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Addressing Mental Health Access with Collaborative Care: A Health Policy Analysis

Samantha Roche MSN, PMHNP-BC

A DNP PROJECT

TITLE: Addressing Mental Health Access with Collaborative Care: A Health Policy Analysis

STUDENT NAME: Samantha Roche, MSN, PMHNP-BC

DNP PROJECT PRIMARY ADVISOR
& DNP PROJECT TEAM MEMBER(S):

Richard Ricciardi, PhD, CRNP, FAANP, FAAN

Karen Whitt, PhD, APRN, FNP-C, AGN-BC, FAANP

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The George Washington University

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Samantha S. Roche

The George Washington University School of Nursing

DNP Project Primary Advisor: Dr. Richard Ricciardi

DNP Project Second Advisor: Dr. Karen Whitt

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Abstract

Background: There is a critical shortage of mental health providers in most areas of the United States. The Collaborative Care Model (CoCM) is an evidenced based model integrating behavioral health services into primary care. Where implemented, the CoCM has improved outcomes for people with common mental health issues. In Suffolk County, New York and across the nation there are a dearth of established CoCM programs despite an ongoing need for mental health services, largely due to startup costs. Legislation allocating federal funding to improve the uptake of CoCM programs was recently signed into law.

Objectives: The aim of this health policy project was to analyze the current state of collaborative care and relevant legislation to facilitate the practical and equitable expansion of the CoCM in Suffolk County, NY.

Methods: A policy analysis was conducted on H.R. 2617 section on Improving Uptake and Patient Access to Integrated Care Services utilizing the eight-fold path developed by Bardach and Patashnik. Project activities were community-based and consisted of interactions with a variety of stakeholders including federal and state legislators, primary care providers, and community members in Suffolk County, NY. Engagement with stakeholders and uptake of CoCM were measured.

Results: Analysis findings were shared with 130 stakeholders, and 82 community members were educated about the CoCM. Over 120 stakeholders and community members actively engaged with the student during implementation. Comments were submitted to the Federal Register and an op-ed was published in Newsday. There were no new CoCM programs implemented in Suffolk County, NY during the project implementation timeline.

Conclusions: Educating key stakeholders about the model, analysis findings, and funding options was an important step in directing implementation funding to the community. Implementation funding is one facet of long-term CoCM sustainability. Future opportunities to improve CoCM uptake exist due to the efforts of this project.

Introduction

The COVID-19 pandemic has brought the need for greater access to mental health services to the forefront. However, there is a critical shortage of mental health providers in most areas of the United States (Health Resources and Services Administration [HRSA], 2023). The Collaborative Care Model (CoCM) of behavioral health integration was designed by scholars at the University of Washington Advancing Integrative Mental Health Solutions Center (AIMS) to facilitate the treatment of mental health concerns within the primary care setting (AIMS, 2023). An embedded behavioral health care manager, psychiatric consultant, and tracking registry support the primary care provider in caring for those in need. The CoCM seeks to address the Institute for Healthcare Improvement (IHI) Triple Aim and was designed to integrate measurement-based care into the treatment model to readily evaluate efficacy and value (AIMS, 2023; IHI, n.d.).

According to the AIMS Center (2023) a plethora of randomized controlled trials and meta-analyses demonstrating the superior efficacy of the CoCM over usual care have been conducted. Where implemented, the CoCM has improved outcomes for people with common mental health issues such as depression, anxiety, and substance abuse disorders, as well as those with comorbid physical health issues such as cancer and diabetes (AIMS, 2023). Unfortunately, barriers to widespread implementation of the CoCM exist, particularly regarding financing and reimbursement of collaborative care (AIMS, 2023; Raney, 2020).

This DNP project consisted of a policy analysis of recent legislation allocating federal funding to improve the uptake of CoCM programs. Facilitators and barriers to expanded implementation of the CoCM were analyzed, and recommendations were developed to improve CoCM implementation and maximize the investment of government funds, particularly in

Suffolk County communities lacking health equity. Moreover, the DNP student engaged in steps designed to educate key stakeholders in Suffolk County, New York about the model and available policies, programs, and funding to foster implementation and spread of CoCM in primary care practices within the county.

Background and Significance

Mental Illness

There are a staggering number of people in the United States with mental health concerns. Nearly 1 in 5 Americans will experience mental illness in any given year (National Alliance on Mental Health [NAMI], 2022). Nearly 53 million adults in the United States suffered with a diagnosable mental health condition in 2020 alone (NAMI, 2022).

It is estimated that the prevalence of depression is anywhere from 5-10% in the United States (McCarron et al., 2021). The number of adults with depression continues to rise over time. The years 2010 to 2018 saw an increase of adults with depression of 12.9%, and those numbers are increasing every year (Greenberg et al., 2021). Adults reporting depression and anxiety symptoms peaked at 40% at the height of the 2020 pandemic and remain high at 33% as of June 2022 (Weiner, 2022). Approximately 2.7 million, or 4.4% of children ages 3-17 were diagnosed with depression pre-pandemic, between 2016-2019 (Centers for Disease Control and Prevention [CDC], 2023).

Anxiety disorders can also cause serious impairments in functioning and quality of life leading to significant loss of productivity. Prevalence of anxiety disorders in adults is estimated at over 19% in any given year, with more than 30% of adults experiencing an anxiety disorder at some point throughout their lives (National Institute of Mental Health [NIMH], n.d.). More than half of adults living with an anxiety disorder experienced moderate to severe impairment in their

functioning (NIMH, n.d.). Approximately 5.8 million children in the United States were diagnosed with an anxiety disorder between 2016-2019 (CDC, 2023).

According to the Substance Abuse and Mental Health Services Administration (SAMHSA, 2021) 40.3 million Americans aged 12 or older met the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5) criteria for a substance use disorder (SUD) in 2020. That includes approximately 28 million with alcohol use disorder, 18 million with drug use disorder, and 6.5 million with both (SAMHSA, 2021). Moreover, approximately 17 million people, or 6.7% of adults in the United States, experienced both a SUD and co-occurring mental illness in 2020 (NAMI, 2022).

The Costs of Mental Illness

The financial consequences of mental illness are numerous. Depression is a leading cause of disability in the United States and is associated with high costs personally and societally (Greenberg et al., 2021). In the United States alone, the cost of depression was estimated to be more than $210 billion in 2010, with primary costs attributed to direct care, suicide-related costs, and workplace costs (Greenberg et al., 2021). An individual patient may spend upward of $10,000 per year treating their depression and other related comorbidities (Leonhardt, 2021). Moreover, a person with mental illness is more likely to develop chronic illness and experience unemployment than the general population (NAMI, 2022). It is estimated that anxiety, depression, and substance abuse combined cost the United States economy between $2.5-8.5 trillion in lost productivity in 2010 alone (Chisholm et al., 2016).

Access to Care

Unfortunately, despite the growing rates of mental health disorders and the staggering costs associated with mental illness, fewer than half of adults in need receive mental health

treatment (NAMI, 2022). Although evidence-based treatments exist, only 46.2% of Americans with mental illness received care in 2020 (McCarron et al., 2021; NAMI, 2022). This is likely due to the dearth of mental health providers in the United States which presents a serious impediment to care access (Weiner, 2022). Nearly half of Americans reside in federally designated mental health professional shortage areas (HRSA, 2023; Kaiser Family Foundation [KFF], 2022) and there are not enough psychiatrists and other mental health providers to adequately meet the needs of Americans.

If no workforce changes are made, the US may experience a shortage of up to 12,000 psychiatrists by 2030 (American Psychiatric Association [APA], 2023). Population growth and increased demand for services has left a widening gap relative to supply of mental health providers (APA, 2023). Psychiatric nurse practitioners and physician assistants play an important role in mitigating mental health provider shortages but fail to fully fill the gaps (HRSA, 2018).

Increasingly, primary care providers (PCPs) are filling the void, with nearly 16% of primary care visits addressing mental health concerns in 2018 (Rotenstein et al. 2023). This is an increase of nearly 50% compared to the decade prior (Rotenstein et al., 2023). Clinicians in primary care are responsible to provide comprehensive whole-person care, which includes mental health. According to Rotenstein and colleagues, anxiety and stress-related disorders, depression, and substance use disorders were the most common concerns addressed during primary care visits. Patients generally view primary care as a cost-effective means of starting or continuing mental health medications (Kyanko et al., 2022). Unfortunately, additional time spent on high complexity direct care and referrals are often inadequately reimbursed in the traditional primary care model (Miller et al., 2011).

Despite time constraints and fiscal challenges, primary care clinicians regularly provide mental health care, referrals, and psychotropics to their patients (Miller et al., 2011; Rotenstein et al., 2023). Rotenstein et al. (2023) found that mental health needs were more likely to be addressed with a patient's own PCP, however, Hispanic and non-White people were less likely to have a mental health concern addressed during a primary care visit than White patients. Patients perceived mental health care as more likely to go unaddressed when the onus was on them to initiate the conversation and were less satisfied with their care when the PCP was acting alone, without collaborating with a mental health professional (Kyanko et al., 2022). Research by Kyanko and colleagues (2022) indicated that patients desired proactive, collaborative mental health treatment; ultimately, PCPs need more resources, training, and support in treating mental health in the primary care setting.

Suffolk County, New York

Suffolk County is a suburb within the New York metropolitan area, with its western border approximately 30 miles from the eastern limits of New York City. Though less congested than its urban counterpart, Suffolk is home to more than 1.5 million people living within 911 square miles (United States Census Bureau, 2022). According to U.S. Census data more than half of Suffolk County residents identify as female (50.4%) and nearly two-thirds are non-Hispanic White (65.7%). Hispanic or Latino residents comprise 20.7% of the population, while 9% are Black and 4.4% are Asian (United States Census Bureau, 2022).

Although Suffolk County is not considered a federally designated mental health professional shortage area (HRSA, 2023), difficulties accessing mental health services are a prominent concern among residents (Winslow, 2023). In fact, more than half of Suffolk County residents indicated that mental health and suicide were top health problems in their community

(Winslow, 2023). Suffolk County mental health resources are not robust. In 2017, the Association for Mental Health and Wellness (AMHW) indicated there was only one comprehensive psychiatric emergency program (CPEP) in the county and just over 400 Office of Mental Health (OMH) licensed psychiatric beds for adults and children. Moreover, there were fewer than 40 OMH licensed outpatient mental health centers serving the county's 1.5 million residents (AMHW, 2017).

Far too often in Suffolk County, police resources are utilized to bridge the gap in mental health services. According to the Suffolk County Police Reform and Reinvention Task Force (Baird-Streeter et al., 2021) there were 4,227 mental health related 911 calls over an eleven-month period from January through November 2020. Approximately 90% of those calls resulted in transport to CPEP or another appropriate psychiatric setting. An overwhelming majority (65%) of those calls originated at private residences and nearly three quarters of all calls (3,099) were prompted by suicidal statements or acts (Baird-Streeter et al., 2021).

Payment for Services

Patients understand that their mental health needs are not being met. According to SAMHSA (2021) in 2020 nearly half of adults perceived an unmet need for mental health services. In addition to a mental health provider shortage, there are a significant number of psychiatrists and mental health professionals who do not participate with Medicare, Medicaid, or commercial insurance plans. From 2013 to 2019 the number of psychiatrists participating in Medicare declined (Oh et al., 2022). Roughly half of all practicing psychiatrists in 2010 declined to participate in private insurance, Medicare, or Medicaid (Bishop et al., 2014).

Despite being the United States' largest payer for mental health services (Medicaid.gov, n.d.), Medicaid continues to fall short regarding access to mental health care. A recent analysis

by Wen et al. (2019) indicated that participation in Medicaid by psychiatrists dropped from almost 48% in 2010 to just over 35% in 2015. This is a significant decrease in an already declining healthcare specialty, a gap which other mental health disciplines cannot fill without systemic change. Low psychiatrist participation with Medicaid indicates poor access to mental health care for a vulnerable population.

The Collaborative Care Model

The CoCM was designed to address some of the most significant barriers to mental health care (AIMS, 2023). First, services are integrated into the primary care setting to reduce stigma surrounding mental health treatment, leveraging a patients existing rapport with their PCP to increase participation (AIMS, 2023). Second, the CoCM is designed to utilize a behavioral health care manager (BHCM), typically a social worker, to assist in the assessment, brief treatment, and coordination of care for the patient (AIMS, 2023). Next, the psychiatric consultant (PC) role is to formulate the patients individualized treatment plan with the BHCM and support the PCP in prescribing psychiatric medications (AIMS, 2023). The PC is usually a psychiatrist or psychiatric nurse practitioner. A depiction of the CoCM team structure can be found in Appendix A.

As described by AIMS (2023) and Raney (2020), the general steps of the CoCM are as follows:

1. The PCP assesses the patient using validated rating scales such as the Patient Health Questionnaire (PHQ-9) and the Generalized Anxiety Disorder scale (GAD-7) and refers the patient to the CoCM program if appropriate.
2. BHCM performs a needs assessment and enters patient data into a registry. The purpose of the registry is to track patient progress and adherence to the plan of care, and to facilitate communication of information among team members.

3. The patient, BHCM, and PC develop an individualized plan of care for the patient, which includes measurable goals using validated rating scales.
4. If appropriate, the PCP prescribes psychiatric medications with consultation and support from the PC as needed.
5. The BHCM may engage the patient in brief, evidence-based therapy interventions. They are also responsible for coordinating treatment with providers in the community, supporting medication management, and facilitating communication among team members.
6. Weekly case review sessions are conducted with BHCM and PC to proactively adjust the plan of care as needed.

Efficacy

The CoCM has been widely studied in less-severe mental illnesses such as depression, anxiety, and SUD (AIMS, 2023; Raney 2020). Serious mental illnesses such as schizophrenia and bipolar disorder are referred directly to traditional specialist psychiatric care. The CoCM offers many benefits to patients and providers, including enabling early intervention in mental illness and a support structure for an already overburdened primary care workforce (APA, 2021b). A robust evidence-base of more than 80 randomized controlled trials, systematic reviews, and meta-analyses have demonstrated that the CoCM is effective in improving outcomes for people with anxiety, depression, and SUD when compared to treatment as usual (AIMS, 2023).

Reimbursement and Financing

CoCM programs and teams are supported by a variety of billing strategies. Traditional fee-for-service billing codes for direct services provided by a licensed mental health professional

are billed when applicable (AIMS, 2023). Additionally, because of the evidence of the CoCM as efficacious and a good value of healthcare dollars spent, Centers for Medicare & Medicaid Services (CMS) authorized several Current Procedural Terminology (CPT) codes that can be billed for behavioral health integration and CoCM services (AIMS, 2023). CPT Codes 99492 through 99494 are bundled payment codes specifically designated for indirect care coordination services or direct services by a traditionally non-reimbursable provider (AIMS, 2023). Medicare reimburses these codes without attestation, diagnostic exclusions, or prior authorization (Raney, 2020) and many commercial insurance companies have followed suit (APA, 2021a), although not all pay at or near the Medicare rate (Raney, 2020). Bundled billing for CoCM codes represents an important strategy in financing CoCM programs and ensuring their sustainability (Raney, 2020).

Value

In addition to improving patient outcomes, research has demonstrated the CoCM is of good value. Several randomized controlled trials and systematic reviews evaluating cost effectiveness of the CoCM support that the model adds value to the healthcare system (Grochtdreis et al., 2015; Jacob et al., 2012; Katon et al., 2012). A systematic review by Jacob et al. (2012) found that utilization of the CoCM averted productivity loss and reduced overall healthcare utilization. Similarly, a randomized controlled trial by Katon et al. (2012) found that participants experienced improvements in physical and mental health outcomes and their analysis indicated improved quality-adjusted life-years.

Needs Assessment

The CoCM is a well validated model of care with over 80 randomized controlled trials and meta-analyses supporting its efficacy over care as usual (AIMS, 2023). According to the

AIMS Center, the CoCM utilizes validated measures and close collaboration among a treatment team to improve outcomes and both patient and provider satisfaction. This integrated model of behavioral health care is a feasible solution to the current mental health crisis and provider shortage. A needs assessment revealed that although CoCM programs exist in Suffolk County, NY and across the country, there are far too few to meet the growing needs of patients with mental health concerns. At present, the only operational CoCM programs in Suffolk County are within 12 primary care offices associated with one major university health systems (A. Jones, personal communication, December 2023).

Although the current FFS reimbursement model poses some fiscal challenges, the greatest barrier to expansion of CoCM programs at this juncture is lack of funding to implement the model in small-to-medium size primary care practices. To address this gap, a provision for funding of CoCM programs was included in the most recent appropriations act and signed into law on December 29, 2022 (Congress.gov, 2023). However, now that this has progressed into the implementation phase it is imperative that the rules for this legislation reflect the intent, and that funding and mental health care reach the intended population. A need for integrated mental health care exists at all levels of primary and specialty care, not solely in the context of state or federally funded clinics or major health systems.

Readiness for Policy Change

Initial readiness for policy change was evaluated in a SWOT analysis found in Appendix B, and ongoing evaluation of readiness for policy change throughout the DNP project was viewed through the lens of Kingdon's Multiple Streams Approach (Smith & Larimer, 2017; Hoefer, 2022). Kingdon posits that the problem stream, the policy stream, and the political stream exist largely independent of the other (Hoefer, 2022). However, policy change occurs

when there is a convergence of factors aligning these streams, opening a "policy window", or opportunity for change (Smith & Larimer, 2017). Momentum in all three streams indicated that there was readiness for change in Suffolk County, NY. Access to mental health care is an established and accepted *problem* in terms of provider supply related to service demand, the CoCM is an evidence-based and recognized *policy* solution, and the passing of recent legislation funding CoCM implementation indicates improving access to mental health care is on the *political* agenda.

Problem Statement

There is an urgent need to expand access to mental health care across the nation. Integrating behavioral health services into primary care is an effective way of expanding the reach of psychiatry and behavioral health services (AIMS, 2023). In Suffolk County, New York and across the nation there are a dearth of established CoCM programs despite an ongoing need for mental health services. Barriers and facilitators of widespread implementation of COCM require examination. Recent legislation has been passed to allow for federal funding of CoCM programs, however active advocacy and involvement in the policy implementation phase is crucial to ensuring funds reach the population for whom they are intended to assist.

Purpose Statement

The purpose of this project was to improve access to mental health care in Suffolk County. This project analyzed the state of Collaborative Care in Suffolk County, New York and the implementation of H.R. 2617 section on Improving Uptake and Patient Access to Integrated Care Services (Congress.gov, 2023). Facilitators and barriers to expanded implementation of this evidence-based model of care were examined, and recommendations were made to apply

delegated funding and increase awareness of this legislation among relevant stakeholders with the goal of improving the uptake of collaborative care in Suffolk County, NY.

Aim and Objectives

Aim

The aim of this health policy project was to analyze the state of CoCM implementation so that recommendations can be made during the implementation phase of H.R. 2617 section on Improving Uptake and Patient Access to Integrated Care Services to mitigate barriers and facilitate the practical and equitable expansion of the CoCM in Suffolk County, NY.

Objectives

1. Conduct a policy analysis of H.R. 2617 Division FF, Title 1, Subtitle C, Chapter 1, Section 1301 section on Improving Uptake and Patient Access to Integrated Care Services, amending Section 520K of the Public Health Service Act (42 U.S.C. 290bb-42).
2. Improve the uptake of CoCM in Suffolk County, NY.
3. Direct federal funding for CoCM program implementation to Suffolk County, NY.
4. Engage with stakeholder organizations.
5. Increase primary care and community awareness of CoCM programs and available resources.

Literature Review

Analysis Question

The aim of this literature analysis is to examine the following question: For adults and children (P), does implementation of the Collaborative Care Model (I) improve access to quality, effective, high-value mental and behavioral health services (O) as compared to care as usual (C)?

Search Strategy and Results

A review of the literature was undertaken to identify and synthesize the existing evidence in support of the Collaborative Care Model (CoCM) and to address the policy analysis question. The databases PubMed, CIHAHL and Cochrane Database of Systematic Reviews were searched utilizing the term "collaborative care model" alone or with the term "access". Studies considered for inclusion were full text English language, published in 2012 or later, and utilized the CoCM framework in an outpatient setting. Studies with seriously mentally ill populations (e.g. people experiencing psychosis-related disorders), settings other than outpatient or ambulatory care, or utilizing a model other than the CoCM were excluded. Additionally, reference lists and the AIMS Center website were reviewed for additional appropriate studies.

A total of twelve articles were appraised using the Johns Hopkins Nursing Evidence-Based Practice model and guidelines as outlined by Dang et al. (2021). The twelve articles were evaluated for their evidence level and quality: Two studies were evidence level I and of high quality. Seven were evidence level III of high or good quality. The three remaining studies were level V evidence and of high or good quality. Regarding methodology, four were systematic reviews, two non-experimental studies, two qualitative analysis, one randomized control trial (RCT), one case study, one expert opinion, and one quality improvement (QI) project. All studies were recent, published between 2012 and 2022, with the majority published within the past five years. The table of evidence is found in Appendix C.

Synthesis of Evidence

The Collaborative Care Model (CoCM) of behavioral health integration was designed by scholars at the University of Washington AIMS Center to facilitate the treatment of mental health concerns within the primary care setting (AIMS, 2023). According to the AIMS Center

(2023) more than 80 randomized controlled trials and meta-analyses demonstrating the superior efficacy of the CoCM over treatment as usual have been conducted. Indeed, this literature search confirms those findings. Eight of the twelve selected studies address different aspects of the efficacy of the CoCM (Archer et al., 2012; Burkhart et al., 2020; Coventry et al., 2015; Duncan et al., 2022; Gochtdreis et al., 2015; Hu et al., 2020; Jackson et al., 2022; Renn et al., 2022).

The systematic review by Archer and colleagues (2012) is a seminal Cochrane review that provides strong evidence of the efficacy of the CoCM for depression and anxiety in adults around the world. Grochtdreis and colleagues (2015) drew similar conclusions. Moreover, in adults, Coventry et al. (2015) found that the CoCM led to improved mental health outcomes and improved self-management of other medical comorbidities such as diabetes and heart disease.

The CoCM is also an efficacious model for other groups. The systematic review by Burkhart et al. (2020) found improved mental health outcomes in children ages 4 years to 21 years. Similarly, Renn and colleagues (2022) explored age differences among those engaged with the CoCM and found both younger adults, ages 18-64 years, and older adults ages 65 years and up experienced meaningful mental health improvement. Efficacy among racial and ethnic minority populations was explored by Hu et al. (2020), who found through their systematic analysis that collaborative care was effective for a variety of minority populations with or without specific cultural adaptations. Even when resources were scarce, Jackson and colleagues (2022) found that collaborative care could work with modifications. Duncan et al. (2022) asserted that telehealth capabilities assisted CoCM programs to maintain a high standard of effective care.

The theme that access to mental health care is improved by collaborative care implementation was reinforced by Burkhart et al. (2020) and Kinnan et al. (2019). The

systematic review by Burkhart and colleagues found increased initiation of mental health treatment in children participating in the CoCM in their primary care setting. Moreover, during the course of a QI project, Kinnan and colleagues implemented a CoCM program. By the end of the project implementation, the authors were able to clear a wait list of 350 patients requiring psychiatric referral at a federally qualified health center (FQHC) and connect new mental health referrals with a collaborative care manager within 1-2 weeks on average.

Challenges of collaborative care emerged in the search. The systematic review by Grochtdreis et al. (2015) noted higher initial costs when implementing the CoCM in primary care. In fact, the QI project by Kinnan et al. (2019) and the study by Weber et al. (2021) were supported by federal grant funding, at least for initial costs. Since the publication of Grochtdreis and colleagues systematic review, however, the Centers for Medicare and Medicaid Services have authorized billing codes specific to collaborative care to reimburse for indirect and care management services (AIMS, 2023). Consequently, Duncan et al. (2022) emphasized the importance of utilizing CoCM billing codes to improve the sustainability of CoCM programs, rather than relying solely on traditional fee-for-service billing structure. A qualitative analysis by Carlo et al. (2019) reinforced that CoCM billing codes are crucial to the financial success of CoCM programs.

Essential to the efficacy and sustainability of the collaborative care program are the team members. While the collaborative care team is traditionally thought of as primary care collaborating with a social worker and psychiatrist, Weber et al. (2021) concluded that nurses can effectively fill CoCM roles, offering more options where human resources may be scarce. Moller and colleagues (2018) explored the perspectives of primary care providers (PCPs) and staff on collaborative care. They found that the PCPs they interviewed were concerned about the

time commitment and sustainability of the CoCM. They concluded that PCPs should be central in program development to reduce perceived burden on this integral workforce. In fact, Kinnan et al. (2019) found that teamwork and buy-in was essential to the success of their QI project. Additionally, as primary care providers became more comfortable with the support of the behavioral health team member and psychiatric consultant, reliance on psychiatric consultation decreased over time.

Overall, the literature analyzed in this review reinforces the robust evidence base available supporting the efficacy of collaborative care. Collaborative care can improve access to care and outcomes for populations across age and race, in a wide range of settings. Despite costs up-front to initiate the model, recent improvements in billing practices provide hope for sustainability.

Framework and Evidence Based Practice Translation Model

The Ohio State University (n.d.) Health Policy Final Project Outline was utilized as a guide to determine steps for project completion. The policy analysis was conducted using the eightfold path as developed by Bardach and Patashnik (2020). The steps of the eightfold path align with the Ohio State project framework. The steps of the eightfold path are:

1. Define the problem,
2. Assemble the evidence,
3. Construct alternatives,
4. Select the criteria,
5. Project the outcomes,
6. Confront the trade-offs,
7. Decide,

8. Tell your story.

Define the Problem

There is insufficient access to mental health care in Suffolk County, New York. Integrating behavioral health care into the primary care setting (CoCM) is an evidence-based solution, however, barriers to widespread implementation of the CoCM exist, particularly the financing and reimbursement of collaborative care (AIMS, 2023; Raney, 2020).

Assemble the Evidence

The structure, function, and evidence base for the CoCM was discussed extensively in the section, "Background and Significance". As previously noted, recently passed legislation, H.R. 2617 section on Improving Uptake and Patient Access to Integrated Care Services allows for a state to partner with local healthcare organizations (Congress.gov, 2023). According to the legislation, these organizations may be qualified community programs, health centers, or primary care practices serving adult or pediatric patients. The bill allocates funding up to $2,000,000 annually for up to five years for to implement integrative collaborative care, or other evidence-based integrative care models (Congress.gov, 2023). Moreover, there is specific language allowing for funds to be utilized for CoCM implementation such as hiring staff, contracting with mental health providers, and purchasing software needed for a registry (Cognress.gov, 2023). These funds were made available through SAMHSA Promoting the Integration of Primary and Behavioral Healthcare (PIPBHC) grants (SAMHSA, 2023).

Construct the Alternatives

Policy options include allowing present trends to continue or allowing CoCM to grow at the current rate without any changes to current strategies for implementation funding.

Alternatively, options for obtaining implementation funding include applying for federal PIPBHC grant funding or requesting funding in the New York State budget.

Select the Criteria

The course of action was determined based on criteria that would improve the uptake of CoCM programs in Suffolk County, New York. This included 1) Which pathway or alternative would garner the greatest amount of funding for Suffolk residents; 2) Efficiency (e.g. is funding already available or is further advocacy required to designate funding); and 3) Timeline.

Project the Outcomes

Allowing present trends to continue will likely yield the current rate of uptake, primarily within the fiscal support of large healthcare organizations in Suffolk County who can support implementations costs. To improve the overall uptake of collaborative care, particularly in smaller healthcare settings and primary care practices, implementation funding is needed. Obtaining federal PIPBHC funding could direct up to $10 million to New York State and, thereafter, Suffolk County with advocacy and strategic partnerships. This is the most efficient policy option because federal funds have already been delegated for this specific purpose. Alternatively, with sufficient interest, legislators can request funding for collaborative care implementation in the New York State budget. However, this option is less desirable than obtaining federal funding since it would take time to advocate for funding, depend on state budget submission timelines, and likely result in funding significantly less than $10 million.

Confront the Tradeoffs

There would be no additional taxes generated by allowing present trends to continue, however, mental health access would be less likely to improve. On the other hand, both options to obtain funding will result in some taxpayer liability. This is discussed further in the “Risks and

Barriers" section. Applying for previously allocated federal grant is likely to yield significantly higher funding for the state without impacting state tax revenue.

Tell Your Story

Based on the previous steps completed in Bardach's eightfold path, the recommendations to improve uptake of CoCM programs in Suffolk County by applying for federal PIPBHC funding were presented to stakeholders. Further review of this stage can be found in later sections.

Methods

Design

The design of this project was a governmental policy analysis of the state of Collaborative Care in Suffolk County, New York and the implementation of H.R. 2617 section on Improving Uptake and Patient Access to Integrated Care Services (Congress.gov, 2023) to provide recommendations to facilitate the practical and equitable expansion of collaborative care in Suffolk County, NY during the DNP project timeline.

Setting

There were multiple settings identified to execute this project. The project was community-based and consisted of interactions with a variety of stakeholders including local federal and state legislators, primary care providers, and community organizations in Suffolk County, NY. These interactions were combination of meetings both in-person, telephone, and virtual, as well as written communications, such as letters and email. All interactions occurred within Suffolk County.

Population of Interest

The population of interest was county residents across the lifespan, adults and children, who could benefit from the expansion of CoCM programs and increased access to mental health care integrated into primary care provider practice within Suffolk County, NY. An addition population of interest were primary care providers practicing within the county could benefit from the support of integrative collaborative care. No data were collected from the population of interest or stakeholders. Participants were not recruited for this project and participant consent was not required.

Formulation of Recommendations for Policy Change

Based on the needs assessment and literature review and analysis, there is a need to advocate for federal funding designated for collaborative and integrative behavioral health care to be directed to Suffolk County, NY in order to increase the uptake and implementation of these programs. First, a systematic policy analysis of H.R. 2617 section on Improving Uptake and Patient Access to Integrated Care Services (Congress.gov, 2023) was conducted utilizing the eightfold path as developed by Bardach and Patashnik (2020). Additionally, significant efforts were made at the grassroots level. The DNP student engaged with local federal legislators, state legislators, and other stakeholders to educate and advocate for funding for collaborative care to be directed to Suffolk County, NY.

Project Interventions: Transition Toward Health Policy Change

Objective 1 Interventions

The DNP student conducted a policy analysis of H.R. 2617 Division FF, Title 1, Subtitle C, Chapter 1, Section 1301 section on Improving Uptake and Patient Access to Integrated Care Services, amending Section 520K of the Public Health Service Act (42 U.S.C. 290bb-42) by

September 15, 2023, utilizing the eightfold path as a theoretical framework (Bardach & Patashnik, 2020).

Objective 2 Interventions

To improve the uptake of CoCM programs in Suffolk County, NY, by December 2023, the DNP student engaged in efforts outlined for objectives 3-5 to increase the number of CoCM programs within primary care practices in Suffolk County, NY. Sample data collection spreadsheets can be found in Appendix D.

Objective 3 Interventions

To direct federal funding for CoCM program implementation to Suffolk County, NY, by December 2023, recommended changes to the proposed rules relevant to H.R. 2617 section on Improving Uptake and Patient Access to Integrated Care Services were submitted during the write-in period as instructed in the Federal Register (Congress.gov, 2023; Office of the Federal Register, n.d.). Additionally, during the DNP project implementation timeline, the DNP student established contact with federal and state legislators with Suffolk County constituency to garner support for directing CoCM funding to this region.

Prior iterations of H.R. 2617 section on Improving Uptake and Patient Access to Integrated Care Services, specifically H.R. 5218 the Collaborate in an Orderly and Cohesive Manner (COCM) Act, introduced in September 2021 by Democratic Representative Fletcher from Texas, garnered bipartisan support in the House of Representatives and had both Democrat and Republican co-sponsors (Govtrack, 2022). As anticipated, the DNP student's advocacy efforts were well received by local legislators of both parties. Specifically, the DNP student engaged federal legislators with Suffolk County constituency: Senators Shumer and Gillibrand of New York, Congressman LaLota of New York's First Congressional District, and Congressman

Garbarino of New York's Second Congressional District. The DNP student also engaged with New York State Senators (Districts 1-4 and 8) and New York State Assembly Members (Districts 1-12). Additionally, members of the New York State Senate and Assembly Committees on Health, Mental Health, and Alcoholism and Drug Use were identified for engagement. The DNP student specifically asked legislators to contact NYS OMH to request they apply for the delegated federal funding. Printed and electronic information sheets with the request and OMH contact information were provided to the legislators.

Objective 4 Interventions

To engage with stakeholder organizations, by December 2023, at least 2 stakeholder organizations of influence such as the New York Nurse Practitioner Association and the local chapter of the American Psychiatric Nurses Association were presented with clear, accessible information on CoCM programs and the recommendations from the policy analysis. Specifically, the DNP student contacted the local leaders and/or policy chair people of the aforementioned organizations to request an in-person or virtual meeting with the goal of garnering organizational support for improving uptake of collaborative care programs in Suffolk County, and garnering further connections related to this venture. During the meeting, the DNP student described the project goals and a "one pager" with critical information and student contact information.

Objective 5 Interventions

To increase awareness of CoCM programs and available resources, by December 2023 at least 3 community informational contacts/meetings were held to educate stakeholder constituents on the CoCM and instruct interested community members on how to express their support of proposed recommendations to HHS. Informational meeting audiences included primary care provider practices, specialist practices, local health fair attendees, and labor union

members/representatives. The DNP student has established contacts within the local primary care workforce and in the community at large who have voiced receptivity to learning more about collaborative care. These contacts were leveraged to garner venues for advocacy and education.

The DNP student met in-person or by phone with a minimum of two primary care providers. The DNP student listened to PCP concerns about providing and referring to mental health services and provided the PCPs and staff with information related to the CoCM, the policy analysis, and available CoCM resources. An informational flyer and contact cards were left with the PCPs and staff to address any follow-up questions or concerns.

Community informational meetings occurred in the form of a lifestyle fair booths, and a during community events. The DNP student was available in-person during the events to interact with the public and provide a one-page informational sheet with information on collaborative care and a sample letter explaining how to contact their representatives to support directing funds to Suffolk County for implementation of CoCM programs. All materials were available in paper and electronic formats.

Measurement Methods, Outcomes, and Impact Evaluation

Objective 2

Outcome Measure. To evaluate the overall impact of the DNP project efforts and to determine if the project served to improve the uptake of the CoCM in Suffolk County, the student utilized resources at the NYS OMH Collaborative Care Medicaid Program (CCMP) to determine the number of primary care practices in the county that have implemented the model (NYS OMH, n.d.). This was monitored at the beginning of the project implementation phase and every 2 months. New York State is one of 19 states where CoCM billing codes are reimbursed by Medicaid (American Psychiatric Association, 2021a), and the CCMP offers a high level of

support to practices choosing to establish CoCM programs and participate with Medicaid reimbursement (NYS OMH, n.d.). Suffolk County Medicaid enrollment is significant, experiencing a 15.2% increase in enrollment in 2020 (Medicaid Matters New York, 2021) and a majority of primary care practices participate in Medicaid (Paradise, 2017). Therefore, this was determined to be a reliable metric as it would be difficult to sustain a CoCM program in Suffolk County without Medicaid in the payor mix. The goal for this project was one or more newly established collaborative care program within a primary care practice within the county by the conclusion of the project implementation phase.

Outcome Measure. Additionally, the DNP student utilized contacts within the NYS OMH CCMP program to determine the number of practices planning to implement a CoCM program in Suffolk County within 6 months of the end of the project implementation phase. This information was assessed at baseline and monitored every 2 months, with a final inquiry at the end of December 2023. The goal for this project was one or more programs in the planning phase by the end of the project implementation timeline.

Objective 3

Outcome Measure. To determine the amount of federal funding allocated for CoCM programs in Suffolk County, NY the DNP student utilized resources at the NYS OMH, the Health Resources and Services Administration (HRSA), and the Substance Abuse and Mental Health Services Administration (SAMHSA) to collect financial data related to the amount of grant funding allocated to this region. This was monitored every 2 months, and the goal was more than $0.

Outcome Measure. Recommended changes to the proposed rules relevant to H.R. 2617 section on Improving Uptake and Patient Access to Integrated Care Services were submitted

during the write-in period as instructed in the Federal Register (Congress.gov, 2023; Office of the Federal Register, n.d.). The expected outcome of this intervention is to direct federal funding to Suffolk County, NY.

Process Measure. To measure engagement with state and federal legislators with Suffolk County, NY constituency, the DNP student logged the name of legislator, party affiliation, date, and type of inquiry (letter, email, phone, or in-person). Initial contact was made and repeated monthly during the DNP project implementation phase until a response is received. The goal was 80% engagement with state and federal legislators. The expected outcome was legislators increased awareness of difficulty accessing mental health care, the CoCM as a policy solution, and support in directing funding to Suffolk County, NY for increased uptake of collaborative care in this area.

Objective 4

Process Measure. Stakeholder organization engagement was measured on a spreadsheet as well. The organization name, date and type of inquiry, and date of response was logged. Initial contact was be made and repeated monthly during the DNP project implementation phase until a response was received. The goal was 2 or more responses to attempts to engage. Expected outcomes included increased awareness of poor access to mental health care in Suffolk County, NY and need for funding for collaborative care programs.

Objective 5

Process Measure. To measure engagement with primary care practices, the DNP student logged the name of the primary care practice and/or provider, the date and type of inquiry, and if a response was received. Initial contact was made and repeated monthly during the DNP project implementation phase until a response was received. The goal was 2 or more responses to

attempts to engage. Expected outcomes were increased awareness of the CoCM, available support for implementation, and need to engage legislators for funding support.

Process Measure. Engagement with community members was measured by logging the name of the community organization, the date and type of inquiry, and the community member response. Initial contact was made and repeated monthly during the DNP project implementation phase until a response was received. The goal was 2 or more responses to attempts to engage. Expected outcomes were increased awareness of the CoCM and need to engage legislators for funding support.

Risks and Barriers

While it seems unlikely that there would be strong opposition to improving access to mental health care, initiating COCM programs come with public and private costs. First, there is an up-front cost to primary care practices that choose to implement the program. Specifically, a small or medium sized private primary care practice might find fiscal resources and human capital resources stretched thin when hiring adequate collaborative care staff pre-implementation and before reimbursement is received. Additionally, the time investment in specifically screening for mental health concerns and addressing them during the course of a routine primary care visit, where patients often experience multiple physical and mental health comorbidities, may be perceived as a significant barrier to implementation. Smaller practices might also lack the necessary time to invest in obtaining grants designated to support CoCM programs.

Second, there is a public cost to grants. Legislators fearful of increasing taxes and expanding government oversight or regulation may hesitate to support reimbursement and expansion of the CoCM. As H.R. 2617 is written, a state agency must apply for grant funding in partnership with local primary care practices (Congress.gov, 2023). If no NYS agency were to

apply during the project implementation timeline, there could be a serious barrier to effective uptake of the CoCM before December 2023. Furthermore, the DNP student had to acknowledge beforehand that healthcare providers and community members who are resistant to change may be unwilling to adapt to innovation. It is possible that stakeholders may be unwilling to engage with the DNP student for a variety of reasons, including disinterest or lack of time, presenting a barrier to DNP project implementation.

Proposed Budget and Resources

The DNP student was financially responsible for costs associated with the DNP project. Costs included time invested, printing literature and contact cards, fair booth donations, and travel expenses for in-person meetings. Printed materials cost no more than $200 and an additional $100 was spent on snacks for primary care providers. The donations for the fair booths were a combined $230. Resources available were online state databases and datasets. Required resources included a computer, online access, and Microsoft suite which had already been acquired by the DNP student. A consultant was not needed for this project.

Few costs were associated with the policy effort which entailed directing previously allocated federal funding to Suffolk County, NY. With utilization of CoCM billing codes, an established CoCM program yields excellent return on investment (Duncan et al., 2022) and the purpose of this policy effort was to direct funding to primary care practices to defray CoCM implementation costs. Ultimately, long-term savings for individual patients and society are expected by way of improved productivity and reduced disability (Greenberg et al., 2021), reduced individual out-of-pocket expenses (Leonhardt, 2021), and reduced overall health care costs (AIMS, 2023).

Project Timeline

The implementation phase of the DNP project occurred during the Fall 2023 semester at The George Washington University. Thus, the implementation phase began on August 24, 2023, and ended on December 11, 2023 (The George Washington University, n.d.). The policy analysis, steps 3 through 7 of the eightfold path (Bardach & Patashnik, 2020) were completed early on during implementation. Step 8 and project intervention activities occurred concurrently through December 2023. Most measures were evaluated at baseline in August 2023 and at monthly or two-month intervals through the end of the project implementation phase in December 2023. A visual representation of the timeline can be found in Appendix E.

Ethical Behavior

The DNP student completed the Collaborative Institutional Training Initiative (CITI) program for basic human research biomedical research and basic human research social and behavioral research courses in February 2023. Moreover, the DNP project was subject to review by The George Washington University Institutional Review Board and was deemed not to be research. To ensure the DNP student adhered to the highest ethical standard of conduct, the Bylaws, Rules, and Statutes of the NYS Legislative Ethics Commission (n.d.), the Code of Official Conduct for the House of Representatives (U.S. House of Representatives Committee on Ethics, 2023), and the Senate Code of Official Conduct (U.S. Senate Select Committee on Ethics, n.d.) were reviewed. Though none was observed, any unethical behavior would have been immediately reported in writing to the NYS Legislative Ethics Commission or appropriate federal agency and the DNP student's advisors.

Evaluation Plan

A driver diagram was utilized in the DNP project evaluation. The National Health System (NHS; 2022) driver diagram toolkit was referenced to develop the driver diagram for this project, found in Appendix F. According to the NHS, this method is well suited for a complex policy analysis and change project. A driver diagram helps to attribute outcome to change and depict theories of cause and effect (NHS, 2022).

The driver diagram identifies the aim, as previously reported: To analyze the state of CoCM implementation so that recommendations can be made during the implementation phase of H.R. 2617 section on Improving Uptake and Patient Access to Integrated Care Services to mitigate barriers and facilitate the practical and equitable expansion of the CoCM in Suffolk County, NY. Primary drivers are 1) to direct federal funding for CoCM to Suffolk County, NY and 2) to increase awareness of barriers to mental health care access and CoCM as a solution. Secondary drivers include 1) CoCM reimbursement exists but starting up programs can be costly, 2) states must apply for federal funding before it can be disseminated to primary care practices, 3) legislators may not be knowledgeable about the CoCM and need for expansion in Suffolk County, NY, and 4) PCP's, community members, and stakeholders of influence may not be aware of the need for CoCM programs, available resources, and potential funding opportunities. To test these driver theories, change activities included 1) conduct a policy analysis and specific feedback to the federal register, 2) meet with legislators to encourage support for CoCM and influence NYS OMH or other appropriate agency to apply for funding, then direct said funds to Suffolk County practices, 3) meet with stakeholder organizations to encourage support for expanding CoCM programs, and 4) meet with PCPs and the public to educate them about CoCM programs, potential funding, and other available resources.

Data Analysis, Maintenance, and Security

Data collection was performed by the DNP student as outlined in Appendix D. The DNP student was responsible for systematically collecting and analyzing all data which was documented in Excel spreadsheets for tracking and comparison. No privacy restrictions or concerns were encountered. Data were collected, maintained, and secured on the DNP student's personal password-protected computer. The DNP student was the sole party with access to the data.

Sources of data included government and organization websites, personal contacts, and stakeholder contacts. State and federal government sites were accessed for data on legislators, these include U.S. Senate and House of Representatives, and NY Senate and Assembly. The NYS OMH (2022) Collaborative Care Medicaid program site offers data on CoCM programs in Suffolk County, and NYS OMH staff provided the most up-to-date information on new CoCM programs. Ultimately, the priority of this project was to improve the uptake of collaborative care programs in Suffolk County. Thus, the number of new programs established or in planning by the end of the implementation timeline was the primary outcome to be measured.

Results

The aim of this health policy project was to analyze the state of CoCM implementation so that recommendations could be made during the implementation phase of H.R. 2617 section on Improving Uptake and Patient Access to Integrated Care Services to facilitate the practical and equitable expansion of the CoCM in Suffolk County, NY.

Objective 1 Results

A policy analysis of H.R. 2617 Division FF, Title 1, Subtitle C, Chapter 1, Section 1301 section on Improving Uptake and Patient Access to Integrated Care Services, amending Section

520K of the Public Health Service Act (42 U.S.C. 290bb-42) was conducted utilizing the eightfold path as a theoretical framework (Bardach & Patashnik, 2020). This legislation allocates funding up to $2,000,000 annually for up to five years for states in collaboration with local agencies or practices to implement integrative collaborative care, or other evidence-based integrative care models (Congress.gov, 2023) through PIPBHC grants (SAMHSA, 2023). Applying for previously allocated federal grant funding was determined to be the most efficient pathway to improve uptake.

Objective 2 Results

Objective 2 was to improve the uptake of CoCM in Suffolk County, NY. During the project implementation timeline there was no change in the number of CoCM programs in Suffolk County, NY. According to personal communications from A. Jones, Director of Primary Care Behavioral Health Integration, NYS Office of Mental Health, there were 12 CoCM programs implemented in Suffolk County, NY at the beginning of the implementation phase, and there was no increase or decline at the end of the implementation phase. Ms. Jones did not provide information on planned CoCM implementation.

Objective 3 Results

Objective 3 was to direct federal funding for CoCM program implementation to Suffolk County, NY. No federal funds were allocated during the project timeline. Ms. Jones of NYS OMH disclosed in late October that NYS had applied for and been awarded PIPBHC grant funds up to $10,000,000 over 5 years, but those funds will be utilized for specific youth mental health programs (A. Jones, personal communication, December 2023).

In September, a request for information adjacent to objective 3 was posted in the Federal Register. Specifically, there was an interest in feedback related ways to expand behavioral health

access including adding coding to allow for payment of interprofessional consultation between primary care and behavioral health providers (Centers for Medicare & Medicaid Services [CMS], 2023). Comments were submitted to the Federal Register on September 9, 2023, and can be found in Appendix G.

To garner support for directing CoCM funding to Suffolk County, the DNP student engaged with federal and state legislators. Four federal legislators were provided with a federal legislative one-pager via mail and email which can be found in Appendix H, the staff of three federal legislators actively engaged with the DNP student, and two informational meetings were held with staff members from the offices of New York Senator Kirsten Gillibrand and Congressman Andrew Garbarino of New York's Second congressional district serving Suffolk County. Additionally, the DNP student sent a local legislative one-pager (Appendix H) to 24 New York State legislators via email. Half (12) of the State legislators' offices engaged with the DNP student, and 10 legislative offices accepted the DNP student's invitation to meet for an informational meeting. Please see Appendix I.

Three state representatives, Senators Weik and Martinez, and Assembly Mental Health Committee Member Gandolfo expressed interest in garnering federal funding though OMH for Suffolk County primary care practices. Assemblyman Gandolfo drafted a letter of support encouraging OMH to apply for PIPBHC funding. However, when it was revealed in October 2023 that OMH had been awarded PIPBHC grant funding for another purpose, these legislators expressed interest in supporting a pilot project for CoCM implementation. A representative from Senator Martinez's office suggested partnering with 5 primary care practices seeking to implement CoCM, at which point the Senator would request $500,000 as a state-budget line item for CoCM implementation. Unfortunately, there was not enough time to recruit 5 practices prior

to the budget deadline, therefore, this pilot program was not able to be accomplished within the project timeline but is still a viable option moving forward.

Objective 4 Results

Objective 4 was to engage with stakeholder organizations to garner support. The DNP student contacted 14 organizations during the implementation timeline. These organizations ranged from interest groups such as the New York Nurse Practitioner Association and AARP, to professional organizations that have implemented or may benefit from CoCM. Responses were received from 5 organizations. Three declined to meet or discuss the topic further, while two organizations accepted the DNP student's invitation to discuss behavioral health integration.

Objective 5 Results

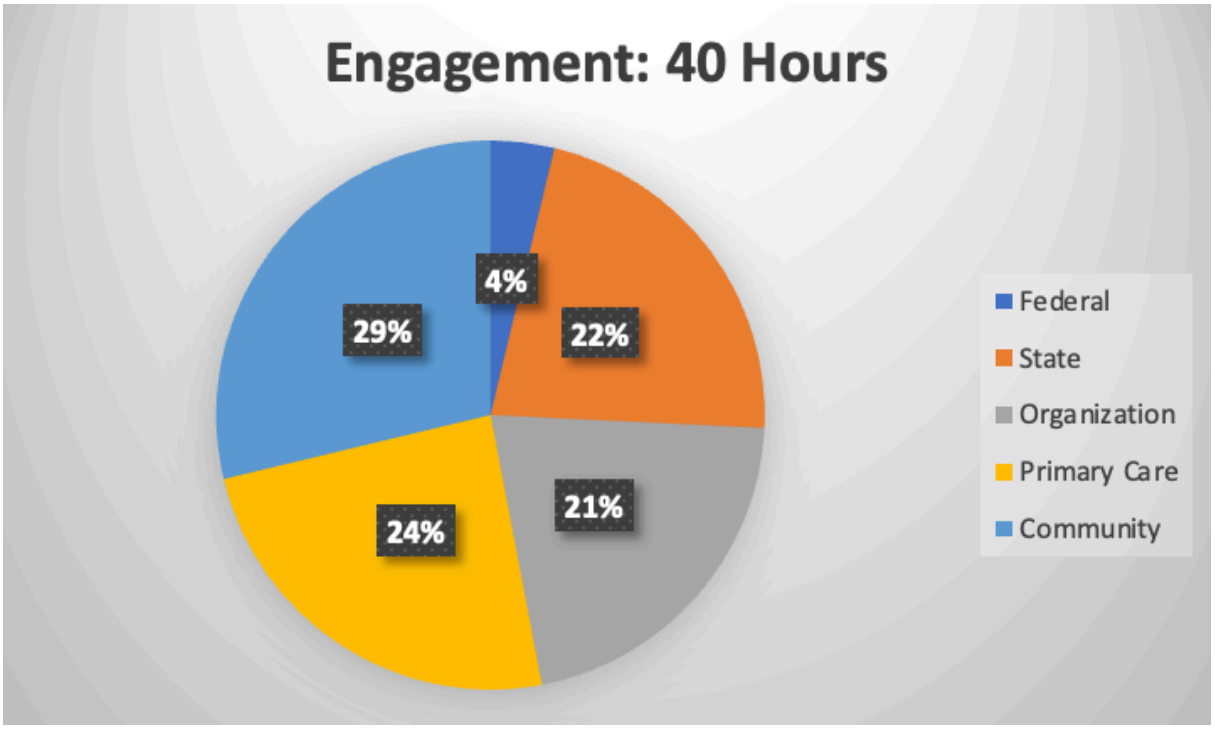
Objective 5 was to increase awareness of CoCM programs and available resources by engaging with primary care providers and community members. The DNP student contacted 71 primary care providers and practices via phone, email, or in-person visits. More than 40 of the 71 practices received a community one-page informational document (Appendix H) by email or hand-delivery. Responses were received from 14 physicians and nurse practitioners, and 10 informational meetings were held by phone or in person.

The DNP student engaged with 82 members of the community at a variety of public events including a lifestyle fair, a craft fair, and "Shop with a Cop" community event. Community members were provided with the community one-page informational document or a business card with information to contact the DNP student. Falling outside the jurisdiction of federal and state funds, the DNP student contacted 17 local county legislators by email as part of the community education effort. Five legislators engaged with the DNP student, and 3 Suffolk County legislators accepted the student's invitation to meet.

Additionally, an Op-ed written by the DNP student describing the need for expanding access to mental health care through the expansion of CoCM was published in Newsday on December 20, 2023. Newsday is the 8th largest daily newspaper in the United States (Statista, 2023), with more than 50,000 paid digital subscriptions (Majid, 2022) and a significant reach in the Suffolk County community. The Op-ed can be found in Appendix J.

Figure 1

Stakeholder Engagement: Distribution of Time Spent



Discussion

As anticipated based on Kingdon's Multiple Stream Approach (Smith & Larimer, 2017), there was significant enthusiasm for behavioral health integration by legislators and the public. Both populations were aware of mental health access problems and eager to learn about solutions to remediate the issue. In particular, state legislators engaged meaningfully to request OMH apply for federal funding. Then, when informed that federal funding would not be made

available for CoCM implementation, legislative members and staff worked with the DNP student to formulate a plan to request funds from the state budget.

Ultimately, there were many barriers impacting CoCM implementation within the DNP project timeline. First, OMH Collaborative Care Medicaid Program staff were not forthcoming with information about applying for PIPBHC funding or planned CoCM programs in the county. This information would have been helpful in formulating strategy and approach early in the implementation phase. Once OMH's award of PIPBHC funding was discovered by legislative staff, it was too late in the state budget planning to allocate funds for 2024.

Knowledge deficit was another barrier to implementation. Despite enthusiasm for improving access to mental healthcare, most stakeholder groups were unfamiliar with the concept of behavioral health integration or the CoCM. This project was an important step toward educating legislators, primary care providers, and the public about strategies to improve mental health access. Moreover, the Newsday Op-ed had significant impact, with widespread reach in the Suffolk County community.

Unfortunately, primary care providers did not match legislators' enthusiasm for integrative care. Although primary care providers expressed a great deal of interest in the support provided by the CoCM, few expressed readiness to change current practice workflows or invest their own funds in the absence of implementation grants. Others did not have the decision-making authority to implement practice changes. There was also a great deal of concern about sustainability of the CoCM past the implementation phase and availability of PCs and BHCMs.

Lessons learned from discussions with organizations who have currently implemented CoCM programs indicated that primary care provider's concerns were not unfounded. Sustainability is an ongoing challenge due to difficulty capturing treatment and care coordination

time for CoCM billing codes, as well as generally low reimbursement. Creation of a billing code to allow for payment of interprofessional consultation between primary care and behavioral health providers (CMS, 2023) would be an important supplement to the current CoCM reimbursement structure and could have a profound impact on sustainability of the CoCM, particularly in smaller practices without larger organizational support. Please see Appendix G for comments submitted to CMS.

Implications

Implications for Healthcare Policy

A robust, multipronged approach to funding and implementing CoCM programs is needed. Both federal and state grants are needed to capture the most funding options for practices choosing to implement innovative models of care like the CoCM. Furthermore, CoCM reimbursement strategies should be carefully evaluated to ensure practices can capture sufficient revenue to sustain programs once they have been implemented. Advocacy for the addition of interprofessional billing codes can further enhance CoCM sustainability.

Implications for Education and Executive Leadership

There was a considerable knowledge deficit among providers and the public about integrative models of care. Nurse executives can serve as educators and change champions of CoCM within healthcare organizations. Moreover, it would be beneficial to incorporate education about the CoCM into nursing curricula to improve awareness of innovative care delivery models. Incorporating education about CoCM and behavioral health integration more broadly into physician and physician associate training could also be helpful in improving uptake of the CoCM.

Implications for Practice

Nurses and nurse practitioners can serve as members of the behavioral health integration team as primary care providers, psychiatric consultants, and behavioral health care managers. However, nurses are not restricted to clinical practice roles; it is important to embrace a mindset shift from advocating for individuals to populations. All three of Kingdon's streams indicate readiness for policy change (Smith & Larimer, 2017). The results of this analysis reinforce that access to mental health care is an established and accepted *problem*, the CoCM is an evidence-based and recognized *policy* solution, and the passing of recent legislation funding CoCM implementation indicates improving access to mental health care is on the *political* agenda. Nurses are well positioned to advocate for reduced barriers to widespread CoCM implementation. Specifically, educating their healthcare organizations, legislators, and communities about CoCM is an important starting point. Other barriers such as implementation cost can be reduced through advocacy for funding at the state and organizational level. Continuing the development of new payment codes allowing for interprofessional consultation reimbursement will be critical for long-term program sustainability.

Implications for Quality and Safety

The robust evidence base for the quality, safety, and efficacy of the CoCM, discussed in previous sections, will continue to grow as more practices and organizations adopt the model. While the focus on quality care is important, it is crucial that patients be able to access care to benefit. Ultimately, quality and safety gaps exist due to poor access to mental health care. The need for mental health care continues to grow at a faster pace than the supply of mental health providers, making implementing and expanding innovative care delivery models imperative as

usual care fails to adequately meet patient needs. Thus, access and quality should remain tandem priorities.

Plans for Sustainability, Dissemination, and Future Scholarship

This project will be disseminated at The George Washington University and is in consideration for the New York Nurse Practitioner Annual Conference in October 2024. The results of this health policy analysis and advocacy project will continue to be shared with local stakeholders, including primary care providers and legislators. Improving the uptake of CoCM in Suffolk County, NY remains a priority of the DNP student beyond the implementation timeline of this project. Work toward creating a CoCM pilot program in Suffolk County with implementation funding from the state budget will continue through 2024. Systematic evaluation of the policies, process, and outcomes will occur.

Conclusion

There is an urgent need to address access to mental health care in America. Integrating mental health services into primary care is an efficient way to expand the reach of mental health in a non-stigmatizing way. The CoCM is a validated and effective integrative model for improving access to mental health care with a demonstrated excellent value. By the end of the implementation phase of this policy project, numerous stakeholders were educated about the CoCM. Ongoing opportunities to improve access to care through improving the uptake of CoCM in Suffolk exist due to the networking and advocacy efforts throughout this project and will be leveraged in the future to improve care access for the community.

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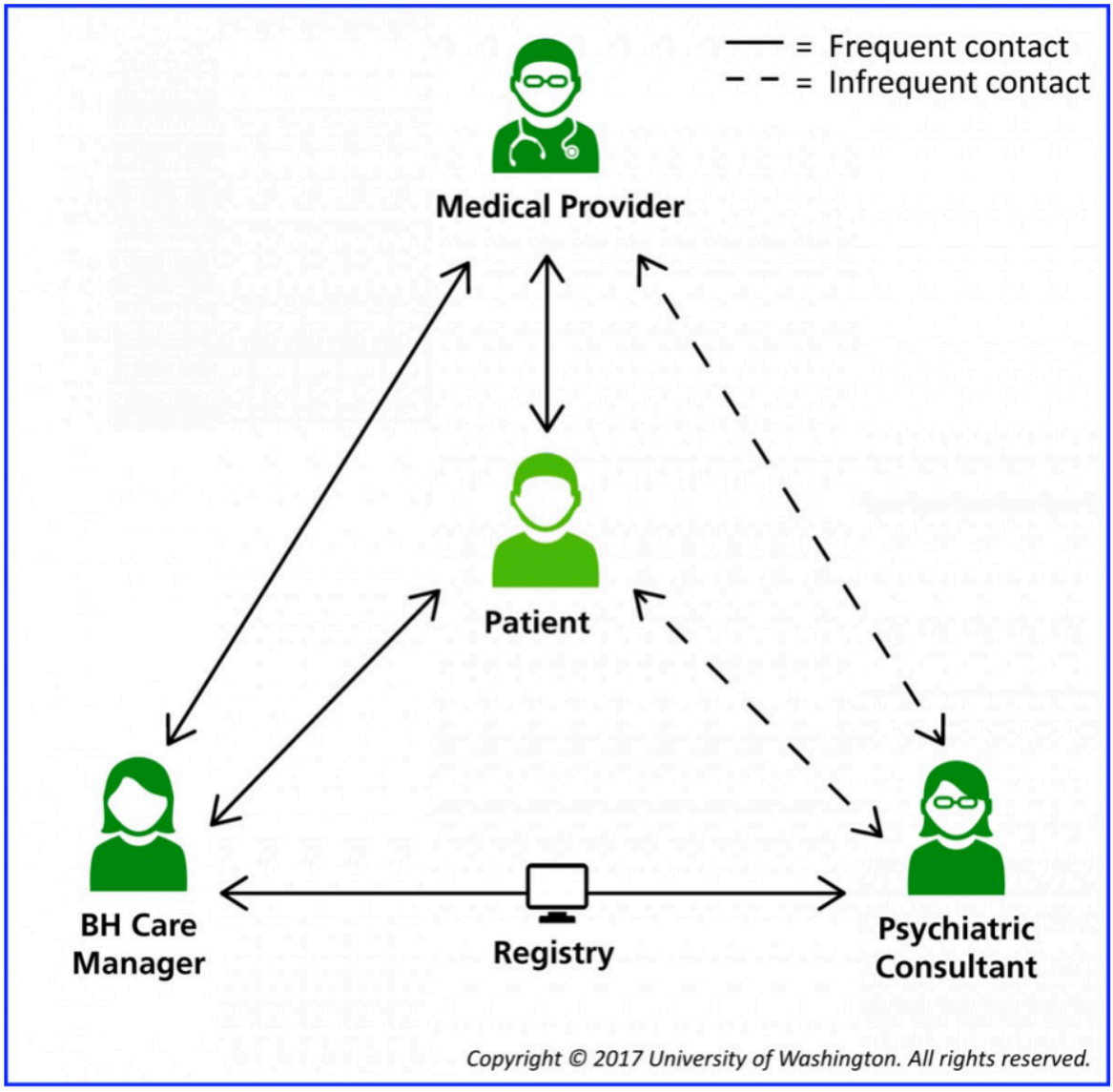
Appendix A

The CoCM Team Structure



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Appendix B

Strengths, Weaknesses, Opportunities, and Threats (SWOT) Analysis

	Helpful To achieving the objective	**Harmful** To achieving the objective

Internal Origin	**Strengths**
	• CoCM is a well validated model that increases access to mental health care
	• CoCM designed to facilitate prompt and coordinated mental health treatment in a low-stigma environment
	• Supports primary care providers, an already taxed workforce
	• Suffolk County has a few CoCM programs already operational within major health systems
	• Medicaid reimbursement for CoCM FFS codes available in NYS
	• NYS OMH offers high level of support to programs participating in CoCM Medicaid program
		Weaknesses
		• Mental health and primary care provider rate/100,000 below state average
		  ○ Concerns about staffing programs considering provider shortages
		• Reimbursement rates for CoCM FFS codes vary by payor, making funding of CoCM programs difficult to project
		• Due to FFS reimbursement model, smaller primary care offices may be unable to implement/staff CoCM programs without additional funding
		  ○ Practices bear responsibility for implementation costs

	Helpful To achieving the objective	**Harmful** To achieving the objective
External Origin	**Opportunities** • Legislators are open to discussing mental health access topics due to the COVID-19 pandemic, mental health is a current legislative priority • Legislation introduced in 117th Congress to obtain HHS funding for implementing and maintaining CoCM passed in Omnibus signed into law on December 29, 2022 • Aligns with IHI Aims	**Threats** • Federal funding has passed but is just entering implementation phase, will take time for rules to be established and funds distributed ○ Low visibility of CoCM in Omnibus • CMS, which usually sets national precedent for other insurers, offers limited options for time-based reimbursement

Appendix C

Evidence Table

Article #	Author, Date & Title	Type of Evidence	Population, Size, Setting	Intervention	Findings that help answer the Analysis Question	Measures Used	Limitations	Evidence Level & Quality
1	Archer, J., Bower, P., Gilbody, S., Lovell, K., Richards, D., Gask, L., Dickens, C., & Coventry, P. (2012). Collaborative care for depression and anxiety problems.	Systematic review	79 randomized controlled trials (RCTs) including 24,308 patients around the world. Databases searched included Cochrane, Medline, EMBASE, PsychINFO, WHO trials portal, and CIHAHL from 1950 through 2012.	Collaborative care compared to treatment as usual (treating within primary care or specialist referral).	Collaborative care improves safe medication use, improved mental health related quality of life, and improved overall patient satisfaction in adults with depression and anxiety.	Antidepressant and antianxiety medication use rates, common depression and anxiety rating scales such as the Patient Health Questionnaire (PHQ-9) and the Generalized Anxiety Disorder scale (GAD-7). Scores were aggregated and analyzed by the researchers.	Despite two researchers independent assessment for bias, there was some risk for bias due to missing data, authors were unable to conduct a rigorous analysis of social function outcomes due to variability in measurement in the included studies.	I, A

2	Burkhart, K., Asogwa, K., Muzaffar, N., & Gabriel, M. (2020). Pediatric integrated care models: A systematic review.	Systematic review	6 RCT and quasi-experimental studies including 1,256 children ages 4 to 21, receiving care in pediatric primary care practices. Databases searched included PsychINFO, CINAHL, PubMed, MEDLINE, EMBASE, Scopus, Cochrane.	Collaborative care compared to treatment as usual (treating within primary care or specialist referral).	Collaborative care increases access to behavioral health treatment and improved mental health outcomes in children 4-21.	Examined outcomes included depression, anxiety, overall mental health status, patient satisfaction. A variety of validated rating scales were utilized to assess outcomes in the included studies, including PHQ-9 and GAD-7.	Unable to generalize to urban population, minority youth, and children under 4.	III, B
3	Carlo, A.D., Corage Baden, A., McCarty, R. L., & Ratzliff, A. D. H. (2019). Early health system experiences with collaborative care (CoCM)	Qualitative	Over 7 months in 2017-2018 15 interviews with 25 respondents including primary care providers, psychiatrists, psychologists, nurses, and	Semi-structured interviews assessing administrative and operational factors related to CoCM including billing processes.	CoCM billing codes bolster the sustainability of CoCM programs. Staff and organizational buy-in are important, along with	N/A	Unable to generalize to non-urban settings or independent primary care practices.	III, A

	billing codes: A qualitative study of leadership and support staff.		staff from 12 health care organizations and 2 payors.		flexibility in navigating billing challenges like inconsistent reimbursement rates among payors (e.g. may need to bill a mix of CoCM codes plus traditional FFS codes depending on payment source).			
4	Coventry, P., Lovell, K., Dickens, C., Bower, P., Chew-Graham, C., McElvenny, D., Hann, M., Cherrington, A., Garrett, C., Gibbons, C. J., Baguley, C., Roughley, K., Adeyemi, I., Reeves, D., Waheed, W., & Gask, L. (2015).	RCT	387 adult patients with a diagnosis of diabetes, heart disease, or both who also screened positive for moderate depression (>/= 10 on the PHQ-9) being treated within primary care practices in the United	Collaborative care compared to treatment as usual (treating within primary care).	Collaborative care can reduce depression and improve self-management of chronic disease in adults with multiple mental and physical health comorbidities.	Primary outcome was reduction of depression symptoms measured with the self-reported symptom checklist-13 (SCL-D13). Secondary outcomes included anxiety (GAD-7), self-	Participating practices, rather than patients, were randomized, therefore blinding was difficult among participants and practice staff. Previously blinded, researchers collected outcome data	I, A

	Integrated primary care for patients with mental and physical multimorbidity: Cluster 59ffectiven controlled trial of collaborative care for patients with depression comorbid with diabetes or cardiovascular disease.		Kingdom. 90% completed trial.			management (health education impact questionnaire), disability (Sheehan disability scale), and quality of life (WHOQOL).	face to face at a follow up appointment, and there was no testing for bias as researchers could have been made aware of participant allocation in this process.	
5	Duncan, M. H., Erickson, J. M., Chang, D., Toor, R., & Ratzliff, A. D. H. (2022). Psychiatry's expanded integration into primary care.	Expert opinion	N/A	N/A	Telehealth can streamline the care process when time for staff is narrow. Full utilization of collaborative care billing codes aids in program resiliency rather than relying on fee-for-service billing.	N/A	N/A	V, A

6	Grochtdreis, Brettschneider, C., Wegener, A., Watzke, B., Riedel-Heller, S., Härter, M., & König, H.-H. (2015). Cost-effectiveness of collaborative care for the treatment of depressive disorders in primary care: A systematic review.	Systematic review	19 cost effectiveness analyses of collaborative care programs from around the world were reviewed. Databases searched included Cochrane, PubMed, PsychINFO, Embase, CINAHL, Econ-lit, and NHS EED.	Cost effectiveness of collaborative care compared to treatment as usual (treating within primary care or specialist referral)..	Most of the studies (13/19) show collaborative care was associated with better care, but higher initial costs. Two studies addressed the cost of low productivity. This has been included for historical context, in the time since publication CMS has introduced collaborative care billing codes which can change the fiscal outcomes.	Cost-effectiveness analysis	There was inconsistent reporting, methodological differences, and differing general patient characteristics across studies making analysis and generalizability problematic.	III, A
7	Hu, J., Wu, T., Damodaran, S., Tabb, K. M., Bauer, A., & Huang, H. (2020).	Systematic review	19 total articles, 10 RCT and 9 observational studies were included.	12 studies examined collaborative care compared to treatment as usual (treating	Collaborative care is effective in improving depression for racial and/or ethnic minority	Depression response and remission was the primary outcome in all studies,	Variability in study duration, variability in outcome measure/ screening tools	III, B

	The61ffectiveness of collaborative care on depression outcomes for racial/ethnic minority populations in primary care: A systematic review.		Search criteria included participants who were racial or ethnic minorities. Databases searched: PubMed, PsychINFO, CINAHL, Cochrane, Embase.	within primary care or specialist referral). 5 studies compared minority patients to white patients in collaborative care.	patients in primary care, with our without specifical cultural or linguistic adaptations.	measured with PHQ-9, Hamilton Depression Rating Scale (HAM-D), Hopkins Symptom Checklist, and other validated depression scales.	used, variation in comparison groups (e.g. all minority groups were pooled and analyzed as a whole rather than as unique groups).	
8	Jackson, J., Dangal, R., Dangal, B., Gupta, T., Jirel, S., Khadka, S., Rimal, P., & Acharya, B. (2022). Implementing collaborative care in low-resource government, Research, and academic settings in rural Nepal.	Case report	Rural Nepal	Implementing collaborative care programs in a government-run public hospital, a non-profit research hospital, and an academic outreach hospital in Nepal.	This article highlights both how collaborative care can be effective in areas with scarce resources, while also illuminating specific challenges such as undersupply of behavioral and primary care professionals, staff turnover,	N/A	N/A	V, A

					and lack of digital infrastructure.			
9	Kinnan, S., Emerson, M. R., Kern, J., & Ratzliff, A. (2019). How a health center eliminated the waiting list for psychiatric services.	Quality improvement project	Project site was a federally qualified health center (FQHC) in midwestern U.S. with more than 41,000 patients in 2017. Staff included 19 MDs, 32 NPs and Pas, and 12 behavioral health therapists. Psychiatric wait list at time of implementation was 350 patients.	Implemented collaborative care model within FQHC. 3 12-month PDSA cycles, leveraging psychiatric residents as psychiatric consultants in the Collaborative Care Model (CoCM).	This article is a recent, practical example of collaborative care improving access to mental health care. Also demonstrates the value of teamwork. Over time, primary care providers were more confident and less reliant on psychiatric consultants. Funding for program obtained by federal grant.	Primary outcome was number of patients on waitlist for psychiatric referral. Over 3 PDSA cycles wait time was down to 1-2 weeks for access to services.	Not discussed.	V, B
10	Møller, M. C. R., Mygind, A., & Bro, F. (2018).	Qualitative	9 Danish primary care providers (PCPs) and 2 care managers across multiple	Semi-structured interview and direct observation over 2-6 days.	Valuable perspective of the PCP when considering collaborative care	N/A	Those supporting collaborative care may have been over-	III, B

	Who needs collaborative care treatment? A qualitative study exploring attitudes towards and experiences with mental healthcare among general practitioners and care managers.		practice sites in urban and rural settings.	Questions included barriers and facilitators to collaborative care and discussion about who needs collaborative care.	implementation. In this study PCPs questioned the time commitment that collaboration would require and the long-term sustainability of the program. PCPs should be central in program development, so they do not perceive additional burden in the implementation of the CoCM.		represented in this study.	
11	Renn, B. N., Johnson, M., Powers, D. M., Vredevoogd, M., & Unützer, J. (2022). Collaborative care for depression	Non-experimental study	3,722 adults (18+) residing in rural western U.S. in primary care with a unipolar depression diagnosis.	Collaborative care for treatment of depression in younger adults (18-64 years) compared to older adults (65+ years).	Collaborative care is effective across age, in both younger adults and older adults.	Depression was primary outcome, measured with the PHQ-9.	There was no comparison group. There was variability across clinics. Other data such as comorbidities and concurrent mental health	III, B

	yields similar improvement among older and younger rural adults.						treatment were not available.	
12	Weber, M., Stalder, S., Techau, A., Centi, S., McNair, B., & Barton, A. J. (2021). Behavioral health integration in a nurse-led federally qualified health center: Outcomes of care.	Non-experimental study, retrospective analysis	118 patients (primarily white females utilizing Medicaid) in a nurse-lead FQHC	Implementation of the CoCM.	The CoCM roles can be effectively filled by nurses and nurse practitioners.	The PTSD Checklist Civilian Version (PCL-C) was administered every 3 months to measure PTSD symptoms, the HAM-D was completed monthly to measure depression, the Bipolar depression rating scale was completed every 3 months to assess depression symptoms related to	Lack of a control group, non-experimental design.	III, B

						bipolar disorder.		

Appendix D

Outcome Measures Tables and Sample Data Collection Spreadsheets

Objective 2: Improve the uptake of CoCM in Suffolk County, NY by December 2023.

Measure	**Measure Type***	**Data Source**	**Sampling Method**	**Timing/Frequency**
Number of new practices implementing the model.	Outcome	NYS OMH Medicaid CoCM program	N/A	Establish baseline and monitor every 2 months.
Standard Measure?**	No			
Numerator	New CoCM programs as of January 2024			
Denominator or Population***				
Exclusions	Existing CoCM programs			
Calculation/Statistic(s)	Numeric			
Goal/Benchmark	>/=1			
Measure	**Measure Type***	**Data Source**	**Sampling Method**	**Timing/Frequency**
Number of new practices planning to implement the model in next 6 months.	Outcome	NYS OMH Medicaid CoCM program	N/A	Establish baseline and monitor every 2 months.
Standard Measure?**	No			
Numerator	Practices planning implementation within 6 months as of January 2024			
Denominator or Population***	Total number of primary care practices			
Exclusions	Existing CoCM programs			
Calculation/Statistic(s)	Numeric			
Goal/Benchmark	>/=1			

Data Elements	**Variable Name**	**Definition**	**Data Type***	**Data Values & Coding**	**Restrictions/ Validation**
Primary Care Practice Site	pcp_site	Name of Primary Care Practice	Text	Alphanumeric	Required
CoCM Status	cocm_status	CoCM in place	Categorical	1, Yes 2, No	Required

CoCM Proposed	proposed_cocm	Planning to implement CoCM within 6 months	Categorical	1, Yes 2, No	Required
Date of Inquiry	inquiry_date	Date of inquiry	Continuous	Date (M-D-Y) 04-01-2023 to 01-31-2024	Required

Objective 3: Direct federal funding to Suffolk County, NY for CoCM programs by December 2023.

Measure	**Measure Type***	**Data Source**	**Sampling Method**	**Timing/Frequency**
Amount of federal funding allocated for CoCM implementation in Suffolk County, NY	Outcome	HRSA and NYS OMH	Data will be gathered monthly	Monitor every 2 months
Standard Measure?**	No			
Numerator	N/A			
Denominator or Population***	Federal funding to Suffolk County, NY for CoCM programs			
Exclusions	N/A			
Calculation/Statistic(s)	Numeric			
Goal/Benchmark	>$0			
Measure	**Measure Type***	**Data Source**	**Sampling Method**	**Timing/Frequency**
Recommendations submitted to Federal Register to direct funds to primary care practices.	Outcome	Federal Register	N/A	Once during public write-in period
Standard Measure?**	No			
Numerator	N/A			
Denominator or Population***	N/A			
Exclusions	N/A			
Calculation/Statistic(s)	N/A			
Goal/Benchmark	Submit recommendations			

Measure	Measure Type*	Data Source	Sampling Method	Timing/Frequency
Number of state and federal legislators contacted with Suffolk County constituency (to encourage support of obtaining CoCM funding).	Process	Spreadsheet	State & federal legislator website	Initial contact and repeat monthly if no response or inadequate response.

Standard Measure?**	No
Numerator	Contacts (letter, email, phone, in person) made to legislators
Denominator or Population***	Total number of state and federal legislators with Suffolk County constituency
Exclusions	N/A
Calculation/Statistic(s)	Percentage/Proportion
Goal/Benchmark	80%

Data Elements	Variable Name	Definition	Data Type*	Data Values & Coding	Restrictions/ Validation
Recommendations	Recc	Specific recommendations to direct funding to primary care practices	Text	Alphanumeric	
Legislator Name	leg_name	Full name of legislator	Text	Alphanumeric	Required
Legislative Affiliation	leg_affiliation	Where the legislator serves	Categorical	1, U.S. Senate 2, U.S. House 3, N.Y. Senate 4, N.Y. Assembly	Required
Legislator District	leg_district	Legislators Elected District	Text	Alphanumeric	Required
Party Affiliation	party	Legislator party affiliation	Categorical	1, Democrat 2, Republican 3, Independent	Required
Date of Inquiry	inquiry_date	Date of inquiry	Continuous	Date (M-D-Y) 04-01-2023 to 01-31-2024	Required
Contact Type	Contact	Letter, email, phone or in person contact made with	Categorical	1, Letter 2, Email 3, Phone 4, In person	Required

		legislator during project timeline			
Response	response	Responded to inquiry	Categorical	1, Yes 2, No	Required
Date of Response	response_date	Date organization responded to inquiry	Continuous	Date (M-D-Y) 04-01-2023 to 01-31-2024	Required

leg_name	leg_affiliation	leg_district	party	inquiry_date	contact	response	response_date
Chuck Schumer	1	NY	1				
Kirsten Gillibrand	1	NY	1				
Nicholas LaLota	2	CD1	2				
Andrew Garbarino	2	CD2	2				
Anthony Palumbo	3	1	2				
Mario R. Mattera	3	2	2				
Dean Murray	3	3	2				
Monica Martinez	3	4	1				
Alexis Weik	3	8	2				
Fred W. Thiele, Jr	4	1	1				
Jodi Giglio	4	2	2				
Joe DeStafano	4	3	2				
Edward Flood	4	4	2				
Douglas Smith	4	5	2				
Philip Ramos	4	6	1				
Jarett Gandolfo	4	7	2				
Michael Fitzpatrick	4	8	2				
Michael Durso	4	9	2				
Steve Stern	4	10	1				
Kimberly Jean-Pierre	4	11	1				
Keith Brown	4	12	2				

Objective 4: Engage with stakeholder organizations by December 2023.

Measure	Measure Type*	Data Source	Sampling Method	Timing/Frequency
Number of stakeholder organization responses/engagements.	Process	Excel spreadsheet	Identified organizations with interest in CoCM or mental health in Suffolk County	Initial contact and repeat monthly if no response or inadequate response.

Standard Measure?**	No
Numerator	Number of responses from stakeholder organizations
Denominator or Population***	Total number of contacts made to organizations
Exclusions	N/A
Calculation/Statistic(s)	Numeric
Goal/Benchmark	2 or more responses/engagements

Data Elements	Variable Name	Definition	Data Type*	Data Values & Coding	Restrictions/ Validation
Stakeholder Organization	org_name	Name of stakeholder organization	Text	Alphanumeric	Required
Date of Inquiry	inquiry_date	Date of inquiry	Continuous	Date (M-D-Y) 04-01-2023 to 01-31-2024	Required
Contact Type	Contact	Letter, email, phone or in person contact made with legislator during project timeline	Categorical	1, Letter 2, Email 3, Phone 4, In person	Required
Response	response	Responded to inquiry	Categorical	1, Yes 2, No	Required
Date of Response	response_date	Date organization responded to inquiry	Continuous	Date (M-D-Y) 04-01-2023 to 01-31-2024	Required

Objective 5A: Increase primary care provider awareness of CoCM and available resources by December 2023.

Measure	Measure Type*	Data Source	Sampling Method	Timing/Frequency
Number of primary care practice responses/engagements.	Process	Excel spreadsheet	Primary care practices in Suffolk County	Initial contact and repeat monthly if no response or inadequate response.

Standard Measure?**	No
Numerator	Number of primary care practice responses or engagement with student
Denominator or Population***	Total number of contacts made to primary care practices
Exclusions	Practices with CoCM already implemented
Calculation/Statistic(s)	Numeric
Goal/Benchmark	2 or more primary care practices

Data Elements	Variable Name	Definition	Data Type*	Data Values & Coding	Restrictions/ Validation
Primary Care Practice Site	pcp_site	Name of Primary Care Practice	Text	Alphanumeric	Required
CoCM Status	cocm_status	CoCM in place	Categorical	1, Yes 2, No	Required
Date of Inquiry	inquiry_date	Date of inquiry	Continuous	Date (M-D-Y) 04-01-2023 to 01-31-2024	Required
Contact Type	Contact	Letter, email, phone or in person contact made with legislator during project timeline	Categorical	1, Letter 2, Email 3, Phone 4, In person	Required
Response	response	Responded to inquiry	Categorical	1, Yes 2, No	Required
Date of Response	response_date	Date organization responded to inquiry	Continuous	Date (M-D-Y) 04-01-2023 to 01-31-2024	Required

Objective 5B: Increase community awareness of CoCM programs by December 2023.

Measure	Measure Type*	Data Source	Sampling Method	Timing/Frequency
Number of community organization responses/engagements.	Process	Excel spreadsheet	Identified community organizations with interest in CoCM or mental health in Suffolk County	Initial contact and repeat monthly if no response or inadequate response.

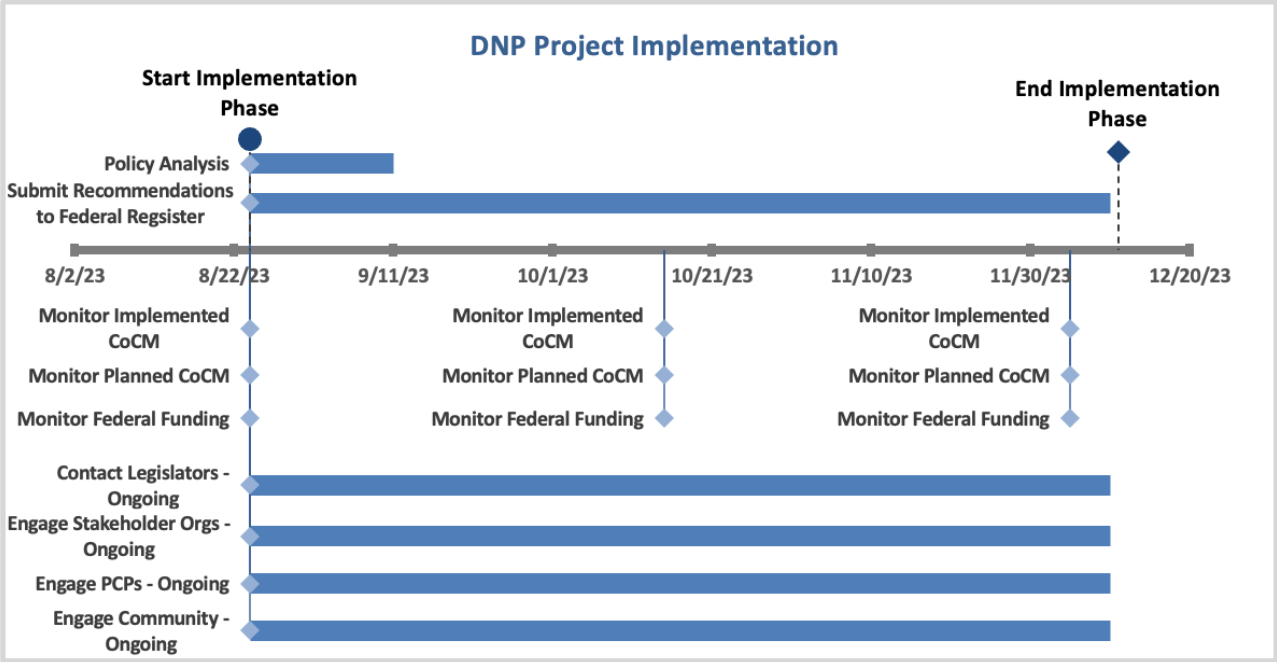
Standard Measure?**	No
Numerator	Number of community organizations responding/engaging with student
Denominator or Population***	Total number of contacts made to community organizations
Exclusions	N/A
Calculation/Statistic(s)	Numeric
Goal/Benchmark	2 or more

Data Elements	Variable Name	Definition	Data Type*	Data Values & Coding	Restrictions/ Validation
Community Organization	community_name	Name of community organization	Text	Alphanumeric	Required
Date of Inquiry	inquiry_date	Date of inquiry	Continuous	Date (M-D-Y) 04-01-2023 to 01-31-2024	Required
Contact Type	Contact	Letter, email, phone or in person contact made with legislator during project timeline	Categorical	1, Letter 2, Email 3, Phone 4, In person	Required
Response	response	Responded to inquiry	Categorical	1, Yes 2, No	Required
Date of Response	response_date	Date organization responded to inquiry	Continuous	Date (M-D-Y) 04-01-2023 to 01-31-2024	Required

community_name	inquiry_date	contact	response	response_date
Trinity Church Isilp				
St Martins Church Amityville				
Islip Senior Center				
Suffolk PBA				
Suffolk SOA				

Appendix E

Project Timeline



Tasks

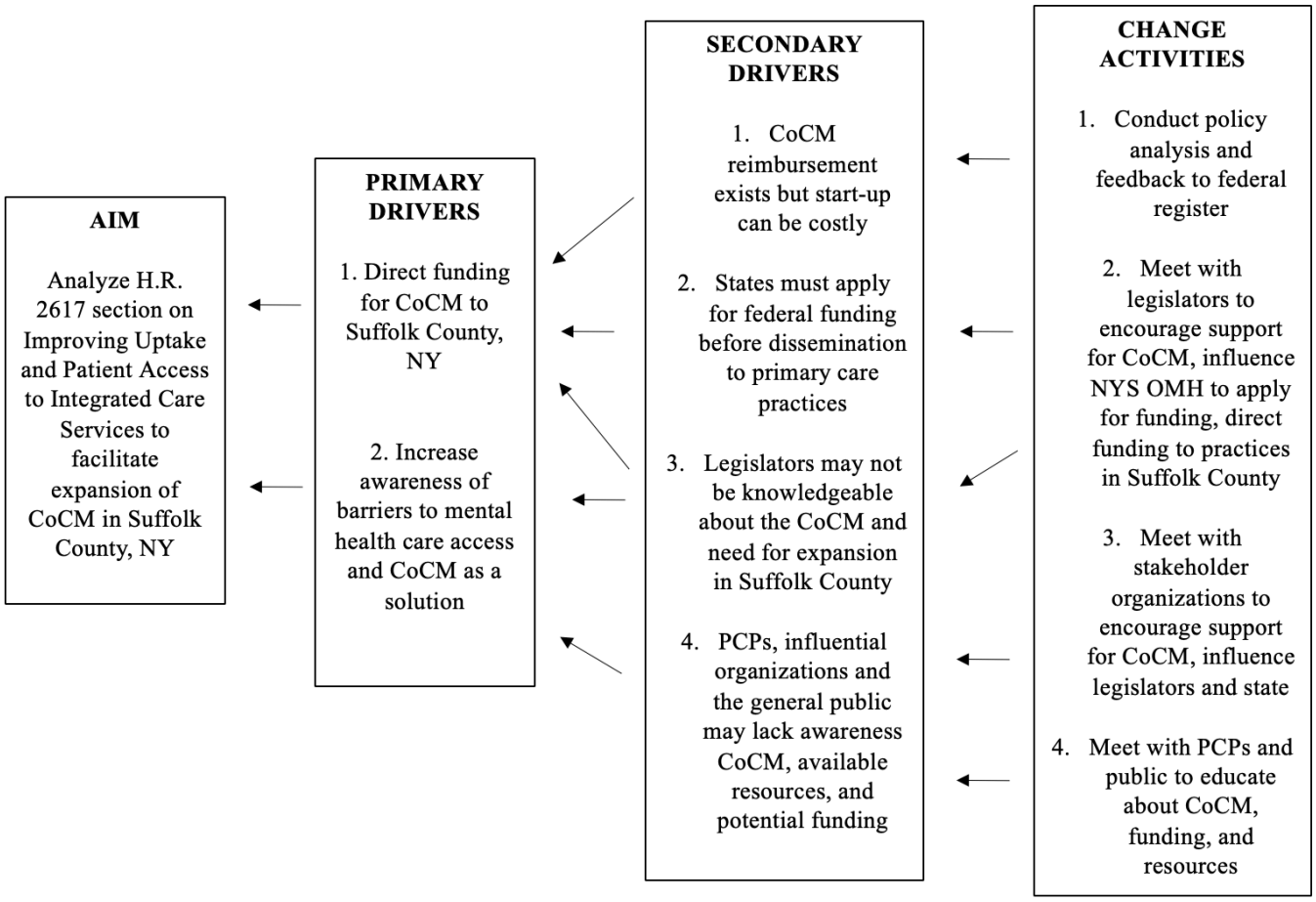
Start	End	Duration	Label	Vert. Position	Vert. Line
8/24/23	8/31/23		Monitor Implemented CoCM	-20	-20
10/15/23	10/20/23		Monitor Implemented CoCM	-20	-20
12/5/23	12/10/23		Monitor Implemented CoCM	-20	-20
8/24/23	8/31/23		Monitor Planned CoCM	-32	-32
10/15/23	10/20/23		Monitor Planned CoCM	-32	-32
12/5/23	12/10/23		Monitor Planned CoCM	-32	-32
8/24/23	8/31/23		Monitor Federal Funding	-43	-43
10/15/23	10/20/23		Monitor Federal Funding	-43	-43
12/5/23	12/10/23		Monitor Federal Funding	-43	-43
8/24/23	12/11/23	108	Submit Recommendations to Federal Regist	12	12
8/24/23	12/11/23	108	Contact Legislators - Ongoing	-60	-60
8/24/23	12/11/23	108	Engage Stakeholder Orgs - Ongoing	-73	-73
8/24/23	12/11/23	108	Engage PCPs - Ongoing	-85	-85
8/24/23	12/11/23	108	Engage Community - Ongoing	-97	-97
8/24/23	9/15/23	18	Policy Analysis	22	22
			Insert new rows above this one		

Milestones

Date	Label	Position
8/24/23	Start Implementation Phase	28
12/11/23	End Implementation Phase	25
	Insert new rows above this one	

Appendix F

CoCM Driver Diagram



Adapted from National Health Service. (2022). Quality, service improvement and redesign tools: Driver diagrams. https://www.england.nhs.uk/wp-content/uploads/2022/01/qsir-driver-diagrams.pdf

Appendix G

Federal Register Submission

Samantha S. Roche, MSN, PMHNP-BC
128 Carleton Avenue
East Islip, NY 11730
Samantha@SouthShoreNP.com

September 9, 2023

Honorable Xavier Becerra
Secretary
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1784-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Proposed Rules, Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies, 88 FR 52262, Section II.J.7 Advancing Access to Behavioral Health Services

Dear Secretary Becerra,

I am a nurse practitioner specializing in mental health and a student of health policy. In my professional role, I provide crucial mental health counseling and psychiatric medication management services to nearly 200 patients and their families in my private practice in New York. As a champion of expanding access to mental health services via Collaborative Care and behavioral health integration, I am writing today in support of new coding allowing interprofessional consultation to be billed by practitioners authorized to diagnose and treat mental illness.

The Collaborative Care Model (CoCM) was designed to address some of the most significant barriers to mental health care (AIMS, 2023). First, services are integrated into the primary care setting to reduce stigma surrounding mental health treatment, leveraging a patients existing rapport with their primary care provider to increase participation (AIMS, 2023). Second, the CoCM is designed to utilize a behavioral health care manager (BHCM), typically a social worker or licensed mental health counselor, to assist in the assessment, brief treatment, and coordination of care for the patient (AIMS, 2023). Next, the psychiatric consultant (PC) role is to formulate the patients individualized treatment plan with the BHCM and to support the PCP in prescribing

psychiatric medications (AIMS, 2023). The PC is usually a psychiatrist or psychiatric nurse practitioner.

Based on my experience and discussions with primary care providers, cost and reimbursement remain significant barriers to the wide-spread adoption of CoCM programs. The PC role generally does not require a psychiatric specialist's full-time attention. For example, I could allocate time in my full-time private mental health practice to contract with a primary care office to provide interprofessional consultation and behavioral health supervision and support services. Unfortunately, the impediment to this is payment. It is not financially feasible for me to allocate time for consultation without reimbursement, thus, as things stand the onus would be on the primary care practice to designate funding for the PC services.

Even if the primary care practice were billing CoCM CPT codes, it could be difficult to capture sufficient revenue to contract with a PC while financially sustaining the other essential elements of the CoCM. In fact, the vast majority of CoCM programs in my area (11 of 12 CoCM programs operating in Suffolk County, NY) exist within one large academic health care organization where the psychiatrists are generally salaried employees performing in the CoCM PC role as an ancillary responsibility or exclusively as a CoCM PC but serving multiple practices concurrently. However, if a psychiatrist or psychiatric nurse practitioner were able to bill for interprofessional consultation services, this would open the door for a psychiatric specialist to effectively collaborate as a PC with primary care providers and CoCM programs in all settings, not only in the context of the fiscal support of a large health care organization.

Adding this coding could have a significant and profound impact on the expansion of CoCM programs and access to mental health care. Thank you for considering these comments. If you have any questions, please reach out to the email above.

Sincerely,

Samantha S. Roche, MSN, PMHNP-BC
Board Certified Psychiatric-Mental Health Nurse Practitioner
Practice Owner, South Shore Collaborative Psychiatry, NP, PLLC

Reference

Advancing Integrated Mental Health Solutions Center. (2023). Collaborative care. https://aims.uw.edu/collaborative-care

Appendix H

One-Pagers: Federal, State, Community Information Sheets

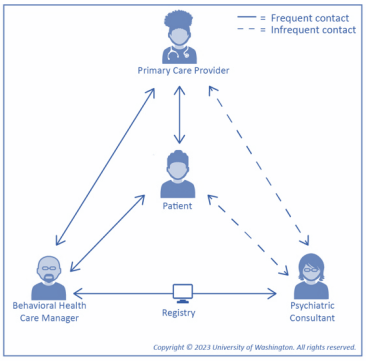
Lack of mental health services is a serious problem. Long wait times for therapy or mental health medication management are common and mental health provider shortages[1] add to the challenge. Suffolk County residents value mental health care[2], and current efforts[3] alone aren't enough.

The Collaborative Care Model is an evidence-based, effective way to integrate mental health care into the primary care setting[4], which can improve your constituent's ability to get crucial mental health care when they need it.

The Collaborative Care Model utilizes a team approach: A primary care provider, a behavioral health care manager, and a consulting psychiatrist. All are trained to provide specialized medication and counseling interventions to help meet your constituents needs.

Why Collaborative Care?
Research demonstrates it is:

- Effective
- Efficient
- Less stigmatizing
- Good value[4]



As of September 2023, there are only 12 Collaborative Care Model programs in Suffolk County[5].

How can you help? There are up-front costs to establishing a Collaborative Care program for primary care practices, and most practices cannot afford to take on the financial risk of hiring the appropriate staff to make the model successful.

Federal Legislators: Please support ongoing federal funding of integrated models of care, such as the Substance Abuse and Mental Health Services Administration "Promoting the Integration of Primary and Behavioral Health Care Integration" grant[6].

References
[1]Jones, B. (2022). Therapist shortage has parents struggling to get teens help as depression, suicides rise. Newsday. https://www.newsday.com/news/health/therapy-teens-depression-suicide-wyotikol
[2]Winslow, O. (2023). Survey: Depression, suicide at top of Long Islanders' health concerns. *Newsday.* https://www.newsday.com/news/health/long-island-health-collaborative-survey-mental-health-lxkum4uf
[3]Gormley, M. (2023). State undertaking $1B 'transformation' to address mental health crisis. Newsday. https://www.newsday.com/news/region-state/state-legislature-kathy-hochul-mental-health-services-covid-19-pandemic-crisis-h5pqqhh9
[4]AIMS Center. (2023). Collaborative Care. *University of Washington.* https://aims.uw.edu/collaborative-care
[5]New York State. (2022). Collaborative Care Medicaid Program. https://aims.uw.edu/nyscc/programs/collaborative-care-medicaid-program-ccmp
[6]Grants.gov. (2023). SM-24-003 Promoting the integration of primary and behavioral health care integration. https://www.grants.gov/web/grants/view-opportunity.html?oppId=349700

For additional information, please contact:
Samantha Roche, MSN, PMHNP-BC
SamanthaRoche@GWU.edu
631-235-4484 • southshorenp.com/policy

About the Author: Samantha is a Suffolk County resident and a board-certified mental health nurse practitioner. She has more than 17 years of nursing experience and currently serves the mental health prescribing needs of nearly 200 patients and families in and around Suffolk County.

Improving Mental Health Access with Collaborative Care

Lack of mental health services is a serious problem. Long wait times for therapy or mental health medication management are common and mental health provider shortages[1] add to the challenge. Suffolk County residents value mental health care[2], and current efforts[3] alone aren't enough.

The Collaborative Care Model is an evidence-based, effective way to integrate mental health care into the primary care setting[4], which can improve your constituent's ability to get crucial mental health care when they need it.

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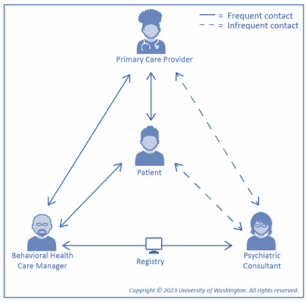

How can you help? There are up-front costs to establishing a Collaborative Care program for primary care practices, and most practices cannot afford to take on the financial risk of hiring the appropriate staff to make the model successful.

State Legislators: Please encourage New York State to apply for federal grant funding[6] every fiscal year. New York State Office of Mental Health Collaborative Care Medicaid Program[5] offers resources for practices billing Medicaid for Collaborative Care billing codes. They are well positioned to apply for federal funding and partner with Suffolk County primary care practices to establish Collaborative Care programs.
Local Legislators: Please request that funding be directed to primary care practices in Suffolk County.

References
[1]Jones, B. (2022). Therapist shortage has parents struggling to get teens help as depression, suicides rise. Newsday. https://www.newsday.com/news/health/therapy-teens-depression-suicide-wyotikol
[2]Winslow, O. (2023). Survey: Depression, suicide at top of Long Islanders' health concerns. *Newsday.* https://www.newsday.com/news/health/long-island-health-collaborative-survey-mental-health-lxkum4uf
[3]Gormley, M. (2023). State undertaking $1B 'transformation' to address mental health crisis. Newsday. https://www.newsday.com/news/region-state/state-legislature-kathy-hochul-mental-health-services-covid-19-pandemic-crisis-h5pqqhh9
[4]AIMS Center. (2023). Collaborative Care. *University of Washington*. https://aims.uw.edu/collaborative-care
[5]New York State. (2022). Collaborative Care Medicaid Program. https://aims.uw.edu/nyscc/programs/collaborative-care-medicaid-program-ccmp
[6]Grants.gov. (2023). SM-24-003 Promoting the integration of primary and behavioral health care integration. https://www.grants.gov/web/grants/view-opportunity.html?oppId=349700

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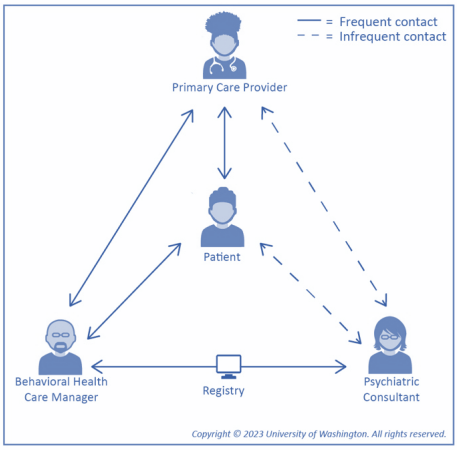
Improving Mental Health Access with Collaborative Care

It's not easy to find timely mental health care services

In our community it is common to experience long wait times for therapy or mental health medication, often weeks and sometimes months. Mental health provider shortages add to the challenge.

The Collaborative Care Model is an evidence-based, effective way to integrate mental health care into the primary care setting, which can improve your ability to get crucial mental health care when you need it.

The Collaborative Care Model utilizes a team approach: Your primary care provider, a behavioral health care manager, and a consulting psychiatrist. All are trained to provide specialized medication and counseling interventions to help meet your needs.



Why Collaborative Care?

Research demonstrates it is:

- Effective
- Efficient
- Less stigmatizing
- Good value

Mental health matters to Suffolk County residents! To really make a difference we need more Collaborative Care Programs in our community. You can help direct government funding to primary care practices in Suffolk County to establish Collaborative Care Programs by writing to your federal, state, and local representatives. Let them know how important improving access to mental health care is to you, and that funding Collaborative Care Programs can help!

Find more information and ways to get involved here:
www.southshorenp.com/policy or contact SamanthaRoche@GWU.edu

Appendix I

Data Collection Tables

leg_name	leg_affiliation	leg_district	party	inquiry_date	contact	response	response_date
Chuck Schumer	1	NY	1	09-08-2023	1,2	1	09-12-2023
Kirsten Gillibrand	1	NY	1	09-08-2023	1,2	1	10-26-2023
Nicholas LaLota	2	CD1	2	09-08-2023	1,2	1	10-02-2023
Andrew Garbarino	2	CD2	2	09-07-2023	1,2	1	10-31-2022
Anthony Palumbo	3	1	2	09-08-2023	2	1	09-26-2023
Mario R. Mattera	3	2	2	09-11-2023	2	2	
Dean Murray	3	3	2	09-11-2023	2	2	
Monica Martinez	3	4	1	09-07-2023	2	1	10-03-2023
Alexis Weik	3	8	2	09-11-2023	2	1	10-06-2023
Patricia Canzoneri-Fitzpatrick	3	9	2	09-07-2023	2	2	
Julia Salazar	3	18	1	09-11-2023	2	2	
Gustavo Rivera	3	33	1	09-11-2023	2	1	09-18-2023
Nathalia Fernandez	3	34	1	09-11-2023	2	1	09-11-2023
Lea Webb	3	52	1	09-11-2023	2	1	09-13-2023
Samra Brouk	3	55	1	09-08-2023	2	1	09-12-2023
Fred W. Thiele, Jr	4	1	1	09-11-2023	2	1	09-20-2023
Jodi Giglio	4	2	2	09-11-2023	2	2	
Joe DeStafano	4	3	2	09-11-2023	2	2	
Edward Flood	4	4	2	09-11-2023	2	2	
Douglas Smith	4	5	2	09-11-2023	2	1	09-12-2023
Philip Ramos	4	6	1	09-07-2023	2	2	
Jarett Gandolfo	4	7	2	09-08-2023	2	1	09-11-2023
Michael Fitzpatrick	4	8	2	09-11-2023	2	1	09-25-2023
Michael Durso	4	9	2	09-11-2023	2	1	09-12-2023
Steve Stern	4	10	1	09-07-2023	2	2	
Kimberly Jean-Pierre	4	11	1	09-11-2023	2	2	
Keith Brown	4	12	2	09-11-2023	2	2	
Aileen Gunther	4	100	1	09-08-2023	2	2	

Appendix J

Newsday OpEd

OPINION / COMMENTARY / GUEST ESSAYS

We must improve access to mental health care on Long Island

It is urgent that we address the mental health care access crisis. Credit: iStock Photo

By Samantha Roche
Guest essay
Updated December 20, 2023

SHARE

Almost everyone on Long Island who attempts to begin counseling or psychiatric medication

This guest essay reflects the views of Samantha Roche, a Suffolk County resident and board-certified psychiatric mental health nurse practitioner.

Available at: https://www.newsday.com/opinion/commentary/guest-essays/mental-health-long-island-gwk1leoa