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.

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Financial Disclosure

No relevant financial relationships to disclose

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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

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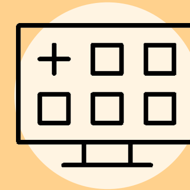
The Results Are In

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.

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Collaborative Care Reimbursement

Medicare Benefit

Recognized by Medicaid in 22 states
!

Commercial Plans

Medicare Advantage

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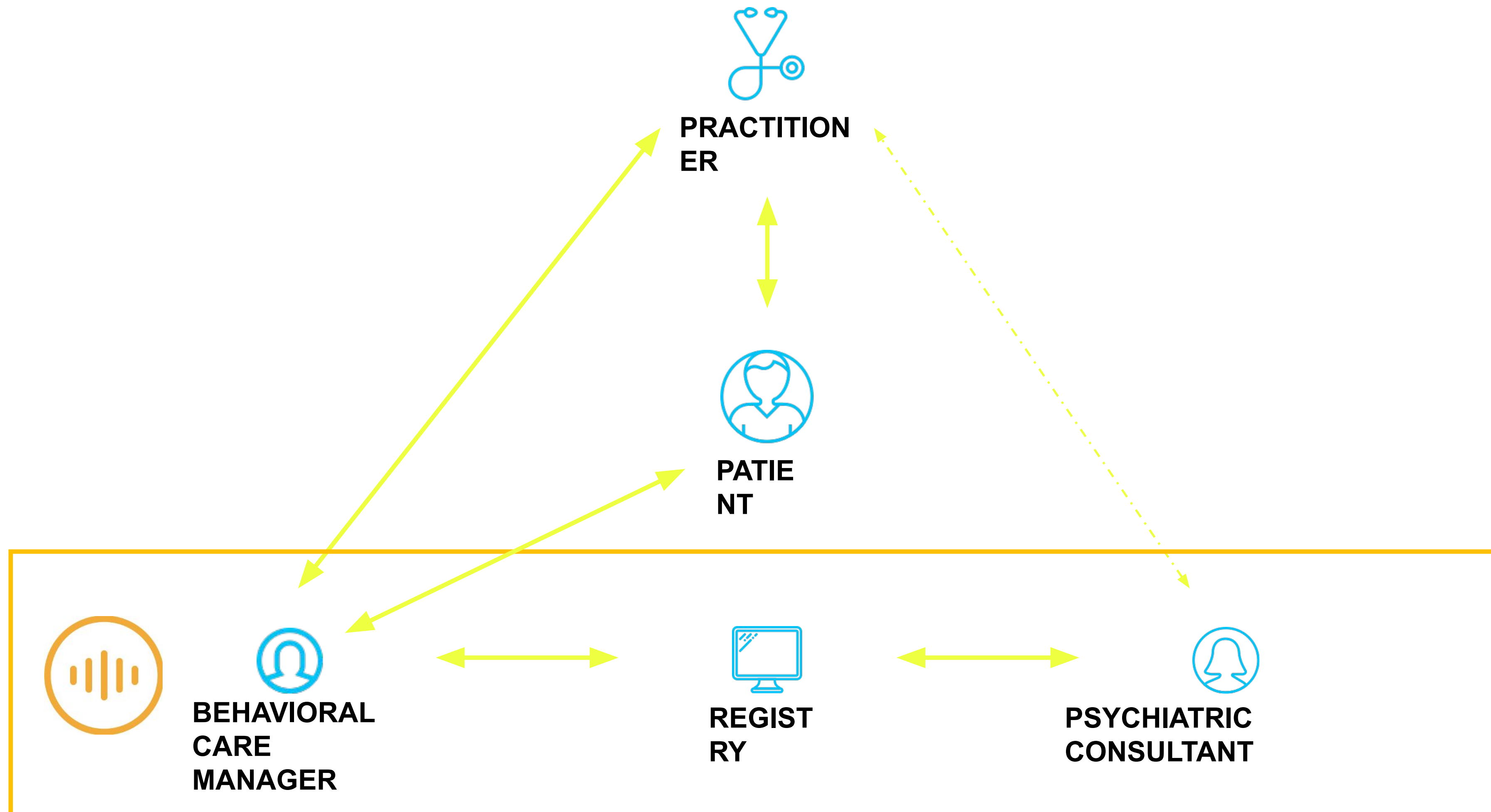
TURNKEY APPROACH TO COLLABORATIVE CARE



Source
The AIMS Center at the University of Washington developed this visual representation of the Collaborative Care Protocol

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Pediatrics and Collaborative Care

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

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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.

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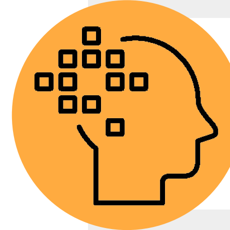
Treatment Options

Evidence-Based Practices

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

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

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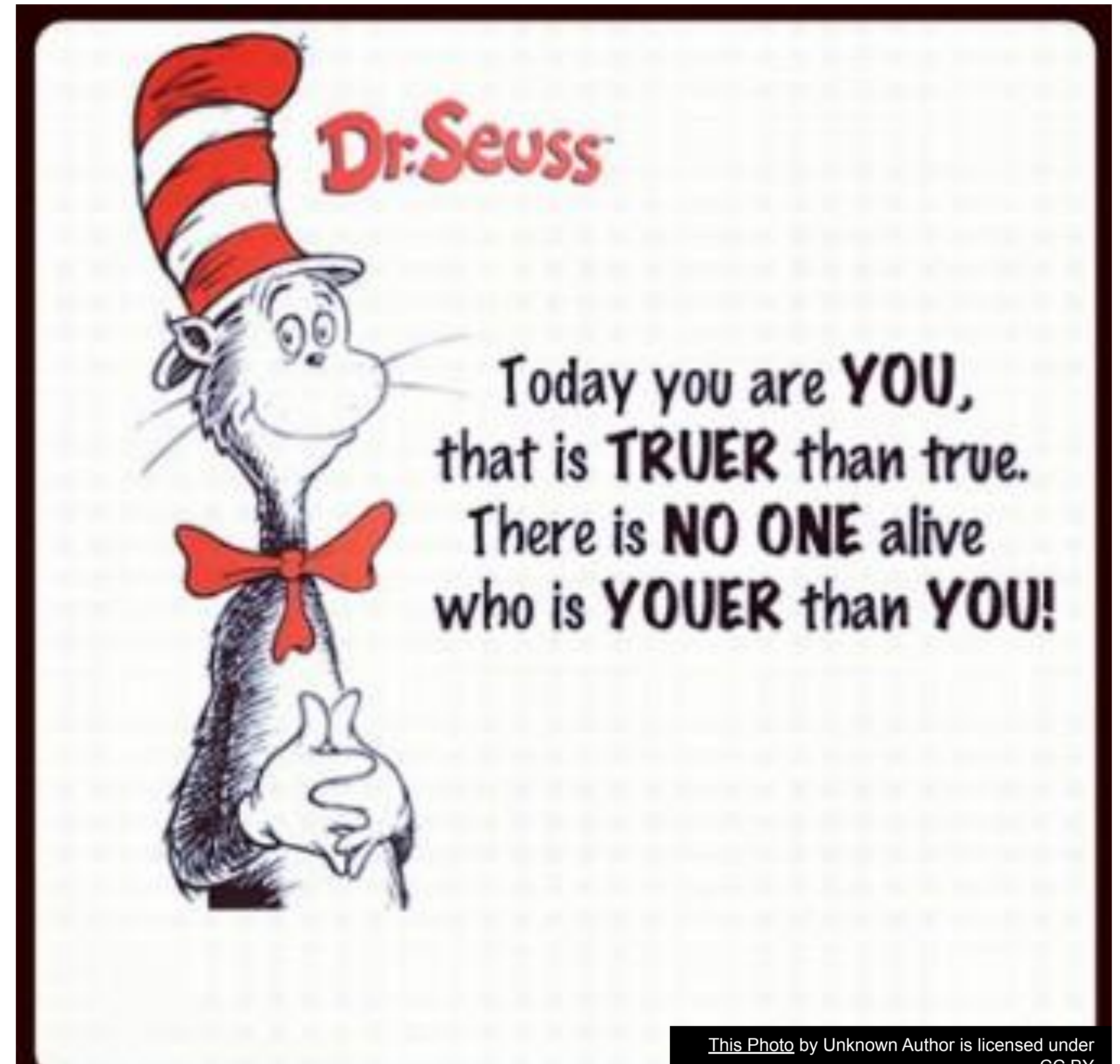
Patient Centered

- ***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



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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

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

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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

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Misconceptions

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

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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

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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

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PCP Education

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

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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

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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.

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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

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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

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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

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

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There is Help !

- Technical assistance through ACU
- Support for implementation
- Options to “build” or “contract”

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Thank you.

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