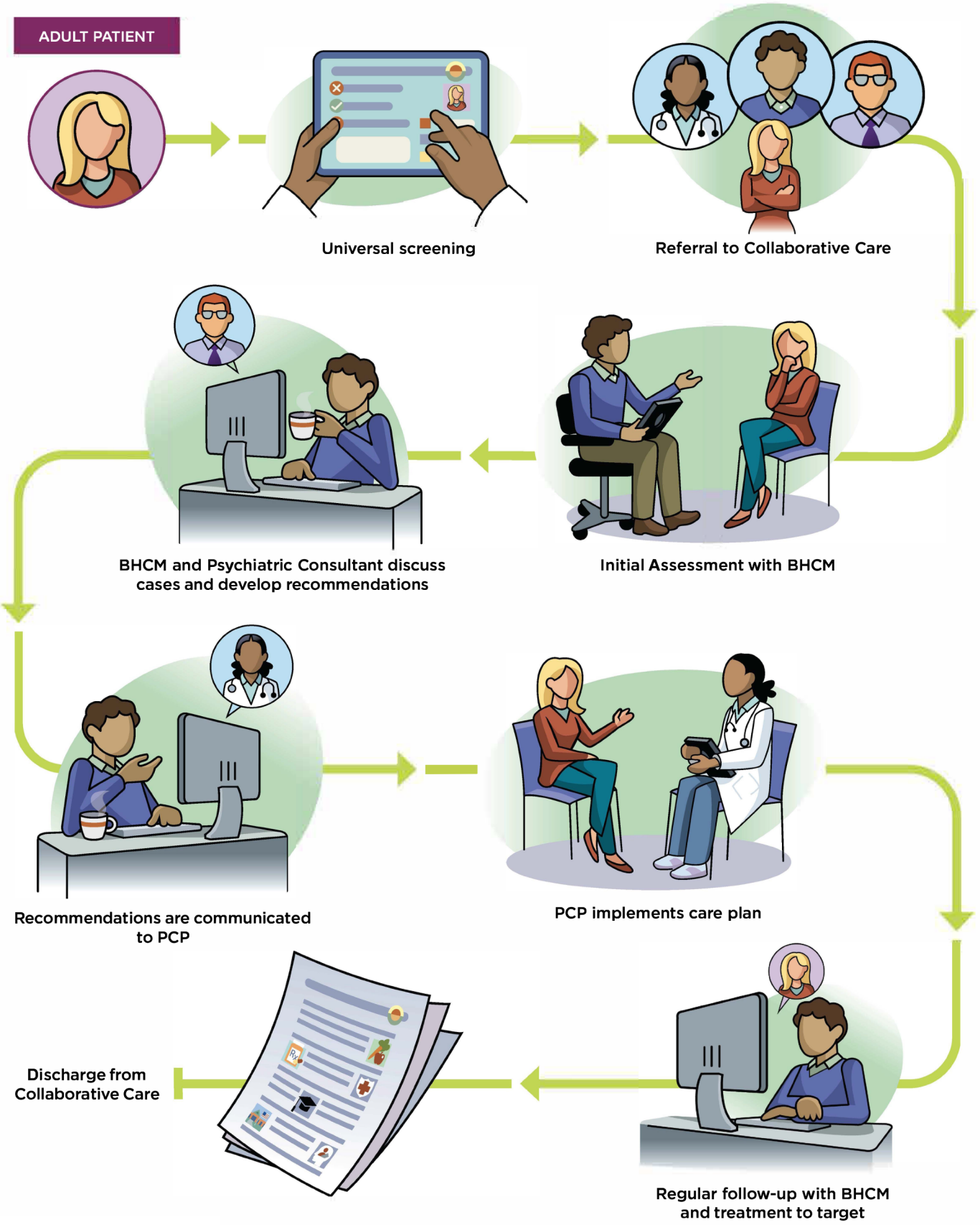
MEADOWS MENTAL HEALTH POLICY INSTITUTE

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

The clinic screens all patients at least annually for common behavioral health concerns (e.g., depression and anxiety) using evidence-based tools such as the PHQ-9.

STEP 2 – Referral to CoCM

Patients who screen positive or present with behavioral health symptoms and meet program criteria are offered enrollment. The PCP obtains verbal consent and facilitates a warm connection to the BHCM.

STEP 3 – Initial assessment with BHCM

The BHCM engages the patient, answers questions about CoCM, reviews the chart, and completes an initial assessment. Findings and evidence-based assessment scores are documented in the patient's chart and CoCM registry.

STEP 4 – BHCM and psychiatric consultant develop recommendations

During weekly systematic case review meetings, the BHCM and psychiatric consultant discuss patients who are new or not improving. They document diagnostic impressions and treatment recommendations, which may include medications, brief behavioral interventions, or outside referrals.

STEP 5 – Recommendations communicated to PCP

Treatment recommendations and diagnostic impressions are documented for PCP review. The PCP reviews them and directs any questions to the BHCM or psychiatric consultant.

STEP 6 – PCP implements care plan

If medication recommendations align with the PCP's clinical judgement, the PCP prescribes them or schedules a visit to further discuss with the patient. The PCP may consult the BHCM or psychiatric consultant at any time.

STEP 7 – Ongoing follow-up with BHCM and treatment to target

The BHCM regularly follows up with the patient to monitor treatment response, deliver brief behavioral interventions, coordinate with outside providers as needed, and update the chart and CoCM registry. Patients are reviewed with the psychiatric consultant as indicated.

STEP 8 – Discharge from CoCM

The BHCM tracks outcomes until the patient meets symptom response or remission targets. Once achieved, a relapse prevention plan is finalized, and the patient is discharged from CoCM and transitioned back to care as usual.

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Adult Clinical Workflow

Detailed clinical workflow for implementing the collaborative care model (CoCM) with adult populations. The CoCM team refers to the primary care provider (PCP), the behavioral health care manager (BHCM), and the psychiatric consultant.

Screening, Referral

After adopting universal behavioral health screening, a clinic must define its CoCM target population and diagnostic scope (e.g., all primary care patients with depression or anxiety). Patients in the target population who screen positive or present with behavioral health symptoms are considered for referral to CoCM.

Typically, the primary care provider (PCP) will introduce CoCM to the patient and offer enrollment. As part of the consent process, the PCP informs the patient that they may receive a monthly bill for CoCM services depending on their insurance coverage (i.e., cost sharing). Verbal consent must be documented in the medical record. Uninsured patients should also be informed of potential billing, though sliding scale arrangements may apply. If the patient agrees to enroll, the PCP facilitates a warm connection with the behavioral health care manager (BHCM).

Initial Assessment

The BHCM reaches out to schedule an initial assessment. During this assessment, the BHCM explores current symptoms, diagnostic and treatment history (including medications, psychotherapy, and higher-acuity care), and co-morbid medical conditions. The BHCM also administers evidence-based assessments such as the Patient Health Questionnaire-9 (PHQ-9) and Generalized Anxiety Disorder-7 (GAD-7), then documents findings in the chart and enters demographic, visit, and assessment data into the registry.

Case Review, Plan Development

During weekly systematic case review meetings, the BHCM and psychiatric consultant review the registry broadly and consider all active patients for discussion. New patients and those not responding to treatment or engaging with follow-up as scheduled are prioritized for detail review. Together, they develop treatment recommendations, which may include medication or brief behavioral interventions, document the plan, and send it to the PCP for review.

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Adult Clinical Workflow

Care plan Implementation

If medication recommendations align with the PCP's clinical judgement, the PCP prescribes them or schedules a visit to discuss further and may direct questions to the CoCM team at any time. This bidirectional collaboration, CoCM provides valuable real-time education opportunities for PCPs, rendering them more knowledgeable about psychopharmacology during future patient encounters.

When brief behavioral interventions are recommended, the BHCM delivers them directly (e.g., motivational interviewing, behavioral activation). Patients requiring more extensive or long-term therapy can be referred to community providers while remaining enrolled in CoCM.

Regular Follow-up and Treatment to Target

Following the initial assessment, the BHCM follows each patient closely. Typically, patients interact with the BHCM multiple times per month during active treatment. At each interaction, the BHCM delivers brief behavioral interventions as recommended, administers evidence-based symptom monitoring tools, and documents scores in the registry. The treatment goal is remission or response for each target symptom (e.g., for depression, remission is defined as a PHQ-9 score below five and response is a reduction of 10 points or 50% from baseline). Of note, the choice of assessment and symptom monitoring tools is discretionary for each CoCM program. The BHCM and psychiatric consultant update treatment recommendations during systematic case review meetings based on patient progress. Care plan updates, including medication changes, are immediately sent to the PCP. On average, adult patients remain in the active treatment phase for four to six months.

Discharge from CoCM

As treatment goals are met, patients transition from active treatment to the relapse prevention phase. BHCM contact decreases to approximately once per month, and the clinical focus shifts to developing a plan to mitigate future worsening of symptoms. This plan incorporates the patient's goals, medication recommendations, and key skills or interventions. After maintaining treatment goals for two to three months, patients are discharged from CoCM and transitioned back to care as usual.