SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Welcome to the June Monthly Call

QTIP

June 10, 2026

QTIP Reminders

- **QIDA Cycle 11 is due next Monday 6/15**
  Please contact Addy if you need assistance
- **Power Hour is Friday 6/26**
  We're addressing Huddles
- **The Summer Learning Collaborative is almost here! Keep an eye on your inbox:**
  - Inside the Practice Slides
  - Fall 2026 Regional Site Visit Poll
  - Mental Health Summer Survey
  - And more!

All headed your way!

Collaborative Care Management

Model and Program

PRISMA HEALTH®

Jessica Anderson, CPC, MSM

Manager, Behavioral Health Program

Ambulatory Care Management

- 23 years with Prisma Health
- Current role since 2020
- Outpatient Practice Manager for Department of Psychiatry 2011-2020
- Office Coordinator for Department of OBGYN 2002-2011

Molly McCurley, LMFT

Supervisor – Ambulatory Care Management

- 5 years with Prisma Health
- In current role since February 2026
- Behavioral Health Care Manager 2021 – 2026
  - Travelers Rest Family Medicine
  - Greenville OBGYN – Verdae

Jessica Lord, BHS, BHA

Behavorial Health Case Worker

Behavioral Health Program - Ambulatory CareManagement

- 11 years with Prisma Health
- In Current role since September 2017
- Behavorial Health Case Worker 2017 – Current
  - Travelers Rest Family Medicine
  - Greenville OBGYN
  - Pediatrics Greer
- Data Entry Operator 2014 - 2017

Jessie Sahms, LPC

Behavorial Health Care Manager

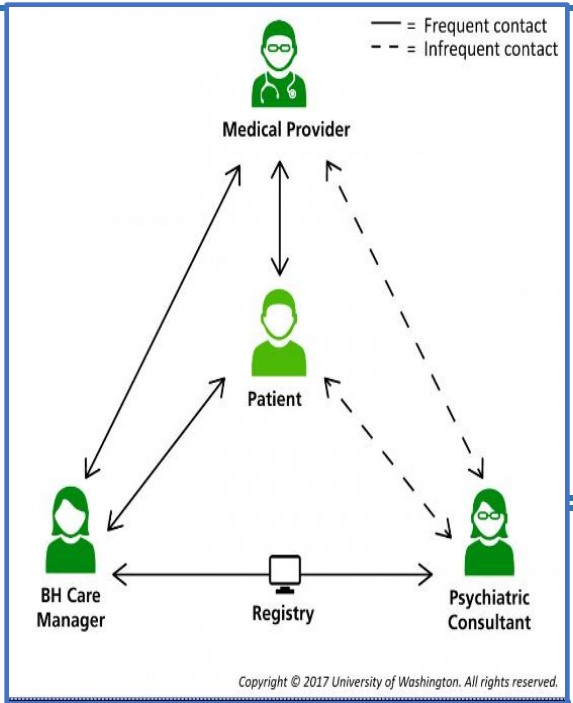
Ambulatory Care Management-Collaborative Care

- 1 year with Prisma Health (started May 2025)
- Assisted Peds ICM team until Peds CoCM launched in November 2025
- Previous experience in School Mental Health (Greater Greenville Mental Health Center), 2019-2025

Collaborative Care Model

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**
- Works closely with the PCPs
- Performs a comprehensive mental health assessment
- Patient engagement and education
- Delivery of brief evidence-based behavioral interventions
- Follow-up to monitor treatment response using standardized instruments with specific goals
- Weekly caseload review with a psychiatric consultant
- Facilitation of referrals to and coordination with community-based agencies, outside mental health or specialty care, substance use disorder services, and social services



Beneficiary

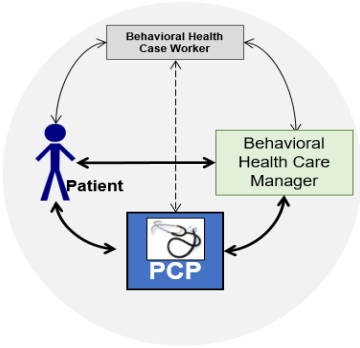
(Patient) is a member of the care team

Treating (Billing) Practitioner

- A physician and/or non-physician practitioner (PA, NP)
- Typically primary care
- Initial point of contact for patients
- Diagnose patients with mental health conditions
- Retain a key role and responsibility in overseeing the coordinated care provided by the team

Psychiatric Consultant

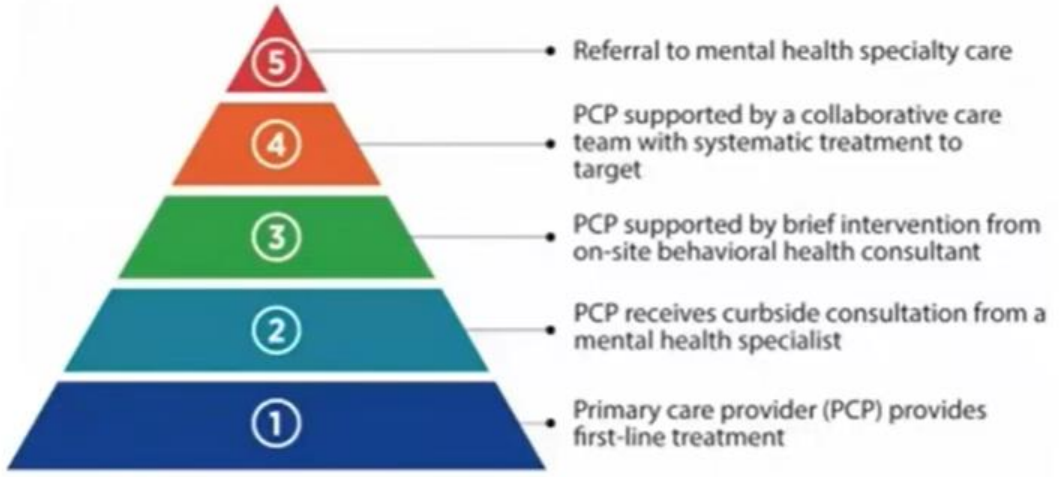
- Psychiatrist or advanced practice provider trained in psychiatry.



Advanced Model with Case Worker/Care Management Representative

- Non-licensed professional
- Enrollment
- Case Tracking
- Care Coordination
- Billing

AIMS Center Stepped Care Model



5 Referral to Mental Health Specialists

4 PCP supported by CoCM

3 PCP supported by PCBH

2 PCP receives curbside consults

1 PCP no behavioral health support

Why the Collaborative Care Model?

- **Use with Diverse Behavioral Health Diagnoses**
  - Can help adherence and improvement for chronic illnesses
  - Better Medical Outcomes
  - Referrals outside of primary care are often unsuccessful
  - Evidence-based treatment approaches
  - Strategic focus on most common, mild-to-moderate concerns
- **50-70% of patients will need at least one change in treatment to get better**
  - Faster improvement in symptoms
- **Decreases cost in acute care, prescriptions and specialty care**
  - Most payers include CoCM in their policies
- **PCPs have an established relationship with the patient**
  - Can strengthen the commitment for patients to take an active role in their care
  - Patients can receive care in a familiar environment
  - Most youth do not access care
  - Minority populations are underserved
- **PCPs are more supported**
  - Generally, more satisfied working within an integrated program
  - Team based care/Expert support
  - Preserves clinician capacity to help more patients

Why Measurement Based Care?

- **Patient/caregiver perspective**
- **Reduce bias**
- **Facilitates treatment planning**
- **Supports case conceptualization**
- **Supports communication with PCP/care team**
- **Identifies need for higher level of care**

- **All Patients aged 5+, CAPS-Child and Adolescent Psychiatry Screener**
- **Anxiety- GAD7**
- **Depression-PHQ 2/9**
- Disruptive Behavior-PSC-17, SDQ
- Trauma-Child Trauma Screen (CTS), CATS
- ADHD- Vanderbilt
- OCD-CYBOCS

Collaborative Care Program

Prisma Health

Collaborative Care

Program Timeline

2017

Program Pilot

- *2 Primary Care Practices*
- *2 Outpatient Therapists*
- *½ a day each week*
- *Psychiatric consultant.*

2018

CPT CoCM Codes

- *AMA Created CPT Codes*
- *Increased time of the BHCMs at pilot sites*
- *Worked with payers on policy change*
- ***Created the Behavioral Health Case Worker Role.***

2019

MInD-I Program

- ***Add OBGYN site for Perinatal CoCM***
- *Team moved to Care Coordination Institute (inVio)*

2020

Duke Endowment Grant Award

- *Goal of grant : to add additional sites including our Midlands market*
- *Organization wide-survey for readiness using the MeHaf*

2021

New Clinics-Upstate (5)

- *Cypress IM Greer*
- *Medical Center Boiling Springs*
- *Easley FM*
- *Easley IM*
- *Liberty FC*

Collaborative Care

Program Timeline

2022

New Clinics-Midlands (2)

- *Forest Drive FM*
- *Blarney FM*

2023

New Clinics-Midlands (2)

- *Dutch Fork FM*
- *Parkridge FM*

2024

New Clinics-Both Markets (3)

- *Keystone FM*
- *Simpsonville FM*
- *North Lake FM*
- *Garners Ferry FM*

2024

Medicaid Begins Covering CoCM

2025

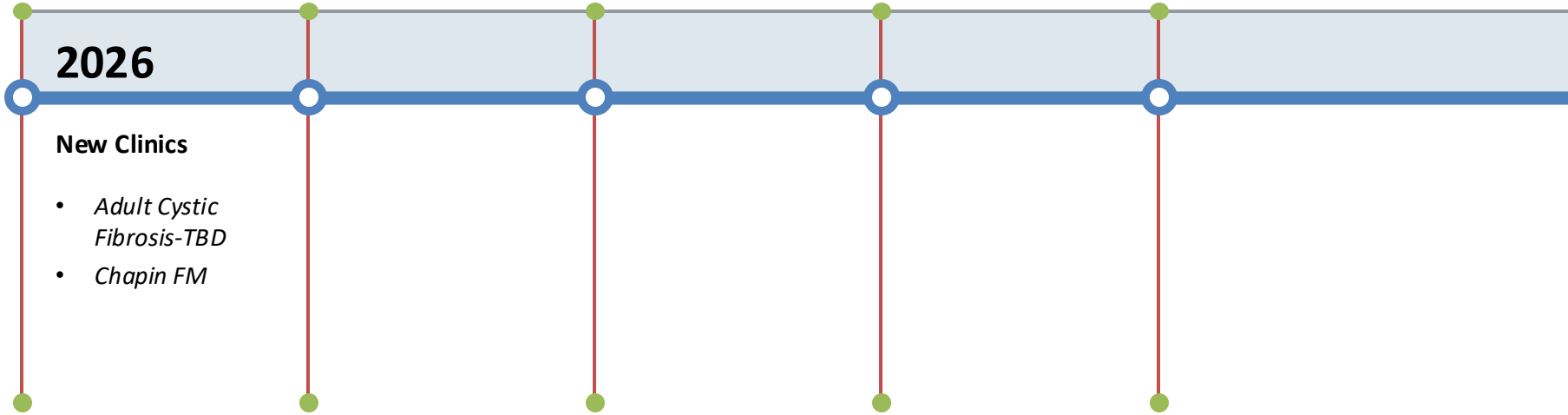
New Clinics-Midlands (2)

Upstate (3)

- *Sumter FM*
- *Bishopville FM (RHC)*
- *Hillcrest FM*
- *North Greenville Primary Care (RHC)*
- *Primary Peds Greer*

Collaborative Care

Program Timeline



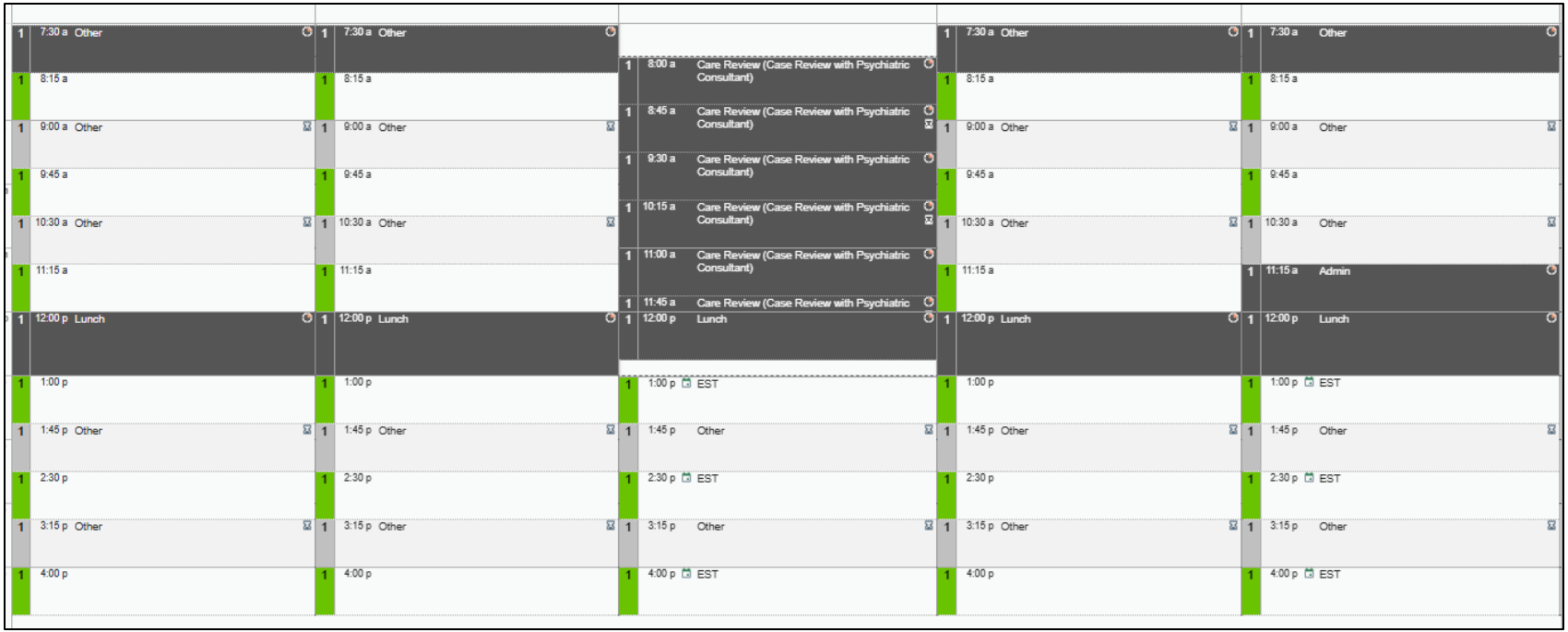
BHCM Experience

- Jessie is a LPC with prior experience in school mental health (elementary and middle school)

<u>Daily/Weekly Routine</u>

- Scheduling template: 45-minute visits for follow ups, 90-minute visits for intakes
- Example: 8:15, 9:45, 11:15, 1:00, 2:30, 4:00 are open slots to see patients
- Weekly Psychiatric Consults are Wednesdays 8:00-12:00
  - Child/Adolescent Fellow is also involved in our staffing
  - This allows time for staffing, documentation, routing notes to PCPs, and following up with patients/parents on consult recommendations
- In between visits: Documentation, responding to MyChart messages/phone calls, waitlist monitoring, collaborate with BHCW on outreach efforts to patients that have canceled/no showed/disengaging in program

Weekly Scheduling Template



BHCM Experience Cont.

Initial Intake (90 minutes)

- Explain CoCM program and purpose of assessment
- Complete Peds CoCM Intake Assessment (psychosocial assessment)
- Initial PHQ9/GAD7 scores
- Treatment Plan
    - Long-Range Goal: Achieve a PHQ9 score and GAD7 score both of 10 or less
        - Task: Provide brief psychotherapeutic interventions for meeting and maintaining goal
        - Task: Update behavioral health screeners monthly
        - Task: Communicate monthly with PCP to provide treatment progress
        - Task: Inform patient of progress
- If appropriate for CoCM, schedule follow-up

BHCM Experience Cont.

Follow Up Sessions (45 minutes)

- Patients under age 5, sessions primarily focus on parenting skills
  - FAST-B Skills
- Patients ages 5+, sessions focus on brief interventions in individual session
  - Parent engagement during first or last 5-10 minutes of visit (significant updates/concerns, med updates, and scheduling next visit)
  - Update PHQ9/GAD7 scores if needed
  - Check In-Identify progress and/or barriers since last visit
  - Deliver brief interventions (ie CBT, Psychoeducation, Problem Solving)
  - Set goal or cope ahead (application of skill) for next 1-2 weeks
  - Route note to PCP if needed

BHCM Experience Cont.

Program Wins

- Supportive PCPs; communication is a mix of in-person or Epic messages, depending on the matter
- Weekly Psych Consult has been an informative experience for all
- Parents and patients are familiar with the pediatric office, helps ease anxieties and increase comfort in first session
- Range of patient ages gives a nice variety of interventions and treatment approach; caseload ranges from age 4 to 21
- Peds-Greer office has been great! Support from two teams (BHCM team and the Peds-Greer team)

Program Difficulties

- High request for late afternoon appointments
- Triaging patients that are higher level of care
  - Can be difficult to tell by referral, or as treatment progresses and new issues arise (referrals to PCIT, family therapy, psychiatry, trauma-focused therapy)
  - PHQ9/GAD7 scores validate limited progress and need for higher level of care
  - Education at assessment can help with these conversations
- Transitioning to a CoCM session from psychotherapy session
- Not necessarily a difficulty, but it's a process to get in sync with the practice (ie getting to know nurses and other clinic staff, getting a good flow with front desk, making sure you're on clinic-wide email distribution lists and provider meetings)

Pediatric Case Study

- Patient is 17 y/o male, presenting issues of anxiety and depression, associated with GI issues, that had been worsening over the past 1-2 years. Endorsed feeling nervous daily, not wanting to leave the house, difficulties with sleep onset, and nightmares. Prior to anxiety onset, he had been struggling with GI issues and diagnosed with IBS. Some fears and frustrations with leaving the house and finding employment due to fear of flare-ups. He also had experienced several deaths and separations within his family during childhood and adolescence.
- Patient was interested in starting medications. Psych consult recommended Celexa to avoid worsening GI symptoms. These recommendations were shared with PCP, and patient followed up with PCP to start medication.
- BHCM continued to meet with patient every 2-3 weeks for brief interventions and track med efficacy/side effects. Brief Interventions included primarily CBT interventions, such as recognizing emotions and triggers, stress management, challenging catastrophic thinking, coping ahead for situations (ie family functions, work, driver's ed/driving test), and establishing boundaries with family members.
- As patient progressed, visits were spaced to 1x month. Completed Mental Health Maintenance Plan in our final session to review strategies if symptoms were to return.
- Overall episode in CoCM was about 5 months
    - Patient was older, motivated, and very engaged in treatment

Billing and Coding

- General BHI Codes
  - 99484
- Collaborative Care Management Codes
  - G2214, 99492-99494
- Rural Health Clinics
  - CMS 2026 Ruling

- Payer Rules/Adoption
  - Medicare/Medicaid
  - Commercial
  - 30 Calendar Day rule
  - Time limits
- Revenue
  - Billed under PCP
- Expenses
  - BHCM Time
  - PC Time
  - BHCW/CMR Time

Lessons Learned

- Strategic Implementation/Growth with Executive Leadership is a must
- Buy in from leadership doesn’t always mean buy in from PCPs/practices (Garners Ferry example)
- Onsite/Hybrid increases engagement across all disciplines and with patients (Easley IM example)

PRISMA HEALTH®

PrismaHealth.org

CMS/SC Medicaid

- SC Medicaid
- (2024-9-24) Collaborative Care Model.pdf

- CMS MLN
- MLN909432 - Behavioral Health Integration Services

Organizations with CoCM

- Prisma Health
- Spartanburg Regional
- MUSC
- McLeod

Introductory Videos

CoCM Intro Video (from the APA)

Daniel's Story: An introduction to Collaborative Care (video link)

FAST-First Approach Skills Training www.seattlechildrens.org/FAST

- https://www.seattlechildrens.org/healthcare-professionals/community-providers/fast/
- FAST Anxiety (ages 7 to 18)
- FAST Behavior (ages 4-11)
- FAST Depression (ages 12-18)
- FAST Early Childhood (ages 1-4)
- FAST Trauma (ages 7-18)
- FAST Parenting Teens (parents with children ages 11-18)

Skill 1	1.1 Child Behavior & Family Cycles 1.2 Understanding Your Family Cycles
Skill 2	2.1 Special Time 2.2 Ideas for Special Time Activities 2.3 Special Time Tips and Troubleshooting 2.4 Special Time Tracking
Skill 3	3.1 Catch 'Em Being Good 3.2 Catch 'Em Being Good Troubleshooting
Skill 4	4.1 Planned Ignoring 4.2 Planned Ignoring Tips and Troubleshooting 4.3 Planned Ignoring Practice
Skill 5	5.1 Giving Good Instructions 5.2 Instruction Traps to Avoid 5.3 Practicing Effective Instructions 5.4 Instruction Goals
Skill 6	When-Then Instructions
Skill 7	7.1 Planning Consequences 7.2 Privilege Pause
Skill 8	8.1 Time Out Tweaks 8.2 When Kids Refuse Time Out 8.3 Time Out Planning Worksheet
Bonus Skill 1	**NEW** Bonus 1: Supporting Healthy Screen Use Bonus 1.2. Creating a Family Media Plan Bonus 1.3: Screen Time Tips and Troubleshooting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