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Provider Training: Behavioral Health Integration

July 27, 2022

Agenda

- Overview of Integrated Care
- Review Integrated Care Models
- Resources and Technical Assistance

Why we're in business

OUR PURPOSE

Transforming the health of the community, one person at a time

What we do

OUR MISSION

Better health outcomes at lower costs

What we represent

OUR PILLARS

Focus on the Individual

+

Whole Health

+

Active Local Involvement

What drives our activity

OUR BELIEFS

We believe healthier individuals create more vibrant families and communities.

We believe treating people with kindness, respect and dignity empowers healthy decisions.

We believe we have a responsibility to remove barriers and make it simple to get well, stay well, and be well

We believe in treating the whole person, not just the physical body.

We believe local partnerships enable meaningful, accessible healthcare.

Recent Training from NC DHHS and NC AHEC

Managed Care Hot Topics: April 22, 2022

Current State

4 out of 10 primary care patients need BH services.

43-60% of those patients are treated solely in primary care.

At best, half of patients who are referred to a BH provider receive services.[1]

Why?

1) Larger network of Primary Care providers
2) Shortage of psychiatric providers
3) Stigma associated with accessing BH

Defining Behavioral Health Integration/Integrated Care

Substance Abuse and Mental Health Services Administration (SAMHSA) defines integration as:

- *"whole person care that focuses on **overall health**; creates partnerships across all aspects of health; and is facilitated by a variety of clinical, structural, and financial arrangements and community supports that **remove barriers** between **physical** and **behavioral health** care"*

Integrated care is not intended to replace traditional mental health care

SAMHSA
Substance Abuse and Mental Health Services Administration

Integrated Care within the Medical Home Model

Improved Health Outcomes[2]

- With CoCM, 45% of patients had a 50%+ reduction in depressive symptoms compared to 19% of usual care participants
- 54% less likely to use emergency services and 49% less likely to need psychiatric inpatient treatment
- Significantly less likely to experience a serious (including fatal) cardiovascular event

Cost Savings[3]

- $3,300 lower average total healthcare costs per patient over a four-year period
- SBIRT saves the healthcare system and society an estimated $6 to $7 for every $1 invested.
- CoCM has shown an ROI of 6:1

Quadruple Aim

Satisfied and engaged patients[3,4,5]

- Reduced costs for patients treated in the PCBH model lead to greater patient satisfaction
- Patients perceived benefits of integrated care include convenience, desire for team-based care, preference for individual versus group counseling, and difficulty accessing community services.

Satisfied Providers[5]

- 96% of physicians agreed that integration with BH in the pediatric clinic improved overall quality of care
- 85% of physicians reported it allowed them more free time
- 78% said it decreased stigma surrounding BH
- PCBH in peds settings allowed PCPs to serve 42% more patients/day, yielding an additional $1,142 in revenue

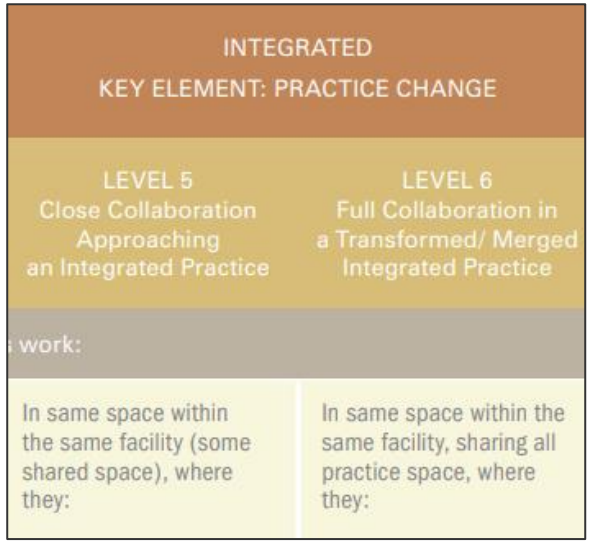
SAMHSA Framework for Integrated Care

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

Integrated Care Models



Screening Brief Intervention Referral to Treatment (SBIRT)*

- Universal screening to identify patients at risk for substance or alcohol misuse
- Brief intervention
- Referral for treatment
- *Some consider SBIRT a clinical pathway, rather than an Integrated Care Model

Primary Care Behavioral Health (PCBH)

- BH Provider is a generalist
- BH Provider acts as a consultant
- Warm handoff and brief intervention
- Mirrors primary care pace
- PCP is the primary “client”

Collaborative Care Model (CoCM)

- Universal screening to identify patients with depression and anxiety for example
- Registry driven and disease focused
- Measurement-based treat to target
- Population-focused

Screening, Brief Intervention, Referral to Treatment

SBIRT Screening

Annual questionnaire

Once a year, all our patients are asked to complete this form because drug and alcohol use can affect your health as well as medications you may take. Please help us provide you with the best medical care by answering the questions below.

Patient name: _____

Date of birth: _____

Are you currently in recovery for alcohol or substance use? ☐ Yes ☐ No

Alcohol: One drink = 12 oz. beer; 5 oz. wine; 1.5 oz. liquor (one shot)

	None	1 or more
MEN: How many times in the past year have you had 5 or more drinks in a day?	○	○
WOMEN: How many times in the past year have you had 4 or more drinks in a day?	○	○

Drugs: Recreational drugs include methamphetamines (speed, crystal), cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

	None	1 or more
How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?	○	○

Developed by SBIRT Oregon, http://www.sbirtoregon.org/resources/annual_forms/Annual%20-%20English.pdf

If +, proceed to AUDIT

If +, proceed to DAST

Patient name: _____

Date of birth: _____

Alcohol screening questionnaire (AUDIT)

Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

One drink equals: 12 oz. beer; 5 oz. wine; 1.5 oz. liquor (one shot)

1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2 - 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have five or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Ne				
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Ne				
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Ne				
9. Have you or someone else been injured because of your drinking?	N				
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	N				

Have you ever been in treatment for an alcohol problem?

I 0-3 II 4-9 III 10-13 IV 14+

Drug Abuse Screening Test, DAST-10

The following questions concern information about your possible involvement with drugs *not including alcoholic beverages* during the past 12 months.

"Drug abuse" refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions, and (2) any nonmedical use of drugs.

The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions *do not* include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

In the past 12 months...		Circle	
1.	Have you used drugs other than those required for medical reasons?	Yes	No
2.	Do you abuse more than one drug at a time?	Yes	No
3.	Are you unable to stop abusing drugs when you want to?	Yes	No
4.	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5.	Do you ever feel bad or guilty about your drug use?	Yes	No
6.	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7.	Have you neglected your family because of your use of drugs?	Yes	No
8.	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9.	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10.	Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	Yes	No
Scoring: Score 1 point for each question answered "Yes," except for question 3 for which a "No" receives 1 point.		Score:	

Interpretation of Score		
Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No problems reported	None at this time
1-2	Low level	Monitor, re-assess at a later date
3-5	Moderate level	Further investigation
6-8	Substantial level	Intensive assessment
9-10	Severe level	Intensive assessment

Drug Abuse Screening Test (DAST-10). [Copyright 1982 by the Addiction Research Foundation.]

Additional SBIRT Screening tools: https://www.sbirt.care/tools.aspx

How Has Drinking Behavior Changed During the COVID-19 Pandemic?

- Research Triangle Institute International (RTI) polled adults across the country about their drinking habits since the beginning of the pandemic

Average drinks per day	↑27%
Frequency exceeding “drinking guidelines”	↑21%
Frequency of binge drinking	↑26%

Screening Brief Intervention Referral to Treatment (SBIRT)

SBIRT Screening/ Intervention	CPT Code*
Alcohol use (AUDIT)	96160
Substance use (DAST)	96160
15-30 min brief intervention*	99408
>30 min brief intervention*	99409

*brief intervention must occur, time standards met, and adequate documentation provided.

NC DHHS Physician Fee Schedule

In addition to **physicians, physician assistants and nurse practitioners**, the following provider types will be eligible to bill the SBIRT CPT codes:

- Licensed Psychologist (LP)
- Licensed Psychological Associate (LPA)
- Licensed Clinical Mental Health Counselor (LCMHC)
- Licensed Clinical Mental Health Counselor Associate (LCMHCA)
- Licensed Clinical Social Worker (LCSW)
- Licensed Clinical Social Worker Associate (LCSWA)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Marriage and Family Therapist Associate (LMFTA)
- Licensed Clinical Addiction Specialist (LCAS)
- Licensed Clinical Addiction Specialist Associate (LCASA)
- Certified Clinical Nurse Specialist (CNS)

BH Providers should work with contracted PHPs to obtain BH Provider Fee Schedule

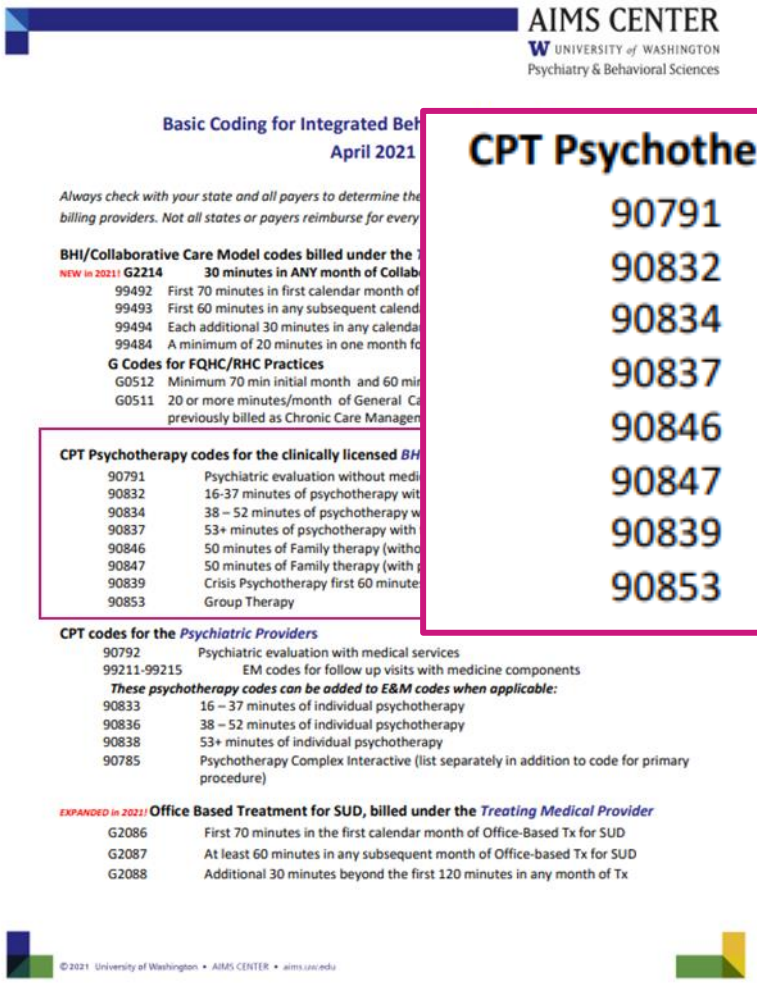
NC DHHS Blog February 9, 2021

Primary Care Behavioral Health

Primary Care Behavioral Health (PCBH)

- Behavioral Health providers, often called BH Consultants (BHCs) in this model, work *alongside medical provider* **in real-time**
  - (Collaborative Family Healthcare Association: PCBH Definition)
- BHCs:
  - are available "on-demand" and act as generalists
  - document in the same EMR with similar template as PCP (i.e. SOAP)
  - can see a patient before, during, or after their PCP appointment.
  - educate the primary care team and act as a consult to PCPs

University of Washington AIMS Center Coding Resources



AIMS CENTER
UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

Basic Coding for Integrated Beh
April 2021

Always check with your state and all payers to determine the
billing providers. Not all states or payers reimburse for every

BHI/Collaborative Care Model codes billed under the
NEW in 2021! G2214 30 minutes in ANY month of Collab
99492 First 70 minutes in first calendar month of
99493 First 60 minutes in any subsequent calend
99494 Each additional 30 minutes in any calenda
99484 A minimum of 20 minutes in one month fo

G Codes for FQHC/RHC Practices
G0512 Minimum 70 min initial month and 60 mi
G0511 20 or more minutes/month of General Ca
previously billed as Chronic Care Manager

CPT Psychotherapy codes for the clinically licensed BH
90791 Psychiatric evaluation without medi
90832 16-37 minutes of psychotherapy wit
90834 38 – 52 minutes of psychotherapy w
90837 53+ minutes of psychotherapy with
90846 50 minutes of Family therapy (witho
90847 50 minutes of Family therapy (with
90839 Crisis Psychotherapy first 60 minute
90853 Group Therapy

CPT codes for the *Psychiatric Providers*
90792 Psychiatric evaluation with medical services
99211-99215 EM codes for follow up visits with medicine components
These psychotherapy codes can be added to E&M codes when applicable:
90833 16 – 37 minutes of individual psychotherapy
90836 38 – 52 minutes of individual psychotherapy
90838 53+ minutes of individual psychotherapy
90785 Psychotherapy Complex Interactive (list separately in addition to code for primary procedure)

EXPANDED in 2021! **Office Based Treatment for SUD, billed under the *Treating Medical Provider***
G2086 First 70 minutes in the first calendar month of Office-Based Tx for SUD
G2087 At least 60 minutes in any subsequent month of Office-based Tx for SUD
G2088 Additional 30 minutes beyond the first 120 minutes in any month of Tx

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CPT Psychotherapy codes for the clinically licensed *BH Providers*

90791	Psychiatric evaluation without medical services
90832	16-37 minutes of psychotherapy with the patient
90834	38 – 52 minutes of psychotherapy with the patient
90837	53+ minutes of psychotherapy with the patient
90846	50 minutes of Family therapy (without patient present)
90847	50 minutes of Family therapy (with patient present)
90839	Crisis Psychotherapy first 60 minutes with the patient
90853	Group Therapy

Codes are general examples and do not account for the coding specific to any one site such as a primary care clinic versus a FQHC or RHC. *Remember to check with your state and all payers to determine the necessary qualifications for the designated billing providers. Not all states or payers reimburse for every code.*

There are different ways to bill for integrated behavioral health care depending on your model and staffing. This handout gives a brief overview of basic CPT and Medicare billing codes for behavioral health integration and Collaborative Care:
https://aims.uw.edu/resource-library/basic-coding-integrated-behavioral-health-care

PCBH Model: Sample Day (example only)

8:30 Follow up: MAT patient
9:00 Intake slot (no show)
9:45 Warm hand off: tearfulness
10:00 Follow up: Depression
10:45 Follow up: Adjustment Disorder
12:30 Curbside consult with PCP for 10AM

1:00 Intake
2:00 Follow up: Insomnia with Anxiety
2:45 Warm hand off: domestic violence consult
3:00 Follow up: Smoking Cessation
3:30 Follow up: No show
4:00 Follow up or Intake

PCBH is typically a mix of billable and non-billable services. There are various slots throughout the day available for warm hand offs and PCP consults, with a few times open for Intakes or Follow Ups

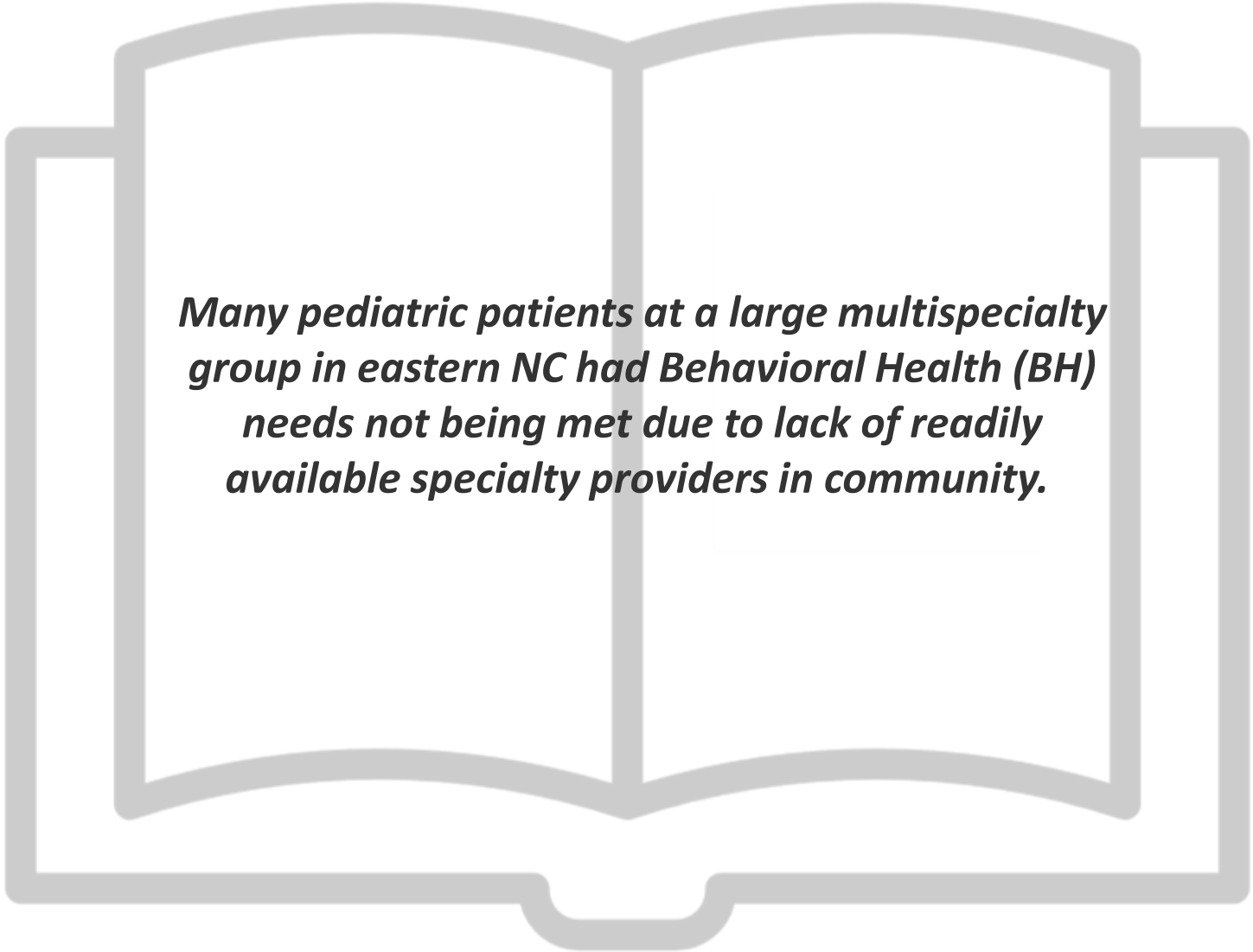
Source: https://www.umassmed.edu/cipc/pcbh/pcbh-short-courses/

Day in the Life: U Mass Example

Source: https://www.umassmed.edu/cipc/pcbh/pcbh-short-courses/

8:30	8:30 Follow up Suboxone	Psychotherapy (16-37 mins)
9:00	9:00 Intake slot- no show 9:50 Warm hand off - tearfulness	No bill No bill
10:00	10:00 Follow up Depression	Psychotherapy (38-52 mins)
10:30	10:45 Late arrival Follow up adjustment disorder	Psychotherapy (16-37 mins)
11:00	11:15 Follow up Anxiety – stress reduction 12:30 Curbside consult with PCP	Psychotherapy (38-52 mins) No bill
1:00	1:00 Intake	Psychiatric Eval without medical services
2:00	2:00 Follow up Insomnia with Anxiety	Psychotherapy (38-52 mins)
2:30	2:30 Last minute cancel 2:45 Consult for domestic violence	No bill – documentation catch up Crisis Psychotherapy first 60 mins with patient
3:00	3:25 Follow up Smoking	Psychotherapy (16-37 mins)
3:30	3:30 No show	No bill
4:00	Follow up or Intake	Psychotherapy (38-52 mins) or Psychiatric Eval without medical services

A Familiar Tale…



Many pediatric patients at a large multispecialty group in eastern NC had Behavioral Health (BH) needs not being met due to lack of readily available specialty providers in community.

Behavioral Health Integration Pilot Using PCBH

- Boice-Willis Clinic (BWC) implemented an integrated care model to increase access for members in need of mild-to-moderate Behavioral Health Support
- With a CCHN Innovations Grant, BWC hired a fully integrated LCSW to join their care team.
- BWC's LCSW supports the clinical team by:
  - Screening members for BH conditions
  - Being readily available for warm-hand offs
  - Initiating therapy in office
  - Seeing members for follow-up appointments as needed
  - Coordinating referrals to BH Providers in the community

Increasing Access, Member and Provider Satisfaction

- What about having an LCSW on the team has benefited physicians and pediatric patients?
- What is working well?

"Its **really nice** to have an LCSW just right there in the office and that helps to give **early assistance** to needy patients."

"Has been **easier** to get help for these patients in a **timely** manner as there are not too many resources out there in our community and the wait has been long."

"Having **access to someone** who can help our patients **quicker** than we have ever had before. My patients and their parents **are truly benefiting** from working with the LCSW."

"She is available in office and can see patients after their appt with provider (**convenient for the parent**). She can **assess the severity** for further referral. She can **follow-up** if they need more frequent counseling."

Case Study Success from BWC

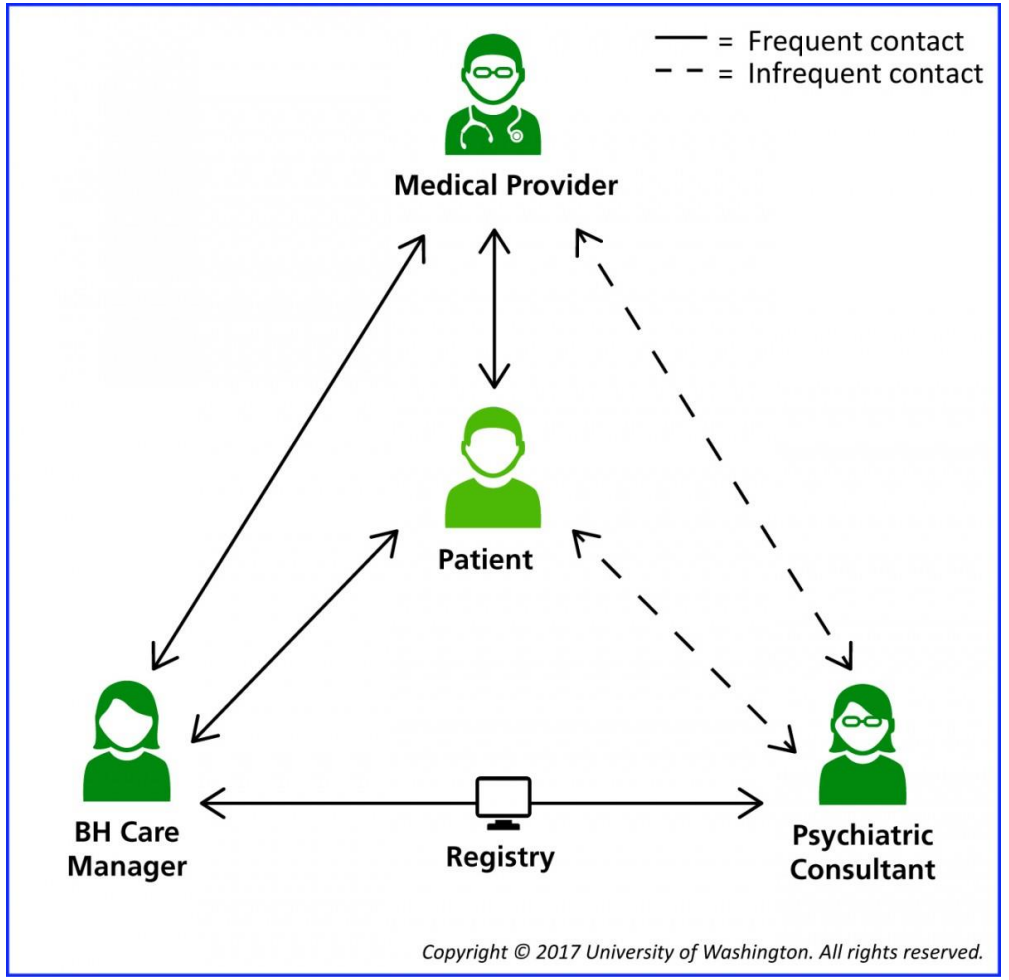
- 13-year-old patient is seen for a routine ear infection
- After the pediatrician addressed the minor medical issues facing the boy, he asked "Is there anything else I can do for you today?“
- The boy paused, looked down and said "yes". He began to cry. He explained that his brother had just been shot -- and he had witnessed it.
- After a moment, the pediatrician asked if the boy would like to talk with the LCSW right down the hall.
- The boy immediately received the additional care he needed.

For questions regarding this Pilot, contact Shannon Robinson, Sr. Performance Analyst with CCHN: srobinson@cch-network.com

The Collaborative Care Model

The Collaborative Care Model

- Team Based
- Population-focused
- Measurement-based Treat to Target
- Reimbursable
  - The CPT Codes record the total monthly time per patient per month and billed by the PCP
  - The bundled payments support the employment of the BHCM and the contracted hours with the psychiatrist



NC Medicaid Bulletin

September 2018

Attention: All Providers

Coverage for Psychiatric Collaborative Care Management

In response to provider requests and to allow reimbursement for behavioral health integration in primary care settings, North Carolina Medicaid is adding coverage for the following evaluation and management codes effective October 1, 2018:

- **99492** – Initial psychiatric collaborative care management, first 70 minutes in the first calendar month
- **99493** – Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities
- **99494** – Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month

Evidence Base for CoCM

IMPACT Study:

"Improving Mood – Promoting Access to Collaborative Treatment"

- >1,800 depressed older adults
- 18 diverse primary care clinics around the US
- Study period: 2 years
- Randomized controlled groups:
  - Treatment as usual
  - IMPACT Treatment (CoCM)

IMPACT Study: Results

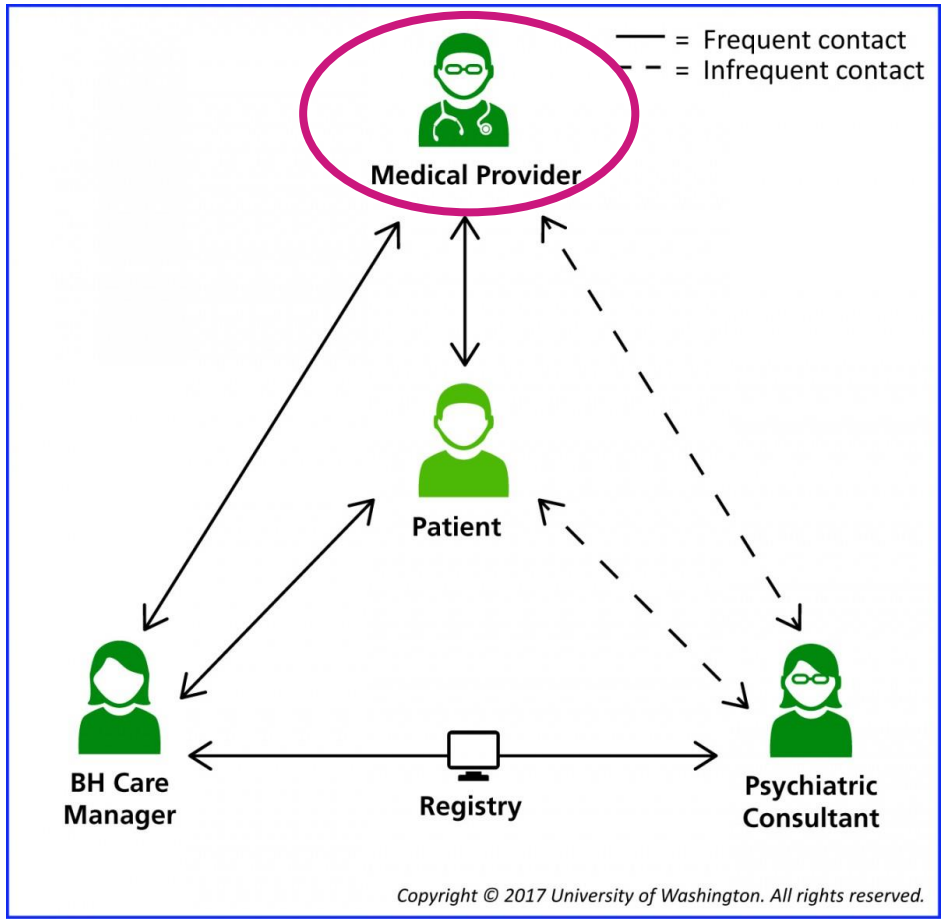
At 12 months, ~half of IMPACT/CoCM patients had a 50% or greater reduction in depressive symptoms

(Tx as usual group: 19%)

- ✓Greater rates of depression treatment
- ✓Increased satisfaction
- ✓Lower depression severity
- ✓Less pain
- ✓Better functioning
- ✓Greater quality of life

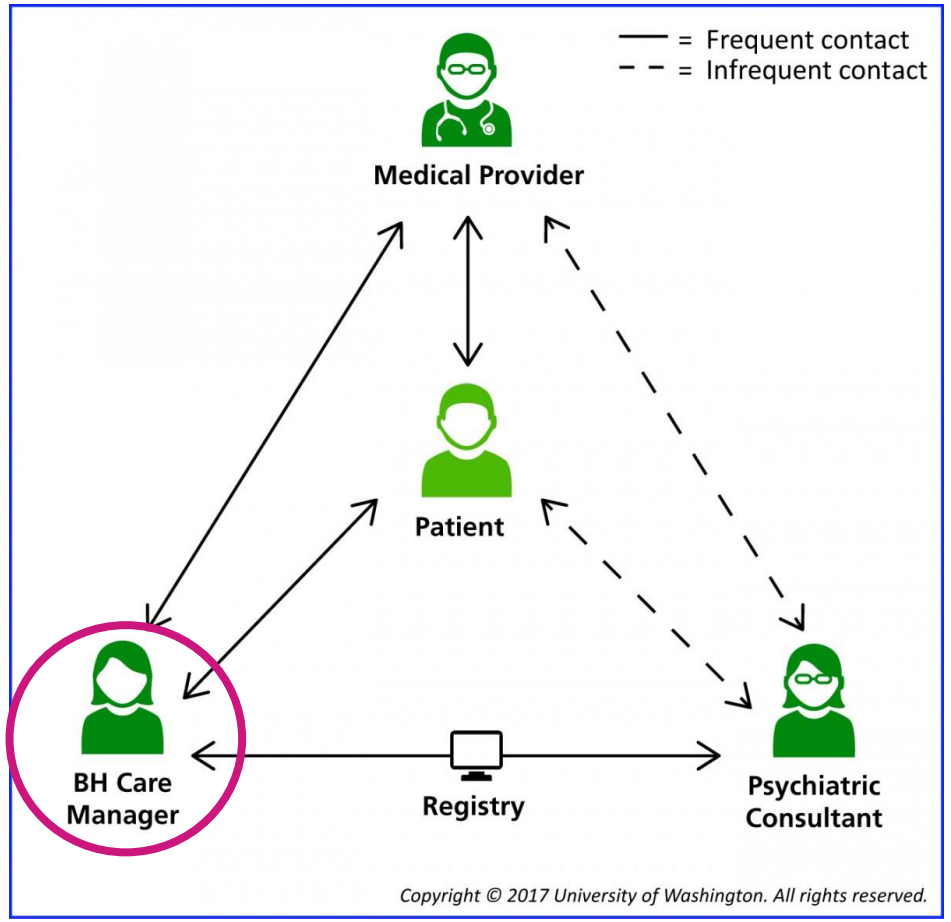
Care Team Role: Medical Provider

- Works in **close collaboration** with the care manager and psychiatric consultant
- Oversees all aspects of a patient's care
- Prescribes a wide range of therapies and medications
- Champions the model for patients and colleagues



Care Team Role: BH Care Manager

- Coordinates the overall effort of the group
- Educates patient about depression
- Provides **brief behavioral interventions** using evidence-based treatment modalities
- Administers validated rating scales and **tracks outcomes on the registry**
- Psychiatric case reviews
- Communicates resulting treatment recommendations back to the PCP

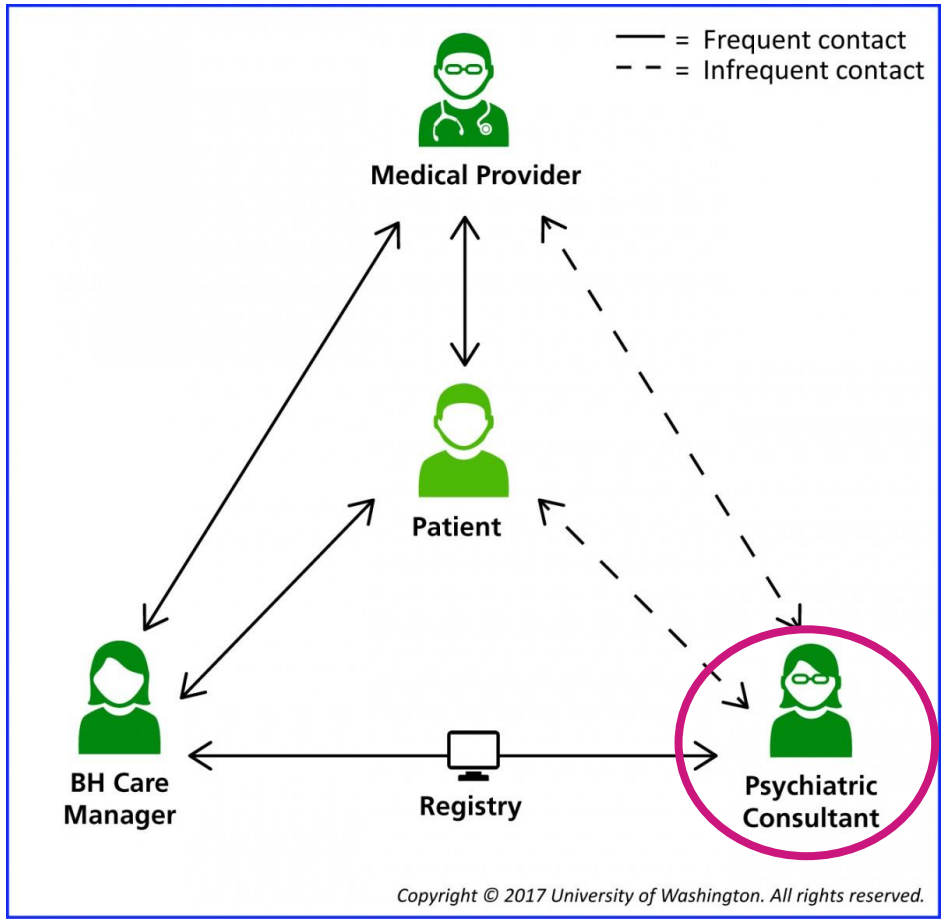


Care Team Role: Psychiatric Consultant

- Supports the PCP and BHCM in treating patients
- Suggests treatment modifications for PCP to consider
- Reviews CoCM case load weekly with the BHCM

Some skills that may be different than usual care:

- Treating patients without seeing them
- Making a treatment plan in a short amount of time and with limited information
- Thinking about the treatment needs of a population of patients



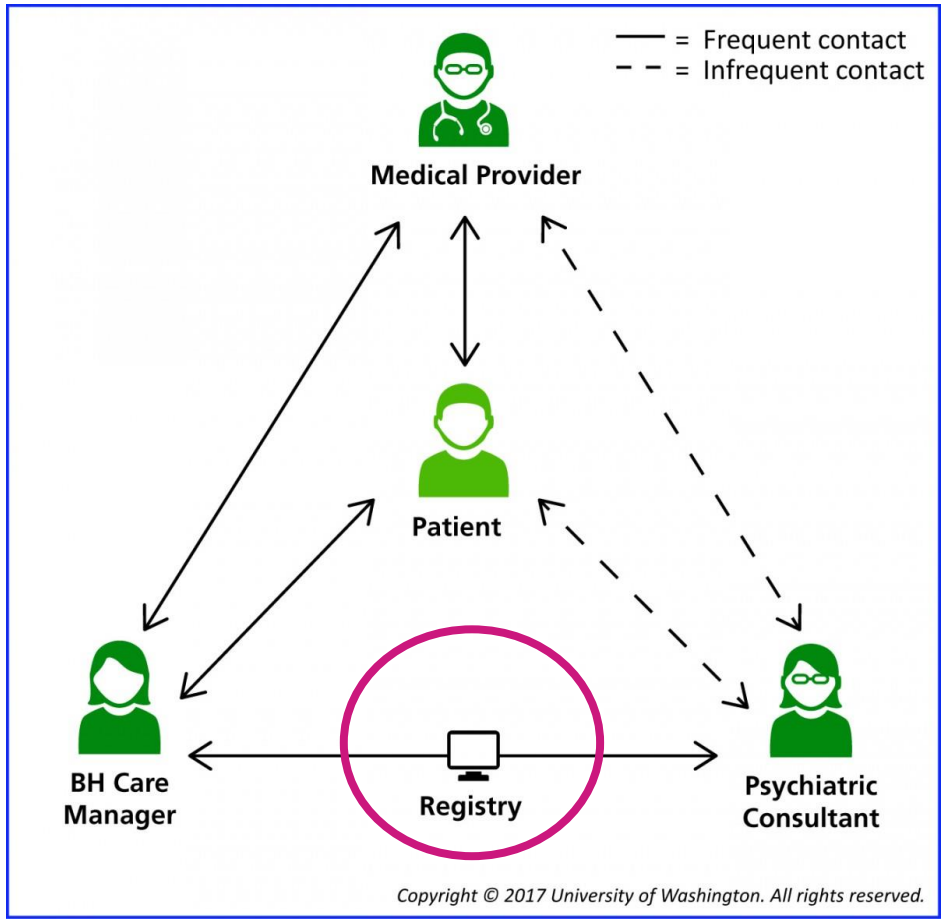
Source:
http://aims.uw.edu/collaborative-care/team-structure/psychiatric-consultant

Registry

Supports measurement-based treatment to target

Requirements:

- Track clinical outcomes and progress at both the individual and population level
- Prompt treatment-to-target
- Facilitate efficient psychiatric consultation and case review
- Additional requirements: AIMs Center



NC Medicaid Billing Guidance

Code	Brief Description
99492	Initial psychiatric collaborative care management, first 70 minutes in the first calendar month
99493	Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities
99494	Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month
G2214	Initial month or subsequent months, first 30 mins per month. At least 16 mins must be provided to use this code. Code cannot be billed with other collaborative care codes.

- **NC Medicaid** guidance on coverage for collaborative care management
- For current rates, see the NC Medicaid Physician Fee Schedule

CoCM Support

CoCM Office Hours

- The **AIMS Center** hosts monthly office hours to support providers with implementation of Collaborative Care, training staff, caseload management and registry tools, and other aspects of integrated care
- When: Third Thursday of every month at 10:00-11:00 am Pacific Time
- Info & registration: https://aims.uw.edu/what-we-do/office-hours

CoCM Technical Assistance from NC AHEC

NC AHEC will offer technical assistance to support providers with:

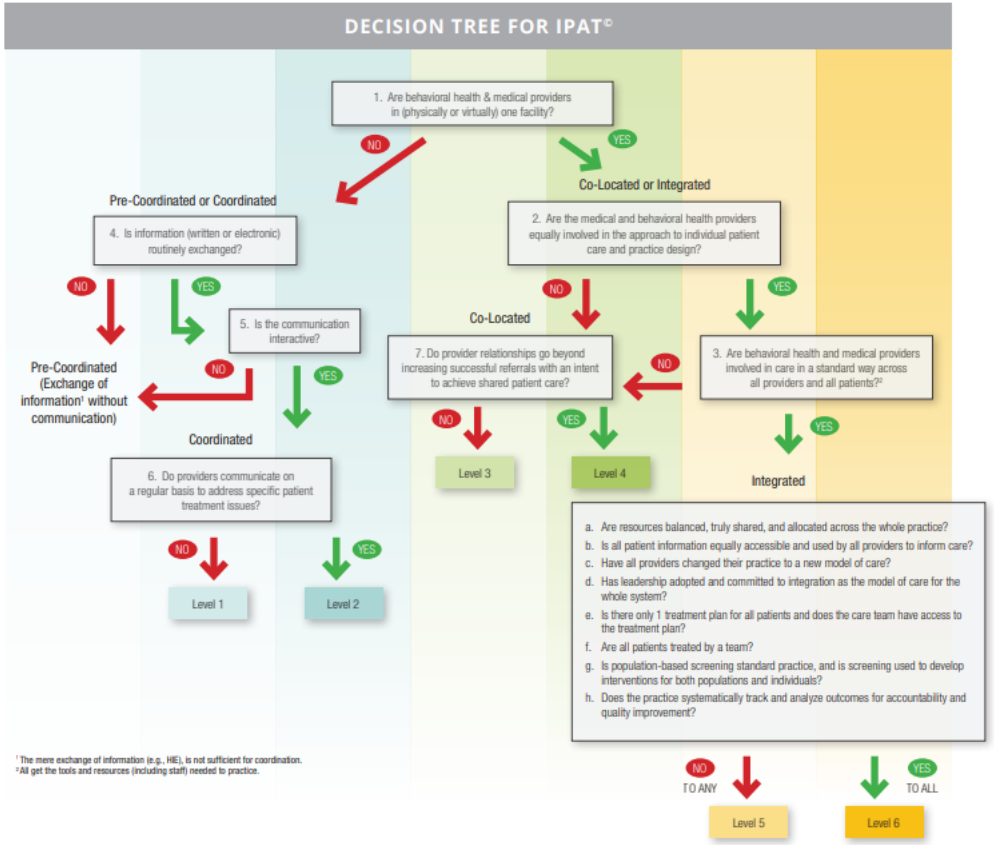
- Workflow redesign
- Orchestrate referrals for psychiatry recruitment via NC Psychiatry Association
- EHR optimization
- AIMs Center Data Registry

Reach out to practicesupport@ncahec.net for support with CoCM assistance!

Practice Assessments for BH Integration

Integrated Practice Assessment Tool (IPAT)

- Designed to be quick to administer
- Built of the SAMHSA framework for integrated care
- 8 question, decision-tree model
- Best completed collaboratively by 2 or more persons who are intimately knowledgeable about the operation of the practice
- Available online



MeHAF (Maine Health Access Foundation) Site Self-Assessment (SSA)

- Measures across 18 dimensions within two domains
  - Integrated Services and Patient/Family-Centeredness
  - Practice/Organization
- 1-10 rating scale for each dimension
- Recommended to get input from each person on the integrated care team
- Available online

Additional Resources

Integrated Care Toolkit and Clinical Trainings

- Toolkits and Clinical Trainings are available under Provider Resources
- Collection of online tools and resources for best practices
- Variety of topics!

Behavioral Health Toolkits for Primary Care Providers

- Anxiety Disorders
- Attention-Deficit-Hyperactivity Disorder (ADHD) Toolkit
- Autism Spectrum Disorders Toolkit
- Bipolar Disorder Toolkit
- Co-Occurring Disorders Toolkit
- Cultural Competency- Humility Toolkit
- Depression Toolkit
- Integrated Care Toolkit
- Schizophrenia-First Episode Psychosis Toolkit
- Social Determinants of Health Toolkit
- Substance Use Disorders Toolkit
- Suicide Risk Toolkit
- Trauma Toolkit

Integrated Health Care Toolkit

- Overview
  - World Health Organization- Integrated Care Models: An Overview (PDF)
  - Integration Framework and Associated Core Measures (PDF)
  - A Quick Start Guide to Behavioral Health Integration for Safety-Net Primary Care Providers (PDF)
  - A Quick Start Guide to Behavioral Health Integration for Safety-Net Primary Care Providers- Slide
- Best Practices
  - Core Competencies for Integrated Behavioral Health and Primary Care
- Screening Tools
  - Culture of Wellness Organizational Self-Assessment (COW-OSA) (PDF)
  - Organizational Assessment Toolkit for Primary and Behavioral Health Care Integration
  - Wellness Organizational Self-Assessment (PDF)
- Helpful Links
  - National Institute of Mental Health-Integrated Health
  - Agency for Healthcare Research and Quality
  - SAMHSA-HRSA Center for Integrated Health Solutions
  - Patient-Centered Primary Care Collaborative
- NC-PAL
  - NC-PAL offers free provider-to-provider behavioral health consultation to address the mental and behavioral health concerns of children, adolescents, young adults up to age 21, pregnant patients, and patients who have recently given birth. NC-PAL will not bill the provider or the patients for telephone consultation. Calling NC-PAL does not establish a physician / patient relationship with an individual patient.
  - BH Consultants respond to questions within the scope of their expertise and can connect providers to one of our child and adolescent psychiatrists. NC-PAL board-certified child psychiatry team is on hand to assist with diagnostic clarification and medication

Behavioral Health Integration Immersion Program

The BHI Collaborative, a partnership between the AMA and seven other leading physician organizations, is launching a new, free initiative designed to provide enhanced technical assistance to physician practices. Learn more here.

Questions?

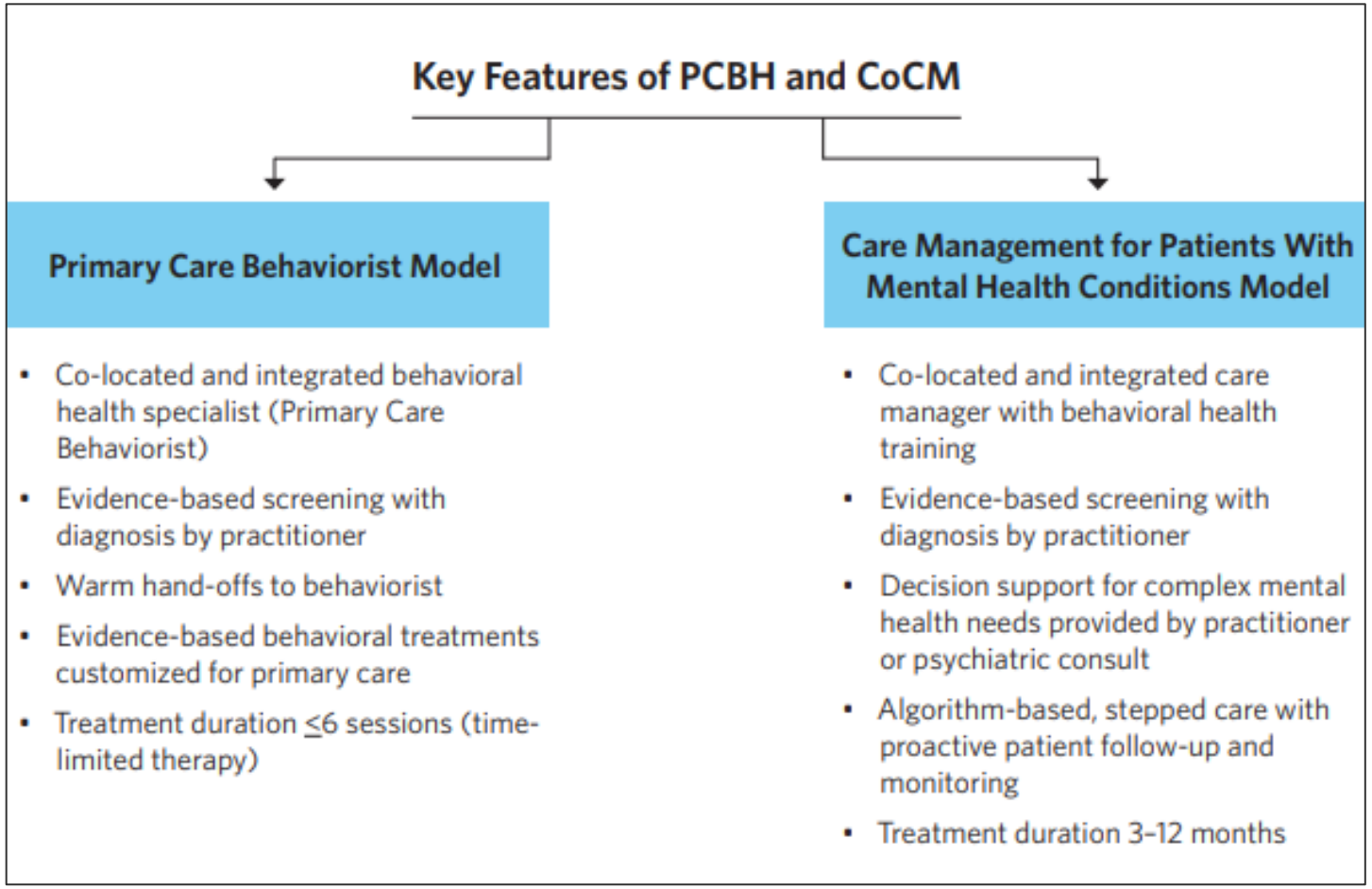
Contact us: NetworkRelations@cch-network.com

Appendix

Research

1. van Eeghen C, Littenberg B, Holman M Kessler R. Integrating behavioral health in primary care using lean workflow analysis: a quality improvement case study. JABFM. 2016;29:385–93.
2. Unützer J, Katon W, Callahan CM, et al. Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. JAMA. 2002;288(22):2836-2845Sdf
3. Eric Christian, Valerie Krall, Stephen Hulkower, and Sue Stigleman Primary Care Behavioral Health Integration: Promoting the Quadruple Aim North Carolina Medical Journal July-August 2018 79:250-255; doi:10.18043/ncm.79.4.250
4. Hine JF, Grennan AQ, Menousek KM, et al. Physician Satisfaction with integrated behavioral health in pediatric primary care. J Prim Care Community Health 2017;8:89-93.
5. Gouge N, Polaha J, Rogers R, Harden A Integrating behavioral health into pediatric primary care: implications for provider time and cost. South Med J. 2016;109(12):774-778.

PCBH vs CoCM



Source: American Psychological Association
https://www.pcpcc.org/sites/default/files/resources/CPH_Integrated%20Behavioral%20Health_180911.pdf

CoCM CPT Codes: 99492

First 70 minutes in the first calendar month

- Outreach to, and engagement in treatment of a beneficiary directed by a treating physician or NPP;
- Initial assessment of the beneficiary, including administration of validated rating scales, with the development of an individualized treatment plan;
- Review by the psychiatric consultant with modifications of the plan if recommended;
- Entering beneficiary in a registry and tracking beneficiary follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.

CoCM CPT Codes: 99493

First 60 minutes in a subsequent month

- Tracking beneficiary follow-up and progress using the registry, with appropriate documentation;
- Participation in weekly caseload consultation with the psychiatric consultant;
- Ongoing collaboration with and coordination of the beneficiary's mental health care with the treating physician or NPP and any other mental health providers;
- Additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant;
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies;
- Monitoring of beneficiary outcomes using validated rating scales; **and**
- Relapse prevention planning with beneficiaries as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment

CoCM Codes: 99494

Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month

- List separately in addition to code for primary procedure
- Use 99494 in conjunction with 99492, 99493

Additional CoCM Code

NC Medicaid is adding coverage for the following HCPCS code effective March 1, 2022:

- **G2214** - Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified healthcare professional. **Must contain the elements of 99492.**