Care Coordination:

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Adding Behavioral Health to your Chronic Care Management Program

Building Leaders – Transforming Hospitals – Improving Care

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45 Years of Delivering Results

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HealthTechS3 is a 45 year old, award-winning healthcare consulting and strategic hospital services firm based in Brentwood, Tennessee with clients across the United States.

We are dedicated to the goal of improving performance, achieving compliance, reducing costs, and ultimately improving patient care. Leveraging consultants with deep healthcare industry experience, **HealthTechS3** provides actionable insights and guidance that supports informed decision making and drives efficiency in operational performance.

Our consultants are former hospital leaders and executives. **HealthTechS3** has the right mix of experienced professionals that service hospital clients across the nation. **HealthTechS3** offers flexible and affordable services, consulting, and technology as we focus on delivering solutions that can be implemented and provide a positive, measurable impact.

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STRATEGY – SOLUTIONS – SUPPORT

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GOVERNANCE & STRATEGY

- Affiliation Consulting
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- Strategic Planning & Market share Analysis
- Community Health Needs Assessment
- Compliance Consulting Services

FINANCE

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- Productivity & Staffing Consulting - Optimum Productivity Toolkit

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- Continuous Survey Readiness
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- Lean Culture
- Customer Experience
- Clinical Resource Management
- Care Coordination – Primary Care Practice
- Physician Practice & Clinic Assessment
- Long Term Care Consulting
- Swing Bed Consulting
- Perioperative Services Consulting

RECRUITMENT

- Executive Recruitment
- Manager and Clinical Positions
- Physician / Provider Recruitment
- Information Technology Professionals
- Interim Placement

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2018 Webinars at a Glance

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CRITICAL ACCESS HOSPITALS - JUST THE QUESTIONS PLEASE - JULY 6

WHOLE PERSON CARE - JULY 12

EXPERT EVIDENCE-BASED ASSISTANCE WHERE IT MATTERS MOST - JULY 18

SWING BED – MORE QUESTIONS PLEASE! - AUGUST 3

THE GOOD, BAD AND UGLY OF INTERIM LEADERSHIP - WHAT YOU NEED TO KNOW BUT WERE AFRAID TO ASK - AUGUST 9

THE POWER OF OBSERVATION: THE FOUNDATION OF YOUR LEAN CULTURE - AUGUST 16

CYBERSECURITY, THE CHALLENGES HEALTHCARE IS FACING - AUGUST 17

COMMUNITY HEALTH NEEDS ASSESSMENT – STRATEGIES FOR ENGAGING THE COMMUNITY - SEPTEMBER 7

EXPERT EVIDENCE-BASED ASSISTANCE - WHERE IT MATTERS MOST - SEPTEMBER 19

INCORPORATING COMMUNITY RESOURCES INTO YOUR CARE COORDINATION PROGRAM - SEPTEMBER 20

QUESTION & ANSWER SESSION ON EXECUTIVE PLACEMENT - SEPTEMBER 28

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Instructions for Today's Webinar

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- You may type a question in the text box if you have a question during the presentation
- We will try to cover all of your questions – but if we don't get to them during the webinar we will follow-up with you by e-mail
- You may also send questions after the webinar to our team (contact information is included at the end of the presentation)
- The webinar will be recorded and the recording will be available on the HealthTechS3 web site: www.healthtechs3.com

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Faith M Jones, MSN, RN, NEA-BC

Director of Care Coordination and Lean Consulting

Faith Jones began her healthcare career in the US Navy over 30 years ago. She has worked in a variety of roles in clinical practice, education, management, administration, consulting, and healthcare compliance. Her knowledge and experience spans various settings including ambulance, clinics, hospitals, home care, and long term care. In her leadership roles she has been responsible for operational leadership for all clinical functions including multiple nursing specialties, pharmacy, laboratory, imaging, nutrition, therapies, as well as administrative functions related to quality management, case management, medical staff credentialing, staff education, and corporate compliance. She currently implements care coordination programs focusing on the Medicare population and teaches care coordination concepts nationally. She also holds a Green Belt in Healthcare and is a Certified Lean Instructor.

Healthcare Focus | 45 Year Company History | Experienced Consultants | Technology Partnerships

Objectives

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Following this presentation, the participant will understand:

- The elements of a Behavioral Health Integration Program
- How BHI aligns with Chronic Care Management
- The reimbursement methodologies for BHI in various types of clinics

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Care Delivery Models

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"…new and evolving care delivery models, which feature an increased role for non-physician practitioners (often as care coordination facilitators or in team-based care) have been shown to improve patient outcomes while reducing costs, both of which are important Department goals as we move further toward quality- and value-based purchasing of health care services in the Medicare program and the health care system as a whole."

Vol. 80 Wednesday, No. 135 July 15, 2015, P 226

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Care Coordination Growth and Development

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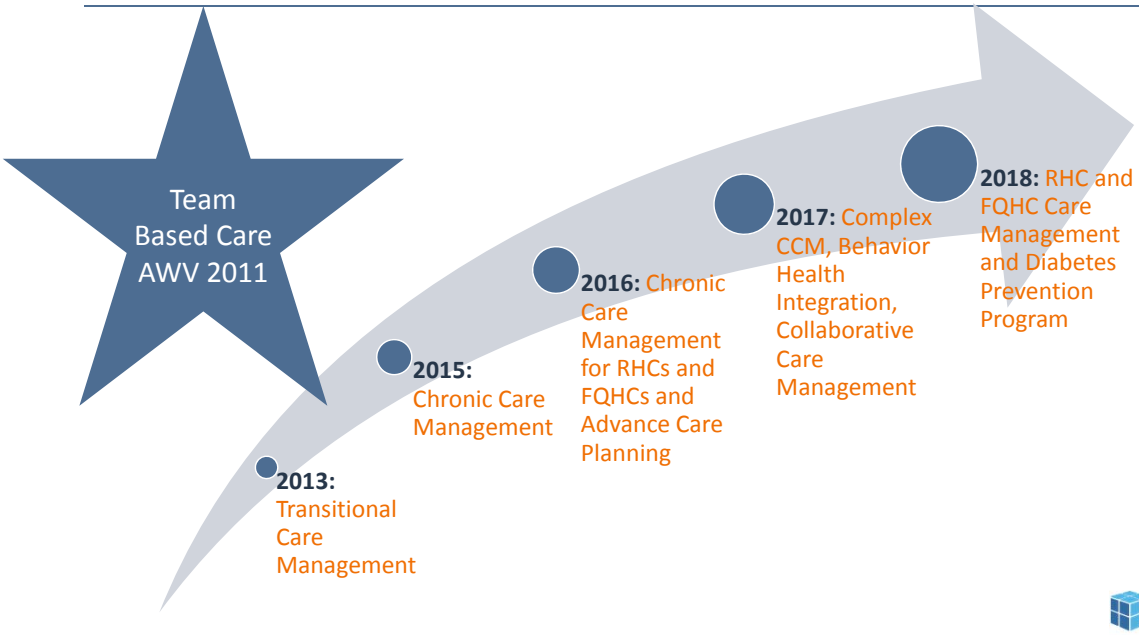

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Changing Models

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"Our goal is to recognize the trend toward **practice transformation** and overall improved quality of care, while preventing unwanted and unnecessary care"

CMS CFR 11-12-2014

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Elements of Chronic Care Management

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Practice Eligibility	Patient Eligibility
• Qualified EMR • Availability of electronic communication with patient and care giver • Collaboration and communication with community resources & referrals • After hours coverage • Care Plan Access • Primary Care Provider supervision of clinical staff	• Medicare Patient • Two or more chronic conditions expected to last at least 12 months or until the death of the patient • At significant risk of death, acute exacerbation, decompensation, or functional decline without management • Patient Consent • CCM initiated by the primary care provider • Documentation of at least 20 minutes per calendar month spent coordinating care

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Elements of Complex Chronic Care Management

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Practice Eligibility	Patient Eligibility
• Qualified EMR • Availability of electronic communication with patient and care giver • Collaboration and communication with community resources & referrals • After hours coverage • Care Plan Access • Primary Care Provider supervision of clinical staff	• Medicare Patient • Two or more chronic conditions expected to last at least 12 months or until the death of the patient • At significant risk of death, acute exacerbation, decompensation, or functional decline without management • Patient Consent • CCM initiated by the primary care provider • ***Documentation of at least 60 minutes per calendar month spent coordinating care*** – ***With medical decision making***

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Behavioral Health Integration Care Team

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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, psychiatry).
- **Beneficiary** – The beneficiary is a member of the care team.
- **Potentially Clinical Staff** – The service may be provided in full by the billing practitioner. Alternatively, the billing practitioner may use qualified clinical staff to provide certain services using a team-based approach. These clinical staff may- but are not required to- include a designated behavioral health care manager or psychiatric consultant.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

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Elements of Behavioral Health Integration

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Patient Eligibility

- Medicare Patient
- "Any mental, behavioral health, or psychiatric condition being treated by the billing practitioner, including substance use disorders, that, in the clinical judgment of the billing practitioner, warrants BHI services. The diagnosis or diagnoses could be either pre-existing or made by the billing practitioner and may be refined over time".
- Patient Consent
- BHI initiated by the primary care provider

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

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Elements of Behavioral Health Integration

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Service Components

- Initial assessment
  - Initiating visit (if required, separately billed)

Initiating Visit

  - An initiating visit (separately billable) is required for new patients or beneficiaries not seen within one year prior to commencement of BHI services. This visit establishes the beneficiary's relationship with the billing practitioner, and ensures the billing practitioner assesses the beneficiary prior to initiating BHI services.
- Administration of applicable validated rating scale(s)
  - Rates Symptom management
- Systematic assessment and monitoring, using applicable validated clinical rating scales

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Rating Scales

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http://thekennedyforum-dot-org.s3.amazonaws.com/documents/MBC_supplement.pdf

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Rating Scales

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Table 1: Adult Symptom Rating Scales for Core Outcome Measures

MEASURE	DOMAIN	# OF ITEMS
PHQ-9	Depression	9
Altman Scale	Mania	5
GAD-7	Anxiety	7
PCL	PTSD	20
PDSS_SR	Panic attacks	7
Audit-C	Alcohol	3
DAST-10	Drug abuse	10
PHQ-15	Somatization	15

http://thekennedyforum-dot-org.s3.amazonaws.com/documents/MBC_supplement.pdf

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Care Planning

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Service Components

- Care planning by the primary care team jointly with the beneficiary, with care plan revision for patients whose condition is not improving
- Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

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Resource Management

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Service Components

- Facilitation and coordination of behavioral health treatment
- Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation

Advance Consent

- Prior to commencement of BHI services, the beneficiary must give the billing practitioner permission to consult with relevant specialists, which would include conferring with a psychiatric consultant. The billing practitioner must inform the beneficiary that cost sharing applies for both face-to-face and non-face-to-face services that are provided, although supplemental insurers may cover cost sharing. Consent may be verbal (written consent is not required) but must be documented in the medical record.

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Continuity of Care

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Service Components

- Continuous relationship with a designated member of the care team

Clinical Staff

- Continuous relationship with the beneficiary and a collaborative, integrated relationship with the rest of the care team.
- May or may not be a professional who meets all the requirements to independently furnish and report services to Medicare.
- May include (but not required to include) a behavioral health care manager or psychiatric consultant.

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Time Tracking

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Service Components

- Documentation of at least 20 minutes per calendar month
- Does not include administrative or clerical staff time.

Supervision

- BHI services that are not personally performed by the billing practitioner are assigned general supervision under the Medicare Physician Fee Schedule (MPFS), although general supervision does not, by itself, comprise a qualifying relationship between the billing practitioner and the other members of the care team.
- General supervision is defined as the service being furnished under the overall direction and control of the billing practitioner, and his or her physical presence is not required during service provision.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

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Elements of Behavioral Health Integration

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Service Components

- Initial assessment
  - Initiating visit (if required, separately billed)
  - Administration of applicable validated rating scale(s)
- Systematic assessment and monitoring, using applicable validated clinical rating scales
- Care planning by the primary care team jointly with the beneficiary, with care plan revision for patients whose condition is not improving
- Facilitation and coordination of behavioral health treatment
- Continuous relationship with a designated member of the care team

Patient Eligibility

- Medicare Patient
- "Any mental, behavioral health, or psychiatric condition being treated by the billing practitioner, including substance use disorders, that, in the clinical judgment of the billing practitioner, warrants BHI services. The diagnosis or diagnoses could be either pre-existing or made by the billing practitioner and may be refined over time".
- Patient Consent
- BHI initiated by the primary care provider
- Documentation of at least 20 minutes per calendar month

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Collaborative Care Management Team

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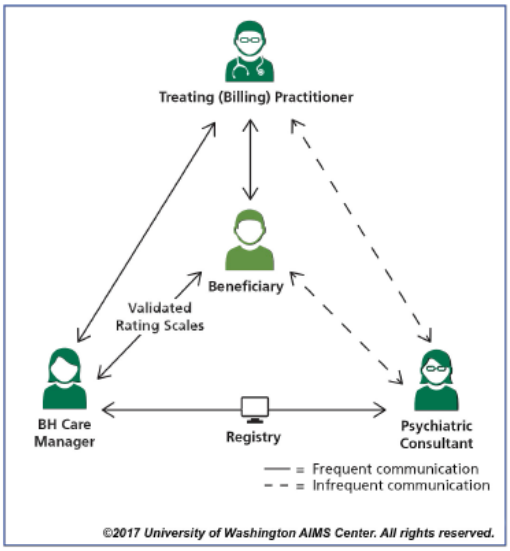
What is CoCM?
A model of behavioral health integration that enhances "usual" primary care by adding two key services: care management support for patients receiving behavioral health treatment; and regular psychiatric inter-specialty consultation to the primary care team, particularly regarding patients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



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Collaborative Care Management Team

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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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Elements of Collaborative Care Management

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Service Components

- Initial assessment by the primary care team (billing practitioner and behavioral health care manager)
  - Initiating visit (if required, separately billed)
  - Administration of validated rating scale(s)
- Care planning by the primary care team, jointly with the beneficiary, with care plan revision for patients whose condition is not improving adequately. Treatment may include pharmacotherapy, psychotherapy, and/or other indicated treatments
- Behavioral health care manager performs proactive, systematic follow-up using validated rating scales and a registry
  - Assesses treatment adherence, tolerability, and clinical response using validated rating scales; may provide brief evidence-based psychosocial interventions such as behavioral activation or motivational interviewing
  - Regular case load review with psychiatric consultant – The primary care team regularly (at least weekly) reviews the beneficiary's treatment plan and status with the psychiatric consultant and maintains or adjusts treatment, including referral to behavioral health specialty care as needed

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

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Elements of Collaborative Care Management

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Patient Eligibility

- Medicare Patient
- "Any mental, behavioral health, or psychiatric condition being treated by the billing practitioner, including substance use disorders, that, in the clinical judgment of the billing practitioner, warrants BHI services. The diagnosis or diagnoses could be either pre-existing or made by the billing practitioner and may be refined over time".
- Patient Consent
- Documentation of:
  - 70 minutes of behavioral health care manager time the first month
  - 60 minutes subsequent months
  - Add-on code for 30 additional minutes any month

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

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Patient Eligibility Comparing CCM and BHI

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CCM	BHI
• Medicare Patient • 2 Chronic Conditions – determined by PCP • Patient Consent (verbal or written) • CCM initiated by the primary care provider – At a visit – Visit not required for "established patient" Established = seen in 12 months • Patient Consent • Plan of Care • Documentation of at least 20 minutes per calendar month	• Medicare Patient • 1 Behavioral Health Diagnosis – determined by PCP • Patient Consent (verbal or written) • BHI initiated by the primary care provider – At a visit – Visit not required for "established patient" Established = seen in 12 months • Patient Consent • Plan of Care including rating scale • Documentation of at least 20 minutes per calendar month

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Model Comparisons

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Model Comparison

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Complex CCM	CoCM
• Care Coordinator – Clinical Staff • Medical Decision Making • Documentation of at least 60 minutes of care coordination per calendar month	• Behavioral Health Car Manager – Formal Education (RN, SW, Psychology) • Psychiatric Medical Consult • Documentation of at least 60 minutes of care coordination per calendar month

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Codes and Reimbursements for CCM

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Chronic Care Management 2018

Provider initiated care planning on enrollment to CCM

- CPT Code G0506
- National Average Reimbursement ~$64.44

Billed per calendar month for 20 plus minutes of care coordination

- CPT Code 99490
- National Average Reimbursement ~$42.84

DOES NOT APPLY TO RHCS AND FQHCS

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Codes and Reimbursement for Complex CCM

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Complex Chronic Care Management 2018

Billed per calendar month for 60 plus minutes of Complex Chronic Care Management

- CPT Code 99487
- National Average Reimbursement ~$94.68

Billed with 99487 for additional 30 min per calendar month for Complex Chronic Care Management

- CPT Code 99489
- National Average Reimbursement ~$47.16

DOES NOT APPLY TO RHCS AND FQHCS

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Code and Reimbursement for BHI

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Behavioral Health Integration 2018

Billed per calendar month for 20 plus minutes of BHI care coordination

- CPT Code 99484
- National Average Reimbursement ~$48.60

DOES NOT APPLY TO RHCS AND FQHCS

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Code for RHCs and FQHCs

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Care Management 2018

Billed per calendar month for 20 plus minutes of CCM care coordination

OR

Billed per calendar month for 60 plus minutes of Complex Chronic Care Management

OR

Billed per calendar month for 20 plus minutes of BHI care coordination

- CPT Code G0511
- National Average Reimbursement ~$62.28

ONLY FOR RHCS AND FQHCS

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Collaborative Care Management

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Collaborative Care Management 2018

Billed per calendar month for 1st month of at least 70 plus minutes of Psych collaborative care

- CPT Code 99492
- National Average Reimbursement ~$161.28

Billed per calendar month for subsequent month of at least 60 plus minutes of Psych collaborative care

- CPT Code 99493
- National Average Reimbursement ~$128.88

Billed with 99492 or 99493 for additional 30 min per calendar month for Psych collaborative care

- CPT Code 99494
- National Average Reimbursement ~$66.60

DOES NOT APPLY TO RHCS AND FQHCS

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Code for RHCs and FQHCs

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Collaborative Care Management 2018

Billed per calendar month for 1st month of at least 70 plus minutes of Psych collaborative care

OR

Billed per calendar month for subsequent month of at least 60 plus minutes of Psych collaborative care

- CPT Code G0512
- National Average Reimbursement ~$145.08

ONLY FOR RHCS AND FQHCS

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Alphabet Soup

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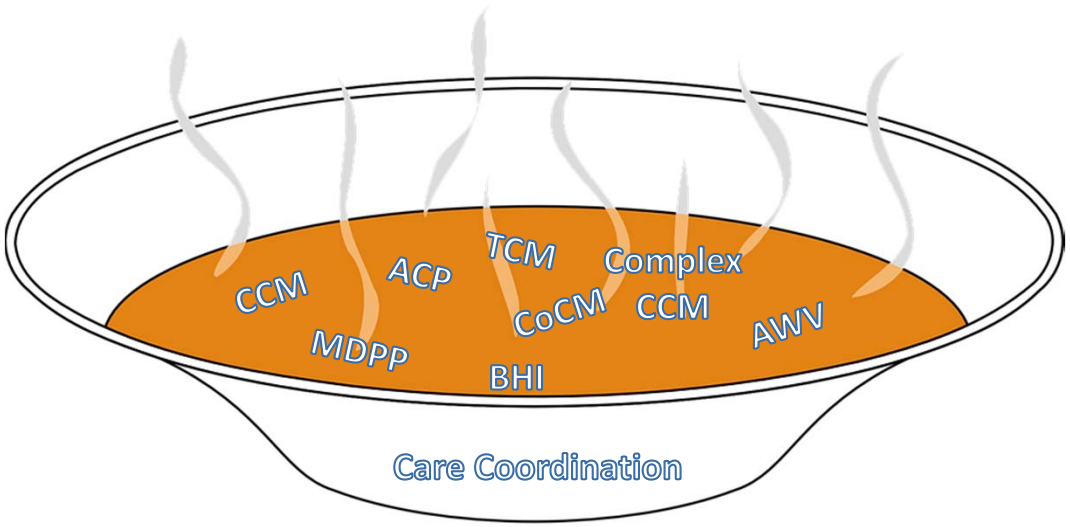

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Thank you!
If you would like more information - or - have questions - or - would like to discuss Care Coordination for your practice, please feel free to contact me.

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strategy solutions support

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