

Collaborative Care Gap Analysis Team Exercise

| Key Component | Score 0 = not at all in place to 5 = fully in place | If you scored low in this category- what are the barriers to having this element in place? | Strengths/Opportunities |
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| 1. Team-based approach to care | | | |
| Clinic has a defined team(s) with clear roles. | | | |
| Behavioral health staff member is a regular member of the clinical care team. | | | |
| The team has created and trained on processes and workflows for hand-offs and communications from one team member to another. | | | |
| PCPs and BHP meet with regularly with consulting psychiatrist/psych NP | | | |
| 2. Evidence-based care | | | |
| The care team understands the evidence for screening for BH conditions in the primary care setting. | | | |
| Providers have reviewed and applied the evidence-based guidelines on depression diagnosis and treatment. | | | |
| The model of “stepped care” is the approach. The team understands this approach and it is used for systematic follow up and treatment adjustment. | | | |
| 3. Measurement-based | | | |
| A repeat PHQ-9 is completed at every contact. | | | |
| PHQ9 is used to monitor progress towards targets, drive purposeful intervention and determine a personalized care plan. | | | |
| A registry is used for tracking targets, close monitoring for follow-up visits and treatment adjustment. | | | |

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| 4. Population-based care | | | |
| The team understands what is meant by population based health care. | | | |
| There is assigned staff to address population based health care as part of their regular role and tasks. | | | |
| There is a planned process for identification and outreach of eligible patients for the collaborative care program. | | | |
| The care team members understand the approach for collaborative care including: targeted treatment monitoring, scheduling follow-up, patient engagement in self-management, education, and coordination for care transitions. | | | |
| 5. Accountable for the care delivered | | | |
| The team has shared accountability for outcomes, treatment targets, resources & training. Everyone contributes to the process. | | | |
| Incentives for targets achieved are offered. | | | |
| There is a maintenance plan for when BH conditions get to the target and a process for ongoing treatment and preventive care needs. The team has a proactive plan for ongoing maintenance care. | | | |