Role of the behavioral health care manager

Learning objectives

- Discuss the key roles and responsibilities of the behavioral health care manager in Collaborative Care.

Role of the Behavioral Health Care Manager

- Coordinates the overall efforts of the treatment team and ensures **effective communication** among team members
- Develops and adjusts **treatment plan** in consultation with psychiatric consultant, referring provider, and the patient
- Medication monitoring and psychoeducation
- Provides **brief interventions** such as motivational interviewing and behavioral activation
- Participates in **systematic case review** in close collaboration with Psychiatric Consultant
- Supports the PCP by providing proactive **follow-up of treatment response**

BHCM as the quarterback

- Coordinates the team to help patients improve

- Conducts brief interventions, seeks consultation, and provides referrals

How Collaborative Care compares

	Traditional Outpatient Mental Health Therapy	Collaborative Care
Access	Patients encounter many barriers to care	• Referral, outreach and enrollment can occur on the same day • Recommendations from PC within 1-2 weeks
Beginning of Treatment	First several sessions focused on assessment	• Shorter assessment • Quicker progression to interventions
Contact Frequency	Once per week, 1 hour session	Shorter, more flexible contacts
Care Team	Team of 1	Multi-person interdiscplinary care team
Treatment Approaches	Eclectic, anything goes	Focus on evidence-based interventions
Outcomes	Often poorly defined. Rarely tracked.	Treat to target

Breakout discussion

- How does your role as a BHCM differ from your previous roles, or other roles you have within the clinic?
- What will be most challenging for you about serving as a BHCM?
- What would you like more training or guidance about?

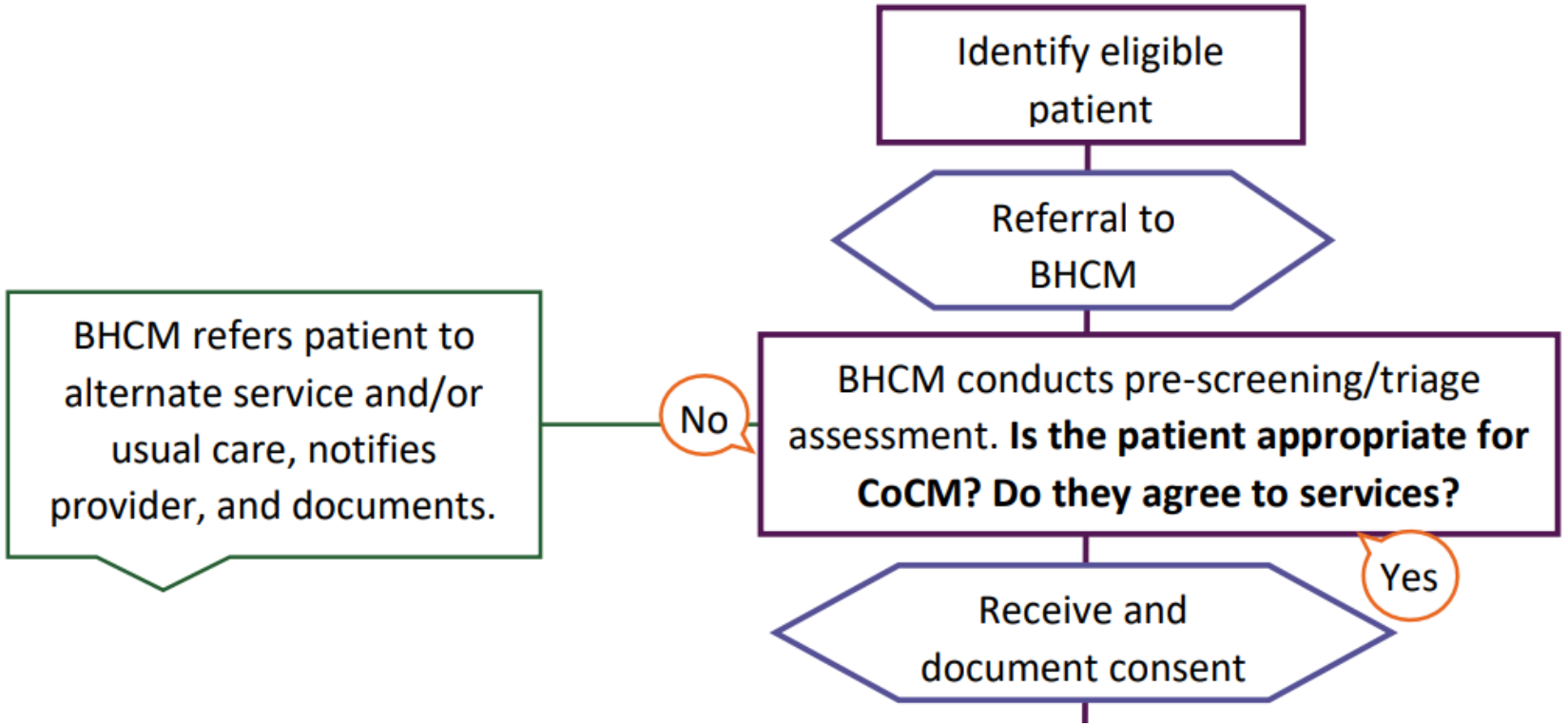
Implementation example

https://www.youtube.com/watch?v=CHTVrBohMdw

The process of CoCM

- **Screening**: identify eligible patients from the general practice population
- **Referral**: connect eligible patients to the CoCM program
- **Engage with the patient**: introduce your role and value of CoCM to the patient
- **Intake assessment**: assess appropriateness for CoCM
- **Initiate treatment**: identify available treatment interventions, develop self-management plan and set stage for relapse prevention planning
- **Track treatment progress**: administer PHQ-9 and/or GAD-7 throughout treatment
- **Adjust treatment**: try different interventions for patients who are not improving
- **Conclude treatment**: complete review relapse prevention plan and discharge patient

Identification and referral



Key

BHCM: Behavioral Health Care Manager

PC: Psychiatric Consultant

TP: Treating Provider

Introducing CoCM to the patient

Introduce yourself and the reason for your contact

- *Hi! I'm Tiffani, the Behavioral Health Care Manager with our Collaborative Care program. I'm calling to introduce myself so I can help you with what you've been going through. Dr. Starlight likes to make sure people feel supported when they're feeling down or anxious and have difficulty sleeping. She asked me to connect with you.*

Describe the psychiatric consultant

- *I work closely with a psychiatric consultant who sends treatment recommendations to Dr. Starlight, including recommendations about medications if you're interested in taking them. I'd like to review your symptoms and history with the psychiatric consultant, so we can make sure you're receiving the best care possible. We review all the patients I work with. Your PCP will remain the lead in your care and appreciates the psychiatric recommendations. What do you think about this?*

Introducing outcome measures to the patient

- **Introduce**: *Along with your physical vital signs like your blood pressure and heart rate, I am also going to ask you questions about how you're feeling as well.*

- **Normalize**: *We ask all our patients these questions.*

- **Explain**: *Your answers will help us know if your treatment is working so that we can do everything possible to help you feel better.*

Treat to Target

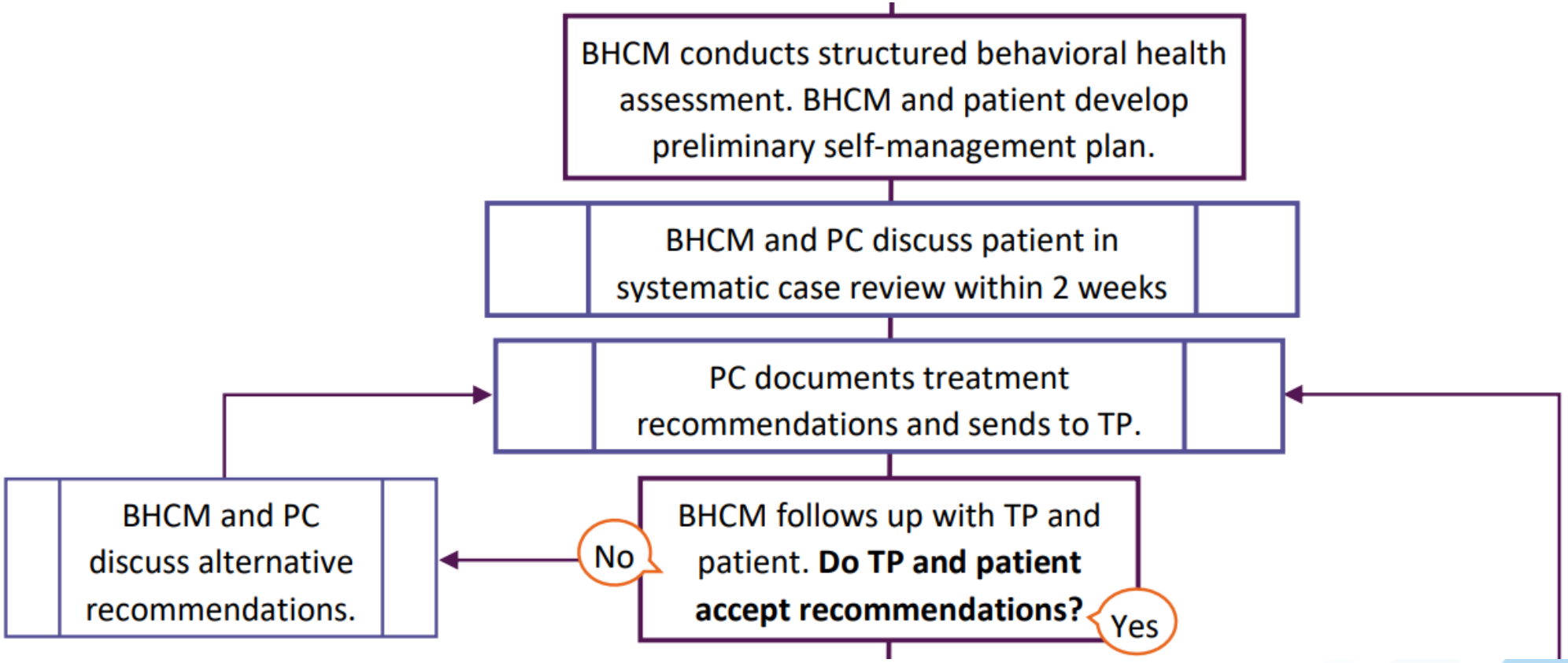
Adjust the treatment plan based on symptom measures

- Treatment adjustments are made until the patient has a treatment response

Measure symptoms frequently

- Use the PHQ-9 and/or GAD-7 every 4-6 weeks at a minimum
- Illustrates the level of treatment response:
  - Improvement: 5-point reduction
  - Response: 50% reduction
  - Remission: Scores of <5
  - Provides information about which symptoms are or are not improving
- Guide treatment adjustment decisions
- Share scores and trends with the patient

Structured assessment and beginning treatment



Suggested frequency of contact

Frequency of contact depends on patient's treatments plan, their level of engagement and if crisis intervention is needed

Treatment Status	Contact Frequency
Active	• Minimum 2 contacts per month • Continue until patient is significantly improved
Monitoring	• Minimum 1 contact per month
After 50% decrease in scores	• Monitor for ~3 months to ensure patient is stable • Complete relapse prevention planning

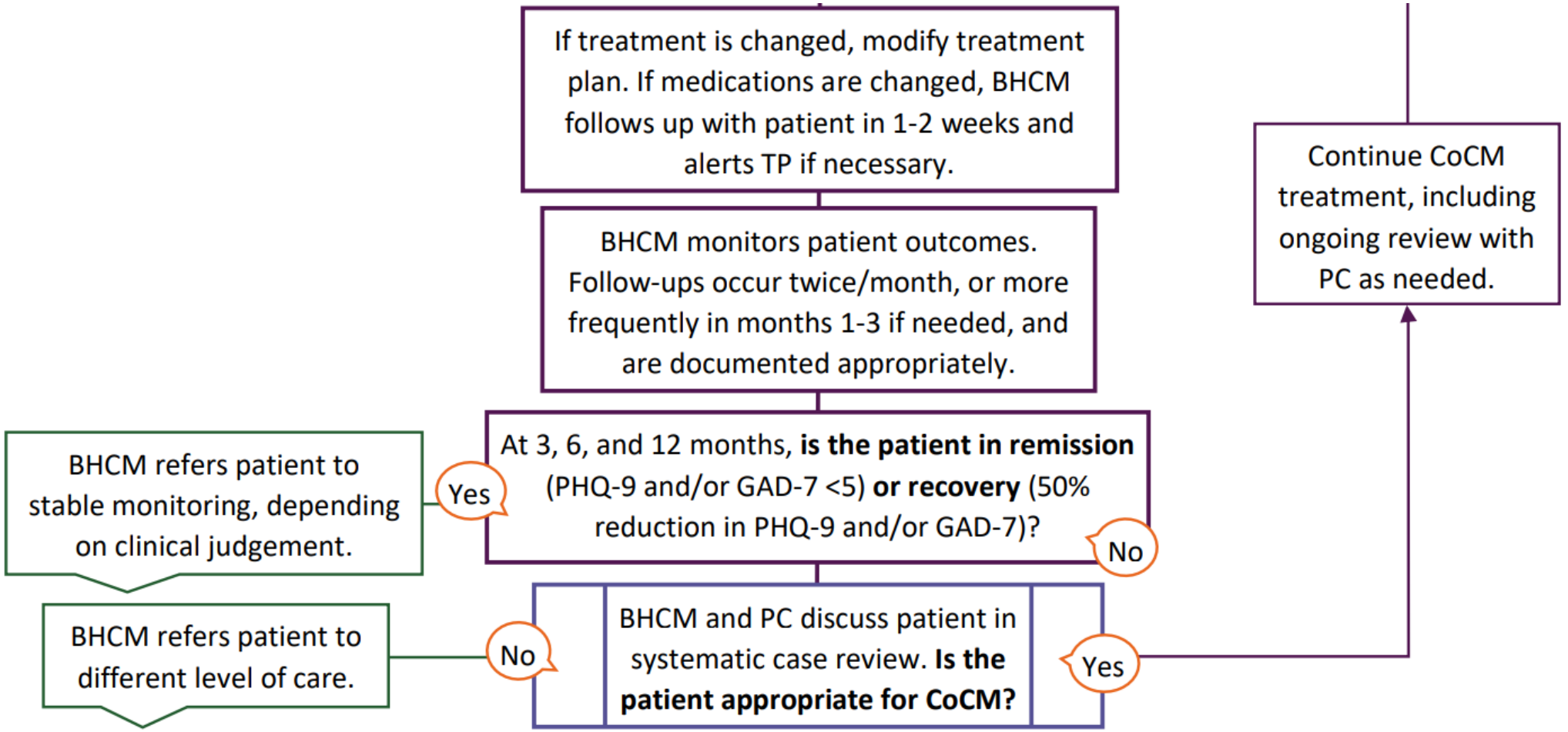
Effective behavioral health interventions in primary care

- Include a patient engagement component
- Are efficient, running no more than 20-30 minutes per contact
- Follow a structured and patient-centered approach
- Are relevant and applicable to diverse patient populations
- Have a substantial research evidence base

Structure of patient contacts

- Each contact should have:
  - A plan and a purpose guided by the BHCM
  - An introduction as to what the BHCM and patient will be doing:
    - *I'd like to spend about 15-30 minutes with you today. I want to start by asking you about your symptoms and then discuss some problem solving around your stress at work. What if anything would you like to discuss during our time together?*
  - A summary of what was covered
    - Remind the patient of the action steps
    - Establish the date of the next contact

Treatment monitoring through treatment conclusion



Resources

- Introducing Collaborative Care
- BHCM- A Week in the Life
- Collaborative Care Clinical Workflow Overview
- CoCM Clinical Workflow Development Guide
- BHCM Comprehensive Job Description
- BHCM EHR Documentation