The Basics of CoCM

Section 2

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

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 at behavioral health specialty 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

More Evidence:

- CoCM is linked to better medical outcomes for patients with diabetes, cardiovascular disease, cancer, and chronic arthritis

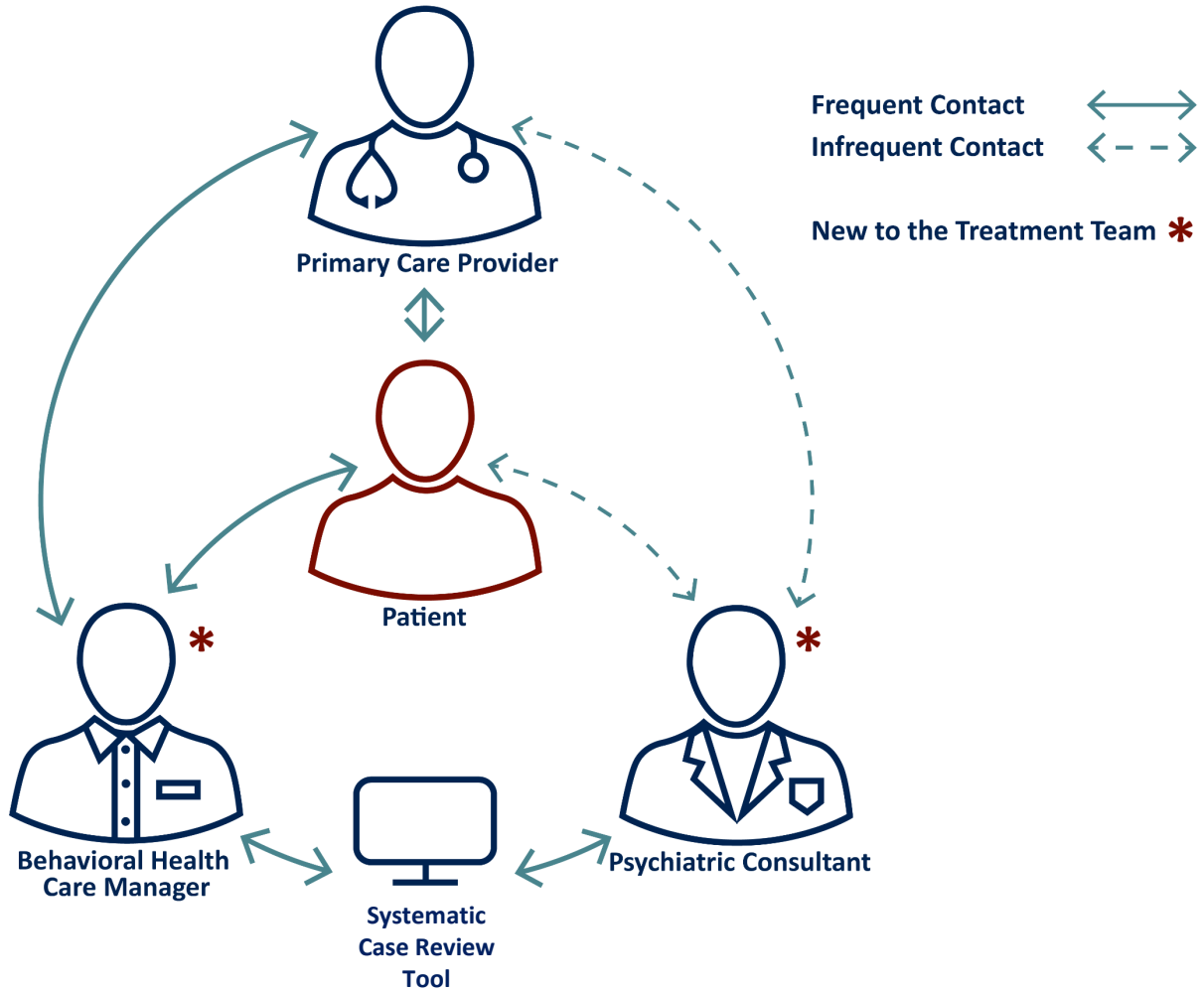
- A 2016 retrospective study at Mayo Clinic found that the time to depression remission was 86 days in a CoCM program while in usual care it was 614 days

https://aims.uw.edu/

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

The Collaborative Care Treatment Team



2 New Team Members: BHCM and Psychiatric Consultant Role

- The psychiatric consultant is a medical professional trained in psychiatry and qualified to prescribe the full range of medications

- Behavioral health care managers are typically social workers, nurses, psychologist or licensed counselors. This person must have a professional license in the state in which they are practicing and specialized BH training. The ability to effectively perform the tasks that need to be completed is much more important than one's credentials. The behavioral health care manager coordinates the overall effort of the group and ensures effective communication among team members

Psychiatric Consultant

- Supports the PCP and BHCM by regularly reviewing cases with the BHCM in scheduled systematic case reviews
- Recommends treatment planning for all enrolled patients, particularly those who are new, not improving, or need medication adjustments
- Reviews treatment plan and makes behaviorally based recommendations
- The psychiatric consultant may suggest treatment modifications for the PCP to consider, recommend the PCP see the patient for an in-person consultation, or directly consult on patients who are clinically challenging or who need specialty mental health services. **The consultant does not see the patient**, except in rare circumstances, and **does not prescribe medications**.
- Documents recommendations
- Provides psychopharmacology education to the PCPs and clinical staff

https://aims.uw.edu/resource-library/psychiatric-consultant-role-and-job-description

Behavioral Health Care Manager

- Manages a caseload of patients
- Works closely with the PCP to facilitate patient engagement and education
- Performs structured outcomes-based assessments along with risk assessment and safety planning
- Systematically tracks treatment
- Supports patient in self-management planning

https://aims.uw.edu/resource-library/care-manager-role-and-job-description

Behavioral Health Care Manager

- Provides brief behavioral interventions, monitors adherence to treatment plan, and supports medication management
- Engages patients in relapse prevention planning
- Uses the systematic case review to systematically review caseload and ensure no patients are falling through the cracks
- **BHCM's come from many different backgrounds and skill sets, e.g. social worker, nurse, licensed professional counselor, psychologist**

The Primary Care Provider:

- Oversees all aspects of a patient's care, diagnoses behavioral health concerns
- Introduces the collaborative care program and makes referrals (ideally a warm hand-off)
- Prescribes medications and adjusts treatment following consultation with the BHCM and the psychiatric consultant
- Speaks with the psychiatric consultant as needed, (this may be infrequent)
- Remains the team lead and will decide whether or not to incorporate recommendations from the consulting psychiatrist

https://aims.uw.edu/collaborative-care/team-structure/primary-care-provider-pcp

The Patient

- Works closely with the BHCM and PCP to report symptoms, set goals, track progress, and ask questions
- Sets goals for treatment with the team
- Actively engages in self-management action planning
- Completes outcome measures
- Asks questions and discusses concerns with the PCP and BHCM
- Understands treatment plan including medication if applicable, (names, doses etc.)

Caregivers/Family

- Can help to provide further patient information in areas such as symptoms, mood, behavior, and baseline functioning of patients
- Can provide support to treatment plans, especially in self-management

Important: Patient chooses level of family involvement

- Ideas for engagement:
  - Discuss the family's shared view of depression (myths, causes, beliefs)
  - Give family members a role in supporting the patient's treatment
    - Check in regarding med adherence if appropriate and permission given by patient
  - Engage family in relapse prevention planning

Summary: What sets CoCM apart?

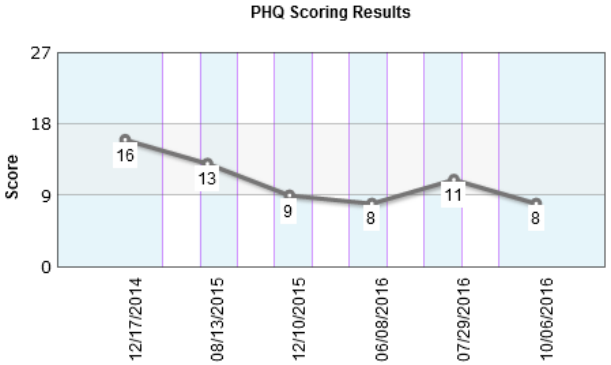
- Population health approach
  - Use of a systematic case review tool to ensure no one falls through the cracks
  - Proactive, tailored outreach, allowing for monitoring and updates in-between PCP visits
  - Treatments are adjusted until patients achieve remission or maximum improvement
  - Data evaluates 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)

Advantages of CoCM

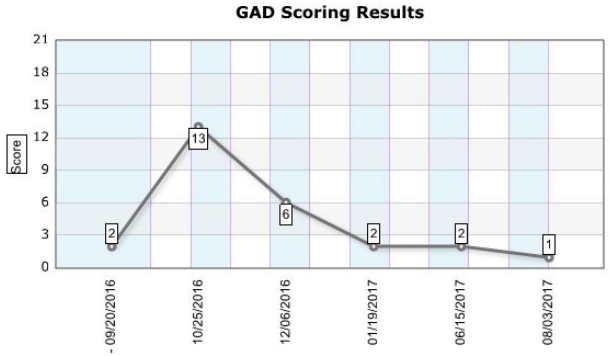
- Objective assessment
- Creates common language
- Focuses on function
- Similar to other health outcomes that are routinely tracked (e.g., BP, A1C)
- Avoids potential stigma of diagnostic terms
- Helps identify patterns of improvement or worsening

Patients shared positive feedback…

"Thank you so much for working so diligently… It really means the world to me to have such genuine support and help like you offer. You honestly saved my life, and I cannot thank you enough."



"Thank you so much for the support and help. I never imagined how helpful all this could be. I was terrified and had been avoiding going to the doctor for so long because it made me feel weak to need help. Thanks."



…as did primary care providers

"[Collaborative Care] has made a huge difference in the ability to manage my patients' mental health in the long term. [Care Manager] has been able to spend more time than the 15 minutes available in clinic with myself, and has been able to provide vital information in helping manage our patients' complex social and mental health concerns (which often, at Ypsilanti, are deeply intertwined). The direct interaction she has with the psychiatrists in providing guidance regarding medication adjustments has been crucial. Additionally, I have had occasions when she will know the patients previously and will attend appointments with myself and the patient, and the insight she has to the case is invaluable. Overall, the program's effect on the patient care at the Ypsilanti clinic has been indispensable and nothing but positive."

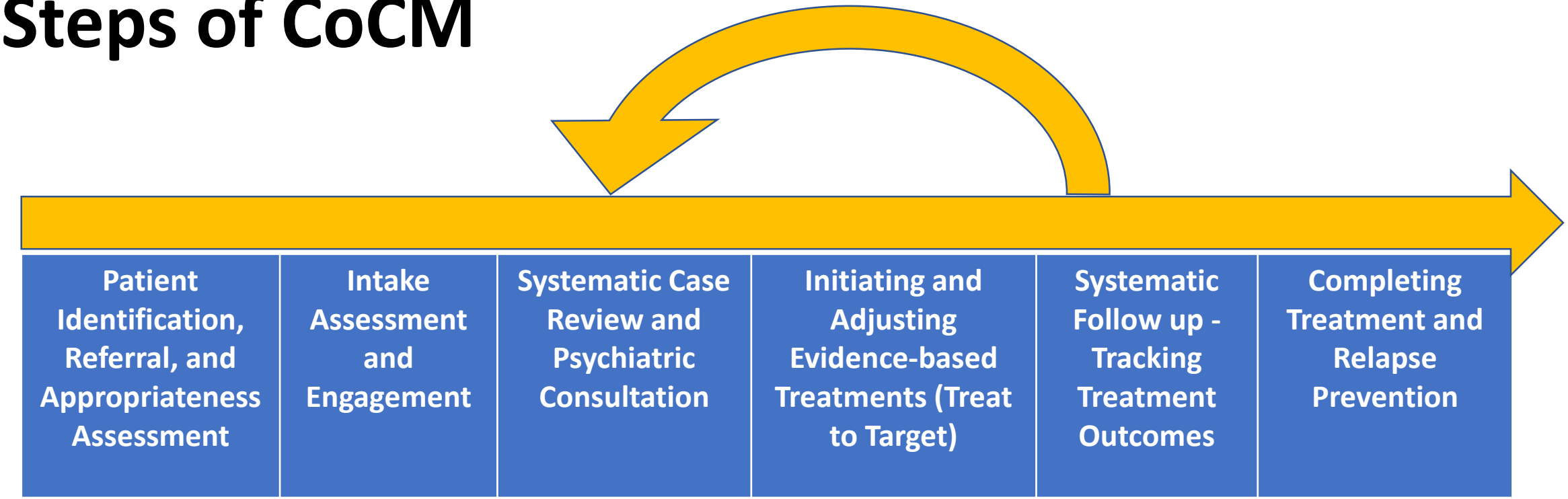
-Jane Chargot, MD, June 2016, Ypsilanti Family Medicine

Daniel's Story

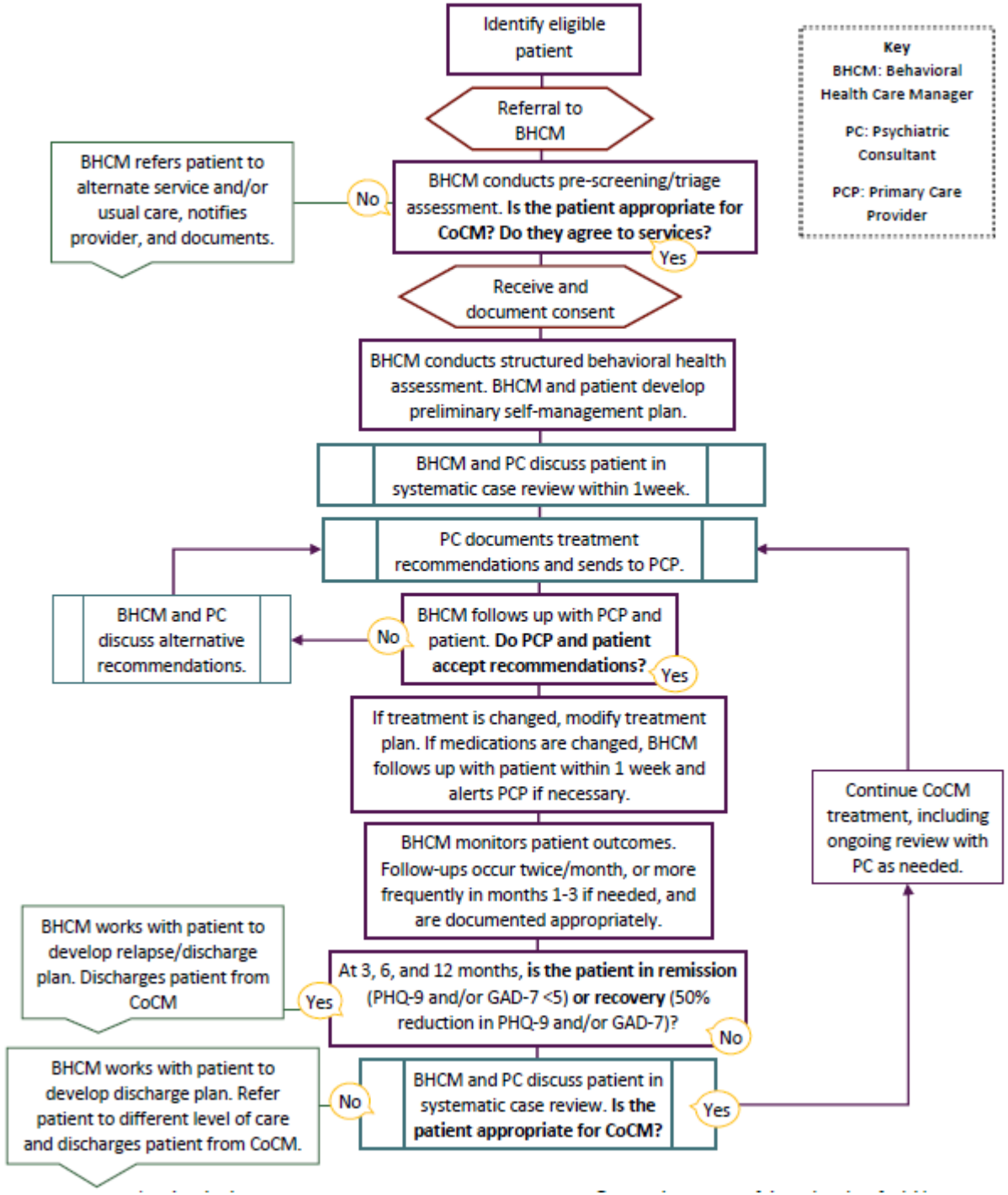
https://www.youtube.com/watch?v=_J-MFMnTrA4

The Process of CoCM

Steps of CoCM



- **Program Oversight and Quality Improvement**


Identify eligible patient
Referral to BHCM
BHCM conducts pre-screening/triage assessment. Is the patient appropriate for CoCM? Do they agree to services?
No
BHCM refers patient to alternate service and/or usual care, notifies provider, and documents.
Yes
Receive and document consent
BHCM conducts structured behavioral health assessment. BHCM and patient develop preliminary self-management plan.
BHCM and PC discuss patient in systematic case review within 1week.
PC documents treatment recommendations and sends to PCP.
BHCM follows up with PCP and patient. Do PCP and patient accept recommendations?
No
BHCM and PC discuss alternative recommendations.
Yes
If treatment is changed, modify treatment plan. If medications are changed, BHCM follows up with patient within 1 week and alerts PCP if necessary.
BHCM monitors patient outcomes. Follow-ups occur twice/month, or more frequently in months 1-3 if needed, and are documented appropriately.
At 3, 6, and 12 months, is the patient in remission (PHQ-9 and/or GAD-7 <5) or recovery (50% reduction in PHQ-9 and/or GAD-7)?
Yes
BHCM works with patient to develop relapse/discharge plan. Discharges patient from CoCM
No
BHCM and PC discuss patient in systematic case review. Is the patient appropriate for CoCM?
No
BHCM works with patient to develop discharge plan. Refer patient to different level of care and discharges patient from CoCM.
Yes
Continue CoCM treatment, including ongoing review with PC as needed.
Key
BHCM: Behavioral Health Care Manager
PC: Psychiatric Consultant
PCP: Primary Care Provider

Identifying 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

Considerations for Screening

- When will screening happen?
  - Annually, every visit
  - More often for unique circumstances (risk factors, other health conditions, life events, discharged from hospital etc.)
- Where will screening happen?
  - Waiting room, triage, exam room
- How will screening happen?
  - Paper form
  - Verbally
- How will results get communicated to the provider?
  - Through EHR
  - Verbally

How is screening happening in your practice?

Screening and Measurement Based Care Tools

- PHQ- 9 Administration Guide from AIMS
- GAD- 7 Administration Guide from VA

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T____ = ____ + ____ + ____)

Disease Registry

- A population health registry that tracks referrals and enrollment for patients with diagnosis of/or screened positive for depression/anxiety
- All screened patients should be added to the registry
- Excellent tool for case finding
- Data gathering tool
  - **This is mandatory for BCBSM**

Disease Registry

MRN	Patient	DOB	Age	Sex	PCP	Last Full PHQ	Last PHQ9 Score	Last GAD-7 Screening Date	Last GAD-7 Score	Last Primary Care Visit	Last Social Worker Visit	Primary Care Next Appt
[redacted]			18 y.o.	Female	Sylvestre, Nastassia Cassandra, MD	10/30/2018		03/13/2020	10	12/27/2019		05/19/2020
			18 y.o.	Female	Gessner, Lynn Michelle, MD	04/14/2020	11	04/14/2020	18	01/08/2019		
			18 y.o.	Female	Gessner, Lynn Michelle, MD	04/23/2020	15	04/23/2020	10	02/10/2020		
			18 y.o.	Female	Sylvestre, Nastassia Cassandra, MD	04/15/2020	7	04/15/2020	15	02/18/2020		05/29/2020
			19 y.o.	Female	Gessner, Lynn Michelle, MD	04/03/2020	11			03/02/2020		05/15/2020
			19 y.o.	Male	Phys, Self-Refer Or No Pcp/Referring	07/24/2018				06/18/2019		05/12/2020
			21 y.o.	Male	Scott-Craig, Thomas Peter Claire, MD	07/17/2018		03/12/2020	14	03/12/2020		
			21 y.o.	Female	Phys, Self-Refer Or No Pcp/Referring	04/10/2020	13	03/23/2020	15	03/23/2020		
			21 y.o.	Male	Cox, Amanda	01/13/2020	20	0	Scroll to Selected Row	01/13/2020	04/27/2018	

Communication

- How will referrals be communicated in your workflow?
- Current workflows, resources, channels of communication

- How will they be documented?
  - **Document and report on how many patients referred and how many accepted/declined**
  - **Of those who declined, what was the reason?**

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:

- Significant cognitive deficits
- Acute safety concerns
- Psychotic symptoms
- Symptoms due to a medical condition
- Severe substance use disorder

Diagnosis and Team Approach

- PCP - recognize the signs of possible diagnosis, perform/review screening tools, evaluates potential medical causes/origins of symptoms, orders labs/tests as needed, coordinates with care manager for further assessment
- BHCM – complete assessment to determine appropriateness for CoCM, (functional impairments, need for higher level of care, crisis management) communicates relevant information to PCP, consults with Psychiatric Consultant during systematic case review if needed for determination
- Psychiatric Consultant – provides expert guidance on diagnosis as needed, assists in determining appropriate level of care
- Patient – provides information about history and symptoms, completes screening tools

Acute Safety Concern: Suicidal Ideation

Suicidal ideation is a common symptom of depression

- Important to know when immediate intervention is needed

  (PHQ-9 question 9 – ***Thoughts that you would be better off dead or of hurting yourself in some way***)

- **A workflow for suicidal ideation should be built into any Collaborative Care model as well as a policy that all practice staff are familiar with**

Engage

- Provide Psychoeducation
- Introduce Collaborative Care
- Refer to BHCM as appropriate

“We provide services here that help with symptoms of _____. I have a member of my team, *name* that I work closely with that helps a lot of my patients who are experiencing these symptoms. She/he and I work together to provide you with treatment options to help you improve and manage your symptoms. There is also another member of our team, Dr. name that we consult with. He/she is an expert in mental health and will help us determine the best treatment. (you won’t actually see this doctor). We know that every person is different so we’ll develop a plan together that works for you. Our goal is for you to feel better as soon as possible.”

Share with the Patient

- The patient is an important part of the team
- The PCP will oversee all aspects of care received at the practice
- The BHCM works closely with the PCP to implement the treatment plan/self-management plan while keeping track of progress and providing additional support
- The psychiatric consultant does not see the patient face to face, but provides guidance for the team
- All team members share one treatment plan to support patient centered goals
- This is not typical therapy. The contacts will be shorter and often by phone

Consent

- Verbal or written
- Documented in EHR before services begin
- Key items:
  - Permission to consult with psychiatric consultant and relevant specialists
  - Billing information (cost sharing), if applicable
  - Disenrollment can occur at any time (effective at end of month, if billing)

Verbal Consent Guidelines

Verification of Coverage

- Consider your workflow to verify patient coverage
  - Does the patient's insurance provider cover CoCM services?
  - Is there a cost share associated with CoCM services?

Reminder: BCBSM has waived cost sharing (deductible, coinsurance and copayments) beginning July 1st 2020

Warm Handoff to BHCM

- If available, Warm Handoff

"I'd like to introduce _____. ( )works closely with me to help patients who are feeling _____(down/worried/depressed/anxious). I'd like for you to meet her while you are here today."

- Call/ask BHCM for exam room drop-in

The Warm Handoff is very effective

  - Leverages the rapport/trust that patient has with PCP
  - Fosters familiarity with new team member
  - Offers opportunity for further assessment

If BHCM is not available:

- Send chart/note for outreach
  - If choosing this option, make sure patients are aware that they will be receiving a phone call

Challenges of Engagement

- When talking with patients about mental health there may be challenges:
  - Lack of understanding of diagnosis
  - Inability to tie current behavior to mental health condition
  - Stigma
  - Preexisting beliefs about psychiatric medications and mental health treatment
  - Religious/cultural beliefs

Assessment by BHCM

- The BHCM completes a comprehensive behavioral health assessment with the patient
- Example of collected information:
  - History of BH including family history
  - History of medications
  - Substance use history etc.

Hello (PCP name)

I had the opportunity to discuss your patient, (NAME), with the clinic's behavioral health care manager, (NAME), in our weekly systematic case review meeting. Please see below for my recommendations.

Brief Summary

Recommendations

Behavioral health care manager, (NAME), will continue to follow patient for symptoms monitoring and support

Possible Side Effects

Scores

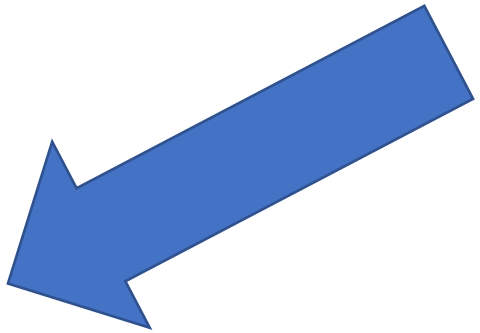
PHQ-9

GAD-7

Background and and Decision-Making

Safety Concerns

EHR Documentation Guide



Substance Use Concerns

Previous Medication Trials

The above treatment considerations and suggestions were based on consultation with the behavioral health care manager and a review of information available in the chart. I have not personally examined the patient. All recommendations should be implemented with consideration of the patient's relevant prior history and clinical status. Please feel free to call me with a any questions about this patient.

Treatment Steps

- Initiate treatment
- Track Treatment
- Follow-up contacts and progress of treatment/self-management plan
- Adjust Treatment
- Assess patient’s improvement as defined by: PHQ-9 and GAD-7
- Adjust treatment accordingly
- Conclude Treatment
- Relapse Prevention Planning or transition to community resources

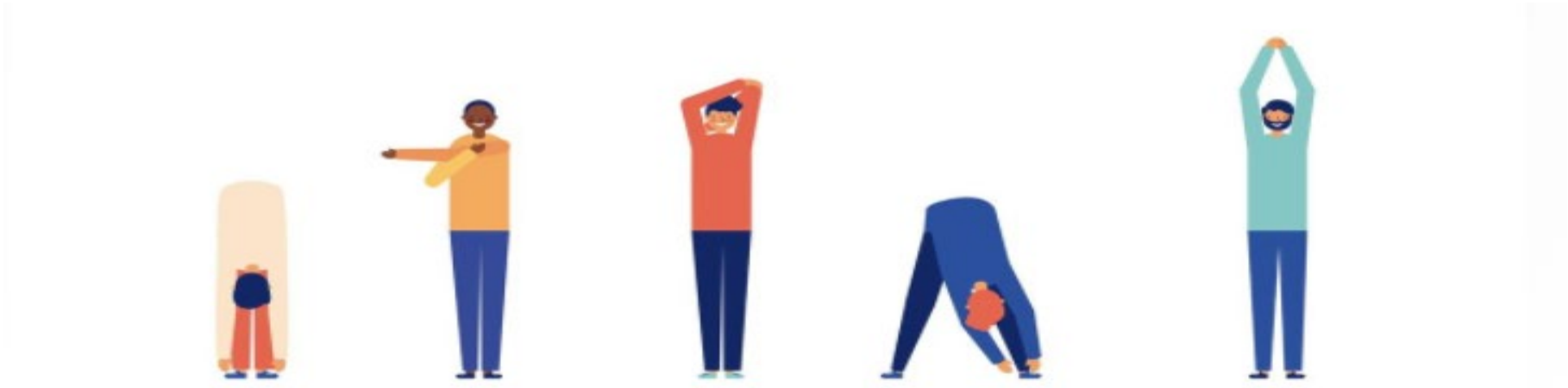
Initial Treatment Planning

- PCP – Completes medical assessment as needed, initiates appropriate treatment with BHCM, prescribes initial medication trial, provides support to patient regarding treatment and communicates with BHCM
- BHCM – Provides psychoeducation about anxiety and depression, coordinates with team to create integrated treatment plan, provides brief behavioral intervention and follow-up plan
- Psychiatric Consultant – supports treatment planning and guides treatment decisions as needed, supports medication concerns
- Patient – Learns about anxiety/depression and treatments options, works with team to develop a plan that reflects goals

Treatment Plan

- Developed by the Care Team ***with*** the Patient
- Goals have observable, measurable outcomes (SMART)
- Outcomes are routinely measured
- Treatment to target
- Treatments are actively changed until treatment goals are achieved
- Clinical outcomes are routinely measured by evidence-based tools

Stretch Break – 15 minutes



BHCM Interventions

- BHCMs will provide:
  - Motivational Interviewing
  - Problem-Solving Therapy
  - Behavioral Activation
  - Medication Monitoring
  - Psychoeducation

Treat to Target

- **Be prepared to adjust the treatment plan until targets are achieved**
  - Monitor patient's progress
  - Provide robust outreach to the patient
  - Assess patient's adherence throughout treatment
    - make adjustments as indicated
  - Proactively seek consultation

Treatment to Target has been used for medical conditions for decades

Diabetes

HTN – hypertension

Self-Management Plan

- Self-management plans are defined as ‘structured documented plans that are developed to support an individual patient's self-management of their condition’
- The BHCM will develop a Self-Management Plan with the patient that all team members should have access to in the chart.

***Example**: Brenda will walk for 15 minutes in her neighborhood on Monday/Wednesday/Friday morning before work for 6 weeks.*

Table 1. Components of self-management of depression[a]	
Component	**Tasks**
Information	Educating self and family members/friends about depression
Medication management	Taking medications as recommended by one's health care provider
	Overcoming barriers to adherence to medications
Symptom management	Using various strategies to manage symptoms of depression
	Self-monitoring of symptoms
	Managing concurrent symptoms of anxiety and/or substance use
	Using techniques to deal with frustration, fatigue, and isolation
	Managing sleep
	Managing symptoms of medical conditions associated with depression
	Relaxation
	Using strategies for preventing relapse of depression
Lifestyle	Exercise
	Overcoming barriers to exercise adherence
	Vacations
	Leisure activities
	Healthy nutrition and diet
Social support	Family support
	Relationships with peers and friends
Communication	Assertiveness
	Communication strategies (eg, with mental health professionals)
Others	Accessing support services
	Creating action plans
	Decision making
	Goal setting
	Problem solving
	Career planning
	Spirituality

[a] Adapted from: Barlow et al[12] and Duggal.[13]

Duggal HS. Self-management of depression: Beyond the medical model. Perm J 2019;23:18-295. DOI: https://doi.org/10.7812/TPP/18-295

Caseload Size Guidelines: 1.0 BHCM FTE

Program and Patient Characteristics	Caseload Size Range	
• High commercial payer • Mostly depression and anxiety; low clinical acuity • Minimal social needs, comorbid medical conditions	90	120
• Commercial, public payer, or uninsured • Mostly depression and anxiety; few higher acuity • Minimal-moderate social needs, substance use, comorbid medical conditions	70	90
• Public payer, uninsured, low commercial • Mostly depression and anxiety; some higher acuity • Minimal-moderate social needs, substance use, comorbid medical conditions	50	70

Actual caseload sizes will vary by patient population and program characteristics

The Role of the Psychiatric Consultant

- Following the assessment by the CoCM, the patient is added to the systematic case review tool and reviewed with the Psychiatric Consultant during systematic case review. Treatment recommendations, including psychotropic medications are made by the PC
- The PC continues to review the BHCM case load and prioritize those patients who are not improving and continues to provide treatment recommendations as indicated
- The Psychiatric Consultant can also provide assistance with diagnosis and help distinguish a patient's appropriateness for CoCM

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 outcomes, PHQ-9 and GAD-7
- Identifies patients who are not responding to treatment

What's the Difference?

Systematic Case Review Tool

Caseload management tool used in conjunction with or built into the EHR

- Summary of key treatment information (e.g., outcome measure scores, dates of contacts) for individual patients and entire caseload
- Used by behavioral health care manager (BHCM) and psychiatric consultant to regularly review the CoCM caseload
- **Clinical tool required for CoCM service delivery**

Disease Registry

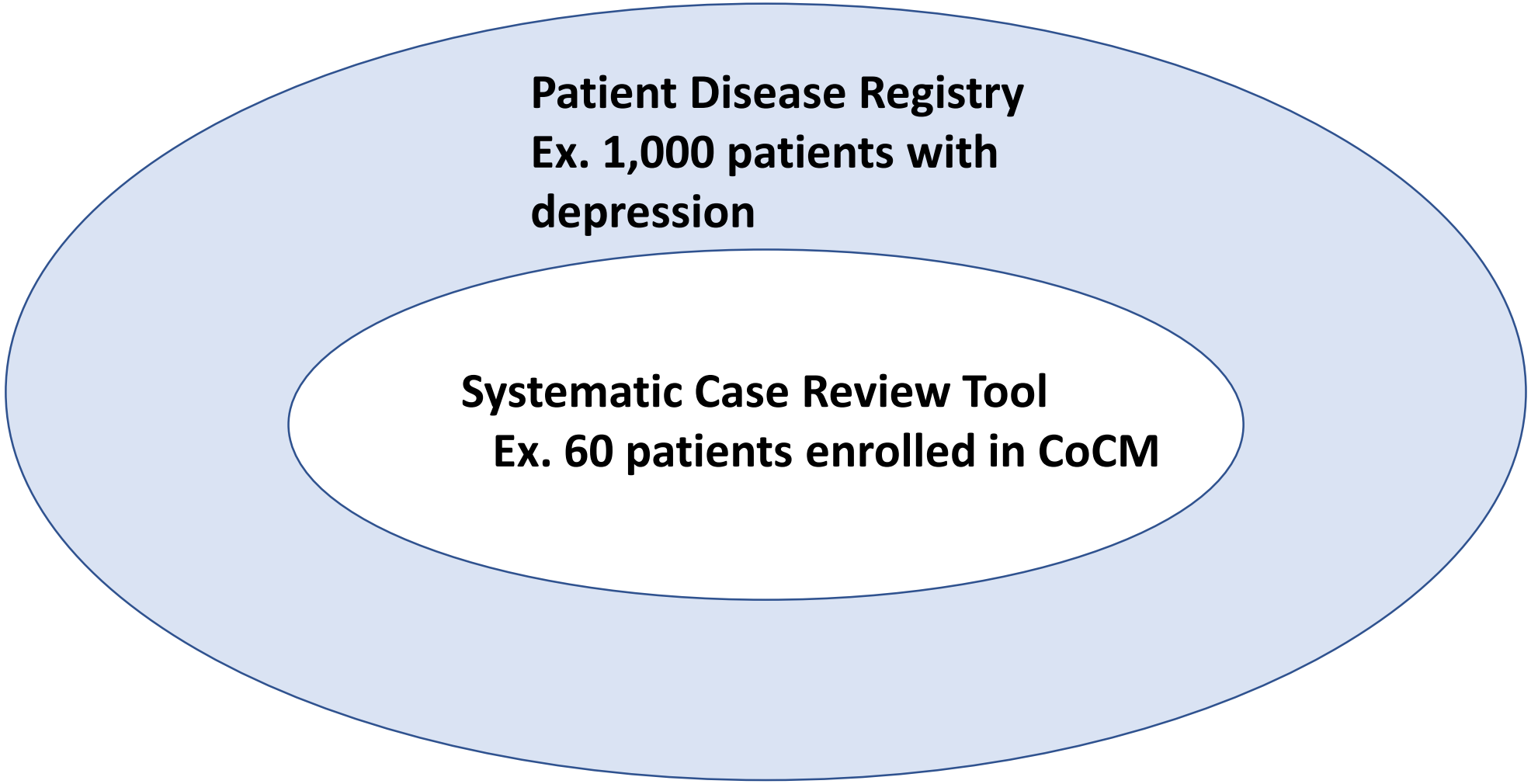
List of patients with a diagnosis of depression, anxiety, or other behavioral health condition

- Could be incorporated with existing chronic disease registry
- Used to identify patients who are eligible for the CoCM services
- Often static

Systematic Case Review Tool

Patient Information		Contact Information					Depression Outcomes					Anxiety Outcomes				Psychiatric Panel Review Information			
Name	Treatment Status	Date of Initial Contact	Date of Most Recent Contact	Number of Patient Contacts Completed	Weeks in Treatment	Date Next Contact Due	Initial PHQ-9	Most Recent PHQ-9	Difference in Most Recent PHQ-9	Most Recent PHQ-9 #9	Date of Most Recent PHQ-9	Initial GAD-7	Most Recent GAD-7	Difference in Most Recent GAD-7	Date of Most Recent GAD-7	Date of Most Recent Panel Review	Flag to Discuss	Patients Not Improving at 8 Wks	Outstanding Psych Recs
Lion, Leo	Active	12/17/18	3/29/19	3	19	4/28/19	21	21	0	0	3/29/19	21	21	0	3/29/19	4/5/19			
Doe, Jane	Active	4/12/19	4/22/19	3	2	4/29/19	17			0	4/12/19	19			4/12/19	4/19/19	Flag to Discuss		
Green, Sky	Active	12/24/18	4/17/19	6	18	5/1/19	17	5	-5	0	4/17/19	18	✓ 4	-6	4/17/19	4/17/19			
Smith, John	Active	2/28/19	4/17/19	2	9	5/1/19	7	8	1	0	4/17/19	21	12	-9	4/17/19	4/19/19		Attn Needed	
Blue, Jeans	Active	4/23/19	4/23/19	1	1	5/7/19	16			0	4/23/19	19			4/23/19	4/26/19	Flag to Discuss		Pending
Yellow, Joy	Active	12/31/18	4/11/19	7	17	5/11/19	19	11	0	0	4/11/19	17	21	0	4/11/19	4/12/19			Pending
Jupiter, Mars	Active	12/17/18	4/29/19	10	19	5/13/19	18	✓ 3	-7	0	4/29/19	21	8	5	4/29/19	4/12/19			
Shine, Sun	Active	4/29/19	4/29/19	1	0	5/13/19	22			0	4/29/19	21			4/29/19		Flag to Discuss		
Michigan, Cherry	Active	10/22/18	4/30/19	13	27	5/14/19	18	21	0	0	4/30/19	20	21	0	4/30/19	4/12/19			
Smile, Big	Active	11/13/18	4/30/19	8	24	5/30/19	20	11	-7	0	4/25/19	17	10	-7	4/25/19	4/26/19			

Note: This example includes many “nice to have” components; more simplified tools will suffice.



Components: Systematic Case Review Tool

Required

- **Patient identification**
- **Treatment status (e.g., active, inactive, relapse prevention)**
- **Date of enrollment and disenrollment**
- **Baseline and most recent outcome measure scores (PHQ-9 and/or GAD-7) and dates**
- **Date of most recent BHCM follow-up contact with patient**

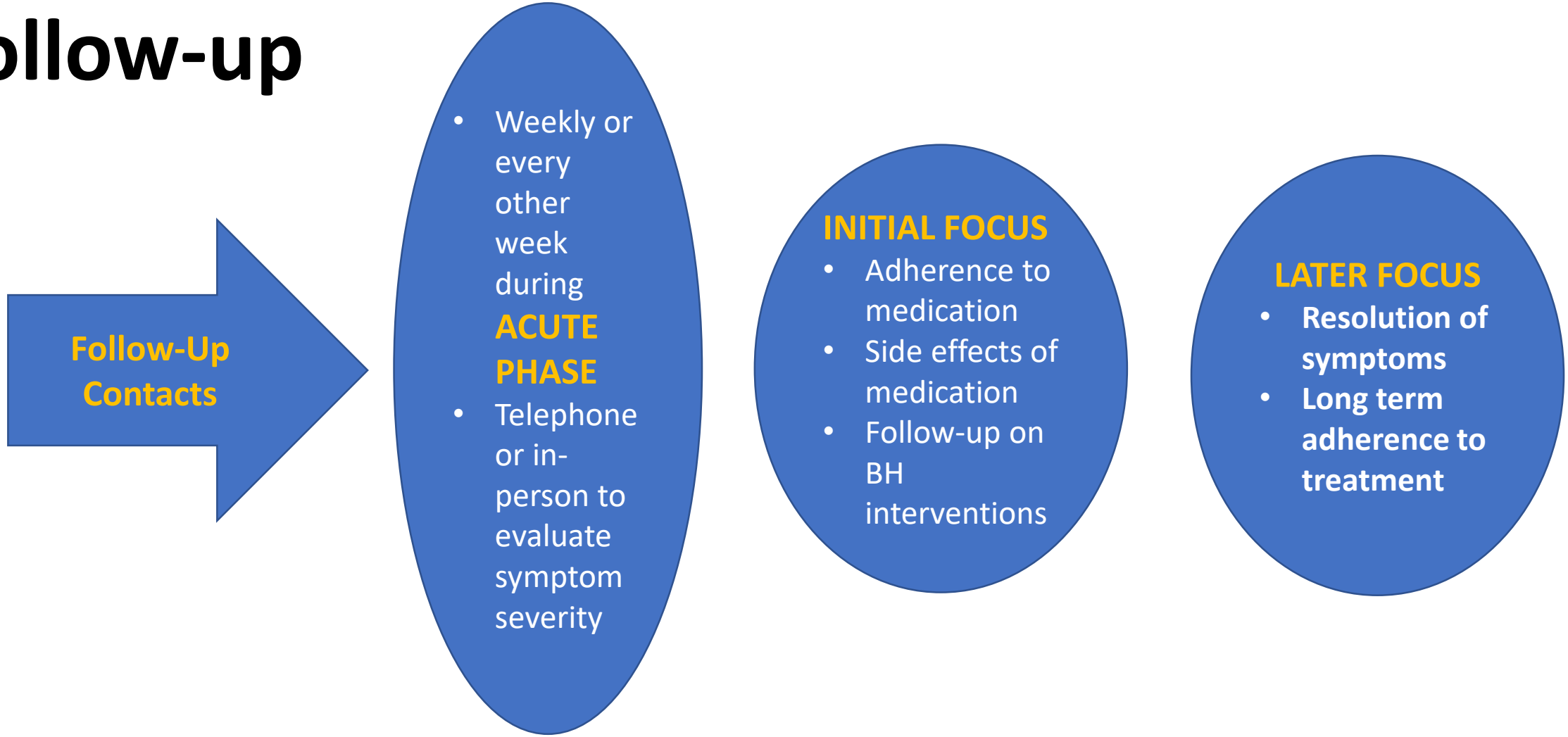
Recommended

- Overall change in PHQ-9 and/or GAD-7 scores
- Most recent change in PHQ-9 and/or GAD-7 scores (i.e., difference in two most recent scores)
- BHCM contact frequency (e.g., one-week, one month) or next contact date
- Date of most recent panel review session
- Outstanding psychiatric treatment recommendations
- Flags to 1) discuss in panel review; 2) visualize patients whose condition is improving or worsening; and 3) to indicate patients who would benefit from contact, updated outcome measures, or panel review session

MCCIST Systematic Case Review Tool Development Guide:

https://mccist.org/wp-content/uploads/2020/10/SCR-Tool-Development-Guide.pdf

Follow-up



Follow Up and Treat to Target

- PCP – Continue to prescribe medications and make treatment adjustments as needed, decide and implement treatment recommendations as appropriate, continue to review treatment plan with patient
- BHCM – Provide brief behavioral interventions, monitor symptoms, update systematic case review tool, talk with patients about medication and review with psychiatric consultant
- Psychiatric Consultant – review case load and prioritize those patients who are not improving, continue to provide treatment recommendations as indicated
- Patient – Continue engagement with the team, follow treatment plan, complete screening measures

Defining Improvement:

- Validated Outcome Measures:
  - PHQ-9 (Patient Health Questionnaire) – Depression screening
  - GAD-7 (Generalized Anxiety Disorder) – Anxiety screening

- Improvement:
  - 5-point reduction in score = Improvement
  - 50% reduction in score = Response
  - Score less than 5 = Remission

- **Tracking PHQ-9 score data is required for CoCM service delivery;** Tracking GAD-7 score data is highly recommended but not required.

Relapse Prevention Planning

- When patients reach remission, the BHCM will engage patient in relapse prevention planning
  - Relapse prevention planning starts at the very beginning of CoCM

- We will review the elements of relapse prevention planning in CoCM training Day 2, (tomorrow)

Referrals outside of CoCM

Transition to Community Resources:

1. Patient not getting better
2. Conditions requiring special expertise
3. Conditions requiring longer-term care
4. Need for recovery-based services (people with serious and persistent mental illness)
5. Patient request

Team Approach

- **Build mutual trust**
  - Uphold role expectations
  - Share patient success stories
- **One treatment plan**
  - Sharing clear goals with tx team and within EHR
- **Clarify roles and workflow**
  - Establish clear roles that all team members understand (through the entire practice)
  - Review and update workflows as needed
- **Establish Communication**
  - Develop, implement and re-evaluate communication

Systematic Case Review

DEMONSTRATION ACTIVITY

Questions?