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TRANSFORMING MENTAL HEALTH CARE
THE COLLABORATIVE CARE MODEL

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LEARNING OBJECTIVES

- **Describe** the defining clinical team, five essential elements, and evidence base of the Collaborative Care Model within the national mental health care landscape.
- **Summarize** at least two evidence-supported benefits of the Collaborative Care Model compared with usual primary care for adults with depression or anxiety.
- **Identify** at least three workforce, financing, technology, or operational barriers limiting the national adoption of CoCM.

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LEVELS OF INTEGRATED HEALTH CARE

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	Coordinated		Co-Located		Integrated	
Collaboration	Minimal collaboration **(Level 1)**	Basic collaboration at a distance **(Level 2)**	Basic collaboration onsite **(Level 3)**	Close collaboration **(Level 4)**	Approaching an integrated practice **(Level 5)**	Fully integrated practice **(Level 6)**
Clinical Delivery	Separate treatment plans, screening and assessment models	Sharing of some treatment plans based on provider relationships, screening may be shared among providers	May use agreed-upon screening for more effective in-house referrals, share evidence-based practices, but separate treatment plans	Specific, standard screenings, collaborative treatment planning, some evidence-based practices shared	Consistent set of screenings guiding interventions, collaborative treatment planning, and evidence-based practices	Universal medical and mental health screenings are standard practice with results available to all providers of care team
Patient Experience	Physical and mental health needs are treated as separate. Patients must handle them separately on their own.	Physical and mental health treated separately but records are shared. Patients are referred but barriers to care can still exist	Patients' health needs are treated separately but at same location. Proximity improves referral process	Patients' health needs are treated separately but warm hand-offs occur to other providers, with improved referral and follow-up	A patient's needs are treated as a team for patients with multiple needs, separately for others, with care responsive to patient needs	All of a patient's physical and mental health care needs are treated seamlessly by a collaborative team

Source: Healthy Minds Policy Initiative, adapted from Heath B, Wise Romero P, Reynolds K. *A Standard Framework for Levels of Integrated Healthcare*. SAMHSA–HRSA Center for Integrated Health Solutions; 2013.

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WHAT DEFINES THE MODEL

DEFINING COCM: AIMS CENTER

- Treats common mental health conditions in medical settings, like PCP office
- Operationalizes the principles of chronic care model
  - Proactive, planned, population-based, and patient-centered
- Goal
  - Improve access to evidence-based mental health treatment for primary care patients
- Principles
  - Patient-centered Care Team
  - Population-Based Care
  - Measurement-based Treatment to Target
  - Evidence-based Care
  - Accountable Care

AIMS CENTER
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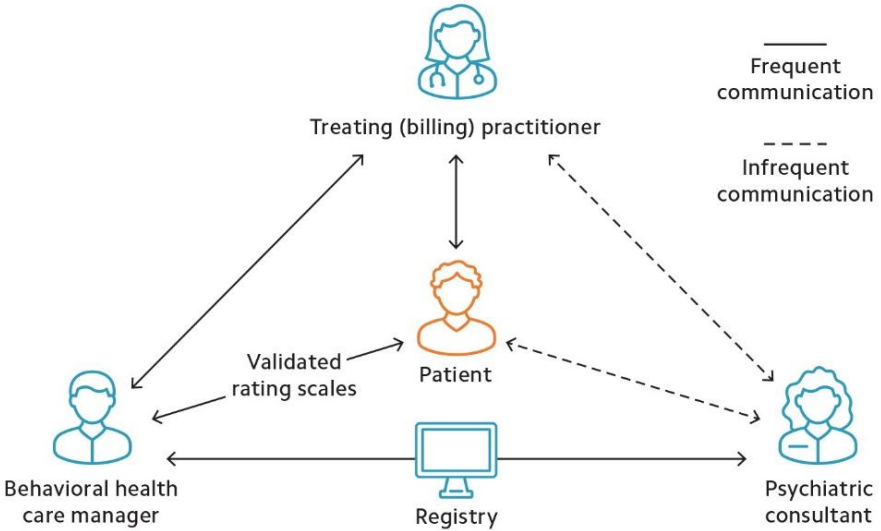
THE CORE TEAM



The Collaborative Care Model (CoCM) is an integrated healthcare model that has demonstrated a **strong evidence base for its effectiveness in treating patients with co-morbid mental and physical conditions**.

This comprehensive framework represents a **paradigm shift** in psychiatric care by fostering integration, improving access, and focusing on patient-centered outcomes.

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FIVE CORE PRINCIPLES OF COLLABORATIVE CARE MODEL

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Patient-Centered Team Care

Shared care plans that incorporate patient goals, familiar location to the patient, reduced duplicate assessments, and increased patient engagement for better health outcomes.

Population-Based Care

Care team shares a defined group of patients tracked in a registry to ensure no one falls through the cracks, and mental health specialists provide caseload-focused consultation.

Targeted Measurement-Based Treatment

Each patient's treatment plan has clearly articulated personal goals and clinical outcomes that are routinely measured, with treatments actively changed if patients are not improving as expected.

Evidence-Based Care

Patients are offered treatments with credible research evidence to support their efficacy, including evidence-based psychotherapies and pharmacotherapy.

Accountable Care

Providers are accountable and reimbursed for quality of care and clinical outcomes, not just the volume of care provided.

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MEASUREMENT-BASED CARE PROCESS

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REGISTRY CONNECTION

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Caseload-Focused Registry Review

A regularly scheduled (commonly weekly) review of a registry that tracks patient information, including screening and tracking tool results, medications, mental health treatment, and follow-up contacts. The psychiatric consultant and behavioral health provider review the registry, focusing on patients who are not improving, and discuss options to intensify or step up their care.

Leveraging Psychiatric Expertise

The caseload-focused registry allows the psychiatric consultant to leverage their expertise to a larger population of patients, rather than just providing ad-hoc advice. The consultant can make recommendations for medication adjustments, changes in behavioral approaches, scheduling face-to-face visits, or referrals to higher levels of care.

Aggregate Data Utilization

In addition to individual patient recommendations, the aggregate data from the registry can be used to identify areas that need more focus or areas of success that warrant dissemination. This pooled data is used by program or quality improvement leadership with across the caseload analysis to evaluate access, engagement, response, remission, fidelity, disparities, and program performance.

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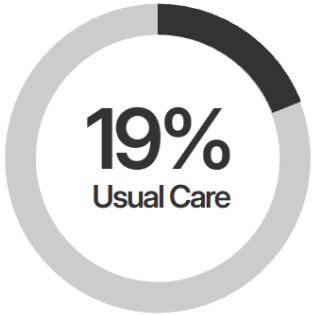
EVIDENCE

THE IMPACT STUDY

50% or Greater Reduction in Depressive Symptoms at 12 Months

The IMPACT study was a national study of Collaborative Care for depression; the largest Collaborative Care study ever conducted. Patients were randomly assigned to receive either usual care or Collaborative Care. Some results include:



Unützer J, et al. Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. JAMA. 2002 Dec 11;288(22):2836-45.

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EVIDENCE BASE

- CALM trial (2010)
  - Roy-Byrne et al.
  - Randomized 1,004 primary care patients
  - Dx: panic disorder, GAD, social anxiety disorder or PTSD
  - Improved symptoms compared to usual care
- Cochrane review (2012)
  - Archer et al.
  - 79 randomized trials with over 24,000 participants
  - Collaborative care improves depression and anxiety outcomes
    - Up to two years later
    - Including MH-related quality of life and patient satisfaction measures
- Systematic review and meta-regression (2014)
  - Coventry et al.
  - 74 randomized trials
  - Collaborative Care effective for patients with depression with chronic physical illness

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ON GOING STUDIES: WHAT OTHER DIAGNOSES MAY BENEFIT

- Depression beyond the senior population
  - Adults with chronic medical illness, adolescents, and perinatal depression
  - Randomized trials supportive
- Bipolar Disorder
  - Supportive but requires further effectiveness and implementation research
- Alcohol and Opioid Use Disorders
  - Promising
  - SUMMIT higher self-reported abstinence at 6 months
  - CLARO no statistical difference
- PTSD
  - Mixed
  - Trauma-Center Coll Care trials reduced symptoms
  - RESPECT-PTSD no statistical difference

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BENEFITS OF THE COLLABORATIVE CARE MODEL

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- Normalizes and de-stigmatizes treatment for behavioral health disorders
- Enhanced access to care
- Early identification and intervention
- Improved outcomes
- Cost Effectiveness
- Addresses both MH and physical health issues simultaneously

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NATIONAL INFRASTRUCTURE

MEDICAL ORGANIZATIONS

- AMA
  - Behavioral Health Integration Collaborative now includes the AMA and 11 national physician organizations, including APA.
  - Provides implementation, workflow, financial-planning, sustainability resources
  - Includes BH integration NOT limited to CoCM
- APA
  - Additional resources specific for CoCM
  - Role-based training
  - Implementation and billing tools
  - Reimbursement guidance
  - Model legislation

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FEDERAL PAYMENT POLICY

- Established psychiatric collaborative care management codes
- CMS 2026 Medicare
  - Additional Payment Pathways
    - CoCM to be added to APCM
    - Rural Health Clinics
    - FQHC
- These changes expand federal payment options, but reimbursement remains inconsistent across Medicaid programs and commercial insurers.
- Practices must continue to evaluate payer-specific coverage and requirements.

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IMPLEMENTATION BARRIERS

- ☒ National adoption remains limited
- ☒ Workforce capacity and training
- ☒ Start-up costs
- ☒ Billing complexity
- ☒ Inadequate reimbursement
- ☒ IT requirements
- ☒ Operational and workflow requirement

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THE WAY FORWARD

- **Expand Impact Research** beyond depressive disorders and co-occurring psychiatric disorders
- **Establish CoCM Implementation Hubs** based on evidence from implementation studies
- **Track Role of Proactive Follow up** to inform benefits studies
- **Broaden Primary Care Team Research** to include attitudes and skills to inform benefits studies
- **Secure Additional Metrics** around financial analysis, organizational support, and sustainability
- **Incorporate in Other Settings for Geropsychiatric Population** such as neurology and physical rehabilitation clinics
- **Leverage Technological Advances**

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REFERENCES / ABBREVIATED

- Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. Unützer J, et al. Journal of the American Medical Association. 2002; 288:2836 2845.
- Treatment of depression improves physical functioning in older adults. Callahan CM, et al. Journal of the American Geriatric Society. 2005; 53(3):367-373.
- The effectiveness of depression care management on diabetes-related outcomes in older patients. Williams J Jr., et al. Annals of Internal Medicine. 2004 Jun 15;140(12):1015-24.
- Improving depression care for older, minority patients in primary care: a randomized trial. Areán PA, et al. Medical Care. 2005 Apr; 43(4):381-390.
- Bauer AM, Williams MD, Ratzliff A, Unützer J. Best Practices for Systematic Case Review in Collaborative Care. Psychiatr Serv. 2019 Nov 1;70(11):1064-1067.
- Archer J, Bower P, Gilbody S, Lovell K, Richards D, Gask L, Dickens C, Coventry P. Collaborative care for depression and anxiety problems. Cochrane Database Syst Rev. 2012 Oct 17;10(10)
- Schillok H, Gensichen J, Panagioti M, Gunn J, Junker L, et al. Effective Components of Collaborative Care for Depression in Primary Care: An Individual Participant Data Meta-Analysis. JAMA Psychiatry. 2025 Sep 1;82(9):868-876.

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REFERENCES / ABBREVIATED

- Coventry PA, Hudson JL, Kontopantelis E, Archer J, Richards DA, Gilbody S, Lovell K, Dickens C, Gask L, Waheed W, Bower P. Characteristics of effective collaborative care for treatment of depression: a systematic review and meta-regression of 74 randomised controlled trials. PLoS One. 2014 Sep 29;9(9):e108114.
- Roy-Byrne P, Craske MG, Sullivan G, Rose RD, Edlund MJ, Lang AJ, Bystritsky A, Welch SS, Chavira DA, Golinelli D, Campbell-Sills L, Sherbourne CD, Stein MB. Delivery of evidence-based treatment for multiple anxiety disorders in primary care: a randomized controlled trial. JAMA. 2010 May 19;303(19):1921-8.
- Watkins KE, Osilla KC, McCullough CM, Griffin BA, et al. Collaborative Care for Opioid Use Disorder and Mental Illness: The CLARO Randomized Clinical Trial. JAMA Intern Med. 2026 Feb 1;186(2):168-180. doi: 10.1001/jamainternmed.2025.7036. PMID: 41460640; PMCID: PMC12750335.
- https://www.healthymindspolicy.org/research/understanding-integrated-behavioral-health-care-and-the-collaborative-care-model
- https://pmc.ncbi.nlm.nih.gov/articles/PMC10570240/

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