VALUEPartnerships
Better Care. Better Outcomes. Better Value.

Blue Cross Blue Shield of Michigan

Blue Cross Blue Shield of Michigan Physician Group Incentive Program Collaborative Care Model (CoCM) Designation Program Criteria

SEPT. 1, 2022 TO AUG. 31, 2023

Contents

Interpretive guidelines and description of capabilities for Collaborative Care (CoCM) Designation Program

Goal: Build Collaborative Care Model (CoCM) provider care teams, which adds both a behavioral health care manager (BHCM) and a consulting psychiatrist to a primary care practice. CoCM requires patient awareness of, and active engagement with, the CoCM model and to clearly define CoCM-specific medical and behavioral health team responsibilities. Integrating this model into practices will increase patient access to behavioral health specialist expertise, reduce stigma associated with specialist visits and allow better behavioral health care in a familiar setting with known providers.

Designation: The Collaborative Care Designation Program recognizes a CoCM practice's commitment to creating an empowered care team, that can deliver the evidence-based care to best meet a patient's behavioral health needs in a patient-centered medical home environment.

The CoCM Designation Program builds on the essential foundation of Blue Cross' longstanding PCMH program to create a culture of sustained attention to the "whole person" philosophy—a critical goal for organizations to thrive.

Blue Cross' first-to-market CoCM Designation Program will be value-based and population-based. It rewards collaboration between practitioners in areas where inter-specialty communication traditionally has not been a part of usual care; this communication dramatically helps improve both access to critical services and ultimately, clinical outcomes.

Beginning with the Sept. 1, 2022, all the capabilities in this document will need to be in place to be eligible for the next CoCM Designation.

All capabilities and guidelines are applicable to primary care practices for eligible current patients regardless of insurance coverage. The definition for "current" patients is the same as for the Patient-Centered Medical Home program.

1.0 Training and Model Building

Primary care, behavioral health care managers, and psychiatrist roles are clearly defined to ensure that care is delivered with fidelity to the original model as described by the University of Washington AIMS Center.

CoCM is a unique model that adds the following to the primary care team:

- Care management support for patients receiving behavioral health treatment.
- A treat-to-target approach to population health.
- Regular psychiatric inter-specialty consultation.
- A team of three individuals to deliver CoCM: the behavioral health care manager (BHCM), the consulting psychiatrist and the primary care provider.
- A tool, accessible to all members of the care team, used to document patient scores, outcomes, recommendations, and treatment changes. We refer to this as a systematic case review tool (SCR-tool).
- Our CoCM Designation program is an extension of our Patient-Centered Medical Home foundation, which is why PCMH Designation is required to become CoCM Designated. We expect all members of the healthcare team to have a solid understanding of PCMH.

1.1

Practice's care team consists of the provider triad described by the CoCM model.

Guidelines

All members of the healthcare team must have a solid understanding of Patient-Centered Medical Home. The CoCM roles and responsibilities for each member include:

a. **Primary care provider** – A state-licensed physician or advanced practice provider who is qualified to prescribe medications.
   - Directs the behavioral health care manager.
   - Oversees treatment plans and overall patient care.
   - Determines whether to implement recommendations of the consulting psychiatrist.
   - Prescribes all medications.
   - Refers patients to CoCM.
   - Claims for CoCM services *must* be billed under the PCP's NPI.

b. **Behavioral health care manager** – A state-licensed, designated individual with formal education or specialized training in behavioral health.
   - Works under the oversight and direction of the primary care provider.
   - Conducts screening assessments at regular intervals.
   - Coordinates care with the PCP.
   - Provides patient education about CoCM and behavioral health disorders, medications, and other treatment options.
   - Supports psychotropic medication management as prescribed by medical providers, focusing on length of time to reach therapeutic range, side effects, adverse reactions, and the potential effects of discontinuance or dosage adjustment.
   - Provides brief interventions, motivational interviewing, problem solving treatment and behavioral activation to facilitate patient engagement and self-management.
   - Monitors and tracks treatment response.
   - Conducts systematic case reviews (SCRs) with the consulting psychiatrist.
   - Communicates recommendations and patient discussions with the PCP and consulting psychiatrist through the SCR-tool (can be in EHR, in a stand-alone tracking system, or in a registry).
   - Facilitates treatment plan changes.
   - Completes relapse prevention and self-management planning.
   - Tracks patient management activities for all care team members to support appropriate billing. *Reminder, time when two care team members are involved in the same activity cannot be duplicated.*
   - Bills for services using the PCP's NPI.

c. **Consulting psychiatrist** – A state-licensed medical professional trained in psychiatry and qualified to prescribe the full range of medications.
   - Consulting psychiatrist *does not* meet with patients or prescribe medications.
   - Participates in the SCR on a regular basis, ideally weekly.
   - Advises the PCP and behavioral health care manager about diagnosis and treatment recommendations.
   - Provides options for resolving issues, including patient adherence, efficacy, or side effects.
   - Recommends adjustments to the treatment plan for newly enrolled patients and patients not progressing.

Required for CoCM Designation: YES	**Predicate Logic: n/a**
Validation notes for CoCM site visit	
• Practice identifies each of the three care team members and describe how they interact to deliver CoCM.	

Resources and Samples:

- PGIP/Training Partner Organizing an Excellent Care Team
- AIMS Center CoCM BHCM: Sample Job Description, Typical Workload & Resource Requirements
- AIMS Center Clinical Workflow Plan

1.2

A member from each of the three roles supporting the practice attends the PGIP-sponsored training unless they meet Capability 1.3 – being deemed by the training partner to be delivering CoCM with fidelity to the CoCM model.

Guidelines

a. PGIP-sponsored training requires: A care team member from each role has attended PGIP-sponsored training delivered by our training partners. New staff should complete training prior to engaging in patient care. Base training requires:
   - 16 hours for BHCMs
   - 4 hours for PCPs
   - 4 hours for consulting psychiatrists

b. Although other practice members do not necessarily need to take PGIP-sponsored training, the practice must ensure that all practice members understand the CoCM model, so that they can answer patient questions and help identify patients who may benefit from a referral either to CoCM or to other community resources.

Required for CoCM Designation: YES, unless Capability 1.3 is met	**Predicate Logic: n/a**
Validation notes for CoCM site visit	
• Show evidence of PGIP-sponsored training, such as a practice list from the PO, or a CME certificate from the training. • Show evidence of training and/or training materials for other practice staff.	

1.3

A practice is deemed to be delivering CoCM with fidelity to the CoCM model unless they meet Capability 1.2 – by attending PGIP-sponsored training.

Guidelines

These are the steps to receiving fidelity status. Once the Fidelity Attestation is delivered, the practice is eligible for designation nomination.

1. PO and practice complete the *Fidelity Worksheet* and submits it to the training partner. The *Fidelity Worksheet* briefly asks questions to determine whether there is evidence to continuing with a full fidelity review.
2. If there is not sufficient evident that the practice is likely to meet the fidelity requirements, the practice must go through PGIP-sponsored training.
3. If there is sufficient evidence that the practice may meet the fidelity requirements, the training partner will have a site visit with the PO and practice to assess fidelity using the *Fidelity Assessment* document.
4. The training partner will discuss the *Fidelity Assessment* results with Blue Cross.
5. Once Blue Cross and the training partners agree that the *Fidelity Assessment* results indicate that the practice is delivering CoCM with fidelity to the CoCM model, the training partner will prepare the *Fidelity Attestation* for signatures by the PO and the training partner.
6. Training partner – By signing the *Fidelity Attestation* document, the training partner attests that they have met with the PO and PU and that the practice is delivering CoCM with fidelity to the model.
7. PO – By signing the *Fidelity Attestation*, the PO attests that they have met with the practice and training partner and are confident that the practice is delivering CoCM with fidelity to the CoCM model.
8. Training partner will deliver copies of the signed *Fidelity Attestation* to the PO, practice and to Blue Cross.
9. Blue Cross makes final determinations about fidelity status.

The practice may have trained through the PGIP-sponsored training, AIMS Center Training or other training.

Fidelity assessment will include review of the following:

- Care team members
- Clinical protocols
- Tools and technology

Required for CoCM Designation: YES, unless Capability 1.2 is met	Predicate Logic: n/a
Validation notes for CoCM site visit	
• Show executed *Fidelity Attestation*.	

1.4

The practice has a BHCM with dedicated/protected time to carry out CoCM activities. Practice has a written policy and/or procedure for these activities.

Guidelines:

a. The BHCM is secured through employment or contract, either by the practice or through their physician organization. This person supports and coordinates the mental and physical health care of patients on an assigned patient caseload along with the patient's medical provider and, the consulting psychiatrist.
b. The BHCM may be involved in other care management activities, such as provider-delivered care management, however, there must be separate and distinct time set aside for CoCM activities. BHCMs who are assigned numerous other duties in a fast-paced clinic setting often fall behind on effectively managing their CoCM caseload.
c. The BHCM may be involved with other behavioral health activities in the office, such as an MSW providing counseling sessions, however there must be separate and distinct time set aside for CoCM activities.
d. If the BHCM is to work within the office setting, the practice has dedicated and private space for patient outreach and for SCR.
e. The BHCM enters patient information and outcome measure scores into the SCR-tool and maintains the SCR-tool to use for the SCR sessions with the consulting psychiatrist. Information about any chronic conditions should be referenced either within the SCR or within the EHR; but must be easily accessible to BHCM and consulting psychiatrist.
f. SCRs are scheduled regularly, ideally, every week.
g. Documents show how the BHCM's functions will be handled in the case of an extended or permanent leave from the practice.

The SCR-tool should contain information about all patients engaged in CoCM, tracked over time so that it is easy to identify if patients are discharged/readmitted and to help detect patterns related to treatment of multiple patients. At a minimum, the SCR tool should contain:

- Appointment tracking.
- Notes from patient intake and ongoing discussions.
- Progression of a patient's results from the PHQ-9 or PHQ-A.

- Notes from the brief interventions used, e.g., motivational interviewing, to facilitate patient engagement and symptom self-management.
- Current treatment discussion with the psychiatrist including medication effectiveness, side effects, etc.
- Notes about the consulting psychiatrist's recommendations from the SCR.
- If the consulting psychiatrist doesn't enter recommendation directly into the EHR or SCR, details about how the consulting psychiatrist reviews documentation for accuracy.
- Details about how/when the PCP accesses those recommendations.
- Notes from the PCP about the specific recommendation, regardless of whether it is accepted, denied, or modified.
- Notes that show communication with the patient about PCP-approved recommendations.

Required for CoCM Designation: YES	**Predicate Logic: n/a**
Validation notes for CoCM site visit	
• Show BHCM's schedule, showing dedicated time to SCR. • Show written policy and/or procedure of the overall BHCM workflow including: – What is included in the SCR and how the SCR is accessed and how it is used. – If BHCM has other responsibilities (e.g., PDCM or BH counseling), show how programs are separate and distinct. – If BHCM services are office-based, show the dedicated and private space (describe if remote). – Show how appointment reminders and show/no-show tracking is utilized and how it is accessed by healthcare team members.	

1.5

Practice has regularly scheduled time with a consulting psychiatrist to participate in Systematic Case Review discussions. Practice has written policy and/or procedure for these activities.

Guidelines:

a. The consulting psychiatrist is secured through employment or contract either by the practice or through their physician organization.
b. The consulting psychiatrist is responsible for a caseload of patients and primarily interacts with the BHCM and occasionally with the primary care provider.
c. SCRs may be conducted by telephone, video, or in person.
d. SCRs are scheduled regularly, ideally weekly.

e. If possible, the consulting psychiatrist should document into the SCR-tool, through the EHR or other means. If the consulting psychiatrist doesn't have access to the SCR-tool or EHR, the BHCM can document in the SCR-tool. Practice must have a process for the consulting psychiatrist to review the accuracy of the documentation.
f. Information about any chronic conditions should be documented either within the SCR-tool or within the EHR; but must be easily accessible to BHCM and consulting psychiatrist.
g. Documents show how patient care will transition if the psychiatrist is absent from the role in the case of an extended or permanent leave from the practice.

Required for CoCM Designation: YES	**Predicate Logic: n/a**
Validation notes for CoCM site visit	
• Provide documentation of the consulting psychiatrist's availability, schedule, and contact information, along with regularly scheduled time. • Show notes or other documentation of a discussion of consulting psychiatrist recommendations, including treatment, cadence of patient/PCP follow up. • Show how the SCR is used to manage population health by using SCR time to discuss multiple patients. • Show an example of a recommendation a consulting psychiatrist wrote in the SCR-tool. • If the consulting psychiatrist does not have access to the EHR, show the written process and/or procedure and an example of a consulting psychiatrist who reviewed a recommendation documented by a BHCM. • Provide contingency plan to provide continuity of care in the absence of the consulting psychiatrist.	

1.6

The PCPs identify appropriate candidates for CoCM, refer to the BHCM, read and respond to consulting psychiatrist's recommendations timely, and support the BHCM. Practice has written policy and/or procedure for these activities.

Guidelines

a. Identify and engage the patient
   - Introduce Collaborative Care to a patient.
   - May acquire informed patient consent. The BHCM may do this depending on practice workflow.
   - Initiate a warm handoff to a BHCM when possible.

b. Determine the diagnosis
   - Formulate using validated screeners, exams, and history.
   - Work with care team to diagnose and treat complex behavioral health conditions.
   - Observe over time.
   - Adjust diagnosis as appropriate.

c. Treat
   - Work with care team and patient to develop a treatment plan.
   - Work with care team to implement treatment and make treatment adjustments.
   - Prescribe medications as needed.
   - Address safety concerns.
   - Monitor physical health and potential medication interactions.
   - Read psychiatric consultant's recommendations and implement recommendations with patient consent and understanding.

d. Claims for the care team's activities are submitted using the PCP's NPI.

Required for CoCM Designation: YES	**Predicate Logic: n/a**
Validation notes for CoCM site visit	
• Practice has a written policy and/or procedure to show how the PCPs identify candidates for CoCM and the referral workflow. • Show examples of health records where the PCP has identified and engaged the patient, diagnoses the patient, and treats the patient. • Practice has a written policy and/or process to show how the PCP is alerted to activity taken and documented by the BHCM. • Show examples of a PCP's response to BHCM notes and consulting psychiatrist's recommendations. • Show where consent is tracked in the patient's health record and how it's accessed.	

2.0 Process Implementation

Primary care, behavioral health care managers, and psychiatrist workflows and processes are clearly defined to ensure that care is delivered with fidelity to the original model as described by the University of Washington AIMS Center.

2.1

The practice has a written policy and/or procedure to show an established process to screen patients for depression using Patient Health Questionnaire–9 or PHQ-A

Guidelines:

a. Practice screens all patients at least annually for depression and interpret the results to identify patients that need further assessment.
b. PHQ-9 or PHQ-A results should be recorded and included in the patients' record and recorded in the SCR-tool upon enrollment.
c. For patients who score less than 10, usually no further activity is needed at this time.
d. Patients who score positive are evaluated to determine if they meet provisional criteria for depression or mood disorder.
e. The PHQ-9 or PHQ-A is administered to all patients enrolled in the CoCM program at least monthly to measure progress toward remission.
f. The practice has a mechanism, detailed in a written policy and/or procedure, in place to track PHQ-9 or PHQ-A results for CoCM patients over time.

Required for CoCM Designation: YES	**Predicate Logic: n/a**
Validation notes for CoCM site visit	
• Show written policy and/or procedure for screening frequency, interpreting, and tracking results. • Show SCR-tool examples of PHQ-9 or PHQ-A scores tracked over time for patients enrolled in CoCM. • Share process workflow for positive screens and follow up.	

2.2

Practice has written policy and/or procedure to obtain consent, as defined by Centers for Medicare & Medicaid Services, from all CoCM candidates prior to delivering CoCM services.

CMS-defined consent:

> ***"Advance Consent***
> *Prior to beginning BHI services, the beneficiary must give the billing practitioner permission to consult with relevant specialists, which would include conferring with a psychiatric consultant. The billing practitioner must inform the beneficiary that cost sharing applies for both face-to-face and non-face-to-face services even if supplemental insurers cover cost sharing. Beneficiary consent may be verbal (written consent is not required) but must be documented in the health record."*

See MLN909432 March 2021 *for details.*

Guidelines:

a. Practice has a written procedure and systematic process to obtain consent from patients (and/or parents or guardians if appropriate) prior to delivering CoCM services.
b. Discussion of consent elements, either written or verbally, can be held between the BHCM and the patient or the PCP and the patient and includes:
    - Explaining to the patient that their symptoms could be helped by including the CoCM team in their treatment.
    - Briefly introducing CoCM. This includes describing additional care team members (BHCM and consulting psychiatrist) and their roles within the program.
        – It can be helpful to have a brochure or handout with this information available to give to patients. Customizable templates are available on the PGIP Collaboration site.
    - Informing the patient there may be associated cost, depending on their insurance, and suggest they contact their insurance carrier or the practice's billing department for more information.
c. Obtains written or verbal consent from the patient to participate in the CoCM program.
d. Documents written or verbal consent in the patient's electronic health record and ensure it's available to all care team members.

Resources and samples:

- American Psychiatric Association toolkits
- AIMS Center - Guidance on Patient Consent and COCM
- MLN Booklet Behavioral Health Integration
- Frequently Asked Questions about Billing Medicare See questions 16 and 17

Required for CoCM Designation: YES	Predicate Logic: n/a
Validation notes for CoCM site visit	
• Show the police or procedure document that documents the systematic process for obtaining consent. • Provide any examples of patient education materials if materials are part of the process. • Show evidence that consent contains these elements: – I have discussed the CoCM 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 (and/or parent or guardian, if appropriate) if the patient is a minor) has agreed to participate in the CoCM and for consultations to be conducted with relevant specialists. • Show where consent is tracked in the patient's health record and how it is accessible to all care team members. ***The documentation used for the Patient-Provider Partnership agreement for PCMH capability 1.1 does not meet the intent.***	

2.3

The practice has written policies and/or procedures to show an established patient selection process and referral pathway.

Guidelines:

a. CoCM care team members assess appropriate treatment pathway for patient who either score over nine on the PHQ-9 or PHQ-A or who talk with the PCP about depression or mood disorder during an office visit.
b. There is an established process for the PCP to refer the patient to the BHCM for further assessment and evaluation for the CoCM program.
c. There is a documented referral pathway to other providers or to other types of treatment.
d. All members of the healthcare team have been educated on the referral pathway.
e. Practice has a written policy and/or procedure about appropriateness of referral to CoCM including what makes a patient an appropriate candidate for CoCM and about treatment options for patients not appropriate candidates for CoCM.

Required for CoCM Designation: YES	Predicate Logic: n/a
Validation notes for CoCM site visit	
• Show written policy and/or procedure for identifying patients who may be appropriate for treatment via the CoCM model, and a referral pathway to CoCM providers or other treatment. • Provide evidence of all members of the healthcare team have been trained on the referral pathway.	

2.4

Practice has a written policy and/or procedure to show their established suicide protocol.

Guidelines:

a. The practice has established suicide protocol if a patient screens positive on the suicidality question on either the PHQ-9 or PHQ-A questionnaire, or if a patient indicates at any given time that they are suicidal or having suicidal ideations.
b. The practice has established response and management protocol in place if patients are suicidal.
c. Process has a response outlined for instances where the patient presents with suicidality in person as well as over the phone or virtually.
d. Practice care team receives training at time of hire and annually. At a minimum the PCP, BHCM and consulting psychiatrist must receive this training, but may be extended to other practice unit members.

Required for CoCM Designation: YES	Predicate Logic: n/a
Validation notes for CoCM site visit	
• Documented written protocol that outlines the process initiated when a patient presents with suicidality in person, virtually, or by phone. • Show example of the suicide protocol safety plan. • Protocols are more detailed and specific than just indicating that a practice or staff person will "Call 911." • Protocol identifies resources that are available for the staff and patient. • Documentation of training staff on suicide protocol within the last 12 months.	

2.5

Practice has a written policy and/or procedure that outlines the BHCM workflow and the expectations for length of patient engagement in CoCM, reasons for ending participation, established transition plans, and individualized relapse prevention plans.

Guidelines:

Patients enrolled in CoCM programs typically see improvement and stay on a caseload for six to nine months. However, CoCM participation may end for various reasons including:

- Patient has realized maximum improvement or remission.
- Patient isn't improving despite appropriate treatment revisions or has a change in status necessitating transition to another level of care.
- The patient choses to move to specialist care, or otherwise chooses to discontinue CoCM.
- Patient has left the practice.
- Patient is no longer participating in CoCM (not returning phone calls, etc.).

Defining Improvement:

Using the validated outcome measures:

- PHQ-9 or PHQ-A – Depression screening

  Improvement:
  - 5-point reduction in score = Improvement
  - 50% reduction in score = Response
  - Score less than 5 = Remission
- The GAD-7 (Generalized Anxiety Disorder) – Anxiety screening (recommended, but not required)

a. The BHCM, together with the patient and other providers on the care team, develop a self-management plan that leads to patient improvement as defined above.
b. Self-management plan is documented in the patient's health record or is otherwise available to all members of the treatment team.
c. Ensure that the patient has an active role in developing their self-management plan.
d. BHCM has frequent contacts, often weekly in the beginning of a CoCM episode, but contact may be less frequent later in the episode. During the CoCM episode, the BHCM performs the following:
   - Conducts full assessments, including use of validated screening and symptom monitoring tools.
   - Monitors patient with validated symptom outcomes measures such as the PHQ-9 or PHQ-A.
   - Works with patient to create and adjust self-management plan.
   - Monitor's medication and any side effects.

- If PCP approves the consulting psychiatrist's recommendation, lets the patient know about any change, and determines patient interest in adopting the PCP-approved recommendations.
- Provides brief therapeutic interventions such as motivational interviewing, problem solving treatment, and behavioral activation.

e. The BHCM documents all activity in the SCR-tool.
f. When the patient reaches target improvement the BHCM should prepares a transition plan.
g. Create relapse prevention plan with patient.
h. If the patient isn't improving despite appropriate treatment revisions; or has a need to transition to another level of care, the BHCM should consult with the other care team members to develop a transition plan for the patient to receive the next level of care. This may include making referrals, following up on referrals or suggesting appropriate community resources.
i. If the patient chooses to move to specialist care or otherwise discontinues CoCM, the BHCM's follow up should include outreach to the patient to create a transition and/or relapse prevention plan.
j. The written transition/relapse plan should be developed with input from patient whenever possible.
k. A written copy of the transition/relapse plan is provided to the patient.
l. BHCMs ensure that patients have a clear understanding of the transition plan including:
    - Current medication list.
    - Recognizing individualized relapse warning signs.
    - Self-management techniques, such as exercise, meditation, and mindfulness to address symptoms before they fully manifest.
    - Who and when to call if they begin to relapse.

.

Required for CoCM Designation: YES	**Predicate Logic: n/a**
Validation notes for CoCM site visit	
• Show the points to be discussed at each BHCM/patient interaction. • Show examples of self-management plans that show how these points are addressed. • Show where the self-treatment plan is located and how it is available to all care team members. • Show where ongoing screening results and symptom monitoring are captured. • Show documentation of the patient agreement with treatment plan and short-term goals. This can include notes such as, "Patient stated that their end goal is X. Patient has agreed to exercise for three hours this week." • Show the written policy and/or procedure to document transition and relapse plans with the elements above listed. • Provide an example of a transition plan. • Provide an example of a relapse plan. • Show that BHCM is documenting brief psychotherapeutic interventions.	