



## Collaborative Care Documentation Templates and Smartphrases

This document provides examples of EHR documentation templates currently used by an organization delivering CoCM services. Please use and adapt as your organization desires. Also note that these examples include “Patient/Parent/Caregiver” for application to adult and pediatric populations.

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## Behavioral Health Care Manager Documentation

### Smartphrases Used for Referral and Introduction to CoCM

#### Progress Note: Unable to reach

Use this smart phrase when you are contacting a patient/parent/caregiver regarding referral for CoCM, but you are unable to reach them.

**Reason for Contact:**

**Type of Contact:**

**Total Time Spent:** \*\*\*

BHCM received referral, reviewed chart, and attempted to contact patient/parent/caregiver for follow up on referral for the CoCM program. Unable to reach the patient/parent/caregiver, but a message with minimal information (due to HIPAA and confidentiality) was left requesting return phone call.

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[signature\*\*\*]

#### Introducing Patient to CoCM using Patient Portal

It is best practice to speak with a patient/parent/caregiver directly to introduce the CoCM program, but this is not always possible. When you have been unable to contact the patient/parent/caregiver directly, you may use this smart phrase to initiate contact via portal regarding referral for CoCM or introducing CoCM to a patient/parent/caregiver.

Dear \*\*\*,

I am reaching out to you because you have been referred to the psychiatric collaborative care (CoCM) program by your **medical provider** @medical provider. One of the goals of the CoCM program is to help you and your medical provider manage your mental health care without requiring you to go to a different doctor. We primarily focus on decreasing symptoms of depression and anxiety. As part of CoCM, you will receive regular contact from me to help you track your progress. This contact could be by phone, email, portal, or face-to-face visits as you prefer. Additionally, I will consult with a psychiatrist who will assist in making medication recommendations. You will not meet with the psychiatrist, but I will have the opportunity to present and discuss any medication concerns or questions you may have with them. The psychiatrist will then make a recommendation to @medical provider name@ on medications that may be helpful for you. to move forward with your medication. Your medical provider will then discuss these options with you and the two of you will decide on a treatment plan. I will keep

@medical provider's name@ and the treatment team up to date so they can make changes to your medications and treatment plan when needed. In addition to tracking your progress, I will also be available to you via phone and at scheduled appointments for additional support to help you meet your treatment goals.

With that said, there are some instances where it is determined that this program may not be the best fit and/or appropriate. Nonetheless, if this is determined, we can assist you in identifying and connecting with other treatment options.

Please let me know if you have any questions/concerns, or if you are interested in scheduling an assessment. I can be reached Monday - Friday at [insert phone number\*\*\*] or by portal message.

I look forward to hearing from you!

Sincerely,

--

[signature \*\*\*]

#### [Attempted Contact via Patient Portal re: Referral](#)

Use this when you have attempted to contact patient/parent/caregiver via portal message regarding referral.

**Reason for Contact:** \*\*\*

**Type of Contact:** \*\*\*

**Total Time Spent:** \*\*\*

This writer sent a portal communication to patient/parent/caregiver to follow up on referral to the CoCM program.

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[signature \*\*\*]

#### [Discussing Referral with Patient](#)

Use this smart phrase when contacting a patient/parent/caregiver about referral to CoCM.

**Reason for Contact:** {ContactReason:39543}

**Type of Contact:** {Type of Contact:38981}

**Total Time Spent:** \*\*\*

**INTERVENTIONS:**

This writer contacted patient/parent/caregiver to discuss patient referral to the psychiatric collaborative care (CoCM) and introduced the CoCM program and provided general information regarding the program. BHCM conducted screening tools of **PHQ9** and **GAD7** for baseline data (included below). Patient/parent/caregiver confirmed patient symptoms of **anxiety** and **depression**. They verbalized interest in engaging in CoCM for additional support and scheduled time to complete an initial assessment on [Date].

**Metrics:**

PHQ-9: GAD-7

**Consent:**

*Patient/parent/caregiver consented to CoCM program participation, including the roles of psychiatric consultant, BHCM, and other relevant specialists. {Yes/No:39546}*

*Patient/parent/caregiver was made aware of their responsibility for potential cost-sharing expenses (copay, deductible) for CoCM services. {Yes/No:39546}*

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[signature \*\*\*]

## Smartphrases Used for Consent for Billing Patients Not Yet Enrolled in CoCM

### Pending Consent

To be used when you contact a patient/parent/caregiver to pitch the program, but they do not consent for billing (would like to check with insurance). If the patient chooses to defer until insurance coverage is confirmed, the BHCM would place an intro note in the chart but add an indication that patient/parent/caregiver defers consent for CoCM participation pending further information/exploration.

**Reason for Contact:** {ContactReason:39543}

**Type of Contact:** {Type of Contact:38981}

**Total Time Spent:** \*\*\*

**INTERVENTIONS:**

This writer contacted patient/parent/caregiver to discuss the psychiatric collaborative care (CoCM) program. Behavioral health care manager (BHCM) introduced the CoCM program and general information regarding the program, including psychiatric consultant role and CoCM billing.

*Patient/parent/caregiver is interested in CoCM, however would like to {Pending Consent Reasons:40898:1}*

*Patient/parent/caregiver is interested in receiving a follow-up call/contact from BHCM.*

*{Yes/No:39546:1}. BHCM will contact patient/parent/caregiver on \*\*\* to review this further.*

**Consent:**

*Patient/parent/caregiver was informed about the CoCM program, the role of psychiatric consultant, CoCM billing, and their responsibility for potential cost-sharing expenses (copay, deductible) for CoCM*

services. Patient/parent/caregiver is interested in CoCM, however full consent is pending until next contact. {Yes/No:39546:1}

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[signature \*\*\*]

### Consent for Billing

You may use this to plug in the consent in a note other than outlined above. For example, if you speak to a patient/parent/caregiver to pitch the program and they want to complete the assessment same day, ensure that you are placing this Smartphrase in your assessment note to indicate consent for billing.

#### **Consent:**

*Patient/parent/caregiver consented to CoCM program, including the roles of psychiatric consultant, BHCM, and other relevant specialists. Yes*

*Patient/parent/caregiver was made aware of their responsibility for potential cost-sharing expenses (copay, deductible) for CoCM services. Yes*

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### Patient Declined Referral

When a patient/parent/caregiver declines CoCM services

#### **Reason for Contact:**

#### **Type of Contact:**

**Total Time Spent:** \*\*\*

#### **INTERVENTIONS:**

This writer contacted patient/parent/caregiver to discuss referral to the psychiatric collaborative care (CoCM) program. Behavioral health care manager (BHCM) introduced the CoCM program and general information regarding the program. At this time, patient/parent/caregiver has declined to participate in CoCM. They are aware that they can connect with @medical provider@ they are interested in exploring CoCM in the future. CoCM remains available for consultation, as needed. No further interventions planned at this time.

#### **Metrics:**

PHQ-9:

GAD-7:

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[signature \*\*\*]

## Smartphrases Used for CoCM Clinical Assessments

### CoCM Intake Assessment

Use the assessment template when you speak with a patient/parent/caregiver for an initial assessment.

**Reason for Contact:**

**Type of Contact:**

**Total Time Spent: \*\*\***

Date of Service: @TD@

Treating Clinician/Clinic: @medical provider@

Type of contact: {Type of Contact:38981}

Total time of contact: \*\*\*

Brief Summary: @NAME@ is presenting with depression and anxiety symptoms, seeking evaluation from the CoCM program. This writer spoke with (patient/parent/caregiver name(s) to complete this assessment.

#### **PLAN:**

Patient/parent/caregiver states that they would like to work on the following concerns: (\*\*\*) insert SMART goals). Patient/parent/caregiver will enroll in the CoCM program for assistance in monitoring symptoms and exploring coping skills, with the goal of decreasing overall symptoms (progress evidenced by PHQ-9 and GAD-7).

**PHQ-9 score: \*\*\***

**GAD-7 score: \*\*\***

**Person(s) Interviewed:**

**Interpreter Required:**  No  Yes: Language-\_\_\_\_\_

#### **ASSESSMENT:**

**Current Clinical Measure:** @PSYCHBEHAVIORALSUMMARYSCORES@

**History Provided by:**

**Name:**

Relationship:  self  parent/guardian  partner  other: \_\_\_\_\_

Mode:  in person  by phone  telemedicine  other: \_\_\_\_\_

Accompanied by:  interviewed alone  
 interviewed with other's present: \_\_\_\_\_

**Name:**

Relationship:  self  parent/guardian  partner  other: \_\_\_\_\_

Mode:  in person  by phone  telemedicine  other: \_\_\_\_\_

Accompanied by:  interviewed alone  
 interviewed with other's present: \_\_\_\_\_

**Current Presentation/Symptoms:** \*\*\* (include time of onset and events that occurred within 6 months prior to onset)

**SI/HI:** Patient/parent/caregiver denies that patient has any historic or current SI/HI, plan, intent, or means. Family member history is also negative for same. Patient /parent/caregiver denied any past patient mental health hospitalizations or suicide attempts. Patient/parent/caregiver denied any patient historic or current non-suicidal self-harm behaviors. Discussed that if symptoms worsen, they should proceed to the nearest Emergency Department or contact 911/988 if patient/family/caregiver feels unable to keep patient safe.

**Safety:**

Presence of Firearms in the home:  yes  no

If yes, how are they stored:

How/Where are medications stored:

Has protective services ever been involved and if so, what were the circumstances and outcomes?

Patient/parent/caregiver were counseled on safe storage of firearms and medications and particular cautions required should suicidal ideation, plan or intent arise.

**Patient Behavioral/Mental Health History:** \*\*\* (ask about: residential/inpatient/partial/day treatment/ED or crisis center visits for mental health concerns; current and past mental health diagnoses given or diagnoses considered)

**Family Behavioral/Mental Health History:** \*\*\* (ask about same and any psychotropic medications, what worked, what did not, how long it was tried and any family narratives surrounding mental health conditions and/or medication/intervention use )

**Current Patient Medications/Compliance:** \*\*\*

**Prior Medication Trials:** No previous medication trials (or include previous medications, dosages, efficacy, length of Tx).

**Substance Use:** Patient/parent/caregiver denies any known patient current or past substance use concerns, including illicit substances or marijuana. Patient/parent/caregiver denies tobacco use, nicotine use and alcohol use. Patient/parent/caregiver denies any family Hx of substance/tobacco/marijuana use or concerns.

**Coping Skills:** \*\*\*

**Medical Conditions:**

@PROBLEMLIST@

Denies any significant medical concerns. They deny any history of HTN, chronic pain, or seizures.

**Psychosocial Detail:** Patient/parent/caregiver verbalizes that they currently live in \*\*\* with \*\*\* (include relationships, i.e., bio mother, stepfather, maternal half-sister, etc.). (PROVIDE FAMILY HISTORY to include adoption/foster care Hx, Hx of developmental delays, etc.) They report involvement in \*\*\* (peer group, school/social activities, school history – grade, any repetition, special education, supports or accommodations: \*\*\*. Patient/parent/caregiver denies any history or current concerns with trauma, violence, abuse, or neglect. They deny any current safety concerns. Patient/parent/caregiver's current employment includes: \*\*\*. They deny any financial concerns at this time.

**BHCM CoCM Interventions:**



- Patient Education:
- Self-Care Plan construction
- Motivational Interviewing: {Motivational Interviewing:38946}
- Behavioral Activation: {Behavioral Activation:38947}
- Problem Solving: {Problem Solving Therapy:38985}
- Relapse Prevention plan development
- Resources Provided: \*\*\*
- Follow-up Time Frame: {1 WEEK, 2 WEEKS, 3-4 WEEKS, 1 MONTH, 2 MONTHS, 3 MONTHS:2100150011}

Support and active listening were provided to the patient/parent/caregiver.  
Response to interventions: engaged, responsive, and interactive.

**Consent:**

*Patient/parent/caregiver consented to CoCM program, including the roles of psychiatric consultant, BHCM, and other relevant specialists. Yes*  
*Patient/parent/caregiver was made aware of their responsibility for potential cost-sharing expenses (copay, deductible) for CoCM services. Yes*

This writer will review information with psychiatric consultant at the next scheduled systematic case review, within the next 1-2 weeks.

DSM 5 Diagnosis:

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[signature\*\*\*]

[Route Note to Treating Provider](#)

Use when patient/parent/caregiver is enrolled in CoCM and you have completed an assessment.

Hi Dr. \*\*\*,

This is a completed assessment for one of your patients within the CoCM program. I will follow up with you after reviewing with the psychiatric consultant, Dr. \*\*\*.

Thanks for the referral,

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[signature\*\*\*]

## Smartphrases Used for Patients Enrolled in CoCM

### CoCM Progress Note

Use as a standard progress note to use when you speak to/meet with a patient/parent/caregiver for routine follow up.

**Reason for Contact:**

**Type of Contact:**

**Total Time Spent: \*\*\***

**BRIEF SUMMARY:** @NAME@ is a .... currently enrolled in the CoCM program for symptom monitoring, coping skills, and support.

#### **UPDATES:**

Medication/symptoms:

Past medication trials:

Therapy/coping skills:

Stressors:

This patient was eligible for and considered for weekly review with the psychiatric consultant.

#### **PLAN:**

**METRICS:** PHQ-9

GAD-7

#### **INTERVENTIONS:**

- Symptom Monitoring: MDD - {SX; Depression:2100140392}  
GAD - {SX; Anxiety:38951}  
Panic - {PANIC:23989}
- Motivational Interviewing: {Motivational Interviewing:38946}
- Behavioral Activation: {Behavioral Activation:38947}
- Problem Solving: {Problem Solving Therapy:38985}
- Goal Setting (patient SMART Goals):
- Patient Education:
- Support/Active Listening:
- Resources Provided:

BHCM used the above interventions. Patient/parent/caregiver engaged, responsive, and interactive.

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[Signature \*\*\*]

### Unable to Reach Enrolled Patient

Use when attempting to contact an enrolled patient for follow up, but you are unable to reach the patient/parent/caregiver.

**Reason for Contact:**

**Type of Contact:**

**Total Time Spent: \*\*\***

BHCM attempted to contact patient/parent/caregiver to follow up on mental health care, medication, symptom management, and general wellbeing. Unable to reach the patient/parent/caregiver, but a message with minimal information (due to HIPAA and confidentiality) was left requesting return phone call.

This patient was eligible and considered for weekly review with the psychiatric consultant.

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[signature \*\*\*]

### Follow-up for Enrolled Patient via Patient Portal

Use when sending a portal message to an enrolled patient for follow up. \*\*\*Make sure to attach outcome measures, if sending!

**Reason for Contact:**

**Type of Contact:**

**Total Time Spent: \*\*\***

This writer sent portal communication to patient/parent/caregiver to follow up on mental health care, medication, symptom management, and general wellbeing. BHCM also included outcome measures for completion.

This patient was eligible and considered for weekly review with the psychiatric consultant.

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[signature \*\*\*]

### Smartphrases Used for Psychiatric Recommendations and Coordinating Care

#### Follow-up with Treating Provider on Psychiatric Recommendation

Use to follow up with treating provider regarding a recommendation from the psychiatric consultant. If treating provider has not responded to recommendation within 1-2 days, recommended to place this progress note in chart and route to physician.

**Reason for Contact:**  
**Type of Contact:**  
**Total Time Spent: \*\*\***

This patient was reviewed with the CoCM psychiatric consultant, Dr. \*\*\*, on DATE\*\*\*. Here are the recommendations:

Please refer to Dr. \*\*\*'s full chart note on DATE\*\*\* for other pertinent information regarding this patient/recommendation.

BHCM is coordinating care with @medical provider@ regarding recommendation.

--

[signature \*\*\*]

### Contacting Patient Regarding Psychiatric Recommendations

Use this Smartphrase when contacting patient/parent/caregiver regarding recommendations made.

**Reason for Contact: \*\*\* Type  
of Contact:**  
**Total Time Spent: \*\*\***

BHCM contacted patient/parent/caregiver to review the recommendations made within CoCM on DATE\*\*\*. BHCM shared the recommendations made by the psychiatric consultant, which were approved by @medical provider@. Patient/parent/caregiver was provided with detailed instructions per the recommendation. This included outlining the recommendation to \*\*\*. Patient/parent/caregiver demonstrated appropriate teach-back and understanding of this recommendation. They were advised to monitor for side effects or reactions and to contact the office with any urgent medical concerns or questions.

{recresponses:45380}

Patient/parent/caregiver verbalized understanding, agreed to recommendations, would like treating provider to fulfill recommendations.

Patient/parent/caregiver verbalized understanding, would like to research the medication(s) and/or interventions, will contact BHCM/office when decided

Patient/parent/caregiver verbalized understanding, disagreed with recommendations.

Patient/parent/caregiver verbalized understanding, would like to wait before moving forward

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[signature \*\*\*]

## Smartphrases used for CoCM Discharge

### Discharged Note to Treating Provider: Unable to Reach Patient

Use this note in the chart when you are discharging a patient from CoCM. If you are speaking with a patient/parent/caregiver and are placing a normal CoCM progress note, you can indicate that the patient is ready for discharge in that note as well.

**Total Time Spent: \*\*\***

This patient has been enrolled in the psychiatric collaborative care (CoCM) program for management and support of depression and/or anxiety. CoCM BHCM has attempted to reach the patient/parent/caregiver on several occasions without success. A follow up letter was sent on @DATE@ to the patient/parent/caregiver and no response has been received. BHCM will discharge patient from CoCM and end episode of care.

Please feel free to re-refer this patient to the CoCM program if further support is indicated. No further interventions planned at this time.

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[signature \*\*\*]

### Discharge: Routine

Use this note in the chart when you are discharging a patient from CoCM.

**Reason for Contact:**

**Type of Contact:**

**Total Time Spent: \*\*\***

**BRIEF SUMMARY:** @NAME@ is a .... currently enrolled in the CoCM program for symptom monitoring, coping skills, and support.

**UPDATES:**

- Medication/symptoms:
- Past medication trials:
- Therapy/coping skills:
- Stressors:

This patient was eligible for and considered for weekly review with psychiatric consultant.

**PLAN:**

It has been discussed and decided that patient is ready for discharge from this CoCM program. We have completed the relapse prevention plan, and this will be uploaded into media. Patient's plan for ongoing care includes (\*\*\*, specialty care in the community, return to usual care with treating provider). Patient/parent/caregiver is aware that they may contact treating provider if symptoms increase, and they need additional support. No further CoCM interventions planned at this time and patient will be discharged from CoCM, but BHCM remains available for consult as needed.

**METRICS:** PHQ-9:  
GAD-7:

**INTERVENTIONS:**

- Symptom Monitoring:
  - MDD - {SX; Depression:2100140392}
  - GAD - {SX; Anxiety:38951} o Panic - {PANIC:23989}
- Motivational Interviewing: {Motivational Interviewing:38946}
- Behavioral Activation: {Behavioral Activation:38947} • Problem Solving: {Problem Solving Therapy:38985}
- Goal Setting (patient SMART Goals):
- Patient Education:
- Support/Active Listening:
- Resources Provided:

BHCM used the above interventions. Patient/parent/caregiver was engaged, responsive, and interactive.

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[Signature \*\*\*]

## Miscellaneous Smartphrases

### Relapse Prevention Plan

Use this template to populate the relapse prevention plan in the chart. This is especially helpful if the patient requests to complete this independently and would like for you to send via portal. Typically, you will have this completed and scanned into the chart prior to discharge.

## Relapse Prevention Plan

**Patient Name:** @NAME@

**Today's Date:**

### Maintenance Medications

- 1.
- 2.
- 3.
- 4.

Contact your provider if you would like to make any changes to your medication(s).

**Other Treatments**

- 1.
- 2.
- 3.

**Personal Warning Signs**

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

**Things I do to Prevent Depression**

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

**If symptoms return, please contact: Treating Provider or identified supports.**

**Contact/Appointment Information:**

**Treating Provider** (: @medical provider@  
Phone: \*\*\*

**Next appointment Date:** | Time:

**CoCM Behavioral Health Care Manager:** \*\*\*  
Phone: \*\*\*

**Routing Notes to Treating Providers**

**Patient Discharge, Enrolled but Unable to Reach**

Use when patient/parent/caregiver is enrolled in CoCM, but not returning calls.

Hi Dr. \*\*\*,

This is a FYI that I am ending episode of care within CoCM today due to non-engagement. Please feel free to re-refer, if needed.

--

[signature\*\*\*]

### Unable to Contact Referred Patient, Not Enrolled

Use this when patient/parent/caregiver is not enrolled in CoCM and not returning calls regarding referral.

Hi Dr. \*\*\*,

This is a FYI that I have been unable to engage the patient/parent/caregiver in the CoCM program after multiple attempts to reach them. At this time, I have sent the patient/parent/caregiver a letter and will discontinue attempts to reach the patient/parent/caregiver. However, if you feel they would benefit from the CoCM program in the future, please do not hesitate to re-refer.

Thank you for the referral.

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[signature\*\*\*]

### Coordinating Care from Recommendation

Use this when patient is enrolled in CoCM and you are attempting to coordinate care regarding recommendation.

Hi Dr. \*\*\*,

This patient was recently reviewed with our psychiatric consultant, Dr. \*\*\*. I am wondering if you have had a chance to review this recommendation. If you agree with the recommendation to [insert recommendation- e.g., increase Sertraline to 100mg] and are willing to send this into the pharmacy, I would be happy to call the patient/parent/caregiver to let them know. I will also plan to follow up with the patient/parent/caregiver within 1-2 weeks for medication monitoring. Please let me know if you have any questions or concerns.

Thank you!

[signature\*\*\*]

### Completed Initial Assessment for New Patient

When patient is enrolled in CoCM and you have completed an assessment.

Hi Dr. \*\*\*,

This is a completed assessment for one of your patients within the CoCM program. I will follow up with you after reviewing with psychiatric consultant, Dr. \*\*\*.



Thanks for the referral,

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[signature\*\*\*]

### Patient Declined Referral, Not Enrolled

Use when patient/parent/caregiver has declined to participate in CoCM

Hi Dr. \*\*\*,

This is a FYI that patient/parent/caregiver has declined to participate in CoCM at this time. Please let me know if the patient/parent/caregiver is interested in exploring CoCM in the future.

Thanks for the referral,

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[signature\*\*\*]

## Letters

### Documenting sending a letter to patient

Use as a template when sending a letter to patient/parent/caregiver.

**Reason for Contact:** \*\*\*

**Type of Contact:** Letter

**Total Time Spent:** \*\*\*

This writer has sent patient/parent/caregiver a letter regarding (discharge, welcome, other\*\*\*). This patient was eligible for and considered for weekly review with psychiatric consultant.

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[signature \*\*\*]

### Patient Referred: No Response

Use this when you have attempted to contact a patient/parent/caregiver regarding a referral but have not been able to reach them.

@DATE@

@NAME@

@ADD@

Dear @PREFERREDNAME@

I hope this finds you well.

Your treating provider at the [insert clinic\*\*\*] believes that you may benefit from the psychiatric collaborative care (CoCM) program. This program is intended to help you and your care team (Dr. @medical provider@, , a psychiatric consultant, and me as the behavioral health care manager) manage your mental health concerns **without** requiring you to go to an outside provider or psychiatrist for assistance.

I tried reaching you by phone to let you know that the program is available to you. We believe that it is a valuable resource in helping patients cope with, and improve, their mental health.

I would welcome the opportunity to tell you more about this program. I can be reached at \*\*\*.

I look forward to hearing from you!

Sincerely,

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[signature\*\*\*]

[Patient Referred, not Enrolled After Initial Contact: No Response](#)

Use this when you have attempted to contact a patient/parent/caregiver regarding a referral but have not been able to reach them.

@DATE@

@NAME@

@ADD@

Dear @PREFERREDNAME@

I hope this letter finds you well. It was a pleasure speaking with you about our CoCM program. As discussed, you are now enrolled in psychiatric collaborative care (CoCM) – an integrated care model offered at the \*\*\*clinic.

**The goal of CoCM is to:**

- Provide the best possible care for patients who are experiencing depression or anxiety through a team-based approach.
- Increase patients access to behavioral health care through their primary care setting, **without** requiring you to go to an outside provider or psychiatrist for assistance.
- Assist patients in improving their mental wellbeing using behavioral health interventions

- Allow access to medications prescribed by the treating provider for depression or anxiety, with the guidance of a psychiatric consultant.
- Use screening tools to help you and your care team monitor your symptoms and progress.

Your care team is invested in helping you achieve your goals. As part of your care team in this program, a psychiatric consultant will routinely review your progress with me and may provide recommendations for medications and other interventions to your team. We believe having a psychiatric consultant is a unique benefit, as you receive expert consideration without requiring you to see another provider. With this, your medical provider will remain the individual that will prescribe and manage all of your medications. Furthermore, you and I will work on coping strategies and other interventions that may help in reducing your symptoms.

Included in this letter is additional information regarding the CoCM program, including an overview of billing, the screening tools we use, and how to access emergency care should you need it.

**BILLING**

The care being provided to you through CoCM is a billable service covered by many insurances. We recommend that you contact your insurance provider to understand your benefits, coverage, copay, or deductible details. Please feel free to provide your insurance provider with the following CPT codes: 99492, 99493, and 99494. If this is not a covered benefit and you are needing assistance, financial assistance is available to you at \*\*\*\*

**SCREENING TOOLS:**

In participating in CoCM, you will be asked to routinely complete questionnaires as a way to assess and monitor symptoms of depression and anxiety. These questionnaires are the PHQ9 (used for depression) and the GAD7 (used for anxiety). The questionnaires are an important part of our work together and will help us to not only track and monitor your progress, but it also helps to guide us on determining if changes to your treatment plan are necessary. If interested, we have included the score key and severity of symptoms for both tools. If you have more questions related to this, please do not hesitate to ask.

Score	Depression (PHQ-9) Severity	Score	Anxiety (GAD-7) Severity
0-4	Minimal or none	0-4	Minimal or none
5-9	Mild	5-9	Mild
10-14	Moderate	10-14	Moderate
15-19	Moderately severe	15-21	Severe
20-27	Severe		

**EMERGENCY ASSISTANCE:**

There may be times where you need emergency assistance outside the hours of your medical provider’s clinic hours. If you have any thoughts related to suicide or feel unsafe in any way, this is a medical emergency and you are encouraged to call one of the following 24-hour numbers:

1. 911
2. 988
3. Michigan Medicine Psychiatric Emergency Services (also known as PES): 734-936-5900
4. Crisis Text Line: Text 741741 24/7 for free crisis counseling

Please know that I am trained to help you with your mental health concerns and can answer questions you may have about the CoCM program, mental health, the screening tools we use, your treatment plan, and/or interventions that may be helpful. Please do not hesitate to reach out to me. I can be reached at \*\*\* or by calling the main office and requesting to speak with me.

Sincerely,

---

[signature\*\*\*]

Relapse Prevention Plan Letter

Use this Smartphrase in two different instances. First, when you have discussed the relapse prevention plan with the patient/parent/caregiver and they request this be sent to them via mail for them to complete independently. Second, if you have completed a relapse prevention plan with patient/parent/caregiver and are sending them a copy of the plan via mail. The template will include the blank copy, as if you are sending to them to fill out. If you are sending them a final copy for their records, please fill this in for them.

@DATE@

@NAME@

@ADD@

Dear @PREFERREDNAME@

I hope this letter finds you well.

With this letter, you will find a helpful tool for your mental health maintenance called a Relapse Prevention Plan. The intention of this tool is to think about warning signs that may contribute to worsening mood and to help you identify these in future situations. It can help you to identify strategies and coping skills that you can use once you identify these symptoms are occurring. Additionally, these

are skills/activities that you can do to help prevent symptoms. If symptoms have escalated, this can serve as a tool to acknowledge that you may need additional assistance with your symptoms (contacting your medical provider, obtain resources, and/or explore re-enrollment with CoCM). Furthermore, this document does include your medications and other treatments to help keep you on track with your treatment goals. Consider keeping this document in a place you might see each month. Some examples of where to keep your relapse prevention plan may be on the fridge, your desk, kitchen table, bedside stand, or where you keep important documents.

We know that depression and anxiety are often episodic in nature, so for some people, your symptoms might return, be challenging, or worsen. If you notice your symptoms returning, do not hesitate to contact your care team, your physician's office, or any of those identified on the bottom of this sheet. Your team can then work with you to adjust your treatment as necessary.

## **Relapse Prevention Plan**

**Patient Name:** @NAME@ Today's

**Date:**

**Maintenance Medications (Medication name, dose, frequency)**

- 1.
- 2.
- 3.
- 4.

**Contact your provider if you would like to make any changes to your medication(s). Do I need a reminder/alarm to take my medications?**

**Other Treatments**

- 1.
- 2.
- 3.

**Personal Warning Signs**

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

**Things I do to Prevent Depression**

- 1.
- 2.
- 3.

- 4.
- 5.
- 6.

If symptoms return, please contact: treating provider or identified supports.

**Contact/Appointment Information:**

Treating Provider: @medical provider@

Phone: \*\*\*

Next appointment Date:        | Time:

CoCM Behavioral Health Care Manager: \*\*\*

Phone: \*\*\*

Thank you for your time. I can be reached at \*\*\*, through patient portal, or by calling the main office and requesting to speak with me.

Sincerely,

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[signature \*\*\*]

## Specialist Provider to Treating Provider Transition Documentation

### Initial Specialist Note to Treating Provider

Dear Dr./Ms./Mr. \_\_\_\_\_,

Your patient , @pt name), is currently under my care for (insert primary Dx here). It is our practice to screen all patients for behavioral and social concerns in addition to addressing medical issues. Upon screening (@patient name@), it was determined that they meet criteria for (@MH Dx@) and has agreed to participate in our Collaborative Care program to address this/these concern(s).

The Collaborative Care program will pair this patient with a Behavioral Health Care Manager who will conduct a comprehensive assessment, consult with our psychiatrist and work with our team and this patient to develop an intervention plan. This plan will include brie , evidence-based interventions and may or may not involve medications to address the identified concerns. We will monitor @pt's name@ carefully to ensure progress and keep you updated periodically to ensure a seamless transition back to your care when their care with us for (Insert name of specialty care here – i.e. OB/GYN, etc.) management is completed.

Please feel free to contact our Behavioral Health Care Manager, @BHCM name/contact number/email@ as needed with any questions and they will coordinate communication as needed.

Thank you for the opportunity to participate in the care of your patient

Best Regards,

@physician name@

@ practice name@

## Specialist Progress Note to Treating Provider

Dear Dr./Ms./Mr. \_\_\_\_\_,

Your patient , @pt name), is currently under my care for (insert primary Dx here) and continues to participate in our Collaborative Care program to address additionally identified concern(s) of @mental health Dx@. Below is a summary of their progress to this point:

(insert most recent progress note here)

The plan for continuing intervention is as follows:

(insert current treatment plan here)

Please feel free to contact our Behavioral Health Care Manager, @BHCM name/contact number/email@ as needed with any questions and they will coordinate communication as needed.

Thank you for the opportunity to participate in the care of this patient.

Best Regards,

@physician name@

@ practice name@

## Care Transition Note

Dear Dr./Ms./Mr. \_\_\_\_\_

I had the pleasure of working with your patient @patient name@ through (insert name of specialty practice). Their (appropriate pronoun for Pt) care has completed with my practice and I am referring them back to you for primary medical care management.

While in my care, @patient name@ was identified as experiencing @Dx code@ and participated in our Collaborative Care (CoCM) model of integrated behavioral health care to manage their symptoms. Below is a summary of the treatment plan developed to address these concerns:

At this point, the recommendations for follow up are as follows:

Cite the relapse prevention plan; outside referrals made; recommendation for treating provider continuance of medication management , etc. ( NOTE: prior to sending this letter, it is recommended that the BHCM or specialty provider talk to treating provider about their comfort in/willingness to continue any established medications. )

Thank you for the opportunity to participate in this patient's care. I remain available to discuss their transition back to your service if that would be of assistance.

Best Regards,  
@medical provider@

## Psychiatric Consultant Documentation

### Treatment Recommendation Sent to Referring Physician

Hello [ Referring Provider NAME] ,

I had the opportunity to discuss patient @NAME@ with our Behavioral Health Care Manager (BHCM) in our weekly clinical meeting. Please see below for my recommendations. Please note that these recommendations are based on consultation with the BHCM and a review of information available in the chart. I have not personally examined the patient. All recommendations should be implemented with consideration of the patient's relevant prior history and current clinical status. The patient is/was instructed not to make any medication adjustments until instructed by you or the BHCM after consulting with you. Please feel free to contact me with any questions about the care of this patient.

[PSYCHIATRIC CONSULTANT NAME]

Pager: 55555

#### **Brief Summary**

#### **Recommendations**

Behavioral health care manager, [NAME], will continue to follow patient for symptom monitoring and support.

**Possible Side Effects** *(consider including the phrases prepared below or creating your own)*



## **Scores**

PHQ-9:

GAD-7:

## **Background and Decision-Making:**

**Safety Concerns:**

**Substance Use Concerns:**

**Previous Medication Trials:**

## **Common Psychotropic Medication Side Effect Statements**

When prescribing for pregnant or nursing patients – consider adding the “general principals” phrases and “general guidelines” phrases listed at the end of this section as relevant to medication recommendations.

### **Alpha-2 Agonists**

Dizziness, drowsiness, fatigue, headache, xerostomia, abdominal pain, GI distress, decreased appetite. Hypotension/orthostatic hypotension may occur.

### **Antiepileptics**

Drowsiness, dizziness, nausea, headache, and tremor. Blood counts and drug levels should be monitored. Inform patient/parent/caregiver to notify clinician immediately if any unusual changes in mood or behavior.

### **Atomoxetine**

Insomnia, headache, drowsiness, hyperhidrosis, decreased appetite, GI distress, sexual dysfunction, and xerostomia. Avoid in patients with uncontrolled cardiovascular disease or in patients with a known history of structural cardiac abnormalities. Inform patient to notify clinician immediately if any unusual changes in mood or behavior. Monitor for an increase in suicidal ideation in children and adolescents.

### **Atypical Antipsychotics**

Metabolic complications (including dyslipidemia, hyperglycemia, weight gain), sedation or insomnia, movement disorders (including restlessness, dystonia, pseudo parkinsonism, tardive dyskinesia), sexual dysfunction. Pediatric patients are at greater risk of developing movement disorders caused by antipsychotics. Baseline and periodic EKGs may be warranted in some instances. Blood counts should be monitored periodically. Labs that should be monitored for metabolic changes include fasting blood glucose/A1c and lipids. Monitoring frequency suggested: baseline, in 12 weeks, then every 6 months (pediatric patients) or yearly (adults).

## **Benzodiazepines**

- Sedation, confusion, dizziness, or changes in cognition. Use with other sedative medications or substance, including alcohol, should be reviewed. If discontinued, the medication must be tapered, particularly if use exceeds 3-4 weeks. Paradoxical reactions/disinhibition is more likely to occur in pediatric and elderly patients and includes symptoms such as: acute excitement, anxiety, vivid dreams, hyperactivity, sexual disinhibition, hostility, rage. Alprazolam, lorazepam, and clonazepam should be avoided in combination with antidepressants as this can cause malformation in the first trimester. Lorazepam, and clonazepam can be used in low doses late in pregnancy

## **Bupropion**

GI side effects (including nausea, vomiting, diarrhea), increase in anxiety, agitation, or insomnia. Inform patient to notify clinician immediately if any unusual changes in mood or behavior. Seizure risk is increased in patients taking higher doses and with additional baseline risk factors. More seizures have been reported in patients using the IR formulation. Inform patient to notify clinician immediately if any unusual changes in mood or behavior. Monitor for increased suicidal ideation in children, adolescents, and young adults.

## **Buspirone**

Dizziness, nausea, and headache. This medication must be taken on a scheduled basis and should not be utilized on a “prn” or “as needed” basis.

## **Clozapine**

Metabolic complications (including dyslipidemia, hyperglycemia, weight gain), sedation, dizziness, drooling, anticholinergic side effects including tachycardia. WBC and ANC should be monitored according to treatment parameters. Baseline and periodic EKGs may be warranted in some instances.

## **Gabapentin**

Increased appetite, weight gain, edema, headache, dizziness, or fatigue. Inform patient/parent/caregiver to notify clinician immediately if any unusual changes in mood or behavior.

## **Hydroxyzine**

Dry mouth, drowsiness, and dizziness. Rare prolongation of QT interval.

## **Lamotrigine**

Dizziness, headache, nausea or vomiting, and rash. Slow titration is necessary to minimize the risk for Stevens-Johnson syndrome. Inform patient/parent/caregiver to notify clinician immediately if any unusual changes in mood or behavior.

## **Lithium**

GI side effects (including nausea, vomiting, diarrhea), sedation, weight gain, tremor, increased thirst, or frequent urination. Hair loss, worsening of dermatologic conditions, like acne or psoriasis, may also occur. Toxicity may be associated with worsening tremor, more severe GI effects, confusion, or ataxia. Monitor serum concentrations and alert patient/parent/caregiver to drug-drug interaction risk with NSAIDs.

## **MAOI**

Fatigue, insomnia, dizziness, constipation, dry mouth, weight gain, sexual dysfunction, changes in blood pressure, including hypertensive crisis if MAOIs are taken with certain other medications or with certain foods. Inform patient/parent/caregiver to notify clinician immediately if any unusual changes in mood or behavior. Consider recommending a medical alert card or bracelet declaring MAOI use.

## **Mirtazapine**

Sedation, increased appetite, weight gain. Inform patient/parent/caregiver to notify clinician immediately if any unusual changes in mood or behavior.

## **Prazosin**

Palpitations, dizziness, drowsiness, headache, fatigue, nausea, and weakness. Orthostatic hypotension, syncope, and GI upset are less common. Slow changes in position and hydration may help with dizziness/orthostasis.

## **Pregabalin**

Increased appetite, weight gain, edema, headache, dizziness, or fatigue. Inform patient/parent/caregiver to notify clinician immediately if any unusual changes in mood or behavior.

## **SNRI**

GI side effects (including nausea, vomiting, diarrhea), initial increase in anxiety (especially in individuals with an anxiety disorder), sexual dysfunction, headaches, or insomnia. Changes in blood pressure may also occur and are most likely to be dose related, particularly with venlafaxine/Effexor. Consider monitoring for antidepressant-induced hyponatremia in elderly patients. Inform patient/parent/caregiver to notify clinician immediately if any unusual changes in mood or behavior. Monitor for increased suicidal ideation in children, adolescents, and young adults.

## **SSRI**

GI side effects (including nausea, vomiting, diarrhea), initial increase in anxiety (especially in individuals with an anxiety disorder), sexual dysfunction, headaches, or insomnia. Consider monitoring for antidepressant-induced hyponatremia in elderly patients. Inform patient/parent/caregiver to notify

clinician immediately if any unusual changes in mood or behavior. Monitor for increased suicidal ideation in children, adolescents, and young adults.

### **Stimulants**

Insomnia, headache, irritability, decreased appetite, nausea, and xerostomia. Avoid in patients with uncontrolled cardiovascular disease or in patients with a known history of structural cardiac abnormalities.

### **TCA**

Sedation, dizziness, constipation, dry mouth, weight gain, or sexual dysfunction. If patient is at risk for QT prolongation, consider obtaining a baseline EKG and repeat as indicated. Blood levels can also be monitored. Consider monitoring for antidepressant-induced hyponatremia in elderly patients. Inform patient/parent/caregiver to notify clinician immediately if any unusual changes in mood or behavior. Monitor for increased suicidal ideation in children, adolescents, and young adults.

### **Trazodone**

Drowsiness, dizziness, headache, dry mouth. Priapism occurs rarely with trazodone.

### **Typical Antipsychotic**

Movement disorders (including restlessness, dystonia, pseudo parkinsonism, tardive dyskinesia), drowsiness, sexual dysfunction, hyperprolactinemia. Pediatric patients are at greater risk of developing movement disorders caused by antipsychotics. Baseline and periodic EKGs may be warranted in some instances.

**For pregnant and lactating patients** – consider using these phrases as relevant to medication recommendations:

#### **General Principles:**

- Treatment always involves the risk of the illness vs. the risk of medication
- There are no "safe" medications. All may involve some degree of risk
- Informed consent is key
- If a patient has done well on only one medication, it may be reasonable to continue that medication.
- Good references: Micromedex, REPROTOX (r), MGH Center for Women's Health website, Hale's Medications & Mother's Milk: A Manual of Lactational Pharmacology - An Essential Reference Manual on the Transmission of Medicine into Breast Milk. 19<sup>th</sup> Edition by Dr. Thomas W. Hale PhD.

## **General Guidelines:**

### **Antidepressants:**

- In general, the literature shows that antidepressant use during pregnancy does not increase the risk of congenital abnormalities, preterm birth, or neurodevelopmental problems long-term. There is a risk of some infants having poor neonatal adaptation syndrome. Symptoms of this (baby being fussy and more jittery) are generally very mild if they occur.
- Persistent pulmonary hypertension in newborns is sometimes listed as a potential side effect of in utero antidepressant exposure. However, this condition is very rare.
- In general, it is always important to think about the risk of untreated depression/anxiety during pregnancy
- No major evidence of risks to breastfed babies whose mothers are taking SSRIs or SNRIs

### **Mood Stabilizers:**

These medications have more risk associated with them.

- Lamictal: typically considered first choice for mood stabilization (especially bipolar in pregnancy). Monitor heart and monitor for rash (risk of Stevens-Johnson syndrome). If breastfeeding baby should be monitored. Generally safe but theoretical risk of Stevens-Johnson syndrome. Monitor baby for toxicity
- Lithium: Increased risk of cardiac malformations during the first semester. High rate of excretion in breast milk. Narrow therapeutic window. Monitor for all other side effects that are common with Lithium. Monitor levels carefully. There are shifts in blood volume during pregnancy and during delivery. There is a high rate of excretion in breast milk. Breastfeeding is not recommended. Would need to monitor the baby closely for toxicity.
- Divalproex: Would not recommend prescribing this to women of childbearing age. Unsafe during pregnancy. Major risk of malformations, craniofacial abnormalities, and neurobehavioral effects. Risk of toxicity to baby in breast milk
- Carbamazepine: Would not recommend prescribing during pregnancy or if breastfeeding (high levels in breast milk)
- Topiramate: Avoid in pregnancy if possible. Some reports of increased risk of cleft palate and low birth weight. Little data related to breastfeeding.
- Oxcarbamazepine: little data. Similar risks to Carbamazepine. Avoid in pregnancy and breastfeeding.

### **Antipsychotics/Neuroleptics:**

- risperidone is the only antipsychotic which has shown some increased risk
- Less data is available on the effect of these medications
- in general, there seems to be no increased risk of congenital malformations to babies exposed to them in-utero (except for risperidone).
- Some of these medications may cause increased breast milk production
- More data about olanzapine and quetiapine than others.
- Would avoid newer ones for now (brexiprazole and cariprazine)

## **Anxiolytics:**

- Most of these are sedating. So, it is important to counsel patient and families about this. Encourage them to take the medication when someone is present (at least the first time). Do not sleep with baby while taking this medication. Start with the end in mind and let them know that the plan is to use short-term.
- With regards to Lactation, monitor baby for sedation. Also, medications with antihistamine may decrease breast milk.