



Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Dennis R. Schrader, Secretary

January 21, 2022

The Honorable Guy Guzzone  
Chair, Senate Budget and Taxation Committee  
3 West Miller Senate Office Bldg.  
Annapolis, MD 21401-1991

The Honorable Maggie McIntosh  
Chair, House Appropriations Committee  
121 House Office Bldg.  
Annapolis, MD 21401-1991

**RE: 2021 Joint Chairmen's Report (p. 113-114) – Collaborative Care Pilot Updates**

Dear Chair Guzzone and Chair McIntosh:

In keeping with the requirements of the 2021 Joint Chairmen's Report (p. 113-114), the Maryland Department of Health respectfully submits the report on the Collaborative Care Pilot Updates.

If you have any questions about this report, please contact Heather Shek, Director, Office of Governmental Affairs, at [heather.shek@maryland.gov](mailto:heather.shek@maryland.gov).

Sincerely,

A handwritten signature in black ink that reads "Dennis R. Schrader".

Dennis R. Schrader  
Secretary

Enclosure

cc: Steven R. Schuh, Deputy Secretary, Health Care Financing and Medicaid  
Heather Shek, Director, Office of Governmental Affairs  
Sarah Albert, Department of Legislative Services (5 copies)

[Page left intentionally blank]



**2021 Joint Chairmen's Report**

**p. 113 - 114**

**Collaborative Care Pilot Updates**

# Table of Contents

<b>Executive Summary</b>	<b>5</b>
<b>Background</b>	<b>6</b>
The Collaborative Care Model (CoCM)	6
Behavioral Health System of Care Integration and Optimization Workgroup	7
<b>CoCM in Maryland Medicaid</b>	<b>8</b>
The CoCM Pilot Sites	8
Reporting Requirements	9
Preliminary Results	9
<b>Current Fiscal Impact in Maryland</b>	<b>11</b>
<b>Statewide Expansion Costs and Considerations</b>	<b>13</b>
Other State Programs	13
Statewide Expansion Estimated Fiscal Impact	14
Other CoCM Initiatives in Maryland	16
<b>Conclusions and Next Steps</b>	<b>17</b>
<b>Appendix A: Detailed Reporting Requirements</b>	<b>18</b>

## **Executive Summary**

Pursuant to Chapters 683 and 684 of the Acts of 2018 (HB 1682/SB 835), the Maryland Department of Health (MDH) was required to establish and implement the Collaborative Care Model (CoCM) Pilot Program in primary care settings in which health care services are provided to Medical Assistance Program participants enrolled in HealthChoice. The legislation required MDH to administer the CoCM Pilot Program and to select up to three pilot sites with certain characteristics to participate. The CoCM pilot is part of MDH's larger strategy to better integrate care for Medicaid participants through recommendations being developed by the Behavioral Health System of Care Integration and Optimization Workgroup. MDH selected three sites to participate in the CoCM Pilot Program via a competitive application process. Funding included up to \$225,000 during the first fiscal year ((FY) 2020) for infrastructure, \$325,000 for services rendered during the second half of fiscal year FY 2020 (January 1, 2020 through June 30, 2020), and up to \$550,000 annually for services rendered for FY 2021, FY 2022, and FY 2023 (July 1, 2020 through June 30, 2023).

Due to the COVID-19 pandemic, enrollment in the CoCM Pilot Program has been more limited than initially projected due to declines in utilization of primary care services. However, preliminary results suggest that the CoCM Pilot Program has improved clinical outcomes. MDH estimates implementing the model statewide would have a fiscal impact of \$18.8 million to \$32.4 million total funds annually. MDH recommends continuing the pilot program until the end of FY 2023 and conducting a full evaluation at that time. MDH will also continue to work with stakeholders, including the Behavioral Health System of Care Integration and Optimization Workgroup, to find innovative ways to improve behavioral health outcomes for participants.

## **Background**

Pursuant to the Joint Chairmen's Report of 2021 (page 113-114), MDH respectfully submits this report on the current status of the CoCM Pilot Program, with a specific focus on initial data and whether this data warrants a statewide implementation.

### ***The Collaborative Care Model (CoCM)***

Pursuant to Chapters 683 and 684 of the Acts of 2018 (HB 1682/SB 835), the Maryland Department of Health (MDH) was required to establish and implement the Collaborative Care Model (CoCM) Pilot Program in primary care settings in which health care services are provided to Medical Assistance Program participants enrolled in HealthChoice.

CoCM is a patient-centered, evidence-based approach for integrating physical and behavioral health services in primary care settings that includes: (1) care coordination and management; (2) regular, systematic monitoring and treatment using a validated clinical rating scale; and (3) regular, systematic psychiatric caseload reviews and consultation for patients who do not show clinical improvement. A collaborative care team is responsible for delivery and management of patient-centered care. Proponents of the model suggest that merging behavioral health with primary care normalizes and de-stigmatizes treatment for behavioral health disorders for the patient. This in turn encourages patients to seek access to the evidence-based behavioral health services available in their regular primary care clinics resulting in improved patient outcomes. Patients are screened through a standardized questionnaire, such as the PHQ-9 for depression or the GAD-7 for anxiety.

The CoCM incorporates a team of three providers: (1) a primary care provider (PCP), (2) a behavioral health (BH) care manager, and (3) a psychiatric consultant. In Maryland's Medicaid program, a physician, nurse practitioner, nurse midwife, or physician assistant may serve as a PCP. The BH care manager possesses formal education or specialized training in behavioral health. The role is typically filled by a nurse, clinical social worker, or psychologist who is trained to provide coordination and intervention who works under the oversight and direction of the PCP. Together, the BH care manager and the PCP form the primary care team. The psychiatric consultant is typically either a licensed psychiatrist or psychiatric nurse practitioner. For purposes of the CoCM Pilot Program, an addiction medicine specialist or any other behavioral health medicine specialist as allowed under federal regulations governing the model may also serve as a consultant.

## ***Behavioral Health System of Care Integration and Optimization Workgroup***

The CoCM pilot is part of MDH's larger strategy to better integrate care for Medicaid participants through the Behavioral Health System of Care Integration and Optimization Workgroup. In response to legislation that was introduced—but did not pass—during the 2019 legislative session, the chairs of the Senate Finance and Health and Government Operations Committees requested MDH to convene stakeholders and make recommendations on how the state should provide, administer, and finance Medicaid behavioral health services. Formed in 2019, paused during calendar year 2020 due to COVID-19, and reconvened in the fall of 2021, the Workgroup aims to better serve Medicaid participants by developing a System of Care that addresses the needs to individuals by aligning the roles of Medicaid, the Behavioral Health Administration (BHA), the nine managed care organizations (MCOs), the administrative services organization (ASO) that administers behavioral health benefits in Medicaid, and local systems management.

The key themes for potential initiatives under discussion by the Workgroup are:

- Value-based payment, measure-based care, quality measurement, and provider management;
- Case management, care coordination, and clearly defining roles within the system;
- Integration of care; and
- Data sharing.

The Workgroup is currently considering and vetting a variety of programs and projects with the potential to forward progress on the themes outlined above. Expansion of CoCM is one proposal under consideration, and Workgroup members will review the data presented in this Joint Chairmen's Report. Other initiatives under discussion include, but are not limited to: establishing standards for behavioral health provider networks and quality; developing a formal structure for addressing high utilizers of services; identifying barriers to billing for co-occurring disorders; reviewing supports needed by MCOs to increase uptake of screening; brief intervention; referral to treatment (SBIRT) by providers; and enhancements to improve behavioral health data sharing with the MCOs. Discussion by the workgroup regarding selection of an initiative to move forward are ongoing.

## CoCM in Maryland Medicaid

In 2016, MDH submitted a Joint Chairmen’s Report on CoCM and whether it could be implemented in Maryland.<sup>1</sup> The report concluded that while CoCM was a clinically-effective model of care, it would require a substantial budget initiative. MDH proposed a one year pilot program to test the model. In 2017, MDH submitted an update to this report, emphasizing that CoCM could play an important role in behavioral health integration.<sup>2</sup> Based on an Institute for Clinical and Economic Review (ICER) estimate and a low prevalence rate of depression (defined as 3%), MDH estimated that implementing CoCM for 200,000 participants would require a \$3 per member per month (PMPM) payment and cost \$7.2 million (\$4.3 million federal funds and \$2.9 million state general funds). MDH again proposed doing a limited pilot program to test the model.

During the 2018 session, the Maryland General Assembly passed HB 1682/SB 835, which required MDH to establish a limited CoCM Pilot Program at up to three sites, one of which was required to be in a rural area. MDH was also required to apply for an 1115 waiver amendment with the Centers for Medicare and Medicaid (CMS) in order to implement the pilot program. MDH received \$550,000 per fiscal year for the pilot program.

MDH applied for an 1115 waiver amendment in June 2019, and CMS approved the waiver in April 2020, with an implementation date of July 1, 2020.

MDH issued a request for applications for the CoCM Pilot Program in Spring 2019, with letters of intent due in April 2019 and applications due in May 2019. Funding included up to \$225,000 in FY 2020 for infrastructure costs as well as \$325,000 for services rendered during the second half of FY 2020 (January 1, 2020 through June 30, 2020), and up to \$550,000 annually for services rendered for FY 2021, FY 2022, and FY 2023 (July 1, 2020 through June 30, 2023). Sites were selected in June 2019 and infrastructure awards began in July 2019. Sites began phasing in enrollment in April 2020 and federal match under the 1115 waiver was available beginning July 2020.

### ***The CoCM Pilot Sites***

MDH selected sites through a competitive process that scored applications based on the quality and scope of the application, including staffing, workflow, target populations, as well as previous experience with CoCM. Privia Health’s three separate applications had the highest scores. Privia submitted separate applications for three distinct practice settings:

---

<sup>1</sup> 2016 Joint Chairmen’s Report (p. 78) Opportunities to Adopt the Collaborative Care Model in the HealthChoice Program. [http://dlslibrary.state.md.us/publications/JCR/2016/2016\\_78a.pdf](http://dlslibrary.state.md.us/publications/JCR/2016/2016_78a.pdf)

<sup>2</sup> 2017 Joint Chairmen’s Report (p. 87) Report on the Approach for the Integration of Behavioral and Somatic Services. [http://dlslibrary.state.md.us/publications/JCR/2017/2017\\_87.89.pdf](http://dlslibrary.state.md.us/publications/JCR/2017/2017_87.89.pdf)

1. Privia Obstetric/Gynecology Practice – expected to enroll a population of 45 pregnant and postpartum individuals into CoCM per year who screen positive for depression.
2. Privia Rural Practice – serving a population with both mental health and substance use disorders, and deploying telehealth to bridge the resource gap that often exists in rural communities. Privia expected to treat 25 CoCM participants at their rural site annually.
3. Privia Urban Practice – serving a population of non-English speakers, specifically Spanish and Mandarin populations. Privia Health proposed building up to enrollment of 185 participants into CoCM across their urban sites annually.

The sites are located throughout the state. Privia’s rural site is in Waldorf, MD; their urban sites are located in Frederick, and Silver Spring; the obstetric/gynecology site is based in Rockville, MD.

### ***Reporting Requirements***

MDH requires selected CoCM Pilot Sites to report on the certain metrics in order to evaluate the effectiveness of the Pilot Program. These include enrollment metrics, screening metrics, and duration of treatment metrics. For a detailed list of required measures, please see Appendix A.

Additionally, MDH evaluated the impact of the CoCM Pilot Program on the number of and outcomes for individuals who:

1. Were not diagnosed as having a behavioral health condition before receiving treatment through the pilot program;
2. Were not diagnosed as having a behavioral health condition before being referred to and treated by a specialty behavioral health provider;
3. Received behavioral health services in a primary care setting before receiving treatment through the CoCM Pilot Program; and
4. Received specialty behavioral health care services before being identified as eligible to receive treatment through the CoCM Pilot Program.

### ***Preliminary Results***

While the CoCM Pilot Program is still ongoing, MDH has begun to analyze preliminary data. Due to the COVID-19 pandemic, the pilot sites were not able to enroll as many participants as they anticipated.

Overall, 399 unique participants have been identified as eligible for CoCM. Of those, 129 participants (31 percent) have completed treatment. 168 participants never enrolled in the program, meaning they were eligible for CoCM after a preliminary screening and received outreach attempts, but never completed enrollment.

**Table 1: CoCM Pilot Program Status Categories and the Number and Percent of Participants in Each Category as of March 2021**

<b>Program Status</b>	<b>Unique #</b>	<b>Unique %</b>	<b>Total #</b>	<b>Total %</b>
Active	78	20%	78	19%
Completed	129	32%	129	31%
Pending	24	6%	25	6%
Not Enrolled	168	42%	186	45%
<b>Total</b>	<b>399</b>	<b>100%</b>	<b>418</b>	<b>100%</b>

For participants who were considered active in CoCM, the average point decrease in PHQ-9 score ranged from a 1.1 to 2.6. For the GAD-7, the average point decrease ranged from 0.04 to 1.3. Decreasing scores for both tests indicate improvements in participants' depression and anxiety.

**Table 2: Mean Change in Test Scores for Active Participants by Quarter**

	<b>Test</b>	<b>Participants</b>	<b>Mean Change</b>
FY 2021 Q2	PHQ-9	38	-2.6
	GAD-7	32	-0.8
FY 2021 Q3	PHQ-9	58	-2.3
	GAD-7	52	-1.3
FY 2021 Q4	PHQ-9	49	-1.1
	GAD-7	46	-0.04

For patients that have been enrolled for more than 70 days, more than 65 percent have had clinically significant improvement, meaning their baseline score dropped more than 50 percent or their score dropped below the level of eligibility for CoCM. In the most recent quarter (FY 2021 Q4), 29 percent of participants achieved remission criteria.

## Current Fiscal Impact in Maryland

MDH adopted Medicare’s payment structure for the CoCM Pilot Program. The fee schedule is as follows:

**Table 3: CoCM Billing Codes**

<b>Codes</b>	<b>Description</b>	<b>Primary Care Rate Setting</b>
99492	First 70 minutes in the first calendar month or behavioral health care manager activities	\$161.28
99493	First 60 minutes in a subsequent month for behavioral health care manager activities	\$128.88
99494	Each additional 30 minutes in a calendar month of behavioral health care manager activities	\$66.60

As of June 30, 2021, MDH, through the pilot sites, has spent \$378,559.61 on the CoCM Pilot Program. \$172,012.44 was spent on infrastructure during the first year (FY 2020) and \$206,547.17 was spent on services through FY 2020-21.

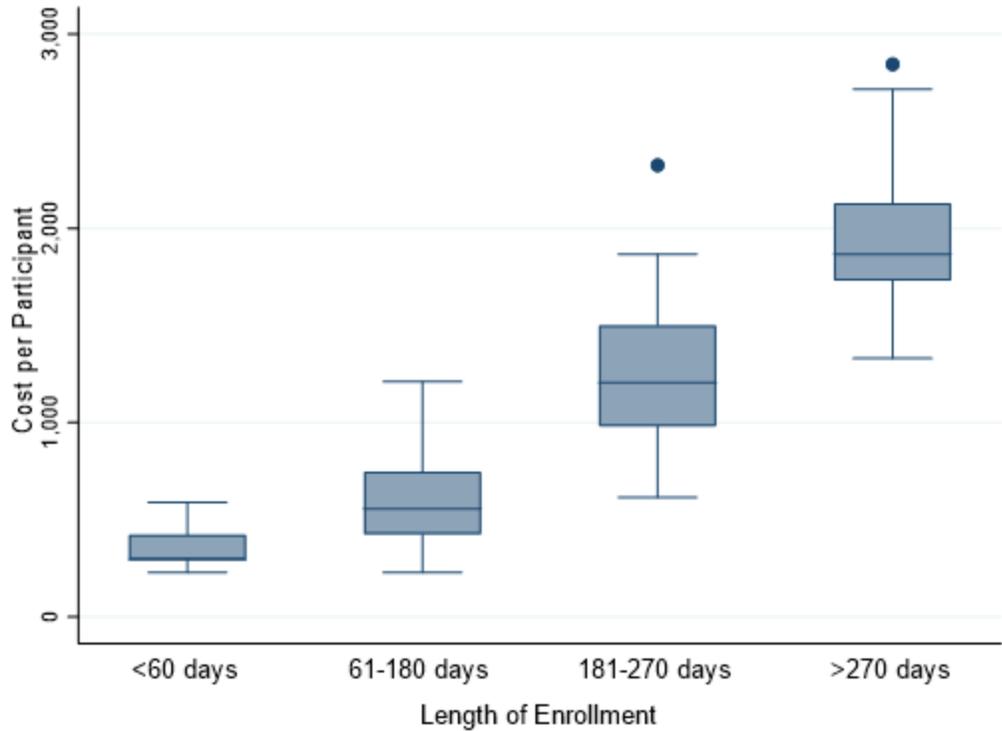
For active program participants, the average cost to the state as of March 31, 2021 was \$996.10 per person with an average length of enrollment of 203 days. The median cost and enrollment are \$752.04 and 175 days respectively. Participants who have either successfully completed the CoCM Pilot Program or been referred to the behavioral health ASO have an average cost of \$645.72 and an average length of enrollment of 91 days. The median cost and length of enrollment is \$552.24 and 73 days respectively. Overall, average charges for active and completed participants are \$775.30, with an average length of enrollment of 134 days. The median cost and length of enrollment are \$556.56 and 112 days respectively.

**Table 4: Length of Enrollment and Cost of Active and Complete Participants in CoCM as of March 31, 2021**

	<b>Mean</b>	<b>Median</b>
<b>Active Participants Only (n = 78)</b>		
Costs	\$996.10	\$752.04
Length of Enrollment (Days)	203	175
<b>Completed Participants Only (n = 129)</b>		
Costs	\$645.72	\$552.24
Length of Enrollment (Days)	91	73
<b>Active &amp; Completed Participants (n = 207)</b>		
Costs	\$775.30	\$556.56
Length of Enrollment (Days)	134	112

A higher average cost per participant was associated with a longer length of enrollment. A simple linear regression model of costs on length of enrollment estimated that, on average, one extra day of enrollment increased costs by \$5.42. For participants enrolled for less than 2 months (60 days), the average cost was \$338.35. These average costs increased based on length of enrollment, with participants who have been enrolled for longer than 9 months (greater than 270 days) having an average cost of \$1,967.79.

**Figure 1: Cost by Length of Enrollment Category for Participants who are Active in or Have Completed the Collaborative Care Model Pilot Program, April 2020 to March 2021**



## Statewide Expansion Costs and Considerations

### *Other State Programs*

As of May 2021, 19 other state Medicaid programs have started reimbursing for CoCM codes (Arizona, California, Illinois, Iowa, Kentucky, Massachusetts, Maryland, Michigan, Montana, Nebraska, New Hampshire, New Jersey, New York, North Carolina, Pennsylvania, Rhode Island, Utah, Vermont, and Washington). Reimbursement for the CoCM codes varies from state to state with New Hampshire having the lowest rates and Montana having the highest for each code.<sup>3</sup>

<sup>3</sup> “Cracking the Codes: State Medicaid Approaches to Reimbursing Psychiatric Collaborative Care.” California HealthCare Foundation, May 2021. <https://www.chcf.org/publication/cracking-codes-state-medicaid-approaches-reimbursing-psychiatric-collaborative-care/>

**Table 5: CoCM Reimbursement Rates in Medicaid Programs**

<b>Codes</b>	<b>Medicaid-Only Ranges</b>	<b>Medicaid Mean</b>	<b>Medicare Rate<sup>4</sup></b>
99492	\$56 to \$176	\$114	\$161.28
99493	\$51 to \$140	\$94	\$128.88
99494	\$27 to \$82	\$49	\$66.60

***Statewide Expansion Estimated Fiscal Impact***

In the 2017 CoCM JCR, MDH estimated that CoCM would cost approximately \$3.00 per member per month (PMPM) based on a 3% prevalence rate of depression.<sup>5</sup> MDH noted that if the prevalence of depression were higher or increased, that the costs associated with CoCM would increase as well.<sup>6</sup> Assuming a \$3 PMPM cost, covering the HealthChoice population of 1.4 million participants would have an estimated annual fiscal impact of \$50.4M.

In calendar year (CY) 2020, approximately 2.9 percent of HealthChoice participants received behavioral health services from an MCO but did not access services through the ASO, suggesting that a 3% prevalence estimate remains accurate. This prevalence rate has remained relatively stable year over year back to CY 2017.

---

<sup>4</sup> Please note that MDH uses the Medicare rate.

<sup>5</sup> Tice, Jeffrey A., et al.. Integrating Behavioral Health into Primary Care. Institute for Clinical and Economic Review. June 2, 2015. Page ES6. [http://icerorg.wpengine.com/wp-content/uploads/2020/10/BHI\\_Final\\_Report\\_060215.pdf](http://icerorg.wpengine.com/wp-content/uploads/2020/10/BHI_Final_Report_060215.pdf)

<sup>6</sup> Report on the Approach for the Integration of Behavioral and Somatic Services and Report on Collaborative Care Revisited. 2017. <https://health.maryland.gov/mmcp/Documents/JCRs/2017/BHIJCRfinal1-18.pdf>.

**Table 6: Number of HealthChoice Participants with Any Behavioral Health Services Covered by the MCO with no ASO Service, CY 2020**

<b>MCO</b>	<b>Total Participants</b>	<b>Number</b>	<b>Percentage</b>
Aetna	47,685	1,082	2.3%
Amerigroup	313,335	6,660	2.1%
Jai Medical Systems	30,717	676	2.2%
Kaiser Permanente	99,170	2,100	2.1%
Maryland Physicians Care	239,685	9,591	4.0%
Medstar Family Choice	105,423	3,379	3.2%
Priority Partners	340,133	10,666	3.1%
United Healthcare	166,470	5,311	3.2%
University of Maryland Health Partners <sup>7</sup>	56,517	1,539	2.7%
<b>Total</b>	<b>1,399,135</b>	<b>41,004</b>	<b>2.9%</b>

As a comparison to the ICER estimate, MDH utilized the preliminary pilot experience to develop an alternative fiscal estimate as described below. MDH assumes that 2.9 percent of all HealthChoice participants would be eligible for CoCM, consistent with the percent that received behavioral health services through the MCOs in CY 2020. MDH also assumes that approximately 42 percent of participants will not be interested in CoCM (consistent with the percent of unique participants that were not enrolled at the CoCM pilot sites) and that 58 percent would be interested in enrolling. Assuming that the cost per participant is consistent with the CoCM Pilot Program data and averages at \$775.30, the total fiscal impact of CoCM would be approximately \$18.4 million annually. If all eligible HealthChoice participants enrolled in CoCM, the fiscal impact could be up to \$31.8 million per year.

Expanding coverage to also include the fee-for-service (FFS) population would increase the estimated fiscal impact. In CY 2020, 68,090 FFS participants did not have Medicare coverage.<sup>8</sup>

<sup>7</sup> Please note that University of Maryland Health Partners became Carefirst in October 2020.

<sup>8</sup> Please note that Medicare participants are already eligible to receive CoCM services through their Medicare plans. Therefore, any CoCM services received by those participants would be paid through Medicare and not the responsibility of MDH.

Approximately 1.2 percent, or 841 of these FFS participants, had a claim with an associated behavioral health diagnosis and received no services through the ASO. Assuming (consistent with the MCO estimate), a per person cost of \$775.30 a 58 percent uptake rate, it would cost approximately \$378 thousand to cover the FFS population. Because these funds would be eligible for a 50 percent federal match, the state cost would be \$189 thousand; the federal cost would also be \$189 thousand. If all 841 participants enrolled in CoCM, it would cost \$652 thousand.

Covering both the FFS population and the MCO population could cost from \$18.8 million to \$32.4 million.

MDH notes that these estimates should be interpreted with caution. Actual uptake and utilization of the program may be higher. Preliminary data from the CoCM pilot program is limited to one year with a relatively small cohort. Additionally, uptake was also limited due to the COVID-19 pandemic; utilization during this time period may not be indicative of normalized trends. Finally, participants who were receiving specialty BH services from the ASO are not eligible for this pilot program. If participants were allowed to receive BH services through the ASO and CoCM simultaneously, utilization rates and costs would increase, potentially up to \$114.5 million to cover the 18.2 percent of the HealthChoice population with a mental health or substance use disorder diagnosis.

### ***Other CoCM Initiatives in Maryland***

#### *Behavioral Health Integration in the Maryland Primary Care Program*

The Maryland Primary Care Program (MDPCP) was implemented in 2019. The MDPCP program provides payments directly for Medicare beneficiaries, while also focusing on total practice transformation that benefits patients across all payers. All 525 primary care practices participating in MDPCP in 2021 are required to integrate behavioral health into their practices. MDPCP provides funding to facilitate the hiring of social workers, CHWs, and care managers in the practices. These staff work with patients to ensure they receive the care and services they need to stay healthy. In addition, over 300 MDPCP practices have implemented Screening, Brief Intervention, and Referral to Treatment (SBIRT) to identify and appropriately refer patients with substance use disorders before the substance use creates a crisis. As of 2021 MDPCP practices also receive an incentive payment to improve performance on screening patients for depression and establishing a follow up plan. Results from the performance measure will not be available until Fall 2022.

In the Collaborative Care Model, practices utilize proactive, relationship-based care management to establish a closed-loop referral system for patients whose behavioral health needs exceed the scope of primary care. Across all MDPCP practices, 100% reported developing a strategy for integrating behavioral health into their practice workflows by the end of the Q3 2021 via the Care

Management or Collaborative Care Model, Primary Care Behaviorist Model, or other approaches for addressing behavioral health needs. Of these, 39% of practices reported using the Care Management or Collaborative Care Model either exclusively or in conjunction with other methods to integrate behavioral health into their practice. Furthermore, as of the end of 2020, 69 MDPCP practices had referred patients to Mindoula, a health management company that connects patients to mental health providers who administer “Collaborative Care” treatment. As of October 2021, Mindoula reports over 90 practices are actively partnered and referring patients.

## **Conclusions and Next Steps**

Preliminary results of the CoCM Pilot Program suggest that receipt of CoCM services is associated with clinical improvement. Given that data from the pilot is limited and enrollment has been impacted by COVID-19, MDH recommends continuing the pilot program to monitor outcomes.

Following completion of the CoCM Pilot Program in FY23, MDH will conduct a more comprehensive evaluation to assess whether it achieved the goal of not only improving clinical outcomes and access to care, but also controlled costs. MDH will continue to work with stakeholders, including the Behavioral Health System of Care Integration and Optimization Workgroup, to find and implement innovative ways to improve behavioral health outcomes for participants.

## Appendix A: Detailed Reporting Requirements

1. **Enrollment** – The total number of Medicaid patients enrolled in Collaborative Care treatment during this month.
2. **Newly enrolled** – Among enrolled patients, the number of patients who were diagnosed with Depression or Anxiety or other targeted behavioral health diagnosis and enrolled in treatment by the BH care manager this month.
3. **Average Duration of Treatment** – Average number of weeks between initial assessment to date of discharge from Collaborative Care.
4. **Monthly Contact** – Number (#) and proportion (%) of patients receiving active treatment in CoCM defined by those patients who have had at a clinical contact this month:
  - a. Numerator: Patients that have had at least one clinical contact this month.
  - b. Denominator: Total number of patients enrolled during this month.
  - c. **Note:** A “clinical contact” is defined as a contact in which monitoring may occur and treatment is delivered with corroborating documentation in the patient chart. This includes individual or group psychotherapy visits and telephonic engagement as long as treatment is delivered.
5. **Clinical Contacts by Phone** – Number (#) and proportion (%) of telephonic touches for patients enrolled in treatment over the total number of touches that month. See note above regarding definition of “clinical contact”.
6. **Improvement Rate** – Number (#) and proportion (%) of patients enrolled in treatment for 70 days or greater who demonstrated clinically significant improvement defined as:
  - a. A 50% reduction from baseline PHQ-9, or
  - b. A drop from baseline PHQ-9 to less than 10
    - i. Numerator: Patients that have met Improvement criteria.
    - ii. Denominator: All patients enrolled in Collaborative Care for 70 days or more.
7. **Remission Rate** – Number (#) and proportion (%) of patients enrolled in treatment for any length of time who have achieved remission criteria (PHQ-9 below 5) during this month:
  - a. Numerator: Patients whose most recent PHQ-9 is below 5.
  - b. Denominator: Total number patients enrolled during this month.
8. **Psychiatric Consultation or Change in Treatment Rate** – Among those enrolled in treatment for 70 days or more who did not improve, number (#) and proportion (%) who whose case was reviewed by the Consulting Psychiatrist with treatment recommendations provided to the Primary Care Provider or Depression Care Manager OR had a documented change made to their treatment plan this month:
  - a. Numerator: Patients who have had their case reviewed by the Consulting Psychiatrist OR had a change documented in their treatment plan this month.

- b. Denominator: Patients that have been enrolled for 70 days or more who have not met clinical improvement criteria this month.
- 9. **Depression Screening Rate** – Number (#) and proportion (%) of all unique adult patients seen during the reporting period who received their annual PHQ-2 or PHQ-9 screening:
  - a. Numerator: Patients that received a PHQ-2 or 9 during this visit, or have been screened in the last year.
  - b. Denominator: All patients seen in the practice for any reason that month
- 10. **Depression Screening Yield** – Number (#) and proportion (%) of all unique adult patients who scored a 10 or greater on their initial PHQ-9 during the reporting period:
  - a. Numerator: Patients that scored a 10 or higher on their initial PHQ-9.
  - b. Denominator: All patients screened with a PHQ-9 during that month.