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Frequently Asked Questions

Collaborative Care in *Specialty* Women's Health Practices

Practical guidance for OB/GYN and women's health providers on implementing the Collaborative Care Model—addressing common concerns about clinical fit, patient ownership, provider coordination, and medication management.

Clinical Case for Collaborative Care

Q: Why does Collaborative Care belong in a specialty women's health practice?

Perinatal depression affects 10-20% of women during pregnancy or the postpartum period, and anxiety disorders affect an estimated 20% of perinatal patients—yet 50-70% of symptomatic women remain undiagnosed, and treatment rates are lowest among antepartum women.[1,2] OB/GYN practices are often the first—and sometimes only—clinical setting where these conditions surface. Without an integrated response, patients are left to navigate a fragmented specialty mental health system they may never successfully access.

Collaborative Care was specifically validated in OB/GYN and perinatal settings. A two-site randomized controlled trial published in the *American Journal of Psychiatry* found significant improvements in depression outcomes and functioning for OB/GYN patients randomized to Collaborative Care versus usual care, with particularly strong effects for uninsured and Medicaid-covered women.[3] A 2026 retrospective cohort study published in *Maternal and Child Health Journal* found that among 185 patients enrolled in a perinatal Collaborative Care program embedded in OB/GYN, over 80% enrolled following referral and more than 70% completed intake within one week[4]—demonstrating feasibility and patient acceptance in real-world practice.

10-20%	~20%	50-70%
of perinatal women experience depression	experience a perinatal anxiety disorder	of women remain undiagnosed

Patient Access and Provider Relationships

Q: Many of our patients have a primary care provider. Won't Collaborative Care step on their toes?

Collaborative Care is designed to coordinate with—not compete with—the primary care provider. The behavioral health care manager serves as a communication bridge: keeping the primary care provider informed of the patient's behavioral health status, any treatment changes recommended by the

psychiatric consultant, and the patient's progress over the episode. This is especially important when a primary care provider is managing medications with behavioral health implications, such as antidepressants or sleep aids.

In practice, this coordination strengthens the primary care relationship rather than displacing it. The Collaborative Care registry provides structured documentation that primary care providers can reference, and the care manager can facilitate warm handoffs, shared treatment goals, and coordinated follow-up. The model explicitly positions the OB/GYN team as a bridge to—not a replacement for—the patient's other providers.

Key principle: The care manager's role is additive. Primary care providers frequently report that Collaborative Care reduces their burden by providing a structured pathway for behavioral health concerns they previously had no clear way to address.[5]

Q: What about patients who don't have a primary care provider?

This is more common than it may appear—and it is one of the strongest arguments for Collaborative Care in women's health. Research from the Kaiser Family Foundation found that while 93% of women ages 18-64 saw a healthcare provider within two years, only 73% had a general wellness visit with a primary care provider.[6] Among younger women (ages 18-35), OB/GYNs are already the most common provider type for wellness visits. For uninsured women and those on Medicaid, the OB/GYN setting is often their primary—or sole—point of contact with the healthcare system.

A study of low-income women on Medicaid at a university OB/GYN clinic found that 38% used the OB/GYN setting as their primary care provider, and nearly 10% identified no primary care provider at all.[7] For these patients, the concern about "stepping on the PCP's toes" does not apply—and Collaborative Care fills a meaningful gap that would otherwise go unaddressed.

Medication Management

Q: We are not comfortable prescribing or managing psychiatric medications. Is that a barrier?

No. The psychiatric consultant provides weekly systematic caseload review, including individualized treatment recommendations, guidance on safe prescribing during pregnancy and breastfeeding, medication continuation decisions, and dosing adjustments for patients already on psychotropic medications at the time of referral. This structure explicitly allows OB/GYN providers to remain focused on obstetric and gynecologic care.

Importantly, the majority of patients enrolled in Collaborative Care do not require medication. Evidence-based brief interventions form the core of the behavioral health care manager's work, and published trials of Collaborative Care in OB/GYN settings show meaningful depression improvement in patients who did not receive pharmacotherapy. The MOMCare randomized controlled trial, for example, offered patients a choice between brief interpersonal psychotherapy and antidepressants, and demonstrated significant improvements in depression severity compared to usual care over 18 months.[8]

Bottom line: The Collaborative Care Model separates the clinical management of psychiatric medications from the OB/GYN's scope of practice. Providers who are not comfortable prescribing psychiatric medications do not need to do so to run a successful program.

Q: What happens when a patient arrives at their first prenatal visit already on a psychiatric medication?

This is a common and clinically important scenario—and one Collaborative Care is well suited to address. When a patient presents on an existing psychotropic regimen, the behavioral health care manager coordinates immediate psychiatric consultation to review the medication in the context of pregnancy or the postpartum period. The psychiatric consultant can advise on the safety profile of the specific medication, recommend dose adjustments if indicated, and support continuity of care—without requiring the OB/GYN to make independent psychiatric prescribing decisions.

This consultation function is one of the most valued aspects of Collaborative Care for OB/GYN teams, as perinatal medication management involves nuanced clinical tradeoffs that benefit from specialist input. The model provides that expertise in a structured, accessible way—typically through a weekly caseload review rather than a separate referral process.

Clinical Workflow and Patient Relationships

Q: Will adding Collaborative Care change the OB/GYN's relationship with their patients?

Evidence suggests it strengthens it. Provider satisfaction is one of the outcomes tracked in Collaborative Care implementation studies, and OB/GYN teams consistently report that having a structured pathway for behavioral health concerns reduces the burden of identifying and navigating mental health referrals. The behavioral health care manager handles the clinical follow-up, patient outreach, and registry tracking—freeing the OB/GYN to remain focused on obstetric care while knowing that behavioral health needs are being actively monitored and addressed.

From the patient's perspective, receiving behavioral health care within their existing OB/GYN setting—from a provider familiar with their pregnancy and postpartum context—reduces stigma and removes the friction of navigating a separate mental health system. Published implementation research consistently cites integration within existing care settings as a key facilitator of patient engagement in perinatal behavioral health treatment.[9]

Q: What does the Collaborative Care team structure look like in a women's health setting?

The core team includes three roles: the treating OB/GYN or women's health provider (who initiates and oversees care), a behavioral health care manager embedded in or working closely with the practice, and a consulting psychiatrist with perinatal behavioral health experience. The care manager is the operational hub—conducting screenings, enrolling patients, delivering brief interventions, maintaining the population registry, and facilitating weekly psychiatric consultation.

In perinatal settings, the care manager role typically requires familiarity with perinatal mood and anxiety disorders, validated screening tools (Edinburgh Postnatal Depression Scale, PHQ-9, GAD-7), and the particular emotional and logistical circumstances of pregnant and postpartum patients. Implementation research recommends that practices prioritize obstetrician and gynecologist satisfaction and population-based care design from the outset, as these factors are associated with stronger adoption.