

THE PATH FORWARD NATIONAL STEERING COMMITTEE

National Alliance of Healthcare
Purchaser Coalitions

American Psychiatric
Association

American Psychiatric
Association Foundation

Bowman Family Foundation

Meadows Mental Health
Policy Institute

THE PATH FORWARD RESET REGIONS AND COALITIONS

California
Pacific Business Group
on Health
Silicon Valley Employers Forum

Florida
Florida Alliance for
Healthcare Value

Kansas
Kansas Business Group
on Health

Maryland, DC & No Virginia
MidAtlantic Business Group
on Health

Minnesota
Minnesota Health Action Group

**NYC metro area including No
New Jersey & So Connecticut**
Northeast Business Group
on Health

Tennessee
Memphis Business Group
on Health
HealthCare 21 Business
Coalition

Texas
Dallas Fort Worth Business
Group on Health
Houston Business Coalition
on Health

Accelerating the Path Forward During Turbulent Times *The Case for Collaborative Care During Covid-19*

We are collectively experiencing a time like no other, where social strife, isolation, and economic hardship combine with unprecedented change and uncertainty. All of this creates a perfect storm for a 2nd pandemic wave of mental health and substance use issues. This is all occurring with a mental health system that has, too often, been unavailable and unresponsive, particularly to communities of color, LGBTQ people, and people living in poverty. These limitations have been exposed in both employer-sponsored healthcare and publicly funded payers which have created massive health inequities for everyone, from those with the mildest symptoms to those with serious behavioral health conditions.

In these desperate times, change must occur quickly and in multiple areas, as opposed to implementing one reform at a time. Given the urgency demanded by the COVID-19 crisis, we should prioritize reforms that are readily implementable without additional testing or validation. The strategic priorities of The Path Forward are already evidenced-based and therefore do not require further research or validation. They are directed at both the general medical system and the specialty behavioral system, have specific actionable recommendations on screening, Measurement Based Care, and expanding in network access to specialty behavioral health care.

These recent events have caused The Path Forward to double down, reprioritize and accelerate our efforts (*see [Preparing for the Second Wave and Tele-Behavioral Health for Employees](#)*). While we understand the need for diverse efforts to create change, we are extremely concerned that some of those efforts will dilute and divert focus on near-term opportunities to improve access and care for all Americans. **Therefore**, we are calling on all organizations that aspire to improve access and care for all Americans to work with us to align priorities so that it will result in immediately essential changes in practices.

More specifically, we are calling upon all mental health advocates to move beyond simply advocating for undefined “best practices in mental health integration with primary care” and instead focus on the Collaborative Care Model in their proposals and recommendations. In short, there is no other evidence-based practice in primary care which is immediately available to be scaled and implemented to increase our country’s ability to systemically screen and treat mental health conditions while reducing health inequities and improving outcomes.

Why Collaborative Care during Covid-19

- Evidence-based
- Scalable and potentially virtual
- Payment mechanisms in place
- Proven to reduce health inequities
- Triages to best use of scarce BH resources

The significant evidence base for Collaborative Care is well-known and broadly acknowledged. In the face of the new challenges posed by Covid-19, mental health advocates must come together to advocate strongly for this as a best practice and not just include it as a suggestion. This includes strongly promoting it through the primary best practice model in various primary care settings across the country. Collaborative Care has been recommended by almost all national policy documents for over 20 years, starting with the Surgeon General’s report of 1999 and continuing through the work of the Kennedy Forum¹ over the last decade, which was instrumental in CMS’s decision to pay for Collaborative Care through Medicare. In addition to over 90 randomized control trials (RCTs), plus many non-academic large scale implementations, it is the only integration model that has a specific billing code and strong evidence of cost savings.

Collaborative Care inherently incorporates Measurement Based Care, another pillar of The Path Forward. It is an objective approach to assessment and treatment and has been shown to reduce health disparities. Studies have shown that the use of measurement-based care will not only identify issues earlier but will improve outcomes by 20 to 60 percent when applied across the course of treatment.

We recognize that there have been a number of integration models promulgated over the past two decades, including the Primary Care Behavioral Health (PCBH) co-location model and the Child Psychiatry Access Program (CPAP) consult model. These integration models represent important efforts to improve the care of behavioral conditions in primary care and have both added value by supporting primary care practitioners. We are hopeful that the evidence for these models will continue to be gathered, building on the lessons and tenets of the Collaborative Care model, including systemic assessment, referral across the spectrum of available and critical resources, disciplined follow through, seamless patient-centered teamwork, and commitment to measurement of outcomes.

“The Collaborative Care Model is one of very few specific interventions in medicine that have been shown via multiple RCTs to reduce disparities by race/ethnicity and/or socioeconomic status in patients’ access to care, quality of care, and outcomes.”

Michael Schoenbaum, PhD

Senior Advisor for Mental Health Services, Epidemiology, and Economics, Division of Services and Intervention Research National Institute of Mental Health

However, at present none of these models have strong research and practice support, evidence of cost savings, and the consistent integration of Measurement Based Care that Collaborative Care offers. And at a practical level, Collaborative Care is currently the only model with a CPT billing code broadly recognized across federal, state and commercial payers, so it is the only model currently viable in fee-for-service systems which still dominates most health services reimbursement and drives many value-based arrangements. While other models may seek new payment mechanisms to integrate behavioral health and primary care, it took over 15 years to develop and implement billing codes for Collaborative Care. With the current COVID-19 crisis, that implementation timeframe is inconceivable and would be a tragedy!

Policy documents seeking to equate Collaborative Care with other interventions should acknowledge the specific evidence that supports that view and define a viable mechanism to support scaling across federal, state and commercial payers. A review of the research published in 2018 on one

¹ <https://www.thekennedyforum.org/vision/integration/>

such model (Primary Care Behavioral Health or PCBH), which requires co-location as a component, had these findings stated as follows:²

- “There was no evidence of greater improvement in patient health status when PCBH was compared to other active treatments”
- “However, there is relatively little research on whether patients benefit from receiving PCBH services. This stands in stark contrast to the well-established evidence-base for Collaborative Care.” (emphasis added)
- “Conclusions: The implementation of PCBH services is ahead of the science supporting the usefulness of these services. Patient outcomes for PCBH are weaker than outcomes for Collaborative Care. “

The Path Forward for Mental Health and Substance Use has prioritized Collaborative Care specifically and Measurement Based Care more generally, as key pillars of our collective agenda because of the strong evidence from both research and practice implementations. As a group, we are very concerned about recommendations to health systems for integration interventions that lack robust practice and research support and a clear mechanism for implementation (e.g., a billing code).

We realize that many health systems are already using one or more of the other integration methods, and we are not recommending that these systems stop using these interventions. Instead, we those systems should be moving to access Collaborative Care as a funding mechanism for their existing programs through whatever workflow and process changes are necessary. This will enable primary care practices (including federally qualified health centers) to expand the use of care managers and Measurement Based Care and at the same time be especially helpful for programs dependent on grants.

In these turbulent times, it is more important than ever to align around a collective agenda that is evidence-based and immediately scalable and sustainable. We can move this agenda forward – together - with a common voice and a realistic and immediate plan for stakeholder engagement. We are open to a broad tent of participation by our advocacy community and again implore all organizations that aspire to improve access and care for all Americans to work with us so that we can see pressing, essential changes in practices across the country. The time is here, the time is now!

² Possemato, K., Johnson, E. M., Beehler, G. P., Shepardson, R. L., King, P., Vair, C. L., ... Wray, L. O. (2018). Patient outcomes associated with primary care behavioral health services: A systematic review. *General Hospital Psychiatry*, 53, 1–11. doi: 10.1016/j.genhosppsy.2018.04.002