



AIMS CENTER
W UNIVERSITY *of* WASHINGTON
Psychiatry & Behavioral Sciences

Advancing Integrated Care for Over 20 Years

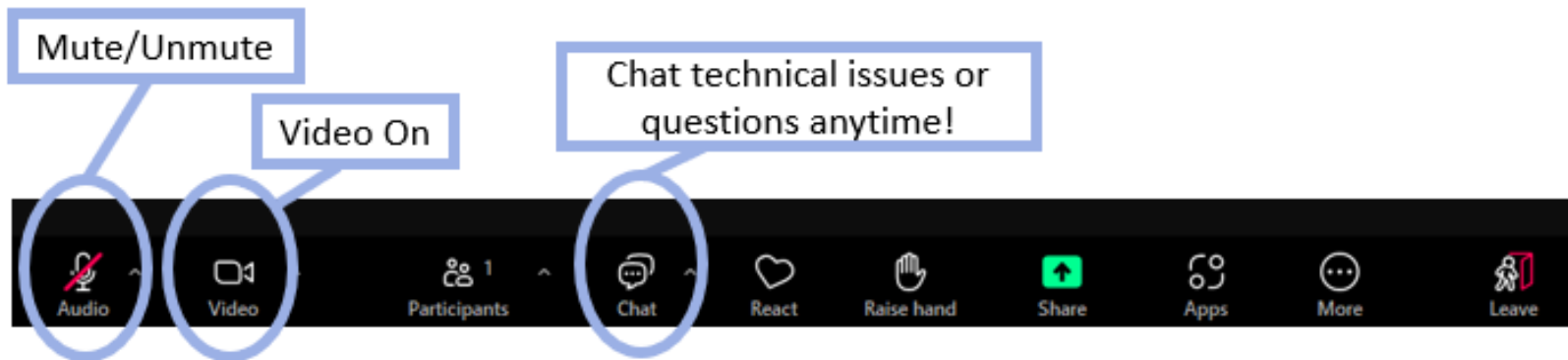
Building Collaborative Care Workflows Part 2

Senior Project Manager & Practice Coach

Ashley Heald, MA, CPHQ

Zoom Housekeeping

- This call is being recorded
- Mute when not speaking
- Audio & video controls in lower left corner



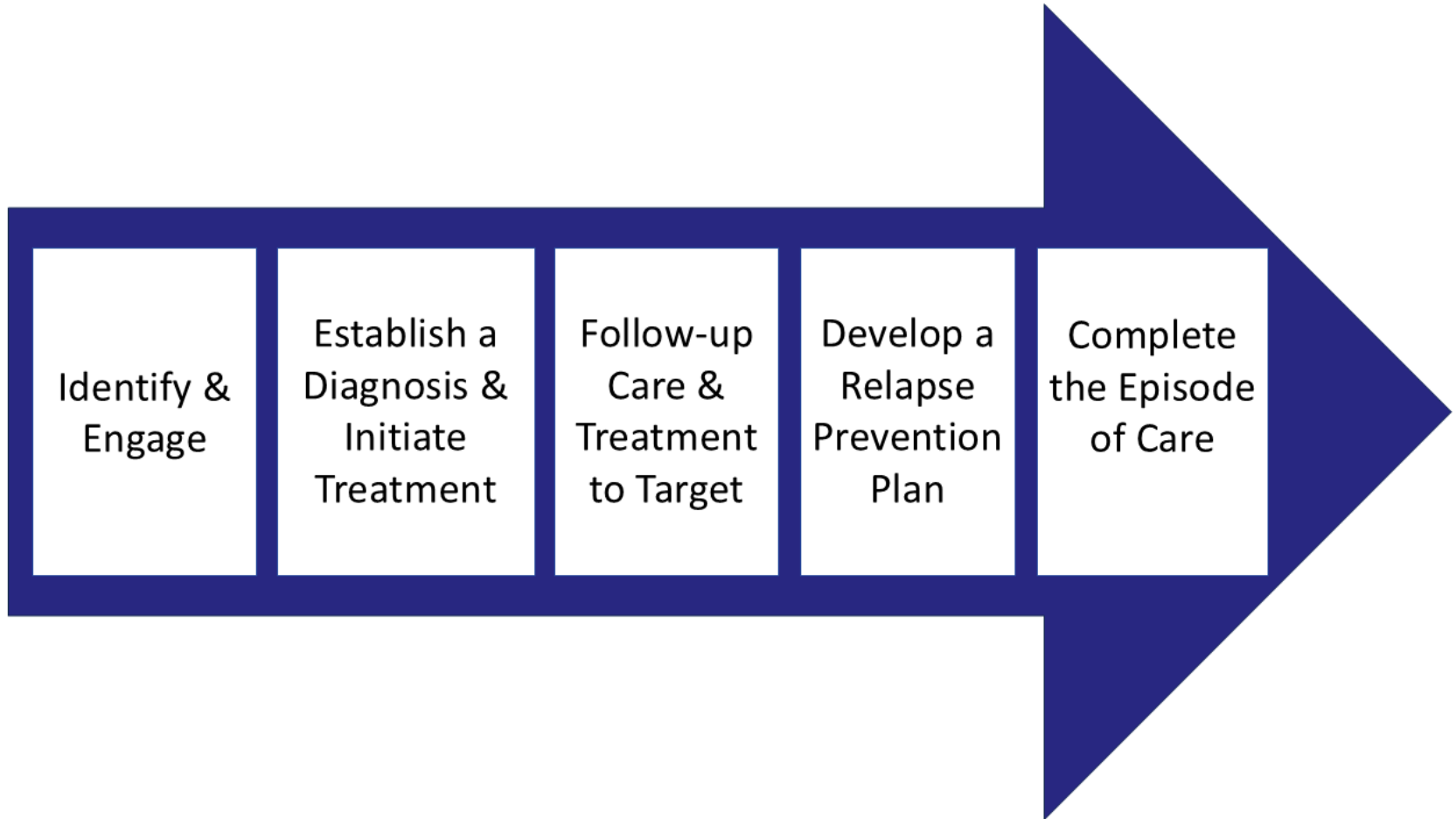


Session Learning Objectives

- By the end of this session, participants should be able to:
 - Name the essential components of the Collaborative Care (CoCM) episode of care
 - Describe important considerations in workflow development
 - Discuss anticipated challenges of implementing new CoCM workflows



Collaborative Care Workflow: Episode of Care



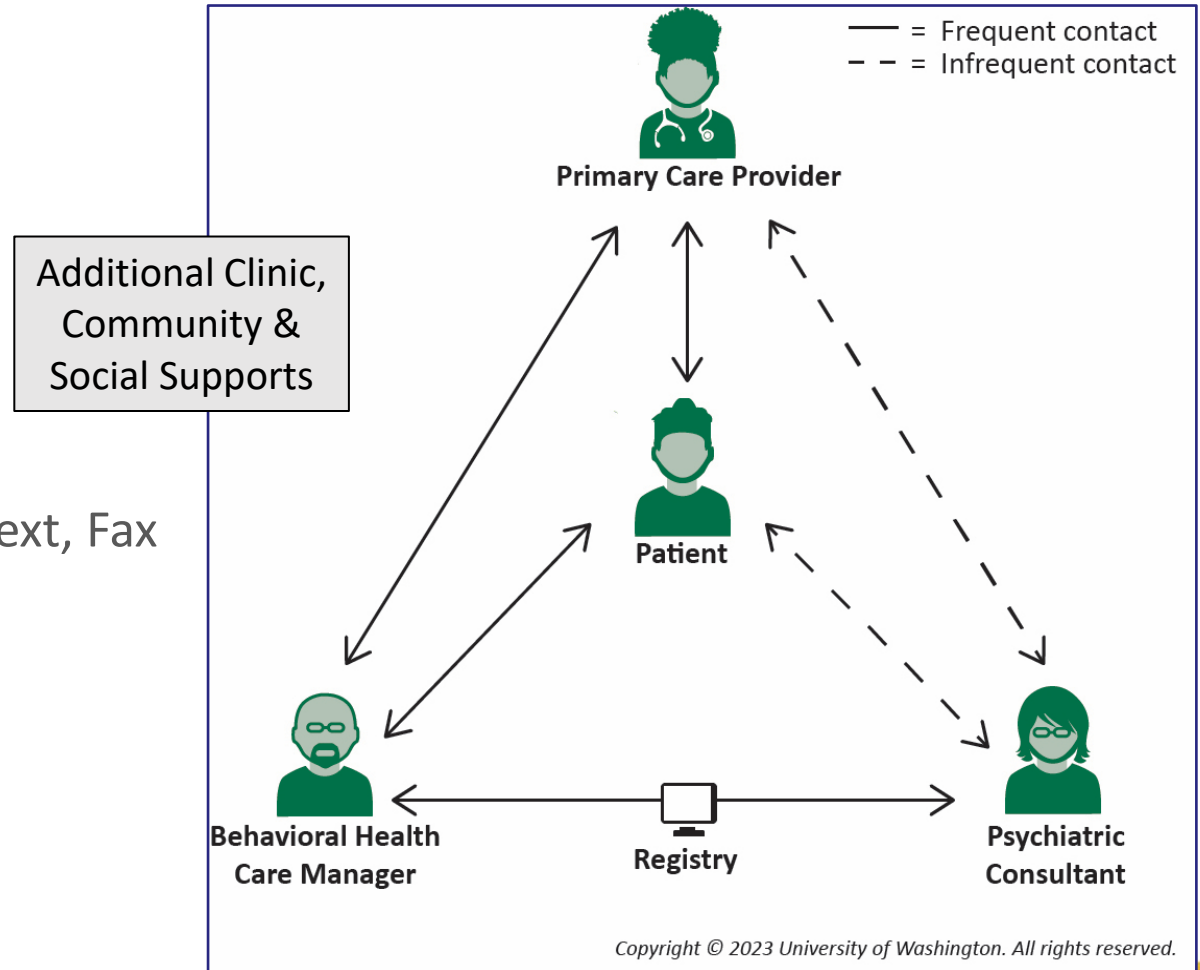
Care Team Communication: How and When?

- Modality

- In-person
- Phone
- EHR
- Clinic Staff
- Electronic
 - Email, Page/Text, Fax

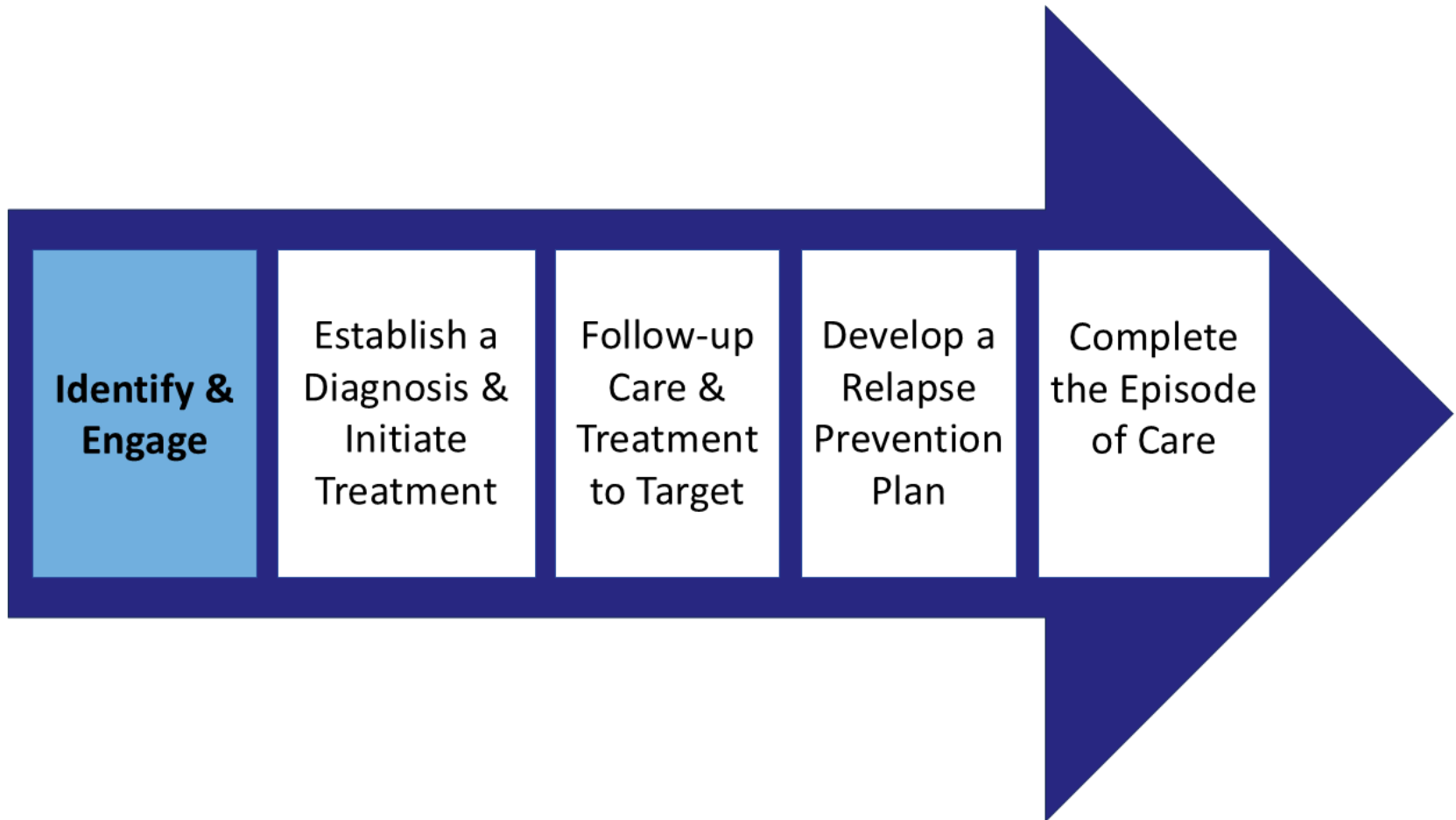
- Frequency

- Scheduled
- As needed





Collaborative Care Workflow: Step 1



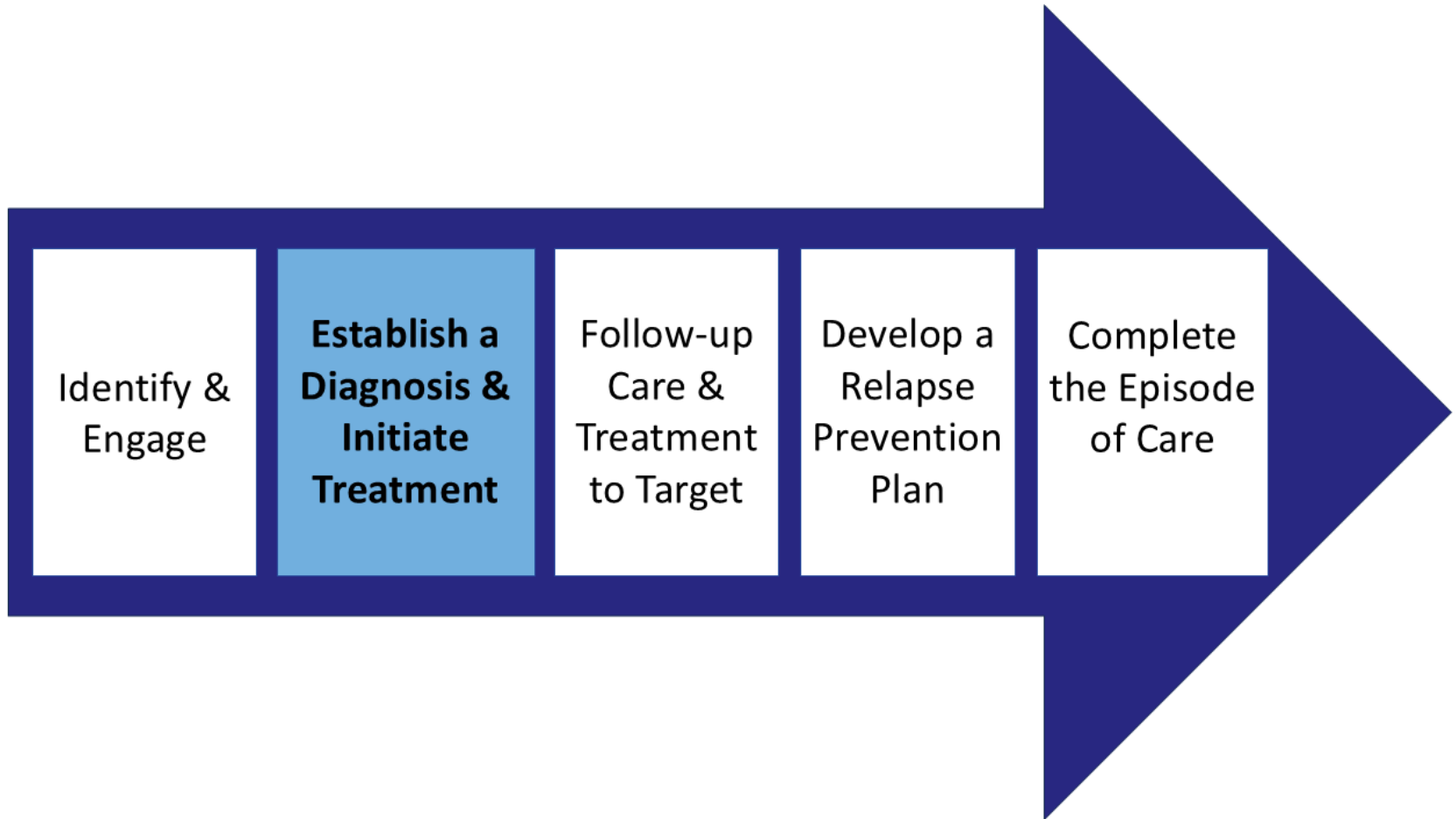


Identify & Engage

- Identify a population of focus
 - Behavioral health screening to identify patients during a PCP visit
 - Using Electronic Health Record (EHR) reports to identify CoCM patients
- Identify safety concerns
- Introduce Collaborative Care
- Engage patient in care



Collaborative Care Workflow: Step 2





Establish a Diagnosis & Initiate Treatment

- Provisional diagnosis will be generated by the team
 - Patient behavioral health measures
 - PCP & BHCM assessment
 - Psychiatric Consultant contribution at SCR
- Introduce care management (measurement-based care) with treatment options to develop a plan
 - Brief EBBI (evidence-based behavioral intervention)
 - Medication
 - Brief EBBI & medication
- Communicate treatment plan across team



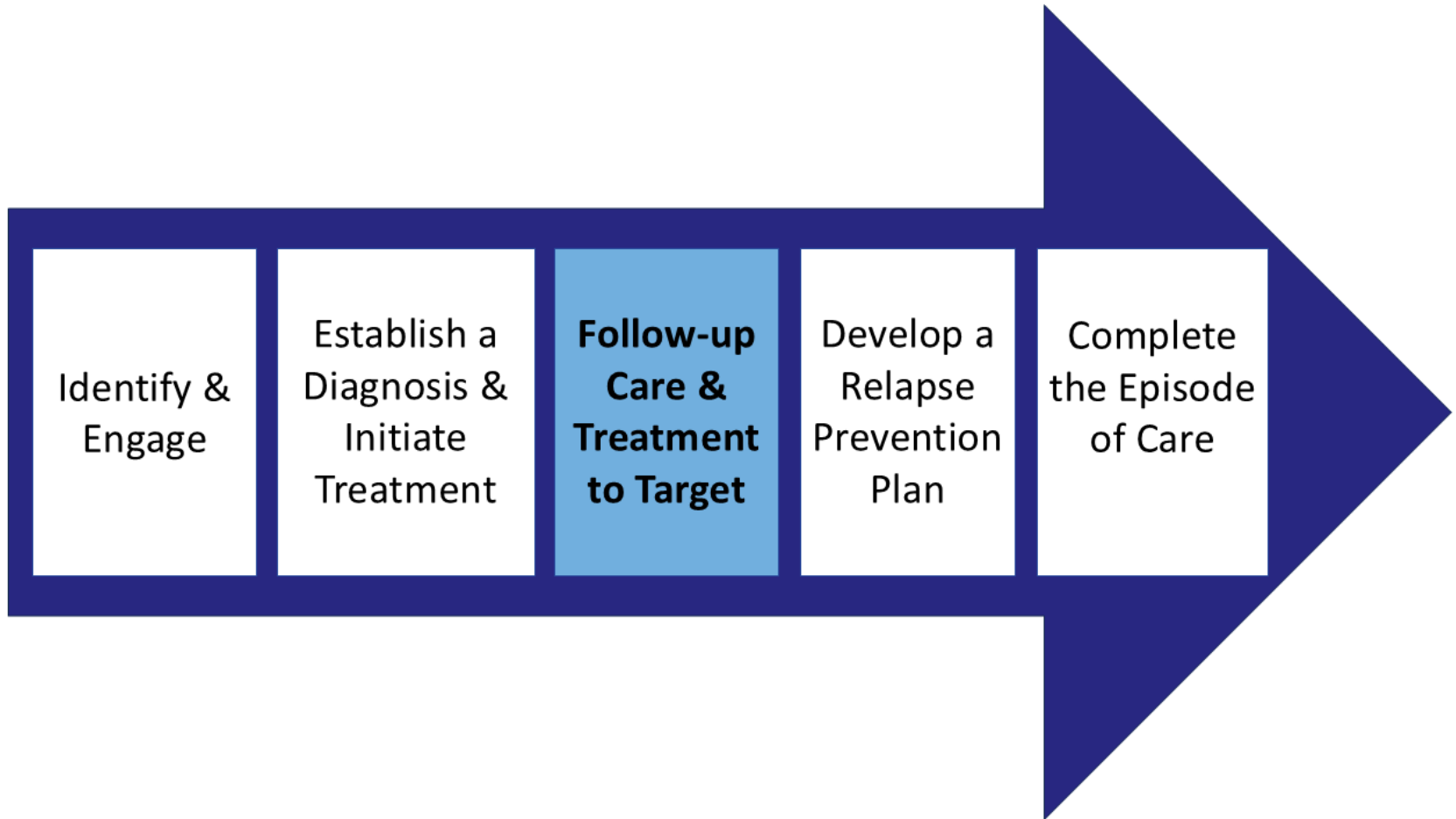
Questions to Consider (1 of 4)

In your setting:

- Who is establishing a diagnosis in your CoCM service delivery?
- How will the BHCM track the patient's progress toward getting medication prescribed?
- What would a BHCM schedule template and/or caseload size look like to accommodate twice monthly appointments?
- What triggers systematic caseload review during the initial treatment phase?



Collaborative Care Workflow: Step 3















Follow-Up Care & Treatment to Target

“What aspect of treatment (if any) can we change to make it more likely that the patient will improve?”

Key Tasks for Follow-Up Care and Treatment to Target (1 of 2)

- Tracking and Outreach – BHCM
 - Track treatment engagement & follow-through
 - Reach out to patients who are not engaged
 - Track symptoms with measurement tools (e.g., GAD-7, PHQ-9)

FLAGS	PATIENT ID 	STATUS 	PHQ-9		GAD-7		CONT			
			FIRST 	LAST 	FIRST 	LAST 	I/A 	F/U 	P/C 	RPP 
99		RPP	14	0*	15	0*	9/15/23	8/2/24*	3/22/24	3/8/24
99		T	12	2*	1	0*	10/3/23	8/6/24*	9/12/24	CONSIDER
99		RPP	0	0	1	1	9/3/24			9/3/24
99		RPP	5	6	1	0	1/18/24	9/11/24	5/31/24	3/7/24
99		T	9	3	0	2	5/23/24	9/5/24*		CONSIDER
99		T	20	7	21	13	3/4/24	9/25/24	9/26/24	CONSIDER
99		T	13	5	9	3	3/25/24	8/28/24*	6/12/24	CONSIDER
99		RPP	17	6	11	1	4/2/24	9/4/24	7/22/24	9/26/24
99		T	18	12	17	6	4/18/24	9/3/24*	9/5/24	



Key Tasks for Follow-Up Care and Treatment to Target (2 of 2)

- Systematic Caseload Review– BHCM and Psychiatric Consultant
 - Utilize psychiatric consultation focused on patients who are not responding to treatment
 - Facilitate timely communication of treatment recommendations to PCP

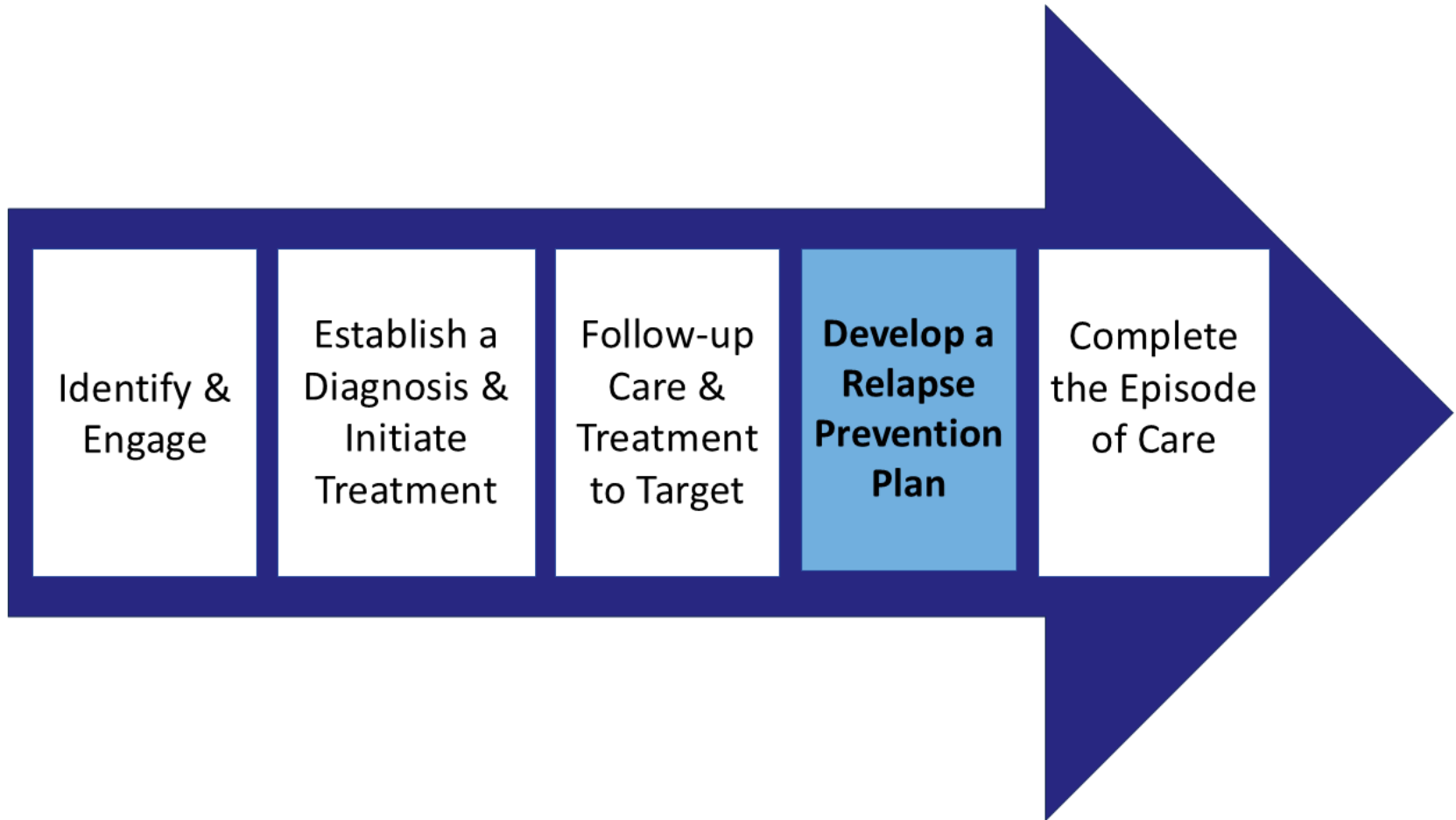


Questions to Consider (3 of 5)

- What frequency is expected for administering symptom monitoring tools?
- Have you built in measures into your registry for symptom monitoring over time?
- What is the expected timeline for the PCP to review & respond to the medication recommendations?
- What are your ideas for how treatment plan updates and Psychiatric Consultant recommendations will be communicated to the patient?



Collaborative Care Workflow: Step 4





Timing the Introduction to Relapse Prevention Planning

- Earlier is Best!
- Missed opportunity if patient drops from the program because they are feeling better
- More time to develop a thoughtful and detailed plan
- Maintains structure of episodic treatment

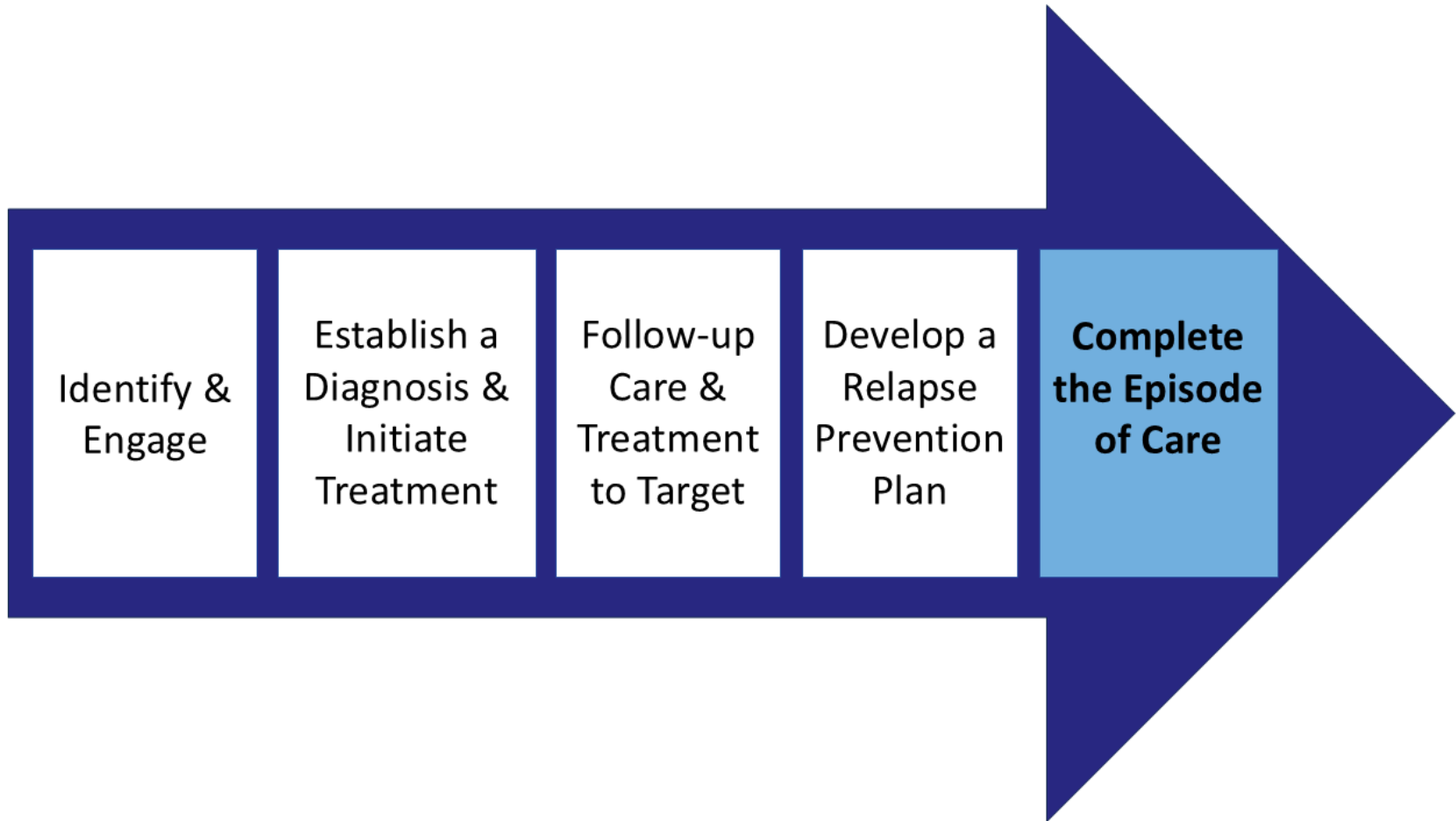


Questions to Consider (3 of 4)

- Communication with the patient
 - What criteria will you use for determining when to begin developing a RPP with a patient?
 - During the Relapse Prevention Plan monitoring phase, how often will the BHCM connect with the patient?
- Communication with the CoCM team
 - How will the RPP be shared with the PCP and psychiatric consultant?
 - Where in the EHR will the RPP be stored?



Collaborative Care Workflow: Step 5





Three Pathways for Completing the Episode of Collaborative Care

1. Patient improvement
 - Assess for symptom & functional improvement
 - Develop RPP and transition back to PCP
2. Lack of follow-up or patient choice
 - Standard protocol for outreach attempts
3. Referral to specialty care
 - Transition plan at any stage of treatment



Questions to Consider (4 of 4)

- How will the PCP be notified that the patient has completed their CoCM episode of care?
- How do you notify the patient that they are no longer part of the CoCM program and steps to return to care?
- What resources do you have for referral to specialty care? Who manages these referrals?



Workflows are Living Documents

- Engage in continuous quality improvement efforts
- Develop a plan to periodically review workflows with key participants
- Share the workflow amongst your team members and use for new staff onboarding



AIMS CENTER

W UNIVERSITY of WASHINGTON

Psychiatry & Behavioral Sciences

Advancing Integrated Care for Over 20 Years

Questions?

