Training Handout for the Online Training for Behavioral Health Care Managers

Thank you for taking the time to learn about Collaborative Care (CoCM) through our online training.

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The purpose of the AIMS Center is to inspire providers, researchers, and decision-makers to transform healthcare and improve patient outcomes. We accomplish this by translating and researching evidence-based approaches to behavioral health integration. To learn more about the AIMS Center and our work, you can visit our website: https://aims.uw.edu/

Questions About the Online Training?

- Website: https://aims.uw.edu/online-bhcm-modules
- Email: aimstrng@uw.edu

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Collaborative Care Fundamentals

Evidence Base

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1

In This Module

- ✓ Rationale for integrated care
- ✓ Evidence base
  - ✓ IMPACT trial
  - ✓ Mental health conditions beyond depression

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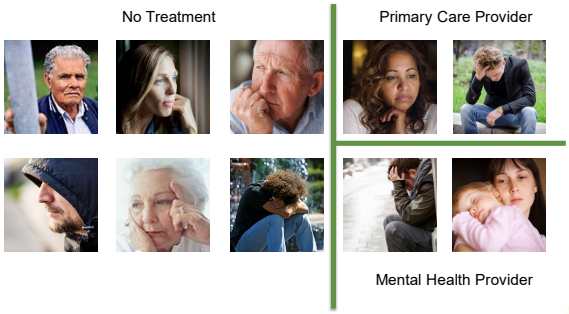
Who Gets Treatment?



Source: Wang et al., 2005

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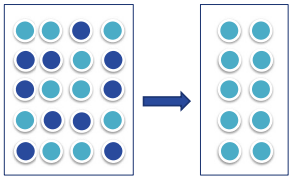
Why Not Just Refer?

Half of those referred do not follow through



Mean # of visits = 2

Source: Grembowski, Martin et al., 2002; Simon, Ding et al., 2012

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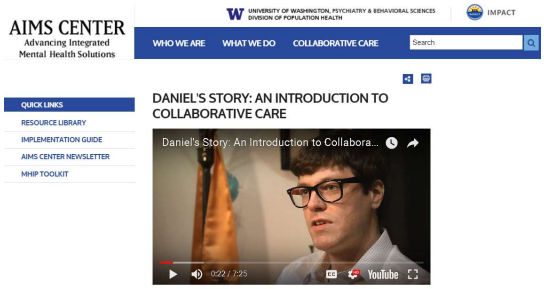
A Better Way to Provide Care



http://aims.uw.edu/daniels-story-introduction-collaborative-care

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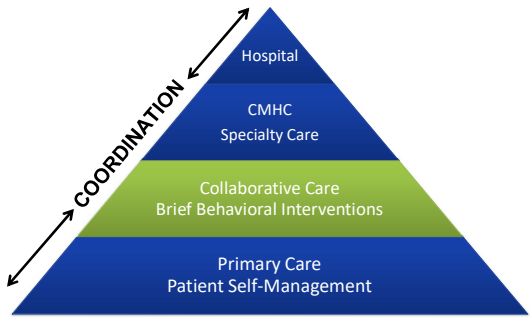
Mental Health in Primary Care Settings



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Evidence Base for Collaborative Care

More than 80 randomized controlled trials have shown collaborative care to be more effective than usual care for common mental health conditions such as depression and anxiety.

First demonstrated in the IMPACT Trial.

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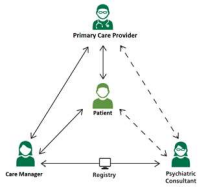
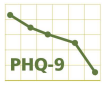
Components of Collaborative Care

Prepared, Pro-active Practice Team



Informed, Active Patient



Outcome Measures

Population Registry

Problem Solving Treatment (PST)
Behavioral Activation (BA)
Motivational Interviewing (MI)
Medications

Treatment Protocols

Psychiatric Consultation

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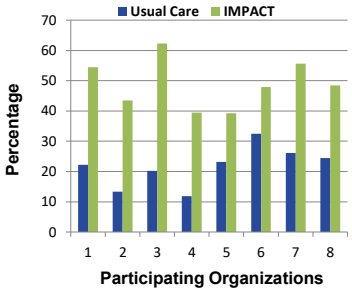
Twice as Many People Improve

50% or greater improvement in depression at 12 months



Source: Unützer et al., 2002, 2005

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IMPACT Trial: Summary

- **Improved outcomes**
  - Less depression
  - Less physical pain
  - Better functioning
  - Higher quality of life
- **Greater patient and provider satisfaction**
- **Reduced healthcare costs**

"I got my life back"

THE TRIPLE AIM

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Collaborative Care for Other Mental Health Conditions

Evidence Base Established	Emerging Evidence
• Depression - Adolescent Depression - Depression, Diabetes, and Heart Disease - Depression and Cancer - Depression in Women's Health Care • Anxiety • Post Traumatic Stress Disorder • Chronic Pain • Dementia • Substance Use Disorders	• ADHD • Bipolar Disorder

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Other Models of Behavioral Health Delivery

Traditional Consultation	Co-Location	Primary Care Behavioral Health
Limited access	Access and interaction	Solidly grounded in a clinical practice culture
Limited feedback	Better communication	Generalist behavioral health provider
Expensive	Long waitlists and limited available providers	Rapid access to brief behavioral interventions
One pass	Limited ability for follow through	Limited evidence base

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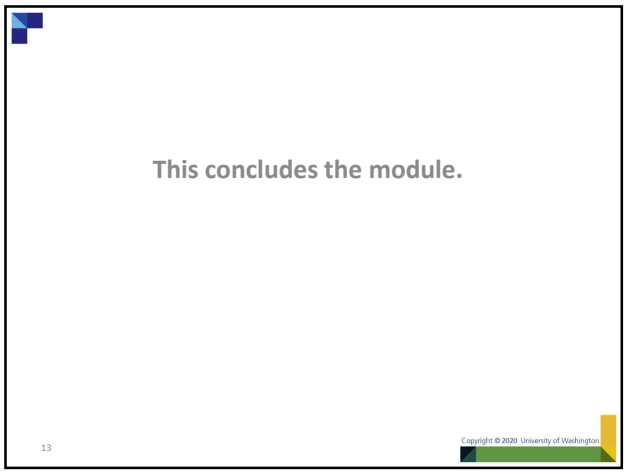
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Core Principles and Team Roles

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16

In This Module

- ✓ Core principles
- ✓ Team roles

17

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Principles of Collaborative Care

- Population-Based Care
- Measurement-Based Treatment to Target
- Patient-Centered Collaboration
- Evidence-Based Care

- Accountable Care

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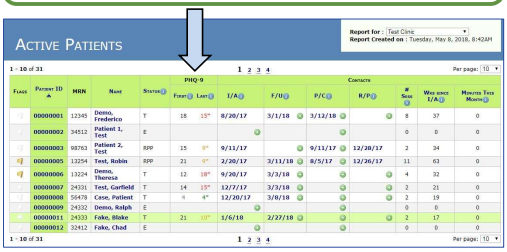
Principle: Population-Based Care

Registry
- Allows proactive engagement and treatment adjustment
- No one falls through the cracks



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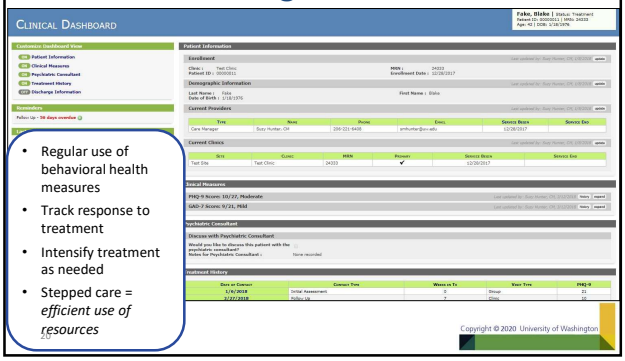
Principle: Measurement-Based Treatment To Target



- Regular use of behavioral health measures
- Track response to treatment
- Intensify treatment as needed
- Stepped care = *efficient use of resources*

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Treatment to Target Drives Early Improvement

In a retrospective study (2008 – 2013) of over 7,000 patients:

Usual primary care: **614 days**

Collaborative care program: **86 days**

Source: Garrison et al., 2016

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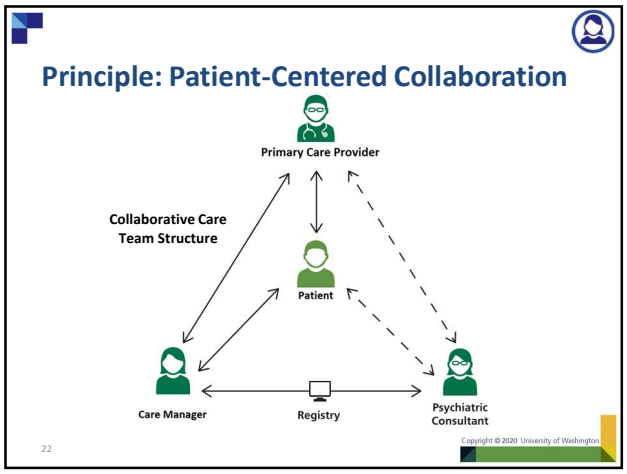
Principle: Patient-Centered Collaboration
Primary Care Provider
Collaborative Care Team Structure
Patient
Care Manager
Registry
Psychiatric Consultant
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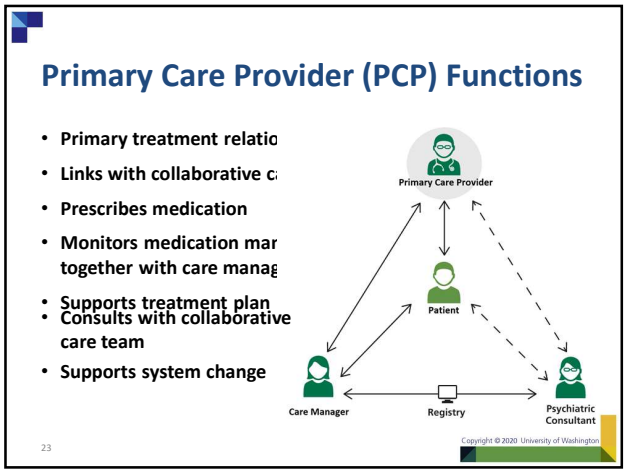
Primary Care Provider (PCP) Functions
Primary treatment relatio
Links with collaborative c
Prescribes medication
Monitors medication mar
together with care manag
Supports treatment plan
Consults with collaborative care team
Supports system change
Primary Care Provider
Patient
Care Manager
Registry
Psychiatric Consultant
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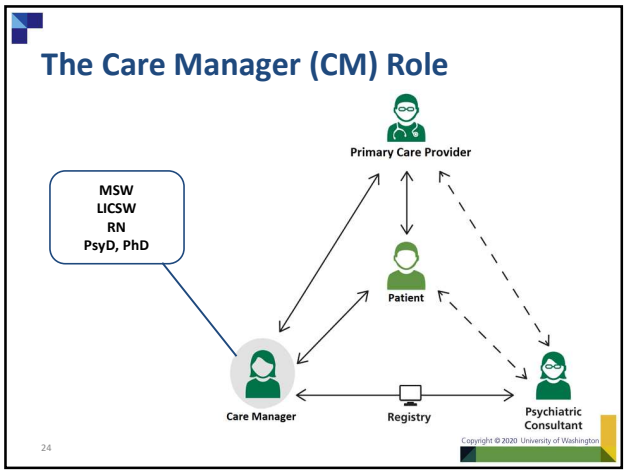
The Care Manager (CM) Role
MSW
LICSW
RN
PsyD, PhD
Primary Care Provider
Patient
Care Manager
Registry
Psychiatric Consultant
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General Care Manager Functions

- **Track and coordinate care**
  - Facilitates patient engagement
  - Performs systematic initial and follow-up assessments
  - Systematically tracks treatment response
  - Supports treatment plan with PCP
  - Reviews challenging patients with the psychiatric consultant weekly

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Care Manager Role in Supporting Treatment Plans

- **Evidence-based brief behavioral interventions**
  - Problem-solving treatment (PST)
  - Cognitive behavioral therapy (CBT)
  - Others
- **Other functions**
  - Behavioral health interventions focused on health behaviors
  - Addressing substance use
  - Social work services

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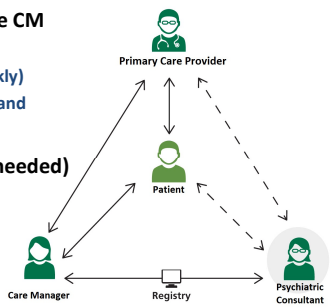
The Psychiatric Consultant (PC) Role

- **Review cases with the CM using the registry**
  - Scheduled (ideally weekly)
  - Prioritize new patients and patients not improving
- **Consult urgently (as needed) with PCP or CM**



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Principle: Evidence-Based Treatment

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Treatment Options

Bio
- Evidence-based medications

Psycho
- Evidence-based psychotherapeutic interventions

Social
- Social support

- Make BOTH medication and non-medication recommendations
- Support whole person treatment
- The treatment that WORKS is the best one
- Review all evidence-based treatment options available
- Discuss pros and cons of each option

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Principle: Accountable Care

- **Access**
  - Provide care to more patients
  - Minimize time from identification to care
- **Accountability**
  - Screening to identify patients in need
  - Make sure patients get better (outcomes)

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2018 NCQA HEDIS Depression Metrics

- Depression Screening and Follow-up for Adolescents and Adults (DSF)
- Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS)
- Depression Remission or Response for Adults and Adolescents (DRR)
  - Measured by PHQ-9 or PHQ-A (12+ years)
  - Remission within 4-8 months of first elevated PHQ-9

Source: NCQA

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Checkpoint

Take a few minutes to reflect on the principles of collaborative care.

1. What do each of these principles mean to you?
2. How is your role aligned with each principle?

- Population-Based Care
- Measurement-Based Treatment to Target
- Patient-Centered Collaboration
- Evidence-Based Care
- Accountable Care

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Workflow

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In This Module

- ✓ Clinical workflow
- ✓ Team responsibilities

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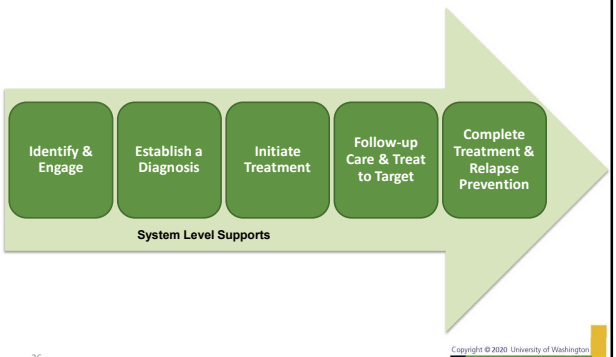
Collaborative Care Workflow



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Culture Clash

Primary Care

- **Action culture**
  - urgency, pace
  - immediate intervention
  - refer to other providers for specialty care

Specialty Behavioral Health

- **Narrative culture**
  - in-depth assessment
  - slower pace

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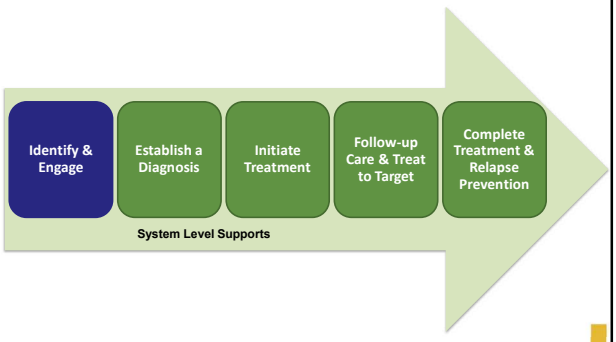
Collaborative Care Workflow



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Identify & Engage

- **Identify people who may need help**
- **Screen for behavioral health problems using valid measures**
- **Identify safety concerns**
- **Introduce collaborative care**
- **Engage patient in care**

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Identifying Patients Using Behavioral Health Measures

- **Behavioral health measures are like monitoring blood pressure!**
  - Identify problem
  - Need further assessment to understand the cause of the "abnormality" (high score)
  - Help with ongoing monitoring to measure response to treatment

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Checkpoint: Identify Safety Concerns

- **What if a patient has active suicidal ideation?**
  - What is your clinic protocol around safety concerns?
  - What is done immediately with the patient?
  - Who would be involved in assessing the patient and initiating care?
  - Who is consulted?
  - What does follow-up look like?

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Checkpoint: Identify

Take a few minutes to reflect on your setting.

- **How are patients in need of mental health treatment identified?**
  - Who administers behavioral health measures?

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Next Steps after Initial Screening

- Tracking patient scores
  - Electronic health record or registry

- Communication between providers
  - Begin engagement!
  - Warm handoffs or "warm connections"

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Early Engagement: What the Research Says

- In studies, 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 *(Bauer, 2011)*
- Follow-up contacts (phone or in person) within four weeks of the initial assessment is key to early improvement *(Bao, 2015)*

44 Source: Bauer et al., 2011; Bao et al., 2015

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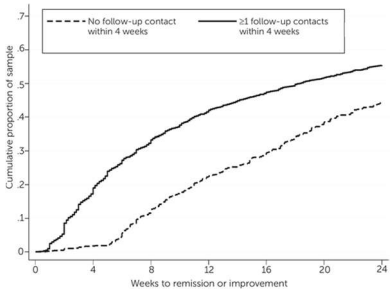
"Front Loading" Care Management Interventions



45 Source: Bao et al., 2015

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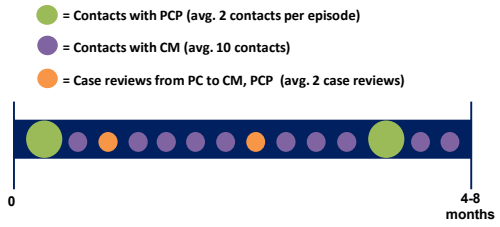
Frequency of Contacts in Collaborative Care Pays Off



50-70% treatment response/improvement

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Checkpoint: Engage

Take a few minutes to reflect on your setting.

- How are patients with a positive screener further assessed?
- Who will engage patients in collaborative care?
- How will you introduce collaborative care to patients?

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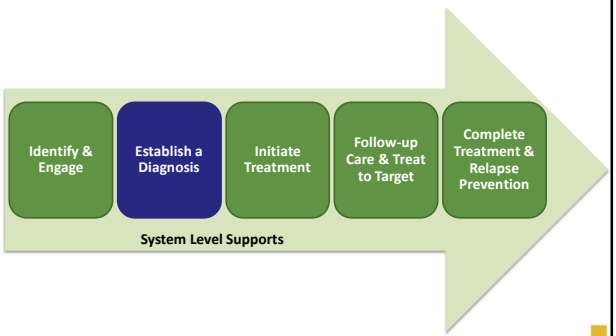
Collaborative Care Workflow



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Establish a Diagnosis

- **Initial assessment**
  - Core areas of screening
- **Co-existing medical conditions**
  - Identify and treat
- **Provisional diagnosis**
  - Team decision
  - Focus of case review w/psychiatric consultant
- **Patient education**
  - About symptoms and diagnosis

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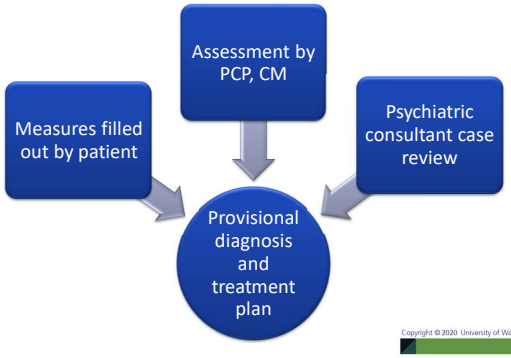
Provisional Diagnosis



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Checkpoint: Establish a Diagnosis

Take a few minutes to reflect on your setting.

- **How do you establish a mental health diagnosis in your clinic?**
- **Who is involved in establishing a diagnosis in your collaborative care program?**
- **How will the diagnosis be recorded?**

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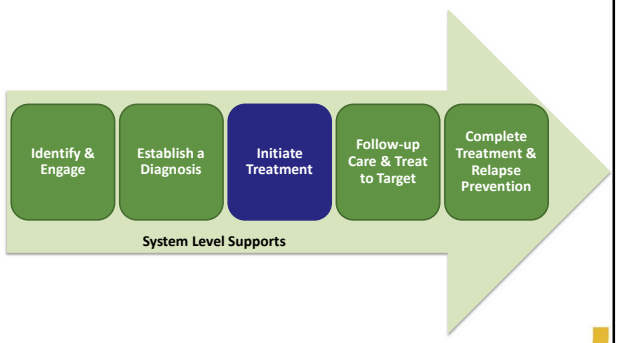
Collaborative Care Workflow



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Initiate Treatment

- Introduce treatment options
  - Biopsychosocial framework
    - Evidence-based psychotropic medications (as indicated)
    - Evidence-based brief behavioral interventions (as indicated), e.g.,
      - Problem-solving treatment (PST)
      - Cognitive behavioral therapy (CBT)
- Educate patient about recommended treatment
- Develop behavioral health treatment plan
- Facilitate referrals (as indicated)
  - Specialty care or social services
- Requires clear team communication!

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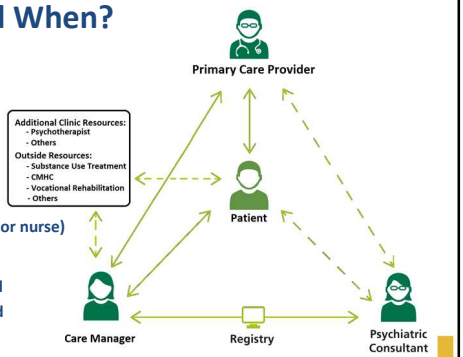
Provider to Provider Communication: How and When?

- Modality
  - In-person
  - Phone
  - Fax
  - EHR
  - Email
  - Staff (MA or nurse)
- Frequency
  - Scheduled
  - As needed



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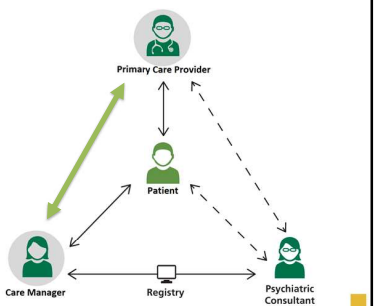
Communication: Care Manager and Primary Care Provider

- Goal to efficiently communicate change clinical and functiona



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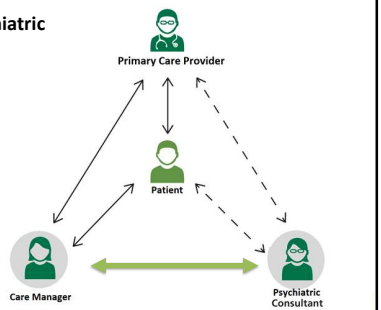
Communication: Care Manager and Psychiatric Consultant

- Goal to provide psychiatric expertise to team



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Psychiatric Consultation: Model Consultation Hour

- Brief check in
  - Changes in the clinic
  - Systems questions
- Identify patients and conduct reviews
  - New patients
  - Requested by CM
  - Not improved w/o note
  - Severity of presentation
  - Disengaged from care
- Wrap up
  - Celebrate successes
  - Confirm next consultation hour
  - Send any educational resources discussed

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Checkpoint: Initiate Treatment

Take a few minutes to reflect on what care looks like in your setting.

- **Who will introduce treatment options to the patient?**
- **Will the patient need to make another appointment with PCP?**
- **How will the CM track the patient's progress toward getting medication prescribed?**
- **How will follow-up be scheduled?**

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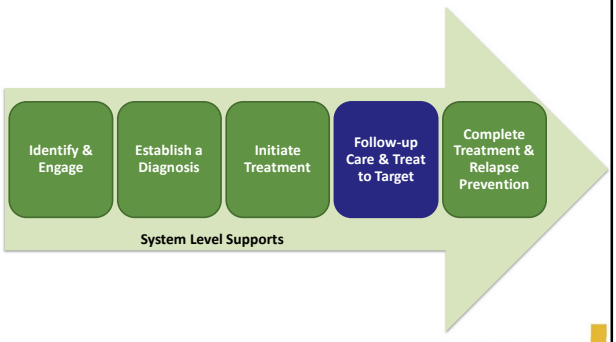
Collaborative Care Workflow



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Follow-Up Care & Treat to Target

"What aspect of treatment can we change to make it more likely that the patient will improve?"

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Typical Course of Care Management Contact Frequency

- **Active treatment**
  - Until patient has ≥50% decrease in symptoms and/or PHQ-9 score under 10
  - Minimum 2 contacts per month
    - Typical during first 3-6 months of treatment
    - Mix of phone and in-person works
- **Monitoring**
  - 1 contact per month
    - After 50% decrease in PHQ-9 achieved, monitor for ~3 months to ensure patient stable

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Key Tasks for Follow-Up Care and Treat to Target

- **Tracking and outreach**
  - Track treatment engagement & adherence
  - Reach out to patients who are non-adherent or disengaged
  - Track symptoms with measurement tools (e.g. PHQ-9)
  - Track medication side effects & concerns
  - Track outcome of referrals & other treatments
- **Treatment adjustment**
  - Assess need for changes in treatment
  - Facilitate changes in treatment plan
  - Proactively adjust treatment if patients are not responding
- **Leverage expertise of psychiatric consultant**
  - Utilize caseload-focused psychiatric consultation focused on non-responding patients
  - Utilize in-person or telehealth psychiatric assessment of challenging patients

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Checkpoint: Follow-Up Care and Treat to Target

Take a few minutes to reflect on the key tasks at this step of the workflow.

How are they handled in your setting?

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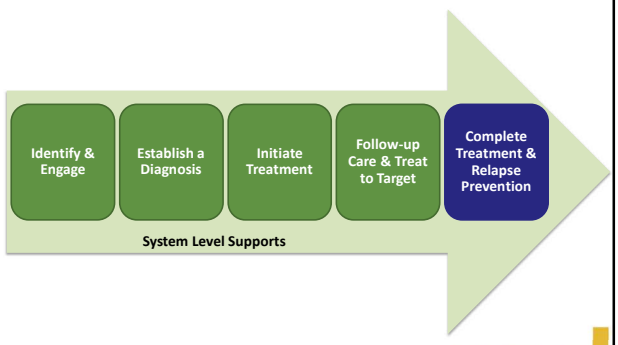
Collaborative Care Workflow



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Typical Course of Care Management

- 6-10 months in collaborative care treatment (average)
- Best if determined by clinical outcomes, not preset
- 50-70% of patients will need at least one change in treatment to improve
  - Each change of treatment moves an additional ~20% of patients into response or remission
- If preset, minimum 6 months in active treatment with option to extend to 12 months if additional treatment change is wanted

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Key Tasks for Complete Treatment and Provide Relapse Prevention

- Assess for completion of goals
- Create & support relapse prevention plan
- Communicate plan to team

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Checkpoint: Complete Treatment and Provide Relapse Prevention

Take a few minutes to reflect on the key tasks at this step of the workflow.

How are they handled in your setting?

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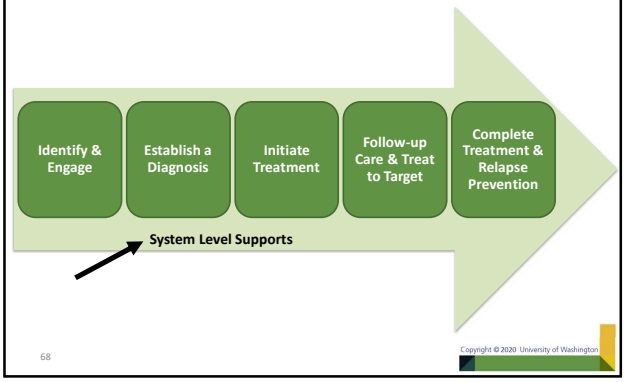
Collaborative Care Workflow



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Provide System Level Supports

- **Provide administrative support for program (e.g., scheduling, resources)**
- **Coordinate communication among team members/providers**
- **Engage in continuous quality improvement efforts**

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Common Misconceptions About Collaborative Care

ALL patients will be treated with medications	→ 10-15% never had medication in original study
ALL patients will receive psychotherapy (brief behavioral interventions)	→ Only 30% of patients in original study ever received psychotherapy
Problem-solving treatment (PST) is the ONLY therapy that can be used	→ PST is a good option, but not the only option
PST is collaborative care	→ Collaborative care is a way of providing care

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Collaborative Care Fundamentals

Registry

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In This Module

- ✓What a registry is
- ✓Who uses the registry
- ✓How the registry supports the principles of collaborative care
- ✓How the clinical team uses the registry to support the workflow

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What Is a Registry?

- A tool used to record data
  - Active tracking of individual patient progress and population progress
- "Registry" is a generic term; examples include:
  - Excel spreadsheets
  - Web-based systems

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Who Uses a Registry?

- Care Managers (CM)
  - Each CM has their own caseload in a registry
- Psychiatric Consultants (PC)
  - The PC views each individual CM caseload
- Clinical Supervisors/Practice Leadership
  - Can manually aggregate data from multiple Care Managers (if applicable)

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Registry and EHRs

- Does not automatically link to your EHR
- Concurrent documentation is most efficient
- All members of the care team, including psychiatric consultants, must have access to the EHR

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Registry and HIPAA Compliance

- Must live in a secure, HIPAA-compliant space
- Important to be able to share securely with the psychiatric consultant

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Registry Critical to Support Collaborative Care

- Identify patients who aren't improving
- Prompt changes in treatment
- Track clinical targets
- Facilitate psychiatric consultations
- Show aggregate population improvement data

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COLLABORATIVE CARE WORKFLOW

Registry

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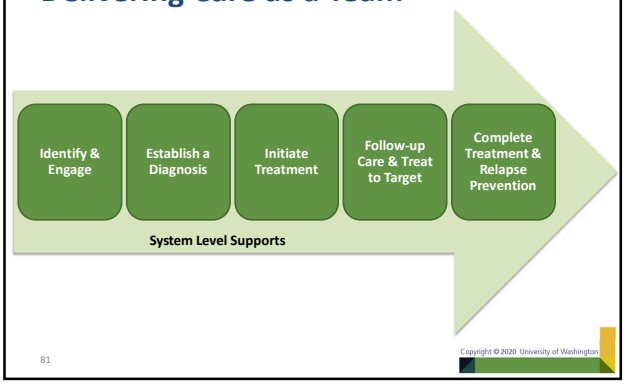
Delivering Care as a Team



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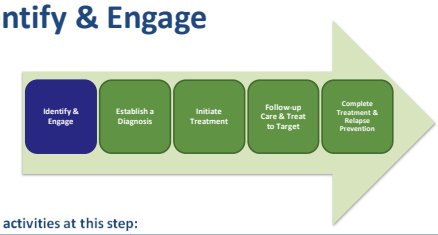
Identify & Engage



Team activities at this step:

Patient	Completes screening and PCP assessment
Primary Care Provider (PCP)	Introduces concept of collaborative care and also CM, if possible
Care Manager (CM)	Available for warm hand-off, outreach, or appointment with patient, ***enters patient information into registry***
Psychiatric Consultant (PC)	No task yet

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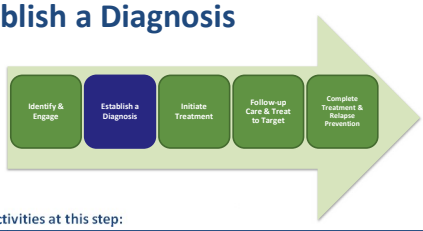
Establish a Diagnosis



Team activities at this step:

Patient	Provides accurate and honest information to PCP and CM
PCP	Reviews/rules out physical causes of mental health distress
CM	Completes assessment and additional screening, ***records any additional screening results in registry***
PC	***Reviews screening information in registry,*** reviews EHR, listens to the CM's observations during case review, determines diagnosis

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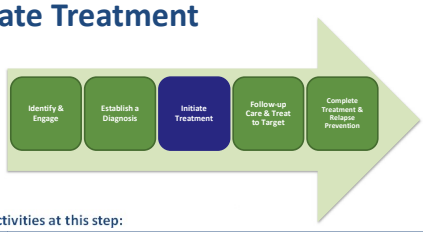
Initiate Treatment



Team activities at this step:

Patient	Engages with PCP and CM, asks questions, communicates concerns
PCP	Writes prescriptions, monitors labs, addresses side effects
CM	Educates patient, monitors response, initiates psychosocial interventions, records clinical notes in the EHR and ***creates an encounter entry in registry at each visit***
PC	***Monitors response by viewing the measurement scores in the registry***, guides CM on patient education

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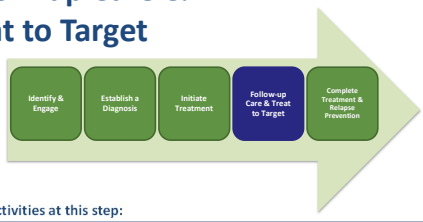
Follow-up Care & Treat to Target



Team activities at this step:

Patient	Works on adherence to medications and behavioral interventions, reports progress or challenges to CM and PCP
PCP	Makes adjustments according to PC recommendations
CM	Monitors response to the initiation of treatment, reviews progress with PC, adjusts behavioral health interventions, ***records outcome measures at every visit in registry***
PC	Assesses response by ***reviewing outcome measures in registry,*** recommends changes if needed

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Prioritizing Patients for Caseload Review

- **Both care manager and psychiatric consultant look at the registry during consultation hour**
- **Identify patients and conduct reviews**
  - **Requested by the care manager**
  - **Not improved without note**
  - **Severity of presentation**
  - **Disengaged from care**
  - **Ready for relapse prevention or referral**

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Complete Treatment & Relapse Prevention

Team activities at this step:

Patient	Develops a Relapse Prevention Plan with PCP and CM
PCP	Continues to monitor medication response and implements long-term medication plan
CM	***Changes treatment status to "Relapse Prevention," continues to record contacts in registry, and eventually closes episode,*** helps the patient develop Relapse Prevention Plan and recognize warning signs, educates the patient about maintaining healthy living
PC	Helps PCP develop long-term medication plan

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Program Management and Clinical Supervision Registry Functions

- Can compare caseload size and patient outcomes across providers or clinics
- Can identify proportion of care management sessions done in-person vs. by phone
- Can identify number of patients needing psychiatric consultation

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Principles of Collaborative Care

- Population-Based Care
- Measurement-Based Treatment to Target
- Patient-Centered Collaboration
- Evidence-Based Care
- Accountable Care

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Principles of Collaborative Care

Population-Based Care
The registry tracks patient populations to prevent patients from falling through the cracks.

Measurement-Based Treatment to Target

Patient-Centered Collaboration

Evidence-Based Care

Accountable Care

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Principles of Collaborative Care

Population-Based Care

Measurement-Based Treatment to Target

The registry tracks clinical outcomes to cue providers when a consultation or systematic change in treatment is needed.

Patient-Centered Collaboration

Evidence-Based Care

Accountable Care

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