



AIMS CENTER

W UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

Resident Rotation: Collaborative Care Consultation Psychiatry

Anna Ratzliff, MD, PhD

Ramanpreet Toor, MD

James Basinski, MD

With contributions from:

Jürgen Unützer, MD, MPH, MA

Jennifer Sexton, MD, Catherine Howe, MD, PhD

Deborah Cowley, MD

Module 6: Building Collaborative Care



Learning Objectives

By the end of this module, the participant will be able to:

- **Understand the steps involved in implementing Collaborative Care Practice**
- **Identify administrative and clinical leadership roles for psychiatrists in Collaborative Care practices**
- **Understand the team building process tool including assessing staff and training needs**
- **Appreciate the necessity of other clinic staff including program managers and ‘primary care champions’ in building and maintaining Collaborative Care teams**
- **Consider themselves a leader with regard to quality assessment and improvement efforts.**
- **Appreciate the need for flexibility and dynamism in creating and continuously improving Collaborative Care teams and their workflows**





Making the 'Business Case' for Integrated Care

- **Improved patient outcomes**
- **Savings in total health care costs**
 - Demonstrated in research (IMPACT, Pathways)
 - Demonstrated in real world evaluations (Kaiser Permanente, Intermountain)
- **Improved patient and provider satisfaction**
- **Improved provider productivity**
 - PCPs have shorter, more productive primary care visits = more visits
 - Mental health consultants in primary care have lower no-show rates
- **Improved productivity**
 - Reduced absenteeism and presenteeism
 - Higher incomes / net worth
- **In safety net populations**
 - Reduced homelessness and arrest rates





PCP Buy-In

- **Landscape**
 - Are overextended and can be difficult to engage
 - Have to learn to use care managers effectively
- **Common resistance**
 - “One more problem I don’t have time for”; “Will just make more work for me”
 - “I already take good care of my patients’ mental illness”
 - “Why won’t you just take these difficult patients – I don’t need this team”
- **Selling integrated care**
 - Promote yourself as a resource; Be engaging (Nicely DONE)
 - Resist ‘regression to co-location’
 - Teach the Collaborative Care model
 - Look at patient outcomes together





BHP/Care Manager Buy-In

- **Landscape**
 - Come from outpatient settings with longer sessions, slower pace
 - Often split between several roles
 - Have to learn primary care world
- **Resistance**
 - Do not all embrace the Collaborative Care model
 - May see themselves as co-located therapists or more traditional social workers
 - Hierarchical tension with PCPs and consulting psychiatrists
- **Selling integrated care**
 - Provide effective care for patients who with limited access to care
 - Work where their skills are valued
 - Work as a member of a team/ reduce isolation





Payment for Collaborative Care

- **Fully capitated**
- **Partially capitated: PCP bills FFS; clinics get payment for care management resources**
- **Case rate payment: for Care Management and Psychiatric Consultation**
 - **DIAMOND Program**





How Psychiatrists Get Paid

- **Indirect Caseload Assessment**
 - Contracted FTE
 - Grants and Special Programs
- **Direct Patient Assessment**
 - Standard Billing Arrangements





Overview of Implementation

Phase 1: Lay the Foundation

Phase 2: Plan for clinical Practice

Phase 3: Build your clinical skills

Phase 4: Launch your care

Phase 5: Nurture your care





Phase 1: Lay the Foundation

- ✓ **Develop an understanding of the Collaborative Care approach, including its history, guiding principles, and evidence base**
- ✓ **Develop strong advocacy for Collaborative Care within organizational leadership and among the clinical team**
- ✓ **Create a unified vision for Collaborative Care with respect to your overall mission and quality improvement efforts**
- ✓ **Assess the difference between your organization's current care model compared to a Collaborative Care model**



Scope of Practice

What is the environment in which you would be consulting and are you comfortable providing support for all these populations?

- **Adults**
- **Children**
- **Pregnant patients**
- **Older adults**
- **Chronic pain**
- **Substance use treatment**

May STRETCH your current scope!
Seek consultation from your
colleagues.





Assessment of Current Practice

Behavioral health services											
...are difficult to obtain reliably.			...are available from mental health specialists but are neither timely nor convenient.			...are available from community specialists and are generally timely and convenient.			...are measured and are readily available from behavioral health specialists who are on-site members of the care team or who work in a community organization with which the practice has a referral protocol or agreement.		
1	2	3	4	5	6	7	8	9	10	11	12
Behavioral health outcomes (such as improvement in depression symptoms)											
...are not measured.			...are measured but not tracked.			...are measured and tracked on an individual patient-level.			...are measured and tracked on a population-level for the entire organization with regular review and quality improvement efforts employed to optimize outcomes.		
1	2	3	4	5	6	7	8	9	10	11	12

Adapted from: <http://www.safetynetmedicalhome.org/>





Phase 2: Plan for Clinical Practice Change

- ✓ **Identify all Collaborative Care team members and organize them for training**
- ✓ **Identify a population-based tracking system for your organization**
- ✓ **Develop a clinical flowchart and detailed action plan for your care team**
- ✓ **Develop a plan for funding, space, human resource, and other administrative needs**
- ✓ **Develop a plan to merge Collaborative Care monitoring and reporting outcomes into existing quality improvement efforts**



Registry Considerations

- **Evaluate the registry function of your EMRs to support Collaborative Care**
 - Clinical Outcomes
 - Key Processes of Care
- **Options**
 - Paper tracking
 - Excel based tracking
 - Web-based registry tools





HIPAA

- **HIPAA allows sharing of PHI, for the *coordination of care*, without a signed release.**
- **The only exception is if there is a stricter state law or if you are a substance abuse treatment facility (42 CFR)**





Collaborative Care Team Building Process

Define Scope and Tasks

Gap assessment of current resources
and workflow

Define team member responsibilities
and integrated workflows

Assess hiring and training needs



Program Staffing

Clinic Population (mental health needs)	% of clinic population with need for care management	Typical caseload size for 1 FTE Care Manager	# of unique primary care clinic patients to justify 1 FTE CM
<u>Low need</u> (e.g., insured, employed)	2%	100	5000
<u>Medium need</u> (e.g., comorbid medical needs / chronic pain / substance abuse)	5%	75	1500
<u>High need</u> (e.g., safety-net population)*	15%	50	333





Phase 3: Build Your Clinical Skills

- ✓ **Describe the Collaborative Care approach, evidence base and guiding principles.**
- ✓ **Describe Collaborative Care's key tasks, including patient engagement and identification, treatment initiation, outcome tracking, treatment adjustment and relapse prevention.**
- ✓ **Develop a qualified and prepared care team, equipped with the functional knowledge necessary for a successful Collaborative Care implementation.**
- ✓ **Develop skills in psychotherapy treatment that are evidence-based and appropriate for primary care.**



Training for BHPs/Care Managers

- **What**
 - Care manager skills: patient engagement, team communication, initiating treatment, patient outcome tracking, and many more!
 - Describe care from a Collaborative Care team
 - Brief behavioral interventions and evidence-based psychotherapy
- **How**
 - Web-based Training
 - Regular Case-based Supervision / Consultation





Training for PCPs

- **What**
 - Describe the PCP role as part of a Collaborative Care team and engage patient in care
 - Develop the functional knowledge needed to be part of a successful Collaborative Care team
 - Understand prescribing directions for psychotropic medications
- **How**
 - Provider meeting
 - Team training





Phase 4: Launch Your Care

- ✓ **Implement a patient engagement plan**
- ✓ **Manage the enrollment and tracking of patients in a registry**
- ✓ **Develop a care team monitoring plan to ensure effective collaborations**
- ✓ **Develop a plan to help patients from the beginning to the end of their treatment, including a relapse**



Troubleshooting Program Challenges

- **Regular check in with care coordinators about workflow issues → work with clinic leadership to address any concerns**
 - You may be the first to hear about concerns in your weekly consultation
- **Walk through the care of patients who do not improve**
 - Did the Collaborative Care get the note?
 - Did the note get to the PCP?
 - Did the PCP see the patient?
 - Did the patient see the PCP?
 - Can the Collaborative Care contact the patient twice a month?
- **Monitor quality aims: Low percentage improvement numbers suggest the need to review workflow and team building as well as patient factors**





Phase 5: Nurture Your Care

- ✓ **Implement the care team monitoring plan to ensure effective team collaborations**
- ✓ **Update your program vision and workflow**
- ✓ **Implement advanced training and support where necessary**
- ✓ **Continue sustainability efforts**



Monitoring: Quality Improvement & Accountability

Patient | Caseload | Program | Tools | Logout Hello, Jurgen (unutzer)

(Switch to Clinic-stat)

CASELOAD STATISTICS L1

CO	# OF P.	CLINICAL ASSESSMENT			FOLLOW UP			50% IMPROVED AFTER > 10 WKS		
		#	MEAN PHQ	MEAN GAD	# OF P.	MEAN #	MEAN # CLINIC	MEAN # PHONE	PHQ	GAD
Care Manager 1	70	68 (97%)	15.1 (n=61)	12.8 (n=52)	62 (91%)	6.7	5.5 (82%)	1.2 (18%)	19 (49%) (n=39)	16 (41%) (n=39)
Care Manager 2	86	86 (100%)	15.9 (n=86)	14.2 (n=84)	79 (92%)	12.4	6.4 (52%)	6.0 (48%)	34 (68%) (n=50)	28 (56%) (n=50)
All	156	154 (99%)	15.6 (n=147)	13.6 (n=136)	141 (92%)	9.9	6.0 (61%)	3.9 (39%)	53 (60%) (n=89)	44 (49%) (n=89)

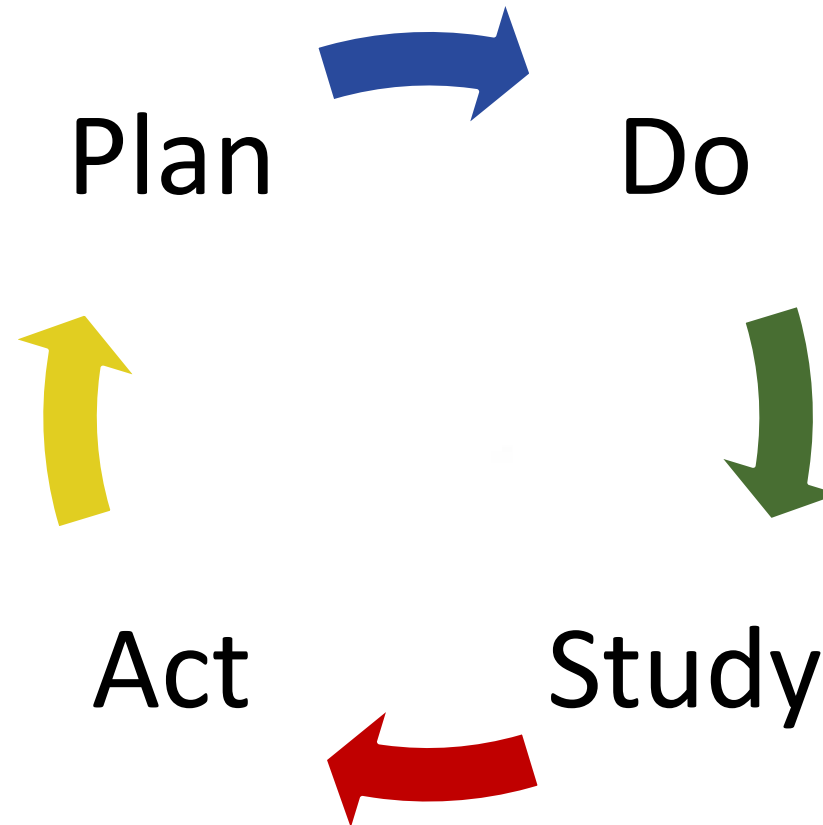
C/C = Continued Care Pls

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PDSA Cycle





Implementing Collaborative 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, PDSA





Reflection Questions

- 1. What challenges have you observed with workflow in your first few weeks of consultation? How has the consulting psychiatrist taken a leadership role around these issues?**
- 2. What Collaborative Care tasks or roles may be easier or harder to create in primary care clinics where you have worked?**
- 3. What would be your strengths and challenges as a clinical or administrative leader in a primary care?**

