COLLABORATIVE CARE

LORA PEPPARD, PHD, DNP, PMHNP-BC

ANNOUNCEMENTS #1

Save the Date!!!!

Cherokee Health Integrated Care Academy (Virtual)

January 13 and 14, 2021

Integrated Care Community of Practice beginning

January 26, 2021

More information at the conclusion of this presentation.

Watch for registration instructions coming soon.

ANNOUNCEMENT #2
THE BHPC INTEGRATED CARE TECHNICAL ASSISTANCE PORTAL IS LIVE.

Portal URL Address: https://bphc-ta.jbsinternational.com/

Health Center Program Patients

HRSA-Funded Health Centers Improve Lives

Nearly 30M people—that's **1 in 11** in the U.S.—rely on a HRSA-funded health center for care, including:

Source: Uniform Data System, 2019

HRSA Health Center Program

Health Center Program Data Overview

More than **97% of HCs** providing MH services

325,732 Patients receiving SUD Services

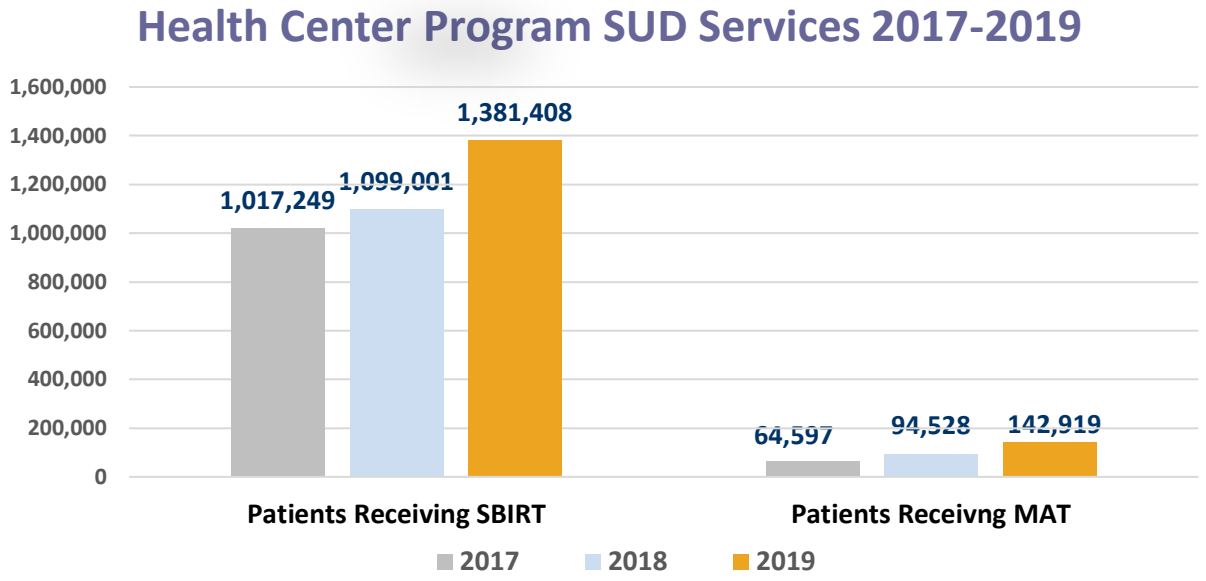
Over **1.8 Million** SUD **Clinic Visits**

SUD and Primary Care Integration

36% Increase in the number of patients receiving SBIRT from 2017-2019

121% Increase in the number of patients receiving MAT services from 2017-2019

32% Health Centers currently providing telehealth for SUD treatment in 2019



Training and Technical Assistance (T/TA) Resources:

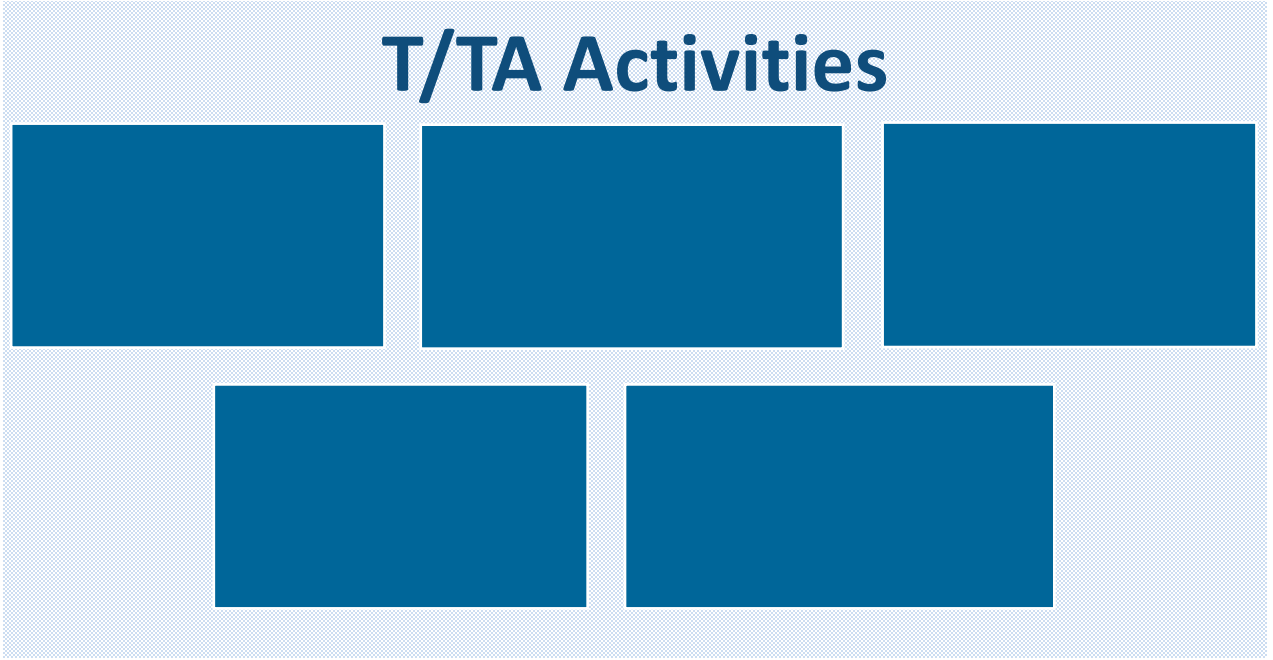
- **JBS International:** https://bphc-ta.jbsinternational.com/
- **UCSF National Clinician Consultation Center's Substance Use Warmline** provides clinician-to-clinician expert consultation addressing integrated behavioral health treatment & chronic pain management; M-F, 9 am to 8 pm ET by phone at 855.300.3595, or by submitting patient cases online (https://nccc.ucsf.edu/clinical-resources/substance-use-resources/)

HRSA Health Center Program

Behavioral Health and Substance Use Disorder Training and Technical Assistance

Topic Areas of TA Include:

- Medication-Assisted Treatment (MAT)
- Pain Management
- Screening Brief Intervention and Referral to Treatment (SBIRT)
- COVID-19
- Tele-Behavioral Services
- Depression Screening
- Social Determinants of Health
- Workforce Recruitment and Retention
- Care Coordination



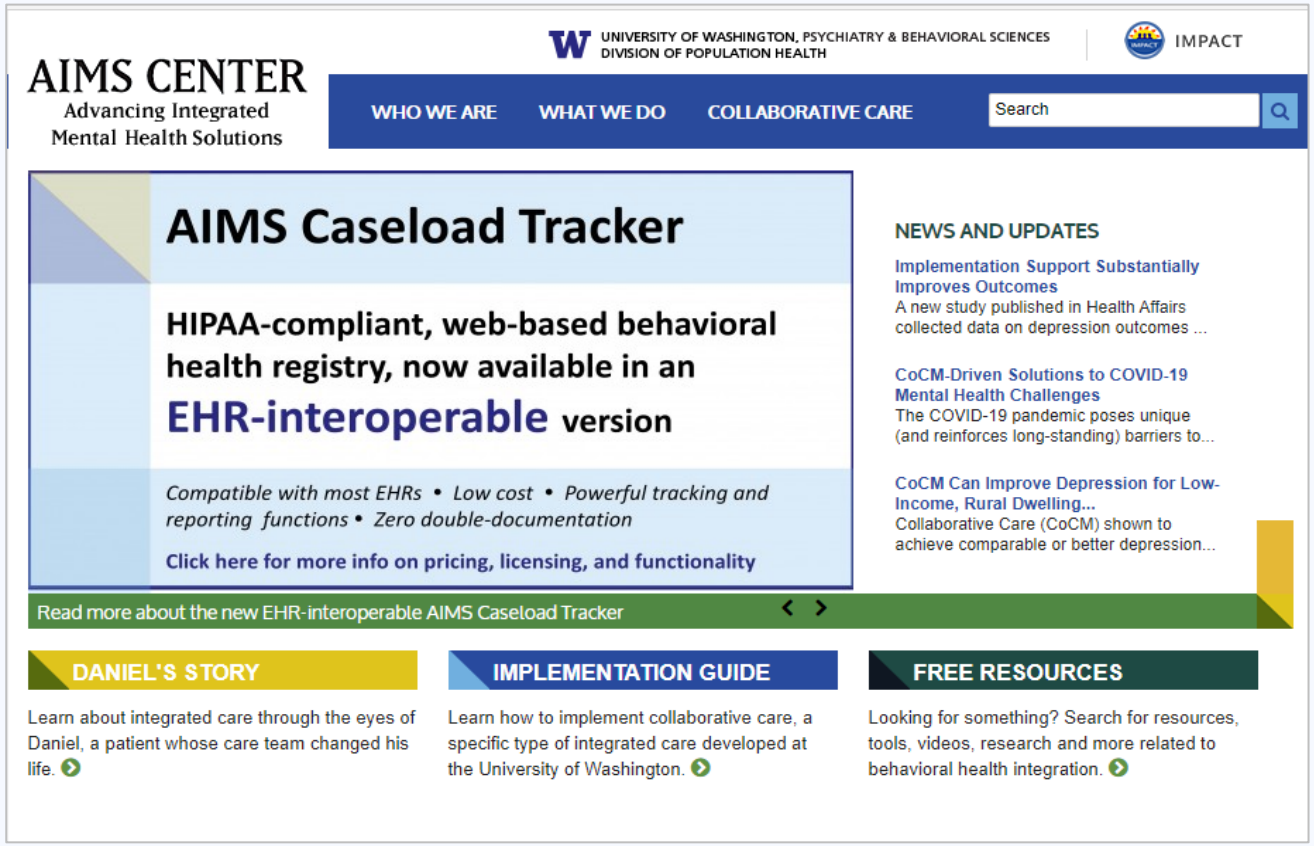
Sign up for TA: https://bphc-ta.jbsinternational.com/

HRSA Health Center Program

OBJECTIVES

1. Review the principles of Collaborative Care and the evidence supporting them.
2. Describe implementation of the Collaborative Care model.
3. Explain evaluation measures for the Collaborative Care model.
4. Discuss application of the Collaborative Care models in different clinics.

ACKNOWLEDGEMENTS



http://aims.uw.edu/

PRINCIPLES OF COLLABORATIVE CARE

Five core principles define collaborative care and should inform every aspect of an implementation. If any one of these principles is missing, effective collaborative care is not being practiced. These principles, along with core components and tasks, were developed in consultation with a group of national experts in integrated behavioral health care in 2011 with support from The John A. Hartford Foundation, The Robert Wood Johnson Foundation, Agency for Healthcare Research and Quality, and California HealthCare Foundation.

Patient-Centered Team Care
Primary care and behavioral health providers collaborate effectively using shared care plans that incorporate patient goals. The ability to get both physical and mental health care at a familiar location is comfortable to patients and reduces duplicate assessments. Increased patient engagement oftentimes results in a better health care experience and improved patient outcomes.

Population-Based Care
Care team shares a defined group of patients tracked in a registry to ensure no one falls through the cracks. Practices track and reach out to patients who are not improving and mental health specialists provide caseload-focused consultation, not just ad-hoc advice. Read how to identify a behavioral health patient tracking system in our Implementation Guide.

Measurement-Based Treatment to Target
Each patient's treatment plan clearly articulates personal goals and clinical outcomes that are routinely measured by evidence-based tools like the PHQ-9 depression scale. Treatments are actively changed if patients are not improving as expected until the clinical goals are achieved. Sometimes called Stepped Care. Read more about Treatment to Target.

Evidence-Based Care
Patients are offered treatments with credible research evidence to support their efficacy in treating the target condition. These include a variety of evidence-based pyschotherapies proven to work in primary care, such as PST, BA and CBT, and medications. Collaborative care itself has a substantial evidence base for its effectiveness, one of the few integrated care models that does.

Accountable Care
Providers are accountable and reimbursed for quality of care and clinical outcomes, not just the volume of care provided. Read more about accountability in our Financing section.

Principles of Collaborative Care

1. Patient-Centered Team Care
2. Population-Based Care
3. Measurement-Based Treatment to Target
4. Evidence-Based Care
5. Accountable Care

IMPLEMENTATION GUIDE

Lay the Foundation

CoCM is a new way of doing medicine and requires an openness to creating a new vision that everyone supports.

- ✓ Develop an understanding of CoCM, its history and guiding principles.
- ✓ Develop strong advocacy for CoCM within leadership and among the clinical team.
- ✓ Create a CoCM vision with your overall mission and QI efforts in mind.
- ✓ Assess the difference between your current model and CoCM.

Plan for Clinical Practice Change

Clearly define team roles, create a patient-centered workflow, and decide how to track patient treatment & outcomes.

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

Build Your Clinical Skills

Effective CoCM creates a team in which all providers work together using evidence-based treatments.

- ✓ Describe CoCM's key tasks, including patient engagement and identification, treatment initiation, outcome tracking, treatment adjustment and relapse prevention.
- ✓ Equip care team with the knowledge necessary to successfully implement CoCM.
- ✓ Develop care team skills in evidence-based interventions appropriate for primary care (e.g. PST, BA).

Launch Your Care

Is your team in place? Are they ready to use evidence- based interventions for primary care? All systems go? Time to launch!

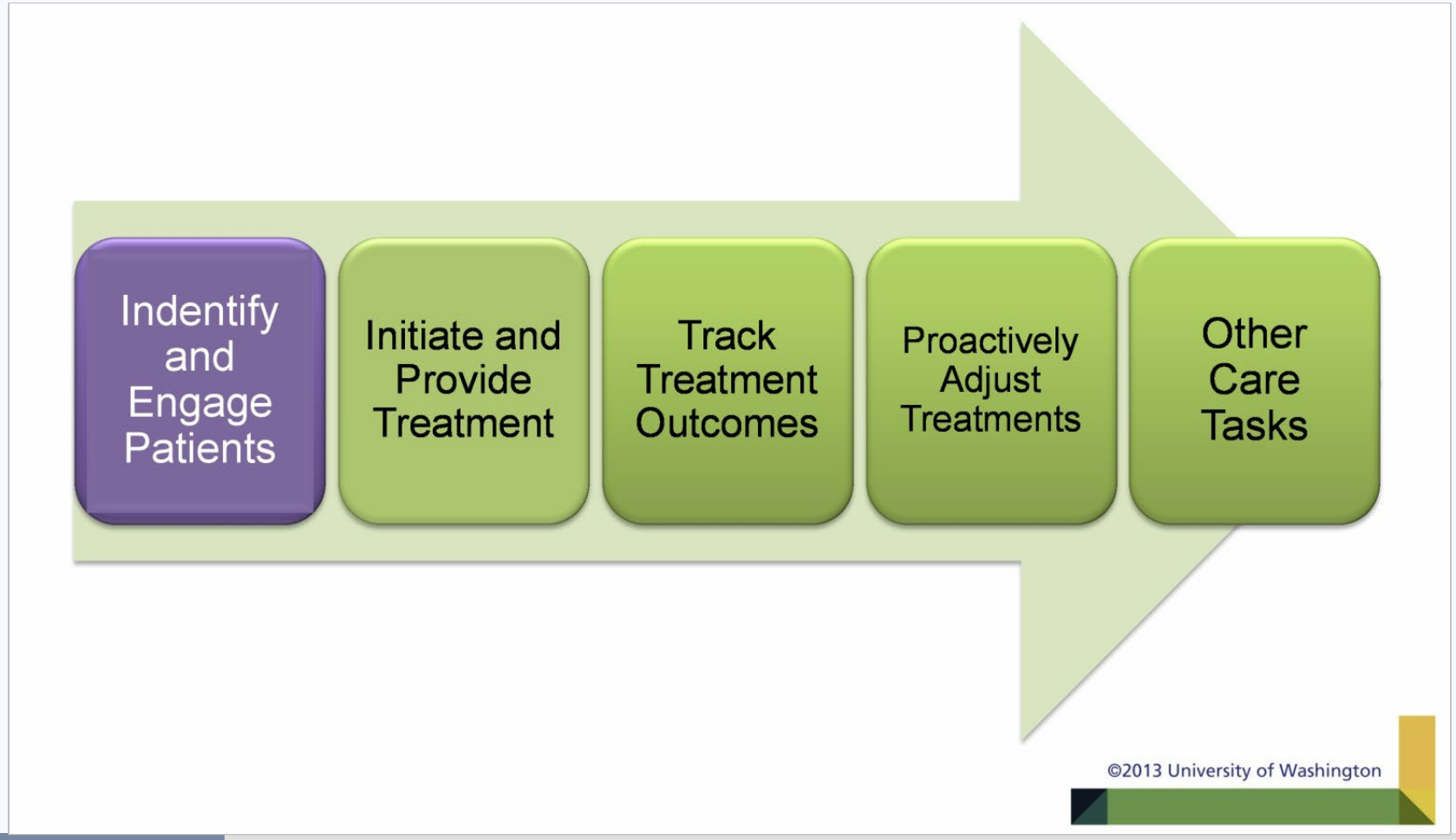
- ✓ Implement a patient engagement plan.
- ✓ Manage the enrollment and tracking of patients in a registry.
- ✓ Develop a care team monitoring plan to ensure effective collaborations.
- ✓ Develop clinical skills to help patients throughout treatment, including a relapse prevention plan.

Nurture Your Care

Now is the time to see the results of your efforts as well as to think about ways to improve.

- ✓ Implement the care team monitoring plan to ensure effective team collaborations.
- ✓ Update your program vision and workflows as needed.
- ✓ Implement advanced training and support where necessary.

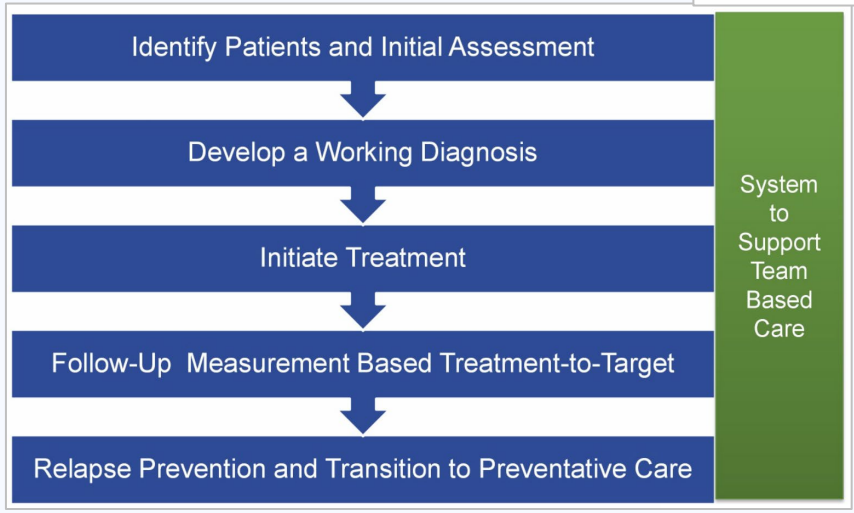
IMPLEMENTATION TASKS



ROLES

Characteristics of Effective Care Managers

- Persistent
- Flexible, open to new ways of practicing
- Adaptable to primary care culture and workflows
- Enjoys working in a collaborative team
- Organized, able to track entire population of patients
- Strong advocate for changing treatments until patient improved



PRIMARY CARE PROVIDER

CARE MANAGER

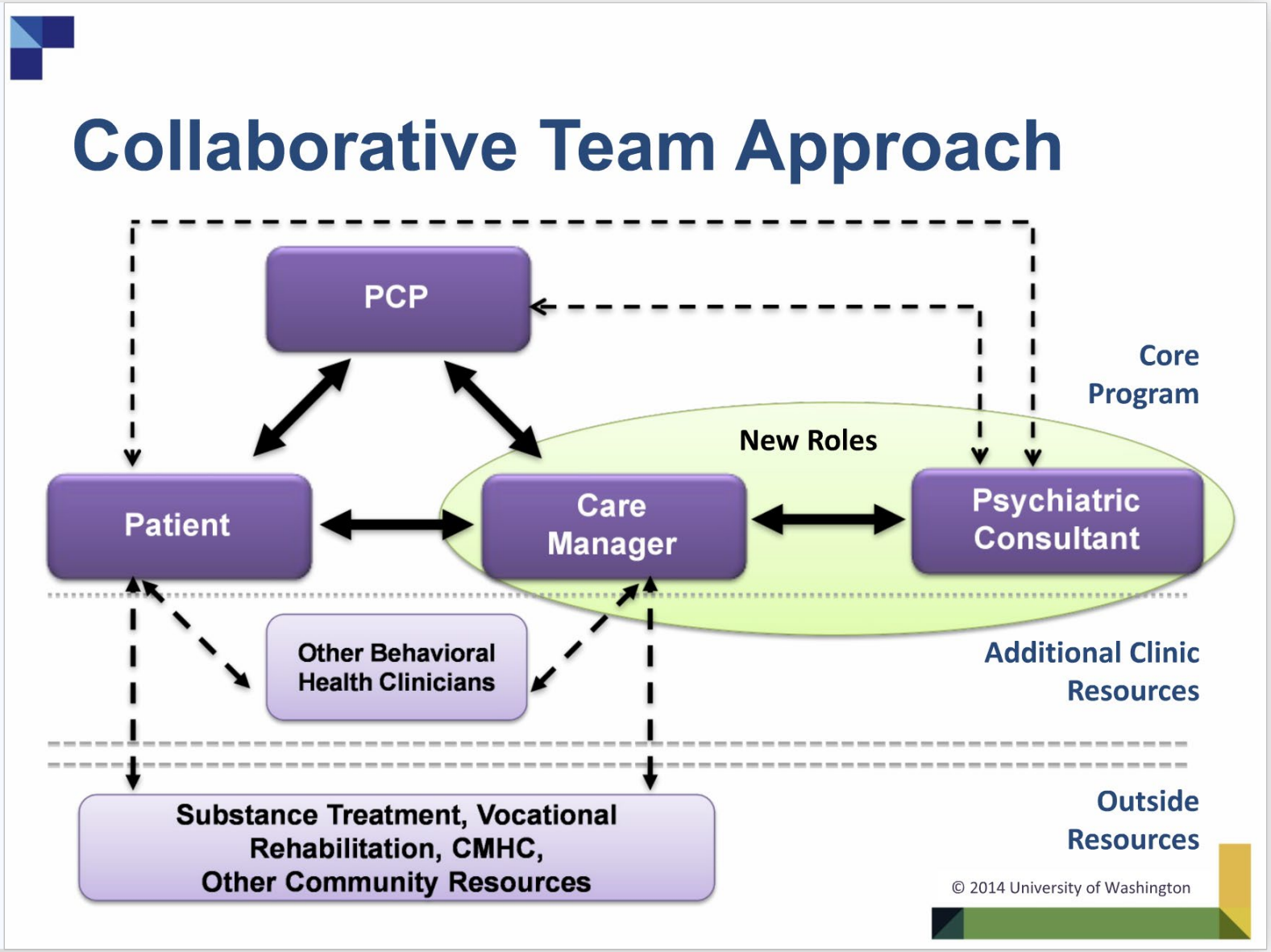
- Supports care managers and PCPs
  - Provides regular (weekly) and as needed consultation on a caseload of patients followed in primary care
    - Focus on patients who are not improving clinically
  - In person or telemedicine consultation or referral for complex patients
  - Provides education and training for primary care-based providers

PSYCHIATRIC CONSULTANT

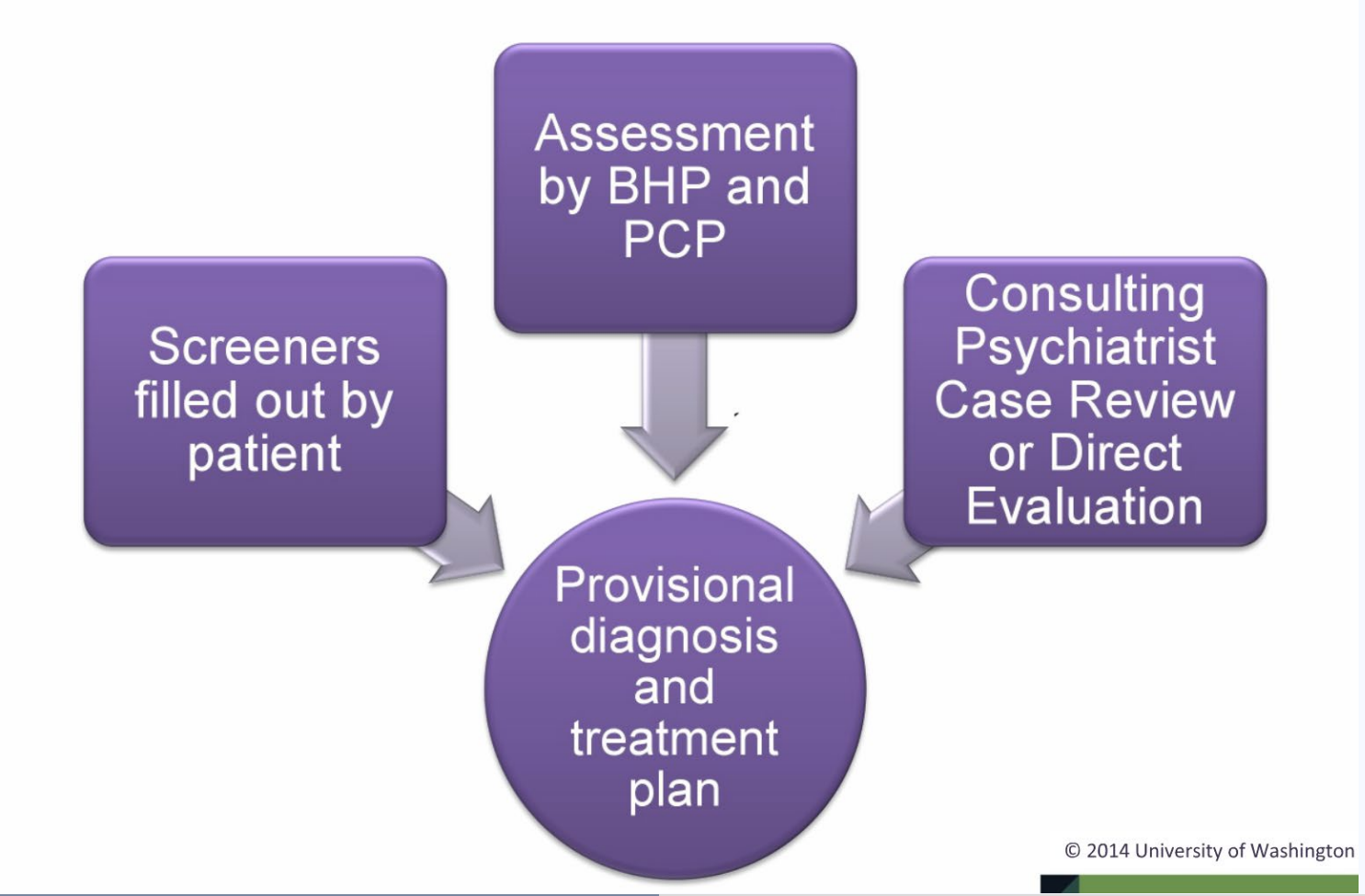
CARE MANAGERS

- Most common
  - MSW, LCSW, MA/MS Counselor, LMFT
- Less common
  - Clinical Psychologist, RN
- All-in-one or split between licensed provider and unlicensed staff
- Coordinates communication among care team
  - Consults with team psychiatrist/psychiatric NP
  - Collaborates closely with patient's PCP
  - Facilitates referrals to specialty care and/or community resources

COLLABORATIVE TEAM APPROACH

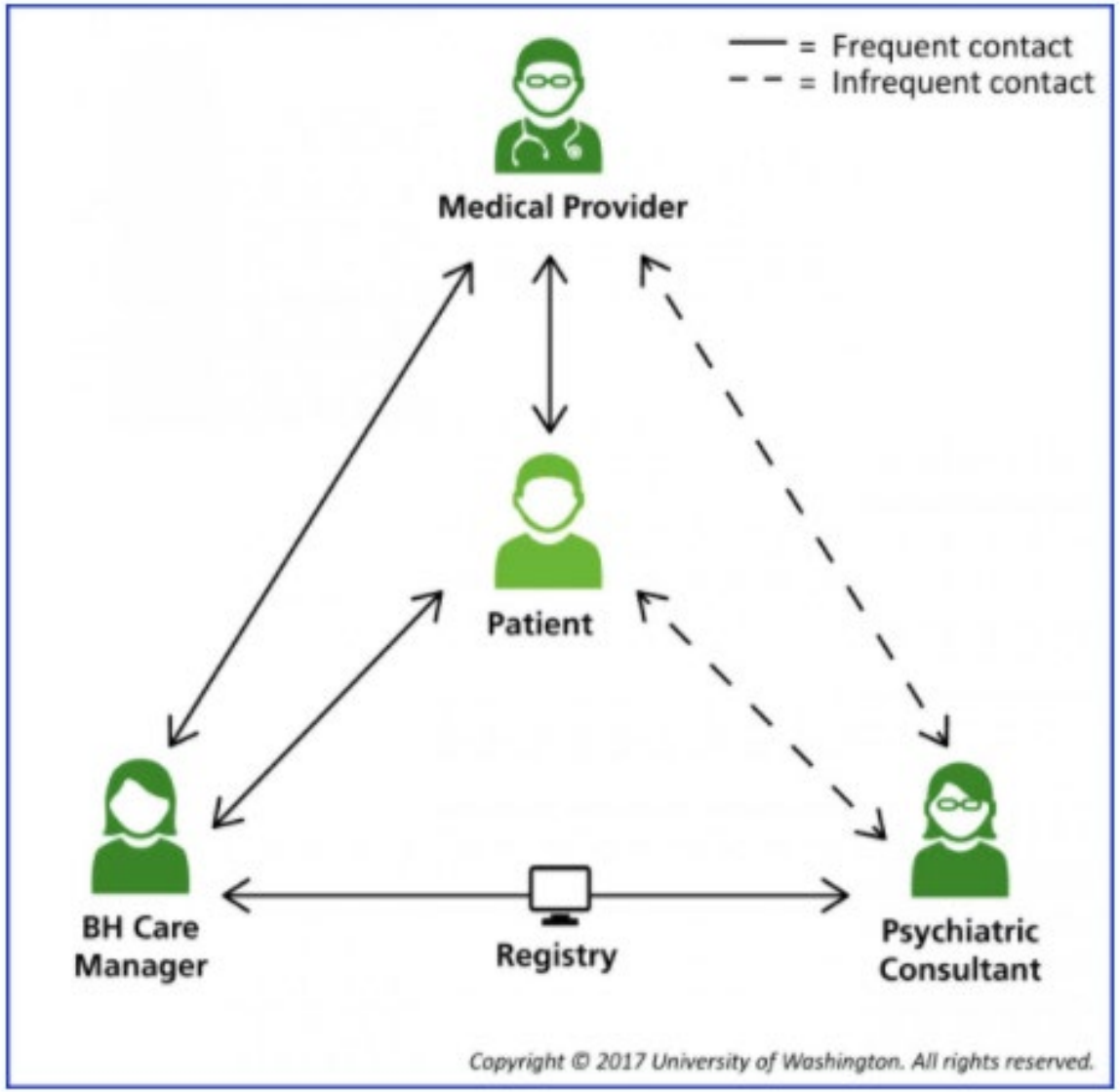


PROVISIONAL DIAGNOSIS



COMMUNICATION: HOW AND WHEN?

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



EVALUATION: DATA COLLECTED IN REGISTRY

Add New Patient | Save | Select "MRN|NAME" from drop-down list (Cell K1), and click "Show Records" to display records | Show Records | Graph Score Changes

Patient Information		Treatment Status & Reminders			Contacts					Measurements				Contact Notes and Psychiatric Case Review		
MRN	Name	Treatment Status & Reminders	Tickler	Episode Number (Episode of care/tx)	Follow-up Contact Number	Date Follow-up Due	Actual Contact Dates	Type of Contact	Billable Minutes	PHQ-9 Score (PHQ-9 target is <5 or at least 50% decrease from initial score)	% Change in PHQ-9 score (PHQ-9 target is <5 or at least 50% decrease from initial score)	GAD-7 Score (GAD-7 target is <10 or at least 50% decrease from initial score)	% Change in GAD-7 score (GAD-7 target is <10 or at least 50% decrease from initial score)	Care Manager Contact Notes and Flag for Psychiatric Case Review (Include notes about appointment reminder calls, referrals to specialty services, etc.)		Date of Psychiatric Case Review (Date of most recent Psychiatric Case Review automatically populates at top)
					Initial Assessment											
0	Last Name, First Name	Inactive		1	Initial Assessment		8/1/18	In person at clinic	30	.		.				
0	Last Name, First Name	Inactive		1	1		8/16/18	In person at clinic	15	4	0%	4	0%	Any treatment notees here		
0	Last Name, First Name	Inactive		1	2		9/6/18	In person at clinic	30	.		.				
0	Last Name, First Name	Inactive		1	3		9/19/18	In person at clinic	60	3	-25%	7	75%			
0	Last Name, First Name	Inactive		1	4		11/7/18	Phone	15	.		.				
0	Last Name, First Name	Inactive		1	5		12/10/18	In person at clinic	30	3	-25%	4	0%			
0	Last Name, First Name	Inactive		1	6		7/1/19	In person at clinic	30	3	-25%	3	-25%			
0	Last Name, First Name	Inactive		1	7		11/18/19	Phone	30	.		.				
0	Last Name, First Name	Inactive		1	8		11/25/19	In person at clinic	30	2	-50%	4	0%			

Date of initial A1C	Initial A1C	Date of Last A1C	Last Available A1C	Date of Initial B/P	Initial B/P	Date of Last B/P	Last Available B/P	Date of Initial BMI	Initial BMI	Date of Last BMI	Last Available BMI	Date of Initial LDL	Initial LDL	Date of Last LDL	Last Available LDL	Date of Initial Cholesterol	Initial Cholesterol	Date of Last Cholesterol	Last Available Cholesterol

WHY TRACK OUTCOMES

- **PROACTIVE TREATMENT ADJUSTMENT**
  - Avoid patients staying on ineffective treatments for too long
  - Treatment plan "shelf life" = 10-12 weeks max
  - Full, partial, no response

SYSTEMATIC FOLLOW-UP

- **KNOW WHEN TO REFER FOR CONSULTATION/GET HELP**

Don't let them linger!

APPLICATION CONSIDERATIONS

- Infrastructure for integration of timely substance use and behavioral health best practices
- Don't underestimate the contribution of readiness to effect
  - Buy-in
    - Rationale
- Can adapt but must maintain fidelity to drivers (principles) of outcomes
- Thoughtful evaluation of impact yields sustainability
  - Consider measures important to organization and community
  - Collaborative care is a secondary prevention model
    - ROI is critical

RESOURCES

Triangle Team Structure diagram
https://aims.uw.edu/collaborative-care/team-structure

Core Principles of Collaborative Care
https://aims.uw.edu/collaborative-care/principles-collaborative-care

Collaborative Care Implementation Guide
https://aims.uw.edu/sites/default/files/Step%20by%20Step%20CoCM%20Implementation%20Guide_110120.pdf

Care Manager Skills
http://depts.washington.edu/aimstrng/cm/

PCP Skills
http://depts.washington.edu/aimstrng/pcp/

Psychiatric Consultant
http://depts.washington.edu/aimstrng/intro/

QUESTIONS

FOR FURTHER QUESTIONS PLEASE EMAIL US AT:

healthcenter_BHTA@jbsinternational.com