MEADOWS MENTAL HEALTH POLICY INSTITUTE
The University of Texas at Austin Dell Medical School
POLICY BRIEF

THE COLLABORATIVE CARE MODEL: Delivering Quality Mental Health Care in the Primary Care Setting

What is Collaborative Care?

The Collaborative Care Model (CoCM) brings together physical and mental health care treatment within a primary care provider's office. In this integrated care approach, a primary care provider, a psychiatric consultant and behavioral health care manager work together to detect and provide established treatments for common mental health problems, measure patients' progress toward treatment targets, and adjust care when appropriate. CoCM is a data-driven, patient-centered approach that multiplies the expertise of scarce mental health clinicians through task sharing, technology, structured teamwork, and telehealth.

Evidence Supporting CoCM

CoCM is extensively supported by scientific studies, with over 90 randomized controlled trials demonstrating its clinical efficacy. Providers use the model to help people with depression, anxiety, and other common mental health problems. The Meadows Institute has studied the impact that universal access to CoCM would have on suicide rates, and the data are clear and encouraging: If every American with depression had access to CoCM, between 9,000 and 14,500 lives could be saved every year.[1]

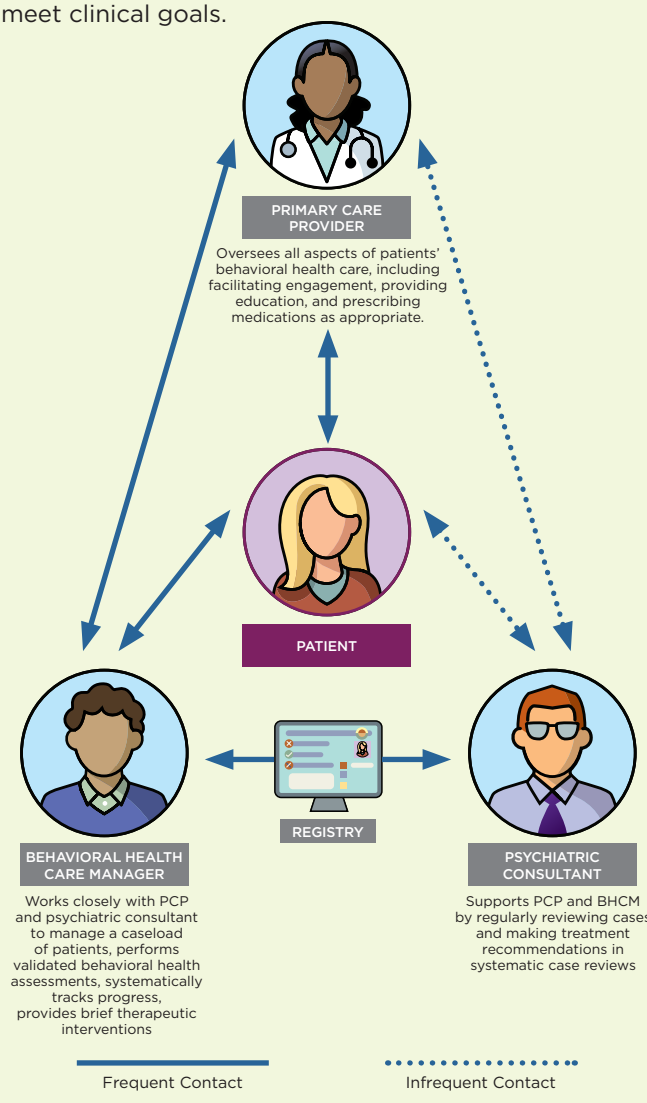
CoCM Financing

CoCM is currently the only integrated mental health model reimbursed in primary care with dedicated billing codes. Covered by Medicare since 2017, by nearly all commercial payers since 2019, and a growing number of Medicaid programs, CoCM has a clear pathway for long-term financial sustainability and increases treatment access for patients. A 2013 study found that CoCM was associated with a 6:1 return on investment, meaning that every dollar spent led to $6 in overall cost-of-care savings.[2]
If only 20% of people with depression had access to CoCM, an estimated $15 billion per year could be saved in total Medicaid spending.[3]

1 https://mmhpi.org/wp-content/uploads/2020/09/COVID-MHSUDPrevention.pdf
2 https://pubmed.ncbi.nlm.nih.gov/18269305/
3 https://www.milliman.com/-/media/milliman/importedfiles/uploadedfiles/insight/2018/potential-economic-impact-integrated-healthcare.ashx

HOW IT WORKS

The Collaborative Care team is led by a primary care provider and includes behavioral health care managers, psychiatric consultants and other mental health professionals all empowered to work together. The team implements a measurement-focused care plan based on evidence-based practice guidelines and focuses particular attention on patients struggling to meet clinical goals.



ABOUT THE MEADOWS MENTAL HEALTH POLICY INSTITUTE
The Meadows Mental Health Policy Institute provides independent, nonpartisan, data-driven, and trusted policy and program guidance that creates equitable systemic changes so all Texans can obtain effective, efficient behavioral health care when and where they need it.

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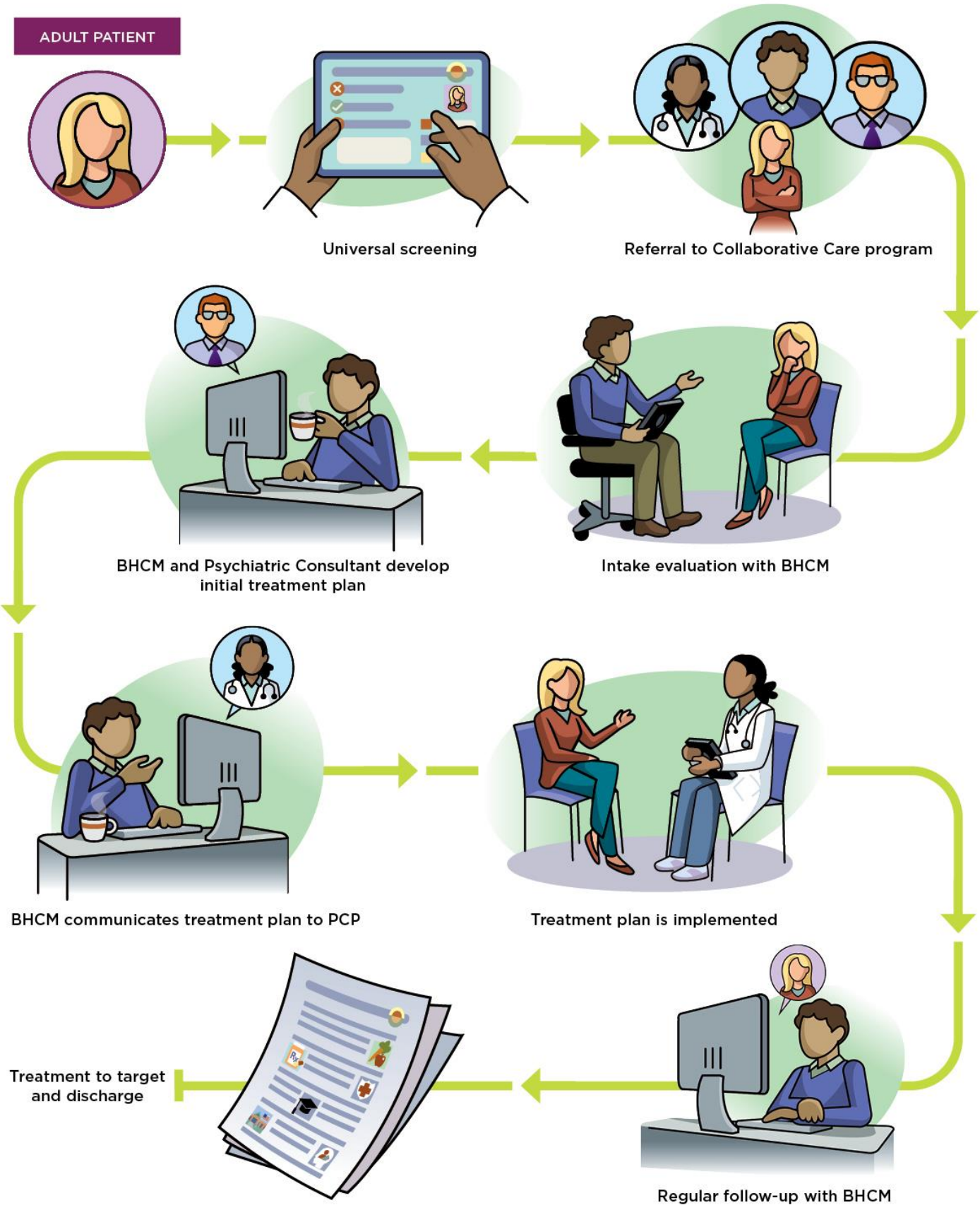
THE COLLABORATIVE CARE MODEL WORKFLOW



Collaborative Care Model

Adult Clinical Workflow

Clinical workflow details for implementing the collaborative care model (CoCM) with adults. The CoCM team refers to the primary care provider (PCP), the behavioral health care manager (BHCM), and the psychiatric consultant.

STEP 1 – Universal screening

Physical health clinic delivers universal screening at least annually for common behavioral health problems, such as depression and anxiety, using evidence-based behavioral health assessments (e.g., PHQ-9).

STEP 2 – Referral to collaborative care model (CoCM) program

Patients who screen positive or display concerning behavioral health signs/symptoms and meet program criteria are offered enrollment in CoCM by their PCP, who obtains verbal consent and facilitates a warm hand-off to the BHCM.

STEP 3 – Intake evaluation with behavioral health care manager (BHCM)

BHCM engages the patient, answers remaining questions about CoCM, reviews the patient's chart, and completes an intake evaluation. BHCM enters evidence-based behavioral health assessments (e.g., PHQ-9) and other patient data into the CoCM patient treatment registry.

STEP 4 – BHCM and psychiatric consultant develop initial treatment plan

In weekly case review sessions with a designated psychiatric consultant, the BHCM discusses new and existing patients who do not demonstrate adequate symptom improvement. They review diagnostic impressions and treatment recommendations, updating as indicated. Treatment planning may include medications, therapy, or referrals to outside resources, depending on patient need, preferences, and service availability.

STEP 5 – BHCM communicates treatment plan to primary care provider (PCP)

BHCM compiles treatment recommendations and diagnostic impressions into an intake report, updates the registry, makes any necessary referrals, and shares the treatment plan with the PCP. Additionally, the BHCM preliminarily discusses the treatment plan with the patient and answers questions.

STEP 6 – PCP implements treatment plan

PCP reviews the intake report, discusses diagnosis and treatment recommendations with the patient, answers questions, and prescribes the recommended medication if it is in line with their clinical judgment. If the PCP has questions or concerns about the treatment plan, they can discuss these with the rest of the CoCM team at any time.

STEP 7 – Regular follow-up assessments with BHCM

BHCM regularly engages with the patient (often twice a month), asking about their experience with medication, measuring treatment response using evidence-based behavioral health assessments, reviewing patients with the psychiatric consultant as indicated, delivering therapeutic interventions, coordinating with outside providers (if applicable), updating the registry, and documenting all findings in the medical record.

STEP 8 – Relapse prevention planning and discharge

Working in collaboration with the psychiatric consultant, the BHCM tracks patient outcomes until the patient meets evidence-based symptom response or remission targets. Once the patient has improved, they engage with the BHCM in relapse prevention planning and prepare for discharge from CoCM back to regular PCP care.

Collaborative Care Model

Adult Clinical Workflow

Detailed clinical workflow for implementing the collaborative care model (CoCM) with adult populations.

Screening and Referral

After adopting universal behavioral health screening, a practice must define the target population and diagnostic scope for its CoCM program. For example, a practice may define its target population as all primary care patients and its diagnostic scope as depression and anxiety disorders. Patients in the target population who screen positive for conditions within the CoCM diagnostic scope or display concerning signs/symptoms of behavioral health problems are then considered for referral to the program.

Typically, the primary care provider (PCP) will inform the patient of the program and offer them enrollment. For billing purposes, the PCP also informs the patient that, depending on their health insurance, they may receive a monthly bill for CoCM services (i.e., cost sharing). This discussion between the PCP and patient is considered the program's "consent process." The patient's verbal consent must be documented in the medical record. Uninsured patients should also be informed that they may receive a bill for CoCM services (though they may not be required to pay the bill due to sliding scale payment arrangements). If the patient agrees to enroll in CoCM, the PCP will connect them with the program's behavioral health care manager (BHCM).

Intake Evaluation

The BHCM connects with the patient via warm handoff in person, by telephone, or through secure messaging to schedule an intake visit. During this visit, the BHCM conducts a full behavioral health evaluation that explores current symptoms in addition to a comprehensive history of diagnoses, treatments (including medication and psychotherapy), higher-acuity care, and co-morbid medical problems. In this evaluation, the BHCM also administers evidence-based assessments, such as the Patient Health Questionnaire-9 (PHQ-9) and the Generalized Anxiety Disorder-7 (GAD-7). The BHCM writes a draft report of the findings from the intake evaluation and enters demographic data, visit data, and assessment results into the patient registry.

Case Review, Plan Development

During weekly case review sessions with the psychiatric consultant, the BHCM reviews the patient treatment registry broadly with each patient being considered for detailed discussion. The BHCM and psychiatric consultant typically discuss new patients and those with acute events first; patients who are not responding to treatment or following up as scheduled with the BHCM are also prioritized. The BHCM, with help from the psychiatric consultant, develops a personalized treatment plan, which may include medication recommendations, brief psychotherapy, and/or psychosocial interventions for new patients. This plan is then clearly described in the BHCM's report, which is preliminarily discussed with the patient, and sent to the PCP. The PCP then reviews the patient's treatment plan with recommendations from the rest of the CoCM team.

Collaborative Care Model

Adult Clinical Workflow

Treatment Plan Implementation

If the psychiatric consultant recommends medications and the PCP agrees, the PCP writes prescriptions or schedules a visit with the patient to further discuss therecommended medications. The PCP is always welcome to ask follow-up questions of the rest of the CoCM team. Due to this bidirectional collaboration, CoCM provides valuable real-time education opportunities for PCPs, rendering them more knowledgeable about psychopharmacology during future patient encounters.

When the CoCM team recommends specific psychotherapy interventions, these services are typically delivered by the BHCM directly. The BHCM most commonly provides brief behavioral health interventions, such as motivational interviewing or behavioral activation, though other modalities may be used as indicated. Patients can be referred to community providers (while still being followed in CoCM), if they require more extensive therapy, long-term therapy, or therapy interventions for which the BHCM is not adequately trained.

Regular Follow-up Assessments

After the CoCM intake visit and initial recommendations, the BHCM closely follows each enrolled patient. Typically, patients interact with the BHCM a minimum oftwo times per month while in active treatment. During each interaction, the BHCM administers evidence-based assessments, and adds follow-up results to the patient treatment registry. The goal for each target symptom is remission, which is defined differently for each instrument. With the PHQ-9, for example, remission is defined as a score of less than five. Patients are also tracked toward treatment response, which is typically defined as a reduction from the baseline score of 50% or more with the PHQ-9. Of note, the choice of instruments is discretionary for each CoCM program. The BHCM and psychiatric consultant update treatment plans for existing CoCM patients during case review sessions based on clinical progress. All treatment plan updates, including updated medication recommendations, are immediately sent to the PCP. Each patient is considered for review in weekly case review sessions with the psychiatric consultant (and is formally reviewed at least once monthly). On average, patients remain in the active treatment phase of the program for three to six months.

Relapse Prevention, Discharge

A patient moves from active treatment into the relapse prevention phase of the CoCM program when they achieve symptom response or remission. At this point, the patient's frequency of visits with the BHCM typically decreases to approximately once per month, and the clinical focus shifts to creating a plan to mitigate future worsening of symptoms. This relapse prevention plan integrates the patient's goals, medication recommendations, and guidance on the use of key therapy skills or interventions. After successful maintenance in relapse prevention for two to three months, patients are typically discharged from CoCM.

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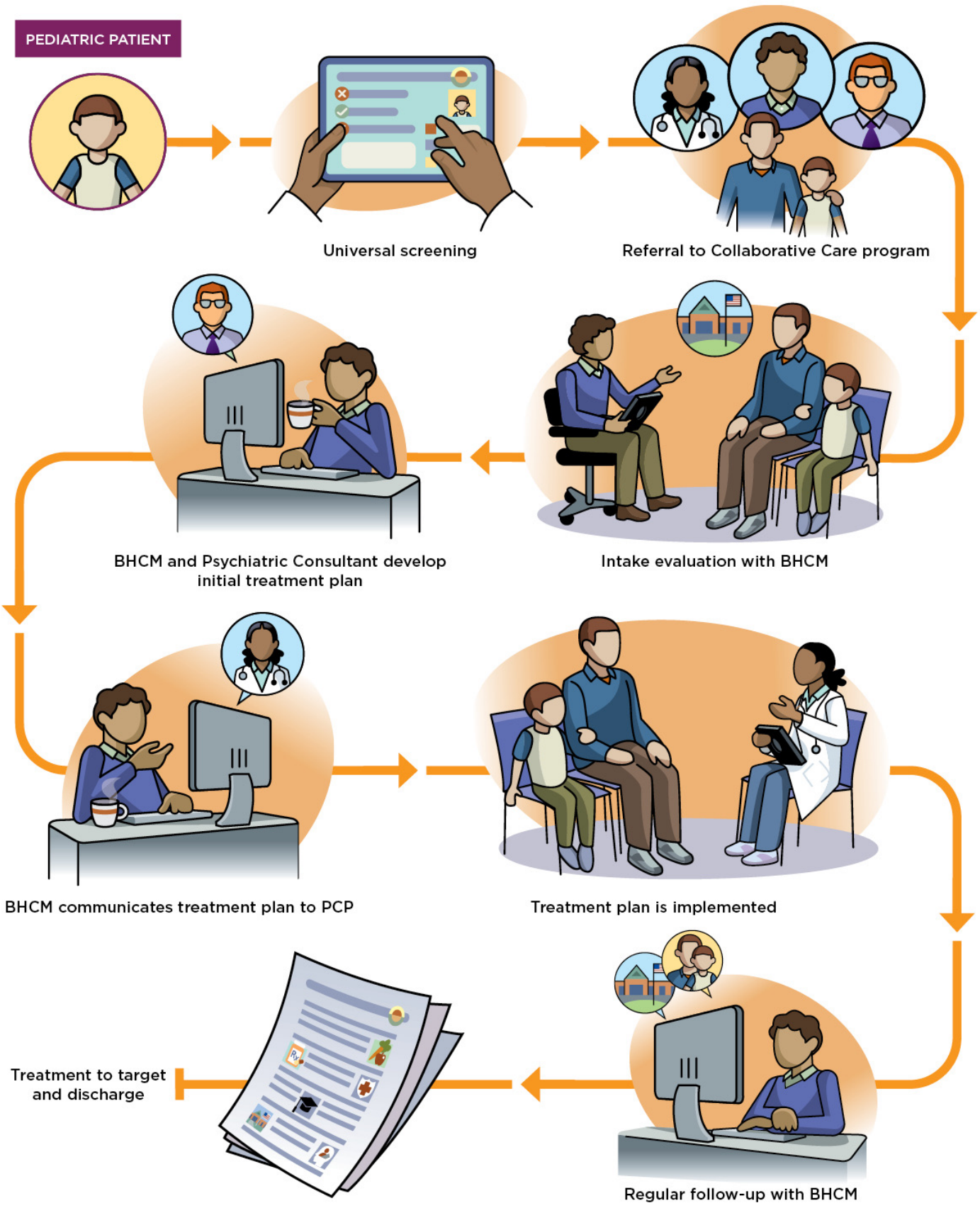
THE COLLABORATIVE CARE MODEL WORKFLOW



Independent and nonpartisan, the Meadows Mental Health Policy Institute works at the intersection of policy and programs to create equitable systemic changes so all people in Texas, the nation, and the world can obtain the health care they need.

Collaborative Care Model

Pediatric Clinical Workflow

Clinical workflow details for implementing the collaborative care model (CoCM) with pediatric patients. The CoCM team refers to the pediatrician, the behavioral health care manager (BHCM), and the child and adolescent psychiatric consultant.

STEP 1 – Universal screening

Pediatric practice delivers universal screening at least annually for common behavioral health problems, such as depression, anxiety, and ADHD, using evidence-based behavioral health assessments (e.g., PHQ-A).

STEP 2 – Referral to collaborative care model (CoCM) program

Patients who screen positive or display concerning behavioral health signs/symptoms and meet program criteria are offered enrollment in CoCM by their pediatrician, who then engages in a consent discussion with the patient and parent/guardian (for minors) and facilitates a warm hand-off to the BHCM.

STEP 3 – Intake evaluation with behavioral health care manager (BHCM)

BHCM engages the patient and parent/guardian, answers remaining questions about the CoCM program, reviews the patient chart, and completes a full intake evaluation. BHCM enters evidence-based behavioral health assessments (e.g., PHQ-A) and other patient data into the CoCM patient treatment registry. If available, BHCM speaks to a representative from the patient's school to collect additional relevant information.

STEP 4 – BHCM and psychiatric consultant case review

In weekly case review sessions with a designated child and adolescent psychiatric consultant, the BHCM discusses new patients and existing patients who are not demonstrating adequate symptom improvement. They review diagnostic impressions and treatment recommendations, updating as indicated. Treatment planning may include medications, therapy, connection with school-based care, or other outside resources, depending on patient need, individual preferences, and service availability.

STEP 5 – Treatment plan development and updates

BHCM compiles treatment recommendations and diagnostic impressions into an intake report, updates the registry, makes any necessary referrals, and shares the treatment plan with the pediatrician. Additionally, the BHCM preliminarily discusses the treatment plan with the patient and parent/guardian, while answering any remaining questions.

STEP 6 – Pediatrician implements treatment plan

The pediatrician reviews the intake report, discusses diagnosis and treatment recommendations with patient and parent/guardian, answers questions, and starts medication if it is in line with their clinical judgment. If the pediatrician has questions or concerns about the treatment plan, they can discuss these with the rest of the CoCM team at any time.

STEP 7 – Regular follow-up assessments with BHCM

BHCM engages with the patient and parent/guardian (often twice a month), asking about experience with medication, measuring treatment response using evidence-based behavioral health assessments, engaging with the parent/guardian or school, reviewing patients' status weekly with the psychiatric consultant as indicated, delivering therapeutic interventions, coordinating with outside providers (if applicable), updating the registry, and documenting all findings in the medical record.

STEP 8 – Relapse prevention planning and discharge

Working in collaboration with the child and adolescent psychiatric consultant, the BHCM tracks patient outcomes until evidence-based symptom response or remission targets are met. Once patients have improved, they engage with the BHCM in relapse prevention planning and prepare for discharge from the CoCM program back to regular pediatric care.

Collaborative Care Model

Pediatric Clinical Workflow

Detailed clinical workflow for implementing the collaborative care model (CoCM) with pediatric populations.

Screening and Referral

After adopting universal behavioral health screening, a pediatric practice must define the target population and diagnostic scope for its CoCM program. For example, a practice may define its target population as pediatric patients between the ages of 4 and 21, and its diagnostic scope as depression, anxiety, and ADHD. Patients in the target population who screen positive for conditions within the diagnostic scope or display concerning signs/symptoms are considered for referral to the program.

Typically, the pediatrician will inform the patient and their guardian of the program and offer them enrollment. For billing purposes, the pediatrician informs the patient and guardian that, depending on their health insurance, they may receive a monthly bill for CoCM services (i.e., cost sharing). This discussion between the pediatrician, patient (as developmentally appropriate), and guardian is considered the "consent process." Verbal consent must be documented in the medical record. Uninsured patients and their guardian should also be informed that they may receive a bill for CoCM services (though they may not be required to pay the bill due to sliding scale payment arrangements). If the patient is ultimately enrolled in CoCM, the pediatrician will connect them with the program's BHCM.

Intake Evaluation

The BHCM connects with the patient and guardian via warm handoff in person, by telephone, or through secure messaging to schedule intake visit. During this visit, the BHCM conducts a full behavioral health (BH) evaluation that explores current symptoms in addition to a comprehensive history of diagnoses, treatments (including medication and psychotherapy), higher acuity care, and co-morbid medical problems. In this evaluation, the BHCM also administers evidence-based assessments, such as the Patient Health Questionnaire-9 Modified for Adolescents (PHQ-A) and the Generalized Anxiety Disorder-7 (GAD-7). The BHCM may, with guardian permission, speak with a school representative to obtain BH assessment teacher reports (e.g., Vanderbilt Assessment Scale) or other relevant collateral information. The BHCM writes a draft report of the findings from the intake evaluation and enters demographic data, visit data, and assessment results into the patient registry.

Case Review, Plan Development

During weekly case reviews with the psychiatric consultant, the BHCM reviews the treatment registry broadly, with each patient considered for detailed discussion. The BHCM and psychiatric consultant typically discuss new patients and those with acute events; patients who are not responding to treatment or following up as scheduled with the BHCM are also prioritized. The BHCM, with help from the psychiatric consultant, develops a personalized treatment plan, which may include parent training, interaction with school-based care, medication recommendations, brief psychotherapy, and/or psychosocial interventions for new patients. This plan is then described in the BHCM's report, which is preliminarily discussed with the patient and guardian and sent to the pediatrician. The pediatrician then reviews the patient's treatment plan with recommendations from the rest of the CoCM team.

Collaborative Care Model

Pediatric Clinical Workflow

Treatment Plan Implementation

If the psychiatric consultant recommends medications and the pediatrician agrees, the pediatrician will write prescriptions and schedule a visit with the patient and guardian to discuss the recommended medications further. The pediatrician is always welcome to ask follow-up questions of the CoCM team. Due to this bidirectional collaboration, CoCM provides valuable real-time education opportunities for pediatricians, rendering them more knowledgeable about relevant psychopharmacology during future patient encounters. When the CoCM team recommends specific psychotherapy, these services are typically delivered by the BHCM directly. The BHCM most commonly provides brief behavioral health interventions, such as motivational interviewing or behavioral activation, though other modalities or psychosocial interventions may be used as indicated. Patients can be referred to community providers (while still being followed in CoCM) if they require more extensive therapy, long-term therapy, or additional interventions for which the BHCM is not adequately trained.

Regular Follow-up Assessments

After the CoCM intake visit and initial recommendations, patients are followed closely by the BHCM. Typically, patients interact with the BHCM a minimum of two times per month while in active treatment. During each interaction between the patient, guardian, and BHCM, the BHCM administers evidence-based assessments, and adds follow-up results to the treatment registry. The goal for each target symptom is remission, which is defined differently for each instrument. With the PHQ-A, for example, remission is defined as a score of less than five. Patient treatment response is also tracked, which is typically defined as a reduction from the baseline score of 50% or more with the PHQ-A. Of note, the choice of instruments is discretionary for each CoCM program. The BHCM and psychiatric consultant update treatment plans for existing CoCM patients during case review sessions based on clinical progress. All treatment plan updates, including updated medication recommendations, are sent to the pediatrician. Each patient is considered for review weekly in case review sessions with the psychiatric consultant (and is reviewed at least monthly). The BHCM also remains in close contact with the patient's guardian to discuss treatment recommendations and proposed changes. Additionally, the BHCM may remain in ongoing communication with school representatives or teachers, if indicated and permissible. On average, patients remain in the active treatment phase of the program for three to six months.

Relapse Prevention, Discharge

A patient moves from active treatment into the relapse prevention phase of the CoCM program when they achieve symptom response or remission. At this point, the patient's frequency of visits with the BHCM typically decreases to approximately once per month, and the clinical focus shifts to creating a plan to mitigate future worsening of symptoms. This relapse prevention plan integrates the patient's goals, medication recommendations, and guidance on the use of key therapy skills or interventions. After successful maintenance in relapse prevention for two to three months, patients are typically discharged from CoCM.

Collaborative Care Model

Patient Registry

The patient registry is a key component and invaluable tool used to implement and operate the Collaborative Care Model (CoCM). Health systems can choose their preferred patient registry platform. There are three primary categories of patient registry options: a simple spreadsheet, a standalone registry application, or a registry integrated into an electronic health record (EHR).

CoCM team members use the patient registry to record outcome measures from validated behavioral health assessments, such as the PHQ-9 and GAD-7. They then can view how each patient is progressing with their treatment over time. As a result, the CoCM team can easily recognize and prioritize patients in need of a treatment adjustment. They also can identify patients at risk of falling out of care.

CoCM Team Member Roles and Responsibilities with Patient Registry

In CoCM, the Behavioral Health Care Manager (BHCM) is the primary user of the patient registry; however, all members of the CoCM team will access and interface with the patient registry at various points in the treatment cycle.

Team Member	Roles and Responsibilities
Behavioral Health Care Manager (BHCM)	• Primarily oversees the patient registry, inputs longitudinal behavioral health assessments and other relevant follow-up data for each enrolled patient; • Tracks patient engagement, including appointments, referrals, and reminders for follow-up patient engagement; • Shares data among CoCM team members; • Communicates regularly with PCPs to review/discuss patient progress and get input on treatment; • Coordinates referrals; and • Updates EHR.
Psychiatric Consultant (PC)	• Reviews registry data, including screening and follow-up behavioral health assessments; • Monitors patient progress; and • Makes initial and ongoing treatment plan recommendations to the PCP through the BHCM.
Primary Care Provider (PCP)	• Reviews registry data; and • Utilizes registry for care coordination and treatment planning.

Collaborative Care Model

Patient Registry

Key Patient Registry Functions

Key features and functions of an efficient patient registry include:

- Track clinical outcomes and progress at both the individual patient level and overall caseload level for the target population;
- Facilitate measurement-based treatment to target by clearly demonstrating whether patients have reached specific symptom improvement targets in an easily understandable and actionable way; and
- Facilitate efficient psychiatric consultation and case review, allowing providers to easily prioritize patients who are new to the caseload, who are at risk of falling out of care, or who need to be evaluated for changes to a treatment plan.

Tracking clinical outcomes and progress

A patient registry should track the baseline behavioral health assessment score(s) (i.e., PHQ-9 or GAD-7), which can be obtained during the initial in-take evaluation. Patient registries also track patient assessment score(s) from each month the patient is enrolled in the CoCM program. The BHCM should compare the patient's most recent score(s) to their initial score(s), as well as their score(s) from previous months to determine progress. Furthermore, a registry can track a patient's treatment history over time, including medication management, which monitors medication dose changes based on symptom severity or adverse effects. When tracking clinical outcomes and progress for a target population, a registry can track caseload size, the frequency of patient encounters with clinicians, and clinical outcomes, such as the number or proportion of enrolled patients who have achieved the evidenced-based treatment target.

Prompting measurement-based treatment to target

Measurement-based treatment to target is one of five principles of CoCM. Each patient's treatment plan should outline individual goals and clinical outcomes that are routinely measured by evidenced-based behavioral health assessments. A patient registry supports treatment to target by documenting each patient's progress toward evidence-based clinical outcome goals. The CoCM team uses this information in decision making for treatment plans, including making treatment adjustments for patients not demonstrating improvement.

Streamlining psychiatric consultation and case review

A patient registry is used by the Psychiatric Consultant, in collaboration with the BHCM, to efficiently review the entire patient caseload, as well as focus on individual patient cases that are either new to the CoCM program, flagged for a possible treatment plan change, ready for relapse prevention planning, or appropriate for discharge. A patient registry can track information from previous case reviews and can identify patients who need more targeted mental health consultations. The registry also tracks when patients are discussed during case review sessions, which prompts the BHCM and Primary Care Provider (PCP) to review each patient at least once monthly while they are in active treatment. This, in turn, ensures case review sessions are not exclusively focused on patients with acute concerns to the detriment of patients with less urgent, but still noteworthy treatment needs.

Patient Registry Options

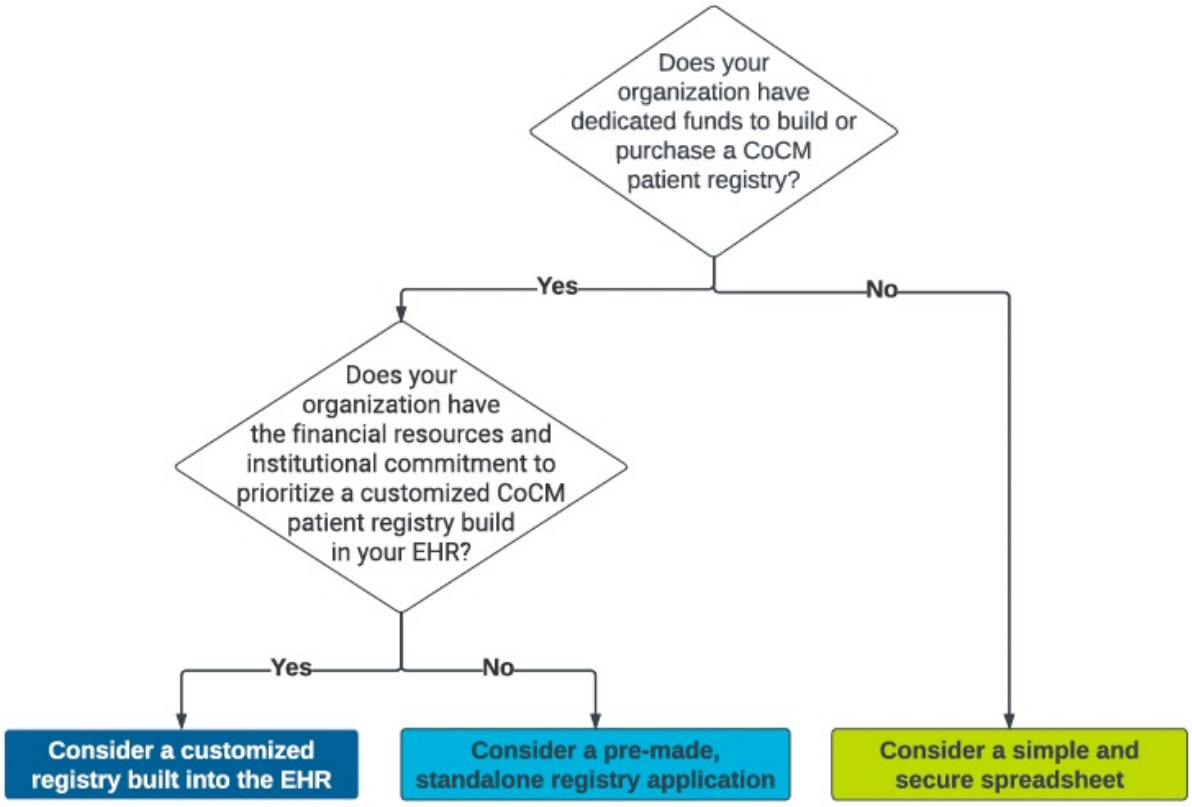
There are three primary categories of patient registry options:
1) a simple and secure spreadsheet;
2) a pre-made, standalone registry application; or
3) a customized registry built into the electronic health record (EHR).

It is important that all registries be used in conjunction with the EHR, even if they are not completely integrated. Below are considerations for the options for a patient registry.

Registry Option	Considerations
1. A simple and secure spreadsheet	• Low or no additional cost; • Simple to use, customize, and update; • Requires some double documentation when not integrated into the EHR: clinical activities documented and tracked within independent system must be updated and uploaded into EHR for effective care collaboration across multidisciplinary care teams; and • Must ensure safeguards and HIPAA protections are in place for protected health information (PHI).
2. Pre-made, standalone registry application	• Typically has moderate additional cost; • May be interoperable with the EHR using an Application Programming Interface (API); and • Requires some double documentation when incompatible with the EHR: clinical activities documented and tracked within independent system must be uploaded/input into EHR for effective care collaboration across multidisciplinary care teams.
3. Customized registry built into a health systems' electronic health record (EHR)	• Typically has significant additional cost, time, and personnel requirements during the building and implementation phases; • Allows all CoCM information technology resources to be in the same technological environment; • Can be customized to eliminate double documentation; and • Can help optimize and streamline billing directly from the patient registry.

Decision Matrix for Health Systems Key Registry Options

Below is a decision matrix to help health systems and clinical teams decide which primary category of patient registry options



Additional Considerations:

Advantages:
- Provides more efficient documentation
- Houses all information in one electronic system
- Creates potential for more advanced calculations and analytics
- Promotes research/evaluation of program at system level
- Facilitates direct communication with patient via medical record portal
- Streamlines billing

Disadvantages:
- Requires a significant financial investment
- Requires internal resources (leadership, IT, additional staff)
- Significantly lengthens time to become fully operational

Advantages:
- Requires less financial investment than a fully integrated registry build
- Accelerates timespan for implementation due to vendor support
- Provides calculations and analytics
- Promotes research/evaluation
- Creates potential for direct exchange between patient and EHR
- Potentially offers indirect billing assistance

Disadvantages:
- Requires double documentation
- May create data silos because data is not all in the same electronic system
- Requires ongoing costs for registry use

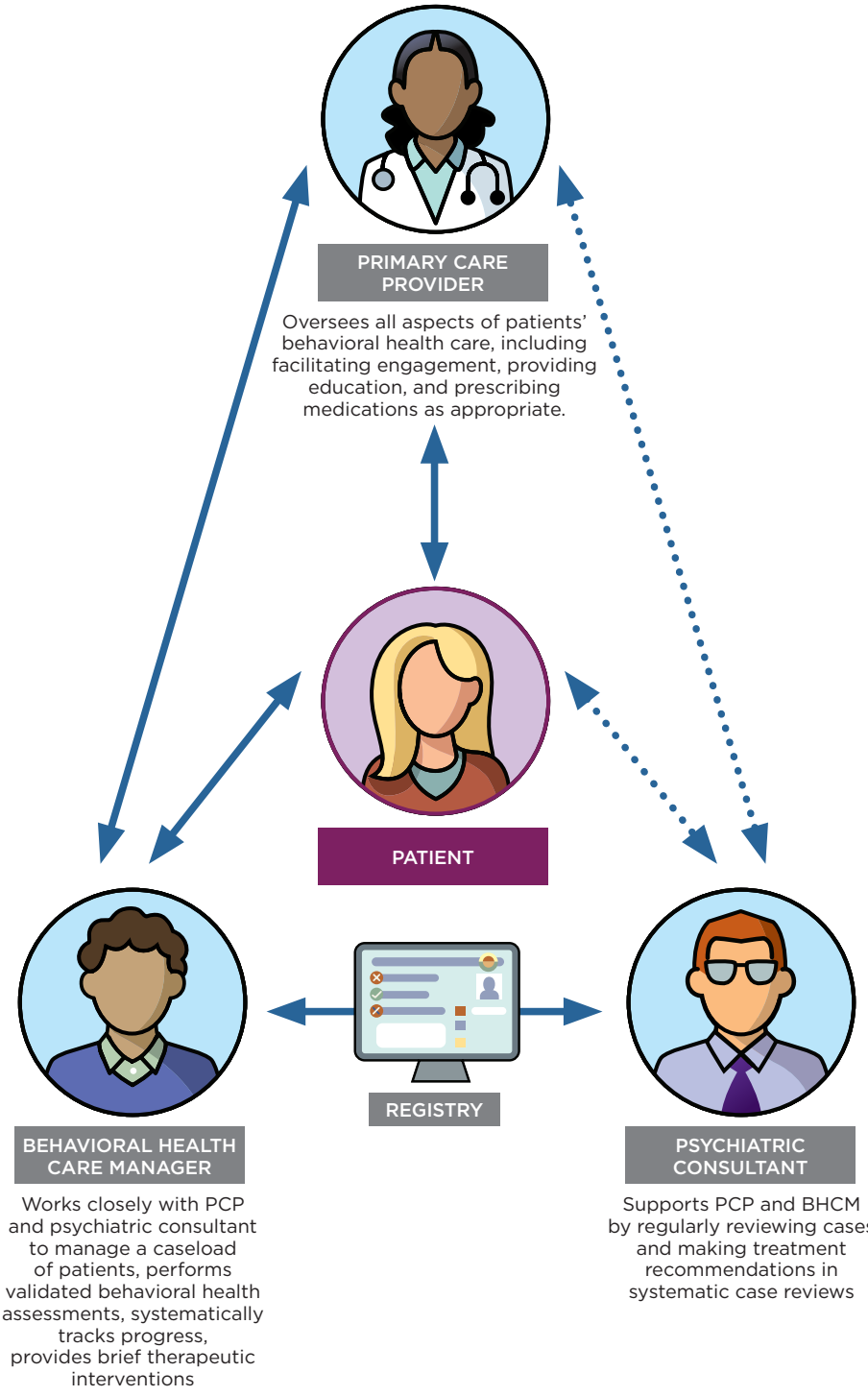
Advantages:
- Provides a cost-efficient, free-of-charge option
- Is fully operational immediately

Disadvantages:
- Limits array of potential calculations
- Does not directly interface with health system medical records
- Requires double documentation
- Separates billing support

Collaborative Care Model

Clinical Team Structure

The Collaborative Care Model (CoCM) Program enables a primary care provider (PCP), a psychiatric consultant, and behavioral health care manager (BHCM) to support the patient in the primary care office by screening for common behavioral health (BH) disorders (e.g., depression or anxiety) during medically focused visits. The CoCM team works together, under the clinical direction of the PCP, to detect and provide evidence-based interventions for BH needs, measure patients' progress toward treatment targets, and adjust a patient's treatment plan when appropriate. When a BH need is detected, the clinical team offers enrollment into CoCM and proceeds according to the Clinical Team Model Structure below.



Collaborative Care Model

Clinical Team Structure

The Collaborative Care Model (CoCM) enables the clinical team to implement measurement-informed care plans based on evidence-based practice guidelines for common mental health problems. Each clinical team member plays a distinct role in CoCM, with key clinical, administrative, and billing responsibilities.

Primary Care Physician (PCP) or Pediatrician

Clinical: Reviews mental health screening assessments and refers patients with positive screens to CoCM. Facilitates education, enrollment, patient engagement, prescriptions for recommended medications, and maintenance care once patient reaches an evidenced-based treatment target.

Administrative: Obtains verbal patient consent for CoCM and communicates with CoCM team regularly.

Billing: CoCM billing is processed under the PCP National Provider Identifier, so patient's medical benefits are utilized instead of behavioral health benefits.

Behavioral Health Care Manager (BHCM)

Clinical: Provides primary behavioral health support for patients through behavioral health assessments, measurement-based care, and brief evidence-based interventions. Meets with patient directly for initial and follow-up assessments and to administer brief therapeutic interventions as needed.

Administrative: Maintains patient registry to track progress, meets weekly with psychiatric consultant to review caseload, and communicates regularly with PCP. Licensure requirements vary by state and payer (many do not require licensure although behavioral health specialized training is recommended as a best practice) and BHCM does not need to be contracted with insurance panels, although, in some cases payers may require to be notified of the BHCMs on staff.

Billing: Records monthly minutes spent on CoCM services for each patient, which are logged in registry and submitted to billing team.

Psychiatric Consultant

Clinical: Provides psychiatric expertise through direct contact with the BHCM and PCP but, in most cases, has no direct contact with the patient. Supervises the BHCM and works with the BHCM and PCP to make treatment recommendations and create personalized treatment plans for each enrolled patient.

Administrative: Can be Psychiatrist, Physician Assistant (PA), or Advanced Registered Nurse Practitioner (ARNP) licensed in the same state as PCP and does not need to be credentialed with patient's insurance. Holds weekly meetings with BHCM to develop treatment plans and make medication recommendations.

Billing: Consultation provided by psychiatric consultant is accounted for in valuation of CoCM codes.

Patient

Clinical: Actively participates in their treatment; remains in direct contact with both the BHCM and PCP.

Administrative: Provide verbal consent prior to enrollment in CoCM.

Billing: In some cases, responsible for a co-pay based on insurance but medical benefits are billed for behavioral health services.

Collaborative Care Model

Transformation Team

Building and implementing the Collaborative Care Model (CoCM) requires a multidisciplinary transformation team who will work together at every level of the organization to design workflows, conduct trainings, enhance technology, and understand administrative nuances of this integrated behavioral healthcare model.

There are three major phases of integrating CoCM into an existing primary care practice and core working groups that will lead the organization through each phase. While the core team of each phase represents the primary change agent for that part of the transformation, certain leaders will re-enter the core team as needed throughout the process.

Plan	Build	Maintain
Identify needs & goals: What resources are required? What impact do we hope to have at the individual and population health level?	*Build the CoCM system: Identify clinical and operations teams, design workflows, build IT infrastructure*	*Launch and maintain CoCM: The clinical team begins treating patients, measuring clinical impact, to continuously monitor and improve workflows*

Transformation Team

• Clinic or Health System Leadership • Finance Team Leader • Clinical Change Leader • Clinical Operations Leader	• Clinical Operations Leader • Information Technology (IT) • Health Care Informatics/Data Analyst • Revenue Cycle and Billing Team • Compliance Representative • Human Resources	• Clinical Operations Leader • Primary Care Provider (PCP) • Behavioral Health Care Manager (BHCM) • Psychiatric Consultant

Collaborative Care Model

Plan

Planning for implementation of the Collaborative Care Model (CoCM) involves identifying resource needs and funding goals, defining team roles, identifying a population-based tracking system, and developing standardized metrics for tracking patient progress.

Clinic or Health System Leadership: Candidates typically include Chief Executive Officer, Chief Medical Officer, Clinic Owner or Partner.

- Works closely with clinical, financial, and operational leaders to implement and sustain the Collaborative Care Model (CoCM).
- Delivers top-down directives on available funding for implementation based on clinic systems, operations, and resources (e.g., clinical need, bandwidth, budgets, hiring).
- Acts as a program champion and provides overall support.

Finance Team Leader: Someone with a deep knowledge of clinic finances and the authority to make capital allocation decisions is needed for this role. This could be a Chief Financial Officer, Director of Finance, or Controller.

- Evaluates information about current system costs and considers potential savings.
- Understands payer landscape and payer mix.
- Signs off on pro-forma and regularly reviews profit and loss statement(s).

Clinical Change Leader: Someone with both leadership support and power as a decision-maker is needed for this role. There is no formal requirement for the candidate to be a primary care provider (PCP) or have a behavioral health background.

- Commits to learning, teaching, and practicing CoCM to fidelity.
- Actively participates in CoCM planning, implementation, and sustainment.
- Provides a bi-directional communication channel from leadership to clinical operations and staff to solve implementation challenges.
- Monitors how the team is adopting the model and offers additional support.

Clinical Operations Leader: Someone with management experience in clinical operations and knowledge of the culture of the clinic health system who can implement best practices is needed for this role. This individual will be deeply involved in the Plan, Build, and Maintain phases of CoCM implementation.

- Assembles key team members needed for systemic changes and facilitates regular team meetings during all three phases of the implementation process.
- Facilitates the development of a standardized metrics dashboard for patient progress measurements.
- Communicates practice change expectations to clinic staff and supports them in overcoming challenges or formulating constructive alternatives.
- Monitors ongoing implementation of CoCM, facilitates data collection for ongoing assessment of quality goals, and shares this data with senior leadership with recommendations for quality improvement.

Collaborative Care Model

Build

Building the Collaborative Care Model (CoCM) system involves identifying the clinical and operations teams, designing workflows, and building the necessary IT infrastructure.

Information Technology (IT)/Electronic Medical Record Build Team : Builds technical systems to support standardized documentation and billing for successful implementation of CoCM. This may be the biggest change from current systems during implementation.

- Provides technical and coding expertise to build a registry or integrate a vendor registry.
- Works with the clinical operations leader to create referral orders, bi-directional interdisciplinary team communication within the EHR, and build out appropriate documentation templates for patient referral and tracking.
- Integrates tools for screening and measurement-based care, tools to aid with patient engagement (e.g., appointment reminders, relapse prevention plans, patient portal use), and tools to capture minutes for easier billing and reimbursement.

Health Care Informatics/Data analyst: Health care information must be translated into usable data.

- Collaborates with IT and clinical team to build/integrate the patient registry by incorporating clinical data from the existing electronic medical record (EMR) system into the registry so the team can treat patients to target. Medical records staff or informatics personnel may support the extraction and integration of reports and data from the EMR.
- Extracts and analyzes data for leadership and clinical team to support the short- and long-term target outcomes of the CoCM program.

Revenue Cycle and Billing Team: CoCM billing is unique as CoCM CPT codes are submitted monthly by the Primary Care Provider and reflects direct and indirect time spent by the Behavioral Health Care Manager with and for the patients.

- Understands the CoCM billing process.
- Assists the finance team in understanding payor mix and how each payor will reimburse for CoCM services. Patient cost-sharing may apply to CoCM and it is helpful to know the out-of-pocket cost prior to the start of services.
- Works with IT to ensure compliance between documentation, patient registry, and billing.

Compliance Representative: CoCM has unique components of consent and care delivery.

- Understands the regulatory and compliance nuances of CoCM for each state and payor.
- Understands state specific requirements for personnel filling roles on the clinical team.
- Reviews documentation templates to ensure they meet requirements for liability, and compliance.
- Works with revenue and billing department to ensure that billing workflows reflect the payor requirements (e.g., Centers for Medicare & Medicaid Services).

Human Resources: CoCM will usually involve creating two (or more) new positions within the clinic or health system— behavioral health care manager (BHCM) and psychiatric consultant roles.

- Modifies job description templates for recruitment for BHCM and psychiatric consultant.
- Works with clinician managers and clinical operations to fill new positions.

Collaborative Care Model

Maintain

Launching and maintaining the Collaborative Care Model (CoCM) system involves the clinical team treating patients and measuring clinical impact to continuously monitor and improve workflows.

Primary Care Physician (PCP) or Pediatrician: Oversees all aspects of patient behavioral health care from initial screening and referral to maintenance care post treatment target.

- Obtains verbal patient consent for CoCM and communicates with CoCM team regularly.
- Facilitates patient referrals, enrollment, engagement, education, medication prescriptions as appropriate, and maintenance care once patient reaches an evidenced-based treatment target.
- Influences clinical operations to implement the Collaborative Care Model (CoCM) and integrates new systems and processes with existing systems.

Behavioral Health Care Manager (BHCM): Acts as the Primary behavioral health support for patients in CoCM, and maintains direct contact with patients, PCP, and psychiatric consultant.

- Manages patient caseload to track patient progress and treatment response, and review caseload of patients with psychiatric consultant on a weekly basis.
- Performs initial and follow-up validated behavioral health assessments, systematically tracks patient progress, and provides brief therapeutic interventions as needed.
- A behavioral health background is a plus, but no specific licensure is required. Behavioral health specialized training for this role includes training in standardized assessments, clinical interviewing, psychoeducation, and brief therapy modalities.
- Facilitates billing by capturing minutes spent with patient and psychiatric consultant, this information is kept in the patient registry and submitted to the billing team.

Psychiatric Consultant: Provides psychiatric expertise through direct contact with BHCM and occasional contact with PCP but, in most cases, has no direct contact with the patient.

- Makes treatment recommendations during weekly systematic case reviews with the BHCM.
- Is available to BHCM for ad-hoc or urgent review based on clinical needs.
- This role is filled by a Medical Doctor (MD) Psychiatrist Physician Assistant (PA), or Advanced Registered Nurse Practitioner (ARNP) licensed in the same state as PCP but does not need to be credentialed with patient's insurance.
- Usually works 1-2 hours per week in partnership with each BHCM to develop treatment plans and makes medication recommendations.
- Does not bill for direct patient care and minutes spent on CoCM caseload. Consultations provided are accounted for in valuation of CoCM codes.