WELCOME PRACTICE FACILITATORS AND CHITAS

WIFI - CCCSPUBLIC
NO PASSWORD NEEDED
**SLIDE TITLE**

**Phase 1**
- BB1.Y1 – Engaged Leadership
  1. Establish value-base agreements with payers
  2. Complete annual budget
  3. Develop GI Team
  4. Attend Collaborative Learning Session (in BB1, but not scheduled until Nov./Dec. 2017)
  5. Set vision for BHI

**Phase 2**
- BB2.Y1 – Use data to drive change
  1. Submit CQM’s quarterly
  2. Review data quarterly
  3. Identify opportunities for CQM improvement
  4. Use data aggregation tool to review cost/utilization data

- BB4.Y1 – Provide Team-based care
  1. Assess baseline team relationship
  2. Develop job descriptions
  3. Identify/implement team-based care strategy

- BB5.Y1 – Build patient partnerships
  1. Identify 3 conditions (at least one BH) appropriate for decision aids/SMS
  2. Select evidence-based decision aids/SMS tools for identified conditions
  3. Establish PFAC/meets quarterly

**Phase 3**
- BB3.Y1 – Empower 75% of patient population
  1. Assess panel and assign PCP care team to 75% of patients
  2. Review attribution lists monthly
  3. Validate PCP care team assignments

- BB7.Y1 – Screen for BH/SUD and link to resources
  1. Identify BH resources (work with RHC)
  2. Identify screening tools for two BH measures
  3. Document process for connecting patients/families with BH resources

**Phase 4**
- BB6.Y1 – Risk stratify/actively manage patients
  1. Identify risk stratification methodology (Adult only)
  2. Identify care gaps

**Phase 5**
- BB8.Y1 – Provide prompt access
  1. 24/7 EHR access
  2. Assess referral pathways for after hours BH support
  3. Identify data sources and technology for bi-directional data sharing

- BB9.Y1 – Comprehensive care coordination
  1. Identify total cost of care
  2. Implement policy for timely follow up for ED and hospital admissions

- BB10.Y1 – Provide fully integrated BH for whole person care
  1. Use identified referral pathways for BH needs
  2. Measure and track BH outcomes
  3. Develop care plans to manage BH conditions

**GLOSSARY**
- behavioral health
- behavioral health integration
- clinical quality measure
- emergency department
## COHORT 2 – 6 MO MAC STATUS

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Activity Description</th>
<th>NP</th>
<th>NS</th>
<th>JB</th>
<th>AA</th>
<th>C</th>
<th>ACTION STEPS</th>
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<tbody>
<tr>
<td>8.1.1</td>
<td>EHR access 24/7</td>
<td>7</td>
<td>2</td>
<td>6</td>
<td>139</td>
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<td>8.1.2</td>
<td>Assess referral pathways/after-hours BH support</td>
<td>34</td>
<td>23</td>
<td>39</td>
<td>58</td>
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<td><strong>PHASE 5</strong>&lt;br&gt;June 15 - Sept 14, 2018&lt;br&gt;START DEVELOPING PLAN</td>
</tr>
<tr>
<td>8.1.3</td>
<td>Data sources/technology for bi-directional data sharing</td>
<td>25</td>
<td>26</td>
<td>48</td>
<td>55</td>
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<tr>
<td>9.1.1</td>
<td>Total cost of care for panel and subset of pts with BH condition.</td>
<td>87</td>
<td>47</td>
<td>14</td>
<td>6</td>
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<td><strong>STRATUS</strong></td>
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<tr>
<td>9.1.2</td>
<td>Policy &amp; Procedure for timely f/u of ED/hosp admit</td>
<td>10</td>
<td>13</td>
<td>49</td>
<td>82</td>
<td></td>
<td><strong>PHASE 5</strong>&lt;br&gt;June 15 - Sept 14, 2018&lt;br&gt;START DEVELOPING PLAN</td>
</tr>
<tr>
<td>10.1.1</td>
<td>Use referral path for BH needs</td>
<td>22</td>
<td>26</td>
<td>37</td>
<td>69</td>
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<td></td>
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<tr>
<td>10.1.2</td>
<td>Plan to systematically measure/track pt BH outcomes</td>
<td>52</td>
<td>48</td>
<td>34</td>
<td>20</td>
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<td></td>
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<tr>
<td>10.1.3</td>
<td>Develop care plans with pt actions to manage BH conditions.</td>
<td>46</td>
<td>22</td>
<td>40</td>
<td>46</td>
<td></td>
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</tbody>
</table>
LET’S SHUFFLE THE DECK
APPROACHES TO INTEGRATED CARE

KYLE KNIERIM
<table>
<thead>
<tr>
<th>Level</th>
<th>Key Element: Communication</th>
<th>Key Element: Physical Proximity</th>
<th>Key Element: Practice Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 1</strong></td>
<td>Minimal Collaboration</td>
<td>Close Collaboration at a Distance</td>
<td>Close Collaboration Approaching an Integrated Practice</td>
</tr>
<tr>
<td><strong>Level 2</strong></td>
<td>Basic Collaboration</td>
<td>Close Collaboration Onsite with Some System Integration</td>
<td>Full Collaboration in a Transformed/ Merged Integrated Practice</td>
</tr>
<tr>
<td><strong>Level 3</strong></td>
<td>Basic Collaboration Onsite</td>
<td></td>
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<tr>
<td><strong>Level 4</strong></td>
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<tr>
<td><strong>Level 5</strong></td>
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<tr>
<td><strong>Level 6</strong></td>
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</tbody>
</table>

**Behavioral health, primary care and other healthcare providers work:**

- In separate facilities, 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

- In separate facilities, where they:
  - 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

- In same facility not necessarily same offices, where they:
  - 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 ill-defined team

- In same space within the same facility, where they:
  - 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

- In same space within the same facility, (some shared space), where they:
  - 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

- In same space within the same facility, sharing all practice space, where they:
  - 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
Care Manager/BHP 4

Care Manager/BHP 3

Care Manager/BHP 1

Care Manager/BHP 2

50-80 patients/caseload
2-4 hrs psych/week/ care coordinator
= a lot of patients getting care
Telemedicine

- Direct patient interactions with a psychiatrist or other behavioral health provider
- Uses video, audio or other technologies to provide services remotely
- Can be used within the clinic or at a spot more convenient to the patient
e-Consults

- Provider to Provider
- Asynchronous
- Answers diagnostic, medication and other patient management related questions
- May or may not lead to direct patient interaction
MODELS OF INTEGRATION IN PRACTICE – ACTIVITY
<table>
<thead>
<tr>
<th>Coordination</th>
<th>Co-located</th>
</tr>
</thead>
<tbody>
<tr>
<td>• In separate facilities</td>
<td>• In same physical facility</td>
</tr>
<tr>
<td>• Communication infrequent</td>
<td>• Have separate systems or share some systems (scheduling, medical records)</td>
</tr>
<tr>
<td>• May or may not appreciate one another’s roles/resources</td>
<td>• Regularly refer to one another</td>
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<tr>
<td></td>
<td>• Communicate about shared patients</td>
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<tr>
<td></td>
<td>• Have a basic understanding of one other’s roles/resources</td>
</tr>
<tr>
<td>Integration</td>
<td>Collaborative Care Model</td>
</tr>
<tr>
<td>• In same facility with shared systems</td>
<td>• Psychiatric consultant</td>
</tr>
<tr>
<td>• Communicate frequently in person</td>
<td>• Care manager/BHP manages panel of high risk individuals</td>
</tr>
<tr>
<td>• Shared patient care plans</td>
<td>• Case consultation with Psychiatrist</td>
</tr>
<tr>
<td>• In depth understanding of one another’s roles</td>
<td></td>
</tr>
<tr>
<td>• May be employed by same entity or contracted full time from another entity</td>
<td></td>
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<tr>
<td>Tele-medicine</td>
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</table>
HOW DO I GET STARTED?

BRIDGET BURNETT, R.SCOTT HAMMOND, ALEX HULST, SAM MONSON, ALEX REED
WORKFORCE DEVELOPMENT

SHANDRA BROWN LEVEY, ALEX HULST, JONATHAN MUTHER
“Outlining the scope of behavioral health practice in integrated primary care: Dispelling the myth of the one-trick mental health pony”


http://psycnet.apa.org/record/2014-28834-001
<table>
<thead>
<tr>
<th>Topic</th>
<th>Column</th>
</tr>
</thead>
<tbody>
<tr>
<td>BHI teams roles and responsibilities</td>
<td>A</td>
</tr>
<tr>
<td>BHP Credentials and skill sets</td>
<td>B</td>
</tr>
<tr>
<td>Specific Pediatric skills for BHPs</td>
<td>C</td>
</tr>
<tr>
<td>FTE comparisons</td>
<td>D</td>
</tr>
<tr>
<td>Processes for integrating a BHP into the team</td>
<td>E</td>
</tr>
<tr>
<td>Barriers</td>
<td>F</td>
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<tr>
<td>Who pays for what?</td>
<td>G</td>
</tr>
<tr>
<td>Advancement ladders for BHP (baseline skills – higher level)</td>
<td>H</td>
</tr>
</tbody>
</table>
LUNCH & COHORT 3 UPDATES

STEPHANIE KIRCHNER AND CARISSA FAIRBANKS
ENGAGING YOUR PRACTICES

ALEX REED
BHI FUNDING SOURCES & BILLING

SHANDRA BROWN LEVEY & JONATHAN MUTHER
Behavioral Health Billing

Shandra M. Brown Levey, PhD
Learning Outcomes

Evaluate the appropriate use of common CPT codes for different settings and payers
Code Overview

Today’s Discussion
- Psychotherapy codes
- H&B codes
- CPC+
- Increasing physician E&M codes as appropriate

Of Note
- CCM
- G-codes
- Role of trainees
Psychotherapy

- treatment for mental illness and behavioral disturbances
- attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.

**Examples**

- 90832* Individual Psychotherapy w/o medical E&M (includes interactive) 30 min (16-37)
- 90834* Individual Psychotherapy w/o medical E&M (includes interactive) 45 min (38-52)
- 90839 Psychotherapy for Crisis, first hour
Health & Behavior*

- behavioral, emotional, cognitive, psychological and social factors important to the prevention, treatment, or management of physical health problems (i.e., diabetes, chronic conditions).

Examples:

- 96152 Health/Behavior intervention ea 15 min face to face; individual
- 96153 Health/Behavior Intervention ea 15 min face to face; group (2 or more patients)
- 96154 Health/Behavior Intervention ea 15 min face to face Family w/Patient
CPC+ anyone?

- 3 Payment Elements
  - 1. Care Management Fee
  - 2. Performance-Based Incentive Payment
  - 3. Payment under the Medicare Physician
- Practices receive a risk-adjusted, prospective, monthly care management fee for attributed CPC+ Medicare beneficiaries.
- CMS.gov for more details
CCM & G-Codes

• CCM
  • CCM (CPT 99490)
  • Complex CCM (99487)
  • Complex CCM Add-On (CPT 99489, use with 99487)
  • CCM Initiating Visit
  • Add-On to CCM Initiating Visit (G0506)

• CoCM formerly Integrated Beh. Service G-Codes
  • G0502 - 99492
  • G0503 - 99493
  • G0504 - 99494
  • G0507 - 99494

• HCPCS G-Codes
  • G0396
  • G0397
E&M code increases

• Medical Providers can increase the level of these visit when appropriate based on time and/or complexity associated with behavioral health condition and engagement which may result from a co-consult or warm hand off.

• Co-Consults (with PCMP and BHC)

• Warm Handoffs & Individual Sessions

• Who can bill with these E&M codes:
  • Medical Providers
Role of Trainees to Extend Reach
Discussion

• How to bill is based on:
  • Patient’s diagnosis
  • Treatment priorities
  • Who saw the patient
  • The patient’s insurance

• Case Scenarios
• Open Discussion
Thank you!
FINDING RESOURCES

- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Care-Management.html

- https://www.integration.samhsa.gov/financing/billing-tools


- https://www.colorado.gov/pacific/hcpf/accphase2

NUTS & BOLTS

SHANDRA BROWN LEVEY, R. SCOTT HAMMOND, ALEX HULST
SUSAN MCDANIEL VIDEO
Traditional Mental Health
Primary Care
TRAFFIC IN HANOI DURING RUSH HOUR
RAPID FIRE BRAIN STORMING

As a table briefly discusses some ideas on the following scenarios. Write your ideas on post-its so we can collect them.

a) Describe what the perfect first day for your BHP would look like when they arrive.

b) Discuss ideas for improving challenging patient situations regarding culture, communication, and privacy.

c) When a practice is limited by physical space, how do they maximize operating more efficiently?

d) What are some communication strategies you can use throughout multiple practices and/or practices with multiple schedules?

e) “What are the pain points your practices are experiencing when addressing the nuts and bolts of BHI?”
PRACTICE INNOVATION PROGRAM
COLORADO

HTTP://WWW.PRACTICEINNOVATIONCO.ORG/SIM/
Keynote

Behavioral Health Integration Reflection

Larry Green, MD
Professor of Family Medicine, Epperson Zorn Chair for Innovation in Family Medicine and Primary Care
University of Colorado, Department of Family Medicine
WHAT WE WANT TO SAY SOMETIMES…. 

HTTPS://WWW.YOUTUBE.COM/WATCH?V=OW0LR63Y4MW
THANK YOU!