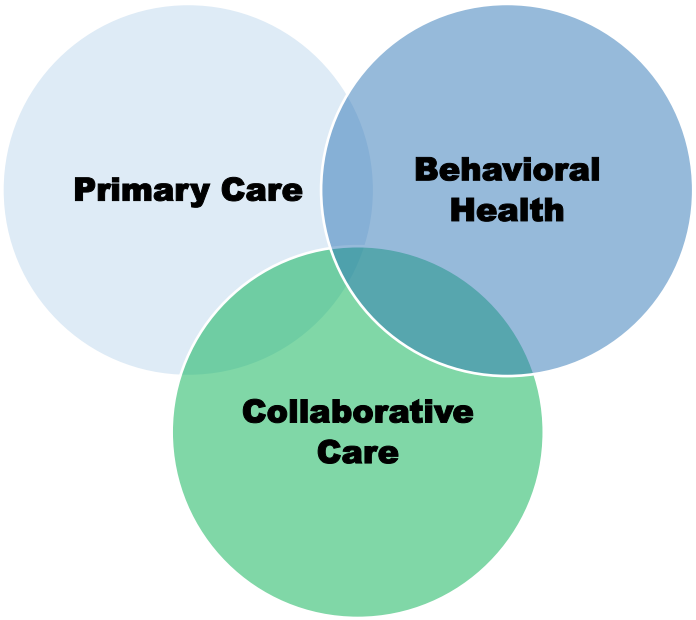
Collaborative Care Playbook

Last Updated: September 2023



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Population Health Care Model Programs Overview

What is a Population Health Care Model Program? Population Health Care Model Programs are programs in which UW Health is proactively partnering with specific populations of patients and their support systems to optimize their well-being and reduce unnecessary costs.

Care model programs and interventions are designed to support the whole health of patients, perform trauma-informed approaches, address the critical impact of social determinants on health outcomes, and engage patients in collaborative goal setting.

What are the Population Health Care Model Core Standards?

A set of values/standards that Care Model and Population Health programs have committed to implementing throughout their programming.

- Patient Identification
- Patient Enrollment
- Patient Engagement
- Staff Engagement
- Care Design
- Discharge/Graduation
- Performance Metrics

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Playbook Aim

WHAT IS THE COLLABORATIVE CARE PLAYBOOK?

This playbook will guide you through how Collaborative Care will work at your clinic. It will help answer questions you or staff might have regarding the implementation of Collaborative Care.

WHY IS THERE A COLLABORATIVE CARE PLAYBOOK?

Collaborative Care is a new model of care, integrating mental and physical health, therefore it requires a new type of inter-departmental collaboration between Psychiatry and Primary Care (Internal Medicine, Family Medicine and Pediatrics). The playbook will help you understand what needs to be done to make Collaborative Care successful.

HOW TO USE THE COLLABORATIVE CARE PLAYBOOK

The Collaborative Care playbook is designed as a reference manual for both providers and staff to reference UW-Health's best practices for implementing and sustaining the Collaborative Care model. Use the playbook to help answer questions you might have about Collaborative Care such as:

- Role differentiation
- Workflow questions
- Maintaining integrity and fidelity to core principals of the model

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Overview of Collaborative Care Program

Background:

Collaborative Care is the UW Health care model for providing improved access to team-based, integrated behavioral health care at UW Health Primary Care Clinics. Collaborative Care is a key strategy in UW Health's Population Health Care Model to address and improve behavioral health outcomes. Development of this program was started in 2017 and implementation began with adult primary care sites in 2018 followed by pediatric primary care sites in 2021. With support of the Senior Director of Behavioral Health, Dr. Shanda Wells is the Manager of Behavioral Health Primary Care for both adult and pediatric work streams.
Adult CC physician leads: Dr. Heather Huang (Department of Psychiatry) and Dr. Mark Micek (Department of Internal Medicine).
Pediatric CC physician leads: Dr. Marcia Slattery (Department of Psychiatry) and Dr. Meriel Rongstad (Department of Pediatrics).

The Human Side of Collaborative Care:

Changing how we provide care to patients is important, but it is easy to get frustrated with new workflows and new rules. At the center of all this work is the patient who has depression or anxiety. They may feel like their world is unsteady, like their sense of self-efficacy is unravelling. They may not even know there is a word for the restless, lonely feeling that they are trying to endure. Sometimes they feel hopeless--unable to imagine that anything will ever be better.

Anyone can open the door of hope for this patient. The receptionist can greet them warmly, remember their name. The MA can give them the screening tool and remind them that, like getting a blood pressure, this information helps guide treatment. The provider can listen to the patient's concerns, clarify a diagnosis and affirm that these symptoms can get a lot better. The Behavioral Health Clinician (BHC) can help the patient engage in a treatment plan, learn skills to get better and stay better whether they use behavioral changes, medication, or both.

The patient uses this new resilience in all their relationships, in their work, in their understanding of themselves. Over time, communities heal as people in those communities heal. Thank you for being willing to engage in this new way of treating patients with anxiety and depression. It means a lot to our patients.

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Overview of Collaborative Care Program

Services:

- Telephone, video, or medical office visits
- Comprehensive behavioral health assessment
- Engage and support the patient, their family, and caregivers
- Develop treatment plans to meet patient and family needs
- Coordination of care by the Collaborative Care team
- Brief evidence-informed behavioral interventions
- Collaborative goal setting
- Team Psychiatry consultation with Behavioral Health Clinician

Documentation:

- Care Team
- Episode of Care
- Primary Care Behavioral Health Collaborative Care Navigator
- Behavioral Health Collaborative Care Reporting Workbench

Elevator Speech: We have a way of treating mood and stress called "Collaborative Care." It uses a team approach, and you can be seen right at this clinic. It really works! People get better twice as fast.

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Collaborative Care Core Principles

The Collaborative Care (CC) model is an evidenced-based method of treating behavioral health conditions in the primary care setting. It has been shown to be effective in treating mild to moderate anxiety and depression. At UW, the Collaborative Care model leverages the established relationship with the primary care provider to better engage patients in treatment for depression and anxiety. The core principles of UW Health's CC program are:

- Evidence-based population management
- Timely communication
- Patient-centered care with patient centered decision making
- Honoring the culture of primary care
- Stepped care

The CC model expands the primary care team to include a care manger (or Behavioral Health Clinician) and a consulting psychiatrist (Team Psychiatrist). The Behavioral Health Clinician (BHC) works collaboratively with primary care providers and engages patients using evidenced-based strategies such as behavioral activation and brief psychotherapy. The BHC also facilitates medication management through consultation with a team psychiatrist. The BHC meets weekly with a team psychiatrist for consultation on new, challenging, and non-improving cases. Throughout this process the primary care physician/APP remains responsible and leads the patient's care.

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Evidence Based Population Management

Goals:

1. *To use a population health lens to help as many patients as possible: Screen patients for depression/anxiety and identify those who want treatment.*
    a. Train providers how to accurately and efficiently diagnose depression/anxiety.
    b. Use Reporting Workbench to: (1) keep track of which patients are improving, and (2) move patients through treatment process.
    c. Understand how many patients should be in a BHC panel and how this population cycles through care.
    d. Maintain the BHC daily schedule: Conduct in-person warm connections and brief 30-minute visits.
2. *To use short-term, evidence-based techniques to treat patients.*
    a. Be flexible within an evidence-based model of treatment.
    b. Use Reporting Workbench to track outcomes measures and to guide stepped-care.
    c. Use Reporting Workbench to guide data-driven care. Using empirically validated, age-appropriate screening tools, the reporting workbench is the cornerstone for data collection.
3. *To systematically address needs of patients who are not improving.*
    a. Use Reporting Workbench to prepare for Psychiatry consult.
    b. Use screening scores to identify patients who aren't improving.
    c. Use stepped-care (medications or brief behavioral interventions) to aggressively manage patient care.

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Timely Communication

Goals:

1. *To contact patients frequently by telephone and in person to maintain engagement.*
    a. BHC schedules intake within 1-2 weeks.
    b. Patient engagement is flexible. Treatment can be done over the phone, video, or in person.
    c. BHC identifies unengaged patients.
2. *To communicate efficiently and effectively within the treatment team.*
    a. BHC's use a crisp, concise presentation format when presenting patients for case review.
    b. Team Psychiatrist reviews intake and documents treatment plan in real-time using **.tpdoc** SmartPhrase.
3. *To communicate efficiently and effectively with primary care providers.*
    a. BHC's understand how to communicate within Health Link different kinds of information to providers—FYI, meds needed, changes.
    b. BHC's build trust with providers and actively foster working relationships.
    c. BHC's shadow providers during their orientation to understand the pace and content of primary care work.

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Patient-Centered Care

with Patient Centered Decision Making

Goals:

1. *To see patients in a familiar setting; i.e. PCP office.*
    a. Warm connection happens in person
    b. PSR and BHC know how to schedule patients for Collaborative Care
2. *To help patients set goals, learn therapeutic strategies and recognize improvement.*
3. *To engage patients in decision making:*
    a. Patient can choose whether they want medications, therapy or both
    b. Use Reporting Workbench to keep track of decisions
    c. Use a stepped care approach to aggressively address depression and/or anxiety symptoms

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Honor Primary Care Culture

Goals:

1. *To see patients in short therapy visits.*
    a. This is not "therapy as usual"— it requires a fundamental shift in perspective.
    b. Behavioral Health Supervisor observes BHC practice to ensure fidelity to the Collaborative Care model.
    c. Regularly assess how BHCs are using their scheduling template to ensure adequate number of patients are being treated.
    d. Regularly assess BHC panel size to ensure an adequate number of patients are being treated.
2. *To see patients in primary care clinic.*
    a. Foster a primary care mindset and use primary care language.
    b. Leverage the existing relationship between the patient and primary care team
3. *To document and communicate efficiently.*
4. *To help providers understand:*
    a. Why Integrated Care is better than Psychiatry referral for uncomplicated depression/anxiety.
    b. The appropriate referral criteria for patients needing further evaluation.

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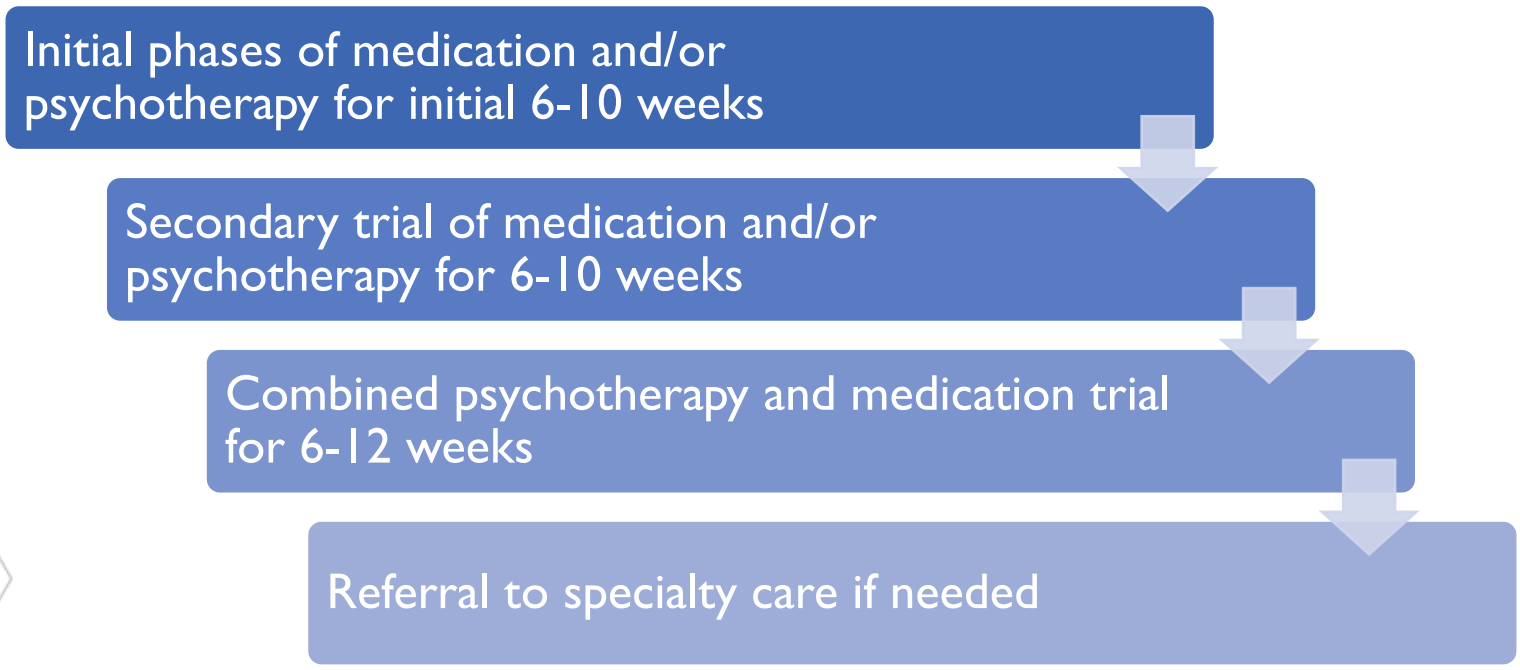
Stepped Care

Goals:

1. *To deliver and monitor mental health treatment effectively.*
    a. Utilize effective treatment methods based on intensity of patient need
    b. Different people require different behavioral health goals
    c. Moving from lower to higher levels of intervention increases effectiveness and lowers costs overall
2. *Patients should not have to wait for mental health services.*
    a. Patients can be seen quickly with a warm handoff occurring the day of referral
    b. Collaborative Care is not a bridge service for new patients while awaiting intake with specialty care



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Patient Identification - Adult

Eligibility:

- UW PCP/APP
- Depression and/or Anxiety Diagnosis or
  - Score ≥10 on PHQ-8 and/or PHQ-9
  - Score ≥10 on GAD-7

Exclusion Criteria:

- Patient is < 18 years old
- Patient currently has a psychiatrist or therapist
- Patient has a diagnosis of:
  - Bipolar Disorder
  - Schizophrenia
  - Dementia
  - Psychosis
  - Cognitive impairment/Developmental delay

Keys to success:

- Patient-centered team
- Population-based care
- Measurement-based treatment to target
- Evidenced-based care
- Stepped-care model
- Accountable care

How to refer:

- Primary Care provider initiates a warm connection to Behavioral Health Clinician
- Consult to Primary Care Behavioral Health Clinician in Health Link

When to do a curbside consult with BHC/Eligibility questions:

- Patient symptoms or severity may be appropriate for collaborative care
- When in doubt, consult with BHC prior to placing an order

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Patient Identification - Pediatrics

Eligibility:

- UW PCP/APP in General Pediatrics and Adolescent Medicine or Family Medicine
- Depression and/or Anxiety Diagnosis OR positive screen for symptoms at a Well Child Check (GPAM) or any visit (Family Medicine)
  - Ages 4+ in GPAM
  - Ages 12-17 in FM

Exclusion Criteria:

- Patient is under 12 years old in Family Medicine or under 4 years old in GPAM
- Patient currently has a psychiatrist or therapist
- Patient has an excluded diagnosis of:
  - Bipolar Disorder
  - Schizophrenia
  - Psychosis
  - Cognitive impairment
  - Developmental delay

Keys to success:

- Patient-centered team
- Population-based care
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- Stepped-care model
- Accountable care

How to refer:

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Patient Enrollment

ROUTINE - NEW REFERRAL TO COLLABORATIVE CARE AGES 4+

1. BHC receives notification from a provider wishing to discuss a possible referral to Collaborative Care.
2. Provider provides BHC with information about patient's presenting problem/symptoms
3. BHC and Provider enter patient's exam room together for "warm connection." If patient is on a telemed visit, provider can send send a secure chat message to BHC asking them to join the telemed visit for a warm handoff.
4. Provider briefly explains collaborative care to the patient and leaves the room to allow BHC to complete the warm connection.
5. BHC briefly discusses presenting problem with patient.
6. BHC explains next steps, including a brief overview of Collaborative Care treatment and billing information. BHC confirms contact information for future outreach.
7. Patient is scheduled to return to clinic in 1-2 weeks for initial assessment appointment (60 minutes).

CONSENT FOR SERVICES

1. Patient ages 4-13 must assent/agree to participation AND have a parent/guardian consent for participation.
2. Patients ages 14-17 must consent to care for themselves; parent/guardian consent is optional.
3. Patients ages 18 and over must consent to care for themselves.

Elevator Speech: We have a way of treating mood and stress called "Collaborative Care." It uses a team approach, and you can be seen right at this clinic. It really works! People get better twice as fast.

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Follow Up Visits

RETURNING PATIENT

1. Review the completed Patient entered screeners. It is ideal to have these completed prior to the visit.
2. Explore how things are going overall, how the patient is feeling, and what coping skills are helpful.
3. If applicable, check in on medication concerns, side effects, and efficacy.
4. Review therapy goals, explore barriers, and adjust as needed.
5. Provide education, introduce therapeutic skills and techniques focusing on the patient's overall goals.
6. Discuss what patient plans to do between sessions and modify or set goal.
7. Discuss length between sessions and have patient schedule with either BHC or PSR at the appropriate interval.

For patients under 18, a parent/guardian may or may not participate in each visit. A parent/guardian is not required to be present but must be available for any patient related safety concerns.

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Patient Engagement

WARM CONNECTIONS

The Warm Connection is the main point of referral for the patient to Collaborative Care. Evidence shows that the warm connection encourages patients to meaningfully engage in care.

Most warm connections happen with the patient is in the office, seeing their medical provider. This allows the BHC to come in the room and introduce Collaborative Care to the patient.

If a patient is being seen for a telehealth visit, warm connections could also occur.

REFERRALS TO COLLABORATIVE CARE

1. Medical Provider should place a consult order:
    a. Under Consult to Primary Care Behavioral Health (Collaborative Care)
    b. Enter **.pcbhbhcwarmconnection** in the order

REFERRALS TO SPECIALTY PSYCH

If a patient needs specialty Psychiatry, the following steps should occur:

1. Medical Provider or BHC (if the patient is enrolled in Collaborative Care) should place a consult order
    a. Under Consult to (Peds) Psychiatry or Consult to (Peds) Psychology – INSIDE UW HEALTH (note for patients under 18, use PEDS consult order)
    b. Specify within the order why a higher level of care is necessary
2. This encounter will auto-route to Behavioral Health.

From there, the Behavioral Health Access Team will be screening patients and scheduling those who need services. If a patient is unable to obtain an appointment here at UW, they will be handed off to the Behavioral Health Access Navigator.

Please note: BHCs should not be a bridge to psychiatry for NEW referrals

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Staff Engagement

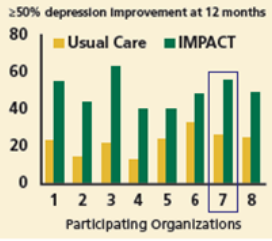
Reasons PCPs Love Collaborative Care

"I practiced for 16 years without it and I will never go back"
primary care physician, UW Neighborhood Clinic

1 Gold Standard of Depression Care

Collaborative Care is the best approach to treating depression, as proven by 79 randomized controlled trials published in a 2012 Cochrane Review. Why practice anything less?

Results of the landmark IMPACT study (1 of the 79 trials in the Cochrane Review) showed that Collaborative Care patients were twice as likely to experience significant improvement even though 70% of usual care patients were prescribed an antidepressant by their PCP.



2 Better Medical Care

Collaborative Care has been linked to better medical outcomes for patients with diabetes, cardiovascular disease, cancer, and chronic arthritis pain.

Collaborative Care has been recommended as a primary prevention strategy for fatal and nonfatal cardiovascular events in patients without preexisting heart disease.

3 Access to experts

Care managers and psychiatric consultants expand the treatment options available and support the care provided by PCPs. From providing psychotherapy when clinically indicated to supporting pharmacotherapy, these experts support you as the primary clinical decision maker.

Only 30–50% of patients have a full response to the first treatment. That means 50–70% of patients need at least one change in treatment. Additional experts can help.

4 Help with Challenging Patients

Many of your most challenging patients likely have un-treated or under-treated mental health conditions. Care managers do the follow-up and behavioral intervention tasks a busy PCP doesn't have time for, tasks that can make a big difference for your patients.

Think co-locating a behavioral health specialist or handing out referrals is enough? Think again. The organization circled (#7) had Masters-level, co-located behavioral health clinicians practicing within the primary care clinic using a referral model. **Collaborative Care still worked twice as well!**

5 It Takes a Team

Collaborative Care uses a population-based, treat-to-target approach similar to care for chronic medical conditions. Knowing when a proactive change in care is needed makes sure that none of your patients fall through the cracks.

Don't fool yourself!
As few as 20 percent of patients started on antidepressant medications in usual primary care show substantial clinical improvements.

AIMS CENTER
UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

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Role of the BHC

BEHAVIORAL HEALTH CLINICIAN (BHC)

The BHC is a trained, licensed therapist (i.e.: social worker, masters-level counselor, psychologist, etc.) who works in a brief, stepped care model. The BHC, along with the team psychiatrist, are new members to the primary care team to assist with behavioral health treatment. The BHC works as the eyes and ears of the team, serving as a liaison between the patient and the other members of the team (i.e.: medical provider and team psychiatrist). Their role falls into 4 categories:

1. Consult with the Team Psychiatrist

BHCs meet weekly with a Team Psychiatrist to staff patients. They get recommendations from the psychiatrist to discuss with the PCP with the goal of moving care quickly.

2. Proactive follow-up

BHCs ensure that patients referred to them do not “fall through the cracks”. They do this by contacting the patient frequently in the beginning of their care and using a reporting workbench to ensure patients are currently engaged in care.

3. Brief therapy

BHCs do brief, stepped care, meaning they use evidenced-based treatment practices in a brief way. Follow up visits are 30 minutes in length and utilize evidence-based practices. However, they also escalate care as fit, meaning they staff the patient with the Team Psychiatrist if patient is not reporting improved symptoms. BHCs can refer to specialty psych care when needed. Patients take around 4-8 months to complete care.

4. Warm connection

BHCs are interruptible at any time. This means they are open to take a “warm connection” or “handoff” from a medical provider even if they are visiting with another patient. The handoff is a brief introduction to the model of care and a way to connect services. This has been shown to double the likelihood a patient will follow up with mental health care.

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BHC Job Description

Education:
Minimum – Master's degree in social work, psychology, or counseling.

If Psychologist - Doctor of Philosophy (PhD) or Psychology (PsyD) in Clinical Psychology or related field.

Work Experience:
Minimum – Two (2) years' experience in an integrated health care environment in a patient/client contact role.
Preferred – One (1) year of experience working with behavioral health issues in a primary care setting.

If Psychologist - One (1) year of post doc experience in the area of Behavioral Health.

Licenses and Certifications:
Minimum - Relevant license and/or certification or license/certification eligible as a Mental Health provider as required in the State of Wisconsin (i.e., Psychologist, Licensed Professional Counselor-LPC, Licensed Clinical Social Worker-LCSW, Licensed Marriage and Family Therapist-LMFT).

If Psychologist - Licensure or eligible for licensure as a Psychologist in Wisconsin.

Required Skills, Knowledge, and Abilities:

- Ability to maintain effective and professional relationships with patients and other members of the care team.
- Comfortable working in a medical setting as part of a multi-disciplinary team.
- Ability to effectively engage patients in a therapeutic relationship, when appropriate.
- Experience with screening, assessing, and carrying out treatment plans for common mental health disorders.
- Working knowledge of differential diagnosis of common mental health disorders.
- Working knowledge of evidence-based psychosocial treatments for common mental health disorders.
- Basic knowledge of psychopharmacology for common mental health disorders.
- Familiarity with social/human service practices, confidentiality, and risk/malpractice issues within health care settings

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Staff Roles

PRIMARY CARE MEDICAL PROVIDER

The medical provider oversees all aspects of the patient's behavioral health care in the primary care setting. They are the member of the Collaborative Care team who initially sees the patient and determines if they are suitable for participation in the model. After diagnosing depression and/or anxiety, the provider invites the BHC to meet the patient for a warm connection, creating immediate access to care. The provider manages any accompanying medication and remains regularly updated on the patient's condition throughout treatment. The medical provider owns treatment of the patient throughout the process but shares the load with the BHC. They use suggestions from the Team Psychiatrist to help guide medications.

TEAM PSYCHIATRIST

The psychiatrist acts as a consultant. They support the primary care team in managing the patient's behavioral health condition through weekly case reviews with the BHC to discuss new, challenging, and non-improving patients. The Team Psychiatrist provides recommendations to guide care, following evidence-based, stepped-care principles.

The Team Psychiatrist is available for one-time evaluation of patients in the Collaborative Care model who may benefit from in-person evaluation. This service is used, on average, in <1% of CC patients.

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Staff Roles (continued)

MEDICAL ASSISTANT

The Medical Assistant supports patient flow through Collaborative Care. They enter the data from the screening forms into Health Link and can support the PCP/APP warm connection process so that the patient can connect with the BHC in a timely manner.

REGISTERED NURSE

The nurse should be comfortable explaining and administering screening tools. They can describe the model to patients and alert medical providers when a patient would be a candidate for CC. They will route appropriate encounters to the BHCs. In adult clinics, RN Care Coordinators (RNCC) will work collaboratively with the BHC in identifying and referring patients.

PATIENT SCHEDULING REPRESENTATIVE (PSR)

Ahead of the appointment, the PSR will assign screening questionnaires per workflow guidelines. If not completed in advance via MyChart, they will provide patient with a tablet to complete the screeners upon arrival at the clinic. After the visit, the PSR may schedule the patient's next visit, as well as any further appointments with the PCP/APP if needed. They will route appropriate encounters to the BHCs.

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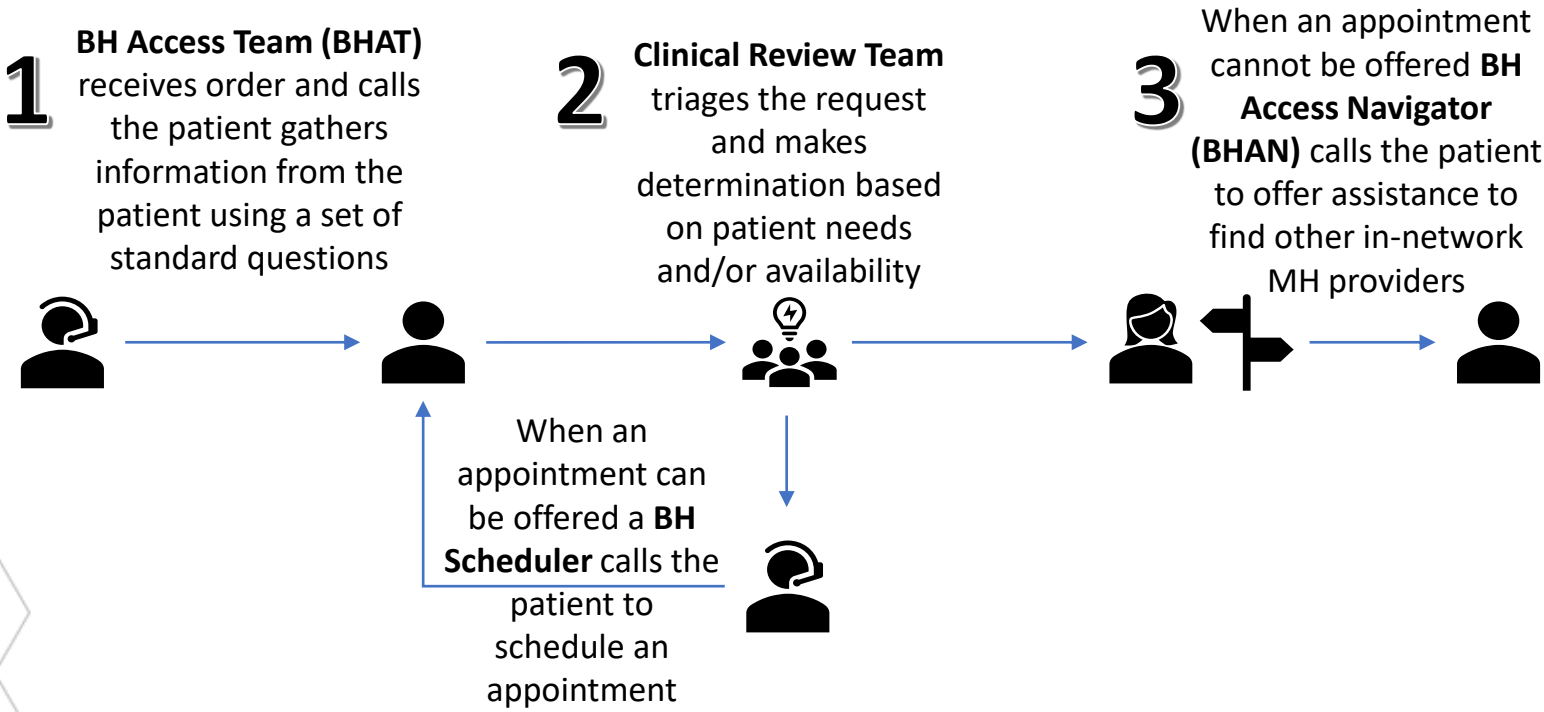
BHAT/BHAN Team

BEHAVIORAL HEALTH ACCESS NAVIGATOR (BHAN)

At times, patients in the Collaborative Care program will need to be referred to specialty psychiatry. In the circumstance where the UW Health specialty Psychiatry clinic is unable to offer the patient an appointment, the BHAN will assist the patient.

The BHAN is knowledgeable about resources and other providers in the community.

The BHAN can help call the insurance company with the patient to find other in-network providers and schedule an appointment.



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Onboarding Tasks for Clinic Managers

For Team psychiatrists

- Make sure to schedule a meeting with the Team Psychiatrist to meet with the provider team.

For BHCs

Note: You will work with the Behavioral Health Supervisor to determine a date to complete the following tasks during the onboarding of a new BHC. Behavioral Health Managers/Supervisors will ensure that the rest of the BHC's onboarding is scheduled.

- Tour Clinic, show office, how phone works, etc.
- General Site-Specific Operational Orientation: Absence scheduling & notification, attendance & punctuality, review requests for time off
- Use of personal property & storage, Mail/Courier system, Register for Outlook training if desired via Employee Self Service, Keys/Security system, Parking. Medical School departments may have their own help desk besides UWMF.
- Safety training for new BHCs (Onsite specific emergency procedures and protective equipment, Incident Reporting Policy, Safety Precautions and first aid response to hazardous materials exposures (e.g. eye wash station)
- Emergency Protocols: Crash cart, code blue, Emergency Procedure manual, CPR status
- Shadowing providers
- Shadowing PSRs, RNs, MA

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Accountability

DYAD ACCOUNTABILITY

Collaborative Care is a team-based model of care, the clinic dyad is responsible for:

- Instilling confidence in the model
- Maintaining integrity to the workflows
- Trouble-shooting and giving feedback to staff members
- Communicating with the Core Team

Please refer to Dyad Training ULearn documents or contact Collaborative Care Physician Leads for further questions.

STAFF ACCOUNTABILITY

The staff is responsible for adhering to workflows and role responsibilities outlined in the playbook.

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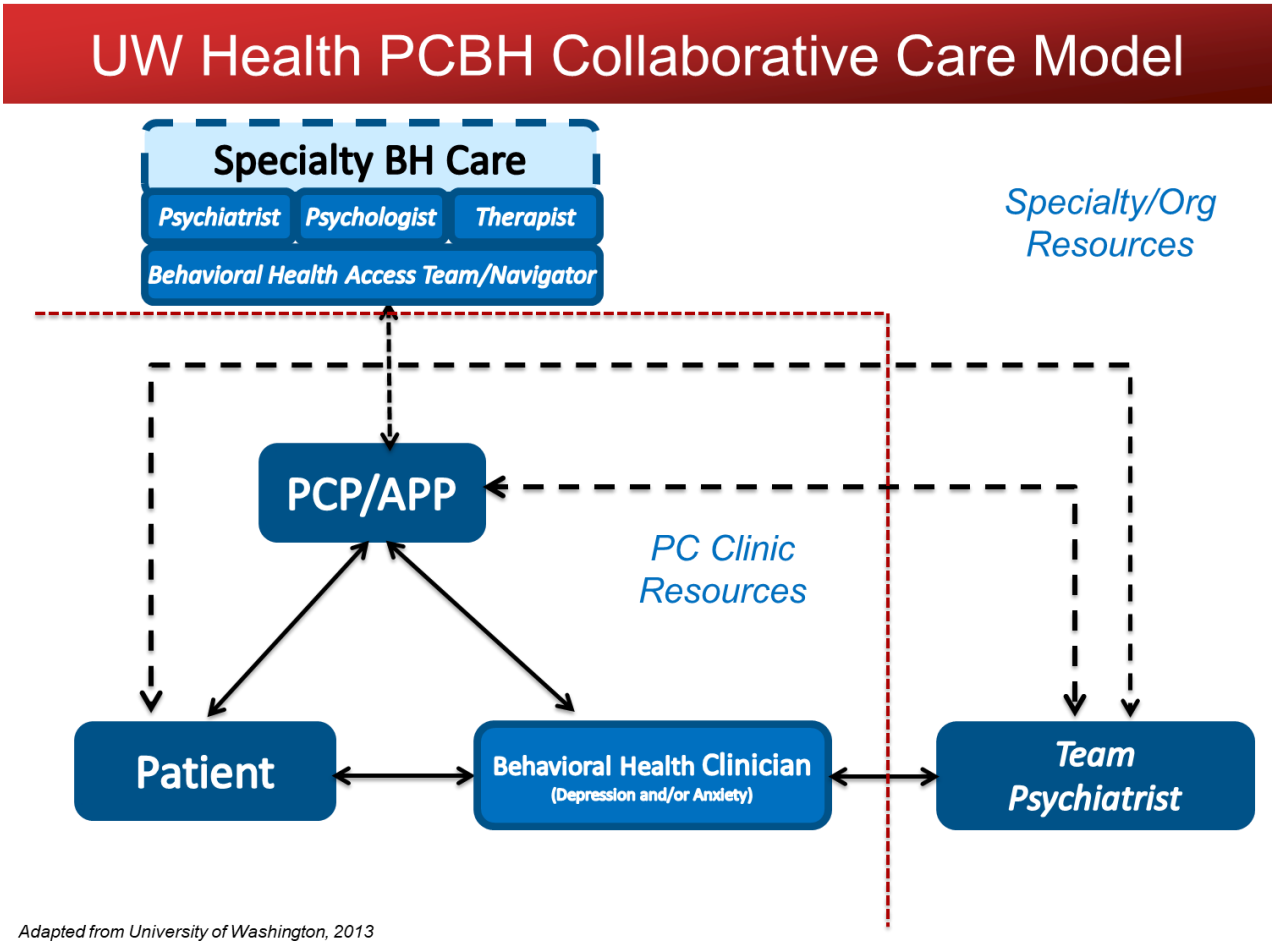
Care Design



Adapted from University of Washington, 2013

Workflows

Adult Collaborative Care:
For Adult Collaborative Care in **Family Medicine** and **Internal Medicine** clinics, please refer to the UW Health Primary Care workflows on U-Connect.

Additional resources can be found at.

The Collaborative Care team has developed a variety of self-evaluation tools for clinical positions to assess how they are adhering to the Collaborative Care model. These worksheets and additional resources can be found on the Adult Collaborative Care page on U-Connect.

U-Learn modules are available:
Behavioral Health Collaborative Care Training - Select Your Pathway (BHC, Clinical Staff, Dyad, PCP/APP, or Team Psychiatrist)

Pediatric Collaborative Care:
For Pediatric Collaborative Care for patients ages 12-17 in **Family Medicine** clinics, please refer to the workflows on U-Connect.

For Pediatric Collaborative Care for patients ages 4 and older in **General Pediatric and Adolescent Medicine** clinics, please refer to the workflows on U-Connect.

Additional information on Collaborative Care can be found on the Pediatric Collaborative Care page on U-Connect.

U-Learn modules are available:

- Family Med Clinical Staff (RN/LPN/MA/PSR) Pediatric Collaborative Care Training
- Pediatric Behavioral Health Collaborative Care for Clinical Staff (RN/LPN/MA/PSR)
- Pediatric Behavioral Health Collaborative Care - Select Your Pathway (BHC, Clinical Staff, PCP/APP, or Team Psychiatrist)

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Workflows: PSR

PSR

- Check-in / Registration – Check for completion of Patient-Entered Questionnaires and offer table in clinic for patient to complete, if needed
- Routing appropriate Health Link encounters
- General scheduling functions

The PSR manages the BHC schedule as they would any provider in the clinic

- Schedules patient appointments on site
- Schedules patient appointments via phone
- Reschedules patient appointments when needed
- NOTE: PSRs should always check to make sure the BHC is on a patient's Care Team before scheduling. If the BHC is not on the Care Team, a note should be sent to the BHC to address.

Templates: Staff who manages templates will need to handle, for each BHC in that clinic:

- Template will need to be built for each BHC using the following codes:
  - BEH HEALTH NEW (409)
  - BEH HEALTH OFFICE VISIT (410)
  - BH TELEMED- PHONE VISIT (3996)
  - BH TELEMED- PHONE VISIT NEW (3997)
  - BH MYCHART VIDEO VISIT RETURN (4533)
  - BH MYCHART VIDEO VISIT NEW (4535)

- Template structure will be provided by Behavioral Health Supervisor
- Template will need to be blocked as needed by BHC (time off, meetings, etc)

Follow Call Routing guidelines for specific scheduling questions

- Routing Primary Care Telephone Calls - Ambulatory - Adult/Pediatric Policy

Workflows: MA, RN, RNCC, Clinic Manager

MA

- No direct MA support needed - BHCs do their own rooming
- Keep rooms stocked with depression and anxiety screening forms
- Routing appropriate Health Link encounters

RN

- No direct RN support needed
- May collaborate on medical issues as needed
- May identify patients who could benefit from Collaborative Care and schedule patient with a PCP provider for evaluation of appropriateness for referral
- Routing appropriate Health Link encounters

RNCC (Adults only)

- Screen and assess patients for possible depression and anxiety, as indicated

Clinic Manager

- Is included in all team functions
- Is responsible for provider and staff adherence to the playbook and is responsible for helping field general questions about Collaborative Care
- Helps in on-boarding BHCs (*similar to on-boarding APPs*)
- Connects with BHC Supervisors regarding BHC performance

Questions about workflows can be directed to Clinical Staff Education.

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Patient Entered Questionnaires

The Collaborative Care program utilizes a variety of screening questionnaires to assess for symptoms of depression and anxiety within the primary care setting. These tools are useful in understanding the severity of the patient's symptoms. Serial administration of the tools can identify trends in symptom severity.

Primary Care visits:

Screening standards are defined in UW Heath's Primary Care Workflows. Questionnaires are assigned in advance of the appointment to patients to complete via MyChart, or on paper/tablet at the time of the clinic visit. For patients who screen positive for symptoms of depression and/or anxiety, and meet other criteria, this can be an entry point into Collaborative Care.

Behavioral Health Clinician visits:

Once a patient is enrolled in Collaborative Care, questionnaires will be automatically assigned based on visit type and patient age.

Questionnaire responses are available in Health Link in several places including:

- Patient Entered Questionnaires section (Rooming Activity)
- Sidebar Report
- Synopsis
- Clinic Schedule Report
- SmartLinks

The Patient Entered Questionnaires Overview document and Health Link training video are available on U-Connect

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Screening Questionnaires

Questionnaires	Assignment criteria (in plain language)
• PHQ-2/8 • GAD-7	• 18+ • *Annual visits
• PHQ-8 • GAD-7	• 18+ • All *BHC visits
• PCBH CC: PEDS PHQ-8,GAD-7,PSS-10,WEMWBS & PRIUSS-3 (bundles the PHQ-8, GAD-7, PSS-10, WEMWBS and PRIUSS-3, and presents a consent question for teens with self-access to MyChart)	• 12-17 • BHC *Intake visit
• PCBH CC: PEDS PHQ-8 & GAD-7 (bundles the PHQ-8 and GAD-7, and presents a consent question for teens with self-access to MyChart)	• 12-17 • BHC *Return visit
• SCREEN FOR CHILD ANXIETY RELATED DISORDERS (SCARED)-CHILD VERSION	• 8-11 • *BHC Intake visit
• PCBH CC: PEDS PROMIS ANXIETY & DEPRESSION V2.0 SHORT SELF-REPORTED	• 8-11 • All *BHC Visits
• SCREEN FOR CHILD ANXIETY RELATED DISORDERS (SCARED)-PARENT VERSION	• 6-11 • *BHC Intake visit
• PROMIS PARENT PROXY SHORT FORM V2.0-DEPRESSIVE SYMPTOMS 6A • PROMIS PARENT PROXY SHORT FORM V2.0-ANXIETY 8A	• 6-11 • All *BHC visits

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Documentation: PCP/APP and TP

Primary Care Provider & Advanced Care Provider (PCP/APP):

- PCP/APP enters Consult to Primary Care Behavioral Health. PCP/APP includes .**pcbhbhcwarmconnection** in their visit note for every patient referred to PCBH Collaborative Care. *Insurance REQUIRES this step be completed.*

Team Psychiatrist (TP):

- **.tpdoc** – use in a telephone encounter in Notes to document the team psychiatrist's assessment and recommendations made during the case review with the behavioral health clinician. When this smartphrase is used, it will populate the date in the "Team Psych Review" column in reporting workbench.
- TP needs to sign off on all BHC intakes

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Documentation: BHC

Smart Phrases:

- **.pcbhwarmconnection –** use in Notes to document the warm connection the behavioral health clinician had with the patient.
- **.bagoal** – use in the Problem List- Emotional Health Goal which will document the patient's behavioral activation goal.
- **.medsmaintenance** – use to document your patient's current outpatient Behavioral Health prescriptions.
- **.phq9multiple** – use to document your patient's previous PHQ and GAD scores.
- **.primarycareoutreachcomment** – use in Outreach Comments if you want to add a note that can be seen across UW Health.
- **.pcbhinitialassessmentnote** – use in Notes to document the initial assessment.
- **.pcbhccoverviewnote** – use in the Problem List which to document patient participation in the PCBH Collaborative Care program, who is the BHC and the date of the initial assessment.
- **.pcbhredflagnote** – use in Notes to document if there were any safety, AODA or other concerns identified in the initial assessment.
- **.pcbhspecialtyreferral –** use in Notes or in Re: Pt Msg by social workers or other specialty providers to communicate to a patient PCP that they have identified a mutual patient may be suffering from depression or anxiety and could benefit from a referral to Collaborative Care
- **.suicideriskassessment** – use in Notes to document a suicide risk assessment.
- **.safetyplan** – use to document if patients presents with suicidal ideation to document a safety plan and provide resources for your patient.
- **.pcbhpsychreferral** – use in comment section of "Consult to psychology" or "Consult to psychiatry" orders in Add Order.
- **.pcbhfollowup –** use in Notes to document your follow up visits (in person, telephone, or Telemed)
- **.ccdischargeletter** – use in a Blank Letter which will be used when a patient is unengaged in the PCBH Collaborative Care Program and will be discharged from the program. (Can use Unengaged patient letter #34060 in the letter tab.)
- **.ccbillingconsent –** use in Notes to document a discussion was made with the patient regarding the Collaborative Care billing codes and the patient consents to billing.
- **.ccmonthlybilling –** use in Notes to document monthly billing, as well as the time spent with the patient, during the current calendar month.

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Billing for Collaborative Care

- **At the end of every month, a bill will be dropped for all the CC services provided in that month**
  - The BHC is the service provider
  - PCP is the authorizing provider

- **BHC will document consent from patient to bill for these services at the beginning of the intake**
  - Applies for both face-to-face and non-face-to-face services that are provided
  - Services include conferring with a psychiatric consultant or other relevant specialists

- **What services are billed?**
  - Face-to-face visits - Office visits, Telehealth
  - Non-face-to-face activities - Outreach calls, curbside consults, and team psychiatry meetings

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Communication

The **Behavioral Health Supervisor** will be the main point person for all things related to the BHCs. The **Behavioral Health Manager** and/or Behavioral Health Supervisor is responsible for hiring, training and helping to onboard new BHCs. The BH Manager/Supervisor is also responsible for the day-to-day operational needs for the model. The BH Manager/Supervisor will work closely with the Clinic Manager to complete operational deadlines and goals associated with onboarding, workplace expectations and performance evaluation. The BH Manager/Supervisor also works with leadership, including the Collaborative Care Medical Directors, to evaluate the program and ensure patient access and fidelity to the model.

The Collaborative Care **physician leads** serve as physician Dyad partners with the Behavioral Health Manager. They facilitate buy-in and support from physician colleagues and others, act as internal experts, and serve as program ambassadors to practicing clinicians. The medical directors serve as liaison between physicians, administration, and executive leadership by providing updates on project status, and fostering mutual understanding, and facilitating solutions. They strive to narrow the gap between evidence-based medicine and current practice and evaluate implementation to ensure fidelity to the model.

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Space

Note: BHCs can see patients in their own office or in an exam room, whichever fits the clinic space best.

Required to have:

- Space must be near clinical staff
- Exam room(s) available if needed to see patients (1 per BHC)

Nice to have:

- Own office(s)
- Near the available exam room(s)

Required Equipment:

- Laptop, single monitor, and headset for remote access
- Non-shared workstation computer with two monitors and a camera for clinic use
- Telephone access; no voicemail
- Printer in vicinity
- Desk with two small and one file drawer
- Basic office supplies

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Budget

All Behavioral Health Clinicians (BHC) expenditures and revenue lie within the clinic budget.

During annual budget season, clinic managers will work closely with the Behavioral Health Manager for Primary Care on checking the previous year's budget and allotting the appropriate amount for the following year.

Budgets should typically include:

- $2,000 a year for Continuing Education Credits annually
- $150 every other year for license renewal

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Graduation/Disenrollment

A patient graduates from Collaborative Care once they have:

1. Reached a significant reduction of symptoms (dependent upon service line) AND/OR
2. Reached remission AND/OR
3. Met their therapeutic goals

Prior to completing care, BHCs recommend relapse prevention visits and will outreach three times to assist with reengagement.

Additional reasons for disenrollment include:

- Referral to higher level of care
- Patient lack of engagement
- Changes in insurance coverage

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Performance Metrics

PROGRAM EVALUATION

- The overarching goals of Collaborative Care are:
  - Improved clinical outcomes (Depression and Anxiety remission or significant reduction in symptoms measured through a variety of screening tools)
  - Improved patient access (total number of patient appointments available and how quickly patients get in – goal to get intake in 1-2 weeks)
  - Improved patient and clinician experience
  - Reduction in utilization and total costs of care across the UW Health system

- We use QlikView (QV0018, QV0036) to review overall program data including total patient enrollment, utilization, symptom severity, number of Episodes of Care, patient engagement, BHC capacity, and more.

- We closely monitor care model program fidelity (e.g. warm hand-offs, time to initial evaluation, consultations with the team psychiatrists, referrals to specialty care, etc.) and provide feedback regarding this to necessary stakeholders.

- A program evaluation was completed for Adult Collaborative Care which demonstrated that the model was cost neutral.

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