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# Tips and Tricks for staying true to CoCM

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## Learning Objectives

**By the end of this session, participants will be able to:**

1. Spot therapy drift in real time and name when CoCM work is quietly turning into therapy.
2. Re-anchor their role as a population-based behavioral health clinician, not a default therapist in primary care.
3. Use simple structural guardrails (time, measures, skills, documentation) to stay aligned with the CoCM model and protect capacity.

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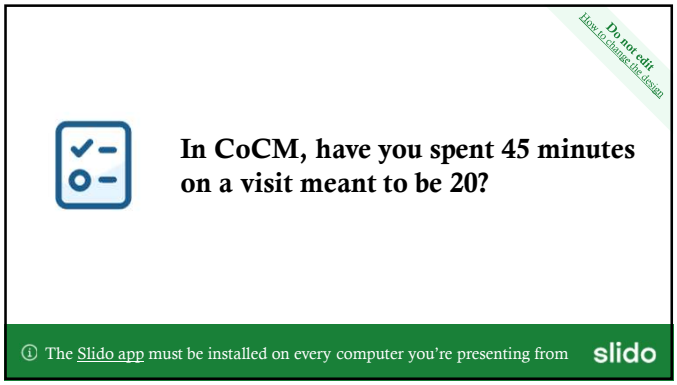
Do not edit
How to change the design
In CoCM, have you spent 45 minutes on a visit meant to be 20?
The Slido app must be installed on every computer you're presenting from
slido

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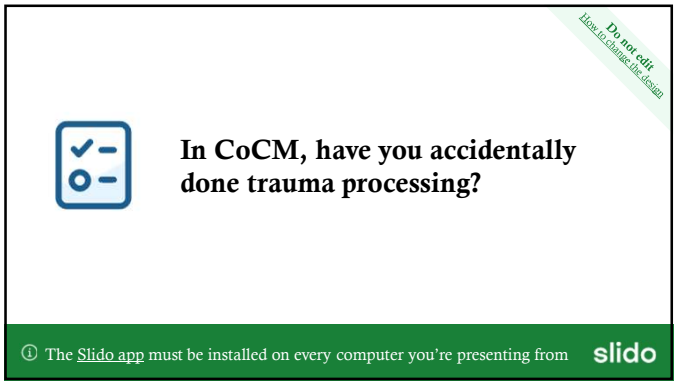
Do not edit
How to change the design
In CoCM, have you accidentally done trauma processing?
The Slido app must be installed on every computer you're presenting from
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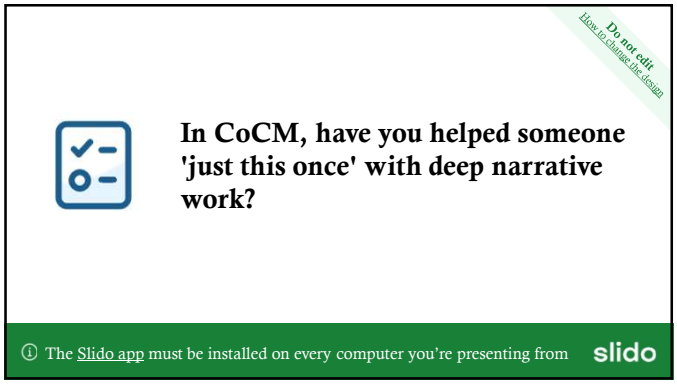
Do not edit
How to change the design
In CoCM, have you helped someone 'just this once' with deep narrative work?
The Slido app must be installed on every computer you're presenting from
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## CoCM Reset

- Population-Based, Measurement-Driven Clinical Model
- Caseload based care
- Brief, structured, functional
- Psychiatric consultation
- Registry guided
- Focus – skills, symptoms, function

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## CoCM Reset

Therapy
- Weekly
- Regularly Scheduled
- Narrative
- 50 minutes
- Deep processing

CoCM
- Brief, interactions without formalized scheduling
- Targeted
- Trackable
- 20 to 30 minutes

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## Why BHCM drift happens

- We're helpers
- Often trained to treat trauma
- Patients expect therapy
- Often identify as therapists
- PCPs send "therapy-ish" referrals

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## Why drift is problematic

- Can't support a full CoCM caseload
- Patients and PCPs get confused as to purpose of treatment
- Model fidelity loss
- Patient registry review not as helpful
- Burnout

**Think of avoiding the drift as protecting your capacity to help the *whole population***

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## What does fit within the BHCM Role

- Behavioral Activation
- Problem Solving Therapy
- DBT Skills
- Grounding
- Motivational Interviewing for health behavior
- Medication Adherence coaching
- Care Coordination
- Relapse Prevention
- Registry Tracking

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## What does **NOT** fit within the BHCM Role

- Long-term therapy
- Trauma Processing
- EMDR
- Parts work
- Narrative exploration
- Exposure Therapy
- Weekly or bi-weekly 50 minute sessions

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## Identifying Therapy Drift

- You're exploring childhood instead of symptoms
- Trauma narrative expands beyond headlines
- Insight work gets more attention than behavior work
- Sessions run 45-60 minutes
- Feeling emotionally spent
- Structure and progress is lost
- Inability to state functional goal of care

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## Practical Tips & Tricks

- Start encounters with: "What's improved or gotten worse since last time?"
- Use a timer
- Repeat the goals every session
- Redirect emotion to skills
- End with: Next skill to try, next thing we're measuring

- "Give me the headline, not the whole article."
- "Let's shift into what skill will help today."
- "My role is to help you stabilize quickly."

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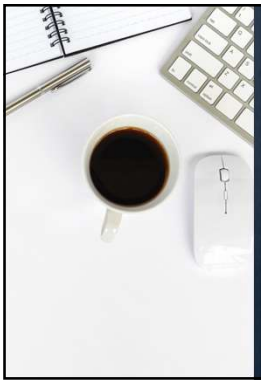

## Structuring your time

- **Documentation– daily protected time**
- **Registry review**
- **Phone follow-ups**
- **Skill building & follow-up sessions**
- **Time on the floor**

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## BHCM on the floor

Being visible and available on the floor allows BHCM to:

- Engage & build rapport with PCPs and nurses
- Pick up warm handoffs and referrals
- Reinforce your role to the team
- Connect with and set clear expectations with patients
  - Also allows real time scheduling for intake
- Keep visits brief

Should result in fewer therapy-leaning referrals

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## Prepping for Psych Consultation

**ID: Name / Age / Gender / DOB / MRN:**
**PCP / Referring Provider:**
**Last Psychiatry Consult Date:**
**Reason for Consult:**
**Current Dx (working + rule-outs):**
**Primary Symptoms:**
**Current Stressors:**
**Screening Scores: - PHQ-9:**
**- GAD-7:**
**- Other:**
**Substance Use:**
**MH History:**
**Safety: SI - none/passive/active**
**Previous Med Trials: - Med / dose / duration / response / SE / reason stopped**
**Current Medications: - Med / dose / adherence / last change**
**Specific Questions for Psychiatry:**
**Recommendations:**
**Total Time Spent:**

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## Maintaining Communication with PCPs

Short, purposeful updates builds trust and solidifies CoCM identity in primary care

- Create dotphrases
- Know what your PCPs prefer to be updated on
- Things to consider communicating
  - Referrals received
    - Engaged/scheduled for intake or unable to engage
  - New symptoms
  - Medication recommendations
  - Barriers to goals
  - Safety concerns
  - Disengagement, relapse prevention, successful discharge back to PCP

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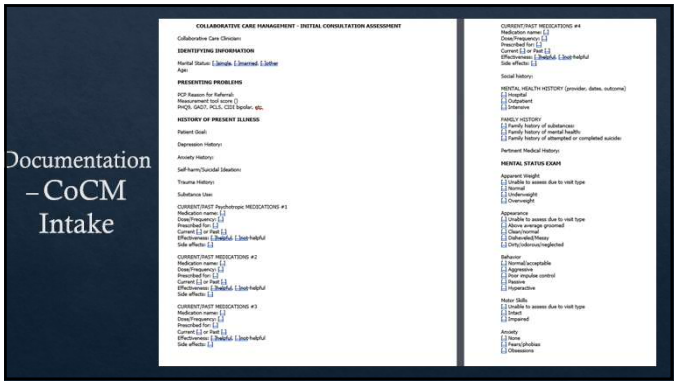
Documentation – CoCM Intake
COLLABORATIVE CARE MANAGEMENT - INITIAL CONSULTATION ASSESSMENT
Collaborative Care Clinician:
IDENTIFYING INFORMATION
Marital Status: [ ]single, [ ]married, [ ]other
Age:
PRESENTING PROBLEMS
PCP Reason for Referral:
Measurement tool score ()
PHQ9, GAD7, PCL5, CSSI Spoiler, etc.
HISTORY OF PRESENT ILLNESS
Patient Goal:
Depression History:
Anxiety History:
Self-harm/Suicidal Ideation:
Trauma History:
Substance Use:
CURRENT/PAST Psychotropic MEDICATIONS #1
Medication name: [ ]
Dose/Frequency: [ ]
Prescribed for: [ ]
Current [ ] or Past [ ]
Effectiveness: [ ]helpful, [ ]not-helpful
Side effects: [ ]
CURRENT/PAST MEDICATIONS #2
Medication name: [ ]
Dose/Frequency: [ ]
Prescribed for: [ ]
Current [ ] or Past [ ]
Effectiveness: [ ]helpful, [ ]not-helpful
Side effects: [ ]
CURRENT/PAST MEDICATIONS #3
Medication name: [ ]
Dose/Frequency: [ ]
Prescribed for: [ ]
Current [ ] or Past [ ]
Effectiveness: [ ]helpful, [ ]not-helpful
Side effects: [ ]
CURRENT/PAST MEDICATIONS #4
Medication name: [ ]
Dose/Frequency: [ ]
Prescribed for: [ ]
Current [ ] or Past [ ]
Effectiveness: [ ]helpful, [ ]not-helpful
Side effects: [ ]
Social history:
MENTAL HEALTH HISTORY (provider, dates, outcome)
[ ] Hospital
[ ] Outpatient
[ ] Intensive
FAMILY HISTORY
[ ] Family history of substances:
[ ] Family history of mental health:
[ ] Family history of attempted or completed suicide:
Pertinent Medical History:
MENTAL STATUS EXAM
Apparent Weight
[ ] Unable to assess due to visit type
[ ] Normal
[ ] Underweight
[ ] Overweight
Appearance
[ ] Unable to assess due to visit type
[ ] Above average groomed
[ ] Clean/normal
[ ] Disheveled/Messy
[ ] Dirty/odorous/neglected
Behavior:
[ ] Normal/acceptable
[ ] Aggressive
[ ] Poor impulse control
[ ] Passive
[ ] Hyperactive
Motor Skills
[ ] Unable to assess due to visit type
[ ] Intact
[ ] Impaired
Anxiety:
[ ] None
[ ] Fears/phobias
[ ] Obsessions

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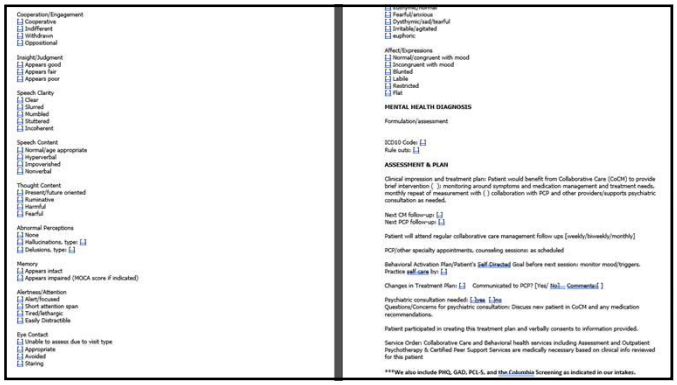
Cooperation/Engagement
[ ] Cooperative
[ ] Indifferent
[ ] Withdrawn
[ ] Oppositional
Insight/Judgment
[ ] Appears good
[ ] Appears fair
[ ] Appears poor
Speech Clarity
[ ] Clear
[ ] Slurred
[ ] Mumbled
[ ] Stuttered
[ ] Incoherent
Speech Content
[ ] Normal/age appropriate
[ ] Hyperverbal
[ ] Impoverished
[ ] Nonverbal
Thought Content
[ ] Present/future oriented
[ ] Ruminative
[ ] Harmful
[ ] Fearful
Abnormal Perceptions
[ ] None
[ ] Hallucinations, type: [ ]
[ ] Delusions, type: [ ]
Memory
[ ] Appears intact
[ ] Appears impaired (MOCA score if indicated)
Alertness/Attention
[ ] Alert/focused
[ ] Short attention span
[ ] Tired/lethargic
[ ] Easily Distractible
Eye Contact
[ ] Unable to assess due to visit type
[ ] Appropriate
[ ] Avoided
[ ] Staring
[ ] Fearful/anxious
[ ] Dysthymic/sad/tearful
[ ] Irritable/agitated
[ ] euphoric
Affect/Expressions
[ ] Normal/congruent with mood
[ ] Incongruent with mood
[ ] Blunted
[ ] Labile
[ ] Restricted
[ ] Flat
MENTAL HEALTH DIAGNOSES
Formulation/assessment
ICD10 Code: [ ]
Rule outs: [ ]
ASSESSMENT & PLAN
Clinical impression and treatment plan: Patient would benefit from Collaborative Care (CoCM) to provide brief intervention ( ): monitoring around symptoms and medication management and treatment needs, monthly repeat of measurement with ( ) collaboration with PCP and other providers/supports psychiatric consultation as needed.
Next CM follow-up: [ ]
Next PCP follow-up: [ ]
Patient will attend regular collaborative care management follow ups [weekly/biweekly/monthly]
PCP/other specialty appointments, counseling sessions: as scheduled
Behavioral Activation Plan/Patient's Self Directed Goal before next session: monitor mood/triggers.
Practice self care by: [ ]
Changes in Treatment Plan: [ ] Communicated to PCP? [Yes/ No]... Comments[ ]
Psychiatric consultation needed: [ ]yes [ ]no
Questions/Concerns for psychiatric consultation: Discuss new patient in CoCM and any medication recommendations.
Patient participated in creating this treatment plan and verbally consents to information provided.
Service Order: Collaborative Care and Behavioral health services including Assessment and Outpatient Psychotherapy & Certified Peer Support Services are medically necessary based on clinical info reviewed for this patient
***We also include PHQ, GAD, PCL-5, and the Columbia Screening as indicated in our intakes.

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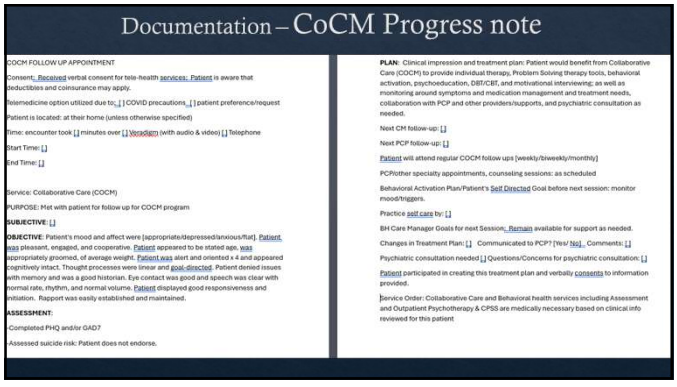
Documentation – CoCM Progress note
COCM FOLLOW UP APPOINTMENT
Consent: Received verbal consent for tele-health services: Patient is aware that deductibles and coinsurance may apply.
Telemedicine option utilized due to: [ ] COVID precautions, [ ] patient preference/request
Patient is located: at their home (unless otherwise specified)
Time: encounter took [ ] minutes over [ ] Vocadiem (with audio & video) [ ] Telephone
Start Time: [ ]
End Time: [ ]
Service: Collaborative Care (COCM)
PURPOSE: Met with patient for follow up for COCM program
SUBJECTIVE: [ ]
OBJECTIVE: Patient's mood and affect were [appropriate/depressed/anxious/flat]. Patient was pleasant, engaged, and cooperative. Patient appeared to be stated age, was appropriately groomed, of average weight. Patient was alert and oriented x 4 and appeared cognitively intact. Thought processes were linear and goal-directed. Patient denied issues with memory and was a good historian. Eye contact was good and speech was clear with normal rate, rhythm, and normal volume. Patient displayed good responsiveness and initiation. Rapport was easily established and maintained.
ASSESSMENT:
-Completed PHQ and/or GAD7
-Assessed suicide risk: Patient does not endorse.
PLAN: Clinical impression and treatment plan: Patient would benefit from Collaborative Care (COCM) to provide individual therapy, Problem Solving therapy tools, behavioral activation, psychoeducation, DBT/CBT, and motivational interviewing; as well as monitoring around symptoms and medication management and treatment needs, collaboration with PCP and other providers/supports, and psychiatric consultation as needed.
Next CM follow-up: [ ]
Next PCP follow-up: [ ]
Patient will attend regular COCM follow ups [weekly/biweekly/monthly]
PCP/other specialty appointments, counseling sessions: as scheduled
Behavioral Activation Plan/Patient's Self Directed Goal before next session: monitor mood/triggers.
Practice self care by: [ ]
BH Care Manager Goals for next Session: Remain available for support as needed.
Changes in Treatment Plan: [ ] Communicated to PCP? [Yes/ No] Comments: [ ]
Psychiatric consultation needed [ ] Questions/Concerns for psychiatric consultation: [ ]
Patient participated in creating this treatment plan and verbally consents to information provided.
Service Order: Collaborative Care and Behavioral health services including Assessment and Outpatient Psychotherapy & CPSS are medically necessary based on clinical info reviewed for this patient

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## Billing

Month/Year:

| Name | Start Month | Minutes | Billing Code | PHQ/GAD | Psych Consult | Status (A, RP, D/C) | Location/ type (FM/IM/OB) | Notes |
|---|---|---|---|---|---|---|---|---|
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## Therapy drift scenario 1

You schedule a 20-minute CoCM follow-up. The patient becomes tearful and starts sharing a detailed trauma story. You don't want to interrupt, and the visit runs 50 minutes.

- Where did drift begin — time, role, or intervention?
- What internal pressure is most likely driving this drift?

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## Therapy drift scenario 2

A patient prefers meeting with you over their outside therapist. They say, "You understand me better than anyone." Sessions are weekly and emotionally meaningful.

- Whose need is being met here — the patient's, yours, or both?
- What happens to your CoCM role if patients experience you as their therapist?
- How would a CoCM-aligned reset conversation sound?

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## Therapy drift scenario 3

Skills aren't sticking. You start exploring attachment patterns and childhood experiences to help the patient "really understand why."

- What does this shift prioritize: insight or function?
- Where does this fall on the "what fits / what doesn't fit" slide?
- What would a skills-based redirection look like in real time?

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## Your work changes primary care

You are a population-based behavioral health clinician

Your fidelity to the CoCM model is your impact

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## Questions?

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