The collaborative care model opportunity many systems are overlooking

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Unmanaged behavioral health needs make it harder for patients to regulate their overall health, and for providers and plans to control their medical spending. In fact, 22% of patients with a behavioral health condition account for 40% of all healthcare spending,[1] And these needs have been on the rise. As of 2025, 18% of U.S. adults report currently having or being treated for depression, up from 10.5% in 2015.[2]

The Collaborative Care Model (CoCM) offers a way for providers to improve patient access to timely and effective behavioral healthcare — without massive service line investment — by integrating behavioral health management into primary care. When implemented well, CoCM can help systems scale their resources, manage complex patients, and reduce total cost of care.[3] But while it's been around for a long time, many providers are still either not using CoCM or not using it as effectively as they could be. Part of the reason is a lack of understanding of the opportunities associated with CoCM and a lack of internal expertise on how to structure and run this model.

Read on to learn why CoCM deserves a closer look and how systems can move from partial implementation to strategic deployment.

CoCM facilitates behavioral health management at scale

CoCM is a structured approach to integrating behavioral health into primary care. It virtually or directly embeds a licensed behavioral health provider, such as a licensed clinical social worker or psychologist, within a primary care (or sometimes specialty care) office as a care manager. This enables real-time collaboration and coordinated treatment for low-acuity behavioral health conditions like depression or anxiety. The setup allows providers to address behavioral health needs during routine medical visits, reducing delays in care and improving continuity. This is especially important for patients with medical and behavioral comorbidities. In the event the primary care-based team identifies a higher-acuity behavioral health need, the primary care provider (PCP) can consult or provide a warm handoff to a consulting psychiatrist.

CoCM delivers measurable benefits across systems

Despite its proven impact, CoCM remains underutilized, often due to persistent misconceptions about its cost, complexity, and clinical burden.

Myth #1: The ROI is unclear.

Many providers assume that implementing CoCM will strain their budgets, but the financial returns tell a different story, especially for those with risk-based contracts. In a study of 1.3 million insured individuals across metropolitan Phoenix and Tucson, practices that used evolvedMD's embedded, in-person CoCM program reduced total cost of care by 15.0% for commercial patients and 15.3% for Medicare patients.[4] This exceeded the savings achieved by other integrated behavioral health programs, which ranged from 2.7% to 13.5%.[4]

15.3%

The percent reduction in total cost of care for Medicare patients when practices implemented evolvedMD's CoCM program.

These savings translate to $1,600 to $2,400 per patient annually, depending on payer type.[4] The reductions stem from lower utilization of high-cost psychiatric services, including a 9% drop in inpatient psychiatric admissions and a 15% decrease in psychiatric professional visits per 1,000 patients per year, for patients who receive care delivered through CoCM.[4]

Similarly, evolvedMD's CoCM program reduced costs for patients with comorbid chronic conditions. Patients with cardiovascular disease or diabetes who received care from evolvedMD experienced 16% and 18% lower risk-adjusted total cost of care, respectively, compared to those treated by other models.[4]

Once the hurdles of initial implementation are addressed, CoCM programs become self-sustaining, making them both effective and financially viable in the long term.

Myth #2: It takes too long to see results.

CoCM is designed for rapid and measurable impact. For example, patients receiving care through CoCM experience up to seven times faster remission from depression.[5] And, since the model allows psychiatrists to reach eight times more patients than traditional care structures, it can improve access measures like a patient's wait time to their next appointment for behavioral healthcare.[5] This is especially important in markets where wait time to see a therapist may be several months.

8X

Psychiatrists can reach up to eight times more patients under CoCM compared to traditional care structures.

Myth #3: This will create even more work for PCPs and drive burnout.

Primary care providers already help manage their patients' diagnosed or undiagnosed behavioral health conditions. This model offers them professional support to ensure care delivery is happening at top of license. Primary care visits often include behavioral health screening. In the event of a positive screen, PCPs find themselves in the position of either taking on the care themselves — which data suggest they do not necessarily feel confident doing — or referring their patient out, with little control or visibility into follow-up care.

A survey of over 700 PCPs, conducted before introducing CoCM for patients with depression and chronic conditions, found that 72% believed the model would be "very helpful" for treating complex patients.[6] Those experiencing burnout were significantly less satisfied with their ability to manage behavioral health needs and reported lower career satisfaction.[6]

CoCM helps alleviate provider burnout by distributing the workload and improving access to behavioral health expertise. Providers are often able to retain patient care within their office and care team without having to take on the behavioral healthcare themselves. When their patients need higher-level care, it is a matter of warm handoff.

Myth #4: It's too complex for our system to implement.

While CoCM requires upfront planning and infrastructure, its design fits within existing primary care workflows. By embedding behavioral healthcare managers directly into clinics, CoCM enables real-time collaboration and care coordination. This approach replaces fragmented referrals with immediate support and longitudinal follow-up, leading to better access and continuity of care.

Case in brief: How Tampa General Hospital implemented CoCM in primary care

Challenge:

Tampa General Hospital identified a persistent gap in behavioral healthcare: Patients with low-acuity behavioral health needs were not receiving timely, coordinated support. The traditional referral process often left them with long wait times to see behavioral health specialists, their insurance was often denied when seeking care, and many individuals abandoned care as a result. This lack of coordination meant manageable issues were at risk of escalating into acute crises, impacting patients' lives, families, and work.

Approach:

In October 2024, Tampa General partnered with evolvedMD to embed behavioral health care managers directly within 20 primary care clinics. Instead of a quick screening and referral slip, patients now receive immediate, longitudinal support from an embedded care coordination team with evolvedMD. This team works shoulder-to-shoulder with Tampa General's primary care providers, ensuring that patients are not only assessed but also actively connected to appropriate behavioral health resources. Patient engagement and outcomes are tracked over time.

Outcomes:

Tampa General reports improved care coordination and more efficient access to behavioral health services. They also report strong enthusiasm among participating PCPs and their teams for expanding the model to additional clinics and specialties.

You don't have to implement CoCM alone

Launching CoCM requires operational infrastructure, behavioral health expertise, and a clear strategy for scale. Some providers have developed this in-house, but many struggle to build this on their own, especially when primary care teams are already stretched thin, and executive bandwidth is focused on fighting fires.

That's why partnership has become a common path forward. Working with a specialized CoCM provider allows systems to move faster, maintain fidelity to the model, and avoid common pitfalls to implementation. These partners may bring the staffing, training, and/or billing support needed to make the model sustainable.

> We really studied the problem and tried to understand from a behavioral health perspective what our gaps were. The partnership model allowed us to move quickly and fill those gaps without overburdening our internal teams.
>
> John Couris, CEO
> Tampa General Hospital

Partnership also helps address access challenges. CoCM increases primary care touchpoints that can strain systems with limited capacity. A CoCM partner organization can "own" the visit, delivering behavioral health services within the PCP setting without adding burden to the provider.

Based on his own experience, and the success Tampa General has seen with the model, Couris recommends that health systems interested in pursuing CoCM follow these steps:

1. **Assess strategic fits and gaps:** Evaluate behavioral health needs and internal capabilities. Identify where external expertise could accelerate progress.
2. **Choose the right partner:** Select a partner whose model complements your system's goals and fills critical gaps in staffing, training, and billing.
3. **Leverage external support for implementation:** Use your partner's infrastructure to maintain fidelity to the CoCM model while scaling efficiently across care settings.
4. **Track outcomes and iterate:** Monitor key performance indicators such as access, coordination, and provider workflow. Use data to refine and sustain the model.

What's next for provider leaders

In anticipation of market forces exacerbating already razor-thin margins, many providers are looking at rationalizing services — and unfortunately, behavioral health services are among the first considered for reduction. Rationalizing behavioral health services may provide upfront financial relief for certain organizations. However, unmanaged behavioral health conditions lead to higher medical spend for patients with comorbid conditions and ultimately strain our healthcare infrastructure by placing the care burden on a system that likely isn't prepared to carry it. Systems are looking for financial and operational lifelines to keep behavioral services up and running without taking away from their bottom line. CoCM can help.

If your organization is exploring ways to strengthen behavioral health integration, start by reviewing the latest research on Advisory Board. Our curated library includes strategic playbooks, expert insights from industry leaders, implementation case studies, and performance benchmarks to help you assess readiness, guide change management, and advance toward sustainable behavioral health systems.

To learn more about how partnership can accelerate CoCM deployment, contact evolvedMD. Their team works with health systems across the country to launch and sustain high-impact CoCM programs whether you're just getting started or looking to scale.

Endnotes

1. 22% of people have a diagnosed behavioral condition. They account for 41% of health care spend. Evernorth Health Services. May 18, 2023.
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6. Whitebird RR, Solberg LI, Crain AL, et al. Clinician burnout and satisfaction with resources in caring for complex patients. General Hospital Psychiatry. July 16, 2016.

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