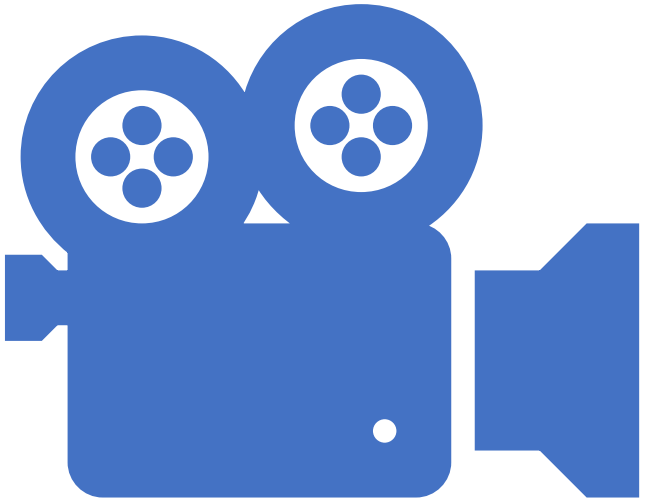
The Collaborative Care Model (CoCM)

Topic	Objectives
Introductions	
The Why **CoCM Model Overview**	• Review the basics of the CoCM model including the evidence behind the model as it relates to the prevalence of mental health needs
The Process of CoCM	• Discuss the process of CoCM from patient Identification to case closure including the use of the systematic case review tool
Team Roles and Responsibilities	• Review the roles and expectations of the CoCM treatment team as well as other team members involved in CoCM in the primary care office and the community
Patient Identification and Tracking	• Discuss the technologies involved in the CoCM process and their application toward population health and treat to target
Billing for CoCM Services	• Review how to bill CoCM services using the CoCM codes
Implementation – what are next steps?	• Illustrate anticipated workflow changes to support CoCM implementation



Virtual Etiquette

- **Video and Audio:**
  - Unless distracting, please turn video ON. This is crucial for building trust and engagement.
  - Test your video and audio before the meeting begins.
  - Try to look at the camera when talking (to mimic the feeling of in-person eye contact).
  - When possible, try to use good camera quality and sound.
  - Adjust your camera if it is too high or low.

- **Meeting:**
  - Please hold off eating during the meeting as it can be distracting.
  - Try not to multitask too much or make sure you're muted.

- **Environment:**
  - Be aware of your backgrounds to not be distracting.
  - Position yourself in the light.
  - Find a quiet place to join or mute yourself as necessary.

Michigan Center for Clinical Systems Improvement (Mi-CCSI)

Who We Are

Regional Non-profit Quality Improvement Consortium

What We Do

Mi-CCSI works with stakeholders to:

- Facilitate training and implementation….
- Promote best practice sharing,
- Strengthen measurement and analysis

Mission

Mi-CCSI Partners to Better Care
We do so through…

- Evidence-based Trainings
- Sustainable Training Impact
- Collaborative and Customized Approaches
- Engaging Heart and Mind
- Enhanced Body Mind Spirit Patient Focus

Vision

Mi-CCSI leads healthcare transformation through collaboration

Michigan Institute for Care Management and Transformation (MICMT)

Who We Are	Partnership between University of Michigan and BCBSM Physician Group Incentive Program (PGIP)
Goal of MICMT	To help **expand** the adoption of and access to **multidisciplinary care teams** providing **care management** to populations served by the physician community in order to **improve care coordination** and **outcomes** for patients with complex illness, emerging risk, and transitions of care.

MICMT
Michigan Institute for Care Management & Transformation

Training and Implementation Support Teams

Who We Are	Michigan Collaborative Care Implementation Support Team (MCCIST) and Michigan Center for Clinical Systems Improvement (Mi-CCSI)
Goal of our teams	To provide ongoing training, implementation support, and ongoing quality improvement to health centers implementing and sustaining the Collaborative Care model.

Mi-CCSI
Center for Clinical Systems Improvement

Michigan Collaborative Care
IMPLEMENTATION SUPPORT TEAM

The Collaborative Care Model

Curriculum developed in partnership with:

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

Michigan Collaborative Care
IMPLEMENTATION SUPPORT TEAM

Mi-CCSI
Center for Clinical
Systems Improvement

Blue Cross
Blue Shield
of Michigan

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MICMT
Michigan Institute for Care Management & Transformation

Disclosure

The Michigan Center for Clinical Systems Improvement (MiCCSI), Michigan Institute for Care Management and Transformation (MICMT), and Michigan Collaborative Care Implementation Support Team (MCCIST) have been contracted by Blue Cross Blue Shield of Michigan for this project.

CME Credit: Physicians, Nurses, Social Workers

- This live series activity, Preparing to Implement Collaborative Care, from 06/10/2020 - 07/31/2020, has been reviewed and is acceptable for credit by the **American Academy of Family Physicians**. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
  - Approved for (1 credit per session) AAFP (Prescribed) credits.
  - AMA/AAFP Equivalency: AAFP Prescribed credit is accepted by the American Medical Association as equivalent to *AMA PRA Category 1 credit*(s)™ toward the AMA Physician's Recognition Award. When applying for the AMA PRA, Prescribed credit earned must be reported as Prescribed, not as Category 1.
- Nurses can use the CME for their state requirements. Information on this can be found on LARA and through the **Michigan Nurse Association** (MNA) at https://www.minurses.org/education-resources/resources-for-practicingnurses/state-of-michigan-ce-requirements/
- This course is approved by the **Michigan Social Work Continuing Education Collaborative**-Approval # 051420-00 The Collaborative is the approving body for the Michigan Board of Social Work

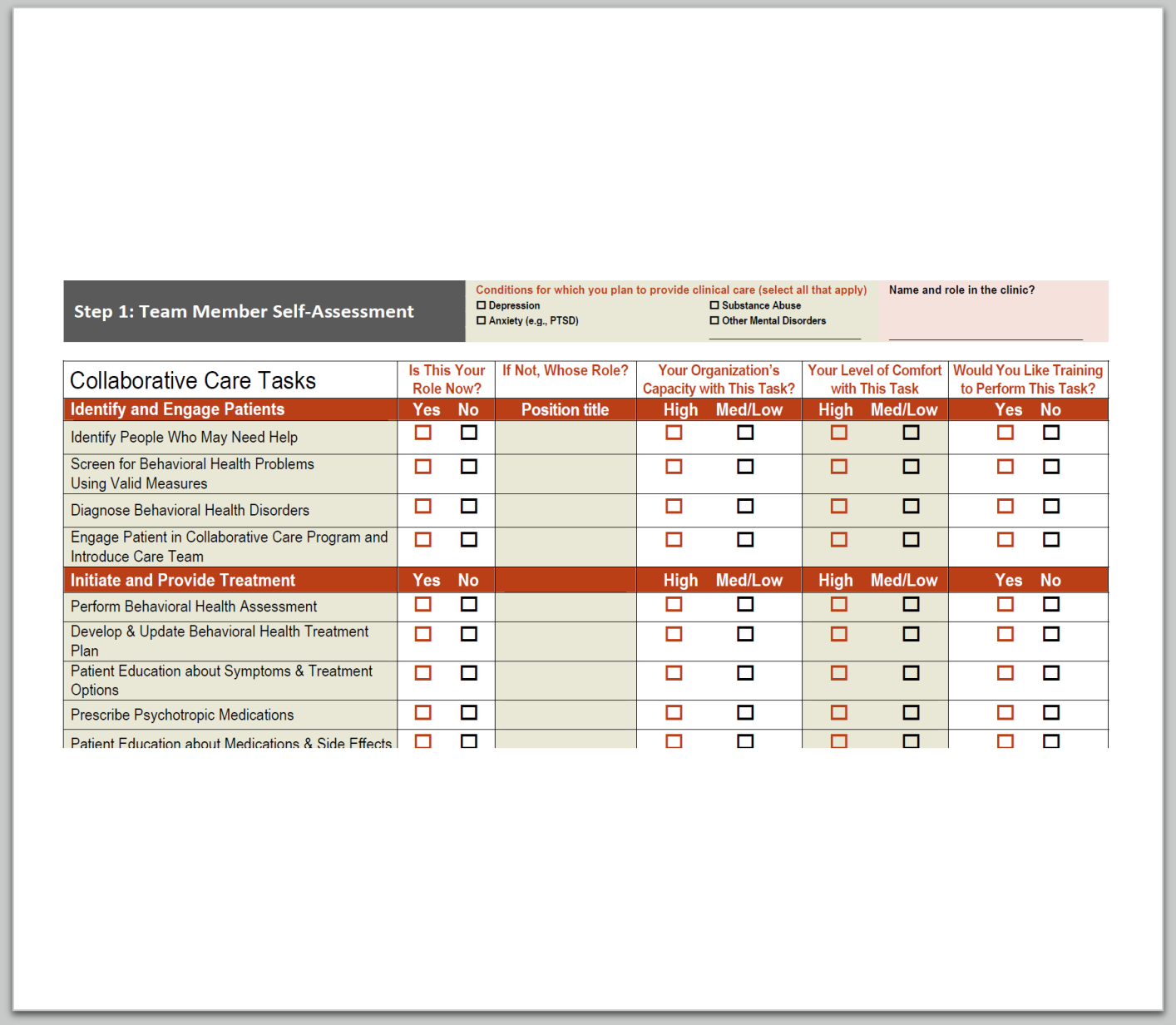
Poll – Who’s here with us today?

Preparing for Today

We will be using the AIMS Checklist Assessment throughout the day, please have this available for use during breakout sessions.

The AIMS Checklist Assessment can be located on our website at https://www.miccsi.org/**collaborative-care-model-training/**

Thank you!



Step 1: Team Member Self-Assessment

Conditions for which you plan to provide clinical care (select all that apply)
☐ Depression ☐ Substance Abuse
☐ Anxiety (e.g., PTSD) ☐ Other Mental Disorders

Name and role in the clinic? _____

Collaborative Care Tasks	Is This Your Role Now?		If Not, Whose Role?	Your Organization's Capacity with This Task?		Your Level of Comfort with This Task		Would You Like Training to Perform This Task?	
Identify and Engage Patients	**Yes**	**No**	**Position title**	**High**	**Med/Low**	**High**	**Med/Low**	**Yes**	**No**
Identify People Who May Need Help	☐	☐		☐	☐	☐	☐	☐	☐
Screen for Behavioral Health Problems Using Valid Measures	☐	☐		☐	☐	☐	☐	☐	☐
Diagnose Behavioral Health Disorders	☐	☐		☐	☐	☐	☐	☐	☐
Engage Patient in Collaborative Care Program and Introduce Care Team	☐	☐		☐	☐	☐	☐	☐	☐
Initiate and Provide Treatment	**Yes**	**No**		**High**	**Med/Low**	**High**	**Med/Low**	**Yes**	**No**
Perform Behavioral Health Assessment	☐	☐		☐	☐	☐	☐	☐	☐
Develop & Update Behavioral Health Treatment Plan	☐	☐		☐	☐	☐	☐	☐	☐
Patient Education about Symptoms & Treatment Options	☐	☐		☐	☐	☐	☐	☐	☐
Prescribe Psychotropic Medications	☐	☐		☐	☐	☐	☐	☐	☐
Patient Education about Medications & Side Effects	☐	☐		☐	☐	☐	☐	☐	☐

Why Care Coordination for Behavioral Health?

1. Chronic behavioral illnesses are not well managed in our acute care system
   - Primary care is set up to manage chronic conditions
     - Measurement is required to track the condition
     - Follow up and treatment adjustments are needed
2. Mental health conditions are chronic conditions (e.g. depression)
   - Most of the care of these conditions is currently happening in primary care
   - We would need 4 times the current specialty resources to meet the mental health needs (pre COVID)
3. We have very strong evidence that the model behind CoCM works better for patients

AIMS CENTER
UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

Why Practice Collaborative Care?

Collaborative care (CoCM) is beneficial to primary care providers (PCPs) and their patients because it offers better medical care, access to psychiatry experts, helps with challenging patient cases, and team collaboration.

1. **Established Evidence Base**
   CoCM has a robust evidence base of over 80 randomized controlled trials and has been shown to be the best approach to treating depression in many populations and settings.

   CoCM has a strong and expanding evidence base for its use with diverse behavioral health diagnoses such as anxiety, posttraumatic stress disorder, chronic pain, and dementia.

2. **Better Medical Outcomes**
   CoCM is linked to better medical outcomes for patients with diabetes, cardiovascular disease, cancer, and chronic arthritis.

   CoCM is recommended as a primary prevention strategy for cardiovascular events in patients without preexisting heart disease (*Psychosomatic Medicine*, 2014).

3. **Help with Challenging Patient Cases**
   Many challenging cases likely have patients with untreated or undertreated behavioral health conditions. Behavioral health providers do the follow-up and intervention tasks that a busy PCP doesn't have time to do, but make a big difference for patients.

   PCPs are generally more satisfied working within an integrated behavioral health care program than within usual care (*Family Community Health*, 2015).

4. **Faster Improvement**
   A 2016 retrospective study at Mayo Clinic found that the time to depression remission was 86 days in a CoCM program while in usual care it was 614 days.

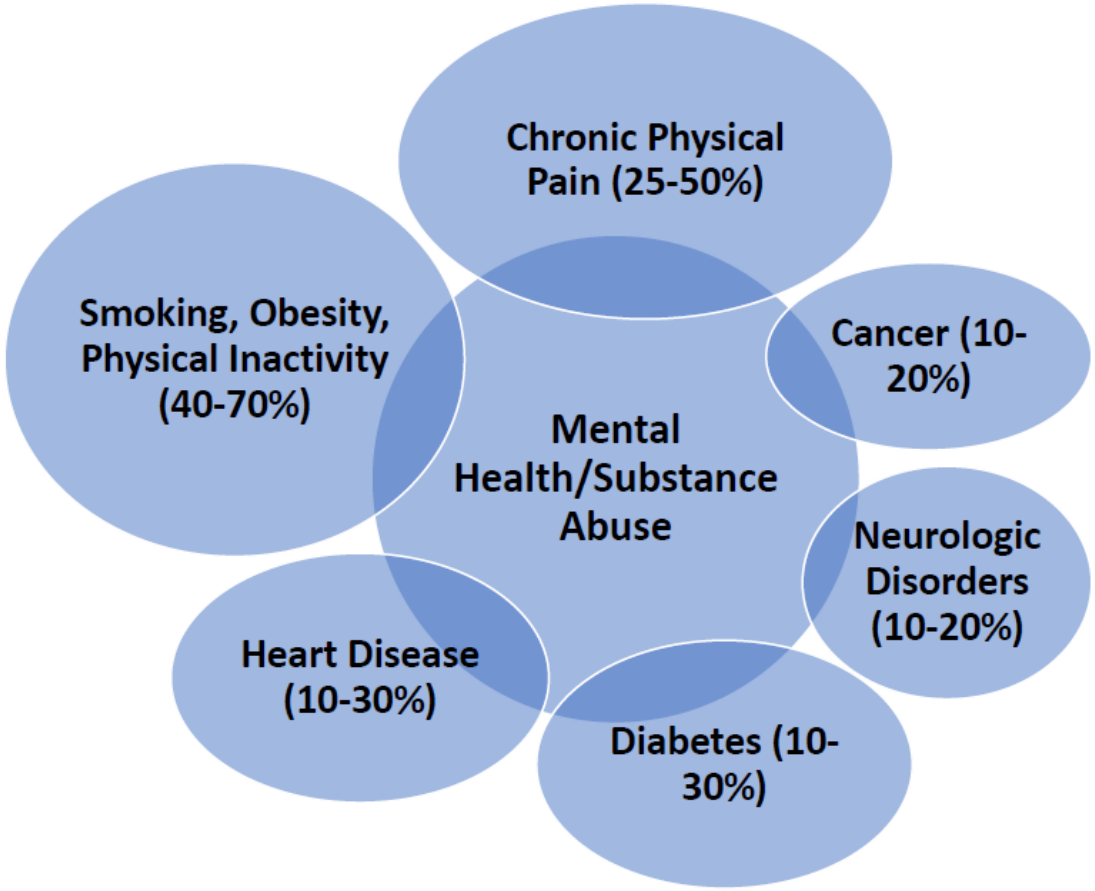
   Analysis of a large CoCM implementation found that early, intense intervention by the behavioral health provider was key to early improvement in patients with depression symptoms (*Psychiatric Services*, 2015).

5. **It Takes a Team**
   CoCM uses an enhanced care team to provide a population based, treat-to-target approach to care. Through shared care planning, the team makes proactive changes in treatment to make sure that no patients fall through the cracks.

   Only 30-50% of patients have a full response to the first treatment. That means 50-70% of patients need at least one treatment adjustment. Additional experts can help.

https://aims.uw.edu/sites/default/files/Why%20Practice%20Collaborative%20Care%20for%20PCPs_121719.pdf

We create a false divide: mind/body. Mental health and medical issues are often together



Little, V,. PhD, LCSW-R, Bodenweber, Z., LMSW (June,10,2018). *Collaboraive Care Taining.* Albany New York

The Evolution of Behavioral Medical Integration

- Need talking points
- Co-location – Collaborative Care
- IMPACT
- TEAMCARE
- DIAMOND
- COMPASS
- Many more

Where is there Evidence for Collaborative Care?

<u>Higher levels of evidence</u>

- Depression
  - Adults and adolescents
  - With medical conditions
  - In a women's health setting
- Anxiety (strongest for panic)
- PTSD
- Chronic Pain
- Substance Use Disorders

<u>Evidence is now being developed</u>

- Bipolar Disorder
- ADHD

Michigan Prior to COVID

- 26% of MI residents report a depression or anxiety diagnosis
  - Higher in Medicaid (59%) and uninsured (33%)
  - Most common among low income residents
    - 40% report a dx in household incomes < $30,000

- PCPs report inadequate MH services
  - 57% for adults, 68% for children

Impact of a Pandemic magnifies the need

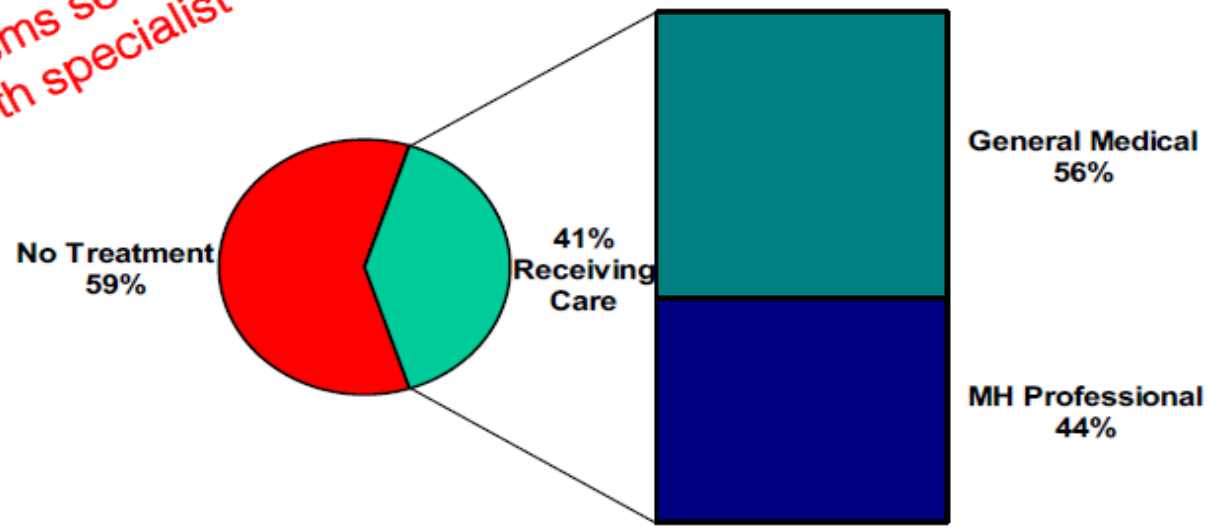
- CDC Morbidity and Mortality Report – August 14,2020
  - Representative panel surveys conducted among 18 and older across the US in June 2020. Results were compared with the year before.
- **Anxiety prevalence was 3X** that in 2019 (24.3% versus 6.5%)
- **Twice as many respondents** (10.7% versus 4.3%) reported **seriously considering suicide** in the previous 30 days (as compared with 2018)
- **1/10** individuals reported **starting/increasing substance use** in pandemic

- More impact in young adults, hispanics, blacks, essential workers, unpaid caregivers for adults, and those already in care for psychiatric conditions.

National Comorbidity Survey Replication

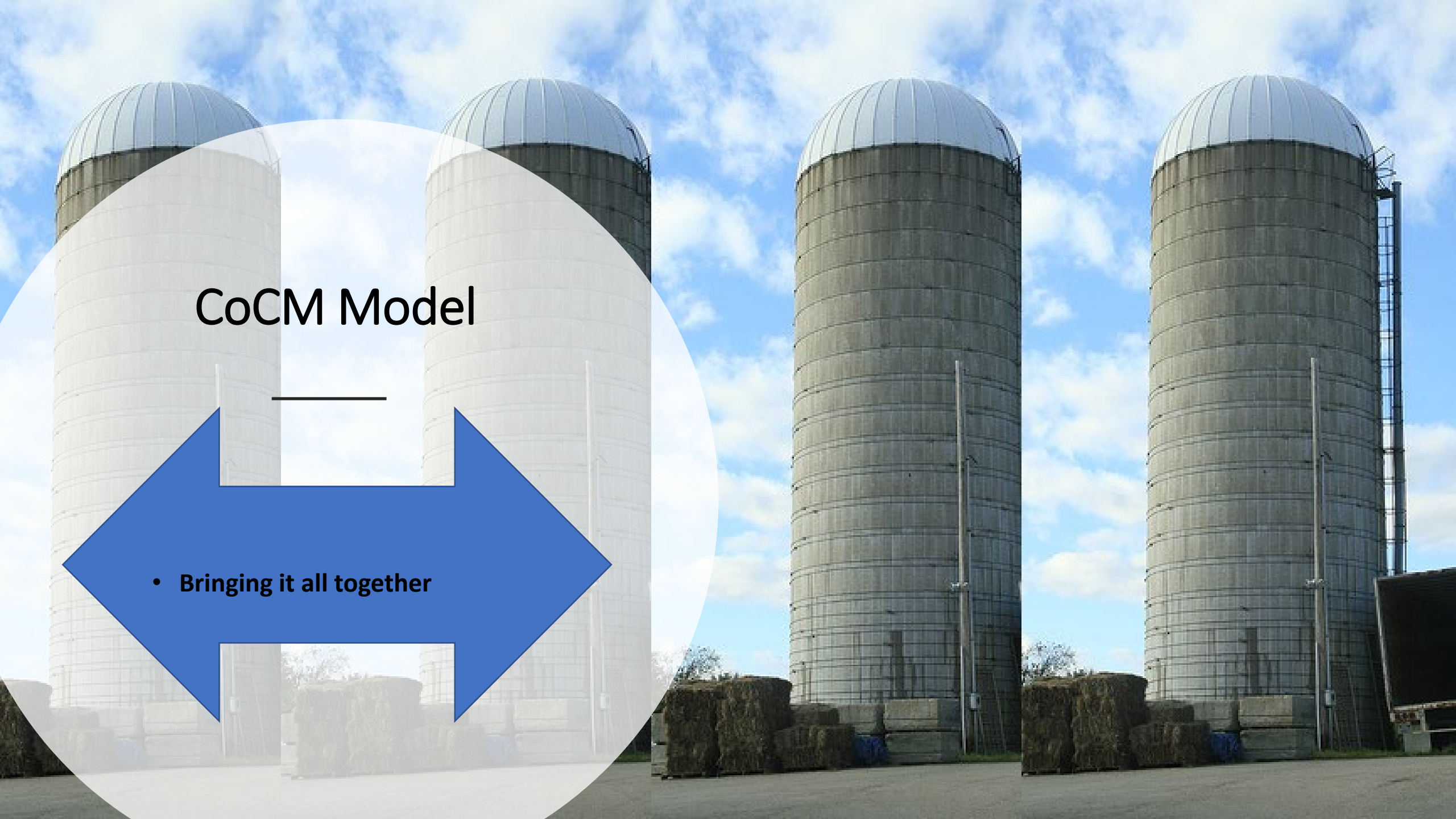
Provision of Behavioral Health Care: Setting of Service

Only 2/10 of patients with diagnosable mental health problems see a mental health specialist



Wang P et al., Twelve-Month Use of Mental Health Services in the United States, *Arch Gen Psychiatry*, 62, June 2005

Traditional Model



CoCM Model

- **Bringing it all together**

How do our PCPs care for patients with Behavioral Health Concerns?

- In a fast-paced environment with competing demands, they manage the best they can
- PCPs prescribe the majority of antidepressants
- Some support with embedded MHPs
  - Typically not population focused
- Refer to Specialty Care
  - Do all patients truly need specialty care?

There Aren’t Enough Psychiatrists

- Shortage of Psychiatrists, long wait times and insurance barriers
- Michigan had 1,180 active psychiatrists in 2018 or 11.84 practitioners per 100,000 residents which is below the national average
- Two-thirds of Michigan Psychiatrists are based in the Ann Arbor-Detroit region
- **Insurance Coverage:**
- 55% of accept insurance vs 89% other physicians
- 55% accept Medicare vs 86% other physicians
- 43% accept Medicaid vs 73% other physicians

University of Michigan Behavioral Health Workforce Research Center. Estimating the Distribution of the U.S. Psychiatric Subspecialist Workforce. Ann Arbor, MI: UMSPH; 2018

CoCM: An Overview

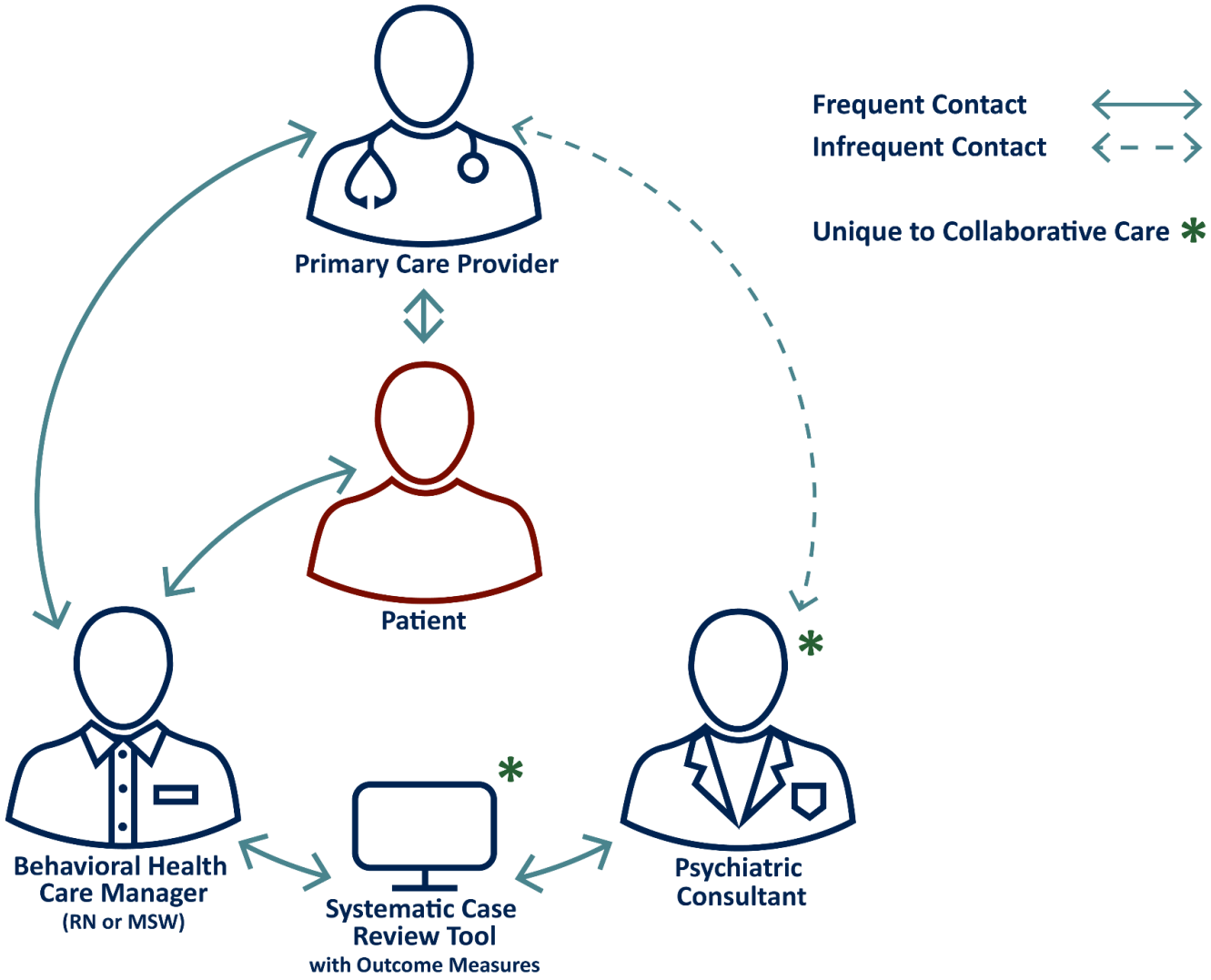
- Most evidence-based integrated behavioral health model
  - 80+ randomized controlled trials prove Collaborative Care provides significantly better behavioral health outcomes than “usual care”
  - 2002: First big trial was published (IMPACT study out of the University of Washington)
- Primary care-based: Meets behavioral heath 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
  - Based on randomized trial with adults over 60

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 can be triaged to higher levels of care

- 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

The Collaborative Care Treatment Team



https://aims.uw.edu/collaborative-care/principles-collaborative-care

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

https://aims.uw.edu/collaborative-care/principles-collaborative-care

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)

Advantages of CoCM

- Objective assessment
- Creates common language
- Focuses on function
- Similar to other health outcomes that are routinely tracked (e.g., BP, A1C)
- Avoids potential stigma of diagnostic terms
- Helps identify patterns of improvement or worsening

What to expect in regard to results?

Original IMPACT trial focusing on depression

- Double response rate at 12 months for depressed adults (45% vs 19%)
  - Same result in all 8 organizations (18 clinics total)
    - Unutzer J. Jama 2002

Mayo experience when implementing the same model

- Three month and six month response significantly better than practice as usual (PAU)
  - Six month response (69% for intervention group versus 53% PAU)
  - Six month remission (53% versus 31%)
    - Both statistically significant
      - Shippee, J Ambulatory Care Management 2013

More Evidence:

- CoCM is linked to better medical outcomes for patients with diabetes, cardiovascular disease, cancer, and chronic arthritis
- Time to depression remission was 86 days in a CoCM program while in usual care it was 614 days
  - Garrison et al, JAM Fam Med, 2016
- A major reason for this has to do with **treat to target**
  - Mayo found that more medication adjustments were made in care coordination than in practice as usual
    - DeJesus et al., Clinical Practice and Epidemiology in Mental Health 2013
- Inertia happens in clinical care – both on the patient side (depressed) and the practice side (busy)

What about anxiety?

- Challenges
  - Anxiety is more than one problem (prevalence of any anxiety as high as 19%)
    - Generalized anxiety, Panic Disorder, Social Phobia, Obsessive Compulsive disorder, PTSD
  - GAD-7 is oriented mostly to generalized anxiety
  - Anxiety is very responsive to therapy (delivered via computer or in person)
- Opportunity
  - A meta-analysis of collaborative care for anxiety (published 2016)
    - Effect size for treating all anxiety disorders was positive but small (SMD = 0.35)
    - Effect size for panic disorder was moderately high (SMD = 0.59)
      - To best address anxiety, need a plan to clarify type and access to therapy.
        - Muntingh, BMC Family Practice, 2016

Other Outcomes

- Satisfaction levels are high
  - Patient satisfaction
  - Provider satisfaction
    - Vickers et al, Gen Hosp Psychiatry 2013.

- BIG CAVEAT – **outcomes depend on proper implementation**
  - Large study on collaborative care in Minnesota (DIAMOND)
  - No different than practice as usual in regards to depression outcomes
    - Big surprise – why?
      - Solberg L. et al, Annals of Family Medicine 2015

MICCSI CoCM Experience
COMPASS CARE RESULTS

Over a mean 11-month follow-up period, among the 3609 patients

- 40% had depression remission or response (50% reduction of reduction of depression symptoms)
- A majority of participants (56%) reported being “very satisfied” with COMPASS care, and there was a significant improvement in satisfaction with depression care
- Assessments of 93 nurse care managers in the COMPASS program found that the patients of care managers who reported spending more time on care management tasks had greater improvements in depression….

CoCM COMPASS CARE PATIENT FINDINGS

Patients who agreed to have their personal information sent to a central evaluation center were contacted to participate in a phone survey about their satisfaction with care before beginning COMPASS care and again 1 year after enrollment

- At enrollment, 48% of patients had moderate depression (as self-reported on the PHQ9), 28% moderate to severe and 25% severe
- In total, 24% of patients experienced depression remission, while 16% experienced response
- Patients with moderately severe or severe depression were less likely to obtain depression remission and more likely to achieve depression response than those with moderate depression
- Depression remission and response rates were generally lower in patients who were enrolled 3 months or fewer compared to patients enrolled for longer periods (remission rates of 11% and response rates of 7% in those enrolled 0–3months vs. remission rates of 19–32% and response rates of 13–22% in those enrolled 6–21+ months, model Pb.001).

Patient and Clinician Satisfaction

- Patients tended to rate their care as “excellent” more often after experiencing COMPASS care (44.6% at 1 year vs. 38.6% at baseline), although this result did not reach statistical significance (OR=1.29, 95% CI: 0.99–1.67)

- There was significant improvement in depression care satisfaction, with 49.7% of patients “very satisfied” with their depression care at 1 year compared to 35.2% at baseline (OR=1.87, 95% CI: 1.42–2.46)

- Clinicians were more likely to be “very satisfied” with resources at 1 year compared to baseline (21.7% vs. 17.4%; OR=1.33, 95% CI; 1.02–1.75). “Very satisfied” care ratings in individual medical groups ranged from 7% to 57% of clinicians at 1 year

Daniel's Story - AIMS