The Basics of CoCM

Section 2

The Basics of CoCM

CoCM: An Overview

- Most evidence-based integrated behavioral health model
  - **80+ randomized controlled trials** prove Collaborative Care provides significantly better behavioral health outcomes than “usual care”
  - **2002: First big trial** was published (IMPACT study out of the University of Washington)
- **Primary care-based**: Meets behavioral health need in patient’s medical home
- Patient **improvements compare to those achieved in specialty care** for mild-moderate conditions
- Return on investment of **6:1**

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Target Population

- Highly evidence-based for **adults with depression and anxiety**
  - Depression and/or anxiety population served by primary care
  - Increasing evidence for **adolescent depression, PTSD, and co-morbid medical conditions**
  - More complex patients should be served at behavioral health specialty clinics
- Defining the **target population**:
  - PHQ-9 and/or GAD-7 of **10 or more**
  - **Diagnosis** of depression and/or anxiety
  - Just started on a new antidepressant, regimen was changed, or PCP could use prescribing guidance

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More Evidence

- CoCM is linked to **better medical outcomes** for patients with diabetes, cardiovascular disease, cancer and chronic arthritis
- A **2016 retrospective study** at Mayo Clinic found that the time to **depression remission was 86 days in a CoCM program** compared to 614 days in usual care

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Components of the Evidence-Based Model

- **Patient-Centered Care**
  - Effective collaboration between BHCMs and PCPs, incorporating patient goals into the treatment plan
- **Measurement-Based Treatment to Target**
  - Measurable treatment goals and outcomes defined and tracked for each patient (PHQ-9/GAD-7)
  - Treatments are actively changed until the clinical goals are achieved
- **Population-Based Care**
  - Defined and tracked patient population to ensure no one falls through the cracks
- **Evidence-Based Care**
  - Treatments are based on evidence
- **Accountable Care**
  - Providers are accountable and reimbursed for quality of care and clinical outcomes

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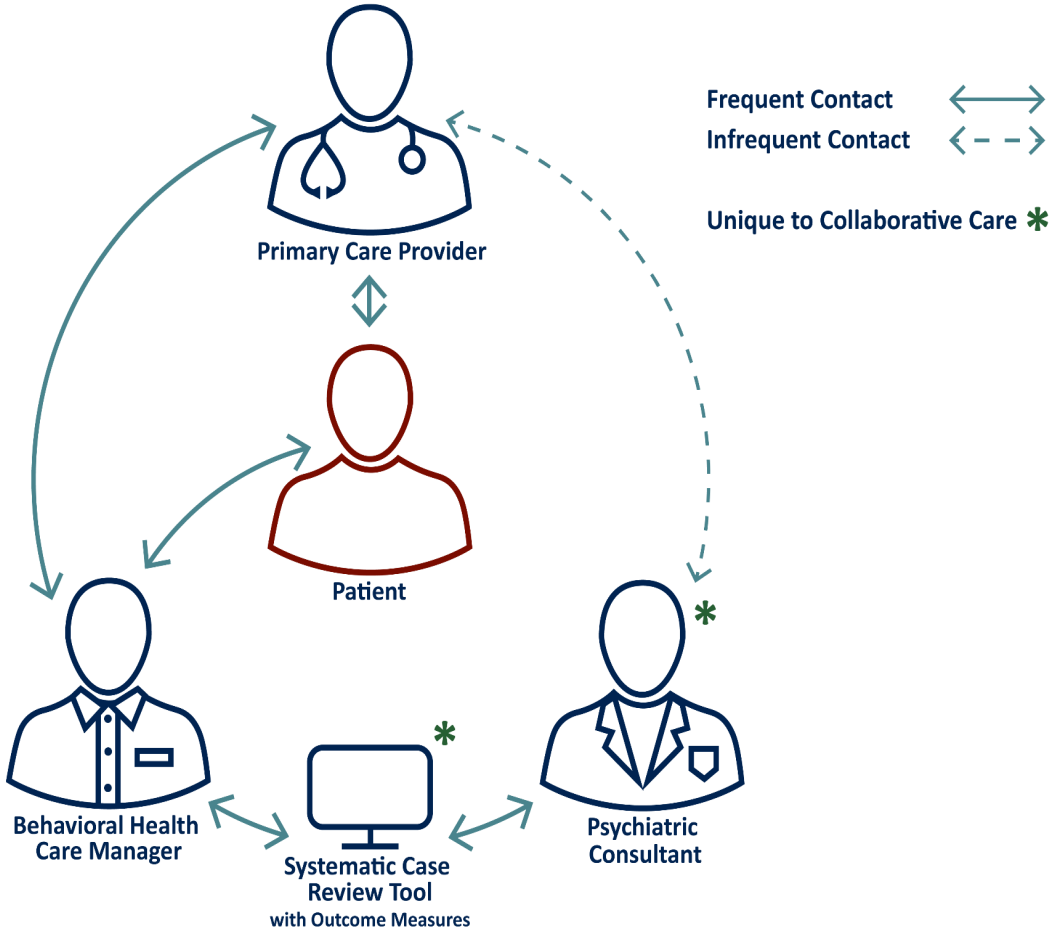
The Collaborative Care Treatment Team



Builds on Team-Based Care

The provision of health services to individuals, families, and/or their communities by at least two health care providers who work collaboratively with patients and their caregivers, to the extent preferred by each patient, to accomplish shared goals within and across settings to achieve coordinated, high-quality care.

Who is on the team?

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The Patient

- **Works closely with the BHCM and PCP** to report symptoms, set goals, track progress, and ask questions
- **Sets goals for treatment** with the team
- **Actively engages** in self-management action planning
- **Completes outcome measures**
- **An active participant on the team. Asks questions and discusses concerns** with the PCP and BHCM
- **Agrees and is willing to take treatment plan actions** including any applicable medication (name, dosage, etc.)

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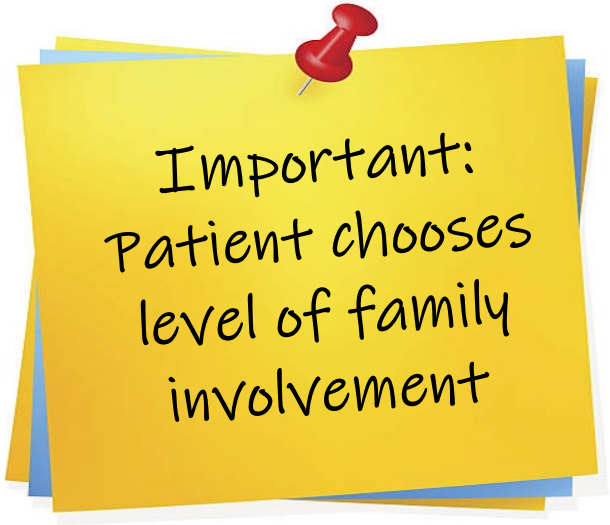
Caregivers and/or Family

- Can help **provide additional patient information** in areas such as: symptoms, mood, behavior, baseline functioning of patients
- Can **provide support to treatment plans**, especially in self-management

Ideas for engagement:

- **Discuss the family's shared views** of depression/anxiety (myths, causes, beliefs)
- **Give family members a role** in supporting the patient's treatment
  - Check in regarding med adherence (if appropriate and permission given by patient)
- **Engage family in relapse prevention planning**



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The Primary Care Provider

- **Oversees all aspects of a patient's care** and diagnoses behavioral health concerns
- **Introduces the collaborative care program** and makes referrals (ideally a warm hand-off)
- **Prescribes medications and adjusts treatment** following consultation with the BHCM and the psychiatric consultant
- **Speaks with the psychiatric consultant** as needed (this may be infrequent)
- **Remains the team lead** and will decide whether or not to incorporate recommendations from the consulting psychiatrist

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Two New Team Members

- **Psychiatric Consultant**—a medical professional trained in psychiatry and qualified to prescribe the full range of medications

- **Behavioral Health Care Manager (BHCM)**—typically social workers, nurses, psychologists or licensed counselors. The BHCM coordinators the overall effort of the group and ensures effective communication among team members.
  - Must have a **professional license in the state** in which they are practicing and **specialized BH training**
  - The ability to effectively perform the tasks that need to be completed is much more important than one's credentials

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Psychiatric Consultant

- Supports PCP and BHCM by regularly reviewing cases with the BHCM in **scheduled systematic case reviews**
- **Recommends treatment planning for all enrolled patients**, particularly those who are new, not improving, or need medication adjustments
- Reviews treatment plan and **makes behaviorally-based recommendations**
- The psychiatric consultant **may suggest treatment modifications** for the PCP to consider, recommend the PCP see the patient for an in-person consultation, or directly consult on patients who are clinically challenging or who need specialty mental health services**. The consultant does not see the patient, except in rare circumstances, and does not prescribe medications.**

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Psychiatric Consultant

- **Advises recommendations –** documents in the EMR if access; or the BHCM'er documents and confirms accuracy.
- **Provides psychopharmacology education** to the PCPs and clinical staff

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Behavioral Health Care Manager

- **Manages a caseload of patients**
- Works closely with the PCP to **facilitate patient engagement and education**
- **Performs structured outcomes-based assessments** (Monitoring PHQ-9/GAD 7) along with risk assessment and safety planning
- Systematically **tracks treatment**
- Supports patient in **self-management planning**

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Behavioral Health Care Manager

- Using motivational interviewing provides brief behavioral interventions, **monitors adherence to treatment plan** and supports medication management
- Engages patients in **relapse prevention planning**
- Uses the systematic case review to systematically review caseload and **ensure no patients are falling through the cracks**
- BHCMs come from **many different backgrounds and skill sets**, e.g. social worker, nurse, licensed professional counselor, psychologist

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Summary: What Sets CoCM Apart?

- **Population health approach**
  - Use of a systematic case review tool to ensure no one falls through the cracks
  - Proactive, tailored outreach allowing for monitoring and updates in-between PCP visits
  - Treatments are adjusted until patients achieve remission or maximum improvement
  - Data evaluates key process measures and patient outcomes
- **Maximizes access** to limited psychiatry time
  - Multiple patients reviewed per hour as opposed to one patient
  - Helps reserve specialty psychiatry time for higher level cases
- **Typically, a short wait time** from referral to receiving an expert psychiatric recommendation (often within one week)

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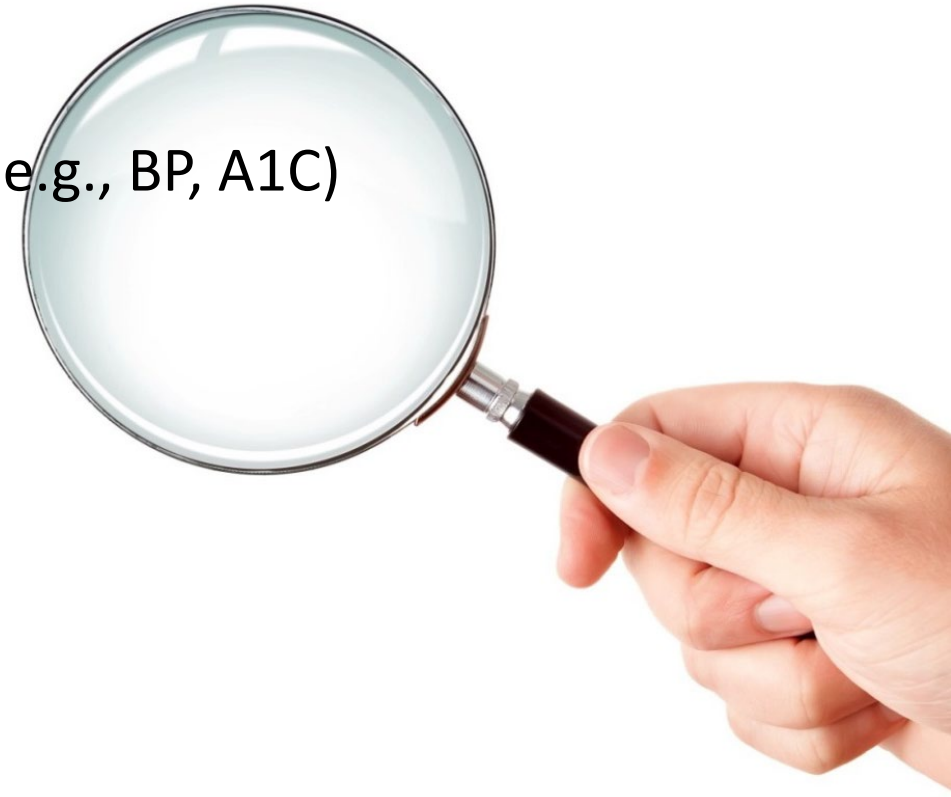
Advantages of CoCM

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



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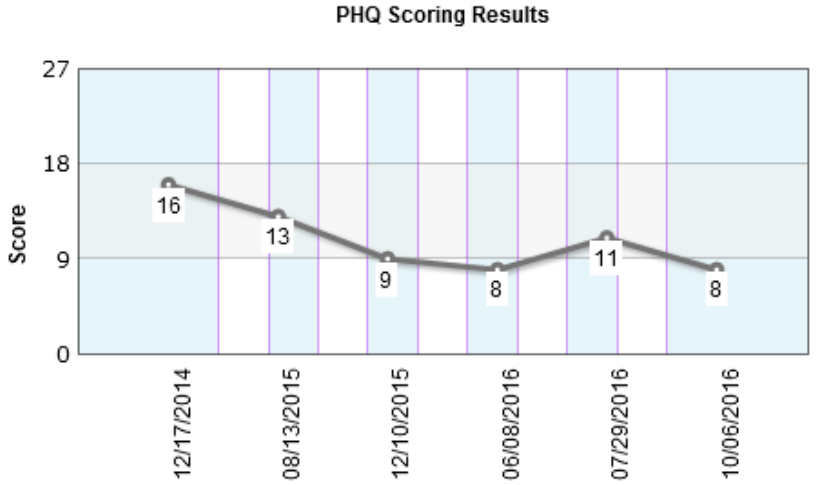
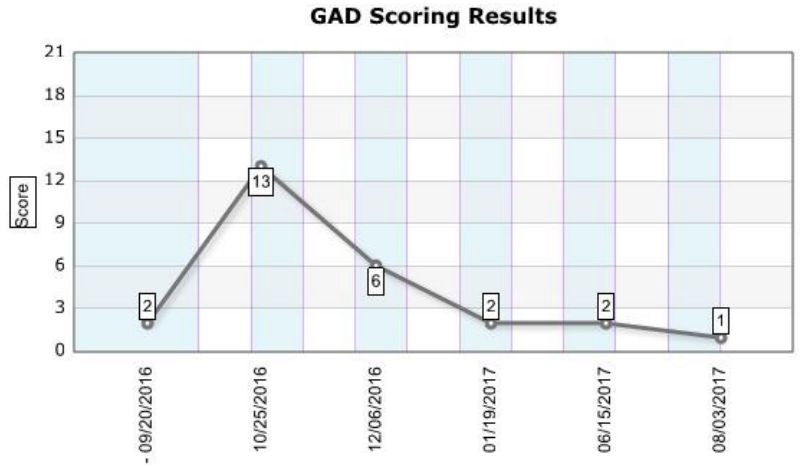
Patients Shared Positive Feedback

"Thank you so much for working so diligently… It really means the world to me to have such genuine support and help like you offer. **You honestly saved my life**, and I cannot thank you enough."

"Thank you so much for the support and help. **I never imagined how helpful all this could be**. I was terrified and had been avoiding going to the doctor for so long because it made me feel weak to need help. Thanks."





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…As Did Primary Care Providers

"[Collaborative Care] has made a huge difference in the ability to manage my patients' mental health in the long term. [Care Manager] has been able to spend more time than the 15 minutes available in clinic with myself and has been able to provide vital information in helping manage our patients' complex social and mental health concerns (which often, at Ypsilanti, are deeply intertwined). The direct interaction she has with the psychiatrists in providing guidance regarding medication adjustments has been crucial. Additionally, I have had occasions when she will know the patients previously and will attend appointments with myself and the patient, and the insight she has to the case is invaluable. Overall, **the program's effect on the patient care at the Ypsilanti clinic has been indispensable** and nothing but positive."

—Jane Chargot, MD; Ypsilanti Family Medicine

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Daniel's Story

https://www.youtube.com/watch?v=_J-MFMnTrA4

Questions?