Collaborative Care Experience Lessons Learned

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Our Collaborative Care Journey

-AHL discovered 'collaborative care' as our organization was emerging from COVID-19 pandemic and identifying the tremendous need for Behavioral Health + Substance Use services

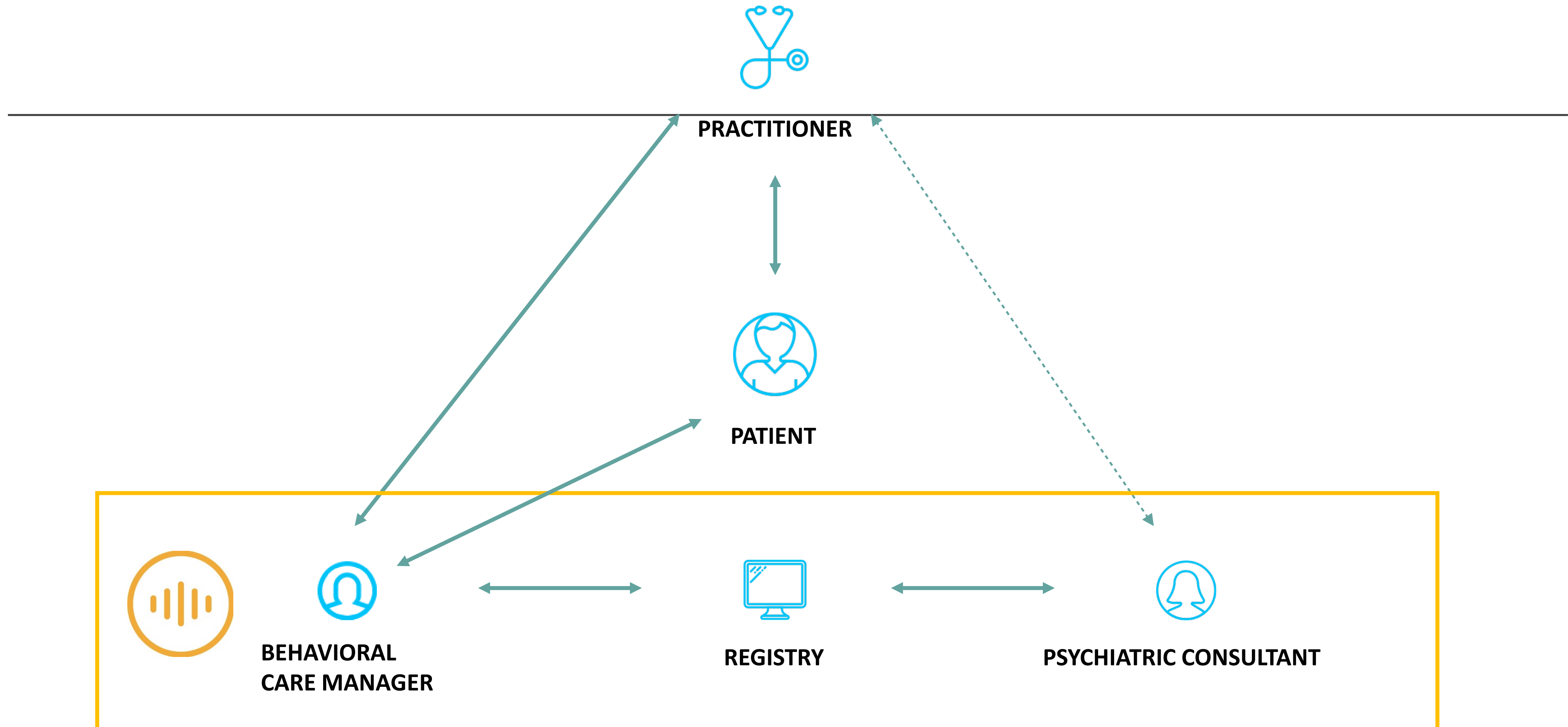
-AHL already had a 'team-based care' approach / model mindset from pre-COVID implementation efforts

-Had identified a need for a 'liaison' type of role within the extended care team to serve a BH integration type of role

-Additionally, we were experiencing lags at that time around credentialing our psychiatrists which was costly

-AHL was a recipient of a planning grant + grant implementation funds through The Rapides Foundation to conceptualize and implement our BHI/Collaborative Care model

TURNKEY APPROACH TO COLLABORATIVE CARE



Source
The AIMS Center at the University of Washington developed this visual representation of the Collaborative Care Protocol

AHL's Proposed Model

Patient Population:

Large Medicare + Medicaid population

Rural

Staffing Model:

3 PCPs + medical assistants (already screening using PRAPARE, PHQ, and GAD7)

2 Health Coaches (already delivering Chronic Care Management)

1 BH Care Manager

1 LCSW

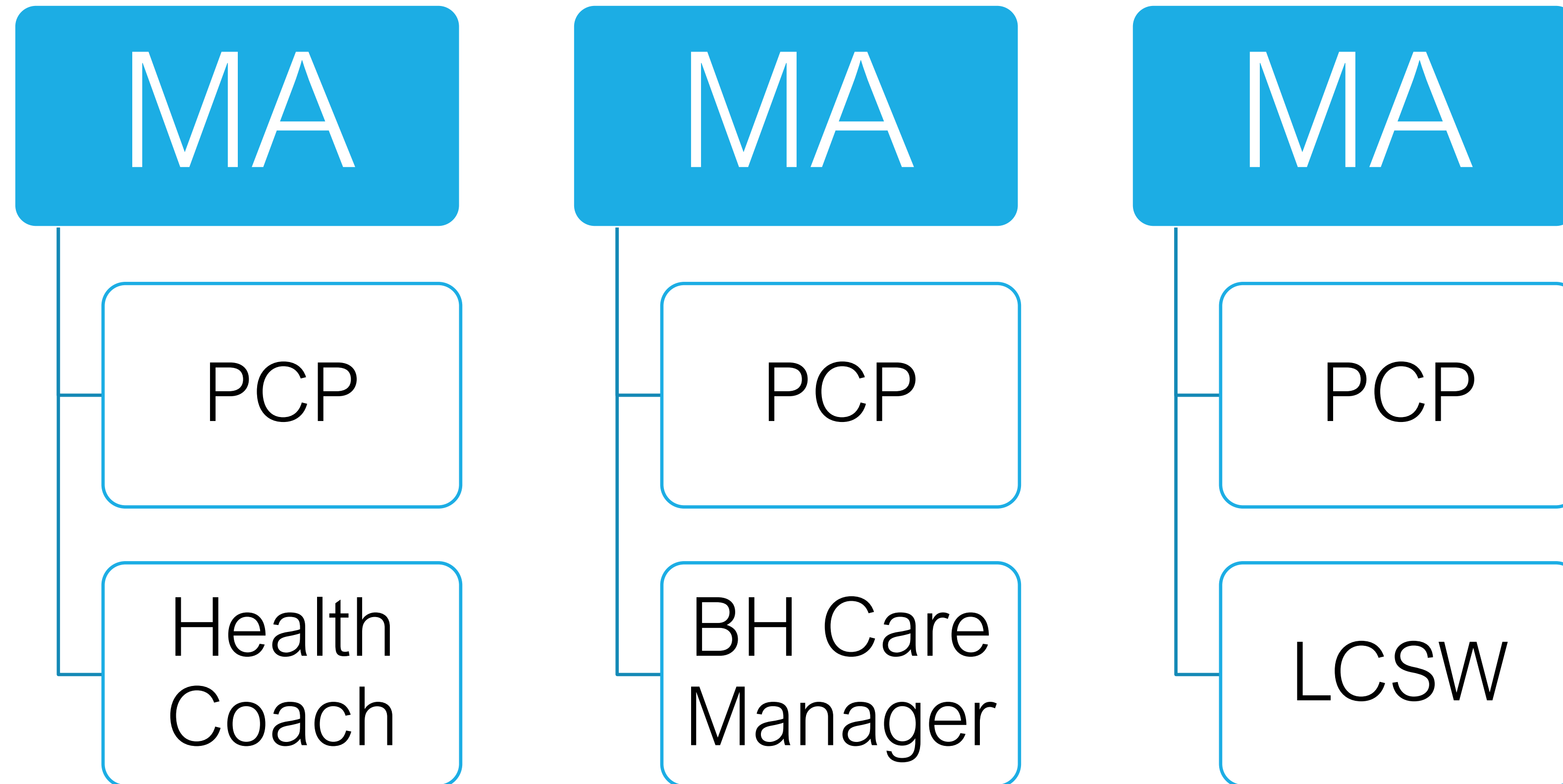
.2 FTE Pscyhiatrist

AHL also has an MAT program

BH Care Manager (new role):

- Provide further screening for patients scoring positive on a PHQ and/or GAD7:
  - Either keep the patient for "Collaborative Care"
  - Refer to the LCSW for higher need patients
  - Address unmet SDOH needs

Access Health Louisiana's Collaborative Care Model – referrals were piecemeal



Challenges

-Extended care team members reported feeling like they were in competition with one another for patients because team was not following workflows we had outlined to route positive screens

-Providers reported viewing the BH Care Manager as an ‘additional step’ to getting patients into BH services:

- Stemmed from a lack of understanding of the model
- Lack of confidence in the individual delivering Collaborative Care (BH Care Manager) – LMSW

-Our protocol was not clear as to how the recommendations would be communicated back to the PCP

- Sometimes a patient case, sometimes in the care plan, sometimes verbally, etc

-Resulted in low referrals, challenges getting patients to accept services, reachable, etc

Strategies

- Education, Education, Education

-Getting Medical Leadership more involved to meet with PCPs and Psychiatric Consultant

-Standardizing the workflow on referrals + how to report back recommendations

-Sharing successes!

-Started with patients already in CCM who had unmet BH needs to crossover into ICCM (Integrated Collaborative Care), then moved into utilizing a registry which populated the pre-visit planning tool for each morning huddle, then combined with daily screening activities to establish the patient load

Lessons Learned

-Having the BH Care Manager play a multi-pronged role was/is challenging to balance out caseload

-Delegate so that Medical Assistants/nurses can queue up Referrals on behalf of the providers

-The model (more frequent touches throughout the month) lended itself to the patients opening up to the BH Care Manager about thoughts of suicide

- We were thrust into rolling out our suicide safer care protocol as a result

-Additionally, we were finding patients reporting social isolation and loneliness, grief due to loss

- Began offering group grief counseling services

-Learned that ICCM is a good alternative pathway to offer for patients with SUD but who may decline MAT services

-Sustainability: Healthy Blue has this reimbursement mechanism for us to be able to deliver these services:

- Can bill for SDOH screening and referral
- Integrated Collaborative Care Management
- Collaborative Case Rounds to discuss high-risk patients with plan Case Managers