AIMS CENTER
UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

Sharing the Responsibilities of the Behavioral Health Care Manager in the Collaborative Care Model

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Advancing Integrated Mental Health Solutions (AIMS) Center Introductions

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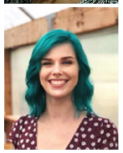


Kristi Malmstrom, BS
Program Coordinator

AIMS Center Background

The purpose of the AIMS Center is to inspire providers, researchers, and decision-makers to transform healthcare and improve patient outcomes. We accomplish this by translating and researching evidence-based approaches to behavioral health integration.

Zoom Housekeeping

- This webinar is being recorded
  - Link to recording and slide set will be sent out following the presentation
- Using the Q&A function
  - Enter your question at any time
  - We'll answer questions when all presenters are done
  - General questions about Collaborative Care Model (CoCM) Implementation and Financing can be answered at Implementation and Financing Office Hours or the AIMS Center website FAQs

Learning Objectives

By the end of this session, participants should be able to:

- Understand how the Behavioral Health Care Manager (BHCM) responsibilities are shared across a variety of clinical settings/ organizations
- Describe the benefits and challenges of having extended team members provide shared Collaborative Care Model (CoCM) responsibilities
- Identify resources available to help with implementation of the BHCM Role

COLLABORATIVE CARE BEHAVIORAL HEALTH CARE MANAGER ROLE

Principles of Collaborative Care

Patient-Centered Team. The patient, primary care and mental health providers collaborate effectively using shared care plans that incorporate patient goals.

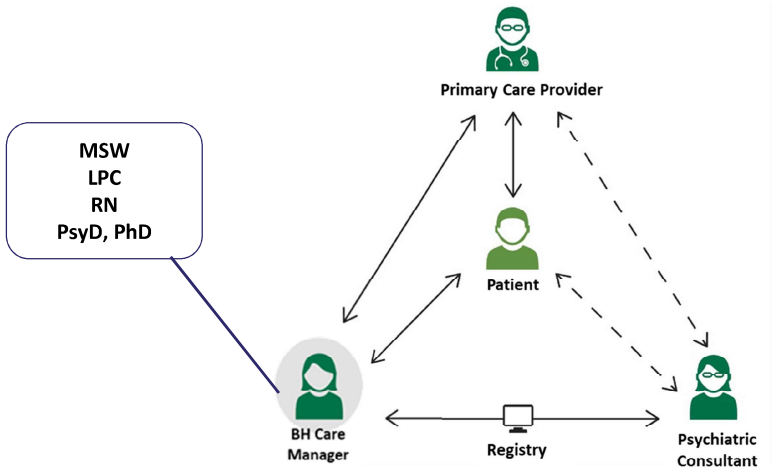
Population-Based. A registry is used to facilitate engagement and outcome tracking in a defined group of patients at the caseload and clinic level.

Measurement-based Treatment to Target. Progress is measured regularly, and treatments are actively changed until clinical goals are achieved.

Evidence-Based Treatments. Providers use treatments that have research evidence for effectiveness.

Accountable. The care team is accountable to the patient and other care team members for quality of care and clinical outcomes, not just the volume of care provided.

Behavioral Health Care Manager (BHCM)



https://aims.uw.edu/collaborative-care/team-structure/care-manager

General BHCM Functions

- **Track and coordinate care**
  - **Facilitates patient engagement**
  - **Performs systematic initial and follow-up assessments**
  - **Systematically tracks treatment response**
  - **Coordinates treatment planning with PCP**
  - **Reviews patients weekly with the psychiatric consultant**
  - **Creates relapse prevention plan with patients stepping down treatment**

Intervention Focused BHCM Functions

- **Provides evidence-based brief behavioral interventions**
  - **Problem Solving Treatment (PST)**
  - **Cognitive Behavioral Therapy (CBT)**
  - **Behavioral Activation (BA)**
  - **Addressing substance use (MI)**
- **Other functions (optional depending on skill set and clinic resources)**
  - **Care coordination**
  - **Referrals to community services**

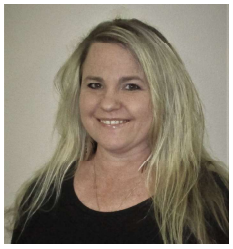
Today's Presenters

- **Alisa Peterson, MSW, LICSW,** Behavioral Health Care Manager and **Marcella Stewart,** Behavioral Health Care Manager Medical Assistant, *Kittitas Valley Health*
- **Jessica Anderson, CPC, MSM,** Behavioral Health Program Manager and **Jessica Lord,** Behavioral Health Case Worker, *Prisma Health*
- **Alisa Aunskul, MSHCM,** Senior Clinical Quality Consultant and **Rosemarie Consolacion,** Population Management Support Coordinator, *Kaiser Permanente*

Kittitas Valley Health

Alisa Peterson, MSW, LICSW

Behavioral Health Care Manager



Marcella Stewart

Behavioral Health Care Manager Assistant

Kittitas Valley Health Introduction

- We are a rural health clinic based in Cle Elum Washington. We have 5 medical providers, onsite MAT program, 1 psychiatric consultant (PMHNP), and 1 behavioral health care manager. Our program has 1 designated medical assistant.
- BHCM caseload is average 75.
- We serve patients of all ages and insurance types Medicare and Medicaid make up 50% of our caseload. Our patients are primarily Caucasian, Native American and Hispanic.

Factors Leading to Inclusion of Additional Staff in CoCM Team

- We modeled CoCM at Family Medicine Cle Elum to alleviate previous frustrations experienced by psychiatric consultant within our co-located clinic
- Time burden for team with phone calls, portal messages, and inbox messages
- Internal and external customer service
- Improve no-show rate

Workflow

- The flow:
  1. BHCM or MA conducts warm hand off at request of PCP
  2. MA contacts to schedule initial appointment, MA confirms schedule day before, cancelled appointments filled from standby list
  3. PSR gives paperwork upon check in, MA rooms patient, paperwork entered in chart
  4. MA coordinates zoom appointments – calls patient to complete PHQ9 GAD7 prior to appointment/resolve technology issues
  5. MA notified when follow up is due, clinical inbox monitored by MA, prior authorizations for medications
- Who is involved: PSR, MA, referral coordinator, clinic MA's if Marcella out (all clinic MA's trained for Collaborative Care)
- Tools:
  - Screening Tools (ROS, PHQ9, GAD7, mood disorder)
  - Lists (Cerner/Revenue Cycle, Cancellation list)
  - Technology (Zoom, AIMS Caseload Tracker)
  - Letters (Follow up reminder, no show, unable to contact, inactive patient)

How Workflow Assists with Meeting Diverse Needs and Population

- Reminder calls decrease number of no shows, opportunity for MA to schedule patients in crisis sooner appointment
- Establish patient relationships that allow for MA to know patient strengths, needs, preferences, and abilities
- MA assists with transportation arrangements if needed
- MA functions as care coordinator between PCP and BHCM and Psychiatric Consultant

Recording of CoCM Activities in EHR for Communication Purposes

- MA is entering measures into EHR, BHCM enters all data into AIMS Caseload Tracker
- All treatment planning documented in EHR
- Shared EHR among entire CoCM team
- Billing department audits for quality

Benefits and Drawbacks of Having Extended CoCM Team Members

- Improves patient compliance with follow up appointments
- Improves clinic flow and maximizes time providers have with patients

Lessons Learned

- Having a designated MA is essential for our program for fewer no shows and patient satisfaction
- Efficient documentation of PHQ9 and GAD7
- Improved productivity with BHCM, less burn out for team
- Improved coordination with PCP, better provider/patient satisfaction
- MA gatekeeper – fielding calls and checking portal

Prisma Health

Jessica Anderson, CPC, MSM

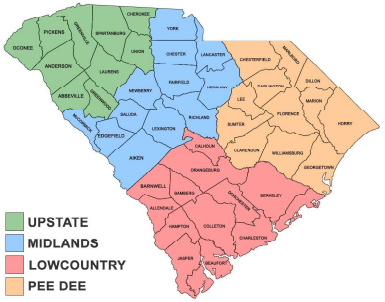
Behavioral Health Program Manager

Jessica Lord

Behavioral Health Case Worker

Prisma Health Introduction

- Prisma Health Care Transformation/inVio Network
  - 298 physician practices
  - 1815 employed physicians
  - 5,167 total doctors and other clinicians in our clinically integrated network (inVio)
- Serve the Upstate and Midlands of South Carolina
  - 22 Counties
- CoCM Program is in 10 locations within the organization
  - 8 in the Upstate
  - 2 in the Midlands
- 5 Behavioral Health Care Managers (LPC/LMFT/LMSW/LISW-CP)
  - Each serve 2-3 practices
- 3 Behavioral Health Case Workers
  - Each serve 2-3 practices
- Average Caseload is 50-60 patients
- Practices with CoCM have between 3-6 providers (MD/DO/NP/PA)



Factors Leading to Inclusion of Additional Staff in CoCM Team

- Pilot program in 2017 used outpatient therapist within the Department of Psychiatry
- Limited time for BHCMs to see patients
- Practice staffing with limited additional bandwidth to add new responsibilities

Workflow

- Practices universally screen for depression for all demographics
- Practices with CoCM also screen for anxiety for all demographics
- Treating provider identifies the patient and sends a referral to CoCM team or has the Behavioral Health Case Worker (BHCW) do a warm connection
- BHCW review referral, chart, contact patient, screen, and schedule
- BHCW schedule follow-up appointments, update care team, track patient appointments, find resources
- Assist non-covered patients with care coordination
- BHCW complete billing of services for practices

Recording of CoCM Activities in EHR for Communication Purposes

- Treating providers use a smart phrase to add the consent to their progress note
- Use of templates to flow information in from multiple areas of the chart
- EPIC Healthy Planet allows us to use a registry to track
  - Patient CoCM status
  - PHQ9 and GAD7 score comparison from initial to current
  - Identify treating provider, BHCM and Psychiatric Consultant (Care Team)
- Team uses encounter and progress notes, flowsheets, and screeners
- All team has access to all CoCM records in the chart
- Use reports to track patient cancellations, no shows, completed visits, referrals, quality metrics

Benefits and Drawbacks of Having Extended CoCM Team Members

- **Benefits**
  - Allows BHCMs to utilize most of their time in clinical care of patients
  - Allows practices to have additional support without needing a full time FTE
  - Allows the CoCM team to work closer together on patient care and needs
  - Gives providers and practices access to the behavioral health team for questions and support
- **Drawbacks**
  - Delays due to using a point person verses the practice staff (i.e., appointment scheduling)

Kaiser Permanente

Alisa Aunskul, MSHCM

Senior Clinical Quality Consultant

Rosemarie Consolacion

Population Management Support Coordinator

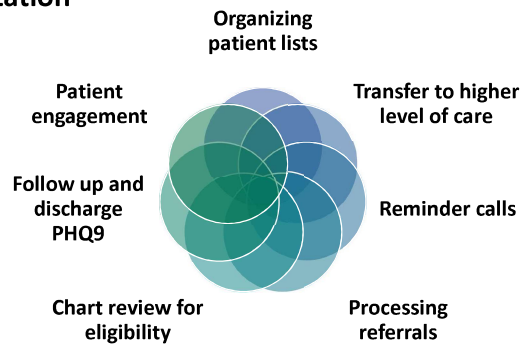
Kaiser Permanente Introduction

- Kaiser Permanente Southern California region
  - 13 Service Areas
  - One CoCM team in each Service Area
  - At least 1 support coordinator to each team

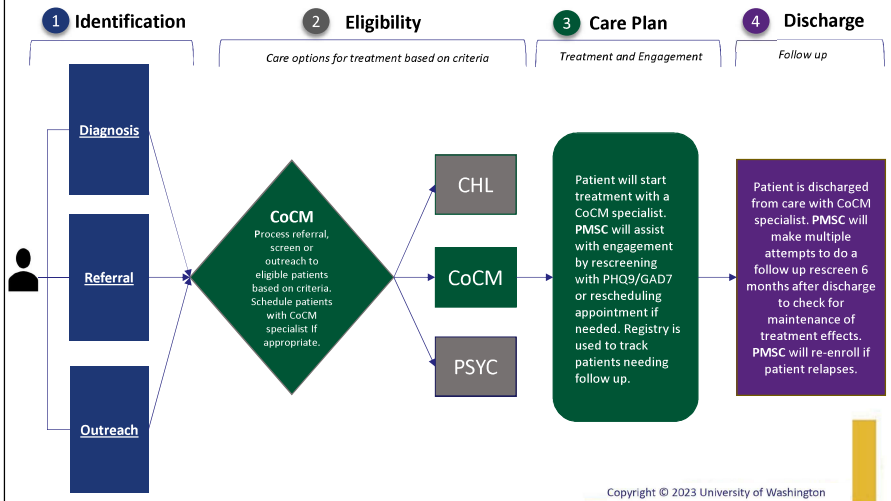
- Collaborative Care Program
  - Depression Population - 405,000
  - Patients treated - approx. 50,000 in the past 5 years
  - Average caseload - 120 per specialist at any given time
  - CoCM population -
    - Diagnoses-MDD, GAD, Adjustment disorder, Grief reaction, Dysthymia
    - PHQ9 5-19
    - GAD7 5-17
    - Pregnant or postpartum women
    - Patients undergoing cancer treatment
    - History of substance use and/or eating disorders
    - History of stroke and/or mild cognitive impairment

Factors Leading to Inclusion of Additional Staff in CoCM Team

- Administrative tasks take away from treating the patient
- Support Coordinator maintains team structure and organization



SCAL Kaiser Permanente CoCM Workflow



How Workflow Assists with Meeting Diverse Needs and Population

- **Support Coordinator can spend additional time working with patients who need support**

Recording of CoCM Activities in EHR for Communication Purposes

- Utilization of the flowsheet to ensure standardized documentation
- Sticky/Appointment notes to prevent miscommunication
- Smart phrases to standardize documentation/letters/emails
- Routing charts for important FYI/actions
- Inbasket/Staff Msg for FYI/actions
- Utilizing shared lists to manage pts (individual med centers/Tableau)

Benefits and Drawbacks of Having Extended CoCM Team Members

- Employee satisfaction
- Assist with possible burnout
- Quality of care
- Access to care
- Standardization
- Boost team morale
- Multiple points of contact

- Duplication of efforts

Lessons Learned

Key Learnings

Identify Roles and Responsibilities

- Develop clear Job Aids
- Standardized workflows to prevent miscommunication

Empowerment

- Encourage your staff to provide feedback and input
- Promote idea sharing amongst the team

Training and education

- Engage staff in shared learning webinars
- Provide educational resources
  - Motivational Interviewing

Team Dynamics

- Encourage communication to help support each other as needed
- Schedule weekly/monthly team huddles

MANY THANKS TO OUR PRESENTERS!

Considerations When Sharing BHCM CoCM Tasks

- Clearly define who is assigned which task
- Patient education about roles
- Clear communication plan
- Coordinate, not duplicate efforts
- How will psychiatric consultation be handled
- Keep behavioral health involved in management
  - —Registry can help

Q & A

Additional Resources

AIMS Center Resources:

http://aims.uw.edu/collaborative-care/team-structure/care-manager

https://aims.uw.edu/training-support/behavioral-interventions

American Psychiatric Association Resources:

https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/get-trained

AIMS Center Implementation and Financial Office Hour Info:

https://aims.uw.edu/what-we-do/office-hours

Upcoming Quarterly Webinars

- 3rd Tuesdays 10-11 AM Pacific
  - April 18, 2023
  - July 18, 2023
  - October 17, 2023
- Upcoming topics
  - Registry Innovations
  - Pediatric CoCM
- Let us know what you'd like to hear about!

WEBINAR FEEDBACK

Thank you for joining us!

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