Collaborative Care: A Solution for Providing Optimal Psychosocial Oncology Care

BY MONIQUE J. MARINO

In a time when mental health needs are surging and access to care is shrinking, cancer programs across the United States are facing a critical challenge. How should they provide timely, effective psychosocial support to patients navigating the complexities of cancer? This issue took center stage during a May 8, 2025 webinar hosted by the Association of Cancer Care Centers (ACCC). The session featured expert insights from William Pirl, MD, MPH, chair of the Department of Psychiatry and Behavioral Sciences at Memorial Sloan Kettering Cancer Center, and Jesse Fann, MD, MPH, medical director of Psychosocial Oncology at Fred Hutchinson Cancer Center and professor at the University of Washington. The webinar had approximately 220 live virtual attendees and over 30 attendees watching the recording, which remains in ACCC's online learning platform.

Dr. Pirl opened the webinar with a sobering reality, stating, "We are in a mental health care crisis right now." He cited data showing that nearly 58 million Americans live with mental illness, yet less than half receive services. Even more alarming, 160 million people—over one-third of the US population—reside in areas with a shortage of mental health professionals. "This shouldn't be surprising," he added, "but it's a wake-up call."

Patients with cancer are often assumed to have better access to psychosocial care, but they are not exempt. Referencing a 2002 study, Dr. Pirl noted that only 35% of cancer survivors with mental health needs accessed services—just 2% higher than the general population.[1] "People with cancer aren't much more connected to mental health services," he said.

As cancer center volumes rise, the strain on psychosocial services intensifies. For example, Dana Farber Cancer Institute, where Dr. Pirl practiced for 7 years, has doubled its patient volume in the past decade. "Ten years ago, oncology teams would thank us for our help," Dr. Pirl reflected. "Now they ask, 'Why can't you just see our patients?'" The problem, he argued, lies in outdated models of care. "Our services aren't designed to treat high volumes of patients," Dr. Pirl argued.

The Collaborative Care Model (CoCM) offers a population-based, team-driven approach to integrating mental health into oncology. Dr. Fann, who has led its implementation at Fred Hutch since 2010, described it as "a system of delivering evidence-based psychosocial oncology care." He emphasized that collaborative care is not simply co-location or communication among providers. "It's not just copying each other on notes or attending rounds," he said. "It's a structured, accountable model."

The CoCM is built around 5 key principles:

1. Population-based care. This entails universal distress screening and proactive identification of needs.

2. Patient-centered team care. Led by a care manager—often a social worker—care focuses on shared decision-making and patient engagement.

3. Measurement-based, treatment-to-target. Validated tools (eg, Patient Health Questionnaire-9 [PHQ-9], General Anxiety Disorder-7 [GAD-7]) are used to track outcomes; treatment adjustments are made based on symptom trajectory.

4. Evidence-based stepped care. Tiered interventions are based on severity: minimal (eg, self-care tools, community support), mild (eg, psychoeducation, supportive therapy), moderate (eg, brief counseling, medication), and severe (eg, referral to psychiatric care or psychotherapy).

5. Accountable care. Mental health management depends upon transparent workflows, regular case reviews, and reimbursement through public and private payer billing codes.

Dr. Fann illustrated how collaborative care transforms efficiency. "As a psychiatrist, I might see 1 or 2 patients in an hour," he said. "With collaborative care, I can address 6 to 12 patients in that same time through case reviews."

Fann also explained that the model elevates the role of social workers, enabling them to practice at the top of their licensure by providing brief counseling, medication support, and care coordination. A survey of Fred Hutch social workers revealed that 100% felt more integrated, satisfied, and clinically effective under the CoCM.

Dana-Farber Collaborative Care Rollout

Dana-Farber's journey began with a pilot at its Merrimack Valley site that was chosen for its high needs and lack of existing services. The pilot brought psychosocial and palliative care together under one umbrella, creating a unified Supportive Oncology Collaborative (SOC). "We created one referral system," Dr. Pirl explained. "No more separate services. Just one coordinated team." Akin to tumor boards, weekly meetings allowed the team to review 5 to 10 patients and adjust treatment plans, increasing patient reach by 50% without additional staffing.

One case involved a woman with metastatic cervical cancer who left her daughter in Florida to seek end-of-life care in Massachusetts. "She was in pain, depressed, and anxious," Dr. Pirl recalled. The SOC team initiated pain management, provided supportive counseling, and later prescribed escitalopram. "Two weeks later, her mood improved," he said. "That's the power of coordinated care."

Collaborative care also offers strategic and financial benefits. "The mental health crisis presents a business opportunity," Dr. Pirl noted. "[The Centers for Medicare & Medicaid Services] (CMS) billing codes make it scalable and cost-effective." Dana-Farber is now using collaborative care as the foundation for two pay-for-performance contracts with Blue Cross Blue Shield of Massachusetts and Point32Health.

A Call to Action

The CoCM offers a scalable, system-level solution to the growing mental health crisis in oncology. By shifting from reactive, fragmented care to proactive, integrated systems, cancer centers can deliver high-quality psychosocial support that meets the needs of diverse patient populations. This webinar laid the foundation for future training and implementation, empowering cancer professionals to lead transformative changes in their institutions. "This model helps us meet patients where they are," concluded Dr. Fann. "It's not just about treating distress—it's about transforming care."

For cancer programs considering implementing the collaborative care model, Dr. Fann offered practical advice. "Start with a pilot," he recommended. "Engage champions. Train your team. Use data to guide decisions. And be in it for the long haul."

Feedback was positive, with participants expressing appreciation for the webinar's practical applicability, its focus on psychosocial aspects of oncology care, and the emphasis on interdisciplinary integration for improved patient outcomes.

Implementation Strategies

Step 1: Preparation

- Define vision, scope, and target population.
- Engage champions across disciplines (eg, oncology, psychiatry, social work).
- Develop workflows for screening, referral, crisis management, and follow-up.
- Create a financing plan and identify metrics for continuous quality improvement.

Step 2: Implementation

- Train staff in core clinical skills (eg, motivational interviewing, behavioral activation).
- Launch pilot programs to refine workflows.
- Address barriers such as staffing, technology, and cultural resistance.

Step 3: Sustainment and Growth

- Expand services based on pilot success.
- Integrate additional components (eg, substance use, palliative care).
- Leverage data to advocate for resources and support.

Benefits for Cancer Programs

Clinical Impact

- Improved access and engagement in psychosocial care
- Enhanced coordination and continuity of care
- Evidence-based treatment adjustments ensure better outcomes.

Operational Efficiency

- Scalable across multiple sites
- Cost-effective and reimbursable
- Able to enhance provider satisfaction and reduce burnout.

Strategic Value

- Aligns with value-based care initiatives
- Strengthens institutional reputation and payer relationships
- Enables innovation in care delivery and research.

First Steps for Implementing Collaborative Care

The second installment of ACCC's Collaborative Care webinar series was held July 24, 2025, and highlighted actionable strategies for implementing the CoCM in cancer centers. Moderated by Past ACCC President Krista Nelson, MSW, LCSW, OSW-C, the webinar featured insights from Dr. Pirl; Dr. Fann; and Ailey Armstrong, MSW, LICSW, an oncology clinical social worker who partners with Dr. Fann at the Fred Hutchinson Cancer Center (Fred Hutch) in Seattle, Washington. These experienced cancer care professionals provided a comprehensive roadmap for integrating population-based psychosocial care into oncology workflows. Over 235 cancer care professionals registered for the event, with approximately 120 attendees actively participating in the live sessions. Participants gained insights into up-front preparation, stakeholder engagement, role definition, workflow development, and strategies for financial sustainability.

Establish Vision and Scope

Dr. Fann emphasized that a clear vision and scope are foundational to successfully implement the CoCM. "It's not just about launching a program," he said. "It's about building a shared purpose that can evolve with institutional priorities." The vision should:

- Define the target population (eg, disease groups, treatment phases, caregivers).
- Identify conditions to be addressed (eg, depression, anxiety, post-traumatic stress disorder, substance use).
- Outline services (in-house vs referral) and discharge criteria.
- Be a living document that adapts to challenges and growth.

Build Stakeholder Buy-In

The presenters emphasized the importance of engaging key stakeholders through tailored strategies that address their unique priorities and concerns to successfully implement the CoCM.

To engage cancer center leadership, it is essential to present compelling data that underscores unmet needs, such as untreated psychological distress or long wait times for appointments. Demonstration of how the collaborative care model aligns with established standards from the National Comprehensive Cancer Network (NCCN®), the American Society for Clinical Oncology, and the Commission on Cancer (CoC)—and underscoring its potential for financial sustainability—makes the case for adoption both clinically and fiscally persuasive.

Dr. Pirl added, "You have to tailor your message. For administrators, it's about benchmarking and cost containment. For clinicians, it's about support and role clarity."

Engaging oncology teams requires a grassroots approach. Informal needs assessments help to identify pain points and opportunities, and messaging focuses on how the CoCM can improve treatment adherence and reduce behavioral disruptions that complicate care delivery. Regular *roadshows* are used to maintain visibility and foster ongoing collaboration across disciplines.

When engaging social work leadership, presenters recommended positioning the CoCM as a mutually beneficial initiative that enhances clinical impact while strengthening professional satisfaction. As Armstrong noted during the session, "It allows us to practice at the top of our licensure," reinforcing the model's value in elevating the role of social workers within the care continuum.

Finally, for psychiatry leadership, the strategy involves highlighting educational benefits, potential funding opportunities, and strengthened integration with oncology teams facilitated by the CoCM. These elements help position the model as a strategic investment in clinical excellence and interdisciplinary collaboration.

Define and Assign Core Roles

Clearly defining roles is foundational; it ensures accountability, streamlines communication, and aligns team efforts with strategic goals. Describe each role, including specific tasks, decision-making authority, and expected outcomes. Consider using a *responsible, accountable, consulted, informed* (RACI) matrix to map out roles. Identify the competencies and experience needed for each role, which helps with hiring, training, and evaluating performance. Clarify how roles interact across departments or teams to avoid duplication and gaps. Establish reporting lines and escalation paths to support decision-making and oversight. Regularly review and update role definitions to reflect evolving business needs or strategic pivots.

Successful CoCM implementation requires a multidisciplinary team with clearly defined responsibilities:

- **An implementation lead** drives the process, coordinates efforts, and develops a management team.
- **An oncology champion** advocates for resources and communicates the model's value.
- **A care manager** takes responsibility for assessments, brief interventions, care coordination, and registry management. Typically, a clinical oncology social worker fills this role.
- **A psychiatric consultant**—a medical doctor or an advanced practice provider—delivers case consultation, treatment adjustments, and education. This role can be filled by remote staff with access to electronic health records (EHRs).

Additional aspirational roles include patient navigators, clinical psychologists, psychiatric nurses, and implementation coaches.

Develop Workflows

Effective workflows translate strategy into action. They define how tasks move through the organization and ensure consistency, efficiency, and quality. Critical elements of workflows include:

- Visualizing current and future workflows to identify bottlenecks, redundancies, or inefficiencies
- Considering how new workflows can be piloted with a small team before scaling
- Aligning workflows with digital tools (content management systems, project management platforms, analytics dashboards) to automate and streamline operations
- Documenting workflows clearly and making them accessible to all stakeholders
- Defining where cross-functional input is needed and how it will be coordinated
- Embedding review and approval steps to maintain standards and compliance
- Incorporating feedback loops to refine processes continuously.

Dr. Fann stressed the importance of specificity and iteration when he noted, "You need to be explicit about who does what and revisit workflows regularly." Key components include:

- Distress screening and triage
- Crisis management protocols
- Follow-up scheduling (in-person and telehealth)
- Outcome monitoring using validated tools (eg, PHQ-9, GAD-7)

- Psychiatric caseload reviews
- Communication with oncology teams
- Warm handoffs and coverage planning
- Quality assurance and billing processes.

Armstrong added, "We're often the first clinical provider patients meet. Our assessments must capture not just mental health history, but how patients relate to their illness, providers, and systemic barriers."

Document Financial Sustainability

Several key elements must be considered to ensure financial sustainability and align implementation with long-term budgetary health and strategic investment. Cost modeling involves estimating up-front and ongoing costs (eg, staffing, technology, training, maintenance). Revenue streams can be built by identifying how the initiative will generate or support revenue (eg, through content monetization, audience growth, operational efficiencies). Return on investment metrics must be identified, and success indicators (eg, engagement, conversion, retention, cost savings) must be defined and tracked rigorously.

Key performance indicators must be monitored regularly, and the strategy should be adjusted based on performance. A comprehensive funding plan—drawing on internal budgets, external partnerships, and potential grants—should be paired with financial forecasts that model optimistic, conservative, and worst-case scenarios. Finally, the financial impact must be communicated clearly to stakeholders to maintain support and transparency.

Measurement-Based Care and Registries

Measurement-based care, a defining feature of the CoCM, ensures that psychosocial interventions are delivered and effective. As Dr. Pirl explained, "We want to make sure people are getting better—and if they're not, we change course." This approach relies on validated instruments to track symptoms over time and guide treatment decisions. Most commonly, cancer programs use tools (eg, the PHQ-9 for depression and the GAD-7 for anxiety) that can be administered electronically via EHR, on tablets, on paper, or verbally during visits. The data collected helps to identify patients who are not improving and who possibly need stepped-up care or treatment modifications. "It's not just about collecting scores," said Armstrong. "It's about using them to tailor care and ensure patients don't fall through the cracks."

A patient registry is essential to measurement-based care. Whether built in Excel or integrated into the EHR, registries should track:

- Patient-reported outcomes over time
- Dates of psychosocial encounters and case reviews
- Treatment plans and interventions
- Flags for safety concerns or review
- Billable minutes (if applicable).

Fred Hutch's model includes EHR patient lists categorized as *active* (currently receiving care) and *inactive* (completed care but monitored for relapse). Collaborative care teams also maintain lists of *team meetings* and *all patients* to streamline caseload reviews and ensure continuity.

Dr. Pirl reassured attendees that starting simple is acceptable. He noted, "You don't need a fancy dashboard to begin. Even basic tracking can make a huge difference in care quality and accountability."

Caseload Reviews and Billing

Caseload reviews are a cornerstone of the CoCM, enabling efficient, collaborative decision-making. Held every 1 to 2 weeks, these reviews prioritize patients with safety risks, moderate to severe distress, or treatment resistance. Dr. Fann emphasized, "We cover 6 to 12 patients per hour. This isn't a case conference—it's a focused, dynamic review." These meetings allow treatment adjustments, discharge planning, and relapse prevention strategies.

Billing for services provided under the CoCM is not yet widespread in oncology, but it offers a path to financial sustainability. Nelson explained, "It's time-based billing with specific documentation and consent requirements. It's not a *silver bullet,* but it can offset costs and demonstrate value." Key billing codes include G2214, 99492-99494, and 99484, with average reimbursement being approximately $144 per patient. Institutions are encouraged to consult CMS guidelines and use tools like the Advancing Integrated Mental Health Solutions (AIMS) Center's financial modeling workbook to build a business case.

Final Thoughts

The webinar closed with a call to action: Start small, build strategically, and leverage existing resources. As Nelson commented, "We are so excited you're here…and really hope ACCC will have more opportunities to bring learnings and education to you." Participants were encouraged to complete a feedback survey to guide future webinars, signaling a continued commitment to advancing collaborative care in oncology. Dr. Fann stressed the need to involve all stakeholders early, stating, "Everyone needs to have buy-in…if you do, then you're going to have a common theme and direction." This collaborative approach ensures sustainability and fosters a shared commitment to improving psychosocial care.

Next Steps

Building on the strong engagement from the initial sessions, next steps will center on expanding opportunities for deeper learning and practical application of the CoCM in oncology settings. Additional webinars are planned to examine specific components of collaborative care in greater depth, with targeted discussion of operational, clinical, and financial considerations most relevant to implementation. To complement these sessions, dedicated office hours will be offered to provide direct consultation and peer-to-peer exchange for cancer centers that are currently adopting the CoCM or actively considering it. Together, these activities are designed to deliver sustained, tailored support that enables oncology programs to advance integration of the model and improve access to comprehensive psychosocial care.

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Recommended Resources:

The AIMS Center at the University of Washington

American Psychiatric Association Collaborative Care Training

PHQ/GAD screeners

CMS Behavioral Health Integration FAQs

Reference

1. Hewitt M, Rowland JH. Mental health service use among adult cancer survivors: analyses of the National Health Interview Survey. *J Clin Oncol*. 2002;20(23):4581-4590. doi:10.1200/JCO.2002.03.077