The Collaborative Care Model (CoCM)

The Behavioral Health Care Manager

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The Role of the BHCM

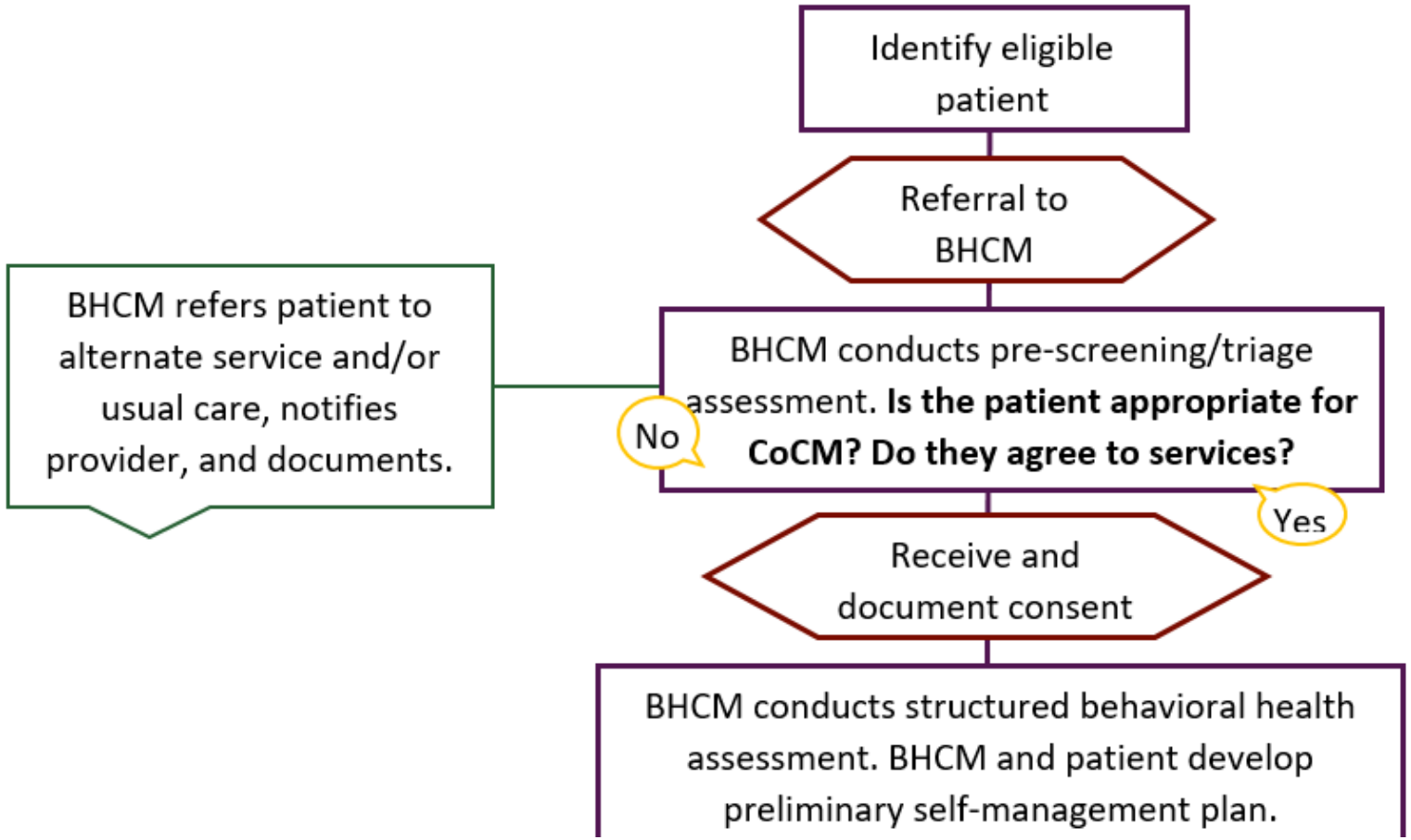
THE PATIENT IS THE CENTRAL FIGURE OF THE TREATMENT TEAM, AND **YOU** ARE THE QUARTERBACK!

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
- Screening 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 – review relapse prevention plan, confidence with self-management and resources if indicated



Key

BHCM: Behavioral Health Care Manager

PC: Psychiatric Consultant

PCP: Primary Care Provider

Definitions

Data is an active member of the treatment team allowing to identify patients, track treatment progress, and trend impact of CoCM services.

Systematic Case Review Tool

- Summary of key treatment information (e.g., outcome measure scores, dates of contacts) for each patient
- Used by behavioral health care manager (BHCM) and psychiatric consultant to regularly review the CoCM caseload

Systematic Case Review

- Weekly meeting between the psychiatric consultant and BHCM to review the caseload and provide expert treatment recommendations
- Fundamental component of CoCM

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

Identifying Eligible Patients

- Referrals from PCP, (warm hand-offs are ideal when available)
- Use of the disease registry

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

Introducing CoCM to Patients

Introduce	Personalize	Introduce	Emphasize	Describe
If possible, introduce via a warm-handoff from the PCP	Personalize the script based on the patient, personal style, and clinical judgment	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

Demonstration

- Listen for the key points of the CoCM Model

ACTIVITY

Enter your breakout room (accept “join” breakout room)

Facilitator for each group

- **Each group will create an introduction to the CoCM program to a patient**
- **Reference slide 8 for ideas**
- **Identify someone in the group to share with the group at large**

Time Allotted – 10 minutes

ACTIVITY - Debrief

Each group shares scripting created

What was a little more difficult?

What went smoothly with your introductions?

Screening, Triage, and Assessment

- Screen using evidence-based 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

Patient Agreement

- Verbal or written (depending on payer requirements)

- Documented in EHR before services begin
- If billing CMS (Medicare and Medicaid) 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)

Outcome Measures:

Polling Questions

- PHQ-9 (To remission - improvement of 5)
- GAD-7 (To remission - improvement of 5)

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 your mood.”
- 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.”

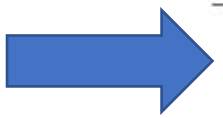
PHQ - 9

- 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

- Alcohol screening
- Drug screening
- CIDI-based bipolar questionnaire
- MoCA (mild cognitive dysfunction)
- PC-PTSD (PTSD screening)
- PCL 5 (PTSD screening)

Single Alcohol Screening Question

How many times in the past year have you had X or more drinks in a day?

 X = 5

 X = 4

a. None
b. 1
c. 2 to 5
d. 6 to 10
d. 11 to 20
e. more than 20

Positive response: Greater than none

Smith, Journal of General Internal Medicine, 2009

AUDIT-C

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

a. Never
b. Monthly or less
c. 2 to 4 times a month
d. 2 or 3 times a week
e. Daily or almost daily

2. How many standard drinks do you have on a typical day when you drink?

a. 1 or 2
b. 3 or 4
c. 5 or 6
d. 7 to 9
e. 10 or more

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

a. Never
b. Monthly or less
c. Monthly
d. Weekly
e. Daily or almost daily

Men: X = 5
Women: X = 4

Add up all points: a = 0; b = 1; c = 2; d = 3; e = 4
Positive screen – men: ≥4 points women: ≥3 points

Exception: All points from item 3

http://www.integration.samhsa.gov/images/res/tool_auditc.pdf

Single Drug Screening Question

How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?

a. None
b. 1
c. 2 to 5
d. 6 to 10
d. 11 to 20
e. more than 20

Positive response: Greater than none

Smith, Journal of General Internal Medicine, 2009

Two-Item Conjoint Screen

(May be added to 2 single screening questions to identify more drug disorders)

1. In the last year, have you ever drunk alcohol or used drugs more than you meant to?

2. In the last year, have you felt you wanted or needed to cut down on your drinking or drug use?

Positive screen: Yes to either or both questions

Does not identify <u>at-risk</u> alcohol or drug use

Brown, Journal of the American Board of Family Practice, 2001

Accuracy of Alcohol and Drug Screens

	Sensitivity	Specificity
	Of those <u>with</u> the condition, what proportion screen <u>positive</u>?	Of those <u>without</u> the condition, what proportion screen <u>negative</u>?
	True positive vs. false negative	True negative vs. false positive
Single Alcohol Screening Question	82%	79%
AUDIT-C	♂: 79% ♀: 80%	♂: 56% ♀: 87%
NIAAA Quantity- Frequency Questions	83%	84%
Single Drug Screening Question	83%	94%
Two-Item Conjoint Screen (TICS)*	79%	77%

*Screens for problem use and dependence, not risky use

Smith, Journal of General Internal Medicine, 2009; http://www.integration.samhsa.gov/images/res/tool_auditc.pdf; Friedmann, Journal of Studies on Alcohol, 2001; Smith, Journal of General Internal Medicine, 2009; Brown, Journal of the American Board of Family Practice, 2001

Interpreting Screen Results

- Screens identify most risky users, problem users and dependent individuals
- False-positives and false-negatives are not unusual
- Because of false-positives …
  - Positive screens are not definite indicators of risky use, problem use or dependence
  - Screens merely indicate which asymptomatic individuals should undergo further assessment
- Because of false-negatives …
  - Screens should not be administered to individuals with symptoms of disorders
  - Those individuals should undergo more in-depth assessment

Drugs, Alcohol and Depression

Considerations for Treatment

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

Bi-Polar and CoCM

Currently research and application to CoCM

The Comprehensive Assessment

Includes:

- Behavioral Health
- Social Needs
- Medical Status

Incorporates the patients:

- Ability
- Knowledge
- Desire

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.

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 and understanding of the diagnosis, linking to the PHQ-9/GAD-7
  - "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?”
  - What is your understanding of your diagnosis of depression/anxiety?
  - “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 – about taking medications?

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, Drug Use, etc..
- Treatment history
- Gain initial understanding of how they feel about their substance use
  - Brief assessment, Intervention/referral to treatment
  - “You’re not worried about how this is impacting you right now.”

Additional Information

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

Psychosocial Details

Does the office conduct a SoDOH screening? If so – review results and identify reported barriers

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

Suicide 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

Strategies for Suicide Risk Assessment:

- Normalize the conversation (“thoughts of suicide are a common symptom of mental health disorders”)
- Be direct
- **You won’t increase the risk of suicide by asking directly about it**. Use specific language, such as:
- *“Are you feeling hopeless about the present or future?”*
- *“Thoughts of suicide, even very fleeting thoughts such as not wanting to wake up in the morning, are common in people with depression and anxiety. Is this something that you’ve experienced?”*
- *“Have you had thoughts of taking your life?”*
- *“Do you have a plan to take your life?”*

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

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 – 3minutes

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

Consider a Patient Welcome Packet

www.miccsi.org

Intake packet example

Care Plan

Remember that discharge planning/preparation starts from the beginning

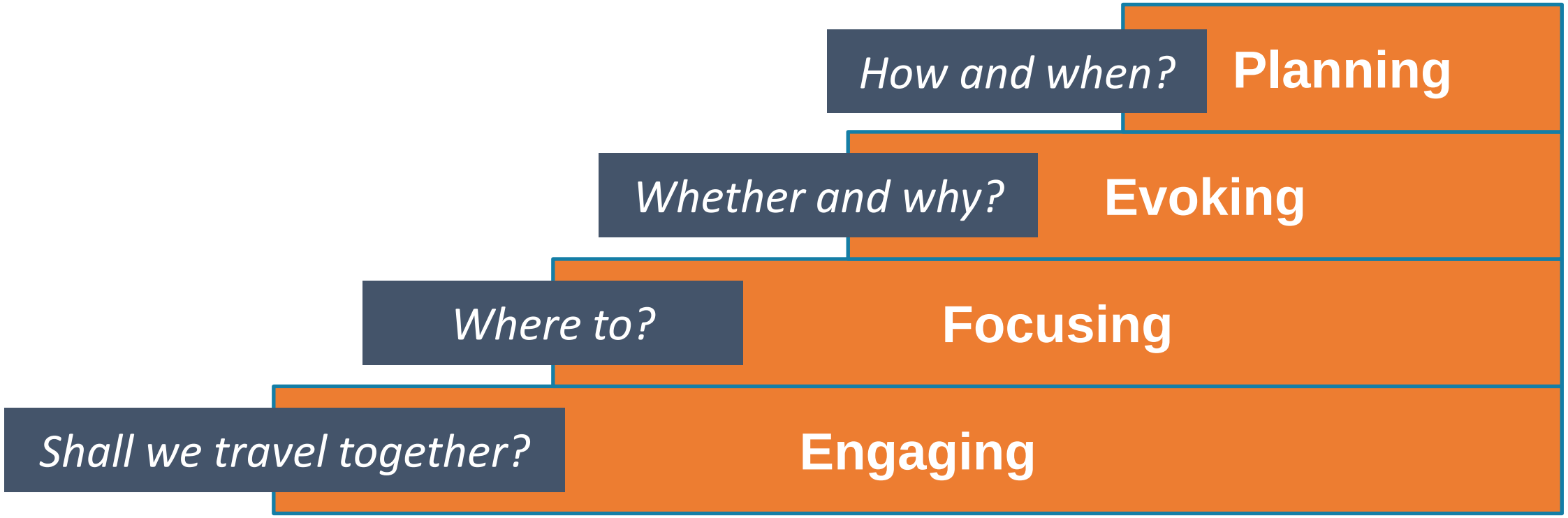
- Developed by the Care Team *with* the Patient
- Goals have observable, measurable outcomes (SMART)
- Outcomes are routinely measured
- Treatment to target
- Treatments are actively changed until treatment goals are achieved
- Clinical outcomes are routinely measured by evidence-based tools

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

POLL – Self-management Action Planning

Planning: First, lay your foundation of MI



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.”
- Let’s get specific – what exercise? How often? When? Where?
- SMART version: “I want to go for a 30 minute walk three days per week for the next two weeks.”

Goals Important to You

-
-
-
-

Healthy Lifestyle

- Exercise regularly
- Avoid addictive substances
- Make healthy food choices and eat at a regular time in a comfortable space
- Get regular sleep

Relationships

- Spend time with others
- Go to social events or get coffee with friends
- Build supportive relationships

Stick With Your Plan

- Take medications as directed
- Keep appointments
- Participate in groups/counseling
- Stay in touch with your care manager
- Work on your goals

Productivity

- Get involved in workplace projects or community events
- Start or keep working on a regular basis
- Get involved in personal or family activities

Self-Reward

- Plan weekly activities that are relaxing or that you have enjoyed in the past like reading or listening to music
- Take up an old hobby or attend a special event

Spiritual

- Connect with a spiritual community
- Look for ways to meet your spiritual needs such as quiet study, meditation, services/ceremonies

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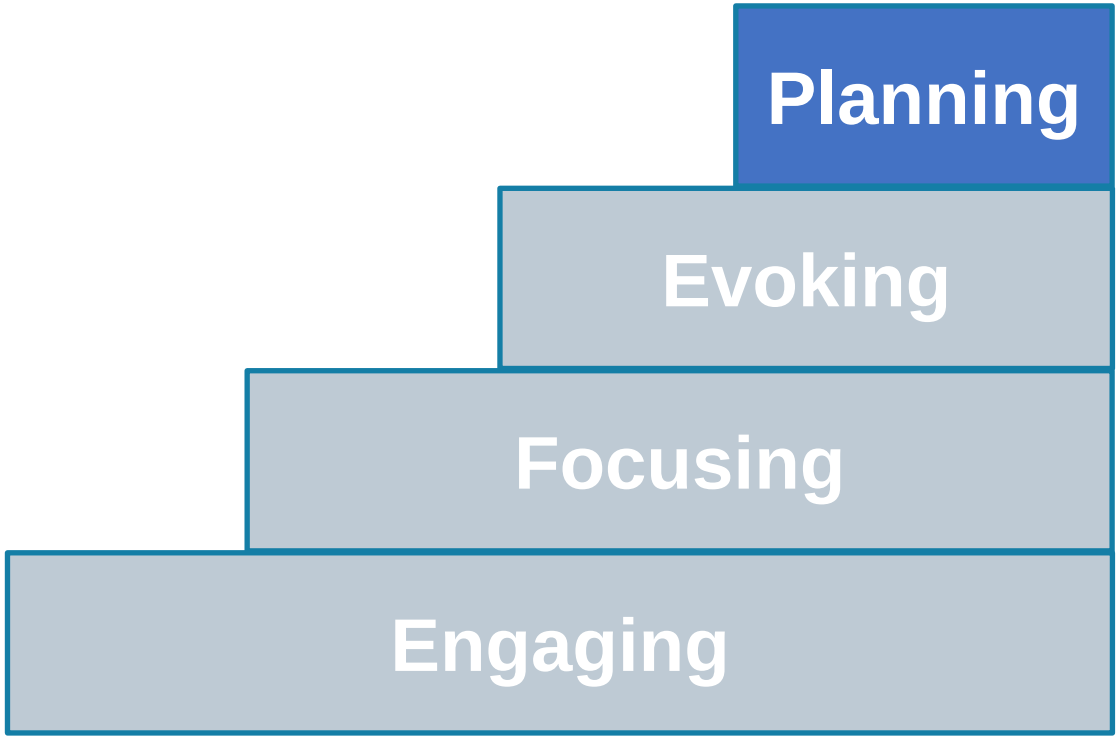
Self-Management Plan- Example items

- ❑ 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?



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!

Real Play 7-10 minutes

Groups will enter breakout rooms

Facilitator takes the role of the patient

Volunteer to take the role of the BHCM

Ask: Is there something you'd like to do to improve your mood?

Allow: Patient to respond Yes – No – Not sure

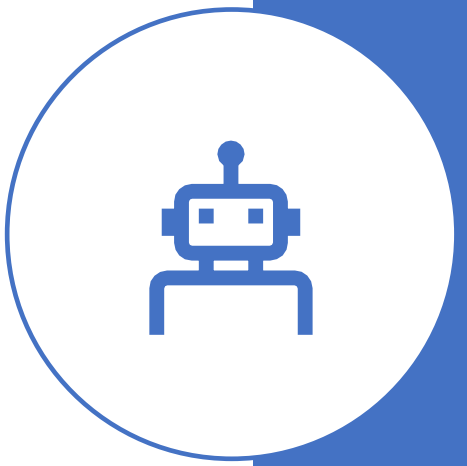
Yes: What are your ideas?

Allow: Patient to come up with ideas

SMART goal: Specific – Measurable – Attainable – Realistic – Timebound

Evaluate confidence/readiness: Use the readiness/confidence ruler

Commitment: Patient repeats plan



Monitoring and Follow-Up

- PCP – Continue to prescribe medications, make medication adjustments as needed, implement treatment recommendations
- BHCM – Provide brief behavioral interventions, monitor symptoms (using the PHQ-9/GAD-7), update registry, 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 review challenges and successes with the treatment plan

BHCM actions in the follow up visit

Use agenda setting to frame the visit

Include the patient's greatest concerns

Repeat PHQ9/GAD 7 to determine progress with treat-to-target

Address any urgent emergent issues

Follow up on the self-management action plan

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?”

Frequency of Contact:

Typical Frequency of Care Management Contact:

- Active Treatment – until patient significantly improved/stable – minimum 2 contacts per month; can occur remotely
- Monitoring – 1 contact per month
- After 50% decrease in PHQ-9 • monitor for ~3 months to ensure patient stable • complete relapse prevention planning
- 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

Concluding the Visit

- Wrap up the visit
  - Summarize the content
  - Review with the patient the action steps and address any questions
  - Establish the date of the next visit

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

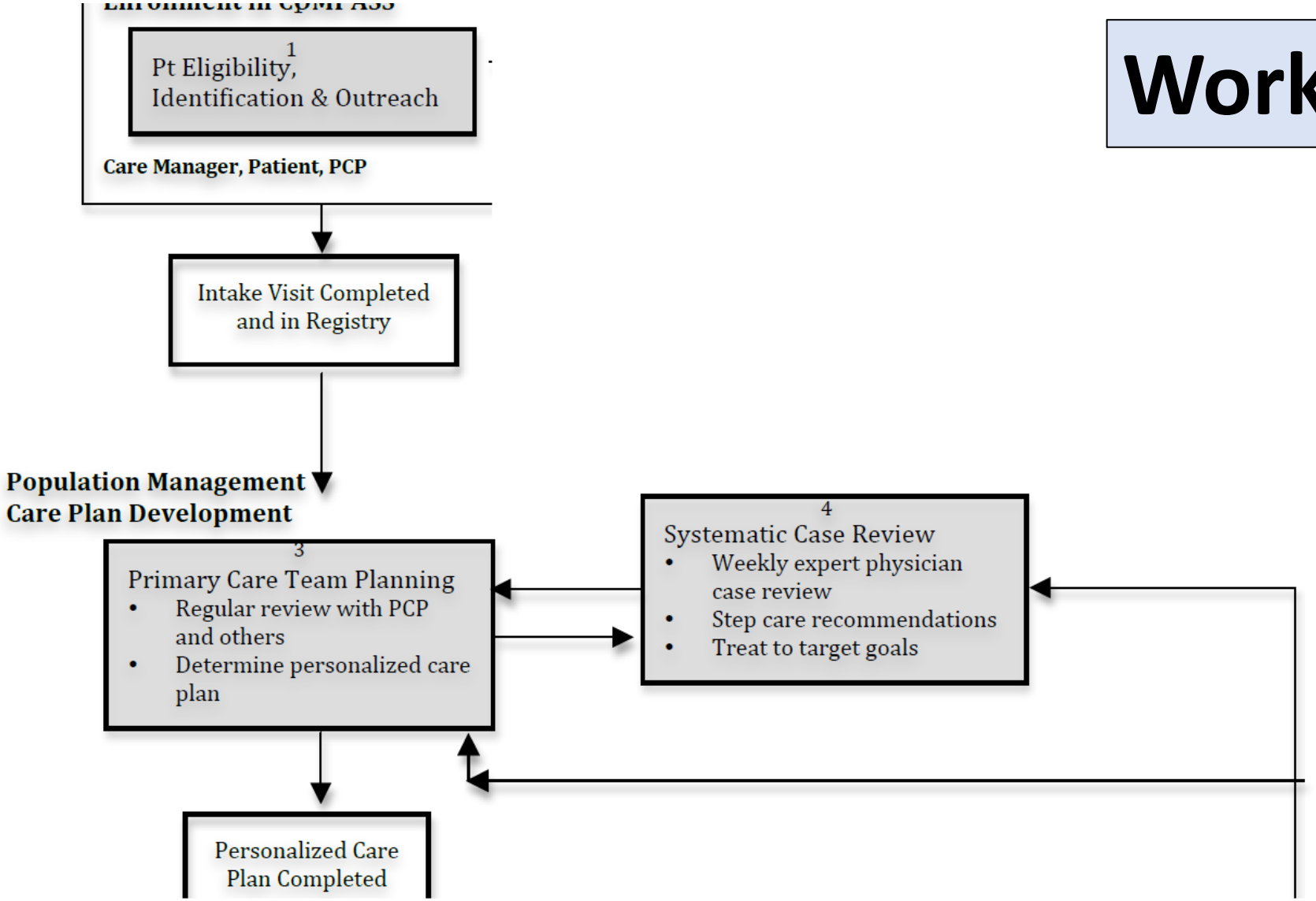
BHCM will manage and populate a clinic-specific systematic case review tool. This will include entering patients, updating information, and viewing the systematic case review tool to dictate daily workflow and tasks

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

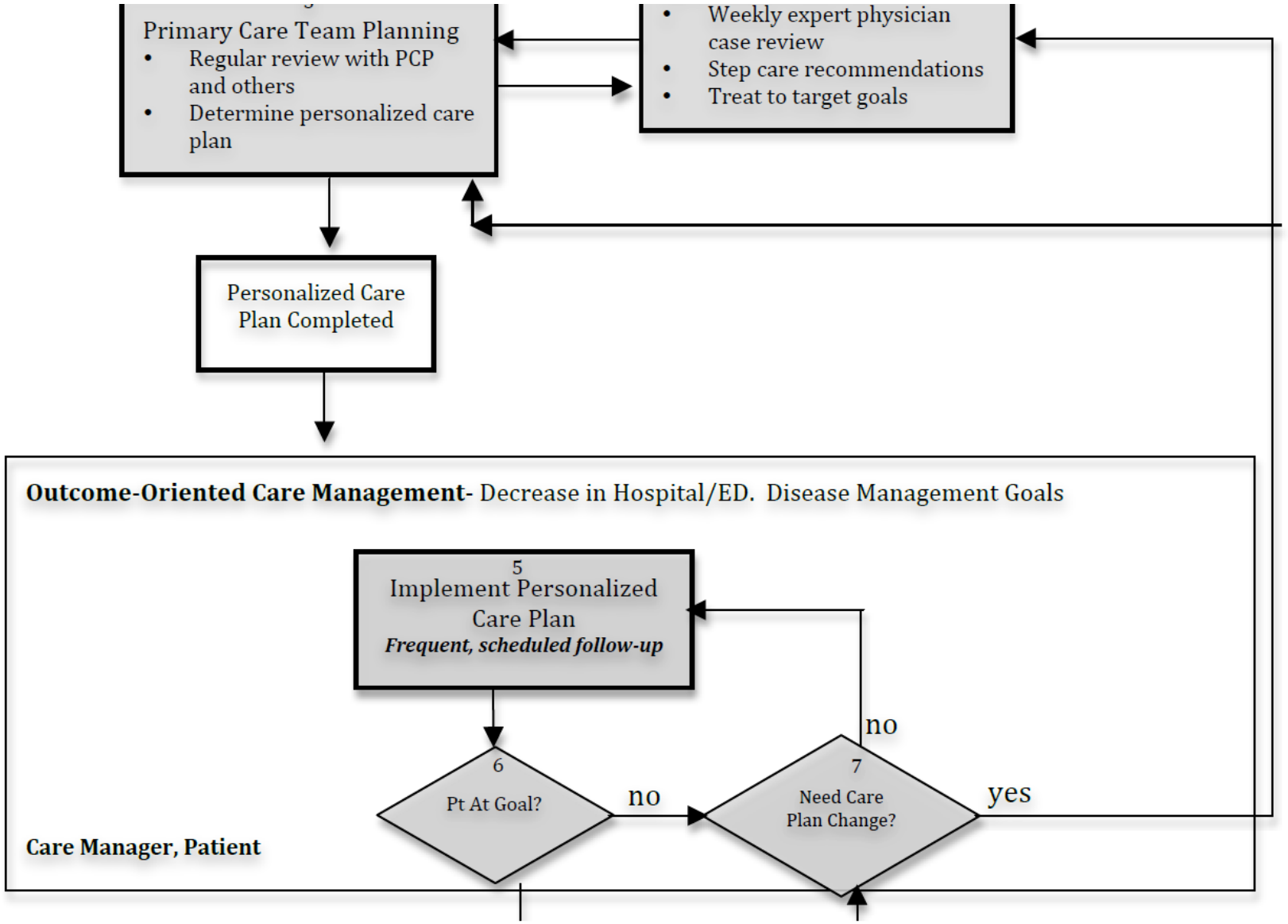
Care Coordination

- 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
- Care Coordination within the team. 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

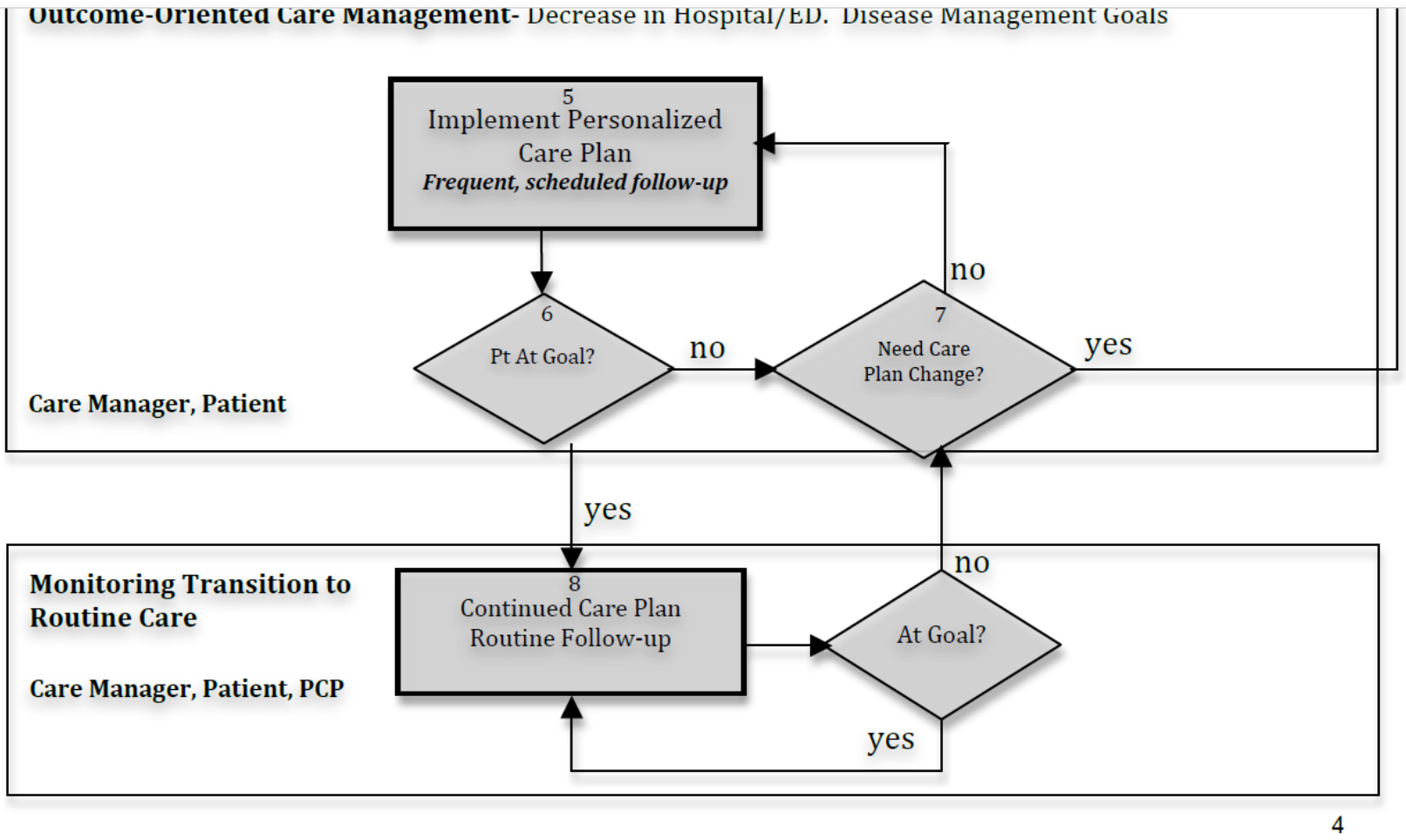
Workflow


1
Pt Eligibility,
Identification & Outreach
Care Manager, Patient, PCP
Intake Visit Completed
and in Registry
Population Management
Care Plan Development
3
Primary Care Team Planning
• Regular review with PCP and others
• Determine personalized care plan
4
Systematic Case Review
• Weekly expert physician case review
• Step care recommendations
• Treat to target goals
Personalized Care
Plan Completed

Workflow

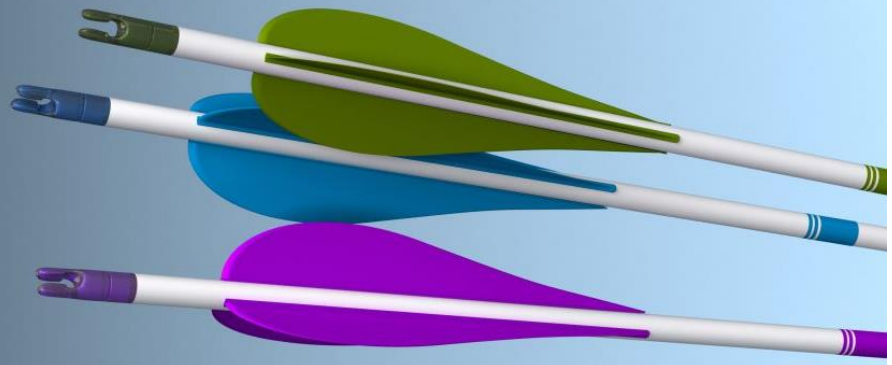

Primary Care Team Planning
• Regular review with PCP and others
• Determine personalized care plan
• Weekly expert physician case review
• Step care recommendations
• Treat to target goals
Personalized Care Plan Completed
Outcome-Oriented Care Management- Decrease in Hospital/ED. Disease Management Goals
5
Implement Personalized Care Plan
Frequent, scheduled follow-up
6
Pt At Goal?
no
7
Need Care Plan Change?
no
yes
Care Manager, Patient

Workflow


Outcome-Oriented Care Management- Decrease in Hospital/ED. Disease Management Goals
5
Implement Personalized Care Plan
Frequent, scheduled follow-up
6
Pt At Goal?
no
7
Need Care Plan Change?
no
yes
Care Manager, Patient
yes
Monitoring Transition to Routine Care
Care Manager, Patient, PCP
8
Continued Care Plan Routine Follow-up
At Goal?
no
yes

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	

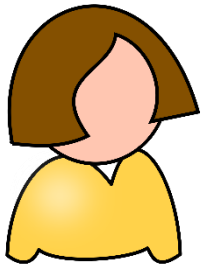


Outcome Targets

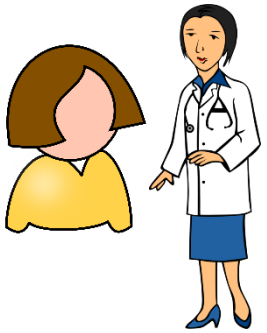
- Ideal target is remission – score less than 5
- Other targets include:
  - 5 point reduction in score
  - 50% reduction in score

Review of Case Studies

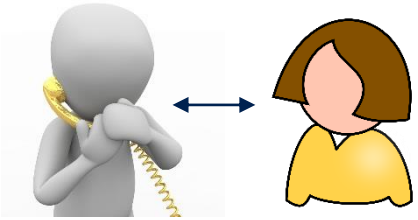
Case Vignette



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.

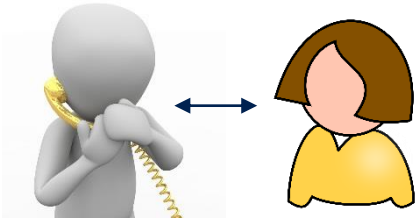
Case Vignette Continued

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.

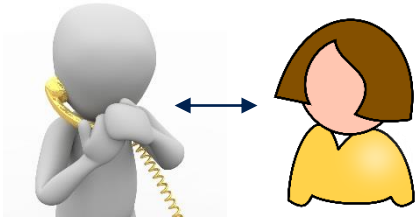
The Care Manager meets with the Psychiatric Consultant later that week, and reviews the case. The Psychiatric Consultant writes a recommendation to the PCP to consider starting a trial of Lexapro. (either the CP or the BHCM sends note to PCP)

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

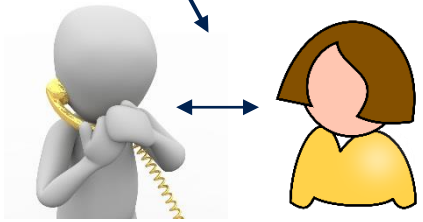


The Care Manager contacts Claire by phone to review the medication recommendation and provide education about potential side effects and what to expect. The patient agrees to start Lexapro, so the Care Manager asks the PCP to send it in to the pharmacy.



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

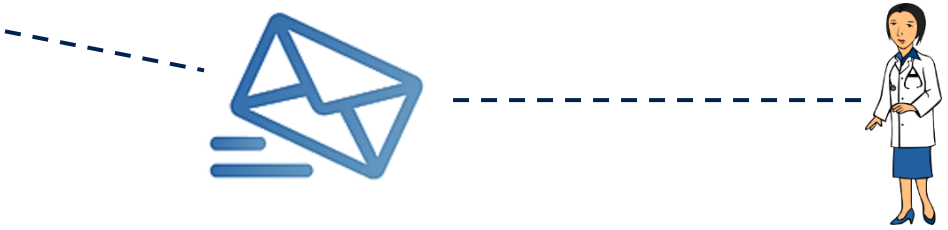
Within 2 weeks the BHCM completes medication monitoring. The BHCM checks in on goals and provides support as appropriate.



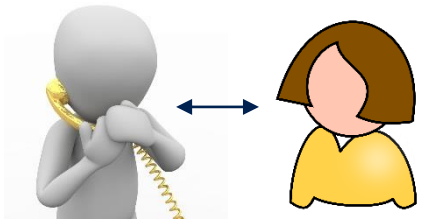
With proactive follow-up by the BHCM, Claire titrates her medication on schedule, per the recommendations of the Psychiatric Consultant. Claire doesn't need to come into the primary care clinic during this time, which is convenient, due to her busy work schedule. Unfortunately, she sees no improvement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

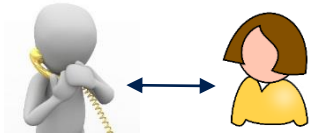


The Care Manager discusses with the PCP and with Claire- they both agree. Per provider orders the Care Manager arranges for the new prescription order.



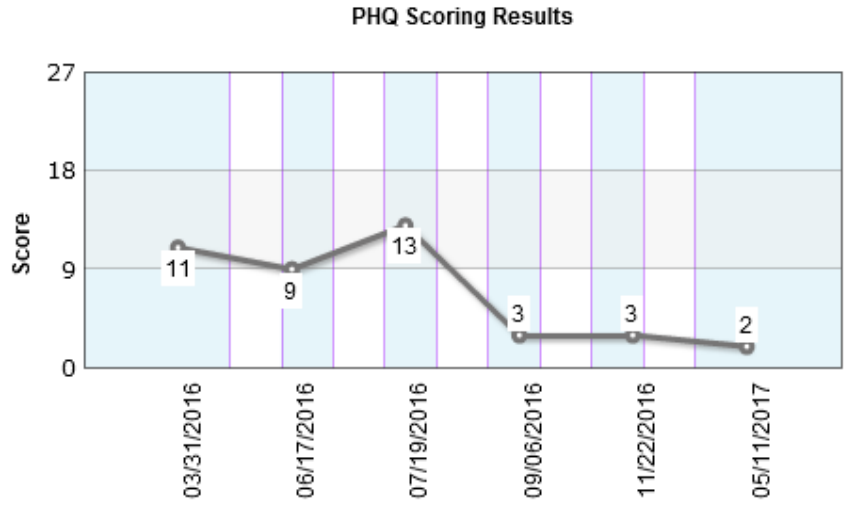
This time, Claire begins to notice a benefit on her mood after several weeks. The Care Manager does proactive monitoring and follow-up, and under the direction of the PCP facilitates the titration of her medication over several months, eventually up to 60mg daily.

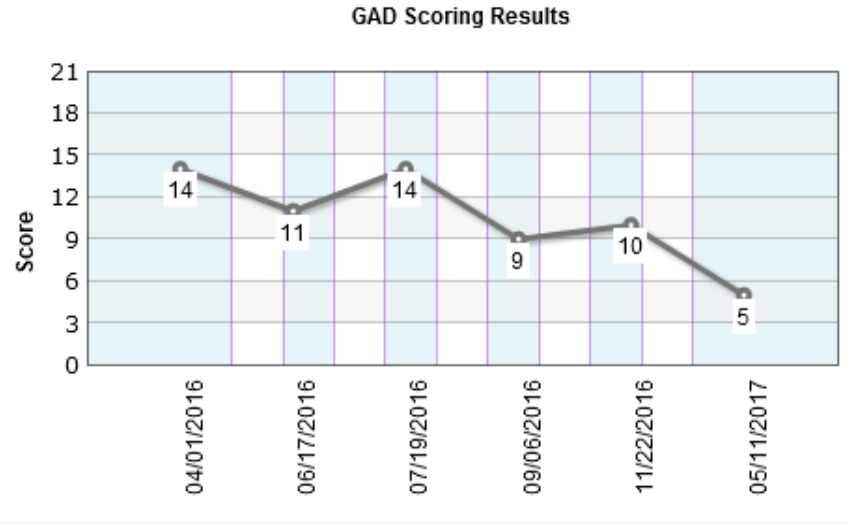
Case Vignette Continued



Over the next nine months, the Care Manager had regular, proactive contacts with Claire. The Care Manager collected the 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?

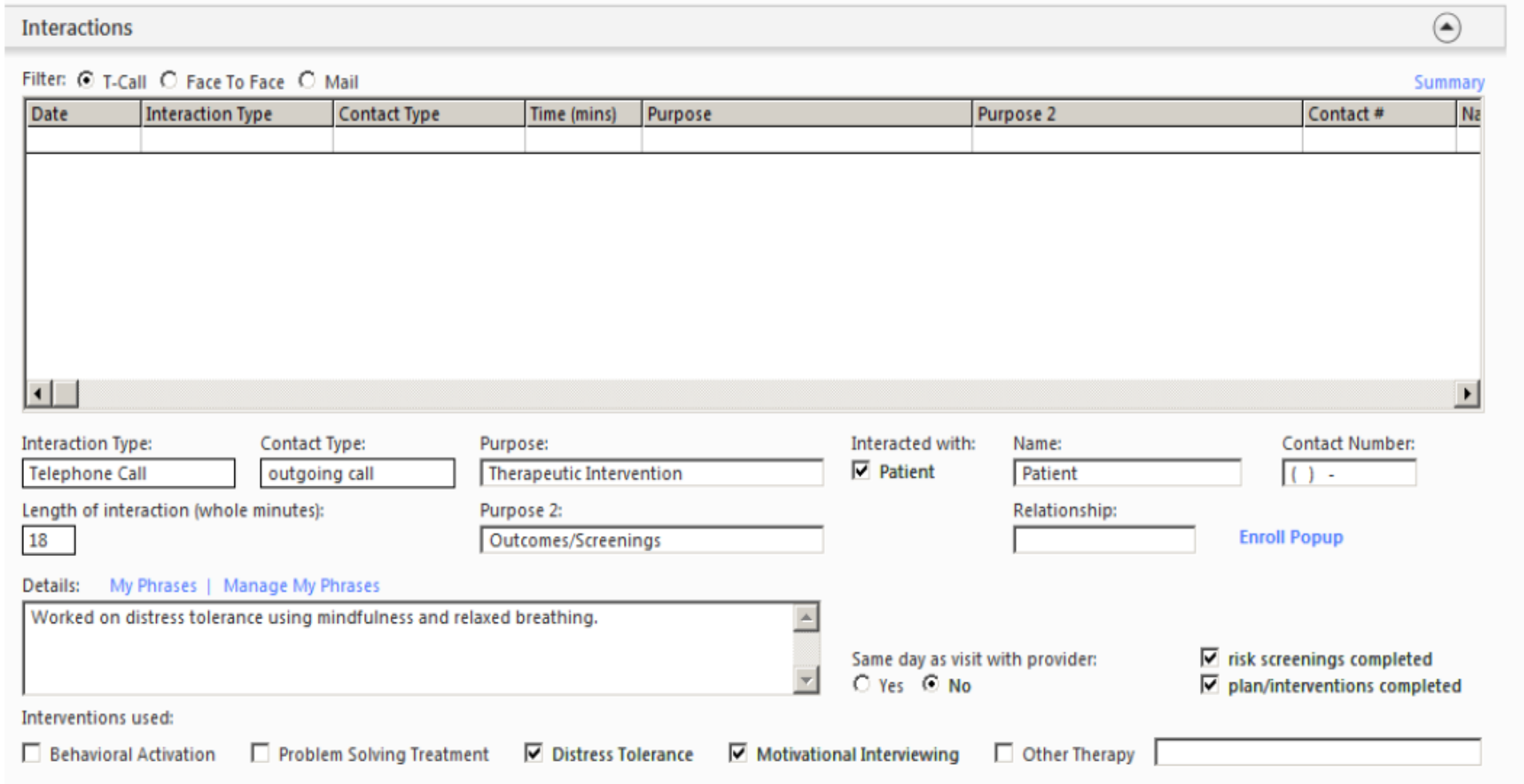
Lunch Break 12 – 12:30

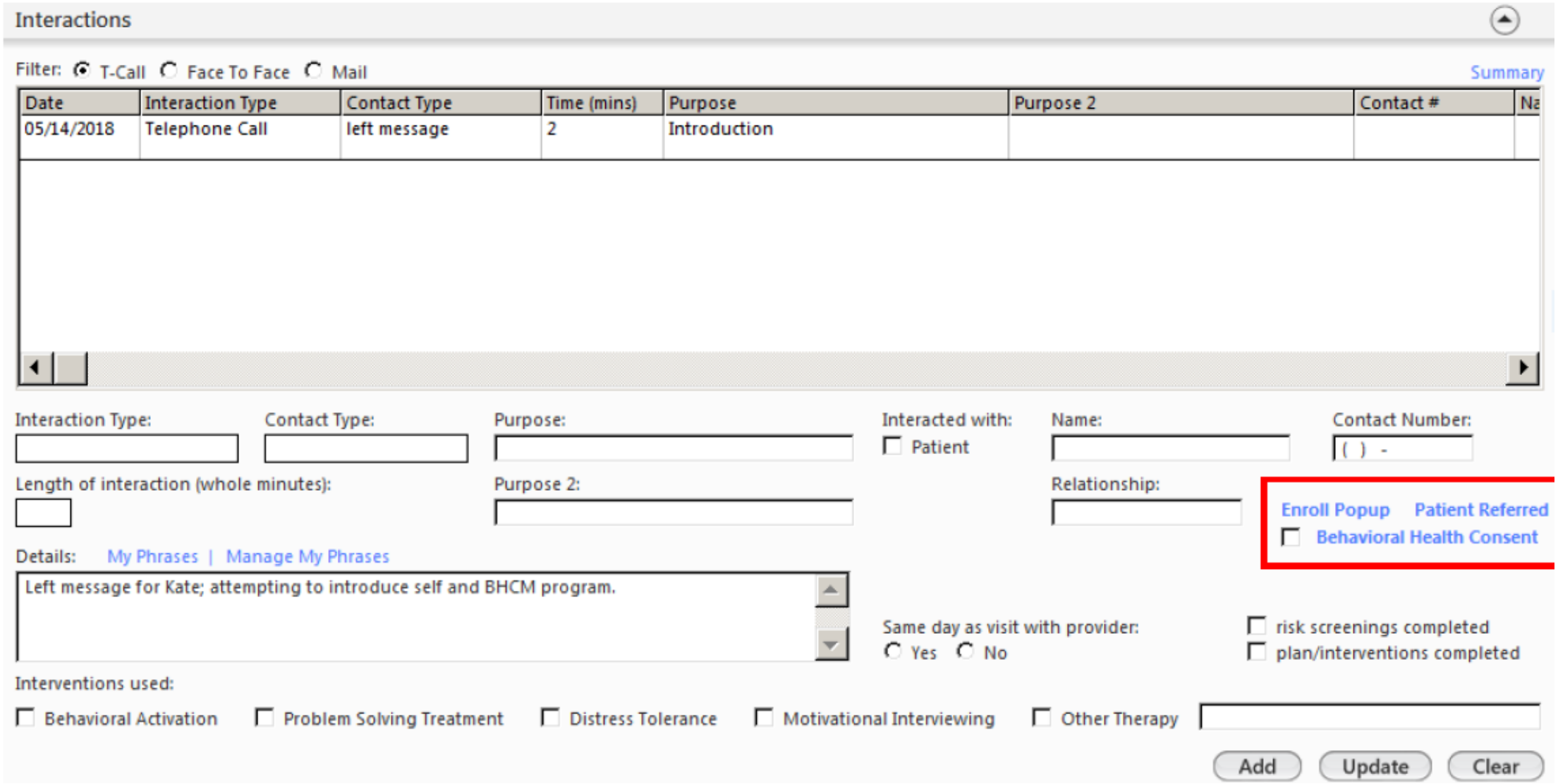
Patient Tracking

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


Interactions
Filter: T-Call Face To Face Mail
Summary
Date
Interaction Type
Contact Type
Time (mins)
Purpose
Purpose 2
Contact #
Interaction Type:
Telephone Call
Contact Type:
outgoing call
Purpose:
Therapeutic Intervention
Interacted with:
Patient
Name:
Patient
Contact Number:
( ) -
Length of interaction (whole minutes):
18
Purpose 2:
Outcomes/Screenings
Relationship:
Enroll Popup
Details:
My Phrases | Manage My Phrases
Worked on distress tolerance using mindfulness and relaxed breathing.
Same day as visit with provider:
Yes
No
risk screenings completed
plan/interventions completed
Interventions used:
Behavioral Activation
Problem Solving Treatment
Distress Tolerance
Motivational Interviewing
Other Therapy


Interactions
Filter: T-Call Face To Face Mail
Summary
Date
Interaction Type
Contact Type
Time (mins)
Purpose
Purpose 2
Contact #
05/14/2018
Telephone Call
left message
2
Introduction
Interaction Type:
Contact Type:
Purpose:
Interacted with:
Patient
Name:
Contact Number:
( ) -
Length of interaction (whole minutes):
Purpose 2:
Relationship:
Enroll Popup
Patient Referred
Behavioral Health Consent
Details:
My Phrases | Manage My Phrases
Left message for Kate; attempting to introduce self and BHCM program.
Same day as visit with provider:
Yes No
risk screenings completed
plan/interventions completed
Interventions used:
Behavioral Activation
Problem Solving Treatment
Distress Tolerance
Motivational Interviewing
Other Therapy
Add
Update
Clear

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

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.

SCR Tool Required Elements

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

SCR Recommended Elements

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

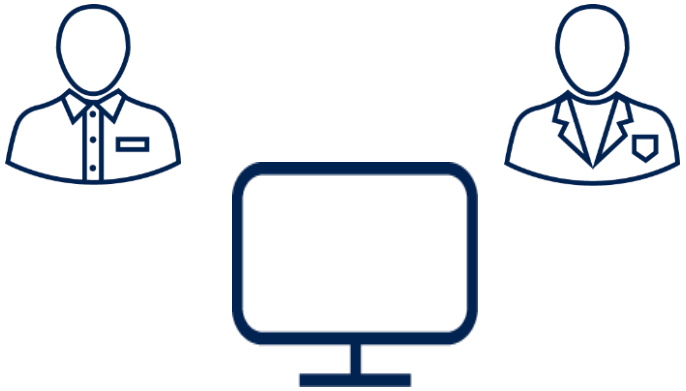
Flags to

1) Discuss in panel review

2) Visualize patients whose condition is improving or worsening; and 3) Indicate patients who would benefit from contact, updated outcome measures, or panel review session

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**

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 panel
    I. Worsening or not improving
    II. Scores in the severe range
    III. Positive score on question 9 on GAD 7
    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

Demonstration

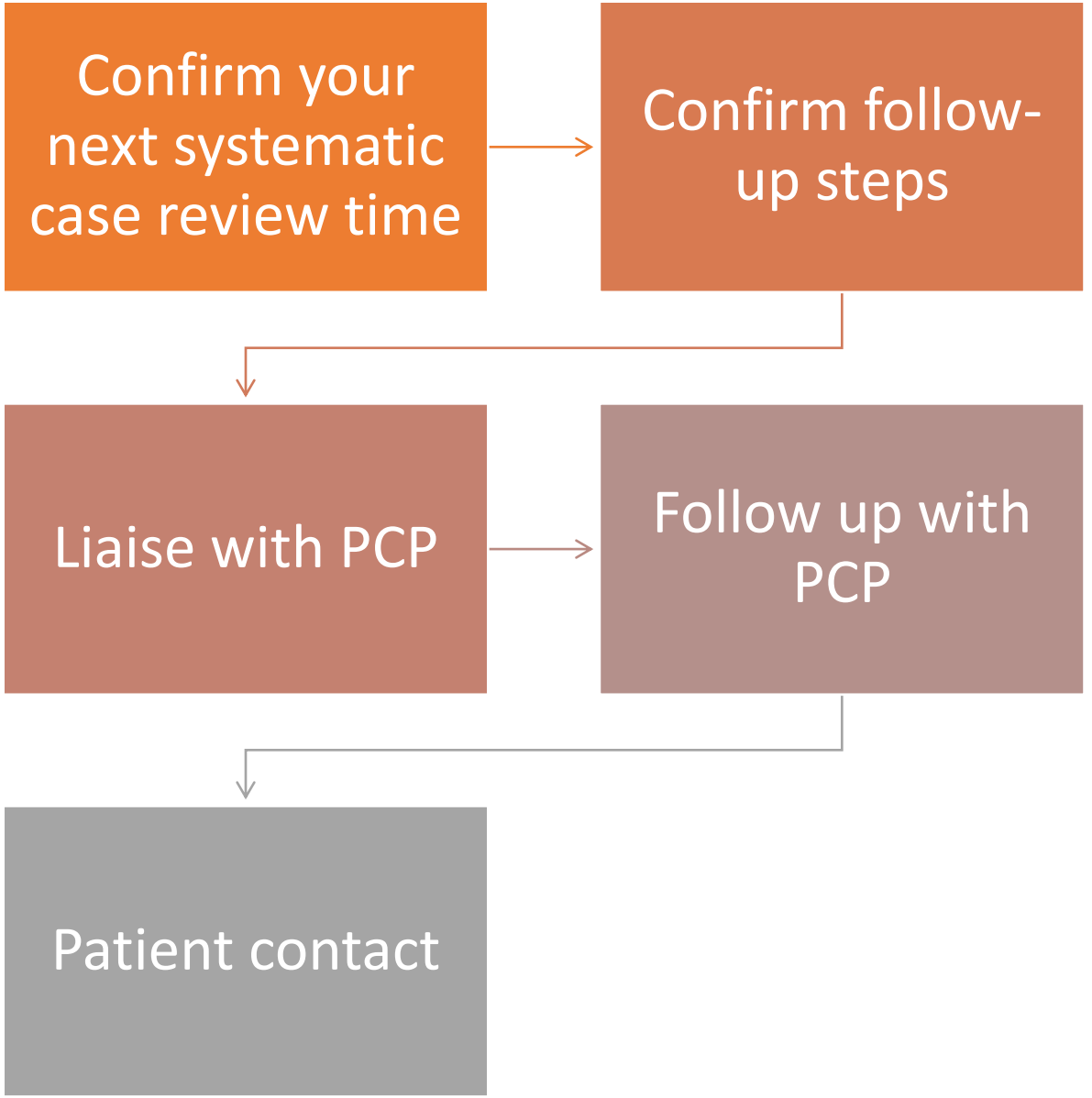
What went wrong

What went well

Patients not responding

- Patients not improving during the critical treatment window should be reviewed with the Psychiatric Consultant in systematic case review

Steps after the Systematic Case Review



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

Questions Around the Systematic Case Review Process

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?