CoCM Program Performance

Section 6

CoCM Program Performance

Program Oversight

Meeting	Goal	Participants	Developing Programs (3-6 Mo)	Mature Programs (6+ Mo)	Required
Systematic Case Review	Provide expert treatment recommendations	BHCM and psychiatric consultant	Weekly	Weekly	**Required**
Program Performance Review	Review performance and operations of CoCM services, including patient outcomes, fidelity, billing, and program operations.	Program manager, clinical supervisor, quality improvement staff Optional: BHCM, PCP champion, leadership, psychiatric consultant, EHR or HIT staff	Monthly	Quarterly	Optional
Clinical Caseload Supervision	High-level review of caseload. Keep the caseload "fluid" by discussing appropriate enrollment, treatment, and triage.	BHCM and clinical supervisor Optional: psychiatric consultant	Monthly	Quarterly	Optional

Note: These are the minimum recommended frequency; review may occur more often as desired by the provider organization or practice.

Program Performance

Infrastructure: A Population-Based Approach

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

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

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

Program Performance

Clinical Caseload Supervision

- Use the systematic case review tool to conduct a **high-level clinical review** of the caseload
  - Evaluate caseload volume, acuity, and needs
- 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**

Program Performance

Program Performance Review

- **Use data** to guide conversation on program performance and optimize service delivery
- **Discuss**:
  - Clinical performance
  - Adherence to the evidence-based model
  - Program operations
  - Financial performance
  - Workforce changes

Program Performance

Monitoring Clinical Performance

Are your patient population's outcome measures **improving as expected** for the specified population?

- Aggregate practice outcomes will vary depending on patient 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

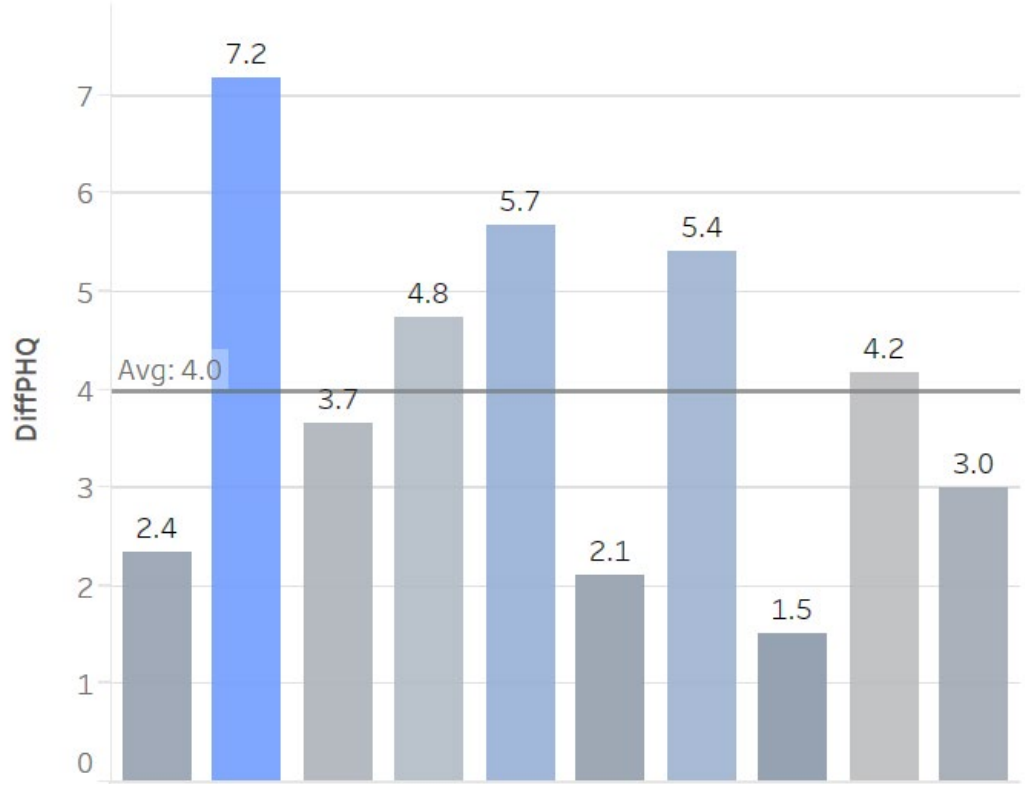
* Improvement is defined as a 5-point reduction, 50% reduction, or score less than 5 in PHQ-9 and/or GAD-7 score

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.

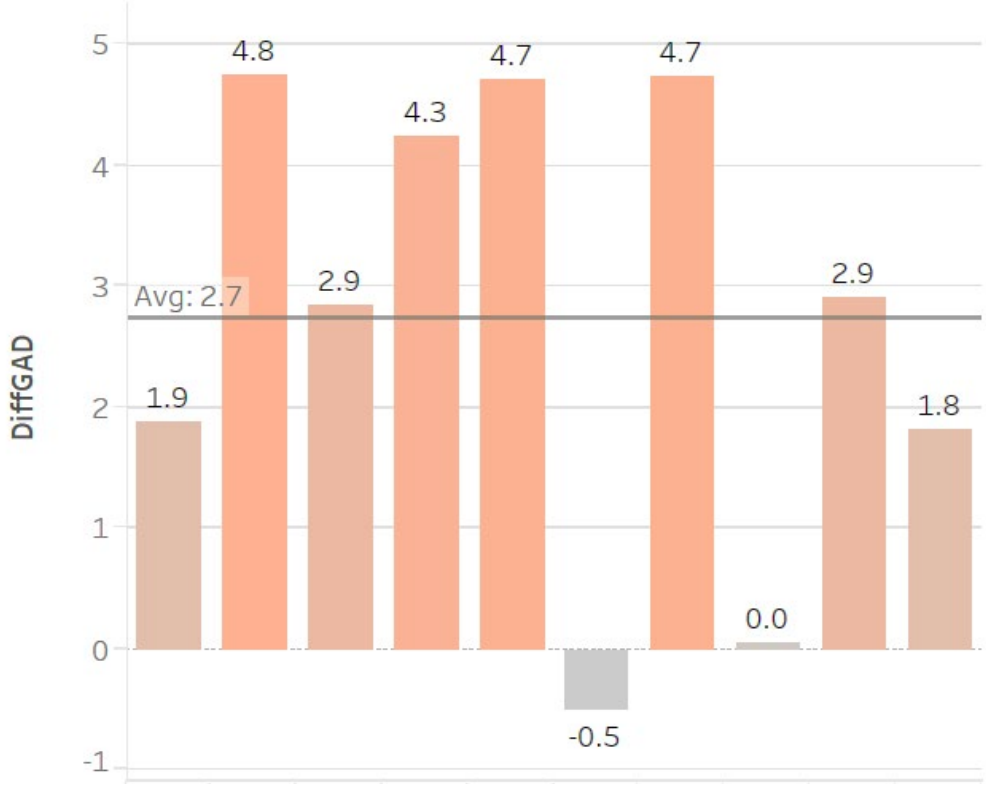
Program Performance

Example: Tracking Patient Outcomes

Change between Mean Initial and Mean Latest PHQ Scores by Location

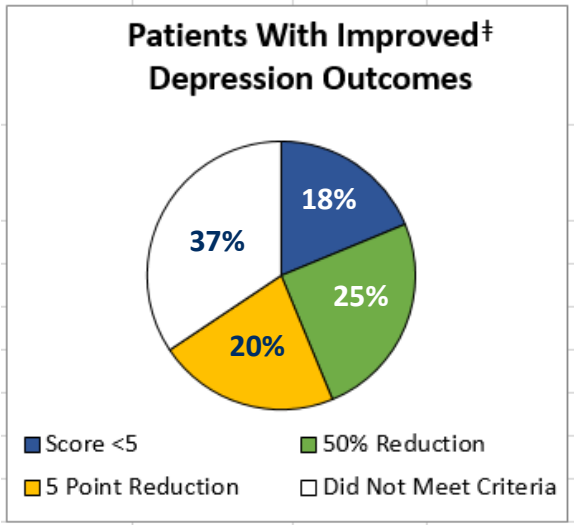


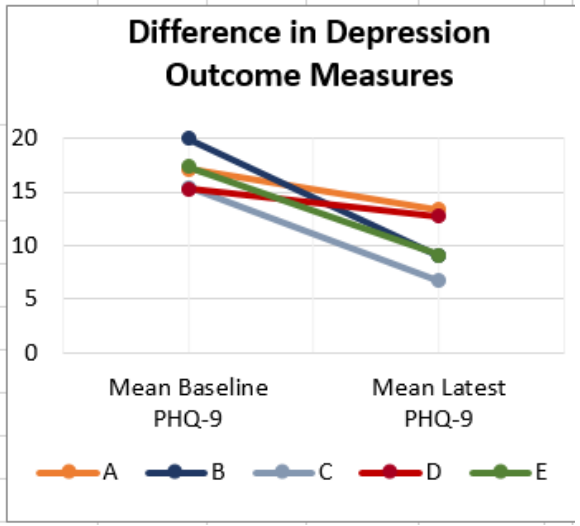
Change between Mean Initial and Mean Latest GAD Scores by Location

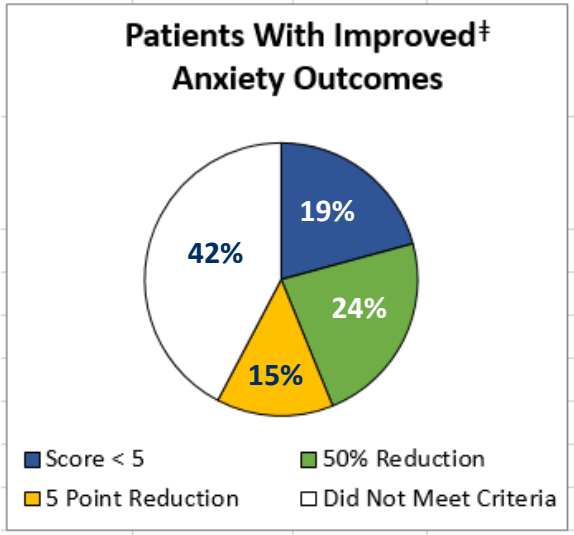


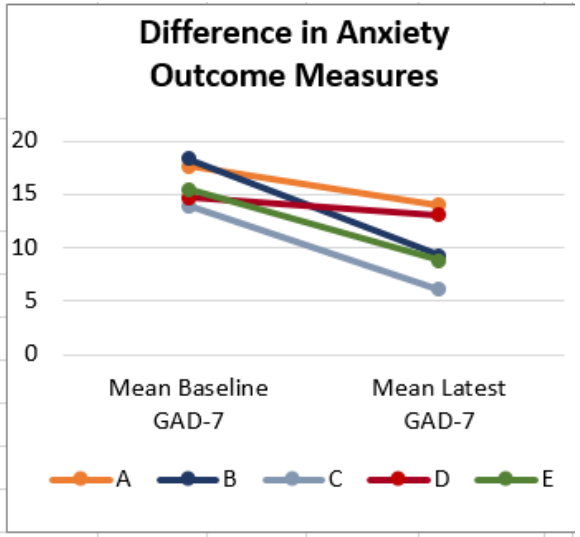
Program Performance

Example: Tracking Patient Outcomes



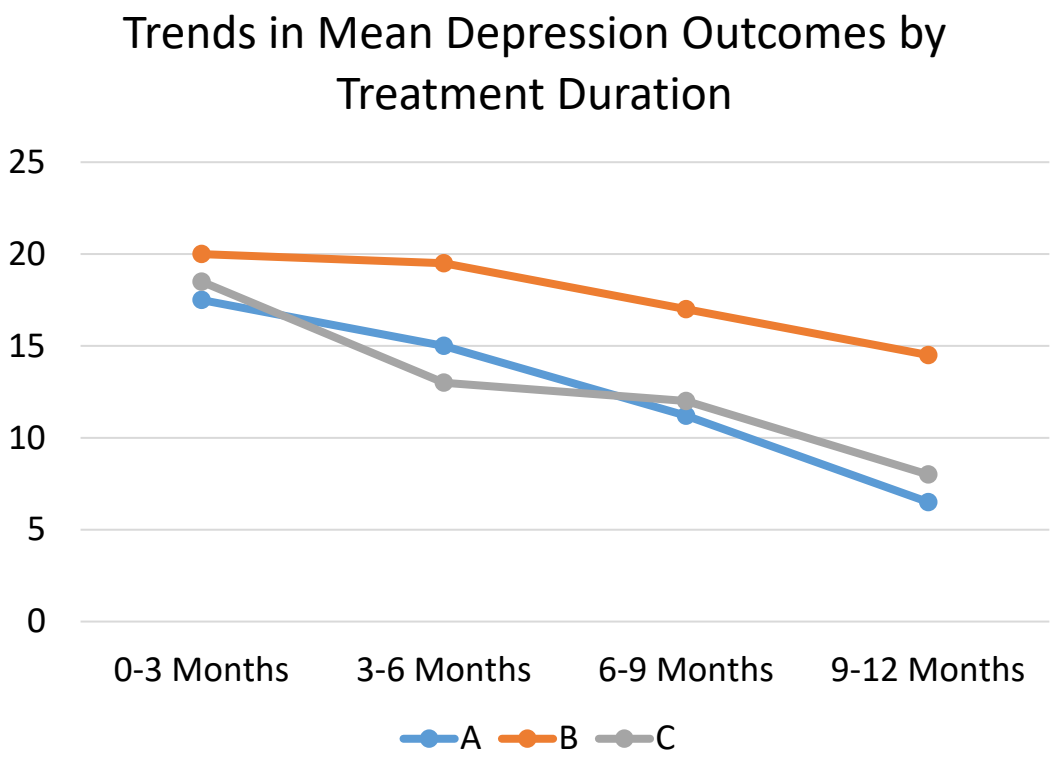


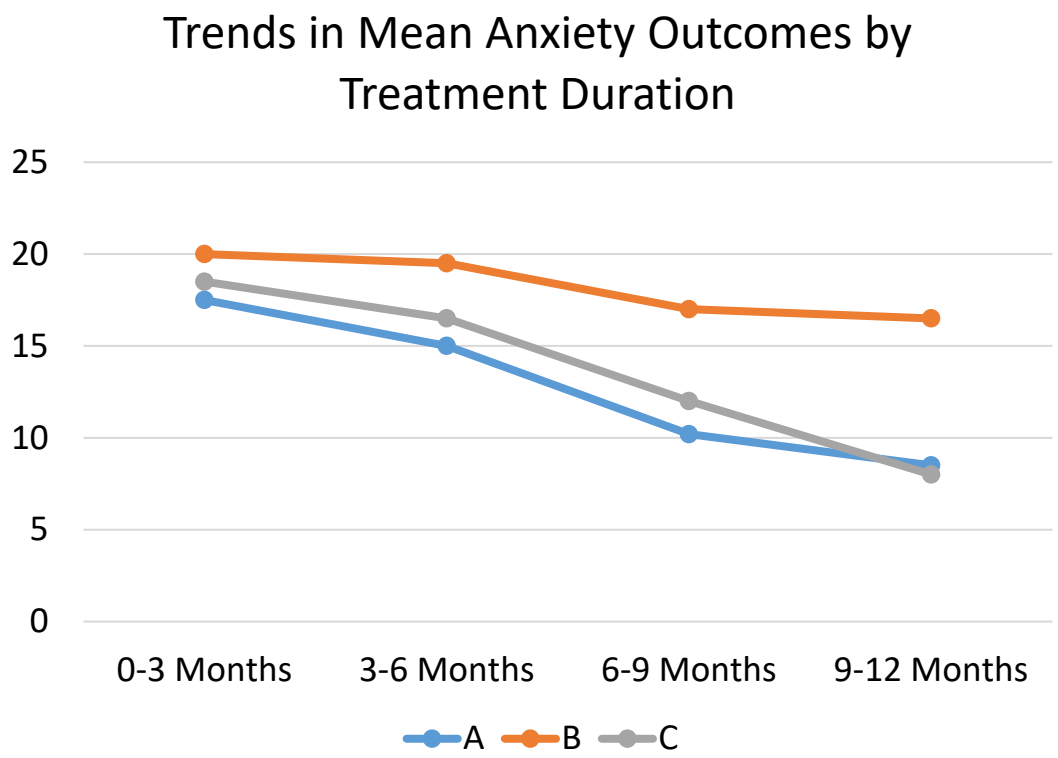




Program Performance

Example: Patient Outcome Trends





Program Performance

Process Measures: CoCM Evidence Base

- Early engagement in CoCM activities is a strong indicator of patients' future success
- Patient should be contacted at least twice per month in the first two-four months of treatment
- Outcome measures (e.g., PHQ-9) should be administered monthly in the first two to four months of treatment

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.

Program Performance

Process Measures: Systematic Case Review

- Patients are discussed with the psychiatric consultant in systematic case review **within two weeks** after being enrolled
- Treatment recommendations from the psychiatric consultant are **approved and implemented** by the PCP and patient

Critical Treatment Window

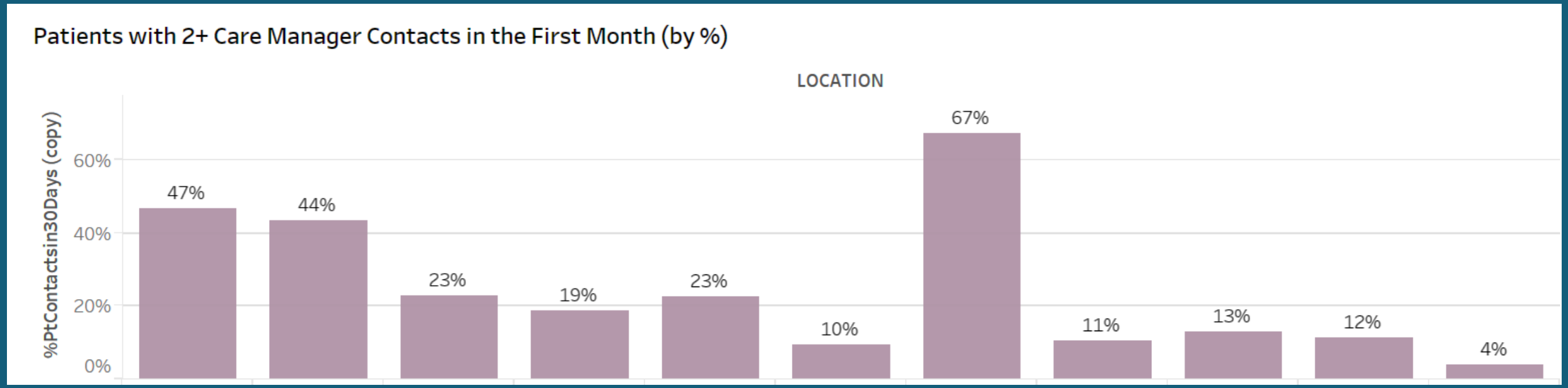
- **Patients not improving* within 8–12 weeks** of treatment should be discussed with the psychiatric consultant in systematic case review to revise treatment recommendation

* 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.

Program Performance

Example: Tracking Process Measures



Program Performance

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 Designation

Year 1 – Participate in training

In 2022, only two capabilities will be needed for a practice to be eligible for CoCM designation.

- Capability 1.1 – The practice must have assembled their care team and understand the interactions within the provider triad.
- Then one of these two capabilities:
  - Capability 1.2 – A practice member from each of the three roles attends the PGIP-sponsored training.
  - Capability 1.3 – A practice is deemed to be delivering CoCM with fidelity to the model. Fidelity means that the CoCM delivery to the original model as described by University of Washington's AIMS Center.

CoCM Designation

Year 2 – 2023

- In 2023, all of the capabilities in this document will need to be in place to be eligible for Year 2 CoCM designation
  - Go to the Collaborative Site to locate this document
  - Ask your training partner or FSR from BCBSM for a copy of the document

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.

Questions?