



**ARKANSAS  
DEPARTMENT OF  
HUMAN  
SERVICES**

**Office of Substance Abuse and Mental Health**  
P.O. Box 1437, Slot N504, Little Rock, AR 72203-1437

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January 6, 2026

Senator Blake Johnson, Senate Chair  
Representative John Maddox, House Chair  
1 Capitol Mall, Fifth Floor  
Little Rock, Arkansas 72201

Dear Senator Johnson and Representative Maddox:

As directed by Section 1 of Act 615 of 2023, I am reporting to the Senate Committee on Insurance and Commerce and the House Committee on Insurance and Commerce concerning the progress and activities under subdivision (f)(1) of this section.

Very respectfully,

A handwritten signature in blue ink that reads "Paula Stone".

Paula Stone  
Director, Office of Substance Abuse and Mental Health

**Progress Report  
Year 3, Quarter 1  
January 1, 2026**

**I. General Description: Integrating Behavioral Health in Arkansas (Award Number: 1H79SM089075-01)**

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Awarded to the Arkansas Department of Human Services (Division of Aging Adult Behavioral Health Services- Office of Substance Abuse and Mental Health)

In partnership with the University of Arkansas for Medical Sciences

**Project Director:** David A. Jones, LCSW

**UAMS Principal Investigator:** Teresa Hudson, PharmD, PhD

**Clinical sites:**

Year 3: UAMS Primary Care Clinics: (Internal Medicine, Family Medicine, Batesville, Pine Bluff, Helena, and Texarkana)

Year 3: East Arkansas Family Health Center (FQHC – West Memphis, Helena locations)

Year 3: River Valley Medical Wellness

Year 3: McGehee Family Clinic

**Collaborators:**

Arkansas Behavioral Health Network (ABHIN): provides implementation facilitation to help primary care practices implement routine behavioral health screening, identify the skills required for each member of the CoCM team, implement and use a CoCM patient registry, and bill for CoCM services. ABHIN also hosts a website with extensive CoCM resources and leads a monthly state-wide conference call for project teams and any other interested clinicians to ask questions and learn more about CoCM.

**Consultants:**

John Fortney, PhD, Professor of Psychiatry and Director, Division of Population Health, School of Medicine, University of Washington. Dr. Fortney is a nationally known expert in integrated care, including testing and implementing the collaborative care model used in this project.

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## **II. CoCM Description**

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The overarching goal of this project is to develop resources that provide education and support for CoCM in multiple primary care clinics across Arkansas. CoCM integrates care for behavioral and physical health, typically in primary care settings. This evidence-based model is effective for the treatment of depression, anxiety, post-traumatic stress disorder (PTSD), alcohol, and other substance use disorders that are among the most common and most disabling health conditions within the US and Arkansas. CoCM is measurement-based and uses a variety of resources to measure progress towards the patient's goals and desired clinical outcomes.

CoCM is a team-based approach to care that includes the patient, the primary care physician (PCP), a behavioral health care manager (BHCM), and a consultant psychiatrist. The BHCM is usually located in the same clinic as the primary care physician, while the consultant psychiatrist is typically based off-site. With the aid of a patient registry, the BHCM coordinates communication across the team, serving as the primary contact and resource for the patient. This role supports the PCP by coordinating the treatment plan and alerting them to patients who are not responding to treatment or experiencing worsening symptoms. When needed, the BHCM communicates with the psychiatric consultant regarding patient treatment. The psychiatric consultant typically offers treatment recommendations when a patient's behavioral health symptoms are not responding to treatment, as demonstrated by at least 50% improvement in symptoms after 10-12 weeks on the treatment plan.

CoCM is a data-driven process, often referred to as measurement-based care. Patients are initially screened for behavioral health symptoms. Once a problem is identified, condition-specific instruments are used to assess the severity of the patient's symptoms and document any changes. For example, the Patient Health Questionnaire-9 (PHQ-9) is a nine-item, validated instrument for measuring depressive symptoms, with lower scores indicating lower symptom severity. The BHCM will periodically administer this to a patient with depression to identify improvement (or potentially worsening symptoms); findings are documented in the CoCM registry. The registry contains patient information, including initial scores on behavioral health screening instruments, subsequent measures of symptom severity, and the treatment plan. This provides a common location for the PCP, BHCM, and Psychiatry Consultant to communicate and review patient progress. This model has been tested in over 90 clinical trials across the US and abroad, including multiple trials in Arkansas. CoCM leads to significantly better outcomes in a shorter period (86 days vs 614 days in usual care).

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## **III. Arkansas CoCM Sites**

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The Arkansas project to integrate CoCM into primary care practices uses a "supply and demand" approach, implementing the model in both UAMS and non-UAMS primary care clinics. UAMS is a teaching institution that not only uses CoCM to treat patients but also educates trainees on CoCM and its application in patient care. Non-UAMS clinics that are not necessarily teaching sites are also learning to use CoCM, thus creating demand for this care. Four health systems are participating in this project.

1. UAMS Primary Care Clinics (UAMS)
2. East Arkansas Family Health Center (EAFHC)
3. River Valley Medical Wellness (RVMW)
4. McGehee Family Clinic (MFC)

UAMS has now implemented CoCM in six primary care clinics and is fully participating in the SAMHSA-required data collection. Two UAMS clinics began enrolling patients in year 1 (Batesville, Internal Medicine); three additional clinics began enrolling in the second quarter of year 2 (Pine Bluff, Helena-West Helena, and Texarkana); and one clinic began enrolling in the last quarter of year 2 (Family Medicine).

EAFHC West Memphis location has fully implemented CoCM and is participating in SAMHSA-required data collection. This site began enrolling patients in February 2025, and by the end of June 2025, the single care manager reached full capacity. The site hired a second BHCM to expand to additional clinics. There are currently 2 clinics providing CoCM at East Arkansas (West Memphis, Helena), with 2 additional sites starting CoCM January 1, 2026.

In the fourth quarter of year 2, ABHIN conducted site visits and trained providers on CoCM at both of the new sites, River Valley Medical Wellness and McGehee Family Clinic.

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#### **IV. SAMHSA-required Objectives**

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- 1. Conduct a Program Readiness review:** This review identified CoCM status at participating sites, including barriers and current or potential facilitators to full implementation of the CoCM model. While the program readiness report was submitted only once, we continue to monitor barriers and facilitators to program implementation across our sites.

**UAMS Clinics:** Six UAMS clinics have implemented CoCM with four BHCMs. UAMS originally planned to integrate the CoCM case registry functionality into the UAMS electronic health record (EHR) to facilitate billing for CoCM and improve efficiency by eliminating the need for team members to document information in both the registry and the EHR. This faced significant barriers, but in the final quarter of year 2, a solution was identified and was fully implemented in year 3, Qtr. 1.

**EAFHC:** Two EAFHC clinics in West Memphis implemented the CoCM model. The site hired a behavioral health case manager and contracted with two consulting psychiatrists to fulfill the psychiatric consult role. This is noteworthy, as the two psychiatrists were already trained in the CoCM model during their medical residencies. They joined ABHIN to educate EAFHC personnel on the CoCM model. Enrollment began in year 2, quarter 2. In Year 3, Qtr. 1, two additional sites were trained on the CoCM model, and services are scheduled to begin on January 1, 2026.

**Recruitment of additional clinics:** The project team identified two additional clinics to join the project: the McGehee Family Clinic in McGehee, Arkansas, and the River Valley Medical Wellness Clinic with locations in Russellville and Hot Springs, AR. ABHIN has begun the implementation facilitation process. Both sites have completed provider education. Due to budget constraints, we had to suspend all work at these sites this quarter.

**Barriers to program readiness:** Identified during this quarter. **1) Hiring and retaining qualified personnel:** This process of identifying, hiring, and retaining qualified personnel has been challenging. Barriers include a shortage of qualified applicants, salaries that are unacceptable to applicants, and high turnover in the data collector positions. The modification and widespread distribution of job announcements have improved hiring for care manager positions at UAMS and EAFHC. We currently have one part-time data collector and have hired an additional full-time person who will start on 2/1/2026. **2)**

**Implementation of routine screening:** Routine screening of primary care patients is a foundational element of CoCM. This typically includes screening for depression and anxiety (the most common behavioral health conditions). We are exceeding our SAMHSA screening goals in primary care, but there is a large number of patients who screen positive who are not referred to our services. **3) CoCM Enrollment:** UAMS patients who screen positive for mental health-related issues have several options for treatment, with one of those options being CoCM. Enrollment in UAMS CoCM has increased from 5% to 15% over the last year. The UAMS clinical team continues to intensify its education efforts for primary care providers to enhance their understanding and utilization of the CoCM model. One strategy utilizes a decision tree to help providers identify patients who would benefit from CoCM and should be offered this type of care. The second strategy is proactively alerting providers to positive depression screens prior to the patient's appointment, thus increasing opportunities for the provider to discuss the CoCM model with patients. The UAMS Clinical Team also collaborated with IT to modify the electronic health record to facilitate easier patient referrals to CoCM for primary care providers. We had our largest number of patients enrolled in Year 3 Qtr 1 to date.

**Implementation Evaluation:** By the end of year 1, it was evident that the program encountered various implementation barriers. The UAMS team, in consultation with the Arkansas DHS office of Substance Abuse and Mental Health, identified implementation barriers and strategies to resolve those barriers that were likely to be useful to other clinics implementing CoCM in Arkansas and potentially other states. To this end, the evaluation team was expanded slightly in year 1 to support the collection of data on barriers and facilitators to CoCM implementation. Using an implementation science based model known as **RE-AIM**, the team is collecting data on: **Reach:** the extent to which the CoCM teams are reaching their target populations; **Effectiveness:** whether CoCM is achieving the desired outcome of treating symptoms of depression and anxiety; **Adoption:** the extent to which the clinics are adopting and using CoCM; **Implementation:** examination of the clinic's fidelity to the CoCM model; and **Maintenance:** evaluation of whether CoCM is becoming part of the clinic's routine organizational practice and policies. Data collection began late in year 2 and is ongoing. Preliminary results are reported on pages 11-12.

- 2. Develop a detailed integration program plan.** This report was completed and submitted to SAMHSA during year 1. This required creating a plan for each clinical system to a) create a CoCM team in each primary care clinic, b) routinely screen all primary care patients for behavioral health treatment needs, c) monitor patient response and adjust treatment as needed and consult a psychiatrist or other behavioral health specialist as needed, d) implement and utilize a registry to track patient progress. Key needs across all three clinical systems were: 1) CoCM-specific registries, and 2) funding for CoCM team members. This project provides funding for both of these needs. The plan also requires grant recipients to work with at least five primary care providers or practices.

In year 2, the project exceeded its goal of having at least five clinics implement the CoCM model, with eight clinics (six UAMS and two EAFHC fully implemented and 2 starting implementation on 1/1/2026). Additionally, McGehee Family Clinic and River Valley Medical Wellness are in the training phase and are expected to start enrolling patients in Year 3.

- 3. Develop formal collaborative agreements:** Originally, this was operationalized as contracts between the state of Arkansas and UAMS (the primary contractor with the state) and between UAMS and EAFHC. To support the sites, UAMS also issues contracts to ABHIN and the University of Washington. The University of Washington houses the AIMS

Center that provides significant CoCM Resources. John Fortney, PhD, is a former UAMS faculty member now located at UW. Dr. Fortney is an expert in the collaborative care model and has conducted foundational research supporting it. His advice on implementing the CoCM model over the past two years has been extremely useful.

UAMS also executed subcontracts with McGehee Family Clinic and River Valley Medical Wellness Clinic to implement the CoCM model. These subcontracts included collaboration agreements governing project work. Considerations for clinic selection focused on areas of the state that are lacking access to behavioral healthcare and areas in the state with high rates of substance use disorders, particularly opioids.

4. **Create a Sustainability plan:** This requires the creation of a written plan for sustaining the collaborative care model in Arkansas at the state and clinic levels after federal funding ends. This was completed in year 1. Several strategies are in place to sustain the model in Arkansas:
  - a. Contract with the Arkansas Behavioral Health Integration Network (ABHIN). ABHIN works across Arkansas to educate providers about the collaborative care model and provide implementation support. ABHIN holds a statewide call for CoCM State Planning council and Stakeholders across the state. This call is open to anyone interested in CoCM and includes questions/answers from clinicians implementing CoCM, educational materials, and general support for CoCM implementation and sustainment. ABHIN also has extensive resources posted on their website <https://abhinetwork.org/> available for use at no cost. ABHIN also hosts a state-wide CoCM conference annually to bring people together to learn about CoCM and share their own implementation stories.
  - b. CoCM implementation in a range of clinic types: In year 1, the project recruited clinics from federally qualified health centers (FQHC) and an academic medical center. In year 2, an independently owned clinic (RVMWC) and a Medicare-certified rural health clinic (McGehee Family Clinic) were recruited. This enables a range of practices to receive support in implementing CoCM. For year 3, we are continuing our work with these existing clinics (UAMS, EAFHC, RVMW, and McGehee Family Clinic).
  - c. CoCM training for physicians: UAMS is now offering training for family medicine residents and psychiatry residents in this model. This is particularly important. As noted above, the project is implementing CoCM across multiple clinic types, creating demand for physicians trained in the model. CoCM training for UAMS residents ensures a steady supply of trained physicians is available to sustain this model in Arkansas.
  - d. Payers recognize and pay for the CoCM model. Arkansas Act 625 from the 2023 Regular session requires healthcare insurers, except Arkansas Medicaid, that offer mental illness and substance use disorder benefits to provide coverage for services delivered via a collaborative care model. Medicare and commercial insurance plans are paying for CoCM. Arkansas Medicaid continues to develop the necessary infrastructure to facilitate billing for CoCM care. This includes a range of policies and procedures, including the specification of management procedures for procedure codes.
5. **Create a State Planning Council for Integrated Care:** This required convening a state-wide council that included the state mental health authority to create a plan for wide implementation of the CoCM across Arkansas. UAMS asked ABHIN, as part of the subcontracted work, to convene and lead this council, which includes the state mental health authority, UAMS project leadership, the three clinical systems working on the project, leadership from any primary care clinic in Arkansas, and other organizations in the state interested in CoCM.

- ABHIN began hosting monthly State Planning Council and Stakeholder (SPCS) meetings on 11/10/23. The meetings are held virtually on the Zoom platform at 12:00 pm on the second Friday of every month. Each meeting is recorded and uploaded to ABHIN’s CoCM webpage along with the agenda, list of attendees, meeting minutes, and any other slides or documents presented during the meeting.
- In addition, the monthly meeting is open to other clinics and entities interested in the collaborative Care Model in Arkansas primary care clinics.

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## **V. Participating Clinical Systems**

- 1) UAMS Primary Care Clinics (six clinics)
- 2) East Arkansas Family Health Center (two fully implemented clinics and two starting enrollment 1/1/2026)
- 3) River Valley Medical Wellness - completed staff training
- 4) McGehee Family Clinic – completed staff training

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## **VI. Project Partners**

### **Arkansas Department of Human Services, Division of Aging, Adult, & Behavioral Health Services**

Paula Stone, Director of the Office of Substance Abuse and Mental Health

David Jones, LCSW, Project Director and Assistant Director of Medicaid Behavioral Health, Office of Substance Abuse and Mental Health

This is the recipient and primary SAMHSA Partner. David Jones, LCSW, is the SAMHSA Project Director.

### **UAMS**

The UAMS is the primary grantee from the Arkansas Department of Human Services for this project. Teresa Hudson, PharmD, PhD, Professor of Emergency Medicine and Psychiatry is the UAMS Principal Investigator. Dr. Hudson oversees the implementation of all aspects of the project and is the primary contact with Mr. Jones. She guides project operations, including monitoring CoCM implementation at each of clinical sites, and works closely with Mr. Jones to manage funding and meet SAMHSA reporting requirements. Amanda Lunsford, MA, serves as the UAMS Project Manager, working closely with Dr. Hudson to execute site contracts, monitor deliverables, enter required data into the SPARS system, and coordinate overall project activities. Michael Cucciare, PhD, is the Director of Evaluation, responsible for collaborating with all clinical sites to collect SAMHSA-required evaluation data and ensure its timely upload into the SAMHSA data collection website. Latunja Sockwell, MS, previously served as co-director of evaluation on the project. Unfortunately, her responsibilities to other funded projects decreased her availability for this project. Given her extensive experience with SAMHSA, she continues to consult with the UAMS team.

### **Arkansas Behavioral Health Integration Network (ABHIN)**

ABHIN is a non-profit organization formed to meet the challenges of integrating behavioral health into primary care across Arkansas, led by Kim Shuler, LCSW. UAMS subcontracted with ABHIN to provide implementation facilitation for the non-UAMS sites. ABHIN provides a range of educational resources and mentoring to the project’s clinical partners, hosts the project’s website with CoCM resources, and serves as the project’s state planning council.

**UAMS Primary Care Clinics:**

The UAMS Clinical Team is led by Tisha Deen, PhD (clinical psychologist), and Shashank Kraleti, MD. Dr. Deen is a fellowship-trained expert in collaborative care mentored by Dr. Fortney. Dr. Kraleti is the Director, UAMS Primary Care and Population Health Service Line and Chair of the Department of Family and Preventive Medicine.

**East Arkansas Family Health Center (EAFHC)**

The EAFHC is a federally qualified health center (FQHC) located along the eastern border of Arkansas near Memphis. The team is led by Susan Ward-Jones, MD. Djuana Smith is the Behavioral Health Lead at EAFHC and works closely with project administration, coordinating CoCM activities at their sites.

**Arkansas River Valley Medical Wellness Clinic**

This clinic was founded and owned by Dr. Kristin Martin. Dr. Kristin Martin, DO, MS, FAAFP, is Board Certified in Family Practice and has extensive experience as an Emergency Medicine physician. Dr. Martin's clinics are an important addition to the project. Dr. Martin's primary care practice includes many patients with opioid use disorder (OUD) diagnoses. Dr. Martin not only provides primary care but also manages OUD for these patients. This type of practice was particularly mentioned as important in the original notice of funding opportunity for this project.

**McGehee Family Clinic**

This is a Medicare-designated rural health clinic with Terry Amstutz serving as CEO for McGehee Hospital and the family clinic. This clinic serves a rural area with agriculture as the primary occupation. The addition of this clinic allows the project to reach members of an important Arkansas industry – agriculture. Agricultural workers have high rates of stress, anxiety, and depression that are estimated to be 2-5 times higher than the national average. Additionally, agricultural workers often do not take time off from work to seek care for these conditions. By integrating screening and treatment for anxiety and depression into routine primary care, no additional time away from their work is required.

**John Fortney, PhD**, Professor of Psychiatry and Behavioral Sciences and Director of the Division of Population Health at the University of Washington College of Medicine. Dr. Fortney is a former Professor of Psychiatry at UAMS. He has conducted extensive research on models for integrating mental health into primary care clinics and is recognized as a leading expert in CoCM implementation. Dr. Fortney is a valuable resource to managing implementation challenges and understanding productivity and sustainability metrics for collaborative care.

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**VII. UAMS Operational Activities:**

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**UAMS Leadership Team:**

This team is responsible for the overall operation of the project. Its activities include monitoring CoCM implementation across all clinics, tracking patient enrollment, generating reports required by state and federal partners, executing subcontracts with key partners, and overseeing all aspects of the project.

While Year 1 of this project laid the groundwork, Year 2 focused on expanding and enhancing CoCM's sustainability. Year 3 will continue these efforts.

We have expanded from 2 clinics in the UAMS system providing CoCM in Year 1 to 6 clinics at UAMS and 2 clinics in the East Arkansas Family Health Center system, with 2 additional clinics starting CoCM on 1/1/2026. We have also begun implementation at both McGehee Family Clinic and River Valley Medical Wellness Clinics, with both sites completing provider training on CoCM. Billing insurance for services is essential to the sustainability of this program. UAMS has been working to integrate AIMS registry features into its electronic health records to automate the billing processes. Although this work was requested at the beginning of Year 1, UAMS IT was unable to implement the necessary EHR (Epic) changes. We contracted with EPIC to perform this work, and it was completed at the end of Year 2. Insurance is now being billed for these services at UAMS. East Arkansas is also working towards this goal.

Dr. Grubbs and the evaluation team continue to gather data on site implementation activities. Two main efforts are underway, including (1) tracking barriers and facilitators of implementation, and (2) tracking stakeholder views of progress within specific domains of our implementation strategy (RE-AIM). Dr. Grubbs recently developed a RedCap survey adapted from the Mid Program Process Tracking Quiz in the Department of Veterans Affairs Implementation and Adaptation Guide. This survey was modified for this study with input from the implementation team and site leads. It was administered to key members of the clinical teams at UAMS and East Arkansas, identified by site leads at each site. The survey asks about key domains of progress, including reach (are the intended patients getting CoCM), effectiveness (does CoCM improve mental health and quality of life), adoption (is CoCM welcomed), Implementation (is CoCM being rolled out as intended), and Maintenance (will CoCM be maintained over time). A brief report of this work is included on pages 11-12.

Additional activities include:

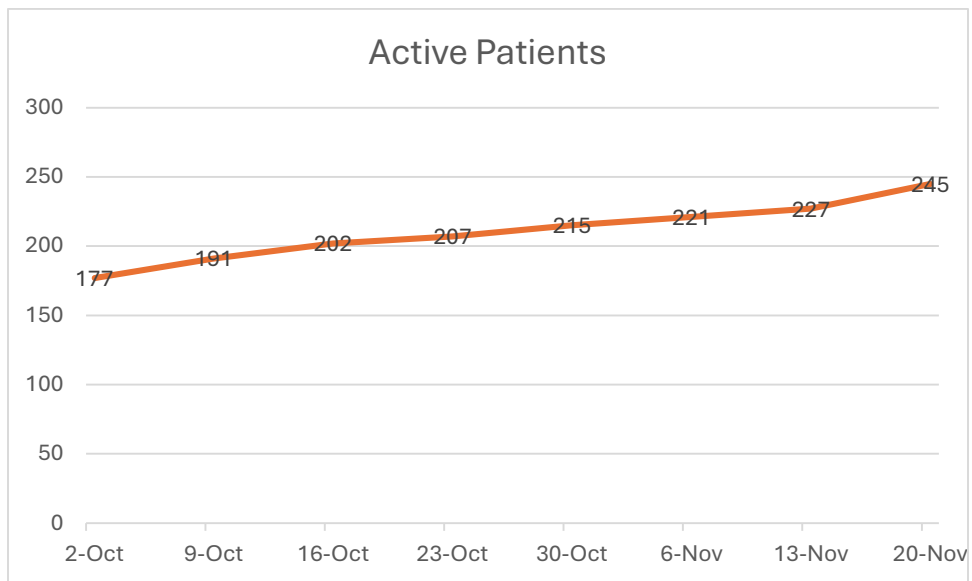
- Continued SAMHSA-required data collection interviews for UAMS and EAFHC enrollees.
- Continued data collection for the implementation evaluation team.
- Continued weekly meetings for the administrative, evaluation, and implementation evaluation teams to ensure communication across all sectors of the project.
- Expanded CoCM model at UAMS and East AR clinics.
- Participated in the monthly CoCM Stakeholders meetings hosted by ABHIN.
- Completed all reports required by the State and SAMHSA.

## **Evaluation & Data Collection**

### **Evaluation Report period October 1 through November 30th**

A. 116 patients have been enrolled in CoCM for this quarter (10/1/25-11/30/25). A total of 508 patients have been enrolled from 8/26/2024-11/30/2025). See enrollment breakdown on pages 15-17.

B. Number of active patients enrolled in collaborative care--The total number of active patients by week for the reporting period is graphed below. The mean number of active patients per week is 211 (SD=21).



C. Six-month follow-up rates--Our current 6-month follow-up rate is 82% (n=32 of 39).

D. Preliminary outcomes--Preliminary results show that patients entering collaborative care demonstrated statistically significant improvements in depression ( $p < .001$ ) and anxiety ( $p < .001$ ) symptoms from baseline to discharge from services.

E. Billing status--Currently, UAMS is the only site billing for collaborative care services. Insurers that are billed for services are Blue Cross Blue Shield, Ambetter, Medicaid, Medicare, United Healthcare. UAMS received reimbursement for 57% of services billed. Barriers to obtaining reimbursement include—not receiving reimbursement for services from Medicaid (#2 insurer of UAMS patients seen for collaborative care), the complexity of billing the codes (monthly aggregation of minutes, required documentation of consent from the PCP), difficulty building and integrating an automated billing system into UAMS's EHR, and complexity of determining the billing provider.

F. Length of stay in collaborative care--Our preliminary findings show that patients enrolled in collaborative care stayed in treatment for a mean of 152 days (SD=103).

G. Success stories

**Case 1:** 52 y/o AA male referred by pcp for issues with anxiety and difficulty with stress management. At intake (March 2025), he endorsed trouble controlling his worrying, low motivation, muscle tension, and trouble concentrating, negatively impacting work and personal life. (low motivation and procrastination at work as well as isolation from friends when feeling overwhelmed or down). His initial screening scores were PHQ9-13 and GAD7-19. The patient was enrolled in the Collaborative Care program and engaged in regular follow-ups with the BHCM every 1–2 weeks over the 6-month period. During difficult times the pt was supported via telephone check-in 2x weekly. Interventions included psychoeducation on anxiety and stress, behavioral activation (going to gym, making special dinners that include new recipes and attending outings with friends when invited) and mindfulness (taught the 5,4,3,2,1 method, box

breathing and progressive muscle relaxation). The pt was also encouraged to journal from various prompts provided by BHCM.

In collaboration with the primary care provider and psychiatric consultant, the patient started on sertraline 25 which was titrated slowly to 50 then 100mg over time (April-May). Titration was based on his response to the med as well as how well he was tolerating the side effects. Over the course of treatment, the patient reported improved and consistent use of coping skills, reduced anxiety, and better distress tolerance by month 5. The pts assessment scores reduced to 4 (minimal depression) and 5 (mild anxiety) at last contact with BHCM. His target scores were 5 or below and he no longer met criteria for active anxiety or depressive disorder and was then discharged (August 2025). He continues to maintain symptom improvements with primary care support and was still taking the sertraline at last contact.

**Case 2:** John is a white male in his mid-30's with a history of Bipolar II Disorder. He presented to his primary care doctor during an episode of depressed mood with anhedonia, sleep disturbance, concentration difficulties, and passive suicidal ideation. He reported that he has stopped taking his mood stabilizer one week prior to the visit. John endorsed a history of multiple psychiatric hospitalizations and one suicide attempt. His doctor noted elevations in his mental health screening scores, indicating severe levels of depression (PHQ9 score = 24) and moderate to severe levels of anxiety (GAD7 = 18).

Consent was obtained from his primary care doctor, and John was reached 3 days later by the behavioral health care manager, who completed an initial assessment and helped John access requested resources for a voluntary psychiatric admission. Approximately 2 weeks later, John followed up with his primary care doctor for medication management. A behavioral health care manager then followed up to help him set goals related to mood and sleep improvement. His initial assessment scores indicated minimal depression (PHQ9 = 0), moderate levels of anxiety (GAD7 = 10), presence of bipolar disorder symptoms (positive MDQ), and PTSD symptoms (PCL5 = 21). Goals were not established as the call dropped, and the patient was unable to be reached via return call.

Over 4 months, John had 7 telephone calls with the behavioral health care manager and 3 case consultations with the psychiatric consultant (PC) focused on simplification of psychotropic regimen for increased adherence, totaling 100 minutes of care. John never saw the PC in person or via telehealth. John worked on management of anxiety and depression symptoms via medication adherence, behavioral activation, and mindfulness. During the Relapse Prevention Planning phase, he reported feeling much better and has returned to pleasurable activities. At the time of disenrollment from Collaborative Care, his PHQ9 score improved from a 24 (severe) to a 2 (minimal) and his GAD7 score changed from an 18 (severe) to a 0 (mild).

**Case 3:** Kate, a Black female in her late 30's, presented to an appointment to establish care with a primary care physician (PCP) and endorsed mild asthma and new-onset anxiety. She was seen in clinic by a PCBH mental health provider for 3 sessions over the course of 3 months. 5 months later, she presented to her primary care doctor for an annual wellness exam and reported recurrence of symptoms of anxiety. Consent was obtained from her primary care doctor, and Kate was contacted 12 days later by the behavioral health care manager, who completed an initial assessment and helped her set goals for her health and mood. Scores from her initial assessment indicated mild symptoms of anxiety (GAD7 = 7) and moderate to severe symptoms of depression (PHQ9 = 17).

Kate's case was reviewed by the psychiatric consultant, and recommendations for medication, treatment, sleep study, and diagnostic testing for ADHD were provided to the PCP. Kate never

saw the PC in person or via telehealth. Medication adjustments and referral recommendations were implemented by the PCP. Over 7 months, Kate had 8 telephone calls with the behavioral health care manager and 7 case consultations with the psychiatric consultant (PC) totaling 273 minutes of care (an average of 39 minutes per month).

During the Relapse Prevention Planning phase, she reported an increased locus of control and symptom reduction. At the time of disenrollment from Collaborative Care, Kate's PHQ9 score changed from a 17 (moderate to severe) to a 0 (minimal) and her GAD7 score changed from a 7 (mild) to a 0 (minimal). She reported that she had recently started a new job and felt optimistic about her future.

## Implementation Evaluation Report (Results from Redcap Re-AIM Survey)

Background: We conducted an end of the year evaluation of two Arkansas Healthcare Systems who have used CoCM for at least one year using an online RedCap survey ([www.seattledenvercoin.research.va.gov/taq/imp/midworksheets.asp](http://www.seattledenvercoin.research.va.gov/taq/imp/midworksheets.asp)).

Findings: A total of 23 stakeholders representing all disciplines in CoCM responded.

- Responses were generally positive, and participants were enthusiastic about the roll-out of CoCM in their clinics.
- Some minor concerns were voiced
  - The roll-out is not consistent across clinics and staff
  - Effectiveness and engagement could be better for patients with more severe anxiety or depression
  - Sites worry about maintaining CoCM after this program is complete.
- **Reach:** Participants highlighted the value of reaching as many people as possible who qualify and satisfaction with the reach so far. Participants thought there is potential to reach more patients, especially those with the greatest clinical need.

Participant quote: *"Thus far the workflow that connects patients with uncontrolled depression and anxiety to CoCM has been great for patients. It has increased Access to Behavioral Health Care, mitigated long waits for psychiatry significantly - rural/under-resourced"*

- **Effectiveness:** Participants viewed effectiveness as very important noting clear benefits for patients engaged in care. There was less enthusiasm about CoCMs benefit for participants with the most severe symptoms.

Participant quotes: *"When patients agree to the service, it works great"* and *"Reduces stigma and [results in] faster symptom improvement."*

- **Adoption.** Participants were enthusiastic about the use of CoCM among staff and leadership in their clinics. Participants thought there could be more providers using CoCM and noted some frustration with the consistency of CoCM adoption across clinics.

Participant quote: *"We are struggling with the providers at our site utilizing the CoCM for their patients - especially our resident physicians, even after multiple educational sessions and getting in front of them to remind them of this resource."*

- **Implementation.** Participants believe their site should stay true to the CoCM model. Participants assigned slightly lower ratings to the consistency of the roll out across all clinics but noted very high quality and consistency of care among the staff who are actively using CoCM.

Participant quote: *“There is a learning curve here and the need to develop effective circles of communication and action. It is a work in progress.”*

- **Maintenance.** Participants assigned the highest ratings for the importance of continuing CoCM in the future. Participants expressed some concerns about the ability of their site to maintain CoCM at the conclusion of the program without changes to billing regulations and institutional support.

Participant quote: *“I think the CoCM is a wonderful resource for our patients and our providers in a place where mental health resources or limited (or the delay to get in with a mental health professional can take months). I think we need to continue to support this model once the grant has expired because it is a huge benefit for our patients.”* Another noted, *“...Without wider payer support, the model sustainability is uncertain.”*

### **Site Activities:**

#### **Arkansas Behavioral Health Integration Network (ABHIN) Activities:**

*Please note that ABHIN stopped activities during Year 3, Qtr 1 due to budget constraints discussed on page 17 and a delay in the notice of award from SAMHSA for year 3.*

- Presented on CoCM at CFHA with EAFHC and Woven Doctors
- Met with the Bowman’s of The Bowman Foundation to discuss CoCM policy matters with continued back and forth communication
- The Bowman’s also presented at ABHIN’s monthly webinar series in October
- Presented on CoCM to Family Well in November
- Attended ABHAC Advisory Council
- Attended CoCM Monthly SIG Meetings
- Attended Quarterly Executive Committee Meetings
- Continued to meet with EAFHC, Woven Doctors, & RVMW

### **UAMS Clinical Activities:**

#### **Program Implementation & Infrastructure**

- **Epic CoCM Build Successfully Launched:** On October 1, 2025, UAMS completed the go-live of its Epic Collaborative Care build, fully replacing the AIMS Caseload Tracker for documentation, registry functions, and billing.
- **Post–Go-Live Optimization:** Reporting and registry fields were refined following implementation, including corrections to screening date logic and enhancements to report refresh capability to support near real-time operational monitoring.

## Workforce Development & Clinical Integration

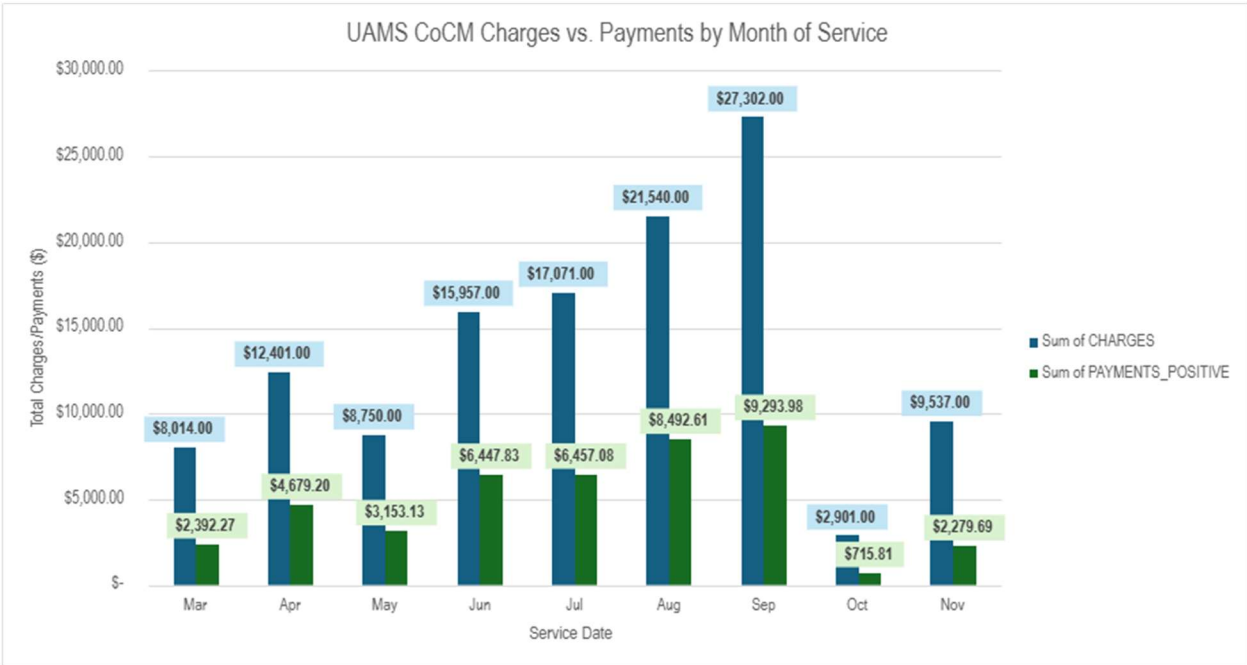
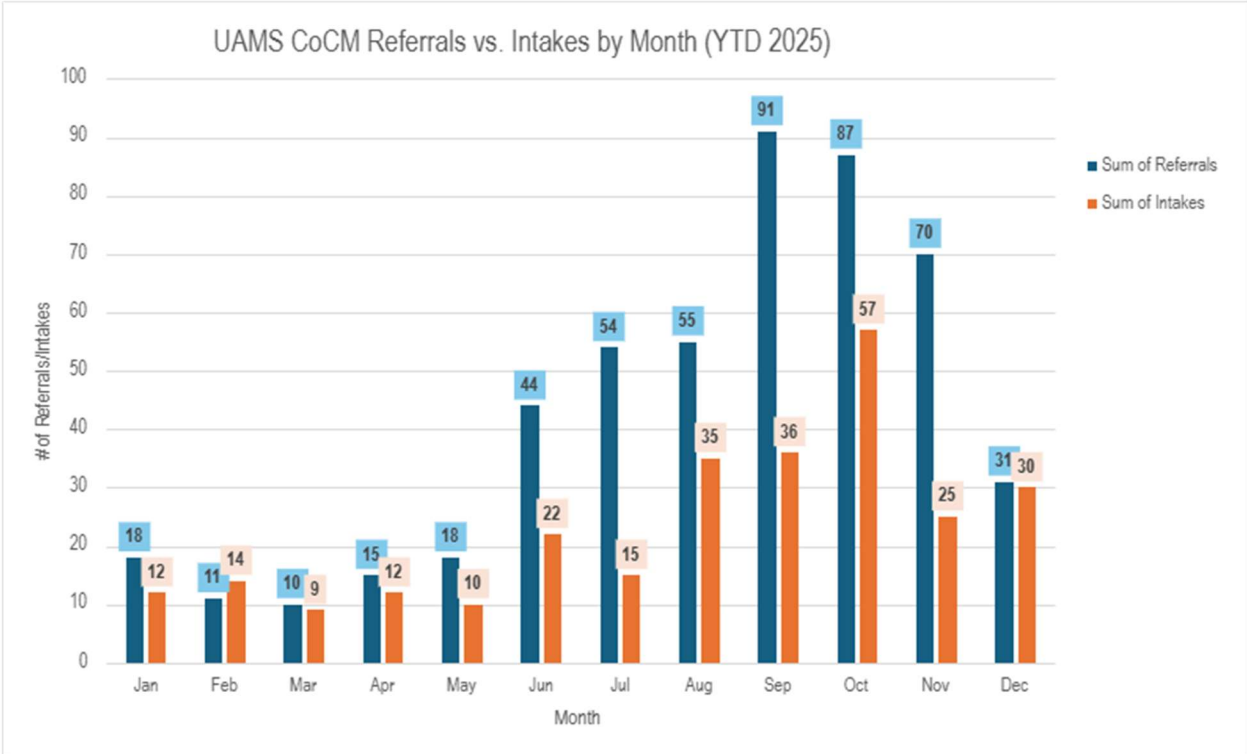
- **Integrated Care Model Support:** Ongoing education was provided to BHCMS and clinic partners to strengthen coordination between Collaborative Care and Primary Care Behavioral Health (PCBH), including shared workflows and patient management.
- **Standardized Referral Pathways:** New Epic In-Basket referral protocols were implemented for Integrated Behavioral Health Team referrals.
- **UAMS CoCM Quarterly All Team Meeting:** A quarterly UAMS CoCM team meeting structure was established to support onboarding, clinical alignment, and problem solving.
- **Targeted Training Needs Identified:** Workforce development priorities were identified related to PTSD and substance use disorders to better meet patient population needs.

## Data, Evaluation & Reporting Capacity

- **De-Identified Data Linkage:** A study ID crosswalk was created to link clinical and evaluation data in REDCap without use of patient identifiers, replacing the prior AIMS-based study ID process.
- **REDCap Workflow Redesign:** Data collection infrastructure was strengthened through redesigned reports and automated notifications to improve tracking of baseline, follow-up, and discharge interviews.
- **Billing Oversight Structure:** A standardized billing report and bi-weekly reporting cadence to the Medical Director were established to support program oversight.

## Billing & Sustainability

- **Automated CoCM Billing Implemented:** UAMS completed its first successful automated Epic billing run for Collaborative Care services.
- **Epic Workflow Alignment:** Documentation and billing workflows were finalized to meet all Collaborative Care billing requirements, supporting long-term program sustainability.
- **Sustained Program Operations:** UAMS maintained six active Collaborative Care clinic sites and continued enrolling patients throughout the quarter.
- **Caseload Sustainability:** Behavioral Health Care Managers (BHCMS) reached or approached sustainable caseload thresholds, supporting program continuity and financial viability.
- **Record high number of monthly intakes (57)** completed in the month of October!



**East Arkansas Clinical Team Activities to Date:**

- Care Managers and Behavioral Health Leads attend weekly evaluation meetings.
- Behavioral Health Lead attends bi-weekly administrative meetings.
- Care Managers are consistently recruiting for the SAMHSA-required evaluation surveys.
- Patient Enrollment into CoCM has been consistent.

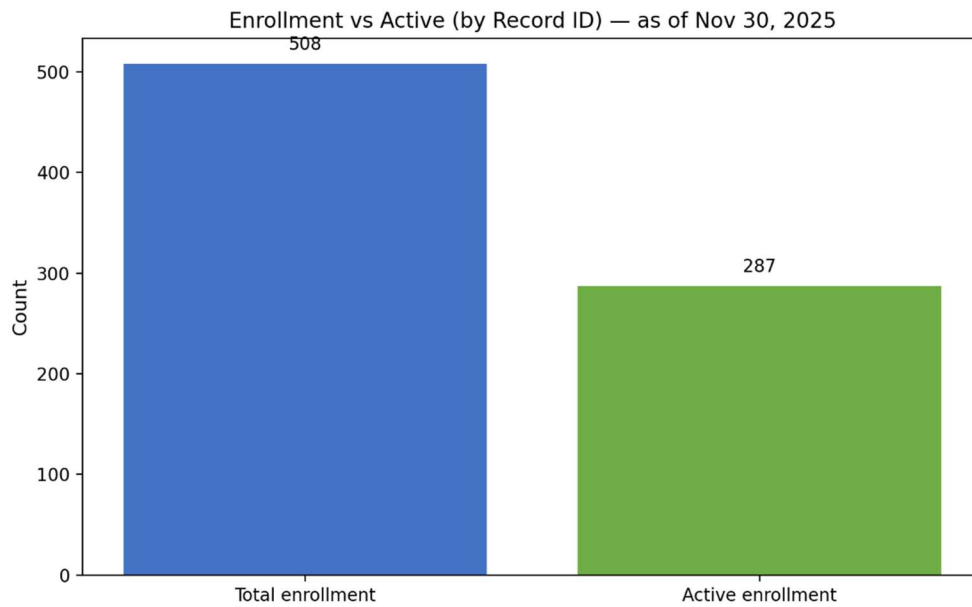
- Added another care manager to the clinical team because the original care manager has a full panel after only six months.
- Expanded CoCM to additional sites and an additional two sites starting 1/1/2026.

**Patient Recruitment Across all Sites**

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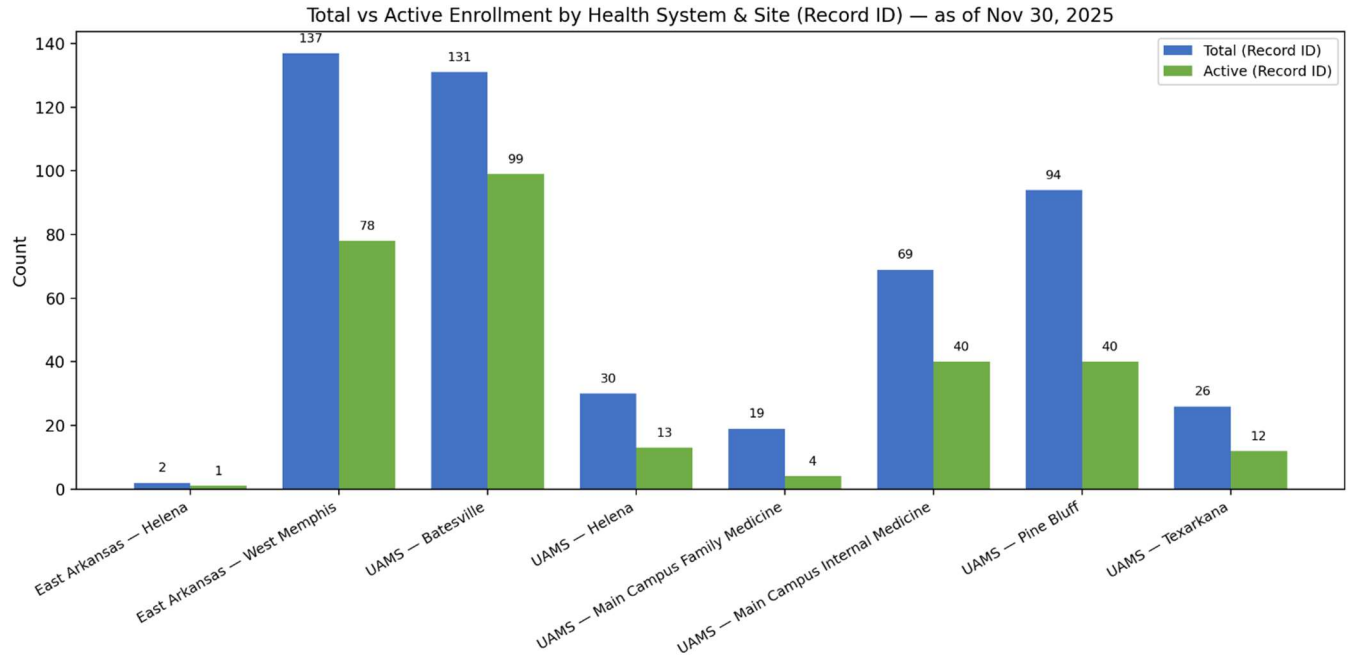
As of November 30, 2025, 508 patients have been enrolled in collaborative care at UAMS and East Arkansas clinics since enrollment began in August 2024. (labeled as total enrollment in the figures below) Currently, 287 patients are actively receiving CoCM. Patients can be discharged for the following reasons:

- 1) Patient has symptom improvement and completes the course of treatment.
- 2) Patient has severe symptoms and is moved to specialty care.
- 3) Patient cannot be contacted for a length of time and does not engage in treatment.



**Total Enrollment for all sites August 2024- November 2025.**

The following chart is a breakdown of total enrollment vs. active enrollment by site.



UAMS began enrollment at the Batesville and Main Campus Internal Medicine in August 2024. Batesville had a total enrollment of 131 patients during that time, with 99 active patients as of November 30, 2025. Internal Medicine had a total enrollment of 69, with 40 active members as of November 30, 2025.

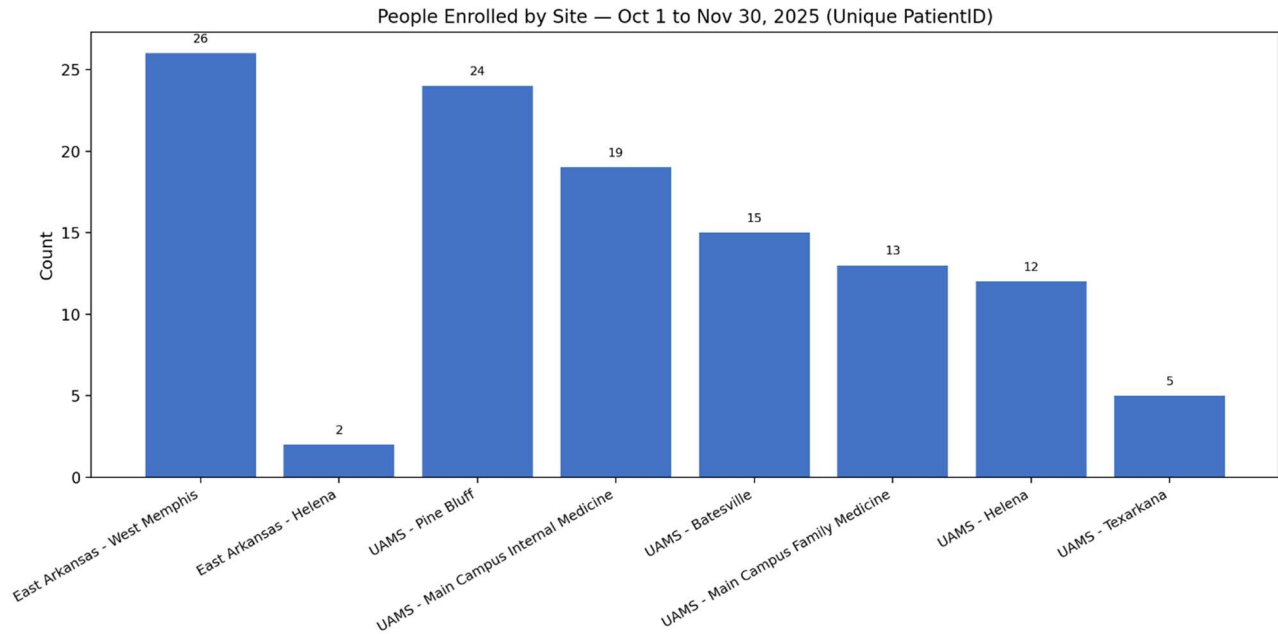
Pine Bluff began actively enrolling patients in December 2024, but they have recently experienced a surge in CoCM due to the loss of the Behavioral Health Consultant at the Pine Bluff Clinic and other specialty care clinics in the area not accepting new patients. This has led to an uptake in services. They have enrolled 94 patients to date and currently have 40 active patients in treatment.

UAMS Texarkana and UAMS Helena began enrolling patients in January 2025. Texarkana has enrolled 26 patients, with 12 being active. Helena has enrolled 30 patients to date, with 13 being active.

UAMS just began enrollment at the UAMS Main Campus Family Medicine clinic in October of 2025 of September and has enrolled 19 patients in CoCM, with 4 being active.

Please note that the number of active patients fluctuates daily as new patients are admitted and other patients are discharged. These numbers represent people who have been referred to CoCM and accepted treatment. They have completed their initial assessment and have been entered into the study database. There are 185 patients who have been referred to CoCM and are being scheduled for initial assessments.

East Arkansas began enrolling patients in February 2025 at the West Memphis clinic. To date, they have enrolled 137 patients, with 78 active patients as of November 30, 2025. East Arkansas- Helena has started enrollment, but they have enrolled 2 patients, with one active. Two additional sites will begin CoCM in January 2026.



## Barriers

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The project has made significant progress implementing the CoCM model. As with most projects, the team faced barriers to implementing various aspects of the problem.

### Current:

**Carry-Forward Funding:** A major barrier for this quarter was the state's decision to decline the carry-forward funds from year 1. This money was earmarked to support new clinics, River Valley Medical Wellness and McGehee Family Clinic, and provide salary support for care managers at UAMS clinics. Once the notice of award (NOA) was received, our team understood these funds were available and moved forward, bringing new clinics to the project. To ensure the project did not incur a deficit, in quarter 4, we had to suspend activities at ABHIN, East Arkansas, McGehee Family Clinic, River Valley Medical Wellness, and the University of Washington.

### Ongoing:

**Executing Contracts:** The process of executing subcontracts between UAMS and clinical sites slowed project implementation. The length of time needed for contracting substantially decreased the amount of time the clinics have available to use the funds. The team is collaborating with UAMS grants accounting to develop strategies to reduce the time required to fully execute clinic contracts going forward.

**Low Recruitment Rates:** We continue to have low recruitment rates into CoCM at the UAMS clinics. This model of care requires primary care providers to make changes to their practices, which they may be resistant to. To overcome this barrier, the UAMS clinical team is working with IT to develop a simple referral process. The UAMS clinical team increased education outreach to primary care providers regarding CoCM, implemented a strategy to alert providers to patients with high depression and anxiety screening scores prior to primary care visits. This approach should make it easier to address behavioral health issues during the appointment.

