CoCM: An Overview

- Most evidence-based integrated behavioral health model
  - **90+ 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 health 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

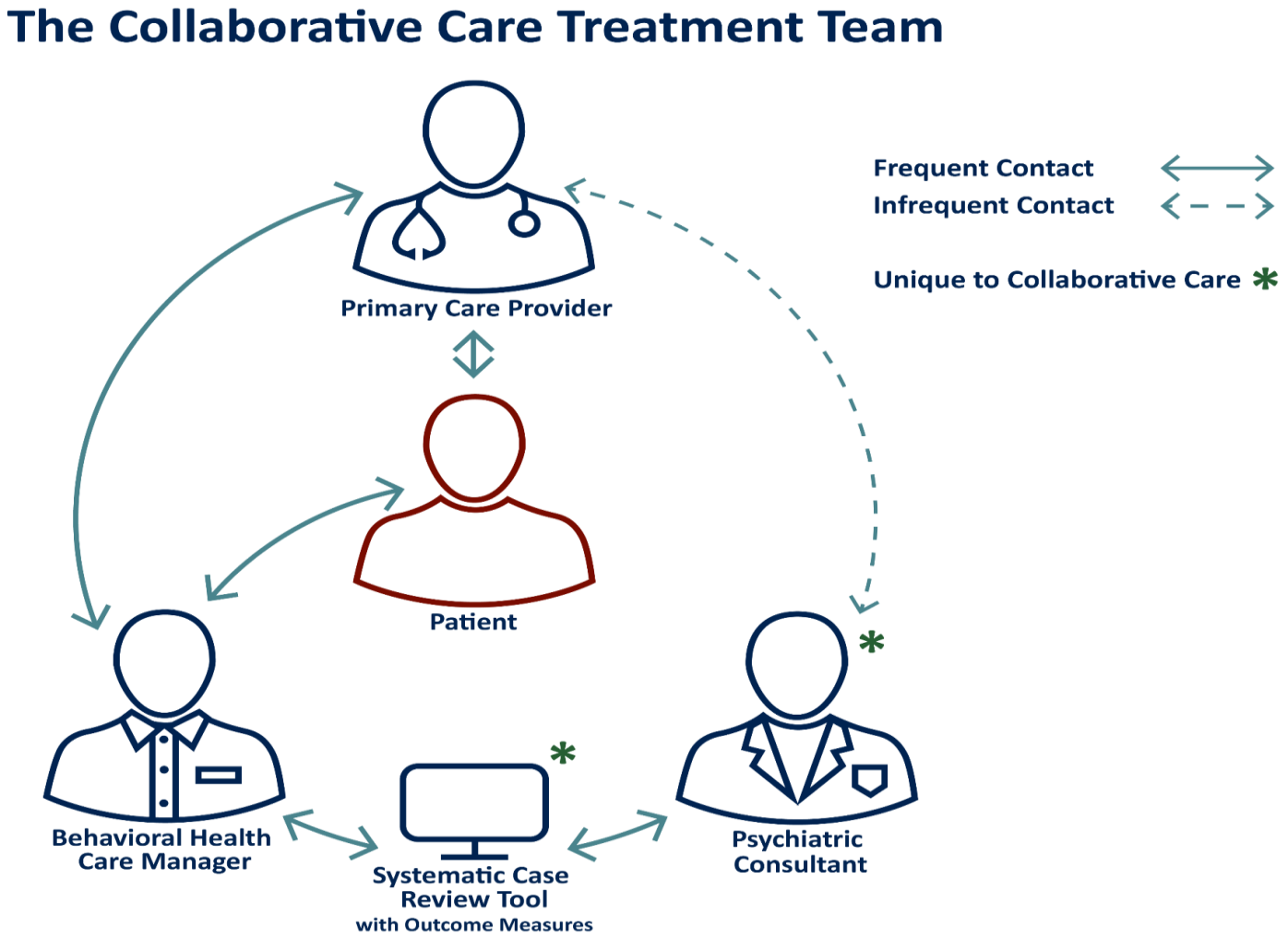
- CoCM is linked to **better medical outcomes** for patients with diabetes, cardiovascular disease, cancer and chronic arthritis
- A **2016 retrospective study** at Mayo Clinic found that the time to **depression remission was 86 days in a CoCM program** compared to 614 days in usual care

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 Basics of CoCM



Two New Team Members

- **Psychiatric Consultant**—a medical professional trained in psychiatry and qualified to prescribe the full range of medications

- **Behavioral Health Care Manager (BHCM)**—typically social workers, nurses, psychologists or licensed counselors. The BHCM coordinators the overall effort of the group and ensures effective communication among team members.
  - 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

Psychiatric Consultant

- Supports 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**
- BHCMs 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** and 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

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 any applicable medication (name, dosage, etc.)

Caregivers and/or Family

- Can help **provide additional patient information** in areas such as: symptoms, mood, behavior, 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 views** of depression/anxiety (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**

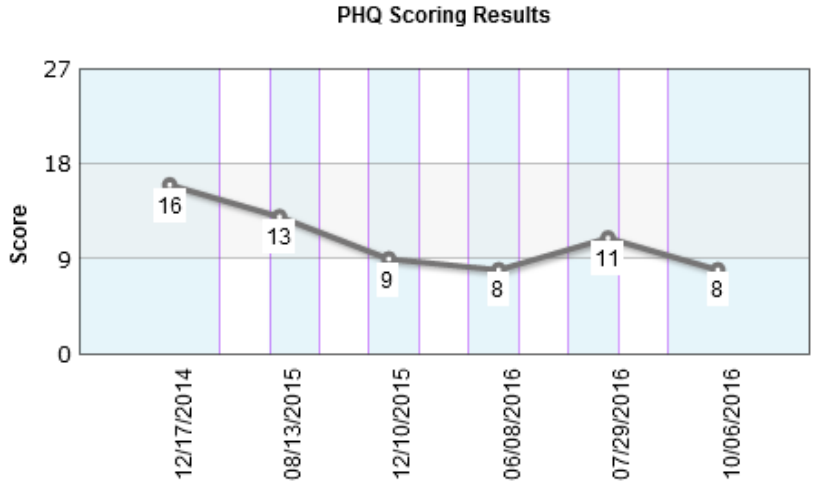
Summary: What Sets CoCM Apart?

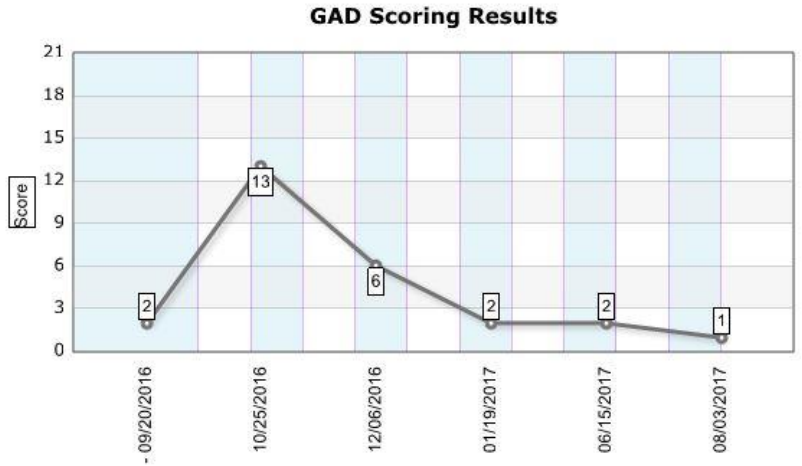
- **Population health approach**
  - Use of a systematic case review tool to ensure no one falls through the cracks
  - Proactive, tailored outreach allowing for monitoring and updates in-between PCP visits
  - Treatments are adjusted until patients achieve remission or maximum improvement
  - Data evaluates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

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; Ypsilanti Family Medicine

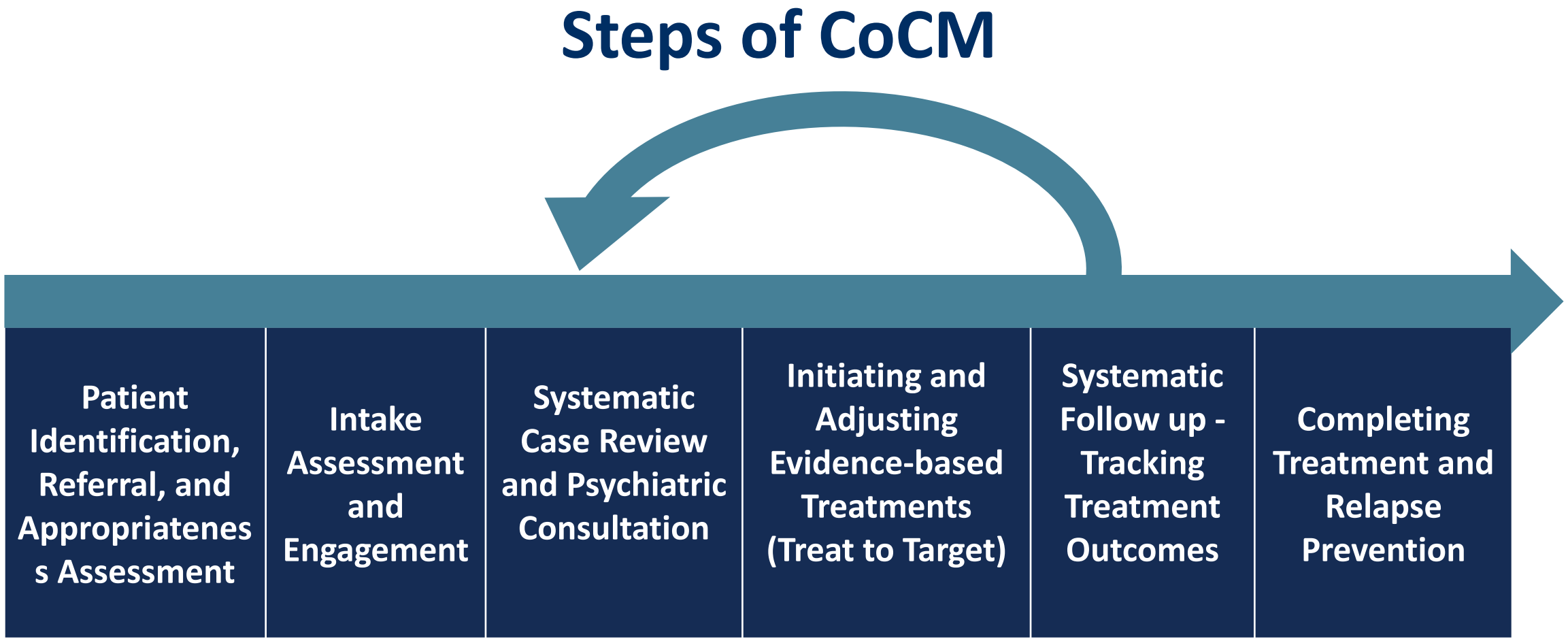
Daniel's Story

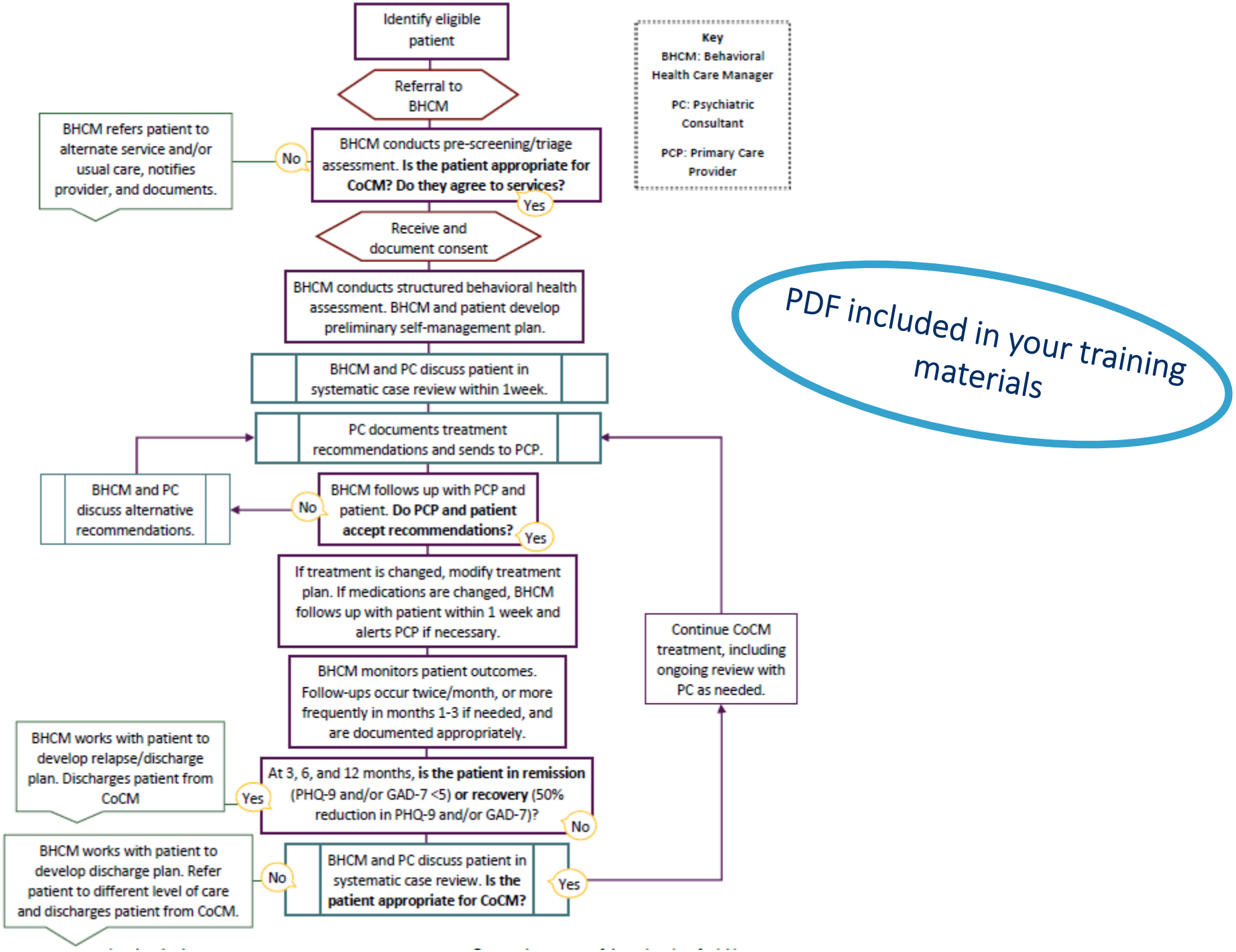
https://www.youtube.com/watch?v=_J-MFMnTrA4

Section 3

The Process of CoCM

The Process of CoCM





PDF included in your training materials

The Process of CoCM

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 candidates:

- 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
  - **Mandatory for BCBSM**

The Process of CoCM

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	

The Process of CoCM

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

Acute Safety Concerns: 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**

Speaking with Patients

"We provide services here that help with symptoms of _____. I have a member of my team, _____, 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. _____, who 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). 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**—contact will be shorter and often by phone

The Process of CoCM

Consent

- Verbal or written
  - Resource: Verbal Consent Guidelines
- 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)

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?

BCBSM has waived cost sharing (deductible, coinsurance and copayments)

Warm Handoff to BHCM

- Call/ask BHCM for **exam room drop-in**
- If BHCM available, provide a warm handoff:

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

- 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

Warm Handoff to BHCM (continued)

- If BHCM is **not available** to meet patient face-to-face:
  - Send chart/note to BHCM for outreach
  - Make sure patient is aware they will be receiving a phone call

Assessment by BHCM

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

Communication and Documentation

- How will the Psychiatric Consultants recommendations reach the PCP?
- How will the BHCM know when the PCP has reviewed the recommendations and decided about implementation?

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

Substance Use Concerns

Previous Medication Trials

EHR Documentation Guide

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.

The Process of CoCM

21st Century Cures Act

Impact on medical documentation visibility by patients

The Process of CoCM

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

The Process of CoCM

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**

The Process of CoCM

Stretch Break—15 Minutes

BHCM Interventions

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

The Process of CoCM

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 (e.g., diabetes, 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

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 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

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

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

The Process of CoCM

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 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

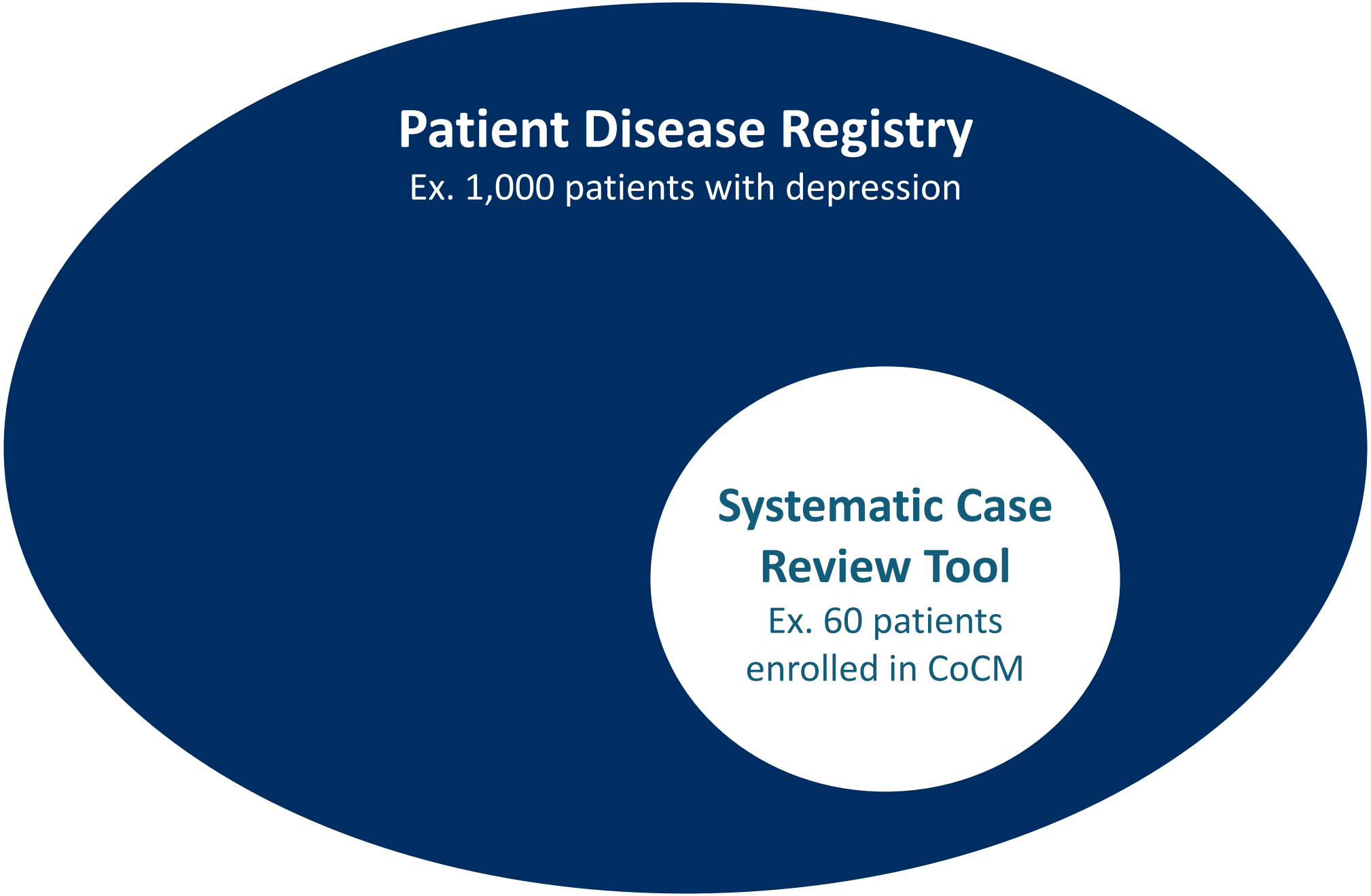
- Could be incorporated with existing chronic disease registry
- Used to identify patients who are eligible for the CoCM services
- Often static

The Process of CoCM

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.


Patient Disease Registry
Ex. 1,000 patients with depression
Systematic Case Review Tool
Ex. 60 patients enrolled in CoCM

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

The Process of CoCM

Follow-Up

Follow-Up Contacts

- Weekly or every other week during **ACUTE PHASE**
- Telephone or in-person to evaluate symptom severity

INITIAL FOCUS

- **Adherence** to medication
- **Side effects** of medication
- **Follow-up** on BH interventions

LATER FOCUS

- **Resolution** of symptoms
- **Long-term adherence** to treatment

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 **tomorrow** in CoCM training Day 2

Referrals Outside of CoCM

Transition to Community Resources:

- Patient **not getting better**
- Conditions requiring **special expertise**
- Conditions requiring **longer-term care**
- Need for **recovery-based services** (people with serious and persistent mental illness)
- **Patient request**

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?

Systematic Case Review

Demonstration Activity

The Process of CoCM

Questions?