

Collaborative care model for mental health, addiction treatment

DEC 30, 2020

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Patients are more comfortable talking to primary care physicians about their mental health in general and especially when we have resources available to support their mental health needs, according to Matthew Press, MD, and Cecilia Livesey, MD. They are two of the architects of Penn Integrated Care at Penn Medicine, a program based on a validated model of integrated physical and mental health care called collaborative care.

“This is not a new concept in medicine,” said Dr. Press. “We took the evidence-based collaborative care model and made a few changes to expand access to mental health care for patients seen in our primary care practices.”

The way it works, according to Drs. Press and Livesey, is that when patients have a primary care visit, which could be for an acute problem or a check-up, patients are given a universal depression screening as part of the routine intake process.

If the screening indicates a concern, or if the primary care physician identifies a concern, a more thorough assessment is given and determinations are made with the patient whether a referral to specialty mental health care is needed or whether can be provided in the primary care setting with the help of a clinical social worker working in tandem with the primary care physician and a consulting psychiatrist.

One difference between usual care and collaborative care is that the referral process happens relatively seamlessly. Whereas it’s common in many parts of the United States for patients to face major obstacles to getting treatment for a mental illness or substance-use disorder, the primary care physician in the Penn Medicine program can easily connect patients to the “front door” of care, where follow-up is optimized for his or her clinical condition, geographic location, insurance status, and availability of psychiatrists and other specialty providers.

Connected to the right care

“Care determinations are tailored for each patient, and we connect each patient to the level of care they need, where they need it,” said Dr. Livesey. “The collaborative care model has proven successful for mild-to-moderate depression, anxiety, alcohol-use disorder, and has shown promise with other conditions, including opioid-use disorder, which is currently under investigation at Penn Medicine and several other institutions.

“We already have many physicians in our system to provide buprenorphine in-office for the treatment of opioid use disorder, and we know this is an area of great need for our patients,” she said.

This approach also benefits the physician. Physicians are more comfortable broaching the topic of mental health when they know they have support and a solution standing by, and it is destigmatizing for the patient.

“It normalizes the experience of seeking behavioral health services,” said Dr. Livesey. “You come in for a checkup for something routine and your mental health is a part of that, you increase the comfort level. The framing and the language and the context increase the likelihood that a patient will be open to some of these interventions.”

The mental health assessment is also critical in that it serves as an objective measurement tool so that patients progress can be monitored.

“You can’t treat diabetes without measuring blood sugar; you can’t treat hypertension without measuring blood pressure. But many treat mental health without measuring symptoms on an objective scale—so we use standardized measurement tools so we know what we are treating and have an objective understanding of it,” said Dr. Press.

50% depression and anxiety remission rate

The results have been impressive: the program currently has close to a 50% depression and anxiety remission rate—that is, not having clinically meaningful symptoms of depression or anxiety as measured by evidence-based self-reported assessments. For patients with a continuing need for treatment, the program supports ongoing care.

Another traditional barrier to treatment for behavioral health is payment. However, the collaborative care model is now supported with sufficient payment through new CPT codes. These codes allow for reimbursement for a set of team-based services provided under indirect supervision of the primary care provider through their medical insurance.

“Collaborative care is no longer dependent on a grant; it’s not a pilot. It’s a real program based on evidence and now a financially stable way to support it,” Dr. Press said. “Early on, we had to work

with insurers to cover the codes, but at this point most insurers cover the codes and those that do not are coming to the realization that this is win-win, very high-value service for patients. Through these codes, collaborative care can be available to physicians everywhere.”

“We recognize that not all physicians or systems may have the experience, staff or technology to enable easy implementation,” said Dr. Press. “But practices, even small ones, should not feel intimidated that collaborative care models are out of reach. There are tools available to support practices, and some practices may find it helpful to share resources with each other.”

In the Penn Medicine model, patients are getting the care they need, and physicians are freed up to treat patients instead of spending hours frustrated in not being able to complete referrals. Physicians also have said that the model provides immense satisfaction from working closely with colleagues specializing in other disciplines.

“I used to feel like I was at sea with no life preserver when it came to mental health care for my patients,” said Dr. Press. “I just didn’t have the tools to help. But with collaborative care, now I do.”

Physicians demonstrate leadership every day to help their patients with a substance-use disorder—or chronic pain. Learn more at the AMA’s End the Epidemic website.