The Collaborative Care Model (CoCM)

The Behavioral Health Care Manager

April 14th, 2021

Topic	Objectives
Introductions	
The Role of the BHCM and the COCM Process	• Explain the key responsibilities of the BHCM as part of the CoCM treatment team • Review the CoCM steps including introduction, screening, assessment, risk assessment, care planning, intervention, monitoring/follow-up and case closure
Tracking Patients	• Examine the BHCM role in the use of a disease registry, systematic case review tool and case presentation to the psychiatric provider as it relates to treat-to-target
Psychotropic Medications and Diagnosis	• Discuss general approach to evaluating patients for anti-depressant and anti-anxiety medications • Review the common anti-depressant and anti-anxiety medications and their relative advantages and disadvantages and common patient concerns
Motivational Interviewing	• Discuss the SPIRIT of motivational interviewing as it applies to patient engagement • Review the skills and principles of motivational interviewing
Behavioral Activation	• Review CoCM evidence based therapeutic interventions including BA, and risk assessment and safety planning in the primary care environment
Maintenance	• Review the patient monitoring process, relapse preventions and transition to routine care
Moving Forward	• Describe the process for next steps once initial training is completed and the practice is ready for implementation.

CoCM BHCM TRAINING TIMELINE

TIME	DURATION	TOPIC
8:00-8:15am	15 MIN	Introduction
8:15 -9:45am	90 MIN	The Role of the BHCM and the COCM Process
9:45-10:00am	15 MIN	STRETCH BREAK
10:00-11:00am	60 MIN	Identifying and Tracking Patients
11:00-12:00pm	60 MIN	Psychotropic Medications and Diagnosis
12:00-12:30pm	30 MIN	LUNCH BREAK
12:30-2:00pm	90 MIN	Motivational Interviewing
2:00-2:15pm	15 MIN	STRETCH BREAK
2:15-3:15pm	60 MIN	Behavioral Activation
3:15-3:45pm	30MIN	Maintenance
3:45-4:15pm	30MIN	Moving Forward

The Behavioral Health Care Manager

Curriculum developed in partnership with:

- **Karla Metzger,** MCCIST
- **Sarah Fraley,** MCCIST
- **Marina Milad,** MCCIST
- **Courtney Miller,** MCCIST
- **Sue Vos,** Mi-CCSI
- **Thomas Dahlborg,** Mi-CCSI
- **Alicia Majcher,** MICMT
- **Gretchen Goltz,** BCBSM
- **Kathleen Kobernik,** BCBSM
- **Emily Santer,** BCBSM

Michigan Collaborative Care
IMPLEMENTATION SUPPORT TEAM

Mi-CCSI
Center for Clinical
Systems Improvement

Blue Cross
Blue Shield
of Michigan

A nonprofit corporation and independent licensee
of the Blue Cross and Blue Shield Association

MICMT
Michigan Institute for Care Management & Transformation

Social Work:

Upon successful completion of The Collaborative Care Model (CoCM): An Evidence and Team-Based Care Approach to Integrating Behavioral Health in Primary Care Trainings Day #2, the participant will earn 7 Social Work CE contact hours

Michigan Institute for Care Management and Transformation is an approved provider with the Michigan Social Work Continuing Education Collaborative. Approved provider Number: MICEC 110216.

CME Approval

The AAFP has reviewed Behavioral Medical Integration - Collaborative Care , and deemed it acceptable for AAFP credit. Term of approval is from 08/24/2020 to 08/23/2021. Physicians should claim only the credit commensurate with the extent of their participation in the activity. Credit approval includes the following session(s):

- 14.00 In-Person, Live (could include online) AAFP Prescribed Credit(s) - Behavioral Medical Integration - Collaborative Care
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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.

Virtual Etiquette

Please mute yourself upon entry and remain muted until discussion time
Please send questions through the chat function

Video and Audio:

- Unless distracting, please turn video ON during break-out sessions. This is crucial for building trust and engagement.
- Test your video and audio before the meeting begins.
- Try to look at the camera when talking (to mimic the feeling of in-person eye contact).
- Adjust your camera if it is too high or low.

Environment:

- Be aware of your backgrounds to not be distracting.
- Find a quiet place to join or mute yourself as necessary.

Starting the Day:

- What 2 topics do you want to make sure we cover today?
- What are your key questions for the day?

Reflections from Day 1

- Who are the main players of CoCM and what are their roles/work?
- Which patients are candidates for CoCM?
- What are the new team processes and workflows that need to be created?
- What is the difference between the patient disease registry and the systematic case review tool?

The Role of the BHCM

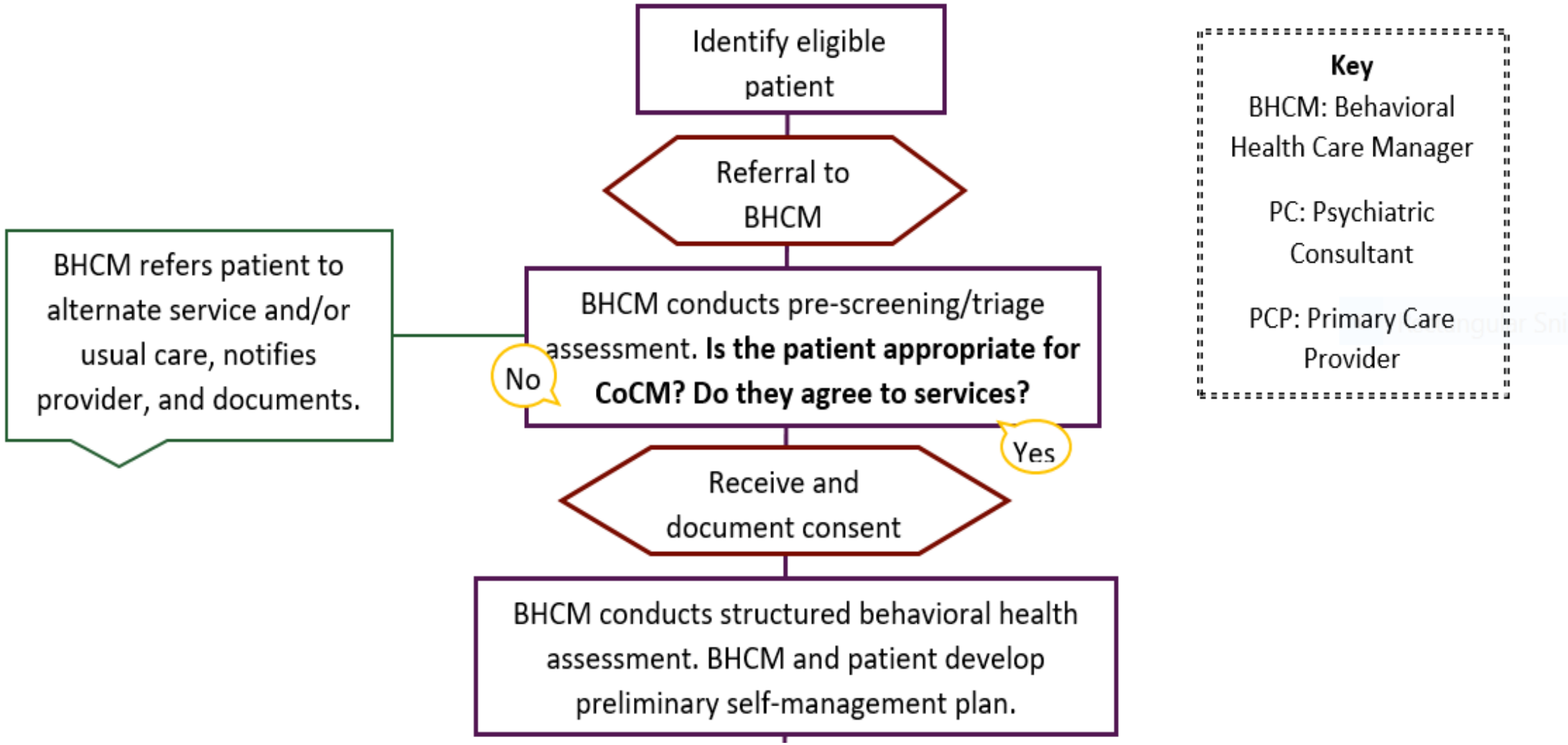
THE PATIENT IS THE CENTRAL FIGURE OF THE TREATMENT TEAM, AND **YOU** ARE THE QUARTERBACK!

What the BHCM Does…

- Coordinates the overall effort of the treatment team and ensures effective communication among team members
- Develops and proactively adjusts treatment plan with consultation of psychiatric consultant
- Medication monitoring and psychoeducation
- Offers brief behavioral health interventions (using evidence-based techniques such as motivational interviewing, behavioral activation, and problem-solving treatment)
- Participates in systematic case review; Close collaboration with Psychiatric Consultant
- Supports the PCP by providing proactive follow-up of treatment response, alerting the PCP when the patient is not improving, supporting medication management, and facilitating communication with the psychiatric consultant regarding treatment changes

The Process

- Screening – identify eligible patients from the general practice population
- Referral – connect eligible patients to the CoCM program
- Assessment -
  - Assess appropriateness for CoCM
  - If appropriate, complete biopsychosocial assessment including diagnostic criteria, medical/medication history
- Initiate treatment – identify available treatment interventions, develop treatment plan and self-management goals
- Track treatment progress over time – administer PHQ-9 and GAD-7 throughout tx
- Adjust treatment as needed – for patients who are not improving
- Conclude treatment – relapse prevention plan and resources if indicated



Introducing CoCM to Patients

- If possible, introduce via a warm-handoff from the PCP
- Introduce the team-based approach, reviewing the role of each team member
- Emphasize the importance of the patient's role in:
  - treatment planning and ongoing care
  - completing screening tools
  - participating in meeting with the BHCM
- Describe the time-limited approach of interventions from the BHCM explaining that this is not therapy
- Personalize the script based on the patient, personal style, and clinical judgment

Sample Script

- Briefly introduce yourself and the reason that you're reaching out to offer support

"Hi! I'm_____ , the Behavioral Health Care Manager with our Collaborative Care program. I'm stopping by/calling to introduce myself so I can help you with your, reason for referral. Our PCPs like to make sure people feel supported when they are diagnosed with, start on a new medication, have symptoms of anxiety/depression, and asked that I connect with you."

Introducing the Psychiatric Consultant

- “I also work closely with a consulting psychiatrist who may have recommendations for your plan of care. He/she is available for medication recommendations if that is something that is a part of your treatment plan. We review all of the patients I work with.”
- “The psychiatrist is able to send treatment recommendations over to your PCP. I’d like to review your symptoms and history with the psychiatrist, so we can make sure you’re receiving the best care possible. Your PCP will remain the “lead” in your care, but appreciates the psychiatric recommendations. What do you think about this?”

Additional information to cover when introducing CoCM to a patient: Click here

INTRODUCE	PERSONALIZE	INTRODUCE	EMPHASIZE	DESCRIBE
If possible, introduce the program through a warm handoff through the PCP	Personalize the script based on the patient, personal style, and clinical judgement	Introduce the team-based approach reviewing the role of each team member	Emphasize the importance of the patient's role in: • treatment planning and on-going care • complete screening tools • participation in meeting with the BHCM	Describe the time limited approach approaches from the BHCM explaining that this is not therapy

ACTIVITY

Enter your group room.

Each person in your group will have the opportunity to practice introducing the CoCM program to a patient

Time Allotted – 15 minutes

ACTIVITY - Debrief

What went smoothly with your introductions?

What was a little more difficult?

Screening, Assessment, and Triage

- Screen using empirically valid outcomes measures such as PHQ, GAD, etc.
- Provide comprehensive behavioral health assessment (substance abuse and mental health history included) both over the phone and in-person
- Evaluate and assign level of care needed based on assessment and resources
- Have knowledge of behavioral health resources internal and external, along with eligibility and access criteria
- Conduct risk assessments and safety planning when indicated
- Provide crisis management when needed

Pre-Screen and Triage Assessment

- Used to determine whether a patient is appropriate for Collaborative Care
- Modality:
  - ❑ Chart review
  - ❑ Discussion(s) with providers
  - ❑ Discussion with psychiatric consultant
  - ❑ Direct patient assessment
- When:
  - At time of referral
  - Later on in clinical care- it's an ongoing process!

Triage Assessment

- ☐ Presenting symptoms of concern
- ☐ Psychiatric treatment history
    - ☐ Has patient been a Community Mental Health (CMH) consumer?
    - ☐ Psychotic disorder diagnosis?
    - ☐ Confirmed or likely personality disorder diagnosis?
- ☐ History of psychosis/hallucinations (auditory/visual)?
- ☐ Prior medications
    - ☐ Mood stabilizers?
    - ☐ Antipsychotics?
    - ☐ Other:
- ☐ Administer core outcome measures (PHQ-9, GAD-7, AUDIT-C)
    - ☐ High-risk AUDIT-C score? Is inpatient or residential treatment indicated?
    - ☐ PHQ-9 and GAD-7 both <10?

Who requires a higher level of care

Patients with:

- Severe substance use disorders
- Active psychosis
- Severe developmental disabilities
- Personality disorders requiring long-term specialty care

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)

Introducing Screening to the Patient

- INTRODUCE: “Along with your physical vital signs like your blood pressure and heart rate, I am also going to ask you some questions about how you’re feeling as well.”
- NORMALIZE: “These are questions we ask all of our patients.”
- EXPLAIN: “Your answers will help your doctor know what to focus on so he/she can give you the best care possible” or “Your answers will help us know if your treatment is working so that we can do everything possible to help you recover/feel better.”

Poll

Familiarity and Use of PHQ 9 and GAD 7

PHQ - 9

- Commonly used and validated screening tool for depression in adults

“Much like taking your blood pressure or temperature, this screening will give us information about your overall health and well-being over the past 2 weeks.”

Generally a score of 10 or above and/or a positive answer on question 9 of the PHQ-9, a screening for suicidal symptoms necessitates intervention.

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

GAD-7

- The GAD 7 is a seven-question form used to screen for signs and symptoms of anxiety and monitor changes in symptoms.

“Much like taking your blood pressure or temperature, this screening will give us information about your overall health and well-being over the past 2 weeks.”

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over 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's 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
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

Additional Screenings to Consider

- AUDIT-C (alcohol use)
- CIDI-based bipolar questionnaire
- MoCA (mild cognitive dysfunction)
- PC-PTSD (PTSD screening)
- PCL 5 (PTSD screening)

AUDIT - C

The Alcohol Use Disorders Identification Test (**AUDIT**-**C**) is an alcohol screen that can help identify patients who are hazardous drinkers or have active alcohol use disorders (including alcohol abuse or dependence)

1. How often do you have a drink containing alcohol?

(0) Never (Skip to Questions 9-10)
(1) Monthly or less
(2) 2 to 4 times a month
(3) 2 to 3 times a week
(4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

(0) 1 or 2
(1) 3 or 4
(2) 5 or 6
(3) 7, 8, or 9
(4) 10 or more

3. How often do you have six or more drinks on one occasion?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

The AUDIT-C is scored on a scale of 0-12 points (scores of 0 reflect no alcohol use in the past year). In men, a score of 4 points or more is considered positive for alcohol misuse; in women, a score of 3 points or more is considered positive. Generally, the higher the AUDIT-C score, the more likely it is that the patient's drinking is affecting his/her health and safety

CIDI-Based Bipolar Disorder Screening Scale

Stem Questions:

1. Some people have periods lasting several days or longer when they feel much more excited and full of energy than usual. Their minds go too fast. They talk a lot. They are very restless or unable to sit still and they sometimes do things that are unusual for them, such as driving too fast or spending too much money. Have you ever had a period like this lasting several days or longer?

2. Have you ever had a period lasting several days or longer when most of the time you were so irritable or grouchy that you either started arguments, shouted at people, or hit people?

McCormick, U., Murray, B., & McNew, B. (2015). Diagnosis and treatment of patients with bipolar disorder: A review for advanced practice nurses. *Journal of the American Association of Nurse Practitioners*, *27*(9), 530–542. https://doi.org/10.1002/2327-6924.12275

Structured Assessment

- Address any questions and prepare for the assessment.
    - “So far, we’ve talked a bit about what Collaborative Care will look like, including your role, my role, and the other team members’ roles. You’ve also shared a bit with me about what’s been going on with you. Given everything we’ve talked about so far, I’d like to **check in** regarding anything that might be on your mind. Then, when you’re ready, we’ll move forward and I’ll ask some standard questions to learn more about you and what we might focus on throughout our time together.”

- **Set expectations** for the patient and provide choice
    - 30-60 minutes, on average – may take place over more than one contact
    - Telephone or face-to-face

Presenting Symptoms

- Assess the patient's current symptoms of concern
  - "Tell me more about what's been going on."
  - "What made you decide to talk with me today?"
  - "You mentioned you've been feeling down; could you share more about how that's been impacting your daily life?"

Behavioral Health History

- Course of illness
  - “How long has this been going on?”
  - “Is this something that is always present for you, or does it come and go?”
  - “What tends to bring on these feelings, if anything?”
- Diagnostic history
  - “What mental or behavioral health diagnoses, if any, have you received from a health care provider?”
  - “Who was it that gave you that diagnosis? When?”
  - Screen for history of psychosis (AH/VH)
- Trauma history
  - It is often appropriate to wait until a trusting relationship is established before screening for trauma
  - Screening tools include the PC-PTSD and the PCL-5

Treatment History- Medications

- Current and past medication names and dosages, (both medical and psychotropic) – what is/was the medication for?
- Prescriber(s) of the medication(s)
- Length of medication trials
  - “How long did you take that medication?”
  - “What made you decide to stop the medication?”
- Effectiveness and side effects
  - “What did you notice when you took that medication?”
  - “Was it helpful? Why/why not?”
  - “What side effects, if any, did you experience?”
- Perceptions and beliefs

Additional Information

- Physical health history
- Sleep
- Functioning status
- Activity level / exercise
- Health literacy

Treatment History- Therapy

- Current and past engagement in therapy
- Where
- Type
  - “What kinds of things did you work on? What did you learn?”
- Length
- Effectiveness
  - “What was helpful about it? What wasn’t?”

Substance Use

- Engage, ask permission, and be nonjudgmental
  - “Would it be okay if I asked you a few questions about how you use substances?”
- Current and past substance use
- Screening tools can be helpful
  - AUDIT-C
- Treatment history
- Gain initial understanding of how they feel about their substance use
  - “How does that impact your depression?”
  - “You’re not worried about how this is impacting you right now.”

Psychosocial Details

- Support system
- Financial issues
- Disability/work status
- Transportation
- Living situation
- Access to phone and adequate minutes for phone-based care management contacts

MCISST Assessment Check List

Love, Work, Play, and Health Questions

LOVE	WORK
- Where do you live? - With whom? - How long have you been there? - Are things okay at your home? - Do you have loving relationships with your family or friends?	- Do you work? Study? - If yes, what is your work? - Do you enjoy it? - If not working, are you looking for work? - If not working and not looking for a job, how do your support yourself?
PLAY	**HEALTH**
- What do you do for fun? - For relaxation? - For connecting with people in your neighborhood or community?	- Do you use tobacco products, alcohol, illegal drugs? - Do you exercise on a regular basis for your health? - Do you eat well? Sleep well?

MCCIST clinical assessment tool

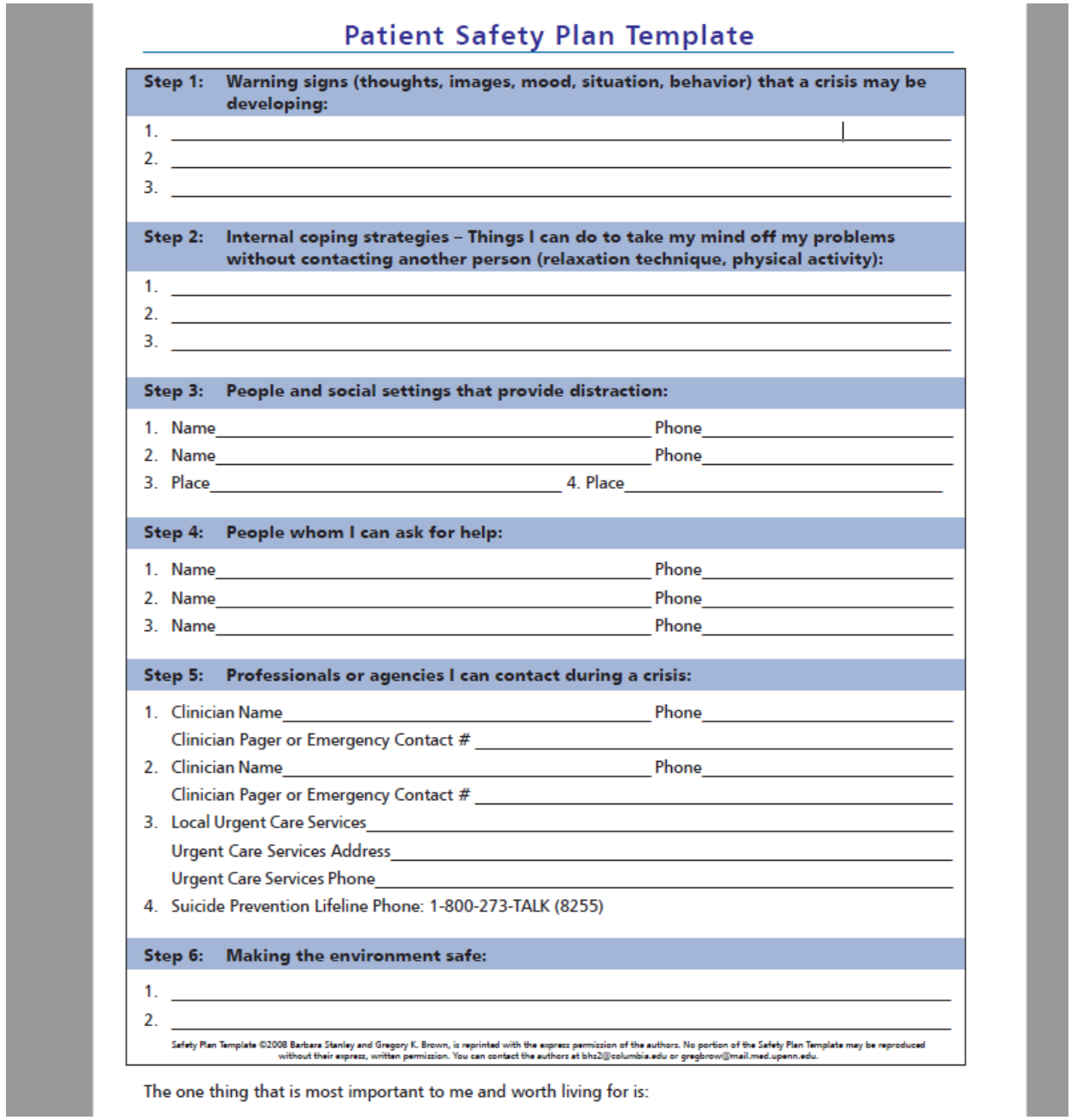
Risk Assessment

- Thoughts of death, harming oneself, and suicide can be common within this population
- When clinically indicated, risk assessments and safety planning should be completed
- Consider your organization’s suicide protocol
- Engage in further training if needed

Key Acute Risk Factors and Behaviors Include:

- Current ideation, intent, plan, and access to means
- Rehearsing a plan (e.g., holding a gun, loading a gun, counting pills)
- Previous suicide attempt/s
- Alcohol/substance use
- Recent discharge from an inpatient psychiatric unit

[MCCIST BHCM materials]



Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place_____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5: Professionals or agencies I can contact during a crisis:

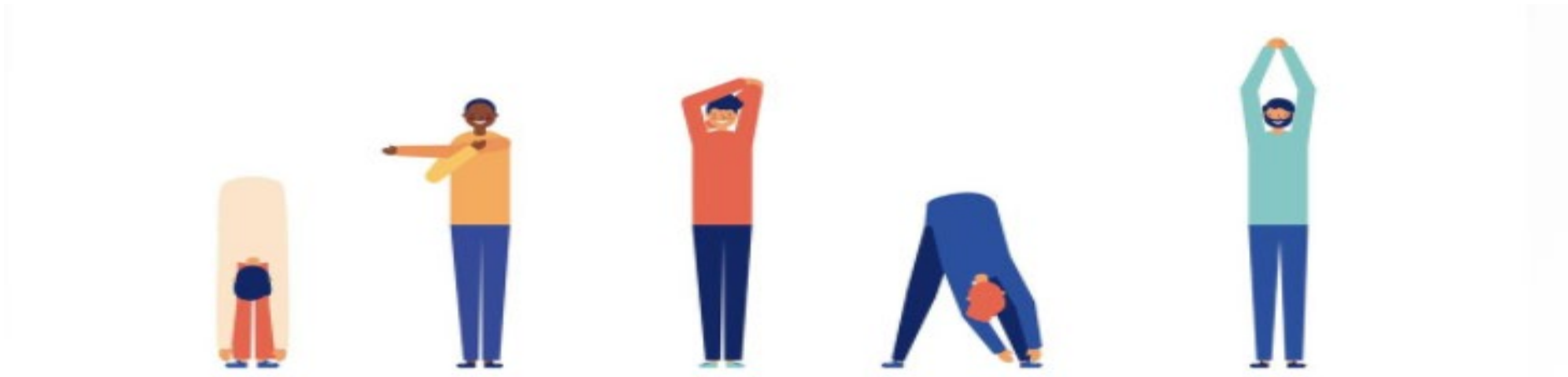
1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services_____
   Urgent Care Services Address_____
   Urgent Care Services Phone_____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

The one thing that is most important to me and worth living for is:

Stretch Break – 5 minutes



Moving Forward

- Acknowledge that this might have felt like a lot of information; elicit any questions or feedback
- Discuss next steps
  - Self-management goals
  - Reminder of upcoming psychiatric consultation as appropriate
  - Frequency of monitoring and next contact
- Contact information
  - Best time to call, permission to talk to others and/or leave a voicemail, confirm mailing address, obtain email address if secure email contacts are allowed by your organization, discuss patient portal
  - Share your contact information and hours
  - Emergency contacts
- Share relevant patient materials

Intake packet example

Care Plan

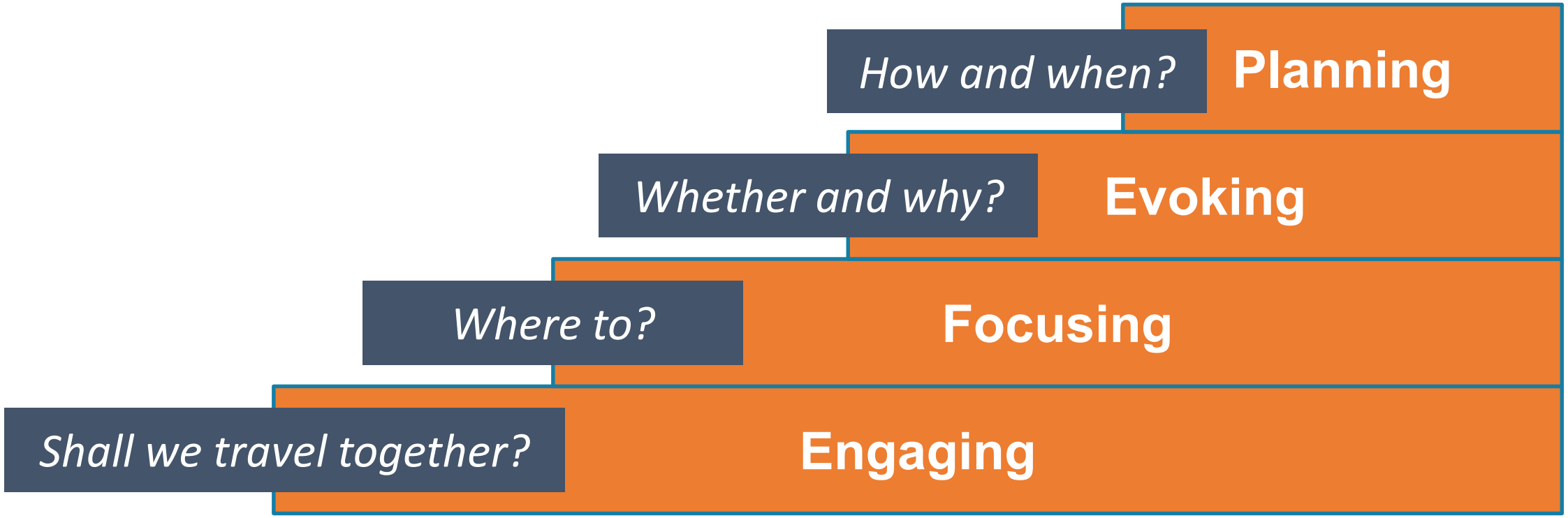
Remember that discharge planning/preparation starts from the beginning

- 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

Self-Management

- A “management style” where patients use the best treatments provided by health care professionals **AND** also approach their illness in a proactive manner, leading to a healthier life
- Self-management teaches skills that continue to work above and beyond the short-term relief that may be gained from self-help strategies

Planning: First, lay your foundation



Engagement

To plan, we need a focus

"You've discussed some difficulties in your marriage, your desire to cut back on your drinking, as well as your goal to lose some weight. We also know that you've been noticing your depression is feeling more difficult to manage lately. Where do you feel is the most important place to focus on first?"

Evoking

- Drawing out patient's own ideas and reasons for change
- The patient is the expert: Elicit, provide, elicit

- Current and past self-management strategies
  - "What have you tried so far that's been helpful?"
  - "What have you tried that hasn't worked so well?"

- Knowledge about their symptoms, diagnosis, and/or treatment
  - "What do you know about depression and how it impacts people?"
  - "What do you know about treatment for depression and anxiety?"
  - "What kinds of things have you already been thinking about trying?"
  - "What would be some benefits if you made this change?"

Self-Management Plans: Initial Goal-Setting

- Summarize what you've talked about and transition into a discussion about goals
  - "I've been able to learn a lot about you, including your history with depression, what you're currently struggling with, and some ideas that you have about where you'd like to go from here. Now we can move toward some self-management goals and treatment that might feel right to you. Where would you like to start?"
- Provide psychoeducation, as appropriate
  - "You're familiar with medication as a possible treatment for depression. Would it be okay if I shared some more information about treating depression?"
  - Behavioral activation, problem-solving, psychotherapy, medication, self-management strategies
- Elicit patient goals
  - "Given everything we've discussed, what do you think you might like to try?"

We have a specific focus. Now, it can be helpful to have a specific plan.

SMART goals

- Specific
- Measureable
- Attainable
- Relevant
- Time-specific

Exercise as part of a depression self-management plan

- “I want to exercise more,” or “I’ll go to the gym every day.”
- SMART version: “I want to go for a 30 minute walk three days per week for the next two weeks.”

Self-Management Plan- Example items

- ❑ Take my medication on a daily basis. If I'm thinking about making a change, call the office
- ❑ Go for a walk this Saturday with my partner
- ❑ Call my friend to schedule a lunch date
- ❑ Practice belly breathing four days this week for five minutes at a time
- ❑ Decrease wine intake from three glasses to one glass in the evenings (alternate with water)
- ❑ Practice "three good things" gratitude exercise 5-7 days/week for the next two weeks
- ❑ Turn off the TV in my bedroom at bedtime every night for the next week. Read instead
- ❑ Visit the library to update my resume
- ❑ Call a therapist and schedule an initial appointment
- ❑ Knit for at least 5 minutes each day for the next two weeks
- ❑ Schedule 15 minutes of "me time" each day for the next week to be quiet and listen to music
- ❑ Practice yoga for 30 minutes, 3 days/week, for the next two weeks
- ❑ Limit caffeine intake to before 4PM each day for the next two weeks

- What would be a reasonable next step toward change?
- What would help this person to move forward?
- Am I remembering to evoke rather than to prescribe a plan?
- Am I offering needed information or advice with permission?
- Am I retaining a sense of quiet curiosity about what would work best for this person?

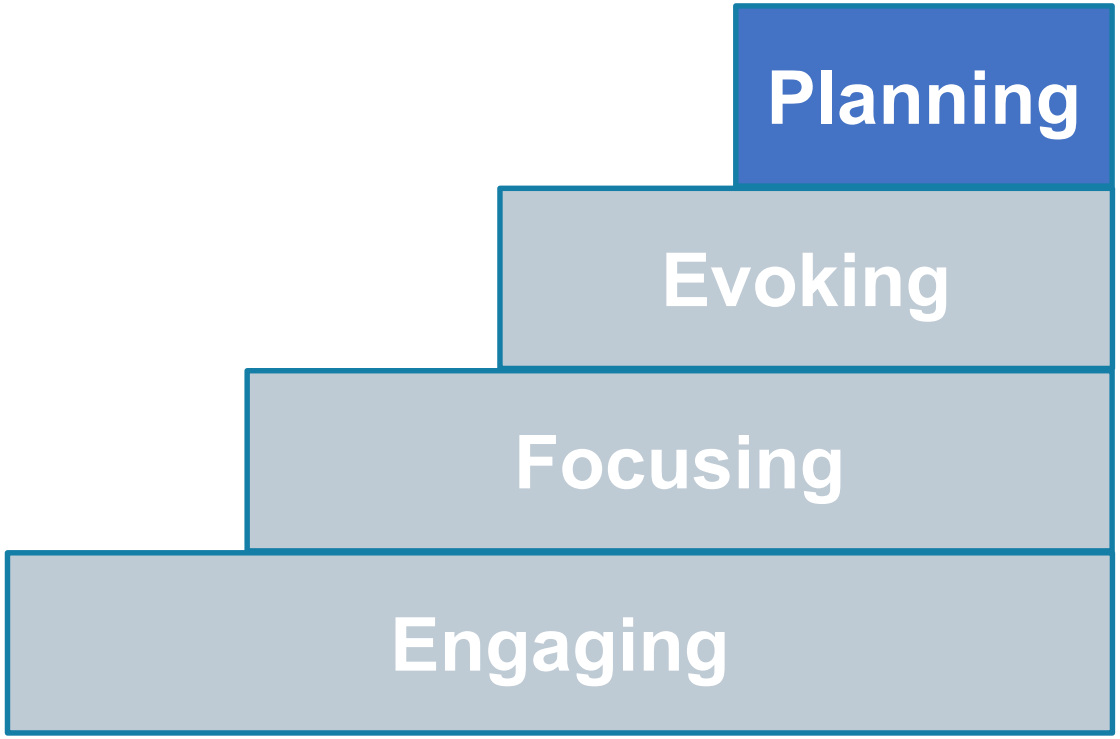


Table 1. Components of self-management of depression[a]	
Component	**Tasks**
Information	Educating self and family members/friends about depression
Medication management	Taking medications as recommended by one's health care provider
	Overcoming barriers to adherence to medications
Symptom management	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

Intake and Self-Management Reminders:

- Use of motivational interviewing is key
  - The patient is the expert; they are more likely to engage in a self-management plan if they believe it is important, right for them, and are confident they can succeed
- Self-management plans will change over time
- Establish next steps, including a plan for follow-up

Give the patient a copy of the plan!

ACTIVITY

Enter your group room.

Work on self-management planning as a group

Time Allotted – 20 minutes

ACTIVITY

Read the following scenario and develop an example of a patient self-management plan. Pretend you have engaged, focused and evoked the patient's ideas for change. Reminder: use SMART

Mr. Davis is a 35yo married male who has scored an 18 on the PHQ-9. He has no past behavioral health treatment. He has noticed symptoms of depression over the last 6 months including, fatigue, little interest in doing things such as playing on his softball team which is something he usually enjoys. He admits to anxiety related to COVID-19. His 75 yo uncle died from complications of COVID 3 months ago. He has been demoted at work and is having trouble paying his bills each month. He finds himself over sleeping resulting in tardiness. His mother has early stage dementia and lives on her own. Mr. Davis worries about her and how long she will be able to remain in her home. He is concerned that if she moves to a facility she will have an increased likelihood of getting COVID-19 and he will have restricted contact. He is losing track of her doctor appointments as her medical care is becoming more complicated.

What Keeps Happening?

- PCP – Continue to prescribe medications, make medication adjustments as needed, implement treatment recommendations
- BHCM – Provide brief behavioral interventions, monitor symptoms, update systematic case review tool, talk with patients about medications, consult with PCP and Psychiatric Consultant
- Psychiatric Consultant – Reviews patients with BHCM, prioritizing new patients, those who are not improving as expected, provide treatment recommendations to Care Team
- Patient – Engage with care team and adhere to treatment plan

Communicating with Patients

- BHCM will engage with patients by telephone (at least 2x/mth for first 1-4 months), in clinic, as well as by mail and/or secure patient portal (based on clinic policy)
- Frequency of outreach will depend on patient's treatments plan, their level of engagement, and if any crisis intervention is needed

BHCM Initial Outreach

What the Research Says:

- Patients with early follow-up are less likely to drop out and more likely to improve (Bauer, 2011)
- Patients who have a second contact in less than a week are more likely to take their medications
- Follow-up contact within four weeks of the initial assessment is key to early improvement (Bao, 2015)

Frequency of Contact:

Typical Frequency of Care Management Contact:

Status	Frequency
ACTIVE	• **minimum 2 contacts per month (can occur remotely)** • **until patient significantly improved/stable**
MONITORING	• **1 contact per month**
After 50% decrease in PHQ-9	• **monitor for ~3 months to ensure patient is stable** • **complete relapse prevention planning**

The BHCM Continuously:

- Monitors symptoms and outcomes on a regular basis and tailors the treatment plan in response to symptom acuity and progress toward goals
- Provides psychoeducation to patients surrounding behavioral health issues in both verbal and written formats
- Routinely engages patients in psychotropic medication monitoring and management, providing education and monitoring for side effects and adherence, as well as supporting patients in improving adherence
- Regularly utilizes brief, evidence-based interventions; frequent use of Motivational Interviewing, Behavioral Activation, and Problem-Solving Therapy, They may also utilize (and possibly CBT techniques, Mindfulness, and SBIRT, amongst other appropriate interventions)
- Routinely performs risk assessments and engages patients in safety planning as needed
- Provides appropriate community and supportive resources to patients, acting as a liaison

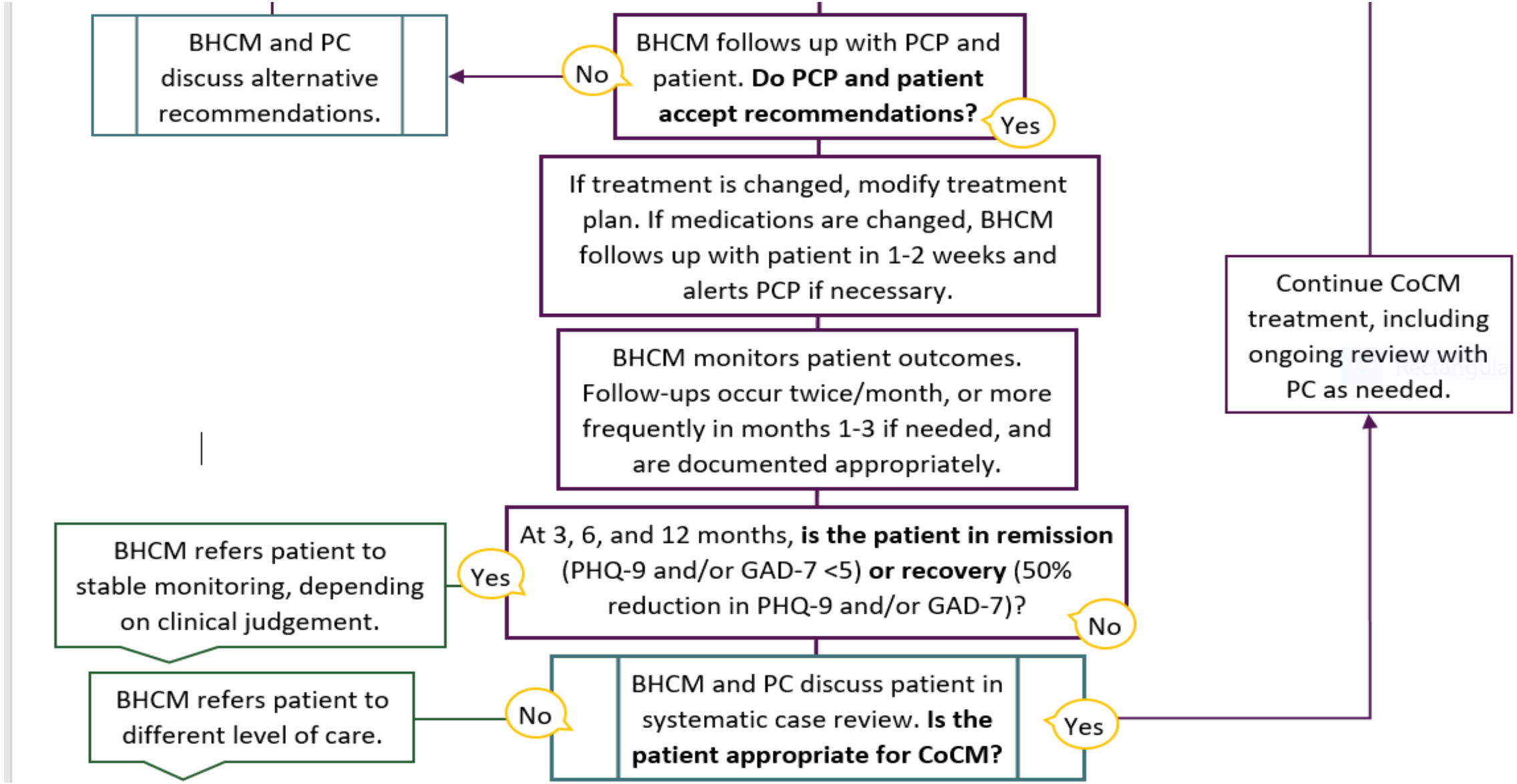
Population Health Management

- BHCM will manage and populate a clinic-specific systematic case review tool. This will include entering patients, updating information, and viewing the systematic case review tool to dictate daily workflow and tasks

- **BHCM will run reports and gather data as appropriate in order to support fidelity to the model**

Care Coordination

- BHCM may perform co-visits with primary care providers and clinical staff as appropriate and requested
- BHCM will alert other clinicians and care providers to treatment plan changes, outcomes, and patient symptoms as appropriate
- BHCM will respond to patient crises as appropriate, which may include phone or clinic follow-up contacts or co-visits
- BHCM will document appropriately in EHR and systematic case review tool (may be one or two separate records, based on clinic technology). This includes sending notes to PCPs and other providers, and providing clear documentation with a summary of patient self-management plans, so the CoCM care team is aware of patient status and current care plan



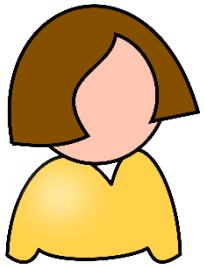
SCR = systematic case review

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
8:30	Review daily clinic schedule. Discuss with PCP whether a co-visits or referrals might be appropriate. Open work queue for the day.				
9:00	Scheduled Intake – FTF	Support call- Med monitor	Scheduled Intake - Phone	Support call- MI around exercise goal	Support call- Beh Act
9:30		Support call- Resource F/U			Support call- Med monitor
10:00	Document intake	Outcomes Call- Beh Act	Document intake- send patient materials (mail)	Outcomes call- Significant improvement. Schedule next contact in 1 month.	Outcomes call- GAD-7 increase. Note for next panel review.
10:30	Outcomes FTF- Meet pt. following PCP appt. PHQ-9 increase; med side effects reported. Note for next systematic case review	Pulled into PCP co-visit. Pt appropriate and interested. Pitch CoCM and schedule intake for tomorrow AM.	PCP approves med recs from yesterday. Call pt. to let them know meds were sent to pharmacy.	PCP co-visit- Risk assessment, safety plan. Pt appropriate for CoCM. Pitch program, schedule intake for tomorrow, FTF.	F/U Monday Intake: Review self-management plan and med recs. Plan to talk again in 1-2 weeks.
11:00	Support call- Med monitor	Documentation	Outcomes call- Teach mindfulness for anxiety	Documentation	Support call- PST
11:30	Follow-up with PCP on medication recommendations	Systematic case review preparation			Follow-up with PCP on medication recs
12:00	**[BHCM takes lunch and other breaks throughout day per department policy; Admin activities (e.g., meetings, supervision) will vary]**				
12:30	Support call- Remission; Relapse Prevention Plan	Further SCR preparation; Admin	Support call- Self-mgmt. plan progress	SCR preparation	Note from PCP- Call pt. re: new Rx from SCR rec
1:00	Outcomes Call- MI around marijuana use	Systematic case review	Support call- Med monitor	Systematic case review	Referral- Schedule intake
1:30			Documentation		FTF Intake
2:00	Outcomes Call- Stable, continue plan	Document- Notes to PCPs re: SCR recs.	Monthly Individual Clinical Supervision	Document- Notes to PCPs re: SCR recs.	
2:30	Documentation	Outcomes call- Improved. Continue current plan.		SCR F/U call- Talk with pt about side effects	Monthly Care Manager Group Supervision
3:00	Question from PCP- Facilitate curbside consult with psychiatry	SCR F/U call- Discuss med rec; pt. agrees. Send note to PCP.	Care coordination- Fax ROI, send measures to pt.'s community therapist	Support call- Med monitor. Pt stopped meds. Note for panel review.	
3:30	Outcomes FTF- schedule f/u call to discuss plan.	Support call- Beh Act	Incoming call- Pt having panic attack. De-escalate; teach skills; safety plan; document.	Outcomes call- Remission; Relapse Prevention Plan.	Documentation- Intake and other contacts
4:00	Documentation	Documentation		Follow-up with PCP on med recs	

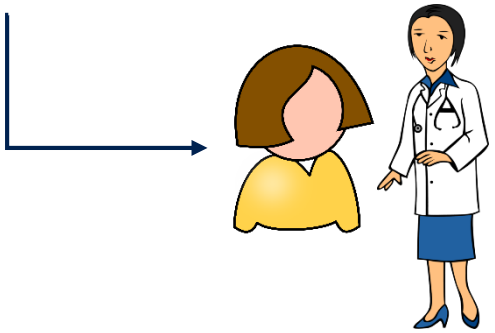
Talking with Patients about Medications

https://aims.uw.edu/resource-library/supporting-antidepressant-medication-therapy

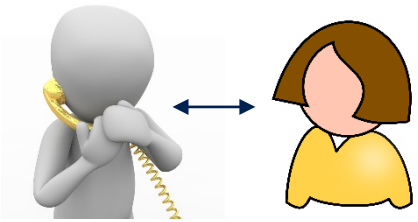
Case Vignette



Claire, a 32 year old woman with a history of anxiety and depression, makes an appointment with a new PCP.



Claire meets with her PCP and shares about her struggles with depression and anxiety. Her PCP completes a brief assessment, completing a GAD-7 and PHQ-9. She suggests enrollment in Collaborative Care, which Claire agrees to. The PCP defers making any treatment changes, pending further assessment by the BHCM. The PCP facilitates a warm handoff by asking the BHCM to follow-up with Claire, and Claire knows to expect her call.



The BHCM contacts Claire by phone to introduce herself, complete a brief assessment, and to share a bit more about Collaborative Care. Claire agrees it could be helpful to enroll in the program. The BHCM offers an intake by phone or in person, and Claire opts to schedule a face-to-face meeting.

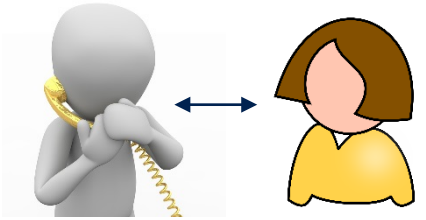
Case Vignette Continued

Claire and the Care Manager meet in person. A thorough assessment is completed, including the patient's behavioral health history, as well as her goals. Claire endorses severe test anxiety, as well as a trauma history, though she doesn't meet criteria for PTSD. She's never been in therapy or tried a psychotropic medication. The Care Manager presents various treatment options. Claire opts for a psychiatric recommendation, would also like to engage in clinical interventions, and decides to more actively pursue an important personal goal of obtaining her GED. The BHCM agrees to consult with a psychiatrist within the next week, provides a referral to a CBT group, and provides a resource for a GED program.

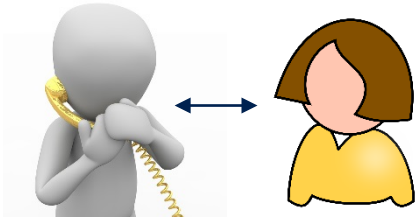
The Care Manager meets with the Psychiatric Consultant later that week, and reviews the case. The Psychiatric Consultant writes a recommendation to the PCP to consider starting a trial of Lexapro. (either the PC or the BHCM sends note to PCP)

The PCP reads it over, and the BHCM reaches out to discuss. They agree this trial is a good place to start.

Case Vignette Continued

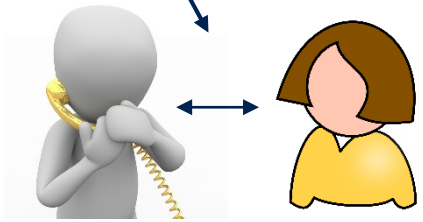


The Care Manager contacts Claire by phone to review the medication recommendation and provide education about potential side effects and what to expect. The patient agrees to start Lexapro, so the Care Manager asks the PCP to send it in to the pharmacy.



Within one week, the BHCM calls Claire to see if she has filled the meds, is taking them and how it's going.

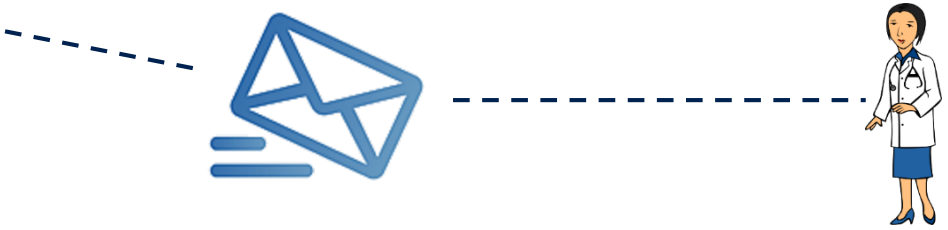
Within 2 weeks the BHCM continues medication monitoring. The BHCM checks in on goals and provides support as appropriate.



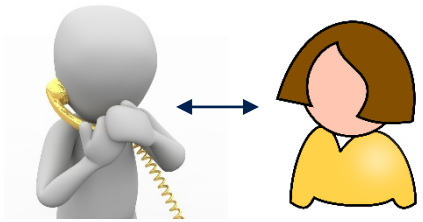
With proactive follow-up by the BHCM, Claire titrates her medication on schedule, per the recommendations of the Psychiatric Consultant. Claire doesn't need to come into the primary care clinic during this time, which is convenient, due to her busy work schedule. Unfortunately, she sees no improvement in symptoms.

Case Vignette Continued

The Care Manager again discusses the case with the Psychiatric Consultant, given Claire's lack of improvement over the past several months. A new recommendation is sent to the PCP to taper off Lexapro and begin a trial of Fluoxetine.

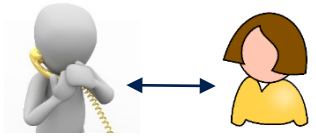


The Care Manager discusses with the PCP and with Claire- they both agree. Per request of the Care Manager, the new medication is sent to the pharmacy by the PCP.



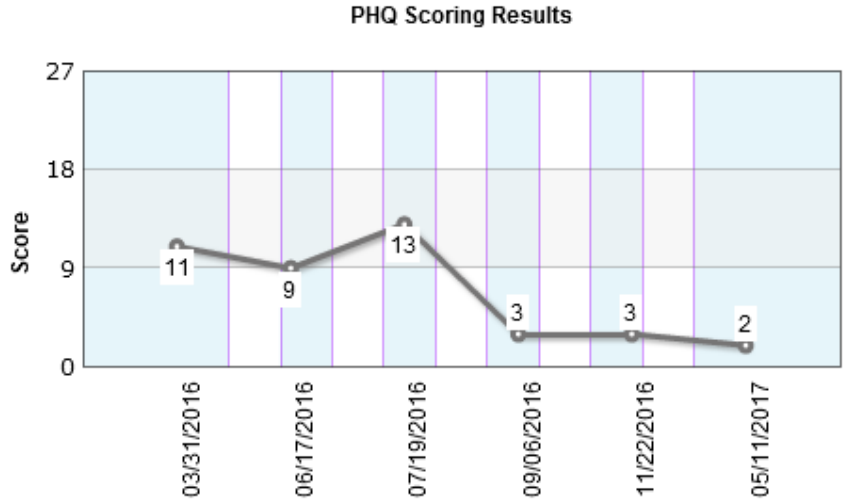
This time, Claire begins to notice a benefit on her mood after several weeks. The Care Manager does proactive monitoring and follow-up, and helps facilitate the titration of her medication over several months, eventually up to 60mg daily.

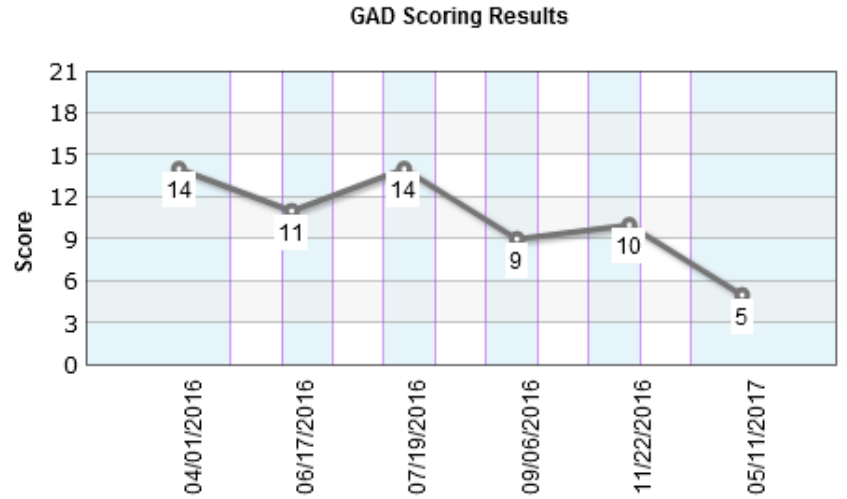
Case Vignette Continued



Over the next nine months, the Care Manager had regular, proactive contacts with Claire. The Care Manager administered outcome measures and reviewed her self-management plan, sending updates to her PCP over time. Fluoxetine was gradually increased to 60mg daily. Claire was unable to fit the CBT Therapy Group into her schedule; in lieu of this, the Care Manager taught coping skills and provided additional resources as needed.

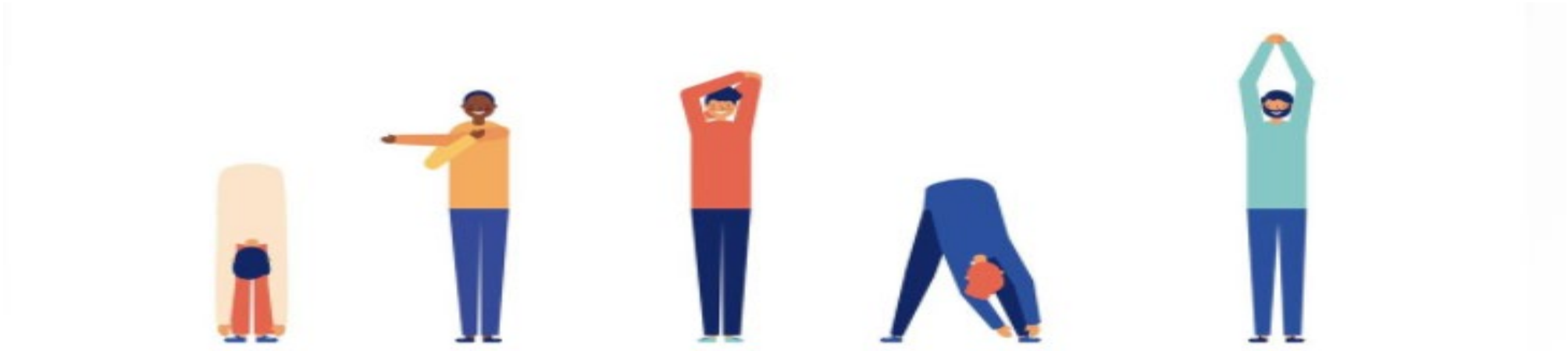
With better-managed anxiety, Claire was able to complete a course and earn her GED, as well as pass her driving test and earn her license. She'd been working on this goal for 16 years. She plans to enroll in college to become an electrician. Her symptoms responded to the medication and have further improved largely in part to achieving her goals.





QUESTIONS?

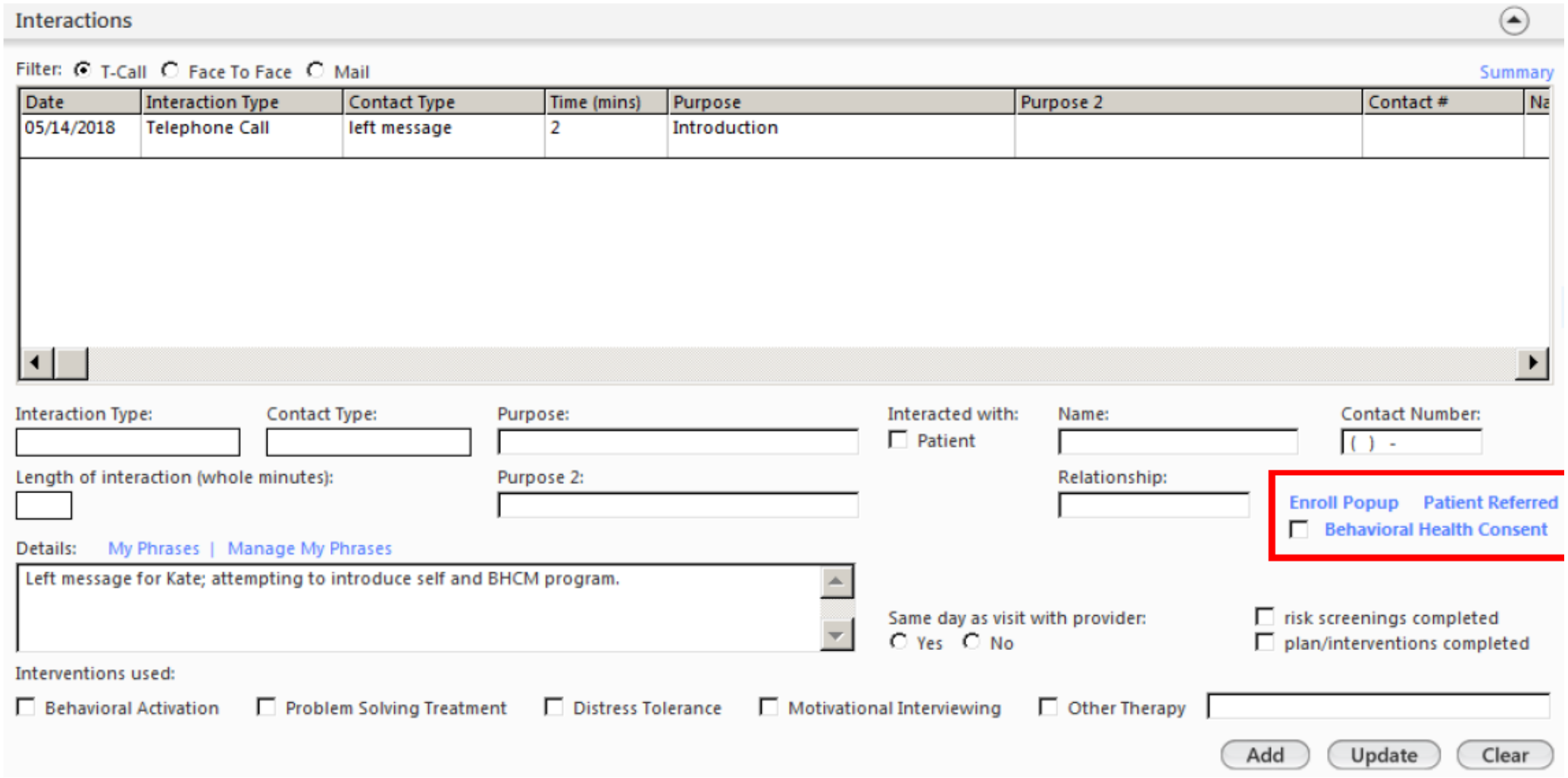
Stretch Break - 15 minutes



Patient Tracking

BHCM:

- Documents patient contacts and outcome measures in EHR and systematic case review tool (if separate from EHR)
- Uses systematic case review tool to manage and track treatment progress for the entire caseload and discuss patients with the psychiatric consultant



Systematic Case Review

Why Use a Systematic Case Review Tool?

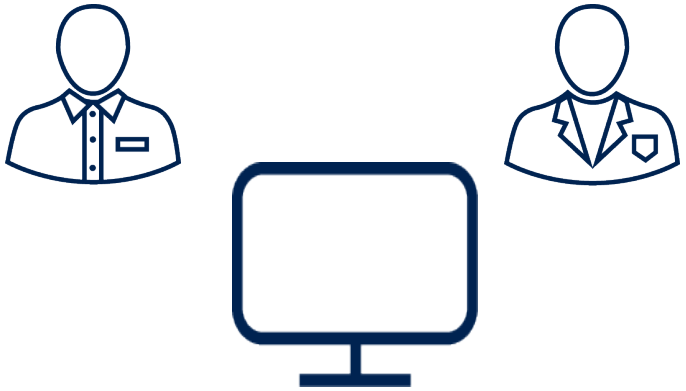
- Population health – making sure patients are not falling through the cracks
- Caseload management at-a-glance
- Track treatment engagement & response
- Prioritize patients who are not responding or disengaged
- Track patients' symptoms with measurement tools (PHQ-9, GAD-7)
- Track medication side effects & concerns
- Facilitate caseload review with Psychiatric Consultant

Systematic Case Review Tool Example

Current Clinic Low High	Patient Name Low High	Birth Date Low High	Level Low High	Status Low High	Enroll Date Low High	Last PHQ Date Low High	Last PHQ Score Low High	PHQ Change Low High	PHQ Date Diff Low High	PHQ #9 Low High	Last GAD Date Low High	Last GAD Score Low High	GAD Change Low High	GAD Date Diff Low High
CLINIC WEST	MARCH, TARA	08/09/1987	2	ACTIVE	11/08/2011	07/15/2013	7	-4	108 days	0	04/20/2016	13	6	31 days
CLINIC WEST	CHERRY, JANE	05/18/1962	3	ACTIVE	08/26/2008	12/12/2013	17	1	44 days	0	04/20/2016	12	2	78 days
CLINIC WEST	RIVER, SANDY	12/25/1958	1	ACTIVE	03/02/2006	10/03/2013	2	2	182 days	0	04/20/2016	14	0	0 days
CLINIC WEST	ZANDER, LAURA	09/01/1953	3	ACTIVE	02/06/2013	11/22/2013	5	1	45 days	0	04/20/2016	21	2	60 days
CLINIC WEST	SMITH, MARY	04/10/1978	3	ACTIVE	08/21/2013	01/08/2014	10	-7	51 days	1	04/20/2016	12	1	91 days
CLINIC WEST	DEMO, ONE	11/27/1976	3	ACTIVE	12/12/2013	05/23/2014	10	0	0 days	1	04/20/2016	2	0	0 days
CLINIC WEST	MANOOGIAN, SARAH	05/15/1952	3	ACTIVE	11/16/2012	12/18/2013	14	-2	119 days	0	03/20/2016	8	0	0 days
CLINIC SOUTH	FLINTSTONE, PEBBLES	07/12/1991	3	ACTIVE	12/12/2013	12/12/2013	10	0	0 days	0	04/20/2016	9	-9	91 days
CLINIC SOUTH	SMITH, MICHAEL	04/12/1992	2	ACTIVE	07/16/2012	10/22/2013	13	0	91 days	0	01/01/2016	6	0	0 days
CLINIC SOUTH	DEMO, DINA	08/27/1981	2	ACTIVE	12/24/2013	12/24/2013	12	0	0 days	0	02/03/2016	11	0	0 days
CLINIC SOUTH	CLARK, SARAH	03/26/1954	3	ACTIVE	07/19/2012	11/25/2013	18	1	33 days	0			0	0 days
CLINIC NORTH	RAISIN, WONDA	10/10/1957	3	ACTIVE	11/29/2012	12/02/2013	9	2	34 days	0			0	0 days
CLINIC NORTH	TEST, FIRST	10/19/1959	3	ACTIVE	12/03/2013	01/16/2015	24	18	371 days	3			0	0 days
CLINIC NORTH	TEST, MARY	01/01/1951	3	ACTIVE				0	0 days				0	0 days

When and where do we meet?

- Half-time BHCM: Typically one hour per week
- Additional time available for curbside consults and questions
- In-person or via HIPAA-compliant videoconference
- **Systematic case review should be scheduled on a weekly basis and should not be done ad hoc**



Leveraging Psychiatry Time

- Goal: About 6-8 patients per hour
- Succinct and thorough

How do I prepare?

- Plan for case presentations
  - New patients
  - Specific case questions
- Gather information
  - Case presentation template
- New BHCMS typically need more preparation time

Preparing for Systematic Case Review

- **BRIEF ID** *(name, age, sex/gender)*
- **REFERRED BY**
- **CHIEF COMPLAINT** *(reason for referral, patient's main concern)*
- **SYMPTOMS OF CONCERN** *(diagnostic criteria – mood, affect, sleep, energy, memory, etc.)*
- **OUTCOME MEASURE SCORES** *(do individual items match up with symptoms of concern?)*
- **SI/HI** *(positive Q9? elaborate on nature of SI, along with safety planning and history)*
- **BEHAVIORAL HEALTH HISTORY AND TREATMENT** *(previous episodes, therapy, hospitalizations, effectiveness)*
- **CURRENT PSYCHOTROPIC MEDICATIONS** *(length, dose, efficacy, side effects, compliance)*
- **PREVIOUS PSYCHOTROPIC MEDICATIONS** *(length, dose, efficacy, side effects, compliance)*
- **SUBSTANCE USE** *(current, past)*
- **MEDICAL CONDITIONS**
- **ALLERGIES**
- **PSYCHOSOCIAL CONCERNS**
- **INITIAL TREATMENT PLAN**
- **OTHER IMPORTANT DETAILS**

Other Information to Share

Share information about what's happening in the practice. Are there new staff members? Are there new initiatives starting?

What is the format of systematic case review?

1. Brief check-in
2. Urgent patients
3. Specific case questions
4. New patients
5. Review the patient systematic case review
    I. Worsening or not improving
    II. Scores in the severe range
    III. Positive score on question 9 on PHQ 9
    IV. Not recently discussed
    V. Not engaging in care
    VI. Been in program for a long time
    VII. In remission and/or ready for relapse prevention

Urgent patients may require contact with the Psychiatric Consultant outside of systematic case review

Patients not responding

- Patients not improving during the critical treatment window should be reviewed with the Psychiatric Consultant in systematic case review
  - Patients not showing improvement by 2-4 months, (typically around 8 weeks) should be brought to systematic case review to evaluate treatment

What is the format of reviewing a case?

1. BHCM presents case uninterrupted
2. PC asks clarifying questions
3. PC discusses treatment recommendations, explaining rationale and BHCM role in implementation
4. BHCM asks clarifying questions
5. Documentation according to your practice protocol

What's Next?

- Confirm your next systematic case review time
- Confirm follow-up steps
- Liaise with PCP
- Follow up with PCP to see if recommendations were implemented, if not discuss reasons and follow-up with Psychiatric Consultant
- Patient contact

Communication Example: BHCM to PCP

Hello [PCP NAME],

I'm writing to follow up on the psychiatric consultation note that was entered by [PC NAME] on [DATE] for [PATIENT NAME]. I'm wondering if you've had a chance to review this recommendation. If you agree with the recommendation to [insert recommendation- e.g., increase Sertraline to 100mg] and are willing to send this in to the pharmacy, I would be happy to call the patient to let them know. I'll be sure to provide the necessary education around this medication regarding side effects, etc.

[If applicable]: I will also plan to follow up with the patient within 1-2 weeks for medication monitoring.

Please let me know if you have any questions or concerns.

Thank you!
[BHCM SIGNATURE]

Patient Contact

1. Remind patient of PC role
2. Review recommendations, including psychoeducation
3. Elicit thoughts and questions; provide any further information
4. Remind the patient that their treatment choices are completely up to them
5. If the patient elects to begin a medication trial, discuss follow-up plans
6. Close the loop! Communicate with the care team

Questions Around the Systematic Case Review Process

More Documentation and SMART phrase examples

Treatment to Target

- Adjusting the treatment plan based on symptom measures is one of the most important components of collaborative care. Clinicians change the treatment until the patient has at least a 50% reduction in measured symptoms.
- Measuring symptoms frequently with PHQ 9, GAD 7, and self report, allows the providers and the patient to know whether the patient is having a full response, partial response or no response to treatment. These measures also provide information about which symptoms may be improving and which may not be. This information is important in making decisions about how to adjust treatment.
- Sharing PHQ-9 and GAD-7 scores and trends with the patient

Review of Process

- Track treatment
- Follow-up contacts and delivering treatment plan
- Adjust treatment as needed
- Assess patient's improvement, as defined by treatment goals and program goals:
- Adjust treatment accordingly
- Conclude treatment
- Relapse Prevention Planning or transition to community resources (this step will be explored later in today's training)

Questions?

Brief Evidence Based Interventions

Behavioral Interventions

Effective behavioral health interventions in primary care:

- Include a patient engagement component
- Time efficient, running no more than 20-30 minutes per contact
- Follow a structured, AND patient-centered approach
- Are relevant and applicable to diverse patient populations
- Have a substantial research evidence base

This is not traditional therapy

Setting the Agenda

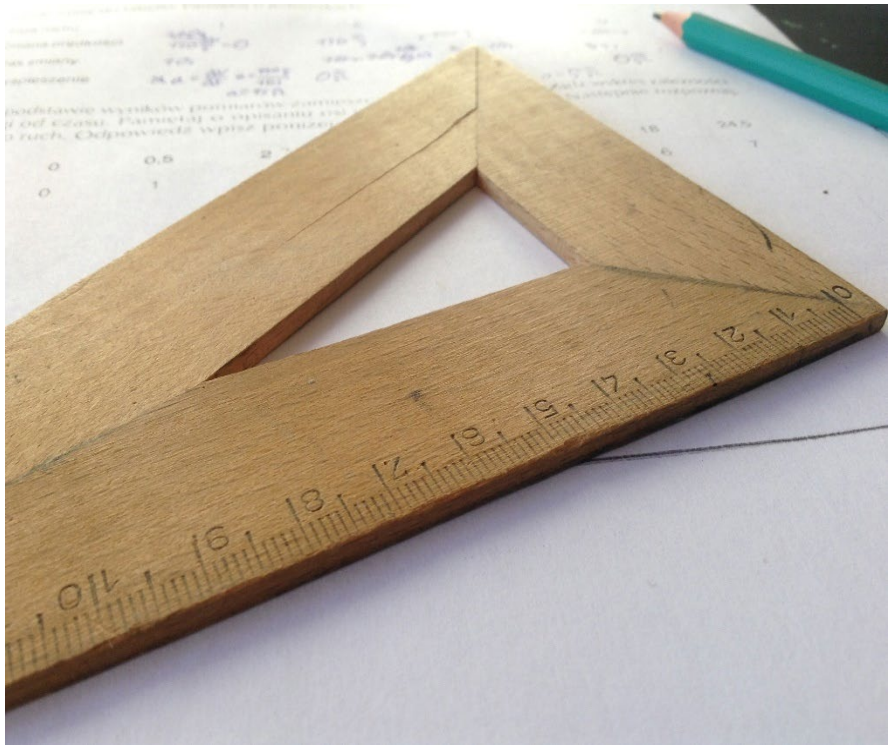
- Each contact should have a plan and a purpose guided by the BHCM
- Each contact should include an introduction as to what the BHCM and patient will be doing today.
  - Ex. “I'd like to spend about 15-30 minutes with you today. I want to start by asking you questions from a symptom monitoring scale and then discuss some problem solving around your stress at work.”
  - “What if anything would you like to discuss during our time together?”

Ending the Contact

- Wrap up the contact
  - Summarize the content
  - Remind the patient of the action steps
  - Establish the date of the next contact

Motivational Interviewing

Personal Identification…



How would you rate your current MI skill level?

How important is it to you to improve your MI skills?

- “The difficult people we encounter can be our greatest teachers”
- Eileen Anglin

What is Motivational Interviewing?

A collaborative conversation style for strengthening a person's own motivation and commitment to change.

Motivational interviewing is a person-centered counseling style for addressing the common problem of ambivalence about change.

Motivational interviewing is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion.

Do you have a smoke detector in your home and change the batteries at least once a year?

Do you buckle up every time you are in the car, even in the back seat?

Do you exercise at least 30 minutes, 3 times a week?

Do you wear a bicycle helmet every time you ride a bike?

Do you wear a personal flotation device every time you get in a boat?

Do you make sure every child who rides in your car up to 8 years old and 80 pounds is in an appropriate car seat or booster every time you drive?

Do you have a fire extinguisher in your kitchen?

Do you floss daily?

Have you practiced a fire safety plan at home and picked a meeting spot outside your home in case of fire?

Do you abstain from using your cell phone while driving?

Ambivalence

It’s totally normal

It can be a good thing

It can also be sticky

The Righting Reflex

We want to direct people down the best path.

Oops…..

Partnership

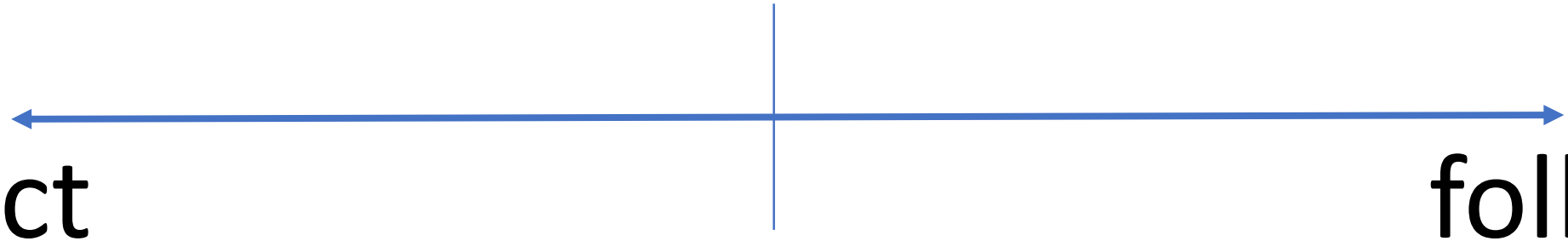
Collaboration

and

Acceptance

Supporting Autonomy

The decision to change is always with the patient, and they are the expert in knowing how to proceed.



guide

Engagement

Why is it so important?

OARS

Open questions

Affirming

Reflecting

Summarizing

Open-Ended Questions

Depression:

Who:

What:

Where:

When:

How:

"An open question is like an open door. You do not know in advance where the person will go with it."
Miller and Rollnick 2013

Affirmations- Tips

- Focus on specific behaviors and processes, rather than static qualities, attitudes, decisions, or goals
- Avoid using the word “I” so as not to evaluate or judge
- Emphasize strengths, rather than focusing on problem areas
- Nurture a competent instead of a deficit worldview of patient
- Think of affirmations as attributing interesting qualities to patients!

Statements

- “I think you are...”
- “I see you as…”
- “I’ve seen this before…”

- “You are…”
- “You feel…”
- “You have…”
- “You believe…”

Reflections

Reflective listening…

- Deepens understanding of meaning through making guesses
- Allows the patient to hear what they've been saying
- Encourages the patient to continue verbally exploring
- Continues and focuses on the patient's own narrative

As a guide, the practitioner is strategic in where to direct attention.

Simple Reflections

- Add little or nothing to what a person has said
- Restates or slightly rephrases the person's content
- Useful, and yet can yield slower progress

patient: "I'm feeling really tense this morning."

PRACTITIONER: "You're tense."

"You're unable to relax."

Complex Reflections

- Adds meaning or emphasis to what a person has said
- Makes a guess at unspoken content or what might come next
- Tends to move the conversation forward and toward change

Patient: “I’m feeling really tense this morning.”

Practitioner: “Something in your life isn’t feeling quite right.”

“You’re a little nervous about being here.”

Types of Complex Reflections

- **Paraphrasing**- “It’s important to you to find a way to feel better.”
- **Double-sided**- “You enjoy smoking marijuana, and at the same time, you’re worried your kids might pick up the habit.”
- **Amplified**- “There’s absolutely no reason they should be concerned.”
- **Continuing the paragraph-** “…and you’re wondering if there’s something more you could be doing.”
- **Feeling**- “You’re curious about what it might be like.”
- **Metaphors**- “You’re trying to gain some traction on tough terrain.”
- **Action**- “If you could find the time to exercise, you would.”

Reflection Activity

Enter your group rooms and practice reflections

- “I’ve tried to quit smoking more times than I can remember.”
- “When I stop smoking I get crazy and restless.”
- “Thinking about quitting is easy. Doing it is another story.”
- “I should quit for my children.”
- “How am I going to cope with cravings?”
- “I don’t think I’ll ever be able to lose weight. I’m too lazy and I like eating too much.”
- “It’s really hard to find time to exercise – and eat well – when I’ve got two little ones at home.”
- “My down-fall is fast food. I think I’m addicted to french-fries.”

My pain is unmanageable without pain medication. The doctor won't give me more. Doesn't he know I've tried everything else?"

- Simple-
- Paraphrasing-
- Double-sided-
- Amplified-
- Continuing the paragraph-
- Feeling-
- Action-

Summaries

Collecting summary

- Gather information together
- Present it back to the patient
- Keep conversation moving forward

Linking summary

- Contrast ideas heard right now with information that has been shared previously
- Highlight disconnection or relationship between the ideas

Transitional summary

- Choose or change the direction of the session
- Prelude to an open question

Preparatory Change Talk

Change Talk

Desire

Ability

Reasons

Need

Commitment

Activation

Taking steps

DARN CAT

Desire

"I *want* to lose some weight."

"I *would like* to get a better job."

"I *wish* I were more comfortable around people."

"I *hope* to get better grades next year."

Ability

“I can…”

“I am able to…”

“I could…”

“I would be able to…”

Reasons

“I would probably have more energy.”

“I might sleep better at night.”

“It would help me control my diabetes.”

“I’d be more attractive and get more dates.”

“I want to be around to see my grandchildren.”

Need

“I need to…”

“I have to…”

“I must…”

“I’ve got to…”

“I can’t keep on like this.”

“Something has to change.”

Mobilizing Change Talk

Commitment

“I promise…”

“I swear…”

“I guarantee…”

“I give you my word…”

“I intend to…”

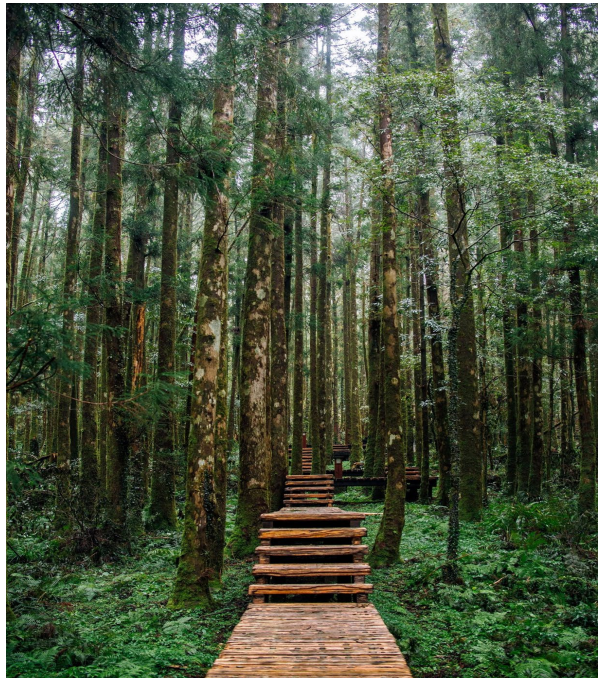
Activation

"I'm willing to…"

"I am ready to…"

"I am prepared to…"

Taking Steps



"I bought some running shoes so I can exercise."

"This week I didn't snack in the evening."

"I went to a support group meeting."

"I called three places about possible jobs."

Sustain Talk

Desire

- "I just love smoking and how it makes me feel."
- "I don't want to exercise."

Ability

- "I've tried, and I don't think I can quit smoking."
- "I think my health will be just fine without exercising."

Reasons

- "Smoking helps me to relax."
- "I just don't have time to fit in any exercise."

Need

- "I have to smoke; I can't get through my day without it."
- "I've got to focus my time and energy on other things."

Commitment

- "I'm going to keep on smoking."
- "I'm just not going to exercise, and that's final."

Activation

- "I'm prepared to accept the risks of smoking."
- "I'm just not ready to consider exercising."

Taking steps

- "I went back to smoking this week."
- "I returned those running shows that I bought."

Evoking Change Talk

Desire

- "How would you *like* for things to change?"
- "What do you *hope* our work together will accomplish?"
- "Tell me what you don't *like* about how things are now."
- "How do you *want* your life to be different a year from now?"

Ability

- "If you did really decide you want to lose weight, how *could* you do it?"
- "What ideas do you have for how you *could* _____."
- "How *confident* are you that you could _____if you made up your mind?"
- "Of these various options you've considered, what seems most *possible*?"

Evoking Change Talk

Reasons

- “Why would you want to get more exercise?”
- “What’s the downside of how things are now?”
- “What might be the good things about quitting drinking?”
- “Finish this sentence: ‘Things can’t go on the way they have been because… “
- “What might be the three best reasons for _____?”

Need

- “What *needs* to happen?”
- “How *important* is it for you to _____?”
- “How *serious* or *urgent* does this feel to you?”
- “What do you think *has* to change?
- “Complete this sentence: ‘I really *must* _____.’ “

“Why haven’t you changed?”

“What keeps you doing this?”

“Why do you have to smoke?”

“What were you thinking when you messed up?”

“Why aren’t you trying harder?”

“What are the three best reasons for you to drop out of this program?”

“What’s the matter with you?”

“How could you want to go back to _____?”

“Why can’t you _____?”

Strategies for evoking motivation

Importance ruler

- "On a scale from 0 to 10, where 0 means 'not at all important' and 10 means 'the most important thing for me right now,' how important would you say it is for you to _____?"

Querying extremes

- "What do you think could be the best results if you did make this change?"

Looking back

- "How has your pain changed you as a person or stopped you from growing, moving forward?"

Looking forward

- "If you did decide to make this change, what do you hope would be different in the future?"

Exploring goals and values

Review of MI Processes from Self-Management Discussion

Readiness Ruler:

Using a scale to determine:

- Importance
- Readiness
- Confidence

1 2 3 4 5 6 7 8 9 10

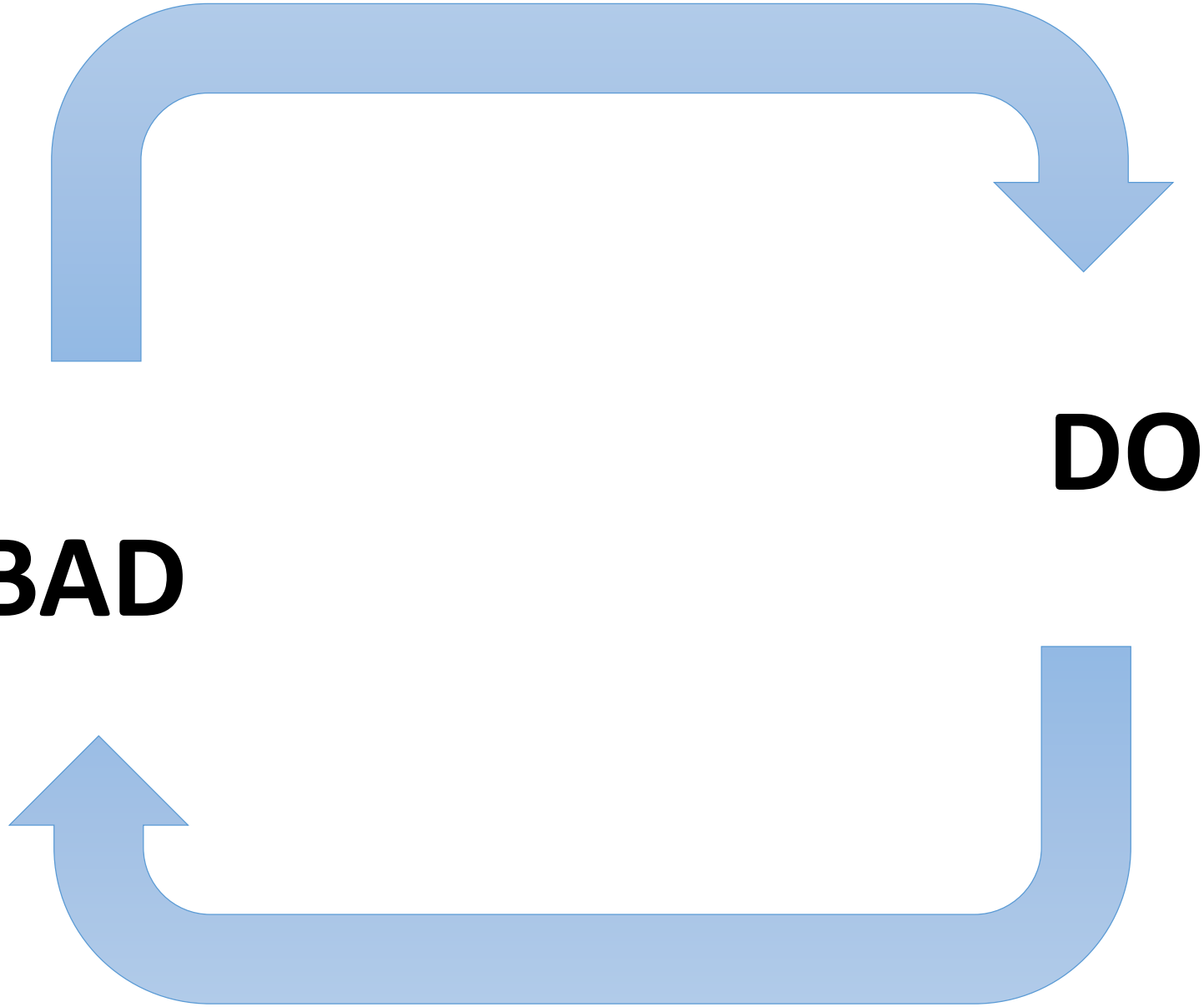
Not Ready Unsure Ready

Questions?

Behavioral Activation

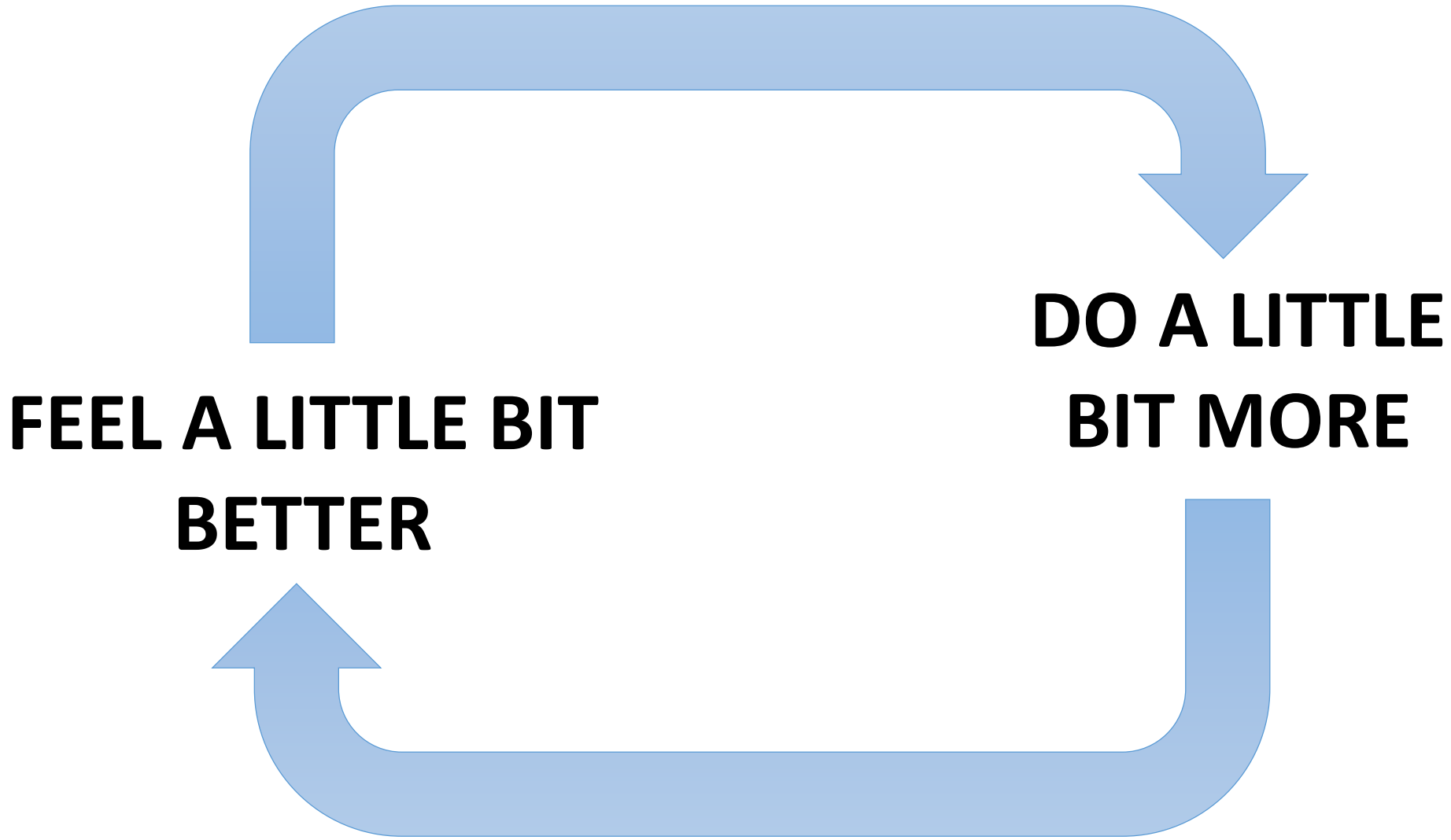
Behavioral Activation

- Evidence-based brief intervention for depression
  - Research shows outcomes to be similar or superior to CBT
  - Comparable outcomes to medication for depression(Dimidjian et al. 2006)
- Aim is to reverse patterns of avoidance and re-engage in reinforcing activities
- Focused on “external” factors rather than internal deficits of individuals
- Cost effective



How Does it Work?

- Encourages re-engagement in enjoyable activities, thus decreasing depression
- Interrupts the cycle of depression
- Breaks pervasive patterns of avoidance
  - Withdrawal, isolation, and not participating in activities
- Helps to re-establish routines



BA follows the "Outside-In" versus the "Inside-Out" approach

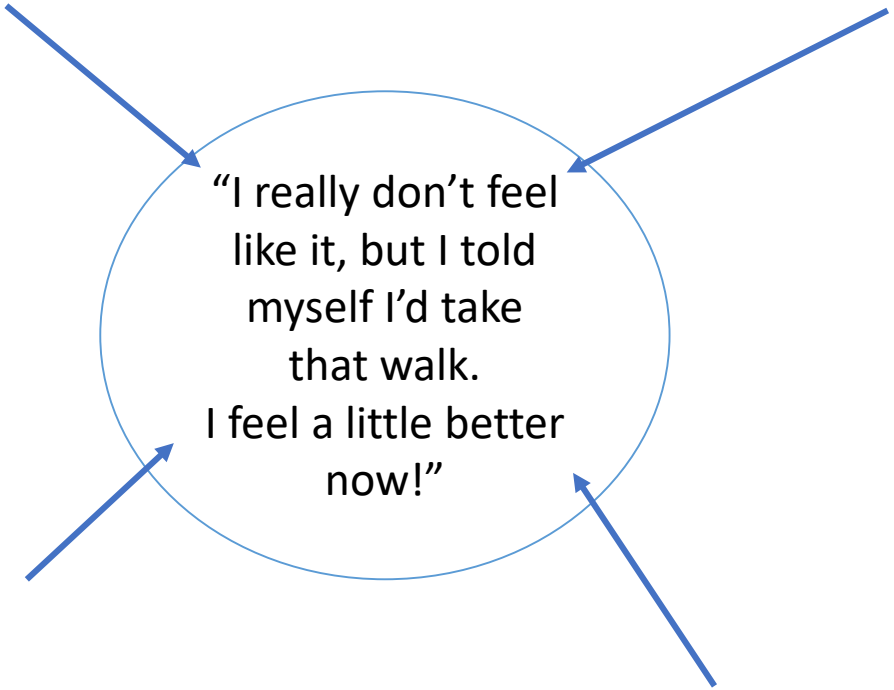
Focus is on altering behaviors that maintain and reinforce depression

INSIDE-OUT

Motivation must come first.

OUTSIDE-IN

Motivation follows action.



Components of Behavioral Activations

1. Orient the patient to treatment
2. Explore values and priorities
3. **Set activity goals**
4. Anticipate and discuss barriers
5. Follow up on the patient's progress
6. Incorporate successes into the Relapse Prevention Plan

Understanding Avoidance
TRAP & TRAC

- TRAP
- Trigger
  - *Demands at work*
- R – Response
  - *Depression, hopelessness*
- AP – Avoidance Pattern
  - *Skip work, stay in bed*

- TRAC
- T – Trigger
  - *Demands at work*
- R – Response
  - *Depression, hopelessness*
- AC – Alternative Coping
  - *Approach the situation with graded behaviors, such as starting with a small, manageable to-do list or talking with boss*

Explore Values & Priorities

- BA is not *just* about getting active – it's about doing so in a meaningful way that provides positive re-enforcement
- *Imagine you woke up tomorrow and the (depression/anxiety) were behind you. Life is exactly as you wish. What would that look like?*
- *What is most important to you in life?*
- *What are you doing more or less of since (e.g., you started feeling sad)?*
- *What gives you meaning?*
- *What do you see other people doing that you wish you could?*

Setting Goals

- Key part of behavioral activation
- Work together to brainstorm a list of activities
  - Tool 1: Activity charting
  - Tool 2: Behavioral analysis
  - Tool 3: Understanding avoidance
- Remember, the patient is the expert – If they generate the activities, they're more likely to be successful

Activity Charting

An Important First Step!

- In order to know how to fix a problem, we need to know what's going on!
- Links behavior and mood

- To many, this might feel meticulous or unnecessary
  - However, people tend to learn a lot about themselves
  - Particularly helpful for patients who lack insight

Activity Monitoring Worksheet

Instructions: Record your activity for each hour of the day (what you were doing, with whom, where, etc.). Record a rating for your mood as you were doing each activity. Mood is rated between 0-10, with "0" indicating "low mood" and "10" indicating "good mood."

	Sun	Mon	Tues	Wed	Thurs	Fr	Sat
5-7:00am							
7:00 am							
8:00 am							
9:00 am							
10:00 am							
11:00 am							
12:00 pm							
1:00 pm							
2:00 pm							
3:00 pm							
4:00 pm							
5:00 pm							
6:00 pm							

Tips:

- Provide worksheets
- Documentation can be simple
- Complete for ~1 week
- Review worksheet together

Behavioral Analysis

- A step-by-step analysis of a specific behavior
  - Can be done quickly in a primary care setting
  - Compliments activity charting
  - Patient and BHCM explore together in a nonjudgmental manner about the role a behavior serves
  - Helps determine anti-depressant behaviors from behaviors that reinforce depression or function as avoidance

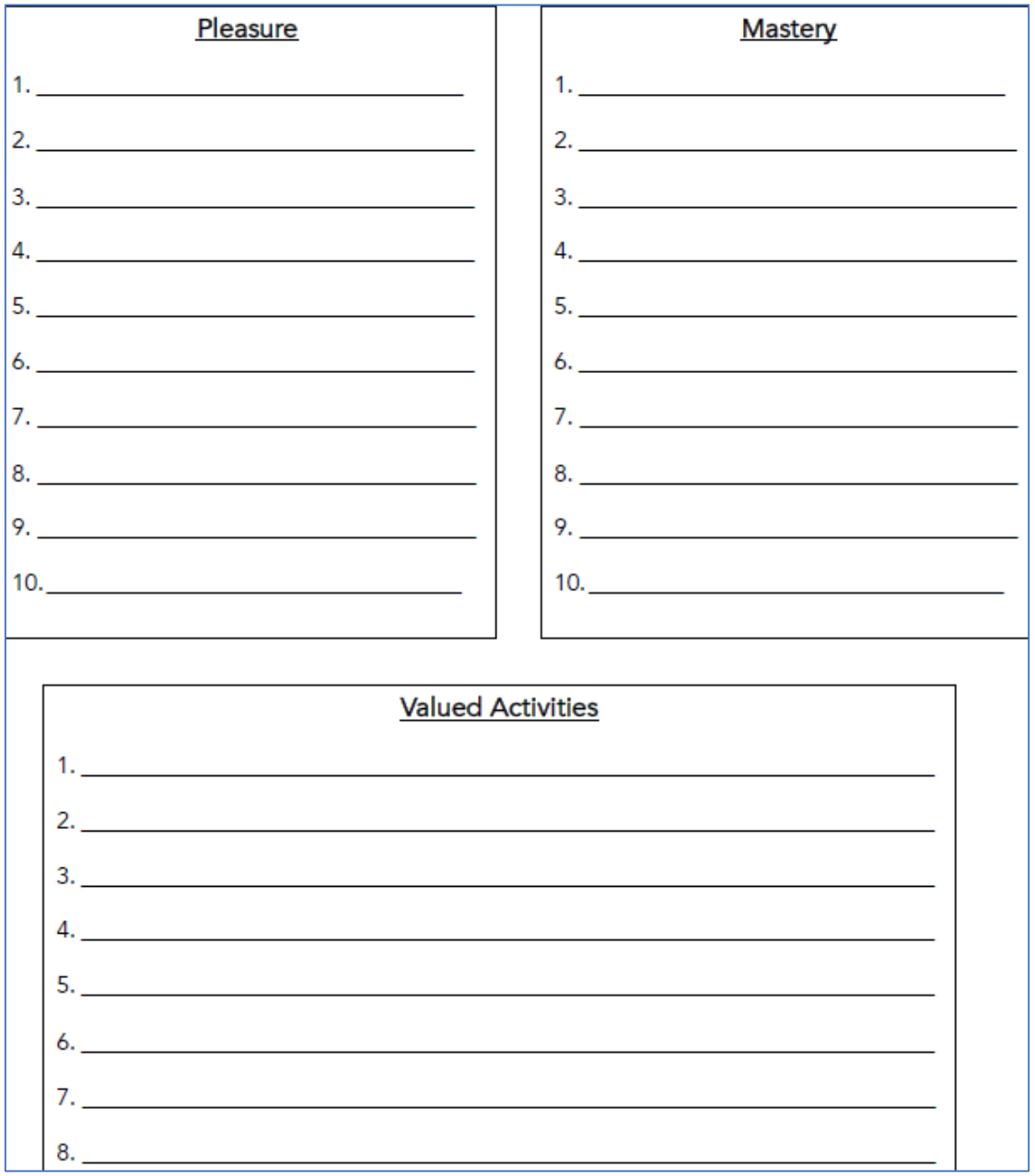
Types of Activities

Pleasure

- This includes activities that we enjoy just for the sake of the activity itself (there is typically no greater goal or learning attached)
- Hobbies, games, nature, friends, and some sensory activities (e.g. a warm bath)

Mastery

- Skill development in a particular area
- Example areas include career, sports, learning an instrument, or art



Work together to create a "Master List" of activities. This will help prepare for the next step: Activity Planning!

Use brain storming and write down immediate activities such as listening to music, and more long range activities like making a photo album

Setting Goals

- Some activities are more accessible than others and may seem “easier” to the patient.
- Have patients rank activities by number, easiest to hardest to complete
- Develop an activity planner. Use a SMART approach to develop a short term goal related to an activity with a low number of difficulty on the activity sheet.
- Continue to increase activity goals both short term and long term as successes are gained.

Don’t Forget to Follow UP!

- Checking in communicates importance and value
- In the case of success, praising efforts can be very reinforcing and rewarding
- In the case of falling short:
  - This can be hard, and it’s also okay! Try not to get discouraged
  - Opportunity to troubleshoot further:
    1. “What got in the way?”
    2. “What might work better?”

- Now what?
  - This is a systematic, gradual process – keep scheduling!
    - Continue doing the things that worked
    - Incorporate new activity goals to keep it fresh and to graduate up

Questions?

Maintenance

Adjusting to End of Treatment

- Discuss treatment timeline and structure from the beginning
- Use PHQ-9 graph to help patients see progress
- Work with patient to find other sources of support
- Encourage the ongoing use of strategies for self-management
- Give specific end date when appropriate, e.g., 2 more session, spread sessions out more and more

Relapse Prevention Planning

- When patients reach remission or maximum gains, the BHCM will engage patient in relapse prevention planning. BHCM will provide patients with a written copy of this plan, and will include in the EHR as able

When is a Relapse Prevention Plan Needed?

- **Sustained Remission (1-3 months)**
- Scores of <5 on the PHQ-9 or GAD-7
- **Sustained Response (1-3 months)**
- 5+ point reduction or 50% reduction of scores from baseline PHQ-9 and GAD-7 scores
- **Patients who will also benefit from a plan:**
- Have gained maximum expected benefit
- Have been referred to and are agreeing to connect to a higher level of care

Framing the Discussion

- Positive framework: This is progress! Share that depression and anxiety, and other mental health symptoms can come and go over time
- Empowerment: Focus on doing what works well
- Know what to do if things feel worse

- **Elicit patient's ideas for using the plan!**

Relapse Prevention Plan: Example

- **Patient Name: Claire**
- **Today's Date: April 1**
- **Maintenance Medications**
- 1. Prozac; 3 tablet(s) of 20 mg daily (60mg total).
- Contact your provider if you'd like to make any changes to your medication(s)
- **Other Treatments**
- 1. Grief support group
- **Personal Warning Signs**
- 1. Having an attitude: feeling cranky, easily irritated
- 2. Exercising less
- 3. More arguments
- 4. Sleeping during the day
- 5. No longer enjoying baking

- **Things I do to Prevent Depression**
- 1. Practicing meditation/breathing in the morning
- 2. Taking my medication
- 3. Exercising regularly (morning walks)
- 4. Engaging in hobbies, such as baking
- 5. Living according to values (parenting, helping family, completing school)
- **If symptoms return, contact: Your Care Manager and/or your PCP**
- **Contact/Appointment Information:**
- **Primary Care Provider**: Dr. Doctor, MD | Phone: 555-555-5555
- **Next appointment**: Date: May 25 Time: 8:00 AM
- **My Care Manager**: Sara | Phone: 555-555-5555
- **Emergency Contact/Crisis Numbers:** 911; 555-5555

MCCIST Relapse Prevention Guide

Elicit

- **Personal Warning Signs**
- What might you notice about yourself that indicates that your depression/anxiety is returning?
- What behaviors would you notice?
- What might you stop or start doing?
- What thoughts come up for you? What feelings?

- **Things I do to Prevent Depression/Anxiety**
- What has been working for you for managing your mental health?
- What helps you feel better when you're feeling down/anxious?
- What helps you be the best version of yourself?
- What do you do? Who do you talk to? What do you think about?

Referrals

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 mental illness)
5. Patient request

Referrals

- Specialist Care
- SUD treatment
- Psychotherapy
- Community Mental Health (CMH)
- Other resources

Referrals

How to make a successful referral:

- Not just a phone number
- Call ahead to help set up connection
- Talk about what your ongoing role will be
- Follow up with referral
- Be realistic about payment / cost / insurance

Coordination with Community Based Services

- If patient is engaged in community-based services (e.g., psychotherapy), BHCM should consider getting patient's permission to obtain a Release of Information (ROI) to coordinate care appropriately. This might include coordination around medication management, sharing outcome measures, as well as diagnostics and treatment planning

QUESTIONS?

Moving Forward

What if?

- Not enough referrals
- Too many referrals… “I can’t keep up!”
- My patient isn’t getting better
- I can’t reach my patient
- Systematic case review is taking too long - I can’t get to all the patients I need to review
- The provider is taking a long time to respond to treatment recommendations

Why Workflows are Important

- Instruct the care team how to accomplish core tasks
- Ensure tasks are completed in a timely, reliable, and efficient manner
- Account for multiple scenarios and include contingency plans
- Answers the questions:
  - **What** is the task that needs to be completed?
  - **Who** is responsible for completing that task?
  - **When** does this task occur?
  - **Where** does the task take place?
  - **How** is the task completed?

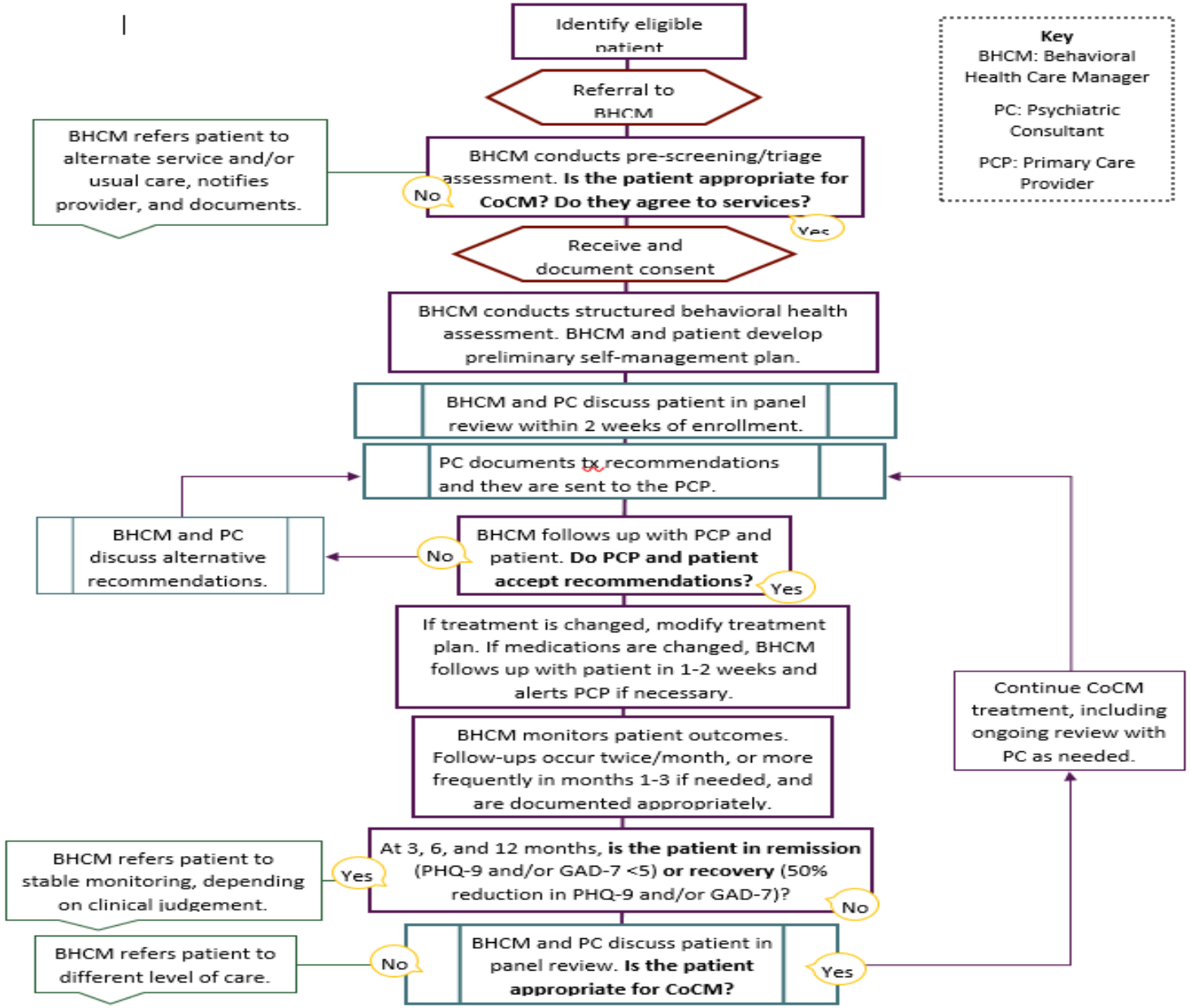
Workflow: Beyond referral and treatment

Who may be help with what:

- Completing outcome measure
- Making appointments
- Fielding phone calls
- Communicating with PCP
- Resources

Communication

- How does communication work in your office?
  - Contacting the Psychiatric Consultant outside of systematic case review time
  - Documenting treatment recommendations
  - Communication with the provider
  - Templates for communication



Resources

https://www.depressioncenter.org/depression-toolkit

https://mccist.org/

Future Training Opportunities

- BHCM
  - Attend 1.5-hour webinar, each month, (45 minutes of topic training and 45 minutes of case discussion and questions) for 3 months after initial training
  - After 3 months, 1x/quarter
  - Possible topics:
    - Behavioral Activation
    - Motivational Interviewing
    - SBIRT
    - Psychopharmacology
    - Self- Management Planning etc.

Post assessment and evaluation

Thank you for attending the 2 day CoCM training.

Please complete the post assessment and evaluation at: https://umich.qualtrics.com/jfe/form/SV_5mML0acovueBbkV

The link was also included in your training confirmation.

Completion of the evaluation is needed for CMEs and CEs.

We will return in 10-minute to conclude the day.

QUESTIONS?

Contact us: MCCIST-Inquiries@umich.edu

Thank you for attending today's training!

Reminder: Please fill out the evaluation form to receive your certificate / CE

https://umich.qualtrics.com/jfe/form/SV_5mML0acovueBbkV