# Collaborative Care Demo

January 5, 2021

Mi-CCSI
Center for Clinical Systems Improvement

Michigan Collaborative Care
IMPLEMENTATION SUPPORT TEAM

MICMT
Michigan Institute for Care Management & Transformation

Blue Cross Blue Shield of Michigan

# Agenda

- **12:00-12:10** Review of the Model
- **12:10-12:40** Demonstration
- **12:40-12:50** Patient Selection
- **12:50-1:00** Questions for Panel

# Objectives

- Review the roles of the BHCM team and the benefits to the patient
- Live demonstration of the Systematic Case Review (SCR)
- Review of patient selection for the CoCM model

# CME and CE

- CME have been obtained through the AAFP
  - Applicable for physicians and nurses
- CE have been obtained for Social Workers through the Michigan Social Work Continuing Education Collaborative

# Disclosures

- Michigan Center for Clinical Systems Improvement (MICCSI) and Michigan Collaborative Care Implementation Support Team (MCCIST) have been contracted by Blue Cross Blue Shield of Michigan (BCSM) for this project

# 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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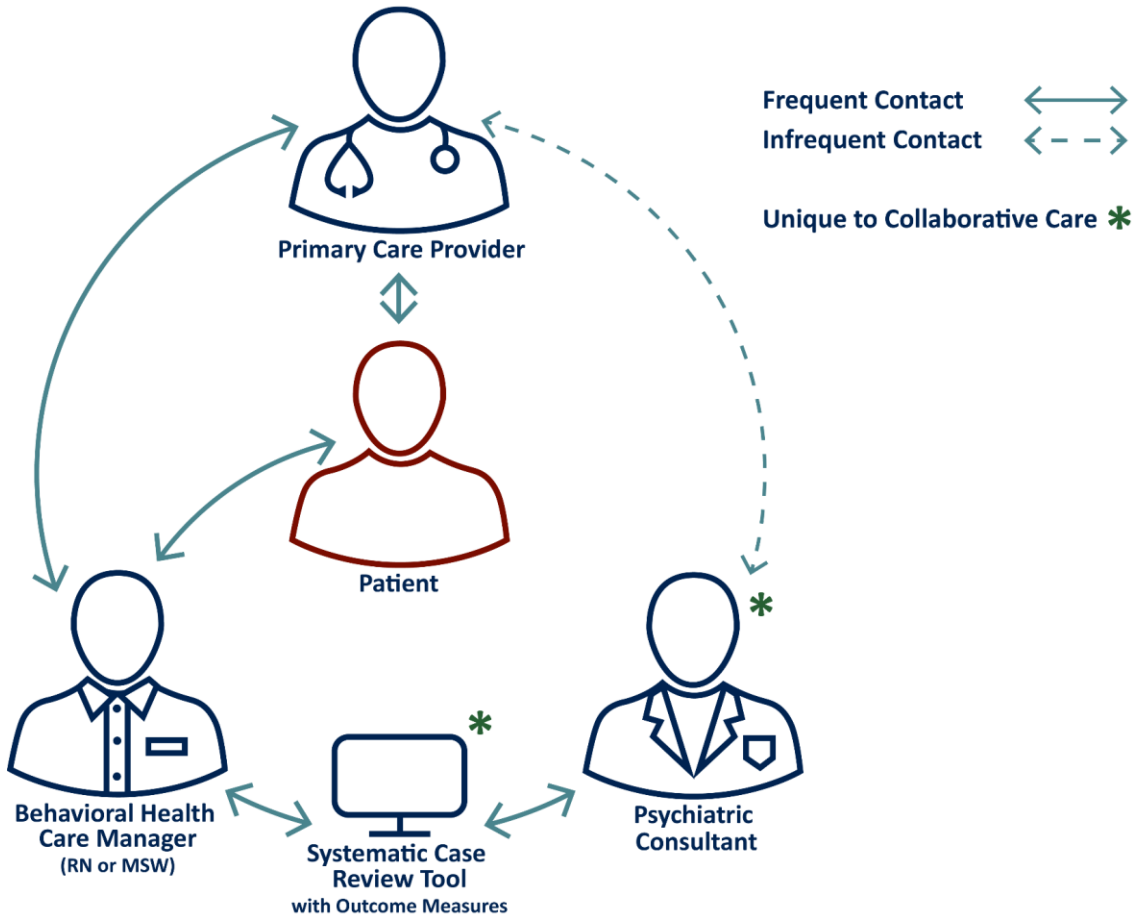
# The Collaborative Care Treatment Team

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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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# Demonstration

## COLLABORATIVE CARE MANAGEMENT

# CoCM Benefits Providers

Phil Baty MD

- Impact on Providers
- Impact on Patient Care

# Busy Life of the Physician

Primary care may have the knowledge to manage these patients, but they're on a track that does not easily allow change

Adding a psychiatrist to the team is more than adding a physician, it may be changing the community norms.

- A Systematic Case Review Team can review 40+ cases
- during their 2 hour, weekly, meeting
- Using a psychiatrist as an advisor to the team allows the PCP to more willingly manage the depression, reserving more complex behavioral cases for psychiatrist referrals

# Registry vs Systematic Case Review Tool

- **Disease registry**
  - Population Health Tool:  Captures measures for chronic conditions
    - Diabetes (A1C, BP, Retinol Eye Exam, Proteinuria)
    - Hypertension (BP)
    - Depression (PHQ 9)
    - Anxiety (GAD 7)
- **Systematic Case Review tool**
  - A care management tracking tool
    - Date of enrollment and disenrollment (discharge from BHCM)
    - Date(s) of f/u with the patient
    - Level of PHQ9/GAD 7 at enrollment and at f/u intervals
    - Status (active, inactive, relapse)

# Systematic Case Review Tool – Why?

- Population Health – no one falls through the cracks
- Easy reference for caseload management
- Easily facilitates systematic case review
- Tracks patient engagement (dates of contact etc)
- Tracks screening tool scores, PHQ-9 and GAD-7
- Identifies patients who are not responding to treatment

# Systematic Case Review – Critical Aspect

- This should happen every week
  - At Mayo – 2 hours per 0.8-1.0 FTE BHCM
- Review new patients first
  - Come up with a plan and get it off to the patient and PCP
    - Note in record by the psychiatrist based on data gathered from BHCM
- Review those needing more attention
  - At Mayo – every patient needs a deeper review once/month
    - documented in the record by the psychiatrist
    - If the psychiatrist does not have access to the medical record it can be by the BHCM
- Finally 'run the list' of all remaining patients to watch for issues
  - Someone hospitalized or in the ED? – no note unless a recommendation

# Case Study Follow Along

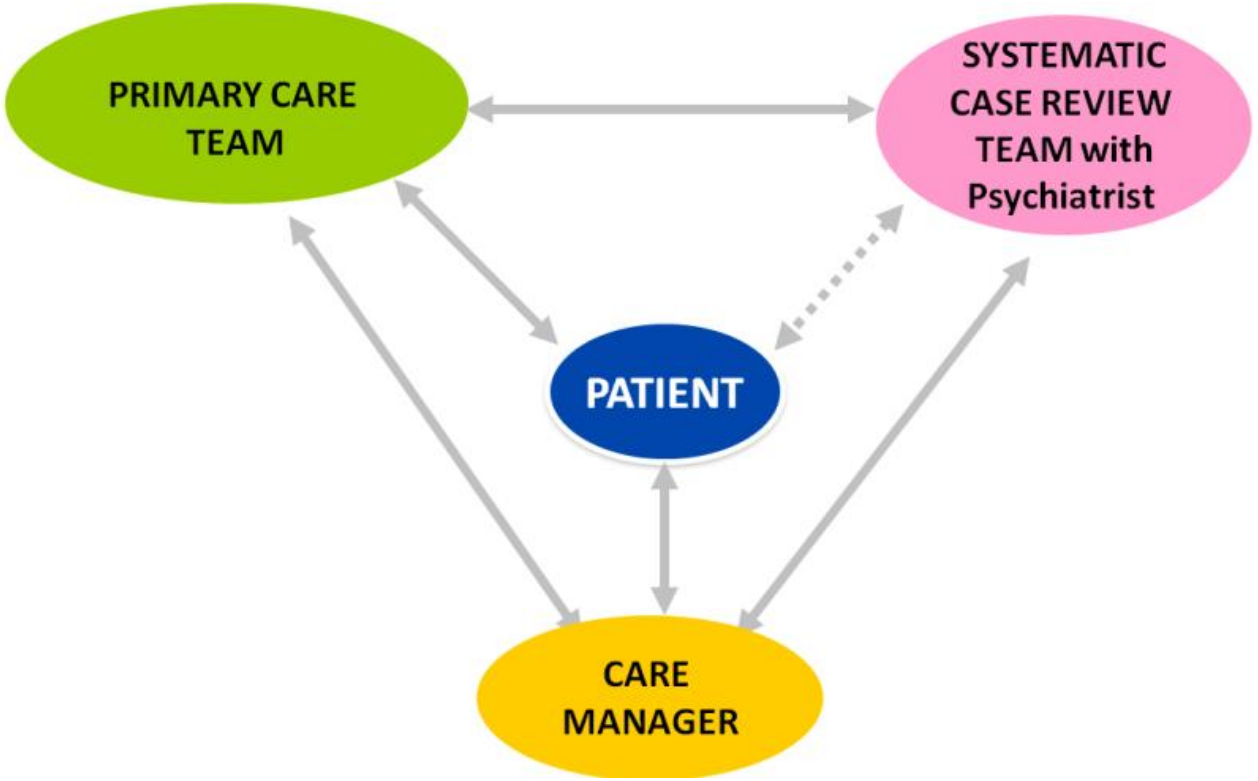
Initial BHCM Note

Initial Psychiatrist Note

Follow up BHCM Note

Follow up Psychiatrist Note

# Systematic Case Review




**DEMONSTRATION ACTIVITY**

Dr. Williams - Psychiatrist
Robin Schreur - BHCM
Phil Baty - PCP

**QUESTIONS**

- ✓ Challenge areas
- ✓ Sharing of experiences
- ✓ Tips and Tricks

# Patient Selection

# Identifying Potential Patients

**Screening/Referrals**

- Diagnosis of depression and/or anxiety
- PHQ-9 and/or GAD-7 of 10+

**Additional Avenues**

- New or changed dose of psychotropic medication
- Patient not responding to psychiatric medication
- Self-report (depression/anxiety symptoms)

**Patient Finding**

- A disease registry can be used to:
  - Identify patients eligible for CoCM services

Patients who are not appropriate:

- Currently under the care of a psychiatrist
- Currently involved with Community Mental Health

# Higher Level of Care

- **Patients with:**
  - Severe substance use disorders
  - Active psychosis
  - Significant developmental disabilities
  - Personality disorders requiring long-term specialty care
- Current CMH consumers or persons requiring CMH-level services

# Considerations

- Cognitive deficits
- Acute safety concerns
- Psychotic symptoms
- Symptoms due to a medical condition
- Substance use disorder
- Significant trauma history

# Questions?