Orientation to Collaborative Care Workflow Development

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Expert Care Manager and AIMS Trainer
Session Objectives

By the end of this session participants will be able to

- Understand the steps in the team building process
- Recognize the importance of including team members in the process
- Know what you need to accomplish to develop a comprehensive workflow
# Implementation Timeline

<table>
<thead>
<tr>
<th>Lay the foundation</th>
<th>Plan for Clinical Practice Change</th>
<th>Build your Clinical Skills</th>
<th>Launch your Care</th>
<th>Nurture your Care</th>
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</thead>
<tbody>
<tr>
<td>Develop an understanding of the Collaborative Care approach, including its history and guiding principles, in key stakeholders</td>
<td>Complete Pre-Launch planning tools re: clinical and support roles, tasks, program monitoring</td>
<td>Plan logistics for in-person training meeting</td>
<td>Select a specific date for launch and communicate this widely to all clinic staff</td>
<td>Monitor program outcomes, match to vision created during Step 1, adjust as necessary</td>
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<tr>
<td>Assess existing assets, strengths and potential barriers to effective implementation</td>
<td>Develop a registry plan that meets minimum requirements</td>
<td>Complete online pre-work modules in advance of in-person training meeting</td>
<td>Ensure all administrative details are in place prior to launch</td>
<td>Follow-up training on specific relevant clinical topics and stage of implementation (as needed)</td>
</tr>
<tr>
<td>Create a vision statement for Collaborative Care at your organization with input from key stakeholders</td>
<td>Develop detailed Clinical Workflow for each clinical location; iterate on it with key stakeholders</td>
<td>Plan EBP certification trainings (when part of support package)</td>
<td>Schedule alternate training for PCPs unable to attend in-person training</td>
<td>Implement internal and external communication plans</td>
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<tr>
<td></td>
<td>Develop an internal and external communication plan</td>
<td>Ensure staff are trained in use of registry for clinical care, consultation and program monitoring</td>
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</tbody>
</table>
Clinical Roles: Patient-Centered Team Care

- Patient
- PCP
- New Roles
  - Psychiatric Consultant
  - Care Manager Role
    - Community Partner
    - Primary Care
Collaborative Care Workflow

Identify & Engage

Establish a Diagnosis

Initiate Treatment

Follow-up Care & Treat to Target

Complete Treatment & Relapse Prevention

System Level Supports

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Purpose of Team Building Process

• Identify both overlap and gaps in care

• Practice change is complex
  – Changes in roles and clinical workflows are particularly challenging

Use this information to plan, Plan, PLAN--Rarely no surprises

• Advance planning significant factor in success of program launch
  – Identify & address as many barriers as possible BEFORE launch
    • Culture Clash
    • Who’s not fully on board?
    • What are the logistical challenges?
    • Who is going to need the most support early on?
Collaborative Care Team Building Process

1. Define Scope and Tasks of integrated care team
2. Assess current resources and workflow
3. Define team member responsibilities and new collaborative workflows
4. Assess hiring and training needs
Team Building Goals

1. Understand core components of Collaborative Care
   – What does it mean to be truly collaborative? How do we integrate Community Partners?

2. Identify overlaps and gaps in current workflow
   – Where can processes be more efficient? Overlap could be complex issue with Community Partners

3. Identify specific action items required
   – Office/phone for CM, training for care team, etc, time for contact with Community Partners

4. Facilitate communication between care team members
   – BH professionals, primary care providers start collaborating!
   – Community Partners
Overall Process

Step 1
- Each staff person completes Step 1 Worksheet

Step 2
- Facilitator compiles Step 1 worksheets into a summary

Step 3
- Small group led by facilitator uses summary to create concrete, specific implementation plan
  - Best with input from all key roles
Collaborative Care Workflow

- Identify & Engage
- Establish a Diagnosis
- Initiate Treatment
- Follow-up Care & Treat to Target
- Complete Treatment & Relapse Prevention

System Level Supports

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Team Building Process: Getting Started

Identify staff to participate

– **ALL Care Team Members**
  - BH professionals, Primary Care Providers, Consulting Psychiatrists

– **Silent Partners**
  - Administrators, Clinic Manager, Front Desk Staff, Medical Assistants, IT Staff, Billing Staff

– **Other Behavioral Health staff**
  - Specialty behavioral health clinic and/or co-located psychotherapists in primary care clinic
Who Participates?

Ideal
- All staff in all roles

• Strategies
  - Use existing meeting time
  - Clinic leadership send message about importance
  - Make time in provider schedules

• Alternative (Last resort)
  - Identify key representative(s) for each role
Team Building with PCPs

Engagement in Team Building Process
- Already overextended
- Action-oriented; may not have patience for “process”
- May not see the value of their participation

Change in Role
- May prefer “referral” to behavioral health provider(s)
- May not feel comfortable with prescribing psychotropic medications
- May be concerned about availability of consulting psychiatrist
Team Building with BHPs

Change in Role

– Misunderstanding of role is most common post-launch challenge
– They don’t all embrace integrated care model
  - Measurement-based, treat-to-target
  - Patients choosing medication as primary treatment
– Self identity may be as psychotherapist or traditional social worker
– May prefer to work independently, balk at transparency and accountability
Team Building with Psychiatric Consultants

Engagement in Team Building Process

– Already overextended
– May not see the value of their participation

Change in Role

– May see themselves as a peripheral member of the treatment team
– May not understand how this role differs from traditional consultation
– May not feel comfortable giving advice about treatment when not directly evaluating patients
Community Partners

• This is a new role so it essential that you have their input
• Including them in discussion helps them understand the full process
• For family member consider having a person represent a family member
“Silent” Partners are Important

- Administrators
  - CEO, CFO, COO, Clinic Manager
- Receptionist / Front desk staff
- Medical assistants
- Nurses, chronic disease management staff
- IT Staff
- Billing Staff
Step 1: Staff Self Assessment

- Define Tasks based on your target patient population, clinic setting, target conditions, etc.
  - You can customize Step 1 worksheet to fit your implementation

- Facilitator introduces Team Building process to everyone who will participate
  - The part they play
  - How the information will be used

- All participants watch “Introduction to Integrated Care” (linked from the Care Partners web site) to give context for completing worksheet
Step 1: Staff Self Assessment

- Customize to best fit your site
- Each staff member completes this worksheet
  - ROLE (not name)
- Individually or in a group
- Make sure they complete ALL columns
Step 1: Staff Self Assessment

Is this your role now?
Step 1: Staff Self Assessment

If no, whose role?
Step 1: Staff Self Assessment

What is your organization’s capacity with this task?

<table>
<thead>
<tr>
<th>Collaborative Care Tasks</th>
<th>Yes</th>
<th>No</th>
<th>Position Title</th>
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<th>Low</th>
<th>Yes</th>
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<tbody>
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<td>Identify and engage patients</td>
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<td>Screen for depression using valid measures</td>
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<td>Support a clinician to support a clinic assessment</td>
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<td>Treat depression</td>
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<td>Diagnose and Provide Treatment</td>
<td>Yes</td>
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<td>High Med Low</td>
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<td>Discuss patient and family (as appropriate) about treatment options</td>
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<td>Discuss patient and family (as appropriate) in Collaborative Care for depression progress</td>
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<td>Develop and make a treatment care plan</td>
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<td>Receive endorsement mandates if indicated</td>
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<td>Evaluate patient about medications and other treatment side effects</td>
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<td>Facilitate patient self-management support and expertise interventions for all patients regardless of treatment modalities</td>
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<td>Help patients who are irritable, depressed, or confused (e.g., CBT, ACT, SP if needed)</td>
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<td>Provide or refer to anxiety, mental health services across primary care, if needed</td>
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<td>Follow up GAD-7 Treatment &amp; Target</td>
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<td>High Med Low</td>
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<td>Test treatment outcomes using a global (e.g., global pain, global depression)</td>
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<td>Self-monitor of adherence and side effects for dose changes in treatment, if needed</td>
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<td>Receive patient and family engagement in treatment</td>
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<td>Require clinical treatment response and use of tools for dose changes in treatment if needed</td>
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<td>Maintenance in regular primary care role to identify patients who are not improving and provide treatment recommendations</td>
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<td>Support time management or clinic to provide case management</td>
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<td>Complete Treatment &amp; Relapse</td>
<td>Yes</td>
<td>No</td>
<td>High Med Low</td>
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<td>Check and support a case management plan</td>
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<td>Program Support and Supervision</td>
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<td>High Med Low</td>
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<td>Support time management among clinic members</td>
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Step 1: Staff Self Assessment

What is your level of comfort with this task?
**Step 1: Staff Self Assessment**

Would you like training to perform this task?
### Step 2 Worksheet: Identify Gaps, Duplicate Services, Training Needs

**Purpose:**
- Identify gaps and duplicate services
- Identify attitudes
- Identify training needs

<table>
<thead>
<tr>
<th>Task</th>
<th>STAFF 1</th>
<th>STAFF 2</th>
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<th>STAFF 5</th>
<th>STAFF 6</th>
<th>STAFF 7</th>
<th>FAMILY MEMBER</th>
<th>PARTNER AGENCY</th>
<th>REFERRAL</th>
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<tbody>
<tr>
<td>Identify and Engage Patients</td>
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<td>Gather information to support clinical assessment</td>
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<td>Establish a diagnosis</td>
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<td>Establish and Provide Treatment</td>
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<td>Educate patient and family (as appropriate) about depression</td>
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<td>Educate patient and family (as appropriate) about side effects</td>
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<td>Develop and initiate a treatment plan</td>
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<td>Prescribe antidepressant medication if indicated</td>
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<td>Provide ongoing psychotherapy (e.g., CBT, IPT) if indicated</td>
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<td>Provide case management to facilitate social and other support services (e.g., housing, food assistance)</td>
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<td>Provide ongoing support to patients and their families (e.g., weekly therapy sessions for substance abuse, family counseling)</td>
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<tr>
<td>Follow-up Care and Treatment to Target</td>
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<td>Track treatment adherence using a variety of methods (e.g., self-monitoring with a therapist, individual and group therapy)</td>
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<td>Track delivery of care management support (e.g., follow-up calls to patients, clinic appointments, case reviews by psychiatrists)</td>
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<td>Maintain patients in treatment (e.g., follow-up calls to patients, clinic appointments, case reviews by psychiatrists)</td>
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<td>Regularly review treatment resources and care providers for possible changes in treatment options</td>
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<td>Participate in regular (weekly) case reviews to identify</td>
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Completed by facilitator

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Can be useful to put information into spreadsheet for easier analysis
**Steps 3 Worksheet: Generate Integrated Care Workflow and Implementation Plan**

**IDENTIFY AND ENGAGE PATIENTS**

<table>
<thead>
<tr>
<th>COLLABORATIVE CARE TASKS</th>
<th>WHO (Name / Discipline)</th>
<th>HOW (Process including Hand-off &amp; Communication Methods e.g., telephone, mail)</th>
<th>WHEN (In terms of patient flow and time constraints)</th>
<th>WHERE (Primary care? CBP? Partner agency? External referral?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify people who may need help</td>
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<td>Screen for depression using valid measures</td>
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**Notes:**

**MOST Important Step!**

Facilitator completes with subgroup of clinic staff

Important to include representatives of each group
Generate Integrated Care Workflow and Implementation Plan

Facilitator leads discussion

Where are we now?
  – Review completed Work sheets #2
  – Gaps, Duplications

Where do we want to be?
  – Practical Ideal

Who will do each Integrated Care Task?
  – Complete WS #3 as a group

Generate Integrated Care Work-Flow & Implementation Plan
  – Share with all clinic staff so they know what to expect
# Workflow Example #1

## Identify and Engage Patients

### Depression Screening

<table>
<thead>
<tr>
<th>Primary Care</th>
<th>CBO and/or Family Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>MA</td>
<td>PHQ-2 given to patients in monthly meeting if positive, PHQ-9 is given by MA and given to provider before seeing patient.</td>
</tr>
<tr>
<td>PCP</td>
<td>reviews score and discusses with patient. If score is &gt; 10, then engage patient</td>
</tr>
<tr>
<td></td>
<td>PHQ-2 given to patients in monthly meeting if positive, PHQ-9 is given by CHW if score &gt; 10</td>
</tr>
</tbody>
</table>

## Patient Engagement

<table>
<thead>
<tr>
<th>Primary Care</th>
<th>CBO and/or Family Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP</td>
<td>CHW designee meets with patient to discuss care options</td>
</tr>
<tr>
<td>Care Manager</td>
<td>Sets up appointment with PCP or encourages return to own PCP</td>
</tr>
<tr>
<td></td>
<td>Explains care team</td>
</tr>
<tr>
<td></td>
<td>Contacts Care Manager</td>
</tr>
<tr>
<td></td>
<td>Sets up warm connection to Care Manager through phone contact</td>
</tr>
<tr>
<td></td>
<td>Sets up PCP appointment</td>
</tr>
<tr>
<td></td>
<td>Sets up Care Manager appointment</td>
</tr>
<tr>
<td></td>
<td>Uses standardized screeners as needed to</td>
</tr>
</tbody>
</table>

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Workflow Example #2

Depression in Primary Care Flow Chart

MA gives pt PHQ9 score or MA/PCP ask PHQ2

- Negative tx of sx
  - Place form for scanning. Follow-ups as needed.

- Positive or documented tx of sx
  - Warm handoff to BHC for interview and assessment.

PHQ9 Scored 0-9
- Provide health ed.Psychoed, beh. or self-_mgmt goals as appr
  - Watchful waiting.

PHQ9 Scored 9-14
- Pt not in OP tx
  - Med mgmt. by PCP w/BHC support

PHQ9 Scored 15-27
- Pt already in OP tx
  - Referral to OP psychotherapy

PHQ9 Scored > 27
- Pt unsatisfied w/OP tx
  - Discuss tx options (below)

Immediate Risk
- Refer to hospital, arrange transport
- Make f/u plan

No Immediate Risk
- Contract for safety
- Make f/u plan

Discuss tx options (below)

BHC f/u visit w/2 and 4 wks
- Monitor monthly until stable for 6 months, intermittent BHC visits afterwards

Score drops 3 points or 50% in 4-6 weeks...
- Consider ...

Score drops less than 50% in 4-6 weeks
- Refer to consultant psychiatrist or to outpatient services

Score drops less than 50% in 8-12 weeks

Pt given referral to MH provider
- BHC f/u phone contact w/2-4 wks to ensure engagement.

Reassess at next PCP visit, check on psych meds

Annual or as needed depression screen, provide psychoeducation as needed, check on psych meds periodically for changes

Psych collab/2 way release
- Phone & PCP f/u as needed

Pt ed. on cons. rights and tx

Psych collab, PCP & phone f/u

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Team Building Process: Final Hints

Flexibility

• Think about how model will work best in your organization

• Think about what stage you are in this process and what time it will take to complete

• Goal = Improved patient outcomes
What is due?

1. Complete pre-work for workflow development
   - Team Building Worksheets and Action Plan
   - Send Step 3 and Clinical Workflow draft to carepartners@uw.edu prior to your workflow planning support call if possible
   - Send completed Step 4 Action Plan to carepartners@uw.edu by August 12, 2015

2. Create Clinical Workflow Chart
   - Send Clinical Workflow to AIMS Center by August 12, 2015
   - Include Care Management Tracking System (CMTS) as a means of communication about the patient in the workflow
   - Include all other forms of communication that may be used around the patient and family member (if applicable)
Questions for the group

What do you need help with?
- Using the forms? Completing Step 3?
- Improving Executive/Medical buy-in to the planning process?
- Planning for use of CMTS by all partners?
- Planning for communication patterns?

Where are you struggling?

Any additional resources that would be helpful?
Next Steps

• Continue to engage your whole change team
• Complete team building process - send in step three to carepartners@uw.edu prior to your workflow planning support call if possible
• Write detailed workflow
• Present workflow as it is on the planning call - have questions planned about your workflow prior to the call.
• Any Questions?

• Let Ashley know if date for the call is a problem