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Blue Cross Blue Shield of Michigan

The Psychiatric Consult Collaborative Care Management Model (CoCM)

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Behavioral Health in Primary Care

- Patients bring their behavioral health needs with them to primary care
- 20% of PCP visits are related to mental health[1]
- PCPs are often the first to see signs of behavioral health issues
- Some PCPs feel ill-equipped (based on lack of time or experience) to adequately address behavioral health issues
- Behavioral health and physical health issues are interwoven
- Integrating behavioral health with primary care allows patients to start addressing these issues within the patient-centered medical home
- Effectively treating behavioral health issues in the primary care setting can enhance access, improve patient satisfaction and lead to medical cost savings
  - Typically, savings is seen in medical treatment costs for patients with comorbid conditions

[1] **Source:** 2010 National Ambulatory Medical Care Survey. Available at http://www.cdc.gov/nchs/ahcd.htm.

General Source: AHRQ: The Academy - Integrating Behavioral Health and Primary Care, and Millbank Evolving Care

Blue Cross and Behavioral Health Integration: Next Steps

While there are many useful models of behavioral health integration, Blue Cross is focusing at this time on a model that has been shown in evidence-based trials to improve behavioral health outcomes *and* reduce costs:

The Collaborative Care model

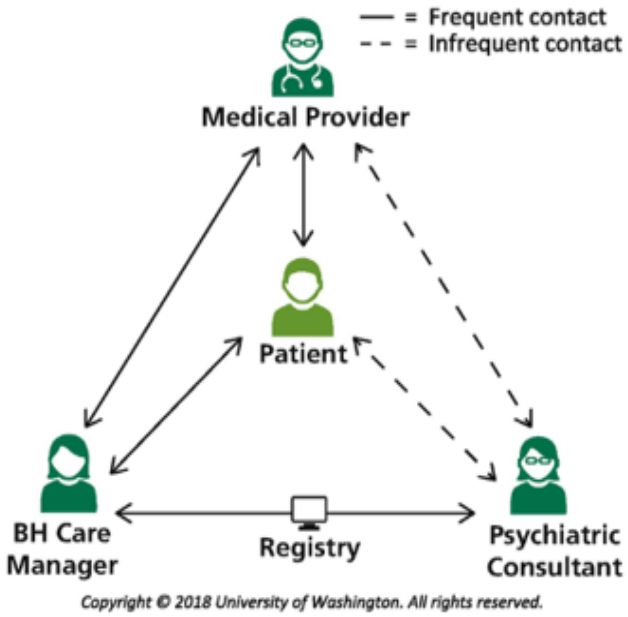
OR

The Psychiatric Consult model

OR

CoCare or CoCM

What is the Collaborative Care (CoCM) Model?



- Operates through a patient-centered care team that shares a registry
- Team includes a PCP, behavioral health care manager (BHCM), and a consulting psychiatrist
- The psychiatrist and care manager meet weekly – typically by phone – for 1-2 hours to review the BHCM's caseload of 60-80 patients with mental health/substance use issues identified through screening in the primary care clinic

- The PCP office bills the Collaborative Care codes and reimburses the psychiatrist; *the psychiatrist does not bill the insurer for his/her time*

CoCM Attributes

Team-based:
led by a PCP with support from a care manager and psychiatric consultant

Population-based:
care team uses a registry to monitor treatment engagement

Patient-centered:
proactive outreach to engage, activate, promote self-management and treatment adherence and coordinate services

Measurement-based:
screening and monitoring of patient-reported outcomes over time to assess treatment response

Evidence-based:
demonstrated cost-effectiveness

Practice-tested:
sustained adoption in hundreds of practices across the country

Benefits of CoCM

- Patients with chronic health conditions are more likely to have behavioral health concerns; they often don't improve until those behavioral health concerns are addressed
- PCPs appreciate having someone with behavioral health expertise readily available
- Patients referred out to behavioral health treatment may not follow up
- Leverages limited psychiatry time
  - 6-8 patients reviewed per hour as opposed to 1 patient
  - Helps reserve specialty psychiatry time for higher level cases

"My offices genuinely feel like this has been an excellent and fundamental change to the way they practice medicine and serve their community." – Alicia Majcher, formerly with HVPA, now with MICMT and Michigan Medicine

Benefits of CoCM (continued)

- Shortens the wait time from referral to receiving an expert psychiatric recommendation
- PCP can continue treatment for cases that are not responding to treatment as expected
- Multiple studies show this model to be effective in treating mental health conditions (e.g., treating depression to remission) and reducing the cost of care associated with comorbid conditions
- Can be coupled with other integration approaches, such as co-location

"I thought I was managing my mild to moderate patients just fine, until Collaborative Care showed me that I wasn't." – Medical Director of Safety Net Clinic in Ypsilanti, MI

Under What Circumstances is the CoCM Model Applicable?

- Highly evidence-based for adults with depression and anxiety
  - Target population – those with "mild to moderate" conditions
  - Increasing evidence for treating adolescent depression and PTSD
- When might a patient benefit from CoCM?
  - Diagnosis of depression, anxiety, or another mild-to-moderate condition
  - Just started on a new antidepressant, regimen was changed, or PCP could use prescribing guidance
  - Routine psychiatric review and systematic monitoring via a patient registry would be helpful to facilitate a tailored psychiatric recommendation
  - Evidence-based brief intervention (e.g., motivational interviewing, behavioral activation) would be helpful in achieving self-management goals
  - Ongoing monitoring and support would be helpful to boost treatment engagement

Are CoCM and PDCM the Same Approach?

No!

SIMILARITIES

- Both are team-based care approaches directed by a PCP
- Both enable the patient-centered medical home to address a wide range of patient needs
- For both, the transition to team-based care requires profound changes in:
  - The culture and organization of care
  - The nature of interactions among colleagues with patients
  - Education and training
  - How practitioners and patients understand their roles and responsibilities[1]

DIFFERENCES

- Neither PDCM nor CoCM will require member cost share, *but the CoCM codes are different from PDCM codes. CoCM codes are not counted toward PDCM rewards or requirements.*
- PDCM is a PGIP program used for commercial PPO patients
- CoCM is an enterprise-wide model that will be used for all lines of business, including BCN products and senior services products

[1]AHRQ: Creating Patient-centered Team-based Primary Care

Is it Easier for a PDCM Practice to Adopt CoCM?

Possibly, so for our first round of CoCM adopters, we will likely draw from our PDCM practices.

- PDCM practices may have the experience to more easily adopt CoCM
- Care managers already in place for PDCM may support the CoCM model, if:
  - The care manager has training and a strong interest in behavioral health
  - The care manager has sufficient protected time for both PDCM and CoCM

What Blue Cross is Doing to Prepare

- Working to eliminate cost-sharing requirements for CoCM codes 99492, 99493 and 99494 along with the general behavioral health integration code 99484
- Cleaning up claim issues that have caused inappropriate rejections
- Gauging PO interest in the model
- Collaborating with training entities to provide free training and ongoing support to launch and sustain the model
- Partnering with MICMT to support the training development and ensure alignment with other care management programs
- Developing incentives and rewards
- Increasing access to psychiatric consultants statewide
- Promoting the model with Blue Cross customers

Incentives and support

Primary Care Physician

- PGIP – 5% VBR *(effective date TBD)*
- Practice support through PGIP Reward Pool *(amounts TBD)*
- *BCN – Provider Recognition Program (under consideration for 2021)*
- Free initial training and ongoing support through training organizations

Physician Organization

- PO rewards *(amounts TBD)* for:
  - Coaching and support of practices
  - Contracting with psychiatrists
  - Registry development and data collection (screening tools and data collection)

Consulting Psychiatrist

- BCN – BHIP reward for consulting psychiatrist
- *PGIP rewards to consulting psychiatrists (TBD)*

Text in italics denotes to be determined

CoCM Requirements

To implement the CoCM model, a practice (in collaboration with the PGIP PO) will need the following:

- A behavioral health care manager (full-time or shared, embedded preferred initially) with *protected time* for this model
  - A social worker or a nurse comfortable working in behavioral health
- An arrangement with a consulting psychiatrist for *protected time* (~1-2 hours/week)
- *Protected time* for a PCP to communicate and participate in care coordination
- A population-health registry that tracks referrals to CoCM, depression scores, anxiety scores and progress in treatment for enrolled patients (e.g., PHQ 9 and GAD 7)
- Systematic depression and anxiety screening protocols
- Commitment to the model and willingness to sustain the model

PO Support and Commitment is Vital!

- Does your PO have the interest and commitment to implement this model
  - Within the next 1-2 months?
  - Within the next 3-6 months?
  - Within the next 6-12 months?
  - After 12 months?
- Is your PO leadership committed to devoting the time and resources necessary to implement this model?
- Do you have experience with PDCM that can be leveraged to support this model?
- Do you have experience integrating behavioral health with general medical care?
- Do you have access to psychiatrists who are interested in supporting this approach?
- Are you willing to provide support for data collection from the participating practices?

Next Steps:

1) *Please fill out the form on your table indicating your PO's level of interest in implementing this model (one form per PO)*
2) *If you are interested, please find and connect with Emily Santer, Kathleen Kobernik and/or Alicia Majcher today*

How Can Your PO Prepare for CoCM?

1) Identify and evaluate interested practice units and champions:

- Are the practices currently using care managers effectively?
- Are the practices using CoCM or other behavioral health integration approaches?
- Are the practices interested in undertaking additional practice transformation?
- Are there PCPs within your PO who can “champion” this model?

2) Identify and collaborate with psychiatrists:

- Do you have relationships with or know of psychiatrists who are interested in the consulting model?
- Do you have relationships with psychiatrists who have done this type of work before?
- Are there psychiatrists within your PO who can “champion” this model?

How Can Your PO Prepare for CoCare? (Continued)

3) Consider workflows:

- Does your PO have the means to share resources among practice units, such as a BHCM or the consulting psychiatrists?
- Can your PO help with the necessary registry function and data collection?

4) Explore available literature and educational resources

- University of Washington AIMS Center (aims.uw.edu)
- Take the two-part APA CoCare online course (psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/get-trained)
- Centers for Medicare & Medicaid Services (cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf)

5) Watch some excellent videos!

- Daniel's story – youtube.com/watch?v=_J-MFMnTrA4
- The Collaborative Care Model (APA) – youtube.com/watch?v=zXZTgq3GyPw

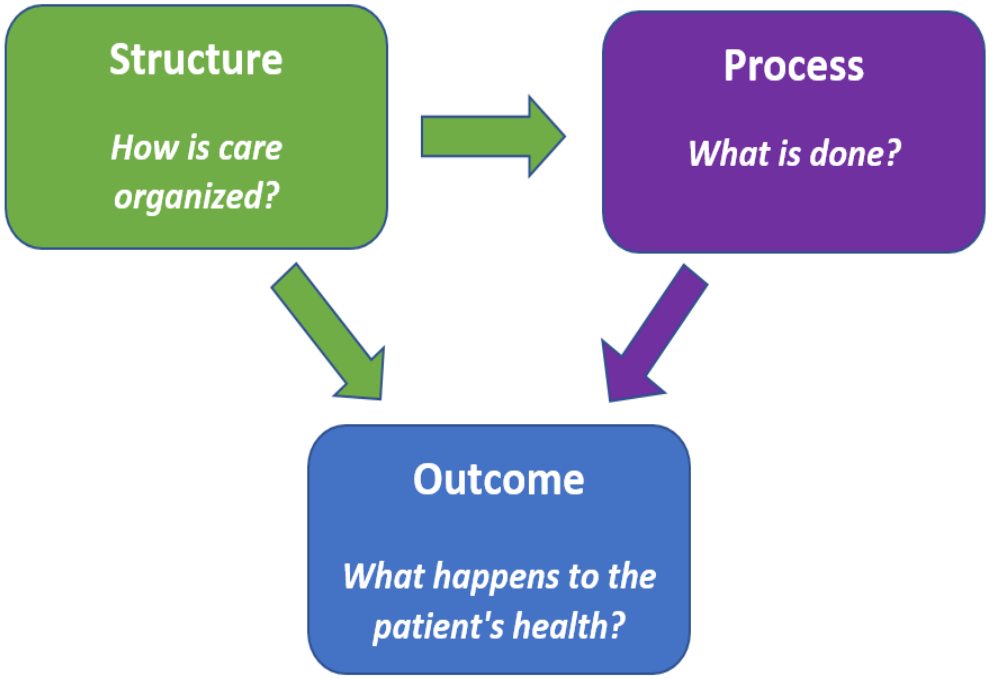
Draft Timeline/Next Steps

Date	Activity
March 13, 2020	Explain approach to POs
	Gauge interest via short questionnaire
	Meet with interested POs at Quarterly
March-20 and April-20	Further discussions with interested POs
April-20 and May-20	Readiness Assessments distributed to interested POs and identified practices
June-20 and July-20	Visits to interested POs to conduct assessment of readiness (or fidelity to model, for those already implementing)
August-20 through Nov-20	Initial trainings
September-20	PCP VBR available to those practicing with fidelity to the model
December-20	PCP practices going through training receive PCP VBR

Appendix

Possible CoCM Process and Outcome Measures

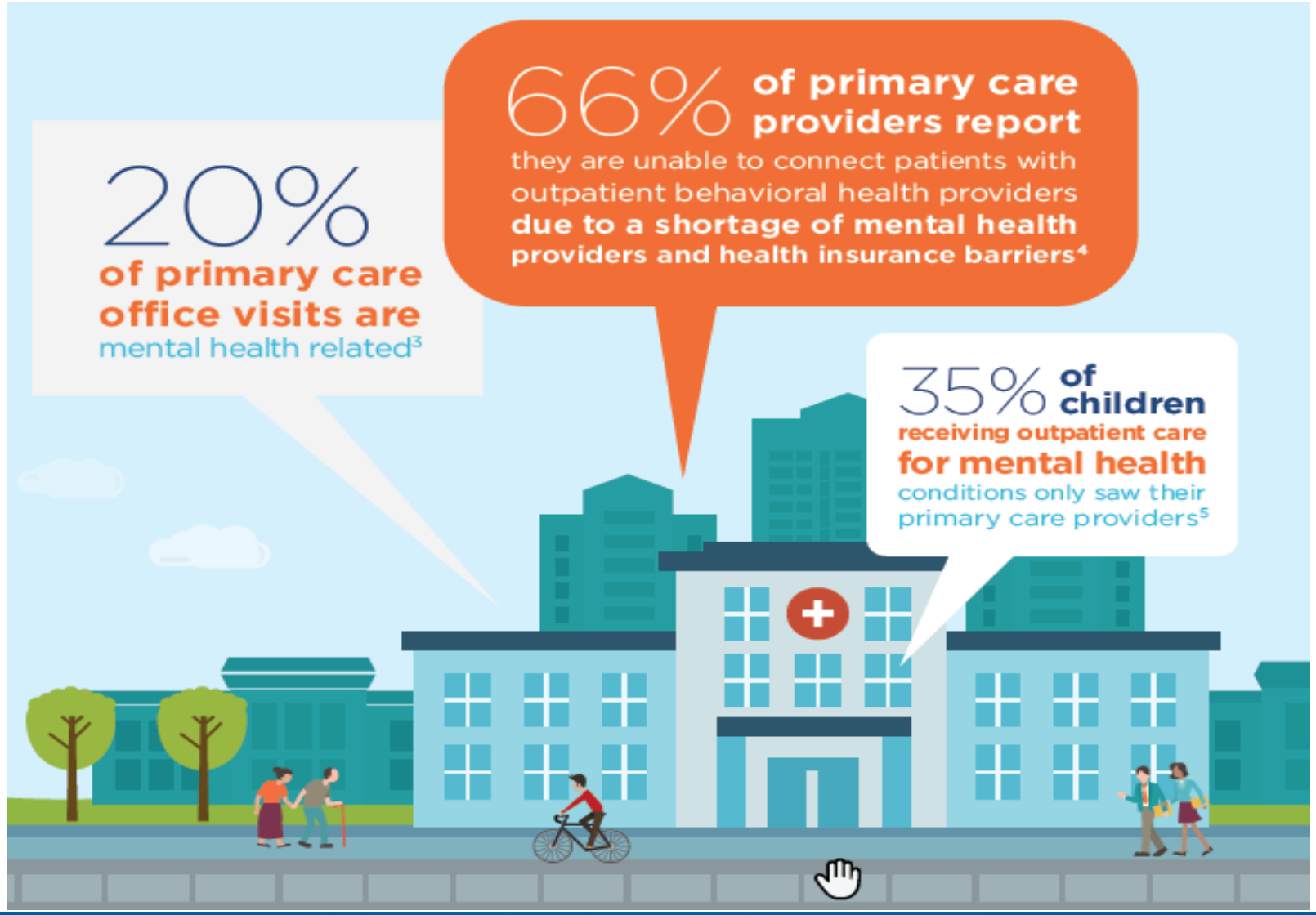
- Use of Patient Health Questionnaire 9 (PHQ 9)
  - PHQ 9 is a common depression screening tool
- Improvement in PHQ 9 scores
- Use of Generalized Anxiety Disorder 7-item (GAD 7)
  - GAD 7 is a common anxiety screening tool
- Improvement in GAD 7 scores
- Savings in medical costs for patients engaged in CoCM
- Identification of patients referred to behavioral care manager



Integration Works!
Examples from the PGIP Integrating Behavioral Health into General Medical Care Initiative

- One PO expanded depression screening:
  - Baseline: 50% of patients screened in 2019
  - Currently 93% of patients receiving screening
- One PO has 10 adult primary care offices with embedded collaborative care, serving 3,000 unique patients over the past 4 years
- One PO increased depression free days – patients in Collaborative Care practices had an average of 39 more depression free days than those not in Collaborative Care practices

Behavioral Health and Primary Care



Source: Eugene S. Farley Health Policy Center