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Harnessing Collaborative Care for Mental Health Demands in the Era of COVID-19

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The COVID-19 era presents unprecedented mental health treatment access challenges. This Viewpoint outlines why Collaborative Care, an extensively evidence-based model for integrated care, is the most promising strategy to meet this critical emerging need.

The COVID-19 pandemic increasingly weighs on the U.S. psyche as it exposes structural inequities, intensifies longstanding mental health access challenges, and vastly increases the number of individuals in need of treatment. Some people have developed neuropsychiatric sequelae[1] following COVID-19 infection, while others have been traumatized in their roles as front-line health workers and first responders. Still others have been stricken with new anxiety or depressive disorders, while those with pre-existing mental health problems have seen their conditions worsen amid social distancing directives. As demands on our already strained and specialty-focused mental healthcare system increase, one of the most promising solutions for the pandemic's unique needs is expediting integration of mental and physical healthcare in the primary care setting, with the Collaborative Care Model (CoCM) being the most evidence-based strategy.

Over the past two decades, more than 80 randomized controlled trials have validated CoCM's efficacy across diverse settings, diagnoses, and populations, thereby establishing its primacy among models for mental health integration[2]. CoCM relies upon a specially trained behavioral health care manager (often, but not necessarily a licensed clinical social worker or registered nurse) to practice in concert with primary care providers (PCPs) and evaluate patients' mental health care needs using common patient-reported outcome instruments (e.g., the PHQ-9 for depression), all while receiving regular input and supervision from a designated psychiatric consultant (which may be staffed by any licensed provider qualified

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to prescribe the full range of psychiatric medications). Through structured case reviews, the behavioral health care manager and psychiatric consultant jointly develop a treatment plan for each patient, which may include medication recommendations to the PCP, short-term psychotherapy, or both. When deemed necessary by the CoCM team, psychiatric consultants may see patients individually for a limited number of visits to assist with diagnostic clarification. Importantly, CoCM is financially supported by novel billing codes recognized by Medicare and many other public and commercial payers, making the model financially sustainable[3].

The pressing need for CoCM is underscored by the fact that our current specialty mental health delivery system is unable meet the expected service demands of the pandemic and beyond. Even before COVID-19, access was limited throughout the U.S.; mental health specialists remain largely confined to solo-clinician practices in urban areas and continue to have poor participation in insurance networks, meaning services are often far from many patients, out-of-network (leading to higher out-of-pocket costs for patients), and effectively siloed from medical teams. CoCM provides solutions, summarized in Table 1, to these and many other problems that have emerged or been exacerbated by COVID-19's arrival.

CoCM brings specialty expertise directly into the setting where most mental health problems are already being treated - primary care. Although CoCM may increase the number of mental health visits for PCPs, the integrated and coordinated nature of care delivered through the model ultimately reduces preventable utilization and demands on PCPs and the health system overall[4]. Further, with primary care increasingly delivered via video chats and secure messaging, CoCM is able to capitalize on telemedicine to facilitate geographic flexibility for patients and providers in this virtual clinical space. While the behavioral health care manager must be prepared to conduct in-person visits if needed, they are encouraged to use the electronic medical record (EMR), telephone, and video conferencing for patient care whenever possible[5]. Using the same technology, the CoCM team can communicate with PCPs as needed. Of note, the CoCM billing codes are designed to account for services delivered between face-to-face visits and are billed in the name of the PCP (partially mitigating specialty mental health network adequacy problems). This, coupled with recent telehealth billing flexibility for physician services, means that all facets of CoCM, including individual virtual visits between the patient and psychiatric consultant, are billable in the COVID-19 era.

Leveraging telehealth also enables CoCM to extend the clinical reach of scarce mental health specialists to include large numbers of patients over expansive geographic areas. Through weekly case review sessions of one or two hours with each behavioral health care manager, a single psychiatrist can contribute their mental health expertise to as many as 100 patients. Further, since psychiatric consultants are not required to see patients in person, co-location with the behavioral health care manager is not essential, allowing them to make clinical recommendations for patients living in rural or underserved areas without needing to travel long distances. This operational flexibility also allows more than one psychiatrist to fill the consultant role in the prevalent scenario where a single provider cannot be secured longitudinally. Of note, other previously described CoCM implementation challenges remain formidable amid the COVID-19 pandemic (e.g., cultural differences between mental health

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and primary care, novel workflow establishment) and clinics are encouraged to consider previously described mitigation strategies in their workflow design[6].

In addition to its operational flexibility, CoCM is versatile and has been validated in the treatment of depression, anxiety, post-traumatic stress disorder and other common mental health conditions[2,5]. This adaptability allows CoCM to leverage the behavioral health care manager and existing infrastructure to quickly target or proactively screen high-risk populations, including those with a history of COVID-19, front-line health care workers and underserved populations. Importantly, during a period where racial/ethnic minority groups have a higher risk of COVID-19 infection and complications, adaptation of CoCM principles has been shown to reduce racial/ethnic minority treatment disparities in the primary care management of depression[7].

COVID-19 has highlighted the U.S. need for more efficient and widespread mental health service delivery, especially for patients with complex medical and psychiatric needs. Our current mental healthcare system is inaccessible and siloed from the rest of medicine, making it poorly equipped to rise to this critical occasion. To meet the increased mental health service needs of COVID-19, healthcare systems nationwide must begin quickly implementing integrated mental health delivery models that are scalable, flexible, and sustainable. With more than two decades of evidence supporting its use across diverse populations and diagnoses, CoCM should form the backbone of our mental health care response to this pandemic and the challenges that lie beyond it.

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References:

1. Troyer EA, Kohn JN, Hong S. Are we facing a crashing wave of neuropsychiatric sequelae of COVID-19? Neuropsychiatric symptoms and potential immunologic mechanisms. Brain Behav Immun. 2020;(April):0–1. doi:10.1016/j.bbi.2020.04.027
2. Archer J, Bower P, Gilbody S, et al. Collaborative care for depression and anxiety problems. In: Archer J, ed. Cochrane Database of Systematic Reviews. Chichester, UK: John Wiley & Sons, Ltd; 2012:2–4. doi:10.1002/14651858.CD006525.pub2
3. Carlo AD, Corage Baden A, McCarty RL, Ratzliff ADH. Early Health System Experiences with Collaborative Care (CoCM) Billing Codes: a Qualitative Study of Leadership and Support Staff. J Gen Intern Med. 2019;15(Table 2). doi:10.1007/s11606-019-05195-0
4. Katon W, Russo J, Von Korff M, et al. Long-term Effects of a Collaborative Care Intervention in Persistently Depressed Primary Care Patients. J Gen Intern Med. 2002;17:741–748. doi:10.1046/j.1525-1497.2002.11051 [PubMed: 12390549]
5. Fortney JC, Pyne JM, Kimbrell TA, et al. Telemedicine-based collaborative care for posttraumatic stress disorder: A randomized clinical trial. JAMA Psychiatry. 2015;72(1):58–67. doi:10.1001/jamapsychiatry.2014.1575 [PubMed: 25409287]
6. Sanchez K. Collaborative care in real-world settings: Barriers and opportunities for sustainability. Patient Prefer Adherence. 2017;11:71–74. doi:10.2147/PPA.S120070 [PubMed: 28115833]
7. Angstman KB, Phelan S, Myszkowski MR, et al. Minority Primary Care Patients With Depression: Outcome Disparities Improve With Collaborative Care Management. Med Care. 2015;53(1):32–37. doi:10.1097/MLR.0000000000000280 [PubMed: 25464162]

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Table 1:

COVID-19 Mental Health Challenges and CoCM-Driven Solutions

COVID-19 Mental Health Challenges	Collaborative Care (CoCM) Solutions
Hospitals and health systems need evidence-based, scalable treatment models to treat the increased incidence of mental health problems in the wake of COVID-19.	CoCM is a scalable population health intervention that has been shown to be effective in more than 80 randomized-controlled trials across diverse settings, diagnoses and populations[2].
COVID-19 has exacerbated existing disparities in health care, particularly for racial/ethnic minorities and vulnerable populations.	Implementation of CoCM has been shown to reduce racial/ethnic depression outcome disparities in primary care[7].
In the wake of COVID-19, primary care mental health needs will increase, and mental health problems require large amounts of time to be properly diagnosed and effectively treated.	CoCM enables primary care providers to deliver higher quality mental health treatment by supplementing existing services with a designated team[2].
COVID-19 has created a rapidly growing need for trauma-focused treatment, but there are a limited number of specialty-trained clinicians.	CoCM has been shown to be effective for post-traumatic stress disorder in multiple randomized controlled trials (including through telehealth delivery)[5].
Mental health services are challenging to provide in-person due to social distancing guidelines and much of primary care has transitioned to virtual delivery.	Research has shown that CoCM is effective through remote telehealth delivery[5]. CoCM billing codes account for services delivered virtually between visits and are billed in the name of the PCP (partially mitigating specialty mental health network adequacy problems)[3].
Patients after COVID-19 infection may have complex neuropsychiatric symptoms and require medical, neurological and mental health treatment.	CoCM is an inherently integrated, multi-disciplinary strategy for treating chronic physical and mental health problems in the primary medical setting[2].
There is a need for proactive outreach to high-risk populations to screen for common mental health problems in the era of COVID-19 and beyond.	The CoCM behavioral health care manager employs a population health approach[2] that can easily be directed toward high-risk populations, such as front-line health care workers or patients recovering from COVID-19 infection.