Organizing an Excellent Collaborative Care Team

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Mi-CCSI Center for Clinical Systems Improvement

Michigan Collaborative Care IMPLEMENTATION SUPPORT TEAM

MICMT Michigan Institute for Care Management & Transformation

Blue Cross Blue Shield of Michigan

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BCBSM is Sponsoring the training to include:

- Funding the cost of training
- Allocation of Funds to physician organizations and practices to participate in training
- Supporting the development of training and ongoing learnings
- Building sustainable payment models

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Etiquette

- You have been muted on entry
- When asking questions:
  - Send questions to ‘All Panelists’ in the chat feature
  - Our team will moderate the session
- When speaking:
  - Please minimize background noise
  - Use either phone or computer audio, but not both
- The session is being recorded

Disclosure

- The Michigan Center for Clinical Systems Improvement (MiCCSI), Michigan Institute for Care Management and Transformation (MICMT), and Michigan Collaborative Care Implementation Support Team (MCCIST) have been contracted by Blue Cross Blue Shield of Michigan for this project.

CME Credit: Physicians, Nurses, Social Workers

- This live series activity has been reviewed and is acceptable for credit by the **American Academy of Family Physicians**. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
  - Approved for (1 credit per session) AAFP (Prescribed) credits.
  - AMA/AAFP Equivalency: AAFP Prescribed credit is accepted by the American Medical Association as equivalent to *AMA PRA Category 1 credit*(s)™ toward the AMA Physician's Recognition Award. When applying for the AMA PRA, Prescribed credit earned must be reported as Prescribed, not as Category 1.
- Nurses can use the CME for their state requirements. Information on this can be found on LARA and through the **Michigan Nurse Association** (MNA) at https://www.minurses.org/education-resources/resources-for-practicingnurses/state-of-michigan-ce-requirements/
- This course is approved by the **Michigan Social Work Continuing Education Collaborative**-Approval # 051420-00 The Collaborative is the approving body for the Michigan Board of Social Work

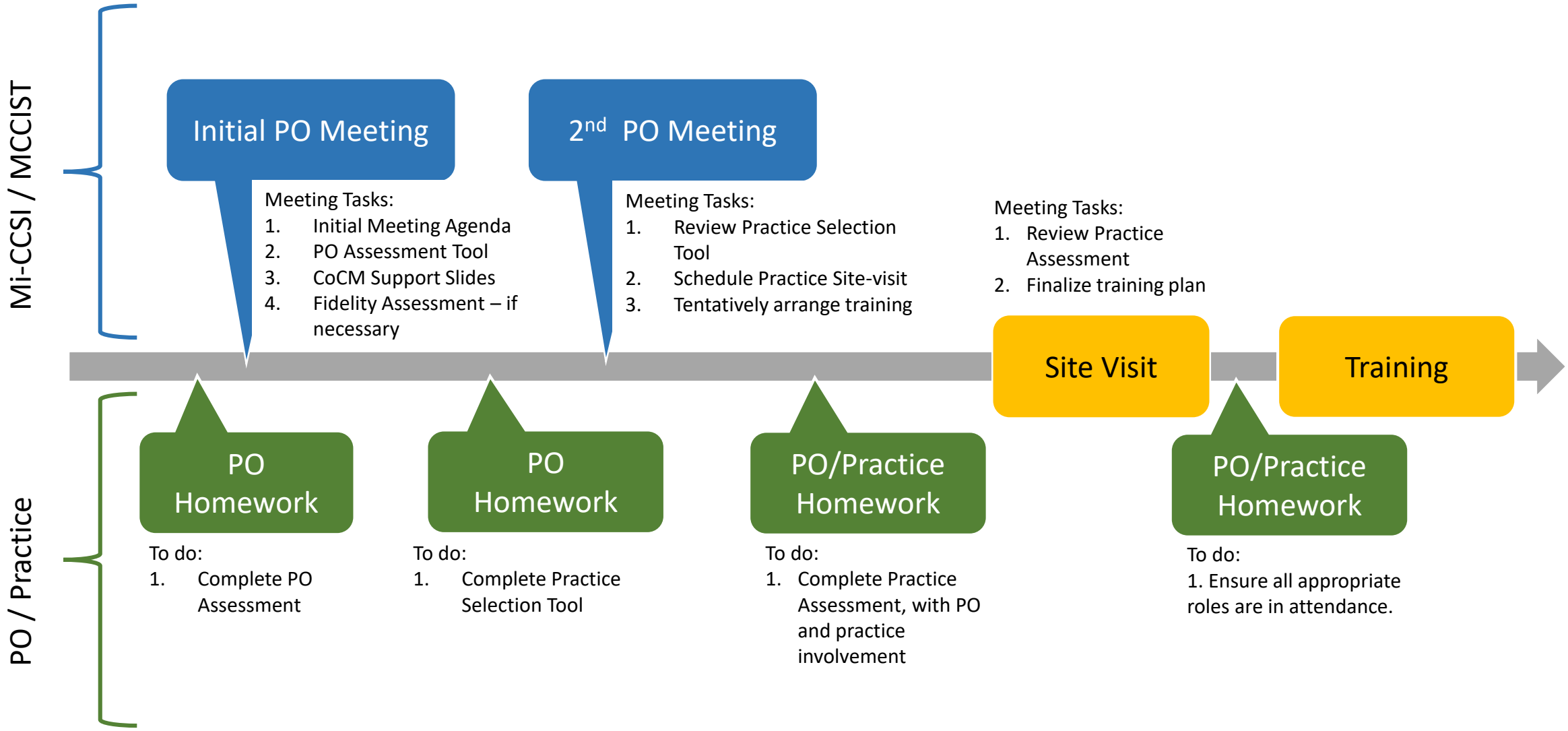
Agenda and Objectives:

- Review the Collaborative Care Model (CoCM)
- Review the roles of the PCP and Care Team, Behavioral Health Care Manager, and the Psychiatric Consultant.
- Review the staffing model/ratios, along with sample job descriptions and contracts.

CoCM Goal: Tailored Consultation

- We recognize each physician organization, and their practices have diverse organizational structures, resources, and timelines.

Our training teams will provide a tailored consultation approach which *will "meet you where you are,"* ensuring your organization is ready to launch and capable of sustaining high-quality CoCM services


Mi-CCSI / MCCIST
PO / Practice
Initial PO Meeting
Meeting Tasks:
1. Initial Meeting Agenda
2. PO Assessment Tool
3. CoCM Support Slides
4. Fidelity Assessment – if necessary
2nd PO Meeting
Meeting Tasks:
1. Review Practice Selection Tool
2. Schedule Practice Site-visit
3. Tentatively arrange training
Meeting Tasks:
1. Review Practice Assessment
2. Finalize training plan
Site Visit
Training
PO Homework
To do:
1. Complete PO Assessment
PO Homework
To do:
1. Complete Practice Selection Tool
PO/Practice Homework
To do:
1. Complete Practice Assessment, with PO and practice involvement
PO/Practice Homework
To do:
1. Ensure all appropriate roles are in attendance.

Overview of the Collaborative Care Model (CoCM)

CoCM: An Overview

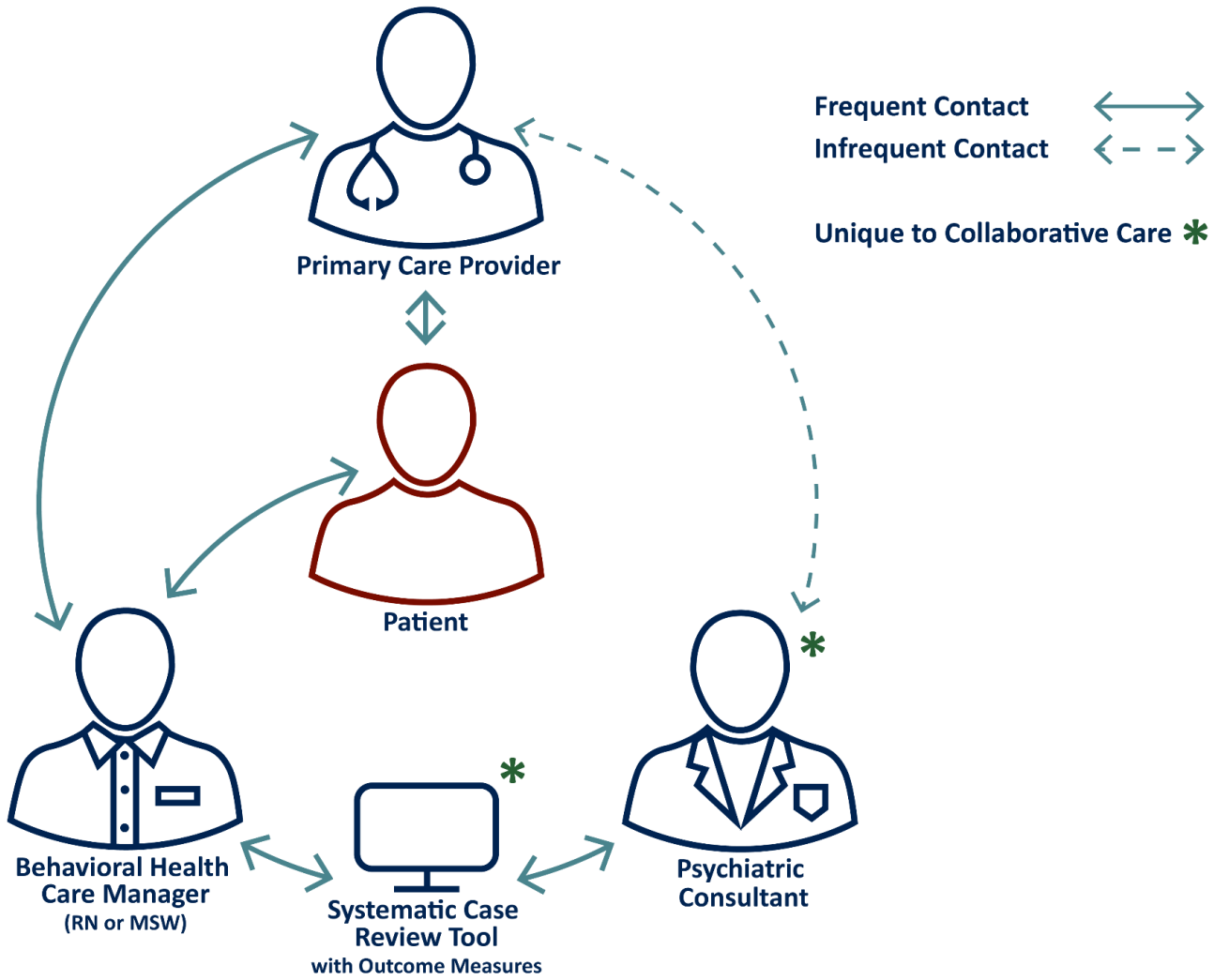
- Most evidence-based integrated behavioral health model
  - 80+ randomized controlled trials prove Collaborative Care provides significantly better behavioral health outcomes than “usual care”
  - 2002: First big trial was published (IMPACT study out of the University of Washington)
- Primary care-based: Meets behavioral heath need in patient’s medical home
- Patient improvements compare to those achieved in specialty care for mild-moderate conditions
- Return on investment of 6:1

Target Population for Adult Collaborative Care

- Highly evidence-based for adults with depression and anxiety
  - Depression and/or anxiety population served by primary care
  - Increasing evidence for adolescent depression, PTSD, and co-morbid medical conditions
  - More complex patients should be served in high-need clinics

- Defining the target population:
  - PHQ-9 and/or GAD-7 of 10 or more
  - Diagnosis of depression and/or anxiety
  - Just started on a new antidepressant, regimen was changed, or PCP could use prescribing guidance

The Collaborative Care Treatment Team



5 Components of the Evidence-Based Model

- Patient Centered Care
  - Effective collaboration between BHCMs and PCPs, incorporating patient goals into the treatment plan
- Measurement-Based Treatment to Target
  - Measurable treatment goals and outcomes defined and tracked for each patient (PHQ-9/GAD-7)
  - Treatments are actively changed until the clinical goals are achieved
- Population-Based Care
  - Defined and tracked patient population to ensure no one falls through the cracks
- Evidence-Based Care
  - Treatments are based on evidence
- Accountable Care
  - Providers are accountable and reimbursed for quality of care and clinical outcomes

Summary: What sets CoCM apart?

- Population health approach
  - Use of a systematic case review tool to ensure no one falls through the cracks
  - Proactive, tailored outreach, allowing for monitoring and updates in-between PCP visits
  - Treatments are adjusted until patients achieve remission or maximum improvement
  - Data evaluates key process measures and patient outcomes
- Maximizes access to limited psychiatry time
  - Multiple patients reviewed per hour as opposed to one patient
  - Helps reserve specialty psychiatry time for higher level cases
- Typically a short wait time from referral to receiving an expert psychiatric recommendation (often within one week)

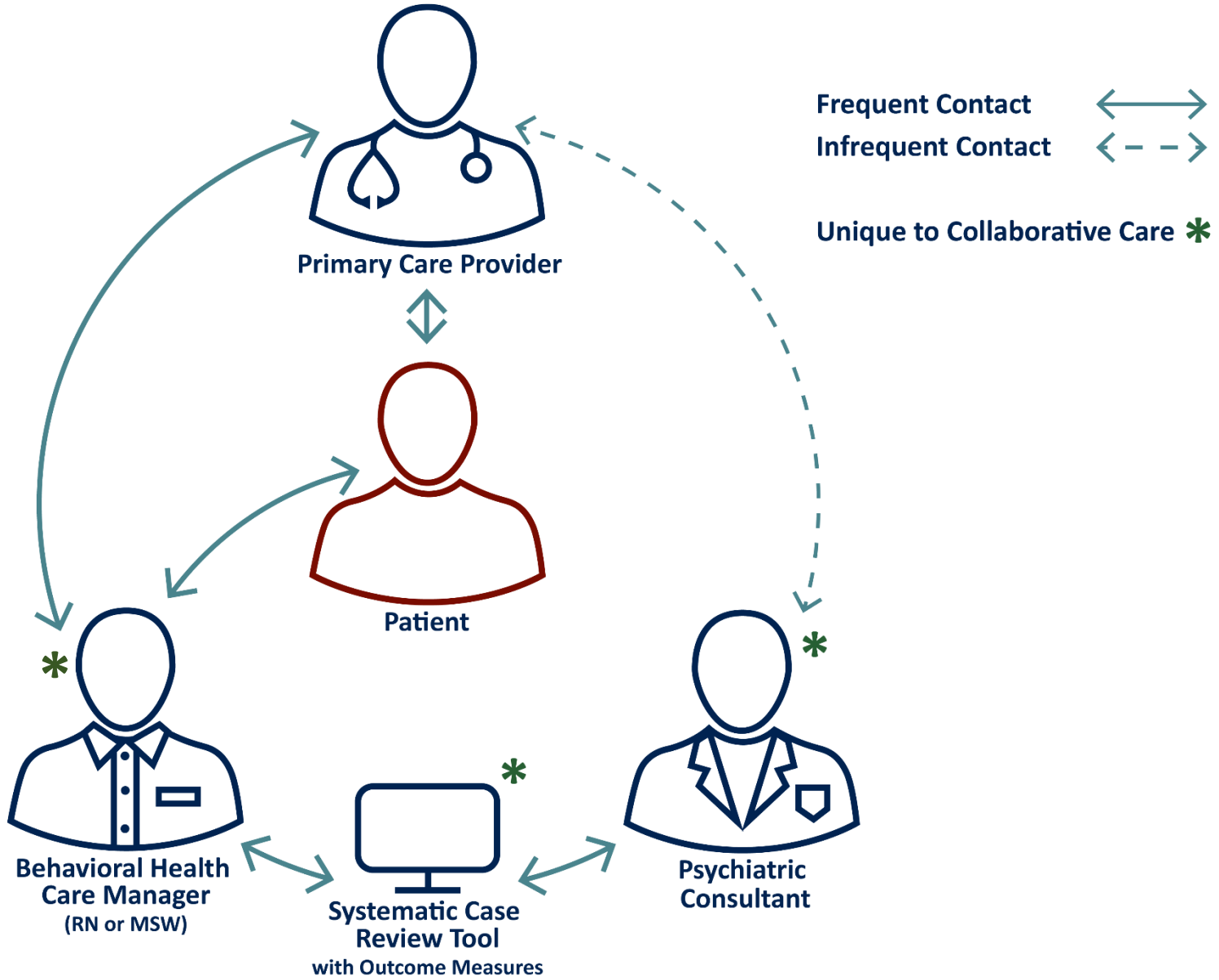
The Treatment Team

CoCM – Team-based Care

- CoCM uses an enhanced care team to provide a population-based, treat-to-target approach to care. Through shared care planning, the team makes proactive changes in treatment to make sure that patients do not fall through the cracks.
- Development of a quality team requires careful design and construction by the leadership.
- Success of the model is based on the flexibility to alter practice patterns and willingness to participate in the team-based model from each member of the team.

The Collaborative Care Treatment Team

CoCM adds two additional clinical staff to the traditional primary care treatment team



5 Core Components

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2 New Team Members

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Collaborative Care Model

BHCM and Psychiatric Consultant - Qualifications

- The psychiatric consultant is a medical professional trained in psychiatry and qualified to prescribe the full range of medications.

- The behavioral health care manager coordinates the overall effort of the group and ensures effective communication among team members. Behavioral health care managers must be licensed and are typically nurses, psychologists, social workers or licensed counselors, but the ability to effectively perform the tasks that need to be completed is much more important than one's credentials.

Treatment Team Activities - Psychiatric Consultant

- Supports a PCP and BHCM by regularly reviewing cases with the BHCM in scheduled systematic case reviews
- Recommends treatment planning for all enrolled patients, particularly those who are new, not improving, or need medication adjustments
- The psychiatric consultant may suggest treatment modifications for the PCP to consider, recommend the PCP see the patient for an in-person consultation, or directly consult on patients who are clinically challenging or who need specialty mental health services. **The consultant does not see the patient**, except in rare circumstances, (generally, this would be a referral to the psychiatrist for individualized assessment and consultation) and **does not prescribe medications**.
- Documents recommendations
- Provides psychopharmacology education to the PCPs and clinical staff

Treatment Team Activities - BHCM

- Manages a caseload of patients
- Works closely with the PCP to facilitate patient engagement and education
- Performs structured outcomes-based assessments along with risk assessment and safety planning
- Systematically tracks treatment
- Provides brief behavioral interventions and supports medication management
- Engages patients in relapse prevention planning
- Uses the systematic case review to systematically review caseload and ensure no patients are falling through the cracks

Ideal Characteristics of BHCM and Psychiatric Consultant

- Behavioral Health Care Manager

- Flexible, nimble, comfortable working remotely with patients (much of work done by telephone)
- Strong patient advocate
- Comfortable creating self management plans and discussing medications with patients
- Trained in motivational interviewing, problem-solving and behavioral activation

- **This is not a traditional therapy position**

- Psychiatric Consultant

- Comfortable with making recommendations without seeing the patient
- Able to trust and value working with BHCM's
- Values concept of populations management
- Good at documenting quickly and efficiently
- Comfortable with technology
- Has attended the APA training in person or on-line or willing to do so

Staffing the Consulting Psychiatrist

- Contracting considerations:
  - Who will be contracting with the psychiatric consultant
  - Time
  - Determine rate of pay
  - Willingness and ability to document in EHR (ideal) or participate in another mechanism for documentation
  - Provide expectations

  - EXAMPLE Contract for Psychiatric Consultation Services

Example segment of a Job Description – Behavioral Health Care Manager

- The behavioral health care manager is a core member of the collaborative care team, including the patient's medical provider and psychiatric consultant, as well as the larger primary care team or medical team. The behavioral health care manager is responsible for supporting and coordinating the mental and physical health care of patients on an assigned patient caseload with the patient's medical provider and, when appropriate, other mental health providers.

- **The position does not include providing therapy**
- sample job description - Behavioral Health Care Manager

Example segment of a Job description – Psychiatric Consultant

- The psychiatric consultant supports the collaborative care team through regular consultation on an assigned caseload of patients. The psychiatric consultant advises the prescribing medical provider on appropriate medications and other treatment strategies, and also provides the care team with educational support on diagnosing and managing behavioral health conditions.

- Job description - Psychiatric Consultant

Integration

- Integrate BHCM and consulting psychiatrist into existing clinic staff, space and flow
  - Private workspace for BHCM
  - Time allotted
  - Ideally, access to a computer and EHR
  - Access and support of training for clinic staff
  - Identification of staff roles in CoCM

It is critical that a BHCM can carve out enough time to actively manage their patients. This role cannot be added to an already full workload.

Staffing Needs:

Caseload Size Range		BHCM FTE	Psychiatric Consultant Hours
30	60	0.5	1 – 2 hours/week
60	125	1.0	3 hours/week

*Note that during caseload size will increase as program matures

*The numbers above are approximations of caseload size and staffing needs

CoCM Treatment Team Activities

- Patient

- Works closely with the BHCM and PCP to report symptoms, set goals, track progress, and ask questions
- Actively engages in self-management action planning

- Primary Care Provider

- Oversees all aspects of a patient's care, diagnoses behavioral health concerns
- Introduces the collaborative care program and makes referrals, (ideally a warm hand-off)
- Prescribes medications and adjusts treatment following consultation with the BHCM and the psychiatric consultant
- Speaks with the psychiatric consultant as needed, (this may be infrequent)
- Remains the team lead and will decide whether or not to incorporate recommendations from the consulting psychiatrist

Key Practice Level Staff

Key Practice Level Staff Activities

Medical Director

- Creates and implements practice policies to ensure safe, effective, and sustainable delivery of care
- Ensures all CoCM team members have appropriate qualifications, training, and credentialing to provide the activities specific to their role
- Ensures all CoCM team members adhere to professional responsibilities with respect to standards of care, documentation, privacy, etc.

Provider Champion

- Commits to learning CoCM, helping to educate their colleagues, and practices the model with fidelity and enthusiasm
- Assists in hiring the other CoCM team members
- Communicates practice change expectations to their PCP colleagues and supports them in overcoming challenges
- Acts as a liaison between the PCP team and the behavioral health care manager and psychiatric consultant, providing a bi-directional communication channel to solve implementation challenges
- Provides ongoing monitoring of how the PCP team is adopting the model and provides additional support to late adopters

https://aims.uw.edu/collaborative-care/implementation-guide/lay-foundation/identify-your-champions

Key aspects of the personnel providing collaborative care can influence outcomes and is the “secret sauce” that goes beyond simply implementing the key tasks and re-engineered workflows

- “Engaged” psychiatric consultant leads to more patients achieving remission
- “Buy-in” by primary care providers is crucial to patient engagement as they are on the front line in “pitching” the model to patients
- Primary care provider “champions” help with rallying colleagues around the model
- Behavioral care managers with a well-defined role are crucial to patient engagement and ensuring key clinic tasks are performed without other distractions
- Strong support from the top leadership is also necessary to provide the team resources critical to meeting defined goals as well as encouragement and support throughout the process

Raney, L.E, M.D., Lasky, G.B.,Ph.D, M.A.P.L., Scott, C., L.C.S.W. (2017). *Integrated Care, A Guide for Effective Implementation, Arlington, VA, American Psychiatric Association Publishing*

Raney, Lori MD. (2028, May). How to implement effective integrated care. *Psychiatric News, Online*

Additional Staff

- Practice Manager
- Clinical Supervisor
- QI Coordinator
- Billing Representative
- Clinical staff responsible for screening and documenting results

Additional Team Members Inside and Outside the Practice

Inside the Practice

- Imbedded behavioral health staff
- Medical Assistants
- Health Coaches
- Community Health Workers

Outside the practice

- Therapist
- Substance treatment
- Vocational rehabilitation
- Specialty Mental Health Clinic

Patient may also require a higher level of care:
Mental Health Therapist
Community based treatment

Next Steps and Resources

Next Steps:

- ❑ Consider staffing abilities for launch practices
- ❑ Work with MCISST or MiCSSI for continued support

Resources:

- ❑ Sample job description - Behavioral Health Care Manager
- ❑ EXAMPLE Contract for Psychiatric Consultation Services
- ❑ EXAMPLE Contract for Psychiatric Consultation Services
- ❑ AIMS Center - University of WA
- ❑ MCISST - Michigan Collaborative Care Implementation Support Team

Questions?