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Collaborative Care Model Fact Sheet

Understanding the Collaborative Care Model (CoCM) Framework

The Collaborative Care Model (CoCM) is a patient-centered integrated care approach that leverages task sharing and population health strategies to treat common mental health problems in medical settings.[1] The CoCM care team is made up of three individuals - the primary care provider, behavioral health care manager (BHCM), and psychiatric consultant. All three work closely together to ensure that patients with common mental health (MH) problems are detected early, referred to CoCM, treated appropriately, and followed closely until their symptoms and functional status improve significantly.

CoCM is extensively evidence-based, with its efficacy being demonstrated by more than 90 randomized controlled trials and several meta- analyses across diverse diagnoses (e.g., depression, anxiety, bipolar disorder), patient populations (e.g., older adults, patients with chronic medical problems) and treatment settings (e.g., Federally Qualified Healthcare Centers, the Veterans Health Administration).[2] Additionally, CoCM has been shown to reduce racial and ethnic disparities in treatment outcomes[3] and is effective when implemented in rural[4] and under-resourced urban[5] treatment settings. Finally, CoCM has designated billing codes that are reimbursed by Medicare, most commercial payers, and a growing number of state Medicaid plans, leading the model to be financially sustainable.[6]

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1 Unützer, J., Katon, W., Callahan, C. M., Williams, J. W., Hunkeler, E., Harpole, L., Hoffing, M., Della Penna, R. D., Noël, P. H., Lin, E. H. B., Areán, P. A., Hegel, M. T., Tang, L., Belin, T. R., Oishi, S., Langston, C., & IMPACT Investigators. Improving Mood-Promoting Access to Collaborative Treatment. (2002). Collaborative care management of late-life depression in the primary care setting: A randomized controlled trial. JAMA, 288(22), 2836–2845.

2 Archer, J., Bower, P., Gilbody, S., Lovell, K., Richards, D., Gask, L., Dickens, C., & Coventry, P. (2012). Collaborative care for depression and anxiety problems. Cochrane Database of Systematic Reviews, 10. https://doi.org/10.1002/14651858.CD006525.pub2

3 Hu, J., Wu, T., Damodaran, S., Tabb, K. M., Bauer, A., & Huang, H. (2020). The Effectiveness of Collaborative Care on Depression Outcomes for Racial/Ethnic Minority Populations in Primary Care: A Systematic Review. Psychosomatics, 61(6), 632–644. https://doi.org/10.1016/j.psym.2020.03.007

4 Unützer, J., Carlo, A. C., Arao, R., Vredevoogd, M., Fortney, J., Powers, D., & Russo, J. (2020). Variation In The Effectiveness Of Collaborative Care For Depression: Does It Matter Where You Get Your Care? Health Affairs, 39(11), 1943. https://doi.org/10.1377/hlthaff.2019.01714

5 Blackmore, M. A., Patel, U. B., Stein, D., Carleton, K. E., Ricketts, S. M., Ansari, A. M., & Chung, H. (2022). Collaborative Care for Low-Income Patients From Racial-Ethnic Minority Groups in Primary Care: Engagement and Clinical Outcomes. Psychiatric Services, 73(8), 842–848. https://doi.org/10.1176/appi.ps.202000924

6 Carlo, A. D., Corage Baden, A., McCarty, R. L., & Ratzliff, A. D. H. (2019). Early Health System Experiences with Collaborative Care (CoCM) Billing Codes: A Qualitative Study of Leadership and Support Staff. Journal of General Internal Medicine, 34(10), 2150–2158. https://doi.org/10.1007/s11606-019-05195-0

CoCM adds two additional members to the primary care team: a BHCM (Behavioral Health Care Manager – a licensed or unlicensed mental health provider such as a social worker or lay health worker trained in CoCM) and a PC (Psychiatric Consultant – a psychiatrist or other prescribing mental health clinician). In CoCM, a defined group of referred patients meeting program inclusion and exclusion criteria (most often mild-moderate depression or anxiety) is closely followed through a treatment registry (i.e., clinical tracker). This treatment registry helps the CoCM team measure and track key mental health symptoms over time and ensures that patients are not lost to follow-up. The PC provides treatment recommendations including medication, when indicated, for the PCP to consider and carry out. The BHCM delivers brief therapeutic interventions (e.g., motivational interviewing, behavioral activation) to help patients with their MH symptoms. CoCM helps achieve the quadruple aim of healthcare reform – improved health outcomes, lower healthcare costs, improved patient experience, and improved provider satisfaction.[7] Additionally, CoCM extends the clinical impact of prescribing mental health clinicians to as many as eight times the number of patients that they could serve individually.[8]

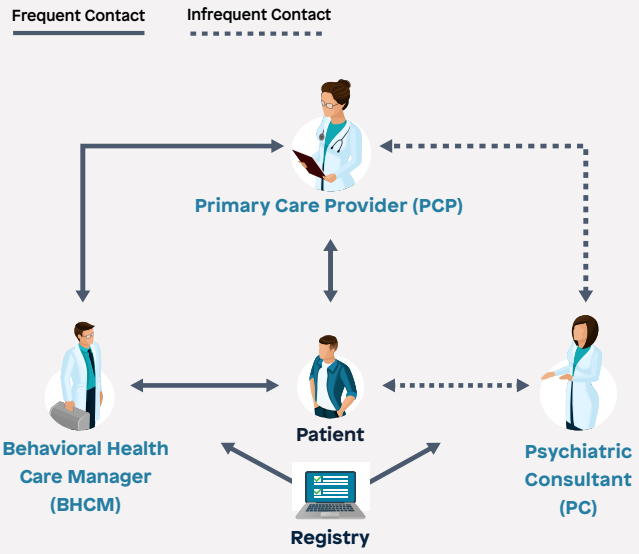
7 Arnetz, B. B., Goetz, C. M., Arnetz, J. E., Sudan, S., vanSchagen, J., Piersma, K., & Reyelts, F. (2020). Enhancing healthcare efficiency to achieve the Quadruple Aim: An exploratory study. BMC Research Notes, 13(1), 362. https://doi.org/10.1186/s13104-020-05199-8

8 Carlo, A. D., McNutt, C., & Talebi, H. (2024). Extending the Clinical Impact of Behavioral Health Prescribing Clinicians Using the Collaborative Care Model (CoCM). Journal of General Internal Medicine, 39(8), 1525–1527. https://doi.org/10.1007/s11606-024-08649-2

What does each member of the team do in CoCM?

Collaborative Care Model (CoCM)

This figure shows the CoCM team structure and treatment registry's vital role in patient-centered care.[9]



Primary Care Provider (PCP)

Oversees all aspects of patients' behavioral health care, including facilitating engagement with the BHCM, providing education, and prescribing medications as appropriate.[10]

- Screens for common mental health problems and refers patients meeting CoCM inclusion criteria into the program
- Obtains patient consent for treatment in CoCM and ensures that they are aware of possible cost-sharing
- Prescribes medication when indicated

Psychiatric Consultant (PC)

Supports PCP and BHCM by regularly reviewing cases and making treatment recommendations in systematic case reviews.[11]

- Provides supervision and treatment guidance to the BHCM
- Participates in weekly, scheduled review of the registry with the BHCM
- In certain cases, writes a brief psychiatric consultation note in the electronic health record documenting diagnostic clarification or treatment plan updates after reviewing a patient with the BHCM
- Communicates directly with PCP only if needed or specifically requested by the PCP

Behavioral Health Care Manager (BHCM)

Works closely with PCP and PC to manage a caseload of patients, performs validated behavioral health assessments, systematically tracks progress, provides brief therapeutic interventions.[12]

- Conducts comprehensive initial CoCM evaluation incorporating validated instruments (e.g., PHQ-9, GAD-7)
- Follows up with patients regularly, assessing symptoms using evidence-based measures
- Assesses for treatment plan adherence and tolerability
- Enters and maintains patient data in the treatment registry
- Provides brief interventions or counseling (e.g., motivational interviewing)
- Participates in weekly, scheduled caseload review with the PC, prioritizing those new to CoCM and those not improving
- Communicates changes in the suggested treatment plan to the PCP
- Tracks minutes spent providing CoCM treatment services to each patient over the course of each calendar month for the purposes of billing

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9 Meadows Mental Health Policy Institute. (2024). Collaborative Care Model—Clinical Team Structure. https://mmhpi.org/wp-content/uploads/2023/08/Tool-5_CoCM-Clinical-Teams.pdf

10 Carlo, A. D. et al., (2024), Extending the Clinical Impact of Behavioral Health Prescribing Clinicians Using the Collaborative Care Model (CoCM)., Journal of General Internal Medicine, 39(8), 1525–1527

11 Carlo, A. D. et al., (2024), Extending the Clinical Impact of Behavioral Health Prescribing Clinicians Using the Collaborative Care Model (CoCM)., Journal of General Internal Medicine, 39(8), 1525–1527

12 Carlo, A. D. et al., (2024), Extending the Clinical Impact of Behavioral Health Prescribing Clinicians Using the Collaborative Care Model (CoCM)., Journal of General Internal Medicine, 39(8), 1525–1527

Five Core Principles of CoCM

1 Patient-Centered Team Care

- The CoCM team works together using a shared care plan that includes each patient's identified goals
- Patients receive care in the familiar environment of their primary care office

2 Population-Based Care

- CoCM includes a defined group of enrolled patients who are initially identified through systematic screening for common mental health conditions (e.g., depression and anxiety) in medical settings
- Enrolled patients are closely tracked in a registry, which helps ensure patients do not fall out of care

3 Measurement-Based Care

- Clinical outcomes are routinely and systematically measured using evidence-based tools

4 Evidence-Based Care

- Patients are offered treatments that have evidence to support their efficacy
- Examples include evidence-based medication prescribing guidance and evidence-based brief psychotherapeutic interventions

5 Accountable Care

- Providers and organizations are held to quality standards, as determined by review of aggregated patient outcomes over time in the CoCM registry[13]

How long will a patient receive CoCM?

CoCM treatment episodes last an average of three to six months. During that time, the team will help clarify mental health diagnoses and implement a treatment plan, often including medication and brief psychotherapeutic interventions (e.g., motivational interviewing, behavioral activation). Once the patient demonstrates symptomatic improvement (as defined by validated measures), the CoCM team develops a Relapse Prevention Plan (RPP). This plan helps the patient maintain their mental health and wellness, while also identifying signs or symptoms that indicate a new episode of care may be needed. After discharge from the CoCM program, a patient can always re-engage with CoCM if needed. In certain cases, when a patient is not showing improvement, the patient may need to receive a higher level of specialty mental health treatment. The CoCM team can help connect that patient with those services as needed.

13 Advancing Integrated Mental Health Solutions (AIMS) Center. (2023). Principles of Collaborative Care. https://aims.uw.edu/principles-of-collaborative-care/

How is CoCM reimbursed through insurance?

CoCM is the only specific, evidence-based integrated mental health model to have designated billing codes. Prior to the initiation of each CoCM treatment episode, the PCP must obtain consent and inform the patient that cost sharing may apply. CoCM billing codes are time-based and reported as the total amount of time the BHCM, in collaboration with the PC, working under the direction of the PCP, spends engaging in clinical activities over the course of each calendar month in a treatment episode.[14] Of note, the CoCM code valuation accounts for BHCM clinical supervision services rendered by the PC, while direct interactions between the PCP and patient are billed separately through usual Evaluation and Management (E&M) codes. CoCM services are reimbursed by Medicare, more than half of state Medicaid agencies, and most private payers. Most payers follow similar cost sharing to other non-preventive PCP services, and if a copay applies, only one monthly charge is due.[15]

14 Meadows Mental Health Policy Institute. (2024). Collaborative Care Model—Billing Basics. https://mmhpi.org/wp-content/uploads/2024/08/Tool_7_CoCM_Billing_Basics_Final-3.pdf

15 Meadows Mental Health Policy Institute. (2024). Collaborative Care Model—Billing Basics. https://mmhpi.org/wp-content/uploads/2024/08/Tool_7_CoCM_Billing_Basics_Final-3.pdf

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