This document shares guidelines for Behavioral Health Care Manager (BHCM) EHR documentation, including documenting consent, intake to the program, as well as various patient contact templates. This document should be reviewed in conjunction with **PC EHR Documentation**[1], which provides guidelines for Psychiatric Consultant (PC) EHR documentation.

Intake

After the BHCM has completed the intake process (see **BHCM Intake Checklist**[1]) with a patient, their enrollment in CoCM will be documented in the EHR. During intake, the BHCM will receive verbal consent from the patient to participate in CoCM. This should be reflected in the EHR through standardized language and a checkbox.

Per CMS guidelines (updated April 17, 2018), "The consent will include permission to consult with relevant specialists, including a psychiatric consultant, and inform the beneficiary that cost sharing will apply to in-person and non-face-to-face services provided. Consent may be verbal (written consent is not required) but must be documented in the medical record."[1]

Two levels of consent language are included in this document. The first includes language that is appropriate for use prior to launch of CoCM billing codes, while the second includes language that is required once CoCM billing has launched.

Pre-Billing Consent Language

This example was provided by Michigan Medicine's Behavioral Health Collaborative Care (BHCC) program, headquartered in Ann Arbor, MI.

Patients are verbally consented into the program and are sent a welcome letter that incorporates the following language:

> BHCC is an integrated care model that helps you address your mental health needs within your medical home. Your care team will consist of: your BHCC clinician (myself), a psychiatric consultant, a medical provider (usually your primary care physician), and possibly other service providers such as care navigators, nurses, dieticians, etc. Please know that the psychiatric consultant and myself review your clinical concerns and the psychiatric consultant will provide recommendations (such as medications and other interventions) back to your doctor. If you agree to BHCC care, please be aware that your care team, including the psychiatric consultant, will access your health information (both in your chart and in talking with your team) in the process of helping you with your mental health.

Required Consent Language for CoCM Billing Codes

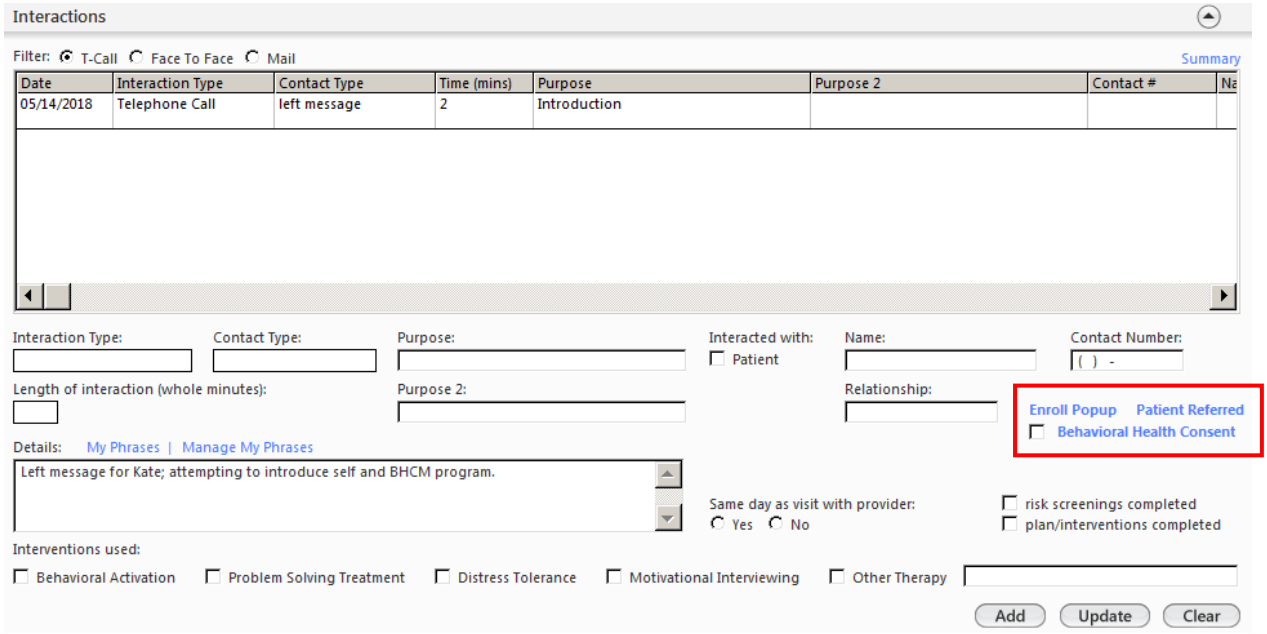
This example was provided by IHA's Behavioral Health Collaborative Care program, headquartered in Ann Arbor, MI.

> Please check box if patient consents to the below.
>
> ☐ I have discussed [site's] Behavioral Health Collaborative Care program with the patient, including the roles of the behavioral health care manager and psychiatric consultant.
>
> I have informed the patient that they will be responsible for potential cost sharing expenses for both in-person and non-face-to-face services.

The patient has agreed to participate in the Behavioral Health Collaborative Care program and for consultations to be conducted with relevant specialists.

IHA uses NextGen EHR, seen below. The red square highlights an example of a checkbox indicating that verbal consent was obtained.

Intake- Clinical Documentation



The BHCM will utilize standardized documentation, which may be developed internally. If supported by the site's EHR, it can be helpful to build templates that can be pulled into the BHCM's documentation.

When documenting self-management plans, it is recommended to include the patient's self-management goals near the top of the note. This can increase the ease of reference by the Treating provider and other care team members.

Of note, outcome measures (e.g., PHQ-9 and GAD-7) may need to be input separately into a form; this is dependent on EHR.

It is also important, for billing purposes, to document the amount of minutes dedicated to Collaborative Care activities. This includes time spent engaging in care coordination and treatment planning. This should be documented in a number field (3-digit field, 0-150, no alpha characters).

Below is an example of an intake note; this may be tailored to the site and EHR.

* indicates data that should be pulled into the patient registry; these items can be buttons built into a form or programmed fields.
☐ indicates a yes/no field

Collaborative Care: Intake Note

Date of Service:
Treating Clinic and Clinician:
Referring Provider:
Mode of contact:
Minutes dedicated to Collaborative Care activities: [minutes 0-150 (3- digit numeric field, no alpha)] *

Brief ID:

Plan:
Patient Self-Management Goals: [text or auto-fill]
Care Manager Interventions:

- Patient Education: ☐* [list education provided]
- Problem Solving: ☐* [text optional]
- Motivational Interviewing: ☐* [text optional]
- Behavioral Activation: ☐* [text optional]
- Self-Management Planning: ☐*
- Symptom Monitoring: ☐*
- Support/Active Listening: ☐*
- Resources Provided: ☐ [list resources provided]
- Follow-up Time Frame: [frequency and/or date]

PHQ-9 score: *
GAD-7 score: *

Additional outcome measure scores [administered and recorded as clinically indicated]**:**

- AUDIT-C:
- CIDI-Based Bipolar Disorder Screening:
- MoCA:

Assessment:
Current Presentation: [text]
SI/HI: [text]
Behavioral Health History: [text]
Current Medications/Compliance: [text, auto-fill optional]
Prior Medication Trials: [text, auto-fill optional]
Substance Use: [text]
Coping Skills: [text]
Medical Conditions: [text, auto-fill optional]
Psychosocial Detail: [text]
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[signature]

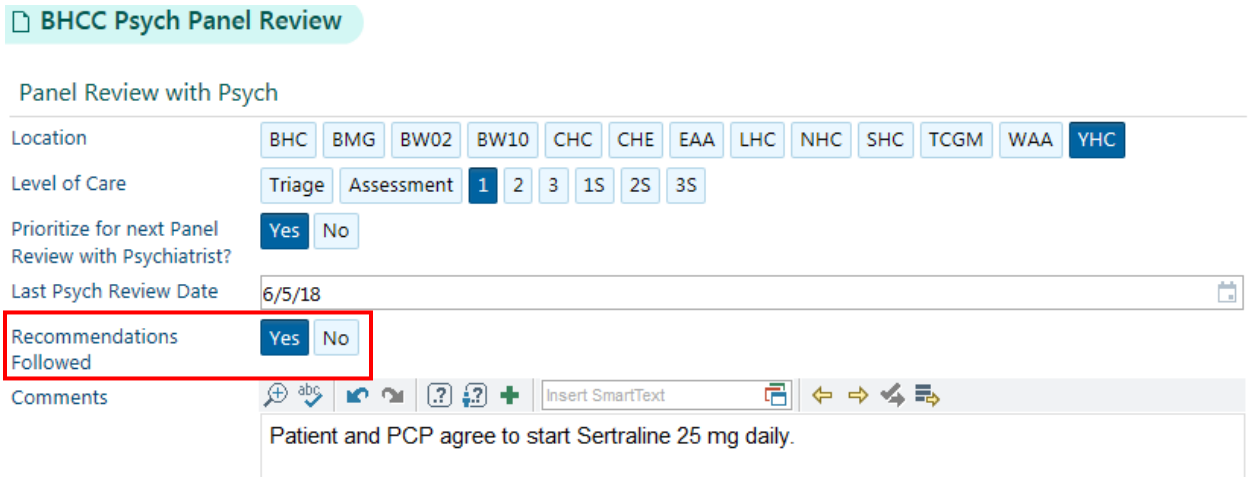
Ongoing Care

Documenting Implementation of Treatment Recommendations

Following intake, the BHCM will review the patient with the Psychiatric Consultant (PC). This should occur within two weeks following intake, typically during scheduled systematic case review time. After reviewing the patient, the PC may make treatment recommendations, such as a medication change or a brief intervention. This will be documented in the EHR (see **PC EHR Documentation**[1]) and reviewed with the patient and the Treating provider. Whenever a PC documents a treatment recommendation, it is important to document whether or not the treatment recommendation was implemented, both for clinical and QI purposes. If the recommendation was not implemented, the reason should be documented (unable to reach patient; Treating provider refused; patient refused; other).

Ideally, this may be documented with a checkbox (or similar) in the EHR. An example is provided below (per Michigan Medicine's Epic EHR), and further detail is provided in **Registry and EHR Recommendations**[1] and **CoCM Report Templates**[1]. If the recommendation was not implemented, the BHCM should have the ability to select the reason (this option is not pictured below).

Note: Implementing "Level of Care" is optional. Should an organization choose to do so, please reference **CoCM Levels of Care**[1].



Progress, Support, and Contact Attempt Documentation

As the BHCM continues to provide patient care, each encounter will need to be documented. As with intake notes, the BHCM will utilize standardized documentation, which may be developed internally. If supported by the site's EHR, it can be helpful to build templates that can be pulled into the BHCM's documentation.

It is recommended to continue including the patient's self-management goals near the top of the note. This can increase the ease of reference by the Treating provider and other care team members.

Of note, outcome measures (e.g., PHQ-9 and GAD-7) may need to be input separately into a form; this is dependent on EHR.

It is important, for billing purposes, to document the amount of minutes dedicated to Collaborative Care activities. This includes time spent engaging in care coordination and treatment planning. This should be documented in a number field (3-digit field, 0-150, no alpha characters).

Below are examples of progress and support notes, some of which include outcome measures and self-management plans, and others of which are more brief. These may be tailored to the site and EHR, and the template utilized will be dependent on the content of the patient contact.

Progress Note

Outcome Monitoring Calls, Discussing Self-Management Plan

Collaborative Care: Progress Note

Date of Service:
Treating Clinic and Clinician:
Mode of contact:
Minutes dedicated to Collaborative Care activities: (minutes 0-150 (3- digit numeric field, no alpha)) *

Brief ID:

Plan:
Patient Self-Management Goals: [text or auto-fill]
Care Manager Interventions:

- Patient Education: ☐* [list education provided]
- Problem Solving: ☐* [text optional]
- Motivational Interviewing: ☐* [text optional]
- Behavioral Activation: ☐* [text optional]
- Self-Management Planning: ☐*
- Symptom Monitoring: ☐*
- Support/Active Listening: ☐*
- Resources Provided: ☐ [list resources provided]
- Follow-up Time Frame: [frequency and/or date]

PHQ-9 score: *
Previous PHQ-9 score on [date]:

GAD-7 score: *
Previous GAD-7 score on [date]:

Additional outcome measure scores [administered and recorded as clinically indicated]**:**

- AUDIT-C:
- CIDI-Based Bipolar Disorder Screening:
- MoCA:

Assessment:
Current Presentation: [text]
SI/HI: [text]
Behavioral Health History: [text]
Current Medications/Compliance: [text, auto-fill optional]
Prior Medication Trials: [text, auto-fill optional]
Substance Use: [text]
Coping Skills: [text]
Medical Conditions: [text, auto-fill optional]
Psychosocial Detail: [text]

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[signature]

Brief Progress Note

Brief Support Calls (e.g., medication monitoring, resource follow-up, checking in)

Collaborative Care: Progress Note

Date of Service:
Treating Clinic and Clinician:
Mode of contact:
Minutes dedicated to Collaborative Care activities: [minutes 0-150 (3- digit numeric field, no alpha)] *

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[signature]

Attempted Patient Contact

Unable to reach patient- First and second attempts

Collaborative Care: Attempted Contact

Date of Service:
Treating Clinic and Clinician:
Mode of contact:
Minutes dedicated to Collaborative Care activities: [minutes 0-150 (3- digit numeric field, no alpha)] *

Attempted to reach this patient for follow-up on [provide detail about reason for contact]. Unable to reach the patient and [provide detail about action taken, e.g., left voicemail]. If no return contact from patient, will attempt contact again [provide date and/or frequency]).
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[signature]

Unable to reach pending patient for enrollment– Third attempt

Collaborative Care Referral: Unable to reach pending patient for enrollment

Date of Service:
Treating Clinic and Clinician:
Referring Provider:
Reason for Referral:
Mode of contact:
Minutes dedicated to Collaborative Care activities: [minutes 0-150 (3- digit numeric field, no alpha)] *

This patient was referred to Behavioral Health Collaborative Care on [date] by [referring provider]. This writer attempted to contact patient on [enter dates of attempts to contact patient] to offer enrollment and complete intake into the Collaborative Care program. Messages were left with request for callback, and a letter was sent today with this writer's contact information. No further contact attempts are planned at this time.

Please feel welcome to again refer this patient to Behavioral Health Collaborative Care in the future if the program may be of further assistance in the care of this patient.

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[signature]

Unable to reach enrolled patient for ongoing care – Third attempt

Collaborative Care Referral: Unable to reach patient for ongoing care

Date of Service:
Treating Clinic and Clinician:
Mode of contact:
Minutes dedicated to Collaborative Care activities: [minutes 0-150 (3- digit numeric field, no alpha)] *

This patient has been enrolled in the Behavioral Health Collaborative Care program for behavioral health care management and support. Behavioral Health Care Manager (BHCM) has attempted to reach the patient on [number of] occasions, leaving [number of] voicemails on [enter dates that voicemails were left].

BHCM has unfortunately been unsuccessful in reaching this patient, and today followed up with a letter to the patient indicating that BHCM will cease contact attempts at this time. The letter indicates to the patient that they may contact BHCM with any future needs.

Please feel free to refer this patient again to the Behavioral Health Collaborative Care program if further support is indicated.
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[signature]

Program Discharge from CoCM- Different Level of Care

Pending or enrolled patient referred to a different level of care

Collaborative Care: Patient referral to different level of care

Date of Service:
Treating Clinic and Clinician:
Mode of contact:
Minutes dedicated to Collaborative Care activities: [minutes 0-150 (3- digit numeric field, no alpha)] *

This patient [was referred to/has been enrolled in] the Behavioral Health Collaborative Care program for behavioral health care management and support surrounding [reason for referral/presenting problem]. Behavioral Health Care Manager (BHCM) has been working with patient for [length of enrollment] on their self-management goals.

Given the level of clinical need as evidenced by [reason for referring to higher level of care, e.g. diagnosis] BHCM [spoke with/sent letter to] patient today regarding a recommendation to connect with a different level of care. Referrals to [list referrals] were provided, and patient was instructed to contact BHCM, Treating provider, or clinic as needed.

Writer will make Treating provider aware of referral to a different level of care. Please feel free to contact this writer with any questions or concerns.
--
[signature]

Enrolled patient referred to stable monitoring (if applicable) and given relapse prevention plan

Collaborative Care: Referral to Stable Monitoring/Discharged from program due to symptom remission

Date of Service:
Treating Clinic and Clinician:
Mode of contact:
Minutes dedicated to Collaborative Care activities: [minutes 0-150 (3- digit numeric field, no alpha)] *

This patient has been enrolled in the Behavioral Health Collaborative Care program for behavioral health care management and support surrounding [reason for referral/presenting problem]. Behavioral Health Care Manager (BHCM) has been working with patient for [length of enrollment] surrounding their self-management plan.

BHCM completed outcome measures with patient on [date]. Scores were as follows:

PHQ-9 score on [date]: *
Baseline PHQ-9 score on [date]:

GAD-7 score on [date]: *
Baseline GAD-7 score on [date]:

Patient's scores indicate [remission from condition/response to treatment] within the context of the Collaborative Care program. Patient was engaged in relapse prevention planning today. Patient was provided with a hard copy of this plan, and encouraged to review their plan at least monthly. See [chart location for relapse prevention plan] for a copy of the patient's relapse prevention plan.

At this time, the patient is being

[referred to stable monitoring for ongoing monitoring of symptoms. Patient agrees to be contacted monthly/every three months/every six months for monitoring. Next contact is scheduled for [date] via [phone/clinic visit]. Patient aware to contact care manager or Treating provider with interim needs.]

[discharged from the Collaborative Care program due to remission/response of symptoms. Patient aware to contact writer and/or Treating provider with worsening of symptoms or any questions, concerns, or needs. No follow-up contact planned at this time.]
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[signature]

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[1]Available via the PRISM Resource Library
[2]Centers for Medicare & Medicaid Services. (2018, April 17). *Frequently Asked Questions about Billing Medicare for Behavioral Health Integration (BHI) Services.* Retrieved from https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Behavioral-Health-Integration-FAQs.pdf