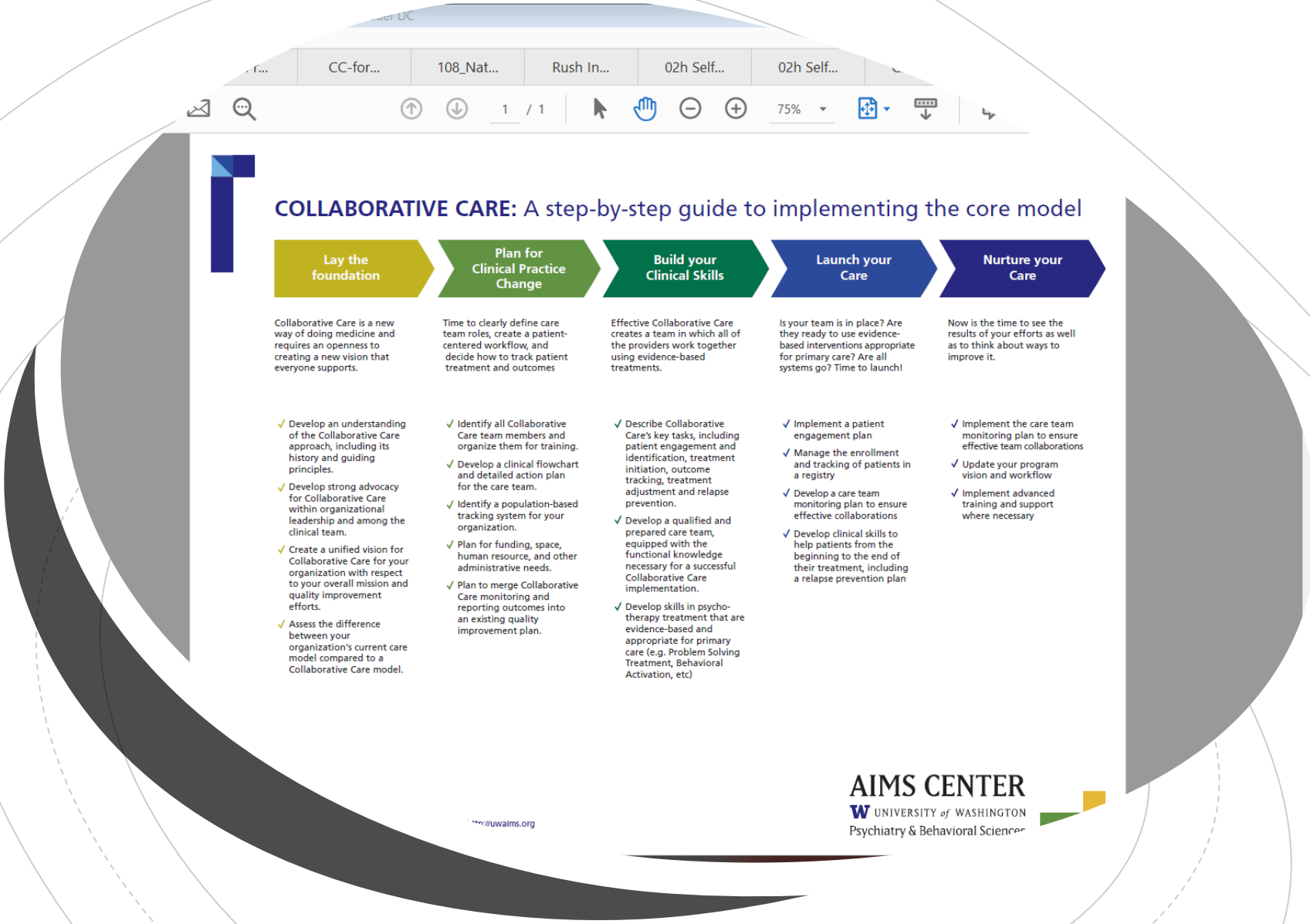
The Process of CoCM

AIMS Team Member Self Assessment

- During this presentation we will be using the Fidelity Assessment Tool.
- It may be found at: https://www.miccsi.org/collaborative-care-model-training/2021-collaborative-care-training-materials/



CoCM
It's a Process

It’s a Team

- PCP – recognize the signs of possible diagnosis, perform/review screening tools, educate, coordinate with BHCM as appropriate
- BHCM – complete assessment to determine appropriateness for CoCM, (functional impairments, need for higher level of care, crisis management)
- Psychiatric Consultant – clarify, refine diagnosis, assist in determining appropriate level of care
- Patient – complete screening tools, self-report of symptoms/problems, agree to provide way to be contacted

Team Approach

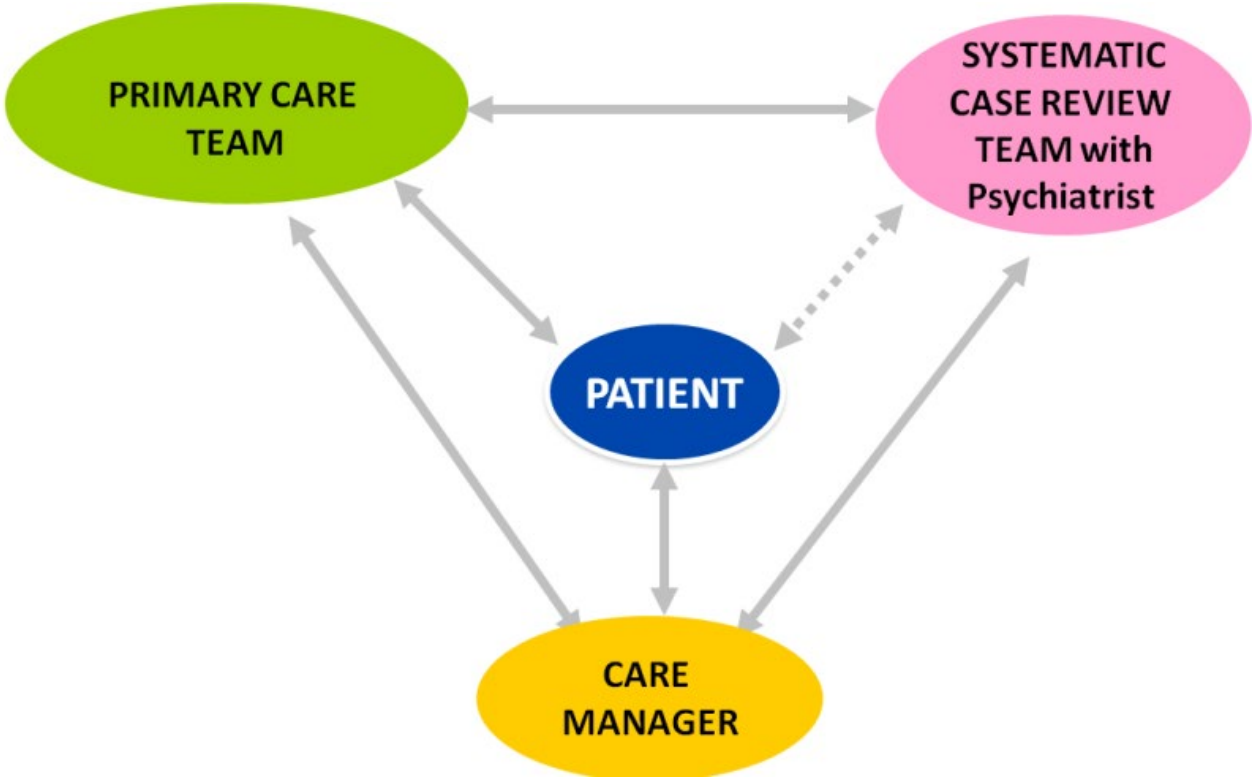
- **Build mutual trust**
  - Uphold role expectations
  - Share patient success stories
- **One treatment plan**
  - Sharing clear goals with treatment team and within EHR
- **Clarify roles and workflow**
  - Establish clear roles that all team members understand (through the entire practice)
  - Review and update workflows as needed
- **Establish Communication**
  - Develop, implement and re-evaluate communication

Steps of CoCM

Patient Identification, Referral, and Appropriateness Assessment	Intake Assessment and Engagement	Systematic Case Review and Psychiatric Consultation	Initiating and Adjusting Evidence-based Treatments (Treat to Target)	Systematic Follow up - Tracking Treatment Outcomes	Completing Treatment and Relapse Prevention

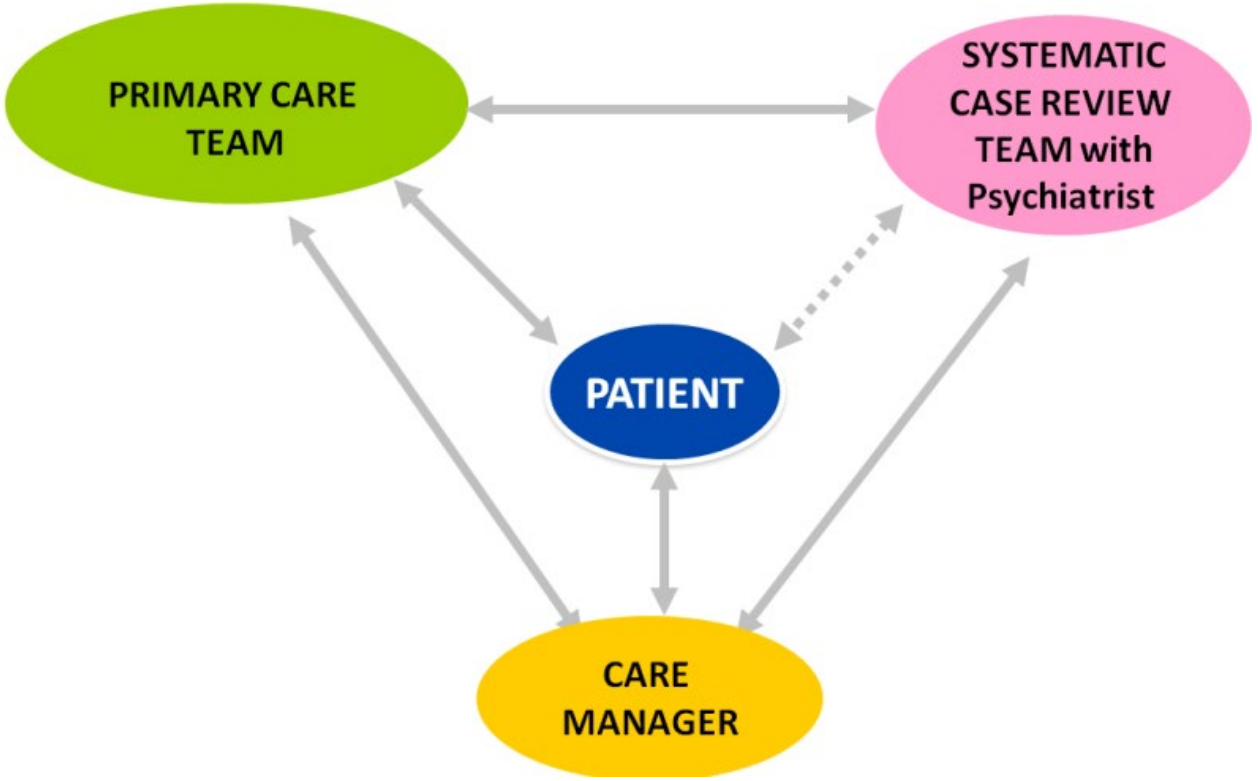
Relentless monitoring and follow up

How Does it Work in the Clinic?



- Patient is seen by Primary Care/show up on eligibility list
  - PHQ-9 and/or GAD-7 score ≥ 10 (moderate)
- Patient introduced to RN care coordinator/contacted
- Patient agrees to participation?
  - More data gathered from patient
    - GAD7, MDQ, AUDIT
    - Past history, social situation, meds, etc.
- Data entered into a **registry** and presented to Psychiatrist (meet once/week) in systematic case review (SCR)

Then What Happens?



- Psychiatrist makes recommendations into the patient chart for the primary care provider
- Primary care provider writes all prescriptions
- Psychiatrist and nurse care manager stay involved until the patient reaches remission
- Patient is discharged back to their primary care team

Going through the Process

- **Patient Identification:** Screening, Registries, Active and Passive outreach
- **Assessment:** Engagement, and Care Planning (self-management action plan and relapse prevention plan)
- **Follow and Monitoring:** Systematic Case Review with the Psychiatrist, Relentless treat-to-target/treatment intensification
- **Case Closure:** Returning to care as usual/community, managing referrals

Identifying Patients for CoCM

- They are identified through the practice
  - At the time of their visit
    - Use of screening tools (PHQ-9 and/or GAD-7) to identify patients at risk
    - Discussion with a primary team member who can make a referral to the BHCM
- Using the disease management registry tool
  - Screening of the population registry tool for the PHQ-9 or GAD-7
    - Create a list or use of a registry which is automatically populated with patients scoring above a threshold
- Use of the practice management system
  - Searching for individuals with a diagnosis of depression/anxiety

Let's Review the Screening Tools Measurement Based Care Tools

- **PHQ- 9** – patient health questionnaire 9-item
- **GAD- 7** – generalized anxiety disorder questionnaire 7-item

  - Both created for use in primary care
  - Translated into multiple languages (https://www.phqscreeners.com/)
  - Meant to be filled out by the patient
  - Both have shorter 2-item versions meant to screen (first two items on the longer tool).

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T____ = ____ + ____ + ____)

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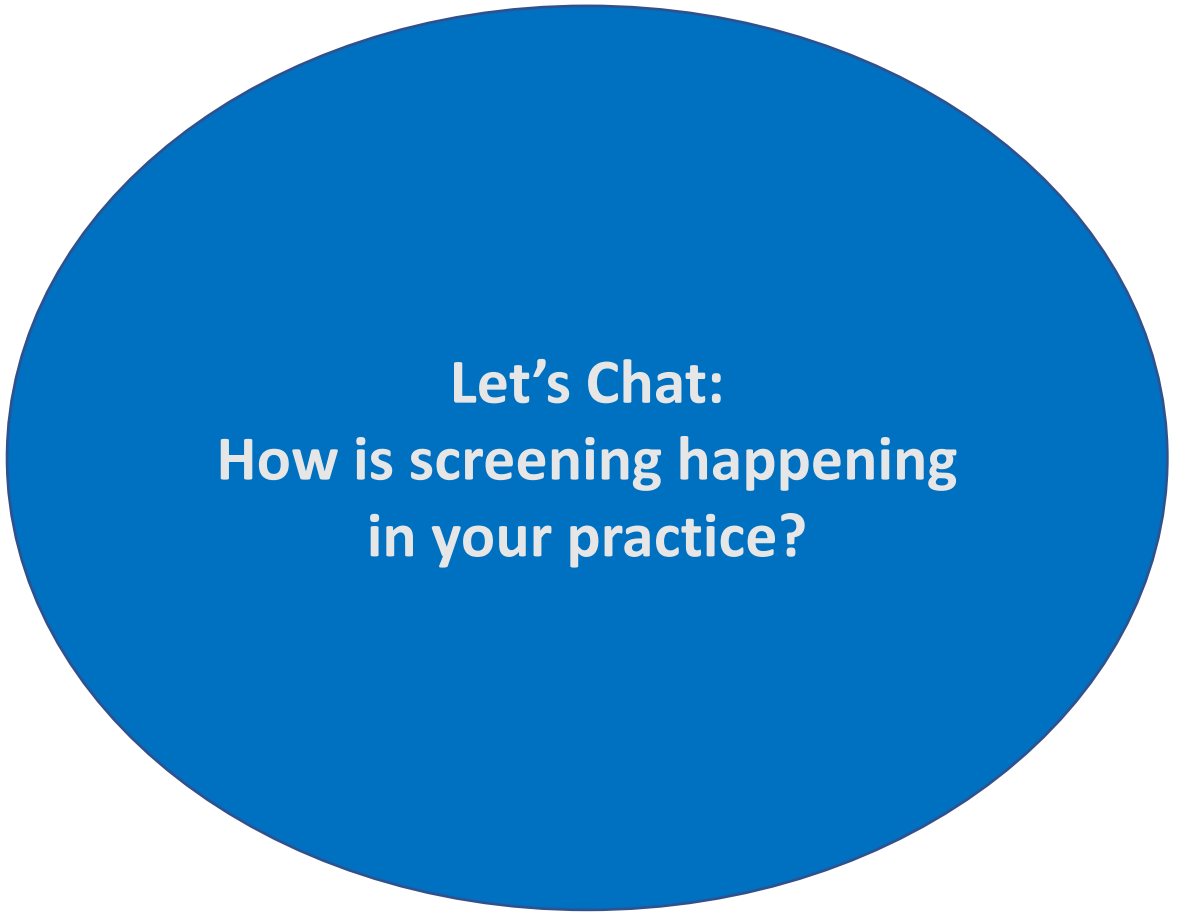
Considerations for Screening

- When will screening happen?
  - Annually, every visit
  - More often for unique circumstances (risk factors, other health conditions, life events, discharged from hospital etc.)
- How will screening happen?
  - Paper form
  - Verbally
  - Waiting room, triage, exam room?
- How will results get communicated to the provider?
  - Through EHR
  - Verbally



How will your clinic identify patient for CoCM?

Discussion on workflows and screening

Diagnosis

- PCP - evaluates potential medical causes/origins of symptoms, orders labs/tests as needed, coordinates with care manager for further assessment
- BHCM – completes full assessment, (including screening for substance use), communicates relevant information to PCP, consults with Psychiatric Consultant during panel review
- Psychiatric Consultant – provides expert guidance on diagnosis as needed
- Patient – provides information about history and symptoms

Considerations:

- Cognitive deficits
- Acute safety concerns
- Psychotic symptoms
- Symptoms due to a medical condition
- Substance use disorder
- Significant trauma history

Introducing the Model

Provider introducing the model and referring to the BHCM

- "We provide services here that help with symptoms of _____. I have a member of my team, *name* ____ that I work closely with that helps a lot of my patients who are experiencing these symptoms. She/he and I work together to provide you with treatment options to help you improve and manage your symptoms. There is also another member of our team, Dr. name__ that we consult with. He/she is an expert in mental health and will help us determine the best treatment. (you won't actually see this doctor). We know that every person is different so we'll develop a plan together that works for you. Our goal is for you to feel better as soon as possible."

Warm Handoff to BHCM

If available, Warm Handoff

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

- Call/ask BHCM for exam room drop-in

The Warm Handoff is very effective

- Leverages engagement and trust that patient has with PCP
- Fosters familiarity with new team member
- Offers opportunity for further assessment

If BHCM is not available:

- Send chart/note for outreach
  - If choosing this option, make sure patients
    are aware that they will be receiving a phone call

Share with the Patient – Listen to the Introduction for the following:

- The patient is an important part of the team
- All team members share one treatment plan to support patient centered goals
- The PCP will oversee all aspects of care received at the practice
- The BHCM works closely with the PCP to implement the treatment plan/self-management plan while keeping track of progress and providing additional support
- The psychiatric consultant does not see the patient face to face, but provides guidance for the team
- This is not typical therapy. The contacts will be shorter and often by phone.

Demonstration of Introduction to CoCM

Activity

Challenges of Engagement

- When talking with patients about mental health there may be challenges:
  - Lack of understanding of diagnosis
  - Inability to tie current behavior to mental health condition
  - Stigma
  - Preexisting beliefs about psychiatric medications and mental health treatment
  - Religious/cultural beliefs

Keeping the depressed or anxious patient engaged in the 1st contact – drop out is common

- **50% patients stop their medications prematurely in regular practice**
  - The Primary provider needs to "**talk up**" the program
    - "this is the way we manage depression and anxiety in our clinic"
    - "I have a lot of confidence in my care manager"
  - **Warm handoffs** are ideal if possible
    - The patient or care manager may not be available but seeing someone's face makes a difference – how to do this in a pandemic?
      - Having a card or handout that shows the picture of the care manager helps
  - In the use of the CoCM codes, the PCP may need to put a note in the record
    - Who will mention the possibility of a fee?

When is a Relapse Prevention Plan Needed?

Start working on the relapse prevention at the beginning of CoCM – A tool to support the patient with his/her ability to self-manage

- An Opportunity to record the response to treatment for future reference
  - What worked well
  - Didn't work well
  - Addressing barriers

- Prepares the patient for discharge from CoCM and includes information they've been hearing all along

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Suicidal Ideation Concerns

Suicidal ideation is a common symptom of depression diagnoses

- Important to know when immediate intervention is needed

  (PHQ-9 question 9 – ***Thoughts that you would be better off dead or of hurting yourself in some way***) – a positive score does not mean a patient is immediately in danger of suicide
- **A workflow for suicide prevention should be built into any Collaborative Care model –** you probably have a plan for chest pain…

Suicide Experience

- Poll

Suicide Plan Key Components

ALWAYS:

- Remain with the patient (in person or on the phone)
- Alert additional office staff for assistance
- Assess immediate risk
  - INTENT
    - The patient is thinking about killing / hurting self
  - PLAN
    - The patient has thought about how to go about completing suicide
  - MEANS
    - The patient has acquired the means for suicide: guns, stash of pills, equipment, etc

**See example of safety plan and protocol in hand-outs

Break

10 – 15 minutes

BHCM Interventions

- BHCMs will engage and support the patients:
  - Motivational Interviewing
  - Shared Problem-Solving
  - Behavioral Activation
  - Medication Monitoring
  - Psychoeducation

Creating the Assessment Tool

Meet and gather key components from the Provider(s) and the Psychiatric Consultant

If the assessment tool is not comprehensive, it will impact efficiency of the Systematic Case Review

The BHCM Assessment

The BHCM completes a comprehensive behavioral health assessment with the patient

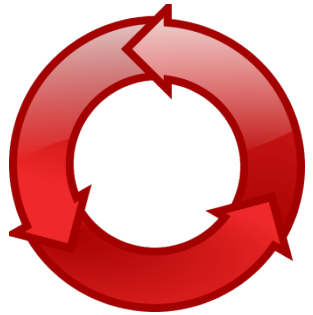
- The initial assessment may take up to 45 minutes
  - Components of the initial assessment includes pertinent medical and behavioral health treatment experience, history, and pertinent clinical parameters
  - The BHCM will identify the patients concerns, beliefs, needs, strengths and desire to incorporate into the patient self-management action plan

- After the initial assessment the BHCM will present the patient's case at the SCR for input and considerations for treatment of the depression/anxiety

The Role of the Psychiatric Consultant

- Following the assessment by the CoCM, the patient is added to the systematic case review tool and reviewed with the Psychiatric Consultant during systematic case review. Treatment recommendations, including psychotropic medications are made.
- The Psychiatric Consultant can also provide assistance with diagnosis and help distinguish a patient's appropriateness for CoCM.
- In weekly SCR, the psychiatrists and care manager review the BHCM case load and prioritize those patients who are not improving and continues to provide treatment recommendations as indicated
- The Psychiatric Consultant acts as an educator to the BHCM and PCP.
- Assist in delivering evidence-based treatment, triaging, and answer questions from the care manager or PCP on these patients between meetings.

Treatment Steps



- Initiate treatment
- Track Treatment
- Follow-up contacts and progress of treatment/self-management plan
- Adjust Treatment
- Assess patient’s improvement as defined by: PHQ-9 and GAD-7
- Adjust treatment accordingly
- Conclude Treatment
- Relapse Prevention Planning or transition to community resources

Registry vs Systematic Case Review Tool

- **Disease registry**
  - Population Health Tool: Captures measures for chronic conditions
    - Diabetes (A1C, BP, Retinol Eye Exam, Proteinuria)
    - Hypertension (BP)
    - Depression (PHQ 9)
    - Anxiety (GAD 7)

- **Systematic Case Review tool**
  - A care management tracking tool
    - Date of enrollment and disenrollment (discharge from BHCM)
    - Date(s) of f/u with the patient
    - Level of PHQ9/GAD 7 at enrollment and at f/u intervals
    - Status (active, inactive, relapse)

Systematic Case Review Tool – Why?

- Population Health – no one falls through the cracks
- Easy reference for caseload management
- Easily facilitates systematic case review
- Tracks patient engagement (dates of contact etc)
- Tracks screening tool scores, PHQ-9 and GAD-7
- Identifies patients who are not responding to treatment

Systematic Case Review – Critical Aspect

- This should happen every week
  - At Mayo – 2 hours per 0.8-1.0 FTE BHCM
- Review new patients first
  - Come up with a plan and get it off to the patient and PCP
    - Note in record by the psychiatrist based on data gathered from BHCM
- Review those needing more attention
  - At Mayo – every patient needs a deeper review once/month
    - documented in the record by the psychiatrist
- Finally, 'run the list' of all remaining patients to watch for issues
  - Someone hospitalized or in the ED? – no note unless a recommendation.

Systematic Case Review Tool

					Plan Type												Optional				
	First Name	Last Name	Birthdate	Gender	DUMMY IDENTIFIER	Comm PPO	MAPPO	BCN	BCNA	Other	NON-BCBS	Date of Referral to CoCM (DD/MM/YY)	Enrollment in CoCM (Y/N)**	If No, Reason (Refusal, No Response, Other)	Baseline PHQ9 Score (0-27)	Date of Baseline PHQ-9 Score (DD/MM/YY)	Most Recent PHQ 9 Score (0-27)	Date of Most Recent PHQ-9 Score (DD/MM/YY)	Baseline GAD-7 Score (0-21)	Date of Baseline GAD-7 Score (DD/MM/YY)	Most Recent GAD-7 Score (0-21)	Date of Most Recent GAD-7 Score (DD/MM/YY)
Blue Cross patients																						
Non-Blue Cross patients																						

** If response is no, please complete the reason column, but there is no need to fill out the PHQ-9/GAD-7 scores

This tool includes the minimum of what would be tracked in a SCR CM Tracking tool. The fields also align with the reporting to BCBSM.

Treat to Target

Be prepared to adjust the treatment plan until targets are achieved

- Monitor patient's progress
- Provide robust outreach to the patient
- Assess patient's adherence throughout treatment
  - make adjustments as indicated
- Proactively seek consultation

What Improvements are we looking for?

- **Improvement**
  - **A 5 point decline in PHQ 9 and/or GAD 7 scores,**

OR

- **Response**
  - **A 50% reduction in PHQ 9 and/or GAD 7 scores,**

OR

- **Remission**
  - **A PHQ 9 or GAD 7 score less than 5**
  - **Remission is associated with lower risk of relapse**

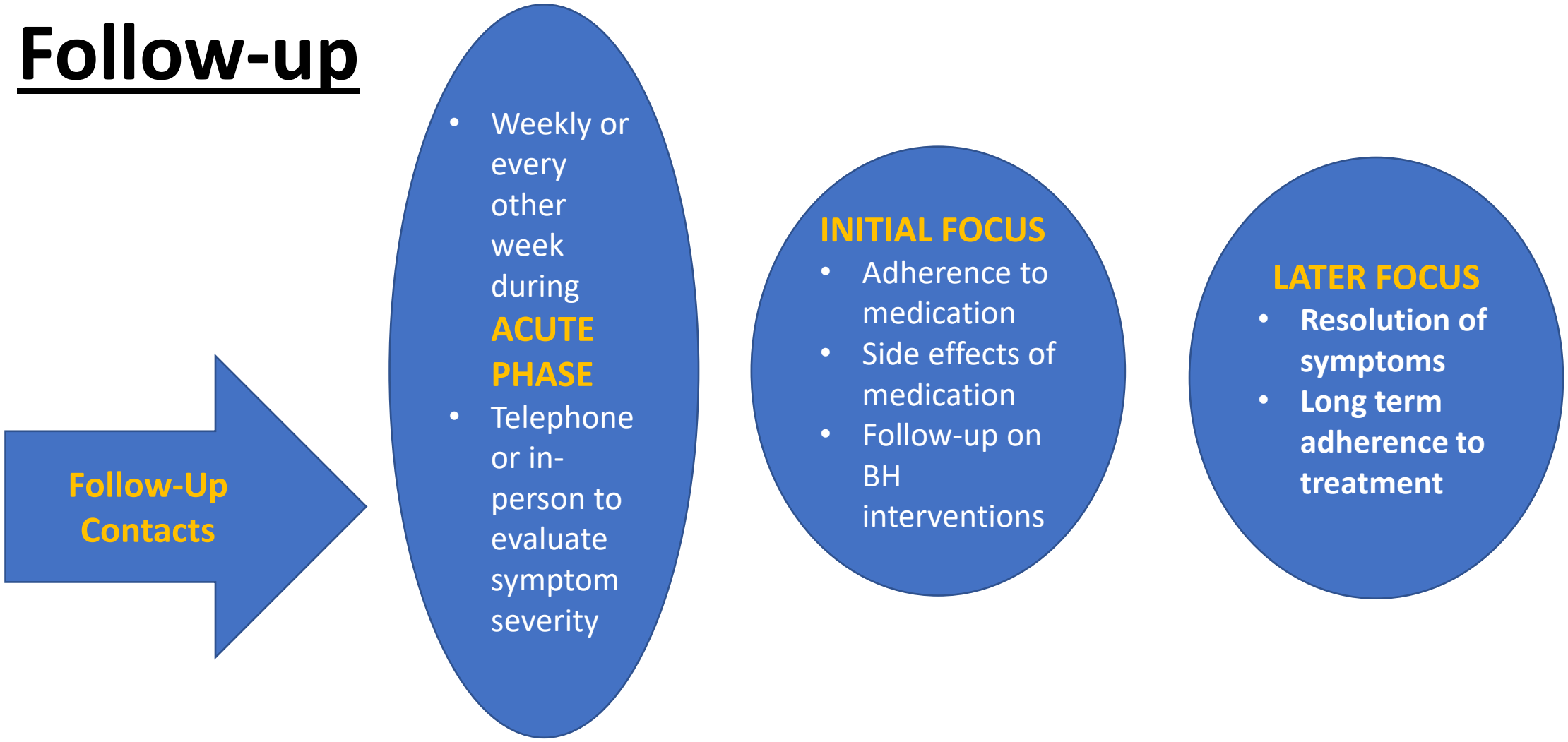
Treatment Plan

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

Initial Treatment Planning

- **PCP** – Completes medical assessment as needed, initiates appropriate treatment with BHCM, prescribes initial medication trial, provides support to patient regarding treatment and communicates with BHCM
- **BHCM** – Provides psychoeducation about anxiety and depression, coordinates with team to create integrated treatment plan, provides brief behavioral intervention and follow-up plan
- **Psychiatric Consultant** – supports treatment planning and guides treatment decisions as needed, supports medication concerns, helps guide needed referrals
- **Patient** – Learns about anxiety/depression and treatments options, works with team to develop a plan that reflects goals

Follow-up


Follow-Up Contacts
Weekly or every other week during ACUTE PHASE
Telephone or in-person to evaluate symptom severity
INITIAL FOCUS
Adherence to medication
Side effects of medication
Follow-up on BH interventions
LATER FOCUS
Resolution of symptoms
Long term adherence to treatment

Self-Management Plan

- Self-management plans are defined as ‘structured, documented plans that are developed to support an individual patient's self-management of their condition

Sample: Depression Management Self-management tool

**See hand-out

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

Higher Level of Care – Varies with access

- Patients with:
  - Severe substance use disorders
  - Active psychosis
  - Developmental disabilities
  - Personality disorders requiring long-term specialty care
  - Those failing to respond to multiple treatment attempts
- Current CMH consumers or persons requiring CMH-level services

Case Closure

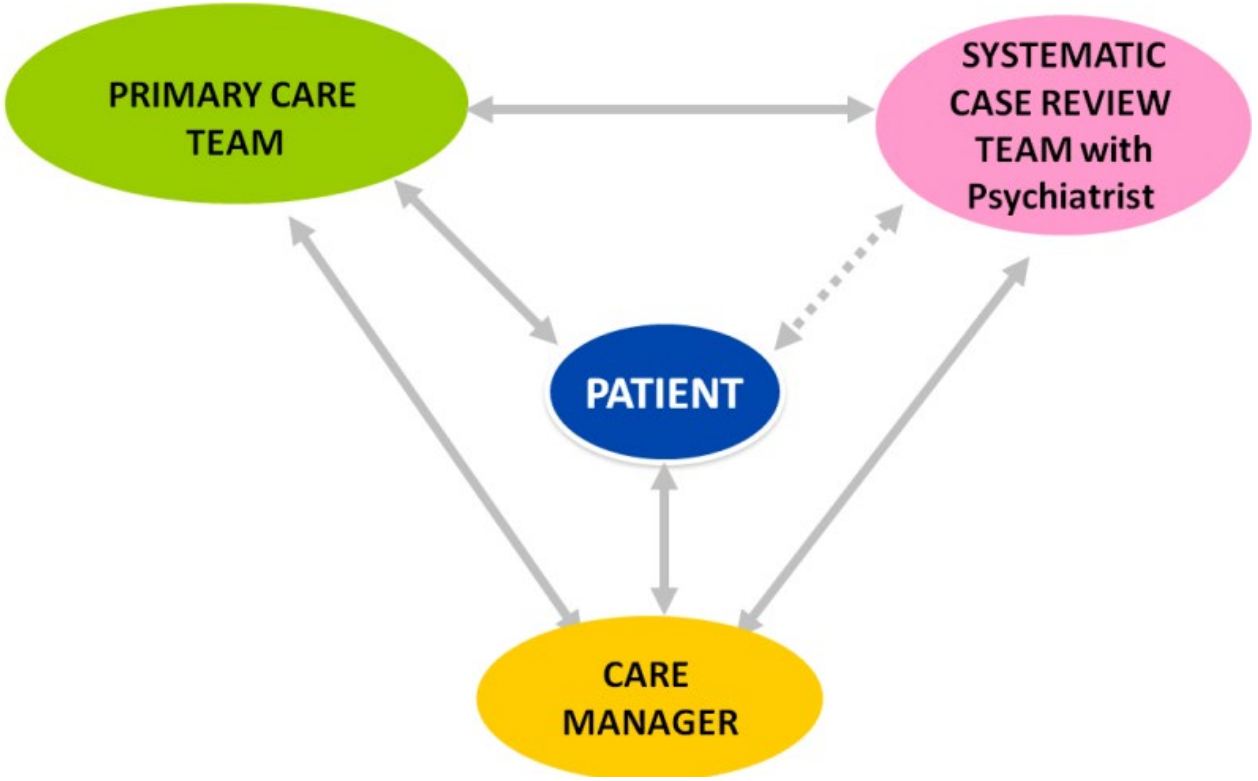
- Completing treatment and return to care as usual
  - PCP team for ongoing population health monitoring
  - Return to other community providers
  - Preparing the patient for self-management
    - Review of the relapse prevention plan
      - Recognizing relapse
      - Awareness of steps and actions to take
      - Who to call if symptoms persist

Referrals

Transition to Community Resources:

1. Patient not getting better
2. Conditions requiring special expertise
3. Conditions requiring longer-term care
4. Need for recovery-based services (people with serious and persistent mental illness)
5. Patient request

Systematic Case Review



DEMONSTRATION ACTIVITY

Case Study Follow Along – In Hand-outs

Initial Care Manager Note

Initial Psychiatrist Note

Follow up Care Manager Note

Follow up Psychiatrist Note

Using the SCR Tool

						Plan Type												Optional			
	First Name	Last Name	Birthdate	Gender	DUMMY IDENTIFIER	Comm PPO	MAPPO	BCN	BCNA	Other	NON-BCBS	Date of Referral to CoCM (DD/MM/YY)	Enrollment in CoCM (Y/N)**	If No, Reason (Refusal, No Response, Other)	Baseline PHQ9 Score (0-27)	Date of Baseline PHQ-9 Score (DD/MM/YY)	Most Recent PHQ 9 Score (0-27)	Date of Most Recent PHQ-9 Score (DD/MM/YY)	Baseline GAD-7 Score (0-21)	Date of Baseline GAD-7 Score (DD/MM/YY)	Most Recent GAD-7 Score (0-21)	Date of Most Recent GAD-7 Score (DD/MM/YY)
Blue Cross patients																					
Non-Blue Cross patients																					

** If response is no, please complete the reason column, but there is no need to fill out the PHQ-9/GAD-7 scores

FAQ – Now and Later

- Should we work with a patient in CoCM if they are already working with a psychiatrist?
- What about liability for the psychiatrist?
- How much detail should be in the psychiatric note?
- Does a psychiatrist have to be available outside of the SCR?
- How many patients can a BHCM follow?
- Does the program overly stress medications for depression?

Questions