Implementing Collaborative Care (CoCM)

Date: January 23, 2024

PRISM

Thank you to Blue Cross Blue Shield of Michigan

Blue Cross Blue Shield of Michigan has contracted with PRISM to provide training and implementation on the evidence-based treatment model of Collaborative Care to primary care practices throughout the state of Michigan.

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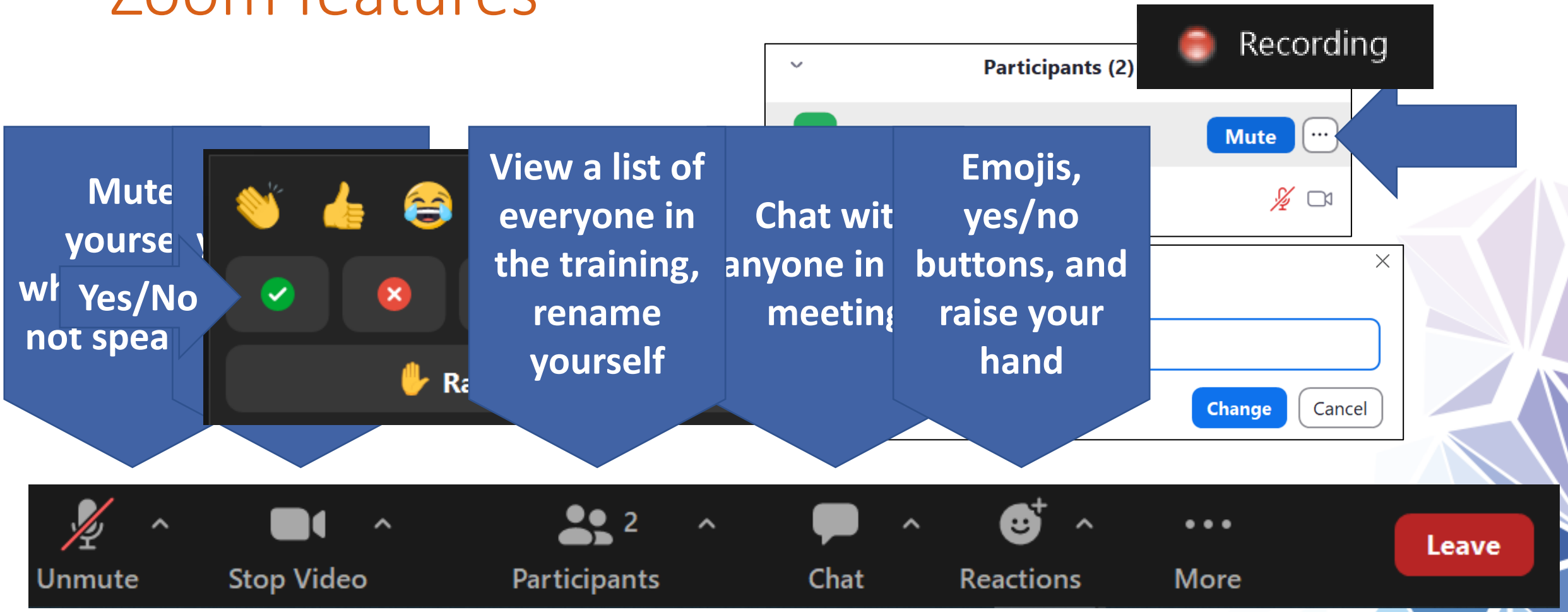
Zoom features



Instructions for behavioral health care managers and other practice staff

- **Following the course completion on 1/25/2024**, you will receive an e-mail from the Michigan Institute for Care Management and Transformation

- Please allow up to 24 hours to receive the e-mail. If you do not receive within 24 hours, please submit an inquiry via the MICMT contact form.

- Please follow the link to complete the evaluation within (5) business days for each session you attend to earn credit.

Disclosures for nursing participants

- No one in control of content has relevant financial relationships with ineligible companies.
- Successful completion of the course includes **having audio and seeing the slides live and joining the course by your individual computer**
  - attend the entire session(s)
  - credit will be awarded commensurate with participation
- Upon successful completion of the Implementing Collaborative Care the participant may earn a maximum of 10.5 Nursing CE contact hours.
- Michigan Institute for Care Management and Transformation is approved as a provider of nursing continuing professional development by the Wisconsin Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

Disclosures for social work participants

- No one in control of content has relevant financial relationships with ineligible companies.
- Successful completion of the course includes **having audio and seeing the slides live and joining the course by your individual computer**
  - must attend day 1 “Basics of Collaborative Care” 8am-9am ET and “Identifying and Referring Patients to CoCM” 9-9:30am ET
  - thereafter attend the entire session(s)
  - credit will be awarded commensurate with participation
- Upon successful completion of the Implementing Collaborative Care the participant may earn a maximum of 10.5 Social Work CE contact hours.
- This course is approved by the NASW-Michigan CE Approving Body. Michigan Institute for Care Management and Transformation is an approved provider with the Michigan Social Work Continuing Education Collaborative. Approved provider Number: MICEC 110216.

Instructions for physicians

- Attendance must be registered within 6 months to be awarded credit.

- Please complete the following steps to fill out the course evaluation and print your certificate:
  - Login to your account at MiCME at https://micme.medicine.umich.edu/
    - You must have a MiCME account to claim credit for any University of Michigan Medical School CME activity.
    - Don't have an account? Click on the "Login or Create a MiCME Account" link at the top of the page and follow the instructions.

  - See CME Activity Information COCM Training 1.23.24 handout for full details.

Disclosures for physician participants

- There are no relevant financial relationships with ACCME-defined commercial interests to disclose for this activity.

- The University of Michigan Medical School designates this live activity for a maximum of 3.25 AMA PRA Category 1 Credit(s) ™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

- The University of Michigan Medical School is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

Learning outcome

- Participants will be able to incorporate workflows and other operational techniques unique to Collaborative Care within their practice to address the behavioral health needs of patients with fidelity to the Collaborative Care Model.

Presenters

- **Sarah A. Bernes**, MPH, LMSW, MBA, Lead Training and Implementation Specialist
- **Molly Crump**, LMSW, Training and Implementation Specialist
- **Ed Deneke**, MD, Clinical Assistant Professor of Psychiatry
- **Sarah Fraley**, LMSW, Training Specialist
- **Karen Gall**, LMSW, ACTP, Training and Implementation Specialist
- **Dayna LePlatte, MD**, Clinical Assistant Professor of Psychiatry
- **Karla Metzger**, LMSW, Program Manager
- **Paul Pfeiffer**, MD, Susan Crumpacker Brown Research Professor of Depression
- **Debbra Snyder**, MS, LLP, CAADC, CCS, Project Manager

Today's Agenda

Time	Topic	Participants
8:00-9:00am ET	The Basics of CoCM	PCP, PC, BHCM
9:00-9:30am ET	Identifying and Referring Patients to CoCM	PCP, PC, BHCM
9:30-9:45am ET	**BREAK**	PCP, PC, BHCM
9:45-10:45am ET	Systematic Case Review and Psychiatric Consultation	PCP, PC, BHCM
10:45-11:30pm ET	Program performance and sustainability	PCP, PC, BHCM
11:30am-12:30pm	**LUNCH**	BHCM
12:30-1:15pm ET	Billing	BHCM
1:15-2:30pm ET	Role of the behavioral health care manager	BHCM
2:30-2:45pm ET	**BREAK**	BHCM
2:45-3:45pm ET	Assessment and diagnosis	BHCM
3:45-4:00pm ET	Conclusion and next steps	BHCM

The basics of Collaborative Care

Learning objectives

- Describe the role of each care team member in Collaborative Care
- List the five principles of Collaborative Care
- Discuss the rationale for Collaborative Care and the evidence supporting its use

The need for Collaborative Care (1 of 2)

- **80%** of people with a behavioral health disorder visit a primary care provider at least once a year[1]
- **Two-thirds** of primary care providers report not being able to obtain outpatient mental health services for patients[2]
- In 2018, Michigan has **11.84 active psychiatrists per 100,000** residents- below the national average[3]

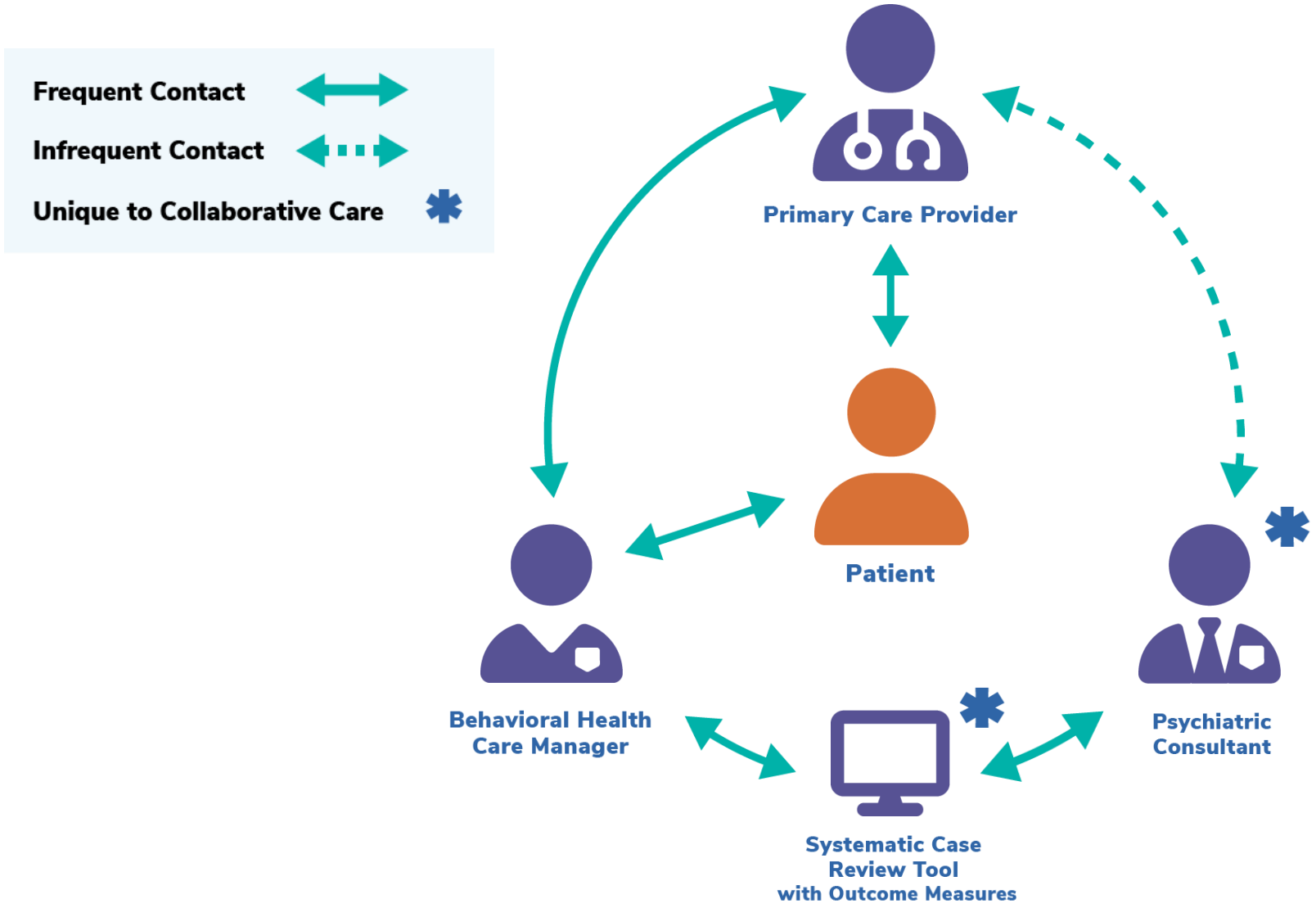
The need for Collaborative Care (2 of 2)

- **30-50%** of patients referred from primary care to outpatient behavioral health do not attend the first appointment[4]
- **50%** of all behavioral health disorders are treated in primary care[5]
- Primary care providers prescribe **68% of antidepressants** in the United States[6]

What is Collaborative Care?

The Collaborative Care Model (CoCM) is an **evidence-based** model for treating common behavioral health problems like **depression and anxiety** in **primary and specialty care settings** including pediatrics, geriatrics, and reproductive health.

Collaborative Care treatment team



Qualifications of the two new team members

Psychiatric Consultant (PC)

- A medical professional trained in psychiatry and qualified to prescribe the full range of medications
- Psychiatrist or psychiatric nurse practitioner

Behavioral Health Care Manager (BHCM)

- Professionally licensed in the state in which they are practicing and have specialized behavioral health training
- Social worker, nurse, psychologist, or licensed counselor

Role of the primary or specialty care provider in CoCM

- **Oversees all aspects of a patient's care**
- Screens for common mental health issues
- Introduces collaborative care and refers patients to the program
- Receives recommendations from the psychiatric consultant and determines whether to accept them
- **Prescribes medications as needed**

Role of the behavioral health care manager (BHCM) in CoCM

- **Manages caseload** of enrolled patients using the systematic case review tool
- Provides **brief behavioral interventions** and supports medication management
- Tracks treatment response and side effects using **standardized scales**
- Supports patient through **self-management planning**, safety planning, and relapse prevention planning
- Participates in **weekly caseload consultation** with the psychiatric consultant

Role of the Psychiatric Consultant (PC) in CoCM

- Participates in **weekly caseload consultation** with the behavioral health care manager
- **Recommends treatment** adjustments, including medications and other interventions
- Educates the rest of the team on psychopharmacology
- **Does not see patient directly**
- **Does not prescribe medications**

Role of the patient in CoCM

- Consents to enrolling in collaborative care
- Reports **symptoms and side effects**
- Learns about the nature of their mental health condition
- Determines which types of **treatments to accept**
- Creates self-management and relapse prevention plans with the behavioral health care manager

Role of caregivers and family in CoCM

- Can be involved **with patient consent**
- Provide **additional information** about the patient
- Family can be engaged in supporting treatment
  - Assist with taking medications as prescribed
  - Engage in relapse prevention planning

What primary care providers are saying

Corey Dean, MD

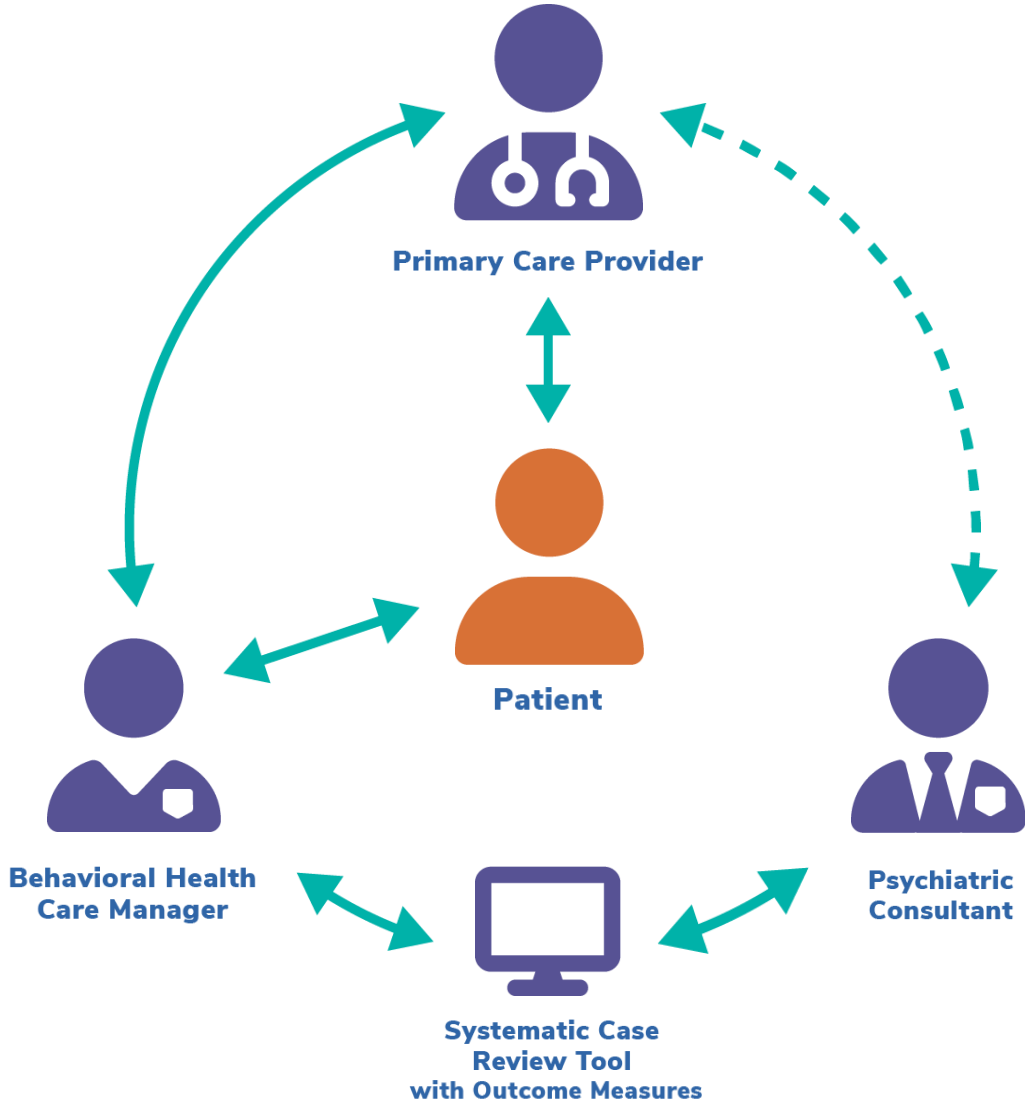
Primary Care Physician
Trinity Health Neighborhood Primary Care- Ypsilanti
IHA Medical Group

Principles of Collaborative Care

- Patient-Centered Team Care
- Population-Based Care
- Measurement-Based Treatment to Target
- Evidence-Based Care
- Accountable Care

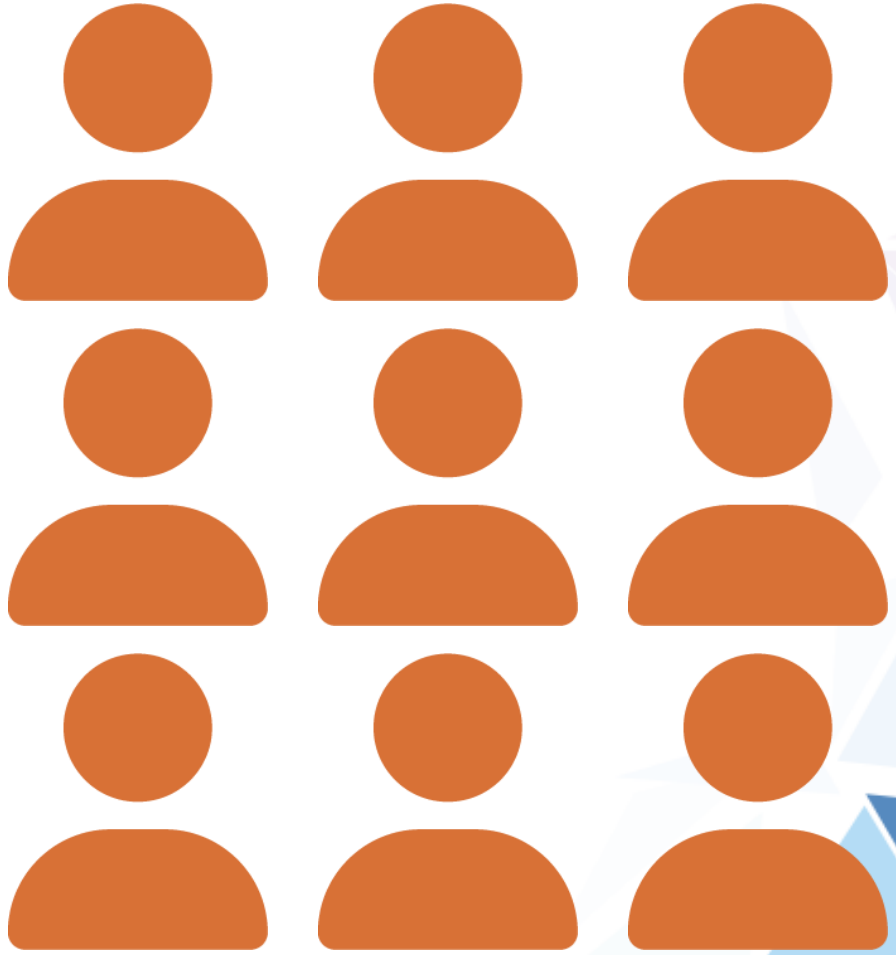
Patient-centered team care

- Primary care and behavioral health providers collaborate using shared care plans that incorporate patient goals.
- Patients can get both physical and mental health care at a familiar, comfortable location.



Population-based care

- The population of enrolled patients is defined and tracked
- Clinical outcomes and engagement are tracked for individual patients and **the population of patients as a whole**



Measurement-based treatment to target

Goal: 50% reduction in symptoms measured by PHQ or GAD within three months

- Measurable treatment goals and outcomes defined and routinely tracked for each patient
- Treatments are actively changed until the clinical goals are achieved
- Adjust treatment every 10-12 weeks if symptoms haven’t decreased by 50%
- 50-70% of patients need at least one change in treatment

Evidence-based care

1. **Treatments used are based on evidence**
   - Motivational interviewing
   - Behavioral activation
   - Problem solving therapy
   - Medications

2. **The overall model has been proven effective**

The evidence for CoCM

- IMPACT study: First trial published by the University of Washington in 2002[7]
- **90+ randomized controlled trials** prove CoCM provides significantly better behavioral health outcomes than usual care[8]
- Centers for Medicare and Medicaid (CMS) created codes for CoCM in 2018

More evidence for CoCM

- Improvements for patients with mild-moderate conditions receiving CoCM are **comparable to improvements for patients receiving specialty psychiatry**

- **Time to remission** for patients with depression in CoCM was **significantly shorter** than patients in usual care[9]

Accountable care

- Providers are accountable for the overall quality and outcomes of healthcare provided to a population of patients

- In order to provide accountable care, the first four principles must be in place

Collaborative Care target population

- Ages 12 and above
- Extensive evidence for:
  - Depression and anxiety
  - PHQ/GAD > 10
- Increasing evidence for:
  - PTSD
  - Bipolar

- More complex patients should be served at behavioral health specialty clinics
- Not recommended for patients with an outside psychiatrist

One patient's story

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

Additional implementation support

- **Advanced Trainings** in adolescent/pediatric and perinatal CoCM offered throughout the year
- **BHCM Discussion Group** offered monthly
- **Webinars** on various collaborative care topics offered monthly
- Ongoing **Implementation Support Calls** for Physician Organizations and practices
- **Ad hoc support** for resources and questions

Disclaimer

Each physician organization and/or practice is solely responsible for all billing practices and medical care and services delivered to its patients and all decisions related to such medical care and services. Neither MICMT or the Regents of the University of Michigan shall be responsible for any delivery of medical care or other services to any patient, or any decisions, acts or omissions of persons in connection with the delivery of medical care or other services to any patient.

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MICMT

Michigan Institute for Care Management & Transformation

Resources (1 of 2)

- University of Washington Advancing Integrated Mental Health Solutions (AIMS) Center
- American Psychiatric Association Learn About the Collaborative Care Model
- AIMS Center Role of the Primary Care Provider
- Behavioral Health Care Manager Job Description
- Psychiatric Consultant Job Description

Resources (2 of 2)

- AIMS Center Checklist of Collaborative Care Principles and Components
- AIMS Center Evidence Base for CoCM

References

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