NATIONAL COUNCIL
for Mental Wellbeing

OPTIMIZING THE PSYCHIATRIC WORKFLOW WITHIN A

TEAM-BASED CARE FRAMEWORK

Acknowledgements

MEDICAL DIRECTOR INSTITUTE

The Board of the National Council for Mental Wellbeing authorized the National Council Medical Director Institute (MDI), which includes medical directors from mental health and addiction treatment and recovery organizations from across the country, in 2015. Drawing from the members' diverse breadth of knowledge and experience, the MDI advises National Council members on best clinical practices and develops policy and initiatives that serve member mental health and addiction treatment and recovery organizations, their constituent clinicians and the governmental agencies and payers that support them.

The MDI developed this paper with input from medical directors, subject matter experts and experienced mental health providers and clinical staff with first-hand experience in direct service provision and administration.

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Introduction

AIM OF PAPER

This white paper was created by members of the MDI, who identified the need for a practice model that could improve treatment quality, patient experience and profitability in psychiatric clinic services and reduce burnout and improve retention of psychiatric providers working in community behavioral health clinics (CBHCs).

The paper describes a model of providing psychiatric care in the CBHC clinic setting that will improve patient outcomes and improve the work experiences of all members of the team providing care. It also clarifies the potential and often underutilized value to a CBHC of the fully deployed psychiatric provider. While the focus is on the psychiatric services, we acknowledge that this is just a piece of the overall team-based care approach within a CBHC.

The companion paper, Making the Case for High-functioning, Team-based Care in Community Behavioral Health Care Settings addresses the applicability of team-based care more broadly throughout CBHCs.

TERMINOLOGY

Nomenclature relating to mental health and addiction has evolved rapidly in an attempt to keep up with changes in practice. Notable examples are the introduction of non-physician psychiatric providers as an important part of the psychiatric workforce and using person first language for the people we serve. For the purposes of this paper, we will use the following terminology:

- **Psychiatric provider:** Psychiatrists, nurse practitioners, physician's assistants and even primary care physicians in some settings, whose functions include prescribing and monitoring psychotropic medications. They also provide initial and ongoing psychiatric assessment, treatment planning, psychotherapeutic and psychoeducational interventions, family and caregiver support and monitoring of intercurrent physical illnesses and coordination with the medical care system.

- **Psychiatric care:** The combined functions just described, provided by the psychiatric provider. This service is enhanced in high-functioning teams.

- **Psychiatric clinic:** The focus of this paper is the psychiatric clinic, defined as the place that provides psychiatric care in most community behavioral health clinics.

- **Community behavioral health clinic:** For the purposes of this paper, we define a CBHC as an agency that provides a comprehensive range of mental health services to individuals in their communities. In certain types of integrated settings, this could also include addiction treatment and recovery services.

Executive Summary

Delivering competent behavioral health care has become more complex in recent years. A renewed focus on social determinants of health and the screening and coordination of physical illness in individuals with serious mental illness (SMI) requires responsiveness to screening for these conditions, monitoring data findings in the electronic health record (EHR) and care coordination within and outside of the psychiatric clinic.

Implementing team-based care for psychiatric clinic services can improve treatment quality, patient experience, profitability and reduce burnout and improve retention of psychiatric providers. This paper presents the rationale and potential steps to implement high-functioning, team-based behavioral health care services and addresses current challenges facing psychiatric practices.

CHALLENGES FACING CBHCS

CBHCs must meet quality care metrics for access to care and evidence-based treatment modalities, while simultaneously decreasing the cost of care. This trend will only intensify. Psychiatric providers working in community settings face problems with workforce shortages, large caseloads, treatment delays, inadequate time and resources and an increasingly complex population, especially among people with SMI, who frequently have chronic comorbid physical conditions and fragmented care. In this challenging health care environment, innovative mental health care delivery models, including team-based care, are not a novelty – they are a necessity.

A PROPOSED MODEL FOR TEAM-BASED CARE IN COMMUNITY MENTAL HEALTH CENTERS

From administrative intake, to medical assessment, to prescriber consultation, to team-based treatment planning, the sample workflow provided in this paper underscores the importance of monitoring the full scope of patients' complex medical and psychiatric problems and of leveraging innovative approaches to reduce waste and curb excess spending.

BARRIERS AND OPPORTUNITIES

There are prominent financial barriers to team-based psychiatric care implementation in CBHCs. The primary hurdle is related to funding additional team members and space needed to provide this care effectively. The existing fee-for-service reimbursement structure is not conducive to this team-based model and requires novel funding arrangements, such as incentivizing quality, performance and outcome benchmarks.

In some cases, financing for team-based care for behavioral health can be built into the payment structure, such as with Certified Community Behavioral Health Center (CCBHC) programs, Another option is to design fee-for-service codes in Medicaid and Medicare that allow for funding team-based care, analogous to the existing CPT codes supporting the collaborative care model in primary care. In addition, CBHCs should consider balancing costs incurred by including the loss of efficiencies and effectiveness in care, provision and coordination and staff burnout and turnover of psychiatric providers.

The Current State of Psychiatric Care in CBHCs

CBHCs are expanding the quality of care provided to people with SMI and improving mental health and addiction treatment and recovery outcomes in a progressively more complex population at a time we are called upon to improve physical health outcomes, address social determinants of health, reduce all-cause medical spending and constrain the cost increases in mental health and addiction services.

In response to concerns around the quality of health monitoring practices and physical care service delivery in mental health and addiction treatment and recovery care, the National Quality Forum (NQF) and other regulatory entities and payers have started shifting their quality measures from process measures to outcome measures (Burstin, 2016). These measures are being incorporated into various value-based payment models; however this results in an array of tasks and requires direct involvement and expertise of mental health care providers in close coordination with each other and other treatment providers (Druss, 2018; Torrey, 2017).

While facing increased performance expectations, CBHCs are having difficulty sustaining adequate numbers of psychiatric and other mental health care staff (Parks, 2017), leading to significant care access and financial problems. For example, psychiatrists working in CMHCs report finding the work frustrating for a number of reasons, such as (Walker, 2015):

- Operating in silos and not having meaningful input on service delivery design (Dean, 2019).
- Lack of adequate time to perform comprehensive evidenced-based care.
- Large caseloads without sufficient clinical support to meet the individual needs of the people receiving services.
- Work settings that restrict the ability to function at the top of their training, which is necessary to have an optimal impact on complex medical and psychosocial needs.
- Extensive administrative burdens that could be managed by others.

A series of studies investigating causes of poor outcomes and provider burnout found that "…it is difficult for even the most motivated and elegantly trained providers to assure that people receive the systematic assessments, preventative interventions, education, psychosocial support and follow-up that they need." (Wagner, 1996). The authors noted that it would require approximately 20 hours per day for a primary care provider to deliver comprehensive evidence-based chronic disease management, acute care and preventive care to a standard sized enrollment panel – an impossible feat that did not include coordinating with subspecialty providers (Østbye, 2005). The number of hours required to provide good care have only increased with the advent of the EHR (Shanafelt, 2016).

Today's psychiatric providers are facing a similar ever-increasing multitude of tasks required to deliver quality care (Torrey, 2017), which is not achievable within the timeframe of a standard psychiatric evaluation or a medication review. All mental health providers experience similar requirements, including mental health and physical health tasks, as well as EHR and administrative tasks.

The Solution

Primary care providers have responded to these challenges by adopting team-based care. Work from the World Health Organization (WHO) (WHO, 2010), the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Quality Forum (Weaver, 2014) have identified team-based care as the key strategy to improve outcomes. Team-based care is central to Patient-centered Medical Homes (PCMHs). The Agency for Healthcare Research and Quality (AHRQ) has developed practice tools that support the implementation of team-based care to further expand its adoption (Knox, 2013).

What actually constitutes team-based care has advanced in the last several years in response to research on team functioning. For example, the difference between multiple disciplines working with the same patient and high-functioning teams has undergone significant clarification in the primary care literature (AHRQ, 2018). Features that characterize high-functioning teams include team ownership of a specified patient panel, clear team member role assignments, effective modes of communication, use of registries and evidence-based clinical pathways to a stepped model of integrated mental health care (Advancing Integrated Mental Health Solutions [AIMS] Center, 2020) and a focus on population health management. Team composition now supports providers functioning at the top of their professional licenses. An entire field related to the core competencies for interprofessional collaborative practice (Reeves, 2017) has emerged.

In contrast to broad adoption of team models in primary care, high-functioning team-based care in CBHCs has been limited to a few distinct populations. The CBHCs that have implemented some versions of team-based care in their community support, case management or psychosocial rehabilitation programs have often not included all mental health providers involved in the clinical care of the person receiving service as full members of the team, especially psychiatry and nursing. Simultaneously, a parallel and siloed medication-focused form of care for people with SMI has evolved in response to poorly reimbursed appointments and other clinical activities performed by the psychiatric providers.

Although medication-centered clinics initially appear to be efficient, the literature in the U.S. and internationally clearly states that "there is near consensus that community-based integrated and comprehensive psychiatric services performed by interdisciplinary teams constitutes the gold-standard for the care of persons suffering from mental illness," (von Peter, 2018; Liberman, 2001). People receiving services need access to professionals with diverse and complementary skill sets across all specialties that function as a unit with clear roles, a shared purpose and seamless coordination to deliver effectively and efficiently comprehensive, individualized, responsive care to treat acute need. (Schuttner, 2018).

The clinical complexity and aspirations of improved mental and physical health performance have outpaced the ability of any single staff member to manage. This includes psychiatric providers and nursing staff who cannot deliver all the needed aspects of mental health and medical care in the psychiatric clinic without the support of a high-functioning team (Nutting, 2011; Torrey, 2017). The psychiatric provider and the nursing staff can lead the team in monitoring and supporting the physical health of people receiving services in interagency collaboration and in population health initiatives.

The Evidence

A robust evidence base supports high-functioning team-based care efficacy in the **physical health literature.** High-functioning teams have delivered outcomes superior to standard care in acute and chronic care settings, including:

- **Increased access** to care and reduced complications (Weller, 2014).
- **Improved safety, reduced errors and better communication** (Smith, 2018; Dehmer, 2016).
- **Reduced hospital admissions,** emergency department utilization, 30-day all-cause readmissions and length of stay (English, 2017; AHRQ, 2016; von Peter, 2018).
- **Improved clinical outcomes** for hypertension and diabetes and reduced mortality rates (WHO, 2010).
- **Improved satisfaction** of people receiving services, including greater acceptance of treatment (WHO, 2010).
- **Decreased provider burnout,** turnover and tension and conflict among care providers (WHO, 2010) and **increased provider productivity and satisfaction** (Smith, 2018; von Peter, 2018).
- **Reduced total costs** (WHO, 2010).

Despite limited adoption of team-based care in CMHCs, the **CMHC literature** shows similar efficacy findings as the primary care literature, including:

- **Increased access** to services (WHO, 2010).
- **Improved quality of life and symptom control** for people receiving services (Kane, 2015).
- **Improved satisfaction** of people receiving services, including greater acceptance of treatment (WHO, 2010).
- **Improved continuity of care** (von Peter, 2018).
- **Decreased suicide rate**s (von Peter, 2018).
- **Increased provider satisfaction** (von Peter, 2018).
- **Reduced total costs** (WHO, 2010).

With wider adoption of the principles underlying team-based care and the reincorporation of the psychiatric provider and the nursing staff as full team members, team-based care can also improve the physical health of the CBHC population. People receiving care for SMI continue to die of preventable medical conditions 25 years earlier than the general population. Consistent communication between mental health and primary care providers, use of registries and evidence-based clinical pathways to screen, monitor and modify the intensity of care for chronic conditions combined with a focus on measurable progress and outcomes are all fundamental to team-based care and essential to reversing this trend.

The Potential Value of a Fully Deployed Psychiatric Provider

A skillful psychiatric provider can add a great deal of value to the clinical enterprise of a behavioral health agency, other than the ability to prescribe, including:

- The psychiatric provider bears clinical license, leadership and responsibility to make final care decisions, especially in complex cases. This responsibility extends to medicolegal decision-making.

- The psychiatric provider can contribute the broadest knowledge of psychiatric diagnosis and treatment, including pharmacological and psychosocial interventions. The responsibility for keeping the team up-to-date on developments in the field should rest with the psychiatric provider.

- The psychiatric provider can act as a role model for teams by demonstrating that boundaries between medical and psychosocial are illusory and must be integrated in the care of patients.

> " Because serious mental disorders are biomedical conditions that require accurate diagnosis, medicolegal decisions and pharmacological treatments, the role of the psychiatrist is of special importance on a mental health team." (Liberman, et al., 2001).

- The psychiatric provider has a special role in educating patients and families because of their in-depth familiarity with diagnosis and range of available treatment, as well as the cultural value ascribed by patients and families to information received directly from the psychiatric provider.

- The psychiatric provider can lead the team in integrated care and interagency collaboration. In a psychiatric setting that monitors and supports the physical health of people with SMI, the psychiatric provider can champion the agency's approach to these issues.

A Workflow for High-functioning, Psychiatric Care Within a Team-based Care Framework

High-functioning psychiatric team-based care includes protocol-based workflows that are responsive to patient and staff needs for all aspects of psychiatric care. Standards of care should be in place for:

- Assessing social determinant needs
- Diagnosis
- Treatment, including for psychosocial needs
- Coordination with primary care
- Prescribing and monitoring of medication side-effects
- Support for care of metabolic diseases common in SMI populations

In a high-functioning, team-based model, patients who see a provider for psychiatric care are engaged in a care pathway, or structured protocol-based workflow process that guides them toward recovery. This ensures that the principles of team-based care are applied effectively and that quality measures are captured and monitored. These procedures permit a systematic approach to the entire population cared for by the clinic rather than an overly narrow focus on individuals' needs at the time of the clinic appointment.
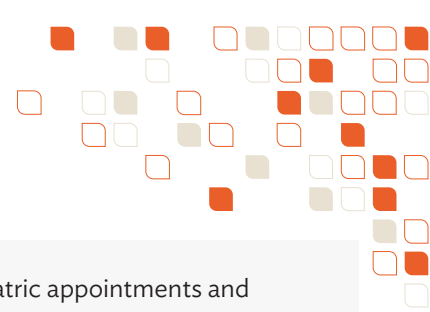
We propose the following workflow, which is similar to those seen in primary care settings. It includes one or more psychiatric providers at a clinical site and uses administrative staff to coordinate appointments, engage in pre-appointment data gathering and offer post-appointment assistance with arranging and supporting aspects of the team's treatment plan.

> "With well-designed workflows, psychiatric care providers can use their limited time for the essential health-promoting work: Connecting therapeutically, integrating patient-specific aggregated data with what is known from the scientific literature and partnering with each patient to develop a practical shared biopsychosocial plan."
>
> (Torrey, et al., 2017, p. 620).

The patient is greeted by administrative team member, who double-checks demographic and billing information and notifies the clinical team of the patient's arrival. An administrative team member may also give the patient clinical rating scale forms to complete, (e.g., PHQ-9). In the Common Ground model, a peer specialist, assisted by specialized software, assists the patient in clarifying their goals and treatment preference prior to the appointment, improving the effectiveness and efficiency of consultations, as well as patient experience of care (Deegan, 2008).

The Common Ground model supports psychiatric patients to make optimal use of their psychiatric appointments and by extension, their psychiatric care by using a structured process, usually in the waiting room of the psychiatric clinic, for patients to discuss their treatment goals and concerns about their treatment with a peer support specialist.

1. The patient sees a team member – in this case, a medical assistant or a peer specialist – who collects clinical rating scale data and performs a clinical update. The clinical update, collected using a structured tool, includes:

   » A progress update with specific structured questions developed by the team for the clinical situation.

   » Vital signs.

   » Review of laboratory tests available or pending, based on the patient's treatment plan or treatment regimen.

   » Reconciliation of medication and review of medication adherence since the last visit.

   » Identification of new questions or concerns.

2. The medical assistant takes the patient to a room in preparation for the prescriber's visit. The medical assistant assembles the information gathered in Step 1 for the psychiatric provider who sees patients in more than one consultation room, as would happen in the primary care setting.

   The psychiatric provider sees the patient (perhaps with the in-room assistance of a scribe), compiles the available clinical information, discusses the patient's symptoms/concerns and initiates or updates the treatment plan. If the patient has any further needs that are not appropriate for the psychiatric provider to address, based on the team's care pathway protocols, they are addressed with a warm handoff to the appropriate team member. These concerns typically include social determinant needs.

3. Following the appointment with the psychiatric provider, the patient meets with a nurse, who may:

   » Review the new plan or changes in health status.

   » Provide health coaching.

   » Give injections of long-acting injectable antipsychotics.

   » Schedule calls between appointments for health coaching and/or support.

   » Provide documentation for disability application, prior authorizations for insurance coverage, etc.

   » Respond clinically to abnormal physical findings (e.g., elevated blood pressure, significantly abnormal laboratory results).

4. At the end of the appointment with the psychiatric provider, the patient meets with a team member who ensures the agreed-upon treatment plan is carried out by making sure prescriptions are ordered and sent; follow-up appointments are scheduled and any barriers to attending their next appointment, like transportation needs, are addressed; needed laboratory studies are ordered; referrals are made; and there is a plan for the team to track the success of referrals.

5. The team implements previously developed, agreed-upon, standard workflows for important and commonly encountered clinical situations. This is comparable to the way primary care clinics have a prearranged routine for assessing patients with a history of asthma, for example. In CBHCs, prearranged workflows might exist for:

   » Lab monitoring of patients receiving atypical antipsychotic medication.

   » Lab monitoring of patients taking lithium.

   » Lost prescriptions or medication.

   » Concerns about the efficacy of a new treatment.

   » Missed appointments.

   » Mildly abnormal labs or physical measurements.

   » Highly abnormal labs or physical measurement.

   » Need for an early refill.

   » Patient-reported concerns (e.g., "I need to talk to someone today.").

6. Finally, the team meets regularly to review psychiatric and medical clinical outcomes using a registry to refine clinical procedures and improve team functioning. The meetings take two forms, each with different goals:

   » **Team huddles** typically lasting no more than a half-hour at least twice a week, but as often as twice a day. Huddles are highly structured and focus on addressing risk stratification and care coordination needs. The psychiatrist does not typically attend huddles.

   » **Team meetings** are longer (typically at least an hour), happen less frequently (no more than weekly) and focus on population health management, standard workflow fidelity and team health (e.g., addressing breakdowns in care provision).

This proposed workflow may seem like an elaborate procedure, but it serves multiple purposes. First, it is unrealistic to require a single individual to provide all the needed assessment, treatment, monitoring and care coordination tasks that high-quality care of persons with SMI require; there are simply too many tasks for one person to execute. In a high-functioning team, each staff member knows their role and is empowered to communicate in a dynamic work environment while standardizing and measuring the quality of care process steps.

SAMPLE TEAM-BASED PSYCHIATRIC CLINIC WORKFLOW

Patient Arrival

- Check-in
- Communicate visit process, wait times
- Prepare for appointment (e.g., Common Grounds model)
- Complete clinical rating scales
- Staff: Front desk, administrator, peer

Psychiatric Visit Preparation

- Chief complaint/reason for visit, new concerns
- Structured interval history
- Vital signs
- Medication reconciliation
- Review clinical rating scales
- Review lab monitoring status
- Pre-document in EHR
- Staff: Medical assistant, nurse

Psychiatric Visit

- Review records
- Welcome and engage client, family
- Review interval history and pre-documentation
- Conduct mental status exam
- Diagnostic review
- Risk assessment, and if necessary, safety plan
- Assess treatment side-effect response
- Review physical health and lab monitoring status
- Shared decision-making (provide psychoeducation, elicit client goals, preferences)
- Psychotherapeutic interventions
- Activate treatment plan (medication, other treatment orders, lab orders, care coordination with primary care, linkage with other team members and care modalities)
- Staff: Psychiatric provider, scribe

Examples of Care Pathways/Algorithms Organizing Care:

- Antipsychotic monitoring
- Lithium management
- Depression tracking with rating scales
- Standard responses to abnormal physical
- Findings, e.g., elevated blood pressure
- Follow-up of emergency department visits
- Follow-up of psychiatric hospitalizations
- Follow-up of medical hospitalizations

Between Visits

- Team huddles
- Team meetings
- Population health activities
- Patient calls between appointments

Patient Departure

- Provide visit summary
- Review new plan of care
- Arrange linkage with other services (primary care, case management, social agencies, transportation)
- Schedule next appointment(s)
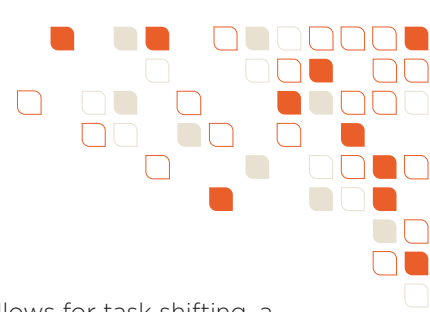- Staff: Front desk, administrator, peer

Post-Provider Tasks

- Injections
- Lab draw or facilitation
- Disability and prior-authorization paperwork
- Health coaching
- Response to abnormal physical findings, e.g., elevated blood pressure
- Staff: Medical assistant, nurse

TASK SHIFTING IN THE PSYCHIATRIC CLINIC

Team-based care requires clear roles, expectation and accountability. This foundation also allows for task shifting, a concept initially developed in areas of the world faced with chronic workforce shortages, but that has shown to be effective in other settings (Belkin, 2019). Task shifting ensures that all staff are working at the top of their professional training by reassigning tasks from one type of health professional to another while ensuring that quality is maintained or improved, and all legal requirements of scope are met.

At first, task shifting might appear to be merely a cost savings measure; however, in practice, it can free staff to deliver care more effectively. For example, by using a trained medical assistant to obtain patient's vitals, rather than a registered nurse (RN), the RN is able to use their advanced skills to coach the patient on health issues and coordinate care with primary care providers. Another example of task shifting is having a clerical staff person gather all the clinical information, such as hospital records or recent labs, prior to the appointment. This spares the psychiatric provider the additional task of searching the patient's chart for missing information and requesting the information, which they would have to review at a later time.

TASK SHIFTING WORKSHEET

Completing the following chart, or one similar to it, is one way to analyze which tasks can be shifted. First, outline all the tasks that need to be completed, then note who is currently responsible and who could also perform it. Then, assign the tasks to the new staff for clear role definition and accountability.

Task	Who does it now?	Who could do it?	Additional training required	What training?	Would protocols enhance efficiency?	Who would develop protocols?
Appointment scheduling						
Appointment reminders						
Prepare chart						
Medication interval history						
Identify barriers						
Adherence						
Vitals						
Symptoms/document medications						
Lifestyle coaching						
Labs						
Medication refills						
Counseling						
Data entry						

Implementation

ASSESSING READINESS

High-functioning, team-based care offers the opportunity for CBHCs to optimize treatment outcomes while reducing wasted resources and curbing excess spending. In most CMHCs, the extreme shortage of psychiatric providers has actually reinforced segregating the provider from the rest of the CBHC enterprise, as their scarcity and expense make time spent on anything other than prescribing unmanageably costly. Agencies believe they do not have the flexibility to experiment with other models of care; however, the current mode of parallel practice cannot meet the needs of patients in this changing marketplace. This contributes to the challenge of psychiatric provider recruitment and retention and undermines the quadruple aim of improved patient outcomes and satisfaction, decreased costs and improved provider satisfaction.

The shift from traditional parallel practices to high-functioning, team-based care, however, is not without challenges or resistance and must be undertaken with careful thought and planning. To successfully meet and sustain team-based care performance goals, the CBHC needs to fully assess the organization's leadership and frontline staff readiness and commitment to develop a new culture supportive of team-based care before moving forward with implementation.

Training High-functioning Teams

A few behavioral health organizations have fully developed high-functioning, team-based psychiatric care. Developing training materials will require input from those few agencies, as well as lessons learned from the development of team-based care in primary care, which is available in the extensive writings on the PCMH (AHRQ, 2014).

In particular, plan to provide access for the psychiatric provider to training, mentoring and support for skills needed to function as a fully deployed psychiatric leader. As per Liberman, et al., 2001, "…acquiring the organizational and communication skills needed for effective teamwork may be a daunting challenge for the psychiatrist. Mentoring, training and clinical experience can build on a psychiatrist's generic skills in this area." Few psychiatric providers possess all the capacities required; therefore, it is wise to maintain a realistic view of areas that require development.

One model for providing this initial and ongoing training is the successful American Psychiatric Association/University of Washington Advancing Integrated Mental Health Solutions (AIMS) Center training on collaborative care as part of the Centers for Medicare and Medicaid Services Transforming Clinical Practice Initiative. This program provided access to in-person or online introductory training, followed by an ongoing online learning collaborative, where additional didactic or group learning could occur and featured the opportunity for psychiatrists working in the field to learn from each other. The National Council MDI also hosts regular training and educational webinars for psychiatrists. To receive notifications for these opportunities, subscribe to National Council e-mails.

For more information on building and implementing effective teams within the team-based care framework, see Making the Case for High-functioning, Team-based Care in Community Behavioral Health Care Settings.

Financial Considerations

The literature suggests team-based care approaches like psychiatrist-led interdisciplinary case reviews improve clinical outcomes, enhance staff performance and improve morale. This carries with it cost savings. For example, a psychiatric interdisciplinary case review in one location showed savings of $824,600 in decreased community hospital days during a three-year period (Rosen, 2019). Today, most CBHCs are funded by fee-for-service reimbursement focused on billing efficiency for discrete services and associated with incentivizing volume, not value-based care.

Value-based alternative payment models that focus on bundling payments for services provided offers a better opportunity to focus on process and outcome quality metrics while supporting team-based approaches. Many CBHCs are in a hybrid market where most contracts are fee-for-service and a few are value-based, for example, bundled payment for a set of services. Value-based models of funding hold more potential to fund the collaborative components of team-based care like curb-side consults, team huddles and team meetings.

Team-based care can optimize both payment approaches because it identifies and optimizes cost offsets. Cost-offset designs focus on identifying the best staff to do a specific set of tasks based on their training, skills and credentials/license. In a team-based care approach, staff focus on collaboration and task optimization by role designation. In a fee-for-service environment, those who cannot bill or who cannot bill at as high a rate as another staff are allocated to optimize their workflow tasks to make the staff who can bill at the highest rate more efficient.

Staff who can bill for their services should not work in silos; they need the collaborative support of their team to optimize their ability to bill while working at the top of their license/credential. In a team-based fee-for-service or hybrid payment marketplace, the team aligns itself to ensure they are on task, on time and within budget as they produce the right value for the person served. A team-based cost offset model approach allows teams to ensure all staff are optimized to support the person receiving services and their team members to ensure efficiency (on time, within budget) and effectiveness (right service, by the right staff, at the right time to achieve the right outcome).

Alternative payment models hold the best potential to fully support team-based care due to the ability to bundle workflow tasks into billable units. The prospective payment system (PPS) is an example of an alternative payment mechanism that is available to Federally Qualified Health Centers (FQHCs) and CCBHCs. FQHCs and CCBHCs receive a bundled payment for each day a qualified service is provided based on the total cost of all services. In states participating in the CCBHC demonstration program, financial support for mental and physical team-based care can be built into the payment structure and includes team-based activities in the cost of care reimbursed to the center.

Some mental health organizations are administratively close enough to partner with FQHCs to permit some of these physical care treatments and monitoring and care coordination functions to be performed and billed by the FQHC partner.

The recently released complex care codes are a bundled payment available in fee-for-service Medicare and some Medicaid programs. While most commonly used in primary care, there is no specific language restricting them from use in mental health settings. The complex care codes pay for care coordination and care management activities of at least 20 minutes in duration or more pursuant to a written treatment plan.

Even within a mental health fee-for-service model, some team care services and roles are potentially billable as peer support, case management, crisis services or psychosocial rehabilitation. Potentially billable team care services/activities could include:

- Obtaining symptom rating scales (PHQ-9, GAD-7).

- Completing a medication adherence and recent history review and reassessment.

- Assisting the person with questions they have for the psychiatric provider.

These activities fall under broad descriptions of skill building, self-management and improving personal interactions that are standard parts of the service descriptions of peer support, case management and psychosocial rehabilitation. Peer support specialists specifically assigned to a high-functioning team can provide highly effective and billable services.

As discussed earlier, routine administrative or documentation tasks from the psychiatric provider and mental health counselors to other staff should permit more efficient use of their time. This cost-offset approach allows for a billable provider to become more efficient with their time and increase care access.

There may also be incentives available for meeting quality metrics. These are common among health plans and public funders may be receptive to negotiation of quality payment arrangements at this transitional time. Metrics might include:

- Substance use disorder (SUD) screening approaches, including Screening, Brief Intervention and Referral to Treatment (SBIRT), the AUDIT-C plus 2 measure, etc.

- Collaboration and provider coordination.

- Medication education and medication adherence.

- Other screening, such as labs and physical health metrics. In Michigan, for instance, CMHC centers are incentivized (or penalized) on standard Healthcare Effectiveness Data and Information Set (HEDIS) measures.

- Reductions in acute psychiatric admissions.

- Reductions in emergency department visits.

Finally, consideration of the financial cost of supporting team-based care should also include the potential financial losses incurred with staff turnover, particularly psychiatrists, who find managing complex cases in the absence of a team untenable. The overall cost of replacing a full-time psychiatrist, including lost productivity and recruiting costs, can be extremely high.

Medicare and Team-based Care Reimbursement

In 2015, Medicare began paying separately under the Medicare Physician Fee Schedule for chronic care management (CCM) services furnished to Medicare-insured persons with multiple chronic conditions (Department of Health and Human Services, 2019). At this time, a number of chronic care management current procedural terminology (CPT) codes (CPT 99490) and complex chronic care management codes (CPT 99487 and CPT 99489) are in use in primary care but are not available to mental health organizations to bill. These would be a productive means of supporting team-based care in the CBHC setting. The exclusion of mental health organizations from this billing stream appears to be a violation of the Mental Health Parity and Addiction Equity Act and should be approached as such by psychiatric advocacy groups.

After January 1, 2021 Medicare will allow billing outpatient clinic Evaluation and Management (E&M) codes (CPT 99201-99215) based on the total duration of time spent to the benefit of the patient or based or the complexity of medical decision making. Time spent to the benefit of the patient can include time consulting or coordinating with other members of the patient's team regarding that specific patient. This allows prescribing team members to bill at higher rates when aspects of team care require work without the patient present.

Recommendations

RECOMMENDATIONS FOR PSYCHIATRIC CLINICS AND ADVOCATES

We recommend implementing a team-based model of psychiatric clinic care in the CBHC setting. It is expected to improve psychiatric and medical clinical outcomes, access issues, services provision experience for all members of the team, retention and financial sustainability in a value-based environment.

Implementation will require an investment in staff, time and workflow change. CBHC chief executive officers and leaders must sponsor this effort and communicate with staff in an intentional way to create engagement around change.

As is possible in local environments, strongly consider engagement and negotiation with payers around a CBHC's ability to meet payers' needs for overall improvements in quality and in cost management. At this time, payers are incentivized to consider such arrangements, even on a pilot basis.

In a financial environment moving toward value-based payment and away from a fee-for-service model, advocate for a payment model that will support team-based care by capturing improvements in overall medical spending is essential for the continued health of CBHCs and similar models. It is worth helping policymakers reframe their understanding of mental health outcomes that the more efficient approach to population care provided by this model could improve, including the often-invisible cost of chronic access problems to other providers and the person receiving services and their families.

THE NEED FOR FURTHER RESEARCH

While research in the business and primary care literature convey the effectiveness and cost savings associated with team-based approaches, evaluation and implementation research in this advanced psychiatric clinic model is needed, with the goal of clarification of the key elements of team-based services design and delivery. Research in psychiatric services in the pediatric population is even scarcer and should be further explored.

Conclusions

Other areas of health care and mental health care, to a lesser extent, have successfully leveraged team-based care in several forms, including the widely implemented PCMH, which may provide an exemplary model for how community mental health adopts team-based care. High-functioning, team-based care offers a number of advantages to CBHCs functioning in the value-based payment environment, such as CCBHCs, including:

- Increased mental health care access, particularly access to psychiatric providers and overall capacity.
- Improved population health outcomes, including mental health, physical health and social determinants of health.
- Increased engagement and satisfaction of people receiving services and provider engagement.
- Reduced staff burnout and turnover.
- Standardized care pathways that increase use of evidence-based approaches and reduce risk of error, gaps in care and duplication of services.
- Improved integration of physical health, mental health and social determinants of health services in mental health organizations.
- Increased organizational capacity to adopt and optimize value-based alternative payment models.

By helping CMHCs meet performance goals and quality care benchmarks, high-functioning team-based care in the psychiatric clinic setting offers a sustainable pathway forward that is consistent with the aims of value-based reimbursement models, helps organizations respond to cost-containment pressures and, most importantly, supports effective behavioral health care.

NATIONAL
COUNCIL
for Mental
Wellbeing

The National Council for Mental Wellbeing is the unifying voice of America's health care organizations that deliver mental health and addiction treatment and recovery services. Together with 3,381 member organizations, serving approximately 10 million adults, children and families living with mental health and substance use disorders, the National Council is committed to all Americans having access to comprehensive, high-quality care that affords every opportunity for recovery.

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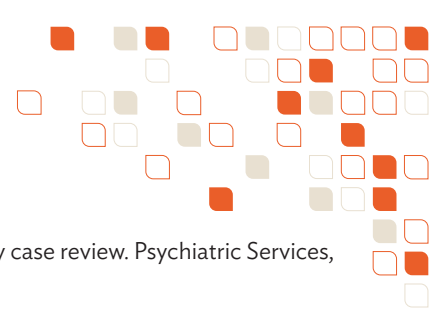
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