

This document is intended to guide the BHCM through the Collaborative Care intake process.

The **triage assessment** is the first step in determining whether the patient is appropriate for Collaborative Care. The BHCM may complete this assessment via chart review, discussion(s) with Treating Providers and other providers, and/or direct patient assessment. These cases can also be discussed with the psychiatric consultant for clarification. The triage assessment process is ongoing, and may occur at the time of referral or later on in the patient care process.

If the patient is a good candidate for Collaborative Care, the BHCM will complete the **structured assessment and initial goal setting** with the patient. The structured assessment may need to be completed throughout more than one patient contact; it is a continuous process.

Some information in the structured assessment checklist may have been gathered during the triage assessment. Items are included in both processes to support a comprehensive assessment.

Triage Assessment

- Presenting symptoms of concern
- Psychiatric treatment history
 - Has patient been a Community Mental Health (CMH) consumer?
 - Psychotic disorder diagnosis?
 - Confirmed or likely personality disorder diagnosis?
- History of psychosis/hallucinations (auditory/visual)?
- Prior medications
 - Mood stabilizers?
 - Antipsychotics?
 - Other:
- Administer core outcome measures (PHQ-9, GAD-7) and consider thresholds
 - PHQ-9 and/or GAD-7 10 or greater?

Introduction and Consent

- Introduce Collaborative Care program
- Ensure patient consent to the program
 - Cover the following items:
 - Permission to consult with a psychiatric consultant and relevant specialists
 - Billing information, if applicable, including deductible and coinsurance for in-person and non-face-to-face services
 - Information that disenrollment from CoCM can occur at any time and will be effective at the end of the month (if billing and applicable)

Structured Assessment and Initial Goal Setting

Structured Assessment:

- Presenting symptoms of concern
- Behavioral health diagnostic history
- History of psychosis
- Risk assessment
- Course of illness (e.g. chronic or episodic)
- Medications
 - Current and past
 - Names of medications
 - Dosages
 - Length of medication trials
 - Effectiveness of medications (why/why not)
 - Side effects of medications
 - By whom medications were prescribed
 - Reasons for discontinuing medications
- Therapy
 - Current and past
 - Type of therapy
 - Length of therapy
 - Effectiveness (What was/wasn't helpful?)
- Trauma history (may leave to future discussion, if clinically appropriate)
- Substance use
 - Current and past
 - Engaged in SUD treatment (current or past)?
- Psychosocial
 - Support system
 - Financial issues
 - Disability/work status
 - Transportation
 - Living situation
 - Access to phone and adequate minutes for phone-based care management contacts
- Relevant medical conditions
- Administer measures
 - PHQ-9
 - GAD-7
 - AUDIT-C (as indicated)
 - CIDI (as indicated)
 - MoCA (as indicated)
- Self-management: What have you tried so far to manage your symptoms?
- Patient knowledge of diagnosis and treatment options

Initial Goal Setting:

- Provide psychoeducation, as appropriate
- Elicit patient goals
- Collaborate in further goal-setting and clinical interventions
 - Self-management
 - Behavioral activation
 - Problem-solving
 - Psychotherapy
 - Medication management
 - Other:

Moving Forward:

- Reminder of upcoming psychiatry consultation
- Establish frequency of monitoring and next contact
- Obtain contact information
 - Best time to call
 - Permission to talk to others
 - Permission to leave a voicemail
 - Confirm mailing address
 - Obtain email address if organization allows for secure email contacts
 - Communicate your contact information
- Send new patient packet with materials as appropriate