Integrating CoCM

Section 4

Challenges

We will discuss **specific challenges** when preparing and implementing the model at the end of this discussion **through an activity**.

Additional Key Practice-level Staff

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Medical Director

- Creates and implements **practice policies** to ensure safe, effective, and sustainable delivery of care
- Ensures all CoCM team members have appropriate **qualifications, training, and credentialing** to provide the activities specific to their role
- Ensures all CoCM team members **adhere to professional responsibilities** with respect to standards of care, documentation, privacy, etc.

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Provider Champion

- **Primary Care Physician**
- **Commits to learning** CoCM, helps to educate their colleagues and practices the model with fidelity and enthusiasm
- Assists in **hiring** the other CoCM team members
- Communicates **practice change expectations** to their PCP colleagues and supports them in overcoming challenges
- Acts as a liaison between the PCP team and the behavioral health care manager and psychiatric consultant, **providing a bi-directional communication channel** to solve implementation challenges
- Provides **ongoing monitoring** of how the PCP team is adopting the model and provides additional support to late adopters

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Team Members

- Embedded behavioral health staff
- Medical Assistants
- Health Coaches
- Community Health Workers
- Practice Manager
- Clinical Supervisor
- QI Coordinator
- Billing Representative
- Clinical staff responsible for screening and documenting results
- Office staff

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Additional Team Members

May be community or practice based

- Therapist
- Substance Use Disorder treatment
- Vocational Rehabilitation
- Specialty Mental Health Clinic

Patient may require a higher level of care:

- Mental health therapist
- Community-based treatment

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	Role - List Clinic Roles											
Task	Front Desk	MA	Provider	Office Nurse	RN Care Manager	SW Care Manager	BH Specialist	Pharmacist	Psychologist	Care Coordinator	Biller	Other (List Role)
Gives the patient a Screening tool to fill out for (Depression - SUD - Anxiety - SDOH....)												
Provides the patient with the purpose of the (Deprssion, SUD...) screening tool												
Provide X counseling to patients that score: • Low risk – provide affirmation and education • At risk – provide brief intervention • Problem use – provide brief intervention and follow up • Likely dependent – referral												
Gives the patient a Screening tool(s) to fill out												
Provides the patient with the purpose of the SDoH screening tool												
Provides counsel to the patient on SDoH												
Triages patient calls related to SUD												
Completes the Intake Checklist												
Creates the medication treatment plan												
Initiates the treatment plan with the patient												
Provides patient education on buprenorphine safety												

Tasks and Roles | Multidisciplinary approach | CoCM Depression Anx.

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Team Collaboration

- **Sharing responsibility** for patient care and outcomes
- **Showing appreciation** for team members
- Integrating the **knowledge and experience of all team members** in patient care
- Regularly implementing **process improvement strategies** to enhance teamwork and patient care
- Having a **mutual understanding** of evidence-based care and ethical principles of patient care

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Team Engagement Considerations

Key aspects of the personnel providing collaborative care can influence outcomes and are the "secret sauce" that goes beyond simply implementing the key tasks and re-engineered workflows

- **Engaged** psychiatric consultant leads to **more patients achieving remission**
- **Buy-in** by primary care providers is **crucial to patient engagement** as they are on the front line in "pitching" the model to patients
- Primary care provider **champions** help with **rallying colleagues** around the model
- Behavioral health care managers with a well-defined role are crucial to patient engagement. The BHCM **ensures key clinic tasks are performed** without other distractions.
- Strong support from the top leadership is also **necessary to provide the team resources** critical to meeting defined goals as well as encouragement and support throughout the process

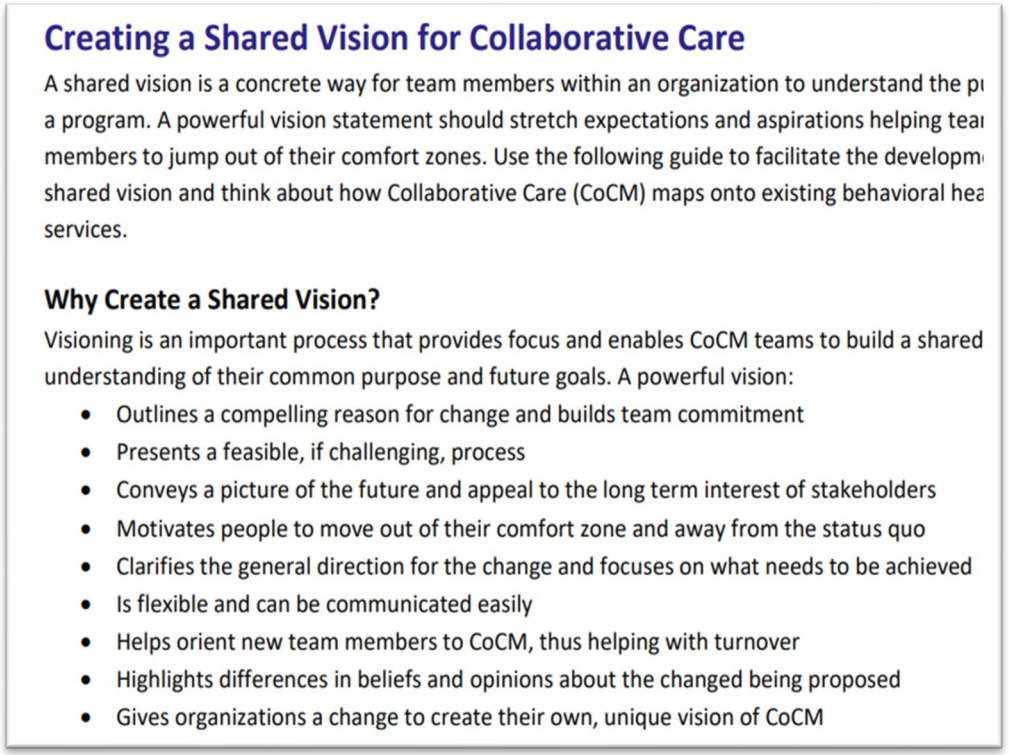
Raney, L.E, M.D., Lasky, G.B.,Ph.D, M.A.P.L., Scott, C., L.C.S.W. (2017). *Integrated Care, A Guide for Effective Implementation, Arlington, VA, American Psychiatric Association Publishing* Raney, Lori MD. (2028, May). How to implement effective integrated care. *Psychiatric News, Online*

Integrating CoCM

Creating a Shared Vision

- A shared vision is a **concrete way** for team members within an organization to **understand the purpose** of a program
- A powerful vision statement should **stretch expectations and aspirations**, helping team members to jump out of their comfort zones
- Visioning is an important process that **provides focus** and enables Collaborative Care (CoCM) teams to **build a shared understanding** of their common purpose and future goals

AIMS Shared Vision Worksheet



Creating a Shared Vision for Collaborative Care

A shared vision is a concrete way for team members within an organization to understand the pu
a program. A powerful vision statement should stretch expectations and aspirations helping tea
members to jump out of their comfort zones. Use the following guide to facilitate the developm
shared vision and think about how Collaborative Care (CoCM) maps onto existing behavioral hea
services.

Why Create a Shared Vision?

Visioning is an important process that provides focus and enables CoCM teams to build a shared understanding of their common purpose and future goals. A powerful vision:

- Outlines a compelling reason for change and builds team commitment
- Presents a feasible, if challenging, process
- Conveys a picture of the future and appeal to the long term interest of stakeholders
- Motivates people to move out of their comfort zone and away from the status quo
- Clarifies the general direction for the change and focuses on what needs to be achieved
- Is flexible and can be communicated easily
- Helps orient new team members to CoCM, thus helping with turnover
- Highlights differences in beliefs and opinions about the changed being proposed
- Gives organizations a change to create their own, unique vision of CoCM

CoCM—Team-based Care

Success of the model is based on the flexibility to alter practice patterns and willingness to participate in the team-based model from each member of the team

Integrating CoCM

Integrating New Team Members

Integrate BHCM and consulting psychiatrist into existing clinic staff, space and flow:

- Private workspace for BHCM
- Time
- If possible - Access to computer and EHR
- Access and support of training for clinic staff
- Identification of staff roles in CoCM

It is critical that a BHCM can carve out enough time to actively manage their patients. **This role cannot be added to an already full workload**.

Challenges and Wrap Up

Break-out Session

Breakout into small groups for discussion

- What are you most nervous about with implementing CoCM?
- What additional training and supports are needed to get your practice started?

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Evaluation

Thank you for attending the CoCM morning training!

The post-training evaluation will be emailed to you shortly after today's training

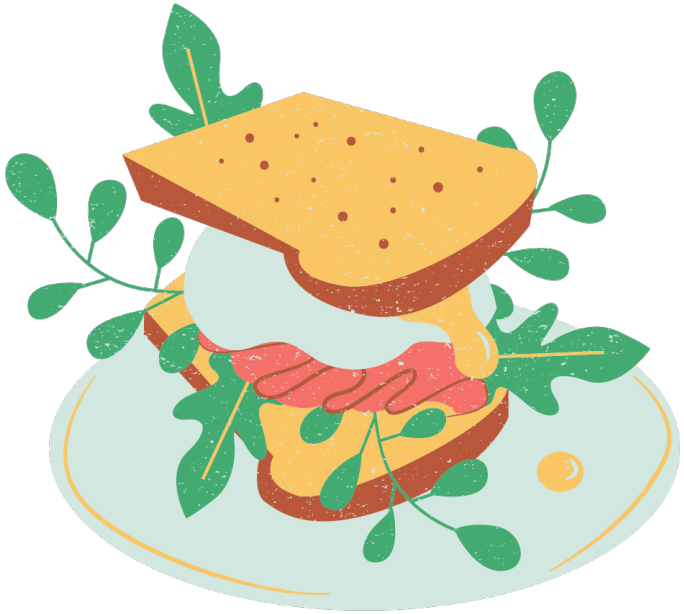
Completion of this evaluation is needed for CMEs

Questions?

CoCM Morning Training
Providers, thank you for attending today's training!

Integrating CoCM

Lunch Break—30 minutes



Psychiatric Consultants:

Join us for a Lunch Discussion with MCCIST Psychiatrists!

12:30–1:15pm

https://umich.zoom.us/j/93399633736#success