Sustaining behavioral health care in your practice

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WEBINAR FAQ

Assembling the BHI care team: Roles and responsibilities

QUESTIONS ADDRESSED BY SARAH COLES, MD

Do you have any comments on how addressing social needs (SDOH) like financial stress, housing etc. affects your behavioral health outcomes?

Undoubtedly, social determinants of health (SDOH) impact behavioral health and physical health outcomes. We have implemented universal screening for SDOH and have also included that as a part of our standard workflow for intake into our Collaborative Care program. If identified, our care manager will connect patients to resources immediately and/or connect them with our social worker. I suggest looking at the AAFP EveryONE project for screening resources and implementation tools. Websites like findhelp.org and the helpline 211 can also be used to identify community resources for patients.

Does your practice include spiritual assessments (FICA, HOPE, etc.), and does it affect your patient outcomes? A recent article suggests that treatment resistant patients are "stuck" because they lack hope or believe they deserve their lot.

We do not have a specific spiritual assessment that we use but often spiritual needs are uncovered in our assessments and addressed.

Can you speak to how BH outcomes may be reflected in evaluation of your clinicians? (Are they measured on BH outcomes?) Most models count RVU, costs, any standard "quality" measurements.

We use depression screening rates and depression remission at 12 months as quality metrics in our practice. These are commonly used quality measurements.

Can you speak to what EMR vendor seems well suited to this level of integration? Are you all doing any advocacy to improve the EMR/interoperability for these collaborations?

EMR interoperability is a big challenge. I know that the American Medical Association and AAFP (amongst many other organizations!) are advocating to improve interoperability. Some EMRs have capabilities built in to facilitate these types of collaborations for documentation, communication, and billing/coding. I suggest reaching out to your EMR vendor to find out what services they currently offer. Resources, including a sample registry and documentation best practices, can be found at the University of Washington AIMS Center (aims.uw.edu).

Does a full-time LCSW generate enough revenue to justify their salary plus overhead?

I wish this could be a more straight forward answer, but unfortunately, it really depends. Your billing model and payer mix make a big difference—for example, in some states, like Michigan, Medicaid previously did not accept the bundled service codes used for the Collaborative Care Model (CoCM). At that time, it made more sense for our organization to seek grant funding to cover a portion of services, or to have one of our behavioral health therapists conduct a 30-minute virtual therapy appointment in lieu of a 15-minute check-in.

Some of the resources provided in our presentation, like the AIMS Center, offer very robust tools and support for billing questions, and can help an organization create a billing strategy for CoCM.

Do they have a higher payor mix that includes Medicaid compared to a standard practice?

Our current practice (Corner Health Center-Michigan) is about 65% Medicaid. We are fortunate to be able to take advantage of some incentive programs through private insurance that give us a pay differential for having Collaborative Care Model (CoCM) services on board at our practice. We also leverage other opportunities at our non-profit, including practice agreements with local hospitals and partner organizations, making use of interns, medical residents, and so on.

Are there hidden requirements for a practice employing an LCSW, such as unexpected malpractice costs, psychiatry collaboration?

Great question. This varies a bit, state-to-state. Like any other practitioner in your practice, LCSW/LMSWs can generally be added to your group malpractice for liability coverage. You'll want to specify that they are doing mental health work or therapy in case a rider is needed. The process of credentialing, accessing an NPI, being added to CAQH, monthly billing and so on, should fold in with your existing credentialing and billing costs. Supervision of LSW or LLMSWs is only required until they are licensed to practice independently. LCSWs are licensed at the state level and need to renew their licensure, meet continuing education requirements and so on, in compliance with your state standards. Those costs may be worth consideration if that is something you offer to your other clinical staff.

Having a strategy in place to cover the cost of the psychiatric practitioner is advised. Some practices split the psychiatrist's time between direct practice and Collaborative Care (CoCM) consulting, in order to create adequate revenue to cover the cost of consulting. Others partner with local hospitals for charitable hours, or with colleges of medicine to create learning opportunities for psychiatry residents.

How separated does the EMR need to be for psychology (HIPPA)? Can they document under the same tablespace if they are an employee of ours, even if he is seeing patients referred to him from other PCPs?

Short answer: Separation is not necessary, HOWEVER, they become your clients once they are entered into your practice's EMR. I'd strongly recommend running this by your liability insurer if you have any doubts.

If you wish to keep another PCP's clientele separate, the mental health practitioner should be documenting in *their* EMR, not yours (not to mention credentialed with their practice, covered by their malpractice, etc.).

If the psychiatric consultant is independent, and is contracting with multiple services for Collaborative Care (CoCM), they should be keeping records for each client in the client's corresponding PCP's EMR.

Longer answer: For an integrated practice—as in, everyone is employed by the same group—it is a perfectly reasonable strategy to allow your mental health practitioners and psychiatrists access to the same EMR you use and utilize it for documentation of their services. My current practice uses an EMR called Athena, and all clinicians have access. We separate services by department, so we can change department view in order to review encounters with the psychiatry department, primary care department, etc. This is achievable with most EMRs, Epic, etc.

One practice I worked with made a conscious decision to partition mental health care away from primary care, because they were concerned about privacy considerations, and that had benefits (security) and drawbacks (challenges with portability, duplication of client records). Another service I worked for had everything fully integrated, and that had different benefits (ease of coordination, everyone on the team being 'in the loop') and drawbacks (more encounters to comb through when looking at client records, issues with billing multiple services from the same point of service on the same day). Minimally, I would encourage you to provide consultants with access to full records for the client upon whom they are consulting. They need access to the same client history (medication allergies, med lists) that primary care does in order to serve the client effectively. Updates to the HIPAA policy (or a CoCM specific program agreement) may be in order, to ensure that clients know that a psychiatric consultant may access their data.