ZENORA HEALTH LLC

Integrated Health Extension For Primary Care Physicians

CoCM & BHI

Executive Health Program

Sleep Disorder

Delivering Mental Health, Executive Health Program and Sleep Disorder - Inside your Practice

ZENORA HEALTH

THE COLLABORATIVE CARE MODEL:
Delivering Quality Integrated Behavioral 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 tele-health.

Evidence Supporting CoCM

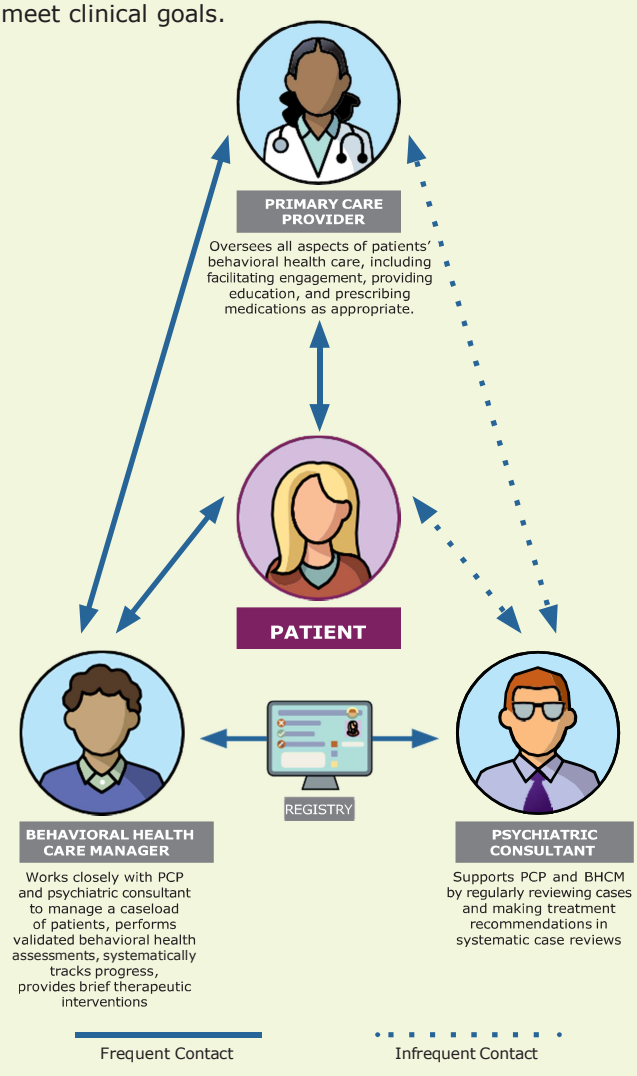
CoCM is extensively supported by scientific studies, with over 90 randomized controlled trials demonstrating its clinical efficacy. Providers use the model to help people with depression, anxiety, and other common mental health problems. The Meadows Institute has studied the impact that universal access 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.

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.
If only 20% of people with depression had access to CoCM, an estimated $15 billion per year could be saved in total Medicaid spending.

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.



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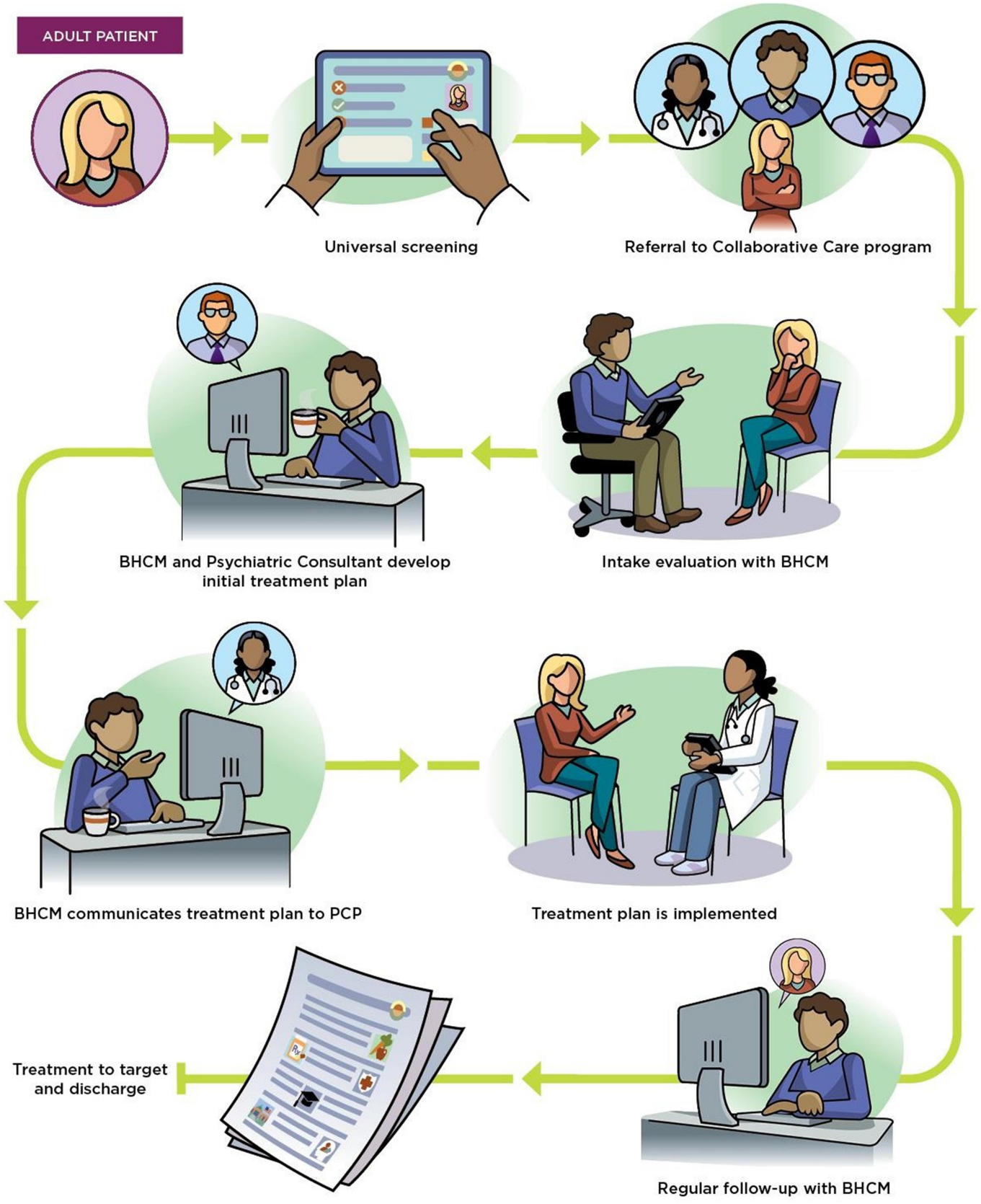
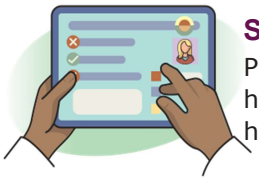
THE COLLABORATIVE CARE MODEL WORKFLOW



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, GAD-7).

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, GAD-7) 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.

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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 the recommended 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 of two 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.

Collaborative Care Model

Sleep Disorder

PMRP–Sleep™ is a structured, preventive behavioral sleep-management program delivered inside primary care using the Collaborative Care Model (CoCM). The program focuses on insomnia, sleep disturbance, and sleep-related mood dysregulation using non-pharmacologic, evidence-informed behavioral interventions, measurement-based monitoring, and medication-alignment support. Clinical workflow details for implementing the collaborative care model (CoCM) with adult patients. The CoCM team refers to the physician, the behavioral health care manager (BHCM), and the psychiatric consultant.

What are Sleep Disorders?

Sleep disorders are conditions that affect your ability to get the rest your body needs and maintain wakefulness. There are over 80 sleep disorders that impact:

- How well you sleep (quality)
- When you fall asleep and if you can stay asleep (timing)
- How much sleep and wakefulness you get (quantity or duration)

Everyone can experience problems with sleep from time to time. But you might have a sleep disorder if:

- You regularly have trouble sleeping.
- You feel tired during the day even though you slept for at least seven hours the night before.
- It becomes difficult to perform regular daytime activities.

What are the major categories of sleep disorders?

The categories of sleep disorders have changed many times over the years. Most recently, the International Classification of Sleep Disorders (ICSD) categorized sleep disorders based on the symptoms, how they affect a person (pathophysiology) and the body system it affects. The brand-new revision to the third edition, ICSD-3R includes the following categories:

- **Insomnia:** You have difficulty falling and staying asleep.
- **Sleep-related breathing disorders:** Your breathing changes while you sleep.
- **Central disorders of hypersomnolence:** You have trouble feeling alert during the day.
- **Circadian rhythm sleep-wake disorders**: Your internal clock makes it difficult to fall asleep and wake up on time.
- **Parasomnias:** Physical actions or verbal expressions happen during sleep like walking, talking or eating.
- **Sleep-related movement disorders:** Physical movements or the urge to move makes it difficult to fall asleep and/or stay asleep.

The ICSD updates regularly to include the most recent information about sleep disorders and the types that fall under these categories.

Collaborative Care Model

Sleep Disorder

Symptoms and Causes

What are the symptoms of sleep disorders?

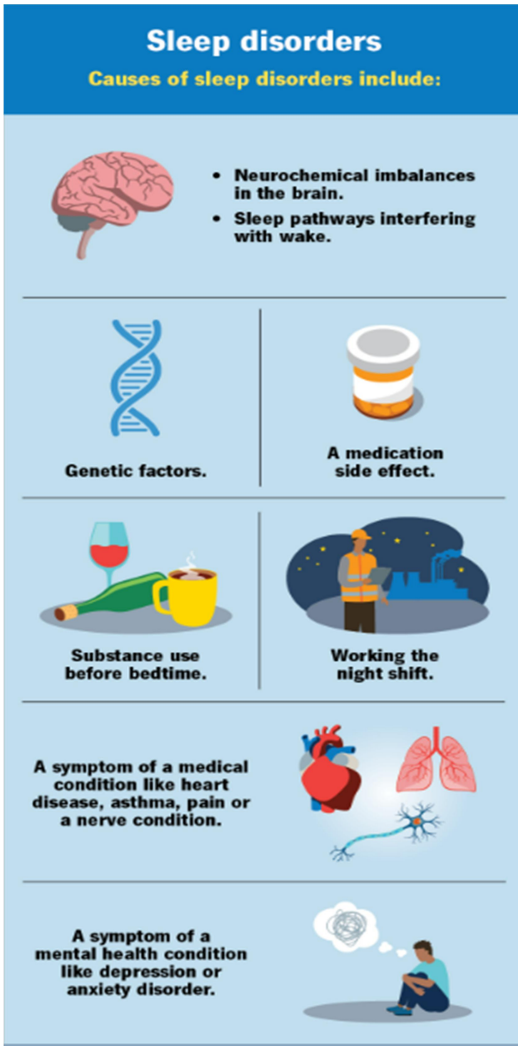
Symptoms of common sleep disorders vary based on the type, but could include:

- Difficulty falling asleep or it takes more than 30 minutes to fall asleep regularly.
- Trouble staying asleep through the night or you wake up often in the middle of the night and can't fall back asleep.
- Snoring, gasping or choking happens during sleep.
- Feeling like you need to move when you relax. Movement relieves this feeling.
- Feeling like you can't move when you wake up.

During the daytime, you may experience additional signs and symptoms caused by a lack of adequate sleep, including:

- Daytime sleepiness, taking frequent daytime naps or falling asleep while doing routine tasks
- Behavioral changes like difficulty focusing or paying attention
- Mood changes like irritability and trouble managing your emotions
- Difficulty meeting deadlines or performance expectations during school or work
- Frequent accidents or falls

If you feel like you're not able to get a good night's rest or have symptoms that interfere with your daytime activities, talk to a healthcare provider.



Diagnosis and Tests

How are sleep disorders diagnosed?

A primary care provider will diagnose a sleep disorder after a physical exam to review your symptoms and testing. Tests can help your healthcare provider learn more about what's causing your symptoms like blood tests or imaging tests.

Primary care provider may ask you to keep a sleep diary. A sleep diary is a record of your sleeping habits. You'll make note of when you go to bed, when you fall asleep and when you wake up each day. You should also make note of any naps you take during the daytime and how you feel before and after sleeping.

It helps to keep a pen and piece of paper near your bed so you don't forget to write these items down. It can be difficult to know what time you fall asleep exactly, so you should estimate what that time is. You might choose to wear a smart watch or a device (actigraph) that records your cycles of rest and activity. This can confirm what time you fell asleep and woke up.

Your primary care provider may recommend you visit a sleep specialist who'll perform a sleep study (polysomnogram). A sleep study is a sleep disorder test that electronically transmits and records specific body and brain activities while you sleep. A healthcare provider will analyze the sleep study data to determine whether or not you have a sleep disorder.

Collaborative Care Model

Sleep Disorder

Do I need to see a sleep specialist?

Your primary care provider may refer you to a sleep specialist if they suspect you have a sleep disorder. A sleep specialist is a highly trained healthcare provider who specializes in how sleep affects your body.

How are sleep disorders treated?

There are several types of treatment options available for various sleep disorders, which could include:

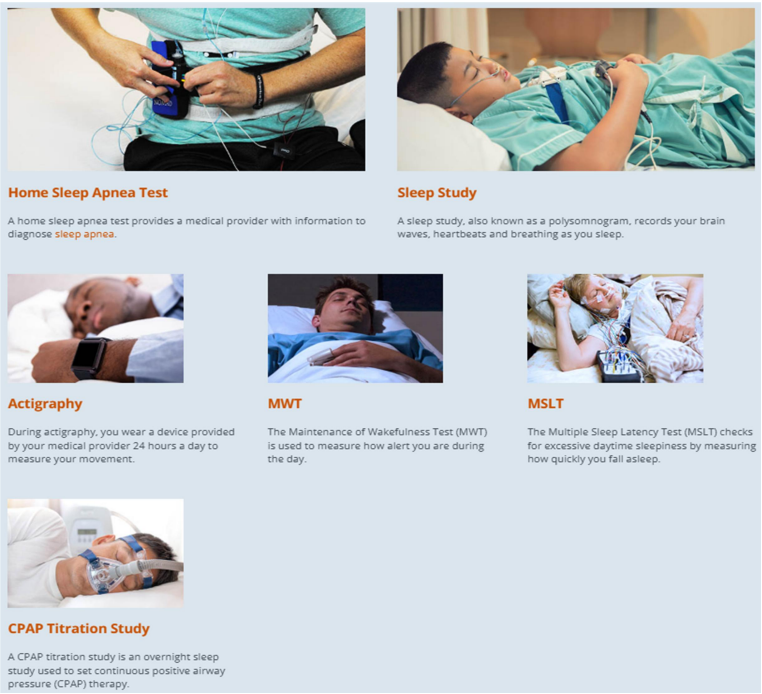
- Changing your sleeping routine to promote a regular sleep schedule and proper sleep hygiene.
- Undergoing cognitive behavioral therapy.
- Taking medications.
- Changing medications or dosages that cause excessive sleepiness (don't stop taking a medication unless your primary care provider approves it).
- Using a CPAP (continuous positive airway pressure) machine or having a neurostimulator implanted to control sleep apnea.
- Using light therapy.

Your primary care provider will recommend treatments based on your situation. They'll also discuss any side effects to look out for before you begin treatment.

Patients

If you're experiencing sleep troubles, know that you're not alone.

The first step is talking to your doctor about your concerns; they may order some tests to determine if you have a sleep disorder. There are many treatment options for sleep disorders and ways to get support.



Sleep Studies and Tests

- **Home Sleep Apnea Test**
- **Sleep Study**
- **Actigraphy**
- **MWT-Maintenance of Wakefulness Test**
- **MSLT-Multiple Sleep Latency Test**
- **CPAP Titration Study**

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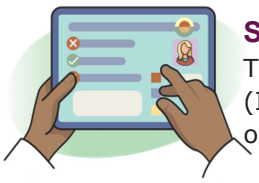
Collaborative Care Model

Sleep Disorder

***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

The clinic delivers annual screening for sleep disorders using the Insomnia Severity Index (ISI) alongside PHQ-9 and GAD-7 tools. The PCP also conducts a brief medical review to rule out physical obstructions like Sleep Apnea.

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

Patients with an ISI score of 15+ or those whose sleep issues hinder recovery from depression/anxiety are offered enrollment. The PCP facilitates a warm hand-off, introducing the BHCM as a specialized "Sleep Coach."

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

The BHCM completes a sleep history assessment and logs baseline ISI data into the registry. The patient is provided with a 14-day Sleep Diary to track patterns, which serves as the foundation for behavioral intervention.

STEP 4 – BHCM and psychiatric consultant develop initial treatment plan

During weekly reviews, the BHCM and Psychiatric Consultant analyze the Sleep Diary. They develop a strategy focused on CBT-I (Cognitive Behavioral Therapy for Insomnia) and determine if medication adjustments are required to support behavioral changes.

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

The BHCM shares the diagnostic impression and the proposed "Sleep Window" with the PCP via an intake report. This ensures the entire care team is aligned on the behavioral goals and any necessary medication tapers.

STEP 6 – PCP implements treatment plan

The PCP reviews the plan with the patient, providing the medical authority to back the behavior. They prescribe or adjust medications in accordance with the consultant's recommendations and their own clinical judgment.

STEP 7 – Regular follow-up assessments with BHCM

The BHCM meets with the patient bi-weekly to deliver CBT-I interventions, such as Sleep Restriction and Stimulus Control. They track progress in the registry, aiming for Sleep Efficiency above 85% and a significant drop in ISI scores.

STEP 8 – Relapse prevention planning and discharge

Once the patient achieves remission (ISI < 10), the BHCM develops a "Bad Night Protocol" to manage future disruptions. The patient is then discharged from CoCM back to regular PCP care with a toolkit for long-term sleep health.

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Collaborative Care Model

Sleep Disorder

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

Screening and Referral

Implementing a Sleep Disorder program within the CoCM framework begins with **Universal Screening** using the Insomnia Severity Index (ISI) to identify patients with clinical sleep disturbances. Following a positive screen, the **Referral and Consent** process involves the PCP explaining the program's behavioral focus and potential cost-sharing before documenting verbal consent and facilitating a warm hand-off to the Behavioral Health Care Manager (BHCM).

During the **Intake Evaluation**, the BHCM collects a detailed sleep history and initiates a 14-day Sleep Diary to establish a baseline in the treatment registry. This data drives the **Treatment Plan Development**, where the BHCM and Psychiatric Consultant collaborate weekly to design a CBT-I (Cognitive Behavioral Therapy for Insomnia) strategy, which the BHCM then **Communicates to the PCP** for medical alignment. The **PCP Implements the Plan** by reviewing behavioral goals and adjusting medications as needed to support the patient's transition to natural sleep. Throughout **Regular Follow-up**, the BHCM delivers evidence-based interventions like stimulus control and sleep restriction, tracking progress until the patient reaches a "Sleep Efficiency" of over 85%. Finally, once remission is achieved, the team provides **Relapse Prevention and Discharge**, giving the patient a "Bad Night Protocol" before returning them to standard primary care.

Intake Evaluation

After the PCP obtains consent, the BHCM connects with the patient via a warm handoff, telephone, or secure messaging to schedule the intake visit. During this session, the BHCM performs a comprehensive evaluation of current symptoms, diagnostic history, previous treatments, and medical comorbidities while administering sleep-specific tools like the Insomnia Severity Index (ISI) alongside the PHQ-9 and GAD-7. The BHCM then drafts a detailed report of these findings and enters all demographic data, clinical assessments, and initial sleep diary results into the patient treatment registry to guide the collaborative care team.

Case Review, Plan Development

In weekly case review sessions, the BHCM and psychiatric consultant utilize the treatment registry to prioritize new patients, those experiencing acute events, or individuals not meeting sleep efficiency targets. Together, they develop a personalized treatment plan incorporating **CBT-I protocols**, medication adjustments, and psychosocial interventions, which the BHCM then outlines in a formal report. This plan is preliminarily discussed with the patient to ensure buy-in before being sent to the PCP, who reviews and implements the team's recommendations within the patient's primary care plan.

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Collaborative Care Model

Sleep Disorder

Treatment Plan Implementation

When the psychiatric consultant recommends sleep-related medications and the PCP agrees, the PCP writes the prescriptions or schedules a visit to discuss the pharmacological approach. This bidirectional collaboration provides the PCP with real-time education on sleep-specific psychopharmacology, enhancing their clinical knowledge for future patient encounters. If follow-up questions arise, the PCP can consult the team at any time to ensure the treatment remains aligned with the patient's medical history.

For behavioral interventions, the BHCM directly delivers brief, evidence-based therapies such as **CBT-I (Cognitive Behavioral Therapy for Insomnia)**, motivational interviewing, or stimulus control. If a patient requires more intensive or long-term specialized therapy beyond the BHCM's training, they are referred to community providers while remaining enrolled in the CoCM program for continued monitoring. This ensures a comprehensive support system that addresses both the physiological and behavioral aspects of sleep disorders.

Regular Follow-up Assessments

Following the intake visit, the BHCM maintains close contact with the patient, typically interacting at least twice a month to deliver active treatment. During these sessions, the BHCM administers sleep-specific assessments, such as the **Insomnia Severity Index (ISI)**, and updates the patient treatment registry to track progress toward clinical remission—defined as an ISI score of less than 10—or a treatment response of a 50% reduction from the baseline score.

Throughout this phase, the BHCM and psychiatric consultant review each patient during weekly case sessions to refine the treatment plan based on clinical progress. Any updates, including adjustments to behavioral protocols or medication, are immediately shared with the PCP for implementation. On average, patients remain in the active treatment phase for three to six months, ensuring they reach stable sleep patterns before transitioning to the final phase of care.

Relapse Prevention, Discharge

A patient transitions from active treatment into the **relapse prevention phase** once they achieve significant symptom response or full remission, such as reaching an ISI score below 10. At this stage, the frequency of BHCM visits typically decreases to once per month as the clinical focus shifts toward sustaining progress and mitigating the risk of future sleep disruptions.

The resulting **Relapse Prevention Plan** integrates the patient's personal goals, long-term medication strategies, and specific guidance on using key CBT-I skills, such as stimulus control or the "Bad Night Protocol." After successfully maintaining these healthy sleep patterns for two to three months, the patient is typically discharged from the CoCM program back to regular primary care.

Collaborative Care Model Executive Program

The Zenora Executive Neuro-Resilience Integration Program (ENRIP)

*In partnership with your primary health provider, Zenora is proud to offer a premium, whole-person layer to your annual executive checkup. While standard physicals focus on your biological data, our **Executive Neuro-Resilience Integration Program (ENRIP)** ensures that your mental, behavioral, and sleep health receive the same elite level of diagnostic attention.*

Why Integrate Neuro-Resilience?

Standard executive physicals often miss critical indicators of **stress, burnout, anxiety, and sleep disorders**. By embedding specialized mental and behavioral health assessments into your yearly visit, we provide a complete picture of your health that standard labs and imaging alone cannot capture.

Comprehensive Assessment Tiers

Our on-site team of licensed psychologists and behavioral health care managers provides a deep dive into your neurological and emotional well-being:

- **Digital Neuro-Screening:** Utilizing high-precision tools for early detection of depression, anxiety, and alcohol use risks.
- **Psychosomatic Evaluation:** Assessing the complex interaction between psychological factors and physical symptoms, chronic illness, or lifestyle-related pain.
- **Advanced Sleep Assessment:** A specialized focus on insomnia, sleep apnea risk, and circadian rhythm issues often caused by high-demand executive schedules.
- **Executive Burnout & Stress Analysis:** Targeted instruments to measure and mitigate the specific pressures of professional leadership.

The Resilience & Risk Report

At the conclusion of your visit, you will receive a structured **Resilience and Risk Report**. This executive summary synthesizes all data into an easy-to-read format:

- **Risk Tiering:** Clear "Green, Yellow, Red" indicators of your current health status.
- **Actionable Findings:** Insights into your psychosomatic profile and sleep health.
- **Strategic Recommendations:** Concrete steps and timing for interventions to optimize your daily performance and long-term health.

A Seamless Path to Longitudinal Care

Our program does not end when you leave the clinic. If a follow-up is recommended, Zenora facilitates a "warm handoff" to your Primary Care Physician (PCP):

- **Collaborative Care Model (CoCM):** We work directly with your PCP to provide ongoing, registry-based care management.
- **Dedicated Support:** You are paired with a Behavioral Health Care Manager who monitors symptoms, supports behavior change, and coordinates directly with your doctor.
- **Psychiatric Case Consultation:** Regular reviews by Zenora psychiatrists ensure your treatment plan remains at the cutting edge of clinical excellence.

Collaborative Care Model

Executive Program

The Zenora Executive Neuro-Resilience Integration Program (ENRIP) offers patients a more holistic and proactive approach to their health than a standard physical exam. By focusing on "Neuro-Resilience," the program addresses the often-overlooked mental and behavioral factors that impact executive performance and long-term longevity.

What are the benefits of program?

The primary benefits for patients include:

- **Whole-Person Health Visibility:** Patients receive a specialized layer of care that specifically screens for stress, burnout, anxiety, depression, and sleep problems—issues frequently missed in standard check-ups.
- **Actionable Insights:** The program generates a structured **Resilience and Risk Report** that categorizes findings into clear risk tiers (Green, Yellow, Red), helping patients understand exactly where they stand.
- **Discreet & Integrated Access:** Patients can access high-level mental, behavioral, and sleep health expertise within the familiar and private setting of their annual executive physical.
- **Specialized Sleep & Psychosomatic Care:** The program provides deep-dive assessments into sleep disorders (like apnea or insomnia) and the relationship between psychological stress and physical symptoms.
- **Seamless Care Transitions:** If a health risk is identified, Zenora coordinates a "warm handoff" to the patient's own Primary Care Physician (PCP), ensuring on-going support through evidence-based collaborative care models.
- **Performance Optimization:** By identifying and managing behavioral risks early, the program helps executives maintain the cognitive sharpness and mental resilience required for high-stakes leadership.

How it is helpful?

Comprehensive Health Visibility

- **Identifies Hidden Risks:** Many yearly physicals miss critical "invisible" factors like burnout, chronic stress, anxiety, and sleep disorders.
- **Whole-Person Approach:** Patients receive a psychosomatic and sleep layer that examines how psychological factors interact with their physical symptoms and chronic illnesses.
- **Advanced Diagnostics:** Access to specialized tools like the PHQ-9, GAD-7, and STOP-BANG ensures that mental and behavioral health's are measured with clinical precision.

Clarity and Strategic Planning

- **The Resilience & Risk Report:** Patients receive a structured synthesis of their results, categorized into clear "Green, Yellow, and Red" risk tiers.
- **Performance Optimization:** Rather than just diagnosing illness, the program provides actionable recommendations to improve resilience and cognitive performance.
- **Expert Consultation:** During the check-up, a provider reviews the findings to explain the health and performance implications of any "red flags".

Seamless and Discreet Care

- **Convenience:** All assessments are conducted on-site during the annual check-up, saving the patient from booking separate specialist appointments.
- **Connected Support:** If a risk is identified, the program handles the "warm handoff" to the patient's Primary Care Physician (PCP).
- **Longitudinal Care:** For those who need it, Zenora provides on-going, registry-based care management (BHI/CoCM), ensuring the patient isn't left to navigate a treatment plan alone

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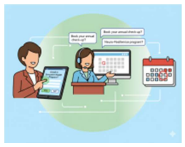
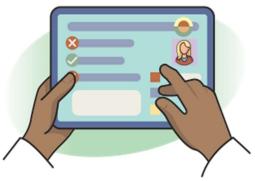
Collaborative Care Model **Executive Program**

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



STEP 1 – Booking and Opt-In

The process begins when a patient books their yearly executive health checkup at the partner clinic. During scheduling or check-in, the patient is educated on the Zenora add-on and chooses to opt-in and provide consent.



STEP 2 – Digital Screening Layer

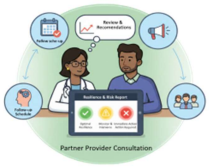
Once opted in, the patient completes initial digital screenings using a tablet or kiosk. These tools assess depression (PHQ-9), anxiety (GAD-7), alcohol use (AUDIT-C), sleep (STOP-BANG), and burnout.

STEP 3 – Detailed On-Site Assessments

Zenora staff, including psychologists and psychiatrists, perform in-depth psychosomatic, health behavior, and psychiatric diagnostic evaluations. This includes assessing the interaction between psychological factors and physical symptoms, as well as specific sleep-related risks.

STEP 4 – Resilience & Risk Reporting

Zenora synthesizes data from all screenings and evaluations to generate a structured Resilience & Risk Report. This report includes an executive summary, a sleep risk profile, and categorized risk tiers: Green (low), Yellow (moderate), and Red (high).

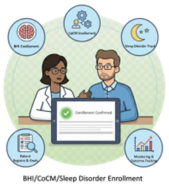


STEP 5 – Partner Provider Consultation

The BHCM shares the diagnostic impression and the proposed "Sleep Window" with the PCP via an intake report. This ensures the entire care team is aligned on the behavioral goals and any necessary medication tapers.

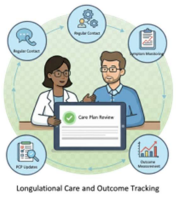
STEP 6 – PCP Engagement and Collaborative Agreement

With the patient's consent, Zenora contacts the patient's Primary Care Physician (PCP) to share the findings and Resilience Report. The PCP then reviews and signs a collaborative care agreement to initiate integrated services.



STEP 7 – BHI/CoCM/Sleep Disorder Enrollment

The patient is officially enrolled in either Behavioral Health Integration (BHI) for lower-intensity needs or the Collaborative Care Model (CoCM) for more structured psychiatric collaboration. The patient is added to a registry to track baseline scores and care plan goals.



STEP 8 – Longitudinal Care and Outcome Tracking

Zenora's Behavioral Health Care Manager (BHCM) maintains regular contact with the patient to monitor symptoms and support behavior change. Outcomes are measured at defined intervals (e.g., repeating PHQ-9/GAD-7) and reported back to the PCP and partner executives annually. The work flow here on follows the BHI/CoCM model of Zenora Health.

ZENORA HEALTH

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). Zenora Health 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.

Collaborative Care Model

Patient Registry

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.

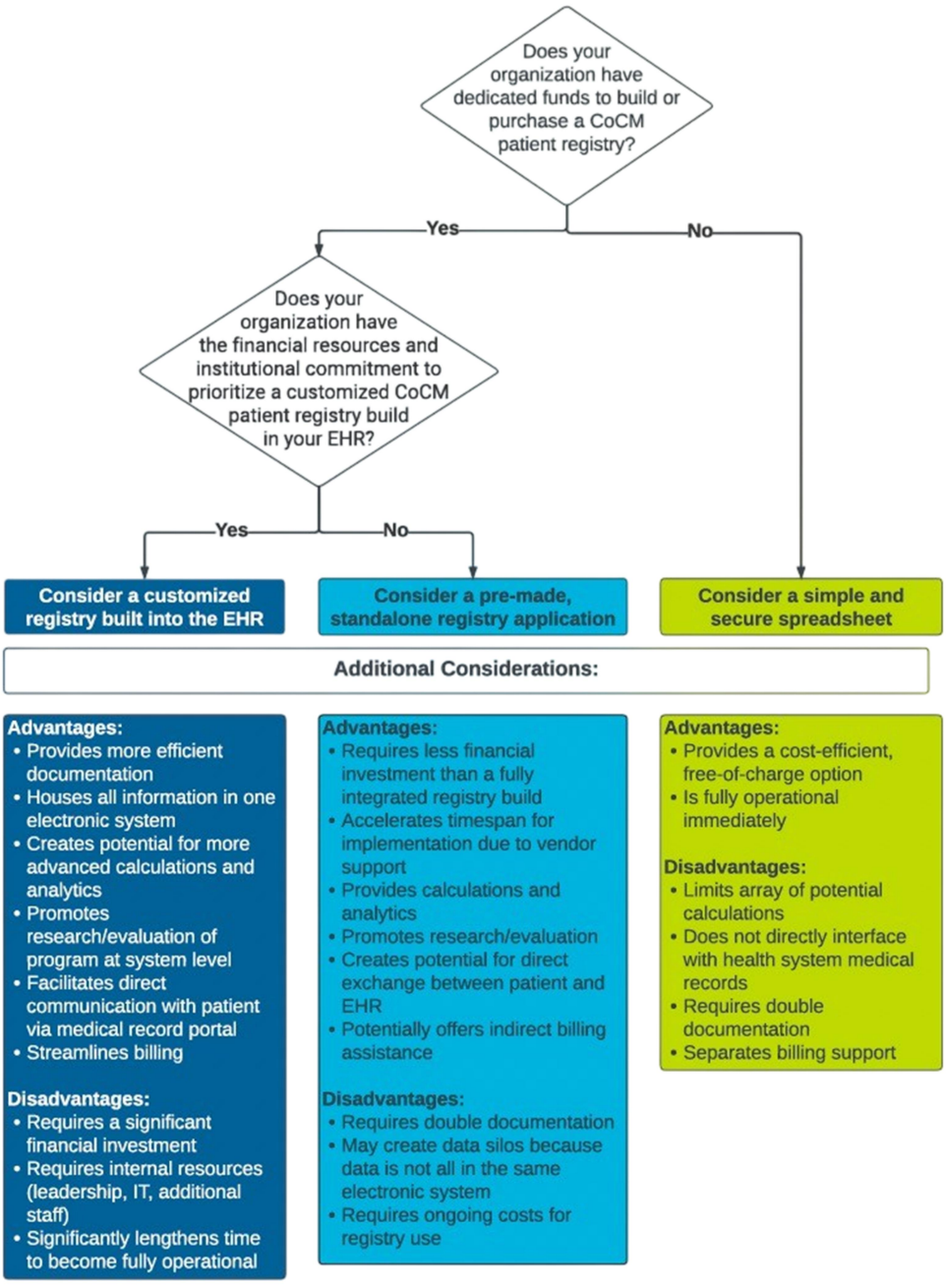
Registry Option	Considerations
1. A simple and secure spreadsheet	• Low or no additional cost; • Simple to use, customize, and update; • Requires some double documentation when not integrated into the EHR: clinical activities documented and tracked within independent system must be updated and uploaded 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.

Collaborative Care Model

Clinical Team Structure

Decision Matrix for Health Systems Key Registry Options

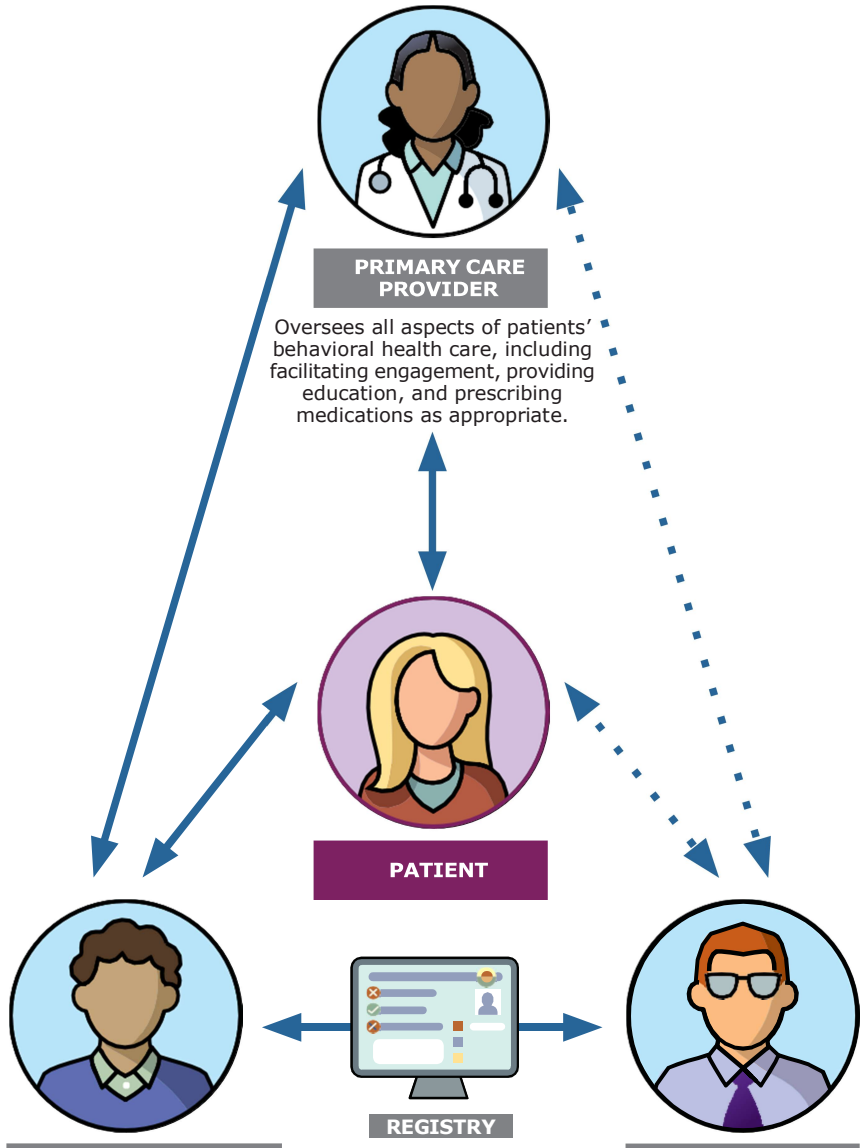
Below is a decision matrix to help health systems and clinical teams decide which primary category of patient registry options.



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.

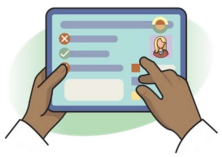


ZENORA HEALTH

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)

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

ZENORA HEALTH

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 payer mix and how each payer 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 payer.
- 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 payer 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, psycho-education, 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.

ZENORA HEALTH

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