The Behavioral Health Care Manager

The Role of the BHCM

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

What the BHCM Does…

- Coordinates the overall effort of the treatment team and ensures effective communication among team members
- 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
- Supports the PCP by providing proactive follow-up of treatment response, alerting the PCP when the patient is not improving, and supporting medication management

The Process

- Screening – identify eligible patients to outreach to
- Care Coordination – Coordinate with the patient's provider team (psychiatrist, PCP, counselor)
- Engage with the patient – introduce your role and value of CM to the patient
- Screening Assessment -
  - Assess appropriateness for Depression – Anxiety monitoring
  - Conducting the biopsychosocial assessment including diagnostic criteria, medical/medication history
- Initiate interventions – 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
- Where indicated review with the treating provider the patient's status and suggestions for treatment
- Case closure – review relapse prevention plan, confidence with self-management and resources if indicated

Definitions

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

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 CM services

Identifying Eligible Patients

- 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
- Other – high utilization and cost

Introduce	Personalize	Introduce	Emphasize	Describe
Introduce your role and benefits to the patient	Personalize the script based on the patient, personal style, and clinical judgment	Reviewing the care coordination communications	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 CM to Patients

Demonstration: Case Manager to Patient

- Listen for the key points of the CM Model in managing depression and anxiety

ACTIVITY

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

Facilitator for each group

- **Each group will create an introduction to the CM program to a patient**
- **Include key talking points**
  - **Warmly greet**
  - **Ask permission**
  - **Understanding of the reason for the outreach and with permission fill in gaps**
  - **Understanding of payer provider relationship**
  - **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)
- Evaluate and assign level of care (risk) needed based on assessment and resources (ie risk score)
- 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

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 – referral to mental health provider – Community Mental Health

Patients with:

- Severe substance use disorders
- Active psychosis
- Severe developmental disabilities
- Personality disorders requiring long-term specialty care
- Bipolar is challenging and requires consideration

Assist with patient coordination and referral as need identified

Patient Agreement

- Patient agrees to ongoing case management services (follow BCBSM protocol)
- Documented

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 treating team 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)

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 depression/anxiety 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

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

How do you conduct a SoDOH screening? Considerations to include:

- 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)

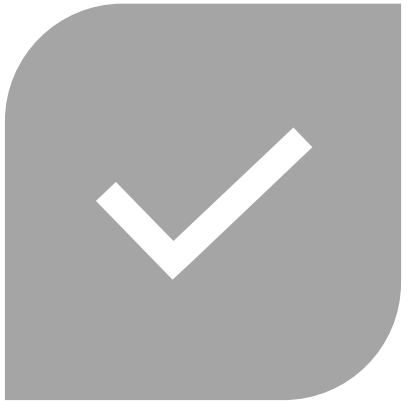
Step 6: Making the environment safe:

1. _____
2. _____

The one thing that is most important to me and worth living for is:

Policy and Procedure

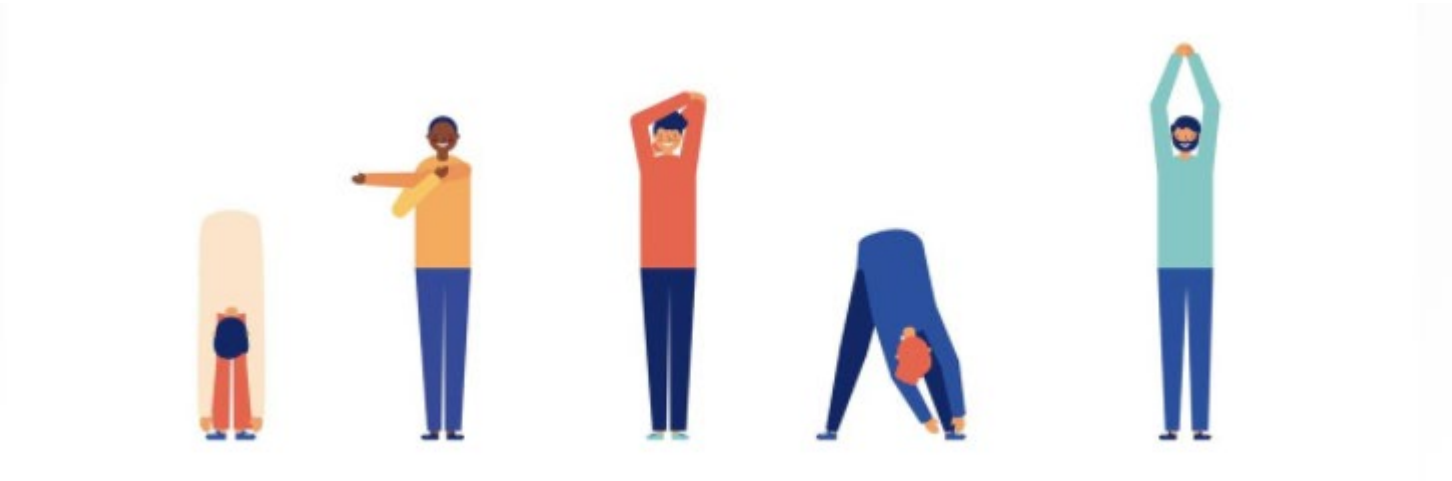
WHAT'S IN PLACE



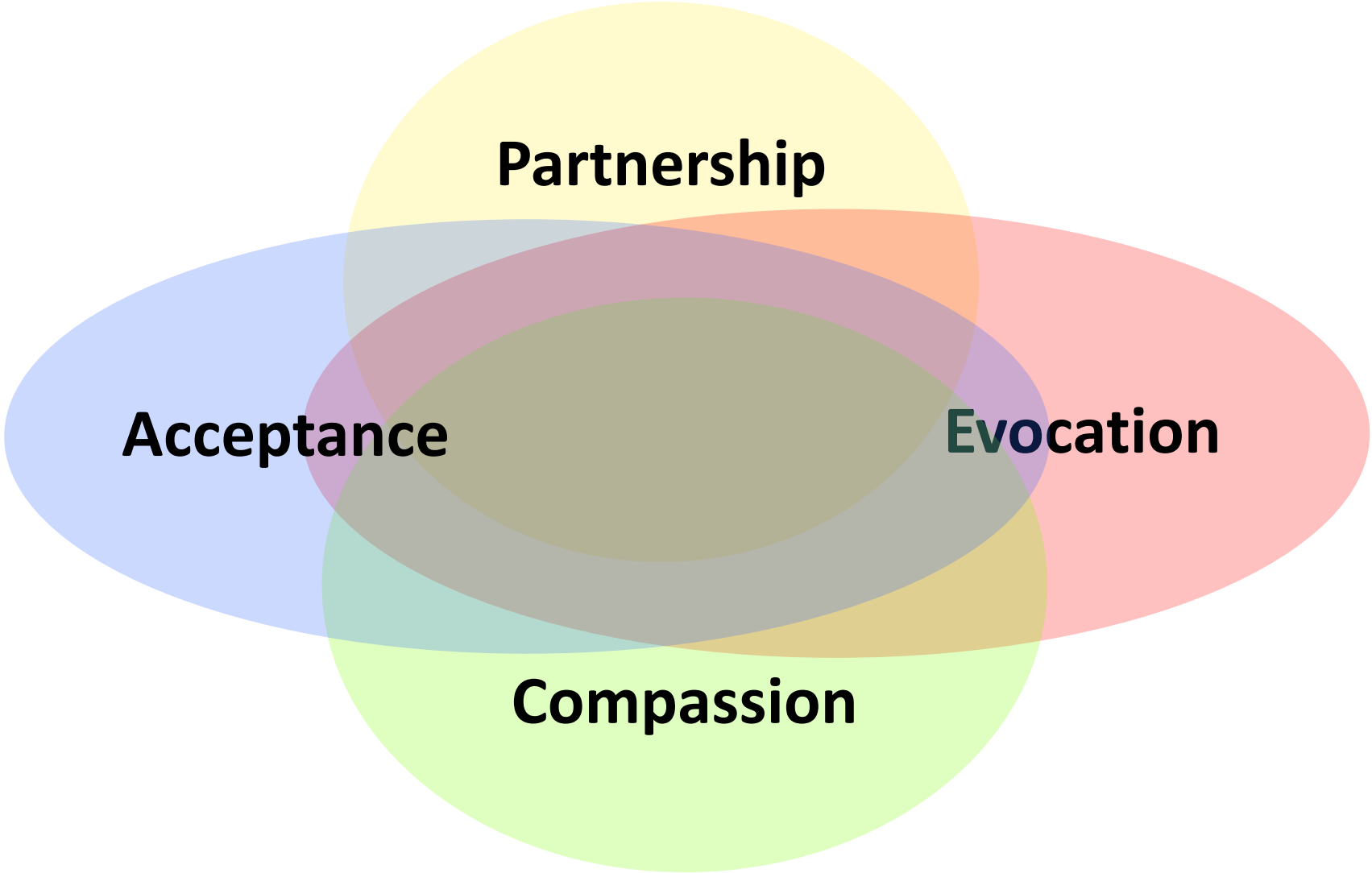
WHERE ARE THERE OPPORTUNITIES

NEXT STEPS

Stretch Break – 3minutes



Spirit of MI



O.A.R.S +I

Open Ended Questions

Affirmations

Reflective Listening

Summaries

+Information Offering

Care Plan

Remember that discharge planning/preparation starts from the beginning

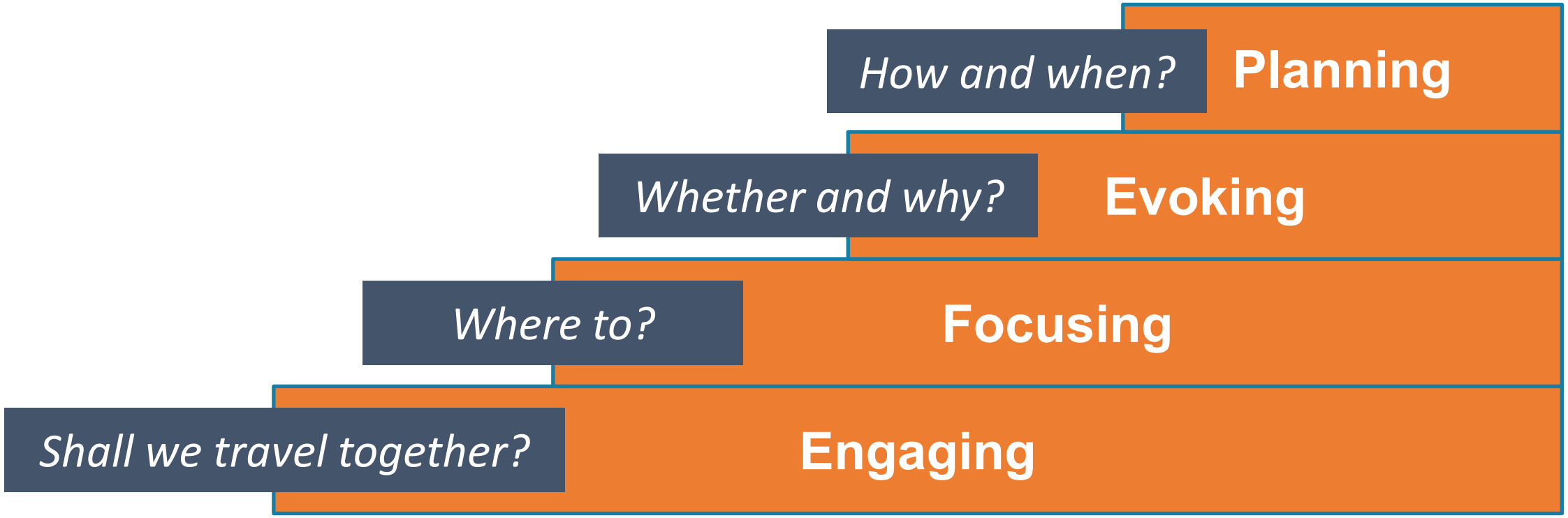
- Developed *with* the Patient
- Goals have observable, measurable outcomes (SMART)
- Outcomes are routinely measured
- Treatment to target
- Treatments are actively monitored until treatment goals are achieved
- Clinical outcomes are routinely measured by evidence-based tools

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

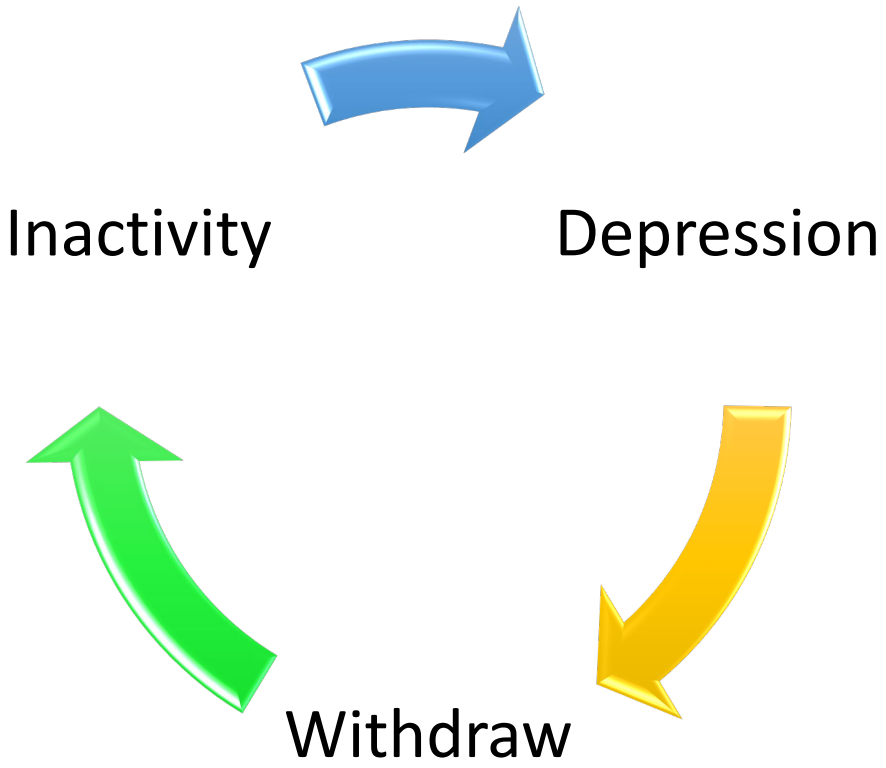
- Current and past self-management strategies
  - "What have you tried so far that's been helpful?"
  - "What have you tried that hasn't worked so well?"

- 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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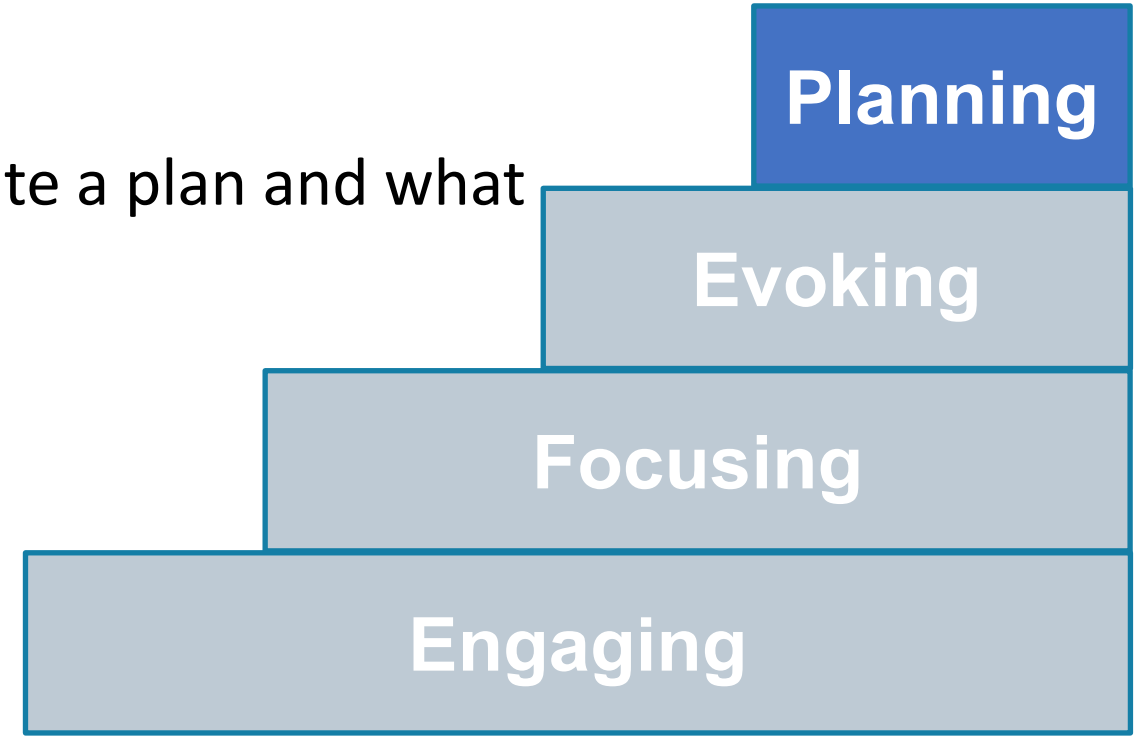
- What would be a reasonable next step toward change?
- What would help this person to move forward?
- Am I remembering to evoke rather than to prescribe a plan?
- Am I offering needed information or advice with permission?
- Am I retaining a sense of quiet curiosity about what would work best for this 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

SELF-MANAGEMENT ACTION PLAN

Patient Name:	**Date:**	
Staff Name:	**Staff Role:**	**Staff Contact Info:**
Goal: *What is something you WANT to work on?* 1. 2.		
Goal Description: *What am I going to do?*		
How:		
Where:		
When:	**Frequency:**	
How ready am I to work on this goal? (Circle number below)		

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

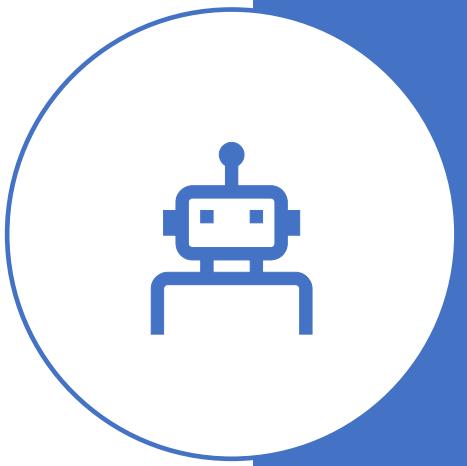
Yes: What are some possibilities? (Share wheel to offer starters)

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/Treating Provider – 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), talk with patients about medications,. **Key actions are identifying progression with treat-to-target and need for treatment intensification.**
- Psychiatric Consultant – Review's patient's response to treatment and makes adjustments as needed
- Patient – Engages with the BHCM and care team. Shares challenges and successes with the treatment plan. Where need identified, patient is advised to inform their treating providers of lack of progress or any concerns

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)

Determine and act upon any urgent emergent issues

Follow up on the self-management action plan

Setting the Agenda

- Each contact should have a plan and a purpose guided by the BHCM
- Each contact should include an introduction as to what the BHCM and patient will be doing today.
  - Ex. “I'd like to spend about 15-30 minutes with you today. I want to start by asking you questions from a symptom monitoring scale and then discuss some problem solving around your stress at work.”
  - “What if anything would you like to discuss during our time together?”

Frequency of Contact:

Typical Frequency of Care Management Contact:

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

BHCM Initial Outreach

What the Research Says:

- Patients with **early** follow-up are less likely to drop out and more likely to improve (Bauer, 2011)
- Patients who have a second contact in less than a week are more likely to take their medications

Concluding the Visit

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

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

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

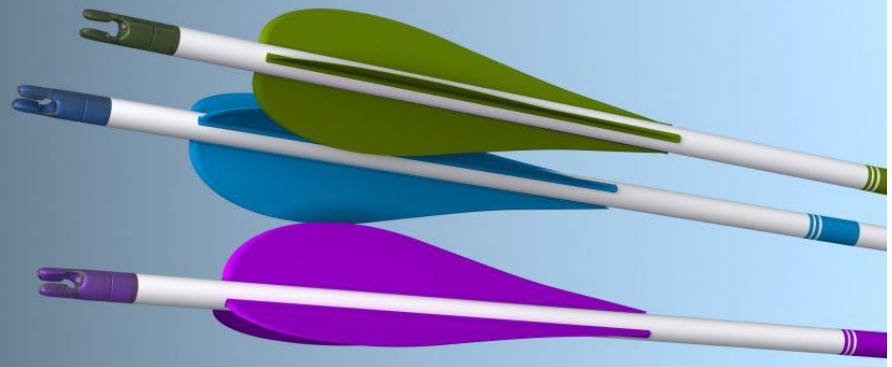
Care Coordination

- BHCM will alert other clinicians and care providers to concerns identified
- BHCM will respond to patient crises as appropriate, which may include phone or clinic follow-up contacts
- Care Coordination within the team. This may include sending notes to PCPs and other providers, and providing clear documentation with a summary of patient self-management plans, that the treating team is aware of patient status and current care plan

Coordinating and Providing Guidance on Referral Management

Coordination with 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



Outcome Targets

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

QUESTIONS?