**Duke WELL Collaborative Care Model**

***What:*** Team-based approach to coordinate care for depression and/or anxiety led by the patient’s primary care doctor and includes a DukeWELL care manager and consulting psychiatrist.

*\*\* Please note, this intervention is not longitudinal traditional therapy. Instead, brief therapeutic interventions focused on behavior change are provided.*



*Collaborative Care Models have been proven to improve depression, anxiety and PTSD, increase adherence and response to treatment and increase patient satisfaction.*

***Who to refer:*** Patients with PHQ-9 score of 10-19 (mild to moderate) with a diagnosis of depression and/or an anxiety diagnosis—GAD7 ≥ 10

*\*\* If a patient has a PHQ-9 score of 20 or greater, they can be referred with additional screening if the provider or social worker determines there is no imminent risk of self harm.*

***How to refer***: Contact DOC Social Workers about reviewing if this is the appropriate plan for your patient. They will review and approve or suggest alternatives. DOC Social Workers will generate the referral to be signed by the referring provider. They will add the smartphrase below in wrap up:

**.cocmref**

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| **Collaborative Care Referral Placed**    You have agreed to participate in a Collaborative Care program. A DukeWELL Collaborative Care manager, a specially-trained licensed nurse or social worker, will reach out to you by phone within 72 hours. You will have phone calls with your care manager every other week to discuss symptoms and how the treatment is working. The care manager will check in regularly with your primary care provider and the team's psychiatrist to develop a personalized treatment plan for any mental health needs. If needed, the Collaborative Care team will help connect you to mental health and community resources and ensure you are getting the best treatment for your depression or anxiety.  If you have any questions or have not received a call within 72hrs, please contact DukeWELL at 919-660-9355. |

**What to communicate to patients about CoCM**: Tell the patient you’d like to refer them to the DukeWELL Collaborative Care Management program and that a DukeWELL team member will be reaching out to them. Inform them that the DukeWELL team member will be asking them a few questions as part of the needs assessment so they can best determine how to establish the care team. After that, they can expect biweekly calls over a period of approximately 6-8 weeks, until symptoms fall into response or remission, or the patient is connected to a higher level of care.

**Your role as PCP:** Work in close collaboration with the DukeWELL and psychiatric teams. The PCP will prescribe therapies and medications as needed and support the treatment plan. The PCP will also champion the model with patients and colleagues.

**Role of the DukeWELL Collaborative Care Management team:** Supports the treatment plan established by the provider and coordinates the overall effort of the care team, while providing education and brief behavioral interventions to the patient. The care manager will administer and validate rating scales and track treatment response, as well as conduct weekly caseload review meetings with the psychiatric team.

*\*\* There is ongoing communication with the PCP and DukeWELL care manager through Epic. DukeWELL will route the chart via high priority internal communication for medication changes after rounding with the psychiatry team. Messages for DOC patients will be sent to the PCP, but if they do not receive a response it will be routed to LEAD resident and attending - Drs. Brown and Hemming. The provider who receives the message will write the prescription and/or contact DukeWELL with further concerns or questions*