AIMS CENTER

UNIVERSITY of WASHINGTON

Psychiatry & Behavioral Sciences

Celebrating 20 Years Advancing Integrated Care

Collaborative Care Implementation Guide

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About

This guide is an introduction to the process of implementing the Collaborative Care Model (CoCM), from the crucial first step of understanding what it is to monitoring outcomes once it is in place. Each step contains learning objectives along with materials to help you achieve them.

Centered around the core principles of Collaborative Care, this guide serves as a roadmap to healthcare leaders, managers, clinicians, and staff in primary care as they:

- start a new Collaborative Care program, or
- expand an existing integrated care or Collaborative Care program, and/or
- partner with community and behavioral health agencies.

It's important to understand that implementing CoCM necessitates practice change on multiple levels. It is nothing short of a new way to practice medicine and requires an openness to doing things differently. We hope this free guide helps you understand the scope of work involved and provides you with the tools you need to get started.



Research has shown that clinics receiving support from the AIMS Center have significantly better patient outcomes. We encourage you to contact us to learn more.

The AIMS Center offers in-depth coaching and training that goes far beyond the contents of this guide and that includes many tools and materials not available on our website. Contact us to learn more.

Implementation Office Hours

Have questions about how to implement a Collaborative Care program? Are you new to CoCM and want to know where to start? Or have you been running a program for several years and have a question on how to fund your program or continuously train new staff? Join AIMS Center staff during a monthly office hour to ask your most burning questions!

Office hours take place on the third Thursday of every month at 10:00-11:00 am Pacific Time. This is an open-ended call, and you may call in at any point during the hour; we will be available to answer questions until 11:00 am. Details to join the meeting are below:

Join URL: https://uw-phi.zoom.us/j/682654694
Phone Number: (646) 876 9923 or (669) 900 6833
Meeting ID: 682 654 694 #
Participant ID: Displayed on screen after clicking Join URL (see above). Press # if you are not using a computer.

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Common Abbreviations

APA = American Psychiatric Association

BHCM = Behavioral Health Care Manager

CoCM = Collaborative Care Model

EHR = Electronic Health Record

PCP = Primary Care Provider

SCR = Systematic Caseload Review

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Step 1: Lay the Foundation

A crucial first step in implementing the Collaborative Care model (CoCM) is understanding how it will fundamentally change your practice. It is a new way of practicing that requires an openness to creating a new vision. Don't skip this step! We can't emphasize enough how important it is.

Learning Objectives

- Develop an understanding of the CoCM approach, including its history, guiding principles, and evidence base
- Develop strong advocacy for CoCM within organizational leadership and among the clinical team
- Create a unified vision for CoCM concerning your overall mission and quality improvement efforts
- Develop a comprehensive sustainment plan
- Assess the difference between your organization's current care model and CoCM

Understanding Collaborative Care

Understanding what CoCM is and how it could look in your organization helps lay the groundwork for implementation. Everyone – including organizational leadership, clinicians, clinic support staff, and administrative staff – needs to understand how things are going to change and why. CoCM can mean different things to different people; now is the time to make sure everyone is on the same page.



Implementation Resources

Use the following AIMS Center website resources to ground your team in the basics of CoCM

- **Learn** about the model by watching Daniel's story: An Introduction to Collaborative Care
- **Explore** the principles of CoCM and how they translate into actions
- **Study** the team structure of CoCM and learn about each team member's role
- **Understand** the evidence behind CoCM



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Identify Your Champions

An effective integrated care program starts with a Clinic Implementation Team to support the overall transition to a new care model. This includes leading pre-launch planning activities, coordinating training activities, and facilitating and monitoring program implementation post-launch.

Identify Implementation Leader

To prepare for the implementation of a new behavioral health integration strategy, such as Collaborative Care, it's helpful to form a Clinic Implementation Team (CIT). This team should be formed by a clinic implementation leader, typically a Clinic Manager, CEO, Behavioral Health Director, CMO, or similar. The CIT Lead should facilitate regular meetings of the implementation team and establishment of a shared vision, assist in hiring team members, and other pre-launch planning activities. Throughout post-launch, the CIT lead should oversee efforts toward program sustainment and quality improvement. This person is critical to the success of the implementation, so it's worthwhile to spend some time deciding who best fits this role.



For a full list of key characteristics and responsibilities associated with this role, see the CIT Lead Role Description

Identify Clinic Implementation Team

The first job of the clinic implementation leader is to form a small core team to participate in planning, launching, and monitoring program implementation. This team should consist of the following members:

Primary Care Provider (PCP) Champion

The PCP Champion will participate in team building and development of specific implementation plans. They will communicate changes and expectations between the implementation team and their PCP colleagues.



See the PCP Champion Role Description for a thorough outline of the role.

PCPs are critical to the success of integrated care. Therefore, it is essential that they have a voice in planning implementation. The best choice for selecting a PCP Champion is a practicing PCP who is supportive of implementing integrated care and who can influence other PCPs in the organization.

Examples of Primary Care Provider(s) include physicians, physician assistants, and/or nurse practitioners.

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Behavioral Health Care Manager (BHCM)

The BHCM is critical to the functioning of CoCM. If you will redeploy existing staff into this role, it's a good idea to include them in the Clinic Implementation Team. As part of the planning team, they will participate in the team building and planning process.



See the BHCM Role and Job Description for a thorough outline of the role.

Psychiatric Consultant

If you can include your psychiatric consultant in the planning and program development process, that is ideal. It is critically important that you identify a psychiatric consultant who is comfortable with the kind of indirect care used with CoCM.



See the Psychiatric Consultant Role and Job Description for a thorough outline of the role.

Assessing Organizational Readiness

We've found that organizations with prior experience in some key areas tend to do better at implementing CoCM. Assessing the strengths and weaknesses you have at the outset will get you primed for the tough work ahead.



Implementation Resources

Use this CoCM readiness checklist to help you think about your ability to successfully implement CoCM.

Create a Shared Vision

A powerful vision statement should stretch expectations and aspirations helping you jump out of your comfort zone. The first step in creating a shared vision is describing the care you seek to give. As Yogi Berra said, "If you don't know where you are going, you probably aren't going to get there."



Implementation Resources

Use this Creating a Shared Vision for CoCM worksheet to facilitate the development of a shared vision for Collaborative Care including:

- Which clinical conditions to treat
- Populations you will serve
- Which kinds of evidence-based psychotherapies to practice
- Think about how this new effort maps on to your existing behavioral health services

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Develop a Sustainment Plan

Part of successfully implementing Collaborative Care in your practice is developing a robust sustainment plan. It is important to think first about creating or improving an effective, measurement-based integrated healthcare delivery model and then determine how to sustain your effort. Long term, quality is the best assurance of sustainability. Will you be able to sustain your integrated care program after launch?

A narrow view of sustainability might only consider finances, but other critical factors play a role in helping practices develop, sustain, and continually refine their model of care. The AIMS Center strongly encourages practices to consider all the ways that practicing CoCM can contribute to the health of your patients and your practice. Many critical factors play a strong role in helping a practice develop a comprehensive sustainment plan. Finances are only one factor.



Implementation Resources

Financial Modeling Workbook

In an effort to help organizations understand the ongoing costs and revenues associated with integrated strategies, the AIMS Center created the **Financial Modeling Workbook** in collaboration with the Institute for Family Health and the American Psychiatric Association. This Workbook focuses on the ongoing costs of care such as BHCM time, Psychiatric Consultant time, administration time, and overhead (including QI efforts) to help practices:

- Estimating visit volume and the number of patients served
- Defining and analyzing how much time staff engage in key integrated care tasks
- Estimating fee-for-service and BHI/CoCM G-code potential revenues more accurately

Additionally, it allows you to play with practice parameters to understand their impact. For example, you can vary the length of appointment times, the percentage of time staff spend on the different components of collaborative care work or other factors to start to better understand how to build or revise clinical workflows.



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Step 2: Plan for Clinical Practice Change

Implementing Collaborative Care requires significant – and often challenging – clinical practice change. Clinics must clearly define team member roles, create a workflow, and identify how to track treatment and outcomes. Each team member should understand CoCM before beginning this step! Review Lay the Foundation, if necessary.

Your implementation leader or someone on your planning team should guide this step (see Identify Your Champions for more information about these roles).

Learning Objectives

- Identify all CoCM team members and organize them for training
- Identify a population-based tracking system for your organization
- Develop a clinical flowchart and detailed action plan for your care team
- Develop a plan for funding, space, human resources, and other administrative needs
- Develop a plan to merge CoCM monitoring and reporting outcomes into existing quality improvement efforts

Build Your Team

In usual care, the treatment team has two members: the Primary Care Provider and the Patient. CoCM adds two new team members: the BHCM and the Psychiatric Consultant. Effective CoCM is a team of providers working together on a single treatment plan. Its success relies on each member of the treatment team understanding their role and believing they have the knowledge and skills necessary to fulfill that role.

A Note on Culture

Team members will need to function outside of the traditional roles they were trained for and rely on each other in ways that may be new or uncomfortable. PCPs are familiar with an entirely different culture than behavioral health specialists, but both perspectives are extremely important, and both need to be woven into a new collaborative culture that sees differences as strengths. The Implementation Leader should carefully consider the pros and cons of re-training existing staff versus hiring new staff, keeping in mind the challenges implementation brings and the personalities involved.



Implementation Resources

The Implementation Leader should identify all relevant Collaborative Care tasks on the Team Member Self-Assessment and tailor the worksheet accordingly. Once appropriately modified, have each team member fill it out.

Next, using responses from the step above, the Implementation Leader should complete the Task Summary Worksheet. Examine the completed worksheet to identify gaps and duplications in tasks as well as opportunities to make each task more efficient. Think about ways to collaborate effectively and discuss critical communication and 'handoff' steps with the Planning Team.

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Create a Clinical Workflow

It's important to know how your team will function the moment a patient walks through the door, including protocols for suicide prevention and patients in crisis. Planning and creating a clinical flow that shows the exact process of what happens when a patient comes to the clinic ensures that no patient falls through the cracks. Mapping a patient's care experience – from identifying a behavioral healthcare need, to initiating treatment, to communicating treatment adjustments – gives a framework for knowing the next step of care.

Implementation Resources

1. The Planning Team, led by the **Implementation Leader**, should systematically review the results from the **Build Your Team** section in order to plan for implementation changes and to document these plans. Discussion should center on gaps, duplication, needed training, and/or re-assignments in the context of the "practical ideal" you are striving for to provide the most effective care for your patients.

2. Next, the Planning Team should fill out a **Clinical Workflow Plan**. For each task—or set of tasks as shown in the worksheet—document who, how, when, and where the task will be completed as part of your implementation plan. This worksheet documents your current situation plus your plans for change and will help you:

   - Document how each CoCM task will be changed/accomplished, including plans for warm connection and communication methods.
   - Document when a task is completed, in terms of patient flow (e.g., intake, initial assessment).
   - Document where the task will be completed. At the clinic? At a partner agency? Through an external referral?
   - Assess whether organizational-level changes are necessary. Staff training needs? Staff hires? Other needs? Additional supervision?

3. Using the completed **Clinical Workflow Plan**, the Planning Team should now create a clinical flowchart showing the exact process of what happens when a patient comes to the clinic. Include a protocol for **suicide prevention** and pay particular attention to communication among team members (e.g., ensuring recommendations from Psychiatric Consultant are communicated to PCP, providing tools to the PCP to ensure patients are referred to the correct team members). Every clinic's flowchart will be unique and there is no right way or wrong way to ensure CoCM tasks get done.

Identify a Behavioral Health Patient Tracking System

The Collaborative Care model requires the ability to track both clinical outcomes and engagement for patient populations of focus and to support systematic changes in treatment for patients who are not improving as expected. This measurement-based, treatment-to-target approach is one of the **core**

principles of CoCM and is essential in ensuring stated goals are being met. It requires a systematic method of tracking information on all patients being treated for behavioral health conditions, like anxiety or depression. How it is done is much less important than that it is done.

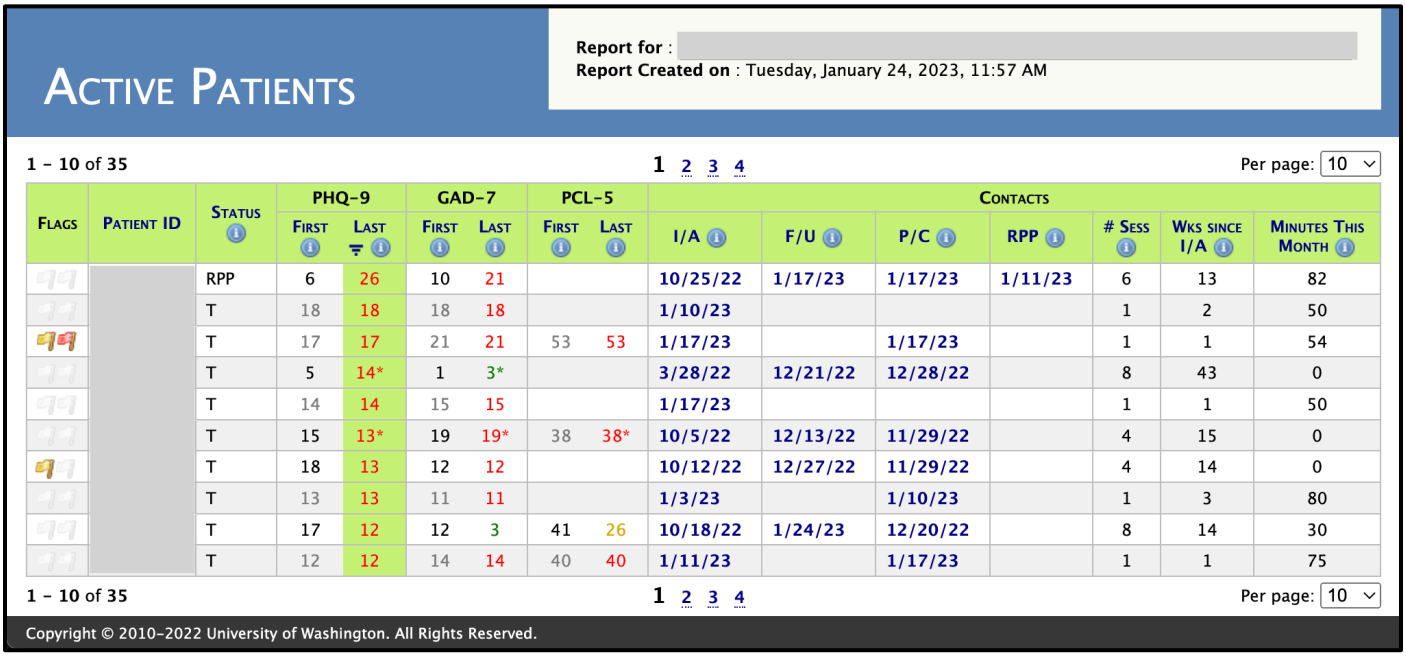
Using Registries to Track Patient Outcomes

The workflow to support measurement-based care is a data-driven process, requiring the care team to actively use a registry to track patient clinical outcomes over time. It is important that registries be used in conjunction with the practice's EHR, if not already built into it. A registry is a caseload management tool used by a BHCM and Psychiatric Consultant to monitor caseloads of patients, track their treatment progress, and identify patients who are not improving as expected and may need treatment adjustments or who are improved enough to complete an active episode of care.

An effective registry must be able to do the following:

- Track clinical outcomes and progress at both the individual patient level and overall caseload level for the target population.
- Prompt treatment-to-target by summarizing patient's improvement and challenges in an easily understandable and actionable way.
- Facilitate efficient psychiatric consultation and case review, allowing providers to easily prioritize patients who need to be evaluated for changes in treatment or who are new to the caseload.

Figure 3 shows an example of a registry at the caseload level. Key processes to monitor include caseload size, the number and percentage of patients on a caseload who have been in contact with the behavioral health provider in a given period of time, and the number or proportion of enrolled patients who have achieved significant improvement.



ACTIVE PATIENTS

Report for :
Report Created on : Tuesday, January 24, 2023, 11:57 AM

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Flags	Patient ID	Status	PHQ-9 First	PHQ-9 Last	GAD-7 First	GAD-7 Last	PCL-5 First	PCL-5 Last	Contacts I/A	Contacts F/U	Contacts P/C	Contacts RPP	# Sess	Wks since I/A	Minutes This Month
		RPP	6	26	10	21			10/25/22	1/17/23	1/17/23	1/11/23	6	13	82
		T	18	18	18	18			1/10/23				1	2	50
		T	17	17	21	21	53	53	1/17/23		1/17/23		1	1	54
		T	5	14*	1	3*			3/28/22	12/21/22	12/28/22		8	43	0
		T	14	14	15	15			1/17/23				1	1	50
		T	15	13*	19	19*	38	38*	10/5/22	12/13/22	11/29/22		4	15	0
		T	18	13	12	12			10/12/22	12/27/22	11/29/22		4	14	0
		T	13	13	11	11			1/3/23		1/10/23		1	3	80
		T	17	12	12	3	41	26	10/18/22	1/24/23	12/20/22		8	14	30
		T	12	12	14	14	40	40	1/11/23		1/17/23		1	1	75

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Figure 3. Example of the AIMS Caseload Tracker Registry Showing Caseload-level Data

Selecting a Registry Tool

Registry tools that support Collaborative Care vary widely in their sophistication, functionality, cost, and scalability. Options include the following:

The CoCM Registry Requirements Guide further details important considerations for a registry.

- Many clinics begin their integrated care programs using a spreadsheet as a registry. Should you choose to develop one, refer to the **registry requirements guide**. Managing caseloads on a spreadsheet can be challenging in regard to scalability and HIPAA compliance.
- The **AIMS Caseload Tracker** is a secure web-based registry for managing behavioral health caseloads in integrated care settings. It is used alongside your Electronic Health Record (EHR) to provide powerful tracking and reporting functions.
- Some organizations pursue customized registry builds within their EHR or in a care management platform. These organizations often find it valuable to use the AIMS Caseload Tracker or similar tool as an interim solution during the build process.

Make an Action Plan

Now that you have a detailed vision of how Collaborative Care will operate in your clinic, what needs to happen before you launch your care?

Implementation Resources

Assess your Administrative Needs
The Administrative Readiness Checklist will help identify the components that need to be in place.

Create an Action Plan
The Action Plan Worksheet can help you put everything into place so you're ready to start training your clinical team. You'll need to draw upon your Clinical Flowchart and Administrative Readiness Checklist from above.

Hire Personnel, if Needed
If you have decided to hire additional members to your team, use the resources below to help.

- Behavioral Health Care Manager Caseload Guidelines
- Behavioral Health Care Manager job description
- Psychiatric Consultant job description

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Step 3: Build Your Clinical Skills

Effective CoCM is a team of providers working together on a single treatment plan. Each member of the care team needs to understand their role and believe that they have the knowledge and skills necessary to fulfill that role. The entire team should complete the Care Team Training together to begin the process of thinking and working as a team and seeing how each role fits into the bigger picture. Ideally, this is a continuation of team building that began in Step 2.

Learning Objectives

- Describe the CoCM approach, evidence base, and guiding principles
- Describe key tasks, including patient engagement and identification, treatment initiation, outcome tracking, treatment adjustment, and relapse prevention
- Develop a qualified and prepared care team, equipped with the functional knowledge necessary for a successful implementation
- Develop skills in psychotherapy treatment that are evidence-based and appropriate for primary care

Care Team Training (For All Members of the Care Team)

Understanding what evidence-based Collaborative Care is and how it could look in your organization is extremely important. Everyone – including the Behavioral Health Care Manager, Primary Care Provider, and Psychiatric Consultant – needs to understand how things are going to change and why. CoCM can mean different things to different people, so undertaking this part of the training together and providing a venue for sharing ideas, thoughts, and concerns is a terrific way to begin building your collective clinical skills.

Learning Objectives

- Understand the Collaborative Care approach, including its evidence base and guiding principles
- Understand key tasks, including patient engagement and identification, treatment initiation, outcome tracking, treatment adjustment, and relapse prevention
- Create a qualified and prepared care team, equipped with the role-specific functional knowledge necessary for success



Implementation Resources

- Daniel's Story: An Introduction to Collaborative Care (video)
- Introduction to Collaborative Care
- Behavioral Health Care Manager Training
- Primary Care Provider Training
- Psychiatric Consultant Training

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Behavioral Health Care Manager Training

The Behavioral Health Care Manager (BHCM) is at the heart of a strong CoCM team, facilitating communication among all team members and acting as the lead contact person for the patient. Effective BHCMs support the PCP in their role by coordinating the overall treatment plan, providing brief psychotherapy proven to work in primary care, supporting medication management, alerting the PCP when the patient is not improving, and communicating with the Psychiatric Consultant regarding treatment changes.



See the BHCM Role and Job Description for a thorough outline of the role.

Learning Objectives

- Describe the BHCM's role, including: engaging patients, communicating with team, tracking patient outcomes and generating treatment options
- Develop the functional knowledge necessary to contribute to a successful Collaborative Care team as a BHCM



Implementation Resources

- Introduction to the BHCM role
- Online Training for BHCMs
- Behavioral Skills Training for BHCMs
- Case Review: Behavioral Health Care Manager with Psychiatric Consultant

Primary Care Provider (PCP) Training

In CoCM, PCP training is largely about learning how to collaborate with a BHCM and Psychiatric Consultant. PCPs continue to oversee all aspects of a patient's care and in that role, become increasingly comfortable prescribing a wide range of therapies and medications.



See the PCP Champion Role Description for a thorough outline

Learning Objectives

- Describe the PCP role as part of a Collaborative Care team
- Develop the functional knowledge needed to be part of a successful team
- Understand prescribing directions for psychotropic medications



Implementation Resources

- Review the care team training materials
- Introduction to the PCP role
- Online Training: Skills for the PCP

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Psychiatric Consultant Training



See the Psychiatric Consultant Role and Job Description for a thorough outline of the role.

Psychiatric Consultants support both the BHCM and the PCP to deliver effective behavioral health care. They do not typically see patients or prescribe medications; however, they are available during business hours for ad-hoc patient and provider consultation as needed. They meet regularly with the BHCM for Systematic Caseload Review (SCR) sessions to discuss a caseload of patients in active treatment, prioritizing reviews of patients who are not improving.

Psychiatric Consultants provide:

- input on diagnostic assessment
- identification of co-morbid behavioral health conditions
- medication recommendations
- overall treatment planning

Treatment recommendations are communicated to the PCP, typically through the electronic health record (EHR). With training in both psychopharmacology and evidence-based psychotherapies, Psychiatric Consultants can support a full range of evidence-based treatments for depression, anxiety, and behavioral health concerns. They can serve as an educational resource as well, for example, presenting on clinical topics or advising on clinic routines related to mental health.

Psychiatric Consultants may include psychiatrists, psychiatric nurse practitioners, or psychiatrically trained physician assistants, depending on the state's scope of practice rules.

LEARNING OBJECTIVES

- Describe the Psychiatric Consultant role as part of a Collaborative Care team
- Develop the functional knowledge necessary to contribute to a successful Collaborative Care team



Implementation Resources

- Introduction to the Psychiatric Consultant Role
- Online training

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Step 4: Launch Your Care

Is your team in place? Are they ready to use evidence-based interventions appropriate for primary care? Are all systems go? Time to launch!

Learning Objectives

- Implement a patient engagement plan
- Manage the enrollment and tracking of patients in a registry
- Develop a care team monitoring plan to ensure effective collaborations
- Develop a plan to help patients from the beginning to the end of their treatment, including a relapse prevention plan

Educate Your Patients

The AIMS Center believes patients have a right to be well-informed about their conditions and care. When the patient and family are an integral part of the health care team, it increases motivation, empowerment, adherence, satisfaction – and most importantly – better health outcomes.

Teaching patients about mental health and mental health treatments can be particularly challenging due to widespread stigma and misconceptions. Patient education can be done in many different ways, including handing out educational materials, showing relevant patient-centered videos, and directing patients to online information. BHCMs should work with PCPs and organizational leadership to develop a suite of accessible tools that are informative, reassuring, and appropriate to the care, treatment, and services provided. Content should be available in appropriate reading levels and personalized to each patient depending on cultural differences and specific needs. Use the resources below to get started.



Implementation Resources

- Daniel's Story: An Introduction to Collaborative Care (video)
  A powerful story that shows how collaborative care can change a person's life.
- Introducing your Care Team
  An editable flyer template that helps introduce your collaborative care team to your patients. Available in both English and Spanish.
- Helping Clinic Staff Talk with Patients about the PHQ-9
  This tool is designed to help clinic support staff answer common questions they may hear from patients.
- Obtaining Verbal Consent for CoCM
  General guidance on introducing CoCM to patients and gathering consent for participation.

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Monitor Implementation Process and Clinical Outcomes

Now that you are providing Collaborative Care, you should begin monitoring your processes and outcomes using whatever metrics you decided on in Identify a Population-Based Tracking System in Step 2: Plan for Clinical Practice Change. Remember, a systematic method for tracking the progress of your patients is crucial for the success of CoCM. Without it, you have no concrete idea if what you're doing is working or not.

If you haven't already done so, decide on how and when you'll review your metrics. You should review, re-evaluate, and adjust them as necessary on a regular basis. Maybe you need to change your goals now that you have real data to work with. Maybe you've met your stated objectives and now want to do even better. Maybe you set different goals for years 1, 2, and 3, and need to adjust them. Having a system in place for regularly reviewing your numbers keeps your entire effort on track.

Looking at your metrics can also help in identifying ways to improve your care. For example, in one implementation we discovered that BHCM A was consistently getting her patients better than BHCM B. By looking at our metrics, we determined that BHCM A did twice as many follow-up calls as BHCM B and were able to test that theory.

Pay for performance may be one way to improve your clinical outcomes, as suggested by the following paper: Quality Improvement with Pay-for-Performance Incentives in Integrated Behavioral Health Care.

Relapse Prevention Planning

Ending treatment well is just as important as starting it well. Relapse prevention planning helps patients understand how to identify when symptoms may be returning and empowers them to do something about it.



Implementation Resources

- Relapse Prevention Plan

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Step 5: Nurture Your Care

As with most things, maintaining Collaborative Care requires continuous work beyond the date of launch. Every implementation faces challenges that must be managed after launch. Now is the time to see the results of your efforts as well as to think about ways to improve them.

Learning Objectives

- Implement the care team monitoring plan to ensure effective team collaborations
- Update your program vision and workflow
- Implement advanced training and support where necessary

Content

We recommend the following activities to keep your care team operating efficiently and effectively with the goal being the best patient-centered mental health care you can provide.

- Monitor implementation process and clinical outcomes and merge into existing quality improvement plan
- Revisit your vision, clinical flowchart, and action plan every six months
- Incorporate post-launch training and implementation support, as needed
- Expand CoCM services to additional sites, conditions, and populations
- Revisit the principles of CoCM every six months and see if they're still at the forefront of your care
- Reboot your team training and communication when new hires come on board or as needed



Real-world CoCM Experience at your Fingertips

The AIMS Center has 20 years of experience working with healthcare organizations to implement CoCM. In our work with hundreds of clinics we have encountered nearly every implementation challenge an organization can experience and we know what works and what doesn't to address those challenges. Our implementation support services offer organizations access to our extensive real-world experience and help them succeed in CoCM implementation. Learn more about the affordable services we offer, contact us today to schedule your free consultation.

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