Collaborative Care Management (CoCM)

A Review

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Disclosures

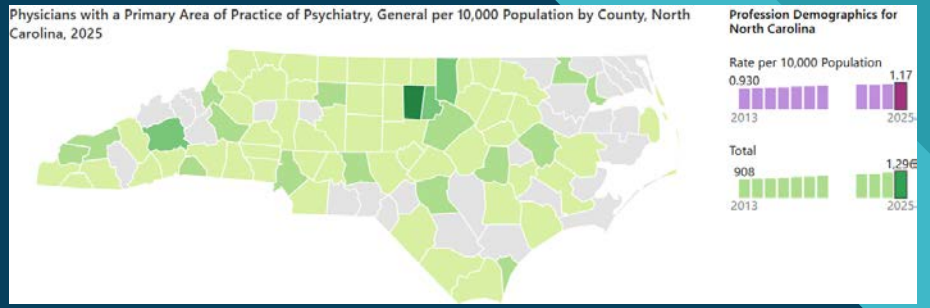
- I serve as a paid subject matter expert consultant for Southern Regional AHEC in development of educational materials for CoCM

Overview

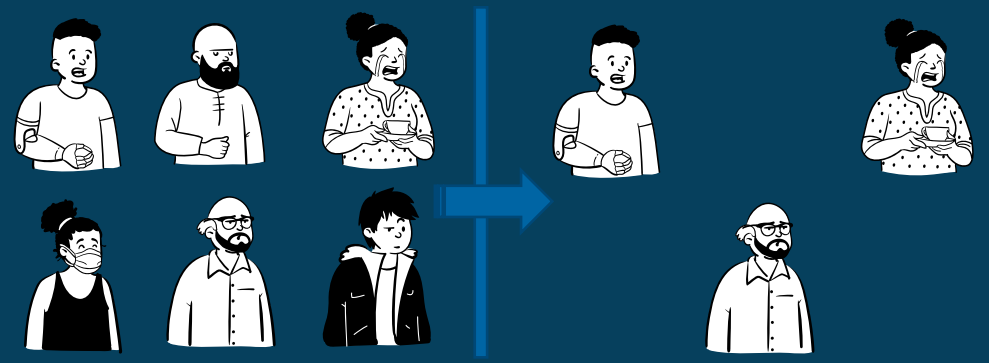
- Review of the CoCM model – history and structure
- Review the evidence base
- Discuss the state of CoCM in the U.S. and North Carolina

Why Integrated Care?

- Mental health conditions are among the most common problems seen in primary care
  - ~15% of primary care patients diagnosed with depression; 24% are receiving any treatment[1,2]
- Demand for care far exceeds the psychiatrist supply
  - 29 counties in NC that lack psychiatrists
- Traditional referral models leave patients behind
  - Half of those referred do not follow-through[3]
  - Average # visits = Two[4]



https://nchealthworkforce.unc.edu/interactive/supply/

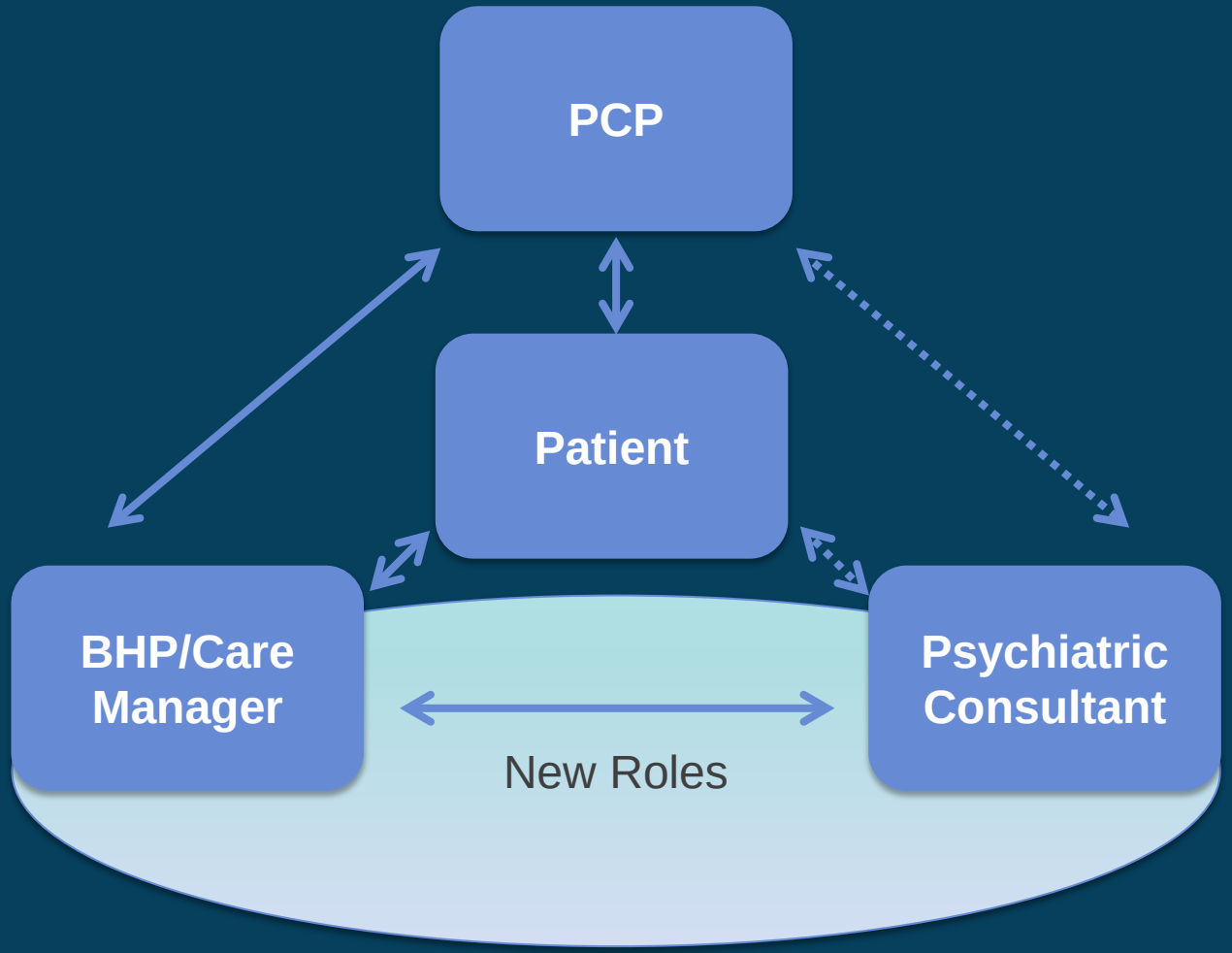


CoCM

Caseload-focused psychiatric consultation supported by a care manager

- Goals:
  - Provide better/quicker access to behavioral health care
  - Consistent, regular communication between behavioral health providers and primary care
  - “Force multiplier” – allows psychiatrist to impact a large number of patients in a limited amount of time (10-20 patients in a half-day)
  - Dynamic – allows for more rapid, brief consultations to adjust treatment more frequently when patients aren’t improving

CoCM



Principles Of CoCM

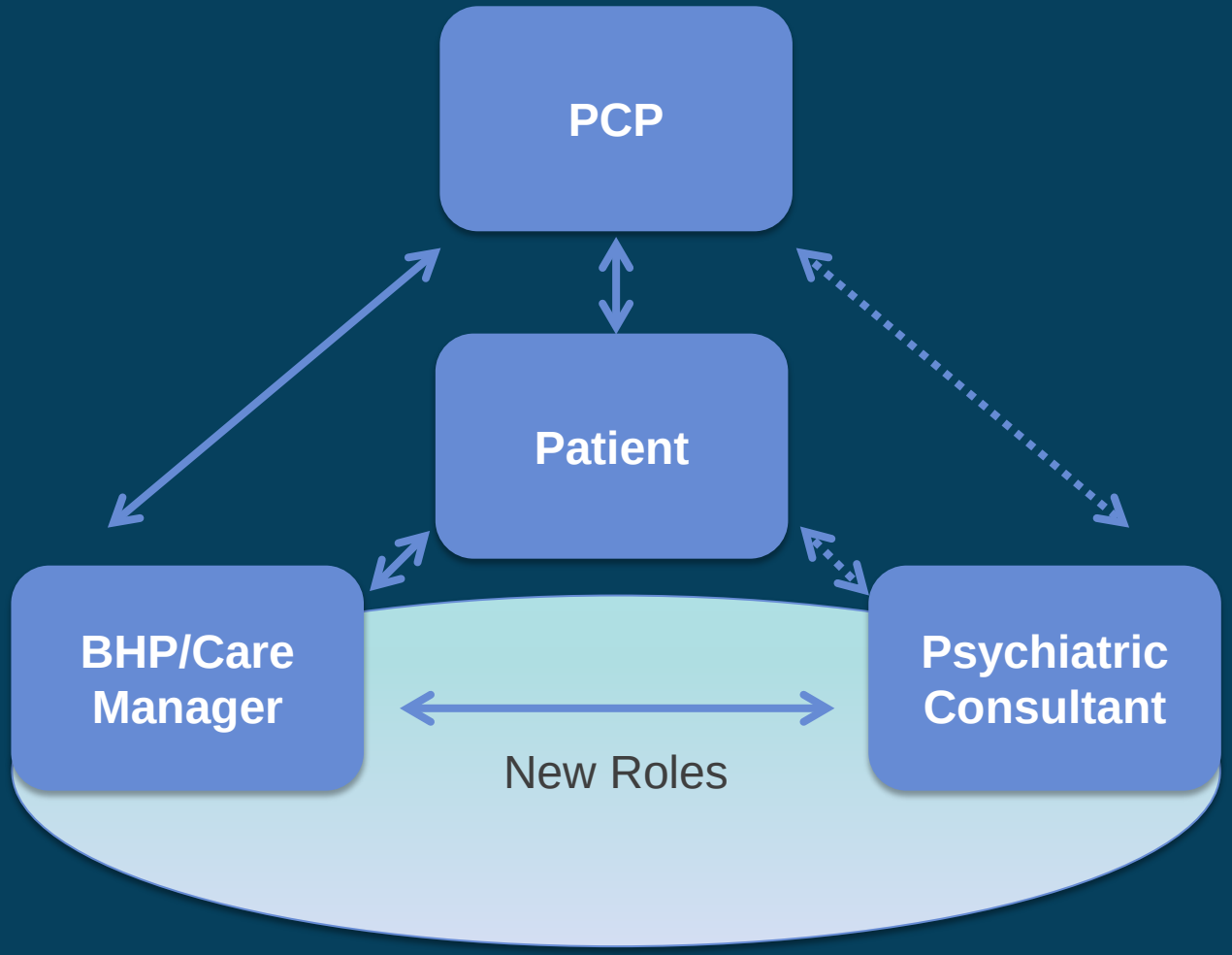
Client-Centered

Population-Based Care

Treatment to Target

Evidence-based Treatment

CoCM

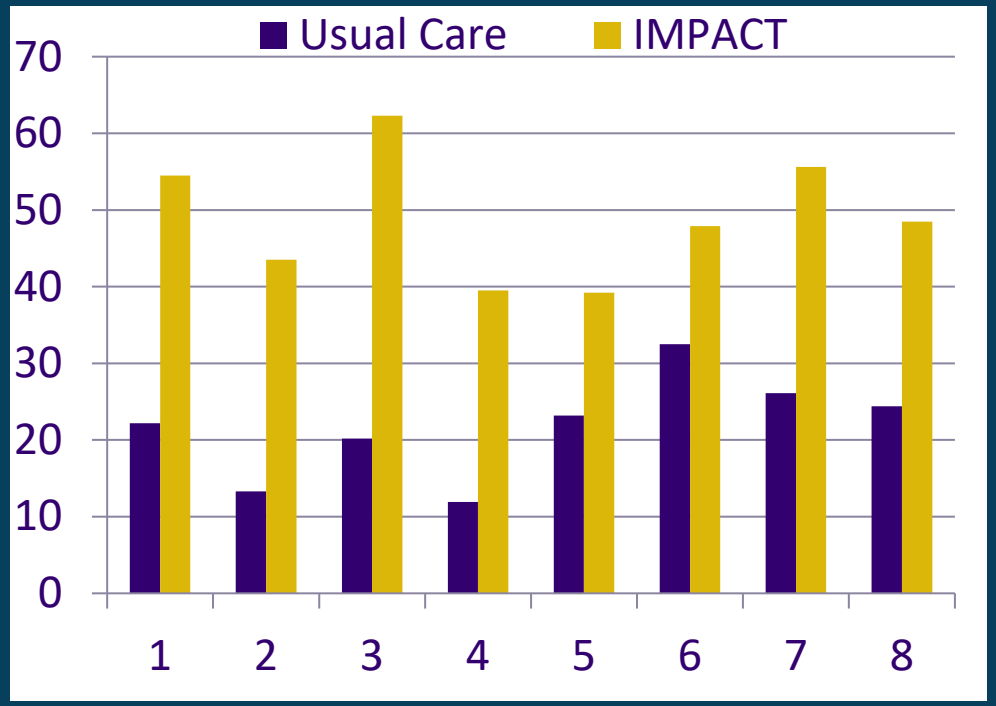


CoCM leverages a team-based, interdisciplinary and systematic approach to screen, treat, and provide follow-up care.

- A team made up of a **Primary Care Provider (PCP)** who is the head of the treatment team, a **Behavioral Health Care Manager (BHCM),** and a **Psychiatric Consultant**.** All providing:
  - Psychosocial treatment and medication management
  - Regular and proactive monitoring
  - Validated rating scales
  - Systemic psychiatric caseload reviews and consultation.

Why CoCM for Depression?

It works!! – over 90 RCTs



- Usual Care – 641 days to improvement[5]
- CoCM – **86** days to improvement!!

It saves money!!

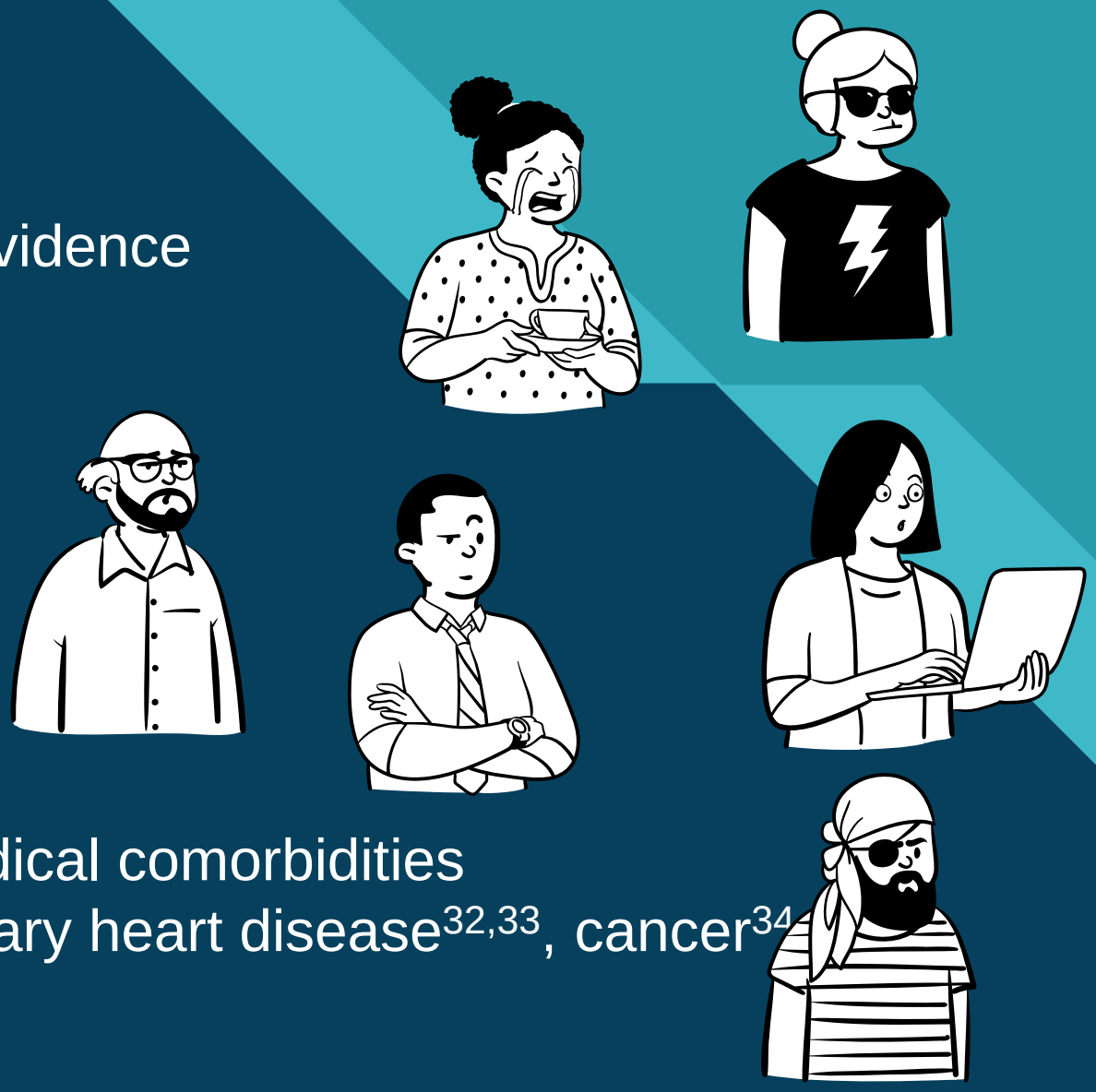
ROI: $ 6.5 SAVED / $ 1 INVESTED (PER PATIENT)[6]

CoCM – The Basics

- Vast majority of randomized control trials (RCTs) look at depression +/- anxiety (>79 RCTs)[7]
  - CoCM significantly improves depression outcomes compared to usual care in the short-term, medium-term, and long-term[8]
- These outcomes seen in a variety of populations/settings
  - Older adults[6]
  - Youth/Adolescents[9]
  - Racial and ethnic minorities[10]
  - Rural populations[11]
  - Low-income populations[12,13]
  - Different clinical settings
    - Primary Care[6], Cardiology[14], Oncology[15], OB/Gyn[16], Infectious Disease (HIV/AIDS)[17], GI (IBD)[18]

CoCM – Beyond The Basics

- Other psychiatric conditions with CoCM evidence
  - Anxiety disorders[21, 22, 23]
  - PTSD[24, 25]
  - Substance use disorders[26, 27]
  - Bipolar disorder[28]
  - ADHD[29]
  - Personality disorders[30, 31]



- CoCM also associated with improved medical comorbidities
  - Diabetes[32, 33], hypertension[32,33], coronary heart disease[32,33], cancer[34] HIV[18]

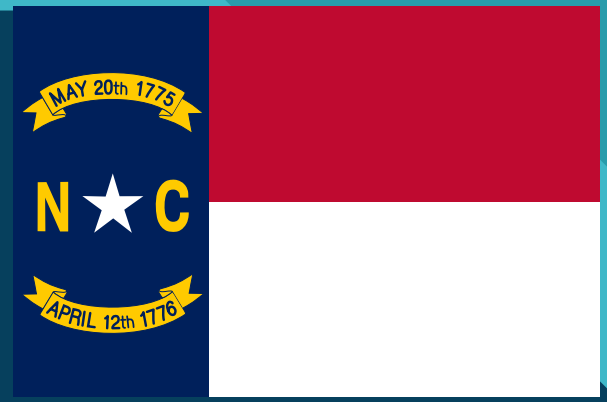
CoCM – The State of the Union

- Despite endorsement from multiple organizations (APA, AMA, AAFP, ACP, AACAP, ACOG, etc.), real-world implementation lags
- Early uptake was low – among Medicare beneficiaries, 10,294 CoCM claims in 2017 → 81,433 in 2018 [35]
- From 2018-2024, commercially-insured CoCM patients increased from 3,814 to 153,356 [36]
    - Use rate (CoCM patients/100,000 patients with MHSU diagnosis) increased from 12 to 317
- Large disparities among states – Mean is 317
    - Use rates range from 1,304 (AZ) to 5 (AK)
        - NC is 272
- Among commercially-insured individuals, from 2018-2022, only 0.01% of individuals with a depression or anxiety diagnosis received CoCM services[37]

Image source: iRoamly

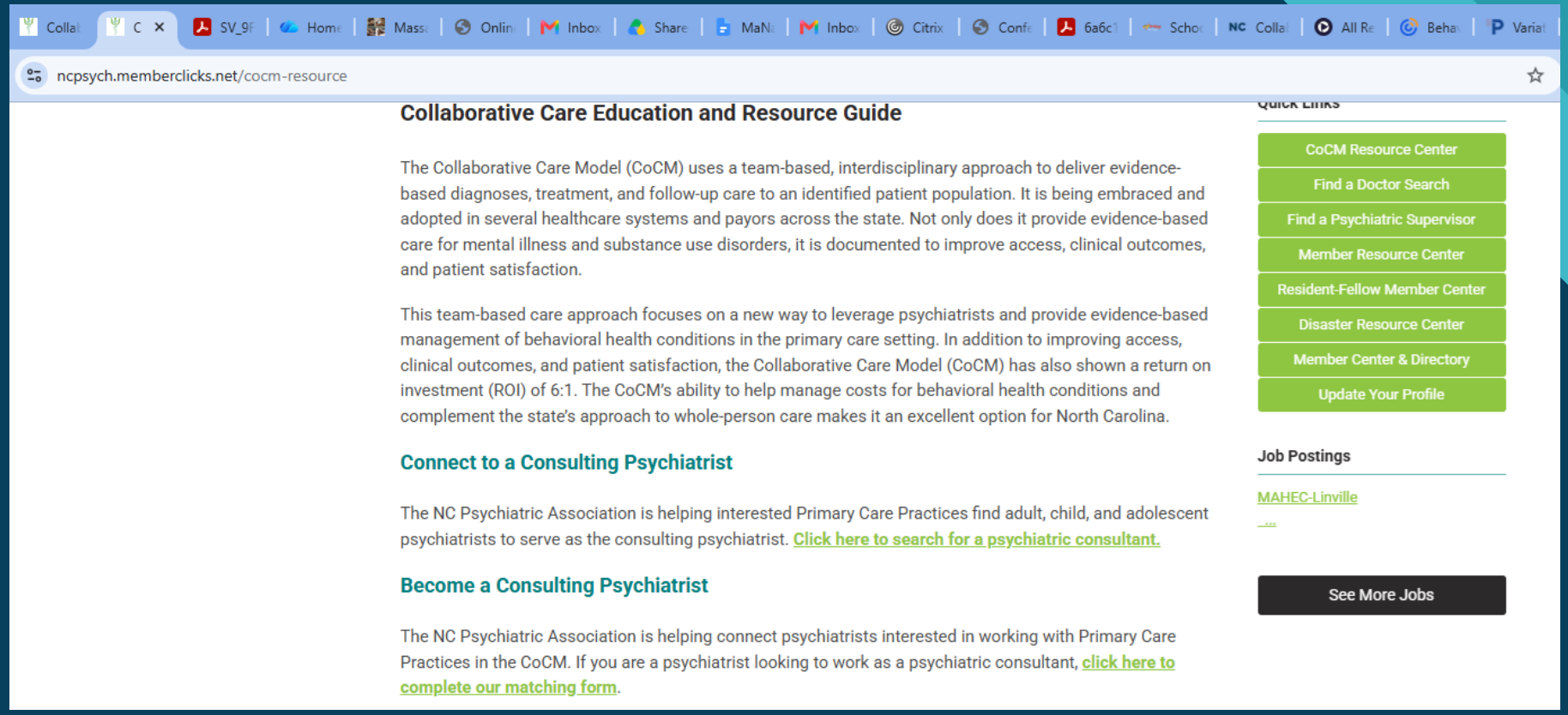
CoCM – Efforts in NC

- Limited early adoption
  - Between 2018-2019, only 915 of the 2 million Medicaid beneficiaries had a CoCM claim[38]
- Jan 2022: NC Medicaid launched a CoCM Consortium that identified strategies to address the major barriers to adoption (financial sustainability and practice operations/change management)[39]
  - Aligning reimbursement across payers
    - Confirmed and promoted commercial adoption
    - Increased reimbursement to 120% of Medicare
    - Removed beneficiary copays
  - Promoting streamlined operations and ensuring fidelity
    - Provided technical assistance and educational modules
    - Worked with NCPA to identify psychiatrists and develop a model contract
    - Developed a custom patient registry
- NC General Assembly earmarked $5 million for capacity building for Medicaid-enrolled primary care practices to adopt CoCM
  - $50,000 per practice in Phase 1 and $30,000 in Phase 2
  - As of 6/30/2026, 68 unique organizations with 113 practice sites had received awards



CoCM and NCPA

- CoCM Resource Guide: https://www.ncpsychiatry.org/cocm-resource
  - Includes background on the model, training opportunities, implementation resources, psychiatric consultant information and matching program



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