INTEGRATION OF PRIMARY CARE AND BEHAVIORAL HEALTH SERVICES:
COLLABORATIVE CARE MODEL

Implementation Toolkit

Last Updated: 02/2018
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HOW TO USE THIS IMPLEMENTATION TOOLKIT

This Implementation Toolkit: Integration of Primary Care and Behavioral Health Services - Collaborative Care Model was developed by OneCity Health to enable partner primary care sites to launch this project and oversee performance. This toolkit is intended for primary care sites who plan to or already have implemented the IMPACT Model/collaborative care for patients to mild to moderate behavioral health issues.

The Toolkit is organized into four major sections:

- **Overview** – This section provides a summary of the project, state mandated requirements metrics, goals and timeline.

- **Step 1: Preparation** – Current resources and workflows will be assessed and a workgroup will be established.

- **Step 2: Intervention Development** – Workflow changes will be evaluated and a launch timeline will be established.

- **Step 3: Launch, Assess, Scale, and Track** – The workgroup will ensure implementation plans are finalized, workflows are communicated, training needs are met and metrics can be collected and reported to OneCity Health.

ONECITY HEALTH SUPPORT DESK

If you have any questions, please contact the OneCity Health support desk:

**Phone Number:** 646-694-7090; Monday through Friday from 9am to 5pm EST

**Email:** ochsupportdesk@nychhc.org, with the subject line “Integration of Primary Care and Behavioral Health Question”
### Key Tasks Checklist

#### STEP 1: PREPARATION

<table>
<thead>
<tr>
<th>Key Tasks</th>
<th>Owner</th>
<th>Deadline</th>
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<tbody>
<tr>
<td>Establish Collaborative Care Implementation workgroup</td>
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#### STEP 2: INTERVENTION DEVELOPMENT

<table>
<thead>
<tr>
<th>Key Tasks</th>
<th>Owner</th>
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<tbody>
<tr>
<td>Review Collaborative Care team roles and responsibilities and identify Collaborative Care team members including depression care manager and consulting psychiatrist; address recruitment needs</td>
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<tr>
<td>Create clinical workflows and stepped treatment plans</td>
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<td>Build staff’s clinical skills</td>
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<tr>
<td>Identify/create Collaborative Care patient identification with a referral form and tracking system</td>
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#### STEP 3: LAUNCH, ASSESS, SCALE AND TRACK

<table>
<thead>
<tr>
<th>Key Tasks</th>
<th>Owner</th>
<th>Deadline</th>
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<tbody>
<tr>
<td>Communicate finalized Collaborative Care workflows with staff</td>
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<tr>
<td>Initiate or expand screening for depression in accordance with USPTF recommendations</td>
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<td>Collect and/or create patient education materials and disseminate to staff</td>
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<tr>
<td>Schedule case review sessions for Consulting Psychiatrist, Care Manager, and PCPs to be held regularly</td>
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<tr>
<td>Ensure tracking and reporting system in place and able to track relevant Collaborative Care data</td>
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<tr>
<td>Complete Collaborative Care Implementation Self-Assessment</td>
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<tr>
<td>Create plan to address areas for improvement based on Self-Assessment results and Collaborative Care Model: Unanticipated Challenges</td>
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OVERVIEW: INTEGRATION OF PRIMARY CARE AND BEHAVIORAL HEALTH SERVICES

BACKGROUND

In the United States, 29% of the adult population has both a mental health condition and a chronic medical condition. Medical and behavioral comorbidities are burdensome for patients and families and fragmented care results in poor outcomes and higher costs. Individuals with mental and/or substance use disorders often have untreated and preventable chronic illnesses like hypertension, diabetes, obesity, and cardiovascular disease that are aggravated by lack of access to appropriate primary care services and challenges navigating complex healthcare systems. Additionally, primary care settings are often the gateway to the behavioral health system, and primary care providers need support and resources to screen and treat individuals with behavioral and general healthcare needs.

Integrated, collaborative care is the systematic coordination of primary care and behavioral health services and the most effective approach to caring for people with multiple healthcare needs. Providing a spectrum of coordinated, accessible behavioral health and primary care services to meet a spectrum of patient needs aims to improve both mental and physical health outcomes and to reduce hospital admissions and ED visits.

PROJECT OBJECTIVE

The objective of this project is to integrate behavioral health, including mental health and substance use disorders, with primary care to ensure coordination of care for both services. Integration of behavioral health and primary care services can serve to: 1) identify behavioral health diagnoses early, allowing rapid treatment; 2) ensure treatments for medical and behavioral health conditions are compatible and do not cause adverse effects; and 3) de-stigmatize treatment for behavioral health diagnoses.

This integration can be achieved through varying models; this toolkit focuses on the Collaborative Care Model for Depression\(^1\), based on the evidence-based IMPACT model, which aims to incorporate behavioral health specialists into primary care coordination teams using collaborative care standards. The Collaborative Care model focuses on depression treatment, but can be expanded to include treatment for anxiety, mild to moderate substance use disorders, post-partum depression, etc.

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\(^1\) AIMS Center. (2016) [https://aims.uw.edu/](https://aims.uw.edu/)
COLLABORATIVE CARE MODEL OVERVIEW

Collaborative Care integrates behavioral health treatment into primary care and other medical settings and has been shown to be more effective and cost-effective than usual care, across diverse practice settings and patient populations\(^2\). Collaborative Care also improves physical and social functioning and patients’ quality of life while reducing overall healthcare costs. The model has been proved to be effective in treating depression, the focus of this toolkit, as well as other mental disorders.

Universal screening is the foundation for identifying patients for Collaborative Care. The Patient Health Questionnaire (PHQ)-2 and PHQ-9 are commonly used and validated screening tools for depression in adults. The Generalized Anxiety Disorder 7-Item Scale (GAD-7) screening can also be used in primary care settings to assess a patient’s anxiety levels over a two-week period and track treatment progress. Practices can screen for alcohol and substance use disorders using the Single Item Screening Questionnaires followed by the AUDIT and DAST-10.

A patient may not be best served via the Collaborative Care Model if s/he has another major mental illness (i.e. Bipolar disorder, Schizophrenia, Dementia); has a severe substance use disorder, or if the patient is currently receiving ongoing behavioral health services outside of the Collaborative Care team.

In the Collaborative Care model, the patient’s primary care physician works with a care manager to develop and implement a treatment plan (medications and/or brief, evidence-based psychotherapy). The care manager and primary care provider consult with a psychiatrist to change treatment plans if patients do not improve.

\(^2\) The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes. [https://www.chcs.org/media/HH_IRC_Collaborative_Care_Model__052113_2.pdf](https://www.chcs.org/media/HH_IRC_Collaborative_Care_Model__052113_2.pdf)
The Collaborative Care Model requirements include the following activities:

1. Implement Collaborative Care Model at Primary Care Sites

2. Utilize Collaborative Care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement

3. Employ a trained Collaborative Care Manager meeting the requirements of the Collaborative Care model

4. Designate a consulting psychiatrist, meeting requirements of the Collaborative Care Model

5. Measure outcomes as required in the Collaborative Care Model

6. Use a treat-to-target and "stepped care" approach, as required by the Collaborative Care Model such that treatment is adjusted based on clinical outcomes and evidence-based practices

7. Use EHRs or other technical platforms (e.g. care management tracking system or registry) to track all patients engaged in this project

**DISCLAIMER ABOUT TITLES:** Utilizing particular titles, such as “Care Manager”, is **not** a requirement of the Collaborative Care Model. Other example titles for this role could include Depression Care Coordinator, Collaborative Care Nurse or Social Worker, Collaborative Care Nurse Care Manager, etc. Sites should utilize any title appropriate for their particular site. The care manager is responsible for supporting the patient and PCP in depression treatment.

**KEY COMPONENTS OF THE COLLABORATIVE CARE MODEL**

1. **Collaborative Care functions in two main ways:**
   - The patient's primary care physician works with a care manager to develop and implement a treatment plan (medications and/or brief, evidence-based psychotherapy)
   - Care manager and primary care provider consult with psychiatrist to change treatment plans if patients do not improve

2. **Depression Care Manager:**
   - This may be a nurse, social worker or psychologist and may be supported by a medical assistant or other paraprofessional. The care manager
   - Educates the patient about depression

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• Supports antidepressant therapy prescribed by the patient’s primary care provider if appropriate
• Utilizes evidence-based brief interventions to treat the patient’s symptoms, including:
  o Motivational interviewing techniques
  o Coaching patients in behavioral activation and pleasant events scheduling
  o Offering a brief (six to eight session) course of counseling, such as Problem-Solving Treatment in Primary Care
• Monitors depression symptoms for treatment response
• Participates in weekly Case Consultation meetings with psychiatric consultant and communicates treatment recommendations to PCP
• Facilitates treatment plan changes for patients not improving as expected
• Documents encounters, progress and treatment recommendations in patient registry
• Completes a relapse prevention plan with each patient who has improved significantly and is nearing graduation

3. Designated Psychiatrist:
• Consults to the care manager and primary care physician on the care of patients who do not respond to treatments as expected
• Suggest treatment plan changes, including medication recommendations and supporting behavioral treatment for patients not improving as expected
• Provide occasional telephonic consultation to primary care providers (PCPs) as needed

4. Outcome measurement:
• Collaborative care managers measure depressive symptoms at the start of a patient's treatment and at least monthly thereafter using a validated assessment tool (e.g. PHQ-9, GAD-7)

5. Stepped care:
• Treatment adjusted based on clinical outcomes and according to an evidence-based algorithm, such as:
  o Aim for a 50 percent reduction in symptoms within 10-12 weeks
  o If patient is not significantly improved at 10-12 weeks after the start of a treatment plan, change the plan. The change can be an increase in medication dosage, a change to a different medication, addition of psychotherapy, a combination of medication and psychotherapy, or other treatments suggested by the team psychiatrist
STEP 1: PREPARATION

The main goal of Step 1: Preparation is to convene key staff members for the implementation of the Collaborative Care model, assess existing resources and establish a baseline understanding of the Collaborative Care model and its objectives.

<table>
<thead>
<tr>
<th>Key Tasks</th>
<th>Implementation Toolkit Resources</th>
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<tbody>
<tr>
<td>Establish Collaborative Care workgroup</td>
<td>• Collaborative Care Implementation Workgroup and Team Roles</td>
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<td>• Appendix A: Collaborative Care Model Workgroup Template</td>
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<tr>
<td>Conduct organizational readiness assessment</td>
<td>• Appendix A: Organizational Readiness Assessment</td>
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<tr>
<td>Discuss Collaborative Care components at provider meetings</td>
<td>• Overview: Integration of Primary Care and Behavioral Health Services</td>
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**Identify Implementation Leader**

It's extremely useful to identify someone with responsibility for leading and facilitating implementation of your Collaborative Care initiative. This person will lead pre-launch planning activities, coordinate training activities, and facilitate and monitor program implementation post-launch. This person is critical to the success of the implementation, so it's worthwhile to spend some time deciding who best fits this role. The Implementation Leader needs to:

- Have authority to allocate the time and resources needed to plan and launch the program;
- Have authority over the areas that will be affected by changes to clinical and administrative systems and practices or have the explicit support of leaders of these areas;
- Coordinate communication internally (senior leadership, Board of Directors, staff, etc.) and externally (patients);
- Support implementation of evidence-based practices that have been proven to improve identification and effective treatment of depression in primary care settings;
- Drive the project, ensuring that organization is meeting targets and timelines;
- Facilitate Team Building process, including development of detailed implementation plan;

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• Ensure collection of data to monitor metrics of implementation success and take responsibility for making program adjustments, as necessary;
• Facilitate the participation of necessary personnel in training and technical assistance activities.

**Identify Planning Team**

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

**PCP Champion**

Primary Care Providers are critical to the success of Collaborative Care. Therefore, it is essential that they have a voice in planning implementation. The best choice is a practicing PCP who is supportive of implementing Collaborative Care and who can influence other PCPs in the organization. Examples of Primary Care Provider(s) include physicians, physician assistants and/or nurse practitioners. The PCP Champion will participate in the Team Building Process and development of specific implementation plans. He/she will encourage their colleagues to participate in planning, training and other activities, as appropriate. The PCP Champion will also participate in review of post-launch metrics to evaluate program success and help brainstorm solutions to areas of the program that need adjustment.

**Care Manager/Behavioral Health Manager Champion**

Like the PCP Champion, the Care Manager Champion is supportive of implementing collaborative care and can influence other Care Managers. Examples of Care Manager include registered nurse, licensed psychologist, or licensed social worker. As part of the Planning Team, he/she will participate in and often lead the Team Building process.

**Psychiatric Consultant Champion**

The Psychiatric Consultant Champion is supportive of implementing collaborative care and can influence other psychiatric consultants. S/he can also provide trainings or conduct in services to the primary care physicians on behavioral health issues or psychopharmacology. Examples of Psychiatric Consultant can include individuals experienced in consultation-liaison psychiatry, geriatric psychiatry, or primary-care-based mental health care.
STEP 2: INTERVENTION DEVELOPMENT

The main goals of Step 2: Intervention Development are to identify and train Collaborative Care team members, develop registry and design clinical workflows (e.g. depression screening, routine clinician review of screening results, use of stepped treatment algorithm, referral to the depression care manager and case reviews with consultant psychiatrist).

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<thead>
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<tr>
<td>Review Collaborative Care team roles and responsibilities and identify and address recruitment needs</td>
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<tr>
<td>Identify Collaborative Care team members including depression care manager and consulting psychiatrist</td>
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</table>
| Create clinical workflows and stepped treatment plans | • Clinical Workflow Plans  
• Treatment Plan Development  
• Appendix A: Clinical Workflow Plan Templates  
• Appendix C: Administering the Patient Health Questionnaires 2 and 9 (PHQ-2 and PHQ-9)  
• Appendix E: Assessing Suicide Risk  
• Appendix F: Treatment  
• Appendix H: Case Review Guides |
| Build staff’s clinical skills | • Building Clinical Skills and Training  
• Appendix D: Increasing Staff Skills |
| Identify/create Collaborative Care patient identification with a referral form and tracking system and/or referral mechanism in the EMR | • Identify Registry and Patient Tracking System  
• Appendix A: Sample Referral Form |
| Complete Implementation Planning Checklist prior to Launch | • Appendix A: Implementation Planning Checklist |
Building Your Team

Team members will need to function outside of the traditional roles they were trained for and rely on each other in ways that may be new or uncomfortable. Primary care providers are familiar with an entirely different culture than behavioral health specialists, but both perspectives are extremely important and need to be woven into a new collaborative culture that sees differences as strengths. The Collaborative Care workgroup should carefully consider the pros and cons of retraining existing staff versus hiring new staff, keeping in mind the challenges implementation may bring and the personalities involved. ⁵

A site may identify more than one care manager, and choose to appoint a particular individual as a data manager for the tracking registry. Additionally, consideration should be made regarding when, where, and who (if applicable) will administer depression screening tools to patients. Any staff member working within the Collaborative Care model who is qualified to perform a depression screening as required within the project can do so (e.g. PCA, LPN, RN, etc.).

If your site decides to hire additional members for your team, see available caseload guidelines and job descriptions on the AIMS Center website: http://aims.uw.edu/collaborative-care/implementation-guide/plan-clinical-practice-change/make-action-plan

COLLABORATIVE CARE TEAM STRUCTURE⁶

Collaborative Care requires a team of professionals with complementary skills who work together to care for a population of patients with common mental conditions such as depression or anxiety. It involves a shift in how medicine is practiced, the creation of entirely new workflows, and frequently the addition of new team members. In usual care, the depression treatment team has two members: the primary care provider and the patient. Collaborative Care adds two more vital roles: the care manager and the psychiatric consultant. Its success relies to a great extent on each member of the treatment team understanding his/her role and believing he/she has the knowledge and skills necessary to fulfill that role. Please remember that the principles and core components of Collaborative Care, not just team members, must be in place in order to practice this model.

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COLLABORATIVE CARE TEAM MEMBERS: ROLES AND RESPONSIBILITIES

In usual care, the depression treatment team has two members: the primary care provider and the patient. Collaborative Care adds two more key people: the care manager and the psychiatric consultant, who contribute to Collaborative Care’s stepped care and diagnosis and outcomes tracking (see below table).

<table>
<thead>
<tr>
<th>Processes</th>
<th>New ‘Team Members’</th>
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<tbody>
<tr>
<td><strong>1. Systematic diagnosis and outcomes tracking</strong></td>
<td><strong>Care Manager</strong></td>
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<tr>
<td>e.g. PHQ-9 to facilitate diagnosis and track depression outcomes</td>
<td>Patient education/self-management support</td>
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<td>Close follow-up to make sure patients don’t ‘fall through the cracks’</td>
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<td><strong>2. Stepped Care</strong></td>
<td><strong>Care Manager</strong></td>
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<tr>
<td>Change treatment according to evidence-based algorithm if patient is not improving.</td>
<td>Support anti-depressant Rx by PCP</td>
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<tr>
<td>Relapse prevention once patient is improved</td>
<td>Brief counseling (MI, behavioral activation, PST-PC, CBT, IPT)</td>
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<tr>
<td></td>
<td>Facilitate treatment change/referral to mental health</td>
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<td>Relapse prevention</td>
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STAFF ROLES AND RESPONSIBILITIES

**Care Manager**

The care manager is responsible for supporting the patient and PCP in depression treatment. It is best practice for the care manager to be full time dedicated to Collaborative Care patients. This individual is often a nurse or social worker. The care manager does this by:

- Providing patient education about depression (or another behavioral health condition such as anxiety) and treatment
- Monitoring patients’ behavioral health conditions (in person and/or by telephone) for changes in clinical symptoms and treatment side effects/complications
- Supporting medication therapy prescribed by the PCP by following up with the patient after medication is prescribed to provide education, monitor for side effects, and coordinate mitigation of side effects, if needed
- Proactively tracking depression symptoms at each contact to monitor the effectiveness of treatment
• Providing brief interventions using evidence-based techniques such as Motivational Interviewing, Behavioral Activation, Brief Action planning and Problem-Solving Treatment
• Facilitating referrals for clinically indicated services outside primary care clinic (e.g. social services)
• Notifying the PCP and Consulting Psychiatrist when the patient has been in treatment for more than 10-12 weeks without adequate improvement
• Coordinating consultation from the psychiatrist regarding treatment changes and communicating that information back to the PCP
• Completing a relapse prevention plan with the patient when they are ready to leave active care management
• Completing a relapse prevention plan with patients in remission and preparing for graduation
• Participating in weekly Case Consultation meetings with psychiatric consultant and communicating treatment recommendations to patient’s PCP
• Documenting patient encounters, progress and treatment recommendations in patient registry and medical record

The typical caseload for a full-time care manager is 100-150 patients, depending on how the program is structured. A caseload should include patients in acute treatment as well as patients who have improved and who are being monitored monthly to ensure that they are stable before being graduated from active care management. Some organizations split the care manager duties into the routine activities that can be handled by a paraprofessional (e.g. Medical Assistant) and those best handled by a more highly trained professional. This can be an efficient use of resources and allows the care manager to carry a larger caseload.

DISCLAIMER ABOUT TITLES: Utilizing particular titles, such as “Care Manager”, is not a requirement of the Collaborative Care Model. Other example titles for this role could include Collaborative Care Nurse or Social Worker, Collaborative Care Nurse Care Manager, etc. Sites should utilize any title appropriate for their particular site. The care manager is responsible for supporting the patient and PCP in depression treatment. Care Managers can be nurses, psychologists, social workers or licensed counselors

Psychiatric Consultant
The Psychiatric Consultant has two primary responsibilities:

• Provide clinical consultation to the care manager and the patient’s PCP (this should occur during regularly scheduled case review meetings between the care manager and Psychiatric Consultant)
• May provide direct patient consultation for patients who are not improving after several treatment changes or who are suspected to need specialty mental health care (e.g. bipolar, substance abuse).
The Psychiatric Consultant meets with the care manager weekly, either in person or by telephone. They review new patients and any patients who have been in treatment for 10-12 weeks without adequate improvement in their depression symptoms. The psychiatrist suggests treatment modifications for the PCP to consider. These weekly meetings typically last an hour.

The Psychiatric Consultant is also available to both the care manager and the primary care providers for ad hoc telephone consultations and for an in-person consultation in those rare instances when that is needed. In the original trial of the Collaborative Care model about 10% of all patients had an in-person consultation with the Psychiatric Consultant.

**Primary Care Provider (PCP)**
The PCP is a central player responsible for encouraging the patient’s participation in depression care activities, prescribing antidepressant medications, providing treatments aimed at comorbid medical conditions and for referrals to specialty mental health care when that is needed. Collaborative Care is designed to support the PCP in their role by coordinating treatment, providing proactive follow-up of treatment response, alerting the PCP when the patient is not improving and facilitating consultation with the psychiatrist regarding treatment changes. The PCP maintains primary responsibility and decision-making regarding patient’s care and medication management. The PCP is expected to communicate with the care manager regarding medication adjustments, counseling or referrals. An effective communication method between the Care Manager and PCP should be determined by each site and may include, but are not limited to: communication via the EMR or email, regularly scheduled meetings, participation in huddles, etc.

**Patient**
Active, informed patients are more likely to adhere to treatment plans and medications. The patient is the most critical member of his/her care team and Collaborative Care is designed to engage the patient as an active participant in their treatment. Education about depression symptoms and treatment is essential in preparing the patient to be an active member of the team. Similarly, once a patient is ready to leave active care management it is important to prepare a relapse prevention plan with the patient to help them identify the early warning signs of depression and make a proactive plan for how to address that if it happens.

**OPTIONAL: Consulting Internist/Primary Care Champion**
Sites may also elect to have a Consulting Internist/Primary Care Champion, who serves as a bridge between the Collaborative Care program, care managers and PCPs and participates in case review meetings.

With the Consulting Psychiatrist, the consulting internist may participate in regularly scheduled weekly caseload consultation to Care Managers and make treatment recommendations for
medication adjustments for patients who have not reached their target values. For patients with Depression plus a chronic disease such as hypertension or diabetes, the Consulting Internist will play a vital role in monitoring these additional chronic conditions and making treatment recommendations to the PCP. This individual may also serve as a bridge between the Collaborative Care program, care managers and other PCPs, helping to educate staff on the model referral process for identified patients.

Clinical Workflow Plans

It is important to know how your team will function the moment a patient walks through the door, including protocols for suicidal patients and patients in crisis. Planning and creating a comprehensive clinical workflow plan ensures that no patient falls through the cracks. Mapping a patient’s care experience -- from identifying a behavioral health care need to initiating treatment to communicating treatment adjustments -- gives a framework for knowing the next step of care.

The Collaborative Care Workgroup should fill out a Clinical Workflow Plans (found in Appendix A). For each task—or set of tasks as shown in the worksheets—document who, how, when, and where the task will be completed as part of your implementation plan. These worksheets documents your current situation plus your plans for change and will help you:

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

Using the completed Clinical Workflow Plan, the Collaborative Care Implementation Workgroup should now create a clinical flowchart showing the exact process of what happens when a patient comes to the clinic. Include a protocol for psychiatric emergencies (e.g., suicidal), and pay particular attention to communication among team members (e.g., ensuring recommendations from psychiatric consultant are communicated to primary care provider, providing tools to the primary care provider to ensure patients are referred to the correct team members). Every clinic's flowchart will be unique and there is no right way or wrong way to ensure Collaborative Care tasks get done.

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Treatment Plan Development

In order to meet the requirements of the program, patients require, at minimum, the following from their PCP/care manager:

- **An initial assessment (e.g. using the PHQ-9) and treatment plan** by the Collaborative Care care manager, entered into the patient registry
- **A diagnosis of depression** documented in the depression registry and in the EMR
- **A minimum of one clinical contact per month with a completed symptom scale (PHQ-9)**
- **A minimum of one face-to-face contact ≥ 15 minutes at least once during the most recent three months**
- If not demonstrating significant improvement* in PHQ-9 score after 70 days in the program, patient should be discussed with consulting psychiatrist at the case meeting. Thereafter, patients should be reviewed every 8-10 weeks with a consulting psychiatrist until they are demonstrating significant improvement.
- In cases where there is no significant clinical improvement, there must be documentation of one of the following:
  - Psychiatric consultation
  - Change in treatment (e.g., change in depression medication, change in coaching intervention, referral to behavioral health).
- **Note:** These are the minimum requires of the program. Patients who are more acute will require more intensive and frequent intervention. Please adjust treatment plan according to the patient’s symptoms as well as recommendations of the treatment team.

* Clinically significant improvement is defined by:
  a. A 50% reduction in PHQ9 score from baseline or
  b. A drop from baseline PHQ9 score to less than 10
Building Clinical Skills and Training

Trainings

Effective collaborative care creates a team in which all of the providers work together on a single treatment plan. Each member of the care team needs to understand his/her role and believe that he/she has the knowledge and skills necessary to fulfill that role. The entire team should complete the Care Team Training together to begin the process of thinking and working as a team and seeing how each role fits into the bigger picture.

Online Training modules can be accessed via the University of Washington AIMS center site (http://aims.uw.edu/collaborative-care/implementation-guide/build-your-clinical-skills) in the following topics:

- Care Team Training (for ALL members of the care team)
- Care Manager Training
- Primary Care Provider (PCP) Training
- Psychiatric Provider Training

The American Psychiatric Association also offers a free online training (with CME credit) for Primary Care Physicians and Psychiatrists:

- Training for Primary Care Physicians – 2 CME
- Training for Psychiatrists – 4 CME

The Webinars and Presentations page on the NYS DSRIP Website has videos intended to assist providers with implementing best practices for integrated care and increase depression care manager skills, specifically under the National Council for Behavioral Health Educational Video Series on Integrated Care.

New York City Department of Health and Mental Hygiene’s (DOHMH’s) Online Learning Module in Screening, Brief Intervention and Referral to Treatment (SBIRT) is available here with continuing medical education (CME) for physicians.

Additionally, the New York State Office of Alcoholism and Substance Abuse Services (OASAS) is offering technical assistance resources and trainings to help our partners implement the Screening, Brief Intervention and Referral to Treatment (SBIRT) program. To request OASAS SBIRT technical assistance and/or training, email SBIRTNY@oasas.ny.gov.
NYC DOHMH’s Buprenorphine Training and Technical Assistance Initiative provides free buprenorphine waiver training and technical assistance for physicians practicing in NYC. Buprenorphine is an effective medication for treatment of opioid use disorders, and can be prescribed in office-based primary care settings. Under current regulations, physicians are required to obtain a waiver to prescribe buprenorphine by completing a standardized, approved 8-hour training course on buprenorphine prescribing. For more information, including dates of upcoming trainings, please email buprenorphine@health.nyc.gov.

For sites who are participating in Mental Health Service Corps (MHSC), a number of webinars (and some in person training) are offered throughout the year to support behavioral health integration. The information should be disseminated regularly via email to site champions as training opportunities are scheduled. If you are interesting in learning more about the MHSC and how to apply, please click here.

See Appendix D for additional resources on increasing skills in providing depression screening tools.

**Identify Patient Registry and Tracking System**

A site implementing the Collaborative Care model will need to:

- Determine IT infrastructure needed to support Collaborative Care patient identification and tracking
- Deploy a Centralized Care Coordination and Management Solution (CCMS) and related registries, to support patient identification and tracking, including training requirements.

The CCMS selected or created should be controlled and managed by the care manager. Solutions may vary depending on the size of a site and needs of a particular site, but must be electronic and capture necessary patient information pertaining to Collaborative Care process and clinical outcomes.

The workflow to support Collaborative Care is a data-driven process, requiring the care team to actively use a registry to track patient clinical outcomes over time. It is important that all registries be used in conjunction with the practice’s EHR, if not already built into it.
Registries that support Collaborative Care must be able to do the following:

- Track clinical outcomes and progress at the individual patient and caseload levels
- Track clinical outcomes for the target population
- Prompt treatment to target by summarizing patient’s improvement and challenges in an easily understandable way, such as charts or lists of patients
- Facilitate efficient psychiatric case review, allowing providers to prioritize patients who need to be evaluated for changes in treatment or who are new to the caseload

Registries can also be helpful in summarizing key processes of care that are important to understand when implementing a successful Collaborative Care program. Key processes to monitor include caseload size, the number and percentage of patients on a caseload who have been in contact with the care manager in a given period of time, and the number or proportion of enrolled patients that have achieved significant improvement.

The example below uses the PHQ-9 depression scale to track signs and symptoms of depression over time and illustrate the kinds of useful reports/information on processes of care that can be generated by a registry:

- Baseline PHQ-9 scores for all patients on caseloads
- PHQ-9 score at most recent follow-up contact
- Number (#) and percentage (%) of patients on the caseload who have had at least one follow-up PHQ-9 score recorded
- Number (#) and percentage (%) of patients whose PHQ-9 score is less than 5 (e.g., symptoms in remission) or whose score has decreased by at least 50%, indicating significant improvement
- Number (#) and percentage (%) of patients whose PHQ-9 scores are not improving after 10 weeks or more in treatment and who have not been reviewed by the psychiatric consultant within the past 8 weeks (e.g. at risk of falling through the cracks)

Registries and Tracking Tools

Clinics may opt to use a spreadsheet as a registry, such as the patient tracking template created by the AIMS Center and found via https://aims.uw.edu/resource-library/patient-tracking-spreadsheet-template.

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**STEP 3: LAUNCH, ASSESS, SCALE, AND TRACK**

The goals of Step 3: Launch, Assess, Scale and Track are to initiate redesigned workflows, hold routine case reviews and monitor and improve implementation of clinical workflows.

<table>
<thead>
<tr>
<th>Key Tasks</th>
<th>Implementation Toolkit Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communicate finalized Collaborative Care workflows with staff</td>
<td>• N/A</td>
</tr>
</tbody>
</table>
| Initiate or expand screening for depression and other behavioral health conditions in accordance with USPTF recommendations | • Appendix C: Administering the Patient Health Questionnaires 2 and 9 (PHQ-2 and PHQ-9)  
• Appendix E: Assessing Suicide Risk                                      |
| Collect and/or create patient education materials and disseminate to staff | • Appendix G: Patient Engagement & Education  
• Appendix J: Community Resources                                           |
| Schedule case review sessions for Consulting Psychiatrist, Care Manager, and PCPs to be held regularly | • Appendix H: Case Review Guides                                      |
| Ensure tracking and reporting system in place and able to track relevant Collaborative Care data | • Appendix G: Collaborative Care Billing                            |
| Complete Collaborative Care Implementation Self-Assessment               | • Appendix A: Collaborative Care Implementation Self-Assessment            |
| Create plan to address areas for improvement based on Self-Assessment results and Collaborative Care Model: Unanticipated Challenges | • Collaborative Care Model: Unanticipated Challenges  
• Appendix B: Quality Improvement Resources                                  |
Collaborative Care Model: Unanticipated Challenges

Either during or soon after the launch of Collaborative Care, you'll run into an issue you hadn’t previously considered. Unanticipated challenges will occur. Go back to the work you've already done, such as your clinical workflow plans, and weave a solution into your plan. Here are some sample barriers and common solutions.

Lack of Appreciation of the Core Principles of Collaborative Care

- Address common misconception that Collaborative Care is the same as co-located care (working in the same place)
- Encourage champions to speak about Collaborative Care at meetings where all providers are gathered to remind staff of the principles and workflows of Collaborative Care
- Focus on goal of improved patient outcomes
- Develop a system to identify and track the population targeted by Collaborative Care
- Deliver evidence based treatment interventions to behavioral health
- Encourage whole team responsibility for quality and outcomes of behavioral health care

Vision is not aligned with Resources

- Leadership buy-in
- Identify and support resource needs
  - Collaborative Care may require additional staff
  - Make sure new staffing is adequate based on expected patient caseload
  - Consider practical needs such as patient registry, private space to see patients, computers, phone
  - Screen for only behavioral health issues the organization has resources to address
  - Address funding concerns
  - Anticipate costs for both short-term start-up and long-term sustainability
  - Consider creative partnerships
  - Assess billing practices
- Champion to advocate for BHPs and other resources
- Identify referral resources and partners (e.g. for social needs)

Communication Challenges

- Provide orientation to all team members and ensure transfer of knowledge from departing members of the team
- Promote clear vision of goals for program
- Develop workflow with special attention to method and timing of team member communication

---

Limited Time and Resources to Build a Team
- Identify facilitator/champion to lead this process
- Leadership to advocate for time to complete assessment and participate in facilitated team building
- Schedule adequate time for team building and give the work group a clear timeline
- Consider using AIMS team building tool or other facilitated process to build team and develop work flow
- Scheduled regular operational meetings after implementation to revisit workflows – don’t be afraid to change them/make them better
- It is never too late to build or re-build a team!

Inadequate Skills in Effective Teamwork
- Plan training and practice specific collaborative care skills (e.g. integrated care planning)
- Train together
  - Ideally all team members participate in training as a group
  - Each member should understand model of program and individual roles/responsibilities
- Consider online programs for training
- Review program effectiveness in regularly scheduled QI meetings after program launch and identify needs for additional training and resources

Individual Concerns about Scope of Practice
- Seek to understand concerns of providers
- Acknowledge strengths of team members and apply those skills to new role
- Clearly define roles through team building within scope of practice for each provider
- Provide training to support team in performing in new roles
- Focus on patient outcomes and collaborative care tasks to reach those outcomes

Team Burnout
- Address lack of resources in initial phase of project
- Focus on good team communication
- Publically share success stories
- Regularly review workflow and revise as needed
- Consider team reflection to address inevitable challenges
APPENDIX A: MATERIALS TO SUPPORT COLLABORATIVE CARE IMPLEMENTATION

Collaborative Care Workgroup Template

**Instructions:** This template can be used to identify your **Collaborative Care Workgroup**

<table>
<thead>
<tr>
<th>Site Name:</th>
<th>Implementation Lead:</th>
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<thead>
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<th>Date:</th>
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<table>
<thead>
<tr>
<th>Name</th>
<th>Email</th>
<th>Job Title</th>
<th>Department</th>
<th>Work Group Role</th>
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<tbody>
<tr>
<td>1</td>
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<td>e.g. Clinical Champion</td>
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</table>
Beginning a Collaborative Care program is a big undertaking and it’s best to know the current strengths and weaknesses of your organization before embarking on a significant practice change. Use this worksheet to assess your readiness.

1. Organizational Capacity for Change
Organizations that understand Collaborative Care involves practice change on many levels do better implementing it.

1. What are your anticipated internal forces for and against change (e.g. strategic priorities, leadership support, organizational culture, experience with practice change, resistance to change)?

2. What are your anticipated external forces for and against change (e.g. financial, performance measures, other)?

3. What are other potential barriers and challenges (e.g. competing priorities, wrong incentives, depression stigma, other)

2. Organizational Support
Organizations that have buy-in from every key stakeholder group are significantly more successful implementing Collaborative Care.

1. How strong is support for Collaborative Care from: 1) PCPs; 2) nursing and medical support staff; 3) clinic manager; 3) behavioral health providers; 4) administrative staff; 5) Board, CEO, CFO, CMO; 6) patients

2. Does the organization have a vision for Collaborative Care that was created and endorsed by all key stakeholders?

3. What challenges will you have in implementing Collaborative Care if you don’t have support from each stakeholder group? How will you address these challenges? Will you be able to implement Collaborative Care without this support? If yes, how?

3. Quality/Process Improvement Initiatives
Organizations with existing quality and process improvement structures in place are typically better able to plan for the practice change involved in Collaborative Care and to effectively institutionalize regular, ongoing program monitoring and adjustment. Organizations that do not

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https://aims.uw.edu/sites/default/files/Organizational%20Readiness%20Worksheet.pdf
Implementation Toolkit: Integration of Primary Care and Behavioral Health Services

have any significant competing quality or process improvement initiatives (e.g. implementation of an EMR or another significant clinical practice change) planned to coincide with launching Collaborative Care are typically more successful.

1. How many quality/process improvement initiatives has your organization completed in the past 5 years?

2. What proportion of these initiatives are now part of usual care?

3. How many significant quality/process improvement initiatives do you have planned for the 12 month period following your planned launch of Collaborative Care?

4. Organizational Strengths and Challenges

Organizations with stable leadership, a realistic assessment of their strengths and weaknesses as an organization and a strong plan for monitoring program outcomes and addressing challenges and are typically more successful implementing Collaborative Care.

1. What is the length of tenure of organizational leadership (e.g., CEO, CMO, CNO, Clinic Manager, and Behavioral Health Director)?

2. What are your organization’s strengths regarding implementation of Collaborative Care? What are your anticipated challenges?

3. What is your plan for addressing both anticipated and unanticipated challenges? For example, what will be the process if the implementation doesn’t go as planned or clinical outcomes are not as expected?

5. Identification of Partners

Organizations that identify key partnerships, when that’s relevant to their Collaborative Care program, and engage these partners in developing a shared vision and implementation plan are generally more successful.

1. Are there any key partners inside or outside the organization (e.g. contract psychiatric consultant, behavioral health department providing psychotherapy, substance us clinics (e.g. OASAS), community organizations helping with identification of patients and/or supporting patients in treatment) that are essential to the Collaborative Care program?

2. What is the best way to engage the partner(s) to insure development of a shared vision, clear understanding of roles and expectations, a plan for implementation, and plans for ongoing monitoring and adjustment when needed?
6. Financing

Organizations with a clear plan for how to fund both the start-up costs of Collaborative Care as well as ongoing program costs do substantially better at sustaining Collaborative Care.

1. What are your organization’s financial incentives and disincentives to implement Collaborative Care?

2. What are your expected start-up costs? How will these be covered?

3. What are your expected program maintenance costs? How will these be covered?
### Clinical Workflow Plan Templates

#### CLINICAL WORKFLOW: IDENTIFY AND ENGAGE PATIENTS

<table>
<thead>
<tr>
<th>COLLABORATIVE CARE TASKS</th>
<th>WHO</th>
<th>HOW</th>
<th>WHEN</th>
<th>WHERE</th>
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</thead>
<tbody>
<tr>
<td>Identification and Engagement of Patients</td>
<td>Name / Discipline</td>
<td>Process (Including Hand-offs &amp; Communication Methods)</td>
<td>In terms of patient flow and time constraints</td>
<td>Clinic? Partner agency? Through an external referral?</td>
</tr>
</tbody>
</table>

- **Identify Patients Who May Need Help**
- **Screen for Depression using PHQ2/9**
- **Diagnose Depression**
- **Engage Patient in CC Program and Introduce Care Team**

**Needed Organization-Level Changes:**
- Staff Hires
- Staff Training
- Clinical Supervision
- Administrative Supervision
- Other Resources needed

**Notes:**

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# CLINICAL WORKFLOW: INITIATE AND PROVIDE TREATMENT

<table>
<thead>
<tr>
<th>COLLABORATIVE CARE TASKS</th>
<th>WHO Name / Discipline</th>
<th>HOW Process (Including Hand-offs) &amp; Communication Methods (e.g., telephone, mail)</th>
<th>WHEN In terms of patient flow and time constraints</th>
<th>WHERE Clinic? Partner agency? Through an external referral?</th>
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<tbody>
<tr>
<td>Perform Behavioral Health Assessment</td>
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<td>Develop &amp; Update Behavioral Health Treatment Plan</td>
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<tr>
<td>Patient Education about Symptoms &amp; Treatment Options</td>
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<tr>
<td>Prescribe Psychotropic Medications</td>
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<tr>
<td>Patient Education about Medications &amp; Side Effects</td>
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<tr>
<td>Brief Counseling, Activity Scheduling, Behavioral Activation</td>
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<tr>
<td>Evidence-based Psychotherapy (e.g., PST, CBT, IPT)</td>
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<tr>
<td>Identify &amp; Treat Coexisting Medical Conditions</td>
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<td>Facilitate Referral to Specialty Care or Social Services</td>
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<tr>
<td>Create &amp; Support Relapse Prevention Plan</td>
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</table>

**Needed Organization-Level Changes:**
- Staff Hires
- Staff Training
- Clinical Supervision
- Administrative Supervision
- Other Resources needed

**Notes:**
## CLINICAL WORKFLOW: TRACK TREATMENT OUTCOMES

<table>
<thead>
<tr>
<th>COLLABORATIVE CARE TASKS</th>
<th>WHO</th>
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<td></td>
<td>Name / Discipline</td>
<td>Process (Including Hand-offs) &amp; Communication Methods (e.g., telephone, mail)</td>
<td>In terms of patient flow and time constraints</td>
<td>Clinic? Partner agency? Through an external referral?</td>
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<tr>
<td>Track Treatment Engagement &amp; Adherence using Registry</td>
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<tr>
<td>Reach out to Patients who are Non-adherent or Disengaged</td>
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<tr>
<td>Track Patients’ Symptoms with Measurement Tool (e.g., PHQ-9)</td>
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<tr>
<td>Track Medication Side Effects &amp; Concerns</td>
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<td>Track Outcome of Referrals &amp; Other Treatments</td>
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### Needed Organization-Level Changes:
- Staff Hires
- Staff Training
- Clinical Supervision
- Administrative Supervision
- Other Resources needed

### Notes:
CLINICAL WORKFLOW: PROACTIVELY ADJUST TREATMENT IF PATIENTS ARE NOT RESPONDING

<table>
<thead>
<tr>
<th>PROACTIVELY ADJUST TREATMENT IF PATIENTS ARE NOT RESPONDING</th>
<th>WHO Name / Discipline</th>
<th>HOW Process (Including Hand-offs) &amp; Communication Methods (e.g., telephone, mail)</th>
<th>WHEN In terms of patient flow and time constraints</th>
<th>WHERE Clinic? Partner agency? Through an external referral?</th>
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</thead>
<tbody>
<tr>
<td>COLLABORATIVE CARE TASKS</td>
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<tr>
<td>Assess Need for Changes in Treatment</td>
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<tr>
<td>Facilitate Changes in Treatment / Treatment Plan</td>
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<tr>
<td>Provide Caseload-Focused Psychiatric Consultation</td>
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<td>Provide In-Person Psychiatric Assessment of Challenging Patients</td>
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<td><strong>Needed Organization-Level Changes:</strong></td>
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<td>• Staff Hires</td>
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<td>• Other Resources needed</td>
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<td><strong>Notes:</strong></td>
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</table>
### CLINICAL WORKFLOW: OTHER TASKS IMPORTANT FOR OUR PROGRAM (ADD AS NEEDED)

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<thead>
<tr>
<th>COLLABORATIVE CARE TASKS</th>
<th>WHO</th>
<th>HOW</th>
<th>WHEN</th>
<th>WHERE</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Name / Discipline</td>
<td>Process (Including Hand-offs) &amp; Communication Methods (e.g., telephone, mail)</td>
<td>In terms of patient flow and time constraints</td>
<td>Clinic? Partner agency? Through an external referral?</td>
</tr>
<tr>
<td>Coordinate Communication Among Team Members / Providers</td>
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<tr>
<td>Administrative Support for Program (e.g., Scheduling, Resources)</td>
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<tr>
<td>Clinical Supervision for Program</td>
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<tr>
<td>Training of Team Members in Behavioral Health</td>
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<tr>
<td><strong>Needed Organization-Level Changes:</strong></td>
<td>Notes:</td>
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<td>• Staff Hires</td>
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<td>• Other Resources needed</td>
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Implementation Planning Checklist

An Implementation Planning Checklist can be completed by the Implementation Lead to assess site’s readiness in implementing the Collaborative Care model.

**PATIENT IDENTIFICATION & TRACKING**

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<tbody>
<tr>
<td>1.</td>
<td>How will your clinic screen and identify appropriate patients (e.g. during patient visit, provider panels, registry, administrative data)?</td>
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<tr>
<td>2.</td>
<td>What measures will you use to track depression outcomes (PHQ-9, others)?</td>
</tr>
<tr>
<td>3.</td>
<td>What system will you use to support outcome tracking (EMR, separate registry, Excel spreadsheet, paper tracking form, web database)?</td>
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**MEDICATION MANAGEMENT**

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<tbody>
<tr>
<td>1.</td>
<td>Does your organization have formulas or guidelines regarding antidepressant use? Do these guidelines need to be adjusted?</td>
</tr>
<tr>
<td>2.</td>
<td>Who will sign/authorize prescriptions and refills (doctors, mental health provider)?</td>
</tr>
<tr>
<td>3.</td>
<td>Who will provide antidepressant medication management?</td>
</tr>
</tbody>
</table>
4. Who will coordinate care, monitor side effects, and adjust antidepressants as needed?

COMMUNICATION

1. What mechanisms do you currently have in place for provider-to-provider communication?

2. How can these mechanisms be used or improved to support depression care management?

3. What are the implications of HIPAA for relationships among the primary care physicians, interested organizations, care managers and mental health consultants?

4. How will mental health providers communicate with primary care doctors and care managers (in person, e-mail, phone, EMR – on or off site)?
5. How and where will care managers document their contacts with patients (e.g. EMR, registry)?

---

**START-UP NEEDS**

<table>
<thead>
<tr>
<th>1. <strong>Consultation:</strong> to educate clinical leaders, practice leaders and managers</th>
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<tbody>
<tr>
<td>2. <strong>Training:</strong> for primary care providers, depression care managers, consulting psychiatrists, practice managers and administrative staff</td>
</tr>
<tr>
<td>3. <strong>Materials:</strong> for patients and for providers and documents for process tracking.</td>
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<tr>
<td>4. <strong>Structural changes:</strong> patient flow, scheduling, communication, financing of care, etc.</td>
</tr>
</tbody>
</table>
Sample Referral Form

Member name: ____________________________

Medicaid number: ________________________ Date of referral: ______________

Dear Colleague:

I am the primary care physician for the above-named member, who has expressed concern about the issues checked below. A course of treatment _____ has _____ has not been started under my care.

**Current concerns:**

- [ ] Depressed symptoms
- [ ] Anxiety symptoms
- [ ] ADHD symptoms
- [ ] Eating disorder
- [ ] Other: ___________________________

- [ ] Substance use
- [ ] Behavior problems
- [ ] Developmental delays
- [ ] Head injury
- [ ] Hallucinations/delusions
- [ ] Mania
- [ ] Parenting

**Current medications:**

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>DOSE</th>
<th>FREQUENCY</th>
<th>LENGTH OF TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- [ ] See attached list

**Medical problems:**

- [ ] Diabetes
- [ ] Asthma
- [ ] Other: ___________________________

**Attached lab results:**

- [ ] CBC
- [ ] Thyroid studies
- [ ] Chem. profile
- [ ] EKG
- [ ] Lipid profile
- [ ] Serum drug level

---

12 Greater New York Hospital Association (GNYHA). Collaborative Care Teaching Guide—Integrating Behavioral Health and Primary Care in Teaching Settings. 2016. [http://www.gnyha.org/PressRoom/Publication/680b5fd2-31eb-4eeb-9dec-ee0ceb1c42be/](http://www.gnyha.org/PressRoom/Publication/680b5fd2-31eb-4eeb-9dec-ee0ceb1c42be/)
Implementation Toolkit: Integration of Primary Care and Behavioral Health Services

Diagnostic tests: ____________________________________________________________
________________________________________________________________________

Recent hospitalizations:

<table>
<thead>
<tr>
<th>MEDICAL PROBLEM</th>
<th>HOSPITAL</th>
<th>DATE OF ADMISSION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PMP information:
Name: __________________________
Address: ________________________
Phone: _________________________
Fax: ___________________________
Collaborative Care Implementation Self-Assessment

Collaborative Care workgroups should complete the following Implementation Self-Assessment form to determine that their site is ready to implement the Collaborative Care model and areas that may require additional work.

<table>
<thead>
<tr>
<th>Evidence-based Depression Care Practices</th>
<th>Fully Established</th>
<th>CIRCLE ONE</th>
<th>Not Yet Developed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Case Identification</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screening with PHQ-2/9 to detect depression</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Positive screens receive follow-up diagnosis</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td><strong>Setting, Staffing &amp; Supervision</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Designated staff (e.g. care managers) to support depression treatment</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Care managers participate in regularly scheduled, ongoing caseload supervision with a psychiatrist</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Primary care staff and providers have access to a consulting psychiatrist who can assist with patients who are not improving as expected</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td><strong>Patient Education</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education about depression and treatment options provided to patients/consumers</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td><strong>Treatment Planning &amp; Delivery</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients/consumers participate in selection of treatment(s)</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Patients/consumers receive follow-up by phone or in-person within one week of starting new medication to assess for side effects</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Patients/consumers receive proactive assistance with management of side effects</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Behavioral activation or pleasant events scheduling provided as part of treatment</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Evidence-based Depression Care Practices</th>
<th>Fully Established</th>
<th>CIRCLE ONE</th>
<th>Not Yet Developed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence-based counseling (such as Problem-Solving Treatment) offered, either as a primary treatment or adjunct to medication therapy</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td><strong>Tracking Treatment Outcomes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-person or phone follow-up at least once every two weeks during the active phase of treatment to monitor response to treatment</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>In-person or phone follow-up at least once a month during the maintenance phase of treatment</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Depressive Symptoms monitored with a tool (e.g. PHQ-9) that quantifies treatment response</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Staff and providers use a registry or other tracking system to follow patients and insure that they don’t fall through the cracks</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td><strong>Treatment Based on Outcomes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All treatment plans have a ‘shelf life’ of no more than 10 weeks. If the patient/consumer is not at least 50% improved at the end of 10 weeks, or PHQ9 is not less than 10, the treatment plan is changed (e.g. increased dose, different medication, add counseling, psychiatric counseling, etc.)</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td><strong>Relapse Prevention</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients/consumers who are in remission complete a relapse prevention plan and receive a copy of it for reference</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td><strong>Payment/Billing</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have a sustainable plan for payment/billing/reimbursement</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>
APPENDIX B: QUALITY IMPROVEMENT (QI) RESOURCES

The Plan, Do Study, Act (PDSA) Cycles is an example Quality Improvement resource to help your practice evaluate the implementation of linking high risk patients to care management resources through Health Home At-Risk at your site, and troubleshoot identified issues.

Plan, Do, Study, Act (PDSA) Cycles

The Plan-Do-Study-Act (PDSA) cycle is part of the Institute for Healthcare Improvement Model for Improvement, a simple yet powerful tool for accelerating quality improvement. Once a team has set an aim, established its membership, and developed measures to determine whether a change leads to an improvement, the next step is to test a change in the real work setting. The PDSA cycle is shorthand for testing a change—by planning it, trying it, observing the results, and acting on what is learned. This is the scientific method, used for action-oriented learning.

The steps in the PDSA cycle are:

- **Step 1: Plan**—Plan the test or observation, including a plan for collecting data
- **Step 2: Do**—Try out the test on a small scale
- **Step 3: Study**—Set aside time to analyze the data and study the results
- **Step 4: Act**—Refine the change, based on what was learned from the test

For more information:
[http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx](http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx)

---

## PDSA Worksheet for Testing Change - Template

### AIM

<table>
<thead>
<tr>
<th>PDSA Cycle # 1</th>
<th>Person(s)</th>
<th>When to complete</th>
<th>Where to complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Every Aim will require multiple small tests of change)</td>
<td>Responsible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Describe your test of change:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### PLAN

<table>
<thead>
<tr>
<th>List the tasks needed to set up this test of change</th>
<th>Person(s)</th>
<th>When to complete</th>
<th>Where to complete</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Responsible</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. 

2. 

3. 

<table>
<thead>
<tr>
<th>Predict what will happen when the test is carried out</th>
<th>Indicator to measure if prediction succeeds</th>
</tr>
</thead>
</table>
### DO

Describe what actually happened when you ran the test.

### STUDY

Describe the measured results and how they compared to the predictions.

### ACT

Describe what modifications to the plan will be made for the next cycle from what you learned.
Sample QI Project Charter: Screening for Clinical Depression and Follow-Up Plan

What are we trying to accomplish?
To improve processes for universal screening for depression so that the screening rate increases to 90% and to ensure at least 40% of patients with a positive screen co-develop a follow-up plan with their primary care team as appropriate. We will accomplish this by:

- Developing a protocol for screening for depression so that each patient seen in primary care receives at least one PHQ-2/9 screening annually
- Developing a protocol for follow up plans for patients with a positive depression screen including referral criteria for Collaborative Care
- In-servicing staff on the depression screening protocol and follow up for positive screens
- Creating outreach strategies for patients that have not completed a PHQ-2/9 screen annually

How will we know that the change is an improvement?

- % of patients seen for any reason in a quarter that have had an annual depression screen
  o EMR report will be developed with analyst
- % of patients with a positive depression screen that received appropriate follow-up care
  o Clinical champion will conduct chart review of patients with a positive screen and evaluation of a follow up plan created in alignment with their preferences and clinic protocol
- % of staff and clinicians in-serviced on depression screening and follow up protocols
  o Implementation lead to track in-service attendance
- % of patients have not completed a PHQ-2/9 screen annually with at least one outreach attempt
  o EMR report will be developed with analyst

What changes can we make that will result in an improvement?
This quality improvement activity will include PDSAs conducted every quarter to test approaches to improve outcomes. Possible tests of change include:

- Does the depression screening rate improve when staff are trained on using a script to administer the PHQ-2/9?
- Will warm handoffs to the Collaborative Care team improve the percentage of patients with a positive depression screen that develop a follow up plan?
- Will telephonic outreach to patients that have not completed a PHQ-2/9 screen annually, improve the depression screening rate?
Sample QI Project Charter: Antidepressant Medication Management

What are we trying to accomplish?
To increase the rate of antidepressant medication management for patients prescribed an antidepressant to 40%. We will accomplish this by:

- Developing a protocol for treatment of depression and follow up by the Collaborative Care team
- In-servicing clinicians on depression treatment protocol and patient education regarding duration of antidepressant therapy and side effects
- Creating outreach strategies for patients that are prescribed an antidepressant to assess if medication is taken as prescribed

How will we know that the change is an improvement?

- % of patients with a diagnosis of depression and who were treated with antidepressants that remained on an antidepressant medication treatment for at least 6 months
  - EMR report will be developed with analyst
- % of clinicians in-serviced on the protocol for treatment of depression and follow up by the Collaborative Care team
  - Implementation lead to track in-service attendance
- % of patients diagnosed with depression and prescribed an antidepressant with at least one outreach attempt every 3 months
  - Registry report will be developed with analyst

What changes can we make that will result in an improvement?
This quality improvement activity will include PDSAs conducted every quarter to test approaches to improve outcomes. Possible tests of change include:

- Does antidepressant medication adherence improve with more frequent contact between the patient and the Collaborative Care team?
- Will telephonic outreach to patients diagnosed with depression and prescribed an antidepressant, improve medication adherence?
- Will a patient activation or self-management mobile app help patients improved medication adherence?
Sample QI Project Charter: Initiation and/or Engagement of Alcohol and Other Drug Dependence Treatment

What are we trying to accomplish?

To increase the rate to 18% of patients 13 years of age and older with a new episode of alcohol and other drug (AOD) dependence who initiated treatment within 14 days of the diagnosis and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit. We will accomplish this by:

- Developing a protocol for screening for substance abuse and engagement of treatment for those with a positive screen
- In-servicing clinicians on the protocol for screening for substance abuse and engagement of treatment for those with a positive screen
- Creating outreach strategies for patients that engaged in alcohol or other drug dependence treatment

How will we know that the change is an improvement?

- % of patients 13 years of age and older with a new episode of alcohol and other drug (AOD) dependence who initiated treatment within 14 days of the diagnosis and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit
  - EMR report will be developed with analyst
- % of clinicians in-serviced on the protocol for screening for substance abuse and engagement of treatment for those with a positive screen
  - Implementation lead to track in-service attendance
- % of patients diagnosed with alcohol and other drug dependence with at least one outreach attempt every week
  - Registry report will be developed with analyst

What changes can we make that will result in an improvement?

This quality improvement activity will include PDSAs conducted every quarter to test approaches to improve outcomes. Possible tests of change include:

- Will warm handoffs to the Collaborative Care team improve the percentage of patients with a positive substance abuse screen that develop initiate treatment within 14 days of the diagnosis?
- Does engagement in AOD treatment improve with more frequent contact between the patient and the Collaborative Care team?
- Will telephonic outreach to patients diagnosed with alcohol and other drug dependence improve initiation and engagement of treatment?
APPENDIX C: ADMINISTERING THE PATIENT HEALTH QUESTIONNAIRES 2 AND 9 (PHQ-2 AND PHQ-9)\textsuperscript{15,16}

HOW ARE THE PHQ-2 AND PHQ-9 TOOLS USED?

The Patient Health Questionnaire (PHQ)-2 and PHQ-9 are commonly used and validated screening tools for depression in adults. The PHQ-2 is a tool used to screen for depression, while the PHQ-9 tool is used to screen and/or diagnose depression, measure the severity of symptoms, and measure a patient’s response to treatment. The PHQ-2 and PHQ-9 are validated tools, developed and owned by Pfizer, and are quick and easy to administer.

WHAT IS THE DIFFERENCE BETWEEN A PHQ-2 AND PHQ-9?

The PHQ-2 is a preliminary screening tool administered prior to the PHQ-9. If a patient responds ‘not at all’ to both questions on the PHQ-2 (asking if the patient has experienced little interest or pleasure in doing things and/or has felt down, depressed, or hopeless in the previous 2 weeks), then no additional screening or intervention is required, unless otherwise clinically indicated. If a patient responds ‘yes’ to one or both questions on the PHQ-2, the PHQ-9 should be administered and scored to inform treatment planning.

WHO CAN USE THE PHQ-2 AND PHQ-9?

The PHQ-2 and PHQ-9 are both publicly available, and no permission is required to use, reproduce, or distribute the tools. Additionally, the tools are free of cost to use and can be incorporated into electronic health records.

WHO CAN ADMINISTER THE PHQ-2 AND PHQ-9 TO PATIENTS?

The PHQ-2 and PHQ-9 are useful tools for integrated care settings, as they can be administered by a variety of different staff and can be used with different approaches. The PHQ-2 and PHQ-9 should be completed by the patient, usually in the waiting room, and then scored by a staff person. Often administrative staff or medical assistants score this form and subsequently enter the score into the electronic health record. In cases where patients have difficulty with reading or comprehension, a staff member can assist the patient in completing the tool. Assistance with completing the tools can be provided by any level of staff who has been trained in understanding the purpose and importance of the PHQ tools and in strategies for engagement and completion of the tools.

\textsuperscript{15} Kroenke K, Spitzer R, Williams W. The PHQ-9: Validity of a brief depression severity measure. JGIM, 2001, 16:606-616.

Each organization will need to identify the PHQ-9 score that necessitates intervention in their particular setting. This is generally a score of 10 or above and/or a positive answer on question 9 of the PHQ-9, which is a screening for suicidal symptoms. A workflow will need to be developed to identify appropriate staff responsibilities and procedures for responding to these scores. This workflow includes review by the team (primary care provider and behavioral health staff, if available). Ideally, this pathway is then embedded into the electronic health record as part of the standard care delivery process.

Patients receiving intervention should be provided with regular follow up and tracked for improvement in their PHQ-9 score. The administration of the PHQ for follow up can be done using phone calls and/or a smartphone application. Results from studies that have analyzed telephonic and electronic administration of the tool have demonstrated that these methods yield similar results to being administered in person. See sample screening in primary care workflow below.

---


STANDARD WORK FOR DEPRESSION: SCREENING IN PRIMARY CARE

Patient Registration

Patient self-administers PHQ2 before vitals

PHQ≥17?

Yes

Complete Visit (Treatment as usual)

No

PHQ≥10?

Yes

RN & PCP Notified

1) Reviews PHQ9
2) Completes clinical assessment

PCP assesses if depression is present

Yes

PCP
3) Enters depression diagnosis in EMR
4) Refers patient to Collaborative Care if appropriate

Warm Handoff to Collab Care SW/RN

No

PHQ9 monitored by PCP who makes referrals as appropriate.
IN WHICH POPULATIONS SHOULD THE PHQ-2 AND PHQ-9 TOOLS BE USED?

The PHQ-2/9 are appropriate to be used with individuals 12 years of age and older. There is also an adapted PHQ-9 for adolescents called the PHQ-9A. Alternative screening tools have been developed and validated for use among special populations including youth and older adults. These alternative tools can be accessed at: https://aims.uw.edu/resource-library/phq-9-depression-scale.

HOW OFTEN SHOULD THE PHQ-2 DEPRESSION-SCREENING TOOL BE ADMINISTERED?

The U. S Preventive Services Task Force (USPSTF) recommends screening for depression in adolescents ages 12 – 18 and in adults, including pregnant and postpartum women. “Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.” The American Academy of Family Physician recommendations mirror those of the USPSTF. The American Academy of Pediatrics recommends depression screening for adolescents beginning at age 11. At this time, there is no definitive guidance on how frequently someone should be screened for depression. The USPSTF states: “The optimum interval for screening for depression is also unknown; more evidence for all populations is needed to identify ideal screening intervals. A pragmatic approach in the absence of data might include screening all adults who have not been screened previously and using clinical judgment in consideration of risk factors, comorbid conditions, and life events to determine if additional screening of high-risk patients is warranted.” Certain populations with higher risks for depression, such as those with HIV infection, may be considered for regular screening. For example, the NY State AIDS Institute HIV guidelines recommend screening “for depression as part of the annual mental health assessment and whenever symptoms suggest its presence.” There is growing consensus that screening using evidence-based tools like the PHQ-9 is a critical component of delivering integrated care. The choice of how often and when is a workflow consideration. At NYC Health + Hospitals, patients are screened at every primary care visit to ensure that regular screening occurs.

WHAT DOES THE PHQ-9 SCORE MEAN FOR TREATMENT PLANNING?

The following chart provides guidance on how to use the PHQ 9 score to inform treatment planning.
Proposed Treatment Actions by PHQ 9 Score$^{21}$

<table>
<thead>
<tr>
<th>PHQ-9 Score</th>
<th>Depression Severity</th>
<th>Proposed Treatment Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>None - Minimal</td>
<td>None</td>
</tr>
<tr>
<td>5-9</td>
<td>Mild</td>
<td>Watchful waiting; repeat PHQ 9 at follow-up</td>
</tr>
<tr>
<td>10-14</td>
<td>Moderate</td>
<td>Treatment plan, consider counseling, follow up and/or pharmacotherapy</td>
</tr>
<tr>
<td>15-19</td>
<td>Moderately Severe</td>
<td>Active treatment with pharmacotherapy and/or psychotherapy</td>
</tr>
<tr>
<td>20-27</td>
<td>Severe</td>
<td>Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management</td>
</tr>
</tbody>
</table>

HOW OFTEN SHOULD THE PHQ-9 TOOL BE RE-ADMINISTERED TO ASSESS CHANGES IN A PATIENT’S STATUS?

The University of Washington’s Advancing Integrated Mental Health Solutions (AIMS) Center develops and tests evidence-based collaborative care resources and tools. The AIMS Center provides the following guidance on how often the PHQ-9 should be administered$^{22}$:

- Symptoms should be re-measured at each contact and at least once per month
- The PHQ-9 and other validated screening tools are not meant to replace the clinical judgement of the provider, but are important tools to assist the clinician and patient identify specific symptoms that cause difficulty for the patient in his or her daily life
- Symptom monitoring also allows the clinician and the patient to identify how the symptoms are responding to treatment over time
- Symptom response enables the team to adjust treatment when needed and to tailor the treatment intervention to the patient’s symptoms

ARE THE PHQ 2 AND 9 TOOLS AVAILABLE IN OTHER LANGUAGES?

The PHQ-2 and PHQ-9 and other versions of the PHQ are translated into other languages. English and translated versions of the instrument can be found at [www.phqscreener.com](http://www.phqscreener.com). The PHQ9 is best self-administered in the patient’s preferred language.

WHERE CAN I FIND ADDITIONAL INFORMATION?

Additional information on administering the PHQ-2 and PHQ-9 can be found at the following website: [www.phqscreener.com](http://www.phqscreener.com)

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$^{22}$ The University of Washington’s AIMS Center. Copyright © 2016 University of Washington. https://aims.uw.edu/
APPENDIX D: INCREASING STAFF SKILLS

Scripts for Staff

Your site may want to provide a script to staff with examples on how to explain the PHQ-2/9 to patients. Examples include:

**Explain Why You Discuss Depression: what these questions are, why you ask them, and the purpose of them.**

- “We give this survey to all of our patients because it’s important for your doctor to know not only how you’re feeling physically today, but also emotionally”
- “Feeling [sad, down, depressed, blue] can interfere with you taking care of yourself and getting/keeping your conditions under control.”
- “You may feel like you have no energy or interest to monitor your [blood sugar, blood pressure, diet].”
- “Forgetfulness can also be a part of feeling sad, so you may miss doses of your medication.”
- “Sometimes people isolate or withdraw from their family and friends. This may make you feel like it isn’t worth it – like you’ll never get better or get a handle on your [diabetes, cholesterol, heart disease].”
- “Studies show that feeling down, sad, or depressed can make your blood pressure go up, your blood sugars stay high, or your cholesterol stay high – even though you may be taking your medications just as your doctor prescribed.”
- “So, it’s important for us to explore your feelings. If you are sad or depressed, then we can work on some things to help you feel better and get more control over your health.”

**Explain How You Assess Depression using a standard form (PHQ-9)**

- “These questions may seem a little formal, but they are written so we can see how you are feeling. Sometimes patients have these symptoms and are not aware of it.”
- “These 9 questions are about symptoms. Just like a cold has symptoms of a runny nose, watery eyes, and cough – depression also has symptoms.”
- “We’ll ask these questions at every session. That way you, I, and your provider can see how your symptoms are changing and if our plan is working”
- “Do you have any questions for me before we start?”

**Common Questions and Suggested Answers When Talking to Patients about the PHQ-9**

Clinics often ask front desk reception, medical assistants, community health workers and other staff who have not had behavioral health training to interact with patients regarding screening and treatment monitoring for depression and other behavioral health conditions being treated in the clinic.
These staff sometimes feel unprepared to discuss these kinds of sensitive issues with patients and it’s important to make sure that they have the support and training they need to feel comfortable with patients. Whether or not clinic staff feel comfortable talking about behavioral health symptoms sends an important message to the patient. It’s important to send the message that the clinic, including all of the clinic staff, feel comfortable addressing these conditions and the clinic treats them the same they do any other condition being treated at the clinic.

This tool is designed to help clinic support staff with answers to common questions they may hear from patients to help increase their comfort talking with patients about the PHQ-9. It’s best for support staff to have the opportunity to role play these with other clinic staff to give them the opportunity to practice before using them with patients. It can also be helpful for support staff to keep this someplace where they can refer to it, as needed, when they get questions from patients.

<table>
<thead>
<tr>
<th>Q: Why do I need to fill this out?</th>
</tr>
</thead>
</table>
| **A:** **If screening:** Your provider is interested in how you are feeling. It’s like taking your blood pressure or temperature but it’s focused on how you’ve been feeling over the past 2 weeks. We ask these questions for all of our patients because we care about how you’re doing in all areas.  
**If already in treatment and being used for follow-up:** Your provider wants to know how you are feeling so that we know if the treatment is working. It’s important to measure regularly so that we can change the treatment if it’s not working. |

<table>
<thead>
<tr>
<th>Q: I don’t have these problems. Why do you want me to fill this out?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A:</strong> It’s like taking your blood pressure or temperature. We check everyone so that we can keep track of how you’re feeling over time. If you’re concerned about these questions you can talk with your provider about it.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q: Do I have to fill this out even if I’m not comfortable answering these questions?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A:</strong> You never have to fill out a form or answer questions that you’re not comfortable with. If you’re concerned about these questions you can talk with your provider about it.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q: I would rather just talk to my provider about these questions instead of filling this out. Is that OK?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A:</strong> Yes, of course.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q: I don’t understand some of these questions. Can you help me?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A:</strong> If you have questions about the specific items on the form and how they apply to you it would be best to talk about that with your provider.</td>
</tr>
</tbody>
</table>
APPENDIX E: ASSESSING SUICIDE RISK

It is important that your clinic has a written policy and procedure about what to do when a patient expresses suicidal ideation. If a patient answers a score of 2=more than half the days or a score of 3=nearly every day to Question 9 of the PHQ-9, then a more in-depth assessment of these thoughts must be conducted.

All staff should be knowledgeable and comfortable with the procedure, as they are dealing with depressed patients where this may come up. The better they know the policies and how to interact with a suicidal patient and what steps to take, the more comfortable staff will feel. It is recommended that staff role-play suicidal clinical situations with colleagues regularly. Practice increases competence.

A concise suicide protocol will include assessing the severity of self-harm, establishing a plan to address the issue and ensure the patient’s care, obtaining needed consultation and assistance, making appropriate referrals for the patient, and following up with the patient to ensure safety.

The P4 Screener

The P4 Screener is an example of a tool your organization can use to assess suicide risk. Any individual who responds “yes” to a question about thoughts of self-harm is asked 4 additional questions—the 4 P’s on past history, plan, probability, and preventive factors. Shaded responses are those that are more concerning for suicidal ideation.

![Image of the P4 Screener]

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23 [http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3067996/]
Implementation Toolkit: Integration of Primary Care and Behavioral Health Services

APPENDIX F: TREATMENT

Diagnostic Flowcharts: Depression and Anxiety\textsuperscript{24,25}

DEPRESSION FLOWCHART

- Symptoms: Does the patient have the symptoms and signs of depression?
  - Physical Symptoms
    - Increased or decreased appetite
    - Weight gain or loss
    - Changes in sleep patterns
    - Decreased or increased motor activity
    - Decreased energy
    - Aches and pains
  - Psychological Symptoms
    - Crying a lot
    - Depressed mood, feeling “bliss”
    - In children, increased irritability
    - Loss of pleasure in activities
    - Feelings of worthlessness
    - Feelings of guilt
    - Difficulty thinking or concentrating
  - Functional Changes
    - Sudden deterioration in functioning
    - Disengages from hobbies and interests
    - Lack of interest in things they used to care about
    - Social withdrawal
    - Lack of interest in sex
    - School failure
    - Lack of productivity at work

Other diagnoses/co-morbidities to consider:

- Diagnosis To Consider
  - Diabetes
  - Hypothyroidism
  - Sleep disorders
  - Multiple Sclerosis
  - Stroke or Parkinson’s disease
  - Dementia
  - Hepatitis B or C

- Other Psychological Disorders
  - Bereavement
  - Adjustment Disorder with Depressed Mood
  - Bipolar Disorder if mood is primarily irritability

- Substance Abuse
  - Cocaine withdrawal
  - Alcohol withdrawal
  - Oral steroids
  - Hormones: estrogen and progesterone
  - Pain medications
  - Benzodiazepines
  - Heart medications (e.g., Crystodigin and Lanoxin)
  - Night time cold medications

\textsuperscript{24} Greater New York Hospital Association (GNYHA). Collaborative Care Teaching Guide—Integrating Behavioral Health and Primary Care in Teaching Settings. 2016. \url{http://www.gnyha.org/PressRoom/Publication/680b5fd2-31eb-4ebe-9dec-ee0cebf1c42be/}

Depression Collaborative Care FAQ

What is the role of the primary care physician after the patient is referred?
PCPs maintain primary responsibility for the patient’s care. They are responsible to provide a depression diagnosis and prescribe medication if it is part of the treatment plan. They are also responsible for communicating with the Care Manager about symptoms monitoring or changes in the patient’s treatment plan.
How frequently should patients be contacted?
- “Warm hand off” occurs at initial visit and first contact should ideally be face-to-face
- Contacts (face-to-face or phone) should occur every 2-4 weeks depending upon acuity of patient’s needs
- At least one face-to-face contact with a licensed clinician (RN, MD, LMSW, LCSW) is required every three months.
- After initiating pharmacotherapy, response should be assessed on a regular basis. The frequency of patient contact is dependent on patient’s severity, but contact weekly or every two weeks is recommended.
- Helpful Tips:
  - Have a conversation with your patient early on what the time commitment looks like for them.
  - Ask your patients to identify a good time to call them and schedule an appointment at that time so you know they will be in a good place to talk.
  - Having difficulty reaching a patient? Check when their next appointment is at the facility and find them there.
  - Ask patients who in their social circle they speak with/see frequently. Ask them for that person’s name and contact info.

When do patients receive coaching?
- Collaborative Care uses brief, evidence based interventions to treat behavioral health conditions. Sometimes, this is referred to as coaching or counseling.
- Patients receive coaching (MI/BAP/CBT/PST) during any clinical interaction with an RN or LMSW.
- Patients leave every interaction with a small, manageable goal that the Care Manager can follow up on at the next contact.

How often should patients be assessed for improvement?
Patients should be administered a PHQ-9 at each patient contact (at least 1x per month)

How frequently should a patient receive psychiatric consultation?
All patients enrolled 70 days or greater who are not demonstrating clinically significant improvement in PHQ-9 score require a psychiatric consultation every 8-10 weeks (once per quarter). New patients should also have a psychiatric consultation to assess what the treatment plan should be. Use your electronic patient identification and tracking tool to help prioritize.

How long are patients enrolled in Collaborative Care for depression?
Minimum of 12 weeks, maximum of 12 months.

How often should treatment plans be revisited?
Treatment plans should be revisited at least every 8-10 weeks. If there is not at least a 50% decrease in PHQ-9 score at the end of 10 weeks, or a drop in PHQ9 score to below 10, the treatment plan is changed.
### Medication Management/Antidepressant Medication Chart

<table>
<thead>
<tr>
<th>MEDICATION CLASS AND NAMES</th>
<th>ADDITIONAL CONSIDERATIONS FOR PATIENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Selective serotonin reuptake inhibitors (SSRIs)</strong></td>
<td></td>
</tr>
<tr>
<td>- Used to treat depression, as well as anxiety disorders</td>
<td></td>
</tr>
<tr>
<td>- Common side effects include insomnia, weight gain, sexual dysfunction, and gastrointestinal upset</td>
<td></td>
</tr>
<tr>
<td>- Serious side effects include bleeding, confusion, and movement problems</td>
<td></td>
</tr>
</tbody>
</table>
| Generic name: citalopram  
*Trade name: Celexa* | Patients prescribed doses of 40 mg or higher may require an EKG to assess for QTc prolongation. |
| Generic name: escitalopram  
*Trade name: Lexapro* | Patients should be aware that dosage changes will take place slowly due to this medication’s high potency. |
| Generic name: fluoxetine  
*Trade name: Prozac* | Patients should be advised that this medication stays in the body for a long time (recommended for patients who have difficulty taking medication consistently). Patients should also be aware that problems may occur if they switch quickly to a new regimen and have fluoxetine remaining in their system. |
| Generic name: sertraline  
*Trade name: Zoloft* | Patients who are women of childbearing age may consider this drug since they can safely take it during pregnancy and lactation. |
| **Serotonin–norepinephrine reuptake inhibitors (SNRIs)** |
| - Used to treat major depressive disorder, other mood disorders, and some anxiety disorders |
| - Common side effects include insomnia, sexual dysfunction, and gastrointestinal upset |
| - Serious side effects include elevated blood pressure and anxiety |
| Generic name: venlafaxine  
*Trade name: Effexor XR* | Patients should be warned about nausea and vomiting side effects for this medication. |
| Generic name: duloxetine  
*Trade name: Cymbalta* | Patients should consider this medication for its ability to relieve co-morbid neuropathic pain or peripheral neuropathy from diabetes. |

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26 Greater New York Hospital Association (GNYHA). *Collaborative Care Teaching Guide—Integrating Behavioral Health and Primary Care in Teaching Settings*. 2016. [http://www.gnyha.org/PressRoom/Publication/680b5fd2-31eb-4eeb-9dec-ee0ceb1c42be/](http://www.gnyha.org/PressRoom/Publication/680b5fd2-31eb-4eeb-9dec-ee0ceb1c42be/)
**Treatment Monitoring and Follow-Up**

**RECOMMENDATIONS FOR DEPRESSION FOLLOW-UP CONTACTS**

Provider or Nurse/Social Worker should follow up with the patient by phone or face-to-face at least within 1-2 weeks after initiation of therapy (meds, BA/PST). Additional follow ups may be suggested by the Psychiatric Consultant.

**Goals of the Follow up Contacts:**
1. Assess for medication adherence
2. Assess for side effects of medication and offer management suggestions
3. Provide coaching using brief, evidence-based interventions (MI/BA/PST/CBT)
4. Assess for suicidality – (see Appendix 2)
5. Repeat PHQ-9 at designated frequency

**Definitions for Monitoring Treatment**
Clinically Significant Improvement: 50% reduction from baseline PHQ-9 score or reduction from baseline PHQ-9 score to less than 10
Response: 50% decrease in PHQ-9 score
Remission: PHQ-9<5 maintained for 2 or more months
The following table outlines example activities that should occur with Collaborative Care, the team member responsible for completing the activity, and the time frame recommended for each activity to occur to provide stepped care treatment adjustments.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Team member(s)</th>
<th>Recommended Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction to Collaborative Care Program</td>
<td>PCP, Collaborative care manager</td>
<td>At time of referral (warm hand off)</td>
</tr>
<tr>
<td>Initial assessment</td>
<td>Collaborative care manager (RN/LMSW)</td>
<td>Within 1 week of referral</td>
</tr>
<tr>
<td>Depression diagnosis</td>
<td>PCP</td>
<td>At time of enrollment</td>
</tr>
<tr>
<td>Initial psychiatric consultation</td>
<td>Collaborative care manager, Psychiatric Consultant</td>
<td>Within 1 week of referral</td>
</tr>
<tr>
<td>Treatment start</td>
<td>Collaborative care manager, PCP</td>
<td>Within 1 week of referral</td>
</tr>
<tr>
<td>F/U with patient re: treatment (e.g. barriers, questions, side effects), progress toward behavioral activation goal</td>
<td>Collaborative care manager</td>
<td>Every 1-2 weeks during initial phase of treatment (while PHQ-9 is not demonstrating clinically significant improvement)</td>
</tr>
<tr>
<td>Determine if current treatment plan has produced significant reduction in symptoms from baseline</td>
<td>Collaborative care manager</td>
<td>8 – 10 weeks from initiation of treatment plan</td>
</tr>
<tr>
<td>Consult w/psychiatric consultant about recommended changes to treatment plan if patient not demonstrating clinically significant improvement after 8 – 10 weeks on current treatment plan</td>
<td>Collaborative care manager, Psychiatric Consultant</td>
<td>8 – 10 weeks from initiation of current treatment plan</td>
</tr>
<tr>
<td>Implement changes to treatment plan, if needed</td>
<td>Collaborative care manager, PCP</td>
<td>No longer than 8 – 10 weeks from initiation of most recent treatment plan; repeat as frequently as necessary to achieve significant reduction in symptoms from baseline PHQ-9</td>
</tr>
<tr>
<td>Follow-up with patient re: maintenance of treatment response</td>
<td>Collaborative care manager</td>
<td>At least 1x per month for 3 months after PHQ-9 has been significantly reduced from baseline</td>
</tr>
<tr>
<td>Activity</td>
<td>Team member(s)</td>
<td>Recommended Timing</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>---------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Complete relapse prevention plan</td>
<td>Collaborative care manager</td>
<td>After PHQ-9 is demonstrating clinically significant improvement measured by: • A 50% reduction from baseline PHQ-9 OR • A drop from baseline PHQ-9 &lt; 10</td>
</tr>
<tr>
<td>Patient graduated from Collaborative Care and back to care of referring PCP</td>
<td>Collaborative care manager, PCP</td>
<td>Depression Diagnosis: PHQ9 sustained below 10 for 3 months or more.</td>
</tr>
</tbody>
</table>

**STANDARD WORK: PHQ-9 SCORE FOLLOW UP**

The following table outlines treatment response and planning per the score of the PHQ-9.

<table>
<thead>
<tr>
<th>PHQ-9</th>
<th>Treatment Response</th>
<th>Treatment Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drop of ≥ 5 points from baseline or PHQ-9 &lt; 5</td>
<td>Adequate</td>
<td>No change in treatment needed. Conduct monthly follow-ups until remission, then at least every 6 months.</td>
</tr>
<tr>
<td>Drop of 2 – 4 points from baseline</td>
<td>Possibly inadequate*</td>
<td>Consider change in treatment • Consider adding pharmacotherapy if not yet part of treatment plan • Increase dose or change medication Change clinical coaching strategy</td>
</tr>
<tr>
<td>No change or improvement</td>
<td>Inadequate*</td>
<td>Obligate change in plan (as above). Consider specialist consultation, collaboration or referral.</td>
</tr>
</tbody>
</table>

* Assess for medication adherence prior to making medication and treatment changes. Identify and address your patients to understand reasons for non-adherence (stigma, cost, side effects, and concerns about addictive potential of meds. Use the Clinical Decision Aid Cards for Depression Medication Choice to guide these discussions)
### MANAGING COMMON SSRI SIDE EFFECTS

<table>
<thead>
<tr>
<th>Side Effect</th>
<th>Epidemiology</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>GI distress (nausea, diarrhea)</td>
<td>Transient; usually improves within 2-3 weeks</td>
<td>Take SSRI with meals. Reassure patient</td>
</tr>
<tr>
<td>Agitation/insomnia (“jittery feeling”)</td>
<td>Transient; usually improves within 2-3 weeks</td>
<td>Take in morning. Reassure patient. Consider adjuvant sedative-hypnotics/anxiolytics</td>
</tr>
<tr>
<td>Sedation</td>
<td>Sometimes improves</td>
<td>Take at bedtime</td>
</tr>
<tr>
<td>Sexual dysfunction (anorgasmia, delayed ejaculation and decreased libido)</td>
<td>Prevalence approaches 50% with all SSRI’s. Does not improve with time!</td>
<td>• Lower dose of SSRI or switch to another SSRI or to buproprion or mirtazapine • Add buproprion (limited, inconsistent data) • Add sildenafil (RTC evidence suggests improvement in men)</td>
</tr>
</tbody>
</table>

### WHEN TO CONSIDER “ACCELERATED” PSYCHIATRIC CONSULTATION?

Nurse/Social Workers and PCPs should consider “accelerated” consultation or referrals with the supervising psychiatrist in the following instances:
1. “Active” suicidal ideation or recent suicide attempts.
2. Psychosis
3. Severe bipolar disorder
4. Significant personality disorder
5. Impairing substance abuse or dependence
6. History of poor response to antidepressant medications
Collaborative Care Case Closure

Graduated
- A Collaborative Care enrollee is considered graduated when s/he has transitioned back to “regular” primary care. His/her PCP has been notified that they have graduated from the Collaborative Care program and their care plan has been adjusted to focus on maintaining good control of their chronic disease(s).
- A patient is eligible for graduation when:
  - Depression Dx: PHQ-9 score < 10 or 50% reduction in PHQ-9 from baseline score sustained over 3 months

Referred Out
- If patients do not demonstrate significant improvement in PHQ-9 score after 6 months, the team should consider referral out of Collaborative Care to more intensive treatment. These patients are no longer tracked or receive care through Collaborative Care.

Dropped Out
- An enrolled patient with no successful Collaborative Care encounter over the course of 6 – 8 weeks and 1 of the following:
  - Patient confirms that they are dropping out during a patient encounter
  - There has been no patient contact after 3 documented attempts to contact the person over at least 6 weeks (i.e. Lost to follow up)

Depression Relapse Prevention Plan
Depression can occur multiple times during a person’s lifetime. The purpose of a relapse prevention plan is to help the patient understand his/her own personal warning signs. These warning signs are specific to each person and can help the patient identify when depression may be starting to return so they can get help sooner – before the symptoms get bad. The other purpose of a relapse prevention plan is to help remind the patient what has worked for him/her to feel better. The relapse prevention plan should be filled out by the care manager and the patient together and available in the patient’s chart.27

Relapse Prevention Plan

Date: ______________

**Purpose:** Depression can occur multiple times during a person’s lifetime. The purpose of a relapse prevention plan is to help you understand your own personal warning signs. These warning signs are specific to each person and can help you identify when depression may be starting to return so you can get help sooner – before the symptoms get bad. The other purpose of a relapse prevention plan is to help remind you what has worked for you to feel better. Both of these put YOU in charge!

**Instructions:** 1. Fill out this form with your care manager. 2. Put it where you’ll come across it on a regular basis. 3. Use the PHQ-9 on the back to self-assess yourself. 4. If you see signs of returning depression, use your prevention plan.

### Maintenance medications

| 1. | _______________________________ | ___________________________ | __________________________ |
| 2. | _______________________________ | ___________________________ | __________________________ |
| 3. | _______________________________ | ___________________________ | __________________________ |
| 4. | _______________________________ | ___________________________ | __________________________ |

**Call your primary care provider or your care manager with any questions (see contact information below).**

### Other treatments

1. ________________________________________________
2. ________________________________________________
3. ________________________________________________

### Personal warning signs

1. ________________________________________________
2. ________________________________________________
3. ________________________________________________
4. ________________________________________________

### Things that help me feel better

1. ________________________________________________
2. ________________________________________________
3. ________________________________________________
4. ________________________________________________

If symptoms return, contact: ________________________________________________

Primary Care Provider: ___________________________ Phone: ___________________________ Email: ___________________________

Care Manager: ___________________________ Phone: ___________________________ Email: ___________________________

Next appointment Date: __________ Time: ________________

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APPENDIX G: PATIENT ENGAGEMENT & EDUCATION

The Collaborative Care Model consists of structured, brief clinical interactions between a Depression Care Coordinator and patient using a “toolbox” of skills including: Motivational Interviewing, Behavioral Activation, Brief Action Planning, Problem Solving Treatment & other brief therapeutic interventions. Medication will be provided to treat the patient as needed.

The patient should have a **minimum of one substantive contact** with a member of the Collaborative Care team per month. In acute phase of treatment, encounters should occur every week or every two weeks. An encounter includes any in-person or phone encounter with a clinical staff person where any aspect of the patient’s care plan was discussed (i.e. medication adherence, Behavioral Activation, Motivational Interviewing, PHQ-9 administration). This does not include visit reminders or voicemails.

The patient should be **engaged** during an initial encounter, which could occur during a warm hand-off or phone contact. *During this encounter, a care manager should* introduce him/herself and the Collaborative Care team and take the following steps:

- Assess patient’s goals, supports and barriers to treatment
- Use active listening so patient knows that you hear and understand his/her priorities
- Meet patients where they’re at. Not all patients will be ready to engage in the program/treatment from day one.
- Set a behavioral activation goal and follow up within the week by phone to see if s/he met their goal.
- Schedule a follow up appointment. Ask: “When is good for you to meet?”

**Tip:** If an enrolled patient is not responsive to voicemails or misses an appointment, try to “catch” them at their next PCP appointment and re-engage them at that time.

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**Patient Education**

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

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differences and specific needs. Resources, including sample flyers introducing the Collaborative Care team, videos, and commonly asked questions can be found at: http://aims.uw.edu/collaborative-care/implementation-guide/launch-your-care/educate-your-patients

**Motivational Interviewing**

Motivational interviewing (MI) is a collaborative, patient-centered technique to elicit and strengthen motivation for change. Resident PCPs can use motivational interviewing as a mechanism to engage patients as treatment plans are developed and updated. Motivational interviewing uses open-ended questions, patient affirmations and reflections, and summaries (known collectively as “OARS”) to guide discussion with patients.

Motivational interviewing has three important elements to involve patients in conversations and decision-making:

- **Collaboration**: Build trust by demonstrating a mutual understanding with patients
- **Evocation**: Prompt patients to share what they prioritize and what they are most interested in changing
- **Autonomy**: Allow patients to take the lead on decisions

Motivational interviewing has four principles that providers should follow:

- **Express empathy**: Consider patient perspectives and concerns, and communicate understanding and support
- **Support self-efficacy**: Highlight strengths patients have displayed during their treatment
- **Roll with resistance**: When a provider does not see eye-to-eye with a patient, the provider should encourage the patient to continue thinking about the best solution for him or her, rather than challenging the patient
- **Develop discrepancy**: Help patients think about their current challenges and behaviors, and how they may conflict with their future, self-identified goals

**MOTIVATIONAL INTERVIEWING RESOURCES**

- **Training Teams** is an organization made up of several groups. Its mission is to provide training and technical support to mental health providers in the Kansas Medicaid program. Their site provides tools for motivational interviewing, including videos, resources for providers, and case studies:
  - **Video**: The Ineffective Physician: Non-Motivational Approach
  - **Video**: The Effective Physician: Motivational Interviewing Demonstration

Behavioral Activation

Behavioral activation is a component of cognitive behavioral therapy and a proven method to treat depression. Behavioral activation encourages patients to decrease the avoidance and isolation that may result from their depression or anxiety. It can take place in one-on-one or group therapy sessions, and often includes patient tools such as activity logs and worksheets.

BEHAVIORAL ACTIVATION RESOURCES

- **Psychology Tools** was created by a clinical psychologist who wanted to develop and share materials, and has additional behavioral activation worksheets:
  - Video: Behavioral Activation
  - Video: Behavioral Activation with a Therapist Role Play: Schedule
  - Video: Behavioral Activation: Primary Care Office Demonstration

Shared-Decision Making

Shared decision-making is a collaborative process that allows patients and their providers to make health care decisions together, taking into account evidence-based medicine, as well as the patient's values and preferences. Shared decision-making can be a component of motivational interviewing.

Shared decision-making can be used in patient treatment planning, medication selection, and other areas of treatment.

SHARED-DECISION MAKING RESOURCES

- Video: Depression Medication Choice—Demo
  - Video: Diabetes Medication Choice—Typical Patient

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30 Greater New York Hospital Association (GNYHA). *Collaborative Care Teaching Guide—Integrating Behavioral Health and Primary Care in Teaching Settings*. 2016. [http://www.gnyha.org/PressRoom/Publication/680b5fd2-31eb-4eeb-9dec-ee0ceb1c42be/](http://www.gnyha.org/PressRoom/Publication/680b5fd2-31eb-4eeb-9dec-ee0ceb1c42be/)

31 Greater New York Hospital Association (GNYHA). *Collaborative Care Teaching Guide—Integrating Behavioral Health and Primary Care in Teaching Settings*. 2016. [http://www.gnyha.org/PressRoom/Publication/680b5fd2-31eb-4eeb-9dec-ee0ceb1c42be/](http://www.gnyha.org/PressRoom/Publication/680b5fd2-31eb-4eeb-9dec-ee0ceb1c42be/)
SHARED-DECISION MAKING FLOWCHART

“How would you like to go about making this decision?”

Informed patient decides  Informed patient defers to clinician

“What is important for you to consider about this decision?”

Risk communication

Use behavioral menu as needed:
- Permission to share
- 2 or 3 Ideas
- Anything else they’ve thought of?

“What do you think you will do?”

If no decisional conflict

Address decisional conflict when present

“Can you tell me back what we’ve talked about regarding this decision so I know if I was clear?”

Document choice

The Spirit of Motivational Interviewing is the foundation for Shared Decision-Making: Compassion, Acceptance, Partnership, and Evocation


BEHAVIORAL ACTIVATION WORKSHEET\textsuperscript{33}

**Scheduling Pleasant – Social – Physical Activities:** Plan at least one activity each day. It is an important way to deal with stress and depression. Schedule out a week’s worth of daily activities.

Each day should contain at least one activity. These can be pleasant, social, or physical activities. For example, a pleasant activity might be putting together a puzzle or some hobby, a social activity might be having tea with a neighbor, and a physical activity might be going for a walk.

*Rate how satisfied you felt after doing the activity:*

<table>
<thead>
<tr>
<th>Day</th>
<th>Date</th>
<th>Activity (What? Where? With whom?)</th>
<th>HOW SATISFIED DID YOU FEEL?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mon</td>
<td></td>
<td></td>
<td>0 = Not Satisfied</td>
</tr>
<tr>
<td>Tue</td>
<td></td>
<td></td>
<td>10 = Super Satisfied</td>
</tr>
<tr>
<td>Wed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thu</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Fri</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sat</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sun</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\textsuperscript{33} Greater New York Hospital Association (GNYHA). *Collaborative Care Teaching Guide—Integrating Behavioral Health and Primary Care in Teaching Settings.* 2016. [http://www.gnyha.org/PressRoom/Publication/680b5fd2-31eb-4e4b-9dec-ee0ceb1c42be/](http://www.gnyha.org/PressRoom/Publication/680b5fd2-31eb-4e4b-9dec-ee0ceb1c42be/)
PATIENT EDUCATION: INITIATING ANTIDEPRESSANT MEDICATIONS

The following information is useful when counseling patients about Antidepressant Medications:

1. Antidepressants work only if taken every day. Benefits from medications appear slowly. Most people need to take an antidepressant for at least 6 weeks to get the full effect.

2. Antidepressants are not addictive.

3. SSRI’s are generally well tolerated.

4. Continue antidepressants even after you are feeling better.

5. Mild side effects are common and usually improve over time. Contact your Nurse/Social Worker or physician for suggestions on how to manage side effects.

6. If you are thinking about stopping your antidepressant please contact your physician or Nurse/Social Worker first.

7. The goal of depression treatment is complete remission: sometimes this takes a few attempts.

8. We will monitor your response to treatment using the PHQ-9 questionnaire. Please complete this form at each visit.

9. Some patients may experience a usually brief period of restlessness/agitation or mood worsening especially with SSRIs. Should this happen to you, contact your PCP/care manager.
APPENDIX H: CASE REVIEW GUIDES

COLLABORATIVE CARE CASE REVIEW MEETINGS

Case review meetings should occur on a weekly basis and involve the Collaborative Care team.

Consultation with the psychiatrist may additionally occur outside the weekly case meeting over the phone or in a one-on-one setting. Newly enrolled patients, patients not demonstrating clinically significant improvement, and/or patients who present another cause for concern to care manager should be prioritized during the case review meetings. Patients who are not demonstrating clinically significant improvement require a psychiatric consultation once every three calendar months (every quarter).

It is important that clinical sites designate an ongoing time and location for case review meetings. One individual should be tasked to run these meetings. Staff should come prepared with a list of patients that has been flagged for the following: Patients who have never had a psychiatric consultation or who are not demonstrating clinically significant improvement in their depression score and have not had a psychiatric consultation that month.

PATIENT’S INITIAL CASE REVIEW GUIDE

The following information is a guide for patient information to discuss during the Case Review meeting between the Consulting Psychiatrist and Care Manager:

Brief ID: MRN, Name, Age, Gender

Suicidality
  - Endorsed?
  - Passive (without plan or intent), active (with plan/no intent) or active (with plan and intent). What was the follow up?
  - Suicidal history

Current Behavioral Health Conditions and Symptoms
  - Baseline PHQ-9 Score
  - Current PHQ-9 Score
  - Diagnosis *all Collaborative Care patients require a Depression diagnosis

History of Behavioral Health Conditions
  - History of behavioral health problems
  - History of behavioral health treatment and effectiveness of treatment
    - Medications: Type? Dosage? Efficacy? Side Effects?
    - Clinical Treatment: Type? Duration? Efficacy?

Psychosocial Factors
homelessness?
• social support?
• domestic violence or history of abuse?

medical problems
• pain?
• diabetes? hypertension? (a1c & bp values)
• body mass index?

current treatment
• medication? if yes: type, dose, efficacy, side effects
• coaching (mi, bap, pst)
• referrals (for concrete resources: housing, education, etc)

patients follow-up case review guide
* to be done when a patient is not demonstrating clinically significant improvement in phq-9 score as demonstrated by:
• a 50% reduction from baseline phq-9 or
• a drop from baseline phq-9 to less than 10

brief id: mrn, name, age, gender, date of enrollment

Suicidality
• Endorsed?
• Passive (without plan or intent), active (with plan/no intent) or active (with plan and intent). What was the follow up?
• Suicidal history

Current Behavioral Health Conditions and Symptoms
• Baseline PHQ-9 Score
• Current PHQ-9 Score
• Diagnosis *all collaborative patients require a depression diagnosis

Medical Problems
• Pain?
• Diabetes? Hypertension? (A1C & BP values)
• Body Mass Index?

Current Treatment
• Medication? If yes: type, dose, efficacy, side effects
• Coaching (MI, BAP, PST)
  • What strategies is the Care manager using?
  • What was the patient’s last Behavioral Activation Goal? Did s/he accomplish it?
• Referrals (For concrete resources: Housing, education, etc)
APPENDIX I: COLLABORATIVE CARE BILLING

NYS OMH reimburses for Collaborative Care Depression treatment for Medicaid patients. In addition, as of January 2017, CMS announced that Medicare will reimburse for Collaborative Care treatment for behavioral health conditions.

MEDICAID COLLABORATIVE CARE DEPRESSION TREATMENT PROGRAM

Article 28 outpatient clinics that have been certified as participants of the NYS Medicaid Collaborative Care Depression Program are eligible to receive supplemental Medicaid payments for collaborative care services provided to Medicaid fee-for-service and Medicaid managed care recipients.

In order to bill for the Collaborative Care Monthly Case Payment, the primary care provider and/or depression care manager must have a minimum of one clinical contact with the patient and a completed symptom scale (PHQ-9) every 30 days. This contact may include individual or group psychotherapy visits or telephonic engagement as long as treatment is delivered. In addition, there must be a minimum of one face-to-face contact with the patient by an appropriately licensed person for a minimum of 15 minutes every three months. This monthly case rate can be billed for up to 12 times. The payment will be $112.50.

To bill for Collaborative Care there must be at least one face to face contact with an appropriately licensed practitioner or face to face contact in a group setting with an appropriately licensed practitioner for the month of the claim or one of the two months immediately prior. For example, to bill for June, there must have been a face to face contact in April, May or June. If this “three month” standard has not been met, the provider may not bill again until the above described contact has occurred. The payment for the monthly case rate code can be billed a maximum of two times. The payment will be $225.00.

For months where there was no face to face contact with a licensed professional, there must be at least one contact with a non-licensed professional (face to face or phone) or a telephonic contact with a licensed professional. In sum, there must be one monthly contact at all times to maintain the monthly case payment. (There must also be documentation of a completed PHQ-9 monthly in the patient’s record, subject to audit, to qualify for the monthly case payment).

25% of the full monthly case payment will be withheld by the state. This retainage will be paid to the provider every 6 months as long as the provider has complied with the full terms of the Collaborative Care program and has documented patient outcomes as specified by the program. Before this rate code can be billed, the monthly case rate must have been billed for 6 months, or for at least 4 months if a patient has left the program. The retainage code can be billed a maximum of two times. The payment will be $225.00.

**MEDICARE PAYMENTS FOR INTEGRATED BEHAVIORAL HEALTH SERVICES**

The Centers for Medicare & Medicaid Services announced final rules for Medicare payments for services provided by primary care providers for patients participating in a collaborative care program or receiving other integrated behavioral health services. The payment structure may be used to treat patients with any behavioral health condition that is being treated by the billing practitioner, including substance use disorders.

Please see below for useful online references that describe the new Medicare benefit including:

  (See pages 61-74 of the PDF; or 80230 –80243 in the print version of the document)
APPENDIX J: COMMUNITY RESOURCES

Behavioral Health Services

- NYC Mental Health Service finder
  https://maps.nyc.gov/mental-health/

- SAMHSA Behavioral Health Treatment Services Locator
  https://findtreatment.samhsa.gov/

- Call 1-800-LIFENET
  Lifenet is a free, confidential help line for New York City residents. You can call 24 hours per day/7 days a week. The staff of trained mental health professionals help callers find mental health and substance abuse services.

  1-877-AYUDESE (1-877-298-3373) in Espanõl
  1-877-990-8585 for Korean and Chinese callers (Mandarin & Cantonese)
  1-212-982-5284 (TTY for hearing impaired)

Social and Functional Needs

- ACCESS NYC
  Determine your eligibility for more than 30 City, State and Federal human service benefit programs (including the benefits listed in the Benefits Guide) at ACCESS NYC, a free online service developed by New York City. You may also apply or renew your application for some benefit programs on ACCESS NYC.
  https://a069-access.nyc.gov/ACCESSNYC/application.do

- Health Information Tool for Empowerment (HITE)
  HITE is a free online resource directory to help connect New Yorkers to over 5,000 free and low-cost health and social services.
  http://hitesite.org/
APPENDIX K: ADDITIONAL COLLABORATIVE CARE MODEL RESOURCES

Additional resources for implementing Collaborative Care and the IMPACT model at your site can be found on the University of Washington AIMS Center site. Specific tools include:

AIMS Center Implementation Guide
https://aims.uw.edu/collaborative-care/implementation-guide

AIMS Resource Library
https://aims.uw.edu/resource-library

University of Washington IMPACT Intervention Manual

DIAMOND for Depression, Institute for Clinical Systems Improvement
https://www.icsi.org/_asset/rs2qfi/diamondwp0614.pdf

Integrated Care Models, SAHMSA-HRSA Center for Integrated Health Solutions
http://www.integration.samhsa.gov/integrated-care-models

New York State Collaborative Care Initiative, AIMS Center, University of Washington
http://uwaims.org/nyscci/pcmh/

Quick Start Guide to Integrated Care for Safety Net Providers, SAHMSA-HRSA Center for Integrated Health Solutions
https://www.thinglink.com/channel/622854013355819009/slideshow

CMS Fact Sheet on Behavioral Health Interventions, Including Collaborative Care
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Behavioral-Health-Integration-Fact-Sheet.pdf

CMS FAQ’s on the Behavioral Health Intervention Codes, Including Collaborative Care
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Behavioral-Health-Integration-FAQs.pdf

NEJM article on payment for Collaborative Care Model

Information on Quality and Payment Reform
SUPPORTING LITERATURE


