Collaborative Care Model

Transformation Team

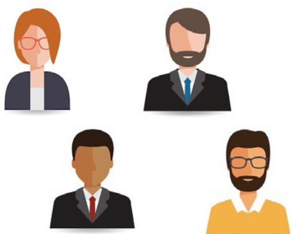
Building and implementing the Collaborative Care Model (CoCM) requires a multidisciplinary transformation team who will work together at every level of the organization to design workflows, conduct trainings, enhance technology, and understand administrative nuances of this integrated behavioral healthcare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

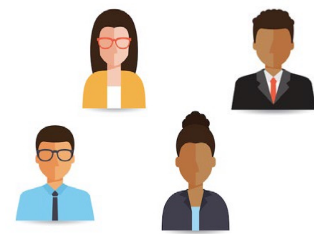
There are three major phases of integrating CoCM into an existing primary care practice and core working groups that will lead the organization through each phase. While the core team of each phase represents the primary change agent for that part of the transformation, certain leaders will re-enter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

Plan	Build	Maintain
• 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





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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.

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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.

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Collaborative Care Model

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.

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