The SAMHSA/HRSA Center for Integrated Health Solutions

**Providing information, experts, and resources dedicated to behavioral health and primary care integration**

**Online:** [www.CenterforIntegratedHealthSolutions.org](http://www.CenterforIntegratedHealthSolutions.org)  
**Phone:** 202-684-7457  
**Email:** Integration@thenationalcouncil.org
University of Washington

AIMS CENTER
Advancing Integrated Mental Health Solutions

Building on 25 years of Research and Practice in Integrated Mental Health Care
This series of five modules is designed to introduce a psychiatrist to the practice of primary care psychiatry. There is a special focus on the developing role of a psychiatrist functioning as part of a collaborative care team. Each module has stated objectives and a content slide set. The core topics are:

Module 1: Introduction to Primary Care Consultation Psychiatry
Module 2: Building a collaborative Care Team
Module 3: Psychiatric Consulting in Primary Care
Module 4: Behavioral Interventions and Referrals in Primary Care
Module 5: Medical Patients with Psychiatric Illness
Module 2: Building an Integrated Care Team
By the end of this module, the participant will be able to:

• Explain the leadership role of a psychiatric consultant in a collaborative care team.
• Describe the primary care practice environment in which an integrated team functions.
• Define the members and roles of an integrated behavioral health team.
• Develop an efficient and effective work flow for their integrated care team. Identify training and other needs to support an effective team.
• Apply knowledge to help implement an integrated care team.
## Roles for Psychiatrists

### Clinical Leader
- Shape behavioral healthcare for a defined population of patients in primary care

### Caseload Consultant
- Consult indirectly through care team on a defined caseload of patients in primary care

### Direct Consultant
- Consult directly by seeing selected patients

### Clinical Educator
- Train BHPs and PCPs
- Both directly and indirectly
Consulting Psychiatrist Leadership

Administrative Leadership

- Negotiate the scope of integrated care practice, contract and payment
- Identify and cultivate the primary care champions and partners
- Help build the collaborative care team
- Support the collaborative care team

Clinical Leadership

- Facilitate the development of clinical protocols
  - e.g., suicidal ideation, psychiatric emergencies, use of controlled substances (benzos, opiates), management of chronic pain
- Facilitate team approach to challenging patients
- More in Module 3
Leading the Development of an Integrated Care Program

- Understand the environment
  - The world of primary care
  - Find and nurture a primary care "champion"
- Identify current resources
  - Team building tools
- Create and support your team
- Develop a clinical workflow
Life of a Busy PCP

Challenges:
• Large patient panels (1,500 – 2,500)
• Fast paced: 20-30 encounters / day
• Huge range of problems / responsibilities
• Full range of medical, behavioral, social problems
• Acute care, chronic care, prevention

Ways to cope:
• Focus:
  • What is the most serious?
  • What is practical to accomplish today?
• Diagnose and treat ‘over time’
• Get help \(\rightarrow\) TEAMWORK

"Everything comes at me and I bat at the problem before me” \(\rightarrow\) hard to keep track of what happens once treatments started

Need practical solutions & effective communication \(\rightarrow\) COLLABORATIVE CARE
Primary Care Landscape

Primary care providers

– Are overextended and can be difficult to engage
– May be concerned about taking on challenging patients and prefer referral to behavioral health specialist
– Have to learn to use care managers effectively

Primary care-based BHPs/Care Managers

– Do not all embrace the collaborative / care management model
– May see themselves as co-located therapists or more traditional social workers and not enjoy working closely with PCPs and consulting psychiatrists
Principles of Integrated Behavioral Health Care

Patient-centered Care

- **Team-based care**: effective collaboration between PCPs and Behavioral Health Providers.
- Nurses, social workers, psychologists, psychiatrists, licensed counselors, pharmacists, and medical assistants can all play an important role.
- “None of us is as smart as all of us.”

Population-Based Care

- Behavioral health patients tracked in a registry: no one ‘falls through the cracks’.

Measurement-Based Treatment to Target

- Measurable treatment goals clearly defined and tracked for each patient
- Treatments are actively changed until the clinical goals are achieved

Evidence-Based Care

- Treatments used are ‘evidence-based’.
Goal: Effective Team-based Collaborative Care

Primary Care Provider supported by Behavioral Health Care Manager

Practice Support

Informed, Active Patient

Outcome Measurement

Caseload-focused psychiatric consultation. Coordination with behavioral health specialists.

Provider Training and Support
Integrated Care Team Building Process

1. Define Scope and Tasks
2. Assess current resources and workflow
3. Define team member responsibilities and integrated workflows
4. Assess hiring and training needs
Team Building Process

- Define Scope and Tasks
  - Assess current resources and workflow
  - Define team member responsibilities and integrated workflows
  - Assess hiring and training needs
Integrated Care: Core Components and Tasks

1. Patient Identification and Diagnosis
2. Engagement in Integrated Care Program
3. Evidence Based Treatment
4. Systematic Follow-up, Treatment Adjustment, Relapse Prevention
5. Communication, Care coordination and Referrals
6. Systematic Case Review and Psychiatric Consultation
7. Program Oversight and Quality Improvement
Customize ‘Tasks’ to Population and Clinical Setting

- What populations will be served?
- What services do we want to provide on site versus referral to community resources?
- What kind of support are the PCPs hoping for?
- What kind of support do BHPs/Care Managers need?

GET SPECIFIC!
Team Building Process

Define Scope and Tasks

Assess current resources and workflow

Define team member responsibilities and integrated workflows

Assess hiring and training needs
**Example Team Building Process: Step 1: Staff Self Assessment**

<table>
<thead>
<tr>
<th>Integrated Care Tasks</th>
<th>Is This A Priority Task?</th>
<th>Is This Your Role Now?</th>
<th>If No, Whose Role?</th>
<th>Your Organization's Capacity with This Task?</th>
<th>Your Level of Comfort with This Task?</th>
<th>Would You Like Training to Perform This Task?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify and Engage Patients</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>High</td>
<td>High</td>
<td>Low</td>
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<tr>
<td>Identify People Who May Need Help</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>High</td>
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<td>No</td>
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<tr>
<td>Screen for Behavioral Health Problems Using Valid Measures</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>High</td>
<td>Medium</td>
<td>No</td>
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<tr>
<td>Diagnose Behavioral Health Disorders</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Low</td>
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<td>Yes</td>
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<tr>
<td>Engage Patient in Integrated Care Program</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>High</td>
<td>Medium</td>
<td>No</td>
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<tr>
<td>Initiate and Provide Treatment</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>High</td>
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<tr>
<td>Perform Behavioral Health Assessment</td>
<td>No</td>
<td>Yes</td>
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<td>Yes</td>
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<tr>
<td>Develop and Update Behavioral Health Treatment Plan</td>
<td>No</td>
<td>Yes</td>
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<td>Low</td>
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<td>No</td>
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<tr>
<td>Patient Education about Symptoms &amp; Treatment Options</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Low</td>
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<td>Yes</td>
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<tr>
<td>Prescribe Psychotropic Medications</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
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<td>No</td>
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<tr>
<td>Patient Education about Medications &amp; Side Effects</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Low</td>
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<tr>
<td>Brief Counseling, Activity Scheduling, Behavioral Activation</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
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<td>Evidence-based Psychotherapy (e.g. PST, CBT, IPT)</td>
<td>No</td>
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<td>No</td>
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<td>Low</td>
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<tr>
<td>Identify and Treat Coexisting Medical Conditions</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
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<td>No</td>
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<tr>
<td>Facilitate Referral to Specialty Care or Social Services</td>
<td>No</td>
<td>Yes</td>
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<td>Low</td>
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<td>No</td>
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<tr>
<td>Create and Support Relapse Prevention Plan</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Low</td>
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<td>No</td>
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<tr>
<td>Track, Treatment Outcome</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Assess Need for Changes in Treatment</td>
<td>Yes</td>
<td>No</td>
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<td>High</td>
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<td>Yes</td>
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<td>Facilitate Changes in Treatment / Treatment Plan as needed</td>
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<tr>
<td>Provide CaseLoad-Focused Psychiatric Consultation</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>High</td>
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<td>Yes</td>
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<tr>
<td>Provide in Person Psychiatric Assessment of Challenging Patients</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>High</td>
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<td>Yes</td>
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<tr>
<td>Other Issues Important for Our Program (Confidence as Needed)</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>High</td>
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<td>Yes</td>
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<tr>
<td>Coordinate Communication Among All Team Members / Providers</td>
<td>Yes</td>
<td>No</td>
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<td>High</td>
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<td>Yes</td>
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<tr>
<td>Administrative Support for Program (e.g., Scheduling, Resources)</td>
<td>Yes</td>
<td>No</td>
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<td>High</td>
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<td>Yes</td>
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<tr>
<td>Clinical Supervision for Program</td>
<td>Yes</td>
<td>No</td>
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<td>Yes</td>
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<tr>
<td>Training of Team Members in Behavioral Health</td>
<td>Yes</td>
<td>No</td>
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Example Team Building Process:
Step 2: Define Current Resources

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<th>Staff 1</th>
<th>Staff 2</th>
<th>Staff 3</th>
<th>Staff 4</th>
<th>Staff 5</th>
<th>Staff 6</th>
<th>Staff 7</th>
<th>Partner Agency</th>
<th>Referral Agency</th>
<th>Total #</th>
<th>Changes Needed</th>
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<td>Identify and Engage Patients</td>
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<td>Screen for Behavioral Health Problems</td>
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<td>Diagnose Behavioral Disorders</td>
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<td>Engage Patient in Integrated Care Program</td>
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<td>Track Treatment Outcomes</td>
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<td>Track Treatment Engagement and Adherence using Registry</td>
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<td>Reach out to Patients who are Non-adherent or Disengaged</td>
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<td>Track Patients’ Symptoms with Measurement Tool (e.g., PHQ-9)</td>
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<td>Track Medication Side Effects &amp; Concerns</td>
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<tr>
<td>Track Outcome of Referrals and Other Treatments</td>
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<td>Adjust Treatment if Patients are Not Responding</td>
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<td>Facilitate Changes in Treatment / Treatment Plan</td>
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<td>Provide Case-Based Focused Psychiatric Consultation</td>
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<td>Provide in Person Psychiatric Assessment of Challenging Patients</td>
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<tr>
<td>Other Tasks Important for Our Program (add tasks as needed)</td>
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<td>Coordinate Communication Among Team Members / Providers</td>
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<td>Administrative Support for Program (e.g., Scheduling, Resources)</td>
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<td>Clinical Supervision for Program</td>
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<td>Training of Team Members in Behavioral Health</td>
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</table>

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Example Team Building Process:
Step 3: Create a Workflow / Action Plan

<table>
<thead>
<tr>
<th>Integrated Care Tasks</th>
<th>Who Name / Discipline</th>
<th>How Process (Including Hand-offs) &amp; Communication Methods (e.g. telephone, mail)</th>
<th>When</th>
<th>Where</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify People Who May Need Help</td>
<td></td>
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<tr>
<td>Screen for Behavioral Health Problems</td>
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<tr>
<td>Diagnose Behavioral Health Disorders</td>
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<tr>
<td>Engage Patient in Integrated Care Program</td>
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</tbody>
</table>

| Notes                                     |                       |                                                                                 |      |       |

| Needs for Implementation                  |                       |                                                                                 |      |       |
| ☐ Staff Hires                             |                       |                                                                                 |      |       |
| ☐ Staff Training                          |                       |                                                                                 |      |       |
| ☐ Clinical Supervision                    |                       |                                                                                 |      |       |
| ☐ Administrative Supervision              |                       |                                                                                 |      |       |
| ☐ Other Resources needed                  |                       |                                                                                 |      |       |

| Timeline                                  |                       |                                                                                 |      |       |
Team Building Process

1. Define Scope and Tasks
2. Assess current resources and workflow
3. Define team member responsibilities and integrated workflows
4. Assess hiring and training needs
Collaborative Team Approach

- PCP
- Patient
- Consulting Psychiatrist
- BHP/Care Manager
- Other Behavioral Health Clinicians
- Substance Treatment, Vocational Rehabilitation, CMHC, Other Community Resources

New Roles
Core Program
Additional Clinic Resources
Outside Resources
Primary Care Provider

- PCP
- Patient
- BHP/Care Manager
- Consulting Psychiatrist
- Other Behavioral Health Clinicians
- Substance Treatment, Vocational Rehabilitation, CMHC, Other Community Resources

Core Program

Additional Clinic Resources

Outside Resources
Primary Care Provider

• Oversees all aspects of patient’s care
• Diagnoses common mental disorders
• Starts & prescribes pharmacotherapy
• Introduces collaborative care team
  • Ideally with “warm hand-off”
• Makes treatment adjustment in consultation with care manager, team psychiatrists, and other behavioral health providers.
Behavioral Health Professional (BHP) / Care Manager - I

- Facilitates patient engagement and education
- Works closely with PCP and helps manage a caseload of patients in primary care
- Performs systematic initial and follow-up assessments.
- Systematically tracks treatment response
- Supports medication management by PCPs
  - Where will patient get medications?
  - Planning for medication adherence
  - Facilitating PCP visit to discuss side effects
BHP/Care Manager – II

- Provides brief, evidence-based counseling or refers to other providers for counseling services
- Reviews challenging patients with the consulting psychiatrist weekly
- Facilitates referrals to other services (e.g., substance abuse treatment, specialty care and community resources) as needed
- Prepares client for relapse prevention
Consulting Psychiatrist

Supports BHPs/care managers and PCPs

• Provides regular (weekly) and as needed consultation on a caseload of patients followed in primary care → Module 3
  • Focus on patients who are not improving clinically → intensification of treatment

• In person or telemedicine consultation or referral for complex patients

• Provides education and training for primary care-based providers
Other Behavioral Health Clinicians

- Patient
- BHP/Care Manager
- Consulting Psychiatrist
- Other Behavioral Health Clinicians

Core Program

Additional Clinic Resources

Outside Resources

Substance Treatment, Vocational Rehabilitation, CMHC, Other Community Resources
Incorporate Other Behavioral Health Clinicians

Can provide valuable services such as:

- Comprehensive assessment
- Evidence-based counseling / psychotherapy
  - Individual or Group
- Behavioral health interventions focused on health behaviors
- Chemical dependency counseling / treatment
- Social work services
‘Silent’ Partners

Patient

BHP/Care Manager

Consulting Psychiatrist

PCP

Other staff and managers

Other Behavioral Health Clinicians

Substance Treatment, Vocational Rehabilitation, CMHC, Other Community Resources

Core Program

Additional Clinic Resources

Outside Resources
‘Silent’ Partners

- Who are they?
  - Receptionists/Front Desk Staff
  - Medical Assistants
  - CEOs, Administrators

- Can be crucial in supporting the integrated care effort

- Important to ‘nurture champions’ here too!
Team Building Process

1. Define Scope and Tasks
2. Assess current resources and workflow
3. Define team member responsibilities and integrated workflows
4. Assess hiring and training needs
Staffing: BHPs/Care Manager

Who are the BHPs/CMs?

• Typically MSW, LCSW, RN, MA, PhD or PsyD

What makes a good BHP/CM?

• Organization
• Persistence
• Creativity and flexibility
• Willingness to learn
• Strong patient advocate
Staffing: BHP/ Care Manager

- Hire new staff vs. re-deploy existing staff
- Split duties between higher and lower skilled staff?
  - e.g., psychologist and medical assistant
- Types of behavioral health care managers: nurses, social workers, counselors, ARNPs, psychologists, etc.
- Caseload / number of care managers needed

THIS IS A ‘REAL’ JOB!
# Ideal Program Staffing in Diverse Clinic Settings

<table>
<thead>
<tr>
<th>Clinic Population (mental health needs)</th>
<th>% of clinic population with need for care management</th>
<th>Typical caseload size for 1 FTE Care Manager</th>
<th># of unique primary care clinic patients to justify 1 FTE CM</th>
<th>Typical personnel requirement for 1,000 unique primary care patients</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Low need</strong></td>
<td>2%</td>
<td>100</td>
<td>5000</td>
<td>0.2, 0.05 (2 hrs / week)</td>
</tr>
<tr>
<td>(e.g., insured, employed)</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medium need</strong></td>
<td>5%</td>
<td>75</td>
<td>1500</td>
<td>0.7, 0.07 (3 hrs / week)</td>
</tr>
<tr>
<td>(e.g., comorbid medical needs / chronic pain / substance abuse)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>High need</strong></td>
<td>15%</td>
<td>50</td>
<td>333</td>
<td>3, 0.3 (12 hrs / week)</td>
</tr>
<tr>
<td>(e.g, safety-net population)*</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
Staffing: Psychiatric Consultant

- Hire new vs. re-deploy
- In-house vs. external consultant
- In-person or telemedicine
- Responsibility for caseload of patients
- Approximately 2-4 hours / week of psychiatric consultant time for each 1 FTE care manager

THIS IS A ‘REAL’ JOB!
Staffing: Program Manager

- Who are they? → Clinical leads, clinic managers etc…
- Keep track of staff, program needs and outcomes and adjust as needed
- Integrate care manager and consulting psychiatrist into existing clinic staff, space and ‘flow’
  - ‘Private’ space to see patients
  - Time ("this is a real job")
  - Access to computer, EMR, charts
  - Support training
Workforce Issues

In general and especially in rural areas:

- Challenges finding qualified mental health providers
  - Care managers, therapists trained in evidence-based treatments
  - Consulting psychiatrists (especially child psychiatrists)
- Not all providers are trained in effective ‘team-care’ which requires effective collaboration and ‘handoffs’
Training for BHPs/Care Managers

- Care Management Skills
- Specific Skills → More in Module 4
  - e.g., Motivational Interviewing; Behavioral Activation; Problem Solving Treatment in Primary Care
    - Didactic
    - Case Supervision
- Web-based Training
  - AIMS Center: http://uwaims.org
  - Mental Health Integration Program (MHIP): http://www.chpw.org/gau/
  - U Mass Training Program in Primary Care Behavioral Health
    http://umassmed.edu/FMCH/PCBH/welcome.aspx
- Regular Case-based Supervision / Consultation
Workflow: Core Components and Tasks

1. Patient identification and diagnosis
2. Engagement in integrated care
3. Evidence Based Treatment
4. Systematic Follow-up/Treatment Adjustment
5. Communication, Care coordination and Referrals
6. Systematic Psychiatric Case Review
7. Program Oversight and Quality Improvement

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Workflow: Core Components and Tasks

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7. Program Oversight and Quality Improvement
Methods to Identify Patients

- PCP referral
- Systematic screening (e.g., PHQ-9 for depression)
- EMR-triggered (e.g. when psychototropic medication is prescribed)
Workflow: Core Components and Tasks

1. Patient identification and diagnosis
2. Engagement in integrated care
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7. Program Oversight and Quality Improvement
“Your Care Team Template”

- Combine with other patient educational materials
- Customize template:
  - Insert staff photos and contact information
  - Put assessment tool (e.g. PHQ-9) on back
  - Make into tri-fold brochure and include other general information for patients
Workflow: Core Components and Tasks

1. Patient identification and diagnosis
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7. Program Oversight and Quality Improvement
Evidence Based Treatment

- **Evidence Based Medication Recommendations**: (See more in Module 3)
  - Consulting psychiatrist to use current standard of care
  - Treatment protocols can be useful guides
- **Evidence Based Therapy**: (See more in Module 4)
  - Motivational interviewing for health behavior change
  - Problem Solving Treatment
  - Behavioral Activation
  - Other evidence-based psychotherapies (e.g. CBT, DBT, IPT etc)

Use evidence-based treatments as available!
Workflow: Core Components and Tasks

- Patient identification and diagnosis
- Engagement in integrated care
- Evidence Based Treatment
- Systematic Follow-up/Treatment Adjustment
- Communication, Care coordination and Referrals
- Systematic Psychiatric Case Review
- Program Oversight and Quality Improvement
Systematic Patient Tracking

Population-based registry to facilitate
- proactive follow-up to make sure patients don’t ‘fall through the cracks’
- planned, effective visits
- treatment adjustment & consultation

50 – 70 % of patients will need at least one change in treatment.
# Paper-based Tracking

## Clinical Tracking Chart

<table>
<thead>
<tr>
<th>Interventionist ID</th>
<th>Patient ID</th>
</tr>
</thead>
</table>

### Patient Information

- **Name**: 
- **Age**: 
- **Gender**: M/F
- **Ethnicity**: 
- **Doctor**: 
- **Dr’s #:**
- **MMSE**: 

### Chronic Medical Conditions

- **PsychoSocial Notes**: (social support, stressors, living conditions, finances, spiritual)

### Medication Information

(name, dose, start date, adherence, changes)

<table>
<thead>
<tr>
<th>Baseline Information</th>
<th>Behavioral Plan</th>
<th>Medication</th>
<th>Depression PHQ Score</th>
<th>Anxiety Oasis Score</th>
<th>MH/Other Consults</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tel/In-P</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Next Visit Date</td>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Visit Information</th>
<th>Behavioral Plan</th>
<th>Medication</th>
<th>Depression PHQ Score</th>
<th>Anxiety Oasis Score</th>
<th>MH/Other Consults</th>
<th>Notes</th>
</tr>
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<tr>
<td>Next Visit Date</td>
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</table>

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Excel®-based Tracking

<table>
<thead>
<tr>
<th>Patient #</th>
<th>Tickler</th>
<th>Patient Information</th>
<th>Contact Dates</th>
<th>Depression Severity</th>
<th>TREATMENT</th>
<th>REFERRAL</th>
<th>OPTIONAL-Process</th>
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<tr>
<td>2</td>
<td>Follow-up Contact number</td>
<td>Action</td>
<td>Name</td>
<td>ID #</td>
<td>Phone</td>
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<td>Contact date</td>
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<tr>
<td>2</td>
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<td>-15%</td>
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<tr>
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<td>Past Due</td>
<td>Genevieve</td>
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<tr>
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<tr>
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<td>Past Due</td>
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<td></td>
</tr>
<tr>
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<td>Past Due</td>
<td>Genevieve</td>
<td>1022</td>
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<tr>
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<td>1</td>
<td>Diane</td>
<td>1034</td>
<td>206-355-5999</td>
<td>5/21/05</td>
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<tr>
<td>2</td>
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<td>Diane</td>
<td>1034</td>
<td>206-355-5999</td>
<td>5/21/05</td>
<td>11</td>
<td>-21%</td>
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</table>
Can track ‘key information’

- Visits
- Medications
- Consultations
- Outcome measures (e.g., PHQ-9)
Web-based Registries:
Efficient ‘summary’ of key clinical information

Clinical Dashboard

- **Member Information**
  - Status: Evaluated - Accepted into Level 1

- **Working Diagnoses**
  - L1: Depression (PHQ-9: 0/27, Minimal); Anxiety (GAD-7: 0/21); PTSD (PCL: 56/85)

- **Assessment**
  - Pt feels significantly better. No depressive sx and only ‘normal’ anxiety. States previously her sister had a fight with her mother, pt became estranged from her mother and sister for a time. Pt continues to have a good relationship with her mother and her sister if mending her relationship with the mother. Pt discussed how she would work with her sister. Reports good relationship w her husband whose mood has significant w his new anti-depressant. She feels that her life in general has improved and has no particular concerns.

- **Safety Concerns**
  - Past Suicide Attempts: None reported.

- **Medications**
  - Sertraline (Zoloft): 50mg

- **Other Treatment**
  - None recorded

- **Activity Goals**
  - Pleasant Events Scheduling: Make it a point to do some things this week that you have identified that you enjoy. • Likes to decorate and was interested in baking, creating her own recipes. • Enjoys reading... • Going soccer games and practices. • Talk to my friends and brother. • Eating at least one meal together w husband and children. Plans pt will use exercise equipment to increase her energy and run. She will borrow sister’s machine.

- **Referrals**
  - 1 referral closed.

- **Outcome Measures**
Web-based Registries:
Efficient ‘summary’ of treatment history.
Web-based Registries: Efficient ‘summary’ of entire caseload

Caseload summaries help manage
- Clinical productivity
- Quality improvement
Web-based Registries:
Efficient ‘summary’ for PCPs and patients.
Workflow: Core Components and Tasks

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Communication: How and When?

- Communication is key to team function!
- Consider modality:
  - In person
  - Staff (MA or nurse)
  - Phone
  - Fax
  - Tele-video
  - Email (careful with confidential information)
  - EMR
- Frequency
  - Scheduled
  - As needed
Communication Strategies

Summarize Discussions

• Next steps / “to dos”
  – Care Manager / BHC
  – PCP
  – Other team members

• Questions for consultant(s)

• Follow-through

Care Coordination and Referrals

• Working with BHP/Care managers for care coordination → Module 3

• Facilitating appropriate referrals → Module 4
Workflow: Core Components and Tasks

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A different approach to recommendations:

- Provisional diagnosis
- Additional work-up needed
- Need for easily accessible information in treatment recommendations:
  - Simple medication protocols
  - Treatment options
  - Psychotherapeutic interventions and referrals

→ See Module 3 and 4
Workflow: Core Components and Tasks

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Implementing Integrated Care

Shared Vision
- How will we know success?
- Shared, measurable outcomes
  - e.g., # and % of populations screened, treated, improved

Engaged leaders & stakeholders
- Clinic leaders & administration
- PCPs, care managers, psychiatry, other mental health providers

Clinical & operational integration
- Functioning teams, communication, and handoffs
- Clear about ‘shared workflow’ & roles of various team members

Adequate resources
- Personnel, IT support, funding

Proactive problem solving re-barriers & competing demands
- Minimize complexity, PDCA
Reflection Questions

Reflective Thinking

- What is the environment of the primary care practice where I consult?
- What are my strengths as a clinical leader?
- What will be challenging for me in a leadership role?
- Who are the primary care champions for me in this effort?

Adapt to Practice (including team building)

- Define the work flow tasks for your collaborative care program
- Identify the champion in the primary care practice you serve
- Coordinate with all behavioral health providers
- Complete the teambuilding process
- Help implement an effective collaborative care workflow


