

## **COLLABORATIVE CARE AT THE UNIVERSITY OF PENNSYLVANIA: “PENN INTEGRATED CARE”**

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### **The Issue**

Mental health and substance use disorders are a leading cause of disease burden in the United States and major driver of healthcare costs. Individuals with these disorders experience two to three times higher medical costs than those without.

Most people who get any mental health or substance use care do so through primary care. Screening in primary care also is the way that many people with these disorders get to specialty care. Yet, less than half of patients referred to psychiatric care follow through.

### **Current State of Collaborative Care Management**

The Collaborative Care Model (CoCM) is recognized as the most successful and evidence-based approach to integrating mental health care and primary care. CoCM improves clinical outcomes, increases patient and provider satisfaction, and reduces health care costs. Primary Care Providers (PCPs) using CoCM can now be reimbursed through new CoCM billing codes, initially adopted by Medicare in 2017 and subsequently codified by AMA-CPT for other payers to adopt. While uptake of the codes has been gradual, today more than forty commercial insurers are reimbursing, as well as many Medicaid agencies.

The University of Pennsylvania is spearheading important innovations in the delivery of collaborative care and is supporting the program through billing the reimbursement codes to multiple insurers in Pennsylvania.

### **Collaborative Care at the University of Pennsylvania**

Penn Medicine, a large health system serving a diverse population, has succeeded in an evidence-based, broad-scale implementation of CoCM through an initiative called Penn Integrated Care (PIC). The Department of Psychiatry partnered with the Primary Care Service Line to develop this innovative program.

PIC began in 8 primary care practices in January of 2018. These 8 practices comprise approximately 100 PCPs serving more than 90,000 patients. Referrals are made to PIC one of three ways: a warm-handoff in the primary care practice to an embedded Mental Health Provider, an electronic order to the PIC Resource Center, or proactive identification of those with high-risk co-morbidities, such as uncontrolled diabetes and depression. In most cases, patients are referred to a telephonic Resource Center, staffed by trained intake coordinators who are supervised by a Licensed Clinical Social Worker.

A challenge common to many CoCM programs is the time commitment required by Primary Care staff and Mental Health Providers to assess and triage patients, especially those who need more specialized services than can be provided in a primary care setting. The centralized Resource Center reduces this burden and allows the practice-based Mental Health Provider to focus on delivering interventions that improve outcomes. The Resource Center leverages the principles of measurement-based care with tools such as the PHQ9, GAD7, PCL-5, AUDIT-C, and CSSRS, among others. This information is fed into a decision-support algorithm which assists the Resource Center in determining the appropriate setting and resources for the patient.

Patients who would benefit from collaborative care are scheduled with a Mental Health Provider, typically a Licensed Clinical Social Worker, in the primary care practice. The Mental Health Provider delivers brief interventions, such as behavioral activation and motivational interviewing, and is also available for urgent safety assessments. Each Mental Health Provider receives weekly and ad-hoc face-to-face consultation with

a Psychiatrist and maintains a registry of patients. An e-consult is available between the PCP and Psychiatric Consultant for complex medication management cases.

PCPs who are part of the PIC initiative have provided extremely positive feedback on the program. Many think that this program has improved clinician satisfaction and helped alleviate the burden of caring for a complex patient population. One PCP, Dr. Jeffrey Jaeger, said, “This is the single most impactful program I’ve seen in my 25 years at Penn.”

### **Innovations in Billing and Insurance**

One of the most common obstacles to successfully implementing CoCM is financial viability. Initial billing for the CoCM codes was limited to Medicare, but now almost all commercial insurers and managed care companies are reimbursing through advocacy and innovative partnerships. Having multiple insurers cover the codes has allowed the participating practices to offer the program across the full population of patients, which has increased access and satisfaction with the program.

### **Major Success and Plans for the Future**

When the program was first implemented, the PIC staff expected approximately 500 patients to participate in the first year. Instead, we received almost 6,000 referrals in 2018, and more than 11,000 by July 2019. This large volume of referrals is due in part to the accessibility of the centralized Resource Center and the acceptance of all mental health concerns and diagnoses. The program has identified more than 1000 patients at risk for suicide through their assessment process as well as hundreds who were endorsing symptoms of mania, psychosis, or post-traumatic stress disorder. These individuals were referred to the Resource Center by a PCP for a variety of reasons, but not identified as urgent cases. This demonstrates how a short visit with a PCP may not always reveal the acuity of a patient’s situation, but CoCM can help rapidly identify these patients and connect them to the care they need. Dr. Matthew Press, the Associate Medical Director of the Primary Care Service Line, noted, “Patients and their PCPs struggled for too long to access timely, high-quality mental health care. PIC is the answer to that struggle and is now foundational to the delivery of advanced primary care.”

Due to the immense success of the program so far, Penn Medicine will expand the PIC program to additional primary care practices, as well as specialty care practices. These additional practices will allow several hundred thousand more patients access to this program.

While this approach has been broad-scale over a large organization, Penn Medicine would like to pave the way for smaller organizations to adopt this model. One of the greatest challenges to implementing CoCM in smaller practices is the commitment of time and resources to make the program successful. Penn Medicine’s program is still in its early stages, but its innovative and inclusive approach can help inform the further adoption and evolution of CoCM.