2021 Advanced Collaborative Care Skills:
Practical Strategies for the Implementation and Sustainment of the Collaborative Care Model

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Advancing Integrated Psychiatric Care for the Medically Ill

CLP 2021

Disclosure: Anna Ratzliff, MD, PhD

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Grant		I	I

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Disclosure: Jürgen Unützer, MD, MPH, MA

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Disclosure: Jürgen Unützer, MD, MPH, MA

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Disclosure: Andrew D. Carlo, MD, MPH

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Disclosure: Jessica Whitfield, MD, MPH

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Overview of Session: Recorded & Live

Section	Presenter
Introduction	Dr. Ratzliff
Lay the Foundation **–Build your CoCM care team implementation through task list exercise.**	Dr. Unutzer
Plan for Clinical Practice Change: Financing **–Decide the best billing strategies for your CoCM implementation using case-based learning.**	Dr. Carlo
Plan for Clinical Practice Change: Workflows **– Develop a process map for screening a population with the PHQ-9.**	Dr. Chang
Build Your Clinical Team **– Practice training a team to use a registry with an interactive activity.**	Dr. Toor
Launch and Deliver Quality Care **Interactive Session – Design an improvement cycle to target Collaborative Care quality metrics.**	Dr. Whitfield
Sustain Your Care **– Complete Implementation and Sustainment Worksheet to explore key strategies to sustain CoCM.**	Dr. Ratzliff
Questions and Conclusions	All

Goals and Objectives

At the conclusion of this session, the participant will be able to:

- Define the five phases of collaborative care (CoCM) implementation and sustainability.
- Identify strategies to engage key partners and stakeholders in CoCM implementation.
- List the ways in which newly available CoCM billing codes are able to support implementation.
- Consider how to tailor and apply learned concepts to support implementation of collaborative care in their own clinical setting.

INTRODUCTION

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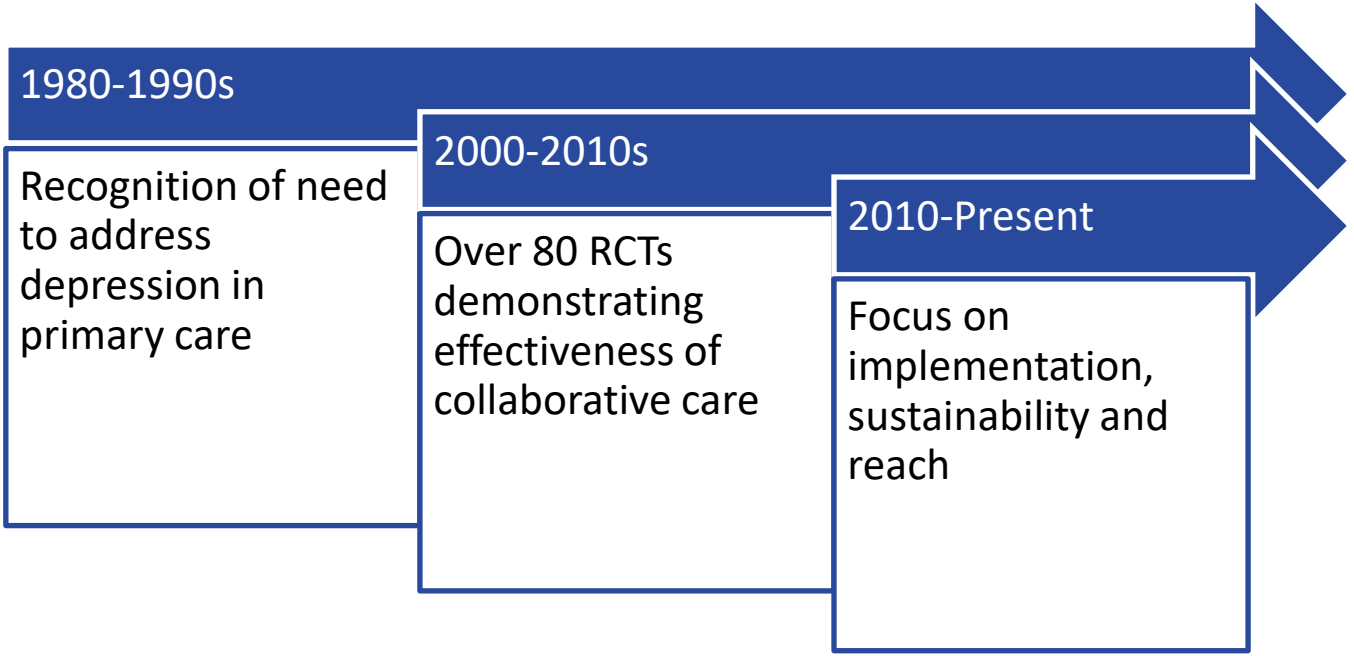
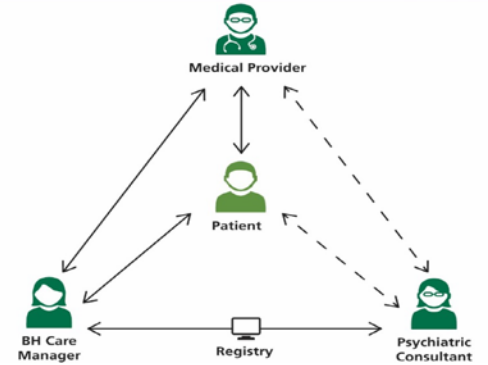
History of Collaborative Care



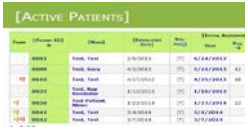
Core Components of Collaborative Care

Prepared, Pro-active
Practice Team



Informed,
Active Patient

Outcome
Measures



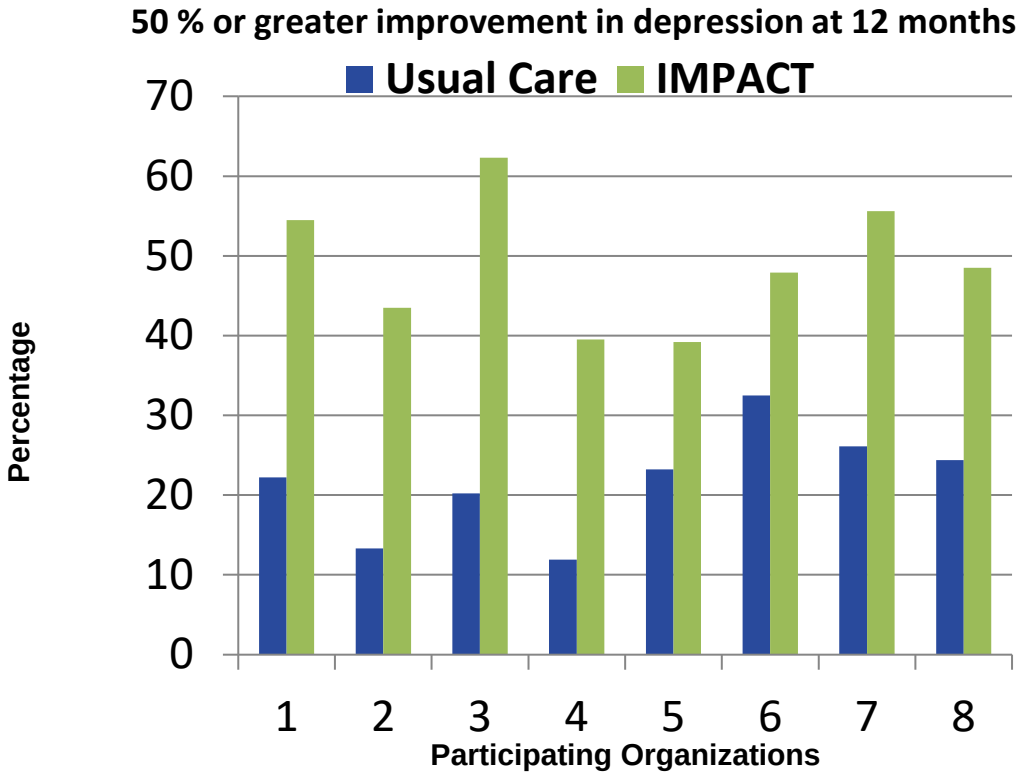
Population
Registry

Treatment
Protocols

Psychiatric
Consultation

Unützer J, Katon W et al. Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. JAMA. 2002.

Twice as Many People Improve



Unützer J, Katon W et al. Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. JAMA. 2002.

IMPACT: Summary

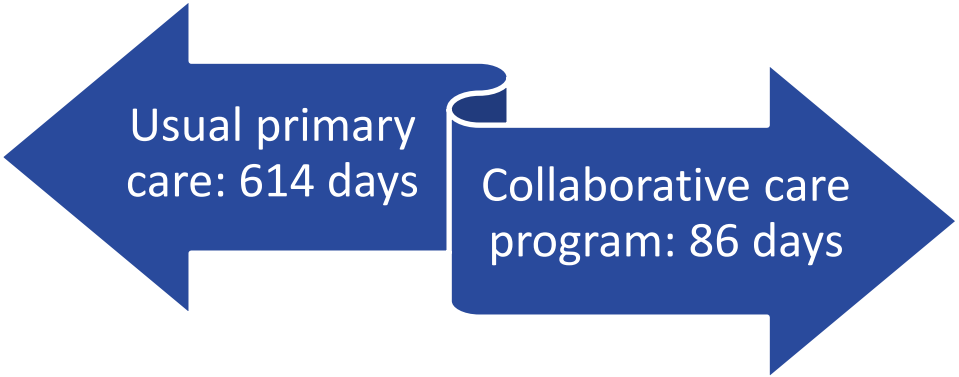
- **Improved Outcomes**
  - Less depression
  - Less physical pain
  - Better functioning
  - Higher quality of life
- **Greater patient and provider satisfaction**
- **Reduced healthcare costs**

"I got my life back"

THE TRIPLE/QUADRUPLE AIM

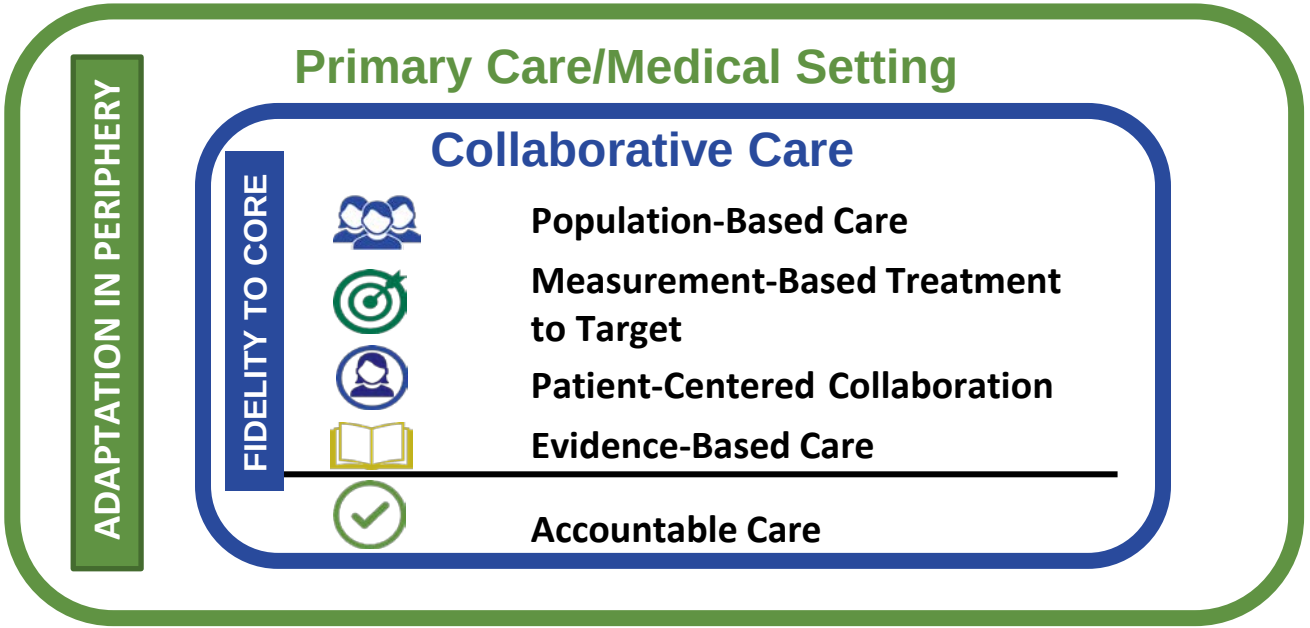
Treatment to Target Drives Early Improvement

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

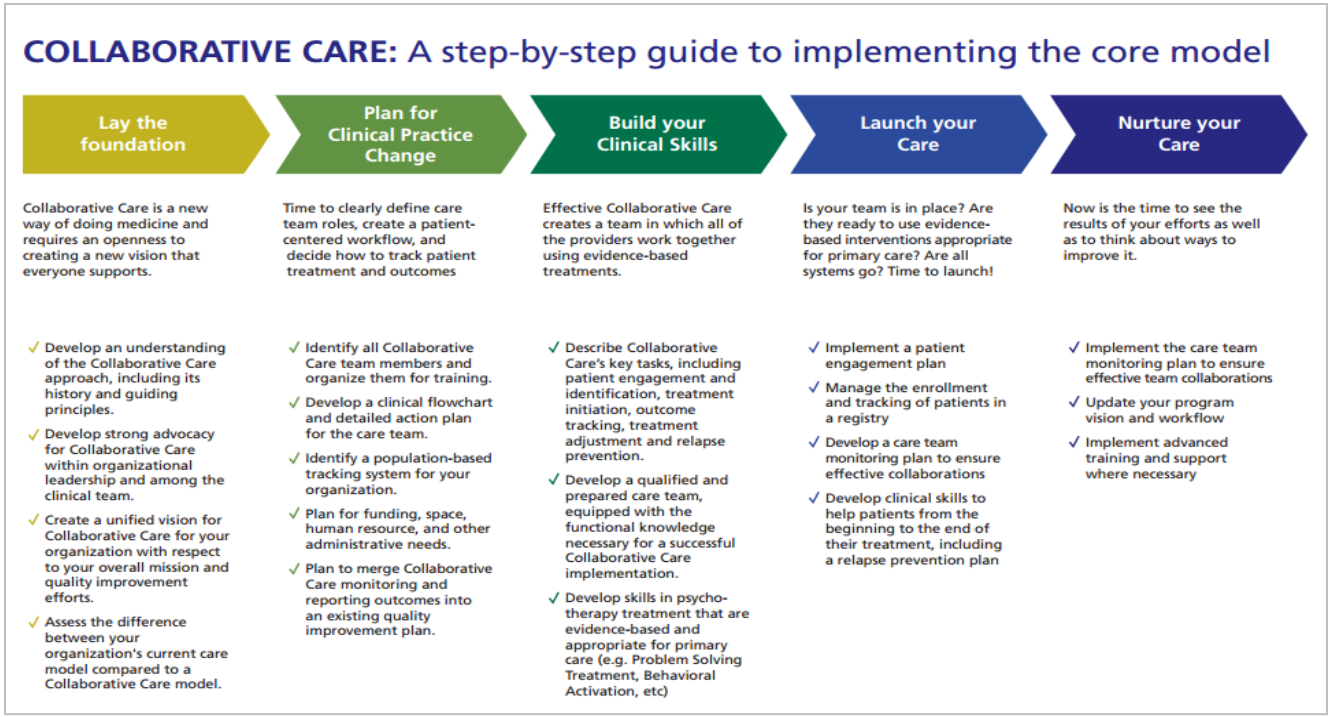


Garrison GM et al, 2016

AIMS Center Implementation Approach



AIMS Center Phases of Implementation



http://aims.uw.edu/

Using Evidence-Based Quality Improvement for Implementation

Balance of centralized strategic decision making and local tactical decision making

Stakeholders from mental health, primary care, community clinics

- **Plan: Tailored protocols, aligned measures**
- **Do: Initial launch**
- **Study: Monthly calls using data reports**
- **Act: Refine workflows as needed**

Strong adoption, low reach: Good fidelity and maintenance

Fortney,JC et al. Implementation outcomes of evidence-based quality improvement for depression in VA community based outpatient clinics. Implement Sci. 2012.

PHASE 1: LAY THE FOUNDATION

Jürgen Unützer, MD, MPH, MA
Professor and Chair
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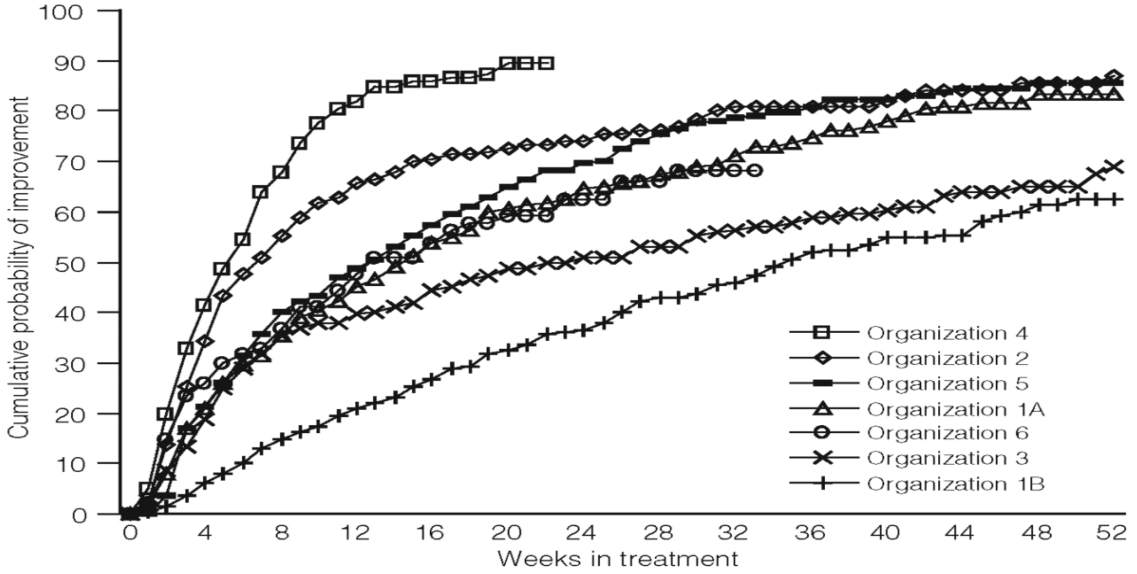
Phase 1: Lay the Foundation (3-12mo)

- ✓ Develop a shared understanding of the Collaborative Care Model
- ✓ Explore the difference between current services and the Collaborative Care model
- ✓ Develop a shared vision for the Collaborative Care Program to be implemented
  - ✓ Why? What? How?
- ✓ Develop advocacy and champions for the Collaborative Care Program to be implemented
- ✓ Consider short term or long term risks and threats to implementation of sustainability of CoCM Program.

Implementation matters

Figure 1

Estimated time elapsed between initial assessment and improvement of depression during the first year of treatment at six organizations[a]



[a] Estimates were truncated when ten or fewer patients remained in treatment at each site.

Bauer et al Implementation of collaborative depression management at community-based primary care clinics: an evaluation. Psychiatr Serv. 2011

Effective Implementation

Table 1. Factors Considered Important for Implementation of DIAMOND

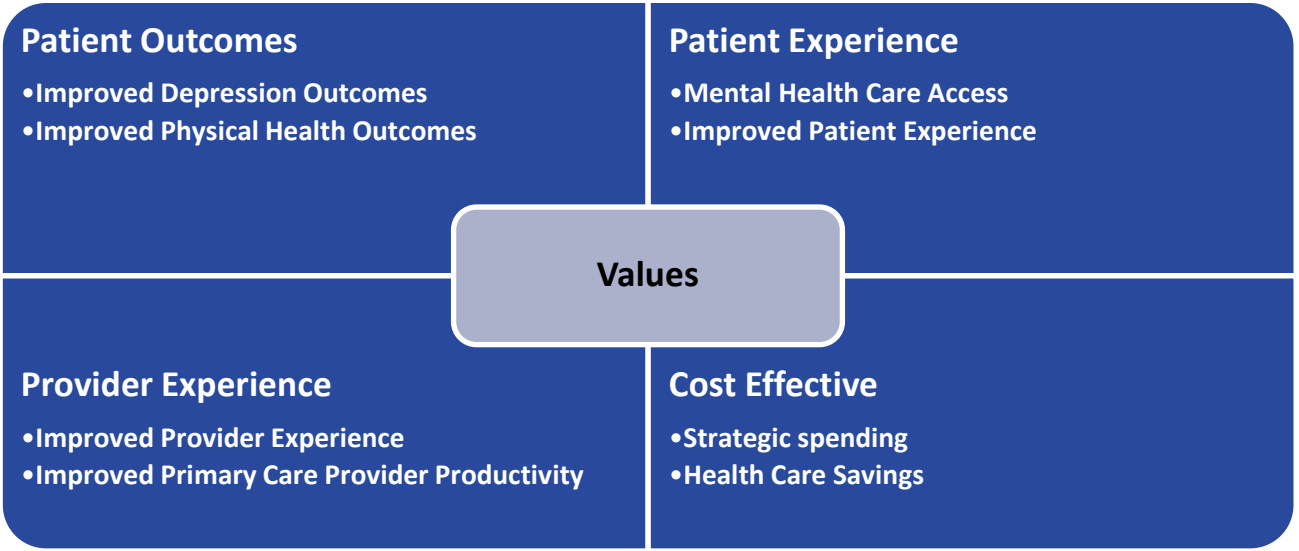
Ranking	Implementation Factor	Definition
1	Operating costs of DIAMOND not seen as a barrier	The clinic has adequate coverage or other financial resources for most patients to be able to afford the extra operational costs.
2	Engaged psychiatrist	The consulting psychiatrist is responsive to the care manager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

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

Whitebird, et al. Effective Implementation of collaborative care for depression: what is needed? Am J Manag Care. 2014.

Why?

The Quadruple Aim defines value from different stakeholder perspectives.



Medical Provider Buy-In

Landscape

- Can be overextended and can be difficult to engage
- Have to learn to use BH team effectively

Common resistance

- “One more problem I don’t have time for”; “Will just make more work for me”
- “I already take good care of my patients”
- “Why won’t you just take care of these difficult patients? Why me?

Selling integrated care

- Teach the collaborative care model (CoCM)
  - Expect questions and possible skepticism/resistance
  - Resist ‘regression to co-location’
- Offer opportunities to shape the care delivery
- Look at current patient outcomes together
- Promote behavioral health providers as a resource

Behavioral Health Provider Buy-In

Landscape

- Behavioral health setting experience
- Multiple roles

Resistance

- New to Collaborative Care Model and measurement-based care
- Co-location bias
- Hierarchical tension

Selling integrated care

- Teach the benefits of CoCM: effective teamwork can be very rewarding.
- Provide effective care for patients who have limited access to care (social justice/health equity)
- Work where their skills are valued
- Work as a member of a team/reduce isolation
- Promote psychiatric consultant as a resource

Psychiatrist Provider Buy-In

Landscape

- Specialist perspective and settings (just send them to Psychiatry)
- Part-time role
- Have to learn primary care world (working on someone else's turf)

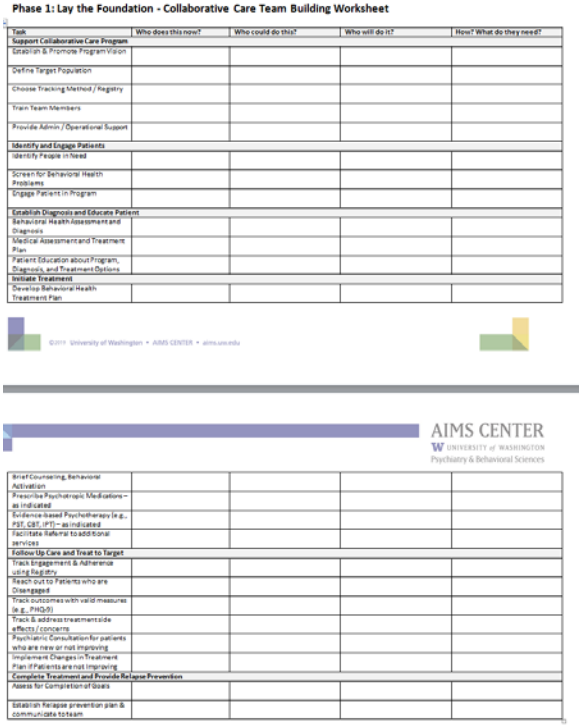
Resistance

- May struggle with indirect care approach
- Worry about liability/professional standards
- May not be comfortable with teaching/supporting team

Selling integrated care

- Teach the benefits of CoCM; Get training and support
- Opportunity to leverage expertise over a population / reach more people
- Provide effective care for patients who have limited access to care
- Work as a member of a team/reduce isolation
- Opportunity to teach / similar to supervising trainees

Self Directed Learning: Team Building Worksheet



Phase 1: Lay the Foundation - Collaborative Care Team Building Worksheet

Task	Who does this now?	Who could do this?	Who will do it?	How? What do they need?
Support Collaborative Care Program				
Establish & Promote Program Vision				
Define Target Population				
Choose Tracking Method / Registry				
Train Team Members				
Provide Admin / Operational Support				
Identify and Engage Patients				
Identify People in Need				
Screen for Behavioral Health Problems				
Engage Patient in Program				
Establish Diagnosis and Educate Patient				
Behavioral Health Assessment and Diagnosis				
Medical Assessment and Treatment Plan				
Patient Education about Program, Diagnosis, and Treatment Options				
Initiate Treatment				
Develop Behavioral Health Treatment Plan				
Brief Counseling, Behavioral Activation				
Prescribe Psychotropic Medications – as indicated				
Evidence-based Psychotherapy (e.g., PST, CBT, IPT) – as indicated				
Facilitate Referral to additional services				
Follow Up Care and Treat to Target				
Track Engagement & Adherence using Registry				
Reach out to Patients who are Disengaged				
Track outcomes with valid measures (e.g., PHQ-9)				
Track & address treatment side effects / concerns				
Psychiatric Consultation for patients who are new or not improving				
Implement Changes in Treatment Plan if Patients are not improving				
Complete Treatment and Provide Relapse Prevention				
Assess for Completion of Goals				
Establish Relapse prevention plan & communicate to team				

AIMS CENTER
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Psychiatry & Behavioral Sciences

- Summarizes ‘tasks’ for the CC team
- Add or remove ‘tasks’
  - Do we need this?
  - Is something missing?
- Each person fills out individually
  - Who does this now?
  - Who could do it?
- Team meets to review
  - Who will do it?
  - What do we need to do it?

Sample Team Building Worksheet

Phase 1: Lay the Foundation - Collaborative Care Team Building Worksheet

Task	Who does this now?	Who could do this?	Who will do it?	How? What do they need?
Support Collaborative Care Program				
Establish & Promote Program Vision	NA	Jane PCP, MD Amy Psychiatrist, MD Abraham Lincoln, MSW	Jane PCP, MD Amy Psychiatrist, MD Abraham Lincoln, MSW	CC Training
Train Team Members	NA	AIMS Center Jane PCP, MD Amy Psychiatrist, MD Abraham Lincoln, MSW	Amy Psychiatrist, MD Abraham Lincoln, MSW	AIMS Center Training CC Toolkit Practice
Provide Admin / Operational Support	Clinic Manager	Clinic Manager	Clinic Manager	
Identify and Engage Patients				
Identify People in Need	PCPs	All clinic staff	MA's PCPs	
Screen for Behavioral Health Problems	---	MDs MA's MSWs	MA's with back-up from PCPs	PHQ-9
Engage Patient in Program	NA	PCPs	PCPs with support from MA's	One page flyer
Establish Diagnosis and Educate Patient				
Behavioral Health Assessment and Diagnosis	PCPs	PCPs Abraham Lincoln, MSW	Care Manager with support from Amy Psychiatrist, MD	Structured Assessment
Medical Assessment and Treatment Plan	PCPs	PCPs	PCPs	
Patient Education about Program, Diagnosis, and Treatment Options	NA	PCPs Abraham Lincoln, MSW Care Managers Amy Psychiatrist MD	PCPs with support from Care Managers	One-page flyer Develop workflow
Initiate Treatment				

PLAN FOR CLINICAL PRACTICE CHANGE: FINANCING AND SUSTAINABILITY

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Assistant Professor
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Phase 2: Plan for Clinical Practice Change (3-6mo)

- ✓ Identify all Collaborative Care Model team members and organize them for training
- ✓ Identify a population-based tracking system for your organization
- ✓ Develop clinical workflows
- ✓ Develop a plan for funding, space, human resource, and other administrative needs
- ✓ Develop a plan to merge Collaborative Care Model monitoring and reporting outcomes into existing quality improvement efforts

Billing for Collaborative Care (CoCM) and Behavioral Health Integration (BHI) Using Novel Billing Codes

Andrew D. Carlo, MD MPH

Objectives

- Describe the primary features of novel billing codes for CoCM
- Identify stipulations for using CoCM billing codes in practice
- Discuss common challenges and advantages associated with the CoCM billing codes
- Describe how CoCM billing codes can help move this evidence-based treatment model toward financial sustainability

Historical Financing for CoCM

- For decades, real-world implementation of CoCM was hampered by the lack of a large-scale, reliable funding source
- To move the model toward financially sustainable, organizations developed unique or tailored funding strategies, including:
  - External grants
  - Alternative payment model contracts with specific payers
  - Using billing codes for individual components of CoCM
- The cumulative results of these strategies were mixed
- Implementation was not as widespread as would be expected from the substantial clinical trial evidence base for CoCM

Carlo AD, Unützer J, Ratzliff ADH, Cerimele JM. Financing for collaborative care—a narrative review. Curr Treat Options Psych. 2018;5(3):334-344.

Behavioral Health Integration Billing Codes

- CMS responded in 2017 by activating four new billing codes for behavioral health integration (BHI) - G0502, G0503, G0504, G0507
- In 2018, these codes were published by Current Procedural Terminology (CPT) as 99492, 99493, 99494, 99484
- First billing codes specifically designed for BHI
- 2 additional codes were then activated for Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) - G0512 for CoCM and G0511 for other forms of BHI not meeting criteria for CoCM
- In 2021, a new code was added for CoCM – G2214
- Now 4 codes specifically for CoCM (99492, 99493, 99494, G2214)
- 1 code for BHI models not meeting CoCM criteria (99484)

Carlo AD, Corage Baden A, McCarty RL, Ratzliff ADH. Early health system experiences with collaborative care (CoCM) billing codes: a qualitative study of leadership and support staff. J GEN INTERN MED. 2019;34(10):2150-2158.

CoCM Codes

- The CoCM codes are fee-for-service in nature and time based
  - Account for the total number of minutes spent by the behavioral health care manager (BHCM), in collaboration with the psychiatric consultant and working under the direction of the PCP/pediatrician, on the treatment of each patient over each calendar month enrolled
- Codes are classified as “incident-to,” meaning they account for services provided by a non-physician after a related physician encounter
- PCP/pediatrician and psychiatric consultant still bill legacy fee-for-service codes in parallel for their direct interactions with patients
- BHCM can bill fee-for-service codes separately for psychotherapy delivered to CoCM patients in the same month as CoCM, though time cannot be counted twice
- Initially reimbursed by Medicare only, but now by most commercial and many Medicaid plans
- Per CMS Medicare Part B regulation, patient must make a monthly 20% co-insurance contribution
- Most commercial carriers have adopted co-insurance
- Medicaid beneficiaries do not make a co-insurance contribution

Carlo AD, Corage Baden A, McCarty RL, Ratzliff ADH. Early health system experiences with collaborative care (CoCM) billing codes: a qualitative study of leadership and support staff. J GEN INTERN MED. 2019;34(10):2150-2158.

CoCM Code Billing Stipulations

- Initial visit must be conducted by the billing practitioner (usually PCP or pediatrician) – this provider must obtain consent for CoCM
- Consent discussion must mention patient cost sharing
- BHCM must conduct regular assessments with validated rating scales and use a treatment registry
- The BHCM must meet with the consulting psychiatrist at least weekly to discuss the patient panel and treatment planning
- No diagnostic specifications or exclusions (any common BH dx is eligible)
- No patient age specifications or exclusions (children are eligible)
- If an integrated care model does not meet these criteria, then the program may still be eligible for billing though 99484 (which has fewer stipulations)

Carlo AD, Corage Baden A, McCarty RL, Ratzliff ADH. Early health system experiences with collaborative care (CoCM) billing codes: a qualitative study of leadership and support staff. J GEN INTERN MED. 2019;34(10):2150-2158.

Knowledge Check

- Which of the following is NOT true of Collaborative Care billing codes?
  - A) The billing provider for the Collaborative Care codes must be the primary medical provider
  - B) The Collaborative Care codes specifically account for individual time spent by the behavioral health care manager and psychiatric consultant
  - C) The Collaborative Care codes account for time spent on a patient's treatment over the course of each calendar month in which they are enrolled in the program
  - D) The Collaborative Care codes do not require the behavioral health care manager to be a licensed clinician
  - Answer: B – the codes only account for the individual time spent by the behavioral health care manager on Collaborative Care services over the course of a calendar month. Individual time spent by the psychiatric consultant (where the behavioral health care manager is not directly involved) does not count.

CoCM Team Staff Billing Eligibility

- Psychiatric consultant needs to be "trained in psychiatry" and be qualified to prescribe "the full range of medications" – does not have to be a psychiatrist
- BHCM does not have to be a licensed clinician, though they must have "formal education or specialized training in behavioral health"
- PCP or pediatrician is the billing practitioner, meaning the codes are billed in their name
- Reimbursement is directly credited to the billing practitioner only
- Psychiatric consultant and BHCM require reimbursement from the primary care or pediatrics practice

Image source: https://journalistsresource.org/health/integrated-care-collaborative-mental-health/

CoCM Codes Structure

- Accrued minutes are based exclusively on time spend by the BHCM
- Minutes cannot be counted twice when multiple providers (i.e., the BHCM and psychiatric consultant) discuss a patient jointly
- 99492 – for the FIRST month of treatment in CoCM
  - Accounts for the first 70 minutes of services rendered for a single patient over the course of the initial calendar month of treatment
  - Must have at least 36 minutes of time to bill the code
- 99493 – for all SUBSEQUENT months of treatment in CoCM
  - Accounts for the first 60 minutes of services rendered for a single patient over the course of subsequent calendar months of treatment
  - Must have at least 31 minutes of time to bill the code
- 99494 – additional time in ANY month of treatment in CoCM
  - Each use of this code accounts for up to 30 additional minutes of services rendered for a single patient over the course of any month
  - Must be used in conjunction with 99492 or 99493
  - Can typically be used no more than twice per patient per month
- G2214 – for ANY month of treatment with an otherwise sub-threshold number of minutes
  - Accounts for the first 30 minutes of services rendered for a single patient over the course of the initial calendar month of treatment
  - Must have at least 16 minutes of time to bill the code

Code Valuation

- All payers differ – check with your local or institutional finance department

Medicare CPT Payment Summary 2021*

CPT	Description	Payment/Pt (Non-Facilities) Primary Care Settings	Payment/Pt (Fac) Hospitals and Facilities
G2214	30 min/month for either initial or subsequent months CoCM services	$66.29	$39.08
99492	Initial psych care mgmt, 70 min/month - CoCM	$157.35	$94.20
99493	Subsequent psych care mgmt, 60 min/month - CoCM	$157.01	$102.93
99494	Initial/subsequent psych care mgmt, additional 30 min CoCM	$61.06	$41.87
99484	Care mgmt. services, min 20 min – General BHI Services	$47.80	$31.05

**Please note actual payment rates may vary. Check with your billing/finance department.*

Image source: https://aims.uw.edu/sites/default/files/Quick%20Guide%20CMS%20BHI-CoCM%202021_0.pdf

Case Study – Billing for CoCM

- 14-year-old boy with history of depression referred to CoCM with PHQ-9 score of 19

Treatment Month	Minutes Spent by BHCM	Codes Billed	Explanation
1	120	99492, 99494 (x2)	99492 (1st 70 minutes in 1st month); 99494 (the 1st 99494 is for minutes 71 - 100); 99494 (the 2nd 99494 is for minutes 101 – 120)
2	50	99493	99493 (1st 60 minutes in 2nd month)
3	90	99493, 99494 (x1)	99493 (1st 60 minutes in 3rd month); 99494 (accounts for minutes 61-90)
4	35	99493	99493 (1st 60 minutes in 4rd month – requires at least 31 minutes to bill)
5	20	G2214	G2214 (1st 30 minutes in 5th month – requires at least 16 minutes to bill)
6	15	Not billable	At least 16 minutes of treatment are required to bill G2214

Billing for Non-CoCM BHI Models

- 99484 – for up to 20 minutes of behavioral health care management delivered in a calendar month
  - Less specific than CoCM codes – covers a variety of models
  - Must include initial assessments and follow-up with evidence-based screening instruments
  - Must include treatment planning with revisions based on patient progress in the program
  - Facilitate or coordinate treatment including therapy, medications and outside referrals
  - Must have a designated member of the team serving as the care manager

Image source: https://aims.uw.edu/sites/default/files/Quick%20Guide%20CMS%20BHI-CoCM%202021_0.pdf

Knowledge Check

- True or False – The Collaborative Care billing codes reimburse for up to 130 minutes of treatment for an enrolled patient in the first month and up to 120 minutes in subsequent months

- Answer: True – Billing 99492 and 99494 x 2 in the first month covers 130 minutes (additional minutes are not reimbursed). Billing 99493 and 99494 x 2 in subsequent months covers 120 minutes (additional minutes are not reimbursed).

Billing for BHI in FQHCs and RHCs

- There is a single code for CoCM (instead of 4) – G0512
  - Accounts for a minimum of 70 minutes of CoCM services in the first calendar month of treatment and a minimum of 60 minutes of CoCM in subsequent months
  - Stipulations are otherwise similar to 99492-99494 and G2214
- Also a single code for non-CoCM models of BHI – G0511
  - Accounts for a minimum of 20 minutes of care management services for a single patient in each calendar month (including first and subsequent months)
  - Stipulations are otherwise similar to 99484

Medicare Codes and Payments Summary 2021*

Code	Description	Payment
G0511	General Care Management Services - Minimum 20 min/month	$66.64
G0512	Psychiatric CoCM - Minimum 70 min initial month and 60 min subsequent months	$157.35

**Please note actual payment rates may vary. Check with your billing/finance department.*

Treating providers may bill only one code for an individual Medicare beneficiary in the same month.

Image source: https://aims.uw.edu/sites/default/files/Quick%20Guide%20CMS%20FQHC%20RHC%202021.pdf

Key Challenges and Best Practices

- Requires careful planning and getting buy-in from key stakeholders for CoCM billing
- Billing requires rigorous minute accrual and code combination ascertainment for each patient at the end of each month (codes billed differs each month based on minutes accrued) – this requires a codified workflow and is typically done manually
- Patients have 20% cost-sharing contribution (except for Medicaid)
- PCP/Pediatrician must do consent and discuss cost-sharing with patient
- Mechanism must be developed to pay BHCM and psychiatric consultant, given that reimbursement goes to PCP or pediatrician
- Billing works best when the technological infrastructure is in place for minute accrual
  - Ideal when minute accrual, registry and EMR are the same system

Carlo AD, Corage Baden A, McCarty RL, Ratzliff ADH. Early health system experiences with collaborative care (CoCM) billing codes: a qualitative study of leadership and support staff. J GEN INTERN MED. 2019;34(10):2150-2158.

Major Advantages of CoCM Billing

- Does NOT require BHCM to be a licensed clinician
- Does NOT require psychiatric consultant to be physically located at the practice
- ANY time that the BHCM spends on a patient's treatment counts toward monthly totals (including clinical documentation in the chart and registry)
- Allows for reimbursement of critical follow-up services delivered between visits, such as phone check-ins between BHCM and patient
- Allows for telehealth treatment delivery with no billing modifier
- Accounts for time spent outside of direct patient care, especially the case review sessions between BHCM and psychiatric consultant
- Does NOT have onerous documentation stipulations
- Valuation includes the BHCM and psychiatric consultant services
- Has components of FFS and bundled payment mechanisms

Carlo AD, Corage Baden A, McCarty RL, Ratzliff ADH. Early health system experiences with collaborative care (CoCM) billing codes: a qualitative study of leadership and support staff. J GEN INTERN MED. 2019;34(10):2150-2158.

Codes Lead to Sustainable CoCM Implementation

- Financial modeling study demonstrates that CoCM billing has financial advantages for practices over billing legacy codes for co-location (Basu et al, 2017)
- Billing codes were implemented successfully in the CoCM program at the University of Washington in Seattle (Carlo et al, 2020)
- A growing number of practices and health systems have implemented CoCM billing in recent years
- Most commercial payers now reimburse for the CoCM codes, as do a growing number of Medicaid plans
- These codes can move CoCM toward financial sustainability

Additional Resources

- American Psychiatric Association (APA): Using the Collaborative Care Model for Special Populations. (https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/implement/special-populations)
- American Psychiatric Association (APA): Treating the Pediatric Population in the Collaborative Care Model. . (https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Professional-Topics/Integrated-Care/Treating-Pediatric-in-the-CoCM.pdf)

PLAN FOR CLINICAL PRACTICE CHANGE: WORKFLOWS

Denise Chang, MD
Clinical Associate Professor
Department of Psychiatry and Behavioral Sciences
University of Washington

Phase 2 (3-6 months): Plan for Clinical Practice Change

- ✓ Identify all Collaborative Care team members and organize them for training
- ☐ Identify a population-based tracking system for your organization
- ☐ Develop clinical workflows
- ✓ Develop a plan for funding, space, human resource, and other administrative needs
- ☐ Develop a plan to merge Collaborative Care Model monitoring and reporting outcomes into existing quality improvement efforts

Develop Registry Capacity

Caseload Overview

			Treatment Status				PHQ-9				GAD-7				Psychiatric Consultation	
			! indicates that the most recent contact was over 2 months (60 days) ago				✓ Indicates that the last available PHQ-9 score is at target (less than 5 or 50% decrease from initial score) ! Indicates that the last available PHQ-9 score is more than 30 days old				✓ Indicates that the last available GAD-7 score is at target (less than 10 or 50% decrease from initial score) ! Indicates that the last available GAD-7 score is more than 30 days old					
View Record	Treatment Status	Name	Date of Initial Assessment	Date of Most Recent Contact	Number of Follow-up Contacts	Weeks in Treatment	Initial PHQ-9 Score	Last Available PHQ-9 Score	% Change in PHQ-9 Score	Date of Last PHQ-9 Score	Initial GAD-7 Score	Last Available GAD-7 Score	% Change in GAD-7 Score	Date of Last GAD-7 Score	Flag	Most Recent Psychiatric Consultant Note
View	Active	Susan Test	9/5/2015	2/23/2016	10	26	22	14	-36%	2/23/2016	18	17	-6%	! 1/23/2016	Flag for discussion & safety risk	1/27/2016
View	Active	Albert Smith	8/13/2015	! 12/2/2015	7	29	18	17	-6%	! 12/2/2015	14	10	-29%	! 12/2/2015	Flag for discussion	
View	Active	Joe Smith	11/30/2015	2/28/2016	6	14	14	10	-29%	2/28/2016	10	✓ 6	-40%	2/28/2016	Flag for discussion	2/26/2016
View	Active	Bob Dolittle	1/5/2016	3/1/2016	3	9	21	19	-10%	3/1/2016	12	10	-17%	3/1/2016	Flag as safety risk	2/18/2016
View	Active	Nancy Fake	2/4/2016	2/4/2016	0	4	.	No Score			.	No Score				
View	RP	John Doe	9/15/2015	3/6/2016	10	25	20	✓ 2	✓ -90%	3/6/2016	14	✓ 3	✓ -79%	3/6/2016		2/20/2016

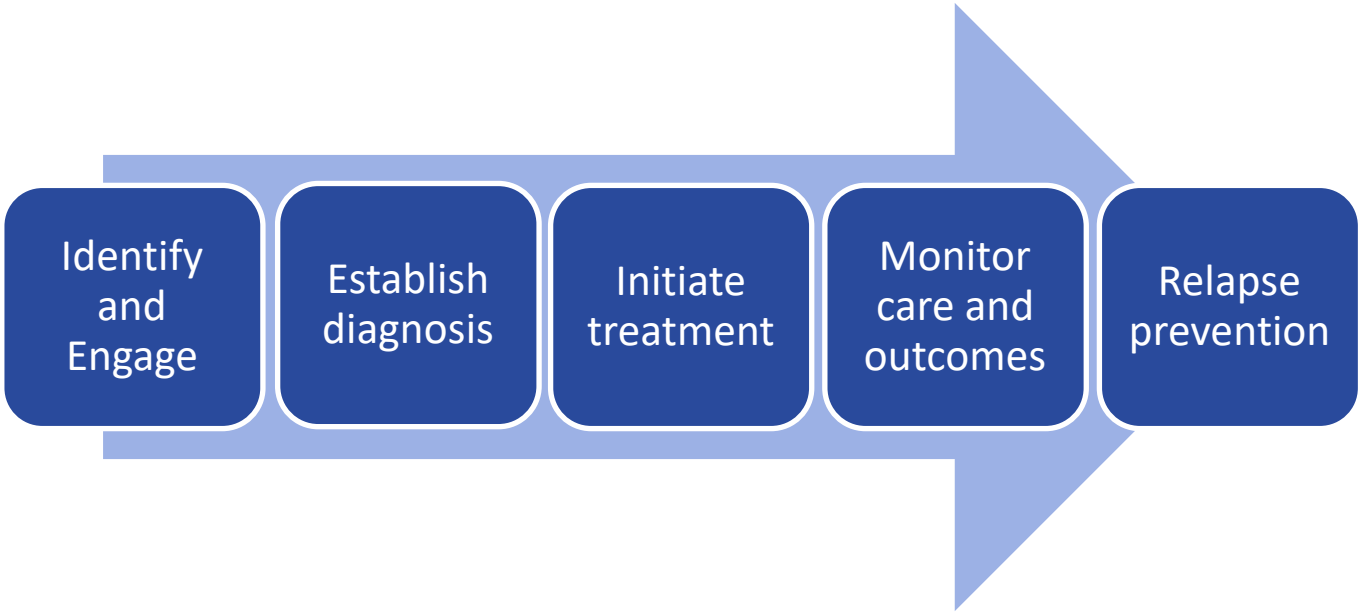
Allows proactive engagement
("no one falls through the cracks")
and treatment adjustment

Important Factors in Implementation

Implementation factor	Definition
Operating costs not a barrier	Clinic has adequate coverage or financial resources for most patients to afford the extra operational costs
Engaged psychiatrist	Consulting psychiatrist is responsive to CM and to all patients, especially those not improving
PCP buy-in	Most providers are supportive of the program and refer patients
Strong Care manager	CM is the right person for the job and works well in the clinical setting
Warm handoff	Referrals from providers to CM are usually face-to-face, not indirect
Strong leadership support	Clinic and medical group leaders are committed to the model
Strong PCP champion	There is a PCP in the clinic who actively supports and promotes the care model
Care manager role well-defined and implemented	CM job description is well-defined with appropriate time, support and dedicated space
Care manager onsite and accessible	CM is present and visible in clinic and available for referrals

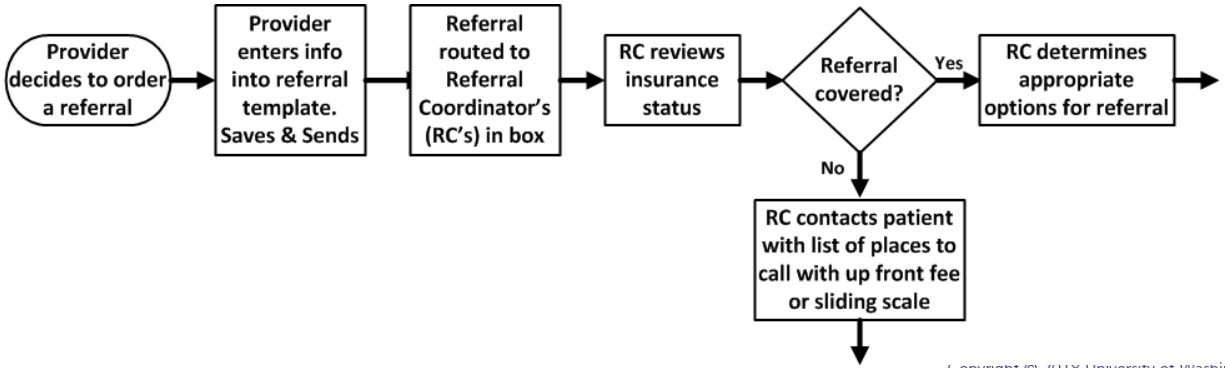
Whitebird, et al. Am J Manag Care; 2014 Sep;20(9):699-707.

Collaborative Care Workflow



Process Mapping

- A workflow is the sequence and interactions of related activities, tasks and steps that make up a process, from beginning to end
- All processes in the workflow should be measurable with clear performance indicators
- A process map visually describes the flow of activities

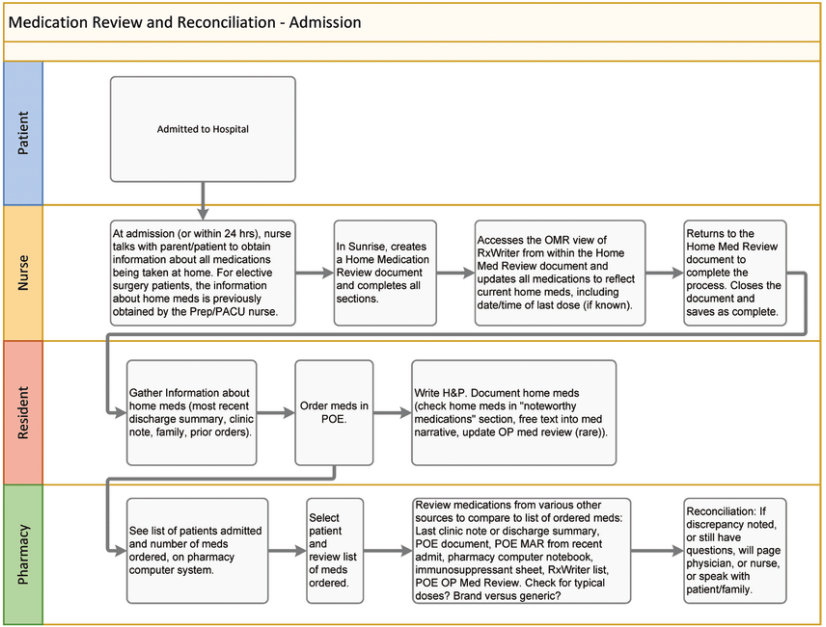


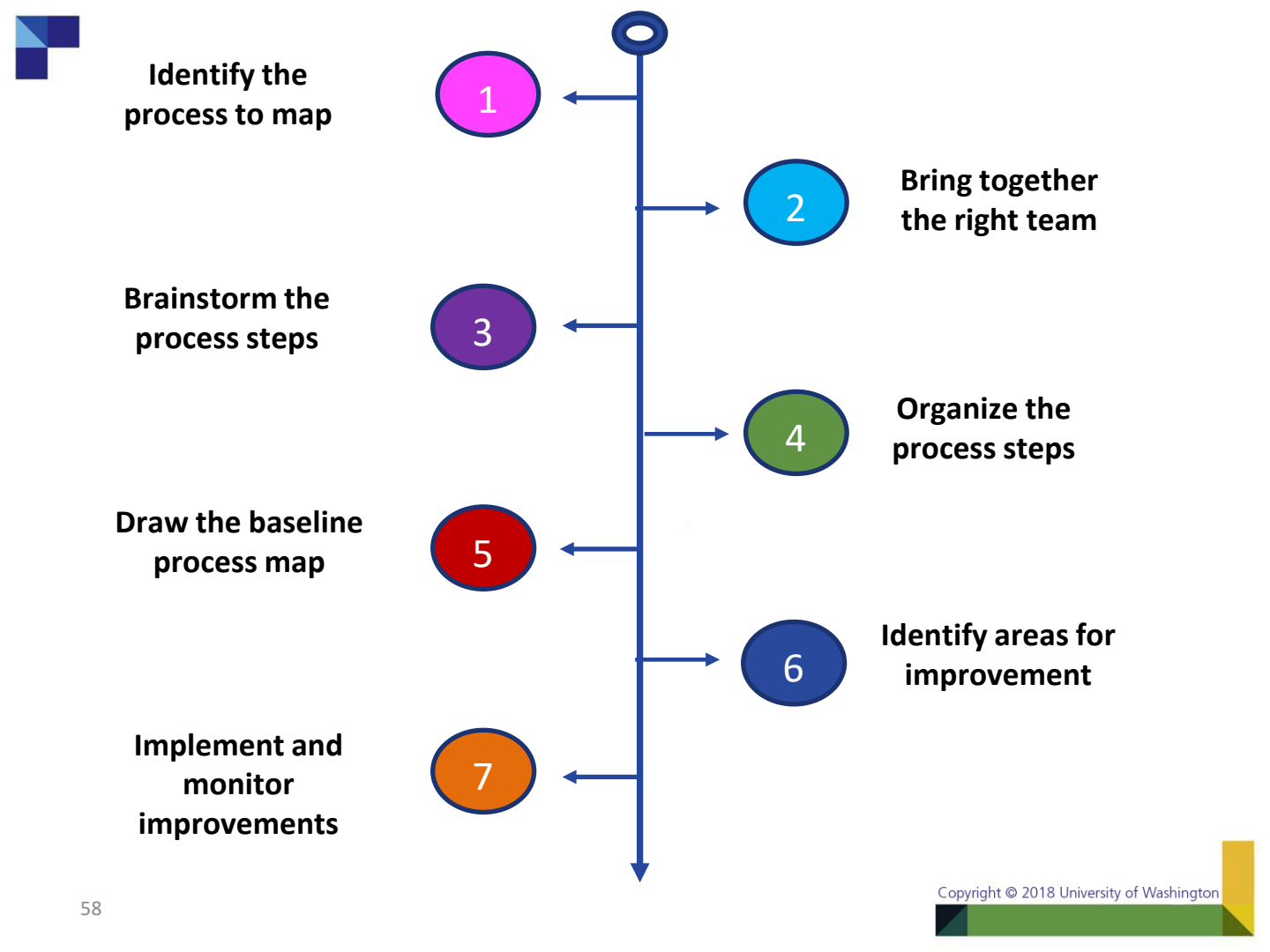
Why Create a Process Map?

- Clear visual definition of current workflow
- Common understanding of work
- Focus on the process not the people
- Illuminate improvement opportunities by clarifying unnecessary work
- Identify metrics to measure improvement

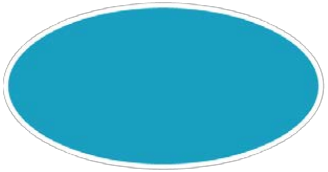
Types of Process Maps

- Basic Flowchart
- High Level Process Map
- Detailed Process Map
- Swim lanes
- Value Stream



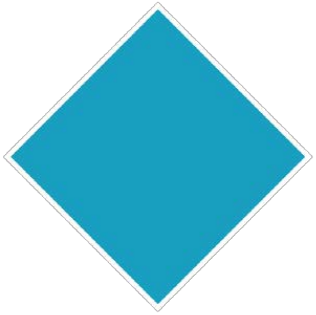


Symbols



Start and end of a process

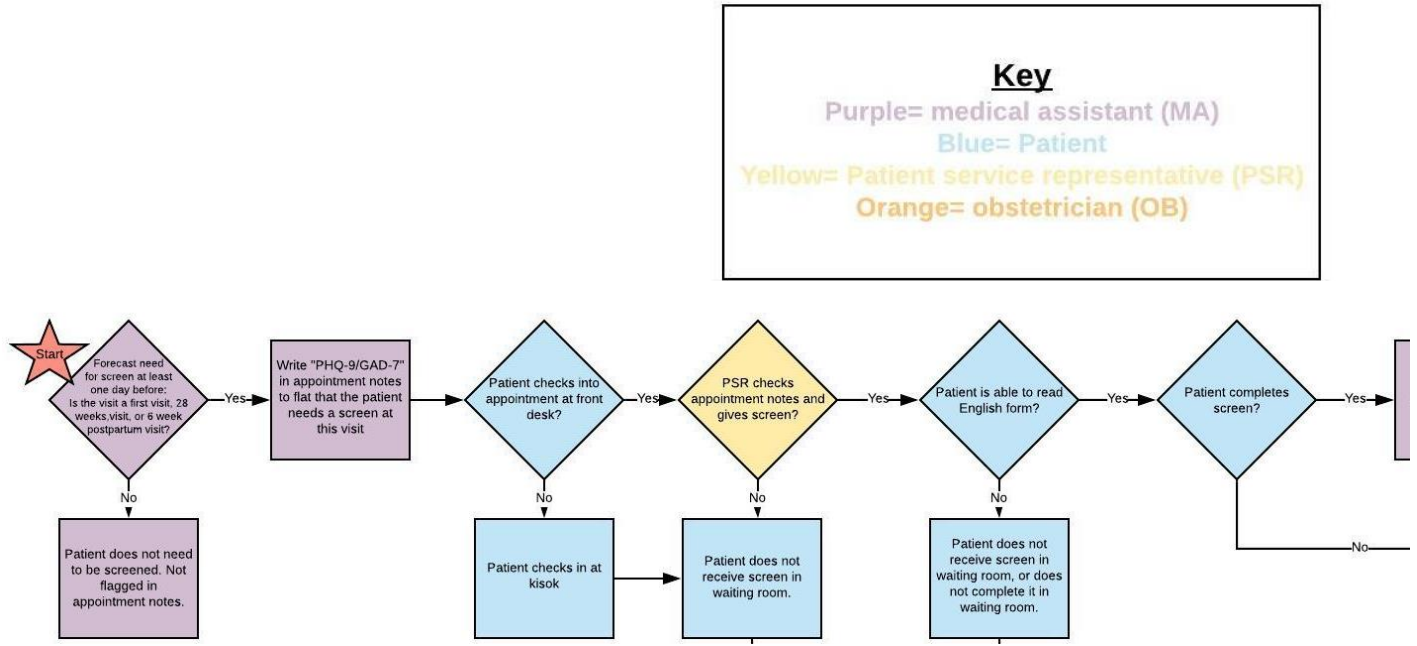
Activity or task



Decision point (yes/no question)

Flow line

Process Map Example



BUILD YOUR CLINICAL TEAM

Ramanpreet Toor, MD
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Department of Psychiatry and Behavioral Sciences
University of Washington

Phase 3: Build Clinical Skills (2-4 weeks)

- ✓ **Describe the Collaborative Care Model approach and guiding principles.**
- ✓ **Describe Collaborative Care Model key tasks.**
- ✓ **Develop a qualified, skilled and prepared Collaborative Care Model team.**

Skills for Collaborative Care Principles

Population-Based Care

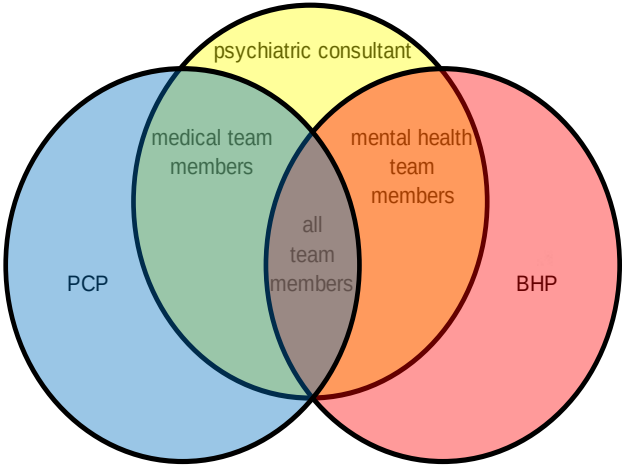
Measurement-Based Treatment to Target

Patient-Centered Collaboration

Evidence-Based Care

Accountable Care

Clinical Training Needs for CoCM Team



All members
Major Depressive Disorder
Anxiety
Somatic Symptoms or Fatigue
Suicide or Violence
Child Psychiatry
Evidence-based medication approaches

Ratzliff A et al. Perceived Educational Needs of the Integrated Care Psychiatric Consultant. Acad Psychiatry. 2015.

Primary Care Provider Role

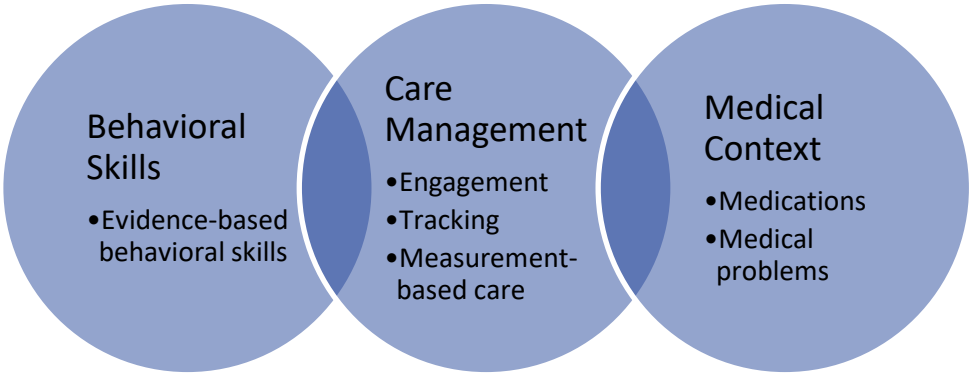
Collaborative Care Basics

- **How to Introduce Collaborative Care Model**
- **How to work with the BH Care Manager**
- **How to get support from Psychiatric Consultant**

Expanded Clinical Skills for Behavioral Health

- **Assessment**
  - Behavioral health measures
- **Treatment**
  - Deliver Evidence Based Medications
  - Support Evidence Based Psychosocial Treatments
  - Management of Suicide Risk

Behavioral Health Provider Role



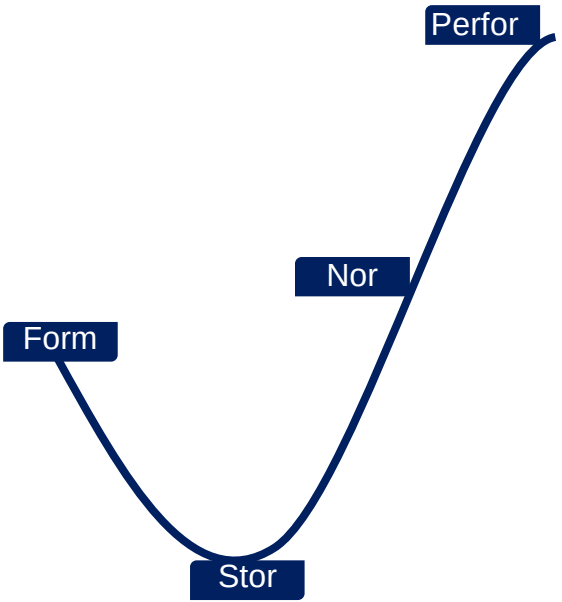
Psychiatric Consultant Role

Clinical Consultation	Liaison

• **Evidence - base**
  • Core principles
• **Assessment**
  • Screening and identification
  • Registry
• **Treatment**
  • Measurement-based treatment to target
  • Indirect case review
  • Relapse prevention
	• **Liaison**
	  • Engaging the medical provider
	  • Working with a care manager
	  • Assessing systems challenges
	• **Learning**
	  • Integrating education into clinical care
	  • Direct teaching
	• **Leadership**
	  • Implementation
	  • Continuous quality improvement

Learning to Be a Team

Tuckman's Model of Team Building



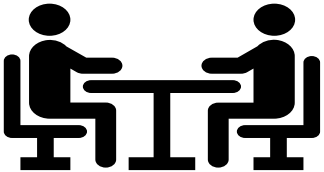
Principles of Effective Teams

- **Shared Goals**
- **Clear Roles**
- **Measurable Processes and Outcomes**
- **Mutual Trust**
- **Effective Communication**

Model Consultation Hour

Clinic updates (~5 min)

- Changes in clinic
- Systems questions



Case reviews (~ 50 min)

- New Cases
- Existing patients:
  - Current concern(safety concern (priority), med side effect, diagnostic etc)
  - High PHQ-9/Gad-7 score with no recent psychiatric review
  - Poor Engagement
- Doing well and need to be moved to Relapse Prevention Plan(RPP)

Wrap up (~ 5 min)

- Celebrate successes!
- Confirm next consultation hour
- Send any educational resources discussed

LAUNCH COLLABORATIVE CARE

Jessica Whitfield, MD, MPH

Acting Assistant Professor, Department of Psychiatry and Behavioral Sciences

Phase 4: Launch Care (3-6 mo)

- ✓ 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 a plan to help patients from the beginning to the end of their treatment, including a relapse prevention plan

Developing a Care Team Monitoring Plan

Step 1
- Select program metrics that reinforce CoCM principles

Step 2
- Review metrics regularly with clinicians and quality / implementation team

Step 3
- Identify potential areas for improvement

Step 4
- Apply QI methods to conduct iterative small-scale tests of change

Step 1

- Select program metrics that reinforce CoCM principles

FIDELITY TO CORE

SAMPLE METRICS

Population-Based Care

# of pts. on active caseload
% of caseload with > 2 contacts / mo
% of caseload with no contact for > 2 mo

Measurement-Based Treat to Target

% of pts. with PHQ-9 score in last 2 weeks
% of pts. not improved w/psych review in ≤ 4 wks
% of pts. with 50% decrease in PHQ-9 after 10 wks

Patient-Centered Collaboration

Frequency of case review meeting
% of pts. on with psych review note in EHR
Time to first (third) available appointment

Evidence-Based Care

HEDIS Antidepressant Medication Management
% of pts. with ≥ 8 sessions of BA / PST

Accountable Care

Step 2

- Review metrics regularly with clinicians and quality / implementation team

Week 4

Site	# of Pts	CM Initial Assessmt	Mean PHQ-9	CM f/u	Mean # visits	2 Contacts / month	Last Mean PHQ-9	# w/ Psych Note	PHQ-9 Improvemt
A	3	1 (33%)	26	0 (0%)	-	-	26	0 (0%)	-

Week 8

Site	# of Pts	CM Initial Assessmt	Mean PHQ-9	CM f/u	Mean # visits	2 Contacts / month	Last Mean PHQ-9	# w/ Psych Note	PHQ-9 Improvemt
A	6	3 (50%)	18	0 (0%)	-	0 (0%)	18	0 (0%)	-

Week 12

Site	# of Pts	CM Initial Assessmt	Mean PHQ-9	CM f/u	Mean # visits	2 Contacts / month	Last Mean PHQ-9	# w/ Psych Note	PHQ-9 Improvemt
A	17	16 (94%)	14.5	9 (56%)	3	0 (0%)	13.7	14 (82%)	2 (22%)

Step 3

- Identify potential areas for improvement

Program Maturity

New

Developing

Mature

Enrollment: *Are we enrolling everyone who would benefit?*

Are there systems issues affecting screening or referrals? Are there sufficient new patients? Are new patients being reviewed? Are improved patients identified for relapse prevention? Are improved patients discharged to make room for new patients?

- **Sample metrics: Active caseload size; % of eligible patients enrolled**

Engagement: *Are we engaging all the enrolled patients into care?*

Are enrolled patients being followed regularly with proactive outreach? Are a variety of outreach methods employed (e.g., telephone, letter, EHR portal, warm connection at primary care visits)?

- **Sample metrics: % of pts. with ≥ 2 contacts/mo; % of pts. with no contact for ≥ 2 mo**

Patient Outcomes: *Are patients improving?*

Are rating scales used regularly? Is treatment to target occurring? What is the quality of treatment? Is treatment evidence-based, appropriate, and taking into account the full biopsychosocial assessment, patient preferences, and barriers?

- **Sample metrics: % of patients with 50% reduction in PHQ-9 after 10 weeks**

Psychiatric Consultation: *Is caseload review consistent and effective?*

Do care manager and psychiatrist prepare for case review? Is an agenda set in the first 5 minutes of case review time? How much time is spent reviewing each patient? Are all patients reviewed regularly? Are priority patients discussed while also capturing patients at risk for 'falling through the cracks'?

- **Sample metrics: % of patients not improved who receive psychiatric case review**

Step 3

- Identify potential areas for improvement

Week 8

Site	# of Pt.	CM Initial Assess	Mean PHQ-9	CM F/U	Mean #	2 Contacts / mo	Last Mean PHQ-9	# w/ Psych Note	PHQ-9 Improvemt
A	6	3 (50%)	18	0 (0%)	-	0 (0%)	18	0 (0%)	-

Enrollment: *Are we enrolling everyone who would benefit?*

Step 3

- Identify potential areas for improvement

Week 12

Site	# of Pt.	CM Initial Assess	Mean PHQ-9	CM F/U	Mean #	2 Contacts / mo	Last Mean PHQ-9	# w/ Psych Note	PHQ-9 Improvemt
A	17	16 (94%)	14.5	9 (56%)	3	0 (0%)	13.7	14 (82%)	2 (22%)

Enrollment: *Are we enrolling everyone who would benefit?*
Engagement: *Are we engaging all the enrolled patients into care?*

Step 3

- Identify potential areas for improvement

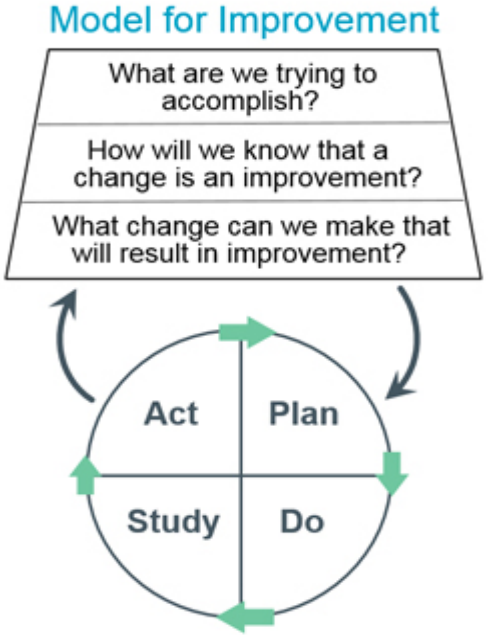
Week 24

Site	# of Pt.	CM Initial Assess	Mean PHQ-9	CM F/U	Mean #	2 Contacts / mo	Last Mean PHQ-9	# w/ Psych Note	PHQ-9 Improvemt
A	21	16 (76%)	15.7	9 (56%)	3.2	5 (26%)	9.5	15 (71%)	8 (89%)

Enrollment: *Are we enrolling everyone who would benefit?*
Engagement: *Are we engaging all the enrolled patients into care?*
Patient Outcomes: *Are patients improving?*
Psychiatric Consultation: *Is caseload review consistent and effective?*

Step 4

- Apply QI methods to conduct iterative small-scale tests of change



SMART Aim Statement

Measures

Interventions

http://www.ihi.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx

Step 4

- Apply QI methods to conduct iterative small-scale tests of change

SMART Aim

Specific, Measurable, Achievable, Relevant, Timely

"We will increase the rate of depression improvement from 35% to 60% in 6 mos."

Interventions: Prioritize based on most important causes.

Pareto principle: 80% of effects come from 20% of causes.

Tools: Driver diagram, Fishbone diagram help identify potential intervention targets

http://www.ihi.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx

Step 4

- Apply QI methods to conduct iterative small-scale tests of change

Measures: Think Broadly. Define precisely. Choose no more than 6.

Outcome measures. The final patient-oriented result.

- ***What patient experiences.*** Example: Depression remission

Process measures. Whether the system is doing the right things to obtain the desired outcome.

- ***What is done to/for the patient?*** Example: % of pts. receiving ≥ 2 contacts/month

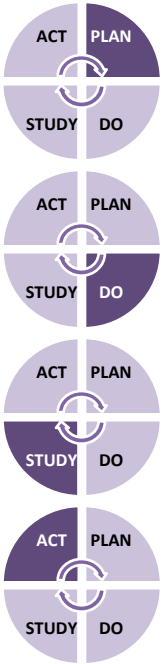
Balancing measures: Unintended consequences or other factors that may affect outcomes.

- ***How else does this affect the system?*** Example: Team member turnover

http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementEstablishingMeasures.aspx
http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementTipsforEffectiveMeasures.aspx

PDSA Cycle Overview

Iterative ***small*** tests of change. One test can reveal a fatal flaw.



Plan

Plan your test. Include your predictions. Plan data collection.

Do

Run your test on a small scale. Document observations and problems. Collect data.

Study

Analyze your results and compare them to your predictions. Summarize and reflect on your learning.

Act

Adapt (modify), adopt (scale up), or abandon (try a different idea). Plan your next PDSA.

PDSA for early launch phase

SMART Aim for Site A to improve poor engagement

Specific, Measurable, Achievable, Relevant, Timely

"Within two months, we will improve engagement by increasing the number of patients on the caseload with >2 contacts per month from 20% to 80%."

Plan:

Interventions: ***1) Set expectations in initial assessment for frequent contacts, 2) During no-shows or down time, prioritize calling patients with no contact in past 2 weeks.***

Measure: ***% of patients with >2 contacts per month on caseload after 2 months***

NURTURE YOUR CARE = SUSTAINMENT

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Professor
Department of Psychiatry and Behavioral Sciences
University of Washington

Phase 5:
Nurture Your Care = Sustainment

- ✓ Implement monitoring plan to ensure core principle fidelity
- ✓ Make adjustments with Continuous Quality Improvement
- ✓ Implement advanced training and support where necessary
- ✓ Continue to assess financial sustainability
- ✓ Update your program vision and workflow

New York Five Year Sustainability: Quantitative Results

Clinic Sustained

- Care Manager: 1.0 FTE
- Number of Patients/FTE: 137
- Improvement Rate: 46%

Clinic Opted-Out

- Care Manager: 0.5 FTE
- Number of Patients/FTE: 58
- Improvement Rate: 7.5%

Moise N et al. Sustainability of collaborative care management for depression in primary care settings with academic affiliations across New York State. *Implement Sci.* 2018.

Continuous Quality Improvement

CO	# OF P.	CLINICAL ASSESSMENT			FOLLOW UP				50% IMPROVED AFTER > 10 WKS	
		#	MEAN PHQ	MEAN GAD	# OF P.	MEAN #	MEAN # CLINIC	MEAN # PHONE	PHQ	GAD
Care Manager 1	70	68 (97%)	15.1 (n=61)	12.8 (n=52)	62 (91%)	6.7	5.5 (82%)	1.2 (18%)	19 (49%) (n=39)	16 (41%) (n=39)
Care Manager 2	86	86 (100%)	15.9 (n=86)	14.2 (n=84)	79 (92%)	12.4	6.4 (52%)	6.0 (48%)	34 (68%) (n=50)	28 (56%) (n=50)
All	156	154 (99%)	15.6 (n=147)	13.6 (n=136)	141 (92%)	9.9	6.0 (61%)	3.9 (39%)	53 (60%) (n=89)	44 (49%) (n=89)

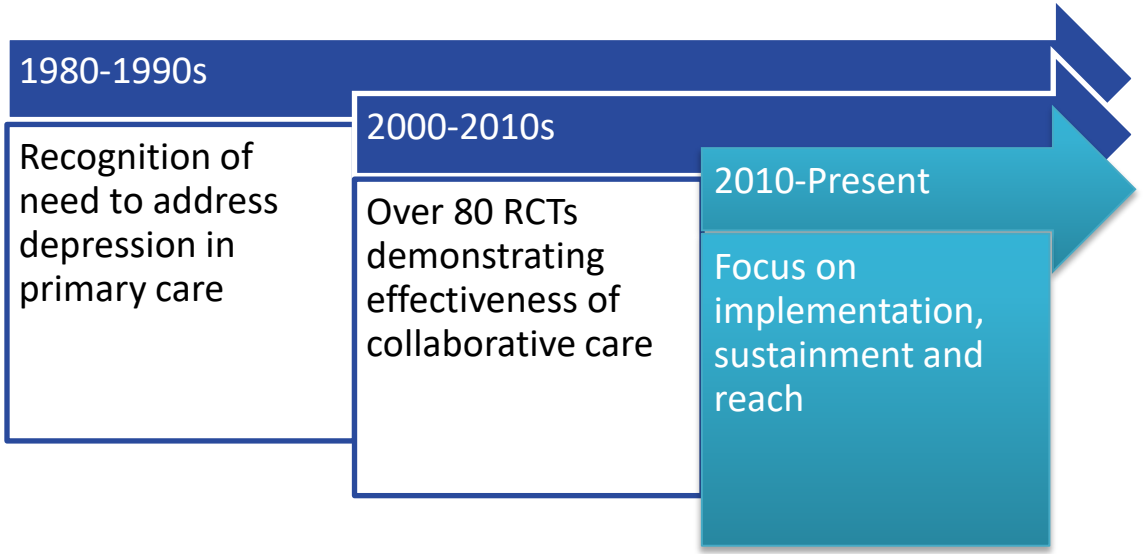
C/C = Continued Care Pl

AIMS Center Phases of Implementation

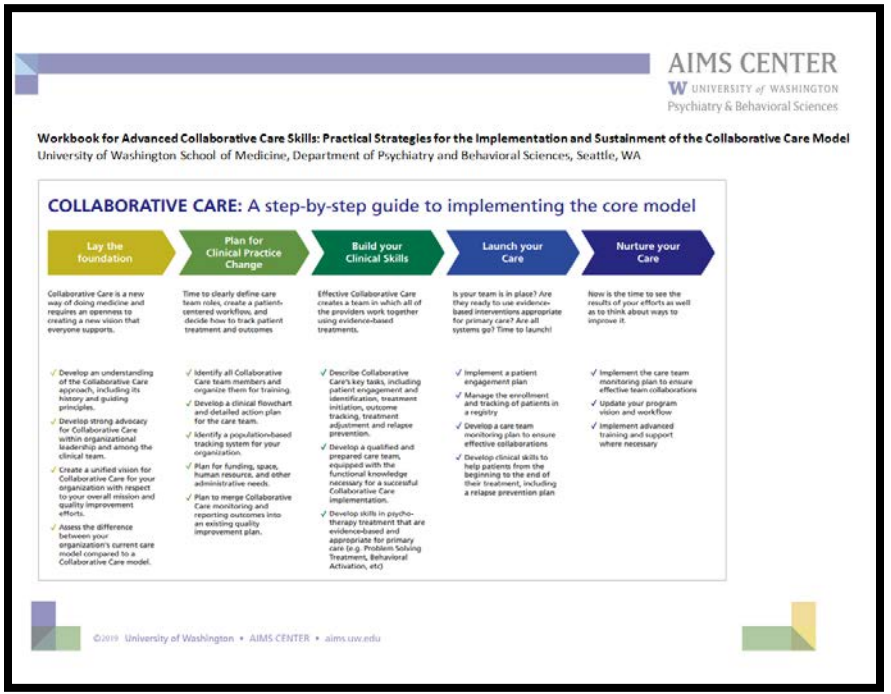
COLLABORATIVE CARE: A step-by-step guide to implementing the core model

http://aims.uw.edu/

Future of Collaborative Care



Activities Workbook



AIMS CENTER
UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

Workbook for Advanced Collaborative Care Skills: Practical Strategies for the Implementation and Sustainment of the Collaborative Care Model
University of Washington School of Medicine, Department of Psychiatry and Behavioral Sciences, Seattle, WA

COLLABORATIVE CARE: A step-by-step guide to implementing the core model

Lay the foundation	Plan for Clinical Practice Change	Build your Clinical Skills	Launch your Care	Nurture your Care
Collaborative Care is a new way of doing medicine and requires an openness to creating a new vision that everyone supports.	Time to clearly define care team roles, create a patient-centered workflow, and decide how to track patient treatment and outcomes	Effective Collaborative Care creates a team in which all of the providers work together using evidence-based treatments.	Is your team is in place? Are they ready to use evidence-based interventions appropriate for primary care? Are all systems go? Time to launch!	Now is the time to see the results of your efforts as well as to think about ways to improve it.
✓ 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.	✓ 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.	✓ 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 psycho-therapy treatment that are evidence-based and appropriate for primary care (e.g. Problem Solving Treatment, Behavioral Activation, etc)	✓ 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	✓ Implement the care team monitoring plan to ensure effective team collaborations ✓ Update your program vision and workflow ✓ Implement advanced training and support where necessary

Resources

- **AIMS Center Office Hours : https://aims.uw.edu/what-we-do/upcoming-presentations/office-hours**
  - **IMPLEMENTATION** Have questions regarding implementation of collaborative care, training staff, caseload management and registry tools, or other aspects of integrated care? Join our implementation office hours to speak with seasoned coaches and experts! Hosted in collaboration with our Washington State Integrated Care Training Program.
    - **WHEN:** Third Thursday of every month at **10:00-11:00 am Pacific Time**
  - **FINANCE:** Hosted in collaboration with the American Psychiatric Association , these sessions address questions on billing, financial sustainability, and our Financial Modeling Workbook.
    - **WHEN:** First Wednesday of every month at **9:00-10:00 am Pacific Time**.
- **Websites**
  - **AIMS Center: http://aims.uw.edu/**
  - **APA Integrated Care: https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care**

Thank you!

AIMS Center:
http://aims.uw.edu/

AIMS Center Team