Patient Identification and Tracking

Collaborative Care Training
Section 4

Objective and Learning Outcomes

Objective

- Discuss the technologies involved in the CoCM process and their application toward population health and treat to target

Learning Outcomes

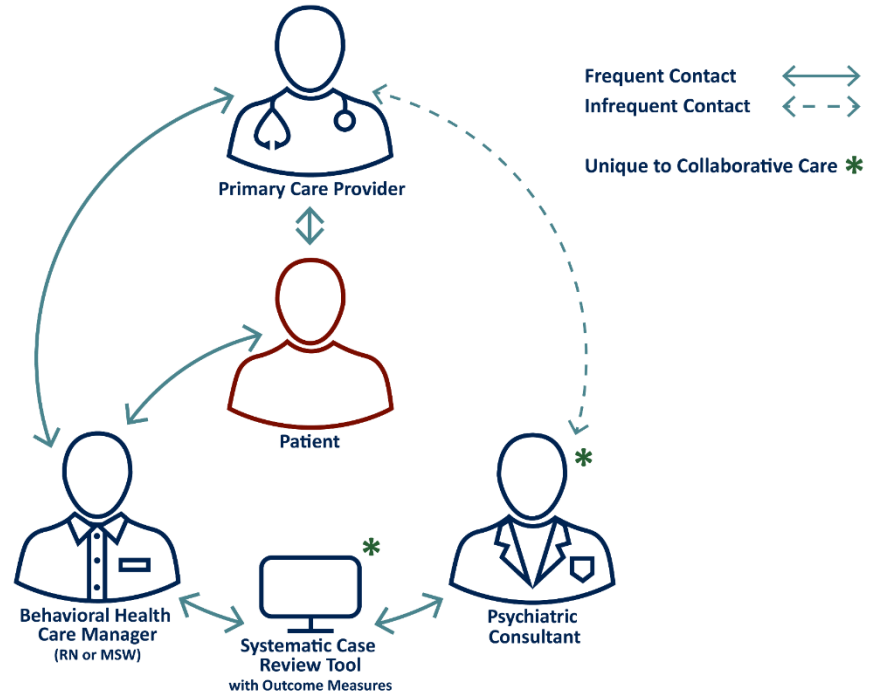
- Explain population health as it relates to CoCM
- Describe how the systematic case review tool is a critical part of CoCM
- Apply the disease registry to patient identification
- Apply a treatment to target approach to the CoCM process

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**
  - Use of systematic case review tool
  - 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

Integrating the BHCM and Psychiatrist

The Collaborative Care Treatment Team



Data-Based Tools to Support CoCM

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
- Need for CoCM service delivery

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
- Used to report to BCBSM

Starts with Patient Identification and Tracking Tools

- Team-based Care Approach
  - Screening
  - Documenting
  - Reports – the Disease Registry

Disease Registry

- Activities
  - Identify patients eligible for CoCM services
  - Identifies individuals with the diagnosis of depression –(optional anxiety)
    - Provides the value to indicate if there is a gap (moderate to severe)
    - Provides the date of the last value

- Required for Inclusion
  - Diagnosis of depression optional anxiety in a clinical setting
  - PHQ-9 optional GAD-7 of 10+
- **Additional Avenues for Inclusion:
  - New or changed dose of antidepressant, antipsychotic, or anxiolytic
- Direct referral to CoCM services

Disease Registry

MRN	Patient	DOB	Age	Sex	PCP	Last Full PHQ	Last PHQ9 Score	Last GAD-7 Screening Date	Last GAD-7 Score	Last Primary Care Visit	Last Social Worker Visit	Primary Care Next Appt
[redacted]			18 y.o.	Female	Sylvestre, Nastassia Cassandra, MD	10/30/2018		03/13/2020	10	12/27/2019		05/19/2020
			18 y.o.	Female	Gessner, Lynn Michelle, MD	04/14/2020	11	04/14/2020	18	01/08/2019		
			18 y.o.	Female	Gessner, Lynn Michelle, MD	04/23/2020	15	04/23/2020	10	02/10/2020		
			18 y.o.	Female	Sylvestre, Nastassia Cassandra, MD	04/15/2020	7	04/15/2020	15	02/18/2020		05/29/2020
			19 y.o.	Female	Gessner, Lynn Michelle, MD	04/03/2020	11			03/02/2020		05/15/2020
			19 y.o.	Male	Phys, Self-Refer Or No Pcp/Referring	07/24/2018				06/18/2019		05/12/2020
			21 y.o.	Male	Scott-Craig, Thomas Peter Claire, MD	07/17/2018		03/12/2020	14	03/12/2020		
			21 y.o.	Female	Phys, Self-Refer Or No Pcp/Referring	04/10/2020	13	03/23/2020	15	03/23/2020		
			21 y.o.	Male	Cox, Amanda	01/13/2020	20	0	Scroll to Selected Row	01/13/2020	04/27/2018	

Note: This example does not show all recommended components; see previous slides for details.

Assessment Template

- Create or update the assessment tool to include most recent PHQ9 (depression) and optional GAD7 (anxiety)
- Based on the assessment tool, create or update the care plan template or note to address barriers

Assessment and Populating the SCR Tool

THE COCARE CM TRACKING TOOL

BASELINE FINDINGS AT THE TIME OF ENROLLMENT

Systematic Case Review

- Use the systematic case review tool to review the caseload
  - Filter through data fields to keep patients from falling through the cracks
- Discuss specific questions from PCPs or patients
- Discuss patients that are:
  - Newly enrolled in CoCM services
  - Not improving or have severe outcome measure scores
  - Not recently discussed with the psychiatric consultant
  - Not engaging in care
  - Improving, in remission, ready for relapse prevention planning, or disenrollment

- Run the list to ensure all are reviewed at minimum monthly

SCR: Start to Finish

1. Actions to Prepare for SCR
2. Document management
3. SCR Meeting
4. Starting reviews and capturing recommendations
5. Recommendations reviewed with the provider
6. Review treatment recommendations with the patient
7. Review patient input, decision on the recommendations

Defining ‘Improvement’: Outcome Measures

- Validated Outcome Measures:
  - PHQ-9 (Patient Health Questionnaire) – Depression screening
  - GAD-7 (Generalized Anxiety Disorder) – Anxiety screening

- Ways to define Improvement:
  - 5-point reduction in score
  - 50% reduction in score
  - Score less than 5 (ideal discharge goal is remission)

- Tracking PHQ-9 score data is required for CoCM service delivery; Tracking GAD-7 score data is highly recommended but not required.

Components: Systematic Case Review Tool

Required

- 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

Recommended

- 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) to indicate patients who would benefit from contact, updated outcome measures, or panel review session

Systematic Case Review Tool

	First Name	Last Name	Birthdate	Gender	Plan Type: 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)	Optional: 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																						
Blue Cross patients																						
Blue Cross patients																						
Non-Blue Cross patients																						
Non-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

Monitoring and Follow Up

- SCR Tracking tool
  - Ongoing contacts
  - Follow up on outcome measure scores – treatment intensification needs
  - Prioritize order of patients to review

Infrastructure: A Population-Based Approach

Systematic Case Review

- Key component of CoCM
- Weekly meeting between the psychiatric consultant and BHCM
- Review the caseload and provide expert treatment recommendations
- Required

Program Performance Review

- Administrative discussion
- Evaluate program performance to optimize delivery of CoCM services
- Review patient outcomes, process measures, billing, staffing, and operations
- Strongly recommended

Note: Caseload review and program review meetings may occur at the provider organization or practice level depending on the oversight structure

Clinical Caseload Supervision

- Clinical discussion
- A high-level review of the caseload with the BHCM and clinical supervisor
- Keeps the caseload "fluid," allowing for enrollment of new patients
- Discuss ongoing development of skills (e.g., Motivational Interviewing, behavioral activation)
- Strongly Recommended

Summary: Recommended Program Oversight

Meeting	Goal	Participants	Developing Programs (3-6 Mo)	Mature Programs (6+ Mo)	Required
Systematic Case Review	Provide expert treatment recommendations	BHCM and psychiatric consultant	Weekly	Weekly	Required
Program Performance Review	Review performance and operations of CoCM services, including patient outcomes, fidelity, billing, and program operations.	Program manager, clinical supervisor, quality improvement staff Optional: BHCM, PCP champion, leadership, psychiatric consultant, EHR or HIT staff	Monthly	Quarterly	Optional
Clinical Caseload Supervision	High-level review of caseload. Keep the caseload "fluid" by discussing appropriate enrollment, treatment, and triage.	BHCM and clinical supervisor Optional: psychiatric consultant	Monthly	Quarterly	Optional

Note: These are the minimum recommended frequency; review may occur more often as desired by the provider organization or practice.

Clinical Caseload Supervision

Goal: Keep the caseload “fluid” – allowing the practice to continue accepting new patients

Recommended:

- Scheduled monthly for developing programs, quarterly for mature programs

- Participants: BHCM and Clinical Supervisor

- Optional Participants: Psychiatric Consultant

Clinical Caseload Supervision

- Use the systematic case review tool to conduct a high-level clinical review of the caseload
  - Evaluate caseload volume, acuity, and needs
  - Evaluate BHCM productivity, capacity for ongoing patient engagement
- Discuss which patients would benefit from:
  - Relapse prevention planning
  - Different level of care
  - Being contacted at a different frequency
  - Discontinuing CoCM services
- Discuss ongoing skill development
- Contact patients to administer outcome measures, complete relapse prevention plans
- Discharge patients or refer patients to different level of care
- Make a note of which patients to discuss during systematic case review
- Follow-up with PCPs
- Explore opportunities for skill development

Caseload Size Guidelines: 1.0 BHCM FTE

Program and Patient Characteristics	Caseload Size Range	
• High commercial payer • Mostly depression and anxiety; low clinical acuity • Minimal social needs, comorbid medical conditions	90	120
• Commercial, public payer, or uninsured • Mostly depression and anxiety; few higher acuity • Minimal-moderate social needs, substance use, comorbid medical conditions	70	90
• Public payer, uninsured, low commercial • Mostly depression and anxiety; some higher acuity • Minimal-moderate social needs, substance use, comorbid medical conditions	50	70

Actual caseload sizes will vary by patient population and program characteristics

Program Evaluation

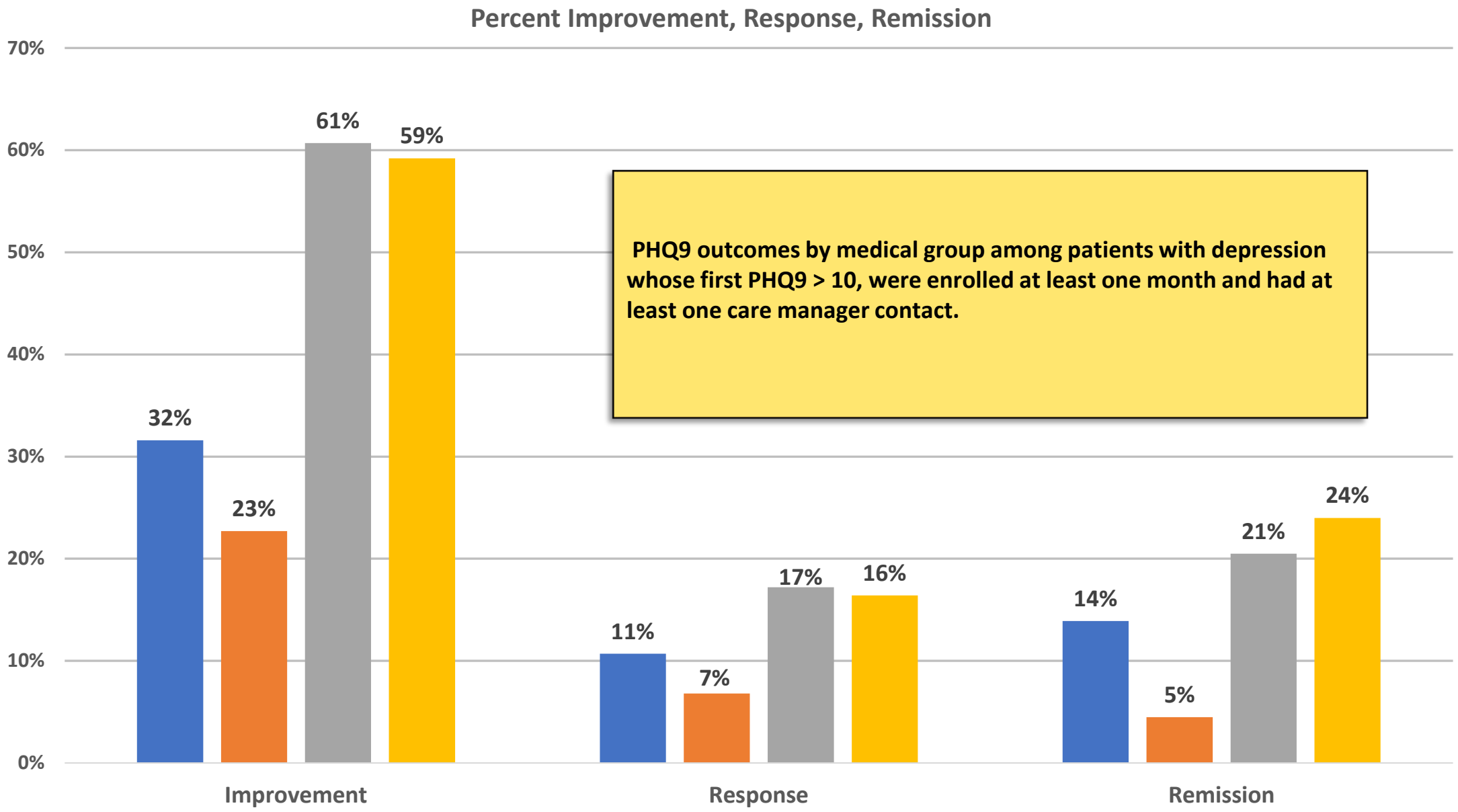
Monitoring Clinical Performance

- Are your patient population's outcome measures improving as expected for the specified population?
  - Review patient outcomes grouped by BHCM, PCP, practice, and time in treatment (e.g., 0-3 months, 3-6 months)
  - Treatment duration range 3-12 months, average of 6 months
  - Target: Approximately 50% of patients should show improvement* after three months of treatment

  * Improvement is defined as a 5-point reduction, 50% reduction, or score less than 5 in PHQ-9 and/or GAD-7 score

Garrison, G. M., Angstman, K. B., O'Connor, S. S., Williams, M. D., & Lineberry, T. W. (2016). Time to remission for depression with collaborative care management (CCM) in primary care. The Journal of the American Board of Family Medicine, 29(1), 10-17.

Tracking Patient Outcomes


Percent Improvement, Response, Remission
70%
60%
50%
40%
30%
20%
10%
0%
32%
23%
61%
59%
11%
7%
17%
16%
14%
5%
21%
24%
Improvement
Response
Remission
PHQ9 outcomes by medical group among patients with depression whose first PHQ9 > 10, were enrolled at least one month and had at least one care manager contact.

Depression Outcomes – F2, F3

% patients with improvement in depression score of 40% and/or reaching remission (PHQ-9 less than 5)

All measures are %	Practice A	Practice B	Practice C
Improvement rate (Goal: 5 points)	74	87	75
Remission rate (Goal: below 5)	26	40	36

Note : Results reflect patients enrolled at least 120 days and repeat PHQ-9 score completed at 120 days

Process Measures: CoCM Evidence-Base

- Early engagement in CoCM activities is a strong indicator of patients' future success
- Patient are contacted twice per month in the first two-four months of treatment (at minimum)
- Outcome Measures (e.g., PHQ-9) are administered monthly in the first two-four months of treatment
- Brief evidence-based therapeutic interventions (e.g. Motivational Interviewing, behavioral activation, problem solving therapy)

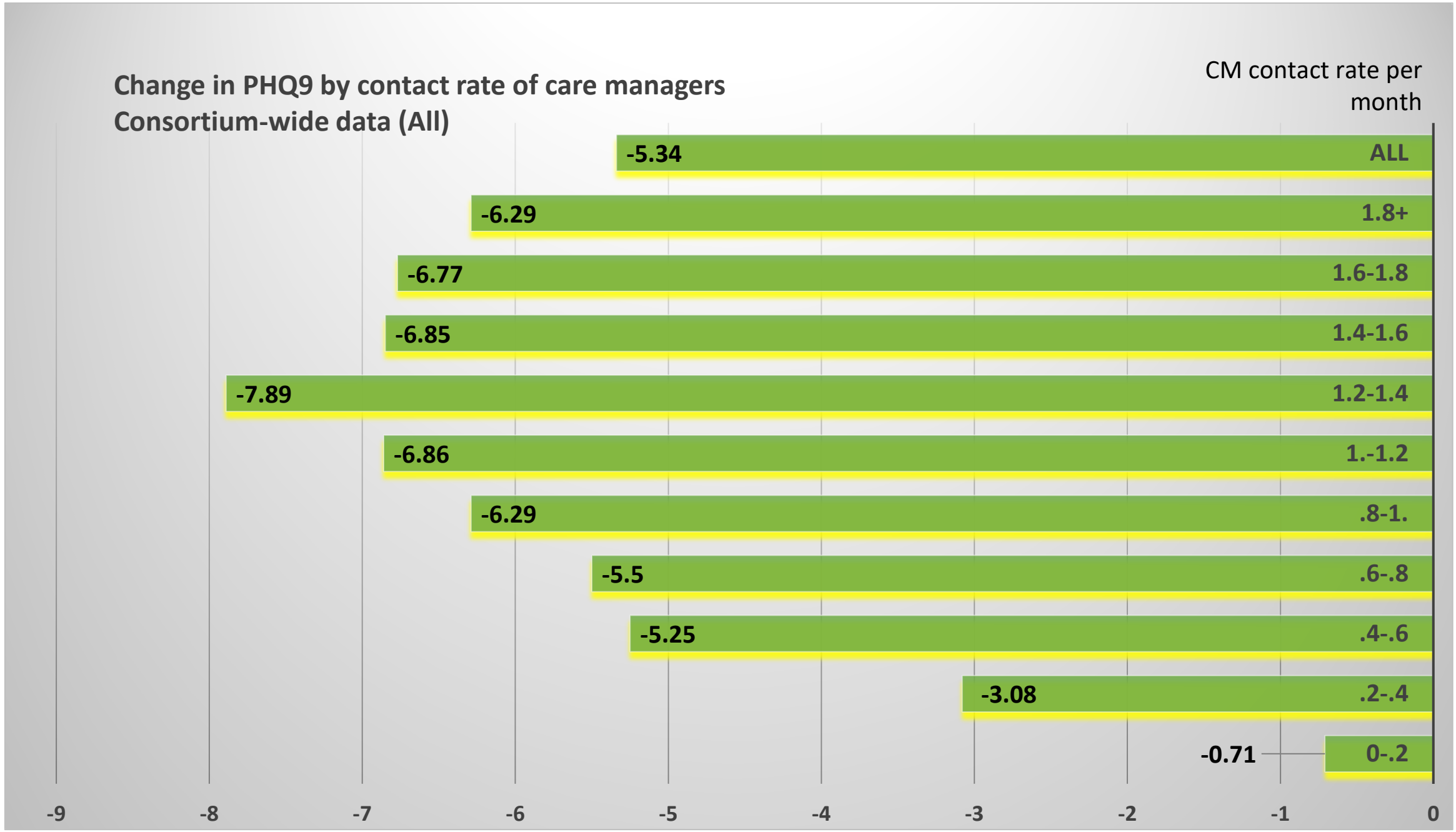
Unützer, J., Katon, W., Williams Jr, J. W., Callahan, C. M., Harpole, L., Hunkeler, E. M., ... & Oishi, S. M. (2001). Improving primary care for depression in late life: the design of a multicenter randomized trial. Medical care, 785-799.

Process Measures: Systematic Case Review

- Patients are discussed with the psychiatric consultant in systematic case review within two weeks after being enrolled
- Expert treatment recommendations from the psychiatric consultant are approved and implemented by the PCP and patient
- Patients not improving* within 8-12 weeks of treatment should be discussed with the psychiatric consultant in systematic case review to revise treatment recommendation

  *improvement is defined as a 5-point reduction, 50% reduction, or score less than 5 in PHQ-9 and/or GAD-7 score

  Unützer, J., Katon, W., Williams Jr, J. W., Callahan, C. M., Harpole, L., Hunkeler, E. M., ... & Oishi, S. M. (2001). Improving primary care for depression in late life: the design of a multicenter randomized trial. Medical care, 785-799.


Change in PHQ9 by contact rate of care managers
Consortium-wide data (All)
CM contact rate per month
-5.34
ALL
-6.29
1.8+
-6.77
1.6-1.8
-6.85
1.4-1.6
-7.89
1.2-1.4
-6.86
1.-1.2
-6.29
.8-1.
-5.5
.6-.8
-5.25
.4-.6
-3.08
.2-.4
-0.71
0-.2
-9
-8
-7
-6
-5
-4
-3
-2
-1
0

Questions?