Toolkit for Creating Collaborative Care Workflows

Introduction

Creating workflows is an essential step to prepare for launching your Collaborative Care (CoCM) program. This toolkit was designed for Clinic Implementation Teams (CITs) to create, implement, and test CoCM workflows in new or existing Collaborative Care programs.

Prior to launching your program, your team will need to think through how the patient will receive care and what team communication/coordination should occur to make this happen. Your team needs to be talking about these processes in detail before the program launches so that you all know what needs to happen, when, and who is responsible for all the steps that need to take place around patient care and team communication.

After launching your program, you will need to continuously refine your workflows to address new implementation challenges, improve patient care, and maintain fidelity to Collaborative Care. This is an expected part of sustaining your program.

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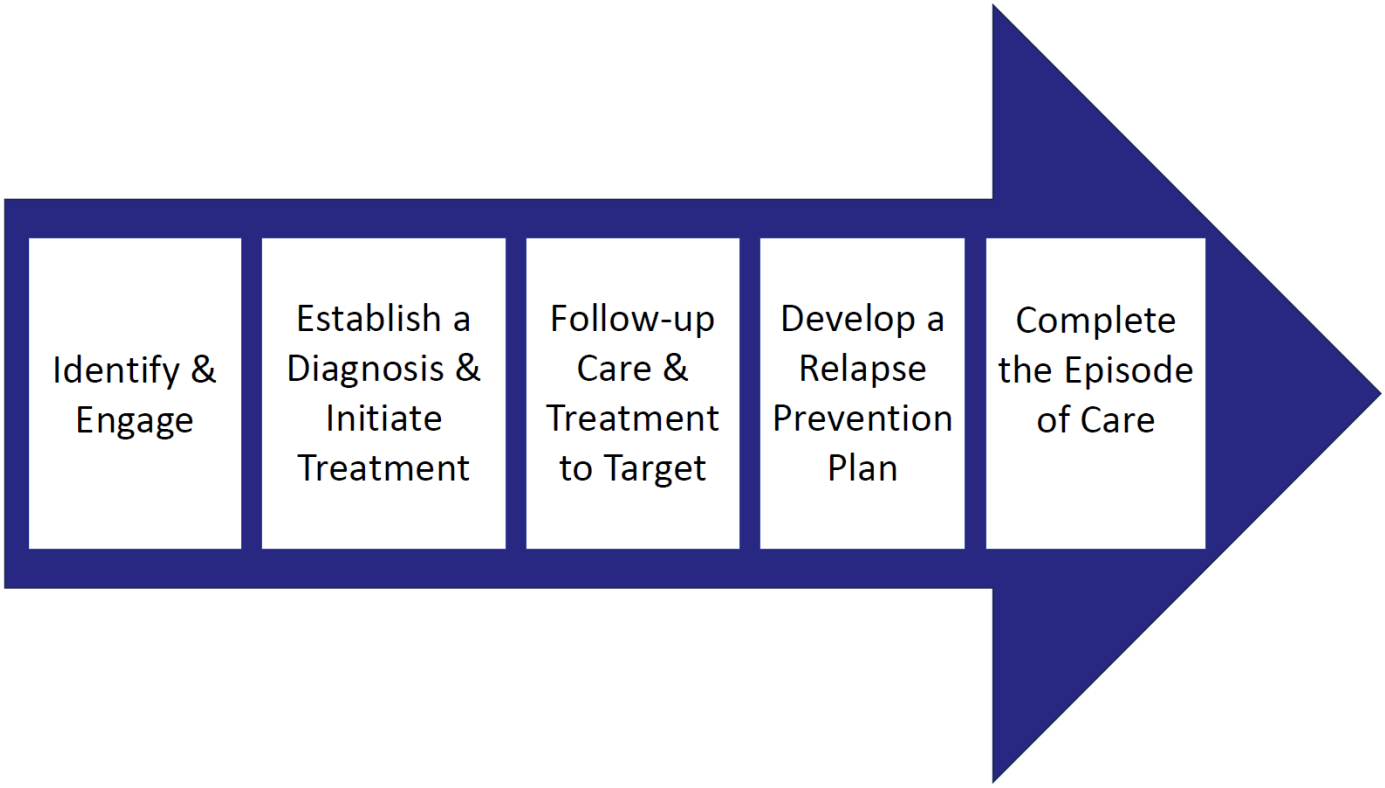
Overview of Workflow Development

Creating workflows is an iterative, team process. This process, much like creating a shared vision, includes a series of team discussions facilitated by the CIT Lead. A good workflow will incorporate your program vision as well as the unique resources and staffing available in your clinic.

1. **Phases of Collaborative Care**

Your workflows will be a detailed version of the phases of CoCM. Each phase will have a unique set of tasks, tailored to the resources available at your site. Though this arrow implies that all tasks occur sequentially, this may not always be the case. Not every patient will experience Collaborative Care in this exact same way.



2. **Visual Workflows or Process Maps**

Workflows can be diagrammed to help visualize a process. We recommend that your team creates a process map or visual workflow for each of the five phases of Collaborative Care. These are useful for ongoing care delivery, continuous quality improvement efforts, and quickly onboarding new program providers. A visual map enhances continuous quality improvements efforts as it allows your team to see where there may be gaps or areas for improvement and creates a reference that's accessible to all when staff or leadership changes. If you have the resources, you may want to create both a workflow graphic for general use and a more detailed narrative protocol specifically for the CoCM team. Whatever your documentation is, make sure it is accessible to those who need it, and describes what you are doing in sufficient detail to fulfill the functions we've described above.

Development Process

1. **Prepare**

Before diving into the mapping process, a CIT will ensure that the following are in place:

- ☐ An operationalized Shared Vision for CoCM that identifies program population of focus.
- ☐ A determination of which evidence-based tools will be used for screening and monitoring of behavioral health symptoms (PHQ-2, PHQ-9, GAD-7, CDI, PC-PTSD-5/PCL-5, AUDIT, PSC-17, Vanderbilt, etc.).
- ☐ Involvement of the CoCM CIT team in the workflow development process.
- ☐ An understanding by all CIT members of the core principles of CoCM, their roles, and the roles of the other care team members.
- ☐ Knowledge of current behavioral health screening, treatment, and referral processes (if applicable).

2. **Convene**

CIT Leads will convene members of the CoCM team to talk through the steps and consider the questions we've posed for each of the phases. Define your team broadly to include all clinical staff who are involved at any point in the patient's care, including primary care providers and administrative staff (e.g., clinic manager, front desk staff). You may not all need to meet every time, but input from anyone whose tasks will be included in the workflow is strongly recommended. In addition, we recommend you also involve a patient and/or family representative in your workflow development process. They can provide valuable insight into steps of the workflow from the patient and family perspective.

3. **Brainstorm and Create a Draft Visual Workflow or Process Map**

Using the prompts in this guide, create a clinical flow showing what happens in your CoCM workflow. We have included in Appendix 1 a Workflow Worksheet to capture your team's process, questions, and next steps. It can also be helpful to start this process with sticky notes and a large table or whiteboard surface on which to arrange them, so that you can work together to visualize how the steps fit together and the order in which they come. Sticky notes can be easily moved around and quickly rewritten as the conversation evolves. This is complex work, and as we've mentioned it is not always linear, so give yourself time and space to experiment.

For each of the five phases, you should be able to:

- Describe the actions required.
- Describe who is responsible for which actions. Note: this may be more than one person.
- Identify where the action will be completed (e.g., in clinic, telehealth, partner organization, referral).
- Identify where decision points are, and which actions follow from each choice.
- Identify the tools needed to complete each task.

4. **Finalize and Disseminate**

Once you have a workflow that looks right, you'll want to document it and disseminate it to providers and staff.

Phase 1: Identify & Engage

In phase one of the CoCM workflow, patients in need of treatment are identified and engaged in care. This phase involves behavioral health screening, introducing CoCM, consenting patients to participate in CoCM and connecting patients to the Behavioral Health Care Manager (BHCM).

1. **Behavioral Health Screening to Identify Patients During a PCP Visit**

   The PHQ-9, GAD-7, and many other screening tools can often follow the same workflow. Determine if this is the case for the tools you are using. Discuss the process for including patients with behavioral health symptoms that are identified by other clinic staff or from a report or population health tool outside of a primary care screening workflow (see #2).

   Consider the following prompts:

   - At which medical visit type is the patient given the validated screening tool(s)?
   - How often?
   - How will you address patient health literacy and/or language needs?
   - Who will assist with completion of screening tool if assistance is required?
   - In what format will screening be completed (paper, on tablet, portal, etc.)?
   - How/who/where will scores be recorded in the EHR?
   - How will the patient be informed of the screening score?
   - How is the PCP informed of the screening score?
   - What happens if PHQ-9 Question 9 is positive?
   - What is your protocol to manage suicidality and crisis?
   - What are your clinical criteria (e.g. clinical observation, symptom screening scores, diagnosis) for referral to CoCM and other BH services?
   - Who uses the criteria to identify patients for CoCM?

Supporting Resources

- Guide: Developing Protocols for Suicide Prevention in Primary Care
- Appendix 2: Evidence-Based Screening Tools & Symptom Monitoring Tools
- Appendix 3: Behavioral Health Screening Workflow Options

2. **Using Electronic Health Record (EHR) Reports to Identify CoCM Patients**

   Many health systems use their EHR data to find patients with a current behavioral health diagnosis that could be offered CoCM. This is especially useful in a new program that has just started providing CoCM, where too few patients are being identified through standard screening protocols. Sometimes virtual CoCM programs also first utilize a patient list to identify patients. It is important that the PCP still then be involved in consenting the patient to care and agreeing that the patient be part of the program. Programs will also need to consider that when there is not an initial PCP connection, patient engagement is often lower.

A report developed for this purpose might include the following data parameters:

- Patients prescribed medication for their behavioral health diagnosis during the past 2-6 months
- Patients diagnosed with a behavioral health condition in the last 2-6 months (include all the possible ICD-10 codes that might be applied)
- Patients scoring 10 or higher (i.e. PHQ or GAD) in the last 2-6 months with no evidence of follow-up in the EHR
- Weighting or risk stratifying a population, considering age, co-morbidities, racial and ethnic background, and social drivers of health

This method requires having staff who can reach out to patients identified in the report to assess their current symptoms, the current services they are receiving, if any, and their interest in participating in the Collaborative Care Program.

3. **Engaging Patients**

   It is critical that the members of the team who are most likely to engage patients in care feel confident in describing Collaborative Care.

   Consider the following prompts:

   - Who introduces the CoCM program to patients?
   - How will different members of the team introduce CoCM to patients? What are your key messages, including offering patient-centered treatment options and introducing the Collaborative Care team?
   - Who documents informed consent or declination of services? Where is this documented? How does the patient get connected to the BHCM?
   - How are patients connected to the program? (e.g. warm connection, EHR referral, phone call, patient portal message)
   - How does the patient schedule their initial BHCM appointment?
   - Who reaches out proactively to patients not engaging in their first BHCM appointment? Where is this documented?

Phase 2: Establish a Diagnosis & Initiate Treatment

In CoCM, you will develop a provisional diagnosis as a team. This is often done very differently from traditional ways of assessing patients. A patient's provisional diagnosis will be generated by a combination of the behavioral health measures filled out by the patient (such as the PHQ-9), as well as the assessment by the PCP, BHCM, and the contributions of the Psychiatric Consultant during systematic caseload review. After a diagnosis is established, the team can provide information to the patient about that diagnosis. This provisional diagnosis will inform the initial treatment plan.

When developing the initial treatment plan, the CoCM team, most often the BHCM, will introduce a range of evidence-based treatment options to the patient. Treatment options may include evidence-based medications or evidence-based brief behavioral interventions, or a combination of both. It is important to educate the patient about recommended treatments and work with them to develop a care plan the aligns with their goals and preferences. When indicated, the team may also need to facilitate referrals to specialty care or social services. A key factor in the success of the initiation of treatment is communication across the team.

Consider the following tasks and questions in your workflow:

1. **Establish a Diagnosis**
   - Who is establishing a diagnosis in your CoCM program?
   - How will the diagnosis be recorded in the EHR, updated, and communicated within the team?
   - Who on the team records the diagnosis?
   - How will the diagnosis be communicated back to the patient?

2. **Initiate Treatment**
   - What is the goal for length of time between referral and initial assessment?
   - Who will review treatment options with the patient?
   - What would a BHCM schedule template and/or caseload size look like to accommodate twice monthly appointments?
   - Who will add the patient promptly to the registry once they are enrolled?
   - What triggers systematic caseload review during the initial treatment phase?
   - How will treatment changes be documented and communicated? By whom and where? (i.e. Morning huddle? In-person? Through electronic messaging system?)
   - How will the BHCM track the patient's progress toward getting medication prescribed?
   - How are follow-up visits scheduled and by whom?

Phase 3: Follow-up Care & Treatment to Target

This phase of the CoCM workflow involves the BHCM making proactive continuous outreach attempts to the patient and tracking patient progress in a registry. This is also the stage where the BHCM and Psychiatric Consultant would discuss the patient during the Systematic Caseload Review (SCR). Both the BHCM and the Psychiatric Consultant should come to the SCR prepared to focus on the patients that need consultation the most, typically patients that are not responding to treatment as reflected in scores on behavioral health outcome measures and the provider's clinical judgment. Any treatment change recommendations would need to be communicated back to the PCP for implementation with the patient, with support from the BHCM. Most teams also find options for the Psychiatric Consultant to communicate as needed with both primary care providers and BHCMs for urgent consultation.

Consider the following tasks and questions in your workflow:

1. **Tracking and Outreach (BHCM)**
   - How will the BHCM track treatment engagement & follow-through?
   - How often will the BHCM reach out to patients who are not engaged in care?
   - What frequency is expected for administering symptom monitoring tools?
   - How will the BHCM monitor and communicate patient medication side effects and concerns?
   - How will the BHCM track outcomes of referrals for other services?

2. **Systematic Caseload Review (BHCM & Psychiatric Consultant)**
   - How will existing patients not responding to treatment be prioritized for psychiatric consultation?
   - How will medication recommendations be relayed to the PCP in a timely manner? When will a medication change require a PCP visit?
   - What is the expected timeline for the PCP to review & respond to the medication recommendations?
   - Will there be an option to utilize in-person or telehealth psychiatric assessment as needed? What will be the criteria for utilizing this resource?

Phase 4: Develop a Relapse Prevention Plan

As patients show improvement with active treatment, they will reach a point where they no longer need the same level of care they did early on. For patients whose symptoms are improving, it is important to develop a Relapse Prevention Plan (RPP) before completing the episode of care. The RPP will list the things that have been most helpful for the patient in reducing behavioral health symptoms and strategies for sustaining improvement. The plan will also contain a list of early warning signs of relapse that are specific to the patient, along with a plan of action.

Consider the following tasks and questions in your workflow:

Develop a Relapse Prevention Plan

- What improvement criteria will the team use to determine that the patient is ready to start to Develop a Relapse Prevention Plan?
  AIMS Center Suggestions:
  - Decrease in PHQ-9 and/or GAD-7 scores by ≥ 5 points from baseline
  - Decrease in the first 2 symptoms on the PHQ-9 (no longer scoring a 2 or 3 on the first two questions)
  - Observed clinical improvement (improved presentation, engagement, self-management of symptoms, etc.) and/or Psychiatric Consultant agrees with timing/plan to initiate Relapse Prevention Plan

- During the Relapse Prevention Plan monitoring phase, how often will the BHCM connect with the patient?
- How will the RPP be communicated to the PCP and Psychiatric Consultant?
- Where in the EHR will the Relapse Prevention Plan be stored? a. Within a progress note? b. Scanned into the chart? c. Problem-based charting (stored under a diagnosis on the patient's problem list) d. Other?
- How will the Relapse Prevention Plan be shared with the patient (a variety of options for the patient to choose is best)? a. Patient portal b. Paper (printed copy or original written Relapse Prevention Plan) c. Patient takes a photo with their phone d. Other?

Phase 5: Complete the Episode of Care

As improved patients complete their episode of care, they can be transitioned back to seeing their primary care provider only for follow-up care, always with the option to return to Collaborative Care should their symptoms worsen in the future. For some patients, however, the episode of care may end abruptly because the patient decides to end treatment due to symptom improvement or intervening life circumstances and becomes "lost to follow-up". For this reason, BHCMs should start developing a relapse prevention plan with the patient early on in treatment. Patients needing support beyond that which can be provided in a primary care setting are typically referred to a higher level of care, with a bridging plan to support the transition to the new service.

Consider the following tasks and questions in your workflow:

1. **Patient improvement**
   - Follow workflow to Develop a Relapse Prevention Plan (see Phase 4)
   - How will the PCP be notified that the patient is returning to their care and will no longer be followed by the CoCM team?
   - How will the PCP know that a Relapse Prevention Plan has been developed, where to find it, and the expectation that they check in with the patient about the plan at PCP visits?

2. **Lack of follow-up**
   - What is your process to follow-up with patients who miss appointments and can't be outreached? How do you reach out to patients and what is your standard number of outreach attempts?
   - How do you notify the patient that they are no longer part of the Collaborative Care program and steps to return to care?
   - How is this communicated to the PCP and Psychiatric Consultant?

3. **Referral to specialty care**
   - Who will facilitate the referral to specialty behavioral health services?
   - Will the patient stay on the Collaborative Care caseload/registry during the bridging to specialty care? How will this be tracked?
   - How and who will monitor the status of the referral until the patient is connected to services?
   - How will the patient transition to specialty care be communicated to the PCP and Psychiatric Consultant?

Testing Workflows & Continuous Quality Improvement

We strongly recommend that you engage your Quality Improvement staff to help with Plan-Do-Study-Act cycles to continuously test your workflow over time.

- Meet with the key participants in the workflow periodically to see where they identify problems in the workflow. This may include reception staff, MAs, RNs, PCPs, and any other staff that are involved in some aspect of Collaborative Care. Include a patient/family representative, when possible, for their feedback on your workflow.

- Send a "fake patient" through the process and debrief the patient's experience with the team. Choose a staff volunteer to simulate a patient visit and go through your current process. Coach your volunteer to have a high screening score. Debrief what went right and what went wrong, and what made people feel uncomfortable. Consider doing this for patients from diverse backgrounds that represent your patient population including different ages, literacy, cultural, and accessibility needs.

Staff Training

Workflows will include clinical staff and other care team members who might not be familiar with talking to patients about mental health concerns. Use materials from this toolkit as well as your own resources to create a custom guide for training staff. Use your custom guide as part of new staff onboarding.

1. Provide a copy of the workflow graphic to all staff and ensure they understand it. Review for knowledge and concerns.

2. If clinical staff are administering behavioral health screening tools, create opportunities for periodic training that includes role play and practice. Make it fun! Ask other staff to be practice patients, responding in role play with various levels of mental health symptoms.

Appendix 1: Workflow Worksheet

Notes
Our Process
Remaining Questions
Next Steps

Appendix 2: Evidence-Based Screening and Symptom Monitoring Tools

Identifying Behavioral Health Screening Tools

There are a variety of tools that can be used for behavioral health screening. Those offered below are designed for primary care and are likely to be found in most Electronic Health Records (EHRs). Note that some screening tools are validated for identification purposes only, while others are also validated to measure symptoms and progress over time. See our Pediatric Collaborative Care Implementation Guide for more information on screening tools for the pediatric population.

Depression and anxiety are the most common behavioral health conditions for patients in primary care settings. Any patient presenting with mental health or substance use concerns should also be screened for suicide risk with a validated screening tool.

<table>
<tr>
<td rowspan="2">PHQ-2: Preliminary depression screening
If either question is positive, then administer the remaining PHQ-9 questions
PHQ-9: Depression screening & symptom monitoring
Validated for ages 12 and up
Administered by clinicians, trained staff, or self-administered by patient
If question # 9 is positive, then conduct additional suicide risk assessment</td>
<td>GAD-7: Anxiety screening and symptom monitoring
Generalized Anxiety Disorder (GAD) 7-item
Validated for ages 12 and up
Administered by clinicians, trained staff, or self-administered by patient</td>
</tr>
<tr>
<td>C-SSRS: Assessing suicide risk
Columbia-Suicide Severity Rating Scale
For assessing suicide risk
Validated for ages 5 and up
Administered by clinicians or trained staff</td>
</tr>
<tr>
<td>MDQ or CIDI: Bipolar screening
MDQ: Mood Disorder Questionnaire
CIDI: Composite International Diagnostic Interview
Consider screening for bipolar at the start of depression treatment</td>
<td>PC-PTSD-5: Preliminary PTSD screening

PCL-5: Screening for PTSD & symptom monitoring
Posttraumatic Stress Disorder Checklist (PCL) 20-item
Use with ages 18+
Administered by clinicians or self-administered by patient</td>
</tr>
<tr>
<td>Preliminary Screening for Substance Use
AUDIT-C: Alcohol Use Disorders Identification Test – Consumption 3 item
SASQ: Single Alcohol Screening Question 1 item
Use with ages 18 and up
Administered by clinicians or self-administered by patient
If positive, conduct additional screening</td>
<td>AUDIT/DAST: Substance Use Screening Tools
AUDIT: Alcohol Use Disorders Identification Test 10-item
DAST: Drug Screening Questionnaire 10 item (question # 1 can be used for preliminary screening)
Use with ages 18 and up
Administered by clinicians or self-administered by patient</td>
</tr>
</table>

Additional Screening Resources

- **PHQ-9 Depression Scale:** https://aims.uw.edu/resource-library/phq-9-depression-scale
- **The Columbia Protocol (C-SSRS):** https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/healthcare/
- **GAD-7 Info. Sheet:** https://www.mirecc.va.gov/cih-visn2/Documents/Clinical/GAD_with_Info_Sheet.pdf
- **Administering the PHQ 2 and 9 in Integrated Care Settings:** https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/2016-07-01_phq_2_and_9_clean.pdf
- **Developing Protocols for Suicide Prevention in Primary Care:** https://aims.uw.edu/resource/developing-protocols-for-suicide-prevention-in-primary-care/
- **SBIRT Screening Forms:** http://www.sbirtoregon.org/screening-forms/
- **NIH Core Resource for Alcohol:** https://www.niaaa.nih.gov/health-professionals-communities/core-resource-on-alcohol/screen-and-assess-use-quick-effective-methods
- **AAFP Screening Adult Patients for Depression:** American Academy of Family Physicians (AAFP) white paper on depression screening
- **HEDIS Depression Measures Specified for Electronic Clinical Data Systems:** https://www.ncqa.org/hedis/the-future-of-hedis/hedis-depression-measures-for-electronic-clinical-data/

United States Preventative Services Taskforce (USPTF) Guidance

- Depression: Recommendation: Screening for Depression and Suicide Risk in Adults | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)
- Anxiety: Draft Recommendation: Screening for Anxiety in Adults | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)

Training Resources

- **Help Clinic Staff Talk with Patients About the PHQ-9**
  This tool is designed to help clinic support staff with answers to frequent questions they may hear from patients about the PHQ-9.
  https://aims.uw.edu/resource/help-clinic-staff-talk-with-patients-about-the-phq-9/
- **Online CoCM Training for Behavioral Health Care Managers**
  The AIMS Center offers a comprehensive online training that will prepare clinicians for success in the Behavioral Health Care Manager (BHCM) role. As part of this training, clinicians learn about the use of behavioral health measures to identify patients and monitor symptoms over time.
  https://aims.uw.edu/behavioral-health-care-managers/
- **Columbia Lighthouse Project Columbia-Suicide Severity Rating Scale (C-SSRS) Training**
  The Columbia Lighthouse Project offers free training in more than 20 languages for using the C-SSRS. Training is not required, and you do not need any mental health experience to use the C-SSRS, however training can be helpful and supportive of staff who are uncomfortable or unfamiliar with it. https://cssrs.columbia.edu/training/training-options/

Appendix 3: Behavioral Health Screening Workflow Options

Initiating PHQ & GAD Administration

This table provides some options for your screening workflow with the PHQ and GAD, though there may be other options for completing these in your setting.

Method of Initiation	Administered By	Mode of Completing	How Recorded in EHR	If the PHQ-9 Question 9 is positive
Automatic by Patient Portal	*Patient Self-administers	Patient Portal Online (phone, web)	Automatic	EHR triggers msg to staff if Q9 is 1+. Trained Staff calls patient to discuss result, see clinic suicide prevention protocol.
During the Front Desk Check-in	*Patient Self-administers	Written on paper	Manually inputted by rooming staff	See clinic suicide prevention protocol.
		Clinic Tablet	Automatic	See clinic suicide prevention protocol
While rooming the patient	*Patient Self-administers	Clinic Tablet	Automatic	See clinic suicide prevention protocol.
		Written on paper	Manually inputted by rooming staff or PCP	See clinic suicide prevention protocol.
	Rooming Staff using EHR prompts	Orally/verbally	Manually inputted by rooming staff	See clinic suicide prevention protocol.
During visit patient reports depression SX or PCP observes	PCP using EHR prompts	Orally/verbally	Manually inputted by PCP	See clinic suicide prevention protocol.

*If the patient does not complete the screener themselves, it should be completed at rooming or during the visit.