



Collaborative Care Management Foundations: A 101 primer on the practices and possibilities

Presented by: Dr. John Kern

Today's Moderator



Shannon Lea, MPH
Senior Program Manager
Primary Care Development Corporation



About PCDC

Primary Care Development Corporation (PCDC) is a national nonprofit organization and a community development financial institution catalyzing excellence in primary care through strategic community investment, capacity building, and policy initiatives to achieve health equity.

Disclaimer

The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), or the U.S. Department of Health and Human Services (HHS).



www.samhsa.gov

“Mitigating Burnout through Integrated Healthcare” Webinar Tip Sheet

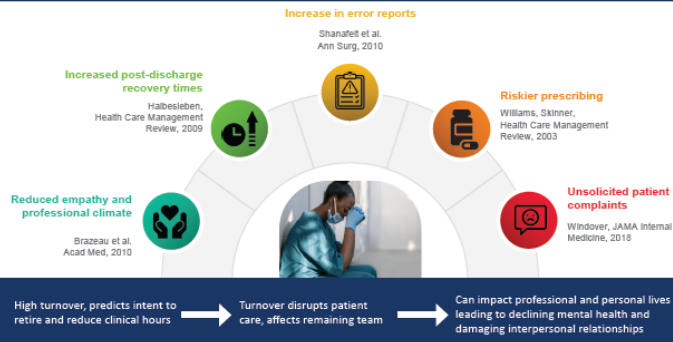


CENTER OF EXCELLENCE for Integrated Health Solutions



MITIGATING BURNOUT THROUGH INTEGRATED HEALTHCARE

IMPACT OF BURNOUT



HOW INTEGRATION CAN MITIGATE THE IMPACT OF BURNOUT

Resources for Health Care Worker Well-Being: 6 Essential Elements



Please click the image above for more resources on each of the essential elements.

Remember that trans-disciplinary connections are protective. They improve patient care and support staff communication and relations.

Examples include:

- Daily huddles
- Weekly meetings
- Treatment planning sessions

The goal is to create space, collaborate, share information, and problem solve together, moving towards an integrated strengths based approach.

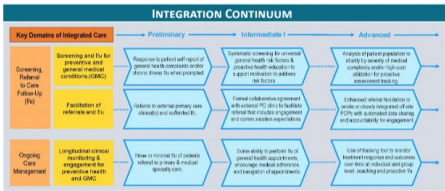
“Mitigating Burnout through Integrated Healthcare” tip sheet can be accessed here:

<https://www.pcdc.org/resources/operationalizing-integration-mitigating-burnout-through-integrated-healthcare-tip-sheet/>

“Integration at Work” Webinar Series Tip Sheets

QUALITY IMPROVEMENT TIPS FOR INTEGRATED CARE SETTINGS

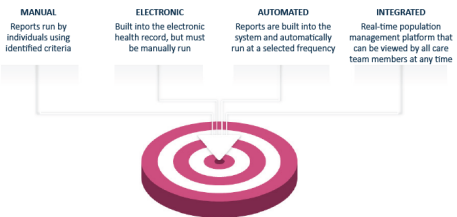
Coordinated Care (off-site)	Co-located Care (on-site)	Highly Integrated Care
Level 1: Minimal Collaboration Patients are referred to a provider at another practice site, and providers have minimal communication.	Level 3: Basic Collaboration Providers share the same facility, but maintain separate cultures and develop separate treatment plans for patients.	Level 5: Close Collaboration Providers develop and implement collaborative treatment planning for shared patients but not for other patients.
Level 2: Basic Collaboration Providers at separate sites periodically communicate about shared patients.	Level 4: Close Collaboration Providers share records and some system integration.	Level 6: Full Collaboration Providers develop and implement collaborative treatment planning for all patients.



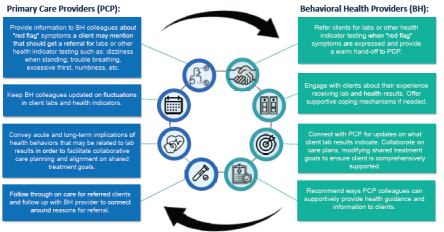
START YOUR JOURNEY WITH THE PREVENTIVE SCREENING ROAD MAP:



TYPES OF REGISTRIES TO HELP MEET YOUR SCREENING GOALS:



LABS AND HEALTH INDICATORS: AN INTEGRATED CARE OPPORTUNITY



Key ways Behavioral Health providers are critical partners within integrated care:

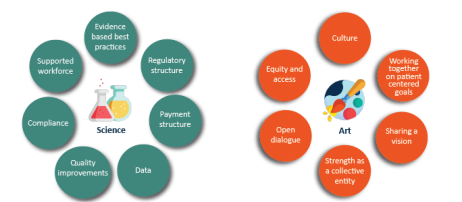
- Improve the skills of primary care providers to recognize behavioral disorders.
- Improve the skills of providers to recognize how behavioral health conditions may manifest as physical symptoms.
- Promote greater adherence to treatment regimens for chronic conditions.
- Help patients understand the ways that emotions can affect how they feel physically.
- Establishing responsive "person centered" goals to manage both physical and behavioral conditions.

POLICY CONSIDERATIONS

- Include details on specific task oriented staff activities.
- Convene stakeholders from throughout organization to develop PC-BH policies and recommendations.
- Incorporate feedback even after policies are drafted as input is key to understanding how a process gets carried out in real time.
- Ensure all guidance is either broad enough for or can specifically account for differences between disciplines. For instance, PCP may focus on *specific clinical markers*; BH may focus on *social and emotional markers*. Good policy and directives would account for both.

Contact us to discuss how our services can help your care teams. Email: cpp@pcdc.org
 The resource was developed in partnership with the Center of Excellence for Integrated Health Solutions.

COMPONENTS OF SUCCESSFUL INTEGRATED CARE PARTNERSHIPS



Considering Cost and Yield in Partnership Equations

Integrated care partnerships can be complex, with different organizations and team members holding different visions. Part of taking an advanced lens on partnerships is determining the cost (input of time, energy and resources) and the yield (client impact, positive staff experience, increase in revenue, etc.) and understanding if shifting or transitioning a partnership is necessary. When the cost is HIGHER than the yield, applying concepts on the wheel to the right can be supportive to recalibrate. When the cost is LOWER than the yield, it is still critical to have methods in place, such as those within the wheel, to keep a forward trajectory where your partnerships remain in a low cost high yield equation.



All recordings and tip sheets from the “Integration at Work” webinar series can be accessed here: <https://www.pcdc.org/what-we-do/training-technical-assistance/integration-at-work-samhsa-webinar-series/>

Audience Demographics Poll

Do you work in a:

- Primary care setting
- Behavioral health setting
- Integrated care setting

Are you working primarily as a:

- MD/DO
- Nurse Practitioner/Registered Nurse
- Physician Assistant
- Medical Assistant
- Therapist
- Social Worker
- Care Manager
- QI Manager
- Informatics
- Other

Please rate your current skills and comfort with the evidence base for Collaborative Care, typical Collaborative Care tasks and team roles, and the principles of Collaborative Care.

- Very Low
- Low
- Moderate
- High
- Very High

Today's Presenter



John Kern MD

Clinical Professor

University of Washington School of Medicine
Department of Psychiatry and Behavioral Sciences
AIMS Center

Collaborative Care: Overview and Discussion

John Kern MD
Clinical Professor
University of Washington School of Medicine
Department of Psychiatry and Behavioral Sciences
AIMS Center





Learning Objectives

By the end of this session, participants should be able to:

- **Understand the evidence base for Collaborative Care**
- **Describe typical Collaborative Care tasks and team roles**
- **Describe the Principles of Collaborative Care**

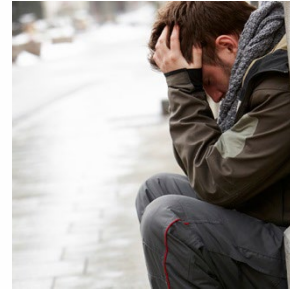


Who Gets Treatment?

No Treatment



Primary Care Provider

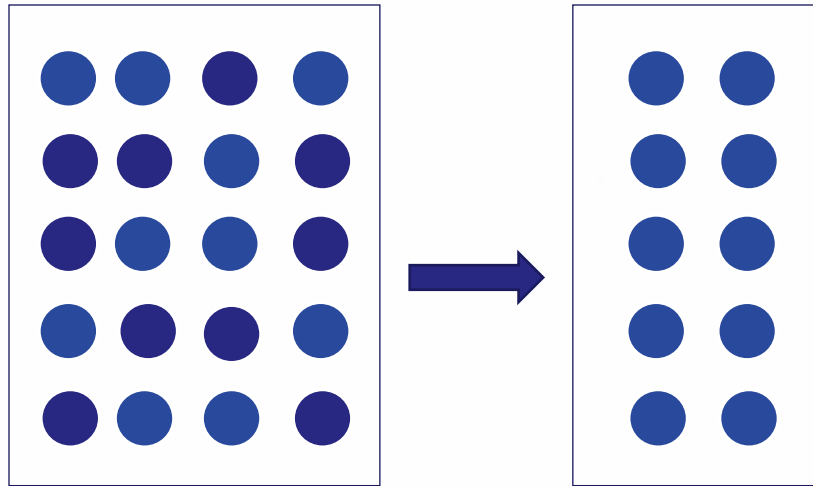


Mental Health Provider



Why Not Just Refer? Patient Factors

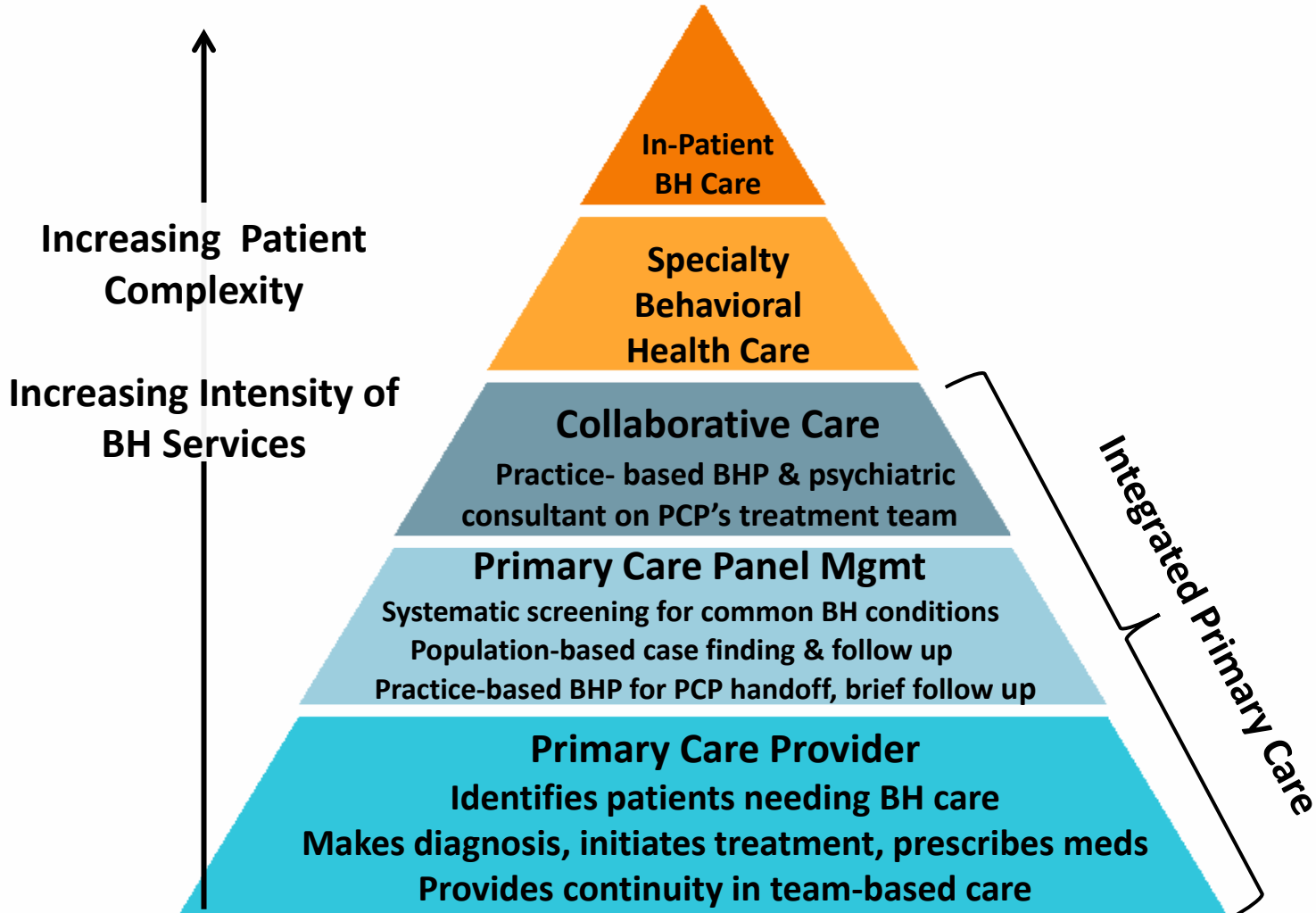
- Half of patients referred to specialty services do not reach the specialist



- And those that do only average 2 visits



Stepped Strategies for Integration

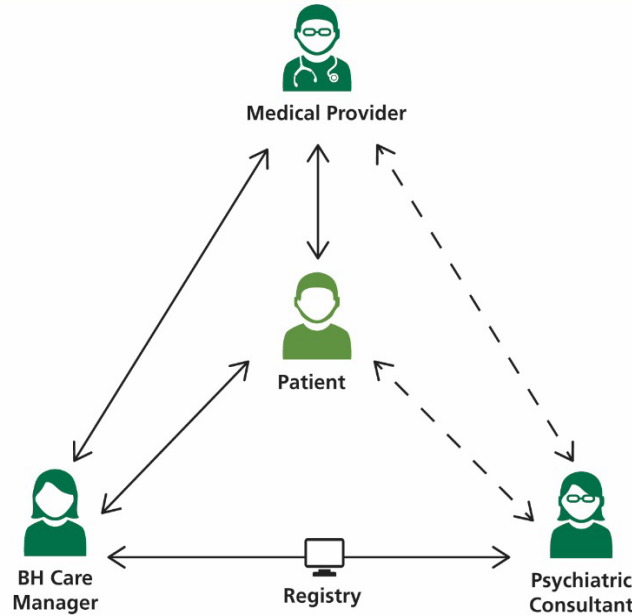




Collaborative Care (CoCM)



Primary care patient-centered team-based care



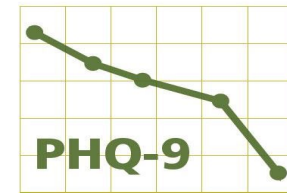
Systematic caseload review with psychiatric consultant (focus on patients not improved)

Plan	[Primary ID]	[Name]	[Encounter Date]	Sta- tus	[Status Assessment Date]	Page
	0001	Test, Test	2/6/2013	[T]	8/24/2013	
	0000	Test, Suzy	4/2/2013	[T]	5/21/2013	12
	0010	Test, Test	4/17/2012	[T]	4/25/2013	18
	0035	Test, Rose Reminger	1/10/2013	[T]	1/10/2013	
	0038	Test Patient, Mharc	1/23/2014	[T]	1/23/2014	22
	0041	Test, Test	3/4/2014	[T]	3/4/2014	
	0042	Test, Test	3/7/2014	[T]	3/7/2014	

Registry to track population

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

Active treatment with evidence-based approaches



Validated outcome measures tracked over time



Evidence Base for Collaborative Care

- First demonstrated in the **IMPACT Trial**
- More than **90 randomized controlled trials** have shown Collaborative Care (CoCM) to be more effective than usual care



<https://aims.uw.edu/collaborative-care/evidence-base-cocm>

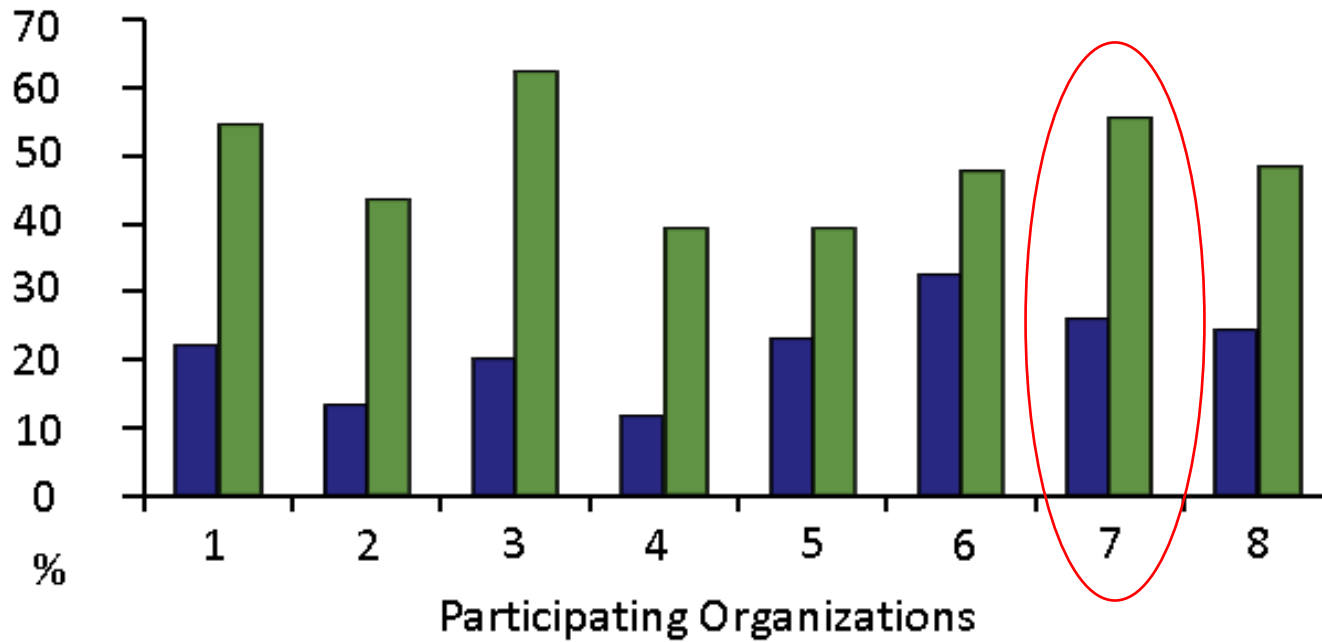


Twice as Many Patients Improve



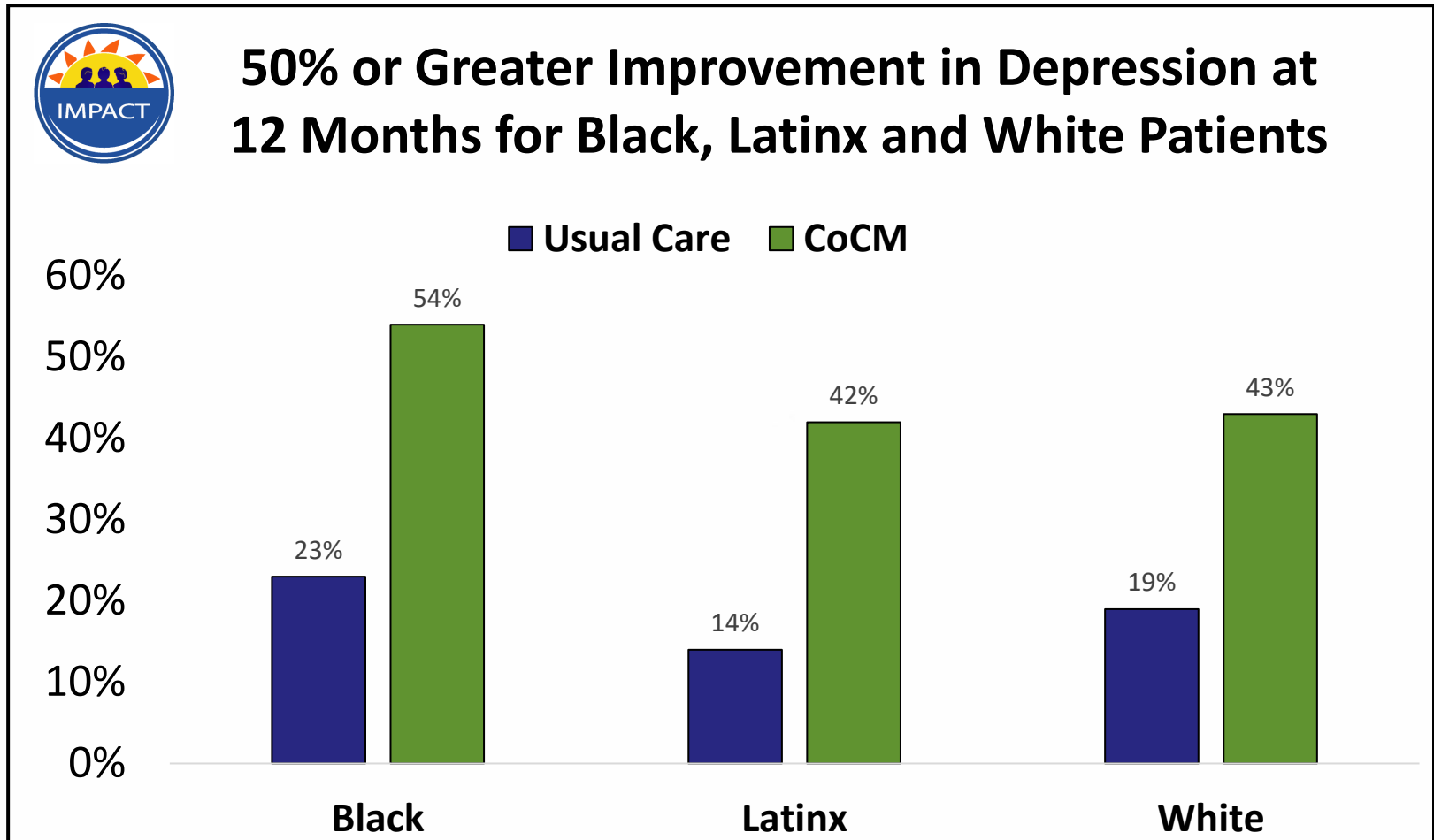
50% or Greater Improvement In Depression at 12 Months

■ Usual Care ■ CoCM





Similar Results for Black, Latinx, and White Patients



(Arean et al., 2005)

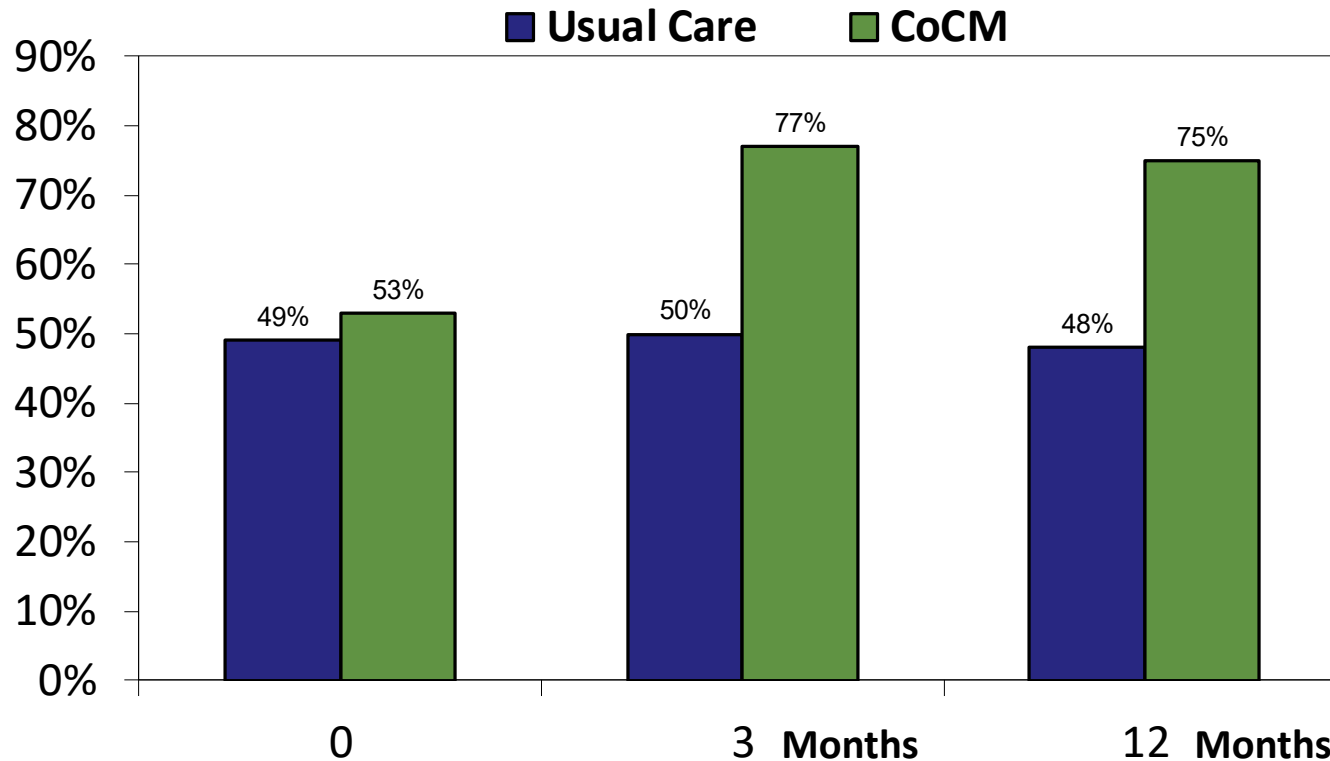
Copyright © 2022 University of Washington



Patients and Providers Satisfied with Care



% of Patients Reporting 'Excellent' or 'Very Good' Satisfaction with Depression Care



Similarly high rates of satisfaction among providers

Copyright © 2022 University of Washington



Collaborative Care for Various BH Conditions

Established Evidence-Base

- **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**
- **Bipolar Disorder**



Principles of Collaborative Care



Patient-Centered Team. The patient, primary care and mental health providers collaborate effectively using shared care plans that incorporate patient goals.



Population-Based. A registry is used to facilitate engagement and outcome tracking in a defined group of patients at the caseload and clinic level.



Measurement-based Treatment to Target. Progress is measured regularly, and treatments are actively changed until clinical goals are achieved.



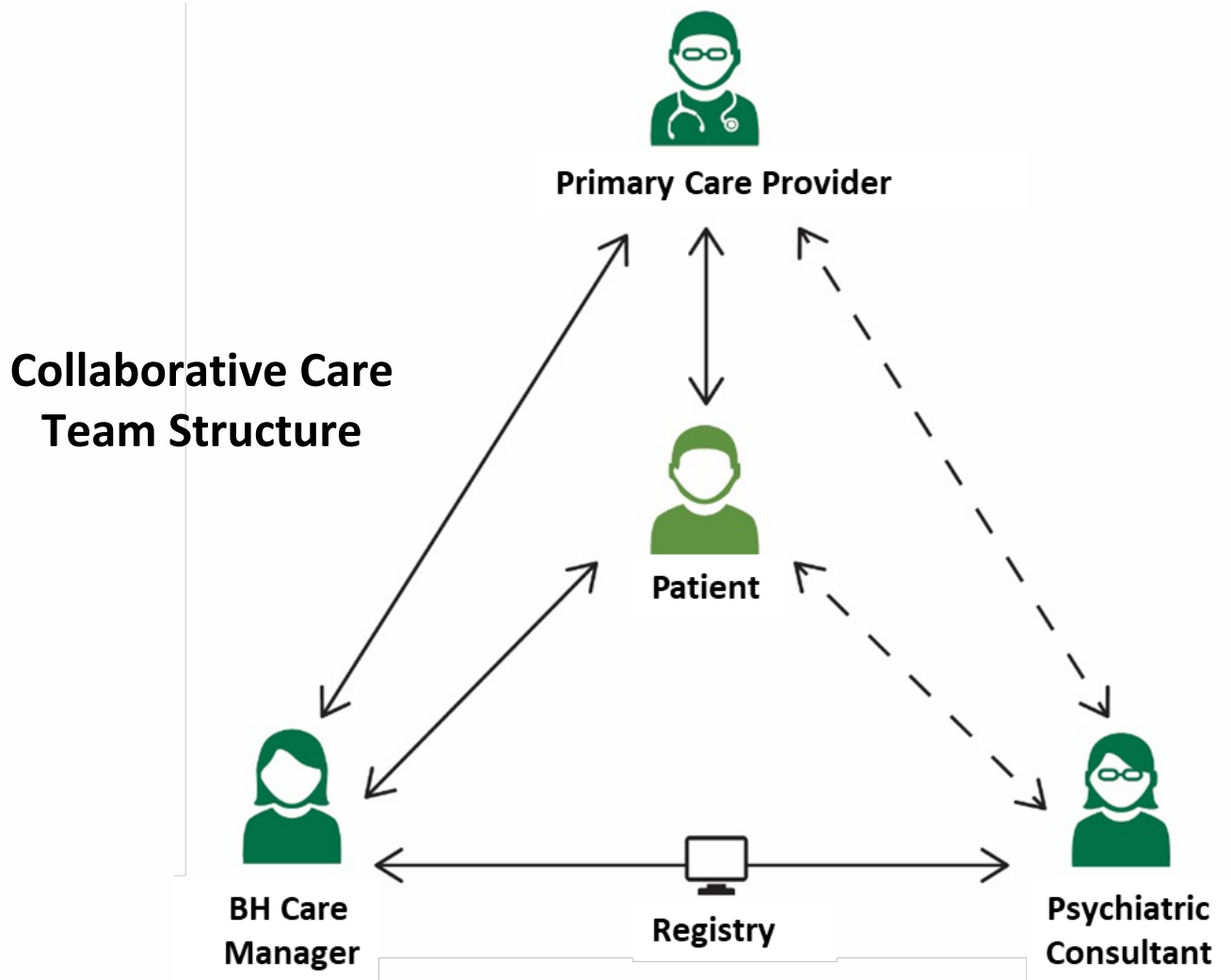
Evidence-Based Treatments. Providers use treatments that have research evidence for effectiveness.



Accountable. The care team is accountable to the patient and other care team members for quality of care and clinical outcomes, not just the volume of care provided.



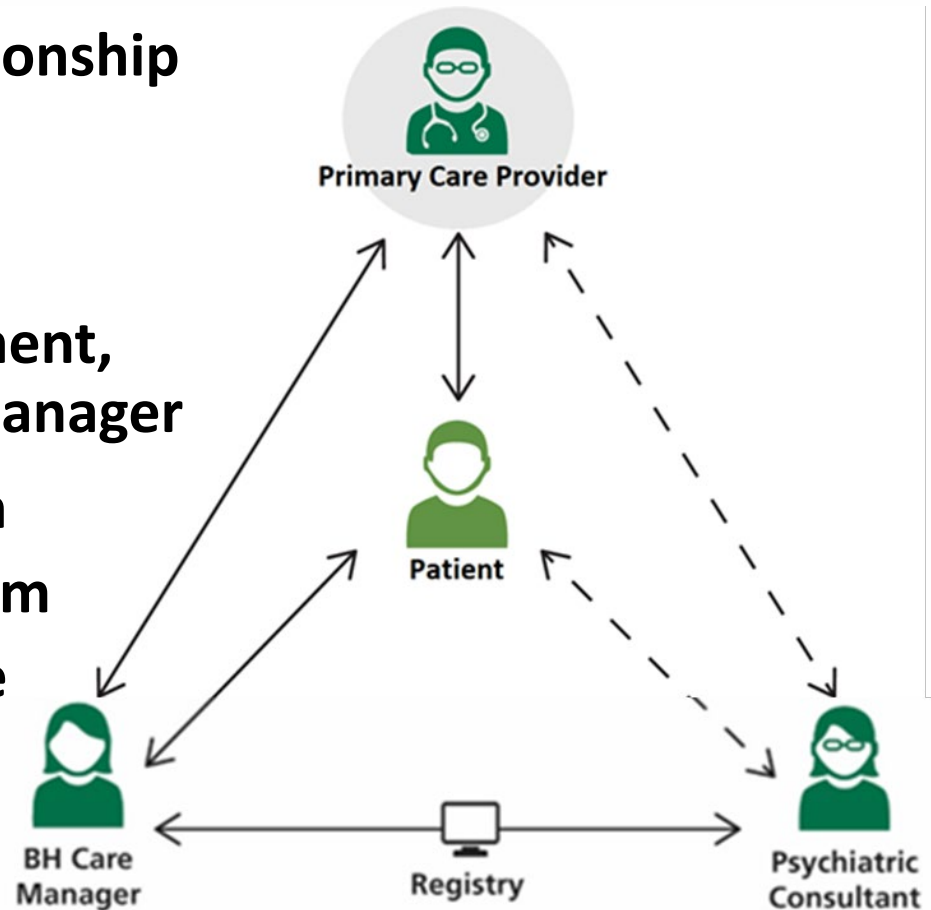
Principle: Patient-Centered Team





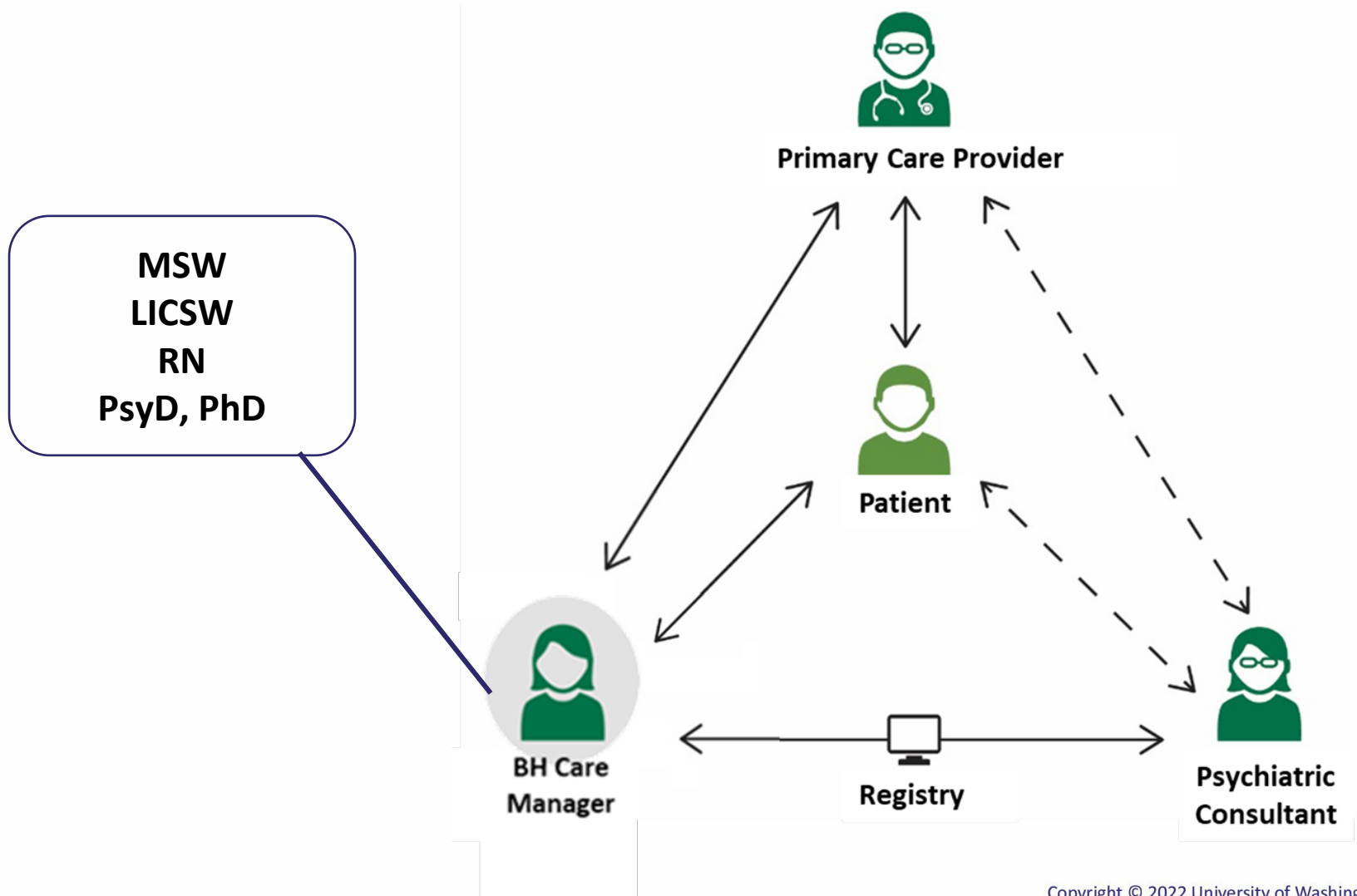
Primary Care Provider (PCP) Functions

- Primary treatment relationship
- Links with CoCM team
- Prescribes medication
- Monitors med management, together with BH care manager
- Supports treatment plan
- Consults with CoCM team
- Supports system change





Behavioral Health Care Manager (BHCM)





General BHCM Functions

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



Intervention Focused BHCM Functions

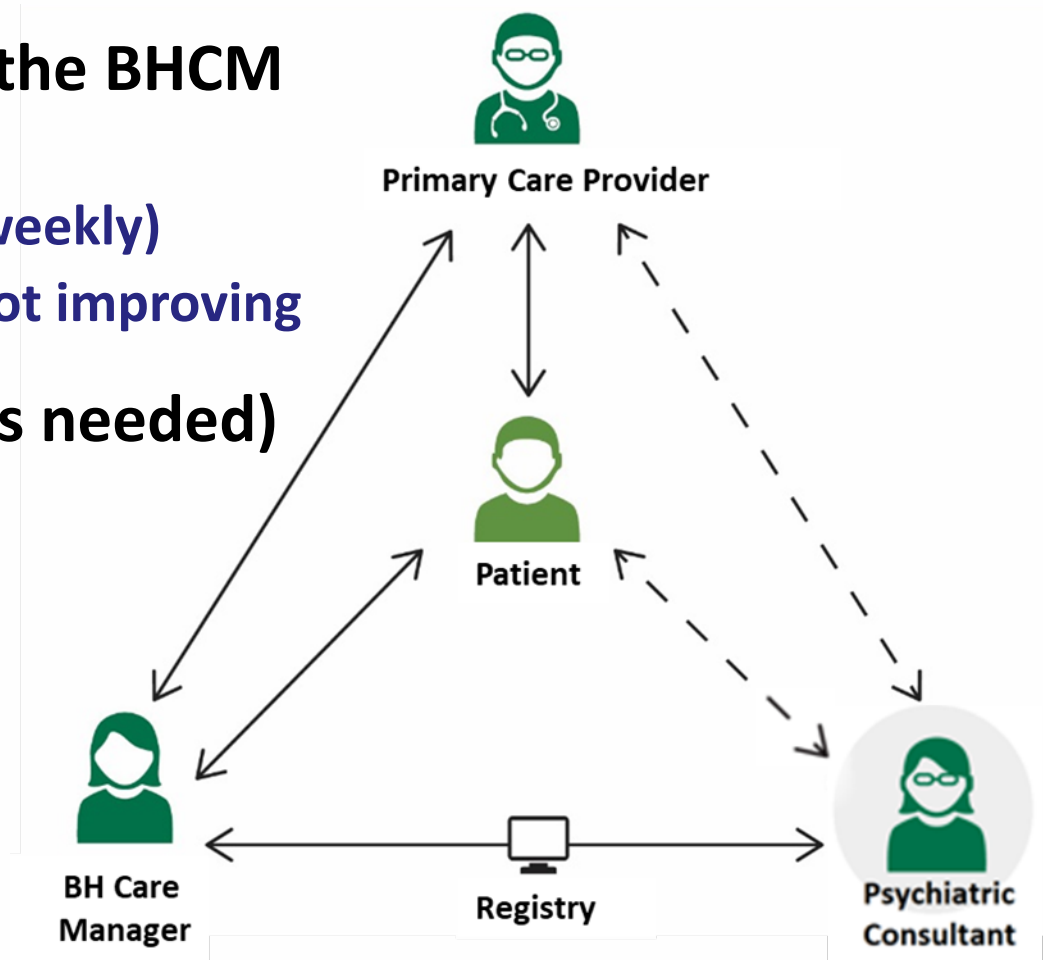
- **Evidence-based brief behavioral interventions**
 - **Problem-solving treatment (PST)**
 - **Behavioral Activation**
 - **Others**
- **Other functions**
 - **General behavioral health interventions**
 - **Addressing substance use**
 - **Social work services**





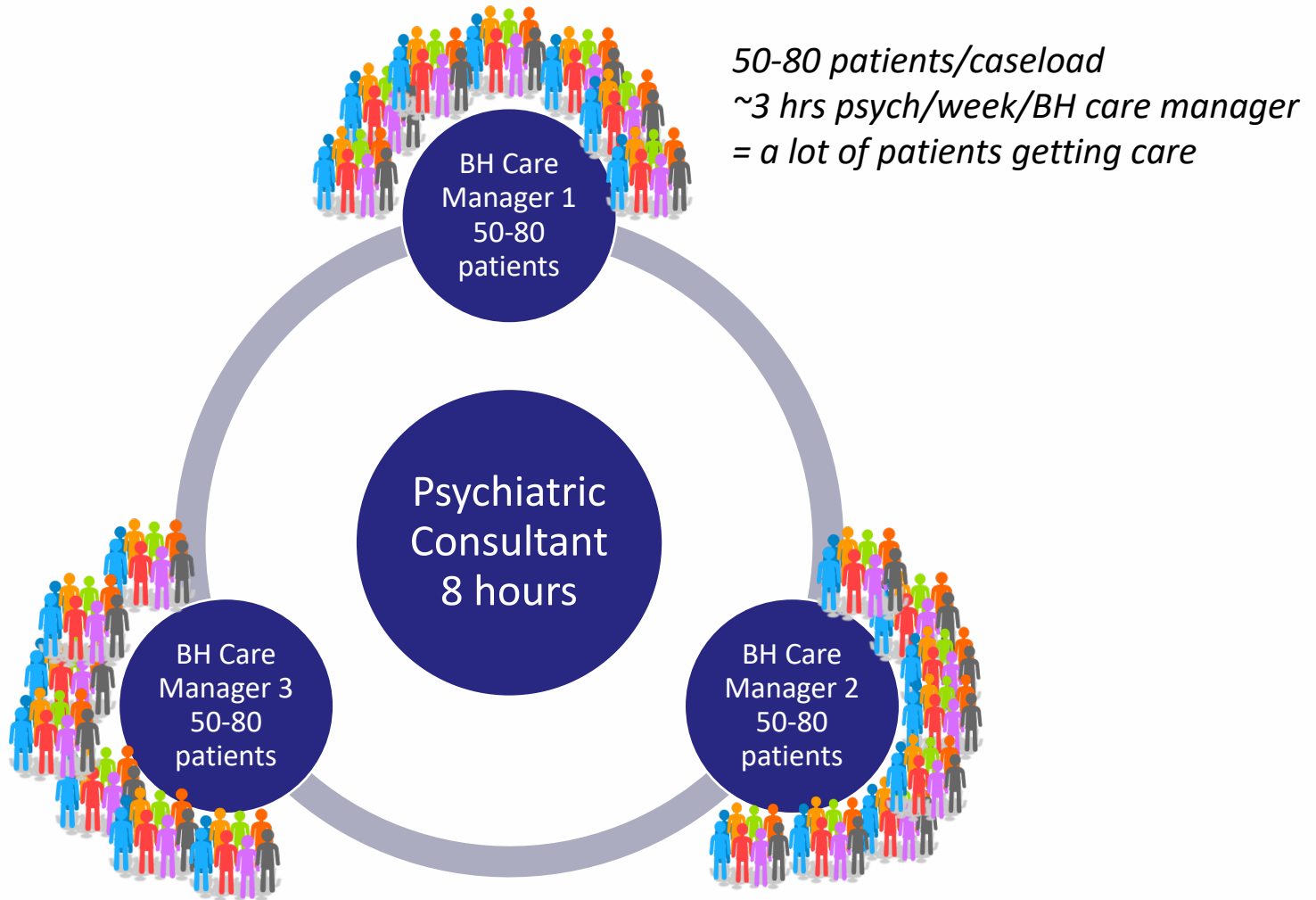
Psychiatric Consultant Functions

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





Access: Leveraging a Psychiatric Consultant





Principle: Population-Based

Registry

- Allows proactive engagement and treatment adjustment

ACTIVE PATIENTS

Report for :
 Report Created on : Wednesday, October 5, 2022, 8:15 AM

1 - 10 of 32

1 2 3 4

Per page: 10

FLAGS	PATIENT ID	STATUS	PHQ-9		GAD-7		CONTACTS						
			FIRST	LAST	FIRST	LAST	I/A	F/U	P/C	R/P	# SESS	WKS SINCE I/A	MINUTES THIS MONTH
99		T	19	19*	10	10*	12/14/21	4/18/22	3/18/22		4	42	0
99		T	16	16*	14	14*	7/23/20	3/25/22	1/13/22		6	114	0
99		T	23	16*	20	17*	9/18/20	4/7/22	1/21/22		5	106	0
99		T	20	16*	17	17*	2/23/22	4/11/22	2/23/22		3	32	0
99		T	15	15*	10	10*	3/24/22				1	27	0
99		T	13	14*	14	2*	12/20/21	4/14/22	4/14/22		4	41	0
99		T	22	13*			1/11/22	4/15/22	1/11/22		3	38	0
99		T	16	13*	19	11*	3/3/22	3/22/22	3/22/22		2	30	0
99		T	10	9*	8	8*	11/12/21	4/13/22	2/3/22		5	46	0
99		T	9	9*			10/19/21	4/15/22	2/18/22		4	50	0



Principle: Measurement-Based Treatment To Target



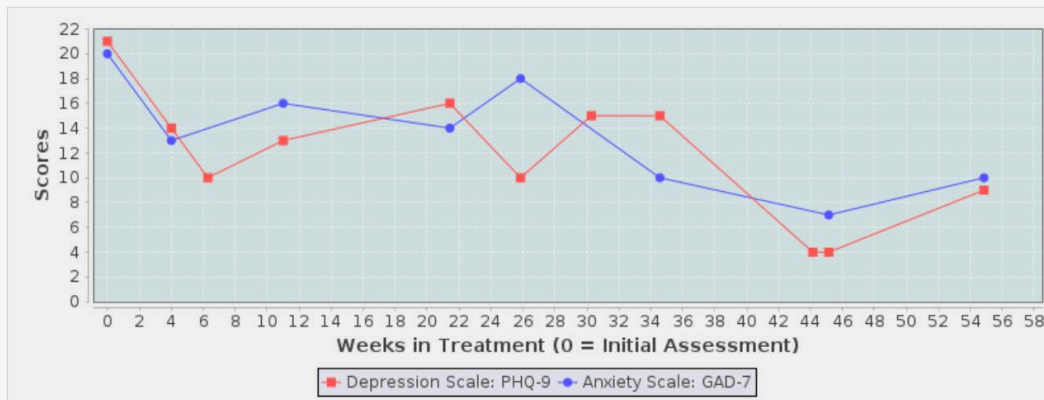
TREATMENT HISTORY

Test, Robin | Status: Treatment
Patient ID: 00000005 | MRN: 13254
Age: 91 | DOB: 3/10/1931

Contacts

DATE OF CONTACT	CONTACT TYPE	WEEKS IN TX	VISIT TYPE	SESSION DURATION	PHQ-9	GAD-7
2/20/2021	Initial Assessment	0	Phone	80	21	20
9/20/2021	Follow Up	30	Clinic	45	15	
10/20/2021	Follow Up	34	Clinic	35	15	10
12/26/2021	Relapse Prevention Plan	44	Clinic	15	4	
1/2/2022	Follow Up	45	Clinic	30	4	7
3/11/2022	Follow Up	54	Clinic	55	9	10
5/10/2022	Psychiatric Consultation	63	Review w/ PCP	23		

Patient Progress





Treatment to Target Drives Early Improvement

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





Principle: Evidence-Based Treatment



Bio

- Evidence-based Medications

Psycho

- Evidence-based Psychotherapeutic Interventions

Social

- Social support

- **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**



Principle: Accountable



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



Telemedicine-Based BH Treatment: What Does the Evidence Tell us?

Practice-Based CoCM

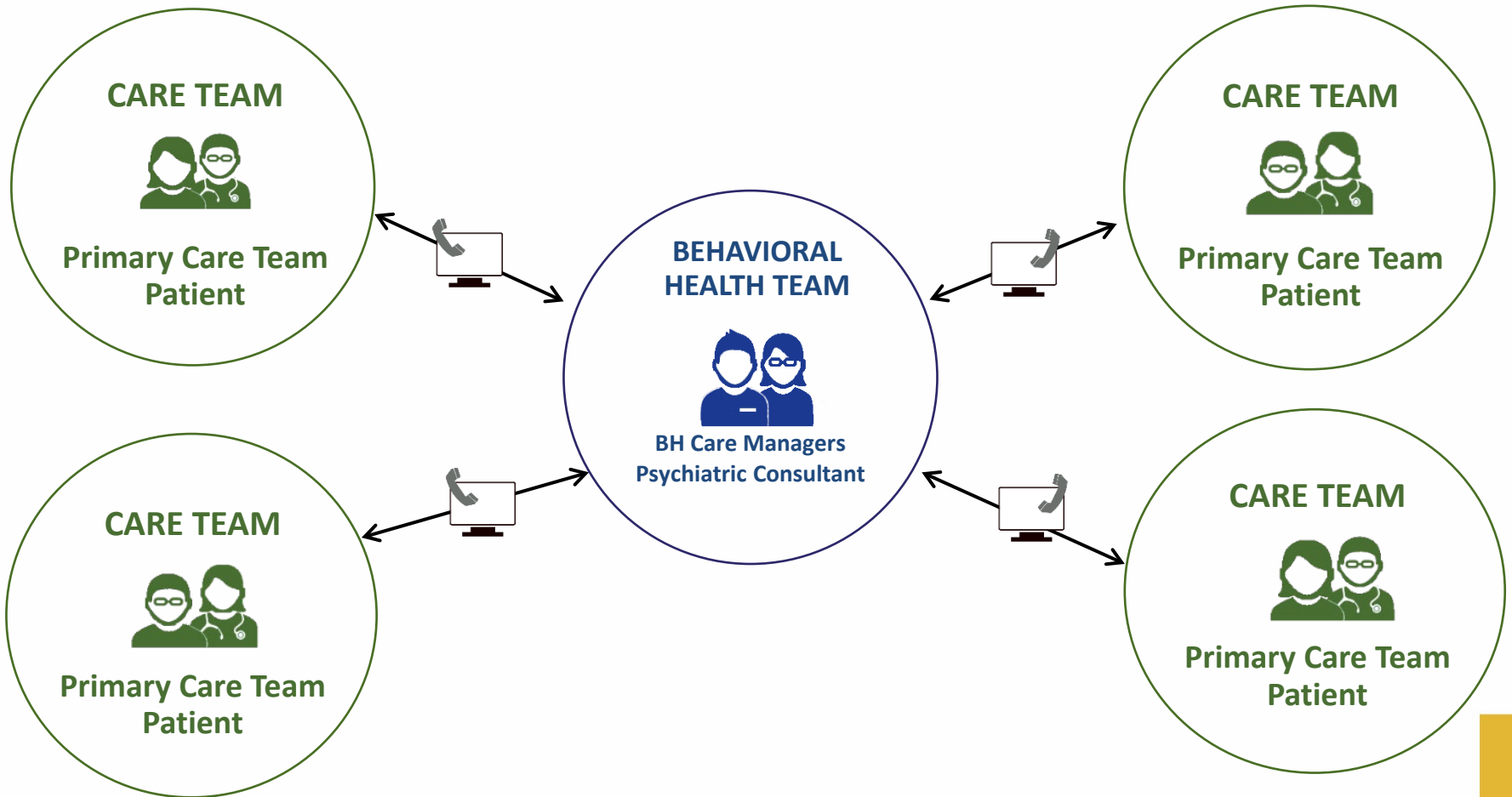
- Includes both in-person and telephone-based interventions
- Over 80 randomized, controlled trials and 2 meta-analyses

Telemedicine-Based CoCM

- 8 published trials with positive results
- 4 of the trials in rural Arkansas CHCs and VA clinics in rural areas
- 4 of the trials used exclusively off-site care managers and psychiatrists



Virtual Collaborative Care





Virtual Collaborative Care Strategies

- **Virtual or Shared Care Teams**
 - Remote or partly offsite Behavioral Health Care Manager
 - Remote Psychiatric Consultant
- **Telephone and Interactive Video**
 - Interventions with patients at home or in clinic through telehealth
- **Shared Electronic Medical Records**
 - Communication among on-site PCPs and offsite virtual CoCM team
- **Shared Collaborative Care Registry**
 - AIMS Caseload Tracker

Post-presentation Skills and Comfort Poll

After attending this webinar, please rate your current skills and comfort with the evidence base for Collaborative Care, typical Collaborative Care tasks and team roles, and the principles of Collaborative Care.

- Very Low
- Low
- Moderate
- High
- Very High



Questions?



Upcoming CoE Events

Leveraging the Untapped Potential of Peer Services in Integrated Care

[Register for the Webinar](#) on Tuesday, February 28, 12-1pm ET

Population Health Office Hour: Real World Examples in Integrated Care

[Register for the Webinar](#) on Thursday, March 9, 2-3pm ET

Interested in an individual consultation with the CoE experts on integrated care?

[Contact us through this form here!](#)

Looking for free trainings and credits?

[Check out integrated health trainings from Relias here](#)

Subscribe for Center of Excellence Updates

[Subscribe here](#)

NATIONAL
COUNCIL
for Mental
Wellbeing



Contact Us



Shannon Lea, MPH
slea@pcdc.org