Collaborative Care

Mi-CCSI
Center for Clinical Systems Improvement

Michigan Collaborative Care
IMPLEMENTATION SUPPORT TEAM

MICMT
Michigan Institute for Care Management & Transformation

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Disclosure

The Michigan Center for Clinical Systems Improvement (Mi-CCSI), 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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Etiquette

Please mute your microphone

- Use the chat box to ask questions, our team will moderate the session
- Minimize background noise when speaking
- Use either phone or computer audio, but not both

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CME Approval

This Live series activity, Preparing to Implement Collaborative Care, from 06/10/2020 - 07/31/2020, has been reviewed and is acceptable for credit by the American Academy of Family Physicians. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Approved for (1 credit per session) AAFP (Prescribed) credits.

AMA/AAFP Equivalency:
AAFP Prescribed credit is accepted by the American Medical Association as equivalent to *AMA PRA Category 1 credit(s)*™ toward the AMA Physician's Recognition Award. When applying for the AMA PRA, Prescribed credit earned must be reported as Prescribed, not as Category 1.

AAFP

CE Credits for Social Work and Nursing

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

Nurses can use the CME for their state requirements. Information on this can be found on LARA and through the Michigan Nurse Association (MNA) at https://www.minurses.org/education-resources/resources-for-practicing-nurses/state-of-michigan-ce-requirements/

AAFP

Objectives

- Review Collaborative Care Model (CoCM) from the clinician standpoint and the benefits of the model
- Demonstrate via simulation a Systematic Case Review.

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AGENDA	
Agenda Item	**Time Allotment**
Brief Introductions of Panel Members	5 minutes
Brief Review of the CoCM	5 minutes
Panel Roles (each panel member provides a brief introduction of themselves and how they have experienced the CoCM)	10 minutes
Existing Patient Case Review	5 minutes
Panelists Answer: What are some of the biggest benefits you have seen of the CoCM?	10 minutes
Panelists Answer: What suggestions do you have for practices considering this model?	10 minutes

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Dr. Renuka Tipirneni, MD, MSc, FACP

Assistant Professor, Department of Internal Medicine, Divisions of General Medicine and Hospital Medicine, and at the Institute for Healthcare Policy and Innovation (IHPI)
Holder of the Grace H. Elta MD Department of Internal Medicine Early Career Endowment Award 2019-2024

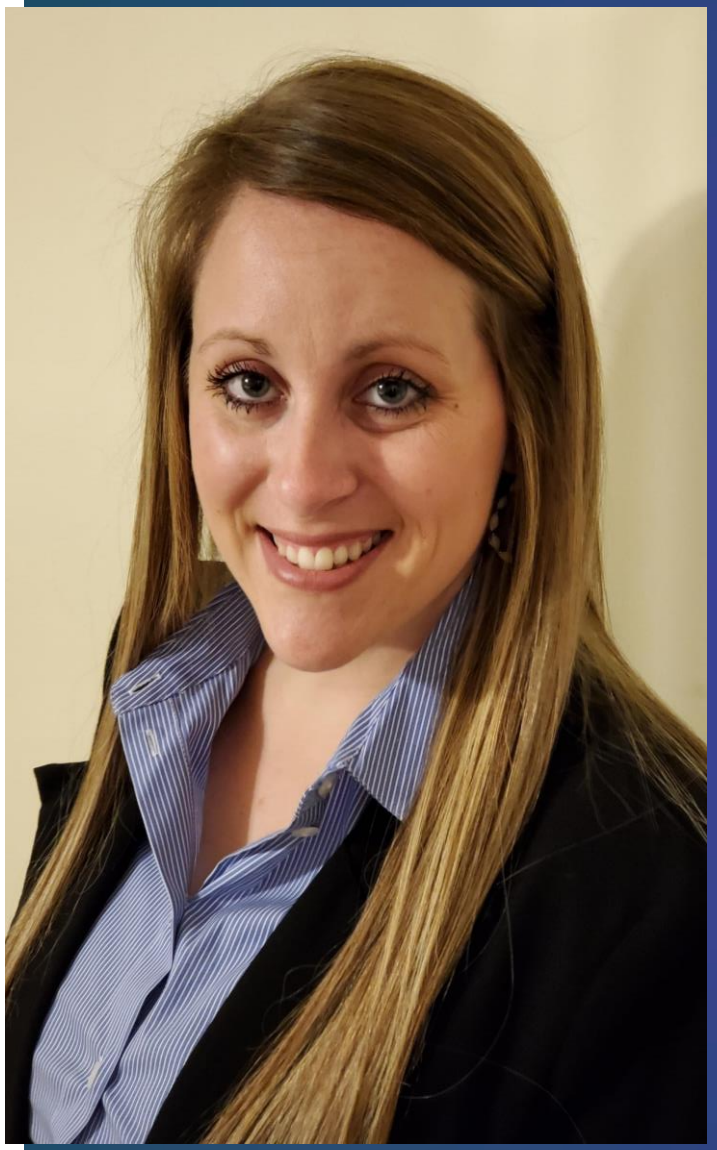
Dr. Tipirneni is an Assistant Professor in the Department of Internal Medicine, Divisions of General Medicine and Hospital Medicine, and at the Institute for Healthcare Policy and Innovation (IHPI) at the University of Michigan. Her clinical practice includes primary care and hospital medicine for adult patients at Michigan Medicine and the VA Ann Arbor Healthcare System. As a primary care physician, she regularly consults with Michigan Medicine's Behavioral Health Collaborative Care program in caring for her patients.

Dr. Tipirneni's research focuses on the impact of health policies and programs on low socioeconomic status, aging and other vulnerable populations, including individuals with co-morbid behavioral and physical health conditions. She was Principal Investigator evaluating Michigan's Medicaid Health Homes program, which focused on enhancing behavioral health integration and addressing social needs for high-risk enrollees in Michigan federally qualified health centers.

Dr. Edward Deneke, MD

Clinical Assistant Professor, Department of Psychiatry, Ambulatory Collaborative Care Lead, and Associate Medical Director for Ambulatory Psychiatry

Dr. Deneke is a Clinical Assistant Professor in the Department of Psychiatry at the University of Michigan Medical School. He also serves as Ambulatory Collaborative Care Lead and Associate Medical Director for Ambulatory Psychiatry at Michigan Medicine. His research and clinical interests include the treatment of comorbid medical and psychiatric disorders as well as management of psychiatric disorders in the primary care setting. He sees patients in ambulatory psychiatry and also serves as the consulting psychiatrist as part of a collaborative care program for a number of primary care clinics.



Ashley McClain, LMSW

Ambulatory Care Social Work Supervisor,
Behavioral Health Collaborative Care

Ashley McClain is a Licensed Master Social Worker in the ambulatory care setting. She currently works as a Behavioral Health Coordinator in the primary care setting, where she works with adult patients. Ashley's role includes providing support to patients who present with symptoms of depression and/or anxiety. She assists in coordinating care between the primary care provider, psychiatric consultant, and patient. Some of the primary responsibilities include monitoring symptoms of depression and/or anxiety, relaying information regarding medication recommendations, exploring coping strategies, and providing community resources where needed. In addition to this, Ashley is a supervisor for the Behavioral Health Collaborative Care program, where she engages in program development and provides support to BHCC social workers.

Alicia Majcher, MHSA

Director of Operations, MICMT
Admin Director of Care Management,
University of Michigan Medical Group

Alicia Majcher is the Operations Director at the Michigan Institute for Care Management and Transformation (MICMT), and the Administrative Director of Care Management at the University of Michigan Medical Group (UMMG). At MICMT, Alicia works with payer and Physician, Registered Dietitians, and Panel Management. Organization (PO) stakeholders to develop and expand care management strategies, communicate best practices, align efforts along a common set of outcomes metrics, and conduct meaningful program evaluation. At UMMG, Alicia is responsible for supporting the overall team-based care strategy and direct management oversight for the Complex Care Management Program, Primary Care Social Work, Behavioral Health Collaborative Care Program

Overview of the Collaborative Care Model (CoCM)

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CoCM: An Overview

- Most evidence-based integrated behavioral health model
  - 80+ randomized controlled trials prove Collaborative Care provides significantly better behavioral health outcomes than "usual care"
  - 2002: First big trial was published (IMPACT study out of the University of Washington)
- Primary care-based: Meets behavioral heath need in patient's medical home
- Patient improvements compare to those achieved in specialty care for mild-moderate conditions
- Return on investment of 6:1

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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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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

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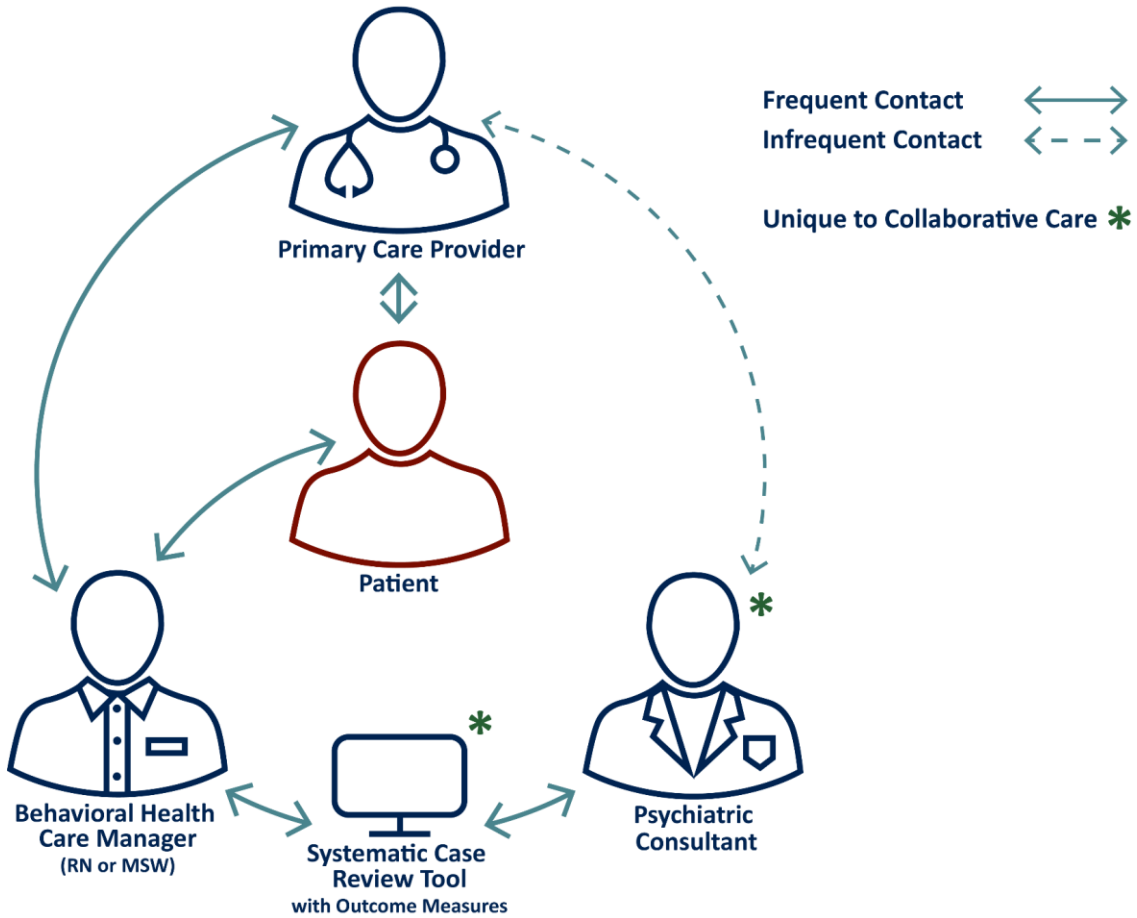
The Collaborative Care Treatment Team



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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
- 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
- Typically a short wait time from referral to receiving an expert psychiatric recommendation (often within one week)

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Our Goal: Tailored Consultation

- We recognize each provider organization and their practices have diverse organizational structures, resources, and timelines.

Our tailored consultation approach *will "meet you where you are,"* ensuring your organization is ready to launch and capable of sustaining high-quality collaborative care services

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Panel Roles

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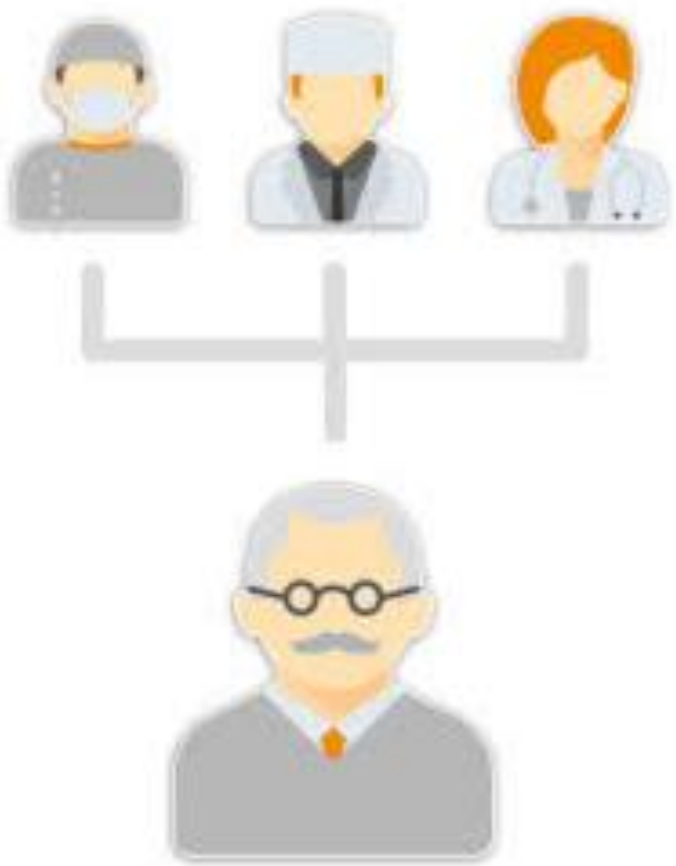
Existing Patient Case Review

Panelists Answer: What are some of the biggest benefits you have seen of the CoCM?



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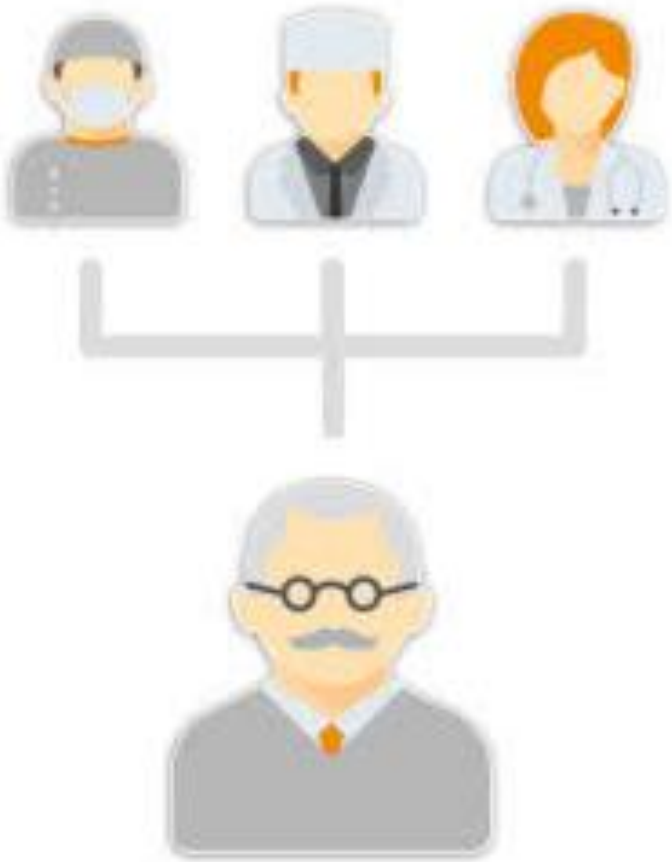
Panelists Answer: What suggestions do you have for practices considering this model?



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Open Questions

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