The Collaborative Care Model (CoCM)

The Behavioral Health Care Manager

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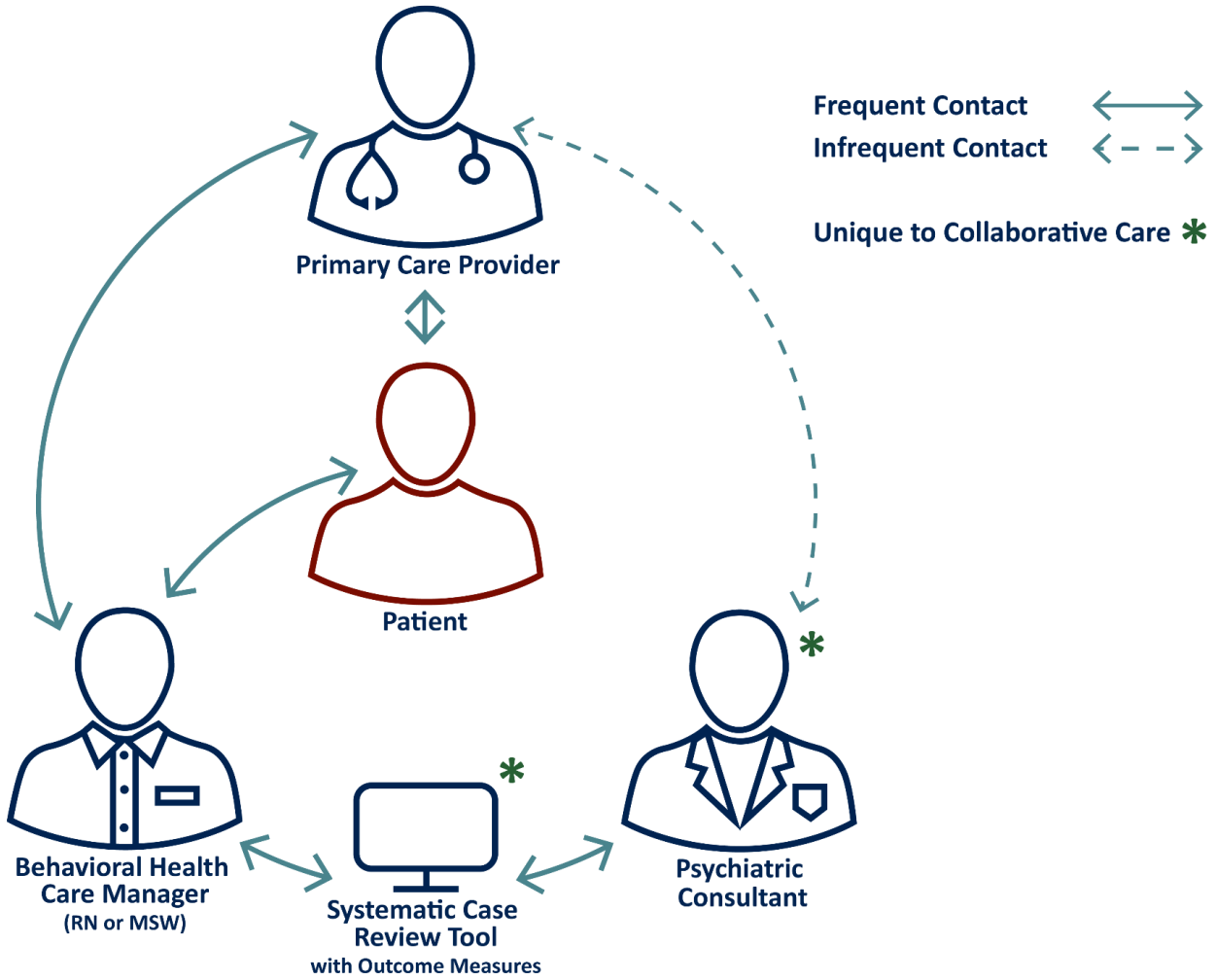
The Role of the BHCM

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

The Collaborative Care Treatment Team



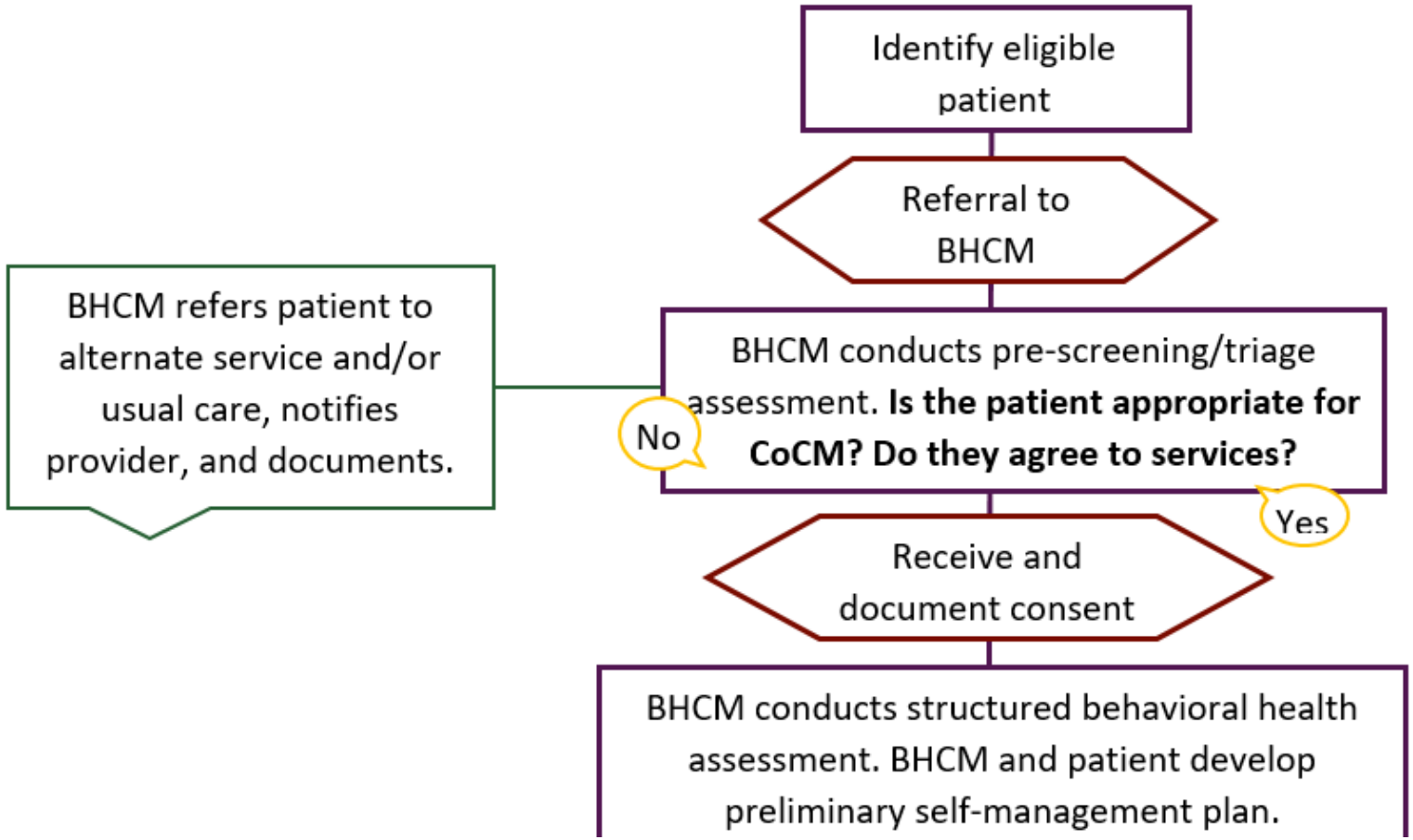
The BHCM is the Glue that keeps the TEAM together

What the BHCM Does…

- Coordinates the overall effort of the treatment team and ensures effective communication among team members
- Provides the psychiatrist advice to the patient's provider, and based on the final decision of the provider shares the treatment plan with the patient
- Between provider visits, regular medication monitoring and psychoeducation
- Offers brief behavioral health interventions (using evidence-based techniques such as motivational interviewing, behavioral activation, and problem-solving treatment)
- Co-creates the relapse prevention plan with the patient
- Participates in systematic case review; Close collaboration with the provider and 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
- Engage with the patient – introduce your role and value of CoCM to the patient
- Screening Assessment -
  - Assess appropriateness for CoCM
  - If appropriate, complete biopsychosocial assessment including diagnostic criteria, medical/medication history
- Initiate treatment – identify available treatment interventions, develop care plan and self-management goals, set stage for relapse prevention planning
- Track treatment progress over time – administer PHQ-9 and GAD-7 throughout treatment
- 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,
- Where PCP is only seeking prescribing guidance and the psychiatrist is willing, consider an e-consult (as a billable service)

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

Introducing CoCM to Patients

Demonstration: Care Manager to Patient

- 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**
- **Include key talking points**
  - **Warmly greet**
  - **Ask permission**
  - **Understanding of the reason for the referral and with permission fill in gaps**
  - **BHCM relationship with the patient’s primary care provider team and team concepts to include the psychiatrist role**
  - **Value to the patient and their role**
  - **What to expect ie frequency and timelines**
  - **Open communication to encourage questions**

- **Identify someone in the group to share with the group at large**

Time Allotted – 30 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
- Bipolar is challenging and requires consideration

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

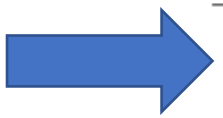
- INTRODUCE: “Along with your physical vital signs like your blood pressure and heart rate, I am also going to ask you some questions about your mood.”
- NORMALIZE: “These are questions we ask all of our patients.”
- EXPLAIN: “Your answers will help your doctor know what to focus on so he/she can give 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

- Conducting the Patient Health Questionnaire
- A screening tool
- Commonly used and validated screening tool for depression in adults
- As a monitoring tool
- Frequency

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)

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."
  - "You mentioned you've been feeling down; could you share more about how that's been impacting your daily life?"
  - "What has been your experience with depression/anxiety in the past?"

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 – consider timing, comfort and engagement when addressing this
  - 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:

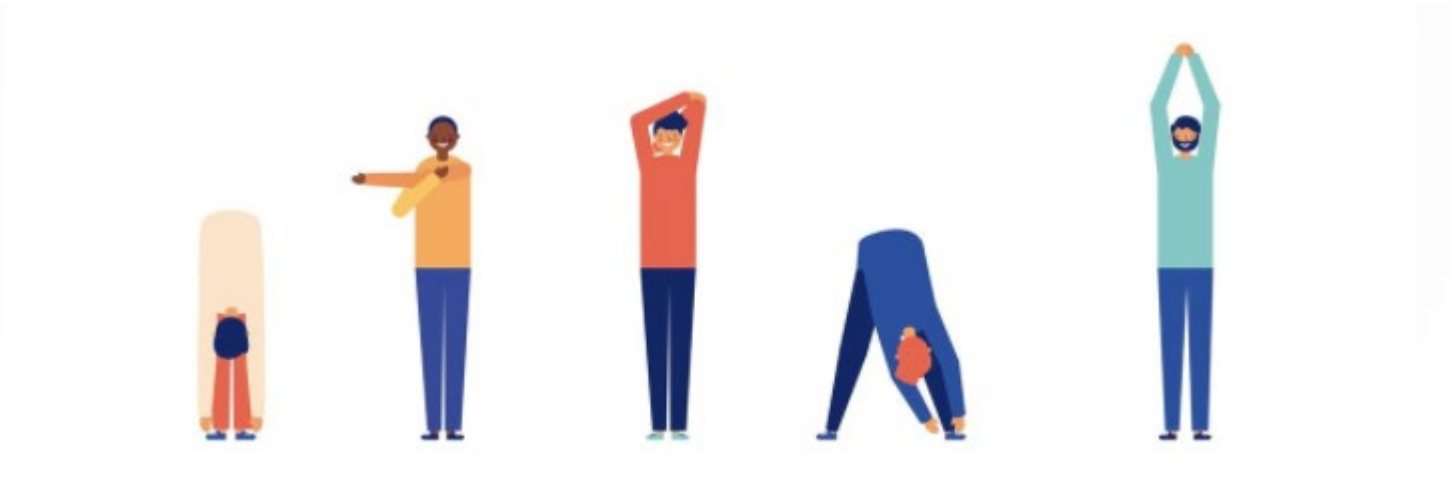
1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services_____
   Urgent Care Services Address_____
   Urgent Care Services Phone_____
4. Suicide Prevention Lifeline 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

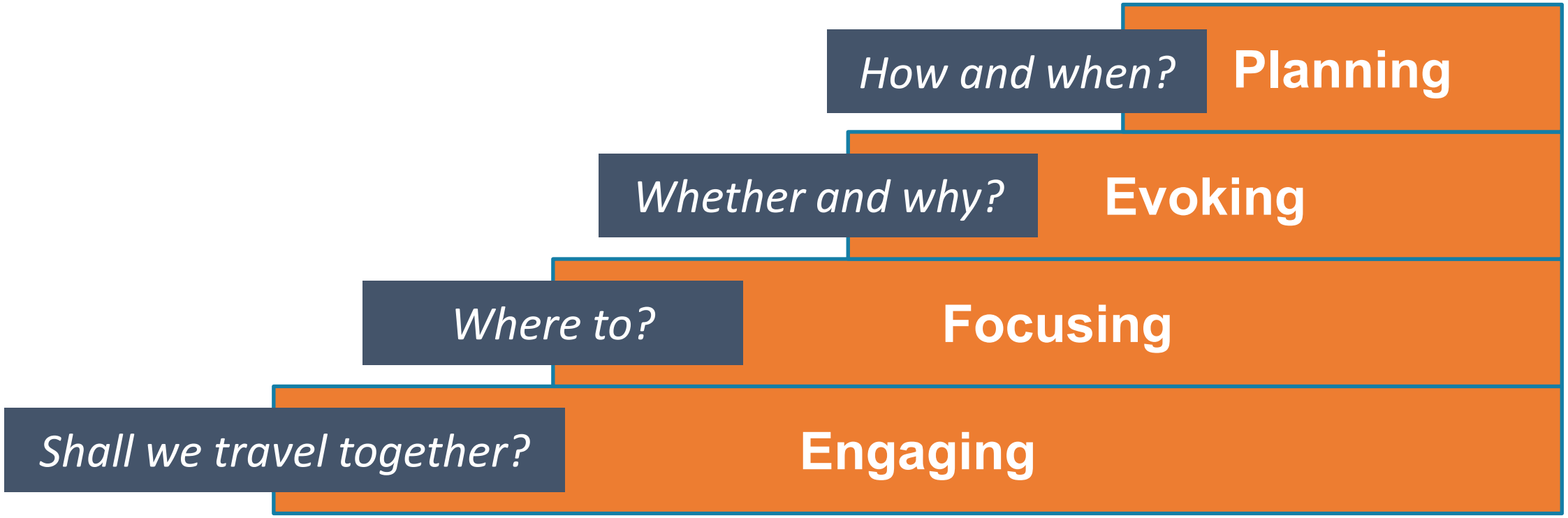
- Developed by the Care Team *with* the Patient
- Goals have observable, measurable outcomes (SMART)
- Outcomes are routinely measured
- Treatment to target
- Treatments are actively changed until treatment goals are achieved
- Clinical outcomes are routinely measured by evidence-based tools

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

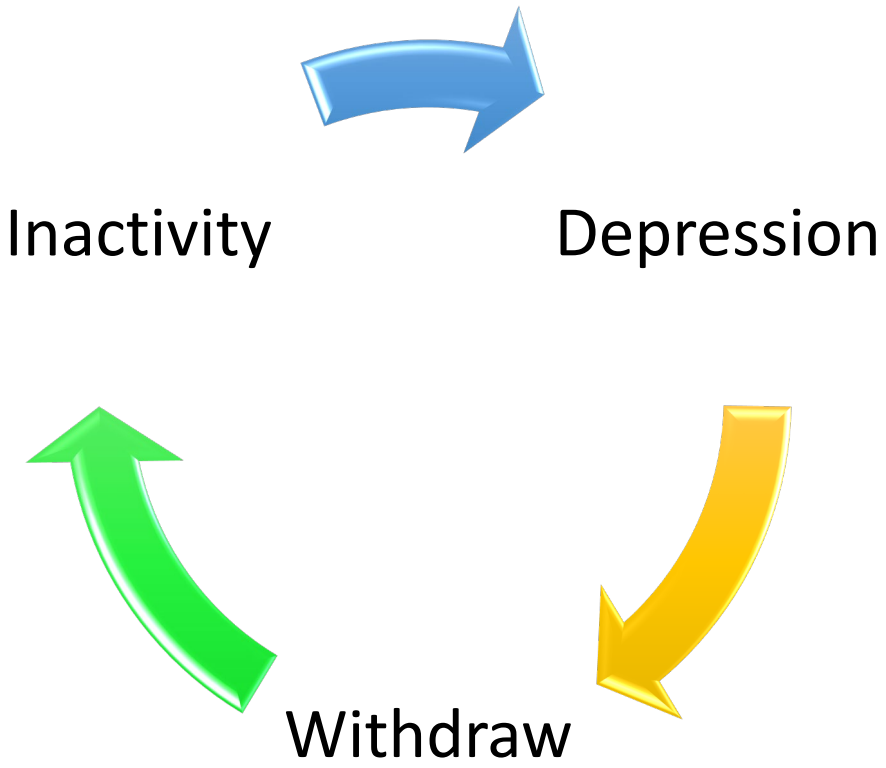
- Current and past self-management strategies
  - "What have you tried so far that's been helpful?"
  - "What have you tried that hasn't worked so well?"

- 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?"

Cycle of Depression



We have a specific focus. Now, it can be helpful to have a specific plan.

SMART goals

- Specific
- Measureable
- Attainable
- Relevant
- Time-specific

Depression and self-management action planning (Breaking the cycle)

- Where would you like to start to improve your depression?
  - “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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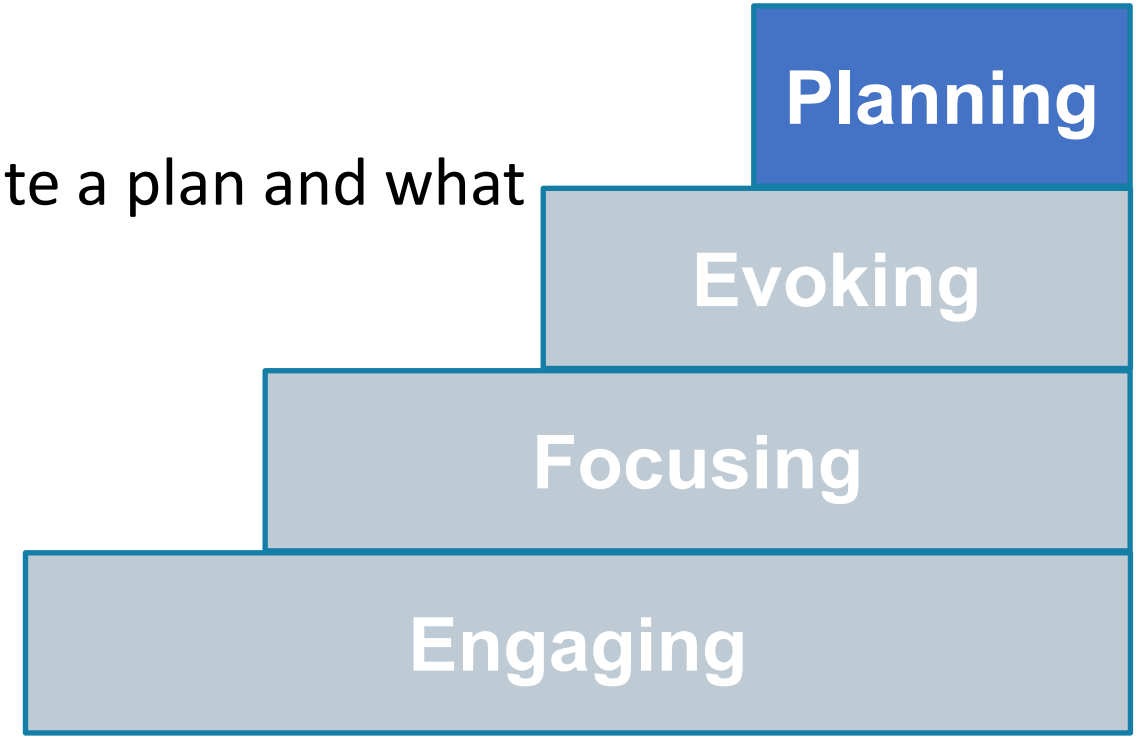
- What would be a reasonable next step toward change?
- What would help this person to move forward?
- Am I remembering to evoke rather than to prescribe a plan?
- Am I offering needed information or advice with permission?
- Am I retaining a sense of quiet curiosity about what would work best for this person?
- What if the patient is not ready to create a plan and what might it mean?
- Provide hope – we can get through it.



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!

Sample Self-management Action Plan

- Insert picture here

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: What could you change in your day to day life that would most impact your mood?

Allow: Patient to respond – provides ideas or not sure

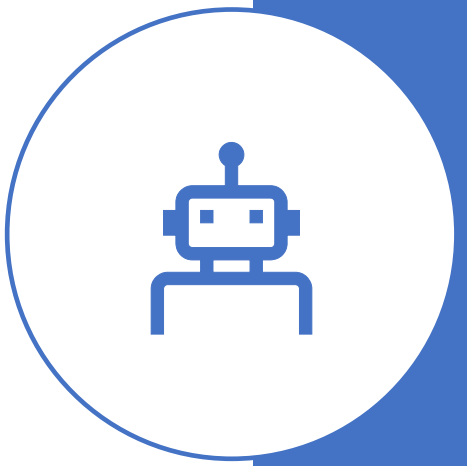
Yes: What are some possibilities? (Share wheel to offer starters)

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. **Key actions are identifying progression with treat-to-target and need for treatment intensification.**
- 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
- Determining when the patient is ready for return to usual care

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 (no more than every 2 weeks)

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:

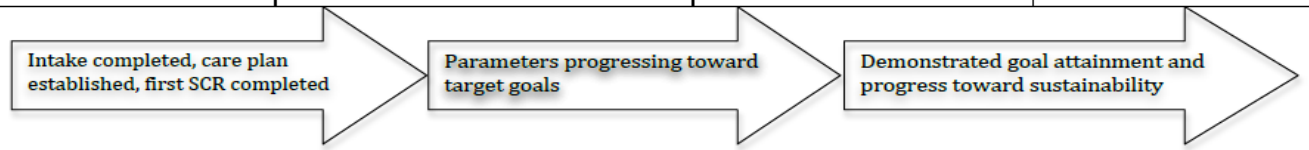
- Active Treatment – until patient significantly improved/stable – minimum 2 contacts per month; can occur remotely
- Monitoring – 1 contact per month
- After 50% decrease in PHQ-9 • monitor for ~3 months to ensure patient stable • complete relapse prevention planning
- Frequency of outreach will depend on patient's treatments plan, their level of engagement, and if any crisis intervention is needed

COMPASS

Care Management Phases & Follow-up Guide

This tool provides recommended guidance for the COMPASS team assisting a patient through the phases of care. Each system has to determine the tailoring needed within their own processes to operationalize this guide to its fullest. Above all, remember the patient is fluid and not a referral to be "handed off" to any one team member and then "given back". Communication leading up to and following each transition is critical to ensure all members of the team including the patient are aligned with the same goals. Stages of change and readiness are parallel aspects of this flow and may resonate with some users in applicability.

Active Engagement Phase *1st & 2nd contacts*	**Active Management Phase** *Weekly contacts in the first month* *Every other week over the next 2-3 months*	**Active Transition Phase** *Frequency gradually extended* *Average duration 5-18 weeks*	**Maintenance Phase** *Monthly to every 3 mo* *Average duration 6-12 months*
• Determine eligibility & appropriateness • Introduce COMPASS & set the roadmap for care • Start building relationship with patient to identify preferences, strengths and challenges • Establish primary care team communication strategy, engagement plans, caseload impact & understanding of patient care needs	• Clinical prioritization, assessment of red flag risks and identify patient preferences • Establish care plan including both short & long term goals for optimal improvement • Purposeful care management using Motivational Interviewing, Behavioral Activation & goal setting that links treat-to-target clinical plan including med intensification with personal health goals by developing strategies for self-monitoring, treatment (including medications) adherence and problem solving skills • Shared understanding of working toward optimal maintenance of the chronic conditions and the organic but intentional process of outcome oriented care management	• Based on pt's progress with clinical and personal goals and agreement that significant improvement has been made. • Less frequent contacts as an opportunity for pt to practice identifying triggers, problem solve and self-monitor. • Duration may need to be variable based on pt readiness, unanticipated pitfalls and ongoing coaching needs but overall becomes longer periods of self-management success. • Starting to build maintenance plan using pts own words for what has contributed to improvement & problem solve obstacles	• Patient has been practicing and more consistently demonstrating self-management including ability to identify triggers, setbacks and opportunities • Maintenance Plan has been developing along the way and patient can now articulate and complete own written plan for sustainment (example: own personal "yellow zone" and when to contact clinic when things come up and assistance is needed) • Schedule established for PCP follow-up and lab/clinical monitoring intervals • Primary care team understanding of maintenance plan including support role and and routine follow up expectations



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Follow Up and Monitoring Guide

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 and agenda of the next visit

Framing the Monitoring Work

- Measurement
- Interventions/approach
- Care planning

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 Treatment
- Routinely performs risk assessments and engages patients in safety planning as needed (PHQ9 – positive to question 9)
- Provides appropriate community and supportive resources to patients, acting as a liaison
- Builds the relapse prevention plan and reviews with the patient regularly

Relapse Prevention Planning

The purpose of a relapse prevention plan is to help the patient understand his/her own personal warning signs.

These warning signs are specific to each person and can help the patient identify when depression may be starting to return so they can get help sooner – before the symptoms get bad.

The other purpose of a relapse prevention plan is to help remind the patient what has worked for him/her to feel better.

The relapse prevention plan should be filled out by the care manager and the patient together.

Sample Relapse Prevention Plan

Relapse Prevention Planning

- Start working on the relapse prevention plan at the beginning of care
- Include it in the way you would record the way the patient most demonstrates
  - When not well
  - What is tried to help and works/doesn’t work
  - What barriers there are to recovery
- Documenting and capturing pertinent information along the journey of remission/maximum improvement makes the work of creating the plan at the end less difficult
- For those that drop out of care, it is something they have been hearing all along

Framing the Discussion

- Introduce the goal of relapse prevention – to develop and sustain self-management skills
- Positive framework: This is progress! Share that depression and anxiety, and other mental health symptoms can come and go over time
- Empowerment: Focus on doing what works well
- Know what to do if things feel worse

- **Elicit patient's ideas for using the plan!**

Relapse Prevention Plan: Example

Relapse Prevention Plan

A Relapse Prevention Plan focuses on stress reduction and self-monitoring and can help you to recognize depression early.

Patient Name: **Today's Date:**

Program activation date:

Contact/Appointment information

Primary Care Provider:_____

Next appointment: Date:_____Time:___

Care Manager:_____ Telephone number:_____

Next Appointment:_____ (circle one-6 mo/12mo follow up call)

**Use the depression-fighting strategies that have worked for you in the past, including taking your antidepressant medication regularly, increasing your pleasurable activities and maintaining a healthy lifestyle.

Maintenance Antidepressant Medications

Diagnosis:_____

1.

2.

You will need to stay on your medications to avoid relapse of depressive symptoms. If you feel you need to change or stops medications-please call your Primary Care Team. Your Physician can help you decide the safest options for medication changes.

Other Treatments

**Write down the problems that can trigger your depression and strategies that have helped you in the past.

• What are some of my everyday stressors?

• What coping strategies have worked for me in the past?

• Are these skills I can use every day or every week?

• How can I remind myself to use these skills daily?

**Watch for warning signs by regular self monitoring. You can check routinely for personal warning signs or telltale patterns of thought or behavior. You may want to ask a partner or friend to let you know if they notice any warning signs

**Use the PHQ test to check your depression score. If your score goes up over 10, it's time to get help again.

Triggers for my depression:

1.

Personal Warning Signs

1.

Coping strategies:

1.

Goals/Actions: How to minimize Stress from Depression

**Try to identify three or four specific actions that will help you. Be realistic about what you can and will do.

**Prepare yourself for high-risk situations.

• What are some problems or predictable stressors that might affect you in the future?

• Can you do anything to make a particular event less likely or less stressful?

• If you can't avoid a stressful situation: can you avoid negative reactions (like criticizing yourself) or react in a more positive way?

1.

2.

3.

4.

When we've made changes in our behavior, there's always a tendency to drift back towards old habits. How can you stop the backward drift?

****Put drift into perspective. We all make plans, but all of us drift away. The key is catching yourself and getting back on track.**

If symptoms return, contact:_____

Patient Signiture_____**Date**_____

Thank you very much for participating in the CoCM at _____!

Relapse Prevention Tool

Elicit – Using MI Skill Open-ended Questions

- **Personal Warning Signs**
- What might you notice about yourself that indicates that your depression/anxiety is returning?
- What behaviors would you notice?
- What might you stop or start doing?
- What thoughts come up for you? What feelings?

- **Things I do to Prevent Depression/Anxiety**
- What has been working for you for managing your mental health?
- What helps you feel better when you're feeling down/anxious?
- What helps you be the best version of yourself?
- What do you do? Who do you talk to? What do you think about?

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

Monitoring
Managing 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

Referrals – Community Resources

- Specialist Care
- SUD treatment
- Psychotherapy
- Community Mental Health (CMH)
- Other resources

Referrals

How to make a successful referral:

- Not just a phone number
- Call ahead to help set up connection
- Talk about what your ongoing role will be
- Follow up with referral
- Be realistic about payment / cost / insurance
- Consider if making the call with the patient would be best

Coordination with Community Based Services

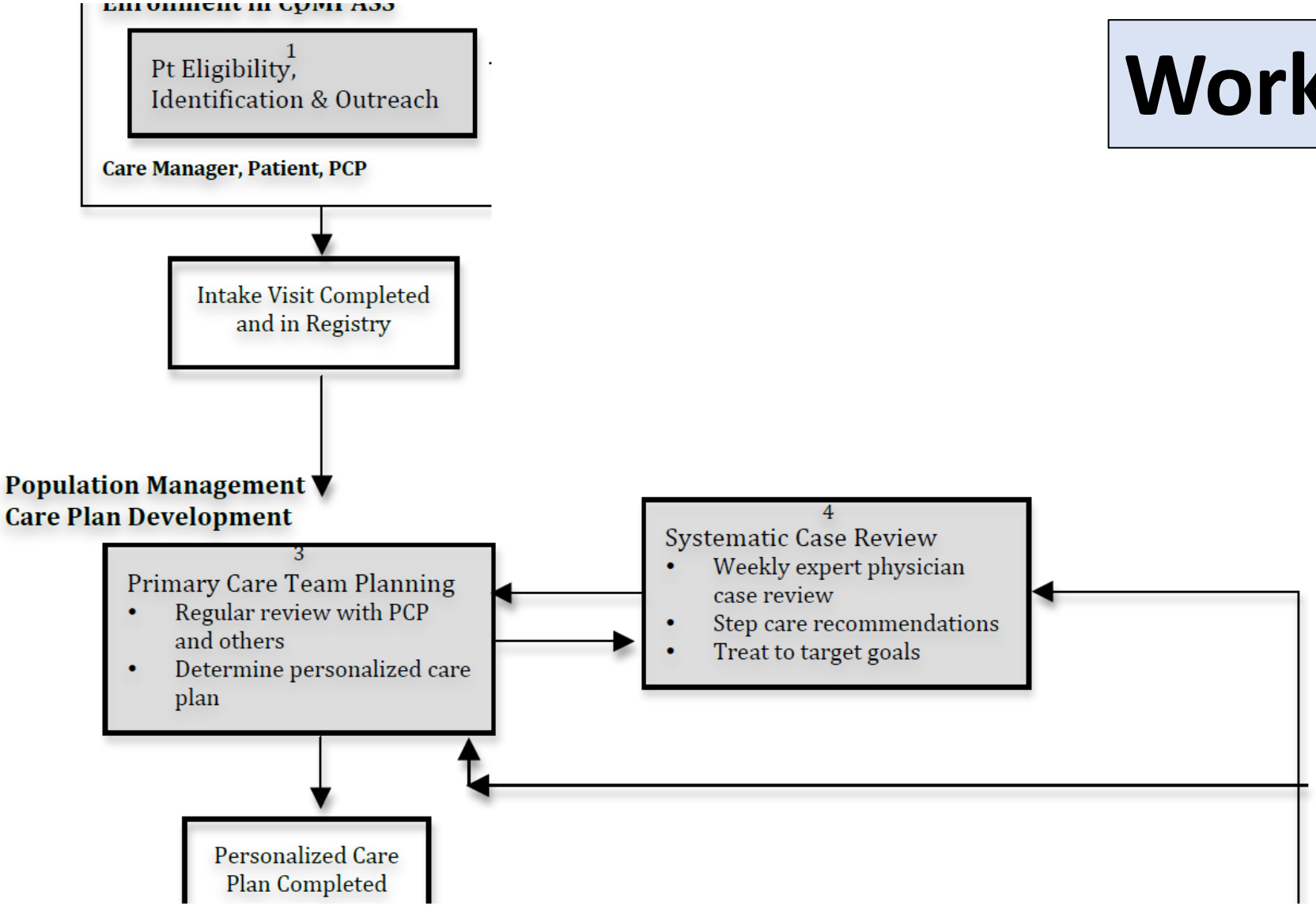
- If patient is engaged in community-based services (e.g., psychotherapy), BHCM should consider getting patient's permission to obtain a Release of Information (ROI) to coordinate care appropriately. This might include coordination around medication management, sharing outcome measures, as well as diagnostics and treatment planning

Population Health Management

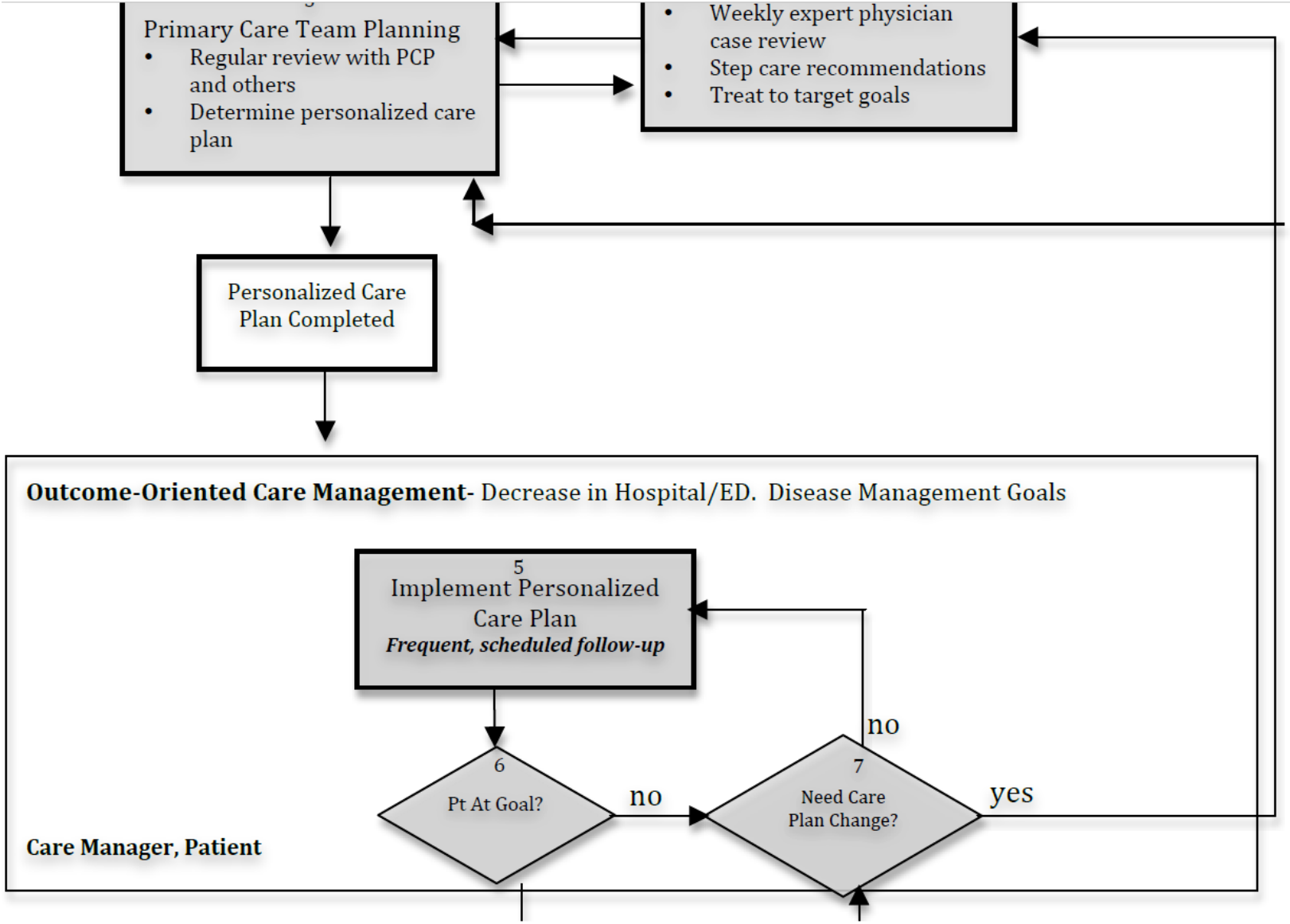
BHCM will manage and populate a clinic-specific systematic case review tool. This will include entering patients, updating information, and viewing the systematic case review tool to dictate daily workflow and tasks

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

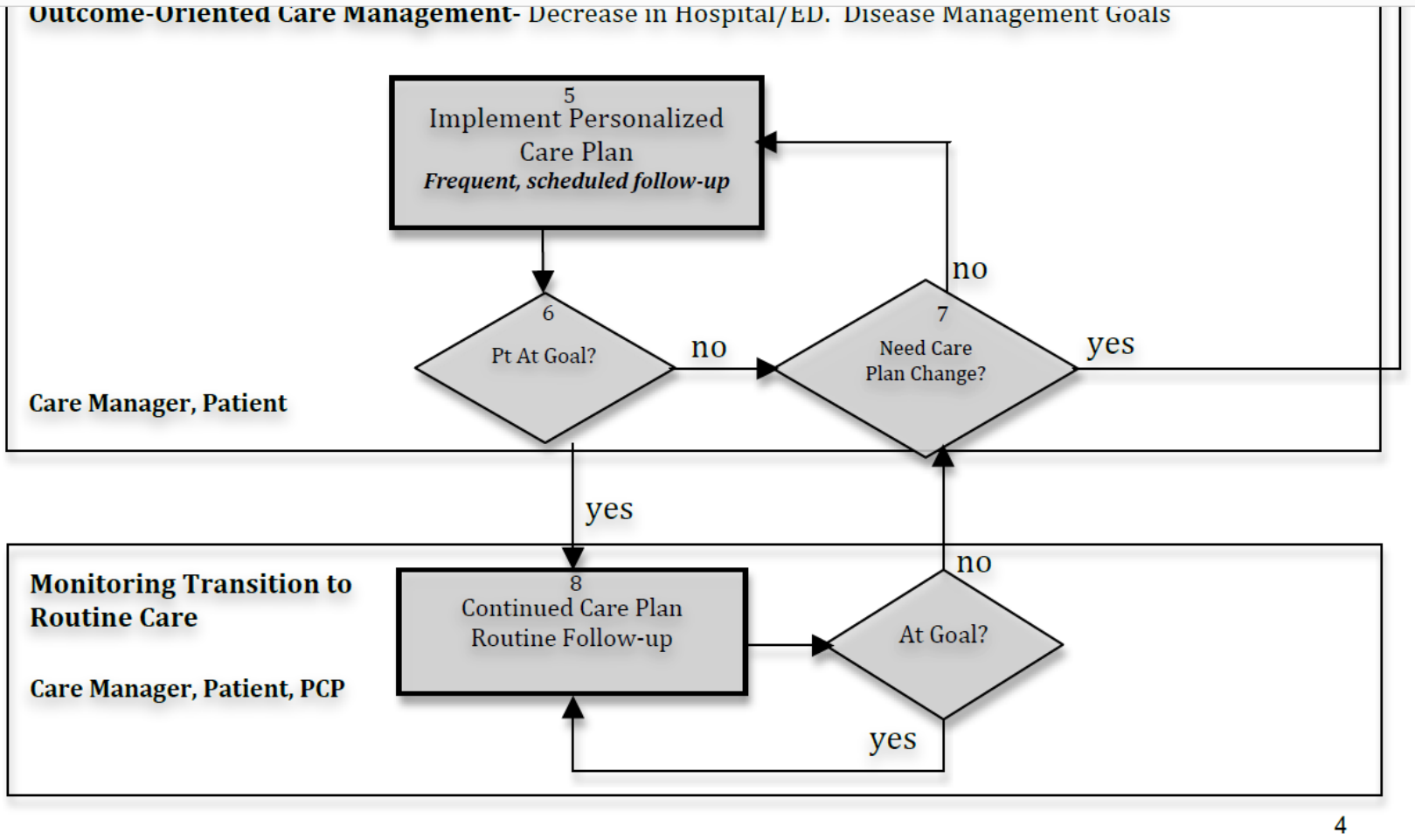
Workflow


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

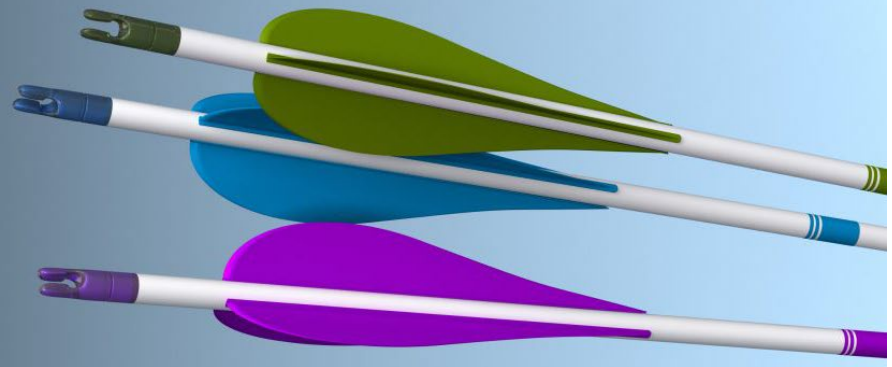

Outcome-Oriented Care Management- Decrease in Hospital/ED. Disease Management Goals
5
Implement Personalized Care Plan
Frequent, scheduled follow-up
6
Pt At Goal?
no
7
Need Care Plan Change?
no
yes
Care Manager, Patient
yes
Monitoring Transition to Routine Care
Care Manager, Patient, PCP
8
Continued Care Plan Routine Follow-up
At Goal?
no
yes
4

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 – when appropriate or if patient requests/drops out
- Relapse Prevention Planning Review or transition to community resources

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

QUESTIONS?

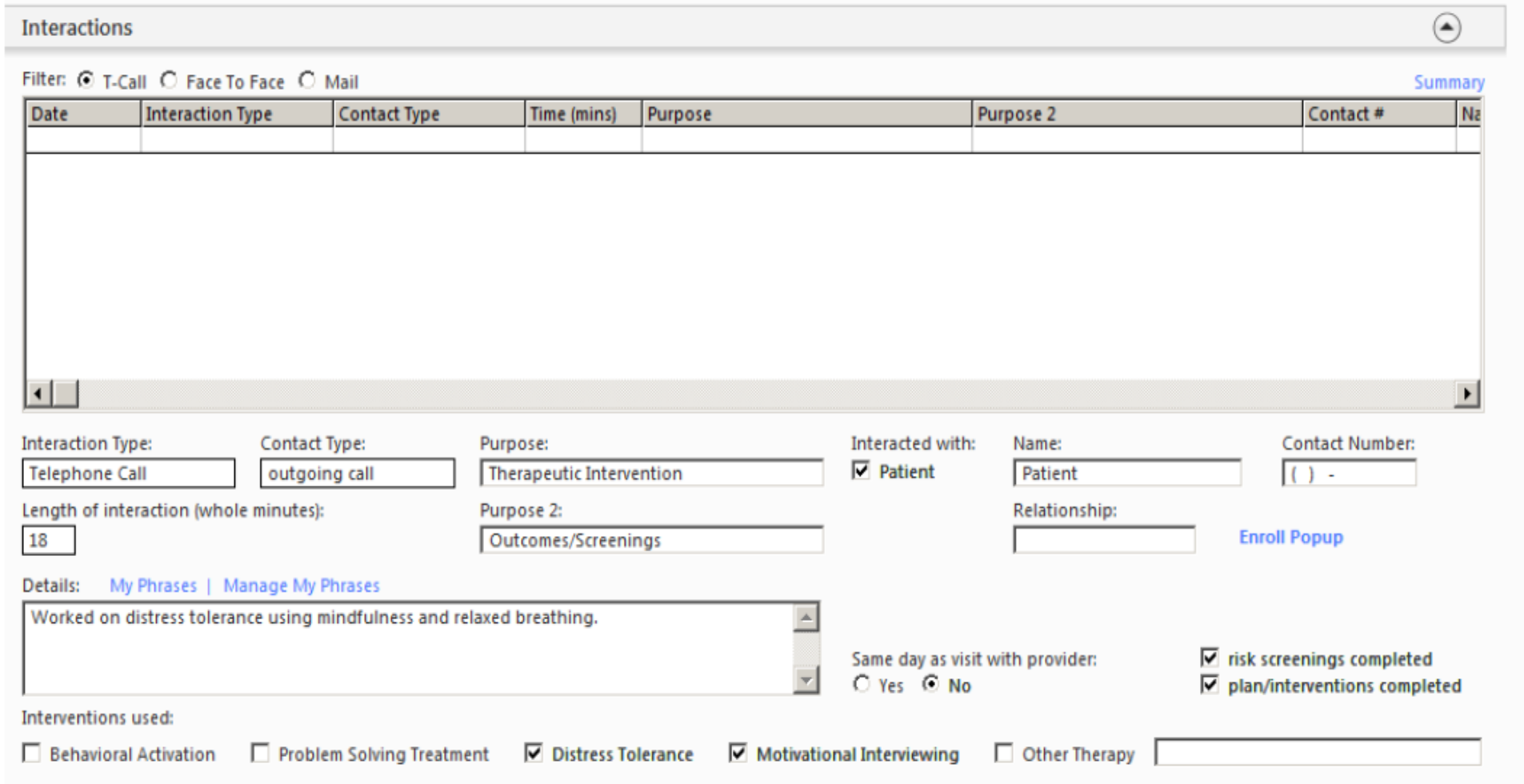
Lunch Break 12 – 12:30

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

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

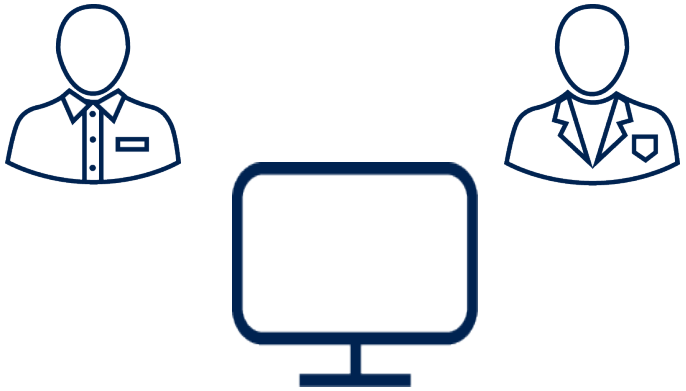
1) Discuss in panel review

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: Determining patients per hour

- Succinct and thorough
- With experience you'll build efficiencies

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. Patients due for review to meet monthly requirement
6. Review the patient panel – run the list
    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

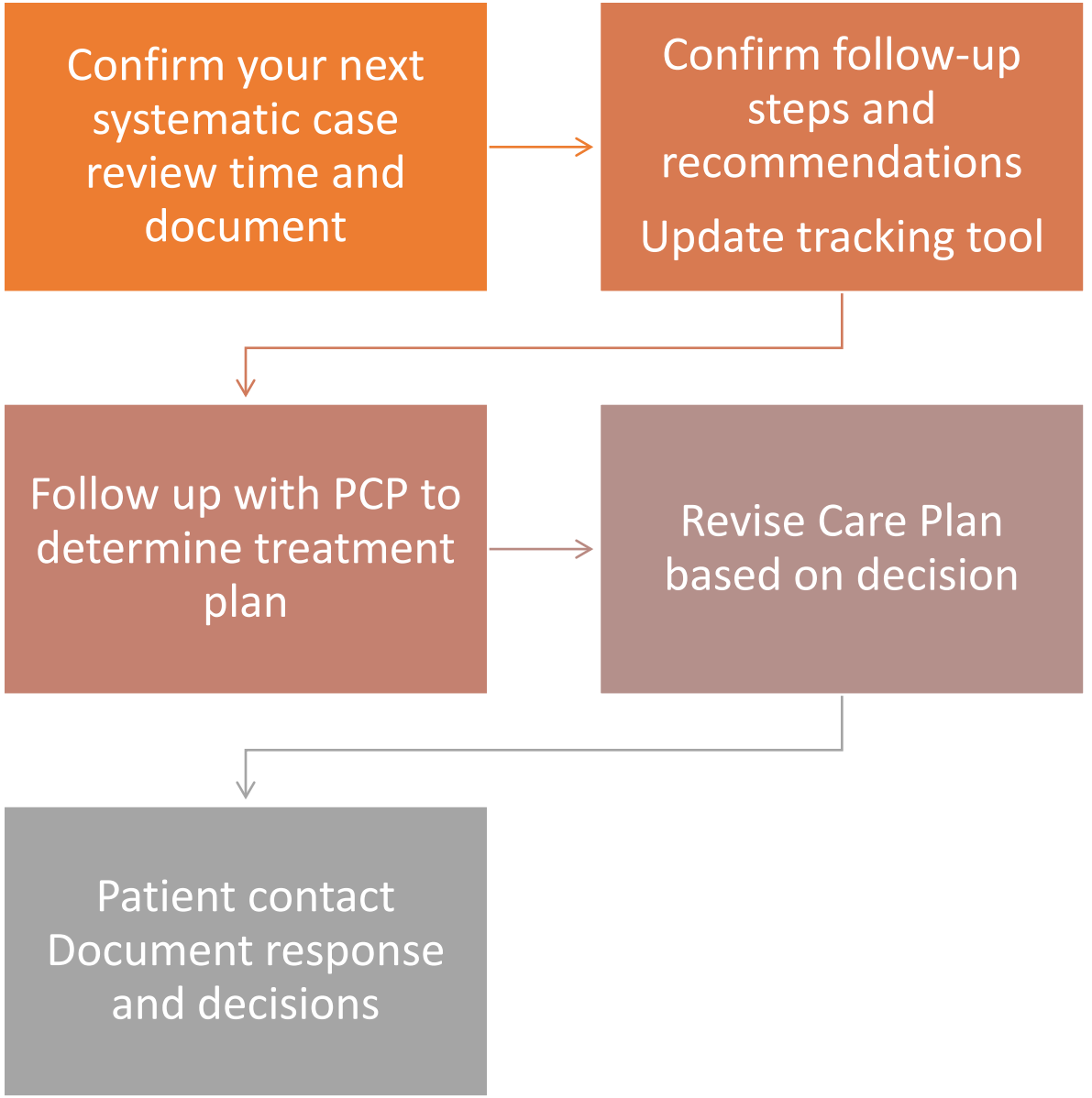
Patients not responding

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

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

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

Adjusting to End of Treatment

- Discuss treatment timeline and structure from the beginning
- Use PHQ-9 graph to help patients see progress
- Work with patient to find other sources of support
- Encourage the ongoing use of strategies for self-management
- Give specific end date when appropriate, e.g., 2 more session, spread sessions out more and more

Questions Around the Systematic Case Review Process

Other Questions?