ACHC COCM Final Workflows
2.15.24

PILOT TESTING:

- Initiation of Care
- Initial Assessment
- Follow Up Care
- Case Review

DRAFT ONLY:

- Phone outreach
- Relapse Prevention
- Patient Re-engagement

COLOR CODE:

Behavioral Health Care Coordinator (BHCC)

Team Psychiatrist (TP)

Behavioral Health Consultant (BHC)

Patient

Primary Care Provider (PCP)

Support staff

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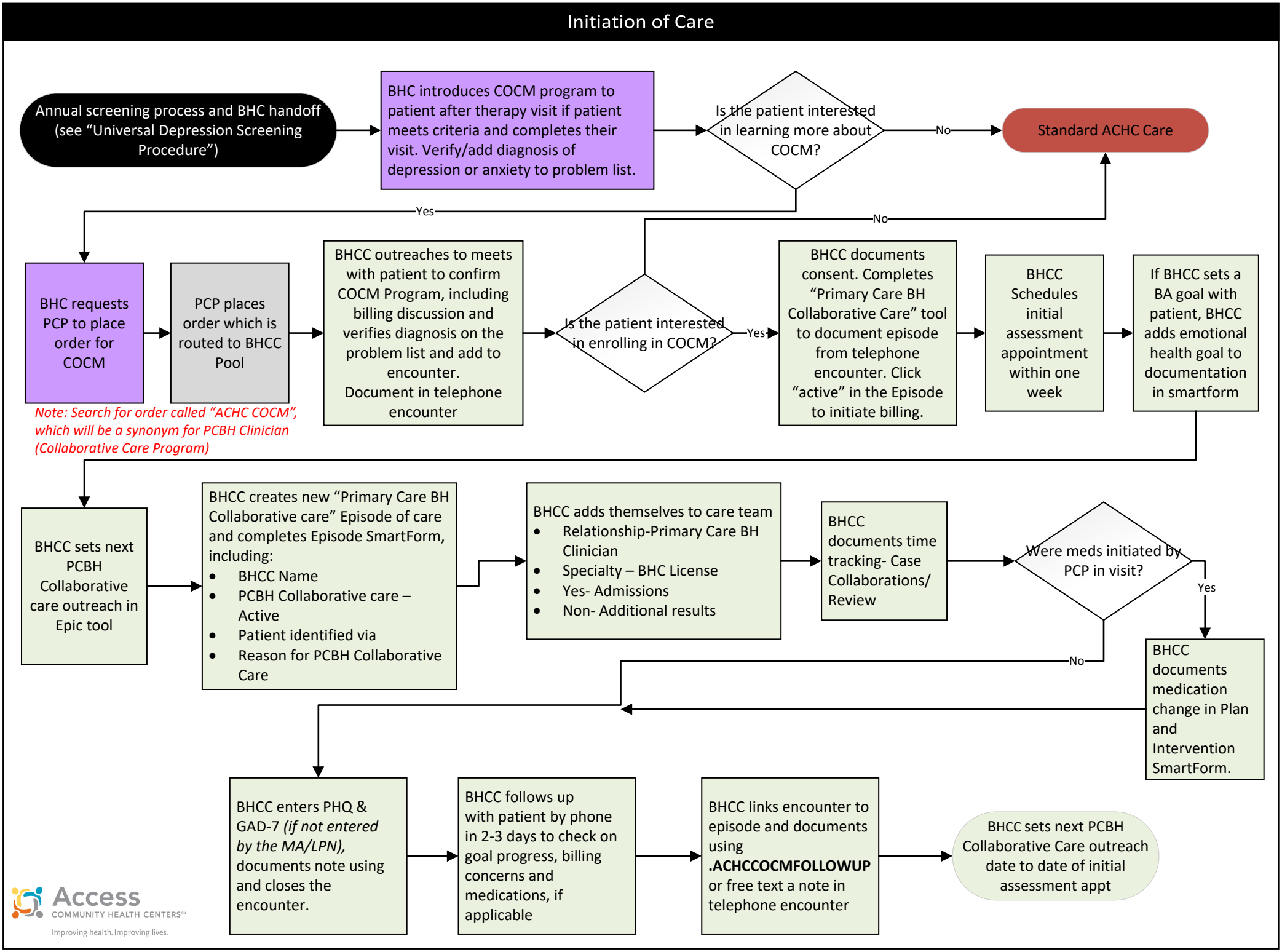
Initiation of Care



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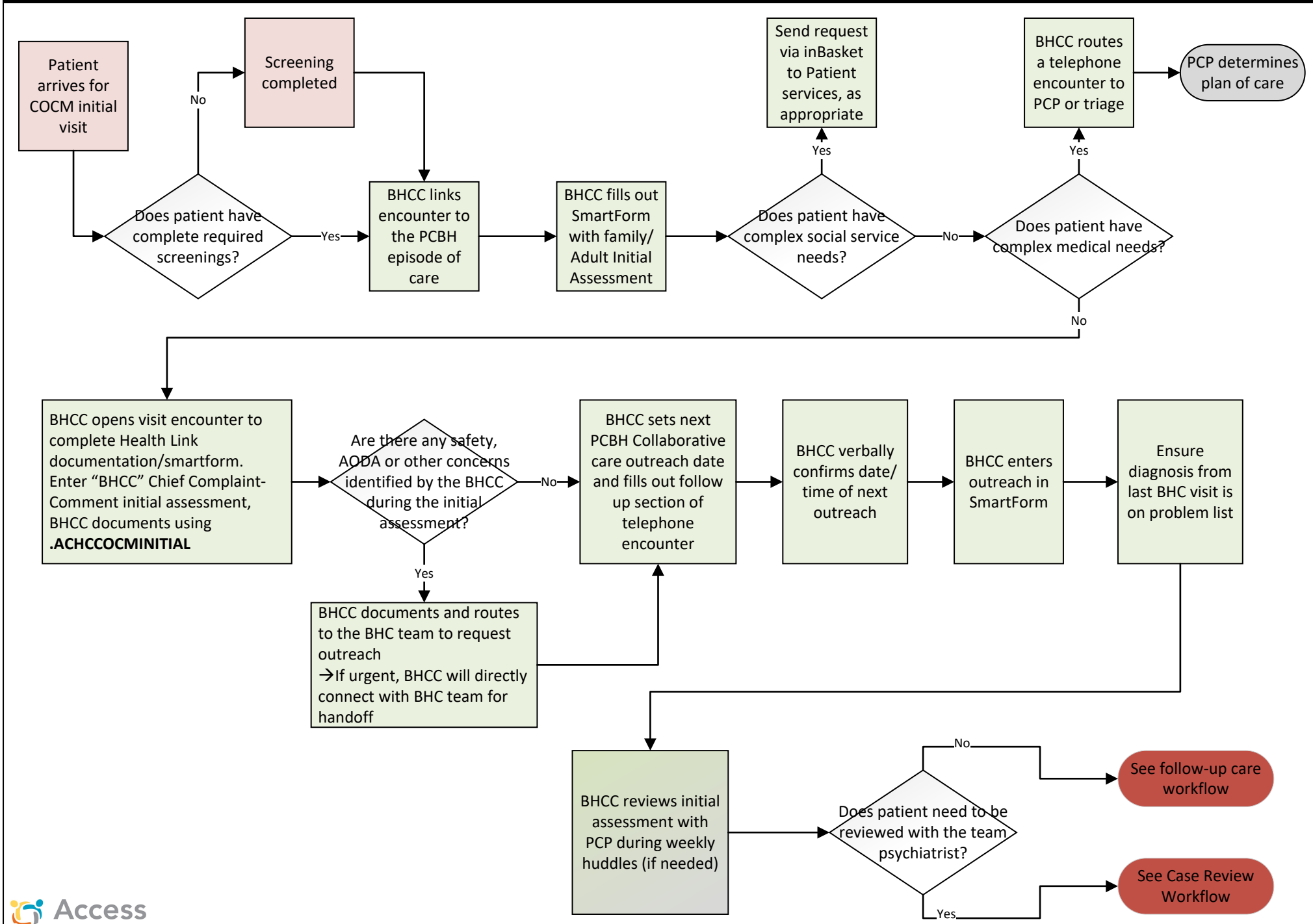
Initial Assessment



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Follow Up Care

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BHCC uses RWB to identify patients to contact

BHCC contacts patients via phone or handoff from PCP/BHC

Recommended contact frequency:
Severe/New: weekly for 4-8 weeks
Mild: Every other week

BHCC able to get a hold of patient?

Yes

No

See unengaged patient workflow

BHCC ensures PHQ completed every 2 weeks. Completes with patient if needed

BHCC opens appropriate encounter. Enter "Behavioral Health Collaborative Care" reason for call/ Chief complaint

BHCC links encounter to the episode of care

Must provide at least one treatment modality:
- BH Activation
- Medications
- IPT

Were medication changes made by the PCP?

No

Yes

BHCC Document medication changes in Plan and Intervention SmartForm

Were brief BH interventions done with patient?

Yes

BHCC Reviews and checks in on goal setting

No

BHCC documents in encounter using .achccocmfollowup and in Primary Care Behavioral Health Collaborative SmartForm

If patient has medical questions, BHCC routes to appropriate clinical pool

For telephone/Telemed:
Document time tracking in patient outreach and indicate contact form. Select PCBH Collaborative Care in the "about" field.
For In person: enter visit diagnosis and PCP as authorizing provider in LOS

BHCC completes the follow up section. Open and route encounter to PCP if there is an actionable item

Improvement:
50% better in 8-12 weeks

Is patient improving?

Yes

No

Remission:
- 50% reduction of symptoms
- Patient's improvement is sufficient as determined by PCP or team psychiatrist

Is patient ready to enter relapse prevention?

Yes

See resiliency Plan and Discharge workflow

No

BHCC and BHC/PCP will huddle weekly for ~10 min

BHCC assesses barriers to progress and routes encounter to BHC if there is an actionable item

1. Patient not improving or needs higher level of care Patients who have been in collaborative care longer than expected
3. ER/Hospital visit related to BH
4. New patient (if necessary)
5. no recent BHC outreach/never discussed
6. Patients ready for relapse prevention
7. Not recently reviewed

Is case review needed with team psychiatrist?

Yes

BHCC discusses next steps with patient

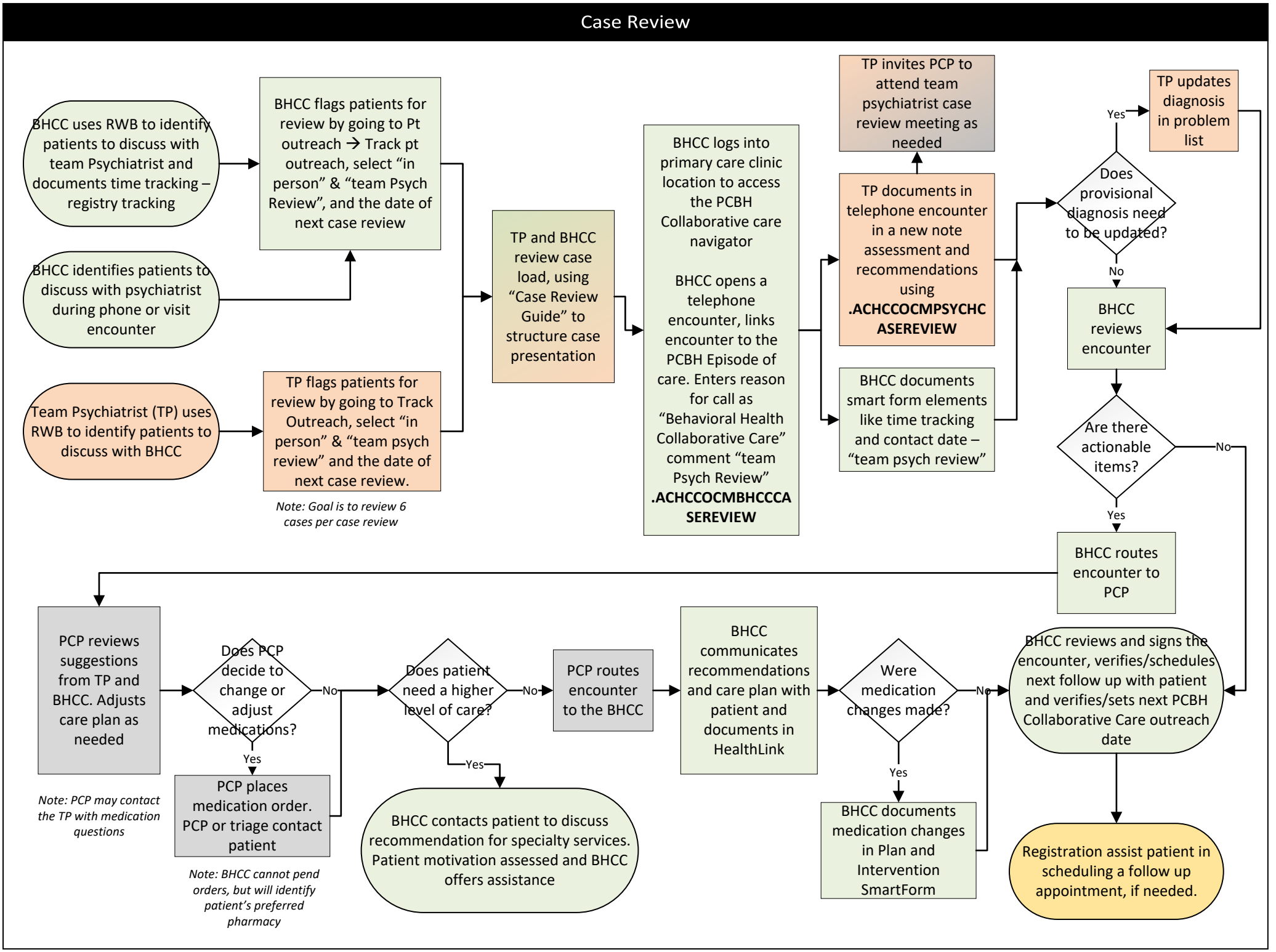
No

BHCC adjusts care plan, determines next contact and sets next PCBH Collaborate care outreach date

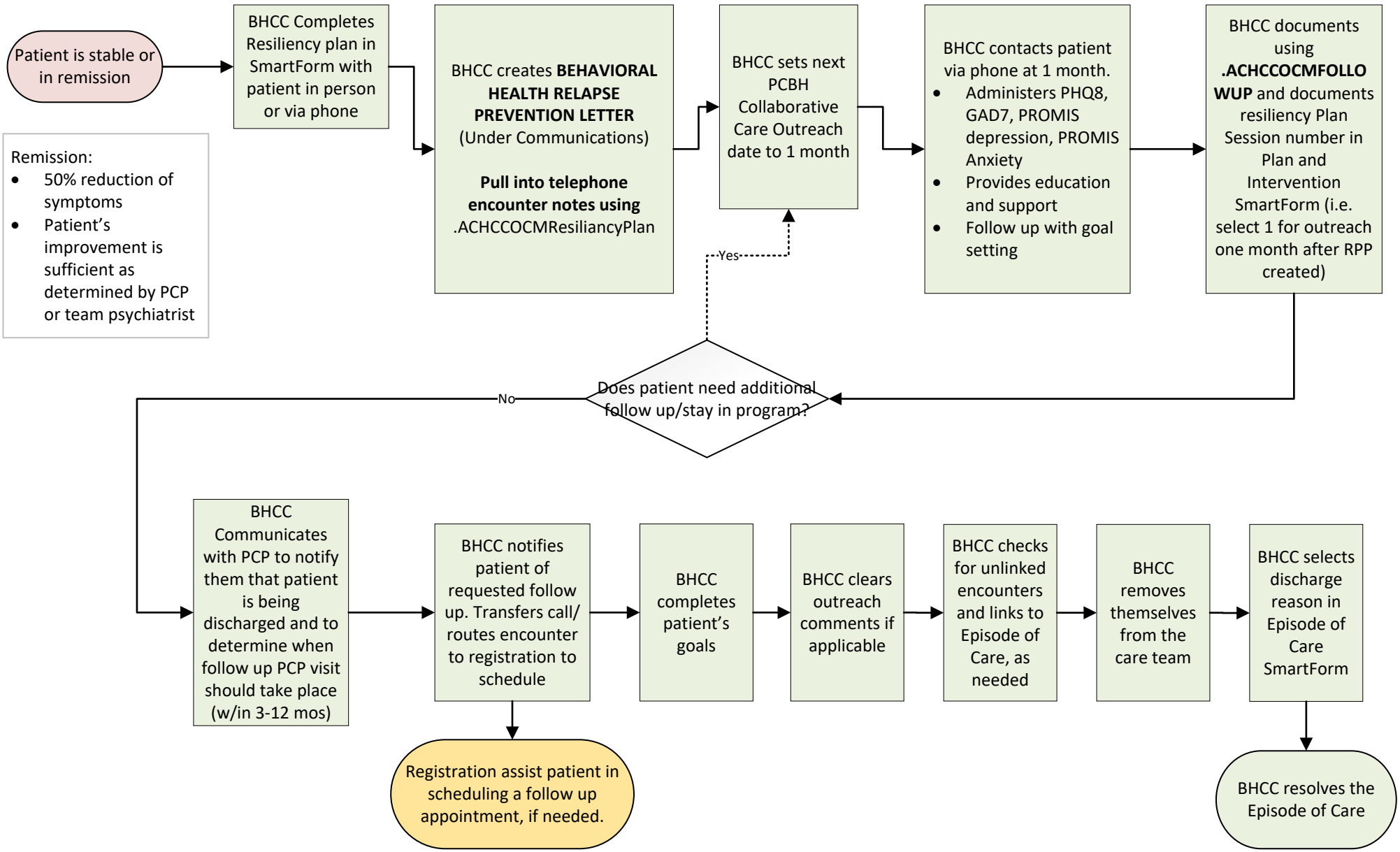
See Case Review Workflow

Schedulers: If a patient is calling to schedule an appointment with the BHCC, confirm they are on the care team before scheduling. If they are not on the care team, route the telephone encounter to the BHCC.

Case Review


BHCC uses RWB to identify patients to discuss with team Psychiatrist and documents time tracking – registry tracking
BHCC identifies patients to discuss with psychiatrist during phone or visit encounter
Team Psychiatrist (TP) uses RWB to identify patients to discuss with BHCC
BHCC flags patients for review by going to Pt outreach → Track pt outreach, select "in person" & "team Psych Review", and the date of next case review
TP flags patients for review by going to Track Outreach, select "in person" & "team psych review" and the date of next case review.
Note: Goal is to review 6 cases per case review
TP and BHCC review case load, using "Case Review Guide" to structure case presentation
BHCC logs into primary care clinic location to access the PCBH Collaborative care navigator
BHCC opens a telephone encounter, links encounter to the PCBH Episode of care. Enters reason for call as "Behavioral Health Collaborative Care" comment "team Psych Review" .ACHCCOCMBHCCCASEREVIEW
TP invites PCP to attend team psychiatrist case review meeting as needed
TP documents in telephone encounter in a new note assessment and recommendations using .ACHCCOCMPSYCHCASEREVIEW
BHCC documents smart form elements like time tracking and contact date – "team psych review"
Does provisional diagnosis need to be updated?
Yes
TP updates diagnosis in problem list
No
BHCC reviews encounter
Are there actionable items?
No
Yes
BHCC routes encounter to PCP
PCP reviews suggestions from TP and BHCC. Adjusts care plan as needed
Note: PCP may contact the TP with medication questions
Does PCP decide to change or adjust medications?
No
Yes
PCP places medication order. PCP or triage contact patient
Note: BHCC cannot pend orders, but will identify patient's preferred pharmacy
Does patient need a higher level of care?
No
Yes
BHCC contacts patient to discuss recommendation for specialty services. Patient motivation assessed and BHCC offers assistance
PCP routes encounter to the BHCC
BHCC communicates recommendations and care plan with patient and documents in HealthLink
Were medication changes made?
No
Yes
BHCC documents medication changes in Plan and Intervention SmartForm
BHCC reviews and signs the encounter, verifies/schedules next follow up with patient and verifies/sets next PCBH Collaborative Care outreach date
Registration assist patient in scheduling a follow up appointment, if needed.

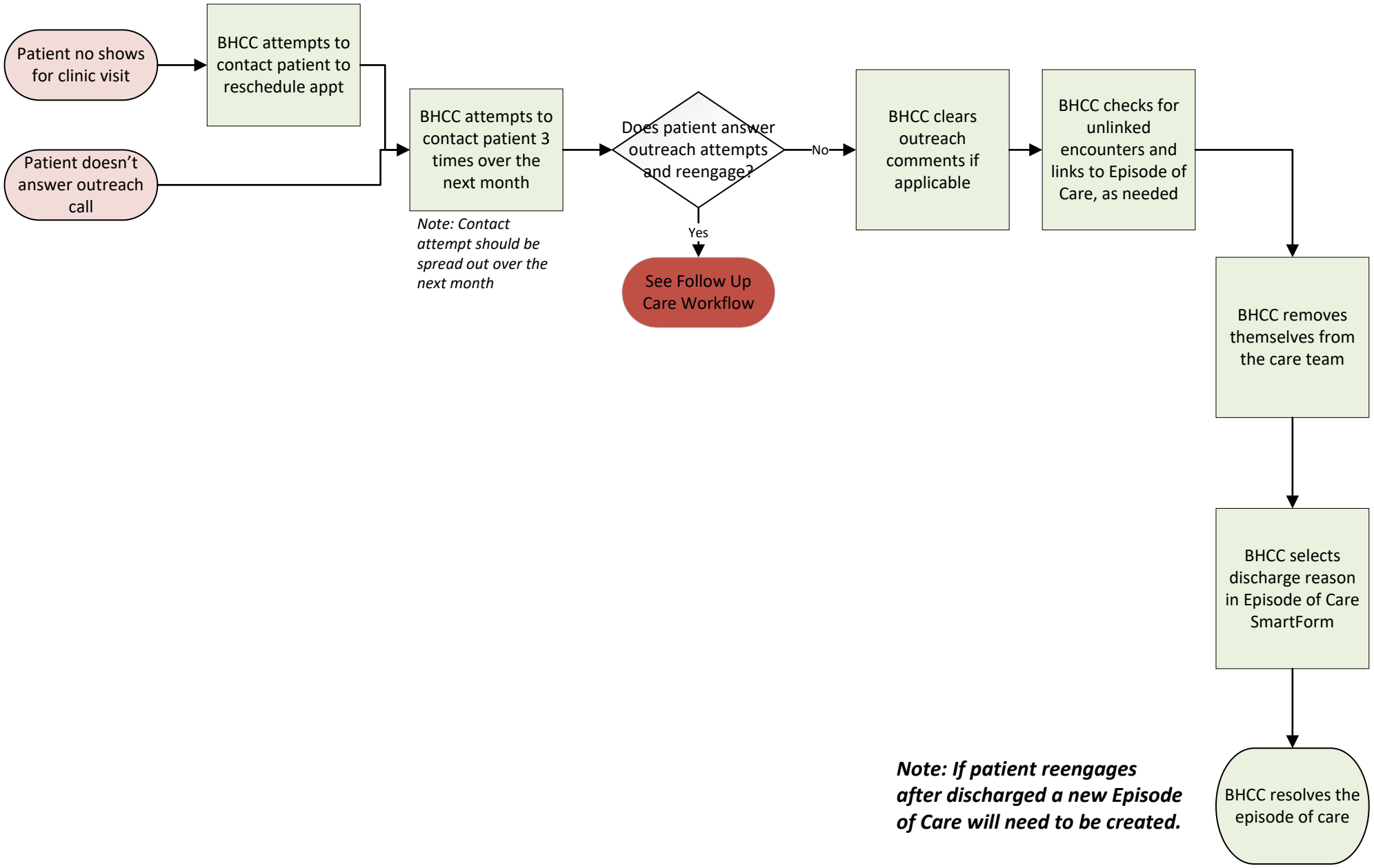
Relapse Prevention and Discharge



Note: If patient relapses or comes back to see the BHCC after being discharged, a new Episode of Care will need to be created.

- *<1 year, review initial assessment and make updates in notes*
- *>1 year, complete a new initial assessment*

Patient Non-Engagement



Note: If patient reengages after discharged a new Episode of Care will need to be created.

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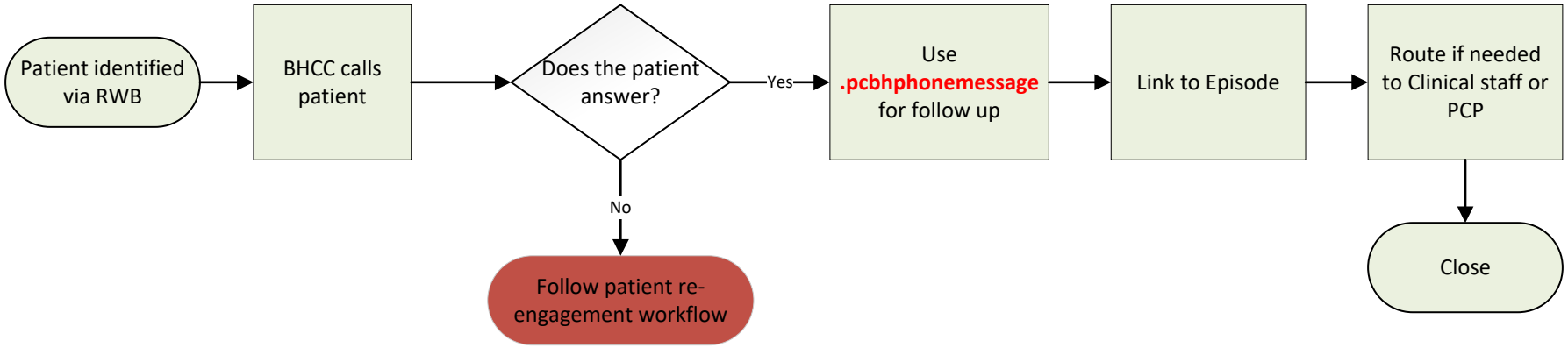
Phone Outreach – NOT CURRENTLY REQUIRED (future review as needed)



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