Michigan Collaborative Care Implementation Support Team (MCCIST)

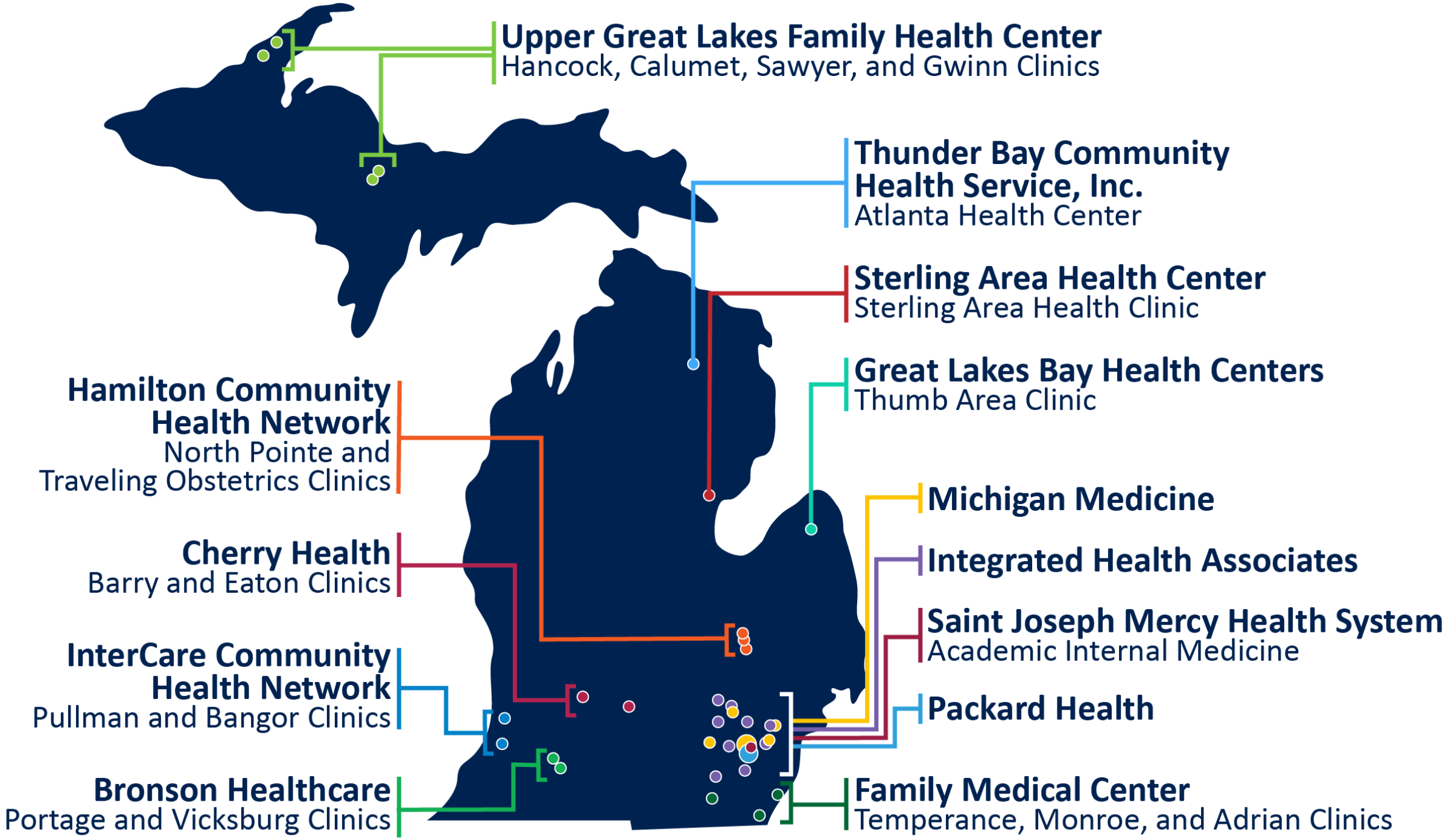
GOALS AND SERVICES

IMPLEMENTATION EXPERIENCE AND OUTCOMES

Our Goal

MCCIST provides consultation and specialized training to health systems implementing and sustaining the Collaborative Care model (CoCM), supporting efforts to expand primary care workforce capacity to treat behavioral health conditions.

In partnership with health systems, MCCIST facilitates the practice transformation to stand up the model with fidelity.


Upper Great Lakes Family Health Center
Hancock, Calumet, Sawyer, and Gwinn Clinics
Thunder Bay Community Health Service, Inc.
Atlanta Health Center
Sterling Area Health Center
Sterling Area Health Clinic
Great Lakes Bay Health Centers
Thumb Area Clinic
Hamilton Community Health Network
North Pointe and Traveling Obstetrics Clinics
Michigan Medicine
Integrated Health Associates
Cherry Health
Barry and Eaton Clinics
Saint Joseph Mercy Health System
Academic Internal Medicine
InterCare Community Health Network
Pullman and Bangor Clinics
Packard Health
Bronson Healthcare
Portage and Vicksburg Clinics
Family Medical Center
Temperance, Monroe, and Adrian Clinics

CoCM: Flexible to Diverse Health Systems

- If you've seen one clinic, you've seen one clinic
  - Conduct a thorough needs assessment to understand unique strengths and challenges
  - Balance of flexibility and adherence to the model
  - Health systems typically have both common and unique implementation challenges
- Psychiatric consultants provide care via various modalities
  - Use of embedded, existing health system psychiatrists
  - Contracting with academic medical centers and community-based psychiatrists (have liaised with MPS)
  - Telehealth: Psychiatric consultant does not have to be on site, which is important for rural clinics
- Further adaptations
  - Working with embedded behavioral health providers
  - Collaborating with Community Mental Health
  - Peer Support Specialists/Community Health Workers
  - Lantern: A CBT application

Patient Registry Example

Patient Information		Contact Information					Depression Outcomes					Anxiety Outcomes				Panel Review	
Name	Treatment Status	Date of Initial Contact	Date of Most Recent Contact	Number of Patient Contacts Completed	Weeks in Treatment	Date Next Contact Due	Initial PHQ-9	Most Recent PHQ-9	Difference in Most Recent PHQ-9	Most Recent PHQ-9 #9	Date of Most Recent PHQ-9	Initial GAD-7	Most Recent GAD-7	Difference in Most Recent GAD-7	Date of Most Recent GAD-7	Date of Most Recent Panel Review	Flag to Discuss
Bond, James	Active	7/23/18	3/14/19	18	34	4/13/19	11	7	-6	0	1/7/19	14	6	-8	1/7/19	3/11/19	
Doe, Jane	Active	9/13/18	3/13/19	15	27	4/12/19	12	6	-8	0	3/12/19	10	1	-3	3/12/19	2/4/19	
Smith, John	Active	11/2/18	3/13/19	14	19	4/12/19	16	16	2	1	2/7/19	11	9	-2	2/7/19	2/11/19	
Michigan, Cherry	Active	7/11/18	3/11/19	12	36	4/10/19	25	21	3	0	3/5/19	10	12	2	3/5/19	3/11/19	
Jupiter, Mars	Active	10/18/18	3/13/19	11	22	4/12/19	23	12	-1	0	3/13/19	11	7	-1	3/13/19	2/18/19	
Johnson, Matthew	Active	11/23/18	3/12/19	11	16	3/26/19	12	18	4	1	3/12/19	11	10	1	3/12/19	2/18/19	
Three, Test	Active	11/8/18	3/1/19	10	19	3/31/19	14	14	9	1	1/31/19	4	12	4	1/31/19	3/4/19	
Smile, Big	Active	9/21/18	3/13/19	9	25	4/12/19	11	7	-9	0	12/31/18	14	7	-8	12/31/18	2/4/19	Flag to Discuss

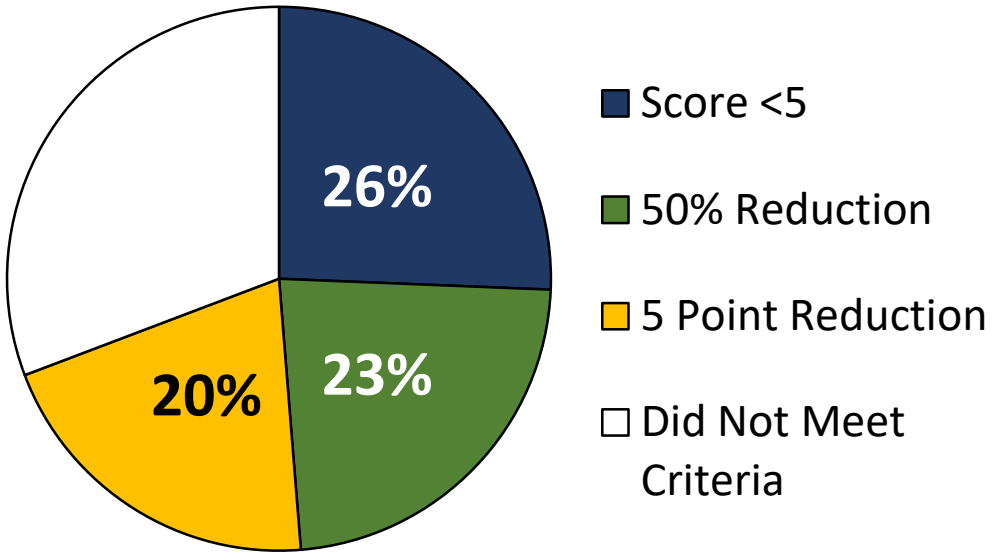
PHQ-9/GAD-7: Highest to Lowest (who isn't getting better?)
PHQ-9/GAD-7: Lowest to Highest (why are these patients still enrolled?)
Enroll Date: Oldest to Newest (why are these patients still enrolled?)
Last Review Date: Oldest to Newest (does this patient need to be reviewed?)

MCCIST Results: Psychiatric Fidelity Measures

Measure (Target Rate)	Description	Overall		A	B (OB)	C	D	E
Early Panel Review Rate (Target: 90%)	Patients discussed with a psychiatric consultant in panel review within their first 2 weeks of enrollment	151 / 159	95%	69%	96%	97%	100%	98%
Critical Treatment Period (50% reduction) (Target 75%)	Patients who are not improving at 8 weeks that are discussed in panel review within 4 - 12 weeks of their enrollment	47 / 49	96%	80%	100%	100%	100%	100%
Recommendation Implementation Rate (Target: 80%)	Psychiatric recommendations that have been implemented (This does not include pending recommendations)	317 / 360	88%	92%	82%	84%	99%	76%

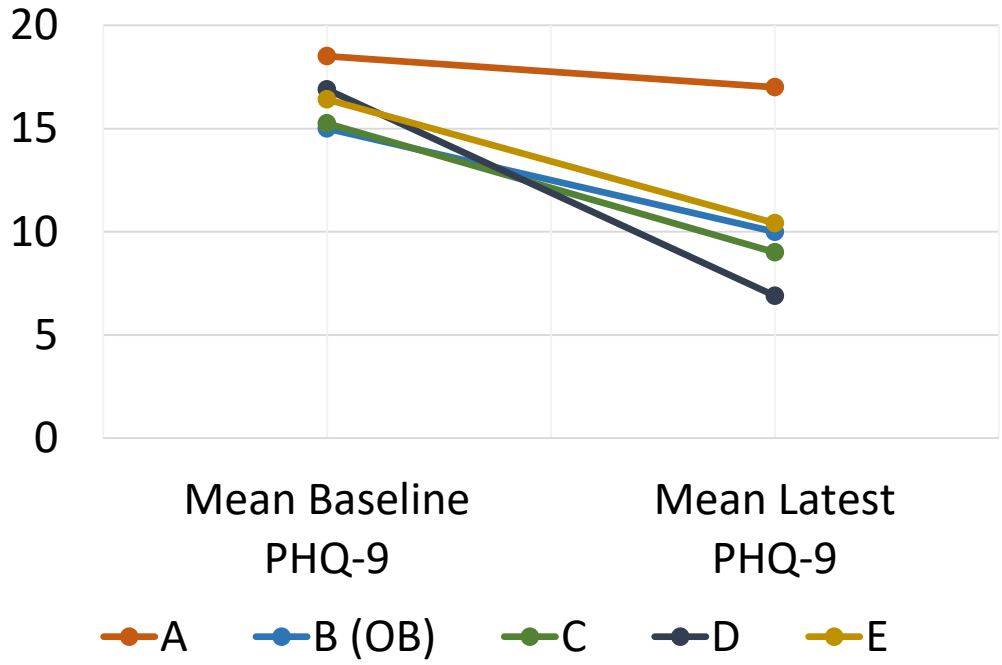
MCCIST: Depression Outcomes 3-6 Months After Enrollment

Patients With Improved Depression Outcomes (n=40)



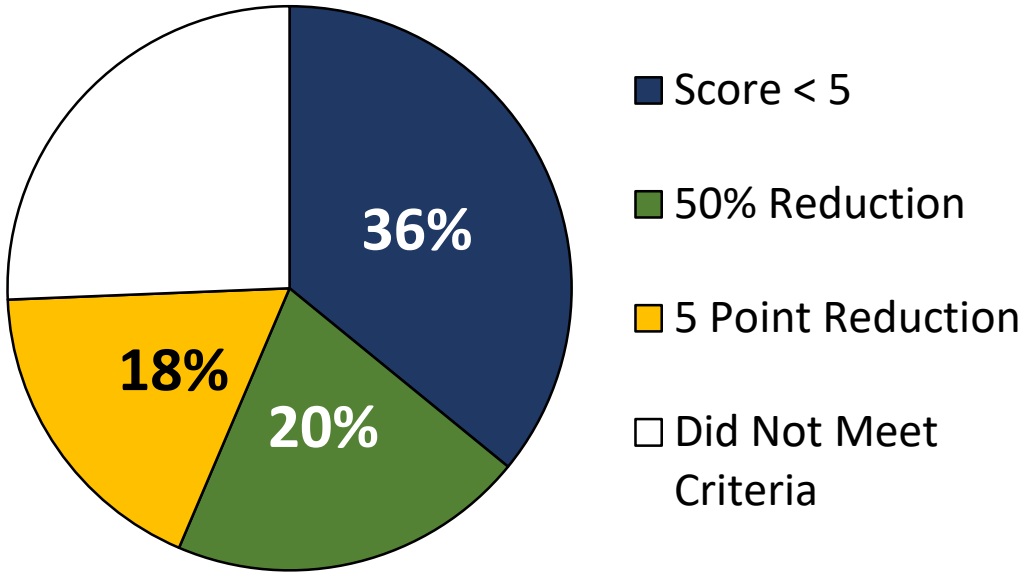
69% of patients demonstrated improved depression outcomes 3-6 months after enrollment

Difference in Depression Outcome Measures (n=40)



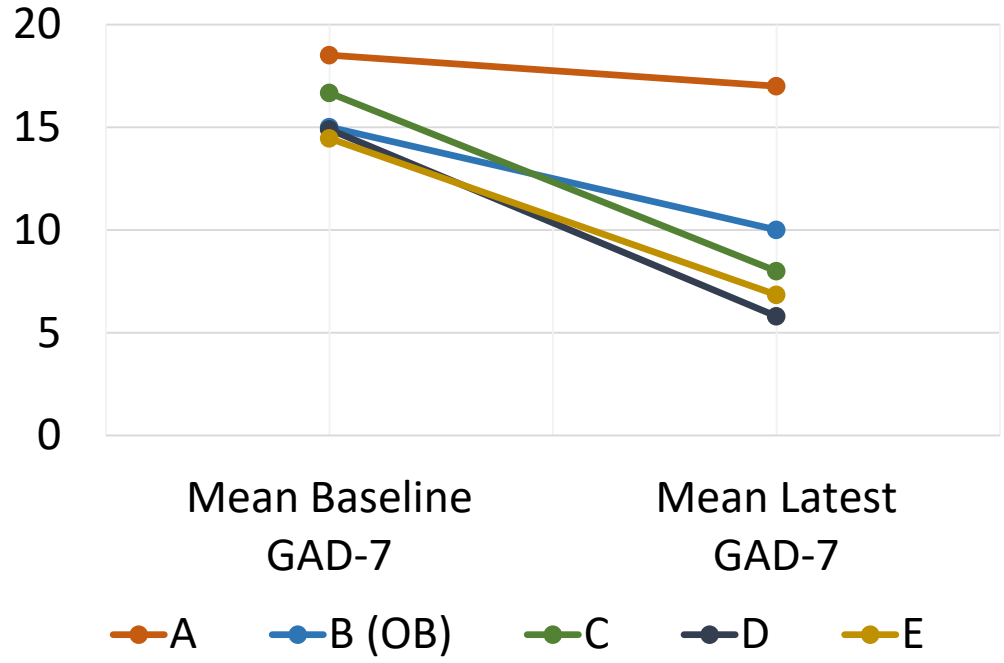
MCCIST: Anxiety Outcomes 3-6 Months After Enrollment

Patients With Improved Anxiety Outcomes (n=39)



74% of patients demonstrated improved anxiety outcomes 3-6 months after enrollment

Difference in Anxiety Outcome Measures (n=39)



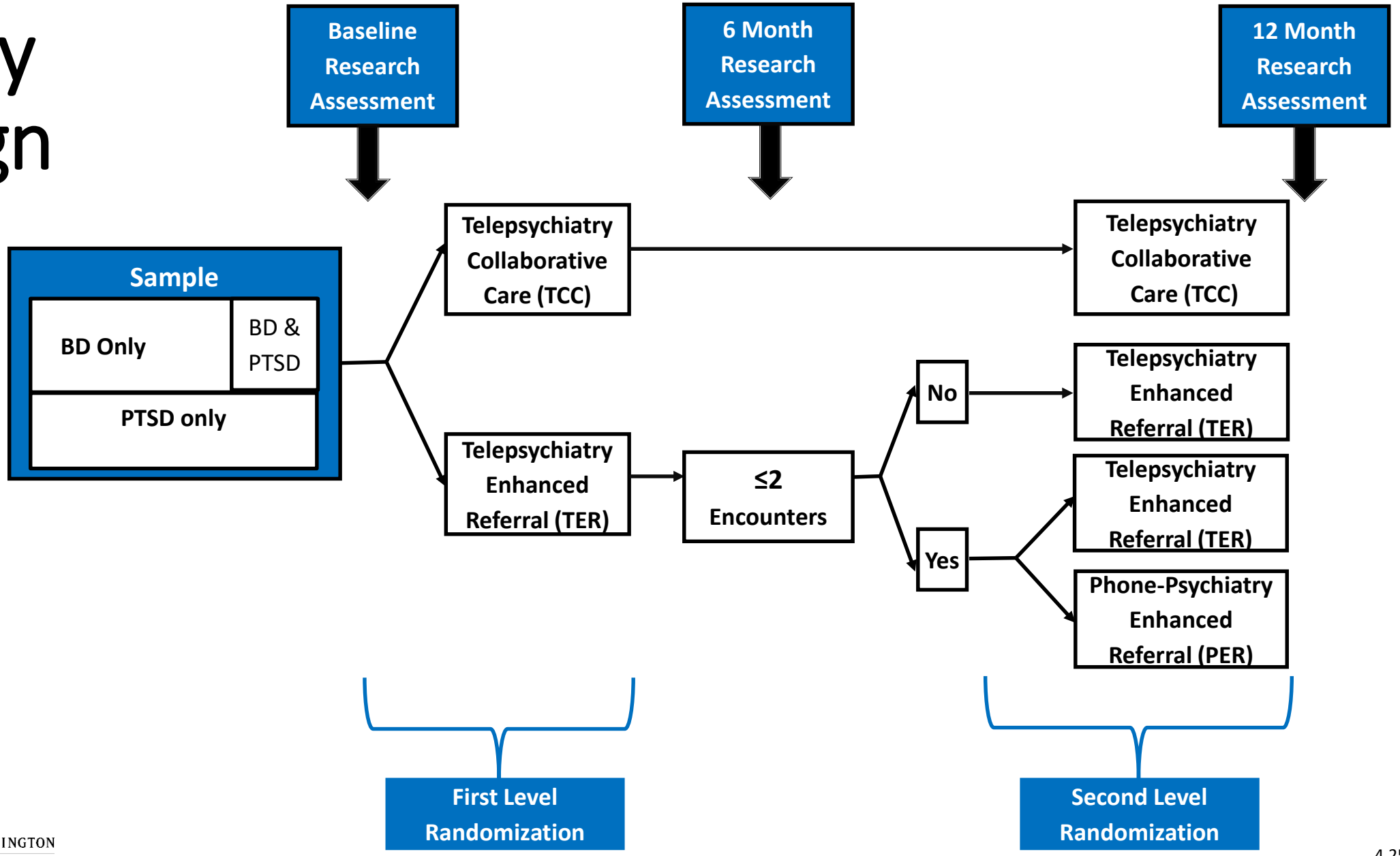
Modifications for Special Populations

- Obstetrics team at Hamilton Community Health Network
  - Perinatal psychiatrist acting as the psychiatric consultant
  - Expanded, tailored intake form based on perinatal psychiatry input
  - Behavioral health care manager attends OB huddles
  - Modified CoCM discharge plan based on due date/delivery (3 months postpartum)
  - Expansion of patient educational resources
  - Perinatal prescribing education for providers at clinic
- Study to Promote Innovative Rural Integrated Telehealth (SPIRIT)
  - Multi-state comparative effectiveness trial evaluating collaborative care and telepsychiatry for patients with bipolar disorder and post-traumatic stress disorder (PTSD)
- Future directions:
  - Interested in integrating CoCM with MAT to improve evidence-based prescribing, treatment adherence, and patient outcomes

SPIRIT: PTSD and Bipolar Disorder

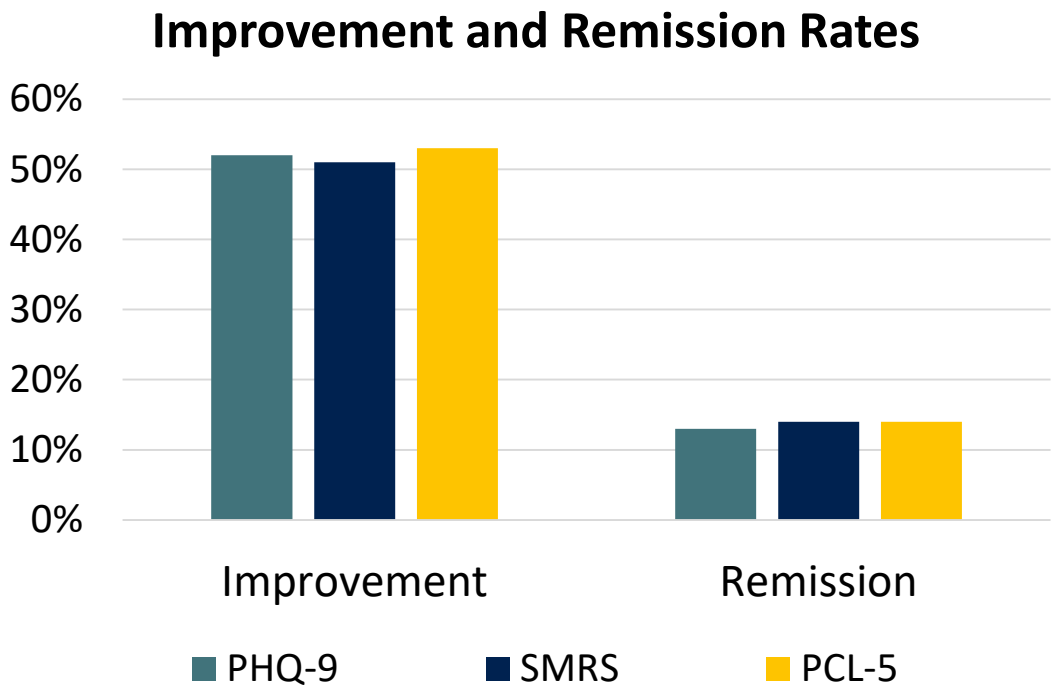
- PTSD and Bipolar Disorder often go undiagnosed and untreated, and are among the biggest contributors to disability and suicidality. These patients are often:
  - Unable to engage in specialty mental health treatment
  - Treated exclusively in primary care
  - Prescribed medications for depression
- Health centers do not have access to existing highly effective treatment options, specifically in rural communities
  - PCPs are often challenged to treat patients with these complex conditions
  - Telehealth allows for innovative treatment options: referrals to specialty care, collaborative care
- Recruitment to end in June 2019, study to conclude in July 2020
  - Transition to sustainable collaborative care programs

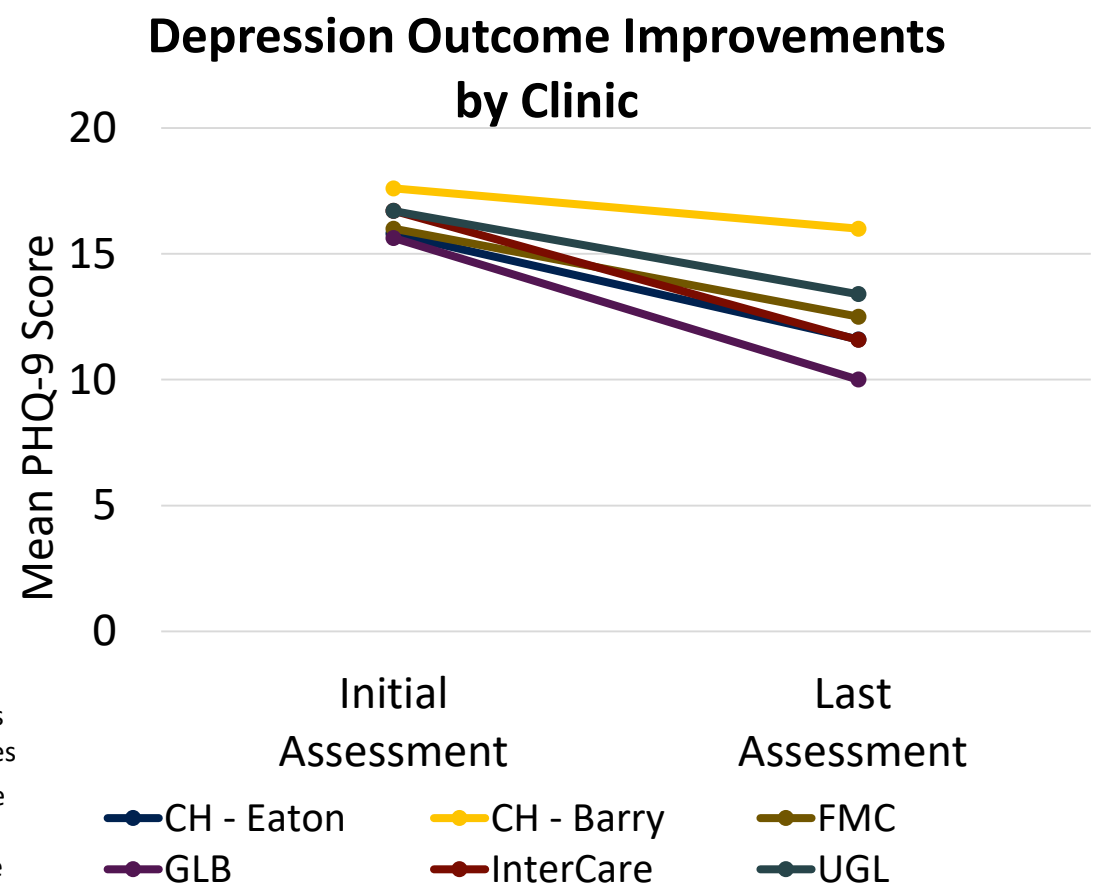
Study Design



SPIRIT: Patient Outcomes in Michigan Clinics

CoCM and Telepsychiatry Combined





Improvement:
- PHQ9/SMRS: % of active patients achieving ≥5 pt improvement between first and last scores
- PCL5: % of active patients achieving ≥10 pt improvement between first and last scores

Remission:
- PHQ9/SMRS: # and % of active patients that have been in treatment for ≥10 weeks and have a score <5
- PCL5: # and % of active patients that have been in treatment for ≥10 weeks and have a score <19

CoCM Sustainability: Billing and Reimbursement

Medicare and Commercial Payers implemented Collaborative Care codes in January 2018

- CPT codes: 99492, 99493, 99494
- G-code (FQHCs and RHCs): G0512
  - Initial Month: 70 minutes
  - Subsequent Months: 60 minutes

Michigan Medicaid has not yet activated these codes

- Medicaid is the largest payer of behavioral health services
- Federally Qualified Health Centers especially impacted given high Medicaid population
- With codes inactive, CoCM is less available and sustainable for all health systems

Billing Experiences

- Some health systems have started billing Medicare and several commercial insurers with varying levels of success

Michigan Collaborative Care Implementation Support Team

University of Michigan

- Gregory Dalack, MD
  Principle Investigator, MCCIST
  gdalack@med.umich.edu
- Paul Pfeiffer, MD
  Principle Investigator, SPIRIT
  ppfeiffe@med.umich.edu
- Ed Deneke, MD
  Psychiatric Consultant
  edwardde@med.umich.edu
- Karla Metzger, LMSW
  Project Manager
  kmetz@med.umich.edu
- Sara Marasco, LMSW
  Training and Implementation Specialist, Clinical Lead
  smcuson@med.umich.edu
- Marina Milad
  Training and Implementation Specialist
  miladm@med.umich.edu

Michigan Primary Care Association

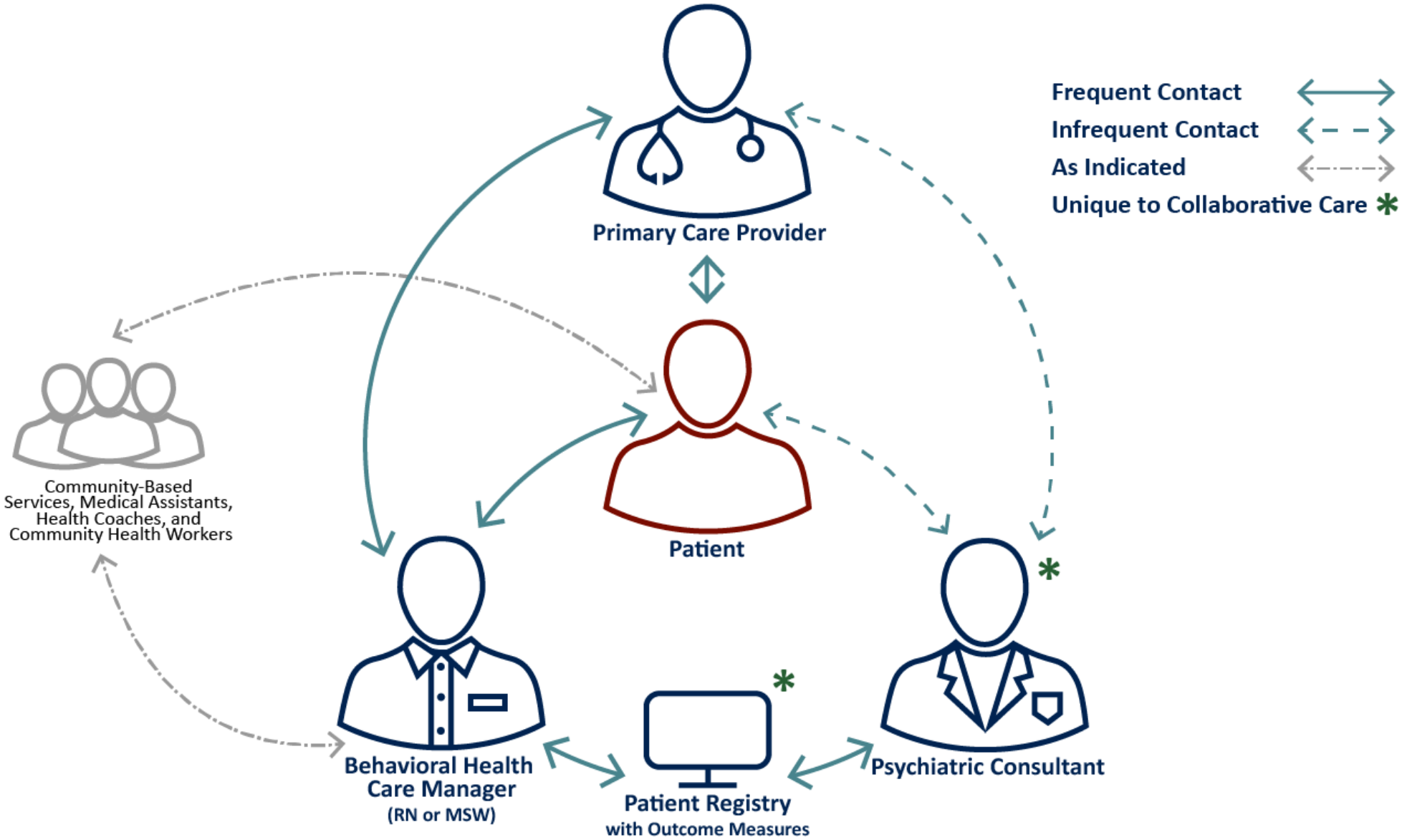
- Dawne Velianoff, LMSW, MUP
  Director of Operations, Training and Programs
  dvelianoff@mpca.net
- Jacklyn Chandler, MS
  Project Specialist
  jchandler@mpca.net

Current and Past Funders

Washtenaw Health Initiative
Washtenaw Health Plan
Blue Cross Blue Shield Foundation
Ethel and James Flinn Foundation
Michigan Health Endowment Fund
Medicaid Match Grants
KCCP Donors

Collaborative Care 101

The Collaborative Care Treatment Team



Primary Care Provider

- Introduces the CoCM program to the patient and makes the referral
- Diagnoses common mental health disorders
- Prescribes medications
- Makes treatment adjustments in consultation with the behavioral health care manager and psychiatric consultant
- Remains the team lead: Oversees all aspects of patient's care

Behavioral Health Care Manager

- MSWs, RNs, or other licensed behavioral health professionals
- Embedded in clinic: Significant phone work and available for both individual and co-visits
- Structured diagnostic assessments, including medication and psychiatric/SUD histories
- Participates in weekly panel review and collaborates closely with psychiatric consultant
- Develops and proactively adjusts treatment with the team
- Ongoing patient monitoring and engagement
  - Outcomes monitoring, medication monitoring, and psychoeducation
  - Monitoring and adjusting self-management plans
  - Brief, evidence-based psychotherapeutic techniques - Not a traditional therapist role
  - Risk assessments and safety planning
- Referrals to specialty care for those not improving or needing higher level of care

Psychiatric Consultant

- Collaborates closely with behavioral health care manager
  - 1-2 hours per week for “panel review”
- Available for formal consultation and curbside consults
- Reviews patient progress using outcome measures and a patient registry
- Documents treatment recommendations to be sent to PCP for consideration
- Provides education and rationale for treatment suggestions in documentation
- Provides clinic-based education for PCPs and staff as needed and requested

MCCIST Services

Pre-implementation Needs

Implementation Planning

- Conduct needs and readiness assessments
- Offer CoCM education and address program buy-in
- Assess and modify clinic workflows and policies to support CoCM
- Engage health system teams in routine planning calls

Technology Development

- Identify and/or develop a population health registry
- Review EHR documentation capabilities and modify as needed

Clinical Training

- Develop personalized training plans for behavioral health care managers and psychiatric consultants
- Lead individual and group training sessions
  - CoCM-specific clinical skills (e.g., intake, triage, self-management planning)
  - Evidence-based brief interventions (e.g., behavioral activation, motivational interviewing)
  - Additional clinical skill training as needed (e.g., risk assessment, diagnostics)

Implementation and Sustainability Planning Needs

Model Optimization:

- Coach CoCM treatment teams to ensure fidelity to the model
- Provide ongoing clinical training and feedback
- Evaluate clinical outcomes and fidelity measures to guide QI initiatives
- Continue to address workflows, referral flow, and buy-in

Sustainability Planning:

- Develop a business case to advocate for program sustainability
- Outline a revenue stream to sustain the CoCM program
- Determine appropriate billing procedures for the model

Unique Roles: Finding the Right Fit

- Behavioral Health Care Manager and Psychiatric Consultant roles are often a major shift in practice for providers
- Specialized training is very important
  - This is provided as part of Collaborative Care pre-implementation work
- Requires flexibility and openness to the model
- Note: Not every provider is the right fit for these roles and may not feel comfortable practicing in this capacity
  - This is okay! It's just best to understand this as early as possible.