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Collaborative Care Management Model

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What is Collaborative Care?

Collaborative Care is an evidence-based model to identify and treat patients with depression and anxiety in health settings.

IMPACT

- **Improving Mood by promoting access to Collaborative Treatment**

- **Randomized control trial 1,800 adults with over 400 primary care providers focused on seniors with depression**

Now Collaborative Care…..

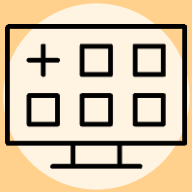
*Unützer et al, Med Care 2001; 39(8):785-99

The Results Are In

Collaborative Care is more effective than care as usual

(over 90 randomized controlled trials)

- Better depression improvement (50% versus 19% Improvement Rate from IMPACT)
- Larger Impact on chronic conditions
- Lowers total Cost of care (the waterfall chart we use in main sales deck)



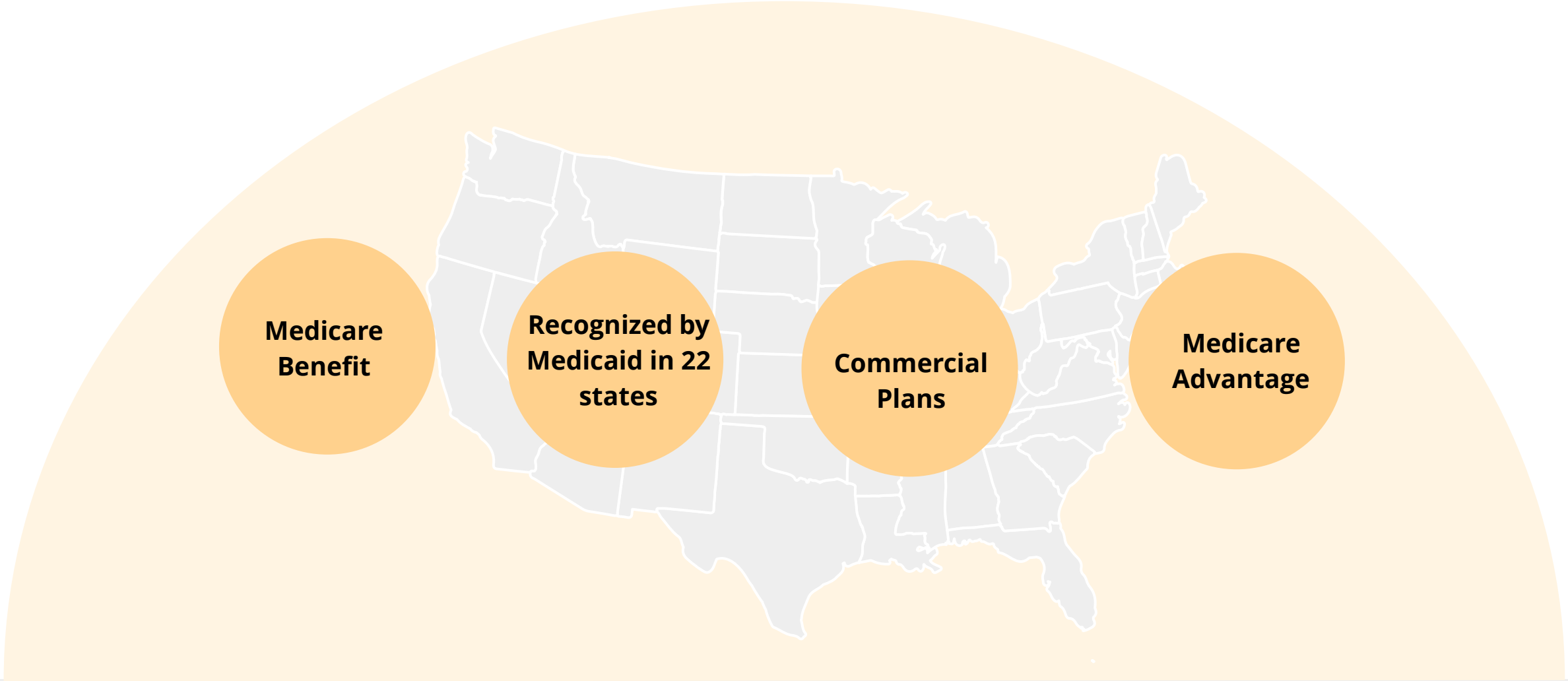
Simple, Sustainable Economic Model

- Reimbursed by Medicare, Commercial Plans, and Medicaid
- Billed under the PCP – use your contracts. Less co-pay for patients

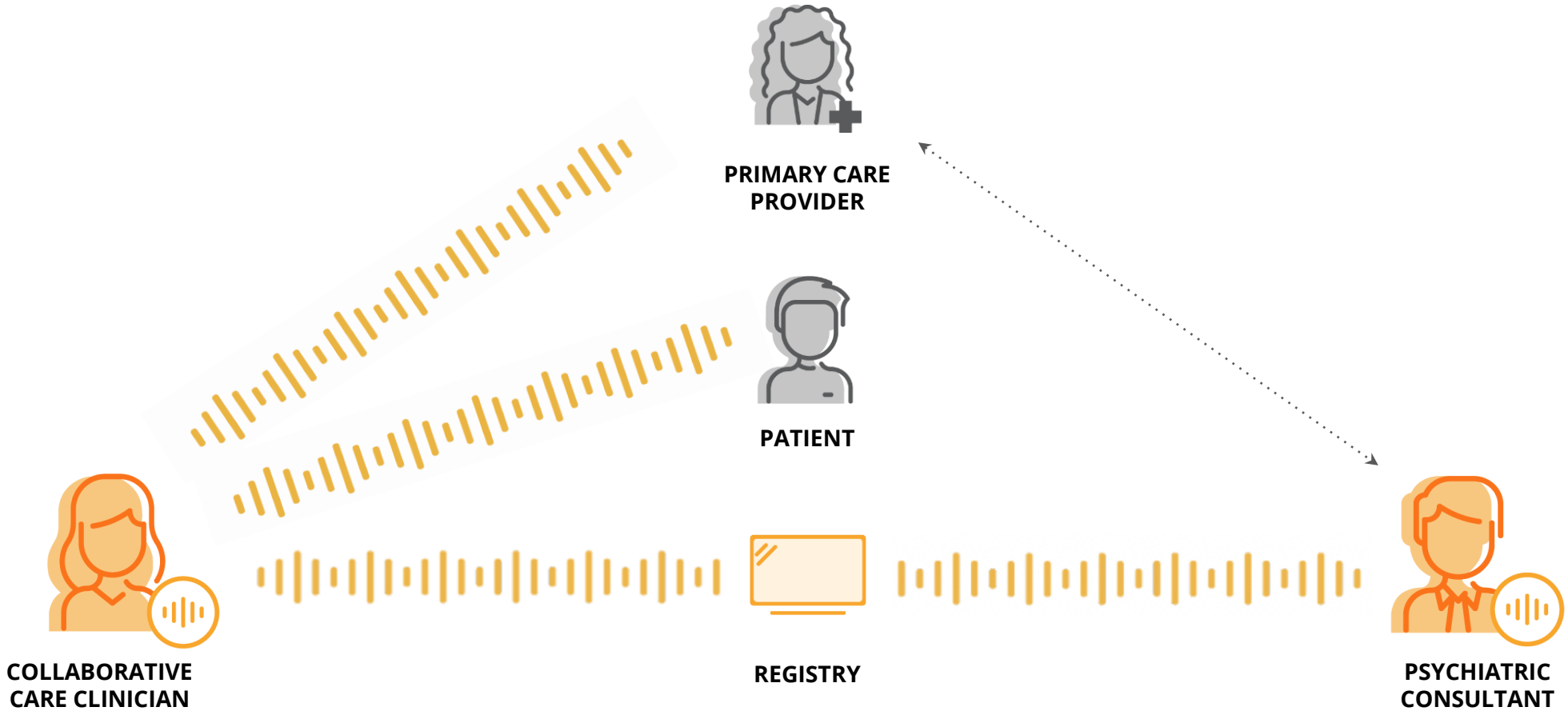
Gilbody S. et al. *Archives of Internal Medicine*; Dec 2006., Thota AB, et al. Community Preventive Services Task Force. *Am J Prev Med.* May 2012;42(5):521-524., Archer J, et al. Cochrane Collaborative. Oct 17, 2012.: 79 RCTs with a total of 24,308 patients

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

Collaborative Care Reimbursement



Turnkey approach to Collaborative Care



Source: Diagram adapted from the AIMS Center at the University of Washington's visual representation of the Collaborative Care Protocol

Pediatrics and Collaborative Care

- Remote works great for adolescents
- Ongoing contacts with reinforcing interventions
- Flexibility
- ADHD is good match with Vanderbilt and same measures

Core principles of Collaborative Care

Patient-Centered Care: Primary care and mental health providers collaborate effectively using shared cared plans.

Population-Based Care: A defined group of patients is tracked in a registry so that no one falls through the cracks.

Treatment to Target: Progress is measured regularly and treatments are actively changed until clinical goals are achieved.

Evidence-Based Care: Providers use treatments that have research evidence for effectiveness.

Accountable Care: Providers are accountable and reimbursed for quality of care and clinical outcomes, not just volume of care.

Short-term by design: Collaborative Care team is planning the “graduation” of a patient from the beginning and working backward. Get patients better and build their relapse prevention capabilities. Average length of engagement under five months. Keep schedule open to keep up with pace of the PCPs.

Treatment Options

Evidence-Based Practices

All choices are clinical interventions, and they can happen repeatedly!

Talk Treatment/Therapy

Cognitive behavioral interventions, problem solving treatment, dialectical behavioral approaches, etc.

Behavioral Activation

Increase adaptive behaviors, re-establish routines, troubleshoot barriers

Medication Adherence

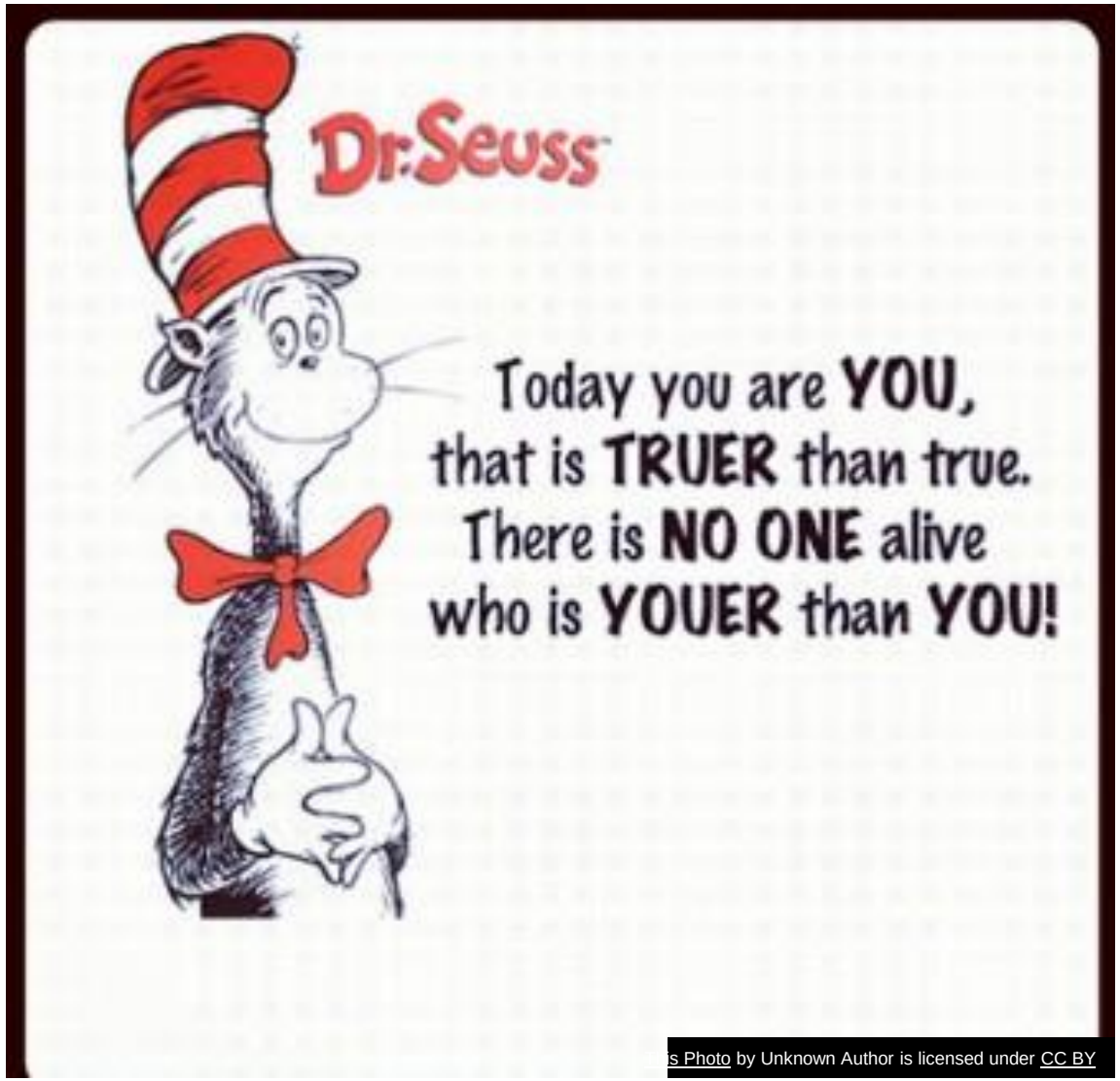
Support patients with prescription regimen

Symptom Monitoring

Tracking thoughts, feelings, screening scores

Patient Centered

- ***Patients*** choose what will work for them
- ***Patients*** can change from week to week
- ***Patients*** can pick one or multiple treatment choices
- No ***Patient*** care should look the same
- ***Patients*** can choose modality



Care Manager

- Does not need to be licensed , per CMS but may vary by state
- Must be “trained” able to do all of treatment choices
- Can be masters prepared, great for students in MSW or counseling programs
- Should be a dedicated person
- Can be remote, expand your staffing options

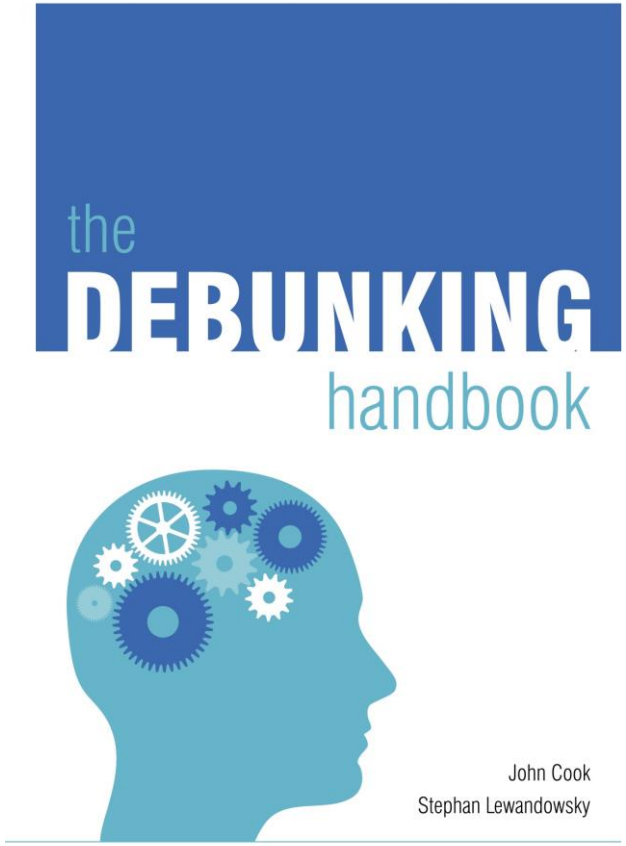
- Can cover multiple locations
- Could be shared
- Does not need to be “credentialed”

The Worst Thing You Can Do……

- Present the choices as a list of “options”
- Don’t let people know they can transition them from week to week
- Let people know that just letting us know how they are doing is an option

Misconceptions

- Cocm is brief treatment
- Cocm is not “therapy”
- Short term goals are not important



Frontloading

- At least 2-3 times in the first week and ongoing for first few weeks
- Like medication……
- 50% more likely to engage
- Adding a goal increase engagement

Q: What clients are appropriate for referral to Collaborative Care?

A: Any client with a PHQ-9/GAD-7 greater than 9

- Depressive diagnoses
- Anxiety diagnoses (including Generalized Anxiety Disorder, Specific Phobias, Social Anxiety Disorder, and Panic Disorder)
- Trauma-related disorders (including Acute Stress Disorder and Post Traumatic Stress Disorder)
- Clients ages 12 and over
- Substance use disorders

PCP Education

- Hand off approach/language
- Entire population
- Avoiding language like therapy or program
- Embracing population health approaches

Case Finding

- Warm hand offs are nice but not enough
- At least two population health approaches
- Systemic approaches with nursing, pharmacy, medical assistants at screening
- Reports- initially or ongoing for patient who score positive, patients on medications, patients with dx on problem list, patient with reason for visit dx

Outcome Measures

- 50% or 10 points at 70 days, 50% should hit this mark
- Most rigorous measure at baseline and then prior to 70 days
- Subclinical is the goal (often forgotten!)
- Share outcomes measures with entire team including providers and track by care manager, provider, site etc.

BHI Code	Behavioral Health Care Manager or Clinical Staff Threshold Time	Activities Include:
CoCM First Month (CPT 99492) (G0511)	First 70 minutes per calendar month	• Initial Assessment • Outreach/engagement • Entering patients in registry • Psychiatric consultation • Brief intervention
CoCM Subsequent Months (CPT 99493) (G0512)	60 minutes per calendar month	• Tracking + Follow-up • Caseload Review • Collaboration of care team • Brief intervention • Ongoing screening/monitoring • Relapse Prevention Planning
Add-on CoCM (Any month) (CPT 99494)	Each additional 30 minutes per calendar month	• Same as Above
General BHI (CPT 99484)	At least 20 minutes per calendar month	• Assessment + Follow-up • Treatment/care planning • Facilitating and coordinating treatment • Continuity of care

Billing Considerations

- Monthly case rate
- Auto added to most commercial contracts
- Sliding fee scales consider bundling
- Start with billing across all payers, FQHC will have to use both codes anyhow
- Consider last Sunday of the month if high volume
- Referral from provider must be documented to “start the clock”
- Consent has to be documented
- 99494 may be limited to twice, cannot be billed independently

- 99484 is not cocm code technically
- Half plus one rules

Time-Based Inclusions

- Psychiatric consultation
- Discussions, case reviews with primary care
- Registry management
- Telephonic work
- Discussions with collaterals
- In-person visits (to be continued)
- If its not documented it's not done!
- Case management/concrete services carved out
- 90% attached to billable event (10% capacity)
- 90% of events billable

- If your EMR is registry does not count
- Do no approximate /guess for time

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Thank you.

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