Collaborative Care Management (CoCM)

E2i Implementation Guide

An evidence-based intervention, adapted for the Health Resources and Services Administration's Ryan White HIV/AIDS Program, that integrates behavioral health care with primary care in order to treat depression and other common psychiatric disorders among people with HIV.

FALL 2021

RYAN WHITE E2i HIV/AIDS PROGRAM

A SPECIAL PROJECT OF NATIONAL SIGNIFICANCE

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Acknowledgments

We would like to thank the following organizations for piloting the implementation of the intervention at their organization. We are especially grateful to the following people who led the implementation at their organization and provided their stories, experiences, and feedback for this Implementation Guide:

Corktown Health
Abigail Batista, Adenia Williams, Apryl Bell, Claudia Jean-Pierre, Denise Vitale, LaTonya Riddle-Jones, Lauren Brown, Jasmine Mays, Jay Fallon, Jennifer Schwartz, Josh Curie, Patrice Wade-Olsen, Patrick Yankee, Sonda Thomas, Teresa Roscoe, Tory Ervin

La Clínica del Pueblo
Jose Segura, Ana Catalina Garcia, Angie Castro, Belen Saravia, Angela Suarez, Oscar Flores, Johanna Arias, Ricardo Fernandez, Luizilda De Olivera, Robin Berlin

Oklahoma State University Center for Health Science's Internal Medicine Specialty Services
Damon Baker, Madhuri Lad, Micah Derby, David McElwain, Erica Quick, Tonya Busby, Angela Bloxham, Melissa Cox, Lisa Jenkins

Our Lady of the Lake Regional Medical Center
Angela Gourney, Angie Brown, A. Kisha Holiday, Tasha Christopher, L. Lee Tynes, Linda Matthews, Julia Cacioppo, Katie Taylor, Misty Eiserloh, Asia Daiges, Michael Stewart, Jonathan Schroeder, Karen Williams, Adaora Uzodi, Matthew Foy, Madeline Heck, Scott Anderson, Dorothy Gant, Linda Tucker, Audrey Davalcourt, Nancy Bailey, Carla Range, Kisha Wells, Renee Macilvain, Jeaneen Northern, Donna Heatly, Cheryl Coleman, Catherine Seamann, Priscar Thornton, Fallon Waguespac, Brenda Roberson, Trina Wallace, Tyrenne Bridges Lakeisha Ingram, D'Lisa Haynes, Stacey Sheppard

Thank you also to Nick Moore and Rachel Kohn, John Snow, Incorporated; and Erica Sawyer, Jordan Hutensky and Katie Burkhart of Fenway Health for designing the Implementation Guide.

Suggested citation: *Collaborative Care Management: E2i Implementation Guide*. Rockville, MD: U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau; 2021.

Funding statement: This product was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of Ryan White HIV/AIDS Program (RWHAP) Part F - Special Projects of National Significance (SPNS) Program awards totaling $20,307,770 with 0% financed with non-governmental sources, and $2,200,000 with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, HRSA, HHS, RWHAP SPNS, or the U.S. Government. For more information, please visit HRSA.gov.

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EXECUTIVE SUMMARY

Collaborative Care Management (CoCM) is an evidence-based integrated behavioral health care intervention that has been adapted by HIV experts in collaboration with community members to improve health outcomes among people with HIV. CoCM provides team-based care that consists of a primary care provider, a behavioral health care manager, and a psychiatric consultant who work together to improve common psychiatric disorders, such as depression, among a shared caseload of clients with HIV. The care team uses standard validated measures and a population-based client registry to closely track client progress and clinical outcomes over time.

This Implementation Guide was developed for *Using Evidence-Informed Interventions to Improve Health Outcomes among People Living with HIV (E2i)*, which tested CoCM within Health Resources and Services Administration's (HRSA) Ryan White HIV/AIDS Program (RWHAP) settings and evaluated its impact. Additional easy-to-use implementation tools, tips, and resources to support replication of CoCM in the RWHAP and other HIV service organizations can be found in the ***CoCM E2i Toolkit***.

INTRODUCTION TO THE IMPLEMENTATION GUIDE

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What is Collaborative Care Management?

Collaborative Care Management (CoCM) is a type of integrated care that treats depression and other common psychiatric disorders in primary care, including HIV care. A team consisting of a primary care provider, a behavioral health care manager, and a psychiatric consultant work closely together to improve the behavioral health of a shared caseload of clients. The care team uses standard validated measures and a population-based client registry to closely track client progress and clinical outcomes over time.

Purpose of the Implementation Guide

The purpose of this Implementation Guide is to provide essential information and tools for understanding, planning, and delivering CoCM in the Ryan White HIV/AIDS Program (RWHAP) and other HIV service organizations. This Guide is part of the ***CoCM E2i Toolkit***, a collection of helpful resources for implementing CoCM. Additional necessary CoCM resources and training can be accessed from ***Advancing Integrated Mental Health Solutions (AIMS) Center at the University of Washington***.

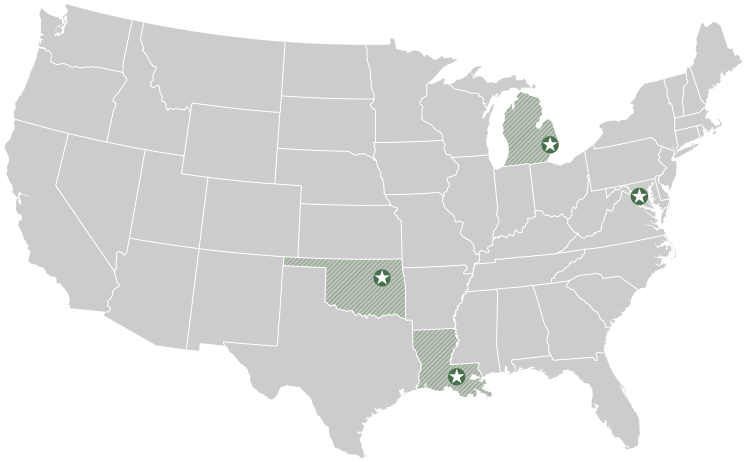
Implementation Guide Background

This Guide was developed as part of the RWHAP Part F Special Projects of National Significance (SPNS) *Program Using Evidence-Informed Interventions to Improve Health Outcomes among People Living with HIV (E2i)*, a four-year initiative (2017-2021) funded by the Health Resources and Services Administration's HIV/AIDS Bureau (HRSA HAB) of the U.S. Department of Health and Human Services. E2i was designed to improve HIV health outcomes for people with HIV who experience persistent gaps along the HIV care continuum, such as engagement in care, retention in care, adherence to antiretroviral therapy (ART), and viral suppression. Because depression and other psychiatric disorders are associated with adverse effects on HIV health outcomes, people with HIV who have psychiatric disorders are among those most in need of interventions that integrate behavioral health care within HIV care settings.

The E2i initiative chose to pilot and evaluate CoCM because of its demonstrated efficacy in improving mental health and HIV health outcomes among people with HIV. Through a competitive request for proposals, four HIV service organizations in the RWHAP were selected to implement CoCM between 2018 and 2020. These sites reported implementation and client outcome data to a team of evaluators who then analyzed these data. The stories, experiences, and evaluation outcomes of these sites are integrated and highlighted throughout this Guide.

The E2i Implementation Sites

FIGURE 1. Locations of the four sites that implemented CoCM through the E2i initiative.



Corktown Health (Detroit, Michigan)
- Federally qualified health center/Community-based Organization
- RWHAP Part A recipient
- 2,400 clients a year; 57% clients with HIV
- 40 employees provide HIV services
- Most common non-medical services accessed by clients with HIV: emergency financial (59%), health education (23%)

La Clínica del Pueblo (Washington, DC)
- Federally qualified health center/Community-based organization
- RWHAP Part C recipient; Parts A and B subrecipient
- 4,500 client a year; 7% clients with HIV
- 130 employees provide HIV services
- Most common non-medical services accessed by clients with HIV: linguistic (87%), outreach (80%), health education (79%)

Our Lady of the Lake Regional Medical Center (Baton Rouge, Louisiana)
- University/Hospital system
- RWHAP Parts A, C, and D recipient
- 1,400 clients a year; 98% clients with HIV
- 30 employees provide HIV services
- Most common non-medical services accessed by clients with HIV: health education (98%), non-medical case management (97%), other professional services (77%)

Oklahoma State University Center for Health Science's Internal Medicine Specialty Services (Tulsa, Oklahoma)
- University/Hospital system
- RWHAP Parts B and C recipient
- 1,300 patients a year; 93% clients with HIV
- 20 employees provide HIV services
- Most common non-medical services accessed by clients with HIV: health education (90%), outreach (80%), referral for health care (68%)

Implementation Science Evaluation

E2i used an implementation science approach to evaluate the intervention. The evaluation aimed to answer the following questions:

- "What does it take to implement SBIRT in HIV service organizations?"
- "To what extent is successful implementation related to better HIV outcomes for the clients?"

E2i evaluators collected CoCM client data from the E2i implementation sites throughout the initiative to measure: engagement in care, prescription of ART, retention in care, and viral suppression. They also collected and reviewed site staff surveys, client encounter forms, site visit reports, meeting notes, and other documents in order to learn more about: key factors for successful implementation; challenges encountered by the implementers; and adaptations to the intervention to achieve more successful implementation. The major findings from the evaluation are reported throughout this Implementation Guide. For more detail on E2i's theoretical approach and evaluation methods, see ***Appendix A***. See also the ***CoCM E2i Toolkit*** for additional evaluation findings reported in manuscripts.

COCM OVERVIEW

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Goal

The primary goal of implementing CoCM is:

» To improve behavioral health outcomes and HIV health outcomes among people with HIV

Intervention Description

CoCM is a patient-centered approach that integrates behavioral health care and primary care to treat common and persistent psychiatric disorders, such as depression and anxiety. In CoCM, a primary care provider, behavioral health care manager, and psychiatric consultant work as a collaborative team to treat and manage the behavioral health of a shared caseload of clients. The care team uses standard validated measures and a population-based client registry to closely track client progress and clinical outcomes over time.

Priority Population

» People with HIV who have co-occurring depression or other psychiatric disorders.

Rationale

» Many people with HIV struggle with depression, anxiety, posttraumatic stress disorder, substance use disorders, and other psychiatric disorders.[1-3]

» Psychiatric disorders create barriers to engagement in HIV care and adherence to HIV medications.[4-6]

CoCM Enrollment at the E2i Sites

122 clients

29–48 years old

59% male

65% Black/African American

32% Hispanic/Latinx

[1] Nanni MG, Caruso R, Mitchell AJ, Meggiolaro E, Grassi L. Depression in HIV infected patients: A review. Curr Psychiatry Rep. 2015;17(1):530.

[2] Machtinger EL, Wilson TC, Haberer JE, Weiss DS. Psychological trauma and PTSD in HIV-positive women: A meta-analysis. AIDS Behav. 2012;16(8):2091-2100.

[3] O'Cleirigh C, Magidson JF, Skeer MR, Mayer KH, Safren SA. Prevalence of psychiatric and substance abuse symptomatology among HIV-infected gay and bisexual men in HIV primary care. Psychosomatics. 2015;56(5):470-478.

[4] Rooks-Peck CR, Adegbite AH, Wichser ME, et al. Mental health and retention in HIV care: A systematic review and meta-analysis. Health Psychol. 2018;37(6):574-585.

[5] Pence BW, Mills JC, Bengtson AM, et al. Association of increased chronicity of depression with HIV appointment attendance, treatment failure, and mortality among HIV-infected adults in the United States. JAMA Psychiatry. 2018;75(4):379-385.

[6] Machtinger EL, Haberer JE, Wilson TC, Weiss DS. Recent trauma is associated with antiretroviral failure and HIV transmission risk behavior among HIV-positive women and female-identified transgenders. AIDS Behav. 2012;16(8):2160-2170.

- Due to stigma related to mental health and substance use, people with HIV may not readily disclose these issues to their primary care provider, nor access referrals when provided.[7]
- Integrating behavioral health with primary care can help people with HIV overcome stigma and other barriers to engagement in behavioral health care.[8,9]

Intervention Background

- CoCM was first developed by Wayne Katon, MD, a psychiatrist at the University of Washington. The AIMS Center, a group of faculty, staff, and consultants at the University of Washington, continues to oversee research and implementation of CoCM.
- The effectiveness of CoCM was established in a study called Improving Mood – Promoting Access to Collaborative Treatment (IMPACT), which was the first large randomized controlled trial of collaborative care for depression in primary care settings. Among older adults (the priority population of the study), IMPACT had more than double the effectiveness of depression treatment compared to usual care.
- Since the IMPACT study, CoCM has been successfully implemented for treating depression in a wide diversity of settings and with a diversity of populations, including people with HIV.[11–14]
- Over 80 clinical trials have found that CoCM improves mental health outcomes and functional status more quickly and more effectively than usual mental health treatment strategies in primary care.

[7] Whetten K, Reif S, Whetten R, Murphy-McMillan LK. Trauma, mental health, distrust, and stigma among HIV-positive persons: implications for effective care. Psychosom Med. 2008;70(5):531-538.

[8] Drainoni ML, Farrell C, Sorensen-Alawad A, Palmisano JN, Chaisson C, Walley AY. Patient perspectives of an integrated program of medical care and substance use treatment. AIDS Patient Care STDS. 2014;28(2):71-81.

[9] Walley AY, Palmisano J, Sorensen-Alawad A, et al. Engagement and substance dependence in a primary care-based addiction treatment program for people infected with HIV and people at high-risk for HIV Infection. J Subst Abuse Treat. 2015;59:59-66.

[10] Unutzer J, Katon W, Callahan CM, et al. Collaborative care management of late-life depression in the primary care setting: A randomized controlled trial. JAMA. 2002;288(22):2836-2845.

[11] Pence BW, Gaynes BN, Adams JL, et al. The effect of antidepressant treatment on HIV and depression outcomes: Results from a randomized trial. AIDS. 2015;29(15):1975-1986.

[12] Proeschold-Bell RJ, Heine A, Pence BW, McAdam K, Quinlivan EB. A cross-site, comparative effectiveness study of an integrated HIV and substance use treatment program. AIDS Patient Care STDS. 2010;24(10):651-658.

[13] Barroso J, Bengtson AM, Gaynes BN, et al. Improvements in depression and changes in fatigue: Results from the SLAM DUNC depression treatment trial. AIDS Behav. 2016;20(2):235-242.

[14] Pyne JM, Fortney JC, Curran GM, et al. Effectiveness of collaborative care for depression in human immunodeficiency virus clinics. Arch Intern Med. 2011;171(1):23-31.

Duration

CoCM continues until a client's symptoms of depression (or other psychiatric disorder) are improved and the patient is able to resume their normal daily activities.

The E2i sites that implemented CoCM included two federally qualified health centers (community health centers) and two HIV clinics located within larger hospital/university systems.

Settings

Any organization that provides primary care for people with HIV can implement CoCM.

Staffing

Care Team

The CoCM care team consists of a:

- **Primary care provider:** Provides primary care services and prescribes psychotropic medications
- **Behavioral health provider:** Serves as the team manager (referred to as the behavioral health care manager) and provides counseling interventions
  - Larger organizations may need multiple behavioral health providers who provide counseling interventions to CoCM clients. These providers may be managed by one central behavioral health care manager or may work as a team.
- **Psychiatric consultant:** Consults on management of clients with the team in person or remotely

More details on the care team's roles and qualifications are described below (see Core Elements, Principle 1: Client-Centered Team Care).

Additional Recommended Staff

To successfully implement and deliver CoCM, HIV service organizations may also need support from:

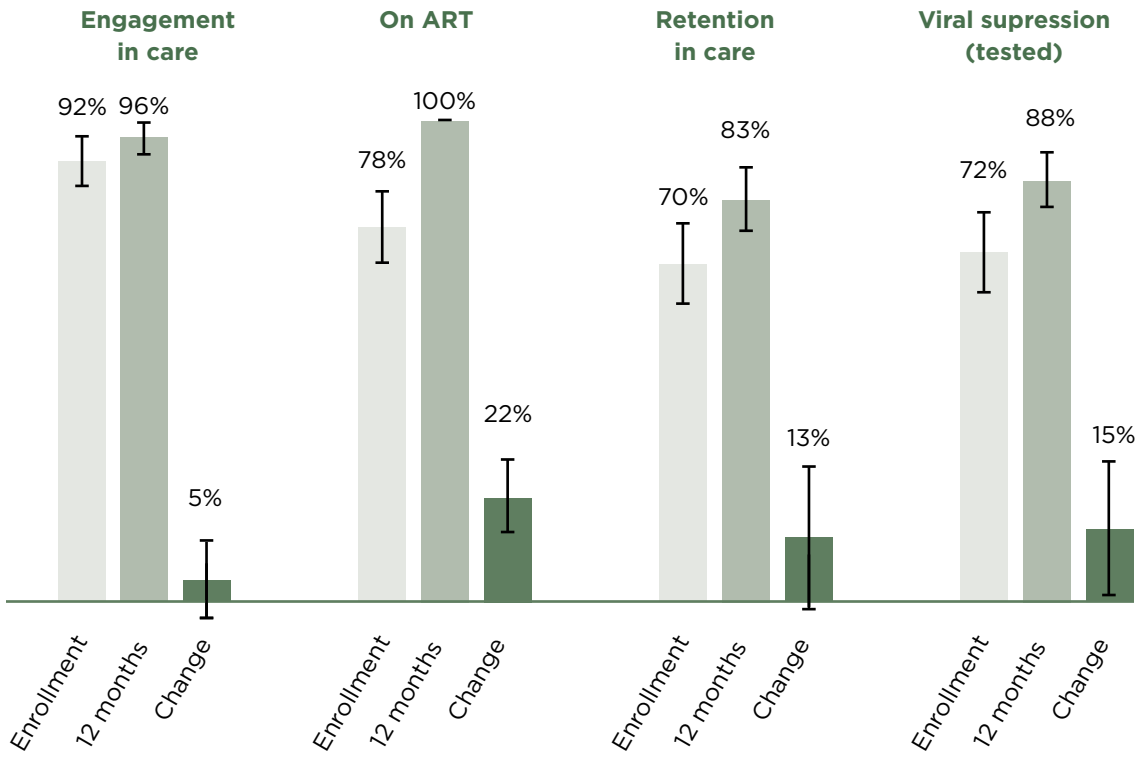
- **Front office staff members:** Hand out screening questionnaires to clients in waiting rooms
- **Information technology (IT) specialist:** Sets up and troubleshoots the client registry (see Core Elements, Principle 2: Population-Based Care)
- **Peer mentors/educators** (i.e., people with HIV from the local community): Build trust with clients, assist clients in navigating the health system, and educate clients about HIV transmission, medication adherence, and self-care
- **Case managers:** Help clients access housing, employment, transportation, and other basic needs and services
- **Nurses and medical assistants:** Support care teams
- **Finance staff members:** Support providers in billing for CoCM

The E2i sites staffed their CoCM programs with behavioral health providers, case managers, nurses, physicians, and psychiatric consultants. One site enlisted peer navigators funded on another project to assist the behavioral health provider with the necessary follow-up phone calls to clients. Because of their shared lived experiences with clients, peers can be instrumental in building client trust, reducing stigma associated with accessing care for psychiatric disorders and HIV, and ultimately boosting client engagement in care.

E2i EVALUATION:
COCM HIV CARE CONTINUUM OUTCOMES

- **Enrollment:** During an 11 to 12 month period, the E2i sites enrolled a total of 122 clients (ranging from 19 to 54 clients at each site) in CoCM. Clients were between 29 and 48 years old. The majority of clients were male (59%). About 65% of clients identified as Black/African American, and 32% identified as Hispanic/Latinx.
- **Outcomes:** The E2i initiative measured HIV care continuum outcomes at the time of enrollment and 12 months later. Among the clients enrolled in CoCM, the percentage with a prescription of ART and who achieved viral suppression increased significantly. Engagement in HIV care remained high throughout the initiative, without significant change. There was no statistically significant change to retention in care.

FIGURE 2. HIV care continuum outcomes among the 122 clients enrolled in CoCM as part of the E2i initiative.



Note: E2i used the following HRSA definitions for HIV care continuum outcomes:

- *Engagement in care* = At least one primary HIV care visit in the previous 12 months
- *On ART (adherence)* = Having been prescribed ART in the past 12 months
- *Retention in care* = At least two HIV care visits in the past 12 months
- *Viral suppression* = Having an HIV viral load test in the past 12 months AND having a result of less than 200 copies/mL at the last viral load test

Client-Centered Team Care

Population-Based Care

Measurement-Based Treatment to Target

Evidence-Informed Care

Accountable Care

CORE ELEMENTS

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Core elements are the "active ingredients" essential to achieving an intervention strategy's desired outcomes. It is critical to closely follow the core elements when implementing an intervention in an HIV service organization; otherwise, the intervention may not work as intended.[15] In CoCM, the core elements are referred to as the Five Core Principles. Although certain strategies, staffing arrangements, and clinical workflows may differ among organizations implementing CoCM, the core principles to operationalize a successful CoCM program remain the same.

Principle 1: Client-Centered Team Care

CoCM adds two new roles to the traditional primary medical care team: a behavioral health care manager and a psychiatric consultant. The focus is on team member function rather than team member title or previous role.

Primary care provider (physician, nurse practitioner, or physician assistant):

- Oversees all aspects of client care
- Diagnoses common psychiatric disorders
- Prescribes psychotropic medications in consultation with the psychiatric provider
- Adjusts medications in consultation with the psychiatric provider and behavioral health care manager

Behavioral health care manager (social worker, nurse, clinical psychologist, or other licensed behavioral health care provider):

- Acts as the "glue" for the care team: facilitates communication and care planning among the client, primary care provider, and psychiatric consultant
- Engages clients, conducts assessments, and tracks treatment progress
- Provides behavioral health care counseling and interventions to the clients, or coordinates with other providers to deliver interventions
- May diagnose mood disorders

Given the central role of the behavioral health care manager, it is critical to offer this role to the right person. Clients with HIV and co-occurring psychiatric diagnoses need someone who is approachable, relatable, engaging, and skilled at building trust.

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[15] Psihopaidas D, Cohen SM, West T, et al. Implementation science and the Health Resources and Services Administration's Ryan White HIV/AIDS Program's work towards ending the HIV epidemic in the United States. PLoS Med. 2020;17(11):e1003128.

Psychiatric consultant (psychiatrist, psychiatric nurse practitioner, or physician assistant trained in psychiatry):

- Provides regular psychiatric case review and consultation weekly or as needed on an assigned caseload of clients
- May be onsite or at a remote location
- Focuses primarily on clients new to the caseload or who need treatment adjustment or intensification due to lack of treatment response

HIV service organizations that are not affiliated with hospitals or are located in rural and lower resource areas may find it challenging to find a psychiatric consultant, as was the case for one of the E2i sites. The site managed to operate without a psychiatric consultant for several months before an individual was identified and hired into the position. The recent growth in telehealth and videoconference, however, should improve prospects for identifying a psychiatric consultant.

Client:

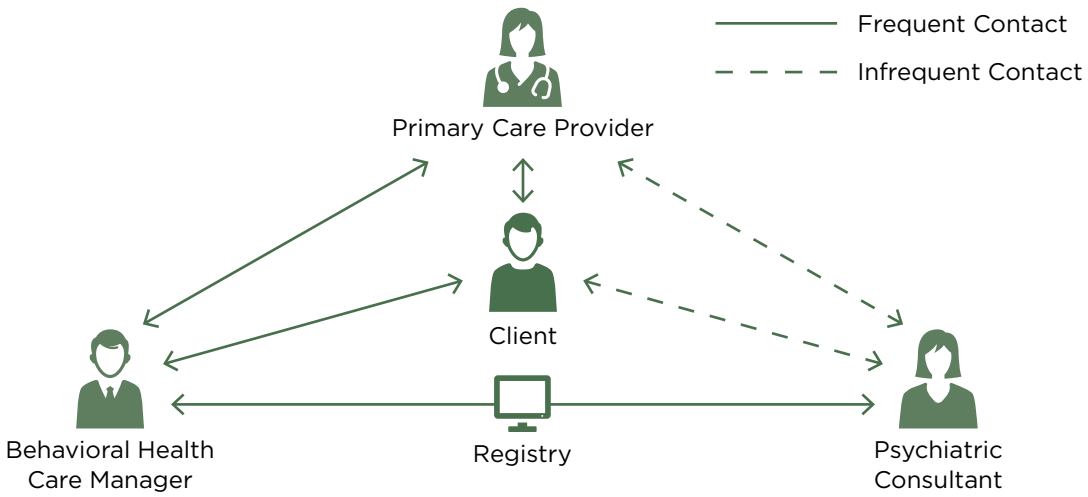
- Contributes own values and personal goals to the treatment plan
- Maintains an active voice in throughout treatment

Prompt and effective communication among care team members is crucial for CoCM success. Care teams meet regularly (e.g., weekly) in person or by telephone/videoconference to discuss their shared caseload and adjust treatment recommendations, as needed, for each client. Care teams also communicate through notes in the electronic health record (EHR) and client registry.

In two of the E2i sites, putting notes in the EHR was the most efficient way to maintain ongoing communication between the psychiatric consultant and the other team members.

As shown in Figure 2, the client communicates more frequently with the behavioral health care manager and primary care provider than with the psychiatric consultant. In fact, clients may never meet directly with the psychiatric consultant.

FIGURE 2. This diagram illustrates the CoCM care team structure and communication routes.



Principle 2: Population-Based Care

In CoCM, data drives the workflow and decision support. Active use of a client registry enables teams to closely track client progress and clinical outcomes over time. A registry must be used alongside or integrated within the practice's EHR system. At least one team member is responsible for maintaining the registry and making sure it runs as expected. This team member can collaborate with an in-house IT staff member to regularly conduct quality assurance audits, troubleshoot issues, and export data needed for consultation among providers.

According to the E2i sites, working as an integrated care team has increased mutual respect among all providers. Behavioral health providers have become more informed about medications, while primary care providers have gained a better understanding of behavioral health needs and treatments. CoCM also reduces client burden because most clients need only meet with the behavioral health provider and primary care provider, and not with the psychiatrist.

Registry Requirements

A CoCM registry must be able to:

- Track when clients are due for screening and follow-up
- Track clinical symptoms, progress, and outcomes at the individual client and caseload levels
- Prompt treatment to target by summarizing client's improvement and challenges in an easily understandable way, such as a graph or chart
- Facilitate efficient psychiatric case review, allowing providers to prioritize clients who need evaluation for changes in treatment or who are new to the caseload

Registries can also help monitor key implementation processes, such as:

- Caseload size
- Number and percentage of clients on a caseload who have been in contact with a behavioral health care provider in a given period of time
- Number or proportion of enrolled clients that have achieved significant improvement in behavioral health outcomes and HIV-related health outcomes

Registry Options

There are currently a few registry options available for purchase, including two HIPAA-compliant registries that can be integrated into the EHR (***AIMS Caseload Tracker*** and ***Care Management Tracking System***). Some organizations have designed their own tracking systems. The AIMS Center also offers guidance for developing a spreadsheet for patient tracking that works well for smaller caseloads of patients.

The E2i sites encountered a variety of challenges with building and using their client registry tools. The sites recommend the following strategies to minimize technical issues and facilitate implementation:

- *Find a client registry tool that can be built into the EHR.*
- *Allow additional time to build and test the registry before launching implementation.*
- *Get support from IT staff during the planning phase in order to build a registry that works well with the EHR.*
- *Establish a system to regularly back-up the data and monitor and audit the registry to make sure it is working as expected.*
- *Recognize that a registry tool may be cost prohibitive.*

Principle 3: Measurement-Based Care and Treatment to Target

Measurement-Based Care

Measurement-based care involves the routine use of validated symptom rating scales to screen for psychiatric distress and to inform treatment decisions and adjustments.

Measurement-based care consists of:

- Screening clients for general symptoms of distress using validated rating scales, such as:
  - ***Patient Health Questionnaire – 9 items (PHQ-9)***[16]
  - ***Patient Health Questionnaire – 2 items (PHQ-2)***[17] followed by the PHQ-9 for those who screen positive
  - ***Generalized Anxiety Disorder 7-items (GAD-7)***[18]
- Enrolling clients that meet a pre-determined cut-off score on the selected rating scale (e.g., clients who score a 6 or higher on the PHQ-9)
- Routinely measuring client symptoms using one or more validated scales during visits with a behavioral health care provider
- Adjusting the client's treatment based on measurement and clinical judgement until the client's clinical goals are achieved

The implementation of screening tools differed among the E2i sites. One site had clients fill out PHQ-9/GAD-7 scales on electronic tablets that fed into the EHR. This site found that using tablets made it much easier to access, upload, and track scores. Another site started with paper PHQ-9 forms, but soon found that clients struggled with the literacy level and with using the rating scale. Staff at that site shifted to verbally administering the PHQ-9 so that clients could ask clarifying questions.

[16] Kroenke K, Spitzer RL, Williams JB. The PHQ-9: Validity of a brief depression severity measure. J Gen Intern Med. 2001;16(9):606-613.

[17] Kroenke K, Spitzer RL, Williams JB. The Patient Health Questionnaire-2: Validity of a two-item depression screener. Med Care. 2003;41(11):1284-1292.

[18] Spitzer RL, Kroenke K, Williams JB, Löwe B. A brief measure for assessing generalized anxiety disorder: The GAD-7. Arch Intern Med. 2006;166:1092-7.

Measuring mental health with a rating instrument does not invalidate a client's feelings or experience, nor does it disregard the complexity of the client's story. Rather, these instruments provide important information about the client that adds to the clinical judgment of the provider in creating and adjusting a tailored treatment plan. Rating scale results also help the care team prioritize which clients to review during team meetings. Over time, many clients use a rating scale to self-monitor their symptoms and prevent relapse.

Treatment to Target

Adjusting the client's treatment plan based on symptom measures is one of the most important components of CoCM.

- CoCM typically requires a change in the treatment plan every 8-12 weeks if the client is not on track for improvement or remission of symptoms.
- Frequent measurement of symptoms allows the care team and the client to know whether the client is having a full response, partial response, or no response to treatment.
- Symptom measures also provide clues about which symptoms are improving and which are not if there is a partial response to treatment.
- This information is critical for making decisions about how to adjust treatment.

The E2i sites did not uniformly implement measurement-based care and treatment to target. Rather than reassess clients with a screening tool on a routine basis, the behavioral health providers would often informally assess how clients were doing. They preferred to use clinical judgment based on the client-provider relationships they had built. The disadvantage to this approach is that they were not able to formally track progress. One of the sites that did more measurement-based care reported that regular assessments helped clients recognize their symptoms of depression and appreciate their improvement over time.

Principle 4: Evidence-Based Care

The CoCM care team works collaboratively to provide treatment to the client. The roles of the team in providing evidence-based treatment are generally as follows:

- **The primary care provider** initiates medication, if indicated.
- **The behavioral health care manager** delivers behavioral or psychotherapeutic interventions.
- **The psychiatric consultant** helps guide the effective application of these interventions.

All team members should be familiar with all of the client's treatments in order to reinforce treatment participation by the client. For example, although the primary care provider typically prescribes the medications, the behavioral health care manager will support medication adherence and may be the first person to hear about side effects. Likewise, although the behavioral health care manager will set behavioral goals with the client, a primary care provider can check in with the client about these goals and can re-emphasize their importance as part of the treatment plan.

Medications

Clients who choose to take medication should be followed closely by the behavioral health care manager who will monitor treatment outcomes and side effects in consultation with the primary care provider and psychiatrist. To learn more about effective medication treatments used in primary care, see the ***summary of commonly prescribed psychotropic medications*** on the AIMS Center website.

The E2i sites found that many of their Black and Latinx clients did not desire to take medications to treat depression. One site reported that clients distrusted medications used to treat mental illness, believing them to be potentially addictive. In addition, stigma related to mental illness was noted as a barrier to taking medication. Site staff encouraged these clients to engage in behavioral health counseling, provided education about medications, and continued to offer medication as an option if/when a client was ready.

Behavioral Interventions

Treatment plans often include behavioral interventions in addition to, or as an alternative to, medications. To be effective in primary care, a behavioral intervention should have credible research evidence to support their efficacy in treating the targeted symptoms. In addition, the interventions should:

- Include a client engagement component
- Follow a structured, but client-centered approach
- Minimize required clinical training and duration of treatment
- Be relevant and applicable to diverse client populations

Of the many existing behavioral interventions, the following have been proven effective in fast-paced settings such as primary care:

- Problem Solving Therapy (PST)
- Behavioral Activation (BA)
- Cognitive Behavioral Therapy (CBT)
- Interpersonal Counseling (IPC)

The standard CoCM model calls for shorter, less intensive counseling sessions, lasting no more than 20-30 minutes a visit.

The E2i sites found that longer sessions of 30-60 minutes were needed for their clients, at least initially. Many clients with HIV face overwhelming psychosocial barriers that must be attended to before being able to focus entirely on mental health or substance use. A shorter time period may work for clients in the maintenance stage.

Principle 5: Accountable Care

Accountable care means holding the care team (and the entire organization) responsible for conducting ongoing quality improvement based on the organization's behavioral health integration goals and client outcome metrics.

Key strategies include:

- **Identifying goals:** All care team members should have a clear understanding of both client- and program-level organizational goals.
- **Defining measurements:** Team members should identify key measurements and strategies to obtain data that can easily be translated into necessary, actionable information.
- **Reviewing progress:** Team members should regularly review data to identify areas for improvement as well as nimbly respond to unmet goals.

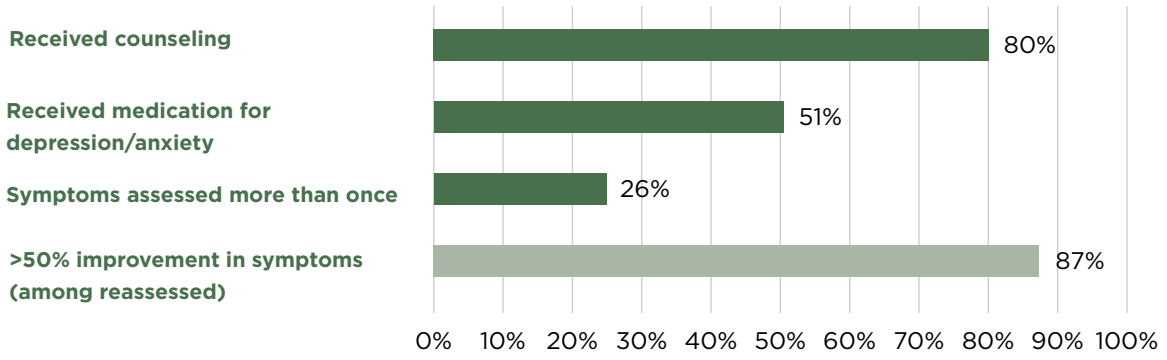
Common data collected to measure progress include:

- Number of clients served
- Client satisfaction survey data
- Client-reported outcomes using standard measures such as the PHQ-9
- Costs associated with care
- HIV-related outcomes such as viral load and CD4 counts

Many teams use familiar quality improvement strategies such as the ***Plan-Do-Study-Act*** (PDSA) cycle to support accountable practice.

E2i EVALUATION:
COCM PARTICIPATION OUTCOMES

FIGURE 3. Participation outcomes among the 122 clients enrolled in CoCM as part of the E2i initiative.



- **Counseling participation:** Nearly all clients (80%) received at least one behavioral health counseling session, with most receiving between two and ten counseling sessions.
- **Depression/anxiety medication prescription:** Half of the clients were prescribed medication to treat depression/anxiety.
- **Re-assessment of depression/anxiety symptoms:** Only one-quarter (26%) of clients were formally reassessed with a screening tool after enrollment.
- **Depression/anxiety symptom improvement:** Among the clients who were formally re-assessed, symptoms declined by at least 50% for most clients (87%).

PLANNING AND IMPLEMENTATION ACTIVITIES

PLANNING AND IMPLEMENTATION ACTIVITIES

The AIMS Center recommends five CoCM implementation steps. For more in-depth guidance on how to implement CoCM, access the tools and resources on the ***AIMS Center website***. Keep in mind that each organization may need to modify the implementation and planning activities for their local contexts.

For other helpful planning tools, see:

Appendix B: General Best Practices for Planning to Implement an Intervention Strategy

Appendix C: CoCM "Go Live" Worksheet

Step 1: Lay the Foundation

CoCM will fundamentally change your practice. It is a new way of doing medicine and requires an openness to creating a new vision that everyone supports.

Understand CoCM

» Planners first need to develop an understanding of the CoCM approach, including its history, core principles, and supporting evidence; the ***AIMS Center website*** has multiple resources

Establish a planning team of "champions"

» Identify a person who will serve as Implementation Leader for CoCM, who will advocate strongly for CoCM among organizational leadership and staff, and who has the authority to allocate time and resources.

» Form a team or workgroup of CoCM "champions;" i.e., staff who demonstrate the commitment, tenaciousness, and passion to convince others of the importance and benefits of CoCM, and to overcome hurdles and move implementation forward.

» Under the direction of the Implementation Leader, the planning team works together to plan, launch, and monitor CoCM implementation.

» To allow for various perspectives on how to tailor the intervention, the team should consist of at least one primary care provider, one behavioral health provider, and a psychiatric consultant; ideally, the team also has members from across all departments and teams (leadership, social workers, administrators, etc.).

» Consider how the team can also meaningfully involve at least one peer (a person with HIV who also represents the priority population) in the planning and implementation of CoCM (see ***AIDS United's resources on meaningful involvement of people with HIV***).

Identifying both a primary care and behavioral health CoCM champion was key to achieving institutional buy-in at one of the E2i sites. The champions bridged the gaps between departments and were helpful when staff in their departments had questions regarding the program.

Gain "buy-in" from leadership and staff

» Provide evidence of the ***cost savings and other benefits of CoCM*** to leadership and staff members.

» Invite staff and leadership to provide input and feedback on planning and implementation.

» Keep the organization up to date on the progress of CoCM implementation through regular updates.

Create a shared vision and plan

» Create a unified and compelling CoCM vision statement that aligns with your organization's overall mission and quality improvement efforts.

» Create a plan for putting the shared vision into practice

Identify medical billing codes and reimbursement options

» Determine potential reimbursement mechanisms for CoCM

- Medicare covers CoCM in all states.
- As of 2021, Medicaid payment for CoCM is available in 17 states.
- Federally qualified health centers often use different coding structures and receive different reimbursement than other health systems for CoCM and other interventions.
- RWHAP-funded organizations can receive technical assistance on health coverage options from the ***Access, Care, and Engagement Technical Assistance (ACE TA) Center***.
- Organizations in states without Medicaid payment for CoCM may consider partnering with allies to advocate for CoCM benefits. Potential allies are local and state chapters of the American Medical Association, members of the American Psychiatry Association, and psychiatry departments in schools of medicine.

Because of differences in state coverage options and billing procedures by organization type, two of the E2i sites found it easy to bill for services, while the other two found it challenging. One of the health center sites had still not worked out a way to bill for CoCM by the end of the E2i implementation period.

» Learn more about recommended billing and coding options for CoCM from the ***AIMS Center resources on financing and reimbursement strategies for integrated services***.

E2i EVALUATION:
COCM IMPLEMENTATION OUTCOMES

To learn more about how the intervention was viewed by the leadership and staff members at the E2i sites, E2i evaluators collected data from the people implementing the intervention. The data included: (1) an organizational survey completed by key site staff once during the planning period, and every six months during implementation; and (2) a review of site documents created during implementation, including site visit reports, meeting notes, and cost workbooks (see *Appendix A*).

Measure (definition)	Results at the E2i sites
Acceptability: how well staff and leadership regard the intervention	All sites found the intervention highly acceptable throughout the initiative and believed the intervention fit well with their organization's mission and goals. In some sites, however, acceptability was low among mental health providers who may have been threatened by the new role of the behavioral health care manager.
Adoption: the intention, initial decision, or action to implement the intervention	Some sites were slow to adopt the intervention at first. However, adoption quickly increased and stayed high at all sites for the duration of the initiative.
Appropriateness: the compatibility of the intervention to address a particular issue or problem	All sites reported that CoCM was highly appropriate and filled a service need.
Feasibility: the extent to which the intervention can be successfully carried out	Initially, some of the sites rated the intervention as highly feasible, while others rated feasibility lower. However, feasibility quickly increased and stayed high for the duration of the initiative. The lower feasibility was likely related to difficulty in finding a psychiatric consultant.
Fidelity: the degree to which a site felt able to (a) implement the intervention as it was intended by the program developers, and (b) monitor progress	Initially, sites varied in their assessment of fidelity; however, fidelity quickly increased and stayed high for the duration of the initiative. Again, this may have been related to the challenges in filling the psychiatric consultant position.
Penetration: the integration of the intervention within the organization	Two sites reported consistently high integration of CoCM over time. The other two sites perceived the integration as more variable but still generally high. One of the larger sites had previous experience implementing CoCM in several of their clinics. This experience made it easier to implement CoCM in another clinic and thereby integrate CoCM more fully into their health system.
Cost: the costs associated with planning and implementation, such as: personnel, training, supplies, incentives, and outreach activities	Costs included both direct and in-kind expenses. The average expenditures for each site were: • *Planning period:* $122,257 • *Recruitment:* $980 per client enrolled • *Implementation activities:* $6,910 per client enrolled • *Supervision and management of intervention:* $3,174 per client enrolled These numbers do not necessarily reflect what it would cost to implement CoCM at other HIV service organizations. Costs per client would be lower in settings with larger populations of people with HIV.

Develop a sustainment plan

Sustainment refers to the ability to maintain programming and its benefits over time. Achieving sustainability typically involves both applying for grants and accessing available reimbursement options (see section above).

- » Develop a comprehensive sustainment plan that moves CoCM beyond the initial implementation and financing.
- » Consider how CoCM adds value to the organization in addition to health care savings; for example, CoCM improves access to mental health care, client satisfaction, and client outcomes.
- » Seek out grants from private foundations or government entities; a successful pilot or demonstration project can often establish proof of concept to win increased financial support from public and private payers.
- » Access the ***Program Sustainability Assessment Tool*** developed by the Center for Public Health Systems Science at the Brown School, Washington University in St. Louis.

Assess organizational readiness

- » Assess the differences between your current care approach and CoCM's approach.
- » Assess your organization's strengths and weaknesses using the AIMS Center's ***Organizational Readiness Checklist***.

Establish partnerships with community organizations

- » Reinforce or establish new partnerships with local organizations that provide services to support your clients' basic and social support needs, such as food banks, housing agencies, LGBTQIA+ organizations, etc.
- » Conducting outreach with local agencies also can bring in new clients, particularly those who initially do not trust or feel comfortable with your organization.

Step 2: Plan for Clinical Practice Change

Implementing CoCM requires significant, and often challenging, clinical practice change. The process takes time and cannot be rushed. Organizations must clearly define team member roles, create a workflow, and identify how to track treatment and outcomes.

Structure the care team

» Each care team member completes a ***Self-Assessment Tool*** that asks them to consider which tasks they fulfill in their current role, their level of comfort with the task, and whether they need more training to perform the task in the future.

» The implementation leader collates the responses to the self-assessment tool, maps out the current team structure and activities, and identifies gaps and duplications in tasks.

Create a clinical workflow

» The planning team reviews the previous step's findings and creates a clinical workflow showing the exact process of what happens when a patient comes to the clinic.

» Access the ***Clinical Workflow Plan***

» As part of the workflow plan, carefully consider when, where, and how to screen clients for symptoms of psychiatric distress:

- Clients may feel more comfortable answering questions on a paper form or electronic device than verbally. Electronic questionnaires (delivered on laptops or tablets) have the advantage of uploading automatically into a client's chart.
- On the other hand, clients with low health literacy may need to be asked the questions verbally.

If screening clients verbally, the E2i sites recommend that the screening be done by a behavioral health provider, rather than a nurse or medical assistant. The advantage is that a behavioral health provider should have the skills needed to put the client at ease for disclosure of behavioral health symptoms and behaviors.

Identify a registry system

» Identify a client registry that will:

- Track clinical outcomes and progress at the individual and caseload level
- Summarize client improvement and challenges in an understandable and actionable way
- Facilitate efficient psychiatric consultation and case review
- Be used in conjunction with, or built into, the EHR

» As described under Core Elements, the ***AIMS Center has registry options***; you can also pursue customized registry builds within your EHR

Assess administrative tasks and make an action plan

» Access the ***Administrative Readiness Checklist*** to begin making a list of administrative tasks to consider when planning CoCM

» Complete an ***Action Plan Worksheet*** for determining the resources needed, potential obstacles, and the due dates for procuring funding, space, staffing, etc.

- More complex registries tend to require more funding
- Prepare for the possible need to hire more behavioral health providers, depending on enrollment numbers

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A sample CoCM workflow from an E2i site is as follows:

1. All clients are screened with the PHQ-2 followed by PHQ-9 during intake

2. Physicians are notified of clients who score > 6 on the PHQ-9

3. Physicians invite the behavioral health provider to explain CoCM to eligible CoCM clients

4. The behavioral health provider works with the psychiatric consultant to develop a care plan, and communicates the plan to the other members of the CoCM team

5. The behavioral health provider administers brief counseling to clients, according to the plan, checks in with clients about symptoms, and tracks progress in the client registry

6. The physician prescribes medications to clients, according to the plan

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Step 3: Build your Clinical Skills

Every member of the care team needs to understand their role and have the knowledge and skills to fulfill their role. Care team training from the AIMS Center is therefore key to successful implementation. Teams may also access technical assistance from the AIMS Center.

Whole care team training

» The care team receives an introductory training together through the ***AIMS Center Care Team Training Module***

Specific role training

Each care team member also receives specific training in their role:

» ***Care Manager Training Module***

» ***Behavioral Health Care Manager Training***

» ***Primary Care Provider Training Module***

» ***Psychiatric Consultant Training Module***

Implementation support

Organizations can also seek support for CoCM implementation during monthly office hours held by the AIMS Center.

Step 4: Launch your Care

Is your team in place and fully trained? Are all systems ready to go? Time to launch!

Develop educational tools

Develop a suite of informative and reassuring resources to educate clients about mental health care and substance use treatments. The suite may include educational materials, client-centered videos, or online links. Clients appreciate receiving a written summary of all behavioral health intervention options offered at the clinic.

Monitor implementation process and clinical outcomes

- Manage client enrollment and tracking in the registry.
- Review the data regularly to make sure you are meeting your enrollment and treatment goals.
- Identify ways to improve care by looking at the metrics. For example: Is one behavioral health provider's clients consistently improving more than the clients of others? Is this provider doing anything differently, such as making more follow-up calls? Perhaps have other providers make more calls to see if this helps improve their clients' outcomes.

Maintenance (relapse prevention) planning

- Develop a plan to help clients maintain their health gains and prevent relapse by having the behavioral health provider fill out the ***Relapse Prevention Plan*** with the client. In the plan, the client and behavioral health provider will note the client's maintenance medications, other treatments, personal warning signs, and things that help the client feel better. This will help clients understand how to identify when symptoms may be returning and empower them to do something about it.

Address unanticipated challenges

- Expect to run into unanticipated challenges while implementing CoCM.
- To inform solutions to these challenges, revisit your vision statement, workflow, etc.
- Talk to all team members about what's working and what needs to be changed. Is more training needed?

CoCM clients at E2i sites experienced barriers to CoCM participation and engagement in care. Barriers included unstable housing, food insecurity, lack of transportation, and lack of childcare. The E2i sites tried to address these issues and increase participation with the following strategies:

- *Working closely with the case managers to better address basic needs before actively engaging clients in CoCM*
- *Offering extended and more flexible hours*
- *Scheduling behavioral health appointments immediately before or after other clinic appointments*
- *Meeting clients where they are and listening closely to their concerns*

Step 5: Nurture Your Care

Now is the time to see the results of your efforts, and to think about ways to improve implementation:

- Continue monitoring process and clinical outcomes.
- Merge CoCM into existing quality improvement plans.
- Revisit your vision, clinical workflow, and action plan every six months.
- Provide regular training and implementation support to maintain a high standard of care and to bring new hires up to speed.

E2i EVALUATION: CHALLENGES, SUCCESSES, ADAPTATIONS, AND LESSONS LEARNED

The E2i sites that implemented CoCM encountered barriers and facilitators to achieving their implementation goals. They also made changes to the original intervention to meet the specific needs of their clients and staff members. Here is a summary of adaptations and lessons learned. Additional information about the sites' experiences can be found in the Program Spotlights below.

- **Reduce stigma and build trust with clients and the community.** The E2i sites found that many clients feared the stigma associated with psychiatric disorders and HIV; some also mistrusted behavioral health providers. To overcome stigma and build trust, the sites recommend that organizations:
  - Hire behavioral health providers who demonstrate empathy and are skilled in engaging reluctant clients.
  - Hire peers to support health education and engagement in care.
  - Recognize that some of the language used in the behavioral health field, such as "therapy," can be off-putting to patients. Language changes help to make the intervention more relatable.
  - Build partnerships with community leaders and organizations that serve sexual and gender minorities, people of color, and people with HIV.
- **Co-locate the behavioral health and HIV care providers.** The E2i sites found that when the HIV and behavioral health care teams shared the same clinical space, the HIV physicians were able to initiate warm handoffs of clients to behavioral health providers.
- **Clarify the roles of behavioral health providers.** In the E2i sites with behavioral health providers that were not involved in CoCM, the role of the CoCM behavioral health care manager was initially confusing to staff. These sites found they needed to clearly define the role of the behavioral health care manager and communicate that role to all staff, especially staff who make referrals. For example, the sites clarified that the CoCM behavioral health provider sees all clients with HIV who score over 6 on the PHQ-9. All other clients were to be seen by the other providers.
- **Do not skip the staff "buy-in" step.** Every member of an organization needs to understand CoCM, how it benefits the organization as a whole, and what their role is in making CoCM effective. Building support for behavioral health care integration across clinic staff and providers greatly facilitated the promotion of CoCM in the E2i sites.

E2i EVALUATION: CHALLENGES, SUCCESSES, ADAPTATIONS, AND LESSONS LEARNED

- **Start small and do not rush implementation.** Given the high prevalence of mental health challenges among people with HIV, staff can quickly became overwhelmed. Increased caseloads made it difficult to track and reassess clients' mental health symptoms and status. The sites recommend taking the time to slowly grow the number of clients receiving screening and referral; otherwise, providers may end up with long waitlists and difficulties with taking routine reassessments and maintaining the client registry tool.
- **Thoughtfully choose or develop a client registry.** The E2i sites encountered a variety of technical and other challenges with building and using their client registry tools. Their recommendations for preventing and minimizing technical challenges are to:
  - Collaborate with IT staff during the planning phase in order to find or develop a registry that can be built into the EHR.
  - Take time to look at the registry options and their costs. Even if you are starting with a small number of clients, you may eventually have a large caseload that requires a more robust registry.
  - Take time to build and test your client registry tool before launching implementation.
  - Establish a system to regularly back-up the data and monitor and audit the tool to make sure it is working as expected.
- **Offer teletherapy and early/late hours to overcome transportation barriers.** Clients who live far away and have transportation barriers need flexible hours and delivery modes to attend appointments. Offering flexible hours and sessions by phone or videoconferencing helped the E2i sites address these barriers.
- **Recognize that routine measurement may be challenging with some populations.** Even though measurement-based care is an important CoCM principle, the E2i sites only reassessed symptoms in about 25% of clients. The behavioral health providers chose instead to informally assess clients using clinical judgment based on talking sessions, possibly because their clients did not feel comfortable with the terms and styles of a standard measure of psychiatric symptoms. The disadvantage to this approach was that the sites could not formally track progress. One of the sites that did more measurement-based care reported that regular assessments helped clients recognize their symptoms of depression and appreciate their improvement over time.

E2i EVALUATION: CHALLENGES, SUCCESSES, ADAPTATIONS, AND LESSONS LEARNED

- **Find a learning community.** The four E2i sites that implemented CoCM benefitted from having quarterly calls and biannual learning sessions with each other to discuss challenges and facilitators, as well as biannual learning sessions to share strategies, feedback, and lessons learned. The sites believe that future implementing organizations would also benefit greatly from similar collaborative learning opportunities.
- **Prepare for change.** One E2i site faced unanticipated challenges to implementation, including seasonal flooding and staff turnover; all sites needed to adjust their workflows significantly when the COVID-19 pandemic began in 2020. The sites found it very helpful to get feedback from all relevant staff about how to adjust the workflow, and they were grateful for having already obtained staff buy-in to CoCM.

PROGRAM SPOTLIGHTS

PROGRAM SPOTLIGHT

Corktown Health

Organizational Background

In 2017, the Health Emergency Lifeline Programs in Detroit, Michigan, opened Corktown Health, a RWHAP Part A recipient, and Michigan's first medical home to focus on the needs of the LGBTQIA+ community and people with HIV. Located just west of downtown Detroit, the agency predominantly serves residents of southeast Michigan.

Implementation Goals and Context

Corktown Health implemented CoCM to address the high prevalence of depression among their clients with HIV. The agency has a fully credentialed behavioral health services program that they have recently integrated into their primary care and HIV specialty care departments. Corktown Health developed a partnership with a third-party psychiatric consultant via telemedicine to complete the CoCM team.

Recruitment and Delivery

All Corktown Health clients are handed tablets in the clinic waiting area to confidentially complete the PHQ-2 and PHQ-9 screening tools at their own pace. Client scores are automatically uploaded into the EHR where clinicians can review scores during the medical or behavioral health visit. Clients who screen positive for depressive symptoms are introduced to the CoCM program and offered a warm hand-off or referral to a behavioral health provider (clinical social workers), who schedules an intake. If a client is not interested

in these services, they are offered other resources and referral information. Some clients who meet eligibility criteria do not enroll in CoCM because they already have a behavioral health care provider at another agency.

Following intake, clients engage in ongoing therapy with the behavioral health provider and/or take antidepressant medication prescribed by their primary care provider and in consultation with the psychiatric consultant. Clients' symptoms are measured regularly with the PHQ-9 and the GAD-7. The CoCM team holds weekly meetings and case conferences to discuss the clients' progress, barriers, and other outcomes.

Adaptations and Innovations

- **Open psychiatric consultant meetings:** The Corktown Health team invites anyone who is interested in working with CoCM clients to attend the weekly consultation meetings with the psychiatrist. These meetings provide the behavioral health team, primary care providers, nurse practitioners, insurance navigators, and case managers the opportunity to share progress updates for clients and discuss treatment and engagement plans with the psychiatric consultant.
- **LOCUS tool:** The Corktown Health team adopted the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) tool to refer and provide external resources to CoCM clients more efficiently.
- **COVID-19 pandemic:** During the COVID-19 pandemic, Corktown Health launched a new platform to provide telehealth services integrated with their EHR. To accommodate clients who did not have access to a computer or smartphone, the team was able to allow face-to-face therapy services in limited circumstances and with safety protocols in place.

Program Integration

Corktown Health successfully integrated the CoCM intervention into their organization with full support and buy-in from leadership and staff. The model has also promoted a more collaborative environment throughout the agency, making it easier for various departments to engage and collaborate for the benefit of clients. The behavioral health providers are cross-funded through different sources, which allows for flexibility and sustainability of staff across various programs. To sustain activities beyond the E2i grant period, Corktown Health is pursuing local foundation funds and are making ongoing efforts to increase billing capacity.

Lessons Learned

» **Champions:** Identifying behavioral health and primary care CoCM champions has been instrumental to achieving institutional buy-in at Corktown Health. The champions bridge the gaps between departments and are helpful when staff in their departments have questions regarding the program.

» **Registry:** The Corktown Health team recommends seeking out a client registry tool that can be built into the EHR, and allowing additional time to build and test the tool before launching implementation. They also note that registry tools can be cost prohibitive.

» **Tablets:** The use of tablets that feed into the EHR has made accessing, uploading, and tracking PHQ-9/GAD-7 scores over the course of treatment much easier for staff and clients.

"As a newer nurse practitioner handling so much in primary care, it has been such a relief to have a consulting psychiatrist to turn to. She lets me gain insight into her thought process and practices, and I have gained confidence in prescribing antidepressants and managing more complex patients with her support and guidance."—Corktown Health nurse practitioner

» **Billing and coding:** The Corktown Health team found they could not use the CoCM billing code in the state of Michigan but could receive reimbursement for behavioral health and psychiatric services.

» **Retention and social determinants of health:** Initially, several CoCM clients were dropping out of counseling after two or three sessions because of housing and food insecurity, lack of transportation, and other social determinants. The Corktown Health team began working closely with the case management team to better address those needs before actively engaging clients in CoCM.

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PROGRAM SPOTLIGHT

La Clínica del Pueblo

Organizational Background

La Clínica del Pueblo (LCDP) provides comprehensive health care and services to low-income, limited English proficient Hispanic/Latinx populations at five sites in the Washington, DC metropolitan area. LCDP is a federally qualified health center, a RWHAP Part C recipient, and a RWHAP Parts A and B subrecipient.

Implementation Goals and Context

LCDP implemented CoCM with the goals of strengthening integration of primary HIV care and mental health services, addressing the high prevalence of depression among their clients, and enhancing patient engagement in HIV care. Before the E2i initiative, LCDP had an established system for integrating behavioral health into HIV care. Despite having access to a Spanish-speaking psychiatric provider, however, the demand for services exceeded the provider's availability. Implementing CoCM enabled LCDP to leverage the Spanish-speaking psychiatric provider as a consultant for the care teams, effectively supplementing the need for her services, while balancing her time restrictions.

Recruitment and Delivery

At LCDP, all new clients with HIV meet with a behavioral health provider for a comprehensive mental health assessment, including depression screening, with the Spanish translation of the PHQ-9. Existing LCDP clients with depressive symptoms are referred by medical team staff to a CoCM behavioral health provider through a warm handoff. Clients who score six points or higher on the PHQ-9 are presented with the opportunity to receive depression care through the CoCM program.

CoCM clients may choose to receive counseling and antidepressant medication(s) or counseling without medication. Due to community stigma about mental health medications, most LCDP clients tend to choose counseling without medication. Regardless of the client's choice, the behavioral health providers consult with the psychiatrist about each individual case and receive support in talking with clients about medication. During each session, behavioral health providers re-administer the PHQ-9 with the client, offering feedback on the client's symptoms and progress. Measurement-based care has helped clients recognize their symptoms of depression and appreciate their improvement over time. To track and monitor clients' symptoms and status, LCDP behavioral health providers and medical staff access the PHQ-9 smart forms that are in their EHR system.

LCDP initially piloted CoCM at their primary site. Once routines and systems were working well at the first site, CoCM team members easily helped staff to implement CoCM at a secondary site by training staff and helping them adapt their workflow and protocols.

Adaptations and Innovations

- **Verbal screening:** Initially, many clients did not complete the depression screening tool when it was offered on paper, reporting that they were unfamiliar with certain terms and did not know how to use the rating scale. Staff quickly shifted to verbally administering the PHQ-9 so that clients could ask clarifying questions.
- **Flexible sessions:** In order to meet the diverse needs of clients, LCDP providers offer flexible scheduling and time allotment for counseling sessions. While clients with more severe depression typically require weekly hour-long sessions, other clients make progress with shorter sessions that are held less frequently.
- **Community health educators and navigators:** LCDP added peer community health educators and navigators as central and integrated members of the CoCM care teams. These paraprofessional staff have regular access to the clients through the support groups they facilitate. Having people from the local community on the team helps to engage clients on a level that is difficult for providers without similar life experiences. Clients feel safer sharing sensitive, clinically relevant information directly with community health workers.
- **COVID–19 pandemic:** To adjust to the COVID-19 pandemic, LCDP started using videoconference and telephone calls for their client sessions. For clients who did not have access to technology or privacy, staff would hold five-minute check-in calls until clients were able to come back in person for medical visits.

Program Integration

CoCM has been successfully integrated into LCDP's staffing and infrastructure. To sustain CoCM beyond the E2i grant period, LCDP will use third-party billing for direct services to clients and will continue to collaborate with the local health department to cover services to clients without insurance. Additionally, as one of the only bilingual service providers in the region, LCDP will seek contract opportunities to expand mental health services into their region.

"CoCM has improved our competency and comfort in addressing behavioral health issues in primary care and has allowed us to expand and strengthen our capacity to provide culturally and linguistically appropriate psychiatric care to a population in high need of this support." —LCDP staff member

Lessons Learned

- **Raise awareness among medical staff:** Busy medical staff often forget to refer clients to CoCM. LCDP suggests holding multiple all-staff education and training sessions over time about the purpose and goals of CoCM, setting up smaller meetings with key medical staff, and putting reminders in EHRs.
- **Hold regular team meetings:** Holding monthly team meetings with a representative from each department to discuss CoCM progress significantly strengthened the LCDP team's capacity to work collaboratively and provide patient-centered care.
- **Involve IT specialists from the beginning:** LCDP recommends getting support from IT staff during the planning phase for CoCM in order to build a registry that works well with the EHR system.
- **Meet your clients where they are:** Vulnerable populations with HIV often cope with multiple complex issues (e.g., substance use disorders, housing instability, and legal concerns) that exacerbate mental health challenges. LCDP emphasizes the importance of listening to client concerns, doing your best to remain flexible and accommodate their needs, and getting support from case managers and health educators to refer to in-house and partner services.

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PROGRAM SPOTLIGHT

Our Lady of the Lake Regional Medical Center

Organizational Background

The Our Lady of the Lake (OLOL) Regional Medical Center is a large health care and hospital system located in Baton Rouge, Louisiana. As a recipient of RWHAP Parts A, C, and D funding, OLOL provides outpatient ambulatory care to people with HIV. OLOL's Early Intervention Clinic (EIC) serves approximately 1,400 clients residing in nine parishes (i.e., counties). In addition to HIV primary and preventive medical care, OLOL-EIC provides behavioral health care, peer navigation, medical case management, and social services to children and adults with or exposed to HIV.

Implementation Goals and Context

OLOL-EIC chose to implement CoCM after observing a high need among their clients for integrated behavioral health services. Prior to implementing CoCM, clients received referrals for mental health care outside of the clinic. To create a CoCM care team, OLOL hired a licensed clinical social worker as the behavioral health provider and manager, who works in conjunction with OLOL's onsite psychiatric consultant and primary care physicians.

Recruitment and Delivery

To identify clients in need of behavioral health care, OLOL-EIC clinic staff screen all clients who enter the system with the PHQ-2, followed by the PHQ-9 for clients with a positive screen. If a client scores higher than six on the PHQ-9, their primary care provider introduces them to the CoCM program during the medical appointment and provides a

warm handoff to the behavioral health provider. If the behavioral health provider is not available to meet right away, the team member who completes the screening flags the client's electronic medical record, which alerts the behavioral health provider to follow-up with the client later.

At the initial CoCM visit, the behavioral health provider performs structured diagnostic assessments for depression, anxiety, post-traumatic stress disorder, and bipolar disorder. Once a client is enrolled in CoCM, the care team develops a plan to treat the client with antidepressant medication and/or brief interventions, such as motivational interviewing.

Although clients appreciate the opportunity to receive integrated behavioral health care, they encounter barriers to regularly attending their behavioral health appointments. Strategies the OLOL-EIC team have implemented to improve retention in behavioral health care include extending hours one day a week, scheduling behavioral health appointments immediately before or after other clinic appointments, and calling clients with a reminder the day before their visit.

Adaptations and Innovations

- **Expansion of integrated services:** To further expand their integrated behavioral health services, the OLOL-EIC team may begin adding Screening, Brief Intervention, and Referral to Treatment (SBIRT) for substance use disorders.
- **COVID-19 pandemic and natural disasters:** A combination of seasonal flooding and the COVID-19 pandemic temporarily reduced resources and staff available to provide services to clients, while increasing client's needs for housing and transportation. To protect the safety of clients and staff, OLOL-EIC developed a process for providing in-person or virtual medical and behavioral health services.

Program Integration

CoCM is fully integrated into OLOL-EIC clinic's workflow and has achieved high institutional buy-in across departments. Physicians, case managers, and nurses feel comfortable communicating and collaborating with the behavioral health provider in order to provide optimal treatment for patients. To promote sustainability, the OLOL-EIC team has developed a comprehensive package of training materials for new and existing behavioral health providers. Using third-party billing for CoCM will help financially sustain the intervention beyond the E2i grant period. Expanding the program to include SBIRT will also allow the team to tap into additional funding opportunities.

Lessons Learned

» **Staff buy-in:** All members of the OLOL-EIC clinic were instrumental in getting the CoCM intervention off the ground. To maintain staff involvement and enthusiasm, the CoCM team has made sure that everyone has a thorough understanding of the intervention. They also keep staff up to date on modifications or changes in the workflow through weekly or bi-weekly check-ins.

» **Client registry tool:** When the client caseload began to grow, the CoCM team encountered technical issues with their registry tool, causing loss of new information. Establishing a system where the registry tool is backed-up, monitored, and audited regularly is recommended.

» **Funding opportunities:** OLOL-EIC suggests looking for additional funding opportunities to help cover the roll out of CoCM, and to use capacity-building opportunities to forecast and predict future costs and program needs.

"Collaborative Care has allowed us to open our eyes to see the various needs of the patient and to make a difference."
—OLOL-EIC staff member

Contact Information

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Oklahoma State University

Organizational Background

Located in Tulsa, Oklahoma State University Center for Health Science's Internal Medicine Specialty Services (OSU-IMSS) is an academic health center serving people in all counties throughout the eastern half of Oklahoma. A recipient of RWHAP Parts B and C funding, OSU-IMSS has over 1,300 clients with HIV, to whom they provide comprehensive primary medical care, HIV specialty care, and care coordination services. OSU-IMSS is based within an osteopathic university medical center with 33 internal medicine residents who deliver care in three-year rotations.

Implementation Goals and Context

OSU-IMSS implemented CoCM with the goal of providing integrated depression and HIV care specifically for Black/African American and Hispanic/Latinx men who have sex with men who have HIV.

Recruitment and Delivery

OSU-IMSS's process for recruitment begins by universally screening all of their clients with the PHQ-9 while the clients wait for their medical appointment. A licensed practical nurse or registered medical assistant enters the PHQ-9 scores into the EHR, flagging clients who are eligible for CoCM. The primary care physician or resident initiates a discussion about CoCM with eligible clients and refers them to the CoCM behavioral health provider for further assessment and a care plan.

Clients may receive medication, therapy, or a combination of the two, depending on their diagnosis and preferences. Medications are prescribed and adjusted by the resident or primary care physician, in collaboration with the CoCM behavioral health provider and psychiatric consultant. The behavioral health provider monitors the client over time using a tracking spreadsheet they adapted from the AIMS Center and consults with the psychiatrist on a weekly basis to discuss complex cases. Clients who meet their mental health goals for a six-month period enter the relapse program (OSU-IMSS renamed this the maintenance stage), while clients who do not improve or have an acute episode may be referred to a psychiatrist or other behavioral health specialist outside the CoCM program.

Adaptations and Innovations

- **Internal medicine residents:** The OSU-IMSS team adapted the CoCM care team model by integrating internal medicine residents into primary care provider roles. Each year, new residents are now trained in CoCM as part of onboarding.
- **Educational materials:** OSU-IMSS developed a brochure in English and Spanish that provides clients with a brief overview of CoCM. The brochure ensures that clients receive all key information about CoCM.
- **Natural disasters and the COVID-19 pandemic:** Seasonal flooding in 2019 caused the clinic to temporarily close, and all appointments were either relocated to a clinic across the street or replaced with telehealth appointments. The COVID-19 pandemic further pushed CoCM visits to telehealth, although some clients continued to receive in-person care. OSU-IMSS staff report that virtual/telephone visits have benefitted patients who live in rural areas or have limited access to transportation.

Program Integration

OSU-IMSS has successfully integrated CoCM into its workflow. All staff have actively participated in providing input into the process of screening and flagging charts, and they continue to show support for CoCM. The OSU-IMSS team maintains organizational buy-in by presenting at all staff meetings. Beginning in 2021, the clinic intends to expand CoCM to all OSU-IMSS clients by adding an additional therapist to collaborate with the residents and physicians. OSU-IMSS will cover the therapist positions through Ryan White Part B and Part C funding, as well as revenue from third-party billing.

Lessons Learned

» **Start small:** OSU-IMSS recommends starting with a small caseload in order to not overwhelm the team. Once the workflow is solidified and the staff feel comfortable implementing the intervention, the team can expand the program to serve a larger client population.

"It was eye opening to see how many clients were able to mask their symptoms of depression when they came to physician appointments. CoCM offers clients the help they want and when they need it." —OSU-IMSS behavioral health provider

» **Electronic health records (EHR):** As a multidisciplinary team, OSU-IMSS relies on using notes and flags in the EHR to communicate across departments, share updates on clients, and track client progress. Having support from information technology staff proved very useful.

» **Workflow:** Establishing concrete and clear processes, policies, and procedures prior to implementing CoCM was immensely helpful for a smooth launch at OSU-IMSS. In addition, it was key to obtain feedback from staff on the workflow when OSU-IMSS was faced with unanticipated changes (i.e., flooding, staff turnover, etc.).

» **Billing and coding:** The OSU-IMSS team were able to maximize billing opportunities by using the CoCM billing code. Understanding how to best reimburse for CoCM based on local policies is essential for the long-term implementation of the intervention.

Contact Information

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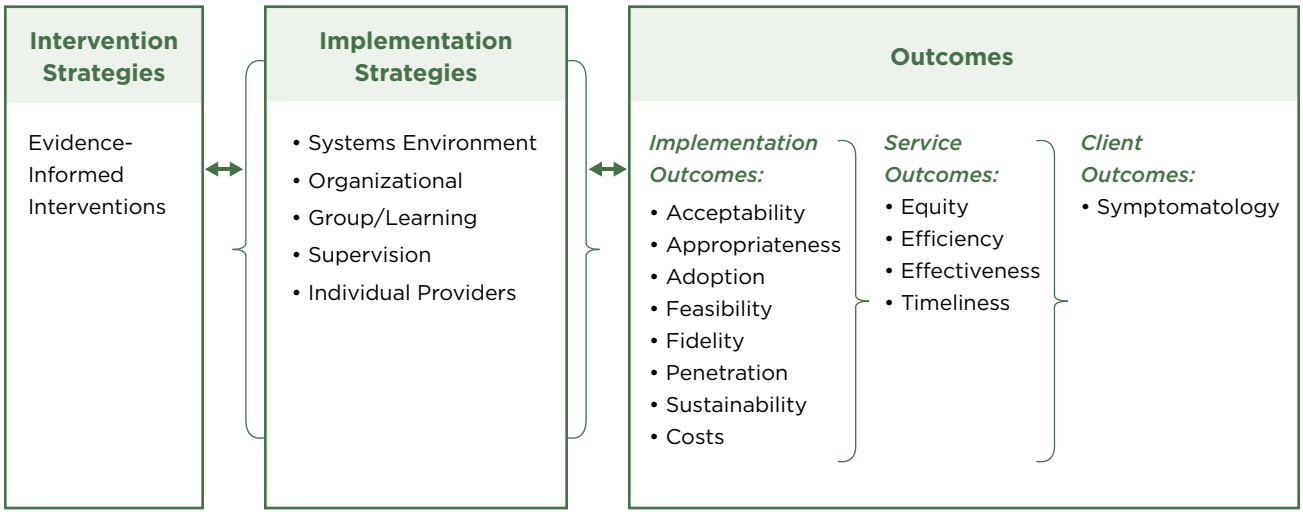
APPENDICES

APPENDIX A. IMPLEMENTATION SCIENCE AND EVALUATION: FRAMEWORK AND METHODS

The Center for AIDS Prevention Studies (CAPS) at the University of California San Francisco conducted the evaluation of the E2i program implementation. The evaluation used the Proctor Model Framework for Implementation Research.[19] This approach suggests that program assessment should include an understanding of the process of implementation and its impact on all people and systems that are involved in the implementation:

1. The core elements of the program (intervention strategies).
2. The efforts to put the program into place (implementation strategies).
3. How the program is viewed by the people involved (implementation outcomes).
4. How the program is delivered (service outcomes).
5. The impact on the participants (client outcomes).

The E2i Proctor Model



[19] Proctor E, Silmere H, Raghavan R, et al. Outcomes for implementation research: Conceptual distinctions, measurement challenges, and research agenda. Adm Policy Ment Health. 2011;38(2):65-76.

Six types of information were gathered over the three years of E2i program implementation. These include:

Organizational Assessment: Every six months the program director completed a survey. This survey had questions about the organization (e.g., number of patients, types services provided, and staffing). It also included questions about program delivery and how the staff views the program.

Proctor Concepts

- Implementation strategies (systems environment, organizational, group/learning, supervision)
- Implementation outcomes (acceptability, appropriateness, adoption, feasibility, fidelity, penetration, sustainability, costs)

Document Review: Evaluators reviewed documents that were created during implementation and technical assistance activities. Documents were created by either the sites themselves or by The Fenway Institute/AIDS United and included: E2i funding applications, site visit reports, quarterly reports, monitoring call notes, cohort call notes, and presentations in meetings.

Proctor Concepts

- Implementation Strategies (systems environment, organizational, group/learning, supervision, individual providers, individual patients)
- Implementation Outcomes (acceptability, appropriateness, adoption, feasibility, fidelity, penetration, sustainability)

Observations: Sites participated in two Learning Session Meetings each year. Evaluators took notes on discussions and presentations. These notes focused on barriers and facilitators to implementation.

Proctor Concepts

- Implementation Strategies (systems environment, organizational, group/learning, supervision, individual providers, individual patients)

Costing Data: Program managers and financial administrative staff completed two cost workbooks. One was for the three-month preparation/planning period and the first year of program implementation. The other was for the second year of program implementation. Costs included personnel and expenses paid for by E2i as well as in-kind donations.

Proctor Concepts

» Implementation Outcomes (costs)

Intervention Exposure: Information was collected on clients who participated in the intervention between September 2018 and December 2020. Demographic information was collected on enrollment forms. Intervention exposure forms were collected whenever staff had program-related interactions with participants. These forms included information such as: date of the interaction, the staff person who had contact, type of interaction, activities completed, and outcomes of the activities.

Proctor Concepts

» Service Outcomes (fidelity, penetration, equity, efficiency, effectiveness, timeliness)

Medical Records: Medical records were collected on participants for the 12 months before enrollment in the program and for the 12 months after enrollment in the program. The information was specific to HIV-related medical care, such as: appointment dates; prescription of ART; viral load test dates; and viral load test results.

Proctor Concepts

» Client Outcomes (symptomatology)

Quantitative Analysis: Organizational assessment data was used to describe organization characteristics and readiness for implementation based on Proctor Concepts. Client level enrollment and intervention exposure data was analyzed using descriptive statistics to understand client demographics, proportions of clients receiving intervention services, and frequencies of exposures. When appropriate, proportion of clients completing the intervention was included. Repeated measures modeling methods were used to assess changes in HIV Care Continuum outcomes for clients enrolled in the intervention. This compared data from 12 months prior to enrollment to 12 months following enrollment. Costing data was analyzed to provide information on cost of intervention implementation per client enrolled.

Qualitative Analysis: Documents and observations were thematically analyzed using the Proctor Concepts. The intervention was the primary unit of analysis.

APPENDIX B. GENERAL BEST PRACTICES FOR PLANNING TO IMPLEMENT AN INTERVENTION STRATEGY

The following are general recommendations for planning to implement an intervention strategy in an HIV service organization.

Create a Planning Team

- Assemble a team of staff "champions" who are invested in the success of the intervention: who will meet regularly to drive planning, implementation, and sustainability; and who will remain committed to overcoming hurdles and moving implementation forward.
- Consider how to meaningfully involve at least one peer (a person with HIV who also represents the priority population) in the planning and implementation of the intervention (see ***AIDS United's resources on meaningful involvement of people with HIV***).
- Hold weekly team meetings or daily "huddles" (i.e., short meetings at the beginning of the day to review client status and discuss recruitment and retention issues, etc.).

Engage Leadership and Staff

Implementing a new service into an established program may require changes in routines, job duties, and administrative procedures. It is essential to obtain buy-in and a firm commitment from the entire organization as early in the planning process as possible.

Meet with executive leadership to discuss:

- How the intervention will support the organization's mission and goals
- The benefits of the intervention for clients and the organization as a whole
- The resources needed to implement the intervention
- The organizational systems and procedures that will be affected by implementation
- The importance of leadership communicating their commitment to the intervention to all staff
- How the intervention team will regularly share the status of the intervention with regard to planning, implementation, enrollment, and client outcomes

Meet with staff members directly and indirectly affected by the intervention to discuss:

- The benefits of the intervention for clients and the organization as a whole
- How staff can help with recruitment and referrals
- Suggestions for outreach and implementation processes
- How the intervention team will regularly share the status of the intervention with regard to planning, implementation, enrollment, and client outcomes

Assess Community Needs

Early in the planning process, organizations should consider conducting an informal or formal needs assessment to better understand the needs of the priority population(s) and how to best tailor the intervention to their needs. Engaging with the local community also helps to establish trust and grow your referral networks.

Community needs assessment strategies include:

- Review existing client data on depression, anxiety, and other psychiatric disorders among clients with HIV.
  - What does the data tell you about the needs of your client population?
- Discuss the intervention with community members, providers, clients, and service agencies through informal or formal interviews or focus groups. Ask for their input on the intervention:
  - What might be barriers to implementation? What can be done to overcome these barriers?
  - What can the organization do to reduce stigma related to behavioral health disorders and HIV?
  - What community agencies would be a good fit for partnerships?

Train All Staff

When implementing an intervention for people with HIV, it is important to train all organizational staff in reducing stigma, enhancing cultural humility, using a trauma-informed approach to care, and providing affirming, culturally-responsive care to all people with HIV, including Black, Indigenous, and other people of color, and including lesbian, gay, bisexual, queer, transgender, and gender diverse people. Training and resources are available from ***TargetHIV***, ***AIDS Education and Training Center Program***, and the ***National LGBTQIA+ Health Education Center***.

Conduct a Pilot Test

Prior to full implementation, it can sometimes help to conduct a pilot test under "real world" conditions to evaluate the feasibility and acceptability of the process flow, forms, and procedures.

- Consider pilot testing with one provider's client panel or with only new clients.
- Use a ***validated quality improvement method*** to guide your pilot test.
- After the pilot, communicate to all staff the results of the pilot: what worked, what did not work, and what changes were made to improve operations.

APPENDIX C. COCM "GO LIVE" WORKSHEET

Purpose

The purpose of the "Go Live" Worksheet is to:

1. Guide the intervention's planning and implementation activities
2. Monitor progress in meeting implementation goals and objectives

Instructions

The team that is leading the intervention should identify a team member to complete this worksheet over time. Use the worksheet to:

- Develop and drive team meeting agendas
- Document decisions made by the team
- Track progress towards goals

Name of organization/ clinic	
Name (Who is completing this worksheet?)	
Intervention goal	To improve the behavioral health and HIV outcomes of people with HIV
Core elements (These are essential to the intervention and cannot be changed)	**1.** Client-centered team care **2.** Population-based care **3.** Measurement-based care and treatment to target **4.** Evidence-based care **5.** Accountable care
Eligible population	People with HIV who have co-occurring psychiatric disorders
Planning and Implementation Activities	
Planning team (Who is on the planning team?)	**1.** Implementation Leader:
	2.
	3.
	4.
	5.
Priority population(s) (If applicable, what demographic groups will you recruit for CoCM?)	**1.**
	2.
	3.
	4.
Geographic catchment area(s) (From which communities will you recruit clients?)	**1.**
	2.
	3.

Language(s) (In what languages will you deliver the intervention?)	**1.**
	2.
Engaging leadership and staff (What strategies will you use to gain "buy-in" and feedback?)	**1. Organizational leadership:**
	2. Relevant staff:
Recruitment, in-reach, and outreach (How will clients be identified and referred?)	**1.**
	2.
	3.
	4.
	5.
Incentives (What incentives are you giving participants, if any?)	
Partner agencies (Who will you partner with for services not offered by your organization?)	**1.**
	2.
	3.
	4.
Billing codes (What billing codes will you use?)	

Sustainment plan (What are you doing to make your program sustainable?)		
Organizational readiness (Who will complete the Organizational Readiness Checklist and when will it be completed?)		
Intervention staff (Who will do what?)	**Role/Task**	**Staff Responsible**
	Primary care provider	
	Behavioral health care manager	
	Psychiatric consultant	
	IT help for client registry	
	Manager of client registry	
	Peer mentor/educator(s)	
	Case manager(s)	
	Additional behavioral health provider(s)	
	Billing team member(s)	
	Screening provider(s)	
	Developer of educational tools	
Self-assessment tool	☐ Behavioral health care manager completed the tool ☐ Primary care provider completed the tool ☐ Psychiatric consultant completed the tool	

Clinical workflow (Describe your proposed workflow. Consider: who, when, what, and where)	
Screening and measurement tools (What tools will you use?)	**1.** Universal screening tool(s):
	2. Measurement-based care tool(s):
Additional tools (e.g., screening, enrollment, referral, and tracking forms; relapse prevention plan)	**1.**
	2.
	3.
Staff training requirements (Check each box when completed)	☐ Whole care team training (AIMS Center) ☐ Behavioral health care manager training (AIMS Center) ☐ Primary care provider training (AIMS Center) ☐ Psychiatric consultant training (AIMS Center) ☐ Inform all staff about CoCM ☐ Train all staff on cultural humility
Staff training plan (When, where, and how will staff be trained?)	
Behavioral health intervention(s) (What types of counseling and behavioral interventions will you use?)	

Client registry (What registry will you use?)	
Educational tools (What resources will you include to educate clients?)	
Evaluation data (What data will you collect to measure progress and client satisfaction?)	
Monitoring of implementation process and clinical outcomes (How will you monitor enrollment, client data quality, and treatment goals?)	
SMART goals (What are your **S**pecific, **M**easurable, **A**chievable, **R**elevant, **T**ime-Bound goals?)	**1.**
	2.
	3.
	4.
	5.

APPENDIX D. COCM RESOURCES

AIMS Center Resources

Below are examples of the resources available on the AIMS Center website:

- Website home page: *aims.uw.edu*
- CoCM evidence-base: *aims.uw.edu/collaborative-care/evidence-base*
- Resource library: *aims.uw.edu/resource-library*
- CoCM team structure: *aims.uw.edu/collaborative-care/team-structure*
- Stepped model of care: *aims.uw.edu/read-about-stepped-model-integrated-behavioral-health-care*
- PHQ-9: *aims.uw.edu/resource-library/phq-9-depression-scale*
- Registry requirements: *aims.uw.edu/resource-library/integrated-care-registry-requirements*
- Patient Tracking Spreadsheet: *aims.uw.edu/resource-library/patient-tracking-spreadsheet-resources*
- Caseload Tracker: *aims.uw.edu/resource-library/aims-caseload-tracker*
- Behavioral interventions: *aims.uw.edu/print/645*
- Problem Solving Treatment (PST): *aims.uw.edu/collaborative-care/behavioral-interventions/problem-solving-treatment-pst*
- Commonly prescribed psychotropic medications: *aims.uw.edu/print/15*
- Financing strategies: *aims.uw.edu/collaborative-care/financing-strategies-collaborative-care*

Other Resources

- Plan Do Study Act Cycle: *http://www.ihi.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx*
- Validated screening and treatment monitoring measures:
  - *http://www.integration.samhsa.gov/clinical-practice/screening-tool*
  - *http://integrationacademy.ahrq.gov/products/ibhc-measures-atlas*
  - *http://www.phqscreeners.com/overview.aspx*