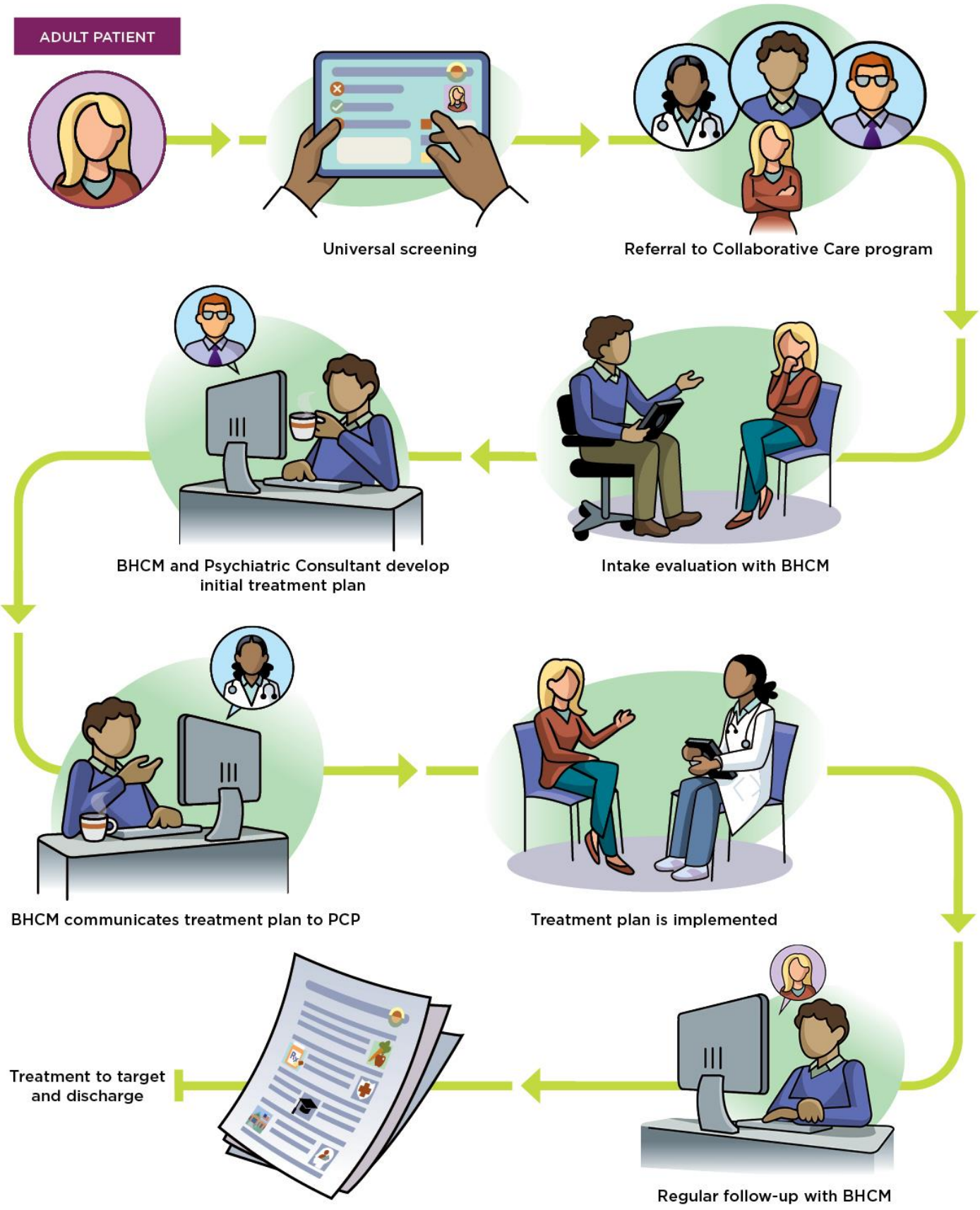
MEADOWS MENTAL HEALTH POLICY INSTITUTE

THE COLLABORATIVE CARE MODEL WORKFLOW



Collaborative Care Model

Adult Clinical Workflow

Clinical workflow details for implementing the collaborative care model (CoCM) with adults. The CoCM team refers to the primary care provider (PCP), the behavioral health care manager (BHCM), and the psychiatric consultant.

STEP 1 – Universal screening

Physical health clinic delivers universal screening at least annually for common behavioral health problems, such as depression and anxiety, using evidence-based behavioral health assessments (e.g., PHQ-9).

STEP 2 – Referral to collaborative care model (CoCM) program

Patients who screen positive or display concerning behavioral health signs/symptoms and meet program criteria are offered enrollment in CoCM by their PCP, who obtains verbal consent and facilitates a warm hand-off to the BHCM.

STEP 3 – Intake evaluation with behavioral health care manager (BHCM)

BHCM engages the patient, answers remaining questions about CoCM, reviews the patient's chart, and completes an intake evaluation. BHCM enters evidence-based behavioral health assessments (e.g., PHQ-9) and other patient data into the CoCM patient treatment registry.

STEP 4 – BHCM and psychiatric consultant develop initial treatment plan

In weekly case review sessions with a designated psychiatric consultant, the BHCM discusses new and existing patients who do not demonstrate adequate symptom improvement. They review diagnostic impressions and treatment recommendations, updating as indicated. Treatment planning may include medications, therapy, or referrals to outside resources, depending on patient need, preferences, and service availability.

STEP 5 – BHCM communicates treatment plan to primary care provider (PCP)

BHCM compiles treatment recommendations and diagnostic impressions into an intake report, updates the registry, makes any necessary referrals, and shares the treatment plan with the PCP. Additionally, the BHCM preliminarily discusses the treatment plan with the patient and answers questions.

STEP 6 – PCP implements treatment plan

PCP reviews the intake report, discusses diagnosis and treatment recommendations with the patient, answers questions, and prescribes the recommended medication if it is in line with their clinical judgment. If the PCP has questions or concerns about the treatment plan, they can discuss these with the rest of the CoCM team at any time.

STEP 7 – Regular follow-up assessments with BHCM

BHCM regularly engages with the patient (often twice a month), asking about their experience with medication, measuring treatment response using evidence-based behavioral health assessments, reviewing patients with the psychiatric consultant as indicated, delivering therapeutic interventions, coordinating with outside providers (if applicable), updating the registry, and documenting all findings in the medical record.

STEP 8 – Relapse prevention planning and discharge

Working in collaboration with the psychiatric consultant, the BHCM tracks patient outcomes until the patient meets evidence-based symptom response or remission targets. Once the patient has improved, they engage with the BHCM in relapse prevention planning and prepare for discharge from CoCM back to regular PCP care.

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Detailed clinical workflow for implementing the collaborative care model (CoCM) with adult populations.

Screening and Referral

After adopting universal behavioral health screening, a practice must define the target population and diagnostic scope for its CoCM program. For example, a practice may define its target population as all primary care patients and its diagnostic scope as depression and anxiety disorders. Patients in the target population who screen positive for conditions within the CoCM diagnostic scope or display concerning signs/symptoms of behavioral health problems are then considered for referral to the program.

Typically, the primary care provider (PCP) will inform the patient of the program and offer them enrollment. For billing purposes, the PCP also informs the patient that, depending on their health insurance, they may receive a monthly bill for CoCM services (i.e., cost sharing). This discussion between the PCP and patient is considered the program's "consent process." The patient's verbal consent must be documented in the medical record. Uninsured patients should also be informed that they may receive a bill for CoCM services (though they may not be required to pay the bill due to sliding scale payment arrangements). If the patient agrees to enroll in CoCM, the PCP will connect them with the program's behavioral health care manager (BHCM).

Intake Evaluation

The BHCM connects with the patient via warm handoff in person, by telephone, or through secure messaging to schedule an intake visit. During this visit, the BHCM conducts a full behavioral health evaluation that explores current symptoms in addition to a comprehensive history of diagnoses, treatments (including medication and psychotherapy), higher-acuity care, and co-morbid medical problems. In this evaluation, the BHCM also administers evidence-based assessments, such as the Patient Health Questionnaire-9 (PHQ-9) and the Generalized Anxiety Disorder-7 (GAD-7). The BHCM writes a draft report of the findings from the intake evaluation and enters demographic data, visit data, and assessment results into the patient registry.

Case Review, Plan Development

During weekly case review sessions with the psychiatric consultant, the BHCM reviews the patient treatment registry broadly with each patient being considered for detailed discussion. The BHCM and psychiatric consultant typically discuss new patients and those with acute events first; patients who are not responding to treatment or following up as scheduled with the BHCM are also prioritized. The BHCM, with help from the psychiatric consultant, develops a personalized treatment plan, which may include medication recommendations, brief psychotherapy, and/or psychosocial interventions for new patients. This plan is then clearly described in the BHCM's report, which is preliminarily discussed with the patient, and sent to the PCP. The PCP then reviews the patient's treatment plan with recommendations from the rest of the CoCM team.

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Treatment Plan Implementation

If the psychiatric consultant recommends medications and the PCP agrees, the PCP writes prescriptions or schedules a visit with the patient to further discuss therecommended medications. The PCP is always welcome to ask follow-up questions of the rest of the CoCM team. Due to this bidirectional collaboration, CoCM provides valuable real-time education opportunities for PCPs, rendering them more knowledgeable about psychopharmacology during future patient encounters.

When the CoCM team recommends specific psychotherapy interventions, these services are typically delivered by the BHCM directly. The BHCM most commonly provides brief behavioral health interventions, such as motivational interviewing or behavioral activation, though other modalities may be used as indicated. Patients can be referred to community providers (while still being followed in CoCM), if they require more extensive therapy, long-term therapy, or therapy interventions for which the BHCM is not adequately trained.

Regular Follow-up Assessments

After the CoCM intake visit and initial recommendations, the BHCM closely follows each enrolled patient. Typically, patients interact with the BHCM a minimum oftwo times per month while in active treatment. During each interaction, the BHCM administers evidence-based assessments, and adds follow-up results to the patient treatment registry. The goal for each target symptom is remission, which is defined differently for each instrument. With the PHQ-9, for example, remission is defined as a score of less than five. Patients are also tracked toward treatment response, which is typically defined as a reduction from the baseline score of 50% or more with the PHQ-9. Of note, the choice of instruments is discretionary for each CoCM program. The BHCM and psychiatric consultant update treatment plans for existing CoCM patients during case review sessions based on clinical progress. All treatment plan updates, including updated medication recommendations, are immediately sent to the PCP. Each patient is considered for review in weekly case review sessions with the psychiatric consultant (and is formally reviewed at least once monthly). On average, patients remain in the active treatment phase of the program for three to six months.

Relapse Prevention, Discharge

A patient moves from active treatment into the relapse prevention phase of the CoCM program when they achieve symptom response or remission. At this point, the patient's frequency of visits with the BHCM typically decreases to approximately once per month, and the clinical focus shifts to creating a plan to mitigate future worsening of symptoms. This relapse prevention plan integrates the patient's goals, medication recommendations, and guidance on the use of key therapy skills or interventions. After successful maintenance in relapse prevention for two to three months, patients are typically discharged from CoCM.