

Chapter 1 **Working as a Team to Provide Collaborative Care**

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Effective integration of mental and primary health care requires the effective sharing of tasks among members of a Collaborative Care team that works together with the patient as the center of the team's efforts. This chapter reviews typical team-member roles, a model of a shared clinical workflow, and core Collaborative Care skills and tools.

Collaborative Care team roles

Focusing on the function, rather than title or previous role, of team members ensures that all the critical tasks of a Collaborative Care program are delivered to provide effective patient care. A formal team-building process can facilitate Collaborative Care implementation. Common roles on a Collaborative Care team include (Figure 1.1):

- Patient
 - The most important person on the team!
 - Works with the primary care provider (PCP) and the behavioral health provider (BHP)/care manager (CM).
 - Reports changes in health, symptoms, and functioning.
 - Sets goals for treatment with the team.
 - Tracks clinical progress using patient-reported outcome measures.
 - Asks questions and discusses concerns about care.
 - Understands treatment plan, including goals of behavioral interventions and names/doses of medications.

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- Primary care provider (PCP)
 - Clinician degrees may include MD, DO (doctor of osteopathic medicine), ARNP (advanced registered nurse practitioner), and NP (nurse practitioner).
 - Oversees all aspects of patient's care.
 - Introduces Collaborative Care team, often with "warm handoff."
 - Diagnoses common mental disorders.
 - Prescribes medications to treat psychiatric illnesses as appropriate.
 - Adjusts treatment in consultation with BHP/care manager, psychiatric consultant, and other behavioral health providers.
- Behavioral health provider (BHP)
 - Clinician degrees may include MSW, LCSW, RN, MA, PhD, and PsyD.
 - Works closely with PCP and helps manage a caseload of patients in primary care (care manager).
 - Facilitates patient engagement and education.
 - Performs structured initial and follow-up assessments.
 - Systematically tracks treatment response using behavioral health measures.
 - Provides brief, evidence-based behavioral interventions or refers to other BHP for these services.
 - Supports medication management by PCPs.
 - Helps patient identify where to get medications.
 - Encourages and supports medication adherence.
 - Brings concerns about medications or side effects to PCP, and schedules PCP visit to adjust treatments as appropriate.
 - Reviews challenging patients in systematic, weekly case review with the psychiatric consultant.
 - Facilitates referrals to other services (e.g., substance abuse treatment, specialty care, and community resources) as needed.
 - Prepares patient for relapse prevention.
- Psychiatric consultant (PC)
 - Psychiatrist or other expert in psychiatry and psychopharmacology.
 - Supports PCPs and BHPs, providing regular (weekly) and as-needed consultation on a caseload of patients followed in primary care.
 - Focuses on patients who are not improving and who need treatment adjustment or intensification.
 - Available to provide in-person or telemedical consultation or, for complex or persistently ill patients, referral.
 - Provides education and training for primary care providers and BHPs as appropriate.

- Other behavioral health providers
 - These may include chemical dependency counselors or other licensed behavioral health professionals.
 - Deliver specialized evidence-based counseling/psychotherapy (individual or group).
 - Support behavioral health interventions focused on health behaviors.
 - Provide chemical dependency counseling/treatment.
 - Facilitate other mental health or substance abuse services.
- Other partners important to include in team building
 - CEO, administrators, medical directors, clinic managers.
 - Medical and mental health leaders/champions.
 - Receptionists/front desk staff, medical assistants.

Collaborative Care shared workflow

A typical course of Collaborative Care will involve contributions from the entire team over a relatively short period of time. Figure 1.2 shows a typical course of Collaborative Care for a common mental health disorder, such as depression. Patients will be identified, assessed, and treated, and complete an episode of care, including relapse prevention.

Figure 1.3 shows common tasks accomplished as part of Collaborative Care. Some clinics may add additional tasks to meet the needs of specific populations or to target specific health problems. For each task, a team will need to decide how, when, where, and by whom the task will be completed as part of a shared workflow. A shared clinical flowchart can be useful to illustrate the process of care when a patient comes to the clinic. Handoffs and communication among team members require special attention. Every clinic's flowchart will be unique.

Core Collaborative Care skills and tools

Skills training (summarized below) will need to be completed before launching a Collaborative Care program.

Introducing the Collaborative Care team approach to the patient

It is important to introduce the patient to the concept of team-based care and to explain how a team of providers will work together to deliver care in the familiar primary care setting. One of the best ways to do this is to have the PCP introduce the patient to the BHP in person, providing a “warm handoff.”

Collaborative Care Team Structure

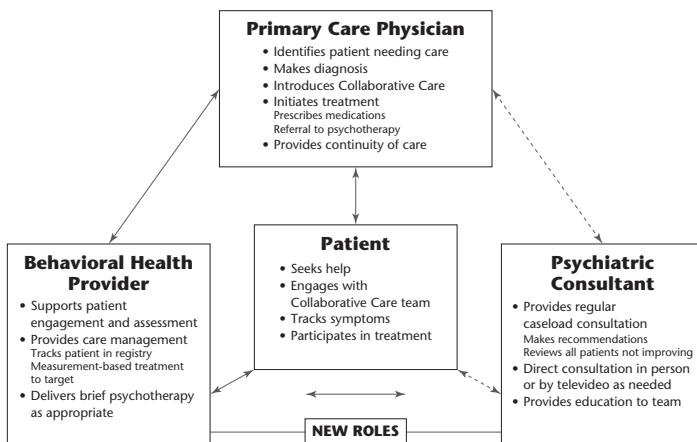


Figure 1.1 Model integrated behavioral health team: There are two new roles added to the primary care setting, a behavioral health provider and a psychiatric consultant. The solid arrows indicate regular communication and the dashed arrows represent as-needed communication.

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	Initial Assessment	Initial Treatment	Follow-Up Treatment						Completion and Relapse Prevention
Time In Treatment	Week 1	Week 1	Weeks 2–Week 16						Week 16 and Beyond
PCP	X	X	X						X
BHP	X	X	X	X	X	X	X	X	X
Psychiatric Consultant		X	X	X	X	X			X

Figure 1.2 Typical timeline of treatment in Collaborative Care.

Prepare System	Provide System Level Supports for Care
	<ul style="list-style-type: none"> • Establish a Program Vision • Define Population Targeted by Collaborative Care • Choose Tracking Method/Registry • Train Team Members • Provide System Level Supports for Care
	<ul style="list-style-type: none"> Identify and Engage Patients <ul style="list-style-type: none"> • Identify People Who Need Help • Screen for Behavioral Health Problems Using Valid Measures • Engage Patient in Integrated Care Program
	<ul style="list-style-type: none"> Establish Diagnosis <ul style="list-style-type: none"> • Perform Behavioral Health Assessment • Identify & Treat Coexisting Medical Conditions • Diagnose Behavioral Health Disorders • Patient Education about Symptoms & Diagnosis
	<ul style="list-style-type: none"> Initiate Treatment <ul style="list-style-type: none"> • Patient Education about Recommended Treatment • Develop & Update Behavioral Health Treatment Plan • Brief Counseling, Behavioral Activation • Prescribe Psychotropic Medications – as indicated • Evidence-based Psychotherapy (e.g., PST, CBT, IPT) – as indicated • Facilitate Referral to Specialty Care or Social Services – as indicated
Patient Care	<ul style="list-style-type: none"> Follow-Up Care and Treat to Target <ul style="list-style-type: none"> • Track Treatment Engagement & Adherence using Registry • Reach out to Patients who are Non-adherent or Disengaged • Track Patients' Symptoms with Valid Outcome Measures (e.g., PHQ-9) • Track Medication Side Effects & Concerns • Track Outcome of Referrals & Other Treatments • Assess Need for Changes in Treatment • Provide Caseload-Focused Psychiatric Consultation Focused on Non-responding Patients • Adjust Treatment if Patients are Not Responding • Facilitate Changes in Treatment Plan • Provide In-Person or Telehealth Psychiatric Assessment of Challenging Patients
	<ul style="list-style-type: none"> Complete Treatment and Provide Relapse Prevention <ul style="list-style-type: none"> • Assess for Completion of Goals • Create & Support Relapse Prevention Plan • Communicate Plan to Team
Ongoing System Supports	<ul style="list-style-type: none"> Provide System Level Supports for Care <ul style="list-style-type: none"> • Provide Administrative Support for Program (e.g., Scheduling, Resources) • Coordinate Communication Among Team Members/Providers • Engage in Continuous Quality Improvement Efforts, Focusing on Patient Panels (Entire Population Served)

Figure 1.3 Tasks of Collaborative Care.

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Another communication strategy is to use a flyer to introduce the care team and each team member's role.

Key information to be shared with the patient:

- The patient is an important member of the team.
- All team members will share one treatment plan to support patient-centered goals.
- The PCP will oversee all aspects of patient care at the clinic.
- The care manager works closely with the patient and the PCP to implement a treatment plan, including keeping track of treatment progress and providing counseling.
- The psychiatric consultant does not see all patients in person but provides valuable expertise to guide treatment for all patients.

Team functioning

Sharing care is often a new skill for care-team members. Effective communication is fundamental to providing high-quality shared care. One of the major challenges to team function around behavioral health is that providers have often trained in “cultures” with different orientations. This culture clash can make it difficult to plan and implement truly integrated behavioral health plans, unless effective team building occurs.

Key strategies to strengthen team functioning include:

Sharing goals: Describe a clear set of behavioral health goals at the organization level. At the patient level, the goal is to have one treatment plan that is shared by all team members. This will often require practical troubleshooting in how to document and share information in electronic medical record systems.

Building mutual trust: Consider opportunities to foster mutual trust and skill building among the care team. Sharing patient success stories and challenges at provider meetings can strengthen team members' commitment to sharing care.

Clarifying roles and workflow: Taking time to establish clear roles and shared workflows is important to support effective teamwork. Workflows should be regularly reviewed as a team to identify areas in which additional problem solving is needed.

Strengthening communication strategies: Agree on communication strategies, including in-person communication, tasking or electronic communication, or using the electronic medical record. Consider daily or weekly huddles to facilitate rapid team communication around challenging patients and organizing team priorities.

Accountable practice

The core concept of accountable clinical care is identifying goals, defining ways to measure those goals, and then regularly reviewing progress toward goals. Accountable practice is key for effective Collaborative Care at the patient and population levels. Common targets for behavioral health teams include access to care, number of patients served, patient satisfaction, patient-reported outcomes using standard measurements (such as the Patient Health Questionnaire, or PHQ-9, for depression), and costs. Many teams find using familiar quality-improvement strategies, such as a Plan-Do-Study-Act (PDSA) cycle, helpful in supporting accountable practice.

Key strategies for accountable care include:

Identify goals: All team members should have a clear understanding of both patient- and program-level goals.

Define measurements: Identify key measurements and strategies to obtain data on these measures in your organization.

Review progress: Regular review of data can help all team members identify areas for improvement. If real-time data on key measures are available, any member of the behavioral health team can examine current data on both process and outcome data to assess progress toward shared goals. This allows teams to nimbly respond to unmet goals.

Registry

A registry is a list of all the patients currently being cared for by a provider or clinic, and is used to keep track of a defined population of patients. Registries allow teams to track patient progress and to reach out to patients who have been identified in the registry as needing help but may have “fallen through the cracks.” This concept may be familiar to primary care practitioners, as many clinics keep registries for other chronic medical conditions, such as diabetes. Using a registry, or having the ability to proactively engage patients in care when they have been “lost to follow-up,” is especially important with mental health disorders such as depression and anxiety, as symptoms of these disorders often include isolation and low motivation. (See online materials for more information on registries.)

Key strategies for effective registry use:

- Typically, each patient is assigned to a specific behavioral health care manager. Date of enrollment, dates of follow-up contacts, and scores on outcome measures (such as the PHQ-9) are examples of information commonly included in a registry.

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- More sophisticated registries have such capabilities as reporting percent improvement for a patient, percentage of the entire patient panel population improved, or reminders for key clinical processes.

Collaborative Care assessment

This information is not meant to replace detailed resources on patient assessment; rather, this book outlines principles for how a team can share assessment of patients in primary care. Special attention is devoted to highlighting how Collaborative Care principles may be incorporated into the assessment process.

Identify chief complaint, associated somatic and psychological symptoms, functional impairment, and safety concerns

Clinicians will identify patients either when they present with symptoms of a mental health disorder or through routine screening of patient populations. The PCP and CM work together to gather enough history to generate a differential diagnosis.

- Measures:** Consider using standard measures to assess common symptoms, such as depression and anxiety symptoms. Some measurement tools can also be used to track response to treatment.
- Past mental health history:** Number and severity of previous mental health episodes, and experience with mental health treatments.
- Current and past history of alcohol or substance use:** Use of prescription or nonprescription drugs or alcohol. History of prior substance abuse treatment.

Common psychological symptoms

Mood and anxiety symptoms, enjoyment/quality of life, relationships, social activities, work or employment status, hobbies, and sex.

Common physical/Somatic symptoms

Physical symptoms such as acute or chronic pain; physical activities such as walking, eating, and sleeping; and side effects of medications.

Common functional impairments

Activities of daily living (how does the patient spend his/her day?). How are symptoms impacting function?

Assessment of safety

All team members should remember this important part of assessment.

- **Self-harm:** Self-harm or suicidal ideation, or history of suicide attempts or other self-harm, such as cutting, or other high-risk behaviors.
- **Thoughts of harming others and other safety risks:** Serious inability to care for self (grave disability) and environmental or social issues posing safety risks: housing/shelter risks, violence (i.e., domestic violence and other dangerous social circumstances).

Team goal: Identify the chief complaint, initial physical exam, gather history, and safety assessment

In most clinics, the PCP will conduct the preliminary steps as part of routine care and then refer to the BHP for additional assessment. Some clinics may opt to routinely screen vulnerable patient populations for common mental health and substance use problems. Especially important will be to plan for consistent safety assessment by all clinic staff.

Working as a team

Patient: Describes symptoms, how symptoms impact daily life, desired treatment goals, and relevant history, such as prior treatments, to the PCP and BHP. Completes measurement tools as part of initial assessment. Shares symptoms of past and current suicidal ideation with the treatment team, informs the team if symptoms worsen. Shares psychosocial and risk factors with the treatment team.

PCP: Gathers health history, conducts physical exam, reviews results from diagnostic studies, and begins to formulate an assessment. Fosters a therapeutic alliance with the patient, introduces the team approach to behavioral health, and provides an introduction to the BHP. Assesses for safety, coordinates with BHP to monitor safety issues and implement treatment plan.

BHP: Completes detailed assessment of psychiatric, social, and substance use history; use of coping strategies; and readiness to engage in self-management. Prompts patient to complete measurement tools. Assesses safety issues and helps with safety planning. Tracks safety plan.

PC: Assists in identifying and evaluating psychiatric symptoms. May suggest additional assessment. Assists in safety planning as needed.

Typical Timeline, Week 1

BHP: Visit 1–2

PCP: Visit 1–2

Case example

31-year-old male, presents to his primary care doctor asking for “sleeping pills.” His PCP takes a history and finds out he has not been sleeping well for the last month, he has been struggling to get work and has missed a few days, he has difficulty concentrating, and his wife is frustrated because he has “just checked out.” His PCP suspects he may be experiencing depression. Mr. A’s PCP introduces him to Collaborative Care and the idea that a team of providers will care for him and treat depression in the primary care clinic. That first day he meets his BHP/care manager, who starts a mental health assessment, including a safety evaluation. Mr. A’s team makes sure he completes a depression measure (in this case, the PHQ-9) to measure his symptoms. Mr. A’s BHP/care manager enters him into the clinic patient registry. Mr. A is also scheduled for a close follow-up appointment to make sure he quickly is engaged in care.

Differential diagnosis and identifying a provisional diagnosis

Rule out common contributing medical problems and substance-related conditions

Some medical conditions can cause, contribute to, or mimic symptoms of mental illness.

- **Medical conditions:** Identify possible medical symptoms that present as psychological symptoms. In general, lab tests are indicated only if there is concern about a particular medical diagnosis.
- **Substance-related conditions:** Consider that substance abuse, withdrawal, or intoxication may present as psychological symptoms.

Develop and refine the differential diagnosis as a Collaborative Care team

A good differential diagnosis is needed to inform decisions regarding evidence-based treatment for behavioral health disorders. Chief complaint, associated somatic and psychological symptoms, and current level of functional impairment related to any symptoms must be assessed. This information helps teams develop an informed provisional diagnosis, which leads to an appropriate integrated-care treatment plan. However, developing a differential diagnosis as a team differs from developing one as an individual clinician. Each team member has an important role in developing differential and provisional/working diagnoses. Table 1.1 illustrates key questions and team goals helpful in generating differential diagnosis.

Table 1.1 Generating a differential diagnosis

Question	Key team goals	Further assessment
Are presenting symptoms caused by a medical problem?	PCP should consider medical causes for all presenting problems. Other team members may also identify medical problems for the PCP to consider.	Refer back to PCP for any medical concerns. Acute concerns are referred for urgent evaluation as appropriate.
Is this distress or a mental health disorder?	Functional assessment helps differentiate life distress from a mental health disorder. All mental health disorders cause significant functional impairment as criteria for diagnosis.	A patient with psychological distress but no formal mental disorder may only need brief supportive engagement and treatment instead of ongoing care management.
Is there a mood disorder?	Depressed mood is a common presentation. The team must work together to differentiate unipolar depression from bipolar disorder. Screening for mania or mixed bipolar disorder symptoms is an important part of assessment of every patient presenting with depression.	Depression alone → Major Depression chapter Depression + history concerning for bipolar disorder → Bipolar Disorder chapter
Is there an anxiety- or trauma-related disorder?	Anxiety symptoms, including somatic symptoms of anxiety restlessness or feeling of fast heart rate, are common presentations in primary care.	See Anxiety and Trauma Disorders chapter for additional assessment.
	<ul style="list-style-type: none"> • The PHQ-9 is widely used to screen for depression and to monitor treatment response. • The CIDI-3 brief structured interview for bipolar disorder can be used to assess for bipolar disorder in patients with depression. <ul style="list-style-type: none"> • Generalized anxiety disorder (GAD): Have you been worrying excessively for greater than six months? Are you a worrier? 	

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Table 1.1 (Continued)

Question	Key team goals	Further assessment
Is there a substance use disorder?	<ul style="list-style-type: none">• Panic disorder: Do you experience sudden attacks of anxiety or unexplained physical symptoms, such as rapid heartbeat, shortness of breath, or chest tightness?• Social anxiety disorder: Are you uncomfortable in or do you avoid social situations?• Post-traumatic stress disorder (PTSD): Do you have a history of trauma or abuse with nightmares and flashbacks?• Obsessive-compulsive disorder (OCD): Do you have any repetitive or intrusive thoughts or behaviors that bother you? <p>Asking about substance use and considering urine toxicology can be helpful to identify substance use disorders in primary care. Symptoms can be caused by intoxication or withdrawal from substances as well.</p>	See Substance Use chapter for additional assessment.
Is the patient experiencing psychotic symptoms?	<p>Patients may complain of depression or other negative schizophrenia symptoms such as loss of motivation or anhedonia. Active psychotic symptoms can range from patients reporting auditory hallucinations to subtle symptoms such as concrete or disorganized thinking.</p> <p>Delusional thoughts or ideas of reference (patients reading special meaning into common occurrences) or thought broadcasting</p>	See Psychosis chapter for additional assessment.

Table 1.1 (Continued)

Question	Key team goals	Further assessment
Is there an acute safety concern?	<p>(other people can hear the patient's thoughts) can occur and should be assessed for.</p> <ul style="list-style-type: none"> • Is the psychosis recent in onset or chronic? • Are the symptoms changing or are they fairly stable over time? <p>This is a crucial step because suicidal thoughts can lead to a suicide attempt. Safety concerns require development of a safety plan. Common safety concerns: danger to self (suicidal ideation, domestic violence situations), danger to others, grave disability (inability to take care of self due to a mental health condition putting the individual at risk of serious harm).</p>	<p>Every clinic should have a clear active suicide protocol developed as part of implementation. Clearly defining whose role it is to manage acute safety concerns should be part of team building. (See online materials for additional information.)</p>
Is there another mental health presentation?	<p>If the patient has screened negative for all the above disorders but still presents with significant functional distress, consider screening for other common presentations, such as chronic pain, attention-deficit hyperactivity disorder (ADHD), or dysfunctional coping style. Consult with PC or refer for additional treatment as appropriate.</p>	<p>Pain can cause functional impairment. See Chronic Pain chapter for additional assessment. Patient presenting with inability to concentrate and/or focus as an isolated symptom or after other mental health comorbidity is treated could have ADHD. See ADHD chapter for additional assessment.</p> <p>The team is struggling with difficult patient interactions; see Challenging Clinical Situations chapter for additional assessment.</p>

Table 1.2 Common conditions in primary care

Behavioral health care in primary care settings focuses on mental health problems commonly encountered in this setting. In each chapter common ICD10 codes will be listed here for easy reference.

Assessment of comorbid psychiatric disorders and psychological difficulties

Many mental health problems are comorbid with both medical and other mental health diagnoses. Common co-occurring illnesses for each disorder are discussed in individual chapters. These are often identified as part of the differential diagnosis process and treatment planning.

Identifying a provisional diagnosis

The differential diagnosis process results in a provisional/working diagnosis (See Table 1.2). Team members may also identify comorbid medical or psychiatric disorders. This provisional diagnosis will inform recommendations for evidence-based treatment. All team members should understand the provisional diagnosis. Team members will learn additional clinical information about the patient, including observations of the patient, over time. Additional observations and information may lead to changes in diagnosis. Tracking a patient over time and adjusting diagnosis and treatment as needed is one of the strengths of Collaborative Care.

Team goal: Generate differential diagnosis and establish provisional diagnosis

Team members share significant information to ensure treatment planning is patient-centered, appropriate, safe, and effective. Discover the mental health comorbidities that should be addressed as part of a comprehensive and effective treatment plan.

Working as a team

Patient: Describes health and mental health history. Works with PCP and BHP and follows through on recommended diagnostic testing; reports patterns of medication use and potential side effects; tracks and reports physical and social activities as recommended by the BHP.

PCP: Evaluates possible medical problems using diagnostic testing and medical consultation as appropriate. Considers common diagnoses and refers to

BHP for additional assessment as needed. Continues to provide general medical care and prescribes medications for common mental health disorders as clinically indicated.

BHP: Conducts a thorough psychosocial assessment. Works with the PCP and PC to work through differential diagnoses to refine mental health treatment targets and plan.

PC: Expands medical and psychiatric differential diagnosis and recommends additional assessment as needed. Assists BHP in differential diagnosis.

Typical Timeline Week 1

BHP: Visit 1–2

PCP: Visit 1–2

Case example

Mr. A's team works together to develop a differential for his presenting symptoms of insomnia. The PCP generates an initial diagnosis of depression after excluding obvious medical comorbidity, such as sleep apnea. This diagnosis is further assessed by the BHP/care manager, who assesses for bipolar disorder, anxiety disorders, and substance use disorders, none of which are found. The BHP/care manager focuses on understanding current functional impairments and Mr. A's goals for treatment.

Collaborative Care treatment

Treatment in Collaborative Care can be broken down into three key phases: (a) initiation of treatment, (b) follow-up and treatment to target, and (c) completion of treatment and relapse prevention. Effective treatment strategies for the Collaborative Care team are reviewed in two chapters: Chapter 10, “Evidence-Based Psychopharmacology for the Collaborative Care Team,” and Chapter 11, “Evidence-Based Behavioral Interventions for the Collaborative Care Team.”

Initiate treatment plan

General approaches

Common treatment approaches are shared by the whole team. These strategies are often important in engaging the patient in treatment.

Patient education

All team members are comfortable in providing basic patient education. Teams can provide this information verbally or by using patient handouts.

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High-quality Web resources may also help. Having common resources that team members utilize can lead to providing consistent information for patients.

Examples of patient education include:

- Information about the diagnosis and typical illness course
- Treatment options available to patient, including pros and cons of options
- Self-management strategies
- How the team will work together to provide treatment
- Roles of different team members
- Expectations for participation in treatment

Setting treatment goals

A core feature of Collaborative Care is setting clearly understandable patient-centered goals supported by the whole team. These goals should be clearly noted in the patient's chart. Goals should have observable, measurable outcomes (i.e., behaviors).

Common strategies for setting Collaborative Care treatment goals:

- Functional improvement: Which current symptoms interfere the most in the patient's life? What would the patient be doing if not experiencing symptoms? How will the patient and the team know if the treatment is effective?
- Behaviorally defined and measurable: Goals should be concrete and specific. Goals must be informed by the patient's perspective. Make sure goals reflect what is of high priority for the patient. Be aware of setting goals the patient does not value or feels are impossible to reach.
- Patients must participate in treatment goal development, and should "own" or at least "co-own" the treatment plan. The BHP makes sure the treatment team is patient-centered and advocates for crafting goals in ways that will be most engaging to the patient. If initial plans do not succeed, the BHP can help explore alternatives that are more likely to help the patient achieve his/her goals.
- Consider using a standard measure to track progress: Tracking symptoms using standardized measures, such as the PHQ-9 for depression, can help the team measure both individual patient as well as aggregate population outcomes.

Using evidence-based treatment

Team members delivering Collaborative Care work together to provide high-quality evidence-based treatments. Because team members have different skills, patients can benefit from choosing from a range of

evidence-based medication and behavioral interventions. Each chapter will highlight current evidence-based strategies for common mental health disorders.

In general, the PCP will initiate medication treatments if indicated and the BHP will focus on delivering behavioral or psychotherapeutic interventions. The psychiatric consultant should help guide the effective application of these interventions. Although each treatment section is divided up by these roles, *all* team members should be familiar with *all* treatments to reinforce treatment participation to the patient. For example, although medications will be prescribed by the PCP, the BHP will support medication adherence and may be the first person to hear about side effects. Conversely, although the BHP will set behavioral goals with the patient, a PCP checking in with the patient about these goals can reemphasize the importance of this part of the treatment plan.

Medications: Each chapter will review current medication options for the specific disorder. Chapter 11 will review general approaches to medication management in primary care and more detailed prescribing protocols for commonly used medications

Brief behavioral interventions: Each chapter will review current behavioral interventions and, as available, adaptations for use in primary care settings. Chapter 10 will give a general overview of delivery of brief behavioral interventions in primary care settings and overviews of key evidence-based psychotherapies.

Safety Planning

Safety planning is a team responsibility. Each team member will have a specific role in assessment, triage, and developing a safety plan defined by their organization. Team members should consider safety planning part of the patient-centered care delivered in a Collaborative Care model. Being supported in providing distressed patients with a safety plan is one benefit of working as part of a Collaborative Care team. Each Collaborative Care team will need to develop a protocol to manage safety concerns that is appropriate for the clinic setting and takes into account state laws and available resources. A sample protocol and safety plan is included in the online materials.

Team goal: Initial treatment planning

Create an initial treatment plan aligned with the patient's treatment goals and appropriate to the biopsychosocial assessment of the patient's unique presentation. The patient should have an initial understanding of the role of each clinician in the plan, a sense that all clinicians are working together and

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with him/her to help achieve the patient's goals, and a clear sense of how the plan addresses his/her concerns and goals.

Working as a team

Patient: Actively participates in exploring treatment options and formulating an initial treatment plan. Voices concerns about the treatment plan. Follows through on initial treatment recommendations, speaks up about issues and concerns as treatment progresses.

PCP: Establishes and maintains therapeutic alliance; educates the patient about components of the treatment plan, in particular the use of medications and other medical treatments; emphasizes the importance of addressing psychosocial contributors to depression and other problems, such as chronic pain and working closely with the BHP; sets and reviews medical treatment goals and monitors progress; prescribes and monitors medications; and makes medical referrals as needed.

BHP: Establishes and maintains therapeutic alliance; addresses crisis management and safety planning strategies; reviews the full treatment plan with the patient and addresses questions and concerns; provides brief behavioral interventions addressing comorbid mental health issues and promoting chronic pain self-management; facilitates communication between team members; and makes and supports referrals (e.g., disability, vocational rehab, social services, chemical dependency, additional psychotherapy).

PC: Resource for diagnosing and treating psychiatric comorbidities; informs treatment planning; supports safety planning; and medication and behavioral management recommendations.

Typical Timeline Week 1

BHP: Visit 1–2

PCP: Visit 1–2

PC: Available for initial case review.

Case example

Mr. A's main focus is on sleeping and he is interested in taking medications. Both the PCP and BHP/care manager feel that input from the psychiatric consultant would be helpful to find a good medication treatment. Mr. A's BHP/care manager discusses his case with the psychiatric consultant by presenting his case over the telephone and after obtaining a basic history,

the psychiatric consultant recommends mirtazapine, an antidepressant that is mildly sedating. The PCP prescribes this medication and the BHP/care manager provides psychoeducation about this choice with a special emphasis on why this is a good choice for the patient goal of improving sleep and how depression treatment will also support this goal. The BHP/care manager again schedules close follow-up by telephone (to assess tolerability of the medication in a week) and a future visit in person in three weeks.

Follow-up and treatment adjustment to achieve treatment to target

Measurement-based practice

Principles of Collaborative Care include regular assessment of symptoms and progress toward clinical goals, as well as adjusting treatment to achieve treatment targets. Collaborative Care teams will schedule regular follow-up to track patient progress toward goals. This proactive approach to patient care often involves outreach to patients who do not attend scheduled follow-up visits. At each follow-up visit, patient response to treatment is assessed by both interview and standardized measures. This approach helps team members quickly identify patients needing treatment adjustments, so patients do not stay on ineffective treatments for too long.

PCP approaches: Focus on common follow-up questions, important monitoring for common medications, common next steps.

BHP approaches: Focus on common challenges encountered in brief behavioral interventions and how to address them. Also, patient engagement strategies discussed.

PC approach: Will evaluate entire active caseload and work with BHP to provide case reviews for patients not improving as expected.

Stepped-care approach

A key principle of Collaborative Care treatment is that care is intensified or changed if patients are not responding to initial treatments. If patients are not achieving treatment goals, the treatment plan should be adjusted. This process is repeated until a patient demonstrates clinical improvement, or until resources in the clinic have been exhausted and a referral to more intensive treatment is needed. Sometimes this involves the psychiatric consultant providing additional case review, via in-person or televideo consultation, to help the team consider other evidence-based approaches.

Referring for additional services: Some patients will need more intensive services than can be offered in primary care. Each chapter will review commonly used criteria for each disorder for when to increase level of care. These will be listed for the typical primary care situations, although availability of resources will vary depending on your practice setting.

Team goal: Be prepared to adjust the treatment plan until treatment targets are achieved

Adjust medications and behavioral treatments as appropriate to step up care. As patients become more engaged in treatment and move toward treatment goals, self-management strategies can begin, and comorbid psychiatric disorders can continue to be treated.

Working as a team

Patient: Participates as a partner in trying treatment strategies and communicates concerns with treatment.

PCP: Addresses therapeutic alliance concerns as needed; consults with the BHP as needed; follows through on medical treatment goals and outcomes of medical referrals as needed; continues to monitor progress; and adjusts prescriptions as needed.

BHP: Continues to address engagement, crisis management, and safety planning as needed. Steps up brief behavioral interventions as needed to address comorbid mental health issues or persistent mental health symptoms.

PC: Informs treatment planning; supports safety planning; advocates for stepping up care and altering medication recommendations as needed; and supports and suggests behavioral management recommendations.

Typical Timeline ~6–12 months

BHP: Every two weeks until completion of treatment.

PCP: Every four to six weeks while adjusting medications, then less often.

PC: Case review at least every eight weeks until improvement and more frequently if needed.

Case example

Mr. A reports having tolerated mirtazapine when contacted by phone a week after his initial appointment. He reports improved sleep but no change in depressed mood. The BHP/care manager provides reassuring psychoeducation that it was a good sign that he was tolerating the medication and experienced improved sleep. The BHP/care manager also explains that typical response for

antidepressant treatment occurs at six to eight weeks. The BHP/care manager introduces the idea of patient activation and helps Mr. A set a goal to call one friend a week to reduce social isolation. Mr. A is reminded to attend his follow-up appointment. At his follow-up appointment, Mr. A reports a little less depression when his PHQ-9 behavioral rating scale is administered. His PCP decides to increase his dose to the middle of the dosing range as previously suggested by the psychiatric consultant note. The BHP/care manager continues to set goals for patient activation. This proactive treatment approach continues for eight weeks until patient has experienced a significant reduction in depression symptoms.

Completing treatment and relapse prevention

Caseload management

Typically, an active caseload in Collaborative Care will only include symptomatic patients. Managing the size of the active caseload will be important as BHPs have to meet with patients regularly and can only manage a specific size caseload at any one time. The decision to graduate a patient should be made as a team. Often the psychiatric consultant and the BHP will discuss patient progress as part of psychiatric consultation.

Completion of treatment

The concept of a defined treatment episode may be new to a treatment team, but it is an important concept for caseload management in Collaborative Care. Ideally, each patient completes treatment by accomplishing improvement in clinical symptoms and daily functioning. Sometimes patients may complete treatment by referral to outside resources.

Relapse prevention

As an episode of treatment ends, relapse prevention planning should be started. Relapse prevention is important for long-term sustainability of a patient's clinical improvement. The patient and the team should work together to identify the treatments and interventions that have supported improvement and the ways in which they can maintain these gains. Ideally this should involve the completion of a written relapse prevention plan (a sample is included in the online materials).

All team members should contribute to this plan:

PCP: Will outline for the patient a medication plan and clear instructions to request reevaluation; frequency of follow-up for regular visits.

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BHP: Is primarily responsible for working with patient to complete relapse prevention plan. Will document this plan in medical record, and will identify warning signs and behavioral approaches to address these with the patient.

PC: Will provide the patient with monitoring, guidance about medications, and clear instructions regarding when to request reevaluation.

Self-help books and Web resources: Each chapter has a section with books and websites to be used for further information and to share with patients as part of the psychoeducation delivered by the Collaborative Care team.

References: Each chapter lists a short bibliography of key papers and resources used to develop the content for the chapter. These may be interesting for members of the team who desire deeper knowledge about a key clinical area.

Team Goal: Relapse prevention

The relapse prevention plan should capture the key treatment strategies that the patient used to improve. This should include both medical and psychotherapeutic approaches that were helpful. The relapse prevention plan should also include recommendations for duration of medications treatment and symptoms to monitor, including when to represent to clinic if symptoms reappear.

Working as a team

Patient: Participates in establishing a relapse prevention plan with the BHP and the PCP; tracks the ongoing plan and reengages in additional care if symptoms or functional impairment significantly worsen.

PCP: Provides plan for ongoing medication management and clear instructions to the patient to request reevaluation if symptoms recur.

BHP: Reviews successes and gains in treatment, as well as the ongoing behavioral changes and treatment plan; clarifies team roles, including with whom the patient should reengage if function declines or symptoms worsen.

PC: Clarifies to the team recommendations for long-term use of medications and supports the BHP in creating a treatment summary and relapse prevention plan as needed.

Typical Timeline After 6–12 months

BHP: Start preparing six to eight weeks before last visit.

PCP: Will convert to care as usual by PCP.

PC: Case review with final recommendations for PCP.

Case example

Mr. A achieves remission of his depression in 10 weeks. At that time the BHP/care manager works with Mr. A to develop a relapse prevention plan. This plan includes early warning signs, effective treatments, and clear instructions for follow-up. The psychiatric consultant includes final medication recommendations. The BHP/care manager continues to meet with Mr. A monthly for three months. As Mr. A continues to experience minimal depression symptoms, he returns to care as part of his PCP's general patient panel, allowing for new patients to be seen by the BHP and receive Collaborative Care treatment.