



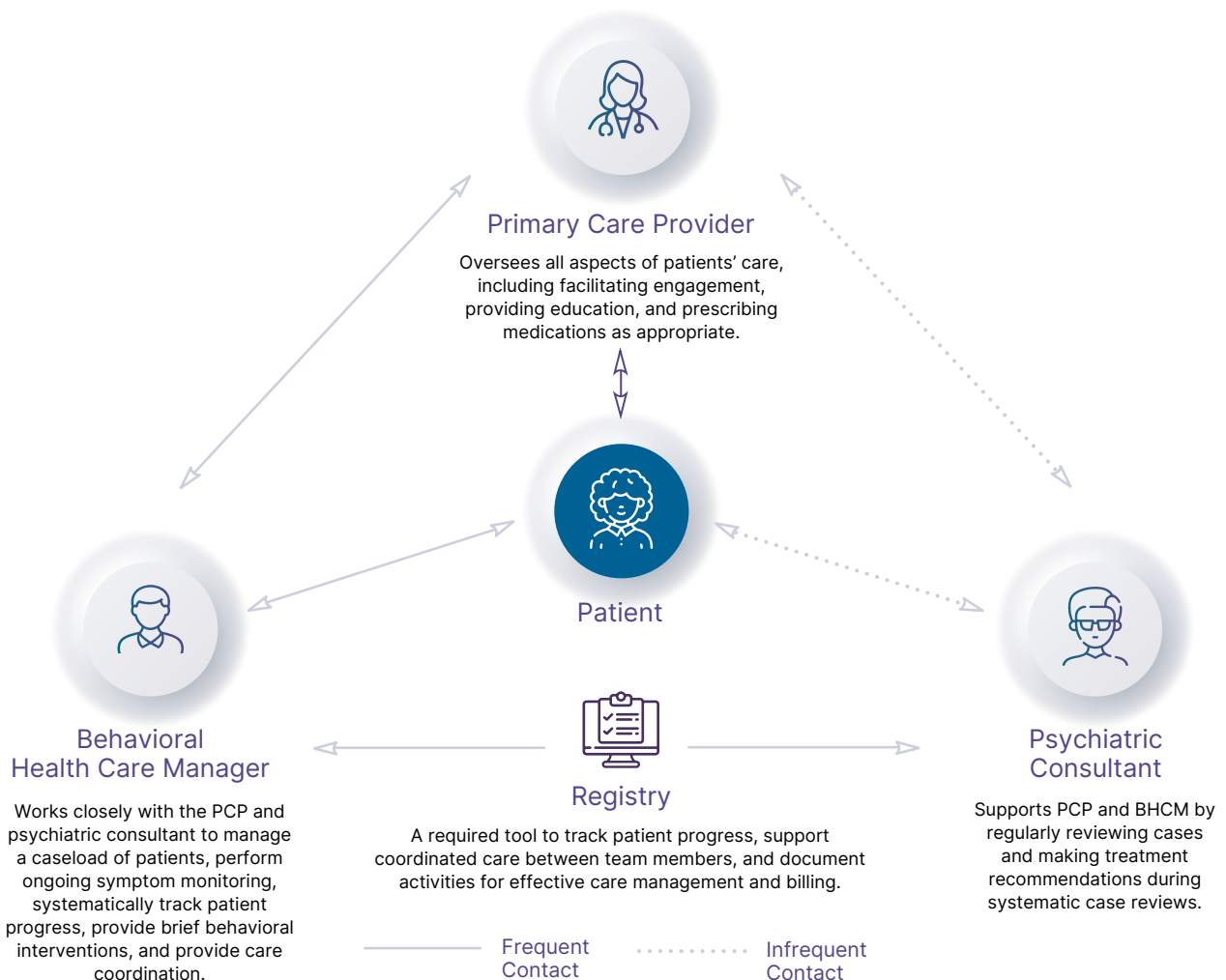
COLLABORATIVE CARE MODEL COMPETENCIES

for Primary Care Clinicians

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 identifies 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 Development

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 Primary Care Provider

The PCP serves as the clinical lead of the CoCM team and holds ultimate responsibility for treatment decisions, which are made collaboratively with the patient. The PCP is also responsible for conducting universal screening, referring and consenting patients prior to enrollment in CoCM.

- **Facilitate warm connection with the BHCM for initial assessment**

Introduce the BHCM to the patient and coordinate a smooth transition for the initial assessment to support patient engagement and continuity of care.

PCP touchpoints in CoCM include:

- **Review screening outcomes and treatment needs with the patient**

Discuss the results of behavioral health screenings with the patient, explain what they mean, and identify areas where treatment or follow-up may be needed.

- **Describe CoCM, offer enrollment, and document verbal consent**

Explain CoCM to the patient, emphasizing how the team-based approach supports their care, offer enrollment and obtain and document verbal consent.

- **Review treatment recommendations and formulate a treatment plan with the patient**

Discuss recommendations from the psychiatric consultant and develop a treatment plan in collaboration with the patient and care team. Address safety concerns and prescribe medications as appropriate.

- **Support ongoing treatment**

Maintain regular contact with the patient, monitor progress toward treatment goals, and adjust the diagnosis or treatment plan as needed in coordination with the care team.

Being a PCP Champion

Beyond the roles described above, successful CoCM implementation requires each practice or clinic to designate a PCP champion who can drive engagement, problem-solve barriers, and model collaborative care. This champion serves as a clinical leader and change agent and is central to the effective implementation and sustainability of CoCM. They foster buy-in for CoCM and shape practice culture through education, advocacy, and connection. The work of PCP champions changes over time from implementation planning to program sustainment and scaling to additional sites.

Key Attributes of a PCP Champion

- Demonstrates enthusiasm for CoCM as an early adopter.
- Maintains the respect and trust of their colleagues.
- Fosters effective communication through relationship building.

Key Responsibilities of a PCP Champion

- Participates in implementation planning meetings and other tasks, including hiring and onboarding new CoCM team members.
- Acts as a liaison between clinic leadership, operations, PCPs, and the CoCM team to address implementation challenges and adapt workflows as needed.
- Promotes culture change among colleagues, emphasizing that mental health is within the scope and responsibility of primary care.
- Educates fellow PCPs on the benefits of measurement-based care, CoCM, and systematic case review.
- Demonstrates consistent use of CoCM workflows in their own clinical practice.
- Coordinates with clinical leadership and practice manager to communicate practice change expectations and shares best practices.
- Mentors colleagues during CoCM adoption and offers additional coaching when needed.
- Fosters high-quality CoCM engagement across providers, positioning CoCM as a solution that improves patient outcomes and reduces strain on PCPs.
- Engages in quality improvement and sustainability efforts.
- Highlights program wins and patient success stories to support a culture of continuous learning and improvement.

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

<https://cocmtraining.westhealth.org/>