

NATIONAL COUNCIL
for Mental Wellbeing

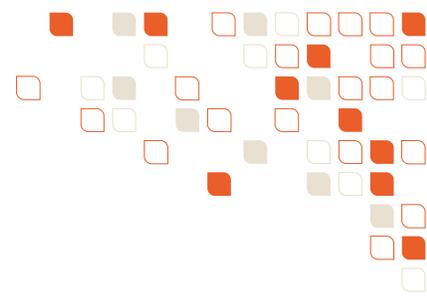


MAKING THE CASE
FOR HIGH-FUNCTIONING,
TEAM-BASED CARE IN

COMMUNITY BEHAVIORAL HEALTH CARE SETTINGS

NATIONAL COUNCIL Medical Director Institute

October 2020



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 behavioral health providers and clinical staff with first-hand experience in direct service provision and administration.

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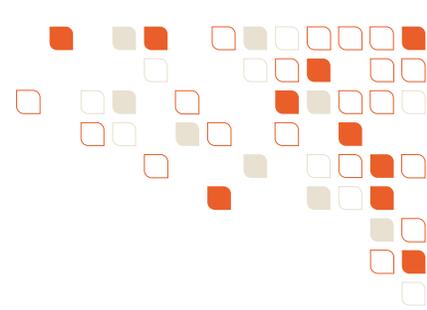
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Introduction

AIM OF PAPER

This paper describes team-based care as the model of delivering mental health and substance use disorder treatment services in community behavioral health clinics (CBHCs) to improve individual care, population health outcomes and the work experiences of all team members who provide care. The paper also presents five critical elements of the model that are necessary for high-functioning team-based care in the CBHC setting and actionable tips for implementation.

Team-based mental health care is often pursued simultaneously with primary care integration, which is sometimes referred to as “reverse integration.” However, CBHCs that have not yet pursued either team-based care or primary care integration should first implement team-based care before tackling primary care integration. Team-based care principles are closely aligned with integration principles, such as the Quadruple Aim (Bodenheimer, 2014) and can set CBHCs for success in improving the personal experience of care, improving the health of individual persons and populations, reducing the per capita cost of health care and improving the staff experience of care provision.

CBHC leaders and staff should use this paper as a resource as they begin to consider, plan for and implement team-based care in their organization.

TERMINOLOGY

Nomenclature relating to behavioral 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 respectfully referring to the people we serve. For the purposes of this paper, we will use the following terminology:

- **Behavioral health care:** Includes mental health and substance use disorder treatment services.
- **Community behavioral health center (CBHC):** An agency that provide a comprehensive range of mental health and substance use disorder services to individuals in their communities.
- **People (or person) receiving services:** Because person-first language (Kirszenbaum, 2015) is the contemporary standard, “people (or person) receiving services” is used in this document in place of patients, clients and consumers. Exceptions are when referring to the specific primary care model of patient-centered primary care or medical home and when quoting a source directly.
- **Psychiatric provider:** Psychiatric providers include psychiatrists, nurse practitioners and physician assistants whose role includes prescribing and monitoring psychotropic medications. Psychiatric providers also perform initial and ongoing psychiatric assessment, treatment planning, psychotherapeutic and psychoeducational interventions, family and caregiver support and monitoring of intercurrent physical illnesses and coordination with medical and social service care systems.
- **Behavioral health providers:** Behavioral health providers (in addition to psychiatric providers) include psychologists, social workers, nurses, licensed professional counselors, licensed marriage and family therapists, counselors with specialized expertise in addiction counseling, and certified peer staff. In a high-functioning team-based care model, all behavioral health providers receive equal support in the same manner as that given to psychiatric providers.



Executive Summary

Despite a wealth of data showing that team-based care leads to equal or better outcomes in efficiency, effectiveness, safety, cost savings and quality, the broad adoption of team-based care in CBHCs remains the exception rather than the rule. Primary care models, such as patient-centered medical homes (PCMHs), have generated much of this data, but some has also come from behavioral health implementations.

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 medical record (EMR) and care coordination within and outside of the CBHC.



A high-functioning team-based model for the behavioral health clinic should be the standard for CBHCs. It is especially critical for health care leaders and administrators, including chief executive officers and board members who face the burden of responding to rising health care costs while meeting ever-present demands for quality, efficient and effective services.

The use of high-functioning, team-based care is a forward-thinking solution to simultaneously address clinical effectiveness, safety, quality and cost containment. This paper presents the rationale and potential steps to implement high-functioning, team-based behavioral health care services and addresses current challenges facing behavioral health care practice.

It delineates a standard for high-functioning, team-based behavioral health care to effectively meet the needs of an evolving behavioral health care system and the expectation to deliver on population health outcomes. Finally, it recommends how policymakers interested in health care reform can encourage the widespread implementation of team-based service delivery models.

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. Behavioral health care staff working in community settings face problems with workforce shortages; treatment delays; an increasingly complex population, especially among people with SMI, who frequently have chronic comorbid physical conditions; fragmented care; large caseloads; and inadequate time and resources. In this challenging health care environment, innovative behavioral health care delivery models, including team-based care, are not a novelty – they are a necessity.



HIGH-FUNCTIONING, TEAM-BASED CARE AS A SOLUTION

High-functioning, team-based care is a solution to the demands of the community behavioral health care workplace that has proven effective in primary care settings and, in limited studies, CBHCs. Widespread uptake and adoption could reasonably address current challenges facing behavioral health providers while responding to the demands of emerging value-based payment models – especially those that incentivize integrated care delivery. Empirical evidence suggests team-based care can improve symptoms, quality of life and satisfaction; decrease hospital admissions and duplication of services; increase continuity of care and access; reduce burnout and improve staff experience of care provision; and reduce medical errors and gaps in service.

A PROPOSED MODEL FOR TEAM-BASED CARE IN CBHCs

From administrative intake to psychiatric nursing assessment to psychiatric provider evaluation to team-based treatment planning, this framework underscores the importance of monitoring the full scope of a person’s complex medical and behavioral health problems and leveraging innovative approaches to reduce waste and curb excess spending.

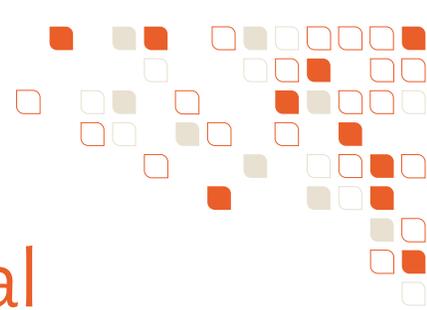
BARRIERS AND OPPORTUNITIES

There are prominent financial barriers to team-based care implementation in CBHCs. The primary hurdle is related to funding the psychiatric provider to attend team meetings, including huddles and team meetings to review complex cases and engage in continuous quality improvement. The existing fee-for-service reimbursement structure is not conducive to this 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 care can be built into the payment structure, such as with Certified Community Behavioral Health Clinic (CCBHC) programs. Another option is to design fee-for-service codes in Medicaid and Medicare that allow for care coordination funding similar to how the Medicare Collaborative Care and Complex Care codes work in primary care and in the states that have turned on the codes in Medicaid. Balance costs attributed to team-based care against potential losses caused by failure to implement, particularly those resulting from the loss of efficiencies and effectiveness in care provision and coordination, including staff burnout and turnover.

MOVING FORWARD

The bulk of literature supporting team-based approaches reflects experience with implementation in medical rather than in mental health and addiction treatment and recovery settings. More clinical trials in these settings will help us better understand the potential effects of the models on clinical, financial and workforce outcomes and to inform clinical and policy decision-making. Sharing and exchanging ideas from CBHCs that have successfully launched high-functioning, team-based care to transfer and disseminate knowledge is a beneficial option in the meantime. The opportunity to improve individual and population outcomes is rich and efforts to inform, train and foster team-based based care among CBHCs will improve not just the behavioral health care system, but health care delivery as a whole.



The Current State of Behavioral Health 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 also called upon to improve physical health outcomes, address social determinants of health, reduce all-cause medical spending and constrain mental health and addiction services costs. It is essential to consistently meet these value-based performance expectations and maintain access to care. To achieve such performance standards, CBHCs must overcome barriers that include addressing increased staff workloads, improving coordination within and across systems and preserving staff well-being

The importance of having a positive impact on the general health, early mortality and number of chronic medical conditions seen in tandem with SMI cannot be understated. In 2006, the National Association of State Mental Health Program Directors (NASMHPD) reported that people with SMI die, on average, 25 years earlier than the general population. In spite of significant efforts during the past decade, the gap in life expectancy has not significantly changed (Olfson, 2017).



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 all behavioral 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 CBHCs 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 peoples' complex medical and psychosocial needs.
- Extensive administrative burdens that could be managed by others.



These challenges are not unique to CBHCs. Primary care has grappled with problems of poor access, increased population complexity, ever-increasing costs, difficulty providing comprehensive and coordinated care, worse than expected outcomes, errors resulting from communication omissions and provider burnout.

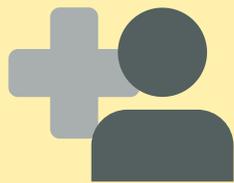
A series of studies investigating causes of poor outcomes and provider burnout found that “...it is difficult for even the most motivated and elegantly trained providers to assure that people receive the systematic assessments, preventative interventions, education, psychosocial support and follow-up 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 EMR (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 behavioral health providers experience similar requirements, including behavioral health and physical health tasks, as well as EMR and administrative tasks.

Communication has also become challenging in the CBHC setting. As the number of tasks increase, so does the complexity and inefficiency of communication. The more providers each individual provider needs to communicate with exponentially increases the time required and the risk of a communication error or omission during care or with handoffs, which is a major cause of serious preventable medical errors and sentinel events (Dollarhide, 2014).

Figure 1: Communication Scenario: CBHC that Does Not Use Team-based Care

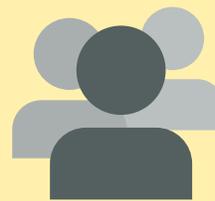
A CBHC employs six psychiatrists and 23 mental health providers (case managers and therapists) who serve as case holders. A total of 451 patients receive their services. Each case manager shares persons-served with each psychiatric provider, making for a needlessly complex set of interactions.



In this scenario, the result is

65

unique psychiatric provider/case holder caseload pairings.



The psychiatrist with the highest caseload in this clinic needs to communicate about

111 PEOPLE SERVED WITH **15**

different case holders. Imagine the potential for errors due to failed communication.

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 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 characterizes 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 behavioral 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.

Team-based care is not unique to primary care and has a long history within behavioral health. The first detailed description of team-based care in the U.S. was in the 1970s when Stein and Test developed assertive community treatment (ACT) to maintain people with complex SMI in the community (Bond & Drake, 2015). They articulated the need to bring fragmented services together to deliver them in a coordinated manner across multiple disciplines, including psychiatry, and added the importance of shared responsibilities within the team. In the late 1970s, similar multi-professional psychiatric clinical models were developed and researched internationally showing clear-cut benefits (Bouras, 1986).

The concept of team-based care was extended to children's wraparound services in the 1980s and Integrated Dual Disorder Treatment (IDDT) and Individual Placement and Support (IPS) provided an evidence-based approach to support employment for people with SMI in the 1990s. Recently, the Recovery After an Initial Schizophrenia Episode (RAISE) trial incorporated high-functioning team-based care as an essential element of the care of individuals with initial onset of schizophrenia spectrum disorders, with improved outcomes compared to the treatment usually provided in CBHC settings across the U.S. (Kane, 2015).

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 (see Appendix). 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 behavioral 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.



“The primary goal of medical teamwork is to optimize the timely and effective use of information, skills and resources by teams of health care professionals for the purpose of enhancing the quality and safety of patient care.” (AHRQ, 2014)



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 skillsets across all specialties that function as a unit with clear roles, a shared purpose and seamless coordination to effectively and efficiently deliver comprehensive, individualized, responsive care to treat acute need. (Schuttner, 2018).

The clinical complexity and aspirations of improved behavioral 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 behavioral health and medical care in the psychiatric clinic without the support of a high-functioning team (Nutting, 2011; Torrey, 2017). Incorporating all providers as full members of the team adds value to the care of the person receiving services and optimizes communication between all team members, which clarifies the diagnostic picture and highlights social determinants of health needs and other barriers to care. Because all members of the team are responsible for the same people receiving services, there are fewer communication errors. 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 boundaries between “medical” and “psychosocial” become illusory, allowing care to be delivered in an integrated manner across systems.



There is near consensus that community-based integrated and comprehensive psychiatric services performed by interdisciplinary teams constitutes the gold-standard for the care of patients suffering from mental illness.” (von Peter, 2018)



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 and addiction recovery team.” (Liberman, 2001)

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 CBHCs, the CBHC 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 rates** (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 behavioral 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.



Fundamentals of High-functioning Team-based Care

GENERAL PRINCIPLES

A team-based model in CBHCs is essential to maintaining an efficient, effective and healthy team. Principles that support processes and structures to maintain team efficiency and effectiveness have been detailed in medical and non-medical settings provide a foundation for making teams in the CBHC setting.

Although teams differ across settings in their specific composition and exact roles and responsibilities, certain commonalities unite all successful high-functioning teams. Shared principles of team-based care ensure “teamness,” or effectiveness and functionality (Mitchell, 2012) and “teaming” behaviors. Teaming is teamwork “on the fly” that reaches across boundaries to coordinate and collaborate to encourage innovation to tackle complex problems and is especially critical to success when work is complex (Edmonson, 2012). Based on the empirical literature of successful team-based approaches, five components have emerged as necessary for effective team-based care (Leipzig, 2002):

- Well-defined and appropriate **team goals**.
- Clear **role definitions and expectations** for team members.
- A real-time, structured yet flexible **decision-making process**.
- Established, open and safe **communication** patterns.
- The ability of the team to **celebrate accomplishments and address breakdowns**.

In addition to providing teams a unified sense of identity, these five factors are essential to achieving what Nutting and colleagues call “adaptive reserve” (Nutting, 2011). When implementing the PCMH model, they found that certain health care teams outperformed others even though staffing, resources, case mix and other factors were constant across teams. Adaptive reserve describes the power of a team where staff members understand their role, workflow tasks and team goals. It is important that the work environment is psychologically safe and transparent with structured decision-making and that conflicts and successes are leveraged for learning and improvement. To better understand how to implement these components, see the section “A Proposed Model for Team-based Care in CBHCs.”

1. Team Goals

The power of shared goals to help people overcome barriers, align their efforts and execute a set of tasks to achieve a common goal is well-documented (Sherif, 1988). A clearly defined and agreed-upon process and outcome target metrics that align with the vision and mission of an organization and demonstrate the improved wellness of the population receiving services is key to achieving value in the current alternative payment marketplace. It is also one of the cornerstones of getting individual staff members to work as a team.



2. Roles and Expectations

Highly effective teams demonstrate teaming behaviors (Edmonson, 2012) that require affective and cognitive skills to work in synch with one another for the team to achieve goals. An essential component of teaming is that everyone knows their role and associated responsibilities. Some team members are credentialed or licensed to do certain activities (e.g., a nurse practitioner is licensed and credentialed to prescribe medications and a peer recovery coach is certified to provide peer support services). Regardless of whether a staff is credentialed or not, all team members need to know their scope of practice, which is defined in their job description but also by the team itself. For successful teaming, all staff must be willing to step up and expand their scope of practice when required to complete tasks and ensure staff feel their teammates are supporting them.

3. Structured Yet Flexible Decision-making Processes

Efficient and effective teaming can only occur if team members establish flexible and psychologically safe communication and decision-making patterns. Communication must be both extemporaneous with activities like curbside consults and structured through regularly scheduled meetings like team huddles. Role definitions help make it clear who has the authority to make certain decisions. However, hundreds of decisions are made during the course of any day; some have the potential for significant legal liability, while others have significant potential to engage or disengage a person in care. Health care providers' decisions carry significant weight and teams must spend time to determine when individual staff can make a decision, when it makes sense to collaborate on a decision and in what context to do this, for example, waiting until a team meeting or under supervision.

4. Open and Safe Communication

“Psychological safety is a belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns or mistakes,” (Edmonson, 2012). Google researched which components make a team efficient and effective and found that psychological safety was the most positively correlated variable. If there is only one variable to focus on when considering how to improve team efficiency and effectiveness, this is it (Google, 2012). Staff members who feel they have a say in their workflow have much lower burnout rates (Maria, 2011) and higher employment satisfaction (Wigert, 2018) than those who feel processes are forced upon them through an external locus of control.

5. Celebrate Accomplishments and Address Breakdowns

Finally, teams define breakdowns and breakthroughs. Often, big breakthroughs come when big breakdowns are recognized and learned from. It is imperative that teams have the ability to recognize when they are underperforming, whether it is on a key population health metric or in supporting each other in the event of staff conflict. Teams must also recognize and take the time to celebrate successes.

Protocols for how teams monitor staff morale and team successes is critical to create an environment that prioritizes safety, structure, learning and improvement. Teams need protocols to help identify and respond to critical incidents and feel supported when critical incidents occur, whether there is a death from suicide or other causes, violence, physical-medical issues or other incidents.

Learning From Leaders

Corporations like Google have researched and implemented team-based approaches and found improvements in team efficiency and effectiveness using the five principles of team-based care. Several resources are available from these organizations to help lead CMACs in developing their team-based care capacities:

- [Team-based Care in North Carolina, a publication of the North Carolina Institute of Medicine](#)
- [The University of Washington's AIMS Center's Team Building and Workflow Guide](#)
- [AHRO's Creating Patient-centered, Team-based Primary Care](#)
- [Google's Guide: Understanding Team Effectiveness](#)



A Proposed Model for High-functioning, Team-based Care in Community Behavioral Health Care

What does high-functioning, team-based care in a CBHC look like? The team-based care principles just described provide the framework upon which the following structural elements can be designed and deployed. Though we address structural elements, details on team services design regarding team services intensity, level of care determination and caseload allocation process and size are beyond the scope of this paper. For more guidance on these topics, access the MTM Services [caseload calculator](#), the [Essential Elements of Effective Integrated Primary Care and Behavioral Health Teams](#) (SAMHSA, 2014) and the National Council's webpage on [standards of care](#).

Based on our review of the literature and examples from the field, the following components are necessary to implement and sustain a high-functioning team-based care approach:

1. Leadership support and a dedicated implementation team.
2. High-functioning, collaborative teams.
3. Measurement-based care pathways and protocols.
4. Person-served engagement strategies and activities.
5. Ongoing training and communication.



The following sections provide details on each of these elements, including implementation tips to get CBHCs started on their journey to adopting this model. These elements are flexible and should be tailored to meet the unique needs of each CBHC.

LEADERSHIP SUPPORT AND IMPLEMENTATION TEAM

Leadership Charge to Implement Team-based Care

High-functioning team-based care offers the opportunity for CBHCs to optimize treatment outcomes while reducing wasted resources and curbing excess spending. Unfortunately, the extreme shortage of psychiatric providers and other behavioral health care staff can artificially reinforce the perception that change is too difficult. Agencies report that they do not have the flexibility to experiment with other models of care. This view is counterproductive and undermines the Quadruple Aim of improving people's experience of care, improving population health outcomes, reducing per capita costs and improving staff recruitment, satisfaction and retention.

The shift from traditional practice to high-functioning team-based care is not without challenges or resistance and requires 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 front-line staff readiness and commitment to develop a new culture that supports team-based care before moving forward with implementation. Committed leadership is key to successful implementation of team-based care principles. It is the foundation of the process and structural components that are necessary for the team to operate efficiently and effectively.



Implementation Team

Once a CBHC has established leadership sponsorship for team-based care implementation, they must identify an implementation champion and assemble an implementation team, which is an interdisciplinary group of staff from across the organization. The implementation team is critical to facilitating organizational change and staff engagement. Under the champion's leadership, the implementation team defines the project mission, conducts an organizational self-assessment to determine baseline clinical and operational strengths and needs, and develops an implementation action plan.

HIGH-FUNCTIONING TEAMS

Developing and Maintaining an Effective Team

- Include staff members in developing and implementing the model so they are engaged in the process and are not passive participants.
- Create team-based incentives for meeting goals for team-based care, for example, success at meeting metabolic monitoring goals.
- Regularly assess team and individual clinical and administrative performance measures to facilitate achievement of goals.
- Hold regular team meetings to discuss how the team is performing, problems, concerns, successes, expectations, etc.
- Use language that constantly promotes and reinforces the idea of “teamness” like “we” versus “I” or “you” and “teaming” – collaborative support of one another.
- Foster a sense of psychological safety among teams. This means creating an environment where staff members feel respected and safe to share ideas, raise criticisms or concerns, ask questions and suggest solutions without fear of embarrassment or retribution. Without psychological safety, teams become ineffective due to their inability to identify and solve problems, exchange ideas and push against the status quo and adopt innovative change. Leaders and team members can foster a sense of psychological safety by ensuring everyone has an opportunity to speak and weigh in on decisions regardless of their position and status within the organization, encouraging constructive criticism, and making “I” statements.
- Emphasize the notion of collective responsibility and accountability so each team member understands that they play an important role in making team-based care successful.
- Engage in ongoing and widespread communication. Culture change requires ensuring team members understand the reasons for adopting team-based care. If they do not understand how and why it leads to better outcomes, they are not as likely to support it. Team members need consistent expressions of support from leadership about the appropriateness and necessity of these changes, as well as opportunities to voice their thoughts and ideas.

Required Skills and Attributes for All Team Members

When hiring and supporting staff development, keep in mind that there are a number of skills and attributes required of team members operating within the team-based care model, including:

- **Demonstrated commitment to the team's goal** of providing high quality behavioral health services as a group toward achieving defined, measurable population health goals. Team members should not only be committed to their own job, but to the work of the team as a whole, including overall population health outcomes.
- **Ability to trust team members**, including acknowledging that all team members have the necessary skills and goodwill to deliver results that contribute towards achieving team goals. They should be aware of the role of others and assist whenever possible as they perform their own assigned tasks.



- **Ability to mine for conflict** by actively identifying and exploring areas of disagreement within the team and engaging in a discussion to resolve the disagreement. Mining for conflict occurs when team members ask for others to disagree and praise and thank those who do offer a different viewpoint. In a team discussion, silence does not always mean everyone agrees; therefore, effective team leaders establish an obligation to dissent so that discussions can take place openly. Otherwise, it is likely that these conversations will happen in isolated pockets, behind closed doors to the detriment of the team. If a team member suspects that unearthed disagreement is lurking in the room, they should gently demand that it be addressed. Using this concept of mining for conflict, team members can experience conflict not as a personal attack but rather as an opportunity to obtain greater clarity.
- **Possess a strong sense of accountability**, whereby team members hold themselves and others accountable for adherence to the agreed-upon workflow and the overall success of the process. Holding each other accountable is the most difficult part of effective teamwork and requires the most discussion and development to achieve.
- **Dedication to a continuous quality improvement process** for achieving administrative efficiency, quality of care and improved clinical outcomes.

Defined Team Structure and Staffing Roles

Team-based care requires clear roles, expectations and accountability. This foundation allows for task shifting, a concept initially developed in areas of the world faced with chronic workforce shortages, that has proven to be effective in other settings (WHO, 2018). Task shifting focuses on ensuring 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 care is high quality and that all legal requirements of scope of practice 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 (MA) to obtain a person's vitals, rather than a registered nurse (RN), the RN can use their advanced skills to coach the person 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 person's chart for missing information and requesting the information, which they would have to review at a later time.



Implementation Tip: Your team can analyze how to shift tasks by first identifying a list of all necessary tasks, then asking the following questions of each task:

1. Who is currently responsible for this task?
2. Who should be responsible for this task?
3. What additional training is required for the appropriate team member to become responsible for this task?
4. Would efficiency be enhanced by developing protocols to complete this task?
5. Which team members should develop these protocols?

Once the team has analyzed tasks and assigned them to the appropriate team members, the team structure and roles should be finalized. The team should be led by a psychiatric medical director-clinical director dyad that leverages the psychiatric and clinical expertise of teams to lead to clinical and financial improvements. While the medical director and clinical director will need to allocate additional time to serving in this operational leadership role, the team-based care model offers other efficiencies to offset the reduction in available clinical time for these staff members (Rosen, 2019).



Each team should spend time defining roles that make sense for their CBHC. Defined team structure and roles may include:

1. **Care Team Coordinator:** Oversees population utilization and outcomes management, provides clinical consultation with other team members, carries a small caseload of people, oversees daily crisis interventions and follow-up.
2. **Behavioral Health Assistant:** Scrubs schedule* and prepares for huddles, answers general team phone, assists with referrals and crisis triage, coordinates administrative tasks, posts compliance reports.
3. **Case Manager:** Works with entire population on practical case management needs; coordinates daily tasks with therapists/other team members; coordinates primary care/other medical appointments; coordinates with outside services, including housing support; provides transportation as needed.
4. **Housing Case Manager:** Works with homeless or housing-insecure population to obtain shelter, temporary, and/or permanent housing; provides proactive support for maintaining housing and preventing eviction.
5. **Employment Specialist:** Works with ready-to-work population using evidence-based practice, individual placement and support (IPS) (IPS, 2020).
6. **Money Manager:** Serves as Social Security representative payee, pays persons' bills; works with people and team members on money management skills toward goal of return to self-payee.
7. **Peer Wellness Specialist:** Participates in treatment planning and delivery, mentors people receiving services to facilitate achievement of person-driven recovery goals.
8. **Clinical Pharmacist and Pharmacy Technician:** Provides medication administration assistance (daily, weekly, monthly) and tracks adherence, conducts comprehensive medication reviews, manages collaborative drug therapy management (CDTM) agreements for clozapine and mood/anxiety/sleep disorders.
9. **Behavioral Health Therapist:** Provides individual/group therapies, clinical coordination and crisis intervention; document care plans and updates.
10. **Nurse:** Provides consultation and triage regarding psychiatric and physical medication needs, scrubs schedule and prepares for and leads huddles, provides check-in support for psychiatric and other medical providers, administers long-acting medication injections, conducts medication adherence tracking.
11. **Psychiatric Provider:** Provides psychiatric evaluation and treatment, conducts case consultations with nurse and other team members care, coordinates care with primary care and other medical providers, reviews and approves (with signature) all MHAs and care plans authorizing care.

***Scrubbing schedules** is the process of reviewing and optimizing clinician schedules so that missed appointments are prevented or are quickly filled by people waiting to have an appointment scheduled.



Clearly Defined Team Norms

Once the team is assembled, members need to establish team norms. Norms are the behaviors team members engage in daily to achieve their shared goals. Often norms are not made explicit through discussion and emerge as a byproduct of interaction and drive team activities. Teams that are thoughtful and deliberate about their norms, including how they interact with one another and the people they serve, the language they use and the demeanor and follow-through on commitments to excellence in health care provision, are in the best position to continually learn and improve on team-based care delivery. Teams should engage in a collaborative process by which they define and adopt a set of norms.



Implementation Tip: The following are sample norms to consider:

- The team continuously defines, practices and refines standard operating procedures by tracking data to monitor the efficiency and effectiveness of protocol-informed workflows to achieve population process and outcomes targets.
- The team provides person-centered care and delivers the right services at the right times by the right team members. Care includes engagement, health literacy and education.
- The whole team is responsible for the whole population served. The daily work is not getting through schedules or completing other tasks, it is the health of the population of people they serve.
- All team members are dedicated to the integrated health and wellness of the population served and the wellness of their team and its members.
- All team members have defined roles and work to the top of their skills and/or licensure.
- All team members operate from the perspective that they can and will assist others when needed within their scope of work or through coordination with a team member who can.

Team Communication Mechanisms

Communication among team members should happen in a variety of structured and unstructured ways, including team huddles, team meetings and curbside consults. Each mechanism serves a particular role in facilitating team communication.

Team Huddles

Huddles are brief meetings (e.g., 10 – 30 minutes) and can occur at a variety of frequencies and should be scheduled to meet the unique needs of each team. For example, they could occur during each shift change, at set times each morning and afternoon or a few times per week. Huddles can occur in person or via phone or video conference. The huddle should only include the team members necessary to review key workflow activities and information needed to review what was done with people who will receive services since the last huddle and what needs to be done with people who are going to be seen before the next huddle. A paper-based, electronic or white board log should track assigned staff follow-up activities. The beginning of the huddle should focus on reviewing what was committed to in the log during the previous huddle.

A team member should be assigned to prepare for and lead the huddle. Preparation includes pulling information on the outcomes of who was seen since the last huddle and the needs of people who are going to have contact with the team following the huddle.



Implementation Tip: Consider the following common huddle elements when developing your huddle protocol:

1. Review log of assigned follow-up tasks from last huddle and provide updates on task completion.
2. Review/scrub behavioral health provider schedules during each huddle.
3. Review/scrub psychiatric provider schedule weekly (resolve no-shows, follow-up requests, etc.).
4. Provide updates on crisis events, emergency department presentations or admissions to a medical or psychiatric hospital for follow-up.
5. Provide updates on psychiatric nurse and psychiatric-medical provider check-ins.
6. Coordinate behavioral health services with other types of care and partners, including primary care and other physical-medical care, specialty providers and other care stakeholders within and outside of the organization.
7. Conduct standard reviews, including annual metabolic labs and AIMS monitoring.
8. Assign tasks and record in log for review during next huddle.

Team Meetings

Team meetings typically last one hour or more and occur weekly or biweekly. While huddles address immediate clinical caseload coordination needs, team meetings serve broader strategic and operational needs, as well as longer-term clinical needs. All team members should attend these meetings, as well as special guests from other internal departments as needed.



Implementation Tip: Consider the following common meeting elements when developing your meeting protocol:

1. Review complex cases.
2. Analyze and respond to population health data.
3. Conduct group supervision to review protocols and initiatives that have been implemented or need to be implemented to engage in continuous quality improvement.
4. Discuss difficulties the team is experiencing with each other or with critical incidents.
5. Celebrate successes and achievements.
6. Discuss ad hoc topics that involves inviting organization staff from outside of the team to work through specific issues (e.g., inviting a housing specialist to work through how to best coordinate and provide housing referrals and follow-up).

Other Communication Mechanisms and Considerations

Although team huddles and meetings are central to the team-based care model, communication among team members takes place through a variety of other mechanisms. In a curbside consult, the treating psychiatrist or behavioral health provider seeks informal information or advice about patient care from a colleague. CBHCs may also use message features through EMRs, white boards and dashboards for information sharing. Decide which methods fit your unique needs to ensure communication continues to happen in between huddles and meetings. CBHCs in rural and frontier locations may have a unique set of challenges since providers may rarely be onsite at the same time, requiring less frequent huddles and meetings or virtual meeting capabilities.



MEASUREMENT-BASED CARE PATHWAYS AND PROTOCOLS

Measurement-based care, care pathways, and clinical and operational protocols are three elements of mental health service delivery that work together to provide a solid foundation for team-based care implementation. A care pathway is a sequential series of clinical and administrative activities (or workflow) that staff engage in to provide care to people receiving services (Morris & Trivedi, 2011; Trivedi, 2006). Grounded in the available evidence-based research and best practice literature, care pathways are designed to provide the needed standard operating procedures for addressing clinical activities, care coordination, billing, documentation, staff time allocation and data reporting required for each step in the workflow process.

Care pathways should be developed within a measurement-based care (MBC) framework. MBC is the practice of basing clinical care on client data collected throughout treatment and is considered a core component of numerous evidence-based practices. MBC can be used to assess valuable information about (a) signs/symptoms, (b) functioning and satisfaction with life, (c) readiness to change and (d) the treatment process via session feedback and a working alliance (Scott, 2015). This objective assessment of progress can be used to initiate modifications to treatment of the individual and to monitor population health and the overall effectiveness of services. In addition to developing clinical measures and benchmarks, CBHOs should develop operational measures and benchmarks in order to engage in a comprehensive continuous quality improvement process.

Lastly, care pathway protocols ensure proper execution of the care pathway workflow and afford the team:

1. Clarity around how, when and by whom critical workflow processes within the care pathways are completed.
2. A system within which to advance and sustain MBC where all clinical and operational activities have process and outcome metrics and benchmarks (e.g., individual and population health outcomes, billing and documentation).
3. The ability to engaging in real-time continuous quality improvement by isolating and changing one element of a workflow protocol using the Plan Do Study Act (PDSA) approach to see if it creates the desired outcome.

Care pathway protocols should be clearly laid out into easy-to-reference steps. Teams often use flowcharts to depict the sequence of work delegated to various team members. Though incorporating protocols is critical, not all care pathway workflow steps should be written into protocols – there are too many things a team does in a day. It is best to start by identifying which protocols are currently in place, if they accurately depict how staff are working, and most importantly, if they are producing the desired measurement-based results. Once the team has analyzed and refined current protocols, determine if the workflow could be enhanced by developing additional protocols or adding or refining measurements and benchmarks.



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



Implementation Tip: For more information on developing care pathways and protocols, see the National Council’s [Toolkit for Designing and Implementing Care Pathways](#).



PERSON-SERVED ENGAGEMENT

People served should be engaged early and often when a CBHO implements changes to care pathways as a result of adopting team-based care. The following are considerations for communicating for engagement:

- Conduct focus groups before implementation to explore person-served concerns about and hopes for the team-based care initiative. Concerns may include changing providers, confidentiality and knowing who to contact. Hopes may include working with a team that knows them well and rapid access to support and expertise.
- Prepare team members to talk with people served about the concept of team-based behavioral health care by developing an “elevator speech” that can help them organize and present the concepts behind providing care in a new way.
- Provide orientation sessions for people served.
- Have people served meet the entire team at the beginning of treatment.
- Create informational materials (e.g., one-page descriptions).
- Offer avenues for ongoing person-served involvement and feedback on the process. For example, send post-care satisfaction surveys and/or set time aside during care appointments for providers to illicit feedback.

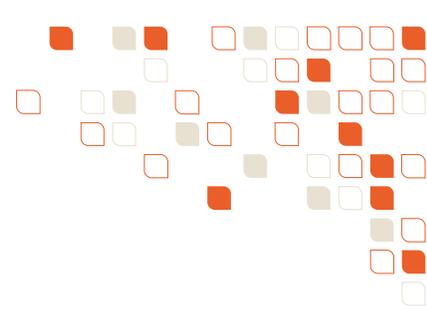
TRAINING AND COMMUNICATION

Plan to provide staff access to training, mentoring and support for skills needed to function as a fully deployed high-functioning team. Training should be provided during the implementation phase and on an ongoing basis for continuous quality improvement and sustainability. Be prepared to consistently communicate with staff the importance of team-based care, the successes of implementation and areas for future development to maintain staff engagement. As stated by Liberman in *Psychiatric Services*, “...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 (Liberman, 2001).



Implementation Tip: Trainings and Resources

- [Cambridge Health Alliance Model of Team-based Care Implementation Guide and Toolkit](#) (Cambridge Health Alliance)
- Center of Excellence for Integrated Health Solutions [Training](#) and [Technical Assistance](#) (National Council)
- [Creating Patient-centered Team-based Primary Care](#) (AHRQ, 2016)



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 CCBCs 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 behavioral 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 behavioral 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 behavioral 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 behavioral 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, CBHC centers are incentivized (or penalized) on standard behavioral 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 on 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 CBHCS AND ADVOCATES

We recommend implementing a team-based model of behavioral health care for people with SMI. 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. Because it is a complex process, organizations should consider implementation in sequential steps: 1) team-based care, then 2) physical and behavioral health integration. Team-based care is essential for effective and efficient integrated health and ideally is done before integration, but if that is not possible, as part of integration.

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 the mental health and addiction treatment and recovery space is needed. Given the broad adoption of integrated behavioral and physical health approaches to care which require team-based care provision, the health care field would benefit from a more comprehensive understanding of key elements of team-based services design and delivery.

Conclusions



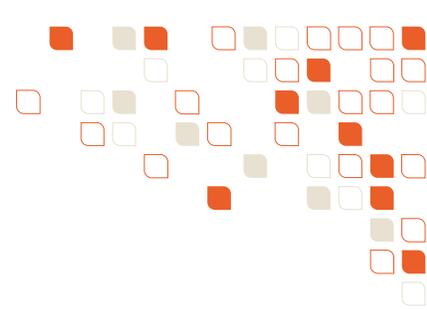
Other areas of health care and behavioral health care, to a lesser extent, have successfully leveraged team-based care in several forms, including the widely implemented PCMH, which may provide an exemplary model for how community behavioral health adopts team-based care. High-functioning, team-based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

- Increased behavioral health care access, particularly access to psychiatric providers and overall capacity.
- Improved population health outcomes, including behavioral 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 behavioral health organizations.
- Increased organizational capacity to adopt and optimize value-based alternative payment models.

By helping CBHCs meet performance goals and quality care benchmarks, high-functioning team-based care 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.



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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Appendix: Examples of Team-based Care Models in CBHCs

A number of behavioral health settings are pioneering the use of high-functioning teams.

BEHAVIORAL HEALTH HOMES

The Missouri CMHC Healthcare Homes program is the most successful example of this approach. It focuses on care coordination and management, building on the traditional community mental health and addiction recovery center team of a psychiatrist or other prescriber plus a community support worker by adding new team members:

- A primary care nurse care manager to do care coordination and care management of both behavioral health and general medical conditions.
- A care coordinator, an unlicensed staff person who assists the nurse care manager and performs tasks that do not require a nursing credential.
- A health home director, responsible for maintaining the disease registry and using data to manage care and achieve performance indicator goals.
- In some cases, peer specialists assist in care coordination and social determinants of care.

This model resulted in reductions in hospital and ED use that was sufficient to cover the increased costs of the care team and generate additional substantial savings in the total cost of care.

VETERANS AFFAIRS BEHAVIORAL HEALTH INTERDISCIPLINARY PROGRAM

The Department of Veterans Affairs (VA) began implementation of the Behavioral Health Interdisciplinary Program at each medical center in 2013. “Working solely at the clinician level with minimal study-funded support, we found that implementing the CCM [complex care management] can reduce hospitalization rates and, for complex individuals, improve health status. The next challenge is to target, scale up and spread implementation for teams that treat populations that are most likely to benefit from CCM care (Bauer, 2019).

CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS (CCBHCs)

A Substance Abuse and Mental health and addiction recovery Services Administration (SAMHSA) program providing cost-based funding to create optimal community mental health and addiction recovery centers with a full array of service, which may include care coordination for physical health outcomes. The cost-based financial model encourages the use of team-based approaches (Community Support Programs Branch, Center for Mental health and addiction recovery Services, 2017).



NAVIGATE: TREATMENT INTERVENTION FOR FIRST EPISODE PSYCHOSIS (RAISE TRIAL)

Navigate is based on a coordinated specialty care model – a form of high-functioning team-based-care where a team of providers, including a psychiatrist, a family clinician, an individual resiliency therapist and a supportive employment and education specialist work in close collaboration to provide optimal multimodal care to individuals early in the course of psychotic illnesses. This has resulted in improved outcomes. According to a review of outcomes of first-episode psychosis, “specialized interventions ... are associated with higher person satisfaction with treatment and improved personal well-being, characterized by better sense of purpose, motivation, curiosity and emotional engagement. These improvements translated into better quality of life and greater involvement in school and work, with an overall reduced burden to the family,” (Fusar-Poli, 2017).

COLLABORATIVE CARE MODEL

The collaborative care model uses a team to provide behavioral health services in the primary care setting. While the use of the collaborative care model has been robustly validated in the primary care setting, it does not have a clear evidence base in the community mental health and addiction recovery setting. However, it has been used explicitly as the organizing principle for very successful programs in that setting, most notably the Missouri Community Mental health and addiction recovery Center Health Home program, which showed impressive improvements in person health outcomes and overall cost reduction, tasks which have been difficult to match in other programs of the kind (HealthNet, 2017).

RESOURCES

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