Creating Collaborative Care Workflows

Creating workflows is an iterative, team process. Much like creating a shared vision, this process includes a series of team discussions facilitated by the Clinic Implementation Team (CIT) lead.

- Your workflows will be a detailed version of the 5 phases of an episode of Collaborative Care (CoCM). Each phase will have a unique set of tasks, tailored to the resources available at your site.
- We recommend the team create a process map or visual workflow for each of the five phases of an episode of CoCM. Make sure the workflows describe the steps in sufficient detail and are accessible to those who need it.

Identify & Engage	Establish a Diagnosis & Initiate Treatment	Follow-up Care & Treatment to Target	Develop a Relapse Prevention Plan	Complete the Episode of Care
-Behavioral health screening and/or population health report to identify patients -Introduce CoCM -Consent patients to participate in CoCM -Connect patients to the Behavioral Health Care Manager (BHCM) -When suicidality is identified through the behavioral health screening process, it is important to have a protocol in place. Guide for Developing Protocols for Suicide Prevention in Primary Care	-BHCM completes Initial Assessment. Enroll patient in CoCM and add them to the registry. -Generate a provisional diagnosis as a CoCM team (PCP, Psychiatric Consultant, BHCM) -Explore treatment options with the patient (brief evidence-based behavioral interventions, medications, or both) -Communicate treatment plans with the CoCM team	-Proactive and continuous outreach from BHCM to the patient -Track patient progress in a registry -Use registry to identify patients who need to be discussed at Systematic Caseload Review (SCR) -Hold SCR weekly sessions between the BHCM And Psychiatric Consultant -Consider frequency for administration of symptom monitoring tools (e.g. PHQ-9, GAD-7, PCL-5, etc.)	-Determine criteria to begin a Relapse Prevention Plan (RPP) -BHCM initiates RPP with the patient -Determine how often to connect with the patient during the monitoring phase -Consider how RPP will be documented, stored and communicated with the patient as well as the CoCM team	Develop a workflow for each possible completion pathway: -Transition improved patients back to their PCP for follow-up care, with the option to return for another episode of CoCM if symptoms worsen -Referral to specialty behavioral health for patients with severe symptoms that are not improving in CoCM -Discontinue episode for patients who cannot be outreached