Behavioral Health Integration Collaborative

"Assembling the BHI Care Team: Roles and Responsibilities"

July 21, 2022

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About the BHI Collaborative

*The BHI Collaborative was established by several of the nation's leading physician organizations** to catalyze effective and sustainable integration of behavioral and mental health care into physician practices.*

With an initial focus on primary care, the Collaborative is committed to ensuring a professionally satisfying, sustainable physician practice experience and will act as a trusted partner to help them overcome the obstacles that stand in the way of meeting their patients' mental and behavioral health needs.

***American Academy of Child & Adolescent Psychiatry, American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, American Medical Association, American Osteopathic Association, and the American Psychiatric Association.*

TODAY'S SPEAKERS

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Assembling the Care Team: Roles and Responsibilities

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PROGRAM DIRECTOR

COLORADO PLATEAU FAMILY AND COMMUNITY MEDICINE RESIDENCY

DISCLOSURES

I do not have any actual or potential conflicts of interest in relation to this program or presentation.

Learning Objectives

1. Identify roles and responsibilities of members of the Collaborative Care team
2. Discuss strategies to recruit and maintain Collaborative Care team members to enhance patient care and integrate behavioral health
3. Increase confidence in successfully implementing Collaborative Care Model in your practice setting

The Need

Primary care providers prescribe 79% of antidepressant medications and see 60% of people being treated for depression in the United States

50% of patients referred to mental health do not follow through

- 80% of those who do follow through are only seen once

Depression is a leading cause of worldwide disability

Only 40.3% of adults with mental illness in Arizona receive any form of treatment from either the public system or private providers.

- 59.7% receive no mental health treatment.

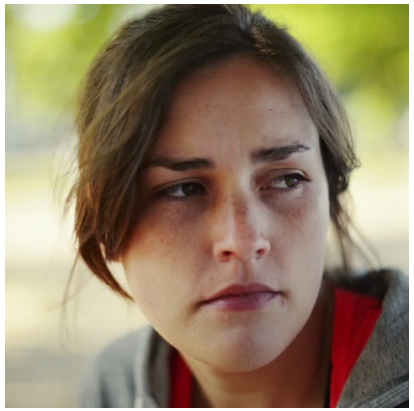
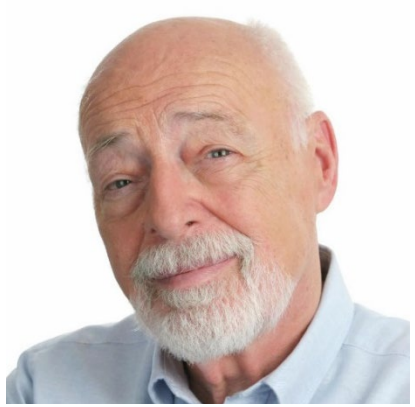
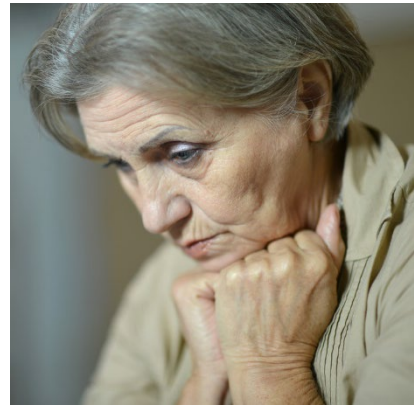
50-70% of patients need at least one change in the treatment plan in order to achieve remission of depression

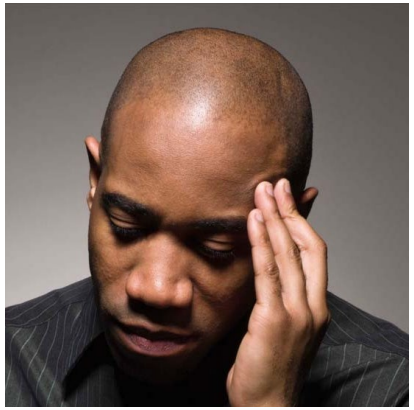
WHO GETS TREATMENT?

No Treatment

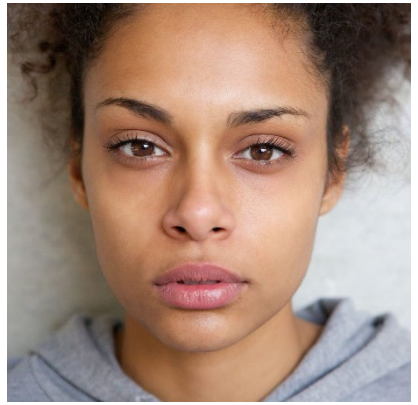
Primary Care Provider



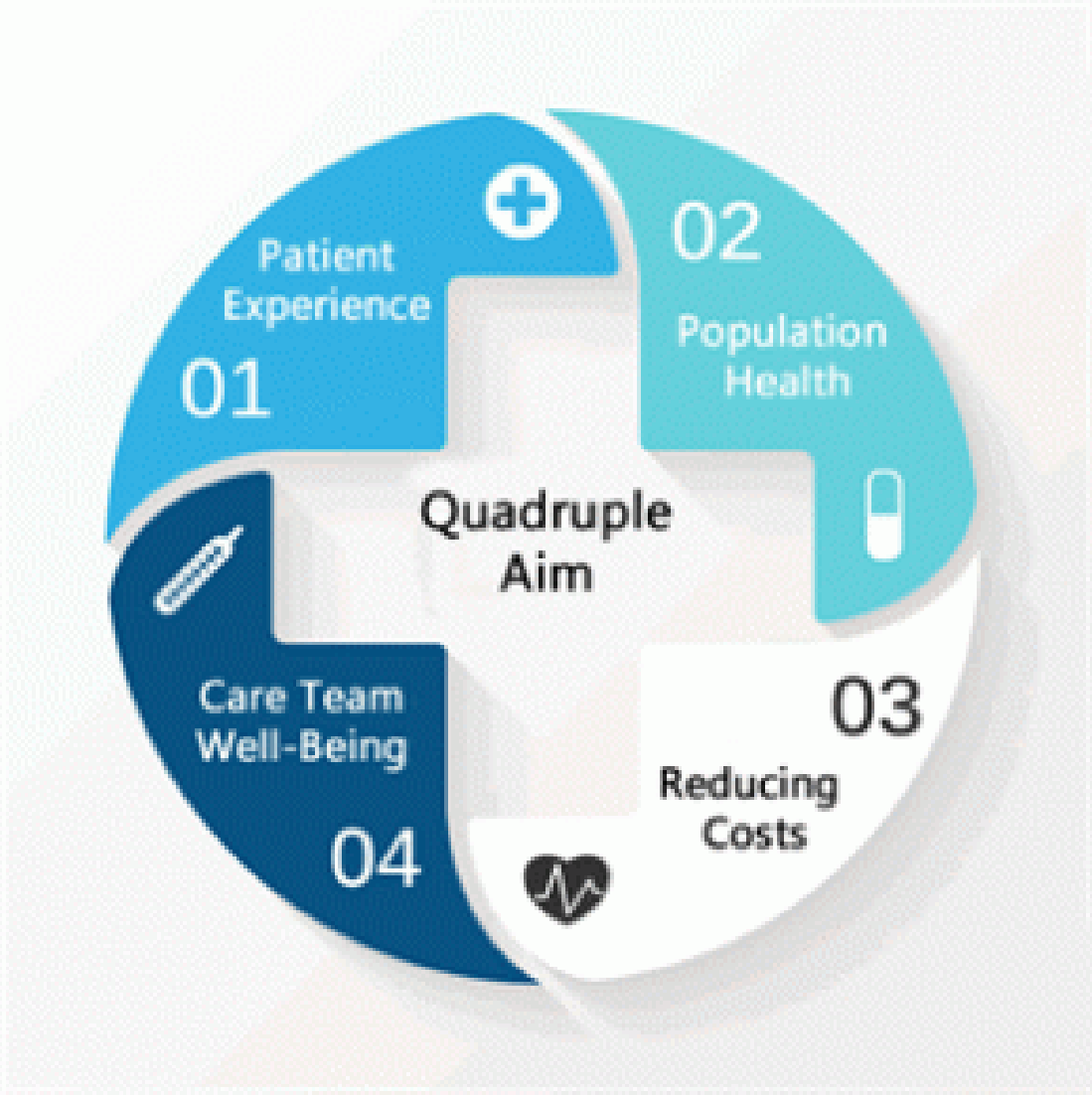










Mental Health Provider



A Solution: Collaborative Care!

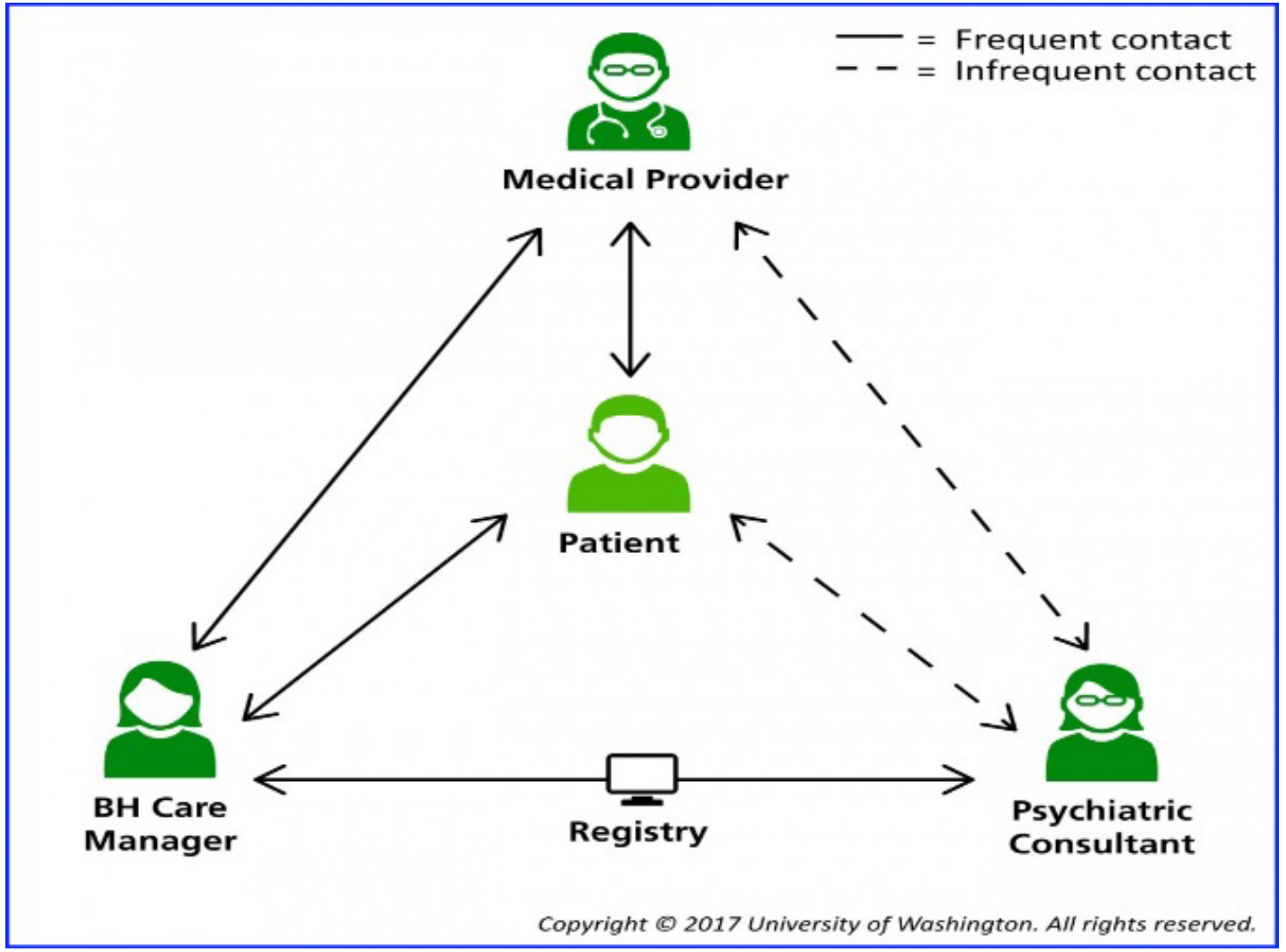
Better access to care

Better outcomes

Decreased costs

Improved patient experience

Improved provider experience



Collaborative Care

Roles

Patient

- Chooses treatment and identifies goals

PCP

- Primary provider of all care

Psychiatrist

- Indirect care provided via consultation with Care Manager

Care Manager

- Coordinates behavioral healthcare, performs initial assessments and systematic follow-up of patients, provides patient education, creates and updates treatment plan, performs brief psychotherapy, completes majority of documentation.

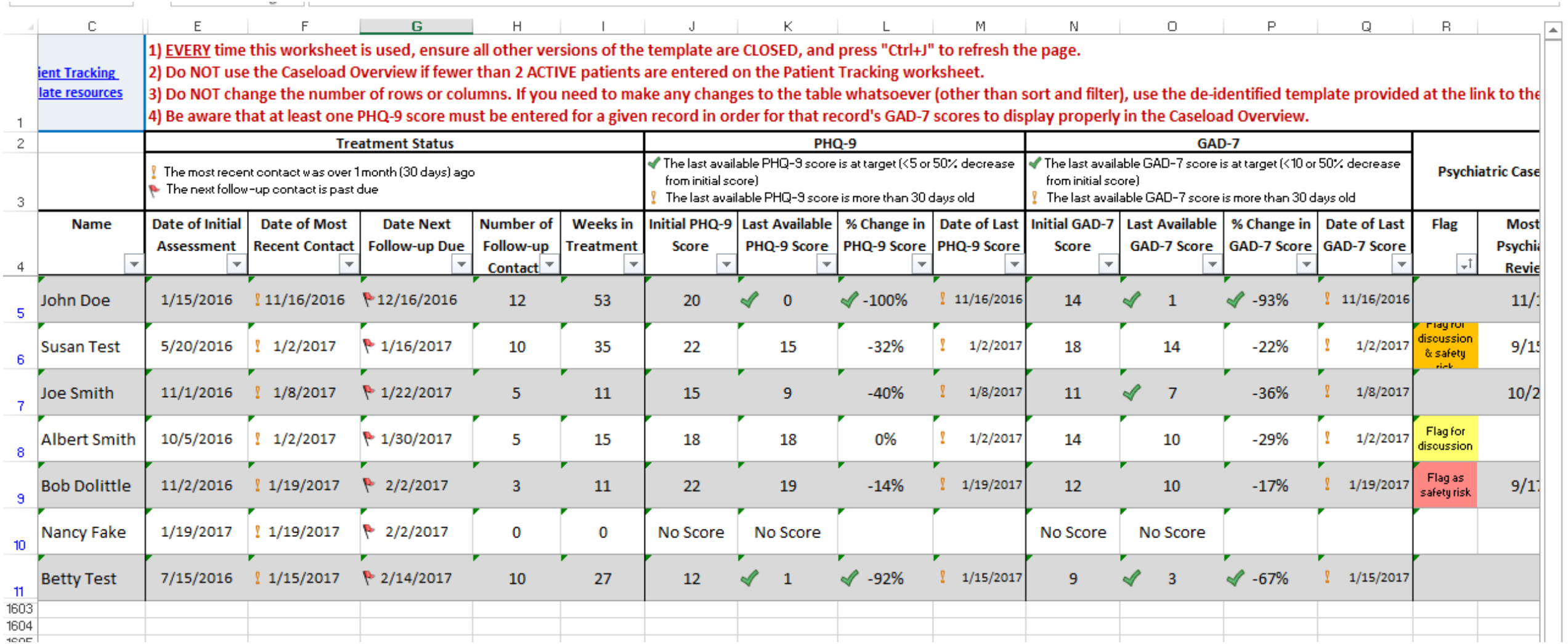
Core Principles

PATIENT CENTERED TEAM CARE	POPULATION BASED CARE
Incorporates *patient goals and choice* of treatment into the plan *Direct* collaboration between primary care and behavioral health providers *Shared* care plans	Defined group of patients Tracked over time (electronic patient registries) Focus on those not improving as expected or at risk to fall out of care

Core Principles

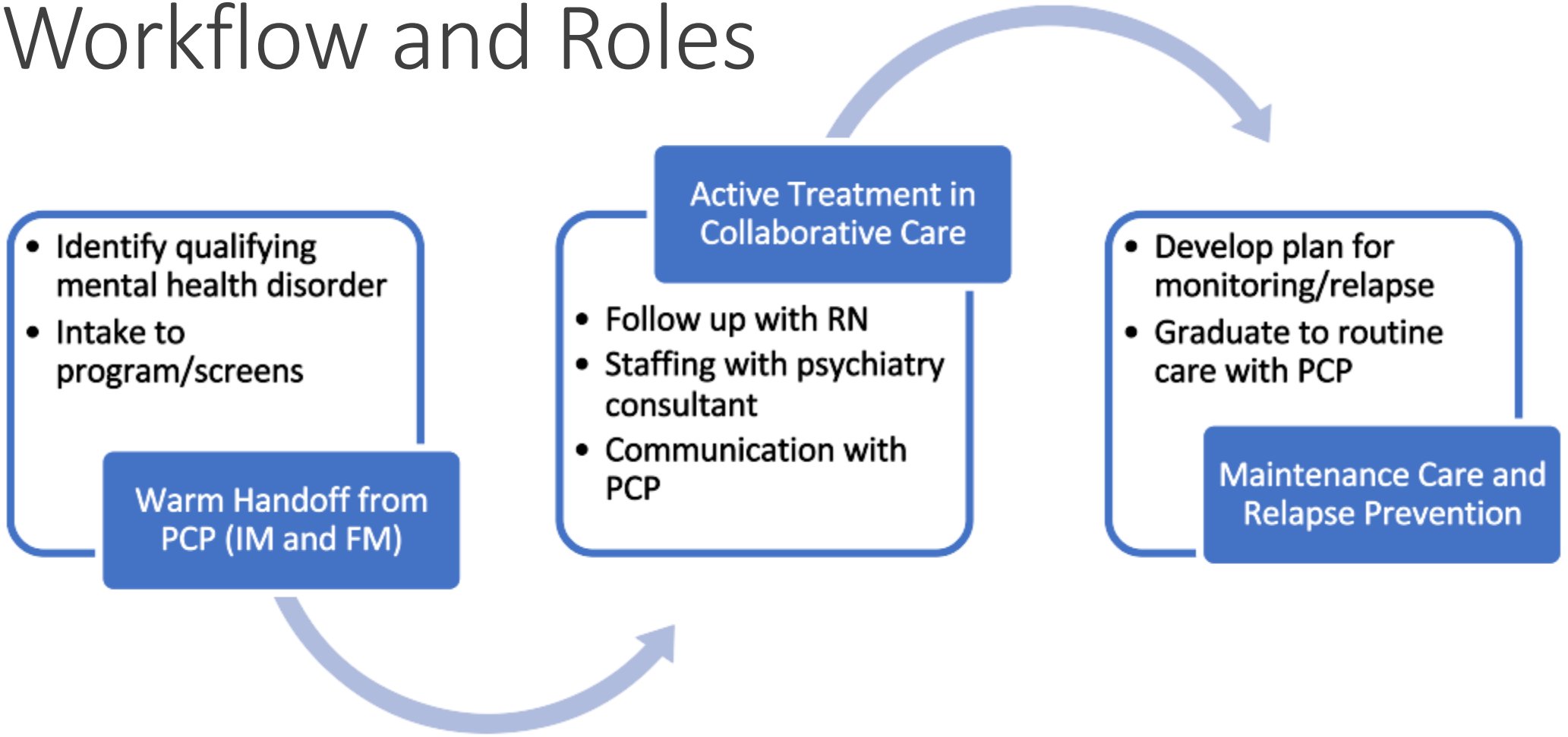
MEASUREMENT BASED TREAT TO TARGET	EVIDENCE BASED CARE
Use of clinical outcome measures to treat to target Standardized assessments like GAD-7, PHQ-9	Treatments utilized are backed by credible research ◦ Pharmacotherapy ◦ Psychotherapy Education to PCPs regarding evidence based treatment ◦ Included in the consultation note

Registry



	C	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	
1	ient Tracking late resources	1) EVERY time this worksheet is used, ensure all other versions of the template are CLOSED, and press "Ctrl+J" to refresh the page. 2) Do NOT use the Caseload Overview if fewer than 2 ACTIVE patients are entered on the Patient Tracking worksheet. 3) Do NOT change the number of rows or columns. If you need to make any changes to the table whatsoever (other than sort and filter), use the de-identified template provided at the link to the 4) Be aware that at least one PHQ-9 score must be entered for a given record in order for that record's GAD-7 scores to display properly in the Caseload Overview.														
2		Treatment Status					PHQ-9				GAD-7				Psychiatric Case	
3		! The most recent contact was over 1 month (30 days) ago ⚑ The next follow-up contact is past due					✓ The last available PHQ-9 score is at target (<5 or 50% decrease from initial score) ! The last available PHQ-9 score is more than 30 days old				✓ The last available GAD-7 score is at target (<10 or 50% decrease from initial score) ! The last available GAD-7 score is more than 30 days old					
4	Name	Date of Initial Assessment	Date of Most Recent Contact	Date Next Follow-up Due	Number of Follow-up Contact	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 Psychi Revie
5	John Doe	1/15/2016	! 11/16/2016	⚑ 12/16/2016	12	53	20	✓ 0	✓ -100%	! 11/16/2016	14	✓ 1	✓ -93%	! 11/16/2016		11/1
6	Susan Test	5/20/2016	! 1/2/2017	⚑ 1/16/2017	10	35	22	15	-32%	! 1/2/2017	18	14	-22%	! 1/2/2017	Flag for discussion & safety	9/15
7	Joe Smith	11/1/2016	! 1/8/2017	⚑ 1/22/2017	5	11	15	9	-40%	! 1/8/2017	11	✓ 7	-36%	! 1/8/2017		10/2
8	Albert Smith	10/5/2016	! 1/2/2017	⚑ 1/30/2017	5	15	18	18	0%	! 1/2/2017	14	10	-29%	! 1/2/2017	Flag for discussion	
9	Bob Dolittle	11/2/2016	! 1/19/2017	⚑ 2/2/2017	3	11	22	19	-14%	! 1/19/2017	12	10	-17%	! 1/19/2017	Flag as safety risk	9/17
10	Nancy Fake	1/19/2017	! 1/19/2017	⚑ 2/2/2017	0	0	No Score	No Score			No Score	No Score				
11	Betty Test	7/15/2016	! 1/15/2017	⚑ 2/14/2017	10	27	12	✓ 1	✓ -92%	! 1/15/2017	9	✓ 3	✓ -67%	! 1/15/2017		
1603																
1604																

Workflow and Roles



Time to remission

Usual primary care: 614 days

Collaborative Care: 86 days

Implementation

Develop Goal:

- Implement evidence-based program to improve behavioral health care in our primary care setting
- Partners: IMC, FMC, and Psychiatry

Research models

- University of Washington AIMS Model

Build the Team

- Identify roles and responsibilities

Create Stakeholder Buy In:

- PCPs, Staff, Psychiatric Consultant, Residents, Administration, Care Manager, Pharmacy, Social Worker, Navigators

Develop workflow

Training

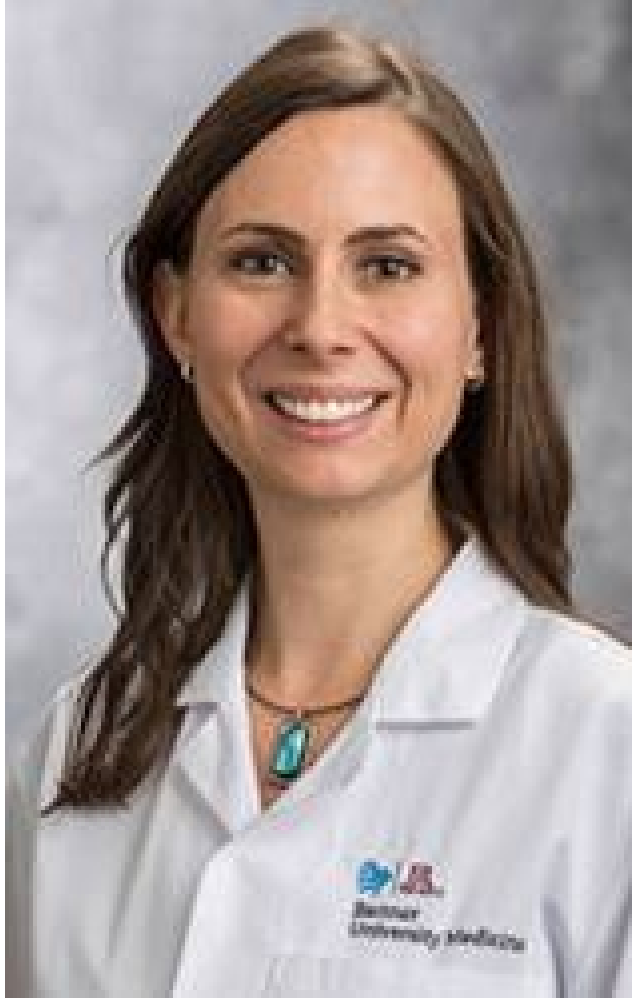
- Rationale, Workflows, Billing and Coding, Behavioral Health Management

Building Your Team

Our Practice

Sites:

- Family Medicine Residency
  - 3 office sites in same building
  - Psychology with limited availability
  - Large, interprofessional practice
- Internal Medicine Residency programs
  - 1 office site in same building as Family Medicine
  - No access to in house behavioral health
  - Large, interprofessional practice
- Psychiatry Residency:
  - 1 office site in same building as IM and FM
  - Previously not integrated with primary care

Our Team

Finding the Right Folks

Identify champions

Recruit broadly

Create stakeholder buy in and Actively engage all members of the team

Use behavioral based interviewing for culture, fit, and skills

Seek diversity, inclusion, and equity

Focus on the mission

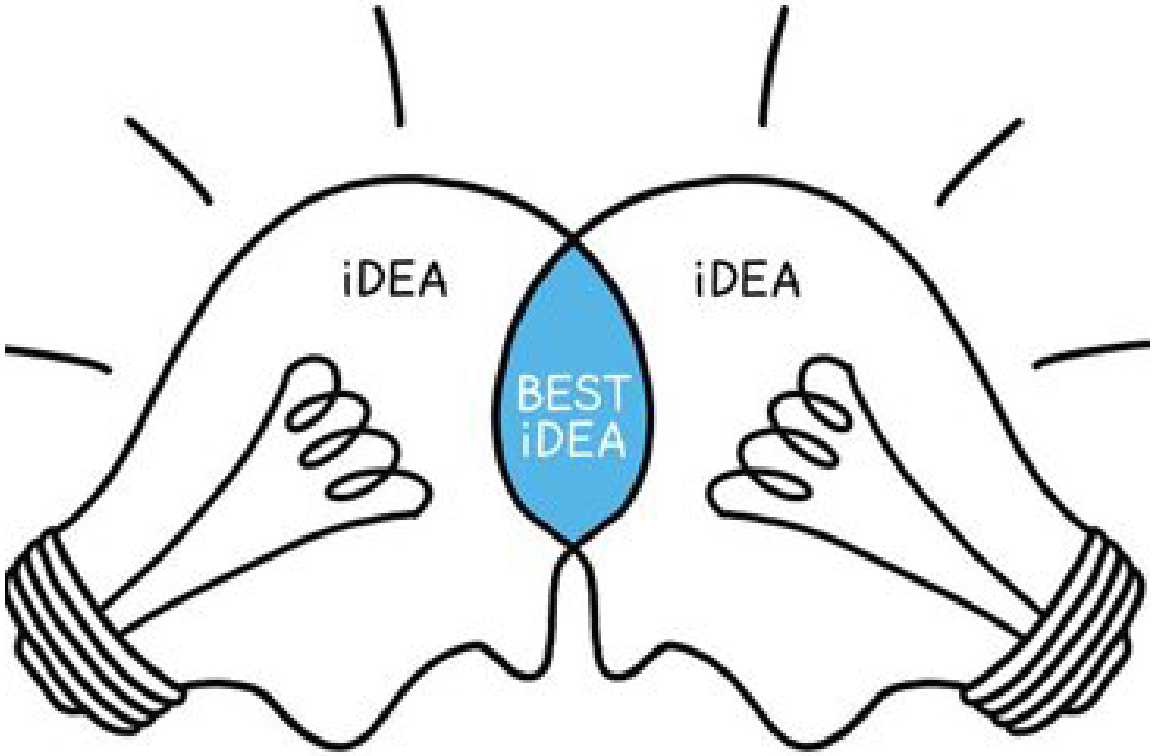
Creatively problem solve barriers and reinforce and reward successes

Train and train again

Allow for psychological safety

Key Steps

- Frequent Team Meetings to Review
- Reinforcement of shared mission and development to culture of integrated behavioral health care
- Iterative Training
- Frequent Process Changes: PDSA
- Identify both challenges and successes
- Work across silos: Billing and coding, EHR, admin, health information exchanges
- Build partnerships with local behavioral health facilities and establish referral patterns



Collaboration

Champion at each site involved at all stages of development and implementation

Build workflows to accommodate all needs/goals

Regular communication using agreed upon format

Frequent touch points

Get specific, actionable feedback

Dynamic nature of the panel

CoCM Results as of March 31,2022
175 patients have received care

PHQ9 - DEPRESSION	GAD7 - ANXIETY
Mean initial PHQ9 score: 16.0	Mean initial GAD7 score: 11.2
Current mean PHQ9 score: 7.0	Current mean PHQ9 score: 5.6
Symptom reduction: 56.3%	Symptom reduction: 50.0%
Reflects pts in active tx or relapse prevention	Reflects pts in active tx or relapse prevention

Benefits to Practice

CLINICIANS

Increase comfort with behavioral health screening, diagnosis, and management

Increase scope of practice
- Support from psychiatry for more complex cases
- Support from care manager

Office visit decompressed

Billable service

Improved detection of SDoH and other factors

Increase capacity

PATIENTS

Remain in primary care home

Increased touch points with patient

Improved access to behavioral health care

Improved behavioral health outcomes

Possibly improved physical health outcomes

Coordination with multiple services
- PCP, SW, pharmacy, psychology, RD, community services

Increase access to primary health care

Safer medication management

Clinician Comments

Check ins for mood during visit were definitely shortened allowing more time for other chronic issues.

Provides a great opportunity for residents to learn how to manage more complex behavioral health problems.

Patients seem more comfortable with engaging in mental health treatment because they get to keep their care in our clinic.

I like that I can call a psychiatrist for advice on med management for meds that I used to just refer out.

It has been particularly nice for more complicated patients that I may have tried to refer outside the office.

Pt's get started on meds earlier and seeing earlier stabilization.

I have treated severe depression, mild-moderate bipolar, and even early psychosis that I would never have started meds on before.

Passively suicidal patient had great support and many check ins that helped her get through a very hard time without needing care outside of our office

Resources

University of Washington AIMS Center https://aims.uw.edu/collaborative-care

CDC The State of Mental Health and Aging https://www.cdc.gov/aging/agingdata/data-portal/mental-health.html

Healthy People 2020 https://www.healthypeople.gov/

Archer J, Bower P,Gilbody S, Lovell K, Richards D, Gask L, Dickens C, Coventry P. Collaborative care for depression and anxiety problems. Cochrane Database of Systematic Reviews 2012, Issue 10.

Unutzer, J., Katon, W et al. Collaborative Care Management of Late Life Depression In The Primary Care Setting: A Randomized Control Trial. JAMA.2002 Dec;288(22):2836-45

Garrison GM, Angstman KB, O'Connor SS, Williams MD, Lineberry TW. Time to Remission for Depression with Collaborative Care Management (CCM) in Primary Care. JAM Board Fam Med, 2016 Jan-Feb;29(1):10-7

USPSTF Screening for Depression in Adults https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/depression-in-adults-screening1

Kessler RC, Angermeyer M, Anthony JC, et al. Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organization's World Mental Health Survey Initiative. *World Psychiatry*. 2007;6(3):168-76.

Thank You!

Please contact scoles@nchcaz.org if you have any questions!

Assembling the BHI Care Team: the Role of the Care Manager

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the corner HEALTH CENTER

Disclosures

- *I do not have any actual or potential conflicts of interest in relation to this program or presentation .*

Learning Objectives

Participants will:

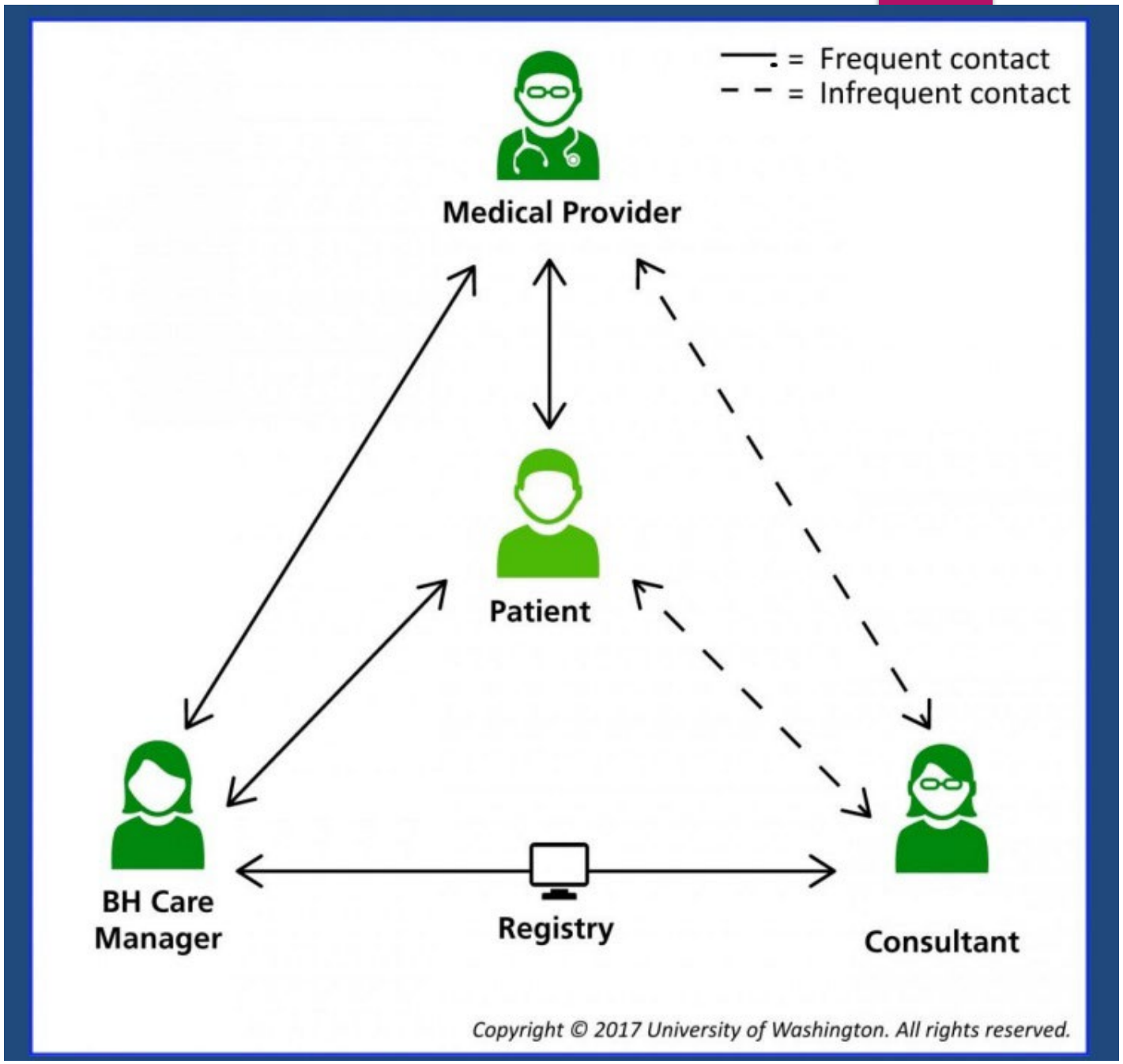
- Briefly review the Collaborative Care Model, including the interaction between the Care Manager and patient, as well as other team members.
- Learn about several examples of adaptations of this model, which are currently in use in non-profit clinic settings.
- Review the primary job functions of the Care Manager, and connect the skills inherent to the Care Manager's role to those of job-seekers, to help ensure a good fit.
- View examples of coordination documents/tools used by a Care Manager.

What is collaborative care?

The image on the right represents the AIMS Center's conceptualization of an integrated Behavioral Health model they call the Collaboration of Care Model.

Traditionally, the consultant would be a psychiatrist, who would review patient cases and advise prescribers.

I encourage you to adapt this model, and similar tools, for the purpose of increasing clinic efficiency, lowering costs, and improving patient outcomes.

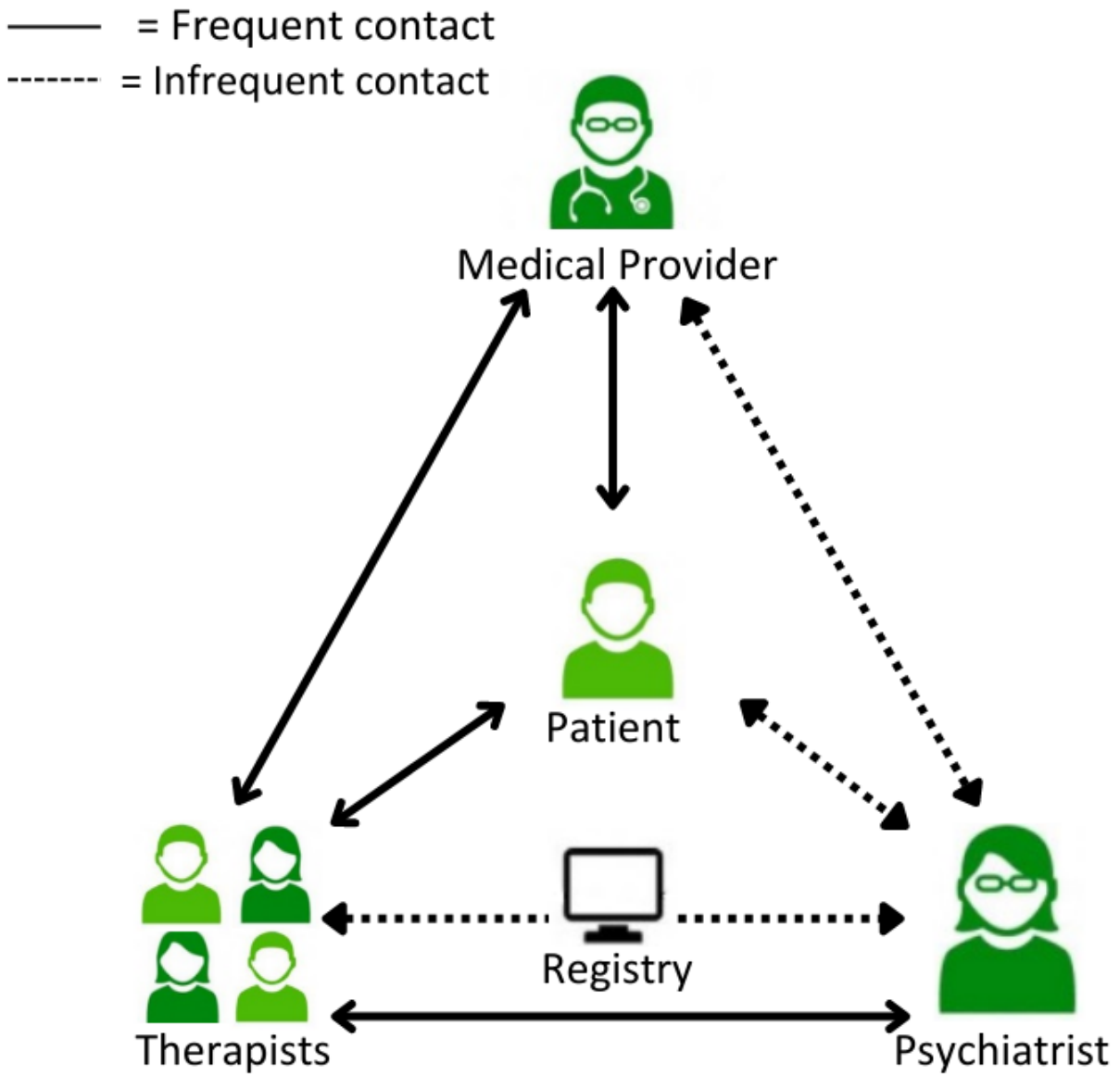


Adaptation scenario #1: Busy Doc

This image is represents the model in place at my previous employer.

This is the team I previously lead, wherein I was tasked to implement CoCM with an existing staff, where therapists, not Care Managers, were already in place.

We made use of the AIMS model, with as much fidelity as possible, but also adapted to suit our psychiatric consultant, who preferred team meetings via Zoom to relying solely on the registry. We recognized that including the PCP wasn't feasible, and defaulted to chart updates.

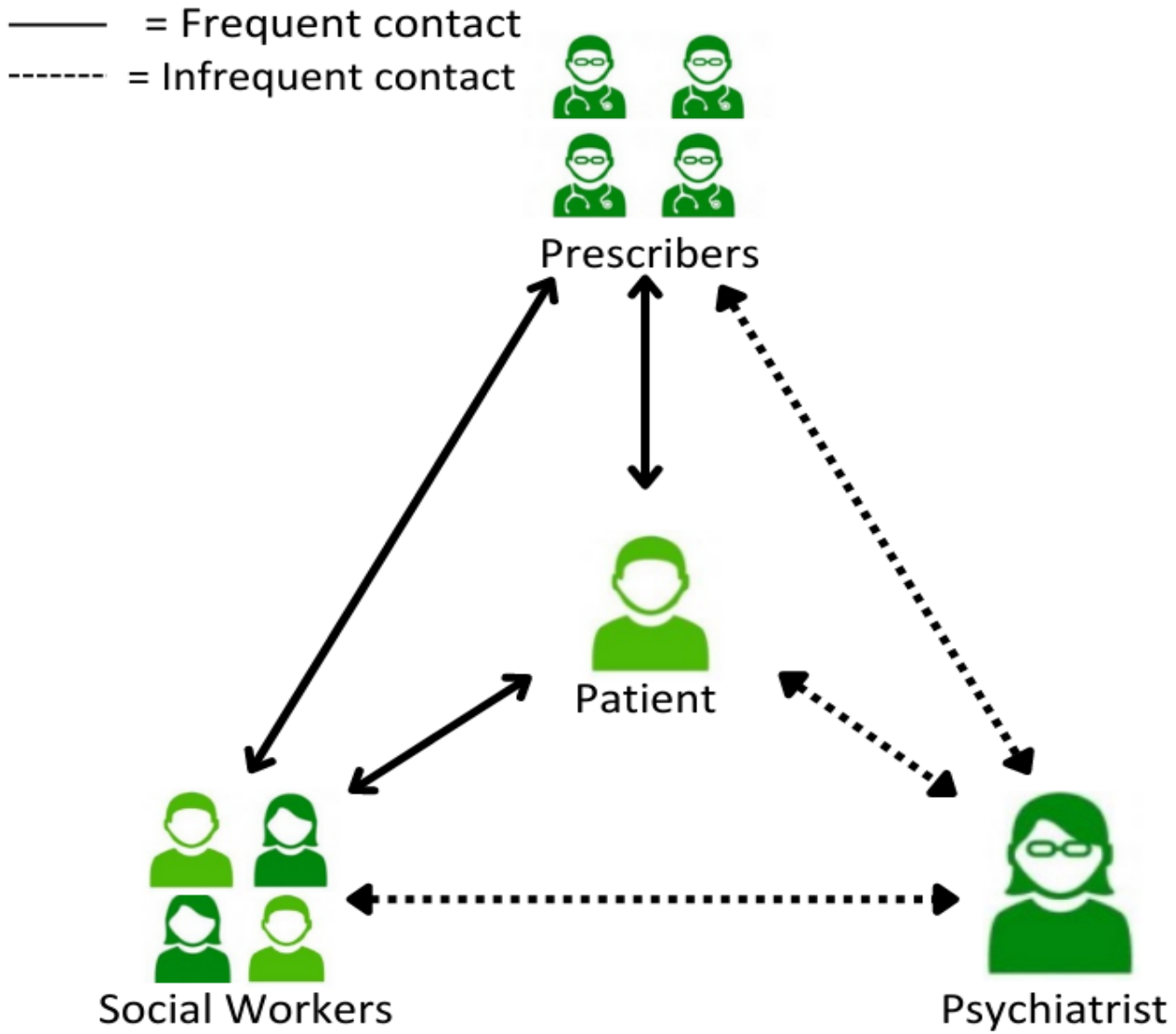


Adaptation Scenario #2: Group Love

This image represents the configuration of my current team at Corner Health Center, where I am the Behavioral Health Manager, supervising a team of clinical social workers, with various roles (Therapists, MIHP, Case Mgmt)

I facilitate a weekly integration meeting with all SW staff present. We also invite our team of multidisciplinary prescribers (NPs, OBs, MDs/residents), and 1-2 psychiatric staff. SW staff are expected to come prepared with cases for review.

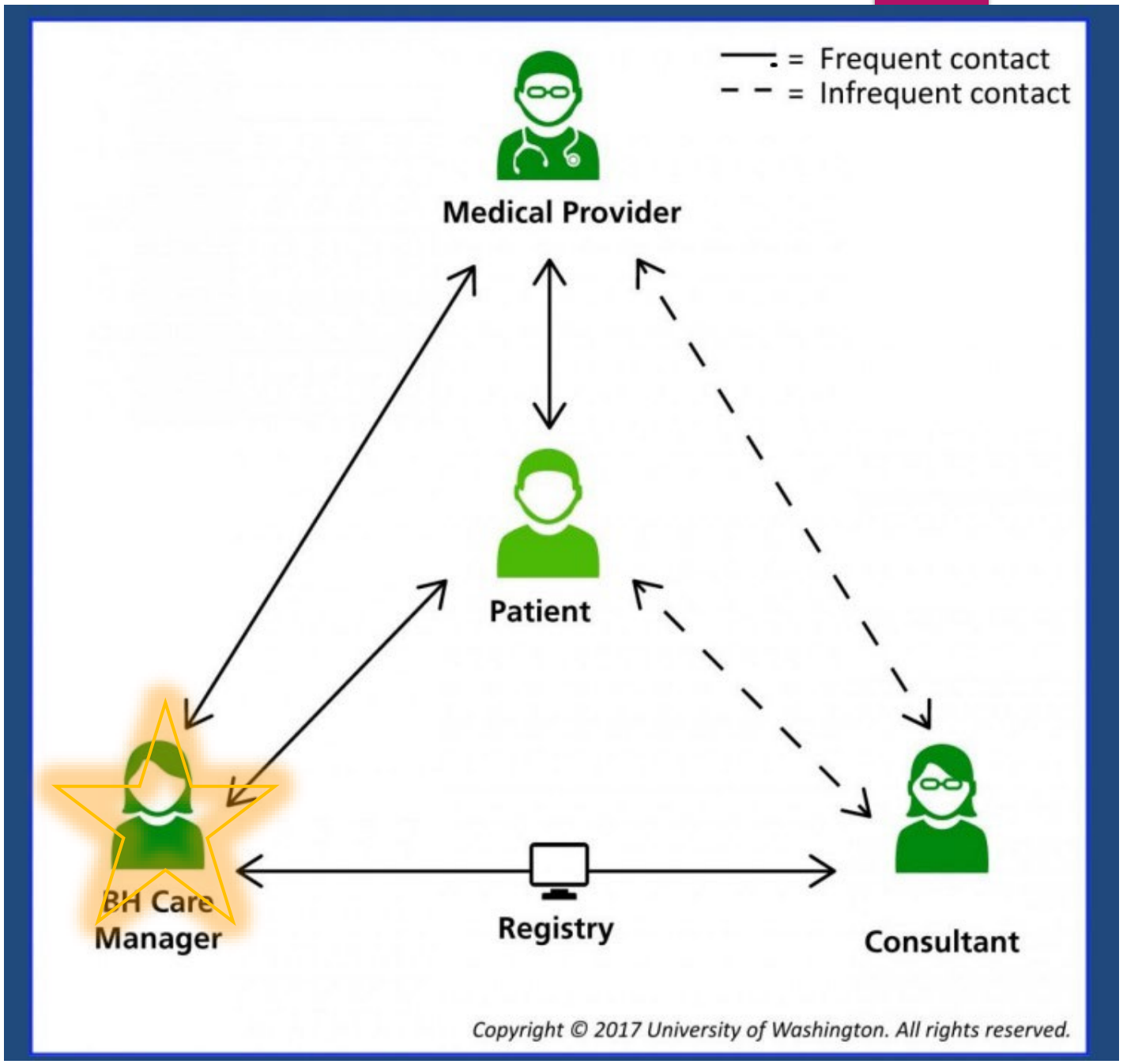
We utilize time to coordinate cases across the entire team, focusing on mental health and socio-medical needs. We do not currently use a registry for patient management, but do use EBP tools for monitoring.



What are the main functions of the Care Manager?

The care manager is the ***star*** of the coordination team. This individual is responsible for:

1. Maintaining a strong connection between the client and the organization.
2. Advocating/communicating on the client's behalf to the medical provider.
3. Accurate documentation of client progress, in order to guide the Consultant's focus.
4. Robust recording of client services/communication with Medical Provider to drive billing.



Breakdown of skills within the CM role

Role:

Maintaining a strong connection between the client and the organization.

Advocating/communicating on the client's behalf to the medical provider.

Accurate documentation of client progress, in order to guide the Consultant's focus.

Robust recording of client services/communication with Medical Provider to drive billing.

Associated Skills:

- Warmth, ability to build and maintain rapport
- Mental health experience; various therapy techniques including MI, Behavioral Activation, BFST, CBT/DBT skills, Suicide response framework.
- Knowledge of MH treatment, ability to provide patient psychoeducation.
- Excellent soft skills and correspondence, including timely responses, proficiency using multiple modes of HIPAA-compliant communication.

Breakdown of skills within the CM role

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Associated Skills:

- Skills of assessment and discernment regarding prioritizing client needs.
- Proficiency with medical language, as well as translation between client and provider.
- Comfort and skill working within a Team setting.
- Creative problem solving skills.

Breakdown of skills within the CM role

Role:

Maintaining a strong connection between the client and the organization.

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Associated Skills:

- Proficiency with data, and use of EHRs, registry tools, reporting tools, spread sheets, etc.
- Mental health assessment skills, including discernment/differential diagnostic capability.
- Must "speak the language" of psychiatry
- Training in the use and interpretation of evidence based assessment tools

Breakdown of skills within the CM role

Role:

Maintaining a strong connection between the client and the organization.

Advocating/communicating on the client's behalf to the medical provider.

Accurate documentation of client progress, in order to guide the Consultant's focus.

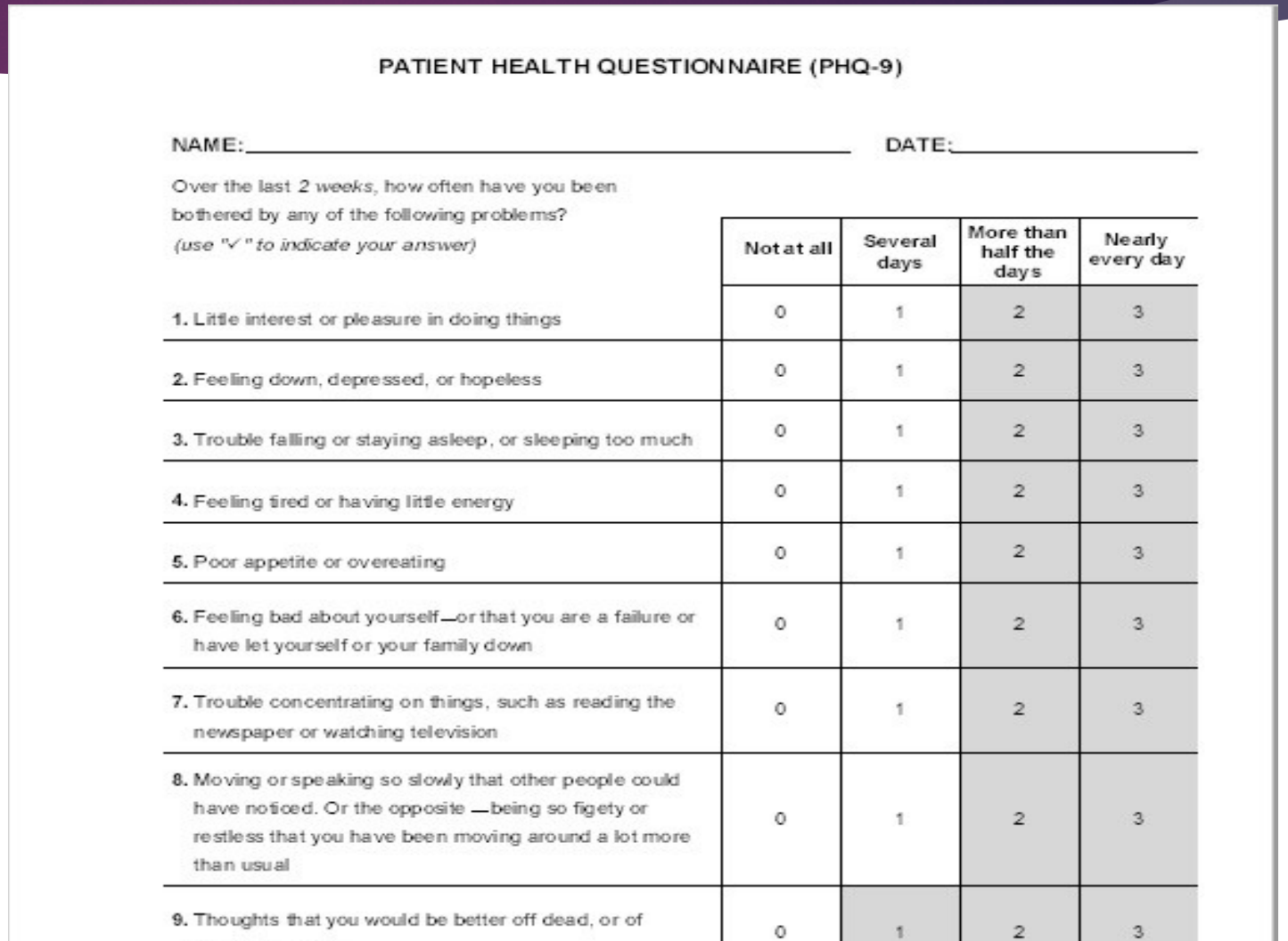
Robust recording of client services/communication with Medical Provider to drive billing.

Associated Skills:

- Accurate, detail oriented recording of client services rendered and provider effort, including referrals, multidisciplinary consultation, patient follow-up, etc.
- Basic knowledge of billing, grant tracking, etc.
- Good time management.
- Strong documentation skills.

Tools: Selecting an Evidence Based Screening

The PHQ-9 is considered the gold standard assessment tool, around which depression-focused CoCM was designed.
That said, you can select any valid, reliable assessment tool to track progress and validate decision-making.
My current teams uses the GAD-7, as well.
While assessments cannot take the place of good clinical judgement, they are an efficient way to steer clinical focus.



PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

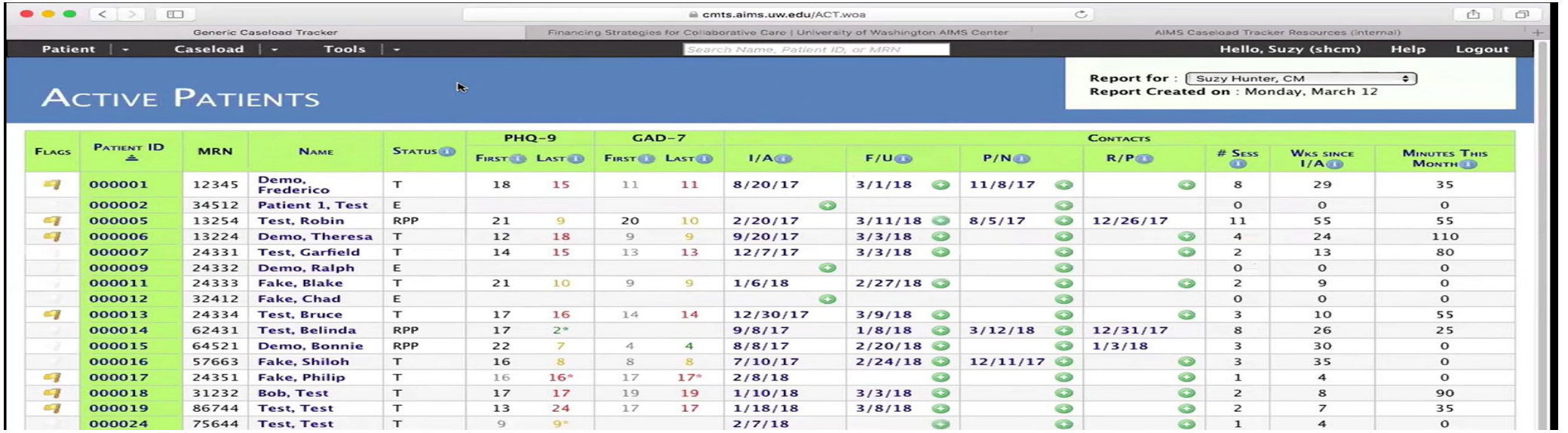
Over the last 2 weeks, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite —being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of	0	1	2	3

Tools: Registry Examples

Diabetes Tracking Worksheet

Patient name	Sex	Date of birth	ID number	Provider	A1c	Date of last A1c	Date of last eye exam	Date of last foot exam	Date of last BMP	LDL	Date of last lipids test	Systolic BP	Diastolic BP	Date of last BP	Co-morbidities
Green, Jane	F	4/21/1957	111-11-1111	Cooper	6.5	3/1/2020	3/31/2019	2/28/2020	2/28/2020	76	2/28/2020	145	91	2/28/2020	HTN, obesity
White, John	M	3/2/1961	222-22-2222	Cooper	5.7	2/26/2020	12/11/2019	2/22/2020	2/22/2020	91	2/22/2020	112	80	2/22/2020	
Black, James	M	7/16/1945	333-33-3333	Cooper	6.3	1/22/2020	7/22/2019	1/21/2020	1/21/2020	104	1/21/2020	110	70	1/21/2020	
Brown, Julie	F	9/8/1963	444-44-4444	Cooper	7.8	2/15/2020	3/18/2019	2/14/2020	11/11/2019	99	11/11/2019	135	85	11/11/2019	HTN, obesity, retinopathy
Doe, Jane	F	1/23/1942	555-55-5555	Cooper	6.8	10/21/2019	7/19/2019	10/22/2019	10/22/2019	87	10/22/2019	130	75	10/22/2019	
Douglas, John	M	2/24/1939	666-66-6666	Cooper	7.5	8/4/2019	2/1/2019	1/7/2020	1/7/2020	86	1/7/2020	120	80	1/7/2020	
Smith, James	M	10/1/1950	777-77-7777	Cooper	6.2	12/17/2019	5/14/2019	12/17/2019	12/17/2019	98	12/17/2019	115	75	12/17/2019	
Lane, Joseph	M	8/29/1969	888-88-8888	Cooper	6.4	1/30/2020	1/29/2020	1/29/2020	1/29/2020	66	1/29/2020	128	80	1/29/2020	
Baker, William	M	1/4/1949	999-99-9999	Cooper	6	12/10/2020	12/15/2019	12/15/2019	12/15/2019	99	12/15/2019	120	75	12/15/2019	



Flags	Patient ID	MRN	Name	Status	PHQ-9 First	PHQ-9 Last	GAD-7 First	GAD-7 Last	Contacts I/A	Contacts F/U	Contacts P/N	Contacts R/P	# Sess	Wks since I/A	Minutes This Month
	000001	12345	Demo, Frederico	T	18	15	11	11	8/20/17	3/1/18	11/8/17		8	29	35
	000002	34512	Patient 1, Test	E									0	0	0
	000005	13254	Test, Robin	RPP	21	9	20	10	2/20/17	3/11/18	8/5/17	12/26/17	11	55	55
	000006	13224	Demo, Theresa	T	12	18	9	9	9/20/17	3/3/18			4	24	110
	000007	24331	Test, Garfield	T	14	15	13	13	12/7/17	3/3/18			2	13	80
	000009	24332	Demo, Ralph	E									0	0	0
	000011	24333	Fake, Blake	T	21	10	9	9	1/6/18	2/27/18			2	9	0
	000012	32412	Fake, Chad	E									0	0	0
	000013	24334	Test, Bruce	T	17	16	14	14	12/30/17	3/9/18			3	10	55
	000014	62431	Test, Belinda	RPP	17	2*			9/8/17	1/8/18	3/12/18	12/31/17	8	26	25
	000015	64521	Demo, Bonnie	RPP	22	7	4	4	8/8/17	2/20/18		1/3/18	3	30	0
	000016	57663	Fake, Shiloh	T	16	8	8	8	7/10/17	2/24/18	12/11/17		3	35	0
	000017	24351	Fake, Philip	T	16	16*	17	17*	2/8/18				1	4	0
	000018	31232	Bob, Test	T	17	17	19	19	1/10/18	3/3/18			2	8	90
	000019	86744	Test, Test	T	13	24	17	17	1/18/18	3/8/18			2	7	35
	000024	75644	Test, Test	T	9	9*			2/7/18				1	4	0

Tools: Create a psychiatric case presentation template

MH Care Manager should present the following information when meeting with the psychiatrist:

- Demographic Information: including age, race, gender, living situation, and other salient identities. Include the circumstances of their referral to Tx. Possible environmental or cultural factors that impact the course of treatment.
- Key Findings: Include current Dx if available, assessment scores, client insight, and observational (MSE) data from your interactions
- History: Chronological list of prior psychiatric Dx, Hx and medication Hx. Other relevant medical data, including SU, family/personal Hx.
- Intervention: Engagement and progress within the current integration program
- Reason for case consultation: Meets criteria for review via the registry, case is up for discharge, etc.

Please remember this is not the CM's personal case formulation, but should be comprised of objective data for the psychiatrist to make their own recommendations.

Resources

- AIMS Center CoCM BH Care Manager Sample Job Description: https://aims.uw.edu/sites/default/files/CareManagerJobDescription_0.pdf
- AMA's EdHub Registry Development Toolkit: https://edhub.ama-assn.org/steps-forward/module/2702745
- Beidas, R. S., Et Al. (2015). Free, brief, and validated: Standardized instruments for low-resource mental health settings. *Cognitive and behavioral practice*, *22*(1), 5–19. https://doi.org/10.1016/j.cbpra.2014.02.002
- Funk, M. (2008). *Integrating mental health into primary care: a global perspective*. World Health Organization.
- PsychDB reference database on the MSE: PsychDB https://www.psychdb.com/teaching/mental-status-exam-mse#:~:text=The%20Mental%20Status%20Exam%20(MSE,guide%20them%20towards%20a%20diagnosis.

Citations

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- Schwartz, J., Wade-Olson, P., Fallon, J., & Riddle-Jones, L. (October, 2018) *Integrated care model for comprehensive transgender care in a small clinic setting* [PowerPoint Presentation]. 2018 Gay & Lesbian Medical Association Conference, Las Vegas, NV.
- University of Washington. (2021). *AIMS Center*. Advancing Integrated Mental Health Solutions. https://aims.uw.edu/

Thank you for your time!

Please feel free to address questions to jschwartz@cornerhealth.org

DISCUSSION QUESTIONS

- Has your practice/organization experienced issues of BHI workforce retention? If so, what steps has your practice/organization taken to address retention?
- How has your practice/organization recruited (or trained current staff) to fill these important BHI roles?
- What closing thoughts would you like to leave physicians with?

BHI Collaborative *"On Demand"* Webinars

Check out other webinars from the Overcoming Obstacles series such as:

- Advancing Health Equity through Behavioral Health Integration
- Addressing Behavioral Health in Primary Care: Non-Pharmacological Services & Treatments
- Beating Physician Burnout with Behavioral Health Integration

Watch all these webinars and more on the Overcoming Obstacles YouTube playlist now!

Collaborative Resource – *BHI Compendium*

The BHI Compendium serves as a tool to learn about behavioral health integration and how to make it effective for your practice and patients.

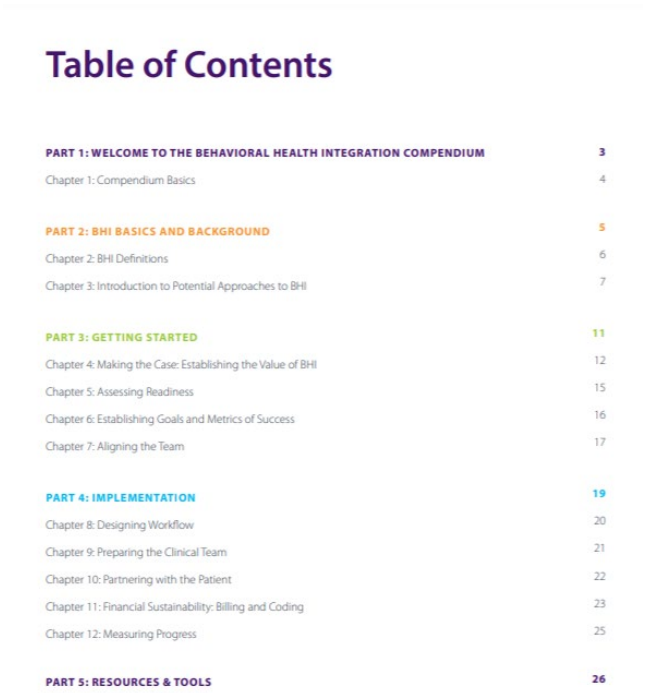
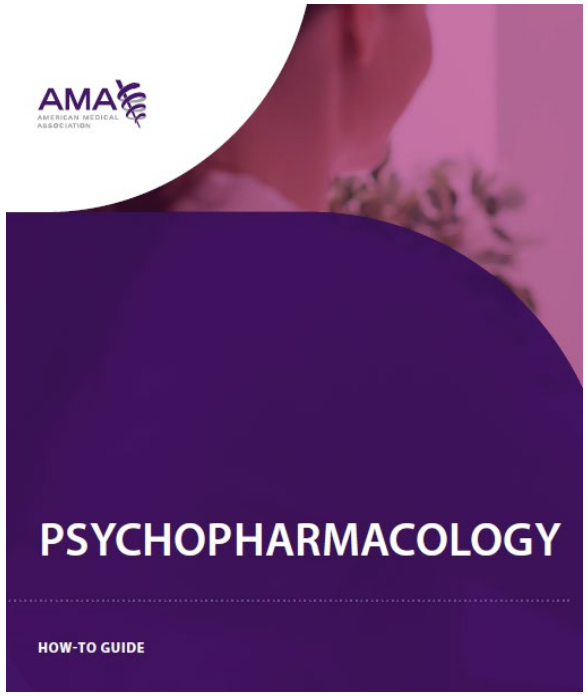


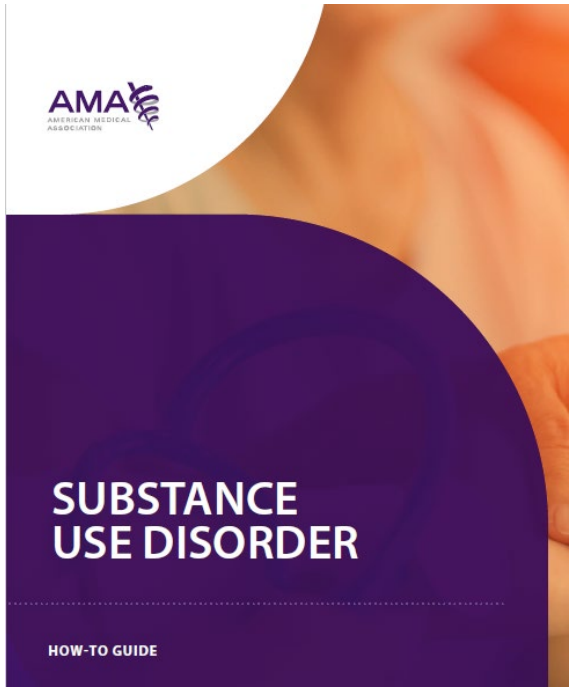
Table of Contents

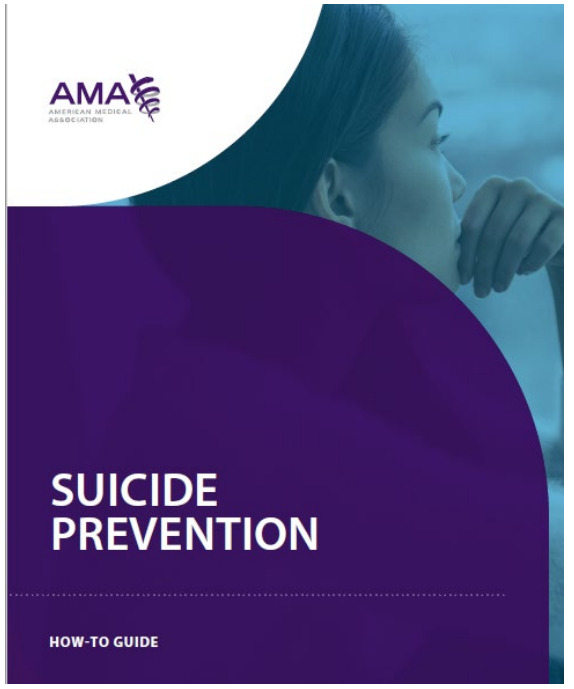
Download Now
to learn how to make the best decisions for the mental health of your patients.

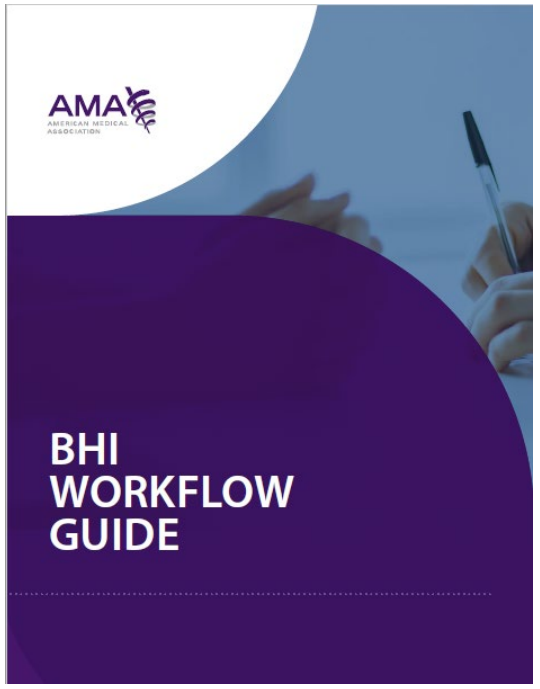
AMA Resources – *How-To Guides*

Access AMA's BHI practice guides for practical strategies, actionable steps and evidence-based resources on four specific areas of effective integrated care: pharmacological treatment, substance use disorder, suicide prevention, and workflow design.










Thank you for joining!