Michigan Collaborative Care
IMPLEMENTATION SUPPORT TEAM

The Collaborative Care Model

MICHIGAN COLLABORATIVE CARE IMPLEMENTATION SUPPORT TEAM

A PARTNERSHIP BETWEEN MICHIGAN MEDICINE AND
THE MICHIGAN PRIMARY CARE ASSOCIATION

Primary care is behavioral health care.

- In a fast-paced environment with competing demands, PCPs manage behavioral health issues the best they can
- PCPs prescribe the majority of antidepressants
- At times, there is some support with embedded behavioral health providers
  - However, typically not population-focused
- Refer to specialty care
  - Do all patients truly need specialty care?

There are not enough psychiatrists.

Population size is increasing, while psychiatry numbers are decreasing.

- US population grew 4.7% from 2005- 2010
- Number of US psychiatrists dropped 1%
- 57% of psychiatrists ≥ 55 years old

Uninsured and underinsured patients have even less access to care.

- 55% of accept insurance vs 89% other physicians
- 55% accept Medicare vs 86% other physicians
- 43% accept Medicaid vs 73% other physicians

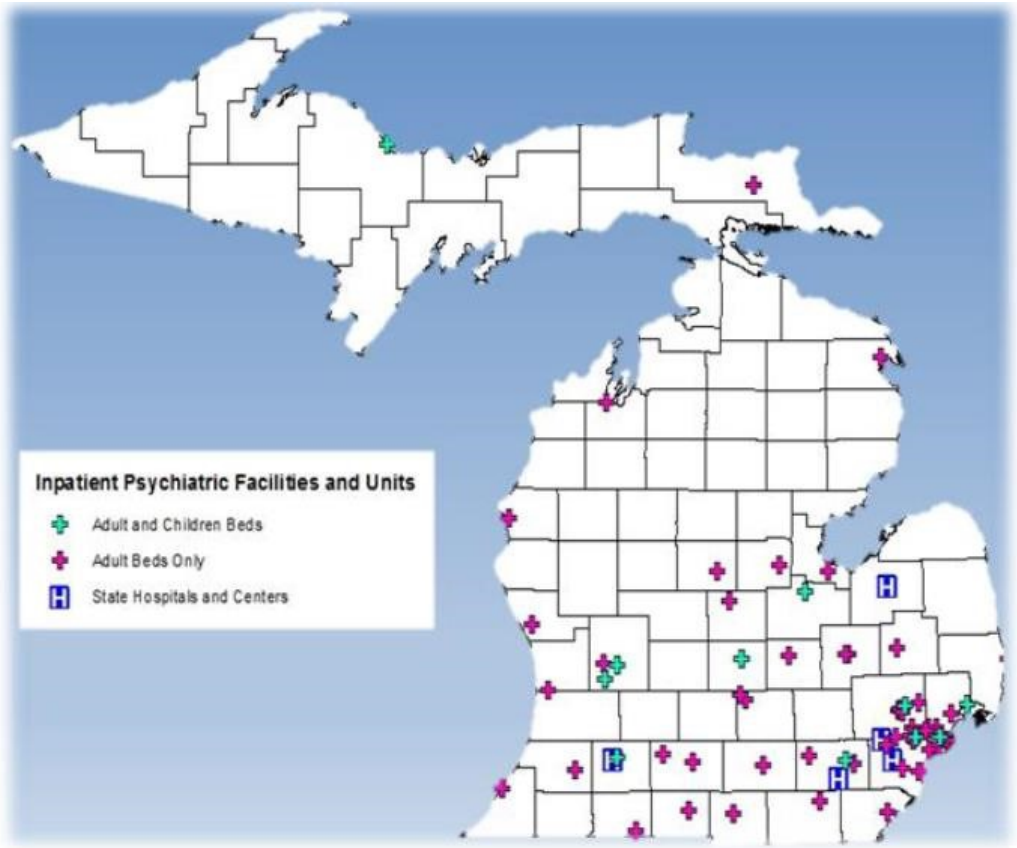
Inpatient Psychiatry in Michigan

Local Inpatient Licensed Beds (private):

- Adult: 2197 beds; 59 facilities
- Child/Adolescent: 276 beds; 11 facilities

State Hospital Beds (public):

- Adult: 720 beds
- Child/Adolescent: 70 beds



This image was developed by Lynda Zeller, Senior Deputy Director of the Behavioral Health and Developmental Disabilities Administration at MDHHS for the *Update and Dialogue: Mental Health & Opioid Policy* presentation on 5/24/2018

Collaborative Care model

- Founded at the University of Washington AIMS Center (IMPACT Trial)
- www.aims.uw.edu
- Over 80 RCTs showing effectiveness
- Cost-effective
- Outcomes in primary care comparable to those achieved in specialty care

Target population

- Most evidence is for adults with depression
- Increasing evidence for anxiety disorders, adolescent depression, PTSD, and co-morbid medical conditions
- SPIRIT Study: Bipolar disorder, PTSD

- Level of need can be impacted by:
  - Trauma
  - Lower socioeconomic status and complex psychosocial needs
  - Access to care

Who might require a higher level of care?

- Patients with:
  - Severe substance use disorders
  - Active psychosis
  - Developmental disabilities
  - Personality disorders requiring long-term specialty care
  - Current CMH consumers or persons requiring CMH-level services

Patient Centered Care

- Team-based care: Effective collaboration between PCPs and Behavioral Health Providers, incorporating patient goals into the treatment plan.

Population-Based Care

- Defined patient population tracked in a registry: no one ‘falls through the cracks.’

Measurement-Based Treatment to Target

- Measurable treatment goals and outcomes defined and tracked for each patient.
- Treatments are actively changed until the clinical goals are achieved.

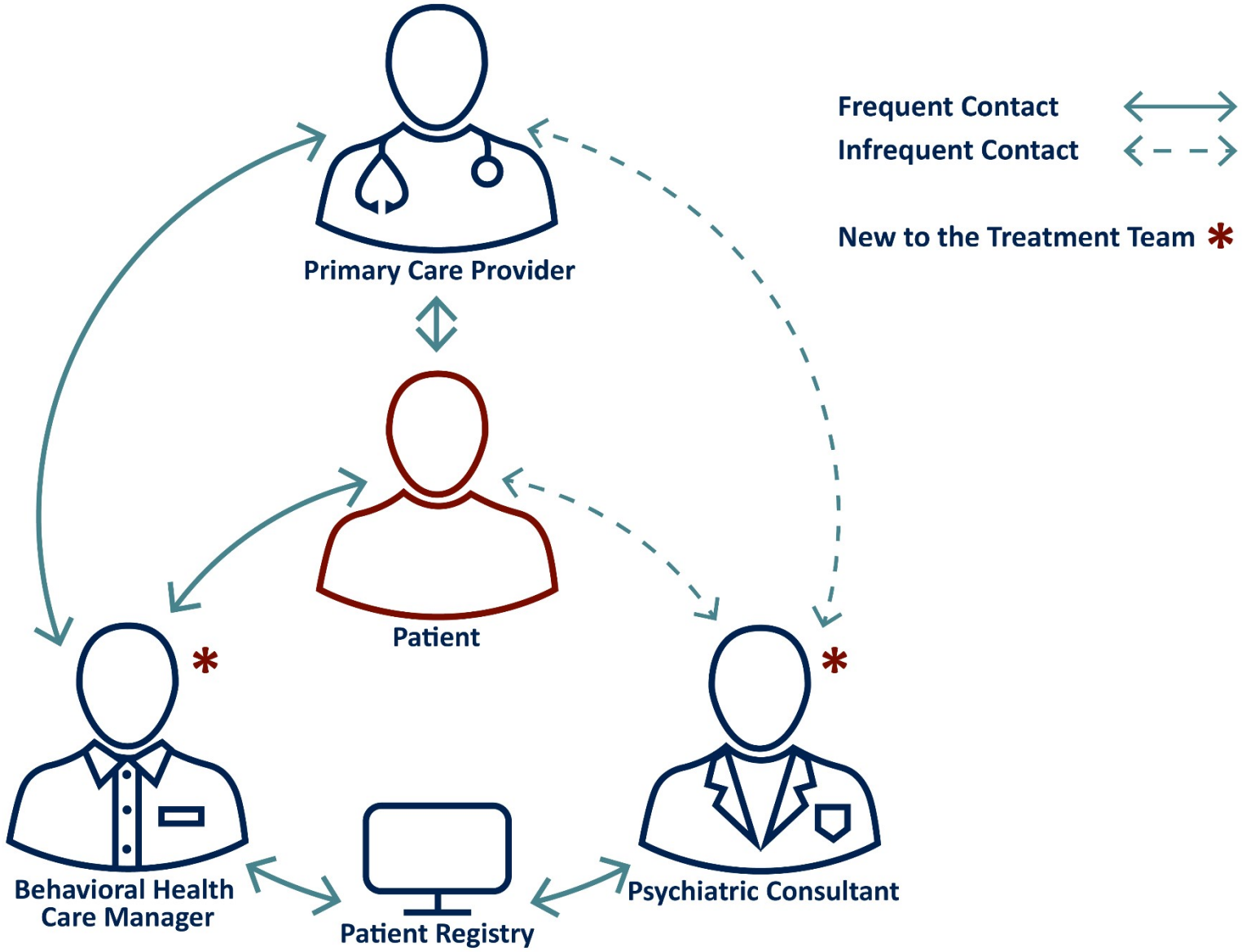
Evidence-Based Care

- Treatments used are evidence based.

Accountable Care

- Providers are accountable and reimbursed for quality of care, clinical outcomes, and patient satisfaction, not just the volume of care provided.

The Collaborative Care Treatment Team



5 Core Components

+

2 New Team Members

=

Collaborative Care Model

Behavioral Health Care Manager

- Often trained as social workers (MSWs), RNs, or other licensed behavioral health professionals
- Embedded in clinic, but also does *a lot* of phone work
- Co-visits, warm hand-offs when possible
- Diagnostic and psychosocial assessments (medication and psychiatric/SUD histories)
- Outcomes monitoring

Behavioral Health Care Manager

- Develops and proactively adjusts treatment plan with consultation of psychiatric consultant
- Medication monitoring and psychoeducation
- Brief, evidence-based psychotherapeutic techniques; Not a traditional therapist role
- Risk assessments and safety planning
- Participates in panel review; Close collaboration with psychiatric consultant
- Referrals to specialty care for those not improving or needing higher level of care

Psychiatric Consultant

- Collaborates closely with BHCM (1-2 hour/week panel review)
- Available for formal consultation and curbside consults
- Track and review patient progress using rating scales and data registries
- Document treatment recommendations to be sent to PCP for consideration
- Education of PCPs and staff as requested or desired by clinic

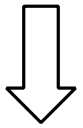
Primary Care Provider

- Introduces the Collaborative Care program and makes referrals
  - Warm handoffs are preferable
- Diagnoses common mental health disorders
- Prescribes medications
- Makes treatment adjustments in consultation with the behavioral health care manager and psychiatric consultant
- Oversees all aspects of patient's care

BHCM and Psychiatric Consultant Team

- “Panel review” 1 hour/week per 0.5 FTE behavioral health care manager
- Systematic review of patient registry
- New patients; not improving; worsening; those that may need to be moved on
- Specific case questions
- Documentation

PCP remains the team lead.



They choose whether to implement recommendations.

Patient Registry Example

Current Clinic Low High	Patient Name Low High	Birth Date Low High	Level Low High	Status Low High	Enroll Date Low High	Last PHQ Date Low High	Last PHQ Score Low High	PHQ Change Low High	PHQ Date Diff Low High	PHQ #9 Low High	Last GAD Date Low High	Last GAD Score Low High	GAD Change Low High	GAD Date Diff Low High
CLINIC WEST	MARCH, TARA	08/09/1987	2	ACTIVE	11/08/2011	07/15/2013	7	-4	108 days	0	04/20/2016	13	6	31 days
CLINIC WEST	CHERRY, JANE	05/18/1962	3	ACTIVE	08/26/2008	12/12/2013	17	1	44 days	0	04/20/2016	12	2	78 days
CLINIC WEST	RIVER, SANDY	12/25/1958	1	ACTIVE	03/02/2006	10/03/2013	2	2	182 days	0	04/20/2016	14	0	0 days
CLINIC WEST	ZANDER, LAURA	09/01/1953	3	ACTIVE	02/06/2013	11/22/2013	5	1	45 days	0	04/20/2016	21	2	60 days
CLINIC WEST	SMITH, MARY	04/10/1978	3	ACTIVE	08/21/2013	01/08/2014	10	-7	51 days	1	04/20/2016	12	1	91 days
CLINIC WEST	DEMO, ONE	11/27/1976	3	ACTIVE	12/12/2013	05/23/2014	10	0	0 days	1	04/20/2016	2	0	0 days
CLINIC WEST	MANOOGIAN, SARAH	05/15/1952	3	ACTIVE	11/16/2012	12/18/2013	14	-2	119 days	0	03/20/2016	8	0	0 days
CLINIC SOUTH	FLINTSTONE, PEBBLES	07/12/1991	3	ACTIVE	12/12/2013	12/12/2013	10	0	0 days	0	04/20/2016	9	-9	91 days
CLINIC SOUTH	SMITH, MICHAEL	04/12/1992	2	ACTIVE	07/16/2012	10/22/2013	13	0	91 days	0	01/01/2016	6	0	0 days
CLINIC SOUTH	DEMO, DINA	08/27/1981	2	ACTIVE	12/24/2013	12/24/2013	12	0	0 days	0	02/03/2016	11	0	0 days
CLINIC SOUTH	CLARK, SARAH	03/26/1954	3	ACTIVE	07/19/2012	11/25/2013	18	1	33 days	0			0	0 days
CLINIC NORTH	RAISIN, WONDA	10/10/1957	3	ACTIVE	11/29/2012	12/02/2013	9	2	34 days	0			0	0 days
CLINIC NORTH	TEST, FIRST	10/19/1959	3	ACTIVE	12/03/2013	01/16/2015	24	18	371 days	3			0	0 days
CLINIC NORTH	TEST, MARY	01/01/1951	3	ACTIVE				0	0 days				0	0 days

Measurement-based care

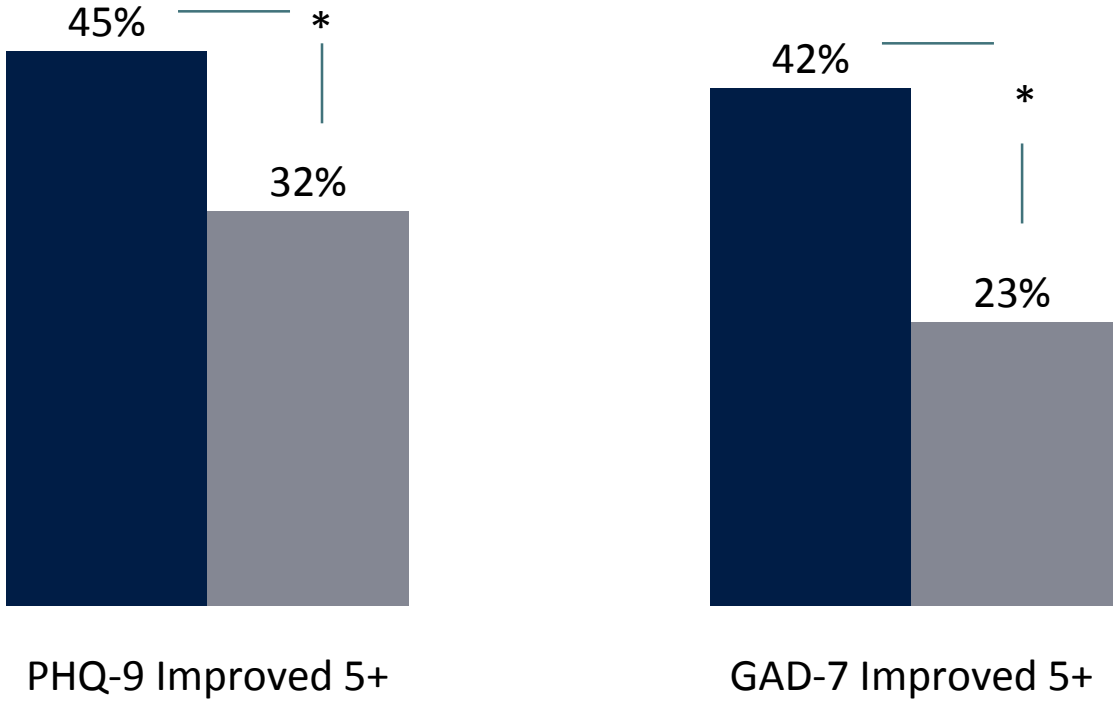
- PHQ-9
- GAD-7
- AUDIT-C
- CIDI-Based Bipolar Screening Scale
- MOCA (seniors)

Brief, evidence-based interventions

- BHCMs will provide:
- Motivational Interviewing
- Problem-Solving Therapy
- Behavioral Activation
- Medication Monitoring
- Psychoeducation

In a Washtenaw County CoCM pilot project,

CoCM patients reported significantly less depression and anxiety than usual care patients at six month follow-up.



**= statistically significant difference ($p < .05$)*

Summary: How is CoCM different?

- Population health approach
  - Use of a patient registry to ensure no one falls through the cracks
- BHCM does not act as a traditional therapist or medical social worker
- Leveraging psychiatry time
  - 6-8 patients reviewed per hour as opposed to 1 patient
  - Helps reserve specialty psychiatry time for higher level cases
- Often a shorter wait time from referral to engagement in care
- Evidence-based
  - Medication and behavioral interventions