The Process of CoCM

Section 3

The Process of CoCM

Targets: Defining Improvement

- **Validated Outcome Measures:**
  - PHQ-9 (Patient Health Questionnaire)—Depression screening
  - GAD-7 (Generalized Anxiety Disorder)—Anxiety screening
- **Improvement:**
  - 5-point reduction in score = Improvement
  - 50% reduction in score = Response
  - Score less than 5 = Remission

Tracking PHQ-9 score data is required for CoCM service delivery.

Tracking GAD-7 score data is highly recommended but not required.

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Steps of CoCM

Program oversight and quality improvement

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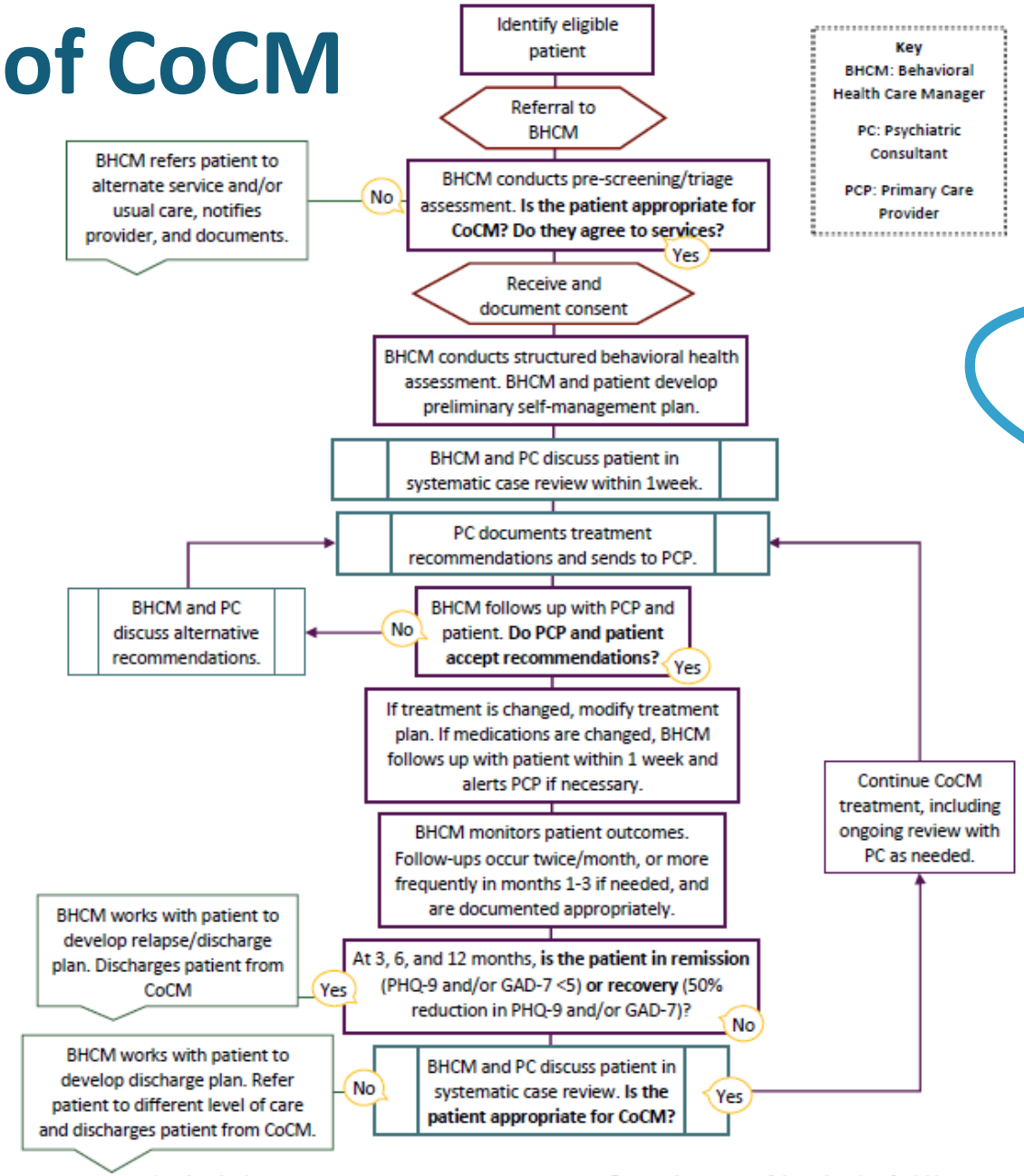

PDF included in your training materials

The Process of CoCM

Identifying Patients

Screening/Referrals

- Diagnosis of depression and/or anxiety
- PHQ-9 and/or GAD-7 of 10+

Patient Finding

- A disease registry can be used to identify patients eligible for CoCM services

Additional Avenues May Trigger Screening

- New or changed dose of psychotropic medication
- Patient not responding to psychiatric medication
- Self-report (depression/anxiety symptoms)

Patients who may not be appropriate candidates:

- Currently under the care of a psychiatrist
- Currently involved with Community Mental Health

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Screening and Measurement-Based Care Tools

GAD-7: Administration Guide from VA

GAD-7

What is it?
Brief Description

- Self-administered 7 item instrument that uses some of the DSM-V criteria for GAD (General Anxiety Disorder) to identify probable cases of GAD along with measuring anxiety symptom severity. It can also be used as a screening measure of panic, social anxiety, and PTSD. It was modeled after the PHQ9 to be used quickly and effectively within a primary care setting.
- When considering a diagnosis, the clinician will still need to use clinical interviewing skills to determine whether the symptoms are causing clinically significant distress or impairment and those symptoms are not better explained or attributed to other conditions (i.e. substance use, medical conditions, bereavement, etc.)

Why should I use it?
Clinical Utility

- Measurement based care emphasizes the use of standardized assessments, and other "tests" to help personalize care and guide treatment decisions.
  - Just as a primary care provider would routinely check glucose levels to better inform their treatment plan for a patient's diabetes, routinely administering rating scales to monitor improvement or a change in mental health symptoms is considered best practice in providing optimal care.

PHQ-9: https://aims.uw.edu/resource-library/help-clinic-staff-talk-patients-about-phq-9

AIMS CENTER
UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

Using the PHQ-9:
A Guide for Medical Assistants, Front and Back Office Staff

What is the Patient Health Questionnaire (PHQ-9)?

The PHQ-9 is a simple, nine question form used to screen depression and monitor changes in signs/symptoms of depression. The patient's PHQ-9 score should be recorded at the beginning of a visit, like blood pressure or other vitals.

Depression screening workflows often include front office staff, medical assistants, and other care team members who might not be used to tracking depression in the same way as other vitals. It is important that the patient sees that all staff feel just as comfortable administering the PHQ-9 as any other vital sign, creating a welcoming environment.

Screening with the PHQ-9

The PHQ-9 can be filled out two ways; directly handing a copy to the patient to complete on their own or being administered verbally by staff as part of the rooming process. Studies have shown that patients can successfully fill out this form by themselves and do not always require assistance. If the PHQ-9 is being administered verbally, it is crucial that the administrator asks the question to the patient exactly as it is written on the form to ensure accurate data.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

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

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

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

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

GAD-7

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

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

Patient Identification During the Visit
Janice Banco

Janice presents to the clinic for her annual wellness visit. Part of the visit will include depression screening.

As part of the planned visit, the office mailed Janice the PHQ9 form and asked her to bring it along to the visit. Janice hands in the form when she registers at the front desk.

The front desk team member clips the form onto the MA's clipboard. The MA opens Janice record and enters the results into the EMR flowchart.

The MA then sends an instant message to the provider informing her the results have been entered, and the score is above 10.

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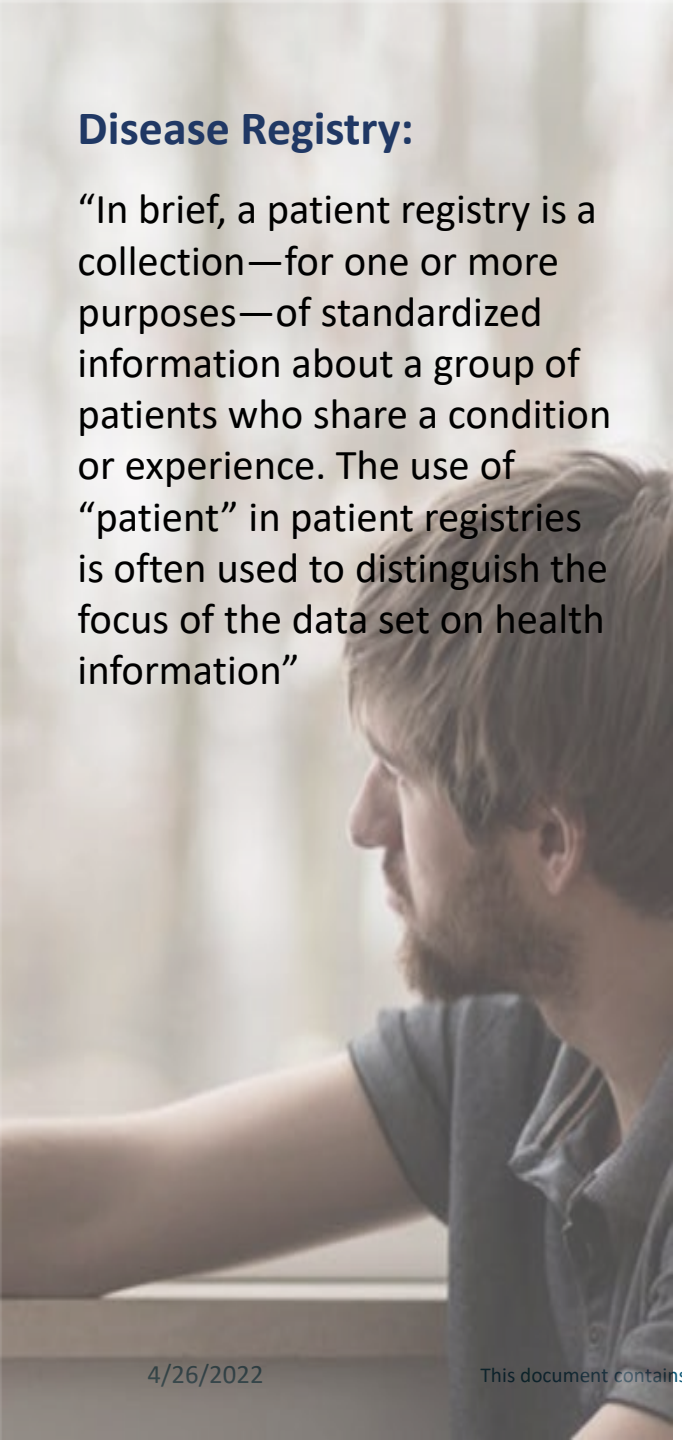
Considerations for Screening

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

Poll: How is screening happening in your practice?



Disease Registry:

"In brief, a patient registry is a collection—for one or more purposes—of standardized information about a group of patients who share a condition or experience. The use of "patient" in patient registries is often used to distinguish the focus of the data set on health information"

Patient Identification Using the Registry
Rob Billinger

It's been 18 months since Rob's last clinic visit. Rob, a veteran, has a history of depressive episodes post-discharge, and has received treatment with medications and therapy a couple of times in the last 5 years.

The population health manager obtains the Disease **Registry Report** and notices Bob hasn't had a PHQ in the last 12 months. He is 6 months overdue.

All patients have an annual screening and when a diagnosis of depression is identified, the date of completion and the score is entered into the registry in this clinic.

All quality metric scores are reported out every quarter, this includes the score and date of the last PHQ.

https://www.ncbi.nlm.nih.gov/books/NBK164514/

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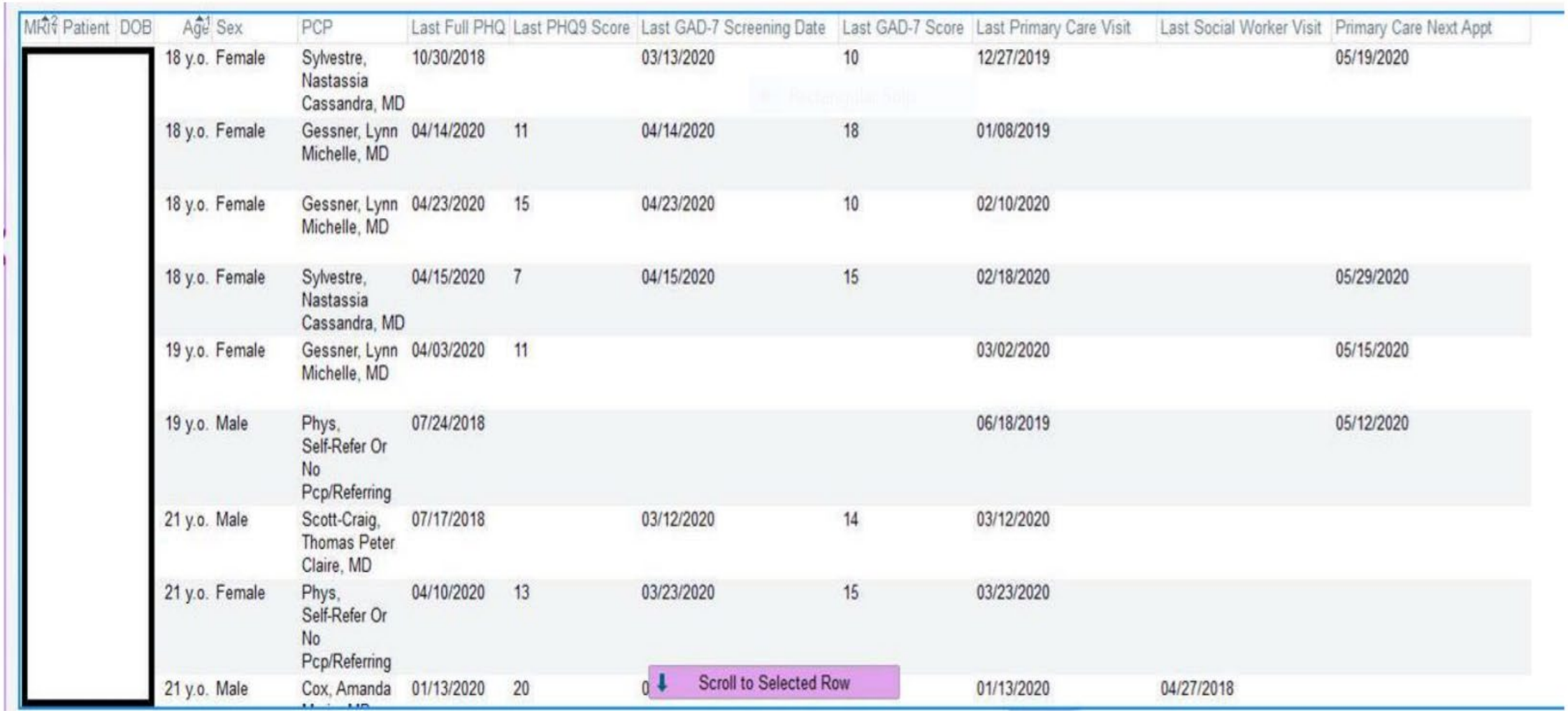
Disease Registry



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		01/13/2020	04/27/2018	

Scroll to Selected Row

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Building CoCM into Standard Work

1. **Determine or identify a standard.**
   Identifying areas where best practices are either non-existent or inadequate.
2. **Establish consensus around the proposed standard.**
   Once you've defined the standard, communicate that information to the rest of the team. The goal is to ensure that everyone understands what that standard is and how it stands to improve processes. Additionally, everyone needs to commit to following the standard.
3. **Confirm that the standard is reasonable and easy to follow.**
   Evaluate the proposed standard to determine whether it's reasonable, fair, and can be followed. For example, you may need to make improvements to the standard to clarify what's expected at each step or to streamline a specific task.

https://www.gembaacademy.com/resources/gemba-glossary/standard-work#:~:text=Standard%20Work%20is%20the%20practice,and%20the%20foundation%20for%20Kaizen.

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Standard Work - Application to CoCM

- Who will **provide** the screening tool? Who will **document** the results?
- How will **referrals** to the BHCM be **communicated** in your workflow?
- Building CoCM into current workflows, resources, channels of communication
- **Documentation and Tracking**
  - Document and report on **how many patients referred** and **how many accepted/declined**
  - Of those who **declined**, what was the reason? (SCR tool standard measurement)

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Managing Patients Benefiting from Higher Level of Care

- **Patients with:**
  - Severe substance use disorders
  - Active psychosis
  - Significant developmental disabilities
  - Personality disorders requiring long-term specialty care
- Currently receiving **Community Mental Health** or better served by CMH-level services

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Other Considerations

- Significant cognitive deficits
- Psychotic symptoms
- Symptoms due to a medical condition
- Severe substance use disorder
- **Acute safety** concerns

Acute Safety Concern Patient
Ginny Bell

Ginny is enrolled into CoCM and is in today after starting new medications for depression.

The MA notes in the medical record the BHCM'er completed a PHQ-9 (3 weeks ago). As it's been over 2 weeks since a screening was done, the MA has Ginny complete a paper PHQ-9 today.

Ginny: I just did this with Chris a couple of weeks ago. Do I really need to do this again?

MA: Your provider wants to know more about your overall health so that we can properly gauge if the treatment is working the way it should. Just like we do with your blood pressure.

Ginny completes the screening form and hands it to the MA.

The MA sees Ginny marked question 9, "Thoughts that you would be better off dead or of hurting yourself in some way? ☑Several Days

The MA alerts the provider and stays with the patient.

Suicidality - Poll

- Screening
- Concerns
- Questions
- Comments

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Acute Safety Concerns: Suicidal Ideation

Suicidal Ideation Is A Common Symptom Of Depression

- Important to know when **immediate intervention** is needed
  - PHQ-9, Question 9: Thoughts that you would be better off dead or of hurting yourself in some way
- A workflow for suicidal ideation should be built into any Collaborative Care model as well as a **policy that all practice staff are familiar with**

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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?”*

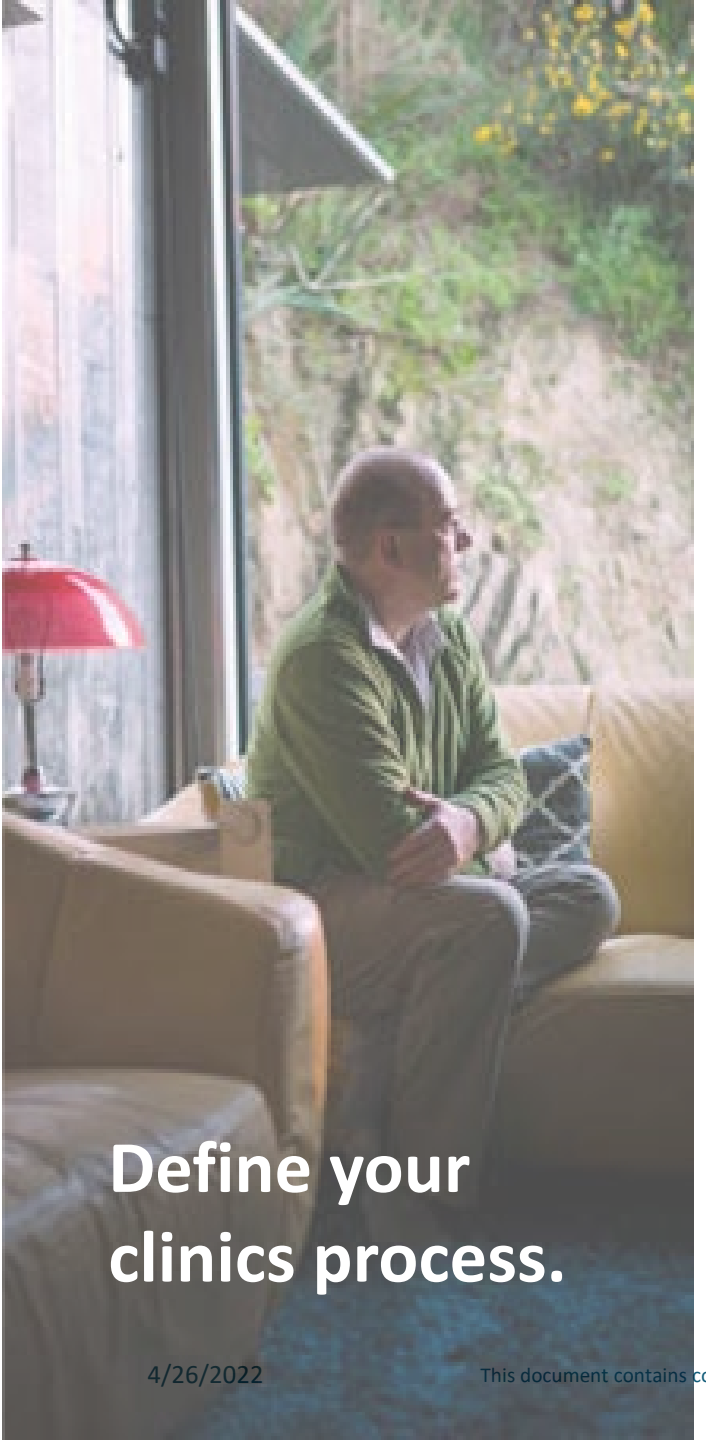
***See Handout #13 Suicide Policy

Suicide Plan Key Components

ALWAYS:

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

Stretch Break—15 Minutes



Defining a Process
Alfred Hitchhock

Alfred (Al) is in today for his routine diabetes check. Part of the planned visit includes having a PHQ2 done.

The MA collects the PHQ2 verbally. She provides the instructions and the response options.

Answer Options:

Not at all	Several Days	More than half the days	Nearly every day

The MA asks: Over the last 2 weeks, how often have you been bothered by any of the following:

1. Little interest or pleasure in doing things?..... Several Days
2. Feeling down, depressed, or hopeless?..... More than half the days

The MA then sends a note to the PCP with the results.

*In this clinic, the PCP completes the PHQ-9 when the PHQ-2 is positive.

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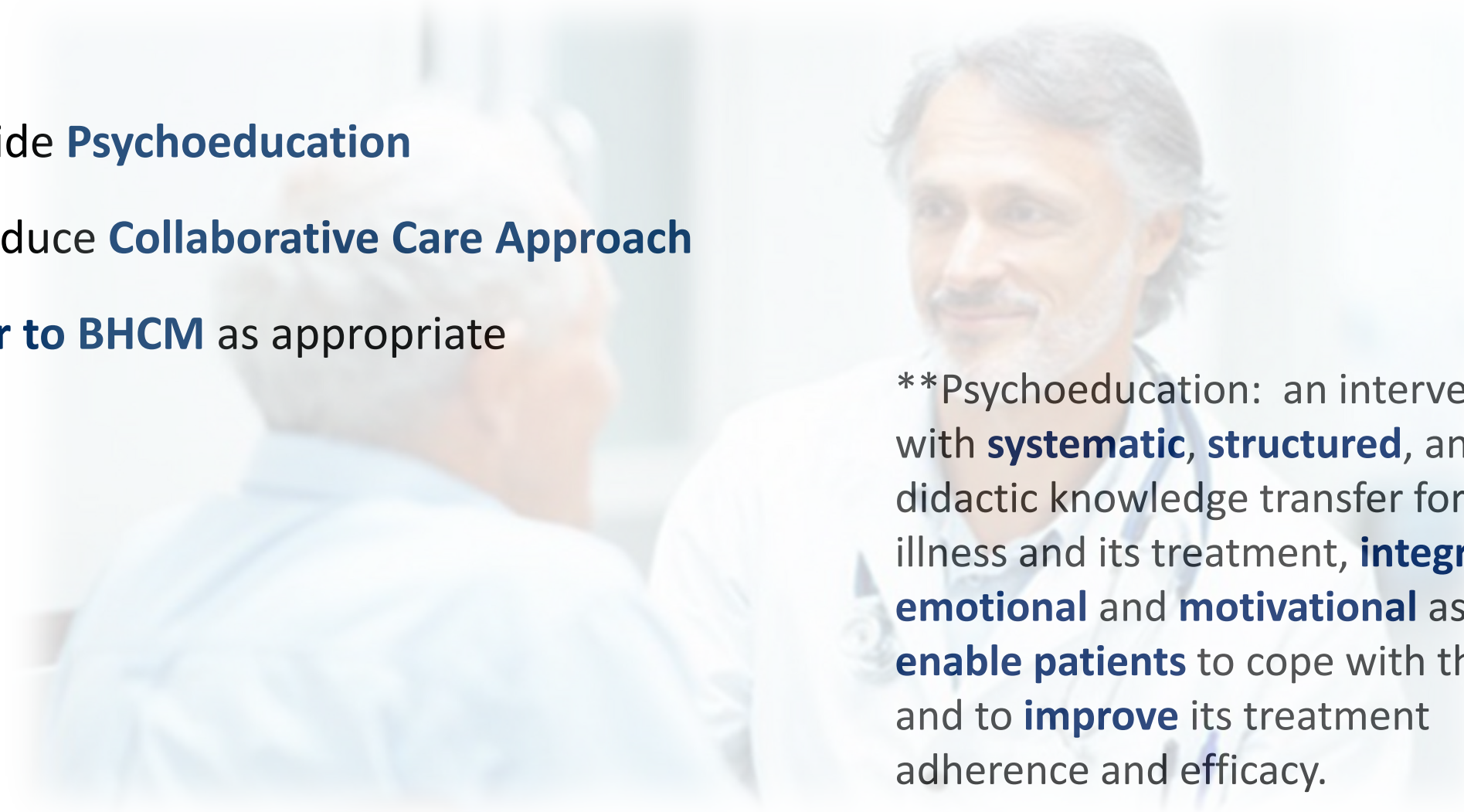
Engage – Starts with the Provider

- Provide **Psychoeducation**
- Introduce **Collaborative Care Approach**
- **Refer to BHCM** as appropriate



Psychoeducation: an intervention with **systematic, **structured**, and didactic knowledge transfer for an illness and its treatment, **integrating emotional** and **motivational** aspects to **enable patients** to cope with the illness and to **improve** its treatment adherence and efficacy.

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Speaking with Patients

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

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Key Talking Points: Provider to the Patient

- The **Patient role**: You are a key **part of the team**
- The **PCP role: I will oversee** all aspects of care received at the practice
- The **BHCM role:** I work closely with the **BHCM'er,** and will make the decisions on what steps to take to implement the treatment plan/self-management plan while keeping track of progress and providing additional support
- The **Psychiatric Consultant role:** We have a new member on the team that provides us with his/her expertise with the conditions of _____. This is a psychiatrist. You will **not** see the psychiatrist. He/She provides guidance to the team to ensure we are offering the most current recommendations and best care for your _____.
- All **Team Members**: We will coordinate and work together to create a shared **treatment plan to support all of your care needs, this includes your input and goals**

Explain: This is **not typical therapy**—The BHCM'er will contact you to follow up. She/he will work with you on ideas and approaches to manage _____. Initially he/she will schedule a visit to complete an assessment then set up times to follow up on your progress. This is often by phone. If counseling is advised, the BHCM'er will assist with setting that up.

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Consent

Verbal or Written

- Resource: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf
- Documented in EHR before services begin

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)

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Verification of Coverage

- Consider your workflow to **verify patient coverage**
  - Does the patient's insurance provider coverage for CoCM services?
  - Is there a cost share associated with CoCM services?

****BCBSM has waived cost sharing (deductible, coinsurance and copayments) for most employer groups.**

Refrain from quoting benefits – best to have the patient check on this.

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Warm Handoff to BHCM

- Call/ask BHCM for **exam room drop-in**
- If BHCM available, provide a warm handoff:

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

- The warm handoff is **very effective**:
  - Leverages the rapport/trust that patient has with PCP
  - Fosters familiarity with new team member
  - Offers opportunity for further assessment

The Process of CoCM

Warm Handoff to BHCM (continued)

- If BHCM is **not available** to meet patient face-to-face:
  - Send chart/note to BHCM for outreach
  - Make sure patient is aware they will be receiving a phone call
  - Reinforce this is how you manage _____, and the BHCM'er is a trusted member of the team

Demonstration of Introduction to CoCM

Activity: Example is in the toolkit

“Introduction of CoCM to the patient”

#5 in the handout

The Process of CoCM

Challenges of Engagement

- When talking with patients about mental health **there may be challenges**:
  - Lack of understanding of diagnosis
  - Inability to tie current behavior to mental health condition
  - Stigma
  - Preexisting beliefs about psychiatric medications and mental health treatment
  - Religious/cultural beliefs
- **Be prepared** for these challenges and **have tools and resources** ready

The Process of CoCM

The BHCM Assessment

The initial assessment may take up to 45 minutes

- Components of the initial assessment includes pertinent medical and behavioral health treatment experience, history, and pertinent clinical parameters and pertinent social challenges and supports
  - History of BH, including family history
  - History of current medical and psychosocial status
  - Current and history of medications
  - Substance use history
- The BHCM will identify the patients concerns, beliefs, needs, strengths and desire to incorporate into the patient self-management action plan

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

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The Role of the Psychiatric Consultant

- Following the assessment by the CoCM, the patient is added to the systematic case review tool and reviewed with the Psychiatric Consultant during systematic case review. **Treatment recommendations, including psychotropic medications are made by the Psychiatric Consultant**
- The Psychiatric Consultant continues to review the BHCM case load and **prioritize those patients who are not improving** and continues to provide treatment recommendations as indicated
- The Psychiatric Consultant can also **provide assistance with diagnosis** and help distinguish a patient's appropriateness for CoCM

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Psychiatrist and BHCM'er Role: Systematic Case Review (SCR)

SCR is a Critical Component to the CoCM Model. Content of SCR outline is collaboratively created with the Psychiatric Consultant and BHCM'er.

- This should happen <u>every week</u>
- Review new patients first
  - Come up with a plan and get it off to the patient and PCP
    - Note in record by the psychiatrist based on data gathered from BHCM
- Review those needing more attention
  - Every patient needs a deeper review once/month
    - documented in the record by the psychiatrist optimal. If not an option the BHCM'er documents the recommendations and repeats back or shares note for verification
- Finally, 'run the list' of all remaining patients to watch for issues
  - Someone hospitalized or in the ED? – no note necessary unless a recommendation.

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Systematic Case Review Tool—Why?

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

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What's the Difference?

Systematic Case Review Tool	Disease Registry
Caseload management tool used in conjunction with or built into the EHR	List of patients with a diagnosis of depression, anxiety, or other behavioral health condition
• Summary of key treatment information (e.g., outcome measure scores, dates of contacts) for individual patients and entire caseload	• Could be incorporated with existing chronic disease registry
• Used by BHCM and psychiatric consultant to regularly review the CoCM caseload	• Used to identify patients who are eligible for the CoCM services
• **Clinical tool required for CoCM service delivery**	• Often static

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Components: Systematic Case Review Tool

Required

- **Patient identification**
- **Treatment status** (e.g., active, inactive, relapse prevention)
- **Date of enrollment and disenrollment**
- **Baseline and most recent outcome measure scores** (PHQ-9 and/or GAD-7) **and dates**
- **Date of most recent BHCM follow-up contact 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

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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.

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MCCIST Systematic Case Review Tool Development Guide

https://mccist.org/wp-content/uploads/2020/10/SCR-Tool-Development-Guide.pdf

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Documentation Consideration: 21st Century Cures Act: Impact on medical documentation visibility by patients

Notes that must be shared:

1. Consultation notes
2. Imaging narratives
3. Laboratory report narratives
4. Pathology report narratives
5. Procedure notes
6. Discharge summary notes
7. History and physical
8. Progress notes

Clinical notes to which the rules do not apply:

1. **Psychotherapy notes that are separated from the rest of the individual's medical record** and are recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session.
2. **Information** compiled in reasonable anticipation of, or use **in a civil, criminal or administrative action or proceeding**.

Note: All *clinicians and organizations **are required to share** medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.*

https://www.opennotes.org/onc-federal-rule/#:~:text=On%20April%205%2C%202021%2C%20federal,the%20rules%20allow%20specified%20exceptions.

The Process of CoCM

Systematic Case Review: Standard Work Considerations Communication and Documentation

- How will the Psychiatric Consultants recommendations reach the PCP?
- How will the BHCM know when the PCP has reviewed the recommendations and decided about implementation?

Hello (PCP name)

I had the opportunity to discuss your patient, (NAME), with the clinic's behavioral health care manager, (NAME), in our weekly systematic case review meeting. Please see below for my recommendations.

Brief Summary

Recommendations

Behavioral health care manager, (NAME), will continue to follow patient for symptoms monitoring and support

Possible Side Effects

Scores

PHQ-9

GAD-7

Background and and Decision-Making

Safety Concerns

Substance Use Concerns

Previous Medication Trials

The above treatment considerations and suggestions were based on consultation with the behavioral health care manager and a review of information available in the chart. I have not personally examined the patient. All recommendations should be implemented with consideration of the patient's relevant prior history and clinical status. Please feel free to call me with any questions about this patient.

EHR Documentation Guide

The Process of CoCM

Systematic Case Review

Demonstration Activity

The Process of CoCM

Getting Started: Initial Treatment Planning

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

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Treatment Plan

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

The Process of CoCM

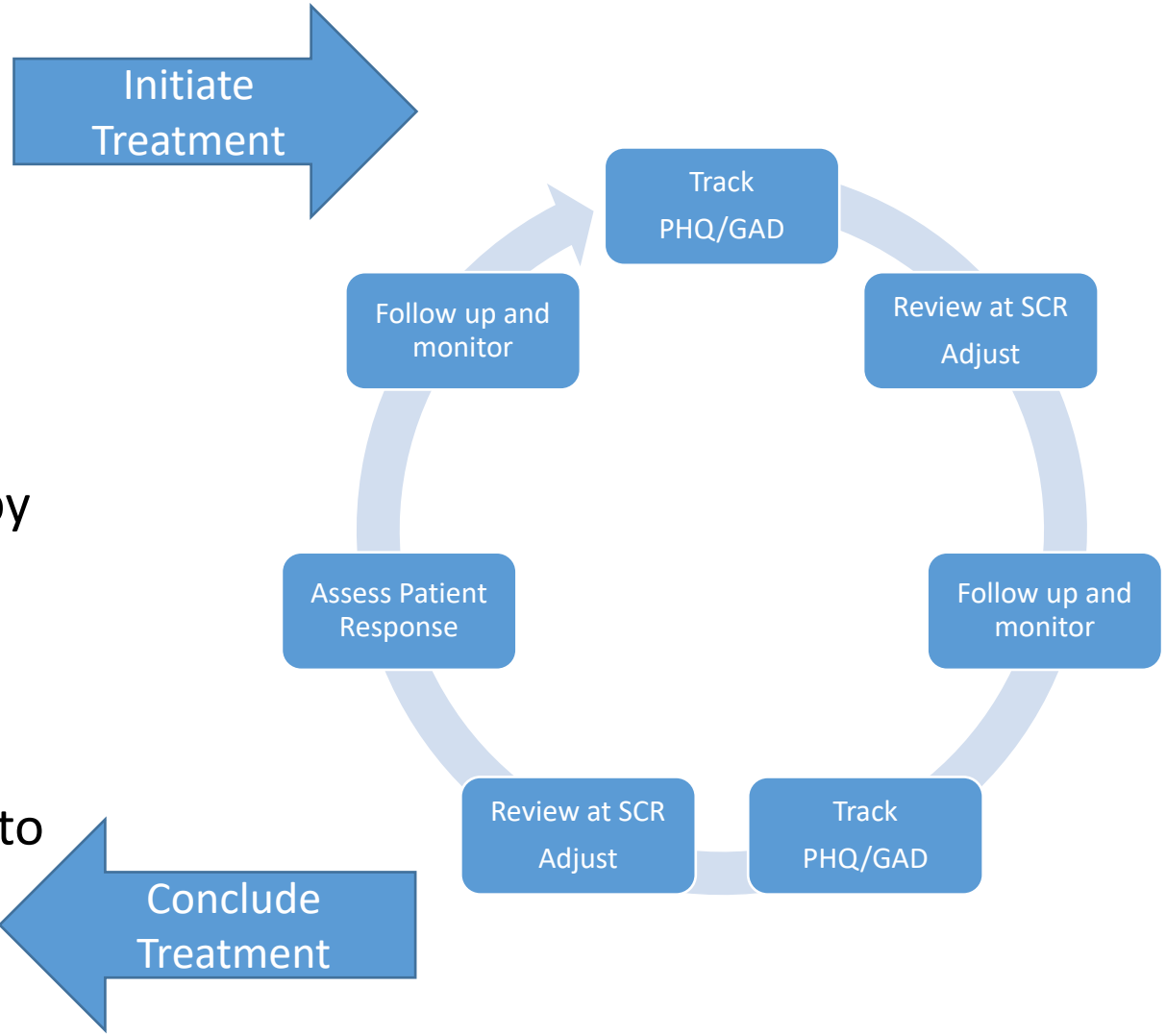
Treatment Steps – Implementation and Monitoring

Initiate treatment

- **Track** Treatment
- Follow-up contacts and **progress** of treatment/self-management plan
- **Adjust** Treatment
- **Assess patient's improvement** as defined by PHQ-9 and GAD-7
- **Adjust** treatment accordingly

Conclude Treatment

- **Relapse Prevention Planning or transition** to community resources



The Process of CoCM

Treat to Target and Treatment Intensification

Be prepared to adjust the treatment plan until targets are achieved (think SCR)

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

Treat to Target has been used for medical conditions for decades (e.g., diabetes, hypertension)

The Process of CoCM

BHCM Interventions

Using the **Spirit** and Concepts of **Motivational Interviewing** the **BHCM will provide**:

- Problem-Solving Treatment
- Behavioral Activation
- Medication Monitoring
- Education

The Process of CoCM

Early On: Self-Management Plan

- Self-management plans are **defined as:** ‘structured, documented plans that are developed to support an individual patient's self-management of their condition’
- The **BHCM will develop a Self-Management Plan with the patient** that all team members should have access to in the chart.

Example: Brenda will walk for 15 minutes in her neighborhood on Monday/Wednesday/Friday morning before work for 6 weeks.

The Process of CoCM

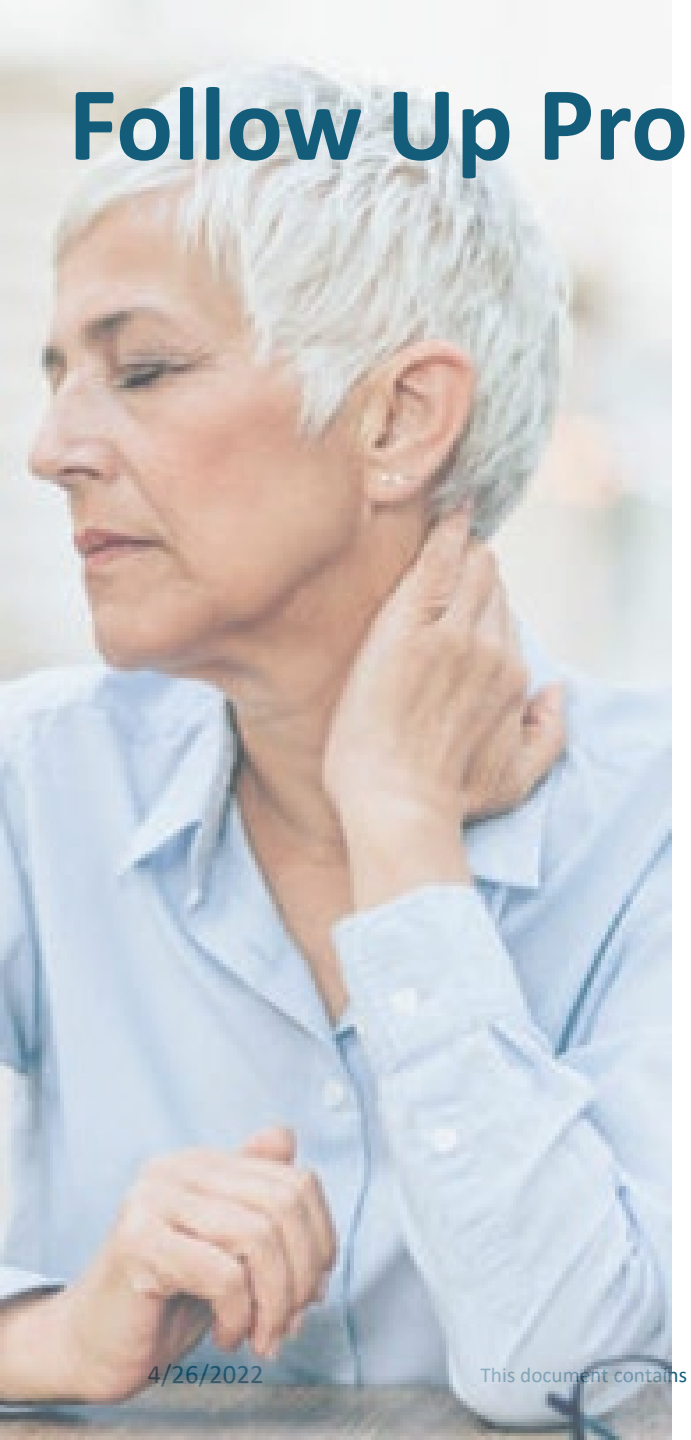
Self Management

Table 1. Components of self-management of depression

Component	Tasks
Information	Educating self and family members/friends about depression
Medication management	Taking Medications as recommended by one's health care provider Overcoming barriers to adherence to medications
Symptom management	Using various strategies to manage symptoms of depression Self-monitoring of symptoms Managing concurrent symptoms of anxiety and/or substance use Using techniques to deal with frustration, fatigue, and isolation Relaxation Using strategies for preventing relapse of depression
Lifestyle	Exercise Overcoming barriers to exercise adherence Vacations Leisure activities Healthy nutrition and diet
Social support	Family support Relationships with peers and friends
Communication	Assertiveness Communication strategies (eg. with mental health professionals)
Others	Accessing support services Creating action plans Decision making Goal setting Problem solving Career Planning Spirituality

Duggal HS. Self-management of depression: Beyond the medical model. Perm J 2019;23:18-295. DOI: https://doi.org/10.7812/TPP/18-295

Follow Up Process: Patient Lindsay Noham



Lindsay's case was initially reviewed with the psychiatrist 4 weeks ago. Lindsay's history did not indicate previous depression episodes, her PHQ-9 score was 15, and she has a BMI of 30 . The psychiatrist recommended Lindsay start on Citalopram. Citalopram is a first line anti-depressant, and related to the obesity, may have a secondary impact on decreased appetite.

There was an initial follow up at 1 week and 2 weeks to closely monitor side effects to the Citalopram.

A few side effects were noted (nausea and constipation), and the BHCM'er provided Lindsay with reassurance they would decrease, and a couple of tips to help manage the side effects.

The BHCM'er let Lindsay know she would also review the side effects with her provider and psychiatrist at the weekly review. The BHCM'er scheduled a follow up visit within a week to review the recommendations and re-assess the side effects.

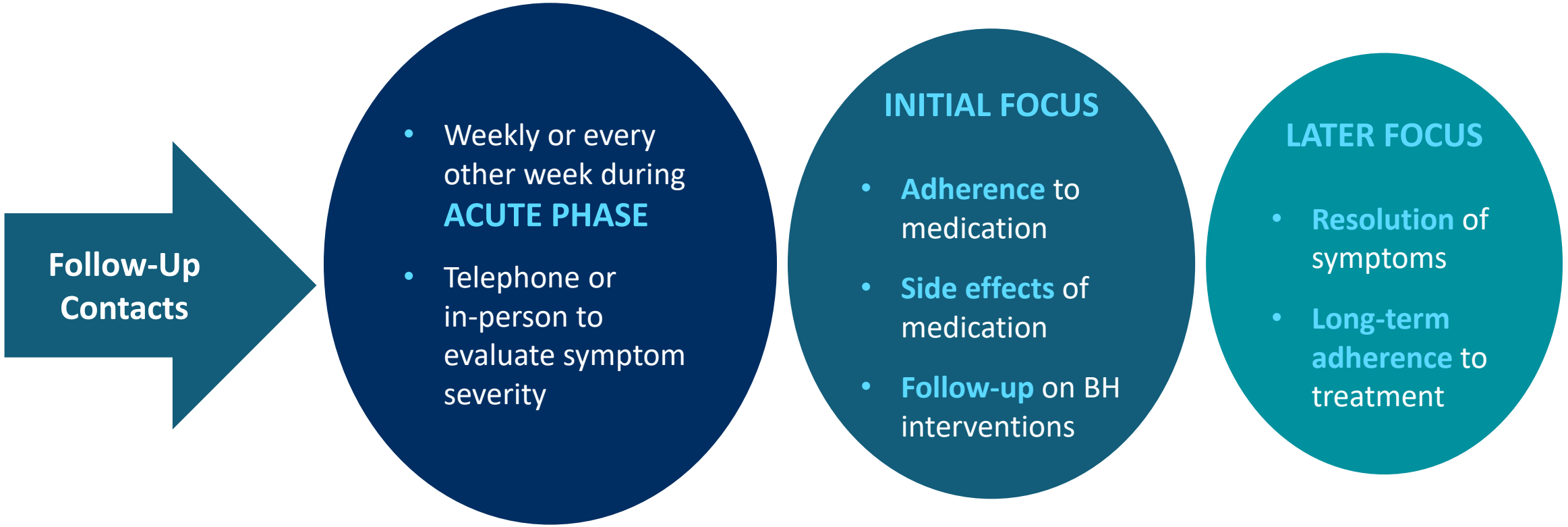
The BHCM'er outreaches to Lindsay today (4 weeks post initial treatment). She greets Lindsay warmly, thanks her for taking the call and reminds Lindsay of the agenda and inquires if there is anything Lindsay would like to add.

Standing Agenda:

- Complete the PHQ-9 (if over 2 weeks since last)
- Review for any risk/safety issues (ER, hospital, new treatment)
- Progress with the self-management action plan (focus on success)
- Open - items for the patient to add

The Process of CoCM

Follow-Up: Frequency



The Process of CoCM

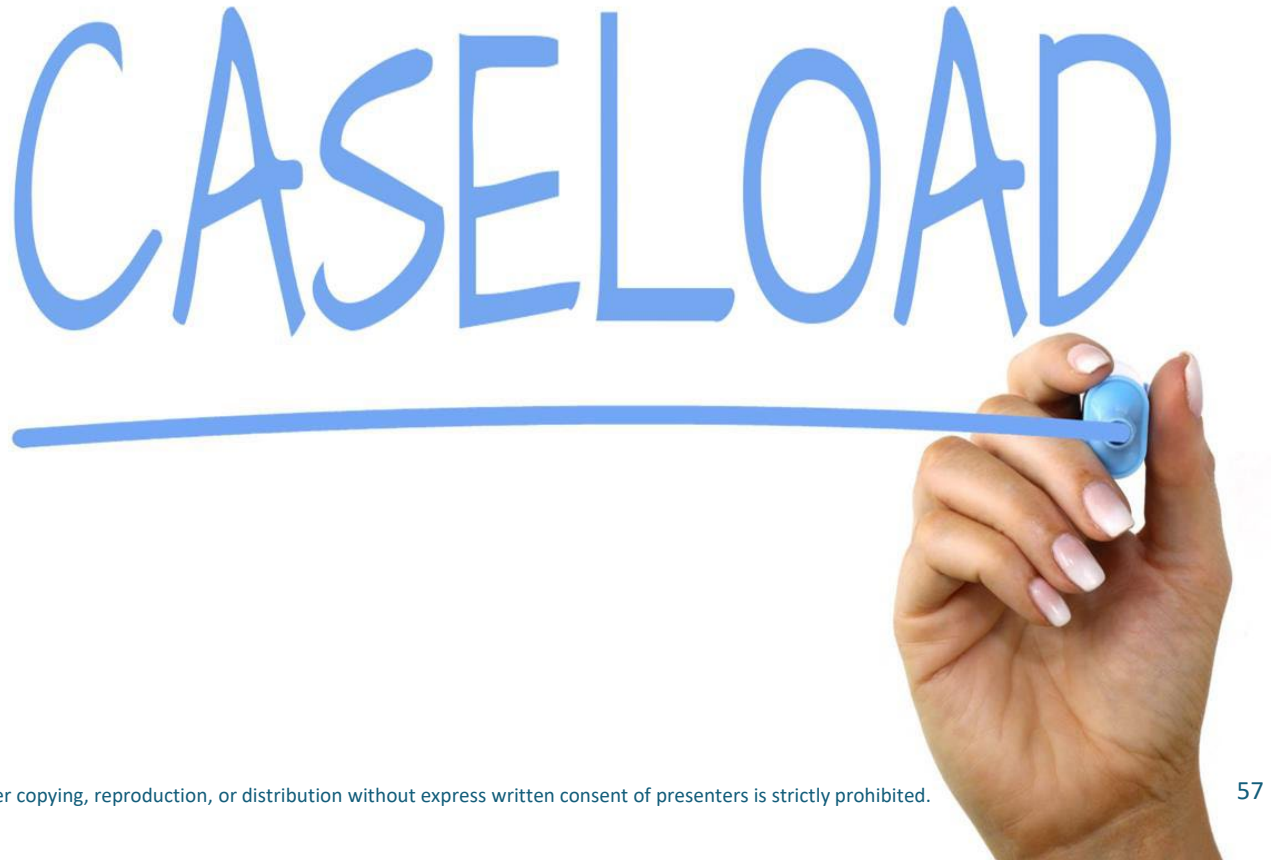
The CoCM Team: Follow Up and Treat to Target

- **PCP**—Continue to prescribe medications and make treatment adjustments as needed, decide and implement treatment recommendations as appropriate, continue to review treatment plan with patient
- **BHCM**—Provide brief behavioral interventions, monitor symptoms, update systematic case review tool, talk with patients about medication and review with psychiatric consultant
- **Psychiatric Consultant**—review case load and prioritize those patients who are not improving, continue to provide treatment recommendations as indicated
- **Patient—**Continue engagement with the team, follow treatment plan, complete screening measures

The Process of CoCM

Additional Considerations:

- Caseload Size
- Eligibility
- Transitioning from CoCare



The Process of CoCM

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

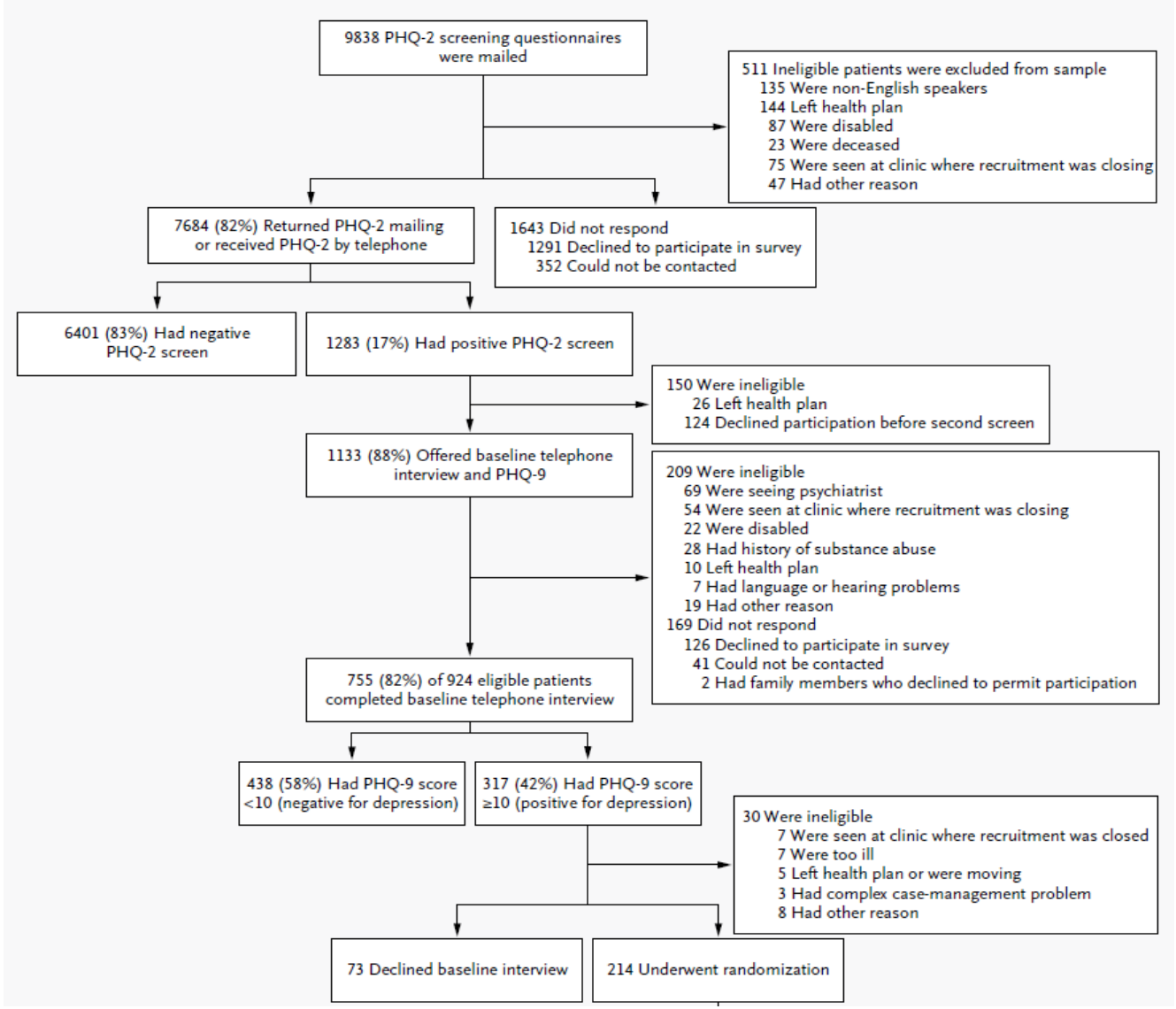
Actual caseload sizes will vary by patient population and program characteristics

Patient Disease Registry

Ex. 1,000 patients with depression

Systematic Case Review Tool

Ex. 60 patients enrolled in CoCM



N Engl J Med 2010;363:2611-20.

The Process of CoCM

Relapse Prevention Planning

Relapse prevention planning **starts at the very beginning of CoCM**

- When patients reach remission, the **BHCM will engage patient** in reviewing and finalizing the relapse prevention planning

**We will review the elements of relapse prevention planning in CoCM training Day 2 and Day 3

The Process of CoCM

Referrals Outside of CoCM

Transition to Community Resources:

- Patient **not getting better**
- Conditions requiring **special expertise**
- Conditions requiring **longer-term care**
- Need for **recovery-based services** (people with serious and persistent mental illness)
- **Patient request**

The Process of CoCM

Recap: Team Roles

- **Team –** starts with a team member providing the patient with the screening tool and documenting it in the patient record. Verification of payer benefit for CoCM.
- **PCP**—recognize signs of possible diagnosis, perform/review screening tools, evaluate potential medical causes/origins of symptoms, orders labs/tests as needed, coordinate with care manager for further assessment
- **BHCM**—complete assessment to determine appropriateness for CoCM (functional impairments, need for higher level of care, crisis management), communicates relevant info to PCP, consults with Psychiatric Consultant during systematic case review if needed for determination. Provides BI and ongoing monitoring with TTT and TI focus
- **Psychiatric Consultant**—provide expert guidance on diagnosis as needed, assist in determining appropriate level of care
- **Patient**—provide information about history and symptoms, complete screening tools

The Process of CoCM

Team Approach

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

Questions?