Poll: What is your role?

Please use the annotate button to mark an "X" in the box that fits best with your role in this project.

Leadership, Administration, Project Management	Clinician	Technology Support (IT, EHR)

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Collaborative Care: Data, Documentation, and Reporting

Marina Milad
Michigan Collaborative Care Implementation Support Team

June 25, 2020

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Agenda and Objectives

- Review the engagement timeline
- Review the psychiatric collaborative care model (CoCM)
- Discuss the documentation and data infrastructure for CoCM services
- Outline data components of the disease registry
- Outline data components of the systematic case review tool
- Outline documentation components for the electronic health record
- Discuss tips and best practices
- Q & A session

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Disclosure

The Michigan Center for Clinical Systems Improvement (MiCCSI), Michigan Institute for Care Management and Transformation (MICMT), and Michigan Collaborative Care Implementation Support Team (MCCIST) have been contracted by Blue Cross Blue Shield of Michigan for this project.

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Etiquette

- You have been muted on entry
- When asking questions:
  - Send questions to ‘All Panelists’ in the chat feature
  - Our team will moderate the session
- When speaking:
  - Please minimize background noise
  - Use either phone or computer audio, but not both
- The session is being recorded

CEU Credit: Physicians, Nurses, Social Workers

- This live series activity, Preparing to Implement Collaborative Care, from 06/10/2020 - 07/31/2020, has been reviewed and is acceptable for credit by the **American Academy of Family Physicians**. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
  - Approved for (1 credit per session) AAFP (Prescribed) credits.
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- Nurses can use the CME for their state requirements. Information on this can be found on LARA and through the **Michigan Nurse Association** (MNA) at https://www.minurses.org/education-resources/resources-for-practicingnurses/state-of-michigan-ce-requirements/
- This course is approved by the **Michigan Social Work Continuing Education Collaborative**-Approval # 051420-00 The Collaborative is the approving body for the Michigan Board of Social Work

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Our Goal: Tailored Consultation

We recognize each physician organization and their practices have diverse organizational structures, resources, and timelines

Our tailored consultation approach *will "meet you where you are,"* ensuring your organization is ready to launch and capable of sustaining high-quality CoCM services

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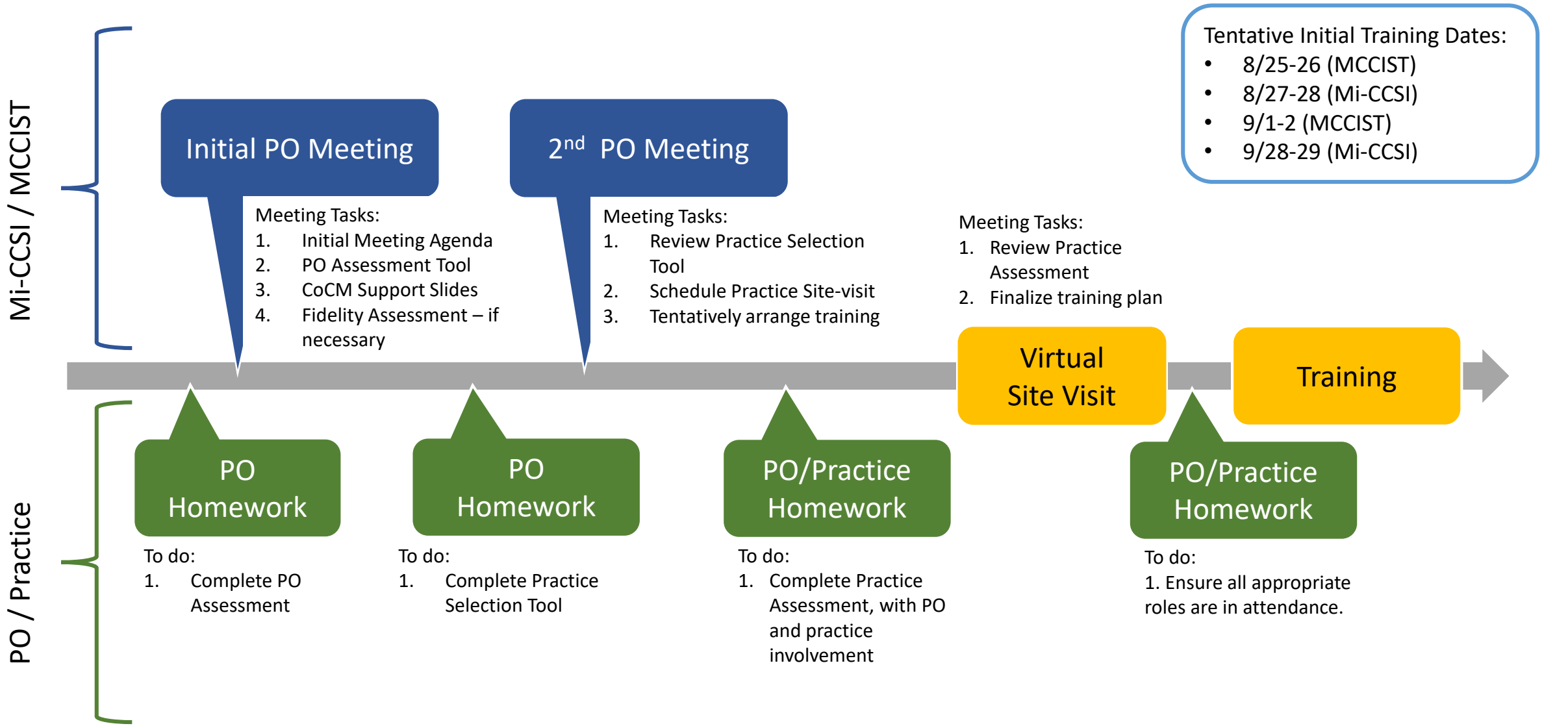

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Overview of the Collaborative Care Model

CoCM: An Overview

- Integrated behavioral health model with the strongest evidence
  - 2002: IMPACT study: First trial published by the University of Washington
  - 80+ randomized controlled trials prove CoCM provides significantly better behavioral health outcomes than “usual care”
- Patient improvements compare to those achieved in specialty care for mild-moderate conditions
- Meets patients’ behavioral heath needs in their medical home
- Return on investment of 6:1

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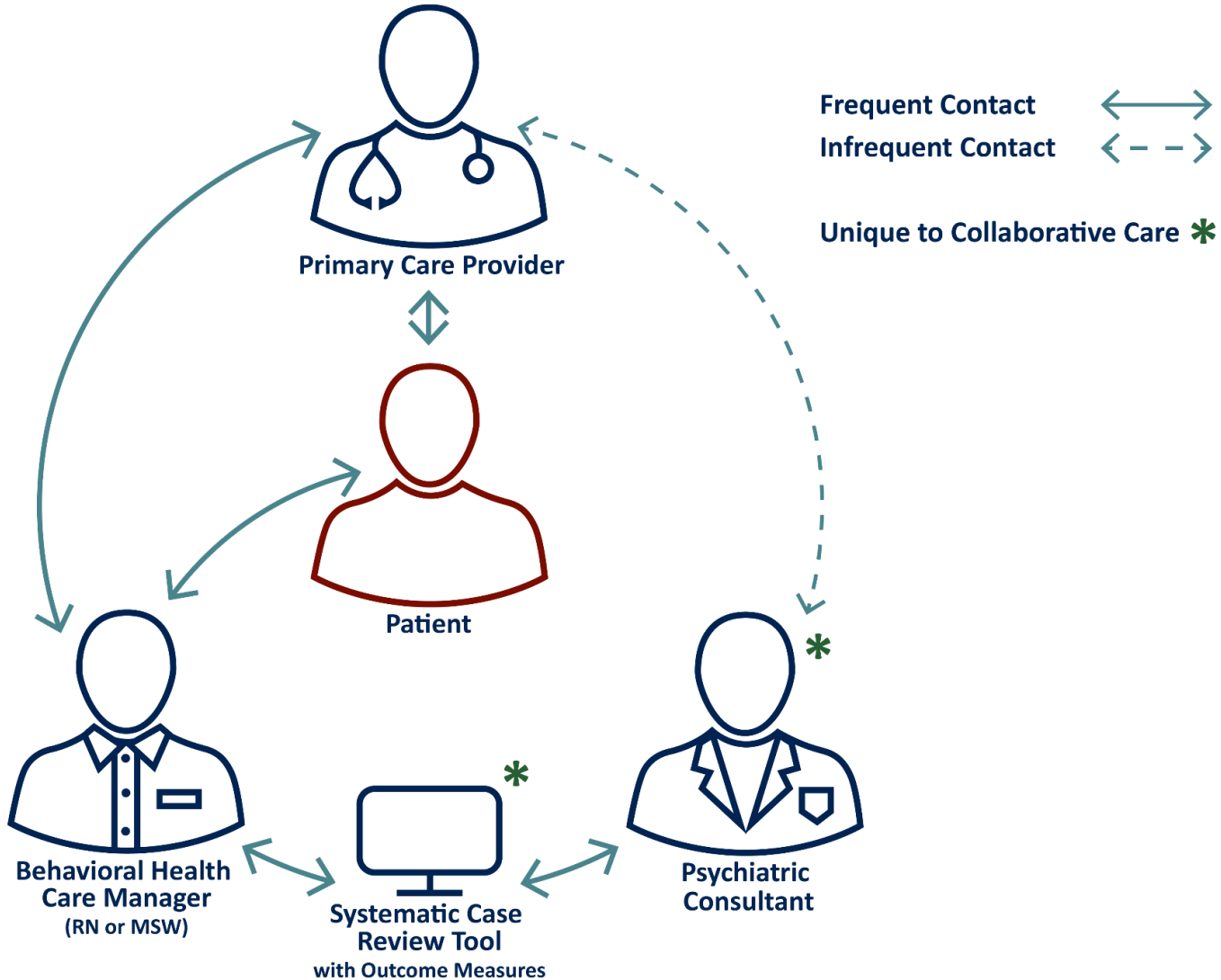
Target Population

- Highly evidence-based for adults with depression and anxiety
  - Depression and/or anxiety population served by primary care
  - Increasing evidence for adolescent depression, PTSD, and co-morbid medical conditions
  - More complex patients should be served in high-need clinics

- Defining the target population
  - PHQ-9 and/or GAD-7 of 10 or more
  - Diagnosis of depression and/or anxiety
  - Just started on a new antidepressant, regimen was changed, or PCP could use prescribing guidance

The Collaborative Care Treatment Team



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Components of the Evidence-Based Model

- **Patient Centered Care**
  - Effective collaboration between BHCMs and PCPs, incorporating patient goals into the treatment plan
- **Measurement-Based Treatment to Target**
  - Measurable treatment goals and outcomes defined and tracked for each patient (PHQ-9/GAD-7)
  - Treatments are actively changed until the clinical goals are achieved
- **Population-Based Care**
  - Defined and tracked patient population to ensure no one falls through the cracks
- **Evidence-Based Care**
  - Treatments are based on evidence
- **Accountable Care**
  - Providers are accountable and reimbursed for quality of care and clinical outcomes

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Summary: What sets CoCM apart?

- Population health approach
  - Use of a systematic case review tool to ensure no one falls through the cracks
  - Proactive, tailored outreach, allowing for monitoring and updates in-between PCP visits
  - Treatment-to-target approach: Treatments are adjusted until patients achieve remission or maximum improvement
  - Data evaluates key process measures and patient outcomes

- Typically a short wait time from referral to receiving an expert psychiatric recommendation (often within one week)

- Maximizes access to limited psychiatry time
  - Multiple patients reviewed per hour as opposed to one patient
  - Helps reserve specialty psychiatry time for higher level cases

Data, Documentation, and Reporting in CoCM

Definitions

Data is an active member of the treatment team allowing to identify patients, track treatment progress, and trend impact of CoCM services.

Systematic Case Review

- Weekly meeting between the psychiatric consultant and BHCM to review the caseload and provide expert treatment recommendations
- Fundamental component of CoCM

Systematic Case Review Tool

- Summary of key treatment information (e.g., outcome measure scores, dates of contacts) for each patient
- Used by behavioral health care manager (BHCM) and psychiatric consultant to regularly review the CoCM caseload

Disease Registry

- List of patients with a diagnosis of depression, anxiety, or other behavioral health condition
- Could be incorporated with existing chronic disease registry
- Used to identify patients who are eligible for the CoCM services

Defining ‘Improvement’: Outcome Measures

- Validated Outcome Measures:
  - PHQ-9 (Patient Health Questionnaire) - Depression screening
  - GAD-7 (Generalized Anxiety Disorder)

- Improvement:
  - 5-point reduction in score = Improvement
  - 50% reduction in score = Response
  - Score less than 5 = Remission

- Tracking PHQ-9 score data is required for CoCM service delivery; Tracking GAD-7 score data is highly recommended but not required.

Leveraging Data to Optimize Service Delivery

- Clinical Utility: Promoting Population-Based Care
  - Use the disease registry to identify eligible patients within practice
  - Use the EHR to communicate treatment recommendations from the psychiatric consultant to PCP
  - Use the systematic case review tool to manage treatment progress for a caseload of participating patients
- Monitoring Quality
  - Evaluate performance, impact, and efficiency of the CoCM program
  - Evaluate if CoCM delivery is aligned with the evidence-based model; advocate for operational changes to address barriers and promote the program's success
- BCBSM Reporting Goals: Value-Based Reimbursement
  - Demonstrate practice-level participation in CoCM services
  - Demonstrate achievement of patient outcome improvements as a result of CoCM services

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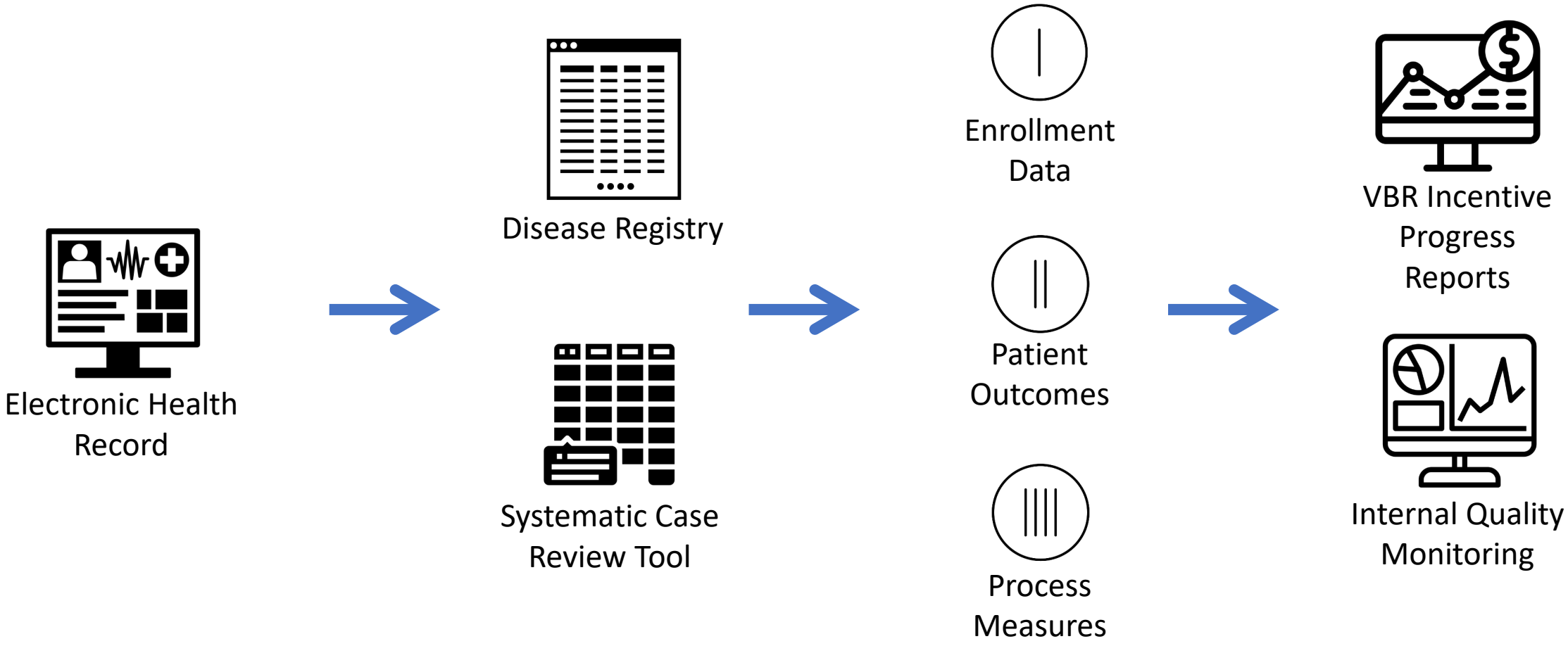
Data Platforms and Utility



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Documentation by Provider Type

Behavioral Health Care Manager (BHCM)

- Documents patient contacts and outcome measures in EHR and systematic case review tool (if separate from EHR)
- Uses systematic case review tool to manage caseload and discuss with psychiatric consultant

Psychiatric Consultant

- Provides recommendations to PCP and BHCM
- Documents treatment recommendations after systematic case review session
- The psychiatric consultant's recommendations will be documented in the EHR; see next slide for additional considerations

Primary Care Provider (PCP)

- Reviews recommendation from psychiatric consultant and implements recommendation, as appropriate
- No specific documentation requirements

Psychiatric Consultant Documentation Considerations

Documentation Options

- Ideal method: Psychiatric consultant documents directly in EHR
- Alternative method: HIPAA compliant workflow to ensure psychiatric consultant documentation is available to the PCP and BHCM

Considerations

- EHR license for psychiatric consultant may not be financially feasible
- Psychiatric consultant access to patient charts in EHR enhances understanding of patient's medical history and past medication trials, allowing for more precise recommendations
- Direct documentation ensures accurate, timely communication of treatment recommendations to the PCP, avoiding errors and minimizing liability concerns
- Direct documentation creates an avenue to educate PCPs on psychiatric diagnosis and medication prescribing, and allows the psychiatric consultant to be more visible, promoting team-based care
- Without direct documentation in the EHR, there must be "tight" workflows to ensure communication and uptake of recommendations

Disease Registry

- A dynamic patient list used to identify patients in the practice with depression and/or anxiety
- Ideally the disease registry integrated with the EHR
- If the practice does not use an EHR or if incorporation of a new disease registry can not be prioritized, a stand alone tool can be adopted on any platform such as Excel, Access, or another database management system
- Can be built upon an existing disease registry
- The following slides describe inclusion and exclusion criteria and suggested variables for data capture

Disease Registry Inclusion Criteria

Required for Inclusion

- Diagnosis of depression and/or anxiety in a clinical setting
- PHQ-9 and/or GAD-7 of 10+

Additional Avenues for Inclusion

- New or changed dose of antidepressant, antipsychotic, or anxiolytic
- Direct referral to CoCM services

Disease Registry

MRN	Patient	DOB	Age	Sex	PCP	Last Full PHQ	Last PHQ9 Score	Last GAD-7 Screening Date	Last GAD-7 Score	Last Primary Care Visit	Last Social Worker Visit	Primary Care Next Appt
[redacted]			18 y.o.	Female	Sylvestre, Nastassia Cassandra, MD	10/30/2018		03/13/2020	10	12/27/2019		05/19/2020
			18 y.o.	Female	Gessner, Lynn Michelle, MD	04/14/2020	11	04/14/2020	18	01/08/2019		
			18 y.o.	Female	Gessner, Lynn Michelle, MD	04/23/2020	15	04/23/2020	10	02/10/2020		
			18 y.o.	Female	Sylvestre, Nastassia Cassandra, MD	04/15/2020	7	04/15/2020	15	02/18/2020		05/29/2020
			19 y.o.	Female	Gessner, Lynn Michelle, MD	04/03/2020	11			03/02/2020		05/15/2020
			19 y.o.	Male	Phys, Self-Refer Or No Pcp/Referring	07/24/2018				06/18/2019		05/12/2020
			21 y.o.	Male	Scott-Craig, Thomas Peter Claire, MD	07/17/2018		03/12/2020	14	03/12/2020		
			21 y.o.	Female	Phys, Self-Refer Or No Pcp/Referring	04/10/2020	13	03/23/2020	15	03/23/2020		
			21 y.o.	Male	Cox, Amanda	01/13/2020	20	0	Scroll to Selected Row	01/13/2020	04/27/2018	

Note: This example does not show all recommended components; see previous slides for details.

Components: Disease Registry

Required

- Patient identification
- Date of referral
- Date of refusal of services
- Date of enrollment and disenrollment
- Baseline outcome measure scores (PHQ-9 and/or GAD-7)
- Diagnosis of depression and/or anxiety (ICD-10)

Recommended

- Referring PCP
- Reason for refusal of services
- Reason for disenrollment of services
- Follow-up outcome measure scores (PHQ-9 and/or GAD-7)
  - If sending patient outcomes to BCBSM for VBR incentive from the disease registry, consider making this a required component

Systematic Case Review Tool

- Dynamic service level detail data set and reporting tool for patients receiving CoCM services
- Used to capture all services and results and assist with coordination of care by summarizing data in the reporting tool and generating reports related to patient outcomes and process measures
- Ideally the systematic case review tool is integrated with the EHR
- If the practice does not use an EHR or if incorporation of a systematic case review tool can not be prioritized, a stand alone tool can be adopted on any platform such as Excel, Access, or another Database Management System
- Fields should be ‘sortable’
- The following slides describe suggested variables for data capture

Systematic Case Review Tool

Patient Information		Contact Information					Depression Outcomes					Anxiety Outcomes				Psychiatric Panel Review Information			
Name	Treatment Status	Date of Initial Contact	Date of Most Recent Contact	Number of Patient Contacts Completed	Weeks in Treatment	Date Next Contact Due	Initial PHQ-9	Most Recent PHQ-9	Difference in Most Recent PHQ-9	Most Recent PHQ-9 #9	Date of Most Recent PHQ-9	Initial GAD-7	Most Recent GAD-7	Difference in Most Recent GAD-7	Date of Most Recent GAD-7	Date of Most Recent Panel Review	Flag to Discuss	Patients Not Improving at 8 Wks	Outstanding Psych Recs
Lion, Leo	Active	12/17/18	3/29/19	3	19	4/28/19	21	21	0	0	3/29/19	21	21	0	3/29/19	4/5/19			
Doe, Jane	Active	4/12/19	4/22/19	3	2	4/29/19	17			0	4/12/19	19			4/12/19	4/19/19	Flag to Discuss		
Green, Sky	Active	12/24/18	4/17/19	6	18	5/1/19	17	5	-5	0	4/17/19	18	✓ 4	-6	4/17/19	4/17/19			
Smith, John	Active	2/28/19	4/17/19	2	9	5/1/19	7	8	1	0	4/17/19	21	12	-9	4/17/19	4/19/19		Attn Needed	
Blue, Jeans	Active	4/23/19	4/23/19	1	1	5/7/19	16			0	4/23/19	19			4/23/19	4/26/19	Flag to Discuss		Pending
Yellow, Joy	Active	12/31/18	4/11/19	7	17	5/11/19	19	11	0	0	4/11/19	17	21	0	4/11/19	4/12/19			Pending
Jupiter, Mars	Active	12/17/18	4/29/19	10	19	5/13/19	18	✓ 3	-7	0	4/29/19	21	8	5	4/29/19	4/12/19			
Shine, Sun	Active	4/29/19	4/29/19	1	0	5/13/19	22			0	4/29/19	21			4/29/19		Flag to Discuss		
Michigan, Cherry	Active	10/22/18	4/30/19	13	27	5/14/19	18	21	0	0	4/30/19	20	21	0	4/30/19	4/12/19			
Smile, Big	Active	11/13/18	4/30/19	8	24	5/30/19	20	11	-7	0	4/25/19	17	10	-7	4/25/19	4/26/19			

Note: This example includes many “nice to have” components; more simplified tools will suffice.

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Components: Systematic Case Review Tool

Required

- Patient identification
- Treatment status (e.g., active, inactive, relapse prevention)
- Date of enrollment and disenrollment
- Baseline and follow-up outcome measure scores (PHQ-9 and/or GAD-7) and dates
- Date of BHCM follow-up contacts with patient

Recommended

- Overall change in PHQ-9 and/or GAD-7 scores
- Most recent change in PHQ-9 and/or GAD-7 scores (i.e., difference in two most recent scores)
- BHCM contact frequency (e.g., one-week, one month) or next contact date
- Date of most recent panel review session
- Outstanding psychiatric treatment recommendations
- Flags to 1) discuss in panel review; 2) visualize patients whose condition is improving or worsening; and 3) to indicate patients who would benefit from contact, updated outcome measures, or panel review session

Recommended Options: Systematic Case Review Tool

- Develop platform within tool that is integrated with EHR
- Stand-alone tools
  - Excel- or Access-based options
    - MCCIST
    - UW-AIMS
  - Independent tool developed by physician organization or practice
  - Need HIPAA compliant manner to share tool with the psychiatric consultant to review weekly during the systematic case review

Components: Electronic Health Record Documentation

Required

- *All of the previously described information*
- Treatment status (e.g., active, inactive, relapse prevention)
- Delivery of brief therapeutic intervention (e.g., Motivational Interviewing, behavioral activation)
- Billable time per patient (i.e., sum of time BHCM delivered CoCM services)

Reporting: BCBSM VBR Requirements

- Eligibility requirements
  - The criteria for receiving VBR will be based on when the patient-centered medical home practice enters the CoCM training and support program
  - Training and support partners will work with BCBSM to ensure fidelity to the evidence-based model for some period after implementation
  - After the first period of receiving VBR, the criteria will become increasingly outcome-based
  - CoCM VBR will be available in addition to other VBR received by the PCP
  - VBR is applied only to commercial PPO claims, not Medicare or BCN claims
  - Initially available December 1, 2020 – August 31, 2021
- Referral and enrollment measures
- Patient Outcome Measure Improvements
  - Change from baseline to most-recent PHQ-9 and/or GAD-7 scores, per patient
  - 5-point reduction, 50% reduction, or score less than 5

Ideal Reporting: Optimizing Service Delivery
(Not required for launching CoCM)

- Monitoring patient outcomes (PHQ-9 and/or GAD-7)
  - Percentage of patients achieving a 5-point reduction, 50% reduction, or score less than 5
  - Aggregated by BHCM, PCP, treatment duration (e.g., 0-3 months, 3-6 months, etc.)

- Monitoring fidelity to the evidence-based model
  - Completion of outcome measures
  - Completion of patient contacts
  - Systematic case review within first 2 weeks of treatment
  - Implementation rate of psychiatric consultant recommendations

- Monitoring service delivery
  - Enrollment; appropriateness of patients
  - Contact frequency from BHCM
  - BHCM time per patient per calendar month
    - Billing for CoCM services uses time-based thresholds on per-member per-month basis; distributing time amongst the caseload can enhance revenue and program efficiency

Tips and Best Practices

- Allow access to EHR records for CoCM program; remove the need to break the glass
  - BHCM notes are independent from counseling or therapy service notes
- Documentation method for the psychiatric consultant should be considered closely
- In the psychiatric consultant EHR note, add the recommendation at the top of the note to promote direct communication to PCP
- Balance the need for reduced double-documentation for BHCMs and quality reporting; what is sustainable for your organization?

Next Steps and Resources

Required tasks to begin training:

- ❑ Identify or build systematic case review tool
- ❑ Create disease registry; or add PHQ-9 and/or GAD-7 to existing disease registry

Additional tasks for sustainable programs:

- ❑ Modify EHR documentation forms for BHCM patient contacts and psychiatric consultant systematic case review session
- ❑ License psychiatric consultant in EHR, as appropriate
- ❑ Create reporting framework to monitor outcome and process measures

These tasks may vary depending on the level of standardized resources throughout participating practices.

Associated resources available on the MICMT website *(Coming Soon!):*

- Data Infrastructure Guide
  - Additional description of fields required and recommended for the disease registry, systematic case review tool and EHR
- EHR Documentation Templates
  - Templates for EHR documentation for members of the CoCM treatment team

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Questions?

The next instructional webinar will discuss:
Selecting Practices to Launch CoCM Services
July 9th at 12 pm

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