BEHAVIORAL HEALTH CARE MANAGER COMPETENCIES

for the Collaborative Care Model

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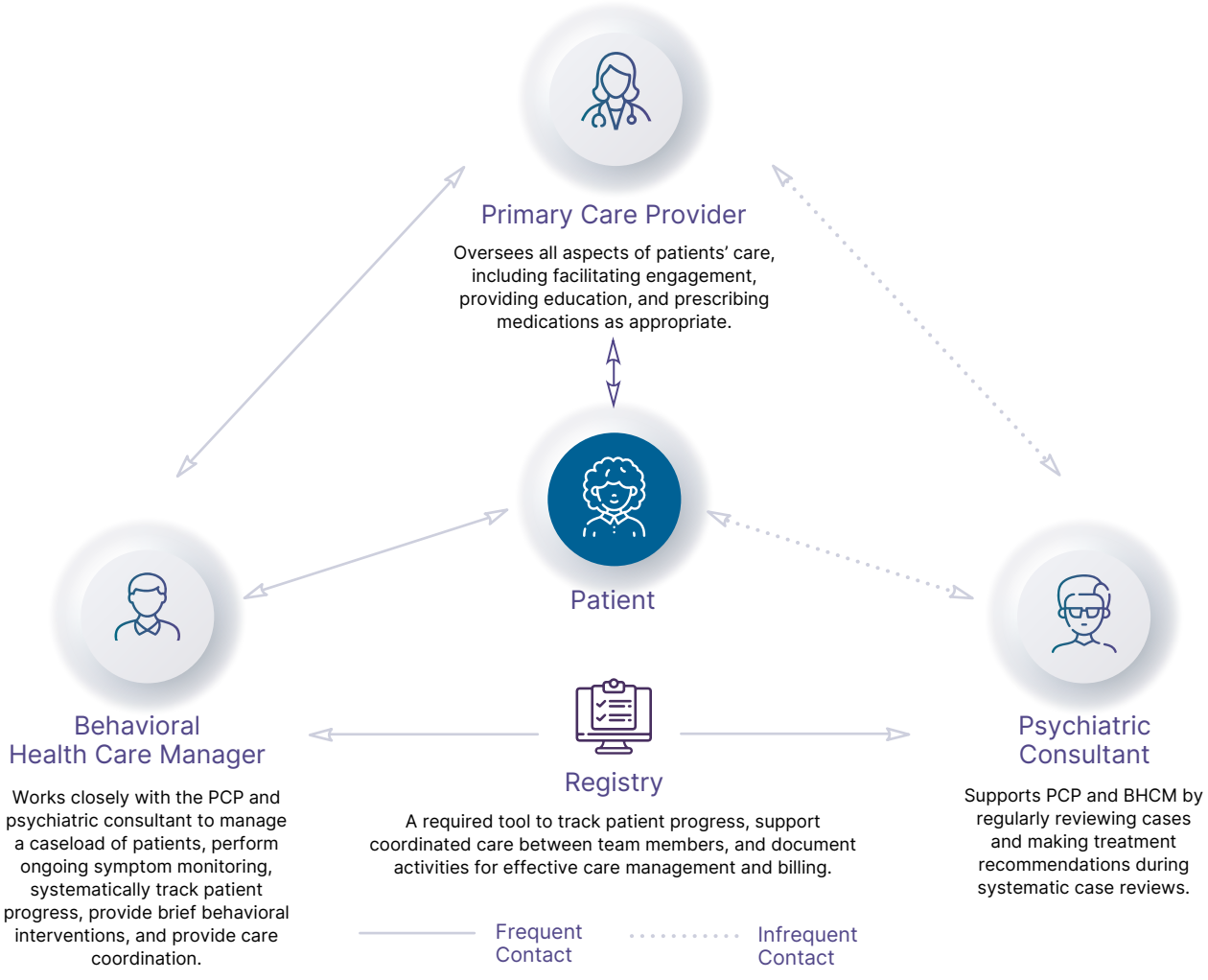
The Collaborative Care Model

The Collaborative Care Model (CoCM), developed by the University of Washington's AIMS Center, is an evidence-based approach to mental healthcare that integrates behavioral health services into primary care settings. By providing behavioral health services where patients are already receiving care, CoCM reduces stigma, leverages existing patient-provider relationships, and promotes holistic care plans.

CoCM brings together an interdisciplinary team including a primary care provider (PCP) or specialty medical provider (e.g., OBGYN, oncologist, etc.), a behavioral health care manager (BHCM), and a psychiatric consultant to deliver high-quality, patient-centered, mental health care. The team collaborates to identify mental health conditions, provide evidence-based treatments, and systematically monitor patients' progress toward treatment goals using a patient registry, adjusting care as needed.



Source: Meadows Mental Health Policy Institute. (2024). Collaborative Care Model Technical Assistance Tools. https://mmhpi.org/cocm/

The CoCM Clinical Workfow

Step 1

Universal Screening

Annual universal screenings using validated tools (e.g., PHQ-9 or GAD-7) are administered to everyone in the target population to help identify undiagnosed or unreported concerns early.

Step 2

Referral to CoCM Program

Based on universal screening or clinical observations, the PCP identifes patients suitable for CoCM, offers a referral, obtains and documents consent, explains cost-sharing, and initiates a warm connection with the BHCM via the EHR.

Step 3

Initial Assessment

The BHCM contacts the patient to schedule the initial assessment. During the initial assessment, the BHCM meets with the patient for 30-60 minutes, documents patient data (e.g., PHQ-9) in the EHR, and establishes a working diagnosis. For complex cases, the PCP and BHCM escalate the patient case to the psychiatric consultant early for diagnostic clarification.

Step 4

Initial Care Plan Develoment

Together, the BHCM and psychiatric consultant create an initial treatment plan. In weekly systematic case reviews, they discuss and update treatment recommendations for new patients, patients who are not improving, experiencing medication changes or side effects, presenting with safety concerns, or in need of diagnostic clarification. PCPs receive recommendations to make informed care decisions while staying updated on patient progress.

Step 5

Care Plan Communication

The psychiatric consultant documents treatment recommendations in a brief note in the EHR and the BHCM relays recommendations to the PCP. The PCP receives the treatment recommendations to guide care decisions, which are discussed with the patient.

Step 6

Care Plan Implementation

The PCP reviews the team's recommendations, discusses diagnosis and treatment recommendations with the patient, answers questions, and prescribes the recommended medication if it is in line with their clinical judgment. Any questions or concerns about the treatment plan are discussed with the CoCM team.

Step 7

Systematic Follow-Up

Patients will typically connect with the BHCM at least twice per month, or less frequently as they improve over time. The BHCM conducts ongoing symptom monitoring using tools like the PHQ-9 and GAD-7 at least once a month and reviews patient progress with the psychiatric consultant. If needed, the BHCM can advise on an update to the care plan and communicate it to the PCP.

Step 8

Relapse Prevention Planning and Discharge

As patients reach their treatment goals, BHCM visits taper and focus shifts to relapse prevention planning. A written plan is created with the patient, PCP, and approved supports. Patients are discharged from CoCM back to the PCP's general patient population and can re-engage in CoCM if symptoms return.

The Behavioral Health Care Manager

The BHCM is the primary coordinator of the Collaborative Care team. They facilitate communication among team members and serve as the patient's main point of contact.

BHCMs must have formal education or specialized training in behavioral health. Some payors have additional requirements for BHCMs. Although BHCMs share some responsibilities with case managers, they have a distinct scope of practice within CoCM.

The core responsibilities of the BHCM falls under 5 key areas:

- **Patient Engagement & Symptom Monitoring**

  For example, facilitating engagement of newly referred patients, conducting ongoing symptom monitoring using validated tools, and providing psychoeducation and brief evidence-based interventions.

- **Measurement-Based Care & Registry Use**

  For example, systematically tracking treatment response and symptom change using the patient registry, tailoring care plans based on ongoing symptom monitoring and registry insights, maintain accurate and timely documentation of clinical encounters and follow-up activities.

- **Psychosocial Support**

  For example, delivering brief, evidence-based behavioral interventions, providing care coordination, and directly connecting patients to community resources.

- **Care Coordination & Team Communication**

  For example, coordinating treatment eforts with the PCP, psychiatric consultant, and external supports, participating in weekly systematic case reviews with the psychiatric consultant, implementing recommendations from the psychiatric consultant in partnership with the patient and PCP.

- **Program Development & Community Integration**

  For example, supporting program quality improvement efforts by identifying care delivery gaps and participating in training, building partnerships with local schools, community organizations, and social service agencies to strengthen wraparound supports.

Use this companion as a reference and return to the asynchronous online training modules for the complete course:

https://cocmtraining.westhealth.org/