



# The Collaborative Care Model (CoCM)

## Research Brief

### Overview

The Collaborative Care Model (CoCM) was developed by the University of Washington in the 1990s. It was established through the seminal IMPACT (Improving Mood-Promoting Access to Collaborative Treatment) Trial (Unützer et al., 2002) as a systematic method for integrating behavioral health into primary care to improve adult depression outcomes (Reist et al., 2022). CoCM is characterized by patient-centered, population-based, and evidence-based care, along with a model that uses standardized assessments to tailor treatment to each patient, and a focus on accountable care. With over 90 randomized controlled trials supporting its effectiveness compared to traditional care, CoCM has a substantial evidence base (University of Washington AIMS Center, n.d.). It is among the most widely adopted and researched integrated care models, alongside the Primary Care Behavioral Health Model (American Psychological Association, 2022).

CoCM operates through a care team consisting of a primary care provider (PCP), a behavioral health care manager (BHCM), and a psychiatric consultant, who collaborate using shared care plans and systematic patient monitoring via a registry (Ho et al., 2023; American Psychiatric Association, n.d.). This multidisciplinary model integrates care management, universal screening, measurement-based approaches, and evidence-based treatments, that help ensure clear provider roles, standardized procedures, regular symptom monitoring, and ongoing consultation (Belsher et al., 2018; French et al., 2023; Meredith et al., 2024; Vera et al., 2010). CoCM has demonstrated effectiveness in managing physical health conditions, including cancer, diabetes, HIV, cardiovascular disease, and substance use disorders (University of Washington AIMS Center, n.d.). As of 2022, 19 state Medicaid programs cover CoCM for adults under fee-for-service programs (Kaiser Family Foundation, n.d.).



# Research Highlights

## Methods

A literature search was conducted in January 2025 across PsycINFO, Medline, and CINAHL, yielding 844 results using the terms (“Collaborative Care Model” OR “CoCM”) AND (outcome OR effect OR benefit OR impact). A parallel search in the Cochrane Library identified one Cochrane Review and 255 clinical trials. After deduplication, 507 articles remained for full-text screening. Based on efficiency considerations and levels of evidence, 31 systematic reviews and meta-analyses were selected for full-text screening, of which 10 systematic reviews and two meta-analyses were included in the scholarly literature evidence summary for this research brief. Notebook LM was used to assist in summarizing the included systematic reviews and meta-analyses, with all summaries fact-checked by the author.

Additionally, a targeted Google Scholar search was conducted using key terms to identify themes not covered in the systematic reviews. A separate search was conducted to identify authoritative sources on CoCM beyond peer-reviewed literature, including organizational websites, toolkits, and reports from leading institutions specializing in integrated care.

## Scholarly Literature

### Summary of Evidence

Multiple systematic reviews and meta-analyses have evaluated the impact of CoCM. Across these reviews, several common findings emerge. First, CoCM consistently outperforms usual care (i.e., standard treatments or services patients would typically receive in that setting in the absence of the CoCM intervention) in improving mental health outcomes, particularly for depression and anxiety, regardless of patients’ race, ethnicity, socioeconomic status, or English proficiency (Hernandez et al., 2024; Hu et al., 2020; Huang et al., 2017; Stuhec & Zelko, 2021; Atlantis et al., 2014; Garcia et al., 2017). Second, while CoCM has been applied in integrated care like the Federally Qualified Health Centers (FQHCs), outpatient clinics, community centers, specialty care, and telehealth (Ell et al., 2008; Siaw & Lee, 2018), it is most frequently implemented and found to be effective in primary care settings (Heavey et al., 2023; Hu et al., 2020; Huang et al., 2017; Yonek et al., 2020). Third, CoCM demonstrates effectiveness across a broad age range, including children, adolescents, youth, adults, and older adults (Burkhart et al., 2019; Hernandez et al., 2024; Menear et al., 2022; Yonek et al., 2020). Although CoCM originated in the U.S., it has also been implemented in Canada, South America, Europe, Australia, Asia, and the Middle East (Siaw & Lee, 2018).

### Effective Components.

Key components of effective CoCM implementation include:

- **Care Team Communication.** Consistent and regular communication among team members is essential for effective implementation. Technology plays a key role in facilitating this communication through electronic health records, email, telephone, and telemedicine platforms, helping to ensure seamless coordination and information sharing (Kruis et al. 2025).
- **A Well-Defined and Supported Behavioral Health Care Manager (BHCM)\* Role.** As central coordinators, BHCMs facilitate communication, troubleshoot challenges, and drive effective implementation. Their ability to adapt to the CoCM and manage administrative responsibilities is essential, particularly in resource-limited settings (Kruis et al. 2025; Yonek et al., 2020).
- **Adaptive Training and Perceived Acceptability of CoCM.** Scalable, high-quality training equips providers with the necessary skills and confidence to implement CoCM effectively, increasing their investment in the model. As clinicians and leaders recognize CoCM’s ability to address unmet needs, training further reinforces its acceptability and drives adoption (Hernandez et al., 2024; Kruis et al., 2025).

*\* In some instances, and depending on organization and system-level factors, “care manager” and “care coordinator” may be used interchangeably.*

- **Population-Based Care, Measurement-Based Care, and Evidence-Based Mental Health Services.** These components are consistently associated with significantly improved primary and secondary outcomes in studies (Yonek et al., 2020). In addition, targeted treatment, care management, and psychiatric consultation are important for improving patient satisfaction, care quality, functional outcomes, and health-related quality of life (Yonek et al., 2020).

## Implementation Settings

CoCM is implemented in various settings, with a focus on primary care (Heavey et al., 2023; Yonek et al., 2020). It has the potential to improve access to high-quality care, particularly in primary care settings where chronic pain and opioid use are prevalent (Heavey et al., 2023). Other implementation settings include FQHCs and other community-based clinics (Heavey et al., 2023; Yonek et al., 2020), veterans affairs healthcare systems (Heavey et al., 2023), hospital outpatient diabetes clinics (Siaw & Lee, 2018), retirement communities and telehealth (Hernandez et al., 2024).

## Served Populations

The CoCM supports diverse groups, including adults, older adults (65+), women, and youth (Hernandez et al., 2024; Menear et al., 2022). It has been implemented among racial and ethnic minorities, such as Chinese Americans, African Americans, and Native Americans/Alaska Natives (Hu et al., 2020; Kruis et al., 2025), as well as low-income individuals, those with limited English proficiency, rural populations, veterans, and the uninsured (Garcia et al., 2017; Hernandez et al., 2024). CoCM also benefits individuals with opioid use disorder (OUD), chronic conditions such as diabetes, cancer, and cardiovascular disease, and those with depression, anxiety, PTSD, or other mental health conditions (Garcia et al., 2017; Hernandez et al., 2024; Heavey et al., 2023).

## Outcomes and Symptom Management

The CoCM has demonstrated effectiveness in improving depression, anxiety, pain severity, and opioid-related behaviors, with outcomes measured through standardized screening and clinical assessments (Garcia et al., 2017; Hernandez et al., 2024). In pregnant and postpartum women, CoCM outperformed usual care in managing depression (Huang et al., 2017), while trials incorporating psychological interventions, with or without antidepressants, showed greater symptom reductions (Coventry et al., 2014). A meta-analysis reported significant depression symptom improvements (Atlantis et al., 2014). Additionally, Hernandez et al. (2024) reported CoCM led to a statistically significant reduction in anxiety symptoms. CoCM was also associated with reduced pain severity and pain-related activity interference and showed promise in reducing opioid prescriptions (Heavey et al., 2023). Additionally, meta-analyses confirmed CoCM's effectiveness in glycemic control, with reductions in glycated hemoglobin level (HbA1c) (Atlantis et al., 2014; Siaw & Lee, 2018).

## Satisfaction and Experiences

Studies indicate a positive relationship between CoCM implementation and patient satisfaction. A clinical trial found high satisfaction with care coordinators among adults with depression (Drummond et al., 2017). Another trial showed significantly greater patient satisfaction, higher provider approval rates, and improved medication adherence in the CoCM group compared to usual care (Finley et al., 2011). Key factors contributing to patient satisfaction, as reflected in the care manager's role, include care coordination, provider communication, access to health information, self-management support, involvement in treatment planning, and assistance with care transitions (Yonek et al., 2020).

## Fidelity

Implementation guidelines for CoCM exist, with authoritative examples from the American Psychiatric Association and Academy of Psychosomatic Medicine (2016) and the University of Washington AIMS Center (2024). A systematic review by Heavey et al. (2023) used the Patient-Centered Integrated Behavioral Health Care Principles & Tasks Checklist (PCC) to assess seven core components of integrated care. The analysis revealed considerable variability in CoCM implementation, as reflected in PCC scores. While higher scores indicated greater adherence to integrated care, some of the most rigorously implemented studies did not yield significant results. These findings highlight the ongoing challenge of identifying essential CoCM elements for intervention success while streamlining others to enhance efficiency.

## Challenges

The implementation of CoCM faces several challenges, including unclear referral processes and misunderstandings about the model, which hinder effective adoption (Smith et al., 2021). Financial barriers also pose significant obstacles, with reimbursement challenges and a lack of streamlined payment systems slowing uptake (Carlo et al., 2018). While CoCM has demonstrated cost-effectiveness, uncertainty regarding implementation and maintenance costs has led some organizations to perceive it as financially unfeasible. Additionally, the adoption of CoCM-specific billing codes has been slow, mirroring the gradual uptake of chronic care management codes nationwide (Carlo et al., 2018).

## Grey Literature

While peer-reviewed literature is the primary source of evidence for CoCM, several authoritative grey literature sources provide essential guidance on its implementation and effectiveness. The AIMS Center at the University of Washington, where CoCM was developed, offers widely recognized toolkits and training materials. The National Library of Medicine reviewed CoCMs and discussed challenges to effective implementation, including inadequate staffing, lack of training, and reimbursement challenges from commercial insurance companies. This review indicated that more widespread implementation of CoCMs can increase patient satisfaction as well as provider satisfaction and confidence in effectively managing patient behavioral health needs (Reist et al., 2022). Greenspace Mental Health Services highlights on their website that the CoCM model reimburses providers based on quality of care and clinical outcomes, a clear distinction from the fee-for-service medical model. The American Psychiatric Association supports CoCM adoption through training programs and financial modeling tools, while the Centers for Medicare & Medicaid Services offer critical billing and reimbursement guidance. Additionally, the National Council for Mental Wellbeing provides practical implementation resources. Collectively, these sources enhance understanding and support the successful adoption of CoCM alongside peer-reviewed research.

TABLE 1. SUMMARY OF EVIDENCE

| Category                    | Key Points                                                                                                                                                                                                                                                                                     |
|-----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Implementation and Training | <ul style="list-style-type: none"><li>• Extensive training in CoCM, supervision of Behavioral Care Managers, and routine feedback are key facilitators for implementation.</li><li>• The American Psychiatric Association has trained thousands of professionals in CoCM as of 2024.</li></ul> |
| Billing and Reimbursement   | <ul style="list-style-type: none"><li>• CoCM-specific billing codes (CPT codes 99492, 99493, and 99494) were introduced in 2018.</li><li>• These codes allow reimbursement for the cumulative time the team spends delivering CoCM each month.</li></ul>                                       |
| Billing and Reimbursement   | <ul style="list-style-type: none"><li>• 19 state Medicaid programs cover CoCM for adults in their fee-for-service programs as of 2024.</li><li>• The model is also supported by Medicare and some commercial payers.</li></ul>                                                                 |
| Future Directions           | <ul style="list-style-type: none"><li>• Efforts are ongoing to promote CoCM adoption, including financial modeling tools and the development of alternative payment models.</li></ul>                                                                                                          |

CoCM is gaining widespread recognition as an evidence-based approach to integrating behavioral health into primary care. Key factors for successful implementation include extensive training, supervision of behavioral care coordinators, and routine feedback. The American Psychiatric Association has played a significant role in training professionals in CoCM. Since 2018, specific CPT billing codes have facilitated reimbursement, with adoption by commercial payers and Medicaid programs in 19 states. Medicare may also support the model (Centers for Medicare & Medicaid Services, 2023; Substance Abuse and Mental Health Services Administration, 2024). Looking ahead, ongoing efforts aim to expand CoCM adoption through financial modeling tools and alternative payment models tailored for behavioral health services (Centers for Medicare & Medicaid Services, n.d.).

## Key Takeaways

- CoCM consistently outperforms usual care in improving depression and anxiety across diverse populations, including racial/ethnic minorities, low-income groups, and those with limited English proficiency.
- While implemented in various healthcare settings, CoCM is most frequently utilized and most effective in primary care.
- CoCM benefits individuals of all ages, including children, adolescents, adults, and older adults.
- Key factors for effective implementation include regular team communication, well-defined Behavioral Health Care Manager roles, ongoing provider training, and measurement-based, evidence-driven care.
- CoCM has demonstrated effectiveness in managing chronic conditions such as diabetes, cardiovascular disease, and pain, in addition to improving behavioral health conditions.
- Studies show that the roles of CoCM's care managers in care coordination, provider communication, and self-management support are key to higher patient satisfaction.
- Barriers to implementation include unclear referral processes, financial constraints, and slow adoption of CoCM-specific billing codes.

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Note: \*Indicates the scholarly and grey literature included in this research brief

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