Sustaining the High-Quality Delivery of Collaborative Care Services

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Michigan Collaborative Care Implementation Support Team

Mi-CCSI Center for Clinical Systems Improvement

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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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- 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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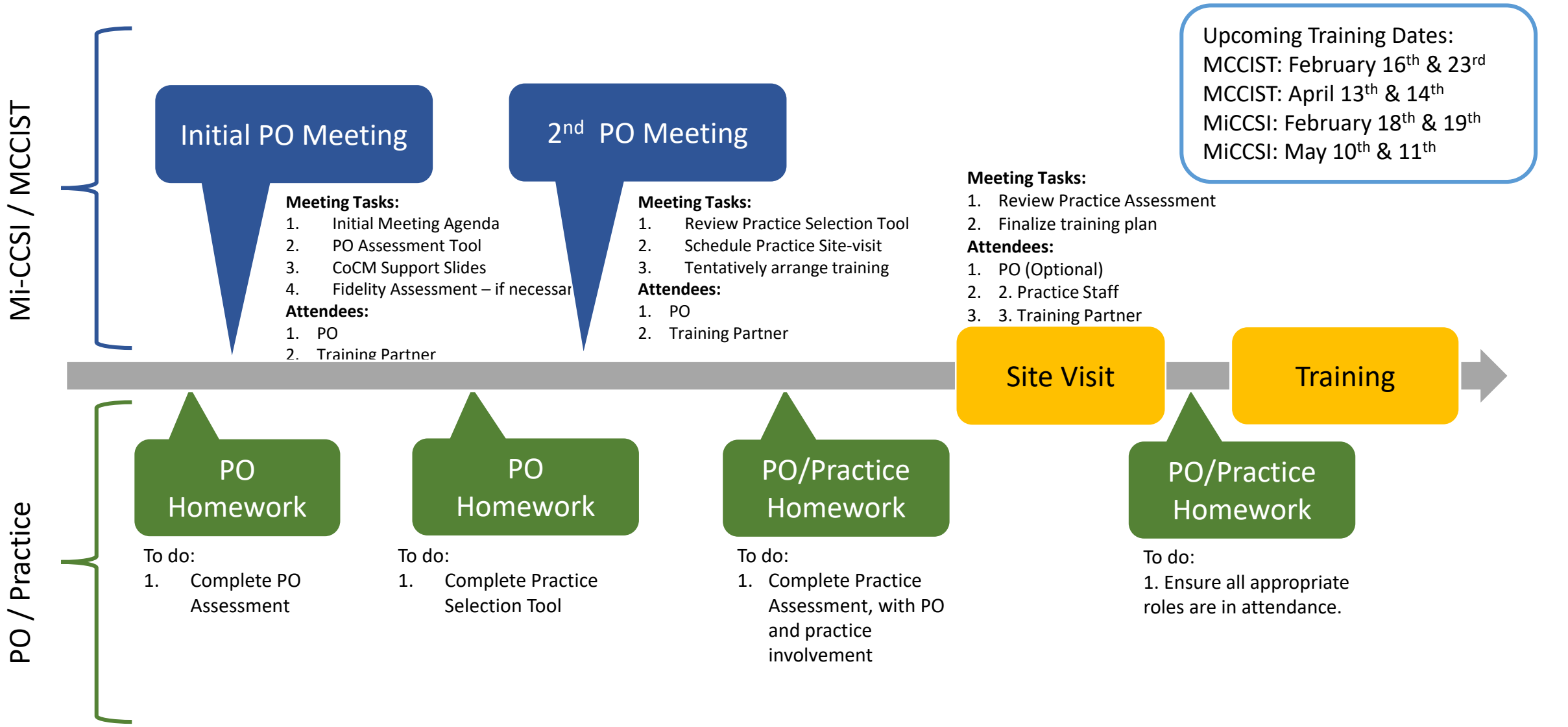
Agenda and Objectives

- Review the collaborative care model (CoCM)
- Discuss strategies to promote the operational efficiency of CoCM services
- Review CoCM CPT codes
- Discuss strategies to promote the financial performance of CoCM services
- Q&A session



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CoCM Training Dates and Attendees

Training Partner	Day 1	Day 2
MCCIST	February 16th	February 23rd
	April 13th	April 14th
MI-CCSI	February 18th	February 19th
	May 10th	May 11th

Please plan to attend a training session with your assigned training partner.

Attendance from PO representation is welcome.

Day	Time	Topics	Attendees
Day 1	8 am – 12:30 pm	Introduction, workflow, team roles and responsibilities	Psychiatric consultant, PCP champion, BHCM, and up to three other staff per practice (e.g., clinical supervisor, practice manager)
	12:30 – 1:30 pm	Peer discussion with practicing psychiatric consultants	Psychiatric consultant
	1 – 4 pm	Patient tracking and identification, billing, implementation	BHCM, and up to three other staff per practice (e.g., clinical supervisor, practice manager)
Day 2	8 am – 4:15 pm	BHCM clinical training	BHCM, clinical supervisor

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Overview of the Collaborative Care Model

CoCM: An Overview

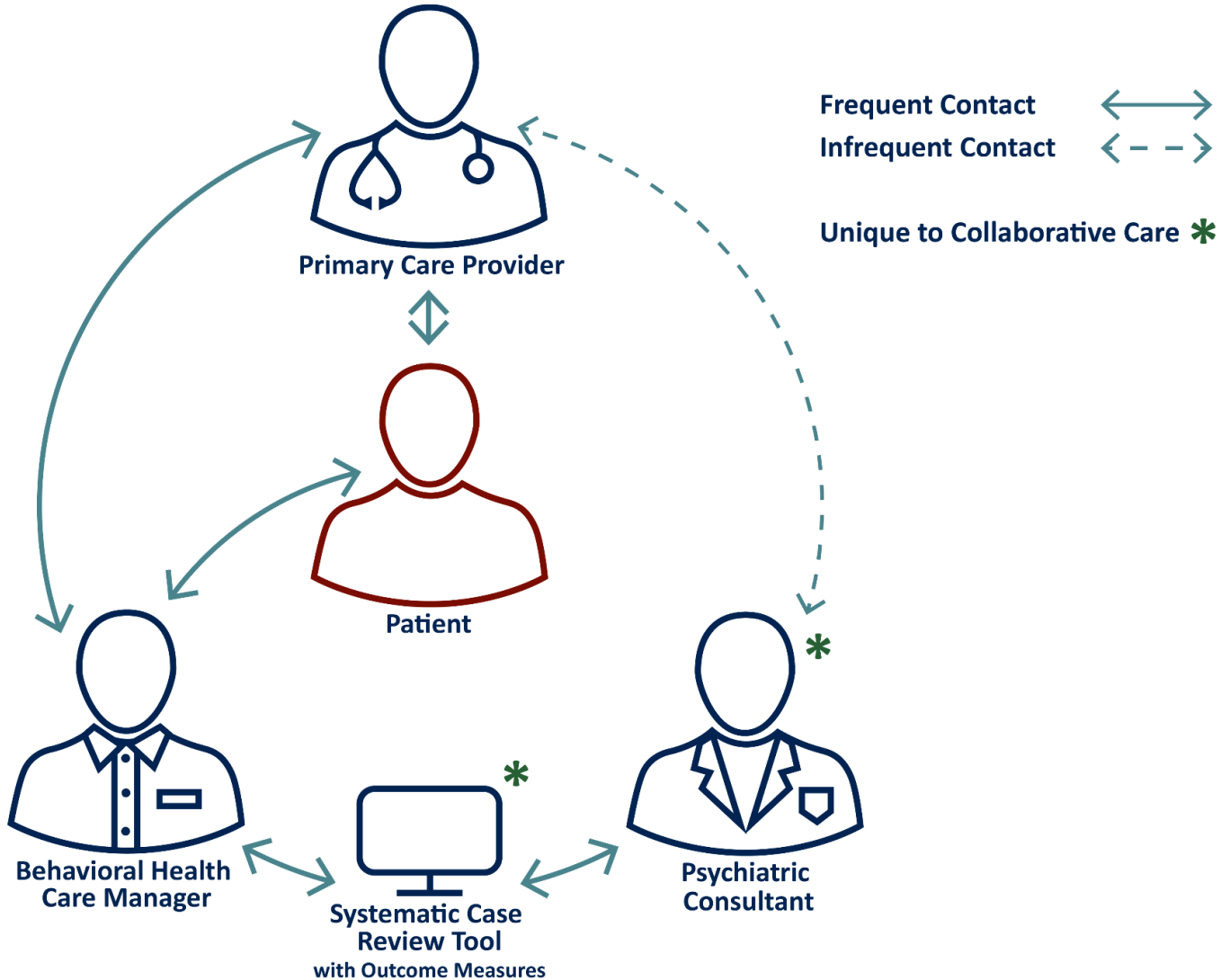
- Integrated behavioral health model with the strongest evidence
  - 2002: IMPACT study: First trial published by the University of Washington
  - 80+ randomized controlled trials prove CoCM provides significantly better behavioral health outcomes than “usual care”
- Patient improvements compare to those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

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

Sustaining the High-Quality Delivery of Collaborative Care Services

Definitions: Program Status

Developing Programs

- First 3-6 months after launching services
- Undergoing programmatic changes (e.g., staffing, leadership, EHR)
- Continuing to revise the clinical workflow

Mature Programs

- After 6 months of launching services or once program has stabilized
- Demonstrating adherence to the evidence-based model and successful patient outcome improvements
- Have not undergone recent programmatic changes

Definitions: Recurring Meetings

Systematic Case Review

- Key component of CoCM
- Weekly meeting between the psychiatric consultant and BHCM
- Review the caseload and provide expert treatment recommendations
- Required

Program Performance Review

- Administrative discussion
- Evaluate program performance to optimize delivery of CoCM services
- Review patient outcomes, process measures, billing, staffing, and operations
- Strongly recommended

Clinical Caseload Supervision

- Clinical discussion
- A high-level review of the caseload with the BHCM and clinical supervisor
- Keeps the caseload "fluid," allowing for enrollment of new patients
- Discuss ongoing development of skills (e.g., Motivational Interviewing, behavioral activation)
- Strongly Recommended

Note: Caseload review and program review meetings may occur at the provider organization or practice level depending on the oversight structure

Systematic Case Review

- Goal: Regularly provide treatment recommendations on the caseload
- Required

- Highly recommended to schedule weekly

- Participants: BHCM, Psychiatric Consultant

Systematic Case Review: Activities

- Use the systematic case review tool to review of the caseload
- Discuss specific questions from PCPs or patients
- Discuss patients that are:
  - Newly enrolled in CoCM services
  - Not improving or have severe outcome measure scores
  - Not recently discussed with the psychiatric consultant
  - Not engaging in care
  - Improving, in remission, ready for relapse prevention planning, or disenrollment

Patient Information		Contact Information					Depression Outcomes				
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
Lion, Leo	Active	12/17/18	3/29/19	3	19	4/28/19	21	21	0	0	3/29/19
Doe, Jane	Active	4/12/19	4/22/19	3	2	4/29/19	17			0	4/12/19
Green, Sky	Active	12/24/18	4/17/19	6	18	5/1/19	17	5	-5	0	4/17/19
Smith, John	Active	2/28/19	4/17/19	2	9	5/1/19	7	8	1	0	4/17/19
Blue, Jeans	Active	4/23/19	4/23/19	1	1	5/7/19	16			0	4/23/19
Yellow, Joy	Active	12/31/18	4/11/19	7	17	5/11/19	19	11	0	0	4/11/19
Jupiter, Mars	Active	12/17/18	4/29/19	10	19	5/13/19	18	3	-7	0	4/29/19
Shine, Sun	Active	4/29/19	4/29/19	1	0	5/13/19	22			0	4/29/19
Michigan, Cherry	Active	10/22/18	4/30/19	13	27	5/14/19	18	21	0	0	4/30/19
Smile, Big	Active	11/13/18	4/30/19	8	24	5/30/19	20	11	-7	0	4/25/19

Systematic Case Review Tool: Abbreviated Version

Systematic Case Review: Outputs

- Psychiatric consultant to send recommendations to PCPs
- BHCM to follow-up with PCPs re: implementing medication recommendations
- BHCM to follow-up with patients
  - Altered treatment recommendations
  - Administer outcome measures
  - Relapse prevention planning
  - Refer to alternative level of care
  - Discontinue CoCM services

Program Performance Review

- Goal: Review performance of CoCM to optimize service delivery
- Highly recommended
- Scheduled monthly for developing programs, quarterly for mature programs

- Participants: Program Manager, Clinical Supervisor, Quality Improvement Staff, PCP Champion
- Optional Participants: BHCM, Psychiatric Consultant, Leadership, Billing Staff, HIT/EHR Staff

Program Performance Review: Activities

- Use program enrollment, patient outcomes, and process measure reports
- Discuss:
  - Clinical performance
  - Fidelity (adherence) to the evidence-based model
  - Program operations
  - Financial performance
  - Workforce changes

Program Performance Review: Outputs

- Take note of areas for monitoring
- Continue discussing opportunities to optimize program delivery
- Share successes with staff
- Share reports or updates with leadership or clinical staff

Clinical Caseload Supervision

- Goal: Keep the caseload “fluid” – allowing the practice to continue accepting new patients
- Recommended
- Scheduled monthly for developing programs, quarterly for mature programs

- Participants: BHCM and Clinical Supervisor
- Optional Participants: Psychiatric Consultant

Clinical Caseload Supervision: Activities

- Use the systematic case review tool to conduct a high-level clinical review of the caseload
  - Evaluate caseload volume, acuity, and needs
  - Evaluate BHCM productivity, capacity for ongoing patient engagement
- Discuss which patients would benefit from:
  - Relapse prevention planning
  - Different level of care
  - Being contacted at a different frequency
  - Discontinuing CoCM services
- Discuss ongoing skill development

Clinical Caseload Supervision: Outputs

- Contact patients to administer outcome measures, complete relapse prevention plans
- Discharge patients or refer patients to different level of care
- Make a note of which patients to discuss during systematic case review
- Follow-up with PCPs
- Explore opportunities for skill development

Caseload Size Guidelines: 1.0 BHCM FTE

Program and Patient Characteristics	Caseload Size Range	
• High commercial payer • Mostly depression and anxiety; low clinical acuity • Minimal social needs, comorbid medical conditions	90	120
• Commercial, public payer, or uninsured • Mostly depression and anxiety; few higher acuity • Minimal-moderate social needs, substance use, comorbid medical conditions	70	90
• Public payer, uninsured, low commercial • Mostly depression and anxiety; some higher acuity • Minimal-moderate social needs, substance use, comorbid medical conditions	50	70

Actual caseload sizes will vary by patient population and program characteristics

Reporting and Monitoring CoCM Services

BCBSM VBR

- Referral, enrollment and refusal rates
- 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

Additional Measures (Recommended)

- Patient Outcomes
  - BHCM, PCP, Treatment duration
- Patient Engagement
  - BHCM patient contacts completed
  - Outcome measures completed
- Systematic Case Review
  - First review with psychiatric consultant
  - Discussion of patients not improving
  - Implementation of recommendations
- Evidence-based Care

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Monitoring Clinical Performance

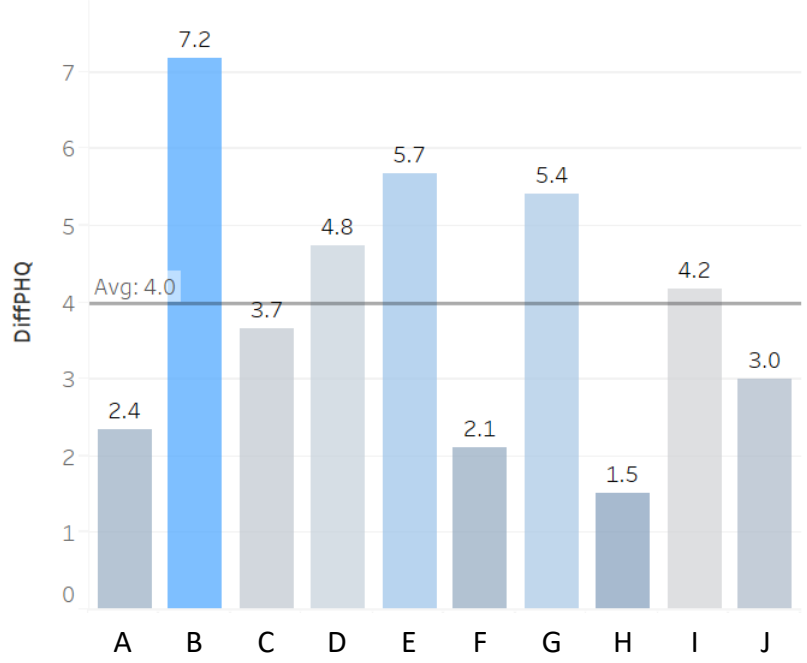
- Are your patient population's outcome measures improving as expected for the specified population?
  - Review patient outcomes grouped by BHCM, PCP, practice, and time in treatment (e.g., 0-3 months, 3-6 months)
  - Treatment duration range 3-12 months, average of 6 months
  - Target: Approximately 50% of patients should show improvement* after three months of treatment

  * Improvement is defined as a 5-point reduction, 50% reduction, or score less than 5 in PHQ-9 and/or GAD-7 score

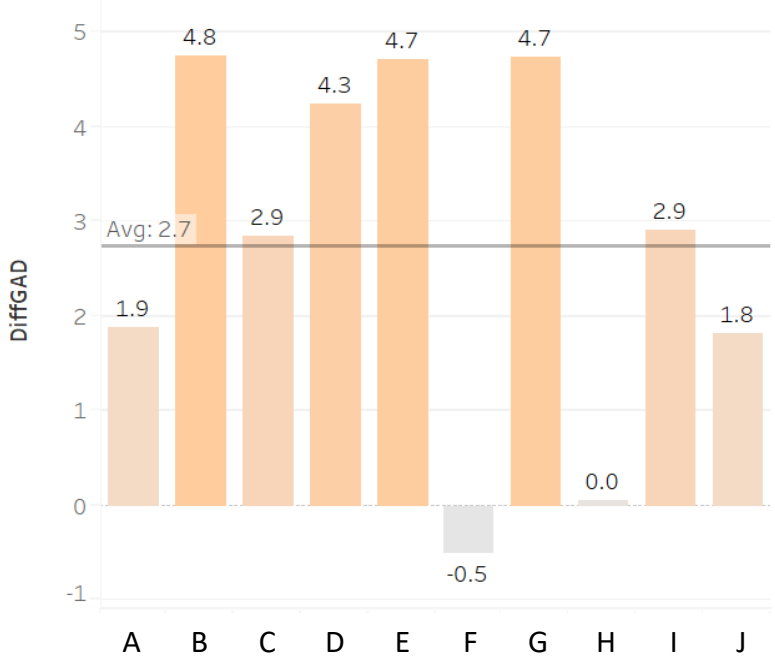
  Garrison, G. M., Angstman, K. B., O'Connor, S. S., Williams, M. D., & Lineberry, T. W. (2016). Time to remission for depression with collaborative care management (CCM) in primary care. The Journal of the American Board of Family Medicine, 29(1), 10-17.

Example: Tracking Patient Outcomes

Change between Mean Initial and Mean Latest PHQ Scores by Location



Change between Mean Initial and Mean Latest GAD Scores by Location



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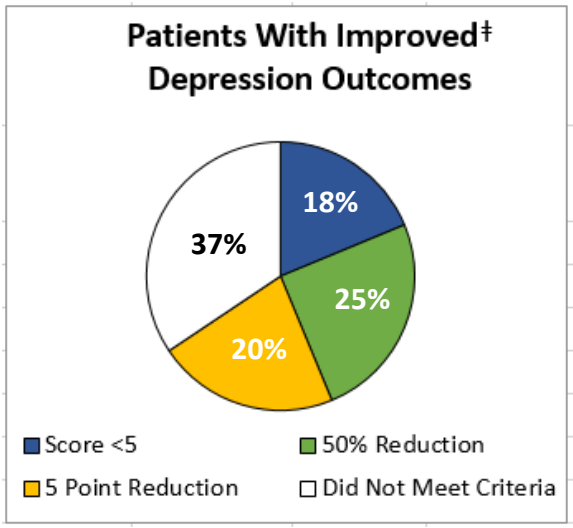

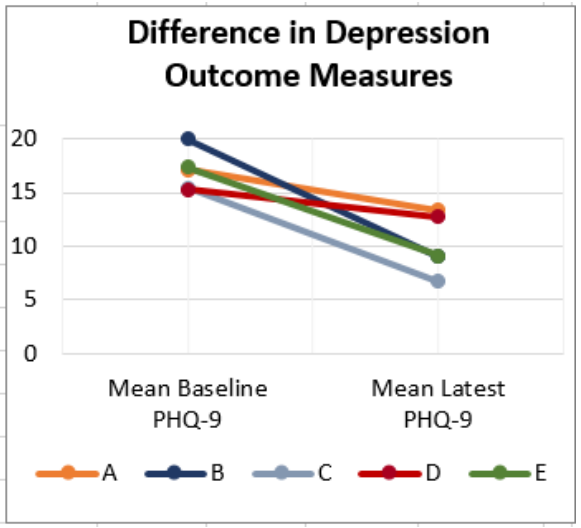

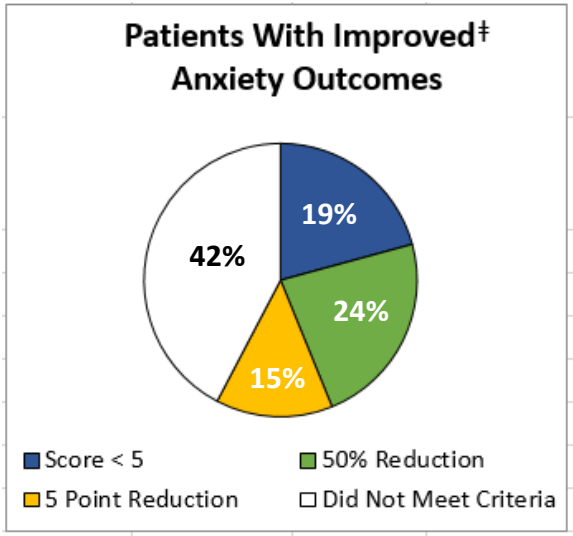

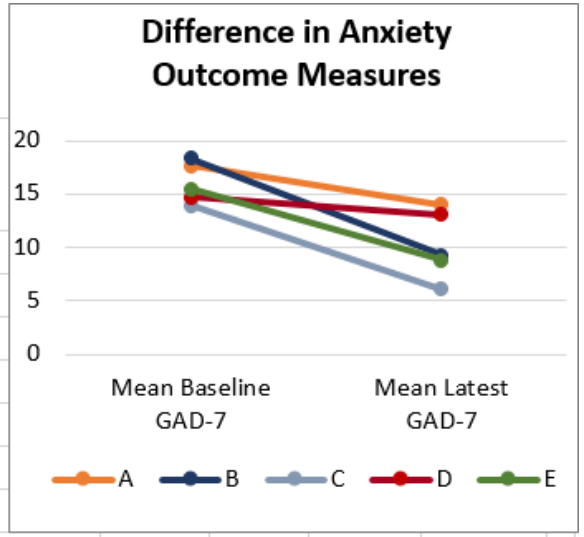

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Process Measures: CoCM Evidence-Base

- Early engagement in CoCM activities is a strong indicator of patients' future success
- Patient are contacted twice per month in the first two-four months of treatment
- Outcome Measures (e.g., PHQ-9) are administered monthly in the first two-four months of treatment
- Brief evidence-based therapeutic interventions (e.g. Motivational Interviewing, behavioral activation, problem solving therapy)

Unützer, J., Katon, W., Williams Jr, J. W., Callahan, C. M., Harpole, L., Hunkeler, E. M., ... & Oishi, S. M. (2001). Improving primary care for depression in late life: the design of a multicenter randomized trial. Medical care, 785-799.

Process Measures: Systematic Case Review

- Patients are discussed with the psychiatric consultant in systematic case review within two weeks after being enrolled
- Expert treatment recommendations from the psychiatric consultant are approved and implemented by the PCP and patient
- Patients not improving* within 8-12 weeks of treatment should be discussed with the psychiatric consultant in systematic case review to revise treatment recommendation

  *improvement is defined as a 5-point reduction, 50% reduction, or score less than 5 in PHQ-9 and/or GAD-7 score

  Unützer, J., Katon, W., Williams Jr, J. W., Callahan, C. M., Harpole, L., Hunkeler, E. M., ... & Oishi, S. M. (2001). Improving primary care for depression in late life: the design of a multicenter randomized trial. Medical care, 785-799.

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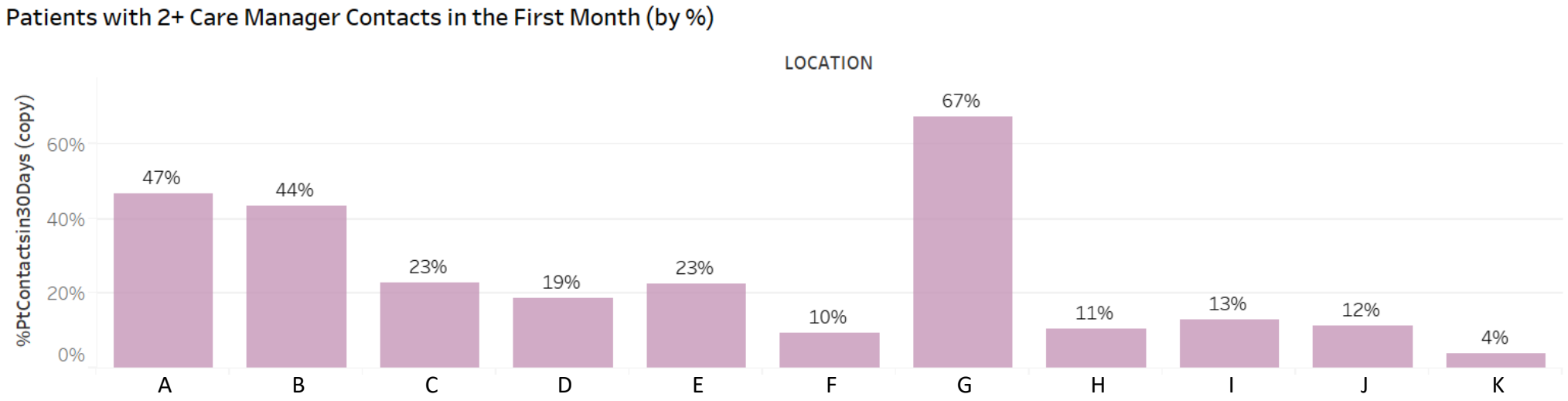
Example: Tracking Process Measures



Example: Tracking Process Measures

Measures			Practices A	B	C	D
Patient Engagement	Early Contact Rate (Target: 75%)	Percentage of patients with 2 or more contacts in the first month	75%	73%	97%	96%
	Early Outcome Measure Completion Rate (Target: 75%)	Percentage of patients* with 2 or more standardized outcome measure(s) (PHQ-9, GAD-7) completed within the first 3 months of their enrollment	95%	96%	90%	98%
Systematic Case Review	Early Systematic Case Review Rate (Target: 90%)	Percentage of patients discussed with a psychiatric consultant in systematic case review within their first 2 weeks of enrollment	88%	82%	100%	98%
	Recommendation Implementation Rate (Target: 80%)	Percentage of psychiatric recommendations that have been implemented (This does not include pending recommendations)	86%	85%	85%	96%
Evidence-based Care	Brief Intervention Use Rate (Target: 90%)	Percentage of patients with documented use of a brief intervention (e.g., Motivational Interviewing, behavioral activation, tangible resource, medication monitoring)	95%	100%	95%	100%

CoCM Billing Basics

- Per member per calendar month
- Incident to the PCP or “billing practitioner”
- Only count BHCM time delivering CoCM services; payment accounts for time spent by all clinical team members but can’t duplicate shared time
- Psychiatric consultant is contracted by PO/practice; CoCM services delivered by the psychiatric consultant are **included** in CoCM payment rate
- Billed alone or with a claim for another billable visit

CPT Code	Month	Time Threshold
99492	Initial Month	36-70 minutes
99493	Subsequent Month(s)	31-60 minutes
99494	Add-on Code: no limit	16-30 minutes
G2214	Any Month (recommended only for subsequent months)	≤30 minutes

Billing by Time Threshold

Codes	Timeframe	Time Spent	Billing Codes
G codes	Initial Month	> 20 minutes	G0511
		> 70 minutes	G0512
	Subsequent Month	≤30 minutes	G2214
		31-60 minutes	G0511
		> 60 minutes	G0512
CPT codes	Initial Month	≤10 minutes	Not billable
		11-35 minutes	99484
		36-85 minutes	99492
		86-115 minutes	99492 + 99494
		116-130 minutes	99492 + 99494 + 99494
		>130 minutes	99492 + 99494 + 99494
	Subsequent Month(s)	≤30 minutes	G2214
		31-75 minutes	99493
		76-105 minutes	99493 + 99494
		105 – 120 minutes	99493 + 99494 + 99494
		>120 minutes	99493 + 99494 + 99494

Commercial Patients

Provider Location	Codes		Timeframe	Time Requirements
Any location	CPT Codes	99492	Initial Month	36 - 70 minutes
		99493	Subsequent Months	31 - 60 minutes
		99494	Add-on (initial or subsequent)	16 - 30 additional minutes
		99484	Initial/Subsequent Month (General Behavioral Health Integration)	11 - 20 minutes
		G2214	Any Month (recommended only for subsequent months)	≤30 minutes

Medicare Patients

Provider Location	Codes		Timeframe	Time Requirements
FQHC/RHC	G code	G0512	Initial Month	> 70 minutes
			Subsequent Months	> 60 minutes
		G0511	Initial/Subsequent Month (General Behavioral Health Integration)	> 20 minutes
		G2214	Any Month (recommended only for subsequent months)	≤30 minutes
Non-FQHC/RHC	CPT Codes	99492	Initial Month	36 - 70 minutes
		99493	Subsequent Months	31 - 60 minutes
		99494	Add-on (initial or subsequent)	16 - 30 additional minutes
		99484	Initial/Subsequent Month (General Behavioral Health Integration)	11 - 20 minutes
		G2214	Any Month (recommended only for subsequent months)	≤30 minutes

Medicaid Patients

Provider Location	Codes		Timeframe	Time Requirements
FQHC/RHC	G code	G0512	Initial Month	> 70 minutes
			Subsequent Months	> 60 minutes
		G2214*	Any Month (recommended only for subsequent months)	≤30 minutes
Non-FQHC/RHC	CPT Codes	99492	Initial Month	36 - 70 minutes
		99493	Subsequent Months	31 - 60 minutes
		99494	Add-on (initial or subsequent)	16 - 30 additional minutes
		99484	Initial/Subsequent Month (General Behavioral Health Integration)	11 - 20 minutes
		G2214*	Any Month (recommended only for subsequent months)	≤30 minutes

*MDHHS MSA has not released the revised fee schedule to include G2214, as of January 27, 2021.

CoCM and Other Care Management

- For some patients, using a care team to treat medical and comorbid medical conditions through the Provider-Delivered Care Management (PDCM) program and using a CoCM behavioral health-focused care team may be appropriate. The treating physician would make such determinations and each program would be subject to its own guidelines and billing rules.
- Other care management programs, such as Blue Cross Coordinated Care may also complement PDCM or CoCM. If a patient identified for Blue Cross Coordinated Care is already in the PDCM, Blue care management nurses would contact the treating provider to discuss the member needs to determine how Blue Cross nurses and the provider might manage care together.
- In most cases, members identified for Blue Cross Coordinated Care won't be enrolled in PDCM and vice versa.
- CoCM can't billed in the same calendar month as chronic care management/general behavioral health integration (99484)

What Activities Can Be Billed?

- Guidance applies to 99492, 99493, and 99494; 99492 requires an initial assessment
- Providing assessment and care management services
  - Any form of patient contact
  - Structured diagnostic assessments
  - Self-management planning; relapse prevention planning
- Administering validated outcome measures (e.g., PHQ-9, GAD-7)
- Using brief therapeutic interventions (e.g., Motivational Interviewing, behavioral activation, problem solving therapy)
- Conducting systematic case review with the psychiatric consultant
- Documenting in EHR, disease registry, or systematic case review tool
  - Does not include strictly administrative or clerical duties
- Liaising with PCP or other clinical staff (e.g., community-based providers)
- "Running" the caseload with the psychiatric consultant (i.e., conducting a systematic review of caseload without specifically discussing the patient)
  - Approximately 5 billable minutes per calendar month

Optimizing Financial Performance

- Has all billable time been documented by BHCM?
  - Create a smartphrase to prompt BHCMs to document billable time
  - Create a documentation checklist to ensure all BHCM clinical time is calculated
  - Add an EHR form to calculate billable time per calendar month

- Review a report of documented billable minute per patient per calendar month
  - Review this report half-way through each month to determine which patients would need additional time to reach the next threshold
  - Review billable minutes by BHCM FTE

Optimizing Financial Performance

- Is clinical time being optimized for the caseload size?
  - Conduct a clinical caseload supervision
  - Assess opportunities to keep the caseload “fluid”

- Is staffing of BHCM and psychiatric consultant appropriate?
  - Discuss if the program would benefit from changing the BHCM FTE or hiring additional BHCM
  - Discuss if additional psychiatric consultant FTE is needed
  - Discuss if the caseload should be capped

Next Steps and Resources

Required tasks to begin training:

- Connect with your training partner to outline next steps for CoCM readiness

Additional tasks for sustainable programs:

- Develop billing smartphrases and/or fields to document billable time in EHR or develop mechanism for BHCM to track billable time
- Develop report template to track billable time per patient per calendar month
- Develop mechanism to evaluate outcome and process measures

Resources available on MICMT and BCBSM collaboration websites:

- Medicare Learning Network CoCM Fact Sheet
- Medicare Learning Network FAQ
- MDHHS MSA Bulletin (Medicaid)
- Guide to Conducting Caseload Review Meeting
- Guide to Conducting Program Review Meeting
- Guide to Billable Activities
- Guide to Optimizing Billable Time

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

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Questions?