

# Care/Case Management Model Cover Sheet

**Program Name:** Behavioral Health Care Management in a Collaborative Care Setting – Partnership Health Center

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## Population Focus:

Patients with depression, anxiety and co-morbid chronic conditions who benefit from engagement with paraprofessionals versus traditional "therapy" who may or may not be taking medication for their BH condition.

## Program Objectives:

To increase access to behavioral health support through the use of the collaborative care model, an evidence-based treatment model using team care, population management, and measurement to a specific target or goal in the treatment of depression.

## Program Description:

BH care managers are key members of a number of care teams at Partnership Health Center. First used in the Improving Mood and Providing Access to Collaborative Treatment (IMPACT), we now hire paraprofessional care managers in a number of programs reviewed in our attached presentation.

## Required Care/Case Management Staff:

The caseload volume depends on the program served by the team, but in the two Mental Health and Substance Use disorder programs described in more detail here, each care manager has the ability to do a warm hand off intervention with about 180 patients in six months, some of them will be managed in traditional therapy by a licensed, billable provider and manage a rolling caseload of 80 patients, averaging 13 new patients a month per BHCM. Care managers link people to services, assess overall need and communicate and advocate need for a change to their treatment plan, and essentially “hold them” without the need for accessing traditional therapy. The BH care managers are also critical in the relapse prevention phase.

## Program Demographics

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**Monthly member count:** 80 members per BHCM/13 new

Average monthly program cost per member: \$178.00 per month= \$14,257 (monthly for 3 care manager cost/patient) divided by 80

Average monthly total benefit cost per population member: service not billable at this time

Monthly provider count: 3

Average # of members per provider: 13 new patients = 80 per month per BHCM average

Average monthly provider program revenue: 0

### Program Measurements

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In the IMPACT program we measured % patients to a 5 point decrease in their PHQ-9 and consistently, 40% or higher saw improvement in their depression reflected by this 5 point or more decrease. We also measured overall improvement in depression symptoms and 50% or higher showed improvement at 12 weeks. The BH care managers followed patients who were not engaged in therapy but needed some support to avoid worsening of their symptoms, medication adherence counseling, and referral to psychiatric prescriber for consultation if symptoms worsened. In the attached presentation we review some estimated cost savings to the system in this model.