The Basics of CoCM

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

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Components of the Evidence-Based Model

- **Patient-Centered Care**
  - Effective collaboration between BHCMs and PCPs, incorporating patient goals into the treatment plan
- **Measurement-Based Treatment to Target**
  - Measurable treatment goals and outcomes defined and tracked for each patient (PHQ-9/GAD-7)
  - Treatments are actively changed until the clinical goals are achieved
- **Population-Based Care**
  - Defined and tracked patient population to ensure no one falls through the cracks
- **Evidence-Based Care**
  - Treatments are based on evidence
- **Accountable Care**
  - Providers are accountable and reimbursed for quality of care and clinical outcomes

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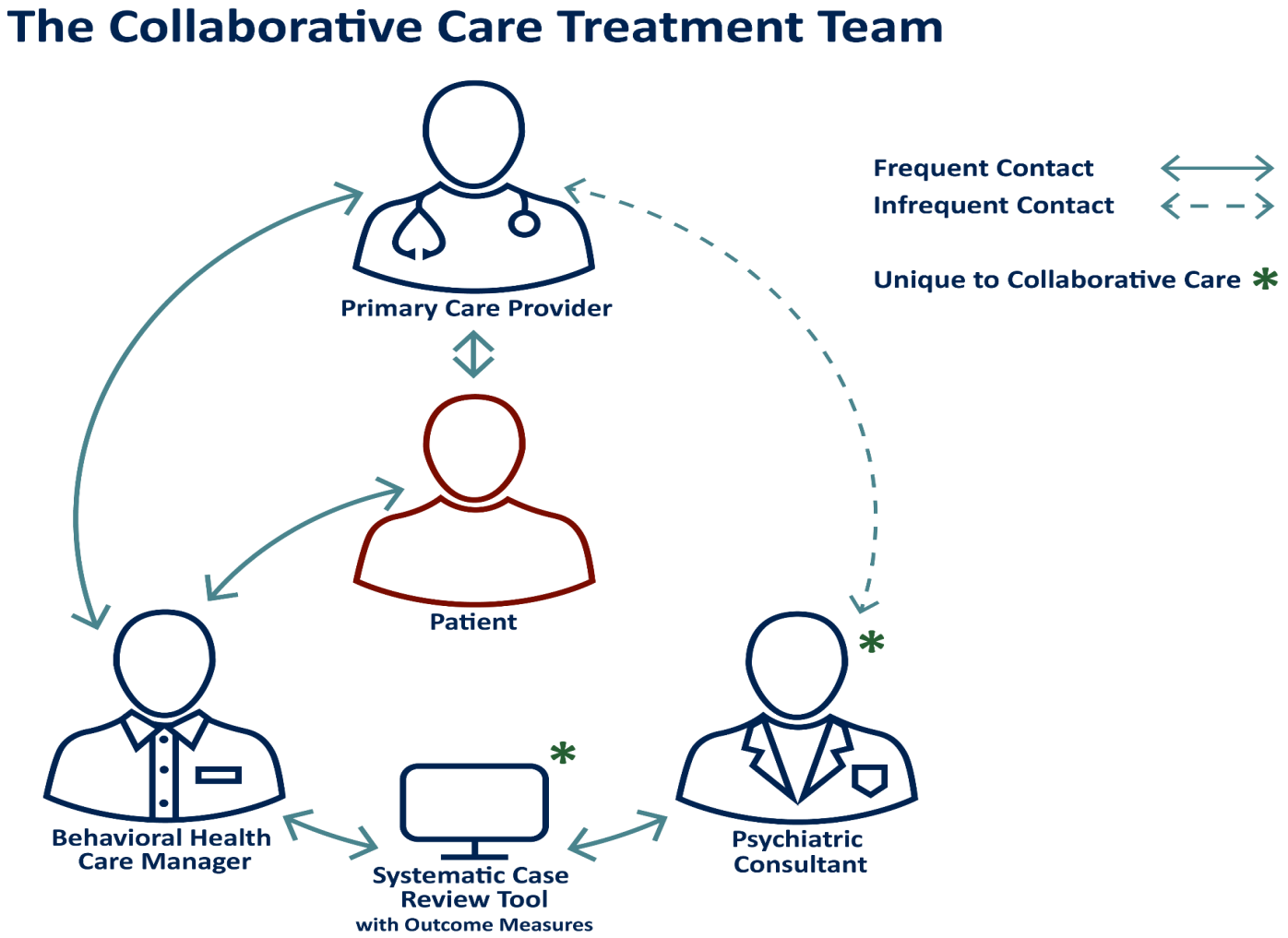

Two New Team Members

- **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)