quality impact
THE COSEHC™ PRACTICE TRANSFORMATION NETWORK
Improving Care Delivery Across the Southeast

Getting Started Guide:

Behavioral Health Management

OBJECTIVE: The Behavioral Health Management Getting Started Guide is a resource to support systems and practices develop effective and efficient processes around behavioral health management, especially with respect to patient identification, risk stratification, treatment, referrals, and quality-based billing.

OVERVIEW

GOALS OF IMPLEMENTING BEHAVIORAL HEALTH MANAGEMENT IN PRIMARY CARE

- Improve patient access to behavioral health providers/decrease in appointment wait time
- Improve patient care quality and continuity
  - Increase use of Patient Health Questionnaire components PHQ-2 and PHQ-9, and of the Generalized Anxiety Disorder 7-item (GAD-7) scale
  - Increase staff satisfaction & retention and increase provider engagement
- Improve care for chronic illness by incorporating behavioral health measures in care standards
- Increase support for primary care physicians (PCPs) by expanding community connections
- Increase billing for behavioral health services
- Improve Healthcare Effectiveness Data and Information Set (HEDIS) mental health measures

BEHAVIORAL HEALTHCARE MODELS

Traditional	▪ Patients are identified and diagnosed concurrently or retrospectively based on presenting symptoms and are treated dominantly for depression, anxiety, and/or bipolar disorder in a primary care setting ▪ Patients whose symptoms do not respond to primary care treatment are referred to a psychiatrist for medication management and to a therapist for counseling ▪ Patients are typically stable, with possible chronic-illness overlay. If a patient becomes dangerous to themselves or to others, they may be taken to an emergency room (ER) for evaluation and hospitalization until stabilized
Consultative/ Referral	▪ Primary care providers reach out to behavioral health specialists (e.g., licensed clinical social workers [LCSWs], psychiatrists) for assistance with patient medication management or for adjunct counseling ▪ Telephonic or e-visits can facilitate the patient-PCP consultations ▪ Again, patients typically are stable with possible chronic-illness overlay
Integrated	▪ The referring physician seeks out additional, on-site specialty services for the patient ▪ This co-location of providers enhances access and improves data-sharing and care continuity ▪ A psychiatrist and care manager may support PCPs and streamline referrals by proactively identifying at-risk populations based on electronic medical record (EMR) data
Collaborative Care	▪ A multidisciplinary approach to the holistic care of patients experiencing chronic illness with an underlying behavioral health diagnoses ▪ Patients with depression and/or anxiety who also have diabetes, chronic obstructive pulmonary disease (COPD), heart failure (HF) or other chronic conditions who are cared for in the primary care setting by a multispecialty team including a PCP/internist, an imbedded behavioral health case manager, a virtual psychiatrist, and other team members as needed
Community	▪ Patients with severe and persistent mental illness (SPMI) may be placed in halfway homes, partial hospitalization programs, and/or structured programs within a community mental health center ▪ These patients require intensive monitoring (specialized outreach), medication management, and crisis intervention
Institutional	▪ Patients with severe mental illness may be institutionalized in short- and long-term inpatient psychiatric settings ▪ Severely-ill patients may require intensive inpatient care coordination, as well as targeted follow-up by a behavioral health specialist or counselor to prevent continued psychotic/self-harm behaviors

AREAS OF CONSIDERATION

BEHAVIORAL HEALTHCARE MODELS

Review the system or practice's budget and determine whether funds exist for a behavioral health services infrastructure. Establish whether software changes are needed to support documentation or data reports informing decision making. Review any existing contracts with behavioral health providers (e.g., psychiatrist, LCSW), as well as the availability and cost of securing these providers. Review and evaluate the system or practice's current behavioral health services billing processes and coding requirements. Identify any potential revenue opportunities that can be leveraged. (Appendix A)

PAYER PAYMENT MODELS

Review and understand payer payment models and government regulations specific to behavioral health. Calculate the percentage of your system or practice's patient population covered by Medicare and Medicaid. Identify whether behavioral health carve-out financing models have specific requirements. Review Medicare's billing requirements and its guidelines for care management services within a collaborative care model. (Appendix B)

PARTCIPATION IN A HEALTHCARE NETWORK

Discuss whether your healthcare network's behavioral health providers have the capacity to meet the needs of your patient population. Identify additional healthcare services that exist within the community; collaborating with these services can improve access, quality, and care continuity.

LEADERSHIP

Determine whether your system or practice's clinical and medical leadership has a comprehensive understanding of the behavioral health services available within the network. Determine whether phased education and training is needed for staff, as well as whether clinicians have been allocated appropriate space. A skilled practice staff is essential to successfully identify, refer, and treat a behavioral health population. Patients with a behavioral health diagnosis may exhibit intrusive, self-destructive, violent, or suicidal tendencies, and the system or practice should have appropriate safety and security policies in place.

COMPETING PRIORITIES

As behavioral health patients may require additional staff time and attention, consider the treatment needs of behavioral health patients alongside daily operations, patient volume, and patient turn-around time. Address any concerns around appropriate space allocation for behavioral healthcare providers and care managers.

ASSESS CURRENT STATE

PATIENT POPULATION

Know your practice or system's behavioral health demand. Build out the capacity and establish the protocol to electronically capture behavioral health diagnoses, medications, and PHQ-9 scores. If you already use patient registries, you may be able to amend an existing registry to use for behavioral health patients; if you do not already use a registry then use an existing report of behavioral health encounter visits. Determine the number of patients in your system or practice with comorbid chronic and behavioral conditions. Determine the number of patients in your system or practice with a PHQ-9 >9.

EXPERTISE

Assess your system or practice's staff and clinician understanding of behavioral health (i.e., ability to define 'behavioral health', including mental health and substance abuse; to identify populations at risk; and to name common screening tools, diagnoses, and treatments/medications). Identify your system or practice's staff makeup in terms of staffing specialists. Consider what your staffing availability is with respect to doctors, certified medical assistants, advanced practice providers, registered nurses, and case managers. Consider whether social workers are a part of your core team. Consider whether you have staff dedicated to contacting complex patients for monitoring/follow-up. Consider whether any members of your staff are trained in motivational interviewing. Consider whether the organizational chart for your system or practice is clear and well-understood by everyone on the care team. Determine who administers the PHQ-9 questionnaire, and if/when a reassessment will be done.

PROVIDERS

Consider whether your system or practice retains or contracts psychiatrists and other psychological providers. Determine the wait time from referral to a behavioral health provider to seeing the specialist. Determine whether your system or practice has real-time, around-the-clock access to behavioral health providers for patients in crisis. Consider when and where medical assistants at your system or practice perform screenings (i.e., before or after seeing provider).

INFRASTRUCTURE

Assess whether behavioral health management is part of your system or practice's strategic plan and whether you have physician champion. Assess whether formal protocols have been established around behavioral health screenings by population age and type. Assess whether your staff feels safe around behavioral health patients.

ANALYTICS AND METRICS

Determine whether your system or practice regularly collects and reports patient health-related goals (including self-reported goals) and status. Research your system or practice's contractual requirements for behavioral health carve-outs, benefits, and billing. Determine whether your analytics platform captures patient utilization and outcomes data. Assess whether patients at your system or practice are confident about self-care. (Appendix C)

BILLING

Determine which services your system or practice currently bills for (i.e., care management, group sessions, social work, psychiatric, case management, behavioral health screenings).

STEP-BY-STEP IMPLEMENTATION INSTRUCTIONS

1. DEVELOP YOUR POPULATION-BASED DATA CAPABILITIES

You may receive data from multiple sources, including your accountable care organization (ACO), EMR, hospital entities, third-party payers, third-party billing entities, and/or finance department.

- Determine how you will electronically capture the following data (both per-patient and in aggregate)
  - Diagnosis
  - Prescribed medications
  - Cost per patient
  - Quality metrics
  - Billing per screening
  - Billing per provider
  - Referrals per provider
  - Behavioral health patient volume per provider
  - Room turnaround time
  - Patient utilization

2. DEVELOP A PROCESS FOR PATIENT RISK STRATIFICATION

- Determine how you will identify chronic and behavioral health conditions as focus populations
- Identify patients at your system or practice with uncontrolled diabetes, HF, and COPD
- Identify your system or practice's behavioral health patients who have not had PHQ-2 or 9 assessments done within the last 6 months, and then further identify those patients who have not had PHQ-9 or GAD 7 assessments done within the last 90 days
- Create a screening plan for patients without a current PHQ-9/GAD 7
- Develop a billing protocol for PHQ-9/GAD 7 screening services that are in accordance with payer guidelines
- Establish a focus around severe depression, anxiety disorder, and bipolar disorder diagnoses
  - Determine what percentage of these patient populations has been admitted to the emergency department (ED) within the last 12 months
  - Prioritize follow-up and evaluation visits for patients with 3 or more admits within the last 12 months
- Determine how many patients with a behavioral health condition at your system or practice are currently seeing a behavioral health provider
- Determine how many patients with a behavioral health condition at your system or practice are currently being prescribed medication for their diagnosis

3. IDENTIFY AND SECURE APPROPRIATE CARE DELIVERY PROVIDERS

- Identify a behavioral health physician champion within your system or practice
- Determine your system or practice's current contractual arrangements with internal behavioral health providers and/or with providers belonging to external practices/organizations
- Assess the capacity of your system or practice's existing staff to accommodate increased patient calls, documentation, screenings, billing processes, and policy & procedure developments
- Identify community crisis teams that can be accessed as needed (e.g., crisis teams associated with the local police department)
- Evaluate whether opportunity exists for in-home monitoring of high-risk patients

4. ESTABLISH APPROPRIATE DIAGNOSTIC TOOLS AND PROTOCOLS

- Establish who will receive behavioral health screenings, as well as when and where these screenings will take place. Consider the following screenings:
  - PHQ-2 and PHQ-9
  - GAD 7
  - Alcohol Use Disorders Identification Test (AUDIT)
  - Drug Abuse Screening Test (DAST)
  - Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT)
  - Alcohol Smoking and Substance Involvement Screening Test (ASSIST)
- Detail screening processes, including timeframes, treatment referrals, and screening locations
- Administer pre-visit patient self-assessments electronically or by telephone

5. DEFINE STANDARDS OF CARE FOR BEHAVIORAL HEALTH POPULATIONS

- Revise/enhance your system or practice's confidentiality policy to include all elements of mental health provisions
- Develop policies/protocols to define which patients should be screened for behavioral health concerns, and include specifications around when, where, and how these screenings should take place
- Develop a protocol for responding to patients indicating or communicating suicidal intent. In the case of opioid use, refer to the appropriate state prescription drug monitoring program
- Educate primary care staff on best practice guidelines for treatment of anxiety disorders and major depression without psychosis
- Adopt and disseminate best-practice guidelines for behavior intervention and patient follow-up
- Create behavioral health referral and communication forms as appropriate (Appendix D)

RESOURCES:

+ American Psychological Association (APA)
+ American Academy of Family Physicians (AAFP)
+ Substance Abuse and Mental Health Services Administration (SAMHSA)
+ Centers for Disease Control and Prevention (CDC)

6. DEVELOP STAFF EDUCATION RESOURCES

- Provide regular behavioral health education with mandatory participation components to all staff members. Topics to address in educational initiatives include:
  - Suicidal ideation management
  - Crisis management
  - Using the PHQ-9 and GAD-7 as screening tools
  - Using the PHQ-9 for behavioral health monitoring, including how to monitor and timeframes for re-assessment, intervention, and follow-up
  - On-site staff and patient safety guidelines

7. MONITOR QUALITY, ACCOUNTABILITY, AND SUCCESS

- Identify the staff members responsible for data capture, as well as how and how often they will report information
- Develop staff awareness around the value of data and quality-outcomes measures
- Identify a clinical champion and use the Plan-Do-Study-Act (PDSA) worksheet tool to test and document change initiatives
- Review behavioral health population data around:
  - Acute care and ED utilization
  - Patient no-shows
  - Follow-up calls
  - Medication adherence
- Establish effective communication channels with behavioral health providers both internal and external to your system or practice to support referrals, care coordination, and data-sharing

ROLES & RESPONSIBILITIES GRID (APPENDIX E)

	Physicians/ Providers	Clerical Staff	MA/ Trained Coaches	RN/Care Manager	Social Worker
Behavioral Health Patient Identification					
Create patient identification reports		x			
Review patient-volume data	x	x			
Treatment and Referral					
Assess Behavioral Health and community offerings and availability			x	x	x
Conduct screenings (PHQ-2, PHQ-9)			x	x	x
Interpret screenings	x				
Monitor depression			x	x	x
Establish practice guidelines	x				
Identify need for referral	x		x	x	x
Provide a referral to a specialist	x				x
Manage referrals to ensure follow-up information is received			x	x	
Patient Management					
Participate in staff education initiatives	x	x	x	x	x
Develop suicidality intervention training and policy development	x	x	x	x	x
Complete billing	x			x	x
Complete follow-up calls			x	x	x
Complete follow-up to assess patient self-management capabilities			x	x	x
Provide educational materials and resources				x	
Follow up on patient medication adherence			x	x	

APPENDIX A

AIMS CENTER
UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

BASIC CODING FOR INTEGRATED BEHAVIORAL HEALTH CARE

Always check with your state and all payers to determine the necessary qualifications for the designated billing providers. Not all states or payers reimburse for every code.

Essential CPT Psychotherapy codes for the clinically licensed *Care Manager* 90791	Psychiatric evaluation without medical services
90832	16 – 37 minutes of individual counseling or family counseling (with or without patient)
90834	38 – 52 minutes of individual counseling or family counseling (with or without patient)
90837	53+ minutes of individual or family as above
90785	Psychotherapy Complex Interactive (list separately in addition to code for primary procedure)
90853	Group Therapy

APPENDIX B

Cheat Sheet on Medicare Payments for Behavioral Health Integration Services

Updated: February 7, 2018

Medicare pays for services provided to patients participating in a collaborative care program or receiving other behavioral health integration (BHI) services. The payment structure may be used for patients with any behavioral health condition being addressed by the treating provider, including substance use disorders.

The codes described below are not billable by Federally Qualified Health Centers or Rural Health Clinics. For information on BHI codes for FQHC and RHC practices; see http://aims.uw.edu/resource-library/cms-behavioral-health-integration-payment-cheat-sheet-fqhcs-and-rhcs.

Useful online resources describing the CMS Medicare codes include the following:

- *Fact Sheet*: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network- MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf
- *FAQ*: https://www.cms.gov/Medicare/Medicare-Fee-for-Service- Payment/PhysicianFeeSched/Downloads/Behavioral-Health-Integration-FAQs.pdf

The codes for the Collaborative Care Model (CoCM) are billed by the treating provider as "incident to" codes and incorporate the services of all three members of the collaborative care team: the treating provider, the behavioral health care manager, and the psychiatric consultant.

99492 (formerly G0502) – First 70 minutes in the first calendar month for behavioral health care manager activities, in consultation with a psychiatric consultant and directed by the treating provider. Must include:

- Outreach and engagement of patients;
- Initial assessment, including administration of validated scales and resulting in a treatment plan;
- Review by psychiatric consultant and modifications, if recommended;
- Entering patients into a registry and tracking patient follow-up and progress, and participation in weekly caseload review with psychiatric consultant; and
- Provision of brief interventions using evidence-based treatments such as behavioral activation, problem solving treatment, and other focused treatment activities.

99493 (formerly G0503) – First 60 minutes in a subsequent month for behavioral health care manager activities. Must include:

- Tracking patient follow-up and progress;
- Participation in weekly caseload review with psychiatric consultant;
- Ongoing collaboration and coordination with treating providers;
- Ongoing review by psychiatric consultant and modifications based on recommendations;
- Provision of brief interventions using evidence based treatments;
- Monitoring of patient outcomes using validated rating scales; and
- Relapse prevention planning and preparation for discharge from active treatment.

99494 (formerly G0504) – Each additional 30 minutes in a calendar month of behavioral health care manager activities listed above.
Listed separately and used in conjunction with 99492 and 99493. 2

Payment for General Behavioral Health Integration Services
CMS provides a separate payment for behavioral health integration services that are delivered outside of the CoCM benefit. A behavioral health care manager with formal or specialized education is not required. CMS rules allow "clinical staff" to provide these services using the same definition as applied under the Chronic Care Management benefit.

99484 (formerly G0507) – Care management services for behavioral health conditions - At least 20 minutes of clinical staff time per calendar month. Must include:

- Initial assessment or follow-up monitoring, including use of applicable validated rating scales;
- Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
- Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and
- Continuity of care with a designated member of the care team.

Medicare CPT Payment Summary 2018* CPT	Description	Payment/Pt (Non-Facilities) Primary Care Settings	Payment/Pt (Fac) Hospitals and Facilities
99492	Initial psych care mgmt, 70 min/month - CoCM	$161.28	$90.36
99493	Subsequent psych care mgmt, 60 min/month - CoCM	$128.88	$81.72
99494	Initial/subsequent psych care mgmt, additional 30 min CoCM	$66.60	$43.56
99484	Care mgmt. services, min 20 min – General BHI Services	$48.60	$32.76

A TOOL TO ASSESS HEALTH CONFIDENCE AND BEGIN ACTION

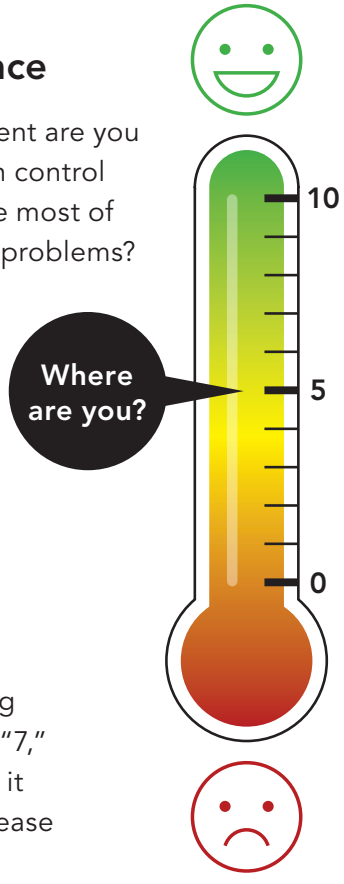
Note: A pdf of this tool can be downloaded from the online version of this article: http://www.aafp.org/fpm/2014/0900/p8.html. Additionally, an electronic version and pdf versions in several languages are available at http://www.healthconfidence.org.

MY HEALTH CONFIDENCE

What number best describes your:

Health confidence

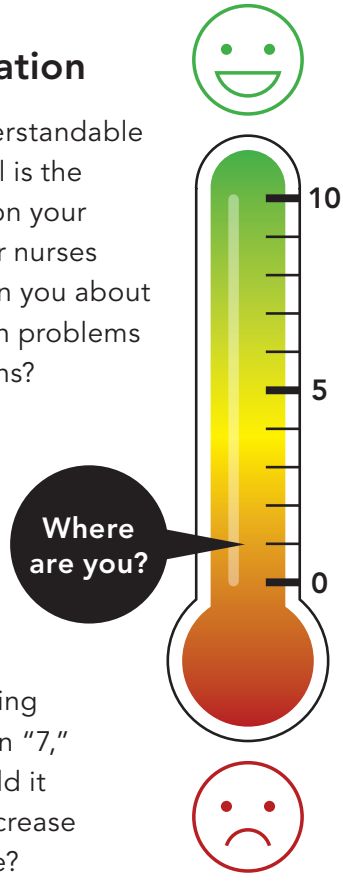
How confident are you that you can control and manage most of your health problems?



If your rating is less than "7," what would it take to increase your score?

Health information

How understandable and useful is the information your doctors or nurses have given you about your heath problems or concerns?



If your rating is less than "7," what would it take to increase your score?

Family Practice Management®

APPENDIX D

COMMUNITY CARE OF NORTH CAROLINA REFERRAL FORMS

Referral to Behavioral Health Services: Section I

DATE _____ MID _____

PATIENT'S NAME _____ DOB _____ PHONE _____

COUNTY _____ LEGAL GUARDIAN _____ PHONE _____

PAYER SOURCE: ____ Medicaid ____ Medicare ____ Health Choice ____ Private ____ Self-pay

This patient is currently receiving medical care services at our practice and is in need of a Behavioral Health Assessment from you/your agency.

Referring Primary Care Provider's name: _____

Address: _____
_____
_____

Phone: _____
Fax: _____
Email: _____

Carolina Access Referral NPI# (if applicable): _____

Referral Request:
Specific concerns/requests/recommendations:

The following patient information is attached:

- ☐ Most recent physical exam
- ☐ Medical diagnosis(es)
- ☐ Medication list
- ☐ Recent lab work
- ☐ Pain agreement (if applicable)
- ☐ Other:

Signature: _____
(Physician, Physician Assistant, Nurse Practitioner, etc.)

Thank you for agreeing to evaluate this patient.

Please fax Section II to the Primary Care Provider listed above.

Developed by Community Care of North Carolina

Behavioral Health Feedback to Primary Care: Section II

Referral back to Primary Care Provider/Practice: _____

DATE _____ MID _____

PATIENT'S NAME _____ DOB _____

BEHAVIORAL HEALTH AGENCY _____ NAME OF CONTACT _____

PHONE _____ FAX _____ EMAIL _____

Mark all that apply

- ☐ Patient scheduled appointment
- ☐ Patient did not schedule appointment
- ☐ Patient went to scheduled appointment on (date): _____
- ☐ Patient did not go to scheduled appointment on (date): _____
- ☐ Behavioral Health Assessment was completed on (date): _____
- ☐ Patient was seen, but refuses to give consent for sharing information at this time
- ☐ Other:

Initial Diagnosis(es)/Diagnostic Impression: (Axis I/Axis II):

- ☐ Medications were prescribed by _____ and list is attached
- ☐ Labs ordered: _____
- ☐ Other information/documents attached: _____

Follow Up Plan

Patient:

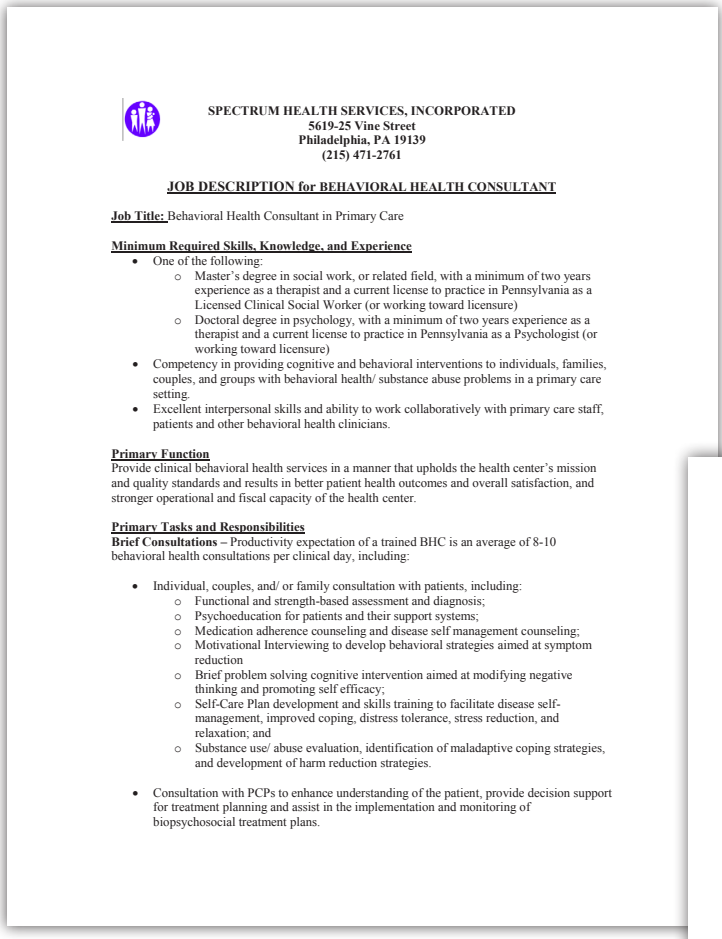
- ☐ Declined behavioral health services
- ☐ Was referred to another agency
  Agency: _____ Phone: _____
- ☐ Agrees to continue behavioral health services with our agency
  Date of next appointment: _____ Type of service: _____
- ☐ Medications to be managed by our agency
- ☐ Medications to be managed by another provider
  Provider name: _____ Phone: _____
- ☐ Pain agreement is recommended
- ☐ Other:

Clinician completing this assessment: _____
Thank you for the opportunity to assess this patient.

Developed by Community Care of North Carolina

APPENDIX E

BEHAVIORAL HEALTH CONSULTANT AND CARE MANAGER JOB DESCRIPTIONS



SPECTRUM HEALTH SERVICES, INCORPORATED
5619-25 Vine Street
Philadelphia, PA 19139
(215) 471-2761

JOB DESCRIPTION for BEHAVIORAL HEALTH CONSULTANT

Job Title: Behavioral Health Consultant in Primary Care

Minimum Required Skills, Knowledge, and Experience

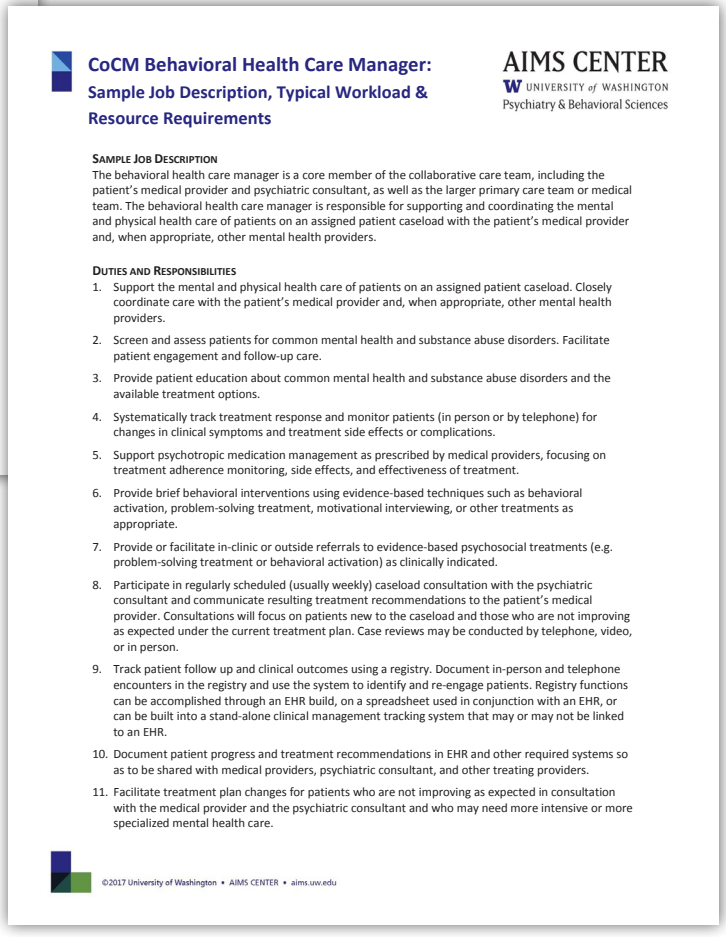
- One of the following:
  - Master's degree in social work, or related field, with a minimum of two years experience as a therapist and a current license to practice in Pennsylvania as a Licensed Clinical Social Worker (or working toward licensure)
  - Doctoral degree in psychology, with a minimum of two years experience as a therapist and a current license to practice in Pennsylvania as a Psychologist (or working toward licensure)
- Competency in providing cognitive and behavioral interventions to individuals, families, couples, and groups with behavioral health/ substance abuse problems in a primary care setting.
- Excellent interpersonal skills and ability to work collaboratively with primary care staff, patients and other behavioral health clinicians.

Primary Function
Provide clinical behavioral health services in a manner that upholds the health center's mission and quality standards and results in better patient health outcomes and overall satisfaction, and stronger operational and fiscal capacity of the health center.

Primary Tasks and Responsibilities
Brief Consultations – Productivity expectation of a trained BHC is an average of 8-10 behavioral health consultations per clinical day, including:

- Individual, couples, and/ or family consultation with patients, including:
  - Functional and strength-based assessment and diagnosis;
  - Psychoeducation for patients and their support systems;
  - Medication adherence counseling and disease self management counseling;
  - Motivational Interviewing to develop behavioral strategies aimed at symptom reduction
  - Brief problem solving cognitive intervention aimed at modifying negative thinking and promoting self efficacy;
  - Self-Care Plan development and skills training to facilitate disease self-management, improved coping, distress tolerance, stress reduction, and relaxation; and
  - Substance use/ abuse evaluation, identification of maladaptive coping strategies, and development of harm reduction strategies.

- Consultation with PCPs to enhance understanding of the patient, provide decision support for treatment planning and assist in the implementation and monitoring of biopsychosocial treatment plans.



CoCM Behavioral Health Care Manager:
Sample Job Description, Typical Workload & Resource Requirements

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Psychiatry & Behavioral Sciences

SAMPLE JOB DESCRIPTION
The behavioral health care manager is a core member of the collaborative care team, including the patient's medical provider and psychiatric consultant, as well as the larger primary care team or medical team. The behavioral health care manager is responsible for supporting and coordinating the mental and physical health care of patients on an assigned patient caseload with the patient's medical provider and, when appropriate, other mental health providers.

DUTIES AND RESPONSIBILITIES

1. Support the mental and physical health care of patients on an assigned patient caseload. Closely coordinate care with the patient's medical provider and, when appropriate, other mental health providers.
2. Screen and assess patients for common mental health and substance abuse disorders. Facilitate patient engagement and follow-up care.
3. Provide patient education about common mental health and substance abuse disorders and the available treatment options.
4. Systematically track treatment response and monitor patients (in person or by telephone) for changes in clinical symptoms and treatment side effects or complications.
5. Support psychotropic medication management as prescribed by medical providers, focusing on treatment adherence monitoring, side effects, and effectiveness of treatment.
6. Provide brief behavioral interventions using evidence-based techniques such as behavioral activation, problem-solving treatment, motivational interviewing, or other treatments as appropriate.
7. Provide or facilitate in-clinic or outside referrals to evidence-based psychosocial treatments (e.g. problem-solving treatment or behavioral activation) as clinically indicated.
8. Participate in regularly scheduled (usually weekly) caseload consultation with the psychiatric consultant and communicate resulting treatment recommendations to the patient's medical provider. Consultations will focus on patients new to the caseload and those who are not improving as expected under the current treatment plan. Case reviews may be conducted by telephone, video, or in person.
9. Track patient follow up and clinical outcomes using a registry. Document in-person and telephone encounters in the registry and use the system to identify and re-engage patients. Registry functions can be accomplished through an EHR build, on a spreadsheet used in conjunction with an EHR, or can be built into a stand-alone clinical management tracking system that may or may not be linked to an EHR.
10. Document patient progress and treatment recommendations in EHR and other required systems so as to be shared with medical providers, psychiatric consultant, and other treating providers.
11. Facilitate treatment plan changes for patients who are not improving as expected in consultation with the medical provider and the psychiatric consultant and who may need more intensive or more specialized mental health care.

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