Mental Healthcare for All

Why Now is the Time to Implement Collaborative Care

Never before have mental health providers been able to do so much to improve mental health. A range of treatments, from pharmacological approaches to device-based interventions and validated cognitive therapies, have reached broadscale levels of acceptance and can be delivered efficiently.

Yet today, getting access to care is seemingly more challenging than at any time in history. An estimated 1 in 5 Americans annually needs mental health treatment, yet due to provider shortages, persistent stigma, prohibitive cost, and inadequate insurance, less than half of these Americans receive care they need. The unmasking of "ghost networks" reveals a national crisis that requires not just policymaker attention, but also urgent action.

Now is the time to embrace sustainable care delivery models, especially within academic medical center (AMC)-led health systems. With dedicated billing codes available, collaborative care is one such care delivery model rooted in science. When coupled with enabling technology, the collaborative care model meets patients where they are and supports primary care physicians and pediatricians on the frontlines of the mental health crisis.

AMC-led health systems are well-positioned to lead and should be urged to adopt and expand collaborative care to reach more patients. Along with their tripartite educational, clinical, and research missions, these systems have been designed to serve all people, including the disadvantaged and under-represented. These health systems hold dominant market positions in often-urban locales and nurture trusted brand reputations. With so much unmet need, now is the time to expand and improve mental healthcare by embracing collaborative care.

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Mental Healthcare for All:
Why Now is the Time to Implement Collaborative Care

By Nathaniel Hundt, Eli Berman, and Isabel Blunt

In 2019, before the Covid-19 pandemic began, an estimated 1 in 5 Americans reported a mental illness - 51.1 million people.[1] Even then, the behavioral health care system in the United States was approaching a breaking point. With an aging workforce - more than 60% of psychiatrists are 55 and older[2] - and a shortage of physicians joining the field at a rate fast enough to replace retirees, the situation cries out for a new model of care delivery, which helps deliver better quality care more efficiently, helping more people, while leveraging experts in a new way.[3]

In this white paper, we will provide an overview of how the pandemic affected mental health care in the U.S. and introduce collaborative care, a delivery model that has picked up support in recent years, due to early results demonstrating its ability to achieve the unique combination of scale, quality, and efficiency in a variety of implementation scenarios. Often, what holds back adoption of new delivery models in healthcare is an understanding of payer dynamics and reimbursement mechanisms. In this paper, we provide a summary of the related billing codes, as there have been a number of positive developments in recent years that pave the way for broader adoption, especially across integrated health systems.

The Impact of Covid-19 and An Aging Industry Burning Out

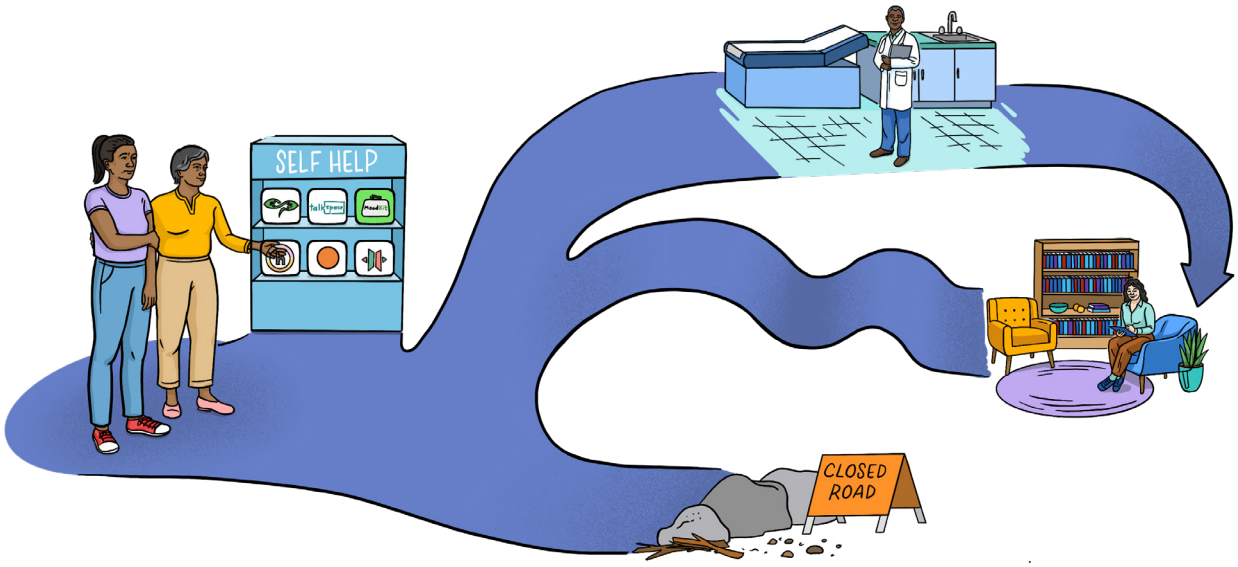
Covid-19 exacerbated the physician supply-demand imbalance in an already hurting health care system. But in mental health, the impacts were more long-lasting and the pandemic revealed latent demand for more services. At the height of the pandemic, 40% of adults reported symptoms of anxiety or depression – compared with 11% pre-COVID.[4] Over time, this percentage dipped to 33% in June 2022, still a dramatically higher number than pre-pandemic levels.[5] Disturbingly, more than 150 million people now live in federally designated mental health professional shortage areas.[6] Children and adolescents are especially underserved; less than half receive the mental health care they need.[7] Within a few years, based on predictions of increasing demand for services coupled with provider retirement, the US will be short between 14,000 and 31,000 psychiatrists.[8]

But it's not just an aging workforce that is making it hard for patients to get the care they need. Psychologists are reporting higher rates of burnout due to increased workload and not being able to meet the demands of treatment for their patients. Based on an American Psychological Association poll of its members, 46% of psychologists reported not being able to meet the needs of their patients in 2022, compared to 30% in 2020.[9]

Broken Delivery Models

In addition, there is an access problem. Nearly 60% of patients who receive some form of mental health treatment, do so from their primary care physician (PCP).[10] Only 20% of adult patients with mental health disorders are seen by mental health specialists.[11]

Behavioral health is increasingly screened for as part of intake surveys during primary care visits. But PCPs are not always trained to treat complex conditions, nor are they often equipped to help patients manage medications for mental health care needs when difficult to manage side effects arise. Studies have shown that PCPs fail to recognize depressive symptoms in 30% to 50% of depressed patients.[12][13] Furthermore, due to fragmentation in provider systems, when patients do see a psychiatrist or behavioral health care specialist, there is little communication between them and their PCP. This fragmentation often leads to unmet needs, poor health outcomes and high societal costs.[14]



While more than 1 in 5 (21%) Americans struggle with mental illness each year, more than half (55%) do not receive treatment. Furthermore, 3 in 5 adults who get mental health treatment receive care from their primary care physician as opposed to a mental health specialist.

The disconnect between primary care and behavioral health, high demand for services and often poor results is leading many health systems in the US and around the world to better coordinate care across the spectrum. The IMPACT study provided seminal research into ways that behavioral health could be integrated into primary care. Interventions delivered positive results that have been further substantiated in numerous studies in the US and abroad.[15] After 12 months, IMPACT participants reported greater reduction in depressive symptoms, experienced greater rates of depression treatment, were more satisfied with depression care, had lower depression severity, less functional impairment and greater quality of life than those in the usual care group.

In a similar study in Sweden, at the 12-month follow-up, patients with mild to moderate depression who were randomized to the care manager program at the primary care center had larger health benefits than the group receiving usual care only. Additionally, the health system reported lower cost and better health outcomes than with "care as usual."[16]

Across Europe and Canada, health systems are experimenting with integrating elements of care. In England, integrated primary and acute care systems are emerging that join general practice, hospital, community and mental health services. In Germany, sickness funds offer integrated care contracts and disease management programs for chronic illnesses to improve coordination among providers in the ambulatory sector and to improve patient care. In Canada, the Strategy for Patient-Oriented Research integrates primary prevention and healthcare services horizontally and vertically across the care continuum.[17]

Introduction to the Collaborative Care Model

Most relevant to the health system-wide integration of behavioral health care is the Collaborative Care Model, pioneered in the U.S. at the University of Washington to address and treat common and persistent conditions, including depression and anxiety. Research shows it is effective, both for patients and the bottom line.

The collaborative care model is actually disarmingly simple. It's an efficient combination of systematic longitudinal assessment with treatment adjustment. It starts in primary care, which is important because most people with depression get seen in primary care and get treated in primary care. The large bulk of antidepressants are prescribed by PCPs, not by psychiatrists. And they aren't necessarily providing these medications in the most effective way.

So, collaborative care is designed to help primary care practices treat depression by using a team approach, with a PCP, psychiatrist and care manager. The psychiatrist is available for consultations and acts as a supervisor for the care managers. The care managers screen patients, and if they screen positive, they can connect them with their primary care provider. They also track patients to make sure they're showing up for visits, obtain PHQ-9 scores and assess them longitudinally to see if they're getting better or worse, and make sure patients aren't falling through the cracks.

There are two primary ways patients can fall through the cracks: one is that they stop coming or stop using their medication. Two is that they keep coming and keep using medication, but don't get any better. The clinical strategy used here is called Measurement-Based Care. There is a continual tracking of the results, and if patients aren't getting better, the team can choose from a list of evidence-based options to step up the care. [These options include] increasing the dosage, adding a medication, or adding psychotherapy. Patients are continuously tracked using PHQ-9s to determine if the stepped up options are helping.

In addition, care managers are trained in a form of brief therapy, called problem-solving therapy, which is short-term, focused and relatively easy to train people in.

- Harold Pincus, MD
Vice-Chair, Columbia University Department of Psychiatry and Healthcare Policy and Management
Co-Director, Irving Institute of Clinical and Translational Research

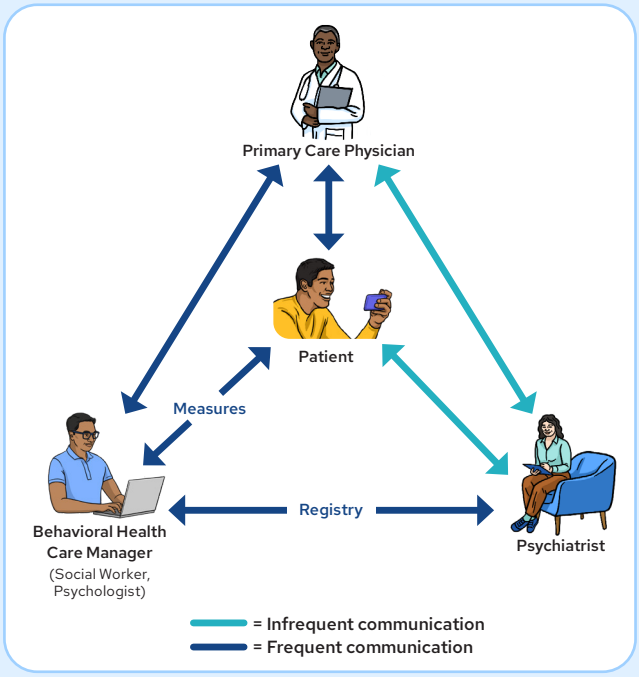
The structure, as the collaborative name would suggest, is team-based and includes a primary practitioner, usually a family medicine doctor, nurse practitioner, or physician's assistant who has the primary relationship with the patient, a behavioral health care manager who may be a nurse, social worker, or mental health professional trained in care coordination and brief interventions to support medications or treatments initiated by the PCP, as well as a consulting psychiatrist who advises the primary care and behavioral health care support team on treatment options or is called in if the patient isn't showing improvement.[18]

MGH CASE STUDY

At Massachusetts General Hospital, the existing psychiatric care model was proving inadequate to meet the growing need for care and services, with coordination and treatment review work remaining unreimbursed, long wait times for new patients, limited ability to address multiple psychosocial needs and burnout among clinicians. A diverse group of staff presented the problems to the leadership team who agreed that an innovative, new approach was needed.

After a planning retreat to agree on a strategy to drive change, the team embarked on a listening tour to hear from a range of providers and support staff across the department, and within the primary care space. Across the board, the feedback from clinicians, intake staff, and patients was consistent with leadership's understanding of the problem.

In response, a planning group developed a team-based care model they called team-based outpatient psychiatry (TOP). The TOP model was influenced by "features of high-performing primary care practices, including a stable team structure, provider colocation, panel management, clearly defined roles and workflows, and emphasis on staffing ratios and effective communication."[19] Each team is composed of a **psychiatrist**, who works with the **nurse practitioner** to focus on medication-oriented treatments, supported by the **medical assistant** who collects relevant medical data and performs administrative tasks. The **psychologist** and **licensed clinical social worker** perform psychotherapy. The whole team is responsible for all the patients, and every member participates in daily huddles and twice-weekly case reviews. The TOP model creates a more collaborative model between TOP teams and primary care practices. This new approach requires "consensus with medical practice leadership, collaborative design of the pass-back process, and commitment from both disciplines to communicate changes and follow up on utilization of the model."[20]



Initial feedback on the program has been positive. Improved access for new patients is shown through the case mix which has remained at 18% new patient evaluation slots and 82% follow-slots, compared with 4% new patient slots in the legacy program.[21] Financial modeling shows that TOP will be financially self-sustaining, via billed clinical revenue. Anecdotal feedback from the TOP team and primary care referring teams shows positive experiences on the part of clinicians, support staff and patients alike.

Andrew Carlo, MD, MPH and Vice President of Health System Integration at Meadows Mental Health Policy Institute told us, "when there's something that has that much evidence, and the mental health crisis is as bad as it is right now, collaborative care should be ubiquitous. But that's not the case. It's still considered a novel model, even though its efficacy has been clearly established for more than two decades. Implementation has been incremental because it involves practice change and the merging of behavioral health and physical health cultures, which are actually quite different. The two groups think about health differently and approach problems differently, and their day-to-day structures and schedules are quite different. The team approach in collaborative care can also be unfamiliar for some folks, since a lot of clinicians are used to working more independently, especially in mental health care."[22]

Importance of Measurement-Based Care

Central to the success of collaborative care is the implementation of measurement-based care and improved outcomes reporting, which also underpins the broader shift value-based reimbursement models. Measurement-based care (MBC) can be separated into four core components: (1) a routinely administered symptom, outcome, or process measure, ideally before each clinical encounter; (2) practitioner review of data; (3) patient review of data; and (4) collaborative reevaluation of the treatment plan informed by data.[23]

Today, fewer than 20% of behavioral health practitioners regularly adopt MBC within their clinical routines. Barriers to implementation occur at all levels of practice. Patients may have initial concerns about confidentiality, feel burdened by surveys if they are cumbersome, and doubt the value of spending time to complete measures if providers do not review results or if they do not return to view progress regularly. Meanwhile, providers may believe their own clinical judgment does not require patient self-reported data. Finally, organizations may struggle to provide easy-to-use digital tools that fit into the clinical workflow and not invest in proper change management practices and training.[24]

> *In primary care, they measure everything. When you go see your primary care doctor, they're going to first check your blood pressure, and then your height and weight. Then they're probably going to ask you questions about your lifestyle and behaviors, such as how many drinks you consume on a daily basis. That's measurement-based care at its core. So it's not that hard of a sell to get them to add a PHQ-9 to their battery of measurement-based care instruments that they're already using. But, there are some idiosyncrasies with behavioral health measurement-based care that have affected the rate of adoption. For example, the PHQ-9 has questions about suicidal ideation, which some PCPs are not comfortable with, especially in the pediatric space. But, in the behavioral health care space, measurement-based care is so uncommon, it's shocking.*[25]
>
> – **Andrew Carlo, MD, MPH**
> Vice President of Health System Integration, Meadows Mental Health Policy Institute

Once again, there are positive examples from other countries where implementation of measurement standards in behavioral health care practices is further along. In the Netherlands, three quality measures (effectiveness of treatment, safety and patient satisfaction) are measured at the start and end of

treatment, and published publicly to hold systems and physicians accountable, and ensure continuous improvement. This monitoring is incorporated into health insurance reimbursement mechanisms.

In the UK, a large-scale effort to improve the use of data collected across all mental health provider organizations resulted in the National Health Service Benchmarking Network, enabling providers and health systems to benchmark their results against others and improve their services where necessary.[26]

Without the integration of measurement-based care in the US, the transition to value-based care in behavioral health truly isn't possible. Physical health improvement can be measured with clear, agreed-upon metrics and vital signs, including blood pressure or A1C levels. In behavioral health, the only consistent metric that is collected is duration and type of treatment through claims data.[27] Measuring value and improvement has been more difficult. But it is time to standardize around a set of best-practice, gold-standard measures that can assess changes in intensity and frequency of symptoms.

According to Pincus et al, "large-scale uptake of value-based models in the US has been slow for several reasons, including a lack of incentives for significant system overhaul, and a lack of accompanying payment infrastructure and improvement strategies to sustain quality care after significant changes to the system have been made. In particular, there are few behavioral, and even fewer integrated behavioral and general medical, healthcare quality measures available to support integrated healthcare systems reform."[28]

Dr. Pincus echoed this in our conversation with him, "Why aren't more people doing this? Because it's hard to get paid for it. There isn't a good way in which fee-for-service, independent practices do this. If you're working fee-for-service, how do you pay the psychiatrist that's giving advice? Is it a salary? Or a consultation fee? Who pays for it? And how do you cover the salaries of the care managers, who aren't always credentialled personnel? The implementation of this has been the problem all along. It really comes down to payment and accountability."[29]

Digital Integration

Implementation of a successful collaborative care model (and with it effective and scalable measurement-based care and a shift to value-based care) relies on a supportive digital behavioral health system, which requires attention to five key elements: (1) patient experience, (2) care team engagement, (3) clinical workflow adaptation, (4) performance management reporting and (5) data management.

Technology makes it easier to provide care and collaboration

Cecilia Livesey, MD, the Chief of Integrated Psychiatric Services at Penn Medicine, cites four ways that technology can make it easier for providers to care for patients: (1) automate processes; (2) centralize and integrate processes; (3) make processes more targeted and precise; and (4) push critical information to more accessible devices and communication portals. One such example is that providers can view surveys completed prior to the appointment and digitally "prescribe" self-serve treatments (e.g., online education resources, behavioral health mobile apps), eliminating time that would have been spent making referrals or delivering education through other channels. To be effective, these new tools must be part of the provider's workflow. In most cases, this means integration with the health system's EHR.[30]

According to Dr. Pincus, "when you have a platform that is PCP, specialist, behavioral health care manager and patient-facing, that's a powerful combination. It can help engage patients, it can help engage the provider team to make them more effective. It can provide the data that they need to track people and it can provide the clinical care guidance about what to do when someone isn't getting better and what steps to take."[31]

Kaiser Permanente Case Study

Noting the lack of care for less than half of adults with mental health conditions in the US, and the prevalence of smartphones and apps pertaining to wellness, Kaiser Permanente embarked on a pilot program to integrate digital technology across their health system to augment care. The team used "human-centered design, a creative problem-solving approach that draws on the social sciences and emphasizes empathy, human needs, and interactions"[32] and conducted interviews with a number of patients and clinicians and staff to better understand the need, and current and desired states of mental health care delivery. Additionally, they did a deep-dive into the current offerings in the digital wellness space to understand how they are used and best practices across industries.

Rather than build a wellness app themselves, the team at Kaiser built a "mental health and wellness digital ecosystem," that includes a curated list of recommended apps (using the American Psychiatric Association's evaluation model), the ability for clinicians to refer patients to apps and to document that referral in their EHR, and to send patients text messages with a link to download apps from their phone, clinician training and support materials, and audio and video information on their member-facing website. They negotiated directly with each app to allow Kaiser members to use them at no charge for six months, and later expanded the library of apps available to Kaiser members without a referral from their clinician.

While the initial roll-out took place throughout 2019, in March 2020, as Covid-19 spread, the team was able to quickly scale up to go beyond mental health, deeper into primary care and into other specialities like obstetrics/gynecology, and move training online so more staff could reach more patients through the digital ecosystem.

More than half of trained clinicians made a referral in measurements taken in the first half year of use, and while patient use dropped off after 3 months, about a third were still actively using the apps. The patients with the highest engagement rates were those referred by a health coach or primary care physician, versus those who were referred by a physician with whom they had less regular contact. To support clinicians and patients, "mapping the solution to several key factors – clinician workflows, visit types, ease of clinician referral to apps, and ease of patients receiving referrals and downloading and beginning to use apps" was key to success.

Momentum in the US

There is momentum across behavioral health care towards collaborative care. The research is clear that it benefits patients and health systems: long-term analyses have demonstrated that $1 spent on collaborative care saves $6.50 in health care costs[33] and a 2013 study found savings in Medicare and Medicaid settings of up to 6 to 1 in total medical costs. If only 20% of people with depression had access to CoCM, the U.S. Medicaid system alone could save an estimated $15 billion a year.[34]

Patients also see benefit when a care team is assigned to them, and physicians are better able to scale their practices: PCPs can focus on their areas of expertise and psychiatrists can treat the patients who need them the most. When measurement-based care is used consistently, patients can better track their symptoms and are more in touch with their care plan.

On January 1, 2017, Medicare began making separate payments to physicians and non-physician practitioners supplying behavioral health integration (BHI) services using the Psychiatric Collaborative Care Model (CoCM) approach to patients during a calendar month. The following year (CY 2018), Medicare began making payment for these services using CPT codes 99492, 99493, and 99494, and established payment for general BHI services using models of care other than CoCM.[35]

Reflecting on barriers to implementation of collaborative care, Dr. Carlo told us: "In 2017, when Medicare activated collaborative care billing codes, a number of commercial payers came on early, but it took many a long time to activate the codes. Medicaid plans are still trickling towards activation. Take Texas, for example, it's the second largest state in the country with a population of 30 million and 5 million on Medicaid, three-quarters of which are children. In 2021, the state legislature, which has prioritized mental health, passed legislation to make collaborative care a Medicaid benefit. I think a state like Texas coming on board creates momentum. It's not that people are against it, it can just take a long

Medicare Fee-for-service Utilization of Services[37]

CPT		CY 2018	CY 2019	CY 2020	△, 2018-2020
99484	Care mgmt svc bhvl hlth cond	22,645	53,804	126,737	459.7%
99492	1st psych collab care mgmt	9,969	16,507	7,252	-27.3%
99493	Sbsq psych collab care mgmt	5,812	16,507	23,754	308.7%
99494	1st/sbsq psych collab care mgmt	16,345	27, 365	14,470	11.5%
99453*	Rem mntr physiol param setup	N/A	21,171	92,766	
99454*	Rem mntr physiol param dev	N/A	59,429	437,734	
99457*	Rem physiol mntr 1st 20 min	N/A	55,862	373,760	
99458**	Rem physiol mntr ea addl 20 min	N/A	N/A	116,189	
99421**	Ol dig e/m svc 5-10 min	N/A	N/A	65,778	
99422**	Ol dig e/m svc 11-20 min	N/A	N/A	109,772	
99423**	Ol dig e/m svc 21+ min	N/A	N/A	82,289	

time to get through any bureaucracy. In spite of these challenges, more than half of states' Medicaid plans now reimburse for collaborative care, increasing access to evidence-based behavioral health care for millions. Additionally, key pieces of legislation have been introduced at the federal level, such as the COMPLETE Care Act, to facilitate collaborative care implementation in practices nationwide by helping to defray some of the associated start-up costs."[36]

There is a misperception that collaborative care activities can't be reimbursed, but a wide variety of behavioral health services can be billed under collaborative care management codes, and CMS has updated the codes since they were first introduced in 2017 to better support organizations implementing the model.

Billable activities include:

- Initial and subsequent psychiatric collaborative care management, inclusive of tracking patient follow-up, outreach to patients, participation in weekly caseload consultation with the care team, monitoring of patient outcomes using rating scales
- Care management services for behavioral health conditions (initial assessment, behavioral health care planning, facilitating treatment and continuity of care) and online digital evaluation and management

Supporting providers so they can focus on their patients and their diagnoses and treatments is the key tenet of our mission at Dr. Katz. As the behavioral health landscape shifts, our aim is to help providers shift with it, so they can continue to deliver high quality care, in a way that is most beneficial to their patients and their practices. Although a software platform cannot by itself solve all problems with mental health care delivery, progress depends on that foundation.

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