



ZENORA HEALTH



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Integrated Behavioral Health Extension For Primary Care Physicians



CoCM



BHI



Sleep Disorder



ZENORA HEALTH

THE COLLABORATIVE CARE MODEL: Integrated Behavioral Health Care in the Primary Care Setting

About Us

Zenora Health is a non-clinical Management Services Organization (MSO). We act as a **Clinical Care Partner** by sourcing, training, and managing the administrative overhead of clinical staff, allowing PCPs to retain 100% clinical autonomy and focus entirely on patient outcomes.

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

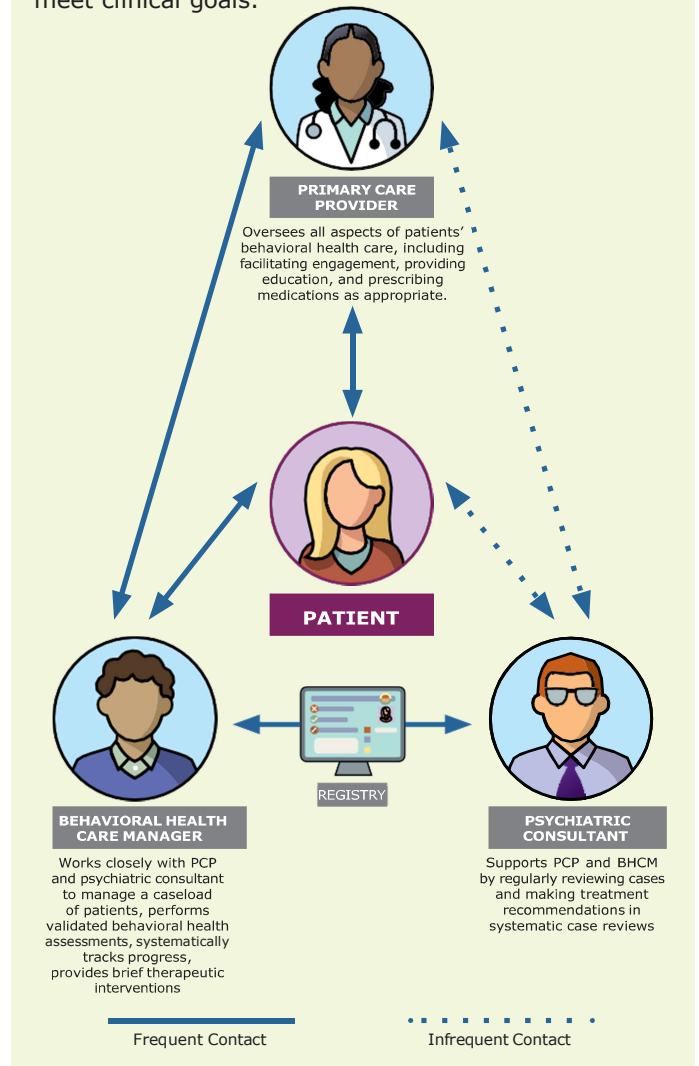
CoCM is extensively supported by scientific studies, with over 90 randomized controlled trials demonstrating its clinical efficacy. Providers use the model to help people with depression, anxiety, and other common mental health problems. The Meadows Institute has studied the impact that universal access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

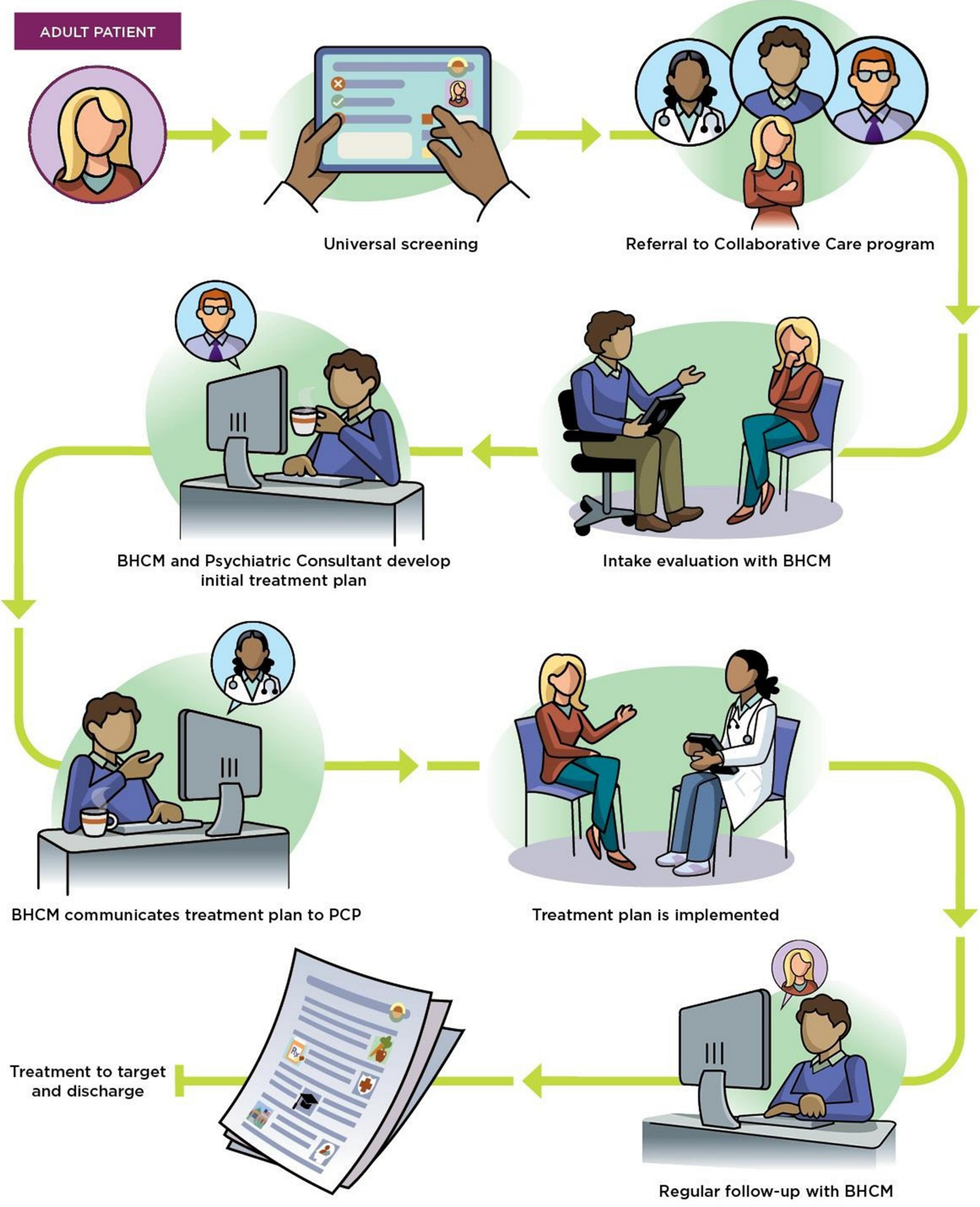
CoCM Financing

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.

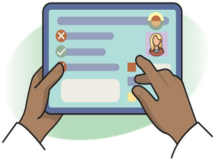




Collaborative Care Model

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 with the help of BHCM at the time of visit or annually for common behavioral health problems, such as depression, sleep, substance abuse and anxiety, using evidence-based behavioral health assessments (e.g., PHQ-9, GAD-7, PSQI, ISI, ESS, AUDIT-C).

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.

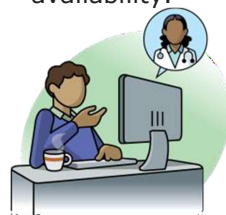


STEP 3 – Intake evaluation with behavioral health care manager (BHCM)

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.



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.



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

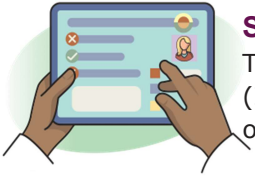
A patient moves from active treatment into the relapse prevention phase of the CoCM program when they achieve symptom response or remission. At this point, the patient's frequency of visits with the BHCM typically decreases to approximately once per month, and the clinical focus shifts to creating a 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 - RPM

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.



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.



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.



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.



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.





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Ready to Transform Behavioral Health in Your Practice?

Contact Us to Get Started


Whether you're launching your first program or scaling across multiple sites—Zenora Health is your partner for sustainable, integrated behavioral health care.


Connect with us to explore collaborative opportunities.

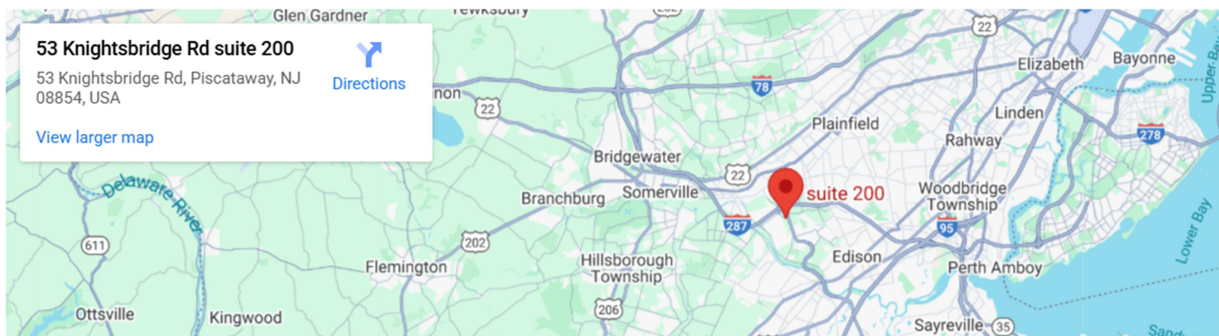
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