Welcome to your quarterly update from SMI Adviser. In spite of the uncertainty caused by the COVID-19 pandemic, we remain committed to advancing evidence-based care for individuals who have serious mental illness (SMI).

The pandemic continues to surface unexpected impacts and upend many of the norms in mental health. It empowers access to care via telehealth. Yet for many individuals and clinicians alike, that is a big adjustment. It forces community-based teams to adapt delivery of Assertive Community Treatment (ACT). It transforms how clinicians prescribe and track medications like clozapine. Yet at the same time, it burdens individuals who have SMI with added disparities that threaten their health.

For SMI Adviser, these last few months allowed for timely reflection. Our team challenged original assumptions around technical assistance as we pivoted to serve the in-the-moment needs of the field. One thing that is certain – the pandemic validates our investment in data infrastructure and contemporary technology. This foundation allows us to ask and answer important questions about clinician needs, information gaps, and how to best use our resources.

There are many other exciting developments. And there is always a role for you – visit our Partner Action Toolkit to find all of our materials and help us raise awareness.

Thank you for being an important part of this initiative.

For questions about SMI Adviser, please contact us at SMIAdviser@psych.org. Our team is here to help you.
A Time for Reflection

Year 2 of SMI Adviser came to a close in early July 2020. Our team took that opportunity to reflect on the changes made necessary by COVID-19. We also took time to look at what we have learned about how clinicians access and use our resources and tools.

- There are immediate and ongoing needs in the field given the impact of the COVID-19 pandemic. We made a pivot to meet those needs via education, resources, and clinical support.
- There are also distinct ways that clinicians use technical assistance. Sometimes it varies by topic and sometimes by profession. We reflected on our original strategy and its assumptions around resources, needs, and delivery.

We are proud to present you with a detailed account on both what we learned and how we adapted.
A Blueprint for Real-Time Change

At the outset of our initiative, our team committed to measure and visualize data in real time. This cuts across all forms of data: registration, consultation, website usage, marketing performance, and much more.

We use a suite of contemporary technology tools to aggregate data and visualize it in charts, maps, and hierarchies. This lets our team uncover trends and opportunities that static data does not easily present. And all of the visualized data is interactive – it allows us to drill down and respond to needs based on specific profession, state, SAMHSA region, types of interactions, webinars, resources, and more.

This data infrastructure fuels an evidence-based approach to how we provide technical assistance to the field. It gives our team the ability to ask and answer questions across any facet of our initiative and respond to needs in real time.
What We Learned About Our Audience

Our original expectation was that psychiatrists would be the primary audience for SMI Adviser given that SMI Adviser is administered by the American Psychiatric Association.

Yet what we see in the data is a broad, interprofessional audience of mental health clinicians. Engagement among social workers rivals that of psychiatrists.

How We Adapted

We added an experienced licensed clinical social worker to our Clinical Expert Team.

We obtained certification to offer social work continuing education and will begin to offer CE credits in September 2020.

Sherin Khan, LCSW
What We Learned About Meeting Educational Needs

**ASSUMPTION**
Our educational plans will primarily be driven by needs assessments collected in advance.

**REALITY**
Just in time learning based on current needs is of high value to clinicians.

Our original vision for how we plan education was that it would be measured and driven by needs assessments and timelines planned in advance.

Yet what we see is that mental health clinicians need and value education and resources that are developed quickly in response to real-world changes.

How We Adapted

We carved out room in the schedule to be responsive to hot topics

Before the Day of Your Appointment

### Identify a private location for your appointment
This should be a place where you can be alone and not interrupted for the duration of your video session.

### Check your technology
Consider what technology you will use for the video session. This might be your computer, an iPad, or your mobile phone. Be sure you know how to work the camera and the volume. Check to ensure that the location for your video session has a strong internet connection. Ask your clinician or their office staff if you need to install any apps on your device in advance. Ask how you will receive a link to the visit and if they can do a test with you to ensure it works.

Organize Billing Details
Check with the office staff about billing in advance of your appointment. Have your insurance information ready and ask about any co-pays.

Prepare your thoughts
Think about what you want to discuss with your provider. Make notes if that helps you.

Start Your Appointment
Sign in and get started
About 3 minutes before your appointment, sign into the video session. Make sure you are using your device correctly and understand your appointment and all its components.

On the Day of Your Appointment

### Get ready for your video session
Do the things you need to do to prepare for your video session. This might include setting up your environment, checking your technology, and making sure you are comfortable.

### Make sure you have any notes about what you want to discuss during the appointment
Also have a pen and paper in case you need to take notes. Bring reading glasses if you need them to see things on the screen, such as rating scales.

Have other questions about telehealth? Visit SMIadviser.org/answers

We created tools to support immediate needs
What We Learned About Educational Formats

Assumption vs. Reality

**Assumption:**
Our primary instructional modality will be one-hour webinars.

**Reality:**
Our audience also values shorter, alternative learning formats.

Our original plan for education formats was to focus on one-hour webinars, which are widely used across continuing education. Yet what we see is clear engagement from mental health clinicians across diverse, shorter, alternative learning formats.

How We Adapted
We are testing short, interactive, engaging formats.

- **Clozapine & LAI Virtual Forum** - unites professionals who prescribe clozapine and LAIs to discuss and share ideas on a trending topic each month.

- **20-minute webinars** - allows clinicians to participate in learning during short windows in their schedules.

- **Video-based answer cards** - enhances our popular text-based answer card format with video content from our clinical experts.

**Clozapine & LAI Virtual Forum**
Meets the first Wednesday of every month
3:30-4:00 pm EST
Starts August 5, 2020

**Sign up for our listserv**
What We Learned About Interprofessional Needs

**Assumption**

Interest in topics would be aligned with the discipline of participants.

**Reality**

Interprofessional participation is the norm in our activities.

Our original expectation was that engagement with specific education topics and resources would be driven by specific professions. For example, psychiatrists and nurse practitioners would drive registration for webinars that focus on medication management.

Yet what we see is clear interprofessional participation across our education, resources, and all types of topics.

**How We Adapted**

We focus on education topics that involve the entire mental health care team.

- Burnout
- CBT for Psychosis
- Criminal Justice Involvement
- Physical Health
- Psychiatric Advance Directives
- Suicide Prevention

**Topics of highest interprofessional participation**

We create tools for use by the entire mental health care team.

**GET THE MY MENTAL HEALTH CRISIS PLAN APP**

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What We Learned About Education Uptake

**ASSUMPTION**
There will be equal uptake across all learning modalities for each topic.

**REALITY**
Some topics are weighted towards particular modalities.

Our original strategy anticipated that there would be consistent engagement in specific topics regardless of the learning modality.

Yet what we see are clear trends that interest in certain topics aligns with specific modalities.

**How We Adapted**
We ensure that our content on specific topics aligns with the modalities where we see higher uptake.

**Example:**
We see high uptake in psychopharmacology topics across our Virtual Learning Collaboratives and Knowledge Base, but less so via 1 hour webinars.

SEE PSYCHOPHARMACOLOGY ANSWER CARDS

Join Our #MissionForBetter at SMIadviser.org
What We Learned About the Landscape

**ASSUMPTION**
We will be an umbrella.

**REALITY**
We are a puzzle piece.

Our original vision was that SMI Adviser would partner with other organizations to deliver all content on SMI under our umbrella.

Yet what we learned is that there are clear advantages to being just one of an array of organizations that offer content on how to care for those who have SMI.

**How We Adapted**

We have routine, consistent communication with several key partners in order to minimize overlap and cover all gaps.

For example, in 2019 we hosted the Second National Conference on Advancing Early Psychosis Care in the United States in collaboration with the Psychosis-Risk and Early Psychosis Program Network (PEPPNET) and the National Institute of Mental Health (NIMH).

**Upcoming:**

We are again partnering with PEPPNET and NIMH to host the Third National Conference on Advancing Early Psychosis Care in the United States. It takes place in Fall 2020. This virtual meeting is free and provides continuing education credits for multiple professions.
What We Learned About Technical Assistance

ASSUMPTION
We would focus mostly on disseminating evidence-based practices.

REALITY
We focus mostly on implementing evidence-based practices.

Our original vision was that SMI Adviser would focus on disseminating gold standards of care.

Yet what the field needs is assistance in how to tailor evidence-based practices to local needs, priorities, and resources. Peer-facilitated learning is a powerful tool to identify solutions for implementation.

How We Adapted

We created more interactive, peer-to-peer modalities alongside expert-led modalities

We launched a listserv for our Clozapine Center of Excellence and Long-Acting Injectable Center of Excellence — and subscribers are steadily growing
What We Learned About Consultation

Our original expectation was that SMI Adviser would constantly field consultation questions from mental health professionals through our on-demand consultation service.

Yet we see a clear trend that clinicians find answers through multiple methods.

How We Adapted

- Increased time for Q&A
- Created answer cards for questions not answered during webinars

53,500+ Total Registrations

33%+ Increase Since April
What We Learned About Intensive Consultation

**ASSUMPTION**
Implementation sites would accept and adopt guidance on how to improve workflows around SMI.

**REALITY**
They are struggling due to COVID-19 and thin resources; it is a challenge to devote attention to change.

Our original plan for Implementation Sites hinged on routine and regular contact with their teams.

Yet even sites ready for change face overwhelming resource challenges and struggle to focus on implementing scalable change.

**How We Adapted**

- Removed routine calls and work around their schedules
- Developed resources to address specific needs
SMI Adviser developed a new tip sheet to help mental health clinicians identify the various types of telehealth visits and associated billing codes. This is a valuable resource for clinicians who are now billing for services they would typically provide in the office.

New Tip Sheet on Telehealth Billing Codes

Tips for Telehealth Billing During the COVID-19 Pandemic

Plan to get reimbursed for services you would typically provide in the office? Then use this primer to identify the various types of telehealth visits and associated billing codes.

Keep in mind that guidelines change often during the COVID-19 crisis. Please reference the links below for the most current details.

1. **TELEHEALTH VISITS THAT REPLACE OFFICE VISITS**

   This is a real-time video visit and is the most common type of mental health digital visit.

   It has the same standards as an in-person visit and should be paid at the same rate. However, it is good to double-check the settings on your billing software to make sure it is correct.

   You can use the same CPT codes you already use with the addition of a modifier -95 in most cases – that tells the payer that the visit was a telehealth visit and a place of service code (POS) that tells the payer the location of the clinician. Coverage policies may vary across payers, especially during the public health emergency. Before you bill, make sure to check and confirm that you can provide and bill the service by telehealth.

   Information listed in italics are those services that can also be temporarily provided by telephone during the COVID-19 crisis.

   - **Initial Psychiatric Evaluation**
     - 90792
   - **Evaluation and Management Outpatient**
     - 90791
   - **Evaluation and Management Plus Psychotherapy**
     - 90793-90795: 30-60 minutes - E/M code: 99241; code: 99242-99245
     - 70-90 minutes - E/M code: 99243; code: 99244-99245
     - 60-124 minutes - E/M code: 99246; code: 99247-99249
     - **Psychotherapy Alone**
       - 90804
     - **Family Therapy**
       - 90805
     - **Group Therapy**
       - 90806

   **Real-time audio video modifier** to add to the end of the billing code. During the COVID-19 crisis, use this for visits that you would typically have in your office.

   - **TELEPHONE VISITS**

     There are CPT codes that describe care provided via telephone alone. They are for medical discussions or assessment and management of a new (delayed during COVID-19 crisis) or established patient.

     - **For physicians and others who can bill for E/M services**
       - 99441: 10-15 minutes
       - 99442: 15-20 minutes
       - 99443: 20-25 minutes
       - 99444: 25-30 minutes
       - 99445: 30-45 minutes
     - **For psychologists, social workers, and others who can bill for E/M services**
       - 99446: 15-20 minutes
       - 99447: 20-25 minutes
       - 99448: 25-30 minutes

   - **VIRTUAL CHECK-IN (G0433)**

     Physicians and others who can bill E/M services can bill for time spent talking to a new or established patient on the telephone or via telephone and video. Generally, the physician is responding to a contact made by the patient. This code should not be billed if the patient has been seen in the 7 days prior to the call or within 24 hours of the sooner available appointment after the brief check-in. The goal of this visit is to see if a patient needs to be seen for further evaluation or if the problem can be resolved through this call.

     - **For those who bill for evaluation and management services that are billable**
       - 99441: 10-15 minutes
       - 99442: 15-20 minutes
       - 99443: 20-25 minutes
       - 99444: 25-30 minutes
     - **For those who cannot bill for evaluation and management services that are billable**
       - G0433: 10-15 minutes
       - G0434: 15-20 minutes
       - G0435: 20-25 minutes

   - **REMOTE PATIENT MONITORING**

     This involves the collection and interpretation of data that is digitally stored and transmitted by a patient to a clinician. An example is a blood pressure monitor that is downloaded daily on any day.

   - **STAY CURRENT**

     Guidelines for telehealth visits change fast. For up-to-date details on telehealth, you can use these resources.

     - SMI Adviser
     - American Psychiatric Association
     - Center for Connected Health Policy
     - Centers for Medicare and Medicaid Services
     - Federation of State Medical Boards

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Access SMI Adviser Materials in Our Partner Action Toolkit

Use our Partner Action Toolkit to share information about SMI Adviser with your staff and colleagues. It contains logos, flyers, text for social media posts, text for listservs, and more. Simply download the files you need.

Join our Mission for Better – help us raise awareness and promote the use of evidence-based care for individuals who have SMI. Post something on social media today and use our hashtag #MissionForBetter.

SAMHSA Spotlight: Mental Health Technology Transfer Center

This section highlights other programs and resources from the Substance Abuse and Mental Health Services Administration (SAMHSA).

The purpose of the MHTTC Network is technology transfer: disseminating and implementing evidence-based practices for mental health conditions into the field. This collaborative network supports resource development and dissemination, training and technical assistance, and workforce development for the mental health field. Their team works with systems, organizations, and treatment practitioners involved in the delivery of mental health services to strengthen their capacity to deliver effective evidence-based practices to individuals.