
What’s your favorite ice cream flavor?

Tuesday, August 8; 11:00am PT

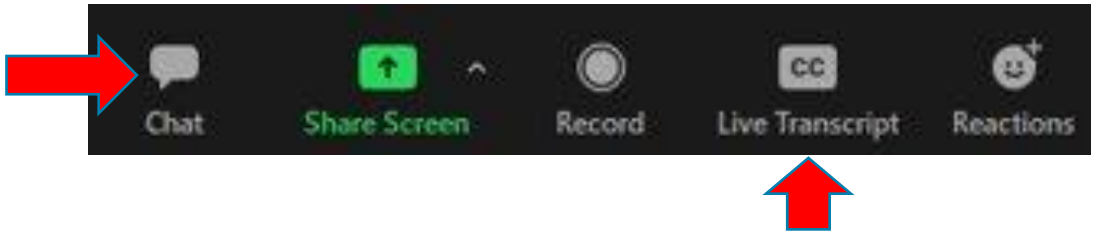
BHI Fundamentals: Integration Concepts and Models (Part 1)

CalHIVE BHI Commons

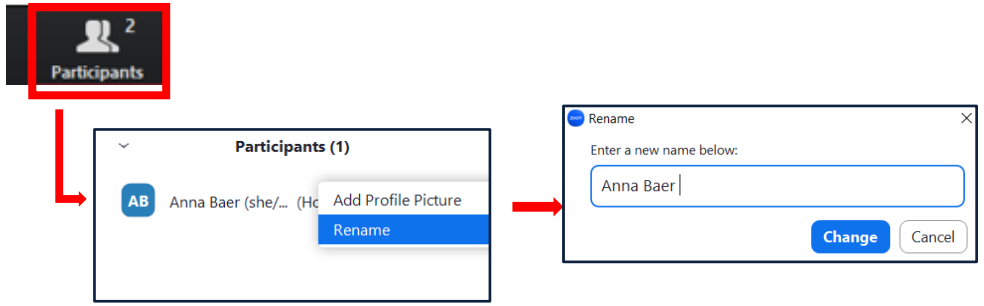
PBGH California Quality Collaborative

Zoom Tips

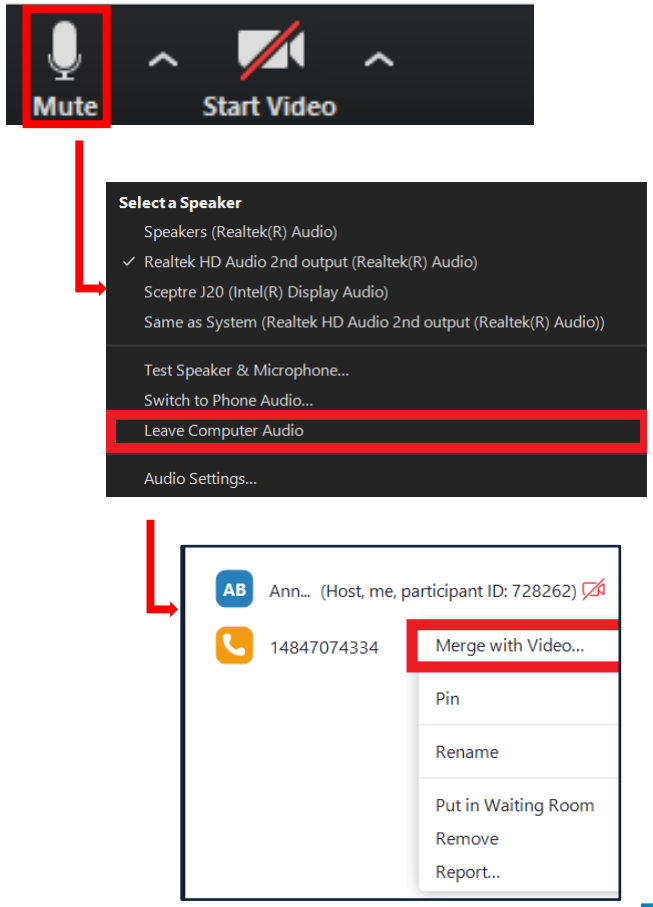
- Attendees are automatically **MUTED** upon entry
- Use the **chat box** for questions



- Request closed captioning with 'Live Transcript' button
- Direct message **Anna Baer** if you have any technical issues
- **Please update your Zoom display name & organization**

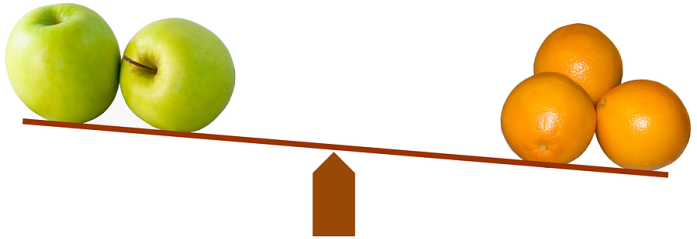


- **If you've dialed in, please link your phone to your video/computer**



Our Agenda

Today, we'll:



Understand the key differences between models for integrating behavioral health into primary care

Explore local factors to support selecting an integration model

Review next steps for selecting an integration model

Engaging today

- Identify organization experience via Zoom annotate
- Share questions through chat
- Check-in with a Zoom poll
- Turn your camera on if you're able to

California Quality Collaborative

Integration Concepts and Models

What is Integrated Care?

Measuring 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

Collaboration

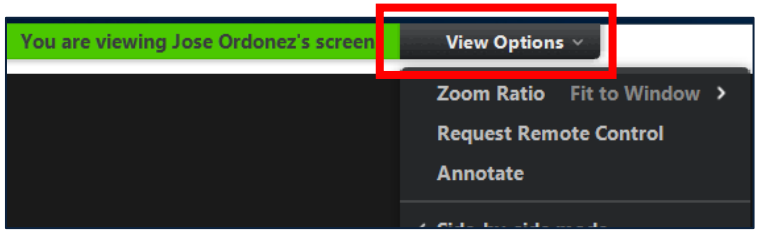
- BH works ***with*** primary care
- Patients perceive they are receiving care from a specialist who collaborates closely with PCP

Integration

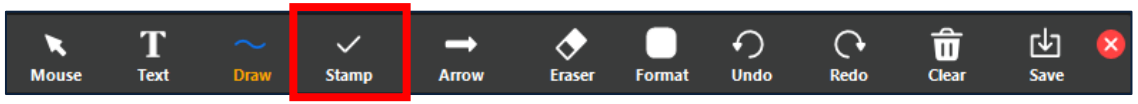
- BH works ***within*** primary care
- Patients perceive BH services as part of their health care with PCP

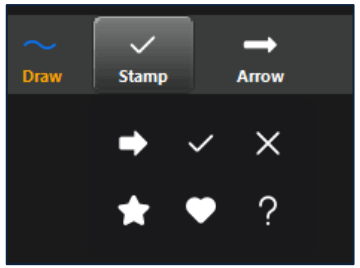
https://www.thenationalcouncil.org/wp-content/uploads/2020/01/CIHS_Framework_Final_charts.pdf?daf=375ateTbd56

Virtual Dot Voting!



At the top of your screen, select **View Options**, then click on **Annotate**.
The following toolbar will appear.



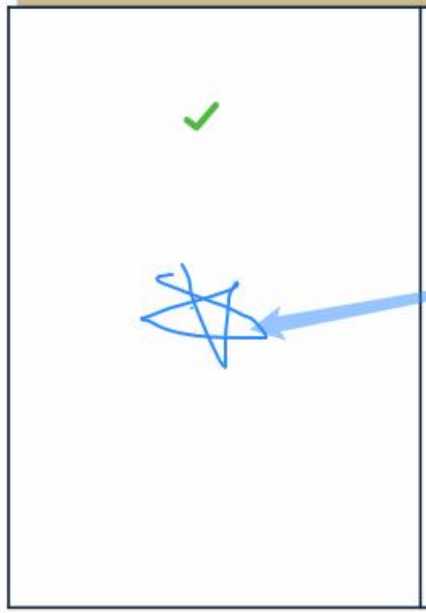


Select **Stamps** to change your shape to place within the voting area

Let's try it!
Place one stamp of your choice in box to right

Measuring 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
					

Source: https://www.thenationalcouncil.org/wp-content/uploads/2020/01/CIHS_Framework_Final_charts.pdf?daf=375ateTbd56

Mythbusting BHI

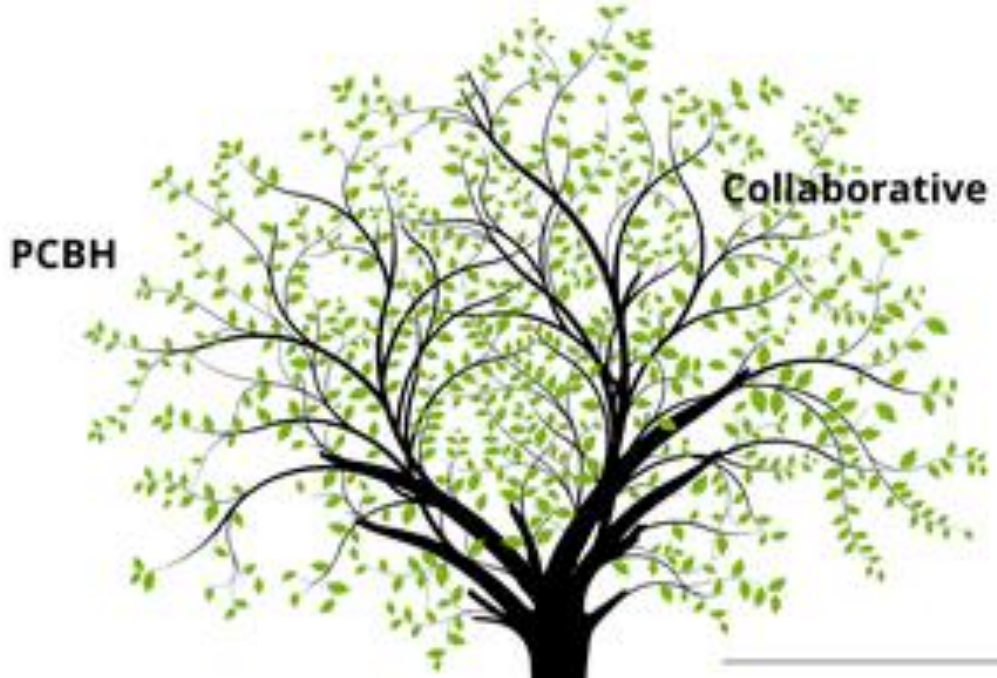
BH Integration is not only…	BH Integration entails…
Co-locating primary care and behavioral health services in the same building	Collaboration across care teams
Aligning primary care and behavioral health teams under the same lines in the organizational chart	Creating internal support for BHI teams to ensure long term sustainability
Consolidating funding /resources for primary care and behavioral health	Long term investment. ROI may take some time.
Contracting an MCO to manage both primary care and behavioral	Buy-in from both providers and patients
A project	Cultural and organizational transformation

California Quality Collaborative

Integration Concepts and Models

How do we define Care Models?

"The Integrated Care Tree of Models & Clinical Pathways Rooted In Perspectives"



Collaborative Care

PCBH

SBIRT

Medication Assisted Treatment

Models

Clinical Pathways

Medical Family Therapy

Trauma Informed Care

Patient Centered Medical Home

ACEs

Chronic Disease Management

Medically Unexplained Symptoms

Triple/ Quadruple AIM

Population Health

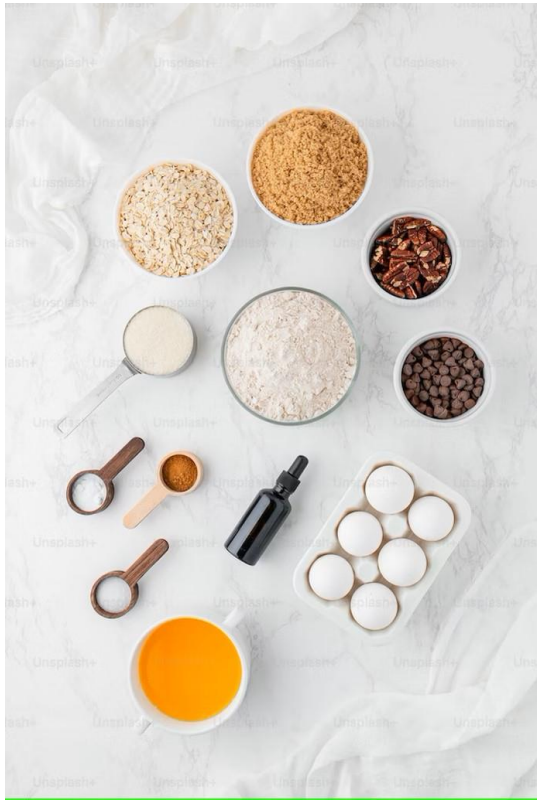
Health Psychology

Biopsychosocial Model

Social Determinants

Perspectives

What do we mean by a model? Why do we need one?



- **Models are delivery strategies that prescribe specific ways in which professionals will work together to provide healthcare services.**
- Work in integrated care models centers on two main models of integrating behavioral and medical care.
- Models provide a set of principles, standards, and best practices that dictate how different healthcare providers will collaborate and coordinate care around the unique needs of the individual
  - Operationally includes: workflows, job descriptions, trainings, data registries

https://www.cfha.net/learn-network/what-is-integrated-care

Do we have to choose just one? How much can we improvise?

It is important to recognize that the ***Collaborative Care*** **and** ***PCBH*** models are **NOT** mutually exclusive.
They serve different, yet overlapping, purposes and complement one another well.

YET only try one when you're first starting out.

How strictly do you need to keep to your adopted model?

- When starting this work, start with a model as closely as possible
- Less room for error, stronger chance for success

https://www.cfha.net/learn-network/what-is-integrated-care/

Clinical Pathways

Clinical pathways are algorithms used to guide care to ensure that persons with specific conditions receive monitored, timely care.

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

- An approach to the deliver of early intervention and treatment to people with substance use disorders and those at risk of developing these disorders

Medication Assisted Treatment (MAT)

- The use of medications, in combination with counseling and other therapeutic techniques, to provide a “whole-patient” approach to the treatment of substance use disorder.

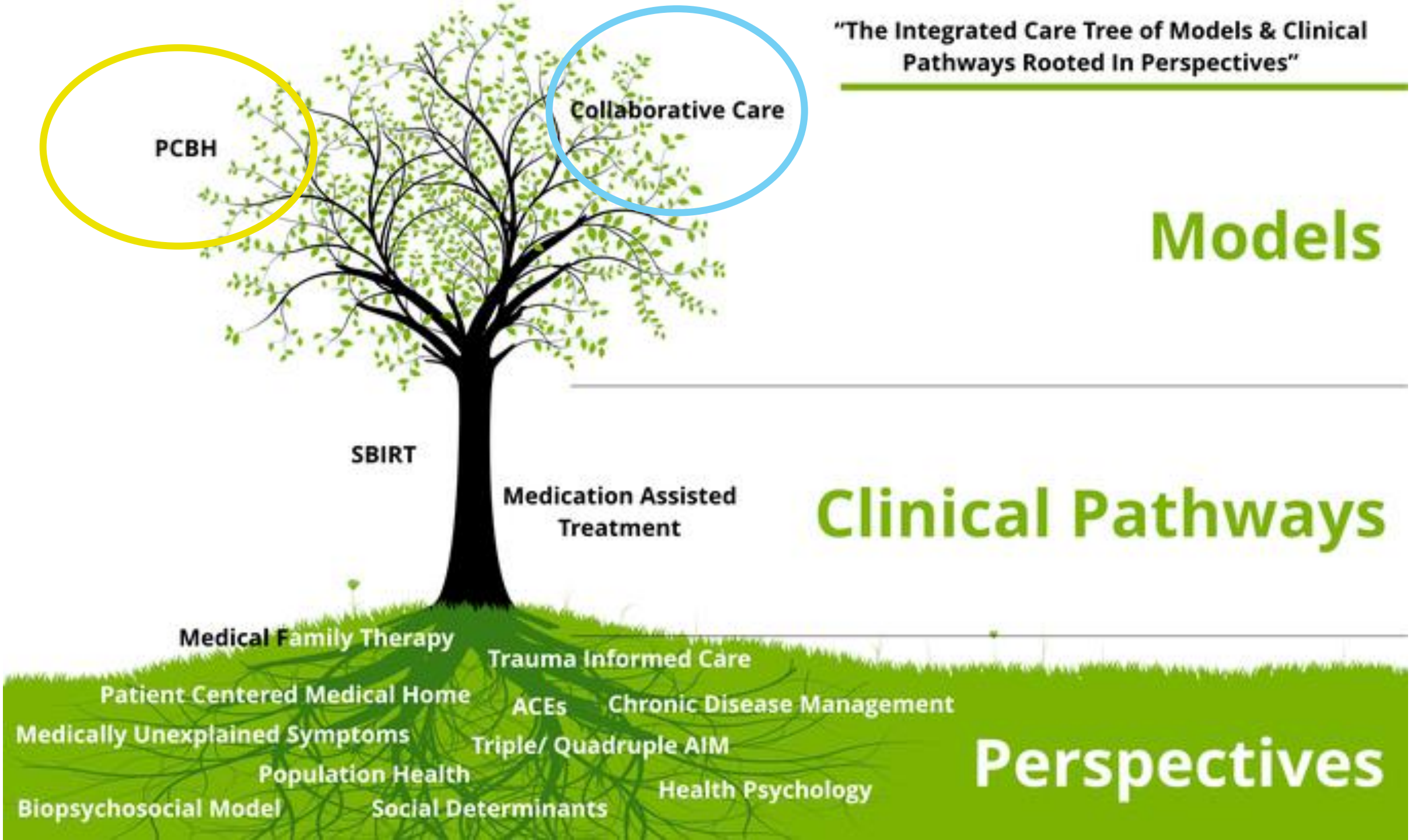
https://www.cfha.net/learn-network/what-is-integrated-care/

California Quality Collaborative

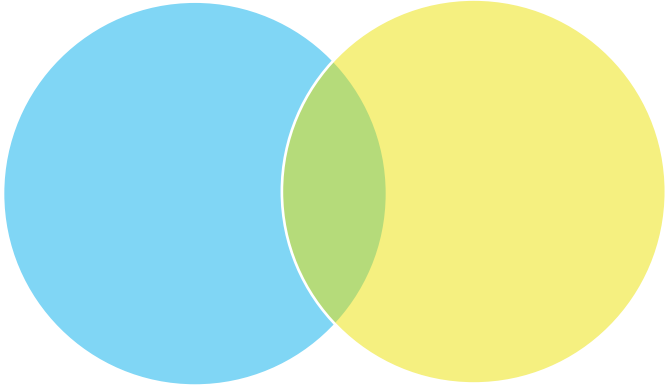
Integration Models

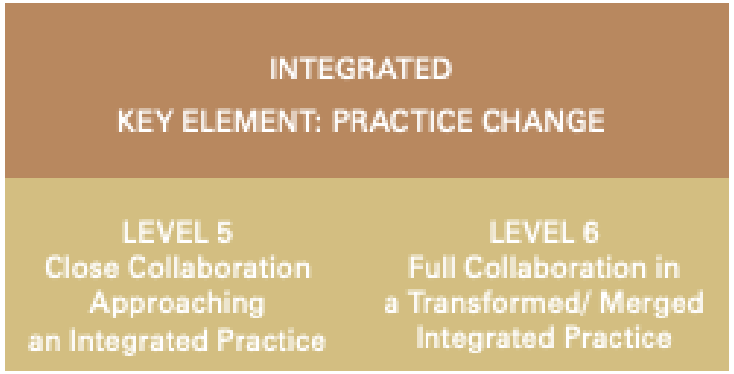
CoCM and PCBH

"The Integrated Care Tree of Models & Clinical Pathways Rooted In Perspectives"



PCBH and CoCM both





Both models offer:

- Interdisciplinary ***team-based care***
- ***Stigma reduction*** in community settings
- Reimbursement codes ***supporting financial sustainability***
- Proven ***long-term cost-savings***
- ***Evidence-based measures*** for treatment planning
- Demonstrated ***very high provider satisfaction***
- Real-time ***availability of behavioral health providers***
- ***Brief interventions for low- to moderate-acuity presentations:*** Both models employ brief interventions to address low- to moderate-acuity cases, preventing unnecessary referrals to overloaded community pathways

Primary Care Behavioral Health (PCBH) Overview

A team-based approach to managing biopsychosocial issues that present in primary care, with the over-arching goal of improving patient functioning

Key components include:

- Adds a Behavioral Health Consultant (BHC) to the team
- Helps identify and remediate medical problems
- Targets the entire clinic/practice population
- Uses traditional CPT codes & General BHI code
- Warm hand-offs to BHC
- Evidence-based behavioral health treatments
- Targeted treatment

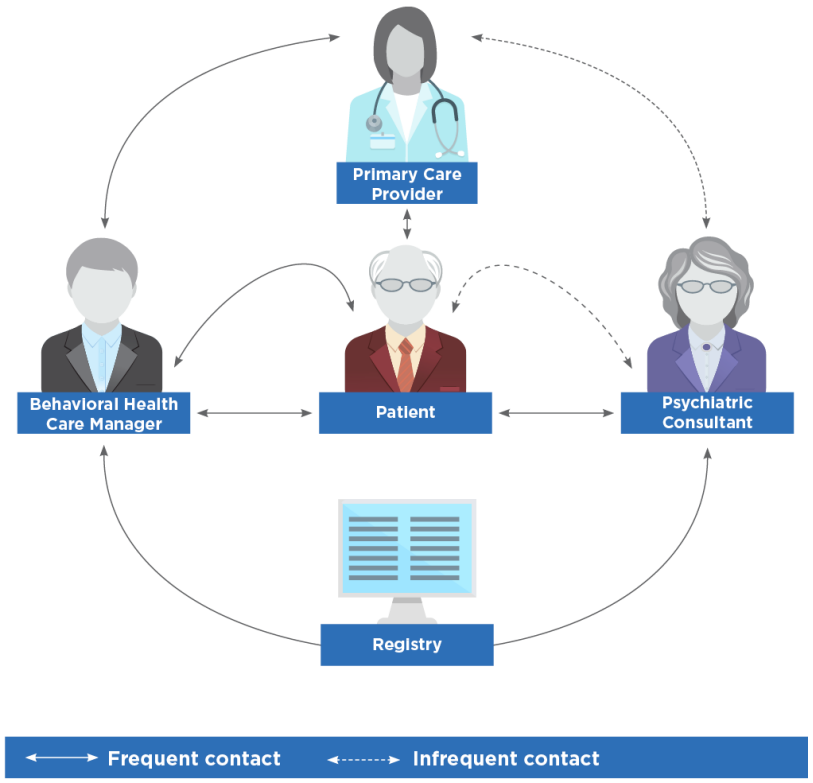
Reiter, J.T., Dobmeyer, A.C. & Hunter, C.L. The Primary Care Behavioral Health (PCBH) Model: An Overview and Operational Definition. *J Clin Psychol Med Settings* **25**, 109–126 (2018). https://doi.org/10.1007/s10880-017-9531-x

Collaborative Care Model (CoCM) Overview

A population health, treatment-to-target model of care that seeks to impact clinical outcomes of patients with depression and anxiety in primary care.

Key components include:

- Adds a Psychiatric Consultant & Behavioral Health Care Manager (BHCM) to the team
- Targets a specific patient population
- Designated CoCM CPT codes
- Patient registry for patient tracking, follow-up and monitoring
- Measurement-Based Care
- Treatment: average 3-12 months



https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/learn

https://micmt-cares.org/collaborative-care-model-cocm-3#:~:text=CoCM%20is%20a%20population%20health,(Systematic%20Case%20Review%20Tool)

CoCM and PCBH Comparison

Clinical / Care Model: Clinical Approach

Workforce: Care Team Members

Health IT: Data/Registry

Financing: Billing/Coding

Sustainability: ROI
see Appendix

- Information on following slides is relevant for organizations in **California**
- Details on slides provided for **reference**; can be covered in Improvement Advising meeting

Clinical / Care Model: Clinical Approach

	Collaborative Care Model (CoCM)	Primary Care Behavioral Health (PCBH)
Overview	• A **protocol-driven** package of behavioral health services provided by a team, including a psychiatric consultant and Behavioral Health Care Manger, chiefly to support primary care providers in the **prescribing of psychotropic medications** for high impact conditions.	• This model is **population based** and includes a licensed behavioral health professional who functions as a Behavioral Health Consultant (BHC) and is a **core member of the primary care team.**
Population	• Treat to target model – focuses on **specific population (mild to moderate depression) – using registry** • The collaborative care model focuses on defined patient populations tracked in a **registry, measurement-based practice and treatment to target.**	• Applied **across the primary care population** for any behaviorally influenced concern • Behavioral health providers offer **health behavior, mental health, and substance misuse interventions to identified patients.**
Treatment/ Interventions	• **Average "episode of care" around 6 months** • Initial assessment followed by brief visits, focus on symptom alleviation	• No defined "episode of care" • **Brief visits, focus on immediate concern of PCP or patient** • Functional and/or contextual assessment
Both Models	• Evidence based models • Proven to increase provider satisfaction, aka reduce "provider burnout"	

Source: Blount, A. (1998). Introduction to integrated primary care. *Integrated primary care: The future of medical and mental health collaboration,* 1-43.

Workforce: Care Team Members

	Collaborative Care Model (CoCM)	Primary Care Behavioral Health (PCBH)
Care Team Members	• Enhances usual primary care by adding two key services to the primary care team, particularly patients with **depression and anxiety**, whose conditions are not improving. • A team of three individuals deliver CoCM services: t**he Behavioral Health Care Manager, the Psychiatric Consultant** and the Treating (Billing) Practitioner	• Mental health provider who provide treatment for a **wide variety of mental health**, psychosocial, motivational and medical concerns, including management of anxiety, depression, substance abuse, smoking cessation, sleep hygiene, and diabetes among others. • **BHC roles acts as a consultant for PCP/MAs & other team members.** "The care team is your first customer."
Licensure	• Master's or Bachelor's level	• LPCC (APCC), LCSW (AMSW), LMFT (AMFT), PhD, PsyD
Other requirements	• Requires psychiatrist access	
Collaboration	• Can lend itself to virtual integration (telehealth)	• Most successful onsite, physically integrated in the office.
Both models:	• Both roles require BH provider to be an **advocate for the patient** and collaborate with PCP and care team.	

Health IT: Data/Registry

	Collaborative Care Model (CoCM)	Primary Care Behavioral Health (PCBH)
Overview	• **Requires population management via registry-** focused on treating a specific population, primarily depression and anxiety	• **Behavioral health SOAP (Subjective, Objective, Assessment and Plan) notes charted to EHR**
Registry	• Required maintenance of **registry to monitor progression** and provide "treat to target" care. • Ensure no one "falls through the cracks"	• **Standard use of EHR** for patient conditions / outreach
Both models:	• **Shared health records** and access for entire care team needed • Treatment note access does not require "breaking the glass"	

Financing: Billing/Coding

	Collaborative Care Model (CoCM)	Primary Care Behavioral Health (PCBH)

Overview	***Billing under Primary Care Provider***
	
	• CoCM specific CPT codes
	  • 99492 – Initial month of service
	  • 99493 – Subsequent months of service
	  • 99494 – add-on codes
	  • G0512* - FQHC, initial and subsequent
	
	• General Behavioral Health Code
	  • 99484
		Billing under Behavioral Health Provider
		
		• Traditional Psychotherapy CPT Codes
		  • 90832 – 30 min
		  • 90834 – 45 min
		  • 90837 – 60 min
		
		• Health and Behavior Codes
		  • 96156- Assessment
		  • 96158- Intervention, individual
		  • 96164- Intervention, group
		
		• General Behavioral Health code
		  • 99484

Both models:	• Check for differences with payors and FQHCs	

Implementation Decision Points

	Collaborative Care Model (CoCM)	Primary Care Behavioral Health (PCBH)
Requirements	• Need for a **psychiatric consultant** • Creation of patient **registry** • Time tracking	• Need for licensed **BH clinicians** • **Physical space** in the office to support collaboration
Both models:	How you will address common barriers to successful integration: • Incorporating **training** across disciplines • Panning for staff **turnover** • Gaining "**buy-in**" from patients, staff, providers or management • Communication and fostering **collaboration** • Changing **stigmatizing, preconceived or outdated attitudes** about treatment	

Quiz Time! Which Model is This?

1. Requires psychiatrist as part of care team and registry
   Answer: CoCM
2. Involves culture change
   Answer: Both
3. Provides care to entire clinic population
   Answer: PCBH

Q&A Session

- Which of these models helps patients reach stable PHQ9/GAD7 sooner or more often?
  - Collaborative Care (CoCM) is a targeted approach that aims to decrease scores on screening tools. Interventions are adjusted based on these scores.
  - The goal is for patients to achieve remission (>5) upon completing the program.
  - Primary Care Behavioral Health (PCBH) addresses depression and anxiety and the behavioral and cognitive beliefs that help to maintain them as well. A robust screening and follow-up process is not excluded from the model.
- Which one has increased staff and patient satisfaction?
  - Both programs have demonstrated increased staff and patient satisfaction.
- How is success measured in the PCBH model?
  - PCBH also utilizes PHQ-9 and GAD7, but may not have follow-up scores as consistently as patients often get what they need in one visit.
  - Success is measured through various indicators, such as the number of referrals, tracking the reasons for referrals (depression, anxiety, chronic disease), provider and patient satisfaction, and quality of life indicators (e.g. PROMIS, Duke).
- For patients who have issues with technology or who have issues with access (e.g, senior patients), what would you recommend regarding the population?
  - Both models can work. Telehealth or remote teams don't always require video technology, as access can be improved through telephone contact.
  - For CoCM or PCBH, a hybrid approach is suggested, with in-person warm handoffs and follow-ups conducted over phone or screen.
  - If technology barriers arise, using the phone is a suitable alternative.

Q&A Session

- What is the goal PHQ9/GAD7 score?
  - Initial scores are meant to identify patients who may benefit from support (in either model).
  - For CoCM, a score of <10 indicates the need for the service. Patients are monitored to ensure scores decrease, with screening tools readministered at least monthly during enrollment. If scores remain stagnant, a discussion with the patient and provider about medications and other interventions is necessary.
  - For PCBH, PHQ/GAD7 scores are also used to identify patients and inform treatment options. However, the goal is to improve functioning so measures of patient functioning are also used.
- When BH billing is discussed with medical group staff, often the response is "we don't bill BH, we only bill medical benefits" how does this work?
  - Teams will need to learn new processes.
  - CoCM is billed "incident to" the primary care physician.
  - PCBH is billed under the BH provider and requires paneling.
  - Billing staff will need to be educated, and documentation standards must be updated.
- What is the role of the consulting psychiatrist in the PCBH model?
  - There is no specific role for a psych consult in PCBH. This can be added on as needed under new consulting code.
- For the CoCM model, do you help us find that psychiatrist partner or is that up to find to reach out to other organizations for find that resource?
  - The CalHIVE BHI Collaborative does not support recruitment/hiring for this role but can offer guidance on the hiring process.
  - It's important to note that the psychiatric consultant role doesn't have to be full-time and existing staff can fill the role.
- Regarding the PHQ9 and GAD7, what is the typical score that would warrant a referral to the BHI team?
  - Specifically, for CoCM, score is 10 or higher on PHQ-9 or GAD-7, indicating mild-to-moderate symptoms of depression or anxiety.
  - If there are any other concerns, but the score is low, a referral may still be warranted.

Q&A Session

- If CoCM is limited to utilizing PHQ9/GAD-7, how are patients that have different language needs/learning differences provided with services?
  - Both the PHQ-9 and GAD-7 have been translated into several languages.
  - Additionally, it is important to note that a BHI provider could utilize the screening tool in a conversational way with the patient to gather pertinent information for patients that may be resistant or have other limitations.
- What are the visit ranges for PCBH (if any)? we've historically functioned with 6-8 and have seen numbers as low as 4 and high as 10.
  - The number of visits varies for each patient in PCBH. Providers may have an initial conversation with the patient in January and then have a brief touchpoint in a March follow-up visit, demonstrating collaboration between primary care and behavioral health.
  - The frequency of touch points can range from only one visit to several, depending on the patient's needs.
  - Typically after 4-6 visits, if patients are not improving, they may need a higher or different level of care. PCBH is solution focused, brief treatment. Patients needing or wanting longer term traditional psychotherapy would be referred to a community provider.
  - Since PCBH mimics the long term relationship of primary care, a patient may present in January with one concern (e.g. care giver burnout) and return six months later with a different presenting need (e.g. grief).
- With PCBH are there holds on the schedule for warm hand off's?
  - Typically, the PCBH schedule allows time for warm handoffs. At least 6 warm handoffs should be accommodated each day, with 3 in the morning and 3 in the afternoon. Additionally, 2-4 scheduled follow-ups should be included.
  - BHCs review schedules in the morning to identify patients who can benefit from services.

Selecting a Model
BHI Implementation Plan

Well, what do we do next?

Each team will complete a BHI Implementation Plan to:

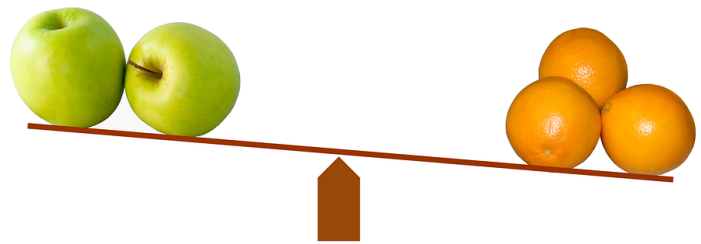
- Guide the decision-making process to select an appropriate Behavioral Health Integration model
- Create a clear plan for implementation at the pilot site

Timeline:

- ❑ August: Review and work on BHI Implementation Plan in Improvement Advising Meeting
- ❑ Fri. September 1st : Pre-Work due (Questions 1-4)
- ❑ Tues. September 12th: Team worktime at CalHIVE BHI Convening
- ❑ Fri. September 29th: BHI Implementation Plan – Integration Model due

Reflection Time

My *a-ha* about integration models is…



Q3 2023 Sprint: Integration Model

JULY

Improvement Advising
- Complete Implementation Milestone Assessment Tool, Needs Discussion, establish regular meetings

Tues. 7/11 (11-12)
CalHIVE BHI Commons – July Kickoff Webinar
- Review CalHIVE program; welcome PO teams

Friday, July 21 – Enrollment File Submission Deadline

Friday, July 28 – Measurement File Submission Deadline

Improvement Advising
Webinars
In Person Events
Data / Reporting
Assignments

AUGUST

Improvement Advising
- Review IMAT and Needs Discussion Results

Tues. 8/8 (11-12)
CalHIVE BHI Commons – Integration Concepts and Models (Part 1)
- Review BHI models; understand how to select one

Tues. 8/22 (11-12)
CalHIVE BHI Commons – Implementation & Staffing (Part 2)
- Identify BH roles & relationship to models

Tues. 8/29(11-11:30)
[OPT] Webinar - Convening Preparation
- Prepare for Sept. 12 convening

SEPTEMBER

Improvement Advising
- Document BHI model (via Implementation Plan); discuss possible pilot site

Tues. 9/12 – S. CA
CalHIVE Annual Convening: Connect, Create & Commit
- Connect with teams & cohort, work on integration model

Thurs. 9/21 (11-12)
Test 2 Data Cycle Webinar

Thurs. 9/28 (1-2)
[OPT] BeeKeeper's Corner - Staffing
- Access tools for staffing, hiring and recruitment

By. Fri. 9/29
BHI Implementation Plan – Integration Model
- Complete Implementation Model determining integration model, including staff

Feedback please!

1. Today's webinar was useful for me and my work *[select one]*
   - Strongly agree
   - Agree
   - Neither agree nor disagree
   - Disagree
   - Strongly disagree

2. Of the topics we covered today, what was especially helpful? *[select multiple]*
   - Understand the key differences between models for integrating behavioral health into primary care
   - Explore local factors to support selecting an integration model
   - Review next steps for selecting an integration model

CalHIVE BHI Network Convening – September 12

Connect, Create & Commit

Teams will deepen relationships with their team and cohort, work on the organization's BHI integration model and develop a vision statement for BHI.

See you there!

- **When?** Tuesday, September 12
- **Where?** The Westgate Hotel, San Diego, CA
- **Who's invited?** Up to seven members of your CalHIVE BHI team is encouraged to come!
- **Cost?** Free to attend

Program Advisor

Peter Robertson
Senior Director,
Practice Transformation

probertson@pbgh.org

Clinical Advisor

Julie Geiler
CFHA Technical
Assistance Associate &
Policy Coordinator

jgeiler@cfha.net

Data Reporting

Jose Ordonez
Manager,
Data Analytics

jordonez@pbgh.org

Improvement Advisors

Kristina Mody
CalHIVE BHI Director
Associate Director,
Practice Transformation

kmody@pbgh.org

Daniela Vela Hernandez
CFHA Technical
Assistance Associate

dvhernandez@cfha.net

Felicia Skaggs
Senior Manager,
Behavioral Health
Integration

fskaggs@pbgh.org

Program Administration

Michael Au
Senior Manager,
Care Transformation

mau@pbgh.org

Anna Baer
Program Coordinator,
Care Transformation

abaer@pbgh.org

Erika Lind
Manager,
Care Transformation
Events and Learning

elind@pbgh.org

California Quality Collaborative

Appendix

Sustainability / Return On Investment (ROI)

	Collaborative Care Model (CoCM)	Primary Care Behavioral Health (PCBH)

Research Examples	• Over 85 publications
	• **IMPACT model:** 4 years depression, older population $840 savings PMPY
	  • 3363 4 years cost savings (not net savings) n=279
	• University of Washington
	  • Foundational Evidence Base
	• Data from the SUMMIT clinical trial found the costs of Collaborative Care are likely to be offset by savings if 25% of patients with opioid use disorder (one of the target conditions in the clinical trial) receive treatment in a panel size of about 85, while achieving better patient outcomes.
		• A 2022 study of PCBH implementation at URMC shows that for nearly 7,000 adults with at least one behavioral health diagnosis, rates of all-cause **emergency department visits decreased by 14.2% after PCBH implementation**
		• Population NET Savings in Alternative Payment Models:
		• Intermountain Integrated Care
		  • 113,000 patients average NET savings $105 PMPY For the population, not just the patients served. 11% fewer admissions, 23% fewer ER.
		• Colorado
		  • 6 practices, primary care 9,000 patients, NET savings $95 PMPY for the entire population, reduction in ER.
		• Cherokee Health System TN
		  • 70,000 patients high need. 28% reduction in total NET cost.

Both models:	• The plan is long-term to see savings	

CIHS Framework

- This integration framework proposes six levels of collaboration/integration. While the overarching framework has three main categories — coordinated, co-located, and integrated care — there are two levels of degree within each category.
- It is designed to help organizations implementing integration to evaluate their degree of integration across several levels and to determine what next steps they may want to take to enhance their integration initiatives.

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

https://thepcc.org/sites/default/files/resources/SAMHSA-HRSA%202013%20Framework%20for%20Levels%20of%20Integrated%20Healthcare.pdf

Resources

1. SAMHSA's "Integrated Care Models: An Overview" (https://www.integration.samhsa.gov/clinical-practice/integrated-care-models) provides an overview of different models of integrated care and their key components.
2. The "Collaborative Care Model" (https://aims.uw.edu/collaborative-care-model) developed by the University of Washington's Advancing Integrated Mental Health Solutions (AIMS) Center provides detailed information on how to implement this model, including care team composition, treatment protocols, and billing and reimbursement considerations.
3. The "Primary Care Behavioral Health (PCBH) Model" (https://www.apa.org/pi/about/publications/caregivers/practice-settings/primary-care/behavioral-health) developed by the American Psychological Association (APA) provides guidance on how to integrate behavioral health services into primary care settings. The handout could include a summary of the key components of the model, such as the importance of communication and collaboration between primary care and behavioral health providers, use of brief interventions and assessment tools, and development of a stepped care approach.
4. The "Behavioral Health Integration Implementation Guide" (https://www.pcpcc.org/resource/behavioral-health-integration-implementation-guide) developed by the Patient-Centered Primary Care Collaborative (PCPCC) provides a step-by-step guide for implementing an integrated care model in a primary care setting, including guidance on financing and reimbursement, developing a care team, and using data to monitor and improve outcomes.
5. The "Behavioral Health Integration Toolkit" (https://www.aafp.org/patient-care/public-health/social-determinants-of-health/behavioral-health-toolkit.html) developed by the American Academy of Family Physicians (AAFP) provides a comprehensive toolkit for primary care providers looking to integrate behavioral health services into their practice. The toolkit includes assessment tools, treatment protocols, and resources for patient education and engagement.

Resources: Provider Satisfaction

Patients in integrated primary care behavioral health settings have reported high levels (e.g., 97%) of satisfaction and increased functioning

- Angantyr, 2015; https://doi.org/10.2224/sbp.2015.43.2.287
- Runyan, 2004; https://doi.org/10.1089/109350703322425527

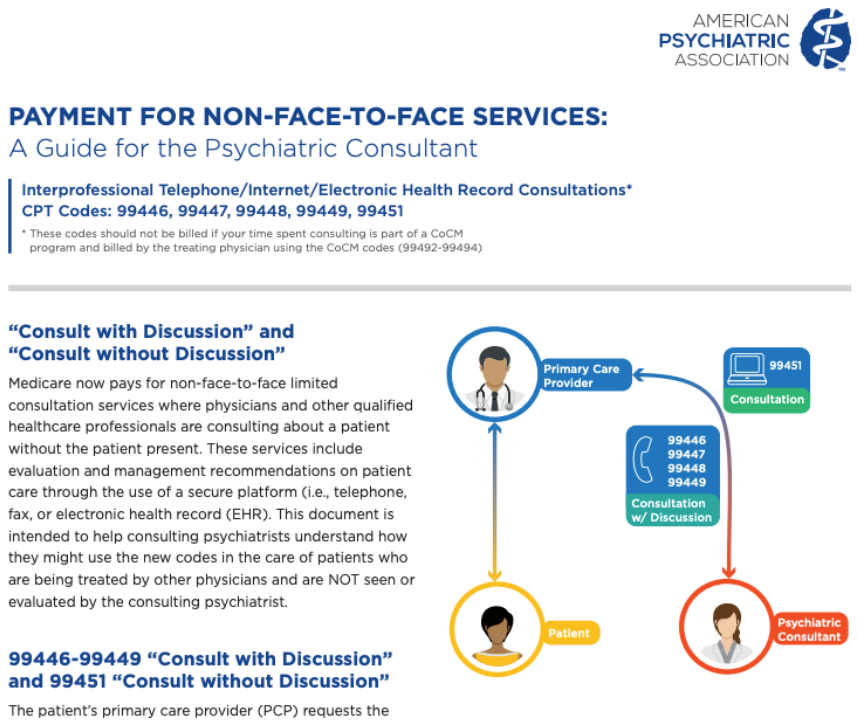
Team-based primary care-behavioral health care has also been shown to improve provider satisfaction and decrease provider burn-out

- Blount, 2003; 10.1037/1091-7527.21.2.121

From: Thenationalcouncil.org

New Psychiatric Consultation Codes

Medicare now pays for non-face-to-face interprofessional “curbside” consultations by psychiatrists with primary care and other physicians.



AMERICAN PSYCHIATRIC ASSOCIATION

PAYMENT FOR NON-FACE-TO-FACE SERVICES:
A Guide for the Psychiatric Consultant

Interprofessional Telephone/Internet/Electronic Health Record Consultations*
CPT Codes: 99446, 99447, 99448, 99449, 99451

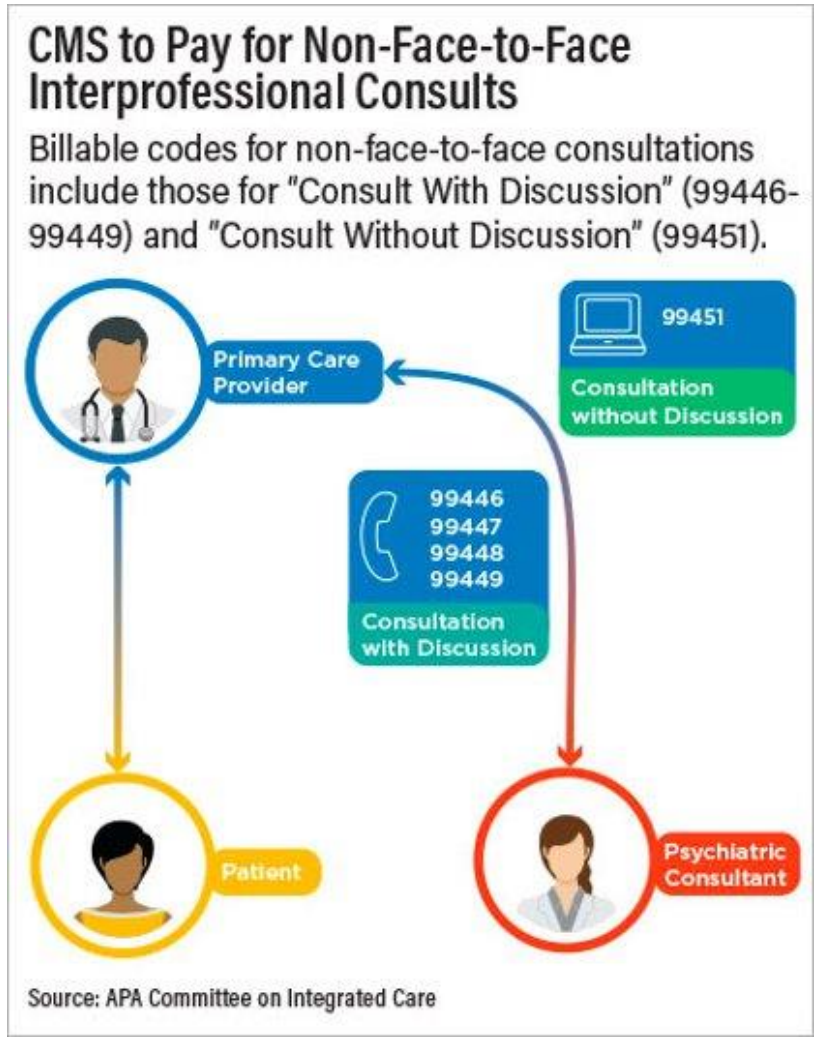
* These codes should not be billed if your time spent consulting is part of a CoCM program and billed by the treating physician using the CoCM codes (99492-99494)

“Consult with Discussion” and “Consult without Discussion”

Medicare now pays for non-face-to-face limited consultation services where physicians and other qualified healthcare professionals are consulting about a patient without the patient present. These services include evaluation and management recommendations on patient care through the use of a secure platform (i.e., telephone, fax, or electronic health record (EHR). This document is intended to help consulting psychiatrists understand how they might use the new codes in the care of patients who are being treated by other physicians and are NOT seen or evaluated by the consulting psychiatrist.

99446-99449 “Consult with Discussion” and 99451 “Consult without Discussion”

The patient’s primary care provider (PCP) requests the



https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Practice-Management/Coding-Reimbursement-Medicare-Medicaid/Coding-Reimbursement/APA-Billing-Guide-Interprofessional-Health-Record-Consultations-Codes.pdf