Collaborative Care Training

July 10, 2018
Albany, NY

Today’s Presenters:
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Zachary Bodenweber, LMSW
Today’s Agenda

1) Collaborative Care Fundamentals
2) The Collaborative Care Medicaid Program (CCMP)
3) Suicide Prevention in Collaborative Care
4) The Collaborative Care Workflow in Action
Collaborative Care

An Overview
Why Integrate Behavioral Health into Primary Care?

1. Access
   Serve patients where they are

2. Patient-Centered
   Treat the whole patient

3. Effectiveness
   Better clinical and financial outcomes
Mental Disorders are Rarely the Only Health Problem

- Chronic Physical Pain (25-50%)
- Cancer (10-20%)
- Neurologic Disorders (10-20%)
- Diabetes (10-30%)
- Heart Disease (10-30%)
- Smoking, Obesity, Physical Inactivity (40-70%)
Services Poorly Coordinated, not Patient-Centered

- Primary Care
- Community Mental Health Centers
- Alcohol and Substance Abuse Treatment
- Social Services
- Vocational Rehab
- Other Community Based Social Services
Primary Care & Mental Health

National Comorbidity Survey Replication
Provision of Behavioral Health Care: Setting of Service

Only 2/10 of patients with diagnosable mental health problems see a mental health specialist.

Wang P et al., Twelve-Month Use of Mental Health Services in the United States, *Arch Gen Psychiatry*, 62, June 2005
Depression Care

• 1/10 see psychiatrist
• 4/10 receive treatment in primary care
• 30 Million people receive antidepressant Rx
  • But only 20% improve
• 2/3 of Primary Care Providers report poor access to mental health for their patients
• Primary Care is the de facto treatment setting for most patients with common mental health conditions like depression and anxiety
• 70% of all antidepressant prescriptions in the United States are written by a primary care provider
Why Collaborative Care?

Collaborative Care is more effective than care as usual (over 80 randomized controlled trials)

- Gilbody S. et al. *Archives of Internal Medicine*; Dec 2006

Collaborative Care also more cost-effective

- Gilbody et al. BJ Psychiatry 2006; 189:297-308.
- Glied S et al. MCRR 2010; 67:251-274.
The Collaborative Care Model

What is it?
• An integrated model of behavioral health designed for primary care
• Introduces two new roles (Care Manager and Psych Consultant) and services to the care team to treat common mental health conditions in primary care

Why is it important?
• Despite the prevalence of mental health conditions such as depression, anxiety, and substance abuse, many people do not receive effective care
• This leads to worsening health outcomes, poor treatment adherence/response, and increased costs
Collaborative Care Team Model

<table>
<thead>
<tr>
<th>TWO PROCESSES</th>
<th>TWO NEW ‘TEAM MEMBERS’</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Systematic diagnosis and outcomes tracking</strong></td>
<td><strong>BH Care Manager</strong></td>
</tr>
<tr>
<td>PHQ-2/9 &amp; GAD-2/7 to facilitate diagnosis and track outcomes</td>
<td>- Patient education / self management support</td>
</tr>
<tr>
<td></td>
<td>- Close follow-up to make sure patients don’t ‘fall through the cracks’</td>
</tr>
<tr>
<td><strong>2. Stepped Care</strong></td>
<td><strong>Consulting Psychiatrist</strong></td>
</tr>
<tr>
<td>a) Change treatment according to evidence-based algorithm if patient is not improving</td>
<td>- Weekly caseload consultation for care manager and PCP (population-based)</td>
</tr>
<tr>
<td>b) Relapse prevention once patient is improved</td>
<td>- Diagnostic consultation on difficult cases</td>
</tr>
<tr>
<td></td>
<td>- Support anti-depressant Rx by PCP</td>
</tr>
<tr>
<td></td>
<td>- Brief talk treatment (behavioral activation, PST-PC, CBT, IPT)</td>
</tr>
<tr>
<td></td>
<td>- Facilitate treatment change / referral to specialty behavioral health, as needed</td>
</tr>
<tr>
<td></td>
<td>- Relapse prevention</td>
</tr>
<tr>
<td></td>
<td>- Consultation focused on patients not improving as expected</td>
</tr>
<tr>
<td></td>
<td>- Recommendations for additional treatment / referral according to evidence-based guidelines</td>
</tr>
</tbody>
</table>
Project IMPACT

• **Improving Mood- Providing Access to Collaborative Treatment**
  • Primary and behavioral health care services are integrated into the primary care setting to treat depression in patients.

• IMPACT study
  • 1998-2003
  • 1,801 older adults from 18 primary care clinics across U.S.
  • ½ randomly assigned IMPACT model/Collaborative Care
  • Found that Collaborative Care more than DOUBLED the effectiveness of depression treatment in primary care settings.
  • Highly cost-effective

http://aims.uw.edu/impact-improving-mood-promoting-access-collaborative-treatment/
Project IMPACT- Study Outcomes
Co-Location is NOT Integration

50% or greater improvement in depression at 12 months

Participating Organizations
IMPACT: Summary

• Less depression
  • IMPACT more than doubles effectiveness of usual care
• Less physical pain
• Better functioning
• Higher quality of life
• Greater patient and provider satisfaction
• More cost-effective

“I got my life back”
THE TRIPLE AIM
Core Principles of Collaborative Care

**Patient-Centered Care.** Primary care and mental health providers collaborate effectively using shared care plans.

**Population-Based Care.** A defined group of patients is tracked in a registry so that no one falls through the cracks.

**Treatment to Target.** Progress is measured regularly and treatments are actively changed until clinical goals are achieved.

**Evidence-Based Care.** Providers use treatments that have research evidence for effectiveness.

**Accountable Care.** Providers are accountable and reimbursed for quality of care and clinical outcomes, not just volume of care.
Patient-Centered Team
Primary Care Provider

- Oversees all aspects of patient’s care as usual
- Establishes provisional diagnosis
- Prescribes medications as appropriate
- Introduces Collaborative Care team and Behavioral Health Care Manager
  - “Warm hand-off”
- Collaborates with Care Manager and Psychiatric Consultant to make treatment adjustments as needed
Behavioral Health Care Manager

- Works closely with PCPs to manage caseload of patients in primary care and support treatment plan
- Facilitates patient engagement and education
- Performs initial and follow-up assessment
- Systematically tracks treatment response
- Supports medication management
- Provides brief, evidence-based behavioral interventions
- Reviews cases with psychiatric consultant weekly
- Facilitates referrals as needed
- Prepares relapse prevention plan with patient
Psychiatric Consultant

• Provides weekly consultation
• Reviews cases for patients who are not improving as expected
• Provides expert treatment recommendations and proposes changes to treatment plan
• Provides diagnostic clarification and addresses diagnostic concerns
• Provides direction for further assessment
• Provides education and training for primary care providers and BHCM as appropriate
• Identifies appropriate referral sources as needed
The Patient

• A fundamental part of the team
• Works with PCP and BHCM
• Reports changes in health, symptoms, and functioning
• Sets goals for treatment with the team
• Tracks clinical progress using self-reported outcome measures
• Asks questions and discusses concerns about care
• Understands treatment plan, including goals of behavioral interventions and names/doses of medications
Comparison of Contacts in Usual Care vs. Collaborative Care

USUAL CARE

3.5 PCP Contacts per year

20% - 40% treatment response/improvement

Based on HRSA report of average PCP visit rates for FQHCs
Comparison of Contacts in Usual Care vs. Collaborative Care

Collaborative CARE

• 3.5 PCP Contacts per year
• 10 contacts with CM (on average)
• 2 case consultations from psychiatrist to CM/PCP (on average)

50% - 70% treatment response/improvement
Population-Based Care

• A defined group of patients is tracked in a registry

• Registry Functions
  • Track and manage caseloads
  • Facilitate the delivery of stepped care

• Care team uses registry to track patients & identify those who are not showing improvement or engaging in treatment

• Ensures that patients do not “fall through the cracks”
  • Especially important for patients with mental health disorders due to symptoms of social isolation and impaired activation
Measurement-based Treatment to Target

• **Treatment Plan**
  • Developed by the Care Team
  • Goals have observable, measurable outcomes
  • Outcomes are routinely measured
  • Flexible treatment options to increase access

• **Treatment to target**
  • Treatments are actively changed until treatment goals are achieved
  • Clinical outcomes are routinely measured by evidence-based tools such as the PHQ-9 and the GAD-7.

• **PHQ-9/GAD-7 Treatment Target (10 weeks):**
  • 50% reduction in symptoms
  • Score < 10
### 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)

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>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</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Feeling nervous, anxious or on edge</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Not being able to stop or control worrying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Worrying too much about different things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Trouble relaxing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Being so restless that it is hard to sit still</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Becoming easily annoyed or irritable</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Feeling afraid as if something awful might happen</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

(For office coding: Total Score T_____ = _____ + _____ + _____)
Evidence-based Treatment

• PCP will prescribe medication as indicated for identified behavioral health conditions
• BHCM will support medication management and focus on delivering behavioral interventions
• Psychiatric consultant will guide the effective application of these interventions

• Although treatment intervention varies by role, all team members should be familiar with all treatments to reinforce patient participation and support goals
  • BHCMs will assist medication management
  • PCPs will encourage and check-in on behavioral health goals
Accountable Care

• **Identify goals:** All team members should have a clear understanding of both patient and program level goals.

• **Define measurements:** Identify key measurements and strategies to obtain data on these measures in your organization.

• **Review Progress:** Regularly review data to identify areas for improvement.
Collaborative Care Medicaid Program (CCMP)

Overview, requirements, reimbursement, and workflow development
NYS Collaborative Care Medicaid Program

- 2013-2014, NYS DOH Medical Home Grant Program established CC programs in academic medical centers

- To sustain the progress, OMH launched the Medicaid program in 2015
  - More than 100 sites currently participating
  - Value based reimbursement
  - Address regulatory and reimbursement barriers
Monthly Case Rate Reimbursement Methodology

- *Collaborative Care services are not reimbursable under most current financing mechanisms*

- PCP coordination time
- BHCM (SW, LMHC, or other) care management and brief intervention, phone and group time
- Psychiatric Consultation, not face-to-face with patient
- Data entry and registry management
Monthly Case Rate Reimbursement Methodology

- Designed a Medicaid Monthly Case Rate
  - Carve out, not Managed Care
  - Value Based
  - Bundled services
- $112.50 per month for non-Article 28 providers
Billing Requirements

To Bill the Medicaid Case Rate each month,

✓ Have a Documented clinical contact that month
✓ PHQ-9 that month
✓ Seen face-to-face by a licensed provider within the last 90 days
Reimbursement

- $112.50 Per Patient Per Month for maintaining engagement
- With 60 patient caseload, $6,750 per month
- $81,000 per year from CCMP Billing

*Can carry caseloads larger than 60*

*Does not include billing for screening, SBIRT, or other billable services that may be part of CC*

AIMS Center Financial Modeling Workbook:
https://aims.uw.edu/collaborative-care/financing-strategies/financial-modeling-workbook
CCMP Case Rate (Article 28)

- For meeting the monthly engagement requirements, providers get 75% of the payment, $112.50.
- After three months of enrollment, if the patient has received one of the following, the practice can receive the 25% Retainage withhold retroactively, and can receive the 25% for each additional month they continue to meet criteria:
  - Patient has met clinical improvement criteria (PHQ9 50% decrease or <10)
  - Documented change to Treatment Plan
  - Documented case review by Psychiatric Consultant
NYS Collaborative Care Medicaid Program (CCMP)

Quarterly Data Reporting Metrics (Collected Monthly)

- Enrollment
- Newly enrolled
- Average Duration of Treatment
- Monthly Contact
- Clinical Contacts by Phone
- Improvement Rate
  - As determined by 50% reduction from baseline PHQ-9/GAD-7 or drop in baseline to less than 10
- Remission Rate (below 5)
- Psychiatric Consultation and/or Change in Treatment Rate
- Screening Rate + Yield (Depression & Anxiety)
- Behavioral Health Care Manager Staffing
<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD 9 Code</th>
<th>ICD 10 Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major depressive affective disorder single episode mild degree</td>
<td>296.21</td>
<td>F32.0</td>
</tr>
<tr>
<td>Major depressive affective disorder single episode moderate degree</td>
<td>296.22</td>
<td>F32.1</td>
</tr>
<tr>
<td>Major depressive affective disorder single episode severe degree without psychotic behavior</td>
<td>296.23</td>
<td>F32.2</td>
</tr>
<tr>
<td>Major depressive affective disorder single episode severe degree specified as with psychotic behavior</td>
<td>296.24</td>
<td>F32.3</td>
</tr>
<tr>
<td>Major depressive affective disorder single episode in partial or unspecified remission</td>
<td>296.25</td>
<td>F32.4</td>
</tr>
<tr>
<td>Major depressive affective disorder single episode in full remission</td>
<td>296.26</td>
<td>F32.5</td>
</tr>
<tr>
<td>Major depressive affective disorder single episode unspecified degree</td>
<td>296.2</td>
<td>F32.9</td>
</tr>
<tr>
<td>Major depressive affective disorder recurrent episode mild degree</td>
<td>296.31</td>
<td>F33</td>
</tr>
<tr>
<td>Major depressive affective disorder recurrent episode moderate degree</td>
<td>296.32</td>
<td>F33.1</td>
</tr>
<tr>
<td>Major depressive affective disorder recurrent episode severe degree without psychotic behavior</td>
<td>296.33</td>
<td>F33.2</td>
</tr>
<tr>
<td>Major depressive affective disorder recurrent episode severe degree specified as with psychotic behavior</td>
<td>296.34</td>
<td>F33.3</td>
</tr>
<tr>
<td>Major depressive affective disorder recurrent episode in partial or unspecified remission</td>
<td>296.35</td>
<td>F33.41</td>
</tr>
<tr>
<td>Major depressive affective disorder recurrent episode in full remission</td>
<td>296.36</td>
<td>F33.42</td>
</tr>
<tr>
<td>Major depressive disorder recurrent episode</td>
<td>296.3</td>
<td>F33.9</td>
</tr>
<tr>
<td>Dysthymic disorder</td>
<td>300.4</td>
<td>F34.1</td>
</tr>
<tr>
<td>Premenstrual tension syndrome</td>
<td>625.4</td>
<td>N94.3</td>
</tr>
<tr>
<td>Premenstrual dysphoric disorder</td>
<td>625.4</td>
<td>F32.81</td>
</tr>
<tr>
<td>Mood disorder in conditions classified elsewhere</td>
<td>293.83</td>
<td>F06.30</td>
</tr>
<tr>
<td>Depressive disorder not elsewhere classified</td>
<td>311</td>
<td>F32.9</td>
</tr>
<tr>
<td>Other mental disorders complicating pregnancy, unspecified trimester</td>
<td>648.4</td>
<td>O99.340</td>
</tr>
<tr>
<td>Other mental disorders complicating pregnancy, first trimester</td>
<td>648.4/648.43</td>
<td>O99.341</td>
</tr>
<tr>
<td>Other mental disorders complicating pregnancy, second trimester</td>
<td>648.4/648.43</td>
<td>O99.342</td>
</tr>
<tr>
<td>Other mental disorders complicating pregnancy, third trimester</td>
<td>648.4/648.43</td>
<td>O99.343</td>
</tr>
<tr>
<td>Other mental disorders complicating the puerperium</td>
<td>648.4/642.44</td>
<td>O99.345</td>
</tr>
<tr>
<td>Puerperal psychosis</td>
<td>293.89</td>
<td>F53</td>
</tr>
<tr>
<td>Unspecified anxiety disorder - <strong>effective January 1. 2018</strong></td>
<td>300</td>
<td>F41.9</td>
</tr>
<tr>
<td>Generalized anxiety disorder - <strong>effective January 1. 2018</strong></td>
<td>300.02</td>
<td>F41.1</td>
</tr>
<tr>
<td>Other mixed anxiety disorder - <strong>effective January 1. 2018</strong></td>
<td>300.09</td>
<td>F41.3</td>
</tr>
<tr>
<td>Other specified anxiety disorders - <strong>effective January 1. 2018</strong></td>
<td>300.09</td>
<td>F41.8</td>
</tr>
</tbody>
</table>
To Apply for CCMP:

• Trained Behavioral Health Care Manager(s)
• Designated Psychiatric Consultant
  • Set day and time for one-hour consultation with care manager
• State-Approved Patient Care Registry
  • Patient Tracking Spreadsheet
  • Care Management Tracking System (CMTS)
  • EHR Build
• Trained Primary Care Providers
• Letter of Support from Leadership
• Approved Collaborative Care Workflow
Why are workflows important?

• Document processes
• Instruct the care team how to accomplish core tasks
• Ensure tasks are completed in a timely, reliable, and efficient manner
• Account for multiple scenarios and include contingency plans
• Answers the questions:
  • What is the task that needs to be completed?
  • Who is responsible for completing that task?
  • When does this task occur?
  • Where does the task take place?
  • How is the task completed?
Collaborative Care Workflow: Core Tasks

• **Screening:** Identify eligible clients from the general clinic population

• **Referral:** Connect eligible clients with the Collaborative Care team for timely (ideally same day) engagement in care

• **Treatment**
  • **Initiate** treatment by introducing available interventions and creating a collaborative treatment plan with the client
  • **Track** treatment progress over time through the use of standardized monitoring tools
  • **Adjust** treatment for non-responsive clients within 70 days from enrollment and on a monthly basis thereafter, as needed
  • **Conclude** treatment by developing a relapse prevention plan to facilitate sustainable maintenance of treatment progress and identify appropriate resources if symptoms return

• **Suicide Prevention:** Assess severity of suicidal ideation and triage as appropriate
CCMP Workflow

• Reviewers will be looking for the following processes to be addressed:
  ✓ Consistent administration of BH Screening tools (75% or more), review, and recording of scores
  ✓ Ability to do a live warm connection (warm handoff) between PCP and care manager some or most of the time and plan for when it is not possible
  ✓ Communication plan in place for getting PC recommendations to the PCP and monitoring the PCP’s response
Screening Workflow

• Purpose: Identify clients eligible for Collaborative Care enrollment from the general population through the use of screening tools.
Referral Workflow

• **Purpose:** Connect eligible patients with the Collaborative Care team for timely (ideally, same day) engagement in care.

• Answers the questions:
  • When do we refer to the Behavioral Health Care Manager?
  • How do we communicate a referral?
  • What do we do if the Behavioral Health Care Manager is not readily available?
Treatment Workflow

• Initiate treatment
  • Brief assessment to explore whether Collaborative Care would be a good fit for the patient and discuss treatment options

• Track Treatment
  • Follow-up contacts and delivering treatment plan

• Adjust Treatment
  • Assess patient’s improvement, as defined by:
    • 50% reduction in baseline PHQ-9 and/or GAD-7 Scores
    • Sub-clinical PHQ-9 and/or GAD-7 scores of below 10
  • Adjust treatment accordingly

• Conclude Treatment
  • Relapse Prevention Planning or transition to community resources
Important to Note...

- A solid Collaborative Care workflow should include all of the core tasks from start to finish
  - From identification and enrollment to discontinuation and relapse prevention

- Each workflow will have unique clinical workflow plans based on staffing, scheduling, resources, space, preexisting processes, etc.
Thorough Workflows

CCMP Workflow

**Administer PHQ2 and record score in eCW:**
12 years and older general population once a year (additional screening if one of the following: pregnant/postpartum, recently hospitalized, Dx with major chronic illness or recent MI)

WHO: Nurse or MA

- If positive PHQ2 administer PHQ9 & GAD7 record score in eCW
- Score 10-14: Mild/moderate symptom severity
  - Provider evaluates patient & generates referral for BH services
  - Nurse or MA

- Score 15 or above: Moderate/severe symptom severity
  - Provider evaluates patient & generates referral for BH services
  - Nurse or MA

**Enter PHQ9 smart form & scan GAD7 eCW**
WHO: Nurse or MA

**Score 9-9**
- Continues care with PCP
- No consultation or evaluation by BH professional

WHO: PCP

**Score 10-14**
- Mild/moderate symptom severity
  - Nurse or MA

**-Warm Hand-Off to BHCM & Document Transfer in eCW**
  - Nurse or MA

**Score 15 or above**
- Moderate/severe symptom severity
  - Nurse or MA

**Begin Active Treatment**
WHO: BHCM

**BHCM to discuss case for psychiatric consultation within 1 week (Due to PHQ9/GAD7 score of 15 or above)**

**End of Treatment: Graduation**
From Collaborative Care
WHO: BHCM & Patient

- Discuss Treatment Options (decision support)
  - Nurse or MA

- Medication Management (controlled medications policies/information)
  - Problem Solving Treatment (PST)
  - Motivational Interviewing (MI)
  - Behavioral Activation (BA)
  - Cognitive Behavioral Therapy (CBT)
  - Psychiatric Consultation (for non-responding patients)

- Discuss use of telephonic interventions/encounters (especially for patients with barriers to engagement)
  - Initial active treatment (first 3-6 months with a minimum of 2 contacts per month)
  - Discuss short term nature of treatment and goal of reducing depression and anxiety symptoms
  - Create Treatment Plan with Patient

**Stages of Treatment**
1. **Active Treatment-to-target:** Initial 3-6 months or until patient improves, as demonstrated by 50% reduction from baseline PHQ9/GAD7 or a drop from baseline PHQ9/GAD7 to less than 10
   - Typically 2 contacts per month or more
   - BHCM utilizes a mix of telephone and in-person contacts
   - Initiate Psychiatric consultation and/or change in treatment if patient’s PHQ9/GAD7 scores are not improving or worsening
   - Introduce & work on Relapse Prevention Plan throughout treatment
   - Monitoring/Maintenance: After 50% decrease in baseline PHQ9 score is achieved or when PHQ9 score falls below 10 (starts termination process)

2. **Monitoring/Maintenance:** Typically 1 contact per month & monitoring continues for approximately 3 months to ensure patient is stable
3. **Termination:** Finalize Relapse Prevention Plan & Cap Treatment

**Complete Safety Plan (Stanley & Brown) & Risk Assessment (C-SSRS)**
WHO: BHCM

**Exception to Warm Hand-off to the BHCM:**
- Patient has Bipolar Disorder
- Patient has Schizophrenia
- Patient has Dementia/Memory Loss
- Patient has Psychosis
- Patient is already engaged in outside BH services
  - If a patient doesn’t qualify for the BHCM, but you have concerns, contact the MA for a warm hand-off to assist with the patient’s needs.

**Exceptions to Warm Hand-off to the BHCM:**
- Patient has Bipolar Disorder
- Patient has Schizophrenia
- Patient has Dementia/Memory Loss
- Patient has Psychosis
- Patient is already engaged in outside BH services

**If applicable indicators are present do additional screening (ie: PHQ9, GAD7 and/or SBIRT) if positive results, warm handoff to BHCM**
WHO: Nurse or MA

**If at any point suicide risk is present treat as positive Q #9 on PHQ9**

**If suicide risk is positive then treat as positive Q #9 on PHQ9**

**Administer PHQ2**
WHO: Nurse or MA

**If positive PHQ2 administer PHQ9 & GAD7 record score in eCW**
WHO: Nurse or MA

**PhQ9 Positive on Q 9**
WHO: Nurse or MA

**Supervise transfer to BHCM**
WHO: PCP

**Who: PCP**

**BHCM to discuss case for psychiatric consultation within 1 week (Due to PHQ9/GAD7 score of 15 or above)**

**Supervise transfer to BHCM**
WHO: PCP
New York State Collaborative Care Medicaid Program
Depression in Primary Care Sample Workflow (Variations Expected)

Patient Present for Medical Care
- PHQ-2 or PHQ-9 given to patient by front desk staff at every appointment (some workflows have the MA or PCP give it to the patient.) OR
- Patient Presents with depressive symptoms (sadness, feelings of helplessness, hopelessness) OR
- Annual screen of PHQ due

Rooming Staff Administers PHQ
- Complete PHQ-2 (or PHQ-9)
- Record score in EHR

Patient Scores Negatively
- Re-administer per initial criteria

Patient Scores Positively
- Rooming staff provides patient with PHQ-9 if patient was initially given PHQ-2
- Provider reviews results with Patient

Positive Q. 9: Immediate Risk
- Identify preferred hospital & arrange direct transportation
- Make follow-up plan
- Document hospitalization
- Document suicidal ideation in problem list in EHR

Warm handoff to care manager/ If CM not available contact (whom?)

Positive Q. 9: No Immediate Risk
- Create safety plan
- Make follow-up visit
- Document suicidal ideation in problem list in EHR

Discuss Treatment Options
- Medication managed in primary care
- Talk therapy in primary care
- Medication & talk therapy

Reassess every 2 weeks with PHQ-9 during active treatment and monthly during maintenance phase of treatment

Score drops below 10 or 50% reduction in score at any 10 week or sooner interval
- Use clinical judgment to consider if patient could get even better than current score. If so, consult and consider a treatment change or adaptation - medication increase? Medication changes? PST?
- After some changes have been tried and treatment team is satisfied with progress then RPP & check in with patient monthly for 3 months
- Consider RPP if no other options are available or patient declines further care

Score Drops < 50% in any 8 - 10 week interval
- Consult and plan changes in care plan
- If first changes don’t work, consider more changes in care plan
- Consider higher level of care, i.e. referral to specialty
- Consider RPP if no other options are available or patient declines further care

Score drops 5 points at any time
- Treatment is beginning to work
- Consider consult for medication increase or be sure patient is following instructions on medication increases recommended by PCP
- Continue therapy if less than 10 weeks treatment or change modality of therapy or add meds if not

Score drops below 5
- RPP & check in with patient monthly for 3 months
- In consultation determine how long patient needs to stay on medications and document in RPP

Score Drops < 50% in any 8 - 10 week interval
- Consult and plan changes in care plan
- If first changes don’t work, consider more changes in care plan
- Consider higher level of care, i.e. referral to specialty
- Consider RPP if no other options are available or patient declines further care

Discuss Treatment Options
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Pathways

- Represents a standardized trajectory of care for the managing of a specified population that takes into account all entry points into an organizational system
- Considered a roadmap that provides a bird’s eye view of organizational processes for Collaborative Care
- When designing a pathway keep in mind:
  - What is the Collaborative Care workflow?
  - What are the different ways that clients can enter our organizational system?
Managing Depression: Clinical Pathways in Primary and Behavioral Health Care

Foundational Performance Metrics:
✓ Screening Rate
90 Days following first PHQ-9 Administration:
✓ Percent of Patients with At Least Two PHQ-9s in Initial 90 Days Following First Out of Patients with At Least One PHQ-9
✓ Percent of Standard Met in Initial 90 Days out Of Patients with At Least 2 PHQ-9 Scores 90 Days preceding Last Administration of the PHQ-9.
✓ Percent of Patients with At Least Two PHQ-9s in 90 Days Prior to Last Out of Patients with At Least One PHQ-9
✓ Percent of Standard Met in 90 Days Prior to Last Out Of Patients with At Least 2 PHQ-9 Scores

Icon Key:
1 Indicates that Clinical Decision Support is in place to support movement along pathway.

Notes:
1. Negative on PHQ-2 is defined as a score of 0; Positive on PHQ-2 is defined as a score of 1-2.
2. Negative Response to PHQ-9 is defined as a score of 0-9; Positive Response to PHQ-9 is defined as a score of 10-27.
3. Active or File to History/Resolved is determined in accordance with guidelines included in Appendix A: Problem List Entry Guidance.
CoCM

Medicare’s Collaborative Care Reimbursement Model
Medicare Collaborative Care Model (CoCM)

- Medicare pays for services provided for patients in Collaborative Care
- The codes for these services are billed by the treating provider as “incident to” services and incorporate the activities of the two additional team members.
- Billed over calendar month service period by volume, or time spent furnishing such services
- 4 Medicare Billing codes to bill for BHI
  - 3 CoCM codes
  - 1 General BHI Services
# BHI Coding Summary

<table>
<thead>
<tr>
<th>BHI Code</th>
<th>Behavioral Health Care Manager or Clinical Staff Threshold Time</th>
<th>Activities Include:</th>
</tr>
</thead>
</table>
| CoCM First Month (G0502) (CPT 99492)          | First 70 minutes per calendar month                              | • Initial Assessment  
• Outreach/engagement  
• Entering patients in registry  
• Psychiatric consultation  
• Brief intervention                                      |
| CoCM Subsequent Months (GO503) (CPT 99493)    | 60 minutes per calendar month                                   | • Tracking + Follow-up  
• Caseload Review  
• Collaboration of care team  
• Brief intervention  
• Ongoing screening/monitoring  
• Relapse Prevention Planning                                      |
| Add-on CoCM (Any month) (GO504) (CPT 99494)   | Each additional 30 minutes per calendar month                   | • Same as Above                                                                    |
| General BHI (G0507) (CPT 99484)               | At least 20 minutes per calendar month                           | • Assessment + Follow-up  
• Treatment/care planning  
• Facilitating and coordinating treatment  
• Continuity of care                                      |
Assistance is available!

Technical Assistance, Coaching, Training, Guidance, and Ongoing Support
Learning Network 3.0
Milestones for clinics implementing the Collaborative Care Model (CoCM)

Key components of collaborative care

**Clinic Training Workflow Protocols**
- Train CoCM staff
- Workflow development

**Staffing Milestones**
- Staffing your CoCM program

**PCP Education**
- PCP readiness for CoCM

**Organizational Relapse Prevention**
- Develop protocols for org. relapse prevention

**Registry and EMRs**
- Tracking population of patients with BH conditions

**Suicide Care**
- Caring for patients at risk for suicide

**Pre-Launch**
- Site education for all staff on CoCM
- Specialized education for CoCM roles
- Training documentation finalized with CCMP
- Patient care initiated – Meet CoCM metrics

**Launch**
- Develop workflow for review by CCMP
- Share workflow with all staff in CoCM sites
- Utilize PDSA to test workflows with data points
- Finalize Workflow

**Post-Launch**
- Design job description & recruitment materials
- Hire or contract provider
- Notify CCMP of hire
- Coordinate CoCM training
- Patient Care - fill CoCM caseload

- PCP education on CoCM and role of PCP
- PCP engagement to assess level of comfort with medication
- Monitor and track hand offs and level of medications
- Fill CoCM Caseload

- Create org. relapse prevention plan – submit plan to CCMP
- Build org. prevention plan with workflows, EMRs
- Implement org. relapse prevention plan
- Fully implemented org. relapse prevention plan

- Identify registry platform
- Submit documentation of registry functionality to CCMP
- Engage IT team or CMTS team to implement registry
- Registry utilization

- Develop a way to identify patients at risk
- Develop a pathway for patients at risk – submit pathway to CCMP
- Implement standardized assessment and safety plan
- Suicide safe care at organization

*Click the blue arrow boxes your organization has completed to mark your progress along the collaborative care continuum*
Learn More...

• New York Center for the Advancement of Behavioral Health Integration
  • [http://aims.uw.edu/nyscc/](http://aims.uw.edu/nyscc/)

• Learning Network
  • Training, Support, and Resources
  • [https://aims.uw.edu/nyscc/training/](https://aims.uw.edu/nyscc/training/)

• AIMS Center
  • Training Modules, Resource Library, & Implementation Guide
  • [https://aims.uw.edu/](https://aims.uw.edu/)

• Join the NYSCCMP Listserv
  • Email [danielle.chapman@omh.ny.gov](mailto:danielle.chapman@omh.ny.gov)
Suicide Prevention in Collaborative Care

Rationale, Workflows, and Tools
Suicide Prevention in Collaborative Care

• As many as 20-40% of patients with major depression experience suicidal ideation, but suicidal plans and behavior are less common
• Primary Care is a crucial setting for suicide prevention intervention
  • Nearly half of patients who complete suicide have seen a PCP within the last month
• Question 9 on the PHQ-9 for suicidal behavior and suicide completion
• A workflow for suicide prevention should be built into any Collaborative Care model
Screening Tools

• One evidence-based screening tool for suicide assessment is the Columbia- Suicide Severity Rating Scale (C-SSRS), which assesses for:
  • Suicidal Ideation
  • Intensity of Ideation
  • Suicidal Behavior

• Best practice in primary care if for this 6-item standardized tool to be administered by primary care staff when clients endorse suicidal ideation (usually identified by positive answer to question 9 on PHQ-9)

• Free online training (45 min.) on Zero Suicide Website at:
COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screen with Triage Points for Primary Care

<table>
<thead>
<tr>
<th>Question</th>
<th>Past month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask questions that are in bold and underlined.</td>
<td></td>
</tr>
<tr>
<td>Ask Questions 1 and 2</td>
<td>YES</td>
</tr>
<tr>
<td>1) Have you wished you were dead or wished you could go to sleep and not wake up?</td>
<td></td>
</tr>
<tr>
<td>2) Have you had any actual thoughts of killing yourself?</td>
<td>NO</td>
</tr>
</tbody>
</table>

If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.

3) Have you been thinking about how you might do this?
   e.g. "I thought about taking an overdose but I never made a specific plan as to when or how I would actually do it...and I would never go through with it."

4) Have you had these thoughts and had some intention of acting on them?
   as opposed to "I have the thoughts but I definitely will not do anything about them."

5) Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?

6) Have you ever done anything, started to do anything, or prepared to do anything to end your life?
   Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn’t swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn’t jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.

   If YES, ask: Was this within the past 3 months?

   Lifetime

   Past 3 Months
Intervention

• Developed by Barbara H. Stanley and Gregory K. Brown, the Safety Planning Intervention is a brief, evidence-based intervention that can help mitigate suicide risk and promote safety among clients who endorse suicidal ideation.

• Many organizations find it helpful to train PCPs and BH staff in this intervention to achieve organizational competency in suicide prevention best practices

• Free online training (45 min) on the Zero Suicide website at:
### 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:
Who conducts further assessment?

- Unique to an organization’s specific staff distribution, practice setting, and client population.
- Many organizations train nursing staff and primary care providers in suicide assessment and safety planning.
- Others identify specialty behavioral health staff to support the Behavioral Health Care Manager in triaging crisis situations that arise in Primary Care.
- Important to have clear delineation of roles and responsibilities.
- If practice’s rely exclusively on BHCM, the urgency of this role often overtakes Collaborative Care responsibilities and the position becomes overrun with crisis management.
Which clients are eligible for Collaborative Care enrollment?

- Suicidal ideation is a common symptom of depression diagnoses
- Important to know when immediate intervention is needed, as well as when patients should be enrolled in Collaborative Care for ongoing treatment
- Patients presenting with imminent risk following suicide assessment, including suicidal intent and/or plan, would benefit from increased, specialty behavioral health services outside the scope of this primary care model of treatment
Managing Suicidality: Clinical Pathways in Primary and Behavioral Health Care

Foundational Performance Metrics:
✓ Percentage of patients with a positive response to Question 9 (Q9) on the Patient Health Questionnaire-9 (PHQ-9) that receive C-SSRS Screen with Triage Points (C-SSRS Screen).
✓ Percentage of patients with a positive C-SSRS screen that have a suicide related entry added to the problem list.
✓ Percentage of patients with suicide active on the problem list that have a completed: Safety Plan, C-SSRS Lifetime/Recent scale, Risk Assessment.

Icon Key:
1 Indicates that Best Practice Advisory Alert supports movement along pathway.
2 Indicates cascading features in place to support movement along pathway.

Notes:
1. Negative on PHQ-2 is defined as a score of 0; Positive on PHQ-2 is defined as a score of 1-3.
2. Negative Response to PHQ-9, Question 9 is defined as a score of 0; Positive Response to PHQ9, Question 9 is defined as a score of 1-3.
3. Negative on C-SSRS Screen is defined as a response of “No” on Questions 2 and 6; Positive on C-SSRS Screen is defined as a response of “Yes” on Question 2 or 6.
4. Active or File to History/Resolved is determined in accordance with guidelines included in Appendix A: Problem List Entry Guidance
Additional Resources (Free + Online)

- Counseling on Access to Lethal Means (CALM) (2 hours)
  - Underlines important of means restriction to a comprehensive approach to suicide prevention and equips participants to have conversations about reducing access to lethal means with patients and their families

- Structured Follow-up and Monitoring (45 min)
  - Outlines the typical three-step procedure for conducting a structured follow-up with a patient who has recently endorsed suicidal ideation
The Collaborative Care Workflow in Action

Best Practices for Implementing the Core Tasks of Collaborative Care
Identifying & Engaging Patients in Care

- Identify & Engage
- Establish a Diagnosis
- Initiate Treatment
- Follow-up Care & Treat to Target
- Complete Treatment & Relapse Prevention
Working as a Team

- **PCP:** Recognize the signs of possible diagnoses, perform/review screening of symptoms, gather additional history, consider potential medical causes, educate, coordinate with Care Manager

- **Care Manager:** Complete assessment of symptoms and functional impairment, safety plan (if indicated), provide psychoeducation, engage, discuss treatment options

- **Psychiatric Consultant:** Clarify, determine, and/or refine diagnosis. Request further information. Assist in determining appropriate level of care.

- **Patient:** Responds to self-report questions, communicates symptoms and problems.
The Importance of Screening

• Routine screening is an important component of any regular check-up

• Targeting symptoms early leads to better outcomes, lessening long-term disability and preventing years of suffering

• Patients identified by score of 10 or above on PHQ-9/GAD-7

• CMS determined that there is adequate evidence to conclude that screening for depression in adults is reasonable and necessary for the prevention and early detection of illness or disability
Depression Screening

• Depression costs approximately $80 billion a year in medical care costs and lost productivity

• Each year about 25 million Americans will suffer from an episode of clinical depression (NAMI)

• Depression is the leading cause of disability worldwide and a major contributor to the overall global burden of disease (WHO, 2018)

• 60-80% of people with depression can be treated successfully if timely diagnosed through screening and provided necessary treatment

• Typical Yield: 10-14%
PHQ-9

- Multipurpose instrument for screening, diagnosing, monitoring, and measuring the severity of depression
- Incorporates DSM Depression diagnostic criteria with other major leading depressive symptoms
- Rates frequency of symptoms
- Question 9 screens for presence and frequency of suicidal ideation
- PHQ-9 Scores ≥ 10 had a sensitive of 88% and a specificity of 88% for major depression
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)

1. Little interest or pleasure in doing things
   - Not at all
   - Several days
   - More than half the days
   - Nearly every day

2. Feeling down, depressed, or hopeless
   - Not at all
   - Several days
   - More than half the days
   - Nearly every day

3. Trouble falling or staying asleep, or sleeping too much
   - Not at all
   - Several days
   - More than half the days
   - Nearly every day

4. Feeling tired or having little energy
   - Not at all
   - Several days
   - More than half the days
   - Nearly every day

5. Poor appetite or overeating
   - Not at all
   - Several days
   - More than half the days
   - Nearly every day

6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down
   - Not at all
   - Several days
   - More than half the days
   - Nearly every day

7. Trouble concentrating on things, such as reading the newspaper or watching television
   - Not at all
   - Several days
   - More than half the days
   - Nearly every day

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

9. Thoughts that you would be better off dead or of hurting yourself in some way
   - Not at all
   - Several days
   - More than half the days
   - Nearly every day

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)

1. Feeling nervous, anxious or on edge
   - Not at all
   - Several days
   - More than half the days
   - Nearly every day

2. Not being able to stop or control worrying
   - Not at all
   - Several days
   - More than half the days
   - Nearly every day

3. Worrying too much about different things
   - Not at all
   - Several days
   - More than half the days
   - Nearly every day

4. Trouble relaxing
   - Not at all
   - Several days
   - More than half the days
   - Nearly every day

5. Being so restless that it is hard to sit still
   - Not at all
   - Several days
   - More than half the days
   - Nearly every day

6. Becoming easily annoyed or irritable
   - Not at all
   - Several days
   - More than half the days
   - Nearly every day

7. Feeling afraid as if something awful might happen
   - Not at all
   - Several days
   - More than half the days
   - Nearly every day

(For office coding: Total Score T___ = ___ + ___ + ___)
Identify and Engage

• Use standardized screening algorithm across patient population
  • Ex. Administer PHQ-2 to all patients yearly, or if prompted by significant event: pregnancy/postpartum, recently hospitalized, Dx of major chronic illness, or heart attack

• PCPs will partner with nursing staff to screen all patients

• Discuss screener scores as a vital sign
  • “Emotional Blood Pressure”
Typical Screening Workflow

- Depression
  - PHQ-2
  - If positive, administer PHQ-9

- Anxiety
  - GAD-2
  - If positive, administer GAD-7
Screening Workflow: Things to Consider

• When will screening happen?
  • Annually
  • More often for unique circumstances (risk factors, other health conditions, life events; i.e. Hep C, HIV, discharged from hospital etc.)

• How will screening happen?
  • Paper form
  • Verbally
  • Waiting room, triage, exam room?

• How will results get communicated to the provider?
  • Through EHR
  • Verbally
Introducing Screening to Patient

1. **INTRODUCE**: “Along with your physical vital signs like your blood pressure and heart rate, I am also going to ask you some questions about how you’re feeling as well.”

2. **NORMALIZE**: “These are questions we ask all of our patients.”

3. **EXPLAIN**: “Your answers will help your doctor 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.”
Sample Script

“This brief questionnaire has questions that we ask all of our patients. It is our way of measuring your mood because we know that health and well-being depend on more than just a healthy body but also a healthy mind. Sometimes feeling sad or down can worsen current medical issues. If this is the case, we want to make sure we are aware, so we can provide you with the best care possible and to connect you with useful resources that we have available at our clinic.”
Talking Tips

DON’T
• Use clinical/psychiatric language (e.g. “mental health,” “psychiatric,” “maladaptive”) unless patient uses these terms first
• Use stigmatizing labels (e.g. “crazy,” “mental,” “abnormal,” “unusual”)

DO
• Use terms such as “behavioral health,” “well-being,” “wellness,” “stress,” “overwhelmed,” “feeling down,” “coping”
• Talk about symptoms instead of disorders/diagnoses
• Emphasize that symptoms are treatable
• Let patients know that your site now provides services that can help them manage these symptoms and feel better
• Rephrase
  • “You must be really depressed”
  • “You need counseling. We have a social worker for you to see.”
  • “You’re just a worrywart”
  • “You’re fine. It will be okay. We’ve all been there.”

• Respond
  • “Why are you asking me this? I’m not crazy!”
  • “Why do I have to do this?”
  • “It’s been like this forever. It’s just my life.”
Using Screening instruments

• Questions must be asked as they are worded on the screening tools
• These are self-report measures, not clinician assessment
• Family/friends may not answer for patient
• Available in nearly every language
  • https://www.phqscreeners.com/
• Can be administered verbally or written
Identify

• If PHQ-9 and/or GAD-7 is greater than or equal to 10:
  • Provide further evaluation, as needed
  • Establish provisional/working diagnosis
  • Enroll in Collaborative Care

• In most clinics, the PCP will conduct the preliminary steps as part of routine care and then refer to Care Manager for additional assessment
What clients are appropriate for referral to Collaborative Care?

A: Any client with a PHQ-9/GAD-7 greater than 9

1) Who is not already engaged in care with behavioral health i.e., not seeing a psychiatrist or a therapist

2) Does not present as high risk – e.g., recent psychiatric hospitalization, active suicidality with intent and/or plan, active homicidality

3) Does not have a previous bipolar disorder diagnosis or active psychosis
Engage

• Provide psychoeducation
• Introduce Collaborative Care
• Refer to Care Manager
  • Warm hand-off
  • Send chart/note in EHR
Psychoeducation

- Important tool in empowering patients to be aware of and manage their own symptoms

- When talking to patients about behavioral health conditions, practitioners and clinicians may face challenges such as:
  - Lack of understanding of diagnosis
  - Inability to tie current behavior to mental health condition
  - Stigma associated with being diagnosed with depression and anxiety
  - Cultural, religious, or other personal factors leading to resistance to treatment
  - Preexisting beliefs about medications and psychotherapy
Psychoeducation

• Depression
  • How depression impacts brain functioning (Diabetes/pancreas ex.)
  • How depression affects people
  • Validate behavioral interventions, equally as effective
  • For severe (>20 PHQ) or chronic (>2 years) depression, combination therapy is recommended

• Anxiety
  • “Anxiety is a normal part of life: a little is helpful, but too much is disabling”
  • “Normal reaction that has just become too intense or triggered at times when it is not needed”
  • Anxiety is a product of genetic makeup, learning, and habit
  • Most effective in combination of behavioral approaches and medication
Introducing Collaborative Care

• Important to introduce the patient to team-based care and explain how providers will work together
• Best way to do this is the “warm handoff”
• You can also develop a flyer/brochure that discusses the care team and each member’s role
Introducing Collaborative Care

• Key Information to be shared with the patient:
  • The patient is an important member of the team
  • All team members will share one treatment plan to support patient-centered goals
  • The PCP will oversee all aspects of patient care at the clinic
  • The care manager works closely with the patient and the PCP to implement a treatment plan, keeping track of progress and providing additional support
  • The psychiatric consultant does not see patients in person but provides guidance for the team
Introduction to Collaborative Care

“We provide services here that help people who are feeling _______. I have a member of my team who helps a lot of my patients experiencing these symptoms. She/he and I work closely to provide support, education, and different options of treatment to help you improve and manage your symptoms. If we need to, we can also consult with an expert in the field, though you wouldn’t see that doctor yourself. We work together as a team to provide you with the best treatments available to help you feel better. One size does not fit all – each person is unique, and together we find what works best for you. So it’s important for you to check-in with your care manager so she can let me know how you are doing. How does that sound?”
Refer to BHCM

• If available, Warm Handoff
  • “I’d like to introduce _______. She works closely with me to help patients who are feeling ____ (down/worried/depressed/anxious). I’d like for you to meet her while you are here today.”
  • Call/ask care manager for exam room drop-in

• 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
Presenting Handoff

• When presenting to a patient, it is helpful to use terms like:
  • Coworker
  • Colleague
  • Someone who specializes in...

• “I work with *name* who is part of our team. I’d like to introduce you to her before you go.”

• To reduce fear/stigma, avoid terms like
  • Therapist
  • Social Worker
  • Mental Health Clinician
Refer to BHCM

• If Care Manager is not available:
  • Send chart/note for outreach
    • If choosing this option, make sure patients are aware they will be receiving a phone call
    • Ask for best number and preferable time of day to be reached
  • Schedule patient with Care Manager
Team Approach

• Strategies to Strengthen Team functioning:
  • Sharing Goals
    • Best practice is to have one treatment plan shared by all team members
    • Clear set of behavioral health goals
  • Building Mutual Trust
    • Share success stories
    • Uphold role expectations
  • Clarifying Roles and Workflows
    • Establish clear roles and workflows
    • Review and update workflows as needed
  • Strengthening Communication Strategies
    • Agree of communication strategies/formats
    • Daily/weekly huddles
Establish a Diagnosis

- Identify & Engage
- Establish a Diagnosis
- Initiate Treatment
- Follow-up Care & Treat to Target
- Complete Treatment & Relapse Prevention
Establishing a diagnosis

• **PCP:** evaluate potential medical causes/origins of anxious symptoms, order labs/tests as needed, coordinate with care manager, arrange for further assessment

• **Care Manager:** provide further assessment, communicate relevant/important information to PCP, screen for substance use, support patient on arranging follow-up, consult with psychiatric consultant

• **Psychiatric Consultant:** provides expert guidance on diagnosis as needed

• **Patient:** Provide information about symptoms and history
Questions to consider

• Are presenting symptoms caused by a medical problem?
• Typical distress or mental health disorder?
• Bipolar/mood disorder?
• Anxiety or trauma-related disorder?
• Is there substance use?
• Is the patient experiencing psychotic symptoms?
• Are there any acute safety concerns?
• How long have symptoms been present?

• All of this information will be shared among the treatment team to develop or refine diagnosis
Differential Diagnosis and Provisional Diagnosis

• Rule out common contributing medical problems and substance-related conditions
  • Identify possible medical symptoms that present as psychological symptoms (consider lab tests if indicated)
  • Consider substance abuse, withdrawal, or intoxication that may present as psychological symptoms

• Identify a provisional/working diagnosis
  • Team members will learn additional clinical information about the patient overtime
  • This will help team members refine/clarify diagnosis upon further assessment and/or consultation
Provisional Diagnosis: Team Decision
Major Depressive Disorder

• More disabling than many chronic medical conditions
  • Starts earlier in life and has greater impact on quality of life

• Associated with:
  • Increased health risk behaviors
  • Less adherence to medical treatment and poorer self-management
  • Increased risk for developing chronic diseases and complications
  • Increased medical costs
  • Early mortality
Major Depressive Disorder

• A) 5 or more present during same 2-week period, marked by change in functioning, at least one of the symptoms is either depressed mood or loss of interest/pleasure.
  • Depressed mood
  • Diminished interest in all, or almost all, activities most of the day nearly every day
  • Significant weight loss when not dieting or weight gain or decrease/increase in appetite
  • Insomnia or hypersomnia nearly every day
  • Psychomotor agitation or retardation nearly every day
  • Fatigue or loss of energy nearly every day
  • Feelings of worthlessness or guilt (excessive/inappropriate)
  • Diminished ability to think or concentrate, indecisiveness
  • Recurrent thoughts of death, recurrent suicidal ideation, or suicidal behavior
Major Depressive Disorder

• B) The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

• C) The episode is not attributable to the physiological effects of a substance or to another medical condition

• Occurrence of the episode is not better explained by schizoaffective, schizophrenia, delusional disorder, or other schizophrenia spectrum or psychotic disorder

• There has never been a manic episode or a hypomanic episode (not attributable to substances or other medical condition)
Generalized Anxiety Disorder

• Comorbid with mood disorders the vast majority of the time
• High frequency of somatic symptoms can complicate diagnosis and lead to increased medical costs
• GAD is one of the most common mental disorders in primary care settings and is associated with increased use of health services
• Twice as common in women as it is in men
• Most report they have felt anxious and nervous for entire life
• Broad range of onset
• Chronic and fluctuating symptoms
• Associated with a significant degree of functional impairment
GAD Diagnostic Criteria

A) Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance)

B) Individual finds it difficult to control the worry

C) Associated with three (or more) of following for more days than not
   • Restlessness or feeling on edge
   • Being easily fatigued
   • Difficulty concentrating or mind going blank
   • Irritability
   • Muscle tension
   • Sleep disturbance
GAD Diagnostic Criteria

D) The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

E) The disturbance is not attributable to the physiological effects of a substance or another medical condition

F) Symptoms not better explained by another anxiety disorder
Anxiety + Depression

• Anxiety in clinical care is often mixed with depression

• Generalized Anxiety Disorder (GAD) is 35-50% comorbid with depression

• Untreated GAD is associated with high rates of medical comorbidity and medical care utilization

• Comorbid depression negatively impacts prognosis and often results in prolonged course and increased functional impairment

• Neurotransmitters involved are serotonin, norepinephrine, and GABA

• Common heritability. Same biological underpinnings.
Symptom Overlap

**GAD**

**MAJOR DEPRESSION**

- Interest
- Appetite
- Esteem
- Suicide
- Agitation
- Dysphoria
- Sleep
- Fatigue
- Restlessness
- Worry
- Tension
- Concentration
- Irritability
Initiate Treatment

1. Identify & Engage
2. Establish a Diagnosis
3. Initiate Treatment
4. Follow-up Care & Treat to Target
5. Complete Treatment & Relapse Prevention
Initial Treatment Planning

**PCP:** Completes medical assessment as needed. Initiates appropriate treatment with care manager. Prescribe initial medication trial. Provide encouragement and support regarding treatment and working with new team member.

**Behavioral Health Care Manager:** Provide psychoeducation about anxiety and depression. Coordinates with team to create integrated treatment plan. Provides brief behavioral intervention. Engage patient in follow-up plan.

**Psychiatric Consultant:** Supports treatment planning. Guides treatment decisions as needed. May support team’s medication or diagnostic concerns.

**Patient:** Learns about anxiety disorder and treatment options. Works with team to develop plan that reflects goals. Agrees to level of engagement in treatment.
Initial Contact with BHCM

• Review PHQ-9 and GAD-7 screeners
• Explore client’s presenting symptoms, including onset, duration, activating events, coping skills/resources
• Gather additional information as needed
• Present treatment options and intervention types offered through Collaborative Care
Intervention Types

• Talk Treatment
  • Brief, structured behavioral health interventions

• Medication Management
  • Medication intervention with supportive services from Care Manager

• Watchful Waiting or Monthly Monitoring
  • Monthly check-in contact with Care Manager, usually by phone
Patient Preference

- What is patient preference impacted by?
  - Beliefs associated with treatment
    - Medication and Talk Treatment
  - Past treatment experiences
  - Stigma/Bias
  - Family/peer treatment
  - Side effects
  - Time needed
  - Goals

- These concerns should be anticipated and addressed in discussion of treatment options
Why Talk Treatment?

• In its best and most effective form, talk treatment is meant to be a learning experience, where your clinician acts much like a teacher or a guide to help you understand where your symptoms come from and what to do about them so that you can regain control of your life. Good intervention is about knowledge, empowerment, and positive change so that patients can learn the tools and strategies for independent symptom management and improvement.

• Language use: talk treatment, therapy, counseling
  • Implications and connotations of each
  • How can this effect patient engagement?
Watchful Waiting

- Patient’s with more mild symptoms and no significant impairment to functioning may reasonably elect for forgo treatment initially
- Clinical follow-up is still important to monitor the course of the disorder and determine change in symptom severity or impact
- This can occur in monthly contact with care manager, at which time PHQ-9/GAD-7 is administered
- Monthly contact can also be used to scale down treatment
Telephonic Encounters

• Include telephone use in discussion of treatment options
• Many patients (and clinicians) are not used to this treatment option
• Offers a flexible, patient-centered option that improves access + engagement

• Fulfills Monthly CCMP contact requirement
Telephone Contacts: Patient Profile

What patients are the best candidates for telephonic encounters?

When should the telephone be used?

How will you ensure care managers have time for telephone contacts?
Why the Telephone?

• The telephone offers a versatile and flexible, patient-centered tool within Collaborative Care.

• What patients does this work best with?
  • Missed/cancelled appointment
  • Transportation barriers
  • Decline on-site appointment
  • Childcare barriers
  • Inconsistent attendance/scheduling conflicts
  • Physical injury/limited mobility/chronic pain
  • Scaling back service use due to depression remission
  • Brief check-ins between scheduled appointments
Setting Treatment Goals

• Set clearly understandable patient-centered goals supported by the whole team and noted in patient’s chart

• Observable, measurable outcomes

• Strategies
  • Functional improvement
  • Behaviorally defined and measurable
  • Patient-centered, patient participation
  • Standard measures included

• Create individualized treatment plan that accounts for patient’s preferences, limitations, resources, access, and other factors
Talk Treatments

• Depression
  • Cognitive Behavioral Therapy (CBT)
    • Relationship between thoughts, emotions, and behaviors
    • Behavioral component
    • Challenging and changing cognitions
    • Reevaluating perceptions and expectations
  • Problem Solving Treatment (PST)
    • Identifies problems and develops action plans
    • 7 step strategy
  • Behavioral Activation (BA)
    • Helps patients reengage in work, social, health, and family activities
    • Behavioral change that targets avoidance and activities that maintain depression
    • Promotes pleasure and mastery through action planning
  • Interpersonal Psychotherapy (IPT)
    • Solve interpersonal and social problems

• Anxiety
  • Modular anxiety treatment (MAT)
    • CBT
    • Relaxation Skills
    • Exposure-based strategies
Training is Available

• In-person trainings with your Technical Assistance Team
• PST and Behavioral Activation training offered through AIMS Center
PCP Role in Behavioral Interventions

• Explain that behavioral interventions are first-line treatments, not

• Introduce talk treatment:
  • “One of our most effective treatments for anxiety/depression involves talking about your symptoms with the care manager. In talk treatment, you will learn how your thoughts, feelings, and behaviors impact your symptoms, and then learn new skills, strategies, and approaches to feel better.”

• Consider prescribing behavioral targets for patient
BHCM Role in Medication Management

• **Psychoeducation**
  - Explaining rationale of treatment
  - Common side effects
  - How medications work – titration, adequate trial, discontinuation syndrome
  - Clinical recommendations

• **Monitoring**
  - Side effects
  - Treatment progress

• **Troubleshooting barriers to adherence**
  - Countering demoralization/hopelessness
    - “It’s been one week”
  - Address fears (dependence, loss of control, laziness, “becoming a zombie”)
  - Enlist familial/spousal support
  - Reinforce instructions

• **Intra-team communication**
  - Provide PCP recommendations
  - Share client reports with PCP and Psychiatric Consultant
Medication

• Provide psychoeducation about medication
• Clarify treatment expectations
  • 2-6 weeks for an initial effect
  • Up to 12 weeks for maximum benefit from a certain dose
• PCP to prescribe medication based on clinical judgment and patient preference (as appropriate)
• Schedule follow-up appointment for medication titration
• The majority of patients (50-70%) will require dose escalations and many will require medication changes or augmentation (med or talk tx)
Common Depression Medications

- Bupropion (Wellbutrin)
- Citalopram (Celexa)
- Duloxetine (Cymbalta)
- Escitalopram (Lexapro)
- Fluoxetine (Prozac)
- Mirtazapine (Remeron)
- Paroxetine (Paxil)
- Sertaline (Zoloft)
- Venlafaxine (Effexor)
- Nortriptyline (Pamelor)
Common Anxiety medications

• SSRIs
  • Citalopram (Celexa)
  • Escitalopram (Lexapro)
  • Fluoxetine (Prozac)
  • Paroxetine (Paxil)
  • Sertraline (Zoloft)

• Mixed Receptor Antidepressants
  • Duloxetine (Cymbalta)
  • Mirtazapine (Remeron)
  • Venlafaxine (Effexor)

• Other Anxiety Medications
  • Buspirone (BuSpar)
  • Hydroxyzine (Vistaril)
  • Prazosin (Minipress)
Follow-up Care & Treat-to-Target

- Identify & Engage
- Establish a Diagnosis
- Initiate Treatment
- Follow-up Care & Treat to Target
- Complete Treatment & Relapse Prevention
Follow-up Care & Treat to Target

- **PCP**: Continue to prescribe medications, make medication adjustments as needed, implement treatment recommendations, talk to patients about BH

- **Care Manager**: Provide brief behavioral interventions, monitor symptoms, update registry, talk to patients about medication, consult with PC

- **Psychiatric Consultant**: Review cases, prioritizing patients not improving as expected, and provide treatment recommendations to care team

- **Patient**: Engage with care team and adhere to treatment plan
Follow-Up Contacts

Weekly or every other week during acute treatment phase:
- In person or by telephone to evaluate symptom severity (PHQ-9, GAD-7) and treatment response

Initial focus:
- Adherence to medications
- Side effects
- Follow-up on activation and PST plans

Later focus:
- Complete resolution of symptoms and restoration of functioning
- Long-term treatment adherence
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.

Follow-up contact within four weeks of the initial assessment is key to early improvement (*Bao, 2015*).
Frequent Contacts & Treatment Response

• Talk Treatment
  • Reporting on progress increases patient’s motivation to act
  • Reminder to patient if they haven’t followed up on goal
  • Time to make a new plan and problem-solve

• Medication
  • Check on adherence
  • Time to talk about side effects/ concerns regarding medications
  • Maximize treatment response if problems are addressed early
  • Consulting in a timely manner
Strategies for Optimizing Adherence

• Provide rationale for use
• Careful attention to side-effects
• Address fear of dependence and loss of control
• Enlist family/spousal support
• Address concerns in relation to patient’s or significant other’s prior experience with medication
• Increase contact with brief phone check-ins
• Specific instructions (take regardless of symptom change, don’t stop on own)
Typical Frequency of Care Management Contact

**Active Treatment**
- until patient significantly improved/stable
- minimum 2 contacts per month
  - mix of phone and in-person

**Monitoring**
- 1 contact per month
  - after 50% decrease in PHQ-9
  - monitor for ~3 months to ensure patient stable
  - complete relapse prevention planning
Core Question Throughout Care

Have the patient’s goals been reached?

- **50% decrease in baseline PHQ-9/GAD-7 score within 70 days/ every month after**
  
  OR

- **Decrease in baseline PHQ-9/GAD-7 score to below 10 within 70 days/ every month after**

  - If **NO**, psychiatric consultation and/or change in treatment
  - If **YES**, document progress and continue to monitor
Stepped Care

Systemic Outcome Tracking (Using the PHQ-9/GAD-7)

Evidence based treatment informed by clinical outcomes/patient goals

If outcomes are not achieved, adjust treatment in consultation with psychiatrist and deliver changes
Each Contact is a Decision Point

- Use a BH measure each time
  - E.g., PHQ-9, GAD-7
  - Review scores

- Track and consider what is happening
  - How long has the patient been in treatment?
  - Improving or not: Could they improve more?
  - Are they engaged?
  - Are there other challenges and how will we overcome them?

- Answer the questions:
  - Is the client getting better?
  - Do I need to consult and/or change what I am doing?
Typical response to treatment changes

6-10 Months average treatment length

- Complete response to initial treatment: 30% - 50%
- Need at least one change in treatment: 50% – 70%

• Each change of Tx moves an additional ~20% of patients into improvement or remission.
Team Goal

• Be prepared to adjust the treatment plan until targets are achieved
  • Monitor progress
  • Proactively seek consultation
  • Provide robust outreach
  • Assess adherence
    • Identify and address reasons for low adherence
    • If adherent to initial treatment, initiate change
  • Make adjustments to treatments already initiated
  • Or add psychotropic medication or behavioral interventions for patients not already receiving them
Changes in Treatment

Change in intervention type
- From telephonic to medication management and/or talk treatment or vice versa

Add intervention type
- Add medication or add talk treatment

Change in medication type

Change in talk treatment modality

Focus on engagement and outreach

Referral and transition to Community Resources
## Working with disengaged clients

### Creative re-engagement strategies
- Refocus on outreach
- Engage your team members (joint sessions, preventive care visits, home visits, etc)
- Send a caring letter
- Propose a change in treatment

### Discharge workflow
- Once all re-engagement strategies exhausted, implement discharge workflow
- Usually after one month of non-response
- Communicate Open Door
PCP Approaches

• No response: Escalate medications incrementally to maximally tolerated dose. If no benefit after eight weeks, switch to another first-line agent in the same or different class. ¼ of patients who fail to respond to an initial SSRI will respond to a different SSRI.

• Partial response: Escalate incrementally to maximally tolerated dose. If inadequate, consider augmentation in consultation with psychiatric consultant

• Note: The anxiolytic effect of antidepressant medication can take longer to show benefit and reach maximum efficacy (12-16 weeks) as compared to the antidepressant effect
BHCM Approaches

• BHCM: Ask about medications at every session. Provide support and problem-solve adherence challenges. Assist in arranging follow-up, addressing side effects, and relaying relevant information to PCP

• Adjust treatment as needed if little or no response after 6 weeks
  • Change in talk treatment modality
  • Talk to patient about adding/adjusting medication

• Assess for adherence and encourage active participation from patient between sessions
  • Problem-solve barriers

• Explore potential referral sources

• Drive measurement-based care through registry use
Why Use a Registry?

• Caseload management at-a-glance
• Track treatment engagement & response
• Prioritize patients who are not responding or disengaged
• Track patients’ symptoms with measurement tools (PHQ-9, GAD-7)
• Track medication side effects & concerns
• Facilitate caseload review with Psychiatric Consultant
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<th>Patient ID</th>
<th>PHQ-9</th>
<th>GAD-7</th>
<th>Initial Assessment</th>
<th>Follow Up</th>
<th>Psych note</th>
<th>Relapse Prevention Plan</th>
<th># Sessions</th>
<th>Weeks since initial assessment</th>
<th>Flags</th>
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**Key**

- **Indicates patient has been flagged for discussion during next psychiatric consultation**
- **Indicates patient has been flagged as a safety risk**
- *Score in the last column will have an asterisk (*) if it is older than the specifications for that clinical measure (ex: if the PHQ-9 is older than 30 days)
# Treatment History

**L1: Depression**

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<th>Date of Contact</th>
<th>Contact Type</th>
<th>Weeks in Tx</th>
<th>Type (L1) / Modality (L2)</th>
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**Patient Progress**

![Graph showing patient progress over time](http://www.jhartfound.org/sif/142)

**Track Measurements Over Time!**
Tracking Clinical Outcomes through Registry

Prevents patients from “falling through the cracks”

Facilitates treatment planning and adjustment

Combats clinical inertia:
Patients staying on ineffective or partially effective treatments
Care Management Tracking System (CMTS)

- HIPAA Compliant Web-based Application developed by AIMS Center
- OMH version customized for CCMP data submission
- With State Approval, free for the first year
  - $1000 a year after that
- Minimizes double-documentation
  - Less than 5 minutes per patient per contact
- Learn More
  - https://aims.uw.edu/nyscc/training/sites/default/files/CMTS%20two-pager%20final.docx.pdf
CASE REVIEW

Working with your psychiatric consultant
Consultation Hour

**Brief check-in**
- Changes in the clinic, systems questions

**Identify patients and conduct reviews**
- Requested by the Care Manager
- Not improving and not recently reviewed
- Severity of symptoms or functional impairment
- Not engaged in care
- Ready for relapse prevention or referral

**Wrap up**
- Confirm next consultation hour
Considerations Before Caseload Review

1. Plan the cases you want to present based on these guidelines

2. Review cases to think about what your concern/question is

3. Think or review chart: Do I have the material/information to aid in answering this question?
Priorities for Consultation

• All patients who have 8-10 weeks of treatment with no improvement/not in remission

• Patients where there is a diagnostic question and/or concern if they need specialized behavioral health program
  • Is severely depressed (PHQ-9 score \( \geq 20 \))
  • Fails to respond to treatment
  • Has side effects from medication
  • Has complicating mental health diagnosis, such as personality disorder or substance abuse
  • Bipolar or psychosis
  • Has current substance dependence
Priorities for Consultation (cont’d)

Patients who are not engaged or have other difficulties in their care

Patients who are on a low dose of an antidepressant for 4 weeks or longer with only little or no improvement

New patients, especially those who are more complex
Identify & Engage
Establish a Diagnosis
Initiate Treatment
Follow-up Care & Treat to Target
Complete Treatment & Relapse Prevention
Completing Treatment

- **PCP**: Continue care as usual, prescribing medications as indicated

- **Care Manager**: Facilitate discontinuation through completion of relapse prevention planning or transition to community resources

- **Psychiatric Consultant**: Make final treatment recommendations to continued medication management and/or referral to appropriate community resources

- **Patient**: Develop relapse prevention plan and/or engage in identified resources. Continue self-monitoring and self-management of symptoms
Relapse Prevention Planning

**Active Treatment**
- Until patient significantly improved/stable
- Minimum 2 contacts per month
  - Mix of phone and in-person

**Monitoring and Relapse Prevention**
- 1 contact per month
  - After 50% decrease in PHQ-9 or 5 point decrease to below 10 from baseline
  - Monitor for ~3 months to ensure patient stable
  - Complete relapse prevention plan
  - Identify with client any remaining clinical goals to address during final sessions
  - Open door
Typical Course of Care Management

- Primary Care Panel
- Collaborative Care Caseload
- Referral to Specialty Mental Health
- Relapse Prevention

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Transition to 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
How to make a successful referral

• Not just a phone number
• Use relationship with known provider
• Call ahead to help set up connection
• Talk about what your ongoing role will be
• Follow up with referral
• Be realistic about payment / cost / insurance.
Develop a list of referral resources

• How do you find them?
  • Word of mouth
  • Colleagues
  • Professional listings – associations, etc

• The phone is your friend
  • Call potential sources of care and talk to them about how you could work together

• Create a clinic list
  • Make sure to develop a formal list that can be shared in the clinic to anticipate turnover
Relapse Prevention Plan

• Introduced and developed throughout treatment
• After ~ 3 months of monitoring with sustained improvement

• Relapse Prevention Plan
  • Empowers patient through self-management after treatment is completed
  • Prevents recurrence of depression and anxiety
  • Helps patient know when to seek help
  • Provides instructions for continued medication management
Start on Monitoring and Maintenance
- Transition from active treatment
- Begins termination process

Throughout Treatment
- Part of patient education
- Work on plan throughout treatment

Termination Session
- Caps treatment
- Provides a structure for final session
Helping patients Adjust to Termination

• Discuss treatment timeline and structure from beginning
• Use PHQ-9 graph to help them see progress
• Work with patient to find other sources of support and identify effective coping skills
• Encourage the ongoing use of strategies for self-management throughout life
• Give specific end date (when appropriate)
  • e.g. two more sessions, spread sessions out more and more
Termination Session:

- RPP facilitates termination session
  - Provides structure for session
    - Helpful for both patient and provider
  - Creates concrete plan for patient self management
  - Reminds patient of progress made
  - Develops concrete plan for self-care and self-monitoring symptoms
  - Clear plan for what to do if symptoms return
    - Mitigates fear of termination
Relapse Prevention Plan

Date: _______________________

Purpose: Depression can occur multiple times during a person’s lifetime. The purpose of a relapse prevention plan is to help you understand your own personal warning signs. These warning signs are specific to each person and can help you identify when depression may be starting to return so you can get help sooner – before the symptoms get bad. The other purpose of a relapse prevention plan is to help remind you what has worked for you to feel better. [both of these put YOU in charge!]

Instructions: 1. Fill out this form with your care manager. 2. Put it where you’ll come across it on a regular basis. 3. Use the PHQ-9 on the back to self-assess yourself. 4. If you see signs of returning depression, use your prevention plan.

Maintenance medications
1. __________, __________ tablet(s) of __________ mg ______ Take at least until __________
2. __________, __________ tablet(s) of __________ mg ______ Take at least until __________
3. __________, __________ tablet(s) of __________ mg ______ Take at least until __________
4. __________, __________ tablet(s) of __________ mg ______ Take at least until __________
Call your primary care provider or your care manager with any questions (see contact information below).

Other treatments
1. ____________________________
2. ____________________________
3. ____________________________

Personal warning signs
1. ____________________________
2. ____________________________
3. ____________________________
4. ____________________________

Things that help me feel better
1. ____________________________
2. ____________________________
3. ____________________________
4. ____________________________
If symptoms return, contact: ____________________________

Primary Care Provider: ____________________________ Phone: ____________________________ Email: ____________________________
Care Manager: ____________________________ Phone: ____________________________ Email: ____________________________

Next appointment: Date: ____________ Time: ____________
Maintenance Medications

• Discuss dose and length of time to continue medications
• Review rationale for staying on meds and explain the importance of discussing with PCP before making any changes
• Review how to handle refills
• Respond to any questions
• First episode of major depression: continue same dose for 4-9 months following remission
• Recurrent depression episodes: continue acute-phase dose for at least two years
• Anxiety: 6-9 months at effective dose before taper off
• Discontinuation: tapering gradually over several weeks reduces rate of relapse and discontinuation symptoms
Other Treatments

• Other health professionals familiar to patient
• Other healthcare services
• Other activities, groups, or appointments that support the patient’s recovery and well-being
• Ex. Diabetic educator, chronic care manager, dentist, cardiologist, acupuncture, chiropractor, etc.
Personal Warning Signs

• Ask patient to identify their personal signs/symptoms

• This is also a part of the safety plan, although warning signs may be different

• Review initial PHQ-9/GAD-7 for symptoms and review score fluctuations in response to life events/stressors
  • Especially if patient is having trouble remembering

• Help patient recall behaviors you know they had in the beginning of treatment
  • e.g. not getting dressed, not contacting friends
Things that help me feel better

• Review and identify strategies that helped improve mood throughout treatment
• Be detailed and specific with activities and weekly goals
• Measurable and observable similar to treatment goals
• Contingency plans
• What to do if symptoms return
• Next appointment with PCP
• Referral review
Example Relapse Prevention Plan

• Medications:
  • Prozac 20 mgs every am. Remain on the medications for at least 6 months. Call the pharmacy for refills and have them contact PCP if you run out of refills. Talk to your PCP before stopping.

• Warning signs:
  • Spending more time in bed, especially in the afternoon
  • Not returning friends’ phone calls or turning down invitations
  • Low energy and lack of interest

• Things that help me feel better:
  • Walk 3 times a week with friend Sue or another neighbor in the morning
  • Go to book club monthly /read daily in the afternoon
  • Deep breathing daily at 8 am
  • Make the bed each morning right away
  • Use PST process when something bothers me
Distributing Plan

• In-person or over the phone
• Handout or mailed
• Discuss ongoing monitoring with PHQ-9 and awareness of warning signs
• PCP to follow-up and reinforce plan in care as usual after completion of Collaborative Care
Discussion + Q&A

Reach out for questions, concerns, and guidance

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