Chapter 2: The Collaborative Care Team Roles and Responsibilities

The Team Structure
The care is delivered by an organized team of professionals including the patient’s regular primary care provider, a care manager (CM) based in the primary care clinic, and a consulting psychiatrist. Weekly team meetings include the CM and the consulting psychiatrist, who discuss new and ongoing patients. Figure 2.1 outlines the typical organization of the collaborative care team.

Figure 2.1 Collaborative Care team structure

The Patient
Collaborative care includes the patient as an active collaborator in his or her treatment.

The initial visit with the CM has a heavy emphasis on patient education and patient activation. As part of the comprehensive clinical assessment, the CM and the patient review educational materials and address any questions about the patient’s condition or available treatments.

The Patient’s Primary Care Provider
The Collaborative Care model is organized to support each patient’s primary care provider (PCP) in providing mental health care for the patient. The PCP is thus a central component of the team and he or she is responsible for initiating and maintaining the vast majority of treatments such

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as prescriptions for psychotropic medications, and treatments aimed at comorbid or underlying medical problems. Each patient’s PCP also has an important role in encouraging and supporting the patient’s participation in the care management activities and behavioral interventions.

The Care Manager
The Care Manager (CM) plays a central role in the care of patients with PTSD and bipolar disorder.

Goals and Responsibilities:
The CM is primarily responsible for the initial assessment and education of each patient. The CM also coordinates the initiation of treatment (psychotropic medications and / or Behavioral Activation) with the patient and his or her PCP at the clinic and closely follows each patient until he or she has reached a clinically significant improvement. Once active treatment is completed, the CM completes a ‘relapse prevention plan’ (for patients in remission) or a ‘maintenance plan’ (for patients who will not benefit from further treatment changes) and follows-up with the patient via monthly contacts to reduce their risk of relapse or recurrence. The CM also documents all services provided to patients using a web-based clinical tracking system.

Clinical consultation:
The CM receives clinical consultation from the consulting psychiatrist during a weekly team meeting that will typically occur by telemedicine (see below). During these meetings, the CM will go over his or her caseload and discuss new patients and their treatment plans as well as ongoing patients who are experiencing difficulties with their treatments or are not responding as expected. This weekly meeting will also facilitate effective and efficient communication and interaction between all members of the clinical team. The consulting psychiatrist will also be available to the CM during the rest of the week to answer clinical or logistic questions. The consulting psychiatrist will be most helpful with specific questions related to the psychiatric condition (bipolar disorder or PTSD), its treatment, and other comorbid psychiatric or substance use disorders.

The Consulting Psychiatrist
The consulting psychiatrist is an expert in diagnostic assessment, treatment planning, and use of psychotropic medications. The consulting psychiatrist has three essential responsibilities.

1. Direct patient consultation at the start of treatment
   a. The consulting psychiatrist will see all patients by telemedicine-based consultation after the patient has seen the care manager for an initial assessment. This will help with diagnostic clarification and to develop an initial treatment plan.

2. Caseload consultation with CM
   a. The consulting psychiatrist meets weekly with the CM to review treatment plans for all new patients and all patients that are not improving as expected.
   b. The consulting psychiatrist is available to the CM by pager to discuss any psychiatric questions or emergencies

3. Direct patient consultation on an as-needed basis for ‘treatment resistant’ patients
a. The consulting psychiatrist may also see a subset of patients who do not have a complete response to treatment after one or more consultation visits to inform subsequent changes in the treatment plan. The need for follow-up direct consultation will be discussed by the consulting psychiatrist and CM during weekly caseload consultation prior to scheduling the patient for this visit.

For patients who have not responded to multiple treatment trials, extended consultation (approximately 1-4 follow-up consultation visits) may be conducted. However, if the consulting psychiatrist decides that a patient’s condition would be better cared for in a specialty mental health setting, he or she may suggest a referral to appropriate specialty mental health care. Extended consultations in primary care do not replace activities normally performed by the CM such as BA but they are focused on a more comprehensive diagnostic evaluation and assessment (see Chapter 5), more detailed treatment recommendations, and possibly more complex psychopharmacological management in collaboration with the patient’s CM and PCP.

During an average week, consulting psychiatrists may spend their time roughly in the following way:

1. Weekly caseload consultation meetings with the rest of the team (CM) - one hour
2. PRN consultation to the CM or primary care doctors during the week - available on pager – < 15 minutes
3. One time consultation (by telemedicine) for all patients entering treatment
4. Follow-up consultation for patients who are not showing a significant clinical response to the first line treatment initiated in primary care after 12 weeks.
5. Extended consultation (up to four follow-up visits) if patients do not show improvement after initial consultation AND a second trial of treatment with the PCP.
6. Quarterly meetings with the CM and the Medical Director of the primary care clinic to review program operation

The approach outlined above attempts to make the most cost-effective use of the consulting psychiatrist’s expertise by focusing his or her efforts on those patients who are more difficult to treat in primary care. It does not eliminate the possibility that some patients may require additional specialty mental health treatment (such as electroconvulsive therapy), and the consulting psychiatrist can suggest a referral to such specialty services at any time as clinically indicated.

There are a number of advantages to providing psychiatric consultations in the primary care clinic. Primary care patients with mental health conditions rarely see psychiatrists in specialty mental health clinics and often do not follow through on referrals to office-based psychiatrists but they are generally willing to see a psychiatrist who comes to consult at their regular primary care clinic. An on-site consultation also makes it more likely that the psychiatric care of a patient will be coordinated with the rest of his or her medical care.

Consulting psychiatrists follow the general treatment guidelines outlined in Chapter 4 but must use their clinical judgment to help develop a treatment plan that is optimal for each patient within these guidelines.