No Wrong Door:

Improving Mental Health Access through Integrated Models

Alycia Jackson, MD
OHSU Dept. Family Medicine

James Koved, MD
OHSU Dept. of Psychiatry

Agenda

- Goals & Objectives
- Why It Matters
- Models of Behavioral Health Integration
- Collaborative Care Model (CoCM) and Why it Works
- Implementing Collaborative Care: Key Steps
- Lessons Learned from a CoCM Implementation Project
- Key Takeaways

Goals & Objectives

- Understand the need of expanding behavioral health services within primary care practices
- Explore the key differences between different types of behavioral health services
- Describe the general steps to implement a Collaborative Care Model (CoCM)
- Outline the key benefits and challenges of the CoCM from an implementation project

Why It Matters

Behavioral Health is an essential and necessary part of primary care

Health care reform is rapidly pushing primary care to integrate behavioral healthcare into the spectrum of services they offer because there is:

- A growing recognition of the tolls of mental illnesses on physical health outcomes
- Rising awareness of their prevalence
- Reduced stigma in seeking behavioral support
- Improved access to coverage for behavioral health services

2024 KEY FINDINGS

23% OF ADULTS EXPERIENCED A MENTAL ILLNESS IN THE PAST YEAR. EQUIVALENT TO NEARLY 60 MILLION AMERICANS.

5% OF ADULTS & **13%** OF YOUTH

REPORTED EXPERIENCING SERIOUS THOUGHTS OF SUICIDE.

2022 HAD THE HIGHEST NUMBER OF DEATHS BY SUICIDE EVER RECORDED IN THE U.S.

18% OF ADULTS IN THE U.S. HAD A SUBSTANCE USE DISORDER IN THE PAST YEAR.

77% OF THEM DID NOT RECEIVE TREATMENT.

1 IN 4

ADULTS WITH FREQUENT MENTAL DISTRESS COULD NOT SEE A DOCTOR DUE TO COST, A 2% INCREASE OVER THE LAST REPORT.

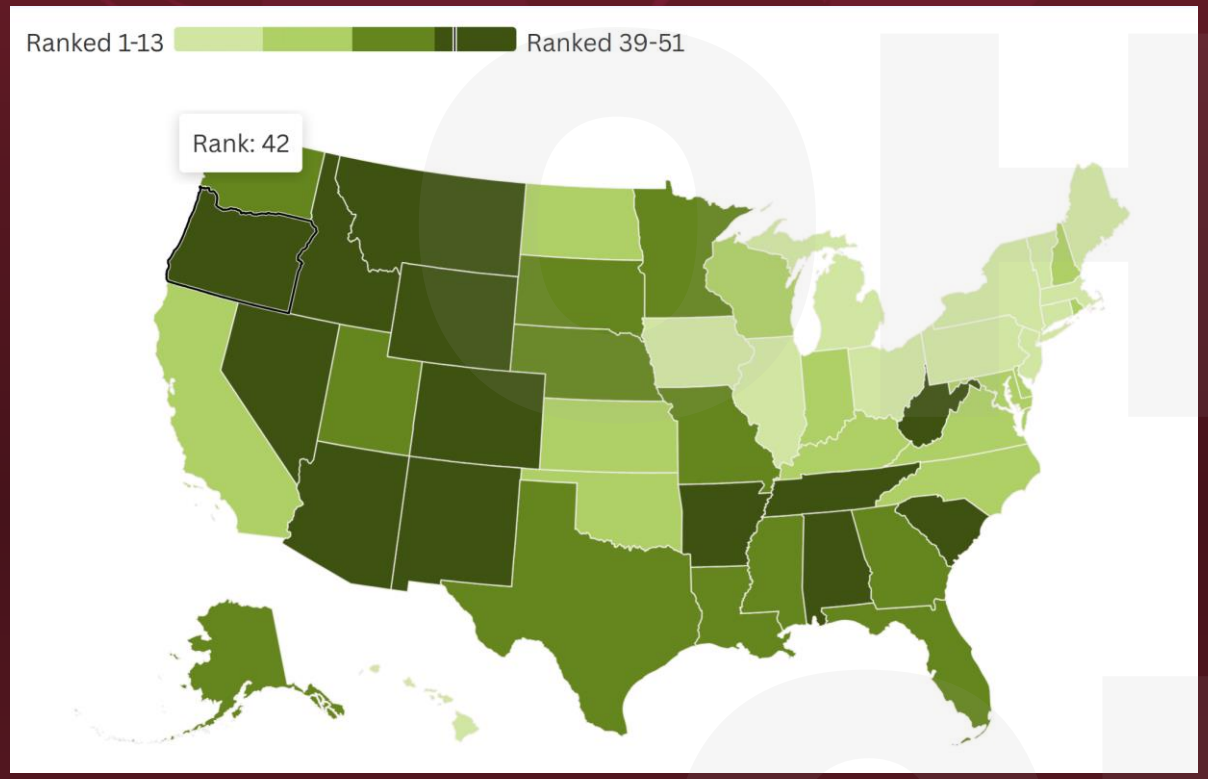
10% OF ADULTS & **8.5%** OF YOUTH

STILL HAVE PRIVATE INSURANCE THAT DOES NOT COVER MENTAL HEALTH.

THERE ARE **340 PEOPLE FOR EVERY 1 MENTAL HEALTH PROVIDER** IN THE U.S.

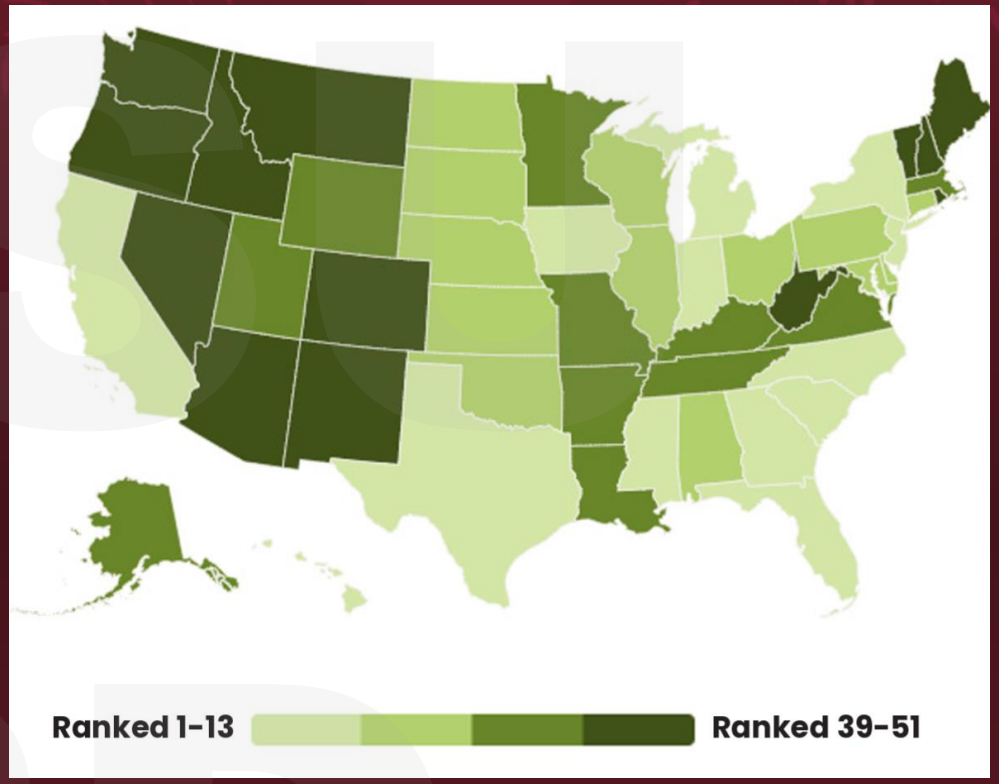
MHA Mental Health America

Overall ranking



Montana	40
Colorado	41
Oregon	42
New Mexico	43
Tennessee	44
Arkansas	45
West Virginia	46
Wyoming	47
Idaho	48
Alabama	49
Arizona	50
Nevada	51

Prevalence ranking



40	Rhode Island
41	Arizona
42	Idaho
43	Montana
44	New Hampshire
45	Vermont
46	Nevada
47	New Mexico
48	West Virginia
49	Maine
50	Colorado
51	Oregon

https://mhanational.org/wp-content/uploads/2025/09/State-of-Mental-Health-2025.pdf

Mental Health in Oregon

Many Oregonians struggle with their mental health.

It is more important than ever to build a stronger mental health system that provides the care, support, and services needed to help people build better lives.

922,000 adults in Oregon have a mental health condition. That's more than **5x** the population of **Salem.**

1 in 5 **adults experience a mental illness** each year.

More than **1 in 20 U.S. adults** experience a **serious mental illness** each year.

236,000 **Oregon adults** have a **serious mental illness.**

1 in 5 of the more than **20,000 people** in Oregon **who are unhoused** have a **serious mental illness.**

1 in 20 adults have **serious thoughts of suicide** each year.

188,000 Oregon adults have **serious thoughts of suicide** each year.

883 lives were **lost to suicide** in Oregon in 2022.

OREGON is facing a mental health crisis.

1 in 6 U.S. adolescents aged 12-17 experience a **major depressive episode** each year.

76,000 Oregon adolescents experience a **major depressive episode** each year.

1 in 9 adolescents aged 12-17 have **serious thoughts of suicide** each year.

46,000 Oregon adolescents have **serious thoughts of suicide** each year.

20% of youth aged 0-17 in Oregon have **experienced 2+ adverse childhood experiences**, which are linked to mental illness and substance misuse in adulthood.

NAMI
National Alliance on Mental Illness

Mental Health in Oregon

More than 1,300,000 people in Oregon live in a community without enough mental health professionals.

The need to address access to mental health care in Oregon is urgent.

3x

more likely for an Oregonian to be **forced out-of-network** for mental health care than for primary care.

53,235

calls were made to Oregon's **988 Suicide & Crisis Line** call centers in 2023.

OREGON is facing a mental health crisis.

1 in 1,448

ratio for school psychologists to students in Oregon's K-12 public schools. This is **worse** than the recommended ratio of one school psychologist for every 500 students.

291,000

adults in Oregon reported needing mental health treatment but not receiving it between 2018-2019. **Cost is a prevailing factor** in not receiving treatment.

Oregonians deserve to get the mental health care they need, when they need it.

NAMI
National Alliance on Mental Illness

NAMI Oregon is part of NAMI, National Alliance on Mental Illness, the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. Learn more at namior.org. For data citations, visit nami.quorum.us/mhpolicystats/.

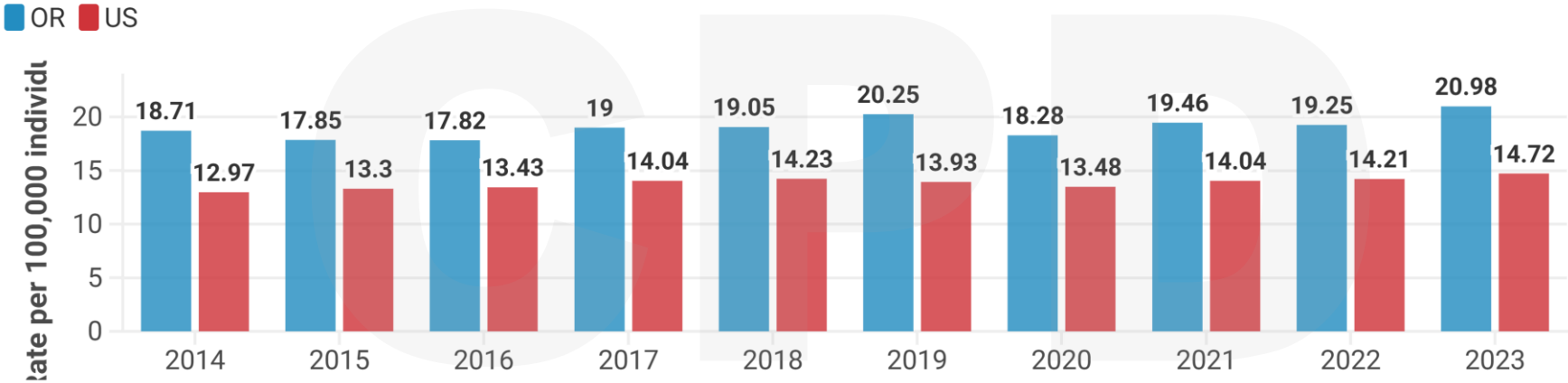
This fact sheet was compiled based on data available in March 2025.

Oregon's Mental Health Crisis

- The current mental health crisis in Oregon is due to a combination of **high needs, systemic fragmentation, workforce strains, and historical underinvestment in key services**
- Oregon's estimated annual burden from major depressive disorder exceeds **$93 billion**, driven by healthcare costs and lost productivity
- Suicide and overdose deaths in Oregon are far above national averages

Oregon and U.S. Age-Adjusted Suicide Rate Per 100,000 (2014-2023)

Suicide rates per 100,000 population in Oregon compared to the U.S. average (2014–2023). Oregon's suicide rate has consistently exceeded the national average.



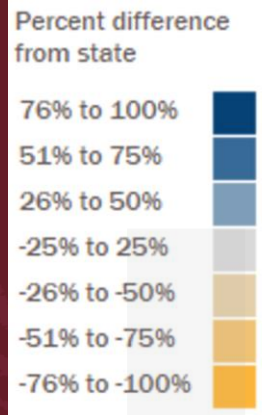
Source: American Foundation for Suicide Prevention

COMMON SENSE INSTITUTE

Gaps in Infrastructure

Infrastructure gaps that contribute to Oregon's mental health crisis include:

- **Limited access** to outpatient and preventative mental health care
  - Increases healthcare resource utilization, worsens patient outcomes, adds to clinician burnout
- **Long wait times** and **gaps in the continuum** of care
- **Fragmentation** in care and **lack of coordination**
- **Reactive** instead of proactive approach to mental health
- Historically **poorly funded**

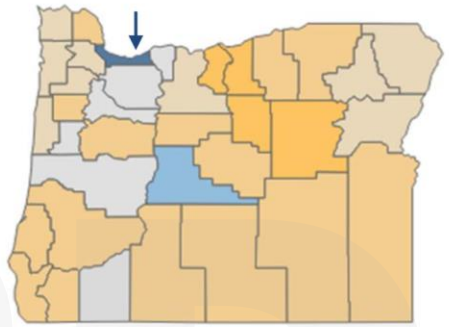


Yellow colors indicate that the county supply is lower than supply statewide. Blue colors indicate that the county supply is higher than supply statewide.

In both cases, the darker the color the larger the difference.

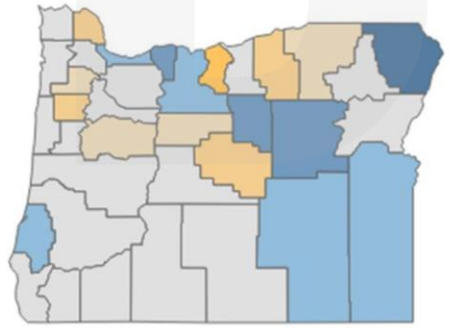
Percent difference in per capita clinical focus area licenses by county

Behavioral Health Care



Behavioral health professionals are concentrated in Multnomah County and relatively underrepresented throughout the rest of the state.

Primary Care



Primary Care and Oral Health professionals are more evenly distributed, though several counties face shortages.

https://www.oregon.gov/oha/HPA/ANALYTICS/HealthCareWorkforceReporting/HaWRP_Supply_Report_2024.pdf

Models of Behavioral Health Integration

What type of Behavioral Health Service does your practice offer?

Traditional Approach

Referral-Based Care

- Traditional Model
- Off-site psychiatrist and/or BH specialist

- **Challenges**
  - More stigma, low patient follow-through
  - Limited feedback/coordination with PCP
  - Poor access

Co-located Care

- BH specialist physically in clinic but operationally separate
- **Academic Setting**
  - Often trainees (psychology, psychiatry, social work)
- **Community Setting**
  - Usually limited BH staffing
  - Productivity pressure
  - Often grant-funded initially
- **Challenges**
  - Not population based
  - No systematic tracking of outcomes

Integrated Approaches

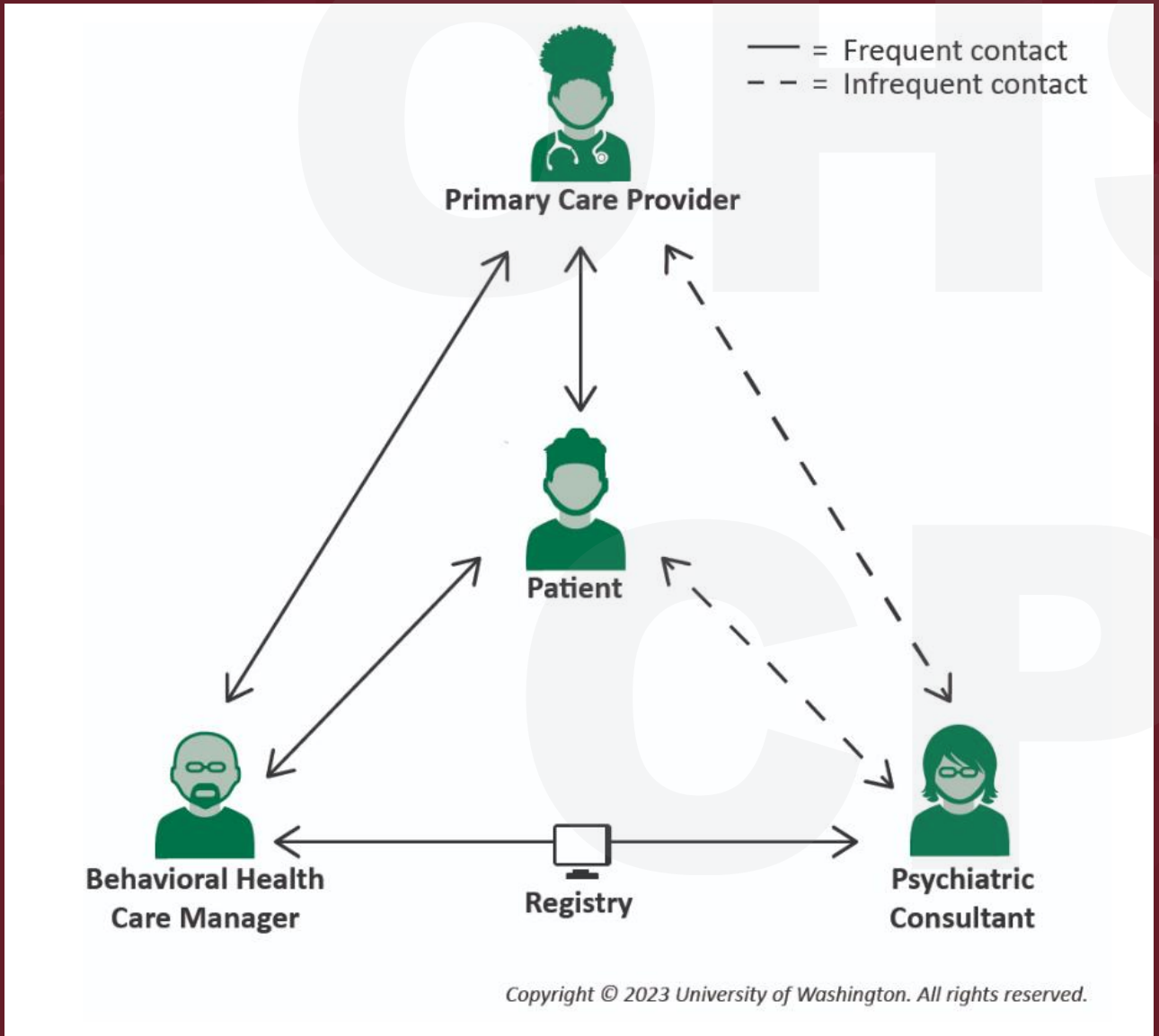
Integrated Care

- BH specialist works with shared workflows, communication and treatment planning
- **Academic Setting**
  - Easy to pilot
  - Strong QI and research infrastructure
  - Cultural acceptance as team-based care
- **Community Setting**
  - Faster decision-making
- **Challenges**
  - Academic: Bureaucracy, trainee rotations
  - Community: Financial pressures, limited IT and data support

Collaborative Care

- Not as easily measured, less studied

Collaborative Care



A specific type of integrated care

Utilizes team-based care to treat common mental health conditions

Implements a measurement-guided care plan based on evidence-based practice guidelines

Tracks patients using a registry

A 2012 Cochrane Review concluded that CoCM had significant effects for improving depression and anxiety outcomes in primary care based off of 79 randomized-controlled trials (Archer et al., 2012).

CoCM Core Principles

Population-Based Care / Panel Management

Measurement-Based Treatment to Target

Patient-Centered Collaboration with Mental Health Specialists

Evidence-Based Care – Systematic Delivery

Accountable Care

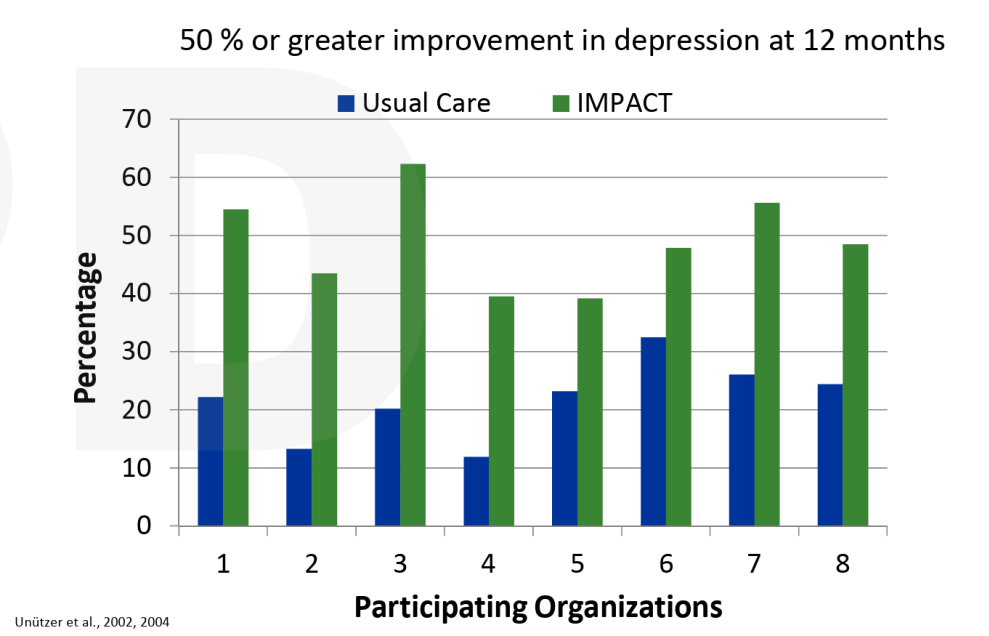
Collaborative Care Management of Late-Life Depression in the Primary Care Setting

A Randomized Controlled Trial

Unützer J, Katon W, Callahan CM, et al. Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. *JAMA*. 2002;288(22):2836-2845. doi:10.1001/jama.288.22.2836

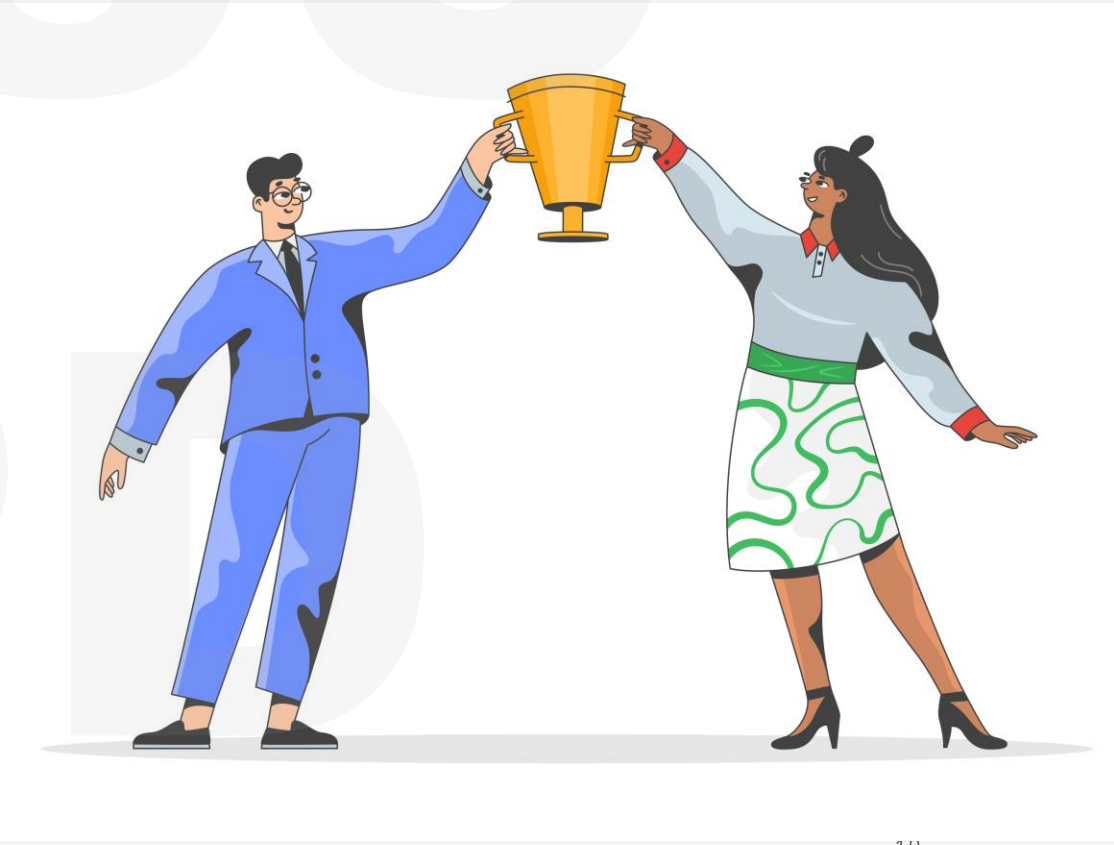
- 1801 older adults with depression over 2 years
- Recruited participants from 18 diverse primary care clinics across the US in Washington, California, Texas, Indiana, and North Carolina
- Half were randomly assigned to receive the depression treatment usually offered by participating clinics, and half were randomly assigned to receive collaborative care (*Unützer, et al., 2002*).

- At 12 months, nearly half of the patients receiving CoCM reported at least a **50% reduction in depressive symptoms**, compared to just 19% of those receiving usual care.
    - CoCM more than doubled the effectiveness of depression treatment and **reduced total healthcare costs** at the same time



IMPACT Trial Findings

- Improved patient outcomes
  - **Less depression**
  - **Less physical pain**
  - **Better functioning**
  - **Higher quality of life**
- Savings of $3,365 per patient (n = 272) over patients receiving usual primary care over a 4 year period
  - More cost-effective with a ROI of $6.50:1
- **Better patient-clinician satisfaction**



Why It Works in Primary Care

- **Evidence based care**
- **Patient-centered**
- **Designed for primary care workflows**
- **Reimbursable under Medicare and many commercial insurance plans**
- **Scalable**

Collaborative Care Reduces Stress and Increases Job Satisfaction and Comfort Prescribing for Primary Care Providers

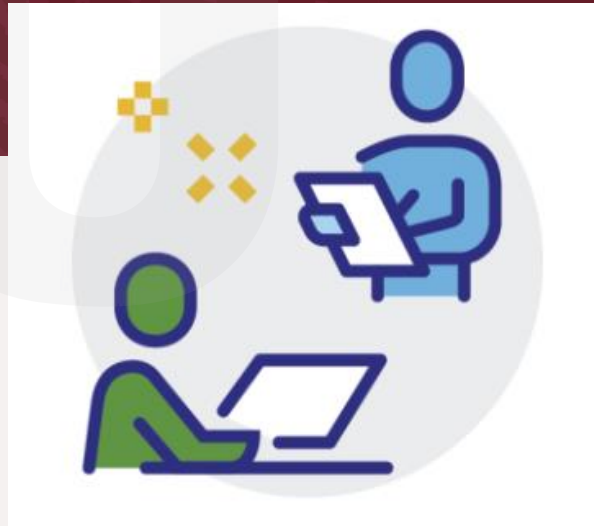
Tina M. Pelishek, RN, BSN; Michael J. Panzer, MD

- 85% of PCPs engaged in CoCM reported reduced stress
- 81% reported greater job satisfaction
- 50% felt more confident prescribing psychotropic medications
- **100% of participants would recommend CoCM to colleagues**

BHCM Role

- Facilitates patient engagement
- Performs systematic initial and follow up assessments
- Systematically tracks treatment response
  - Average case load is about 40-60 patients
  - Dependent on payer mix and patient complexity
- Reviews difficult cases with the psychiatric consultant
- Supports the treatment plan with the PCP

Psychiatric Consultant Role



- Using the patient registry, review the case list with the BHCM weekly
- Prioritize patients that are not improving
- Identify and assist with urgent referrals to higher level of care
- Education is an essential aspect of the psychiatric consultant's duties
  - Intent is to build the capacity of multidisciplinary team members to treat mental health conditions

About 5-7% of patients require direct psychiatric consultation

Common Consultation Requests:

- ❑ Diagnostic Clarity
- ❑ Address Treatment Resistant Mental Health Disorders
- ❑ Make recommendations for managing difficult patients

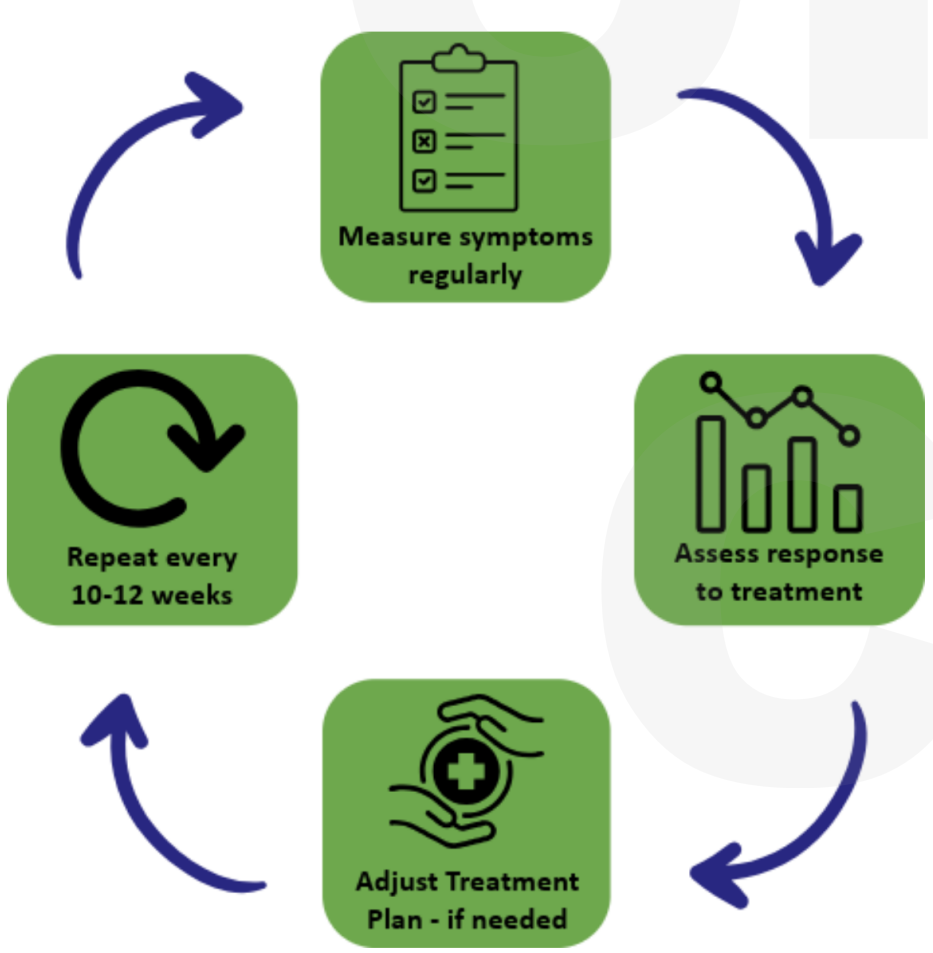
PCP Role

- Oversees and remains in charge of all patient care
- Reviews the care being provided by the Collaborative care team including medication recommendations
- Prescribes all medications to the patient and any additional testing if needed

Training

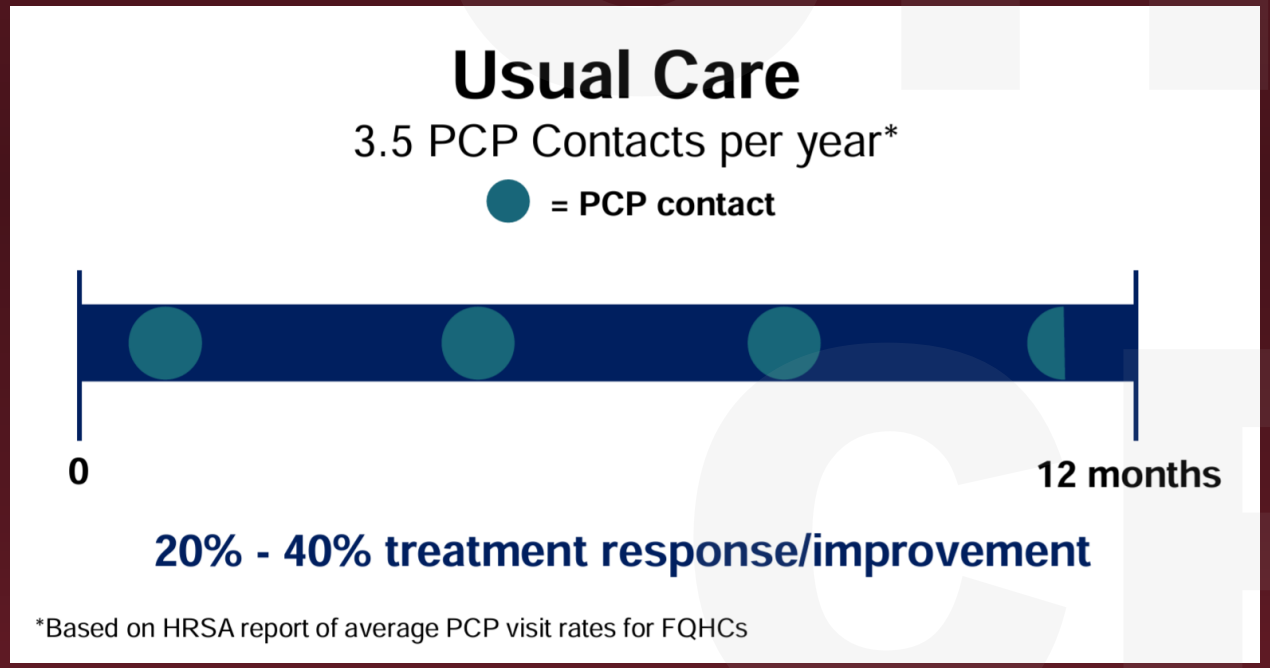
- ✔ **Applying the Integrated Care Approach: Skills for the PCP** – Free, CME-eligible course developed by the AIMS Center and the American Psychiatric Association

CoCM: A Stepped Care Approach



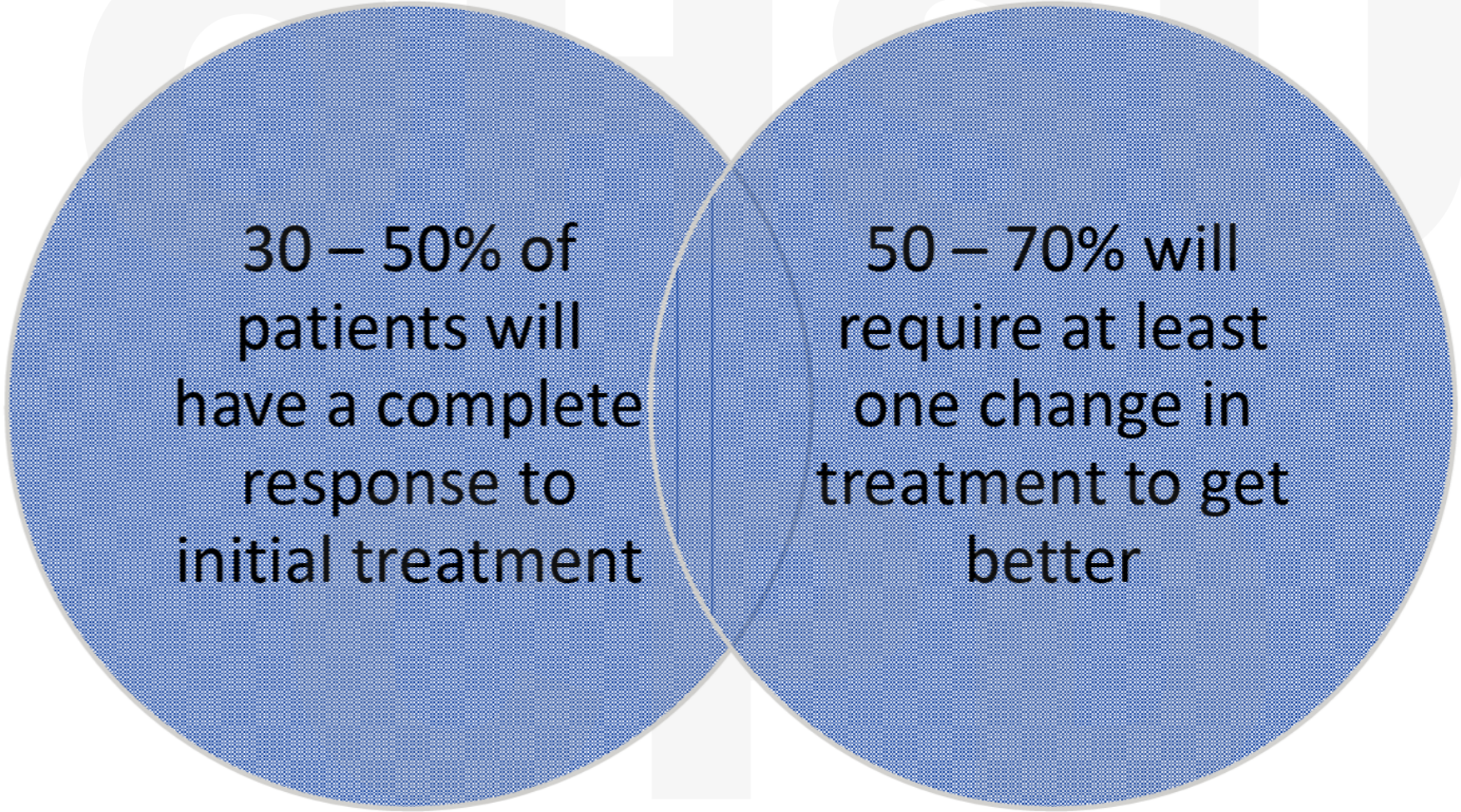
1. Administer screening
2. If screening is positive, enroll with BHCM
3. Brief interventions with BHCM
4. Regular weekly psychiatric consultation with medication recommendations
5. Ongoing measurement and treatment adjustment. Change the treatment plan every 10-12 weeks if the patient's symptoms haven't improved by at least 50%
6. Return to care of PCP after completion of mental health episode or at least a 50% reduction in symptoms

Usual Care vs. Collaborative Care



MOST PATIENTS NEED TREATMENT ADJUSTMENTS

AMERICAN PSYCHIATRIC ASSOCIATION



- ✓ Increases access to care in a less stigmatizing environment than traditional specialty behavioral health settings
- ✓ Offers non-medication treatments
  - ✓ Research shows patients from racial/ethnic minority groups have a stronger preference for non-medication treatments.
  - ✓ One of the things that differentiates CoCM from usual care is the addition of behavioral treatments offered in the medical setting
- ✓ Increases access to evidence-based behavioral health care, something that is not available to all patients equitably

CoCM Reduces Disparities

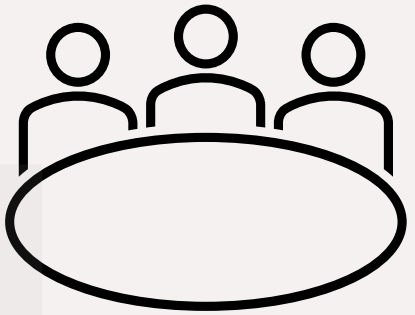
Implementing Collaborative Care

Key Steps

1. **Planning & Readiness**
2. **Create/Recruit the Team**
3. **Workflow & Technology**
4. **Billing & Sustainability**

Collaborative Care Implementation Guide

- Budget for implementation: Staffing FTE, Technology cost
- Plan for clinic space utilization
- Distinguish between CoCM and other BH services



Academic Setting

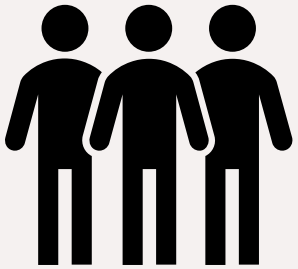
- Align with departmental goals
- Secure a Faculty champion
- Integrate into training curricula

Community Setting

- Focus on high yield populations
- Assess staffing capacity
- Evaluate payer mix early

Planning & Readiness: Key Steps

- Secure a psychiatrist (0.1-0.5 FTE)
- BHCM position could be a LCSW, MSW, LPC, PsyD, PhD, RN
  - *Can consider students such as CSWA, but will need to secure a supervisor*
- PCP will act as the primary prescriber



Academic Setting

- Consider senior resident as the psychiatric consultant with faculty oversight
- Consider psychiatry resident acting as the BHCM with faculty oversight

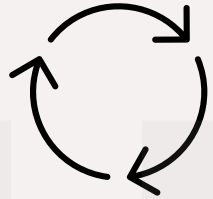
Community Setting

- Psychiatrist may require remote presence
- Cross-train BH staff

Create/Recruit the Team: Key Steps

Workflow & Technology: Key Steps

- Create and operationalize clinic workflow
  - Consider marketing, multiple staff trainings and check-ins
- Assess for EMR integration
- Utilize a patient registry for Systematic Caseload Review



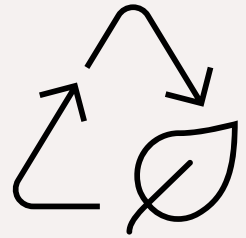
Academic Setting

- Have easier access to data analysts
- Have more complex EMR builds

Community Setting

- Simpler workflow preferred
- May need to rely on third-party registries

- Establish a billing plan
  - Fee For Service (FFS) vs. CoCM CPT global billing



Academic Setting

- Have easier access to data analysts
- Have more complex EMR builds

Community Setting

- Simpler workflow preferred
- May need to rely on third-party registries

Billing & Sustainability: Key Steps

Billing For Collaborative Care

What Primary Care Practices Need to Know

Collaborative Care CPT Codes:

- **99492** – Initial month (first 70 minutes)
- **99493** – Subsequent months (first 60 minutes)
- **99494** – Add on code (each additional 30 minutes)

Key Requirements:

- Behavioral Health Care Manager involvement
- Psychiatric consultant review
- Time-based documentation
- Documentation of Use of Validated rating scales

Payors:

- Covered by Medicare
- Covered by many commercial plans
- Medicaid coverage varies by state
- Value-based contracts may support integration without CPT codes

CoCM Billing Considerations

Academic Setting

- Often underutilize billing due to:
  - Global budgets
  - Grant funding
- Split professional/technical fees
- Opportunity to transition from grant funded pilots to sustainable billing

Community Setting

- Billing is essential for survival
- Strong incentive to:
  - Track time accurately
  - Train staff on documentation
  - Engage PCPs consistently

CoCM is also highly effective at treating co-morbid mental health and chronic medical conditions including:

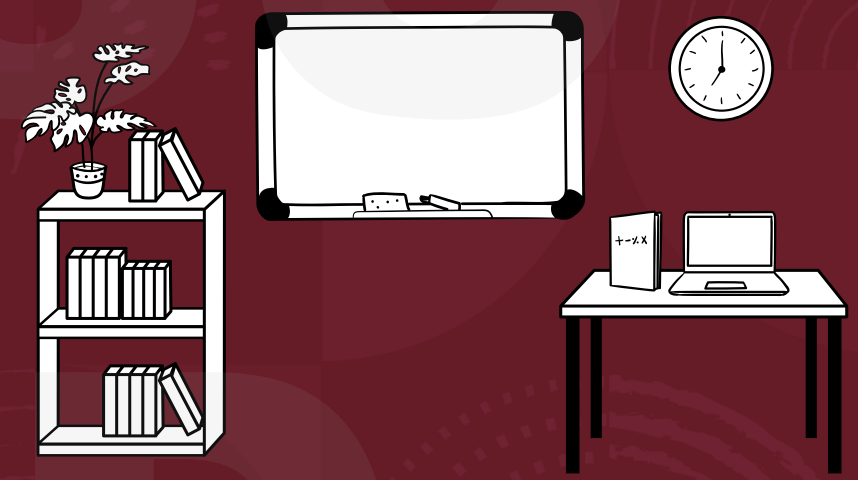
- Cancer
- Diabetes
- Cardiovascular disease
- HIV
- Opioid Use Disorder
- Obesity
- PTSD
- Chronic Pain
- Dementia

There is emerging evidence for use in:

- ADHD
- Bipolar disorder

Other CoCM Applications

Lessons Learned from a CoCM Implementation Project



Our Clinic

- Community Family Medicine Practice ~7000 patients
  - Payer Mix: 25% Medicaid, 65% commercial, 10% Medicare
- Community Hospital system has a partnership with an Academic Institution but financially independent
- Training site for a Family Medicine Residency Program
- Suburban setting that quickly becomes rural
- 1 BH consultant
- Poor access to specialty psychiatric care
- Poor access to community mental health services

Psychiatric Consultant

Behavioral Health Care Manager

Clinician Champion/ Medical Director

Practice Manager

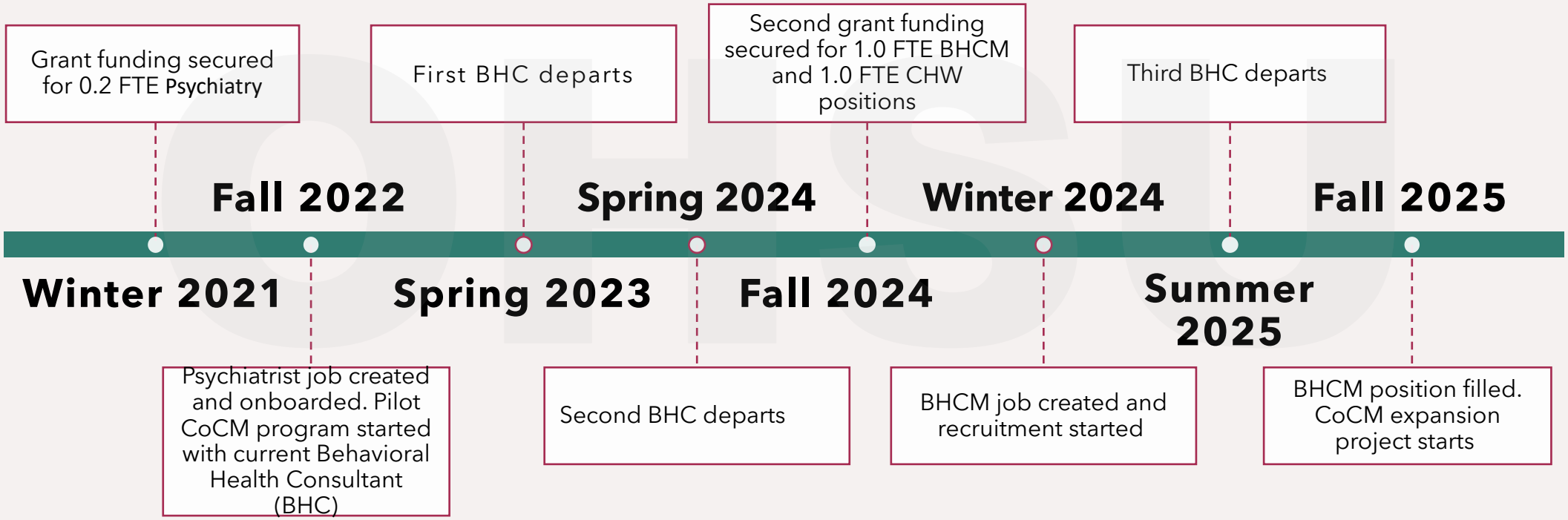
Community Health Worker

Existing BH Professional

Our Team Members

Community Health Worker Role

- Provides support to patients, especially around any SDOH barriers that the patient is requesting assistance with
- Can assist with health education, care coordination, patient navigation
- Can provide cultural safety and humility
- Can provide resources and a bridge to community organizations



Our Project Timeline

Our Implementation

Phase 1

- Staff: 1 BHC, 0.2 FTE psychiatrist, PCP champion
- Inclusion criteria
  - Pregnant or <12mo post-partum
  - PHQ9 or GAD7 >= 5
  - Desire to participate
- Separate but concurrent Family Centered Visit initiative
- Addition of one-time psychiatric consults for all adult patients

Phase 2 Expansion

- Staff: 1 BHCM, 1 CHW, 0.2 FTE psychiatrist (from budget), PCP champion
- Inclusion criteria
  - Adult age >= 18
  - PHQ9 or GAD7 >= 10
  - Desire to participate
- Continued CoCM for pregnant/postpartum patients
- Continued one-time psychiatric consults for all adult patients

Outcomes of our CoCM Program

- From Aug 2022 - Aug 2023:
  - Increased postpartum visit attendance from 82.8% -> 92.3% (compared to 74.7% Hospital system)
  - Improved completion of well child visits at 1 year of age from 33.3% -> 40%
- From Jan 2023 – Jan 2024:
  - 54 patients offered one-time psychiatry consults
  - 5-10 messages/week + in person case consultation

- Improved outcomes for pregnant/postpartum patients with Depression and/or Anxiety
- Reduced PCP burden and increased satisfaction from patients
- Improved and expedited access to psychiatric expertise
- Enhanced training environment for learners
- Reduced psychiatric specialty referrals
- Addressed health inequities with support from our Community Health Worker

Team Cohesion

Underestimated practice culture change within an already established integrated BH model

Struggled with hiring an engaged and motivated BH professional for the BHCM position

Variable PCP engagement

Required frequent education for clinicians/staff

Health System Organizational Challenges

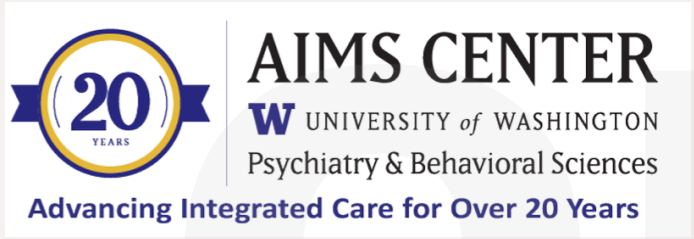
BHCM job position was new and required editing to differentiate it from a supervisor/managerial role

Never hired a LPC before which delayed the onboarding process

Billing complexity

Hard to track financial return

Pitfalls & Challenges



AIMS Center

- ✓ Resource Library
- ✓ Integrated Care Implementation Support
- ✓ Office Hours
- ✓ Quarterly Collaborative Care Webinar Series

American Psychiatric Association

Collaborative Family Healthcare Association

Key Resources

Key Takeaways

Behavioral health is primary care and should be viewed as a core tenet of the care we provide to our patients

Behavioral Health Integration exists on a spectrum with integrated behavioral health models that can be implemented into primary care

The Collaborative Care Model is the most evidence-based and scalable model that can reach more patients than other integrated models

Collaborative care improves patient outcomes for common mental health conditions, reduces PCP stress and improves PCP job satisfaction

Academic and community settings face different challenges including workforce and funding model challenges, but these challenges can be overcome

Questions?

References

1. https://www.americashealthrankings.org/explore/measures/Depression_a/OR
2. Common Sense Institute: https://www.commonsenseinstituteus.org/oregon/research/healthcare/oregons-mental-health-crisis-access-outcomes-and-the-cost-of-inaction
3. https://www.oregon.gov/oha/HPA/ANALYTICS/HealthCareWorkforceReporting/HWRP_Supply_Report_2024.pdf
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    1. https://aims.uw.edu/collaborative-care/
    2. https://aims.uw.edu/resource-library-home/
7. CMS: https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/downloads/behavioral-health-integration-faqs.pdf
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