to start to understand the Access circumstances. Access already has access to the tool used by UW which is the primary care behavioral health collaborative care navigator/smart form.
Work with UW to turn on or build required functionality		August 15, 2023	Completed	●	Don't need to turn on, but will need training on how to use it.
Review smart phrases and make required changes	Beth/Ashley	June 20, 2023	Completed	●	Have UW examples. Think we need to make changes. Have done several. need to do a few more. Tracy adapting some of the pick lists.
Ticket/build for new billing rule	Tracy	July 1, 2023	Completed	●	Community Connect liaisons helping to prioirtize. Expect early July to have buld completed around coding. They need to get permission for Tristans time.
Billing					
Identify codes for use with model		February 20, 2023	Completed	●	We know will need to use Gcode. Outstanding question on if this will be majority rule. Also unsure if tool will use the 99 codes and then switch to gcode on the back end.
Clarify if majority rule will be allowed for Medicaid	Kay	July 1, 2023	Completed	●	Have validated that 60 minutes is required for Medicaid.
Assign fees to new codes	Carmen	April 15, 2023	Completed	●	Fee schedule still being updated, but request is in.
Develop specialty fee schedule for COCM services	Jo/Carmen	May 1, 2023	Completed	●	Could write off uninsured.
Test billing process/follow claims	Tracy	August 1, 2023	Completed	●	WQ has been established
Validate billing process/rules for Medicare and Commercial	UW Billing	May 1, 2023	Completed	●	Expect these to be the same as UW uses.

CoCM in Action: Building the Workforce

- April 2022 increase in FTE of consulting psychiatrist time (0.25 to 0.75 FTE)-building capacity
- Hire Behavioral Health Care Coordinators (BHCC)
  - Initially included MSW level care coordinators
  - Adjusted minimum requirement to have Bachelor's degree in Social Work, Psychology, or Human Services with additional trainings provided in Motivational Interviewing to increase the pool of applicants
  - Additional engagement with CFHA related to trainings to support care coordinator competencies
  - BHCC attended UW Continuing Studies conference on Motivational Interviewing in August 2023

CoCM in Action: Building the Workforce

Collaborative Care Model Providers

Providers qualified to provide collaborative care services are identified in the table below.

PROVIDER	QUALIFICATIONS	TASKS AND ROLES
Treating practitioner (billing provider)	• Any provider qualified to use evaluation and management codes, except psychiatrists • Primary care or specialty care providers • Must be enrolled in Wisconsin Medicaid	• Directs the behavioral care manager • Oversees the member's care, including prescribing medications, providing treatments for medical concerns, and making referrals to specialty care when needed • Remains involved through ongoing oversight, management, collaboration, and reassessment
Behavioral care manager	• Bachelor's degree in a human service-related field and one year of direct, supervised experience working with individuals in the behavioral health field • Works under the supervision of the billing practitioner • Enrollment in Wisconsin Medicaid not required	• Administers validated rating scales (for example, PHQ-9 scale for depression, GAD-7 for anxiety) • Develops a care plan • Provides brief psychosocial interventions (for example, motivational interviewing) • Collaborates with billing practitioner • Consults with psychiatric consultant • Has continuous relationship with the member • Does not include administrative or clerical staff (Time spent in strictly administrative or clerical duties is not counted towards the time threshold to bill behavioral health integration codes.) • Maintains registry for tracking patient follow up and progress

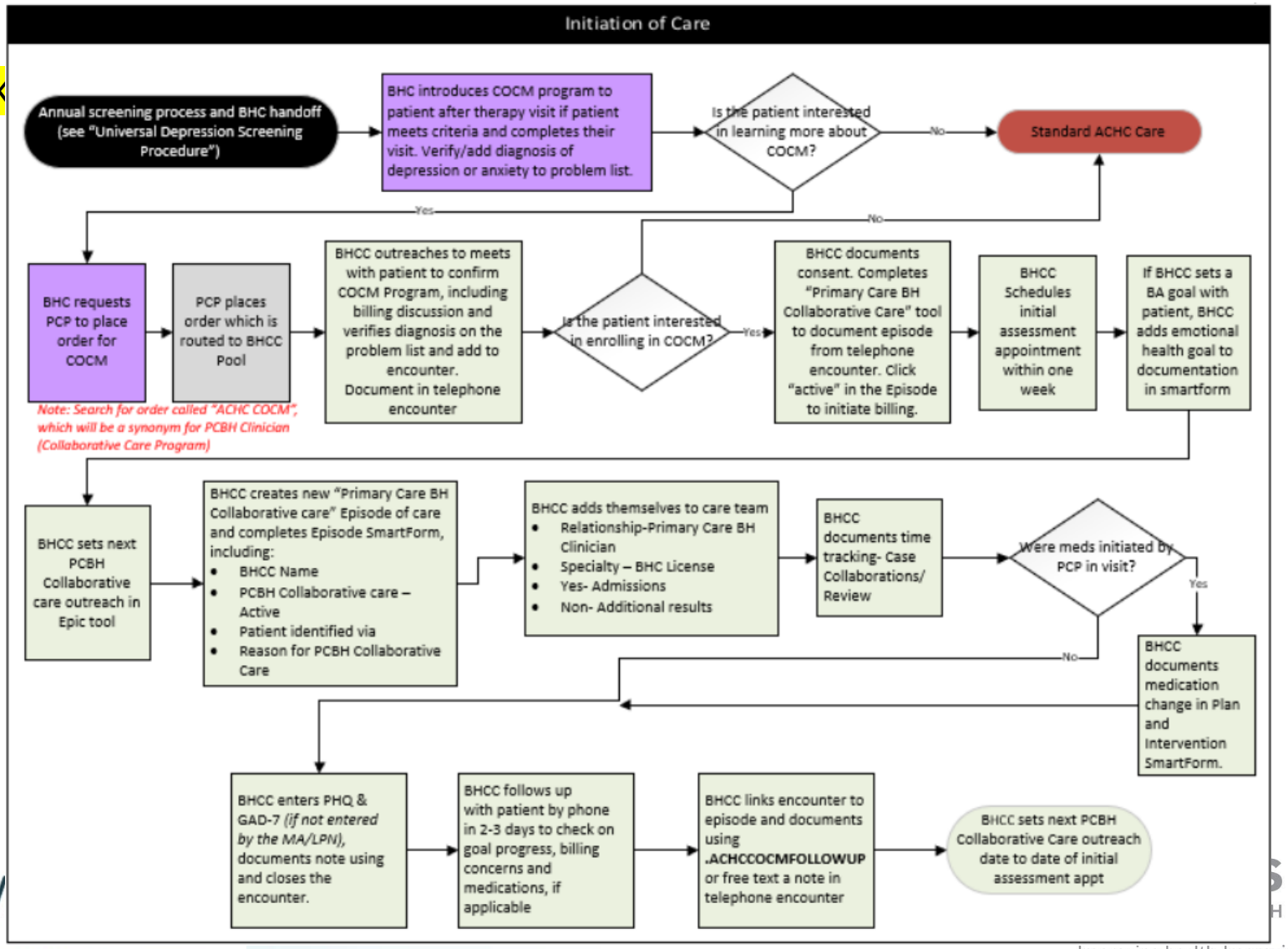
July 2022, NO 2022-25, Wisconsin Forward Health Update

CoCM in Action: Building the Workforce

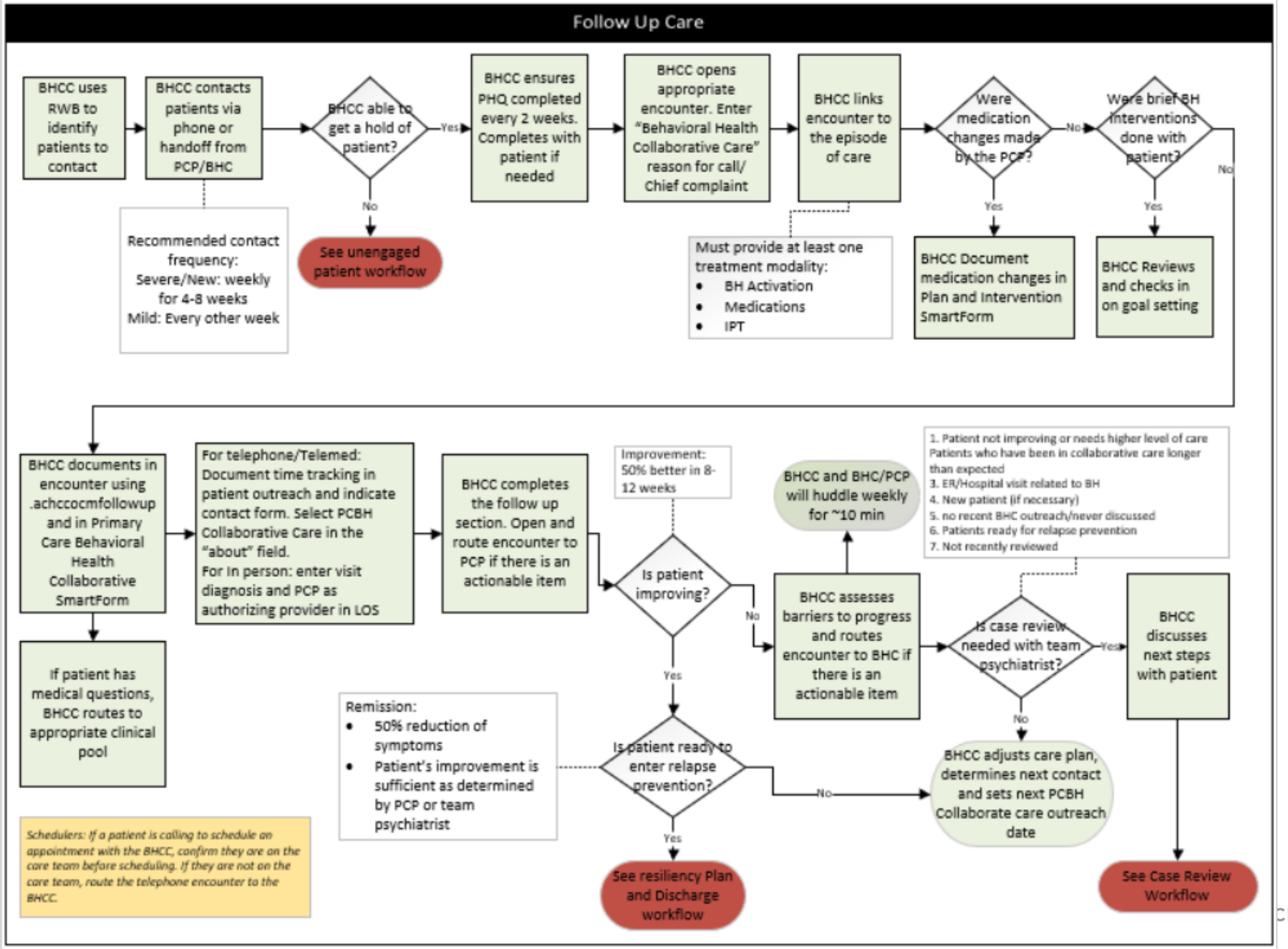
PROVIDER	QUALIFICATIONS	TASKS AND ROLES
Psychiatric consultant	• A licensed psychiatrist, psychiatric advanced practice nurse, or psychiatric-certified physician assistant • Must be enrolled in Wisconsin Medicaid; may be enrolled as a prescribing, referring, ordering professional	• Meets with the primary care team to review the member's treatment plan and status, meets at least weekly • Advises and makes recommendations as needed • If fully enrolled in Wisconsin Medicaid, may render services directly to the member that are separately billed; activities reported separately are not included in the time applied to collaborative care model

July 2022, NO 2022-25, Wisconsin Forward Health Update

CoCM in Action: Building the Workflows



CoCM in Action: Building the Workflows



Consulting Psychiatrist at Access: Julie Nielsen-Witkovsky, MD

- Skilled clinician
- Key Collaborator
- Educator
- Extensive experience in integrated care settings

Services provided:

Chart review
In-person and virtual consultations with patients
Verbal recommendations to PCPs
Education (formal and informal)

Primary Care Physician ALWAYS retains prescribing authority

Go-Live August 2023

What is the Collaborative Care Model (CoCM)?

- A behavioral health integrated model focused on the reduction of depression and anxiety symptoms
- Involves a new team structure (BHC, BHCC, PCP, & Psychiatric Consultant) and services to treat depression and anxiety
- Billed monthly under Medical Services <u>once a month</u>

BHCC

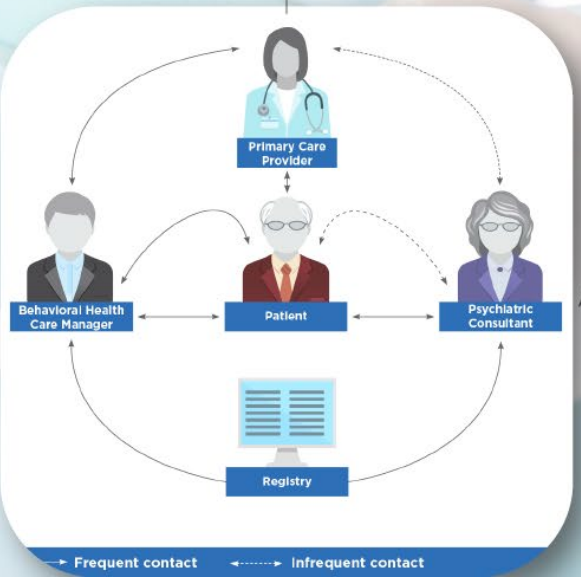
- Manages caseload of patients, systematically tracks progress of symptom reduction
- Works closely with PCP to facilitate patient engagement
- Presents patients in systematic case review
- Performs structured assessments & brief Evidence-Based Interventions (MI, CBT, FACT)

Primary Care Provider

- Primary treatment relationship
- Prescribes medication
- Consults with CoCM team
- Supports treatment plan

Psychiatric Consultant

- Supports PCP and BHCC in systematic case reviews
- Makes recommendations for treatment plan for patients who are: new, not improving or need medication adjustments
- Does <u>NOT</u> see the patient
- Does <u>NOT</u> prescribe medications



Who to Refer

- Patients with a depression or anxiety diagnosis or experiencing symptoms
- Patients scoring 10 or above on the PHQ-9 or GAD-7
- Patients receiving psychotropic medications

How to Refer

- Inform your patient that you have new members of your team who provide additional support and services to help them feel better with their presenting depression and anxiety symptoms
- Discuss with the BHC team as usual

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Enhanced support between clinic visits to progress depression treatment

Positive feedback from care managers who are enjoying CoCM patient contacts and opportunities to provide more support

Gratitude from patients for increased sense of connection to their care team

Outreach, supportive contacts, goal setting, coaching, medication review and resource connection

Team based approach to treatment of behavioral health concerns

Increased patient engagement to improve outcomes

CoCM Impact

CoCM in Action: Scaling the Work and Shared Learning

Key Deliverables to be shared with Other CHCs in WI:

- Inclusion criteria recommendations
- Workflow examples
- Documentation recommendations
- Training materials
- Recommendations and considerations for implementation

Collective Impact and Gratitude

- Big thank you to the Collaborative Family Healthcare Association (CFHA) for their Technical Assistance related to CoCM implementation and specifically Daniela Vela Hernandez, LMFT, Technical Assistance Associate, Collaborative Family Healthcare Association

- Gratitude to WPHCA for the project management support by Kay Brewer for keeping this project organized and moving forward

- Many thanks to Molly Jones and Sashi Gregory from WPHCA for assisting with advocacy with DHS to support fiscal sustainability of integrated care practices in the state of WI and to support a healthier community by supporting whole person health

- **Our Goal is to scale this work not only at Access but across the state of Wisconsin to support integrated behavioral health care being a routine part of primary care for all Wisconsinites.**

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Recommended Resources

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Collaborative Family Healthcare Association (www.cfha.net)

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Recommended Resources

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