INTRODUCTION TO THE COLLABORATIVE CARE APPROACH
LEARNING OBJECTIVES

• List history of integrated care models and the evidence-base for the Collaborative Care Model (CoCM).
• Describe the differences in workflow between traditional psychiatry and psychiatric consultation in collaborative care.
• Name the five core principles of collaborative care.
• Apply knowledge of a registry to facilitate treatment-to-target and psychiatric case reviews.
TRANSFORMING CLINICAL PRACTICE INITIATIVE
APA Support and Alignment Network
FUNDING ACKNOWLEDGEMENT

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The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.
In September 2015, the Centers for Medicare and Medicaid Services (CMS) awarded $685 million to 39 national and regional collaborative healthcare transformation networks (PTNs) and supporting organizations (SANs) for the Transforming Clinical Practice Initiative (TCPI).

TCPI supports practice transformation through nationwide, collaborative, and peer-based learning networks.
TWO COMPONENTS OF TCPI

– **Practice Transformation Networks (PTNs)**
  Medical group practices, regional health systems, and regional extension centers
  • Recruit clinicians into their networks
  • Provide on the ground support to practices
    *Examples: Practice redesign to prepare for alternative payment models, quality improvement coaches, PDSA cycles, EMR optimization, etc.*

– **Support and Alignment Networks (SANs)**
  National and regional professional associations and public-private partnerships
  • Provide CME, MOC, and tools for practice transformation
  • Support PTN recruitment
APA SAN OBJECTIVE: TRAIN, READY, CONNECT

Train psychiatrists & primary care physicians in collaborative care model through online or live trainings; and continued education through learning collaboratives, and implementation TA for practices in PTNs.

**TRAIN**
- Online
- In person
- Learning collaboratives

**READY**

**CONNECT & IMPLEMENT**

New reimbursement!

- Over 2600 trained in 49 States
- PTN collaboration with implementation
- Webinars: financial modeling, sustainability and coding

[www.psychiatry.org/SAN](http://www.psychiatry.org/SAN)
• Anna Ratzliff, MD, PhD receives royalties from Wiley for a book on integrated care.
OBJECTIVES

- List history of integrated care models and the evidence-base for the Collaborative Care Model (CoCM)
- Describe the differences in workflow between traditional psychiatry and psychiatric consultation in collaborative care
- Name the five core principles of collaborative care
- Apply knowledge of a registry to facilitate treatment-to-target and psychiatric case reviews.
# AGENDA

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00-8:50</td>
<td>Overview of Collaborative Care (Ratzliff)</td>
</tr>
<tr>
<td>8:50-9:20</td>
<td>Assessment as Part of a Collaborative Care Team (Ratzliff) - Patient Cases</td>
</tr>
<tr>
<td>9:20-9:30</td>
<td>Break</td>
</tr>
<tr>
<td>9:30-10:00</td>
<td>Treatment as Part of a Collaborative Care Team (Ratzliff) - Registry Practice</td>
</tr>
<tr>
<td>10:00-10:30</td>
<td>Practice Example (Korsen)</td>
</tr>
<tr>
<td>10:30-11:00</td>
<td>Financing and Next Steps (Ratzliff)</td>
</tr>
</tbody>
</table>
DANIEL: A COLLABORATIVE CARE STORY

http://aims.uw.edu/daniels-story-introduction-collaborative-care
OVERVIEW OF COLLABORATIVE CARE
THE CHALLENGE

Behavioral Health
Psychiatric disorders cause:
- 25% of all disability worldwide*
- 10% of Years Lived with Disability (YLD) from depression alone
- 3x diabetes, 10x heart disease, 40x cancer
- In the US, one suicide every 14 minutes

Health Behaviors
- Behavior determines ≈ 50% of all mortality and morbidity
- Unhealthy behaviors are major drivers of health care costs
- 40 – 50% struggle with treatment adherence
- Employers struggle with absenteeism and presenteeism

*C. Murray, GBD Study, Lancet 2012
WHO GETS TREATMENT?

Wang et al., 2005
WHO GETS TREATMENT?

No Treatment

Primary Care Provider

Mental Health Provider

Wang et al., 2005
WHY NOT JUST REFER?
PATIENT FACTORS

• Half of those referred do not follow through.

• Mean # of visits = 2

Grembowski, Martin et al., 2002
Simon, Ding et al., 2012
WHY NOT JUST REFER?
PROVIDER FACTORS

1 in 5: unmet need for non-prescribers
96% unmet need for prescribers

Thomas KC et al., 2009
### OTHER MODELS OF CONSULTATION

<table>
<thead>
<tr>
<th>Traditional Consultation</th>
<th>Co-Location</th>
<th>Behavioral Health Consultant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited access</td>
<td>Access and interaction</td>
<td>Solidly grounded in a clinical practice culture</td>
</tr>
<tr>
<td>Limited feedback</td>
<td>Better communication</td>
<td>Generalist BHP</td>
</tr>
<tr>
<td>Expensive</td>
<td>Long waitlists and limited available providers</td>
<td>Rapid access to brief behavioral interventions</td>
</tr>
<tr>
<td>One Pass</td>
<td>Limited ability for follow through</td>
<td>Limited evidence base</td>
</tr>
</tbody>
</table>
COLLABORATIVE CARE: THE IMPACT STUDY

Effective Collaboration

Prepared, Pro-active Practice Team

Practice Support

Informed, Active Patient

Outcome Measures

PHQ-9

[Active Patients]

Population Registry

Treatment Protocols

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

Psychiatric Consultation

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TWICE AS MANY PEOPLE IMPROVE

50% or greater improvement in depression at 12 months

Unützer et al., 2002, 2004
IMPACT: SUMMARY

1) Improved Outcomes
   — Less depression
   — Less physical pain
   — Better functioning
   — Higher quality of life

2) Greater patient and provider satisfaction

3) More cost-effective
   (ROI $6.50: 1)

“I got my life back”

THE TRIPLE AIM
Now over 80 Randomized Controlled Trials (RCTs)

- Meta analysis of Collaborative Care (CC) for depression in primary care (US and Europe)
- Consistently more effective than usual care

Since 2006, several additional RCTs in new populations and for other common mental disorders

- Including anxiety disorders, PTSD
- Emerging evidence for ADHD, alcohol and substance use disorders

Archer, J. et al., 2012
## HOW WELL DOES IT WORK WITH OTHER DISORDERS?

<table>
<thead>
<tr>
<th>Evidence Base Established</th>
<th>Emerging Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Depression</td>
<td>• ADHD</td>
</tr>
<tr>
<td>- Adolescent Depression</td>
<td>• Bipolar Disorder</td>
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<tr>
<td>- Depression, Diabetes, and Heart Disease</td>
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<td>- Depression and Cancer</td>
<td></td>
</tr>
<tr>
<td>- Depression in Women’s Health Care</td>
<td></td>
</tr>
<tr>
<td>• Anxiety</td>
<td></td>
</tr>
<tr>
<td>• Post Traumatic Stress Disorder</td>
<td></td>
</tr>
<tr>
<td>• Chronic Pain</td>
<td></td>
</tr>
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<td>• Dementia</td>
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<td>• Substance Use Disorders</td>
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**Evidence Base Established**

- 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

**Emerging Evidence**

- ADHD
- Bipolar Disorder
PRINCIPLES OF COLLABORATIVE CARE

Population-Based Care

Measurement-Based Treatment to Target

Patient-Centered Collaboration

Evidence-Based Care

Accountable Care
Caseload Overview

<table>
<thead>
<tr>
<th>View Record</th>
<th>Treatment Status</th>
<th>Name</th>
<th>Date of Initial Assessment</th>
<th>Date of Most Recent Contact</th>
<th>Number of Follow-up Contacts</th>
<th>Weeks in Treatment</th>
<th>Initial PHQ-9 Score</th>
<th>Last Available PHQ-9 Score</th>
<th>% Change in PHQ-9 Score</th>
<th>Date of Last PHQ-9 Score</th>
<th>Initial GAD-7 Score</th>
<th>Last Available GAD-7 Score</th>
<th>% Change in GAD-7 Score</th>
<th>Date of Last GAD-7 Score</th>
<th>Flag</th>
<th>Most Recent Psychiatric Consultant Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year</td>
<td>Active</td>
<td>Albert Smith</td>
<td>8/13/2015</td>
<td>12/2/2015</td>
<td>7</td>
<td>29</td>
<td>18</td>
<td>17</td>
<td>-6% (Flag for Discussion &amp; Safety Risk)</td>
<td>12/2/2015</td>
<td>14</td>
<td>10</td>
<td>-29%</td>
<td>?</td>
<td>1/2/2015</td>
<td>1/2/2015</td>
</tr>
</tbody>
</table>

FREE UW AIMS Excel® Registry (https://aims.uw.edu/resource-library/patient-tracking-spreadsheet-example-data)

Allows proactive engagement ("no one falls through the cracks") and treatment adjustment!
PRINCIPLE: MEASUREMENT-BASED TREATMENT TO TARGET

Weeks in Treatment (0 = Clinical Assessment)

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

Usual primary care: 614 days

Collaborative care program: 86 days

Time to Remission for Depression with Collaborative Care Management in Primary Care: [http://www.ncbi.nlm.nih.gov/pubmed/26769872](http://www.ncbi.nlm.nih.gov/pubmed/26769872)

JAM Board Fam Med, 2016 Jan-Feb
PRINCIPLE: PATIENT-CENTERED COLLABORATION

New Roles

PCP

Patient

BHP/ Care Manager

Psychiatric Consultant

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PRIMARY CARE PROVIDER FUNCTIONS

- Primary treatment relationship
- Links with Collaborative Care Team
- Prescribes medication
- Monitors medication management, together with care manager.
- Supports treatment plan.
- Consults with Collaborative Care team.
- Supports system change.
BHP/CARE MANAGER HAS TWO FUNCTIONS

CARE MANAGER
MSW
LCISW
RN
PsyD, PhD

PCP

Patient

BHP/ Care Manager

Psychiatric Consultant

New Roles

© University of Washington
CARE MANAGER FUNCTIONS

- 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
BEHAVIORAL HEALTH PROFESSIONAL (BHP) FUNCTIONS

- Evidence-based psychotherapy
  - Individual or Group
- Behavioral health interventions focused on health behaviors
- Chemical dependency counseling
- Social work services
PSYCHIATRIC CONSULTANT ROLE

New Roles

PCP

Patient

BHP/ Care Manager

Psychiatric Consultant

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BASIC PSYCHIATRIC CONSULTANT FUNCTIONS

• Review cases with the care manager using the registry
  ✓ Scheduled (ideally weekly)
  ✓ Prioritize patients that are not improving

• Consult urgently (as needed) with PCP or Care Manager
‘DAY IN THE LIFE’ OF A PART-TIME PRIMARY CARE PSYCHIATRIC CONSULTANT

8 AM - 12 PM:
- Duties in a community mental health center or other clinical setting:
  - Clinical and administrative
  - Available for urgent curb-side consultations from primary care

12 PM - 1 PM:
- Lunch: 30 min discussion of clinical topic with PCPs during provider meeting

1 PM - 5 PM:
- Duties as primary care consultant including:
  - Work with BHP/Care managers
  - See patients from caseload
  - Monthly integrated care team meeting for caseload review, QI, and strategic planning
Consultation ranges from informal to formal

**INFORMAL**
- Curbsides, advice to PCP and BHP, no charting, not paid and not supervisor of BHP

**CONSULTATIVE**
- Curbsides, advice to PCP and BHP, no charting, not paid and not supervisor of BHP

**COMBINED**
- Curbside with BHP, document recommendations in chart and paid

**COLLABORATIVE**
- Direct with patient after other steps unsuccessful, written opinion and paid

**FORMAL**
- If psychiatric consultant provides administrative and clinical supervision of BHP → ultimately responsible

**SUPERVISORY**

Consultation should reduce risk:
- Care manager supports the PCP
- Use of evidence-based tools
- Systematic, measurement-based follow-up
- Psychiatric consultant

APA liability white paper:

Olick et al, Fam Med 2003
Sterling v Johns Hopkins Hospital., 2002
“The above treatment considerations and suggestions are based on consultations with the patient's care manager and a review of information available in the Mental Health Integrated Tracking System (MHITS). I have not personally examined the patient. All recommendations should be implemented with consideration of the patient’s relevant prior history and current clinical status. Please feel free to call me with any questions about the care of this patient.”

- Dr. X, Psychiatric Consultant
- Phone #
- Pager #
- E-mail
PRINCIPLE: EVIDENCE-BASED TREATMENT
TREATMENT OPTIONS

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

**Bio**
- Evidence-based Medications

**Psycho**
- Evidence-based Psychotherapeutic Interventions

**Social**
- Social support
PRINCIPLE:
ACCOUNTABLE CARE
Pay-for-performance cuts median time to depression treatment response in half

Unützer et al., 2012
ASSESSMENT AS PART OF A COLLABORATIVE CARE TEAM
Common outpatient psychiatry presentations

- Mood disorders
- Anxiety disorders
- Substance use disorders
- Psychotic disorders
- Cognitive disorders

Common primary care presentations

- Depression
- Anxiety
- Unexplained physical symptoms
- Somatic presentations & somatoform disorders
- Acute and chronic distress
- Adjustment disorders
- Pain
A DIFFERENT KIND OF ASSESSMENT: CARE SHAPED OVER TIME

Traditional Consult

One Session = One Assessment

Collaborative Care Case Review

Review 1 in Jan: Acute Distress?
Pt still has high PHQ & impairment
Review 2 in Mar: MDD and initiate treatment
A DIFFERENT KIND OF ASSESSMENT:
USING BEHAVIORAL HEALTH MEASURES

Depression Scale
- PHQ-9

Anxiety Scale
- GAD-7

PTSD Screen
- PCL-5

Alcohol Screen
- AUDIT-C

Drug Screen
- DAST-10
- CRAFFT

Bipolar Screen
- CIDI
- MDQ
Behavioral health measures are like monitoring blood pressure:

- Identify that there is a problem
- Needs further assessment to understand the cause of the “abnormality”
- Helps with ongoing monitoring to measure response to treatment including how each symptom is responding to treatment
PHQ-9

Over the last 2 weeks, how many days have you been bothered by any of the following problems?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at All</th>
<th>Several Days</th>
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<tr>
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<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<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 asleep, staying asleep or sleeping too much</td>
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<td>1</td>
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<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
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</tr>
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If you checked off any problem on this questionnaire so far, 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?

<table>
<thead>
<tr>
<th>Difficulty Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not difficult at all</td>
</tr>
<tr>
<td>Somewhat difficult</td>
</tr>
<tr>
<td>Very Difficult</td>
</tr>
<tr>
<td>Extremely difficult</td>
</tr>
</tbody>
</table>
### UNDERSTANDING THE PHQ-9 SCORE

<table>
<thead>
<tr>
<th>Score</th>
<th>Severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 4</td>
<td>No Depression</td>
</tr>
<tr>
<td>5 – 9</td>
<td>Mild Depression</td>
</tr>
<tr>
<td>10 – 14</td>
<td>Moderate Depression</td>
</tr>
<tr>
<td>≥ 15</td>
<td>Severe Depression</td>
</tr>
</tbody>
</table>

**Are there safety concerns?**
If Question 9 is a score > 0, needs to be assessed for safety

**Is it depression?**
MDD: needs to have either Question 1 or Question 2 with a score of >2
BHP/care manager is trained to inquire systematically as you would:

- Depressive symptoms
- Bipolar Screen
- Anxiety symptoms
- Psychotic symptoms
- Substance use
- Other (Cognitive, Eating Disorder, Personality traits)
- Past Treatment
- Safety/Suicidality
- Psychosocial factors
- Medical Problems
- Current medications
- Functional Impairments
- Goals
TEAM BASED BASIC DIFFERENTIAL DIAGNOSIS

**Mood**
- Depression
- Mania/Hypomania

**Anxiety and Trauma Disorders**
- Generalized anxiety
- Panic attacks
- PTSD
- OCD

**Psychosis**
- Primary
- Secondary

**Substance Use**
- Alcohol
- Illicit
- Prescription

**Organic**
- Cognitive function
- Relevant medical history
PROVISIONAL DIAGNOSIS

Screeners filled out by patient

Assessment by BHP/care manager and PCP

Psychiatric consultant case review (or direct evaluation)

Provisional diagnosis
TOLERATING UNCERTAINTY

- Tension between complete and sufficient information to make a recommendation
- Often use risk benefit analysis of the intervention you are proposing
- Compare this with the uncertainty you experience in standard practice

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### CASE 1: PHQ-9 SCORE = 13

<table>
<thead>
<tr>
<th>Over the last 2 weeks, how many days have you been bothered by any of the following problems?</th>
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If you checked off any problem on this questionnaire so far, 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
The first part of the CIDI-3 consists of asking two stem questions. If either Question 1 or Question 2 is positive, continue with the criterion B Screening Question. If both are negative, than the measure is negative and the patient does not likely meet the criteria for bipolar disorder.

**Euphoria Stem Question:**
1. Some people have periods lasting several days when they feel much more excited and full of energy than usual. Their minds go too fast. They talk a lot. They are very restless or unable to sit still and they sometimes do things that are unusual for them, such as driving too fast or spending too much money. Have you ever had a period like this lasting several days or longer?
   
   *If this question is endorsed, the next question (Irritability Stem Question) is skipped and the respondent goes directly to the Criterion B screening question.*

**Irritability Stem Question:**
2. Have you ever had a period lasting several days or longer when most of the time you were so irritable and grouchy you either started arguments, shouted at people or hit people?

**Criterion B Screening Question**
3. People who have episodes like this often have changes in their thinking and behavioral at the same time, like being more talkative, needing very little sleep, being very restless, going on spending sprees, and behaving in many ways they would normally think inappropriate ways they would normally think inappropriate. Did you ever have any of these changes during your episodes of being excited and full of energy or very irritable or grouchy?
### CIDI-3

**# CIDI questions positive:**  
**Risk of bipolar**

<table>
<thead>
<tr>
<th># CIDI questions positive</th>
<th>Risk of bipolar</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Very high: 80%+</td>
</tr>
<tr>
<td>7-8</td>
<td>High: 50-79%</td>
</tr>
<tr>
<td>6</td>
<td>Moderate: 25-49%</td>
</tr>
<tr>
<td>5</td>
<td>Low: 5-24%</td>
</tr>
<tr>
<td>0-4</td>
<td>Very low: &lt;5%</td>
</tr>
</tbody>
</table>

Think of an episode when you had the largest number of changes like these at the same time. During that episode, which of the following changes did you experience?

1. Were so irritable that you either started arguments, shouted at people or hit people?
2. Did you become so restless or fidgety that you paced up and down or couldn’t stand still?
3. Did you do anything else that wasn’t usual for you – like talking about things you would normally keep private, or acting in ways that you would usually find embarrassing?
4. Did you try to do things that were impossible to do, like taking on large amounts of work?
5. Did you constantly keep changing your plans or activities?
6. Did you find it hard to keep your mind on what you were doing?
7. Did your thoughts seem to jump from one thing to another or race through your head so fast you couldn’t keep track of them?
8. Did you sleep far less than usual and still not get tired or sleepy?
9. Did you spend so much more money than usual that it caused you to have financial trouble?
# CASE 2: PHQ-9 SCORE = 13

Over the last 2 weeks, how many days have you been bothered by any of the following problems?

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<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 concentratting 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>

If you checked off any problem on this questionnaire so far, 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?

<table>
<thead>
<tr>
<th>Difficulty Level</th>
<th>Not difficult at all</th>
<th>Somewhat difficult</th>
<th>Very Difficult</th>
<th>Extremely difficult</th>
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### CASE 3: PHQ-9 SCORE = 13

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<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>
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<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>2. Feeling down, depressed or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>3. Trouble falling asleep, 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>
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<td>2</td>
<td>3</td>
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If you checked off any problem on this questionnaire so far, 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 (circled)
- Extremely difficult
Suicide screening and evidence-based screening can be done efficiently by the collaborative care team using validated tools:

- Columbia-Suicide Severity Rating Scale (C-SSRS)
- Suicide Assessment Five-Step Evaluation and Triage (SAFE-T)

A collaborative care team can put in place an efficient suicide risk response protocol that makes this difficult scenario MUCH EASIER for the PCP and clinic.
### COLUMBIA SUICIDE SEVERITY RATING SCALE – 1

#### SUICIDE IDEATION DEFINITIONS AND PROMPTS:

<table>
<thead>
<tr>
<th>Ask questions that are in bold and underlined.</th>
<th>Past month</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ask Questions 1 and 2</strong></td>
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</tr>
<tr>
<td><strong>1) Wish to be Dead:</strong></td>
<td></td>
</tr>
<tr>
<td>Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up?</td>
<td><strong>YES</strong></td>
</tr>
<tr>
<td><em>Have you wished you were dead or wished you could go to sleep and not wake up?</em></td>
<td><strong>NO</strong></td>
</tr>
</tbody>
</table>

| **2) Suicidal Thoughts:**                     |            |
| General non-specific thoughts of wanting to end one’s life/commit suicide, “I’ve thought about killing myself” without general thoughts of ways to kill oneself/associated methods, intent, or plan.” | **YES** |
| *Have you had any actual thoughts of killing yourself?* | **NO** |

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

| **3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act):** |            |
| Person endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. “I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.” | **YES**    |
| *Have you been thinking about how you might do this?* | **NO** |

| **4) Suicidal Intent (without Specific Plan):** |            |
| Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as oppose to “I have the thoughts but I definitely will not do anything about them.” | **YES**    |
| *Have you had these thoughts and had some intention of acting on them?* | **NO**    |
### SUICIDE IDEATION DEFINITIONS AND PROMPTS:

#### Past month

<table>
<thead>
<tr>
<th>5) Suicide Intent with Specific Plan:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.</td>
</tr>
<tr>
<td><em>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</em></td>
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</table>

<table>
<thead>
<tr>
<th>6) Suicide Behavior Question</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</em></td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td><strong>If YES, ask:</strong> <em>Was this within the past 3 months?</em></td>
</tr>
</tbody>
</table>

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### Response Protocol to C-SSRS Screening (Linked to last item marked "YES")

- **Item 1**: Behavioral Health Referral
- **Item 2**: Behavioral Health Referral
- **Item 3**: Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
- **Item 4**: Behavioral Health Consultation and Patient Safety Precautions
- **Item 5**: Behavioral Health Consultation and Patient Safety Precautions
- **Item 6**: Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
- **Item 6**: 3 months ago or less: Behavioral Health Consultation and Patient Safety Precautions
SUICIDE ASSESSMENT FIVE-STEP EVALUATION AND TRIAGE (SAFE-T)

RESOURCES

- Download this card and additional resources at www.sprc.org or at www.stopsuicide.org

ACKNOWLEDGEMENTS

- Originally conceived by Douglas Jacobs, MD, and developed as a collaboration between Screening for Mental Health, Inc. and the Suicide Prevention Resource Center.
- This material is based upon work supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) under Grant No. 1U79SM57392. Any opinions/findings/conclusions/recommendations expressed in this material are those of the author and do not necessarily reflect the views of SAMHSA.

National Suicide Prevention Lifeline
1.800.273.TALK (8255)

NATIONAL SUICIDE PREVENTION LIFELINE
1.800.273.TALK (8255)
PSYCHIATRIC CONSULTANT ROLE: DIRECT CONSULTATION

- Different than seeing patients in traditional consultation
- Approximately 5 – 7% of patients may need direct consultation

Patients pre-screened from care manager population

- Already familiar with patient history and symptoms
- Typically more focused assessment, tele-video OK

Common indications for direct assessment

- Diagnostic dilemmas
- Treatment resistance
- Education about diagnosis or medications
- Complex patients, such as pregnant or medically complicated
TREATMENT AS PART OF A COLLABORATIVE CARE TEAM
A DIFFERENT KIND OF TREATMENT: CARE SHAPED OVER TIME

Traditional Consult

One Session = One Time Recommendation

Collaborative Care

Jan: Review 1 → MDD and initiate treatment
Engaged with team but still symptomatic
Feb: Review 2 → Adjust treatment
Engaged with team but persistent symptoms
Mar: Review 3 → Intensify treatment
## EXAMPLES OF EVIDENCE-BASED BEHAVIORAL APPROACHES

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Evidence-Based Behavioral Approaches</th>
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<tbody>
<tr>
<td><strong>Major Depression</strong></td>
<td>Problem-Solving Treatment</td>
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<tr>
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<td>Behavioral Activation</td>
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<td></td>
<td>Cognitive Behavioral Therapy</td>
</tr>
<tr>
<td></td>
<td>Interpersonal Therapy</td>
</tr>
<tr>
<td><strong>Anxiety Disorders</strong></td>
<td>Modular Anxiety Treatment (CALM)</td>
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<td></td>
<td>Cognitive Behavioral Therapy</td>
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<td><strong>PTSD</strong></td>
<td>Cognitive Processing Therapy</td>
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<td>Prolonged Exposure</td>
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<td><strong>Substance Use</strong></td>
<td>Harm Reduction</td>
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<tr>
<td>Disorders</td>
<td>Motivational Interviewing</td>
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<td></td>
<td>Brief Interventions for Alcohol</td>
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<tr>
<td><strong>Chronic Pain</strong></td>
<td>Cognitive Behavioral Therapy</td>
</tr>
<tr>
<td></td>
<td>• Negative thoughts about chronic pain</td>
</tr>
<tr>
<td></td>
<td>• Pain interference in life</td>
</tr>
<tr>
<td></td>
<td>• Acceptance of chronic pain</td>
</tr>
<tr>
<td></td>
<td>• Pain self-management strategies</td>
</tr>
</tbody>
</table>
RECOMMENDATIONS: MEDICATION TREATMENT

Focus on evidence-based treatments and treatment algorithms

Details about titrating and monitoring

Brief medication instructions
## PRINCIPLE:
POPULATION-BASED TREATMENT

### Caseload Overview

FREE UW AIMS Excel® Registry ([https://aims.uw.edu/resource-library/patient-tracking-spreadsheet-example-data](https://aims.uw.edu/resource-library/patient-tracking-spreadsheet-example-data))
**PRINCIPLE: MEASUREMENT-BASED TREATMENT TO TARGET**

<table>
<thead>
<tr>
<th>DATE OF CONTACT</th>
<th>CONTACT TYPE</th>
<th>WEEKS IN Tx</th>
<th>VISIT TYPE</th>
<th>PHQ-9</th>
<th>GAD-7</th>
<th>BIPOLAR SCREEN</th>
<th>PTSD SCREEN</th>
<th>CURRENT MEDICATIONS</th>
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</thead>
<tbody>
<tr>
<td>1/19/2016</td>
<td>Clinical Assessment</td>
<td>0</td>
<td>Clinic</td>
<td>15</td>
<td>13</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>1/29/2016</td>
<td>Psychiatric Consultation Note</td>
<td>1</td>
<td>Phone w/ CC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2/2/2016</td>
<td>Follow Up Contact</td>
<td>2</td>
<td>Clinic</td>
<td>12</td>
<td>11</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2/5/2016</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2/10/2016</td>
<td>Psychiatric Consultation Note</td>
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<tr>
<td>2/10/2016</td>
<td>Psychiatric Consultation Note</td>
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<td>Phone w/ CC</td>
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<td>2/23/2016</td>
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<tr>
<td>4/26/2016</td>
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<td>6</td>
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<td>Fludoxetine HCL (Prozac) 20mg</td>
</tr>
</tbody>
</table>

**Collateral Contacts**

<table>
<thead>
<tr>
<th>DATE OF CONTACT</th>
<th>NAME</th>
<th>ROLE</th>
<th>AGENCY</th>
<th>CONTACT INFORMATION</th>
</tr>
</thead>
</table>

No Records Found

**Patient Progress**

![Graph showing patient scores over weeks in treatment](image)
STAR-D SUMMARY

REPEATED TREATMENT ATTEMPTS ARE PAR FOR THE COURSE, THEY SHOULD BE PART OF THE PLAN!

Level 1: Citalopram
~30% in remission

Level 2: Switch or Augmentation
~50% in remission

Level 3: Switch or Augmentation
~60% in remission

Level 4: Stop meds and start new treatment
~70% in remission

Rush, 2007
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
  - Both phone and in-person contacts are appropriate

Monitoring

- 1 contact per month
  - After 50% decrease in PHQ/GAD (or similar) achieved
  - Monitor for ~3 months to ensure patient’s mood symptoms are stable
Collaborative Care

- = PCP contact (avg. 3.5 contacts per year)
- = Contacts with BHP/CM (avg. 10 contacts)
- = Case reviews from psychiatric consultant to BHP/CM, PCP (avg. 2 case reviews)

50% - 70% treatment response/improvement
WEEKLY CASELOAD CONSULTATION

BHP/Care Manager

Psychiatric Consultant

Photo credit: Courtesy of the John A. Hartford Foundation

Photo: © University of Washington
MODEL CONSULTATION HOUR

- **Brief check-in**
  - Changes in the clinic
  - Systems questions

- **BOTH looking at registry during consultation hour**

- **Identify patients and conduct reviews**
  - Requested by BHP/CM
  - Not improved w/o note
  - Severity of presentation
  - Disengaged from care
  - Ready for relapse prevention or referral

- **Wrap up**
  - Celebrate successes
  - Confirm next consultation hour
  - Send any educational resources discussed
RECOMMENDATIONS: OTHER INTERVENTIONS

Beyond medications
- Behavioral, brief psychotherapy
- Referrals and community resources

Support managing difficult patients
- Working with demanding patients
- Protocols for managing suicidal ideation
- Working with patients with chronic pain
TYPICAL COURSE OF CARE MANAGEMENT: DURATION

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

© University of Washington
EXERCISE: USING A REGISTRY

Processes of care:
• Clinical Assessment → Goal: Completed
• Follow-up Contacts → Goal: Contact 2X per month
  % of active patients with psychiatric consultation note → Goal: patients without improvement every 2 months

Clinical outcomes:
• Look for improved patients with PHQ-9 and GAD-7 scores less than 10 or 5+ point decrease

<table>
<thead>
<tr>
<th></th>
<th>Clinical Assessment</th>
<th># of Sessions</th>
<th>Weeks in Tx</th>
<th>Last Follow-Up Contact</th>
<th>Psych. Note</th>
</tr>
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<tbody>
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<td>12</td>
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<td>11</td>
<td>झ़ञ़णञ़णझ़ढ़</td>
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<td>5</td>
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<tr>
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<td>20</td>
<td>1</td>
<td>झ़ञ़णञ़णझ़ढ़</td>
</tr>
</tbody>
</table>
Current Patient Overview

• Which patients need consultation?
• How do you know?
  ✓ Patients not improving?
  ✓ Patients not engaging?
  ✓ Patients ready for relapse prevention?

Workbook page 10
PRACTICE EXAMPLE
Experience with Collaborative Care and Behavioral Health Integration in Maine
Outline

• Overview of MaineHealth system and BHI program
  - Current roles for psychiatry

• Challenges to implementation of collaborative care
  - Why is Minnesota different from Maine?
## History of Behavioral Health Integration Program

<table>
<thead>
<tr>
<th>Years</th>
<th>Activity</th>
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<tbody>
<tr>
<td>2002-2004</td>
<td>MacArthur Foundation Initiative on Depression in Primary Care</td>
</tr>
<tr>
<td>2003-2007</td>
<td>RWJ Foundation Depression in Primary Care Program</td>
</tr>
<tr>
<td>2007-2010</td>
<td>Maine Health Access Foundation Behavioral Health Integration Program</td>
</tr>
<tr>
<td>2010-2013</td>
<td>Transition to sustainability</td>
</tr>
<tr>
<td>2014-Present</td>
<td>Sustainable clinical service</td>
</tr>
</tbody>
</table>
Screening for common behavioral health conditions

Initiate Treatment

Adjustment to illness

Health behavior change/ Stress-related symptoms

Integrated behavioral health services

Psychiatric Consultation services

Specialty care by referral
System-wide spread of Behavioral Health Integration

• Almost 50 FTE’s working in over 70 practices
  - Most LCSW’s
  - Most 0.5 FTE or more, a number of practices with 1.0 FTE

• Wide variety of practices
  - 22 family medicine, 13 internal medicine and 15 pediatrics
  - 8 Ob-Gyn
  - A variety of others including diabetes, cardiology, neurology, several obesity programs, pain clinics, oncology and
    4 school health centers
Essentially, all models are wrong, but some are useful.

(George E. P. Box)
Behavioral Health Clinician model

- Behavioral health clinician (BHC – most often psychologist or LCSW) works side by side with PCPs
  - Brief, problem-focused treatment approach
  - Warm handoffs
  - Broadly applied to mental health problems and to behavioral and psychosocial aspects of physical health problems
Collaborative Care Model

Primary Care: Screening, diagnosis, management

Patient with depression

Care Management: Self-management and monitoring

Psychiatry: Informal consultation and population management
Child psychiatry access program

• Phone access to triage service that might help with:
  - Telephone consultation between PCP and child psychiatrist
  - Evaluation of child by psychiatrist
  - Referral for specialty mental health services
  - Referral to community organization

• Provider lunch and learns and other educational activities
How do we use psychiatrists?

• Monthly and ad hoc case reviews with integrated social workers
• Informal consultation directly to primary care
  - Messaging using the EMR
  - Phone calls
• Lunch and learn didactic and case based teaching
Mayo Clinic Implementation

- Care managers embedded in primary care
- Dedicated psychiatrists for caseload review AND other types of support for primary care
  - Hallway consults
  - One or two session face to face consults
- Using model for conditions other than depression
  - Anxiety disorders (using GAD-7 for screening and follow up)
  - Bipolar disorders
- Behavioral health clinicians to provide direct patient care and to link to other available behavioral health services
Why is Minnesota/Mayo different?

• DIAMOND program
• Public reporting of results
• Reimbursement differences
• Organizational culture
## NINE FACTORS FOR EFFECTIVE IMPLEMENTATION

<table>
<thead>
<tr>
<th>Ranking</th>
<th>Implementation Factor</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Operating costs of DIAMOND not seen as a barrier</td>
<td>The clinic has adequate coverage or other financial resources for most patients to be able to afford the extra operational costs.</td>
</tr>
<tr>
<td>2</td>
<td>Engaged psychiatrist</td>
<td>The consulting psychiatrist is responsive to the care manager and to all patients, especially those not improving.</td>
</tr>
<tr>
<td>3</td>
<td>Primary care provider (PCP) “buy-in”</td>
<td>Most clinicians in the clinic support the program and refer patients to it.</td>
</tr>
<tr>
<td>4</td>
<td>Strong care manager</td>
<td>The care manager is seen as the right person for this job and works well in the clinic setting.</td>
</tr>
<tr>
<td>5</td>
<td>Warm handoff</td>
<td>Referrals from clinicians to the care manager are usually conducted face-to-face rather than through indirect means.</td>
</tr>
<tr>
<td>6</td>
<td>Strong top leadership support</td>
<td>Clinic and medical group leaders are committed and support the care model.</td>
</tr>
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<td>7</td>
<td>Strong PCP champion</td>
<td>There is a PCP in the clinic who actively promotes and supports the project.</td>
</tr>
<tr>
<td>8</td>
<td>Care manager role well defined and implemented</td>
<td>The care manager job description is well defined, with appropriate time, support, and a dedicated space.</td>
</tr>
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<td>9</td>
<td>Care manager on-site and accessible</td>
<td>The care manager is present and visible in the clinic and is available for referrals and patient care problems.</td>
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</table>

DIAMOND indicates Depression Improvement Across Minnesota—Offering a New Direction.

FINANCING AND NEXT STEPS
OVERVIEW OF IMPLEMENTATION

Lay the foundation

Collaborative Care is a new way of doing medicine and requires an openness to creating a new vision that everyone supports.

- Develop an understanding of the Collaborative Care approach, including its history and guiding principles.
- Develop strong advocacy for Collaborative Care within organizational leadership and among the clinical team.
- Create a unified vision for Collaborative Care for your organization with respect to your overall mission and quality improvement efforts.
- Assess the difference between your organization’s current care model compared to a Collaborative Care model.

Plan for Clinical Practice Change

Time to clearly define care team roles, create a patient-centered workflow, and decide how to track patient treatment and outcomes.

- Identify all Collaborative Care team members and organize them for training.
- Develop a clinical flowchart and detailed action plan for the care team.
- Identify a population-based tracking system for your organization.
- Plan for funding, space, human resource, and other administrative needs.
- Plan to merge Collaborative Care monitoring and reporting outcomes into an existing quality improvement plan.

Build your Clinical Skills

Effective Collaborative Care creates a team in which all of the providers work together using evidence-based treatments.

- Describe Collaborative Care’s key tasks, including patient engagement and identification, treatment initiation, outcome tracking, treatment adjustment and relapse prevention.
- Develop a qualified and prepared care team, equipped with the functional knowledge necessary for a successful Collaborative Care implementation.
- Develop skills in psychotherapy treatment that are evidence-based and appropriate for primary care (e.g. Problem Solving Treatment, Behavioral Activation, etc).

Launch your Care

Is your team in place? Are they ready to use evidence-based interventions appropriate for primary care? Are all systems go? Time to launch!

- Implement a patient engagement plan
- Manage the enrollment and tracking of patients in a registry
- Develop a care team monitoring plan to ensure effective collaborations
- Develop clinical skills to help patients from the beginning to the end of their treatment, including a relapse prevention plan

Nurture your Care

Now is the time to see the results of your efforts as well as to think about ways to improve it.

- Implement the care team monitoring plan to ensure effective team collaborations
- Update your program vision and workflow
- Implement advanced training and support where necessary

© University of Washington
# NINE FACTORS FOR EFFECTIVE IMPLEMENTATION

Table 1. Factors Considered Important for Implementation of DIAMOND

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DIAMOND indicates Depression Improvement Across Minnesota—Offering a New Direction.

<table>
<thead>
<tr>
<th>Medicare</th>
<th>FQHCs and RHCs</th>
<th>All Other Providers</th>
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</thead>
<tbody>
<tr>
<td>G0511</td>
<td>BHI</td>
<td>99484</td>
</tr>
<tr>
<td></td>
<td>CoCM</td>
<td>99492</td>
</tr>
<tr>
<td>G0512</td>
<td></td>
<td>99493</td>
</tr>
</tbody>
</table>

As of January 1, 2018
### MEDICARE COCM BILLING

#### Core components

1. **Active treatment and care management for an identified patient population**
2. **Use of a patient tracking tool to promote regular, proactive outcome monitoring and treatment-to-target**
3. **Regular (typically weekly) systematic psychiatric caseload reviews**
   - The psychiatrist and BHCM do not bill separately; Contract with the PCP practice
   - The patient must provide general consent for the service and they will have a co-pay
   - Interaction does not have to be face-to-face
   - Care manager and psychiatrists can also bill additional codes for therapy etc.

<table>
<thead>
<tr>
<th>2018 Code</th>
<th>Description</th>
<th>2018 Rate</th>
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<tbody>
<tr>
<td>99492</td>
<td>CoCM - first 70 min in first month</td>
<td>$161.28</td>
</tr>
<tr>
<td>99493</td>
<td>CoCM - first 60 min in any subsequent months</td>
<td>$128.88</td>
</tr>
<tr>
<td>99494</td>
<td>CoCM - each additional 30 min in any month (used in conjunction with 99492 or 99493)</td>
<td>$66.60</td>
</tr>
<tr>
<td>99484</td>
<td>Other BH services - 20 min per month</td>
<td>$48.60</td>
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</table>

For FQHC and RHC Only

- **G0511 CCM – General Care Management**
- **G0512 CoCM: Psychiatric Collaborative Care Model**

# AIMS CENTER FINANCIAL MODELING WORKBOOK

## Net Financial Impact

### TOTAL REIMBURSEMENT

<table>
<thead>
<tr>
<th>Total Reimbursement:</th>
<th>Monthly Case Rate Reimbursement</th>
<th>Billable Individual Services Reimbursement</th>
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<tr>
<td>Monthly Case Rate Reimbursement + Billable Individual Services Reimbursement</td>
<td>$102,026.70</td>
<td>$358,126.84</td>
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\[
\text{Total Reimbursement} = \text{Monthly Case Rate Reimbursement} + \text{Billable Individual Services Reimbursement} = \$460,153.54
\]

### TOTAL COST

<table>
<thead>
<tr>
<th>Personnel</th>
<th>Annual Salary per 1.0 FTE</th>
<th>Salary Cost Per FTE</th>
<th>Fringe Benefits % of Salary</th>
<th>Fringe Benefits Cost</th>
<th>Personnel Subtotal</th>
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<tr>
<td>Care Manager</td>
<td>$65,000.00</td>
<td>$156,000.00</td>
<td>24.0%</td>
<td>$37,440.00</td>
<td>$193,440.00</td>
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<tr>
<td>Psychiatric Consultant</td>
<td>$210,000.00</td>
<td>$42,000.00</td>
<td>15.0%</td>
<td>$6,300.00</td>
<td>$48,300.00</td>
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</tbody>
</table>

\[
\text{Personnel Costs} = \text{Annual Salary per 1.0 FTE} \times \text{FTE} + \text{Fringe Benefits Cost} = \$241,740.00
\]

Organizational Overhead: \(35.0\%\) of \(\text{Personnel Costs} = \$84,669.00\)

\[
\text{Total Cost: Personnel + Overhead} = \text{Personnel Costs} + \text{Organizational Overhead} = \$326,340.00
\]

### NET IMPACT

\[
\text{Net Impact} = \text{Total Reimbursement} - \text{Total Cost} = \$139,804.54
\]

---

https://aims.uw.edu/collaborative-care/financing-strategies/financial-modeling-workbook

© 2018 American Psychiatric Association. All rights reserved.
Virtual drop-in times for advice on codes and sustainability:

First Wednesdays @ 9 AM PT

November 7 & December 5

Details to join office hour at AIMS website: aims.uw.edu/collaborative-care/financing-strategies/financial-modeling-workbook
THE NEXT STEP: LEARNING COLLABORATIVES

- Ongoing learning ---- 12-week course online
- Practical support for next steps/Community
- Free! – sponsored by APA SAN grant
- 14 hours CME Category 1
- Maintenance of Certification
  - One MOC-4 PIP [Improvement in Medical Practice] Clinical Module requirement
  - 8 MOC-2 non-CME self-assessment credits for peer review
ALIGNED APA ACTIVITIES

Practice Management
Helpline:
1-800-343-4671 or practicemanagement@psych.org
STAY UP TO DATE

Stay up-to-date on APA’s SAN offerings, additional information on collaborative care at:

www.psychiatry.org/SAN
**Step 1:** Consider each statement in the checklist below. Put a check mark in the left column next to any tasks that you do now in your current practice. Put a check mark in the right column next to any tasks that you consider areas that you could work on in your practice. **Do not worry about the shaded area until Step 2.**

<table>
<thead>
<tr>
<th>I do this now!</th>
<th>My Current Practice</th>
<th>Possible Areas to Improve</th>
<th>My Practice Goal</th>
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</thead>
<tbody>
<tr>
<td>Population-Based Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I maintain a list of all my currently active patients.</td>
<td></td>
<td></td>
<td>Population-Based Care</td>
</tr>
<tr>
<td>I use a registry to track all my patients and to help identify patients who may be ‘falling through the cracks’.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I actively reach out to patients on my caseload who are not following up or not improving.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I consider the entire population of potential patients when I think about delivering care.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>