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Editorial

Innovation in Mental Health Care: Expanding Collaborations and Building Digital Tools

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Since the COVID-19 pandemic began, Americans have experienced a surge in mental health challenges and an increased need for mental health care services across age groups, from geriatric to pediatric patient populations.[1,2] In response, remote psychiatric screening and services became widely available through telemedicine. Patient familiarity with virtual care thus was born of the COVID-19 era, in and beyond the field of psychiatry. COVID-19 also shone a spotlight on mental health and elevated America's focus on the oncoming challenges of geriatric care all the way to the White House, securing anticipated funding in the FY23 budget.[3] The support is none too soon, as in the coming years we will face an unmatched increase in the number of aging Americans and the number of aging Americans with mental health conditions. Resources that enable partners to work together to identify and treat mental health challenges are greatly needed, especially when we consider that up to half of those with mental health conditions already go untreated.

The remote screening tool designed by Urmanche et al.[4] is a good example of partnership and technology combining to create an on-ramp toward mental health care through a community health setting. The program is admirable for numerous reasons, including clear dedication to process and iterative design; supporting an especially vulnerable population; and contributing to our understanding of relationships between COVID-19 stressors, symptoms, and mental health conditions. The research-practice partnership (RPP) of Urmanche et al. helped a community-based social services organization to identify and track older adults' mental health symptoms using a new, jointly developed remote tool. Urmanche's academic team was able to study associations between symptoms and engagement with and effectiveness of the tool. RPPs connect research/academic institutions with

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practice institutions for collaborative problem-solving.[5]

In their study, Urmanche et al. examined systematic distress levels and associations between different domains of functioning. They found clients who stayed at home more days reported higher levels of depressive, anxious, and COVID-19 trauma symptoms and that those with higher depression symptoms reported higher anxiety, loneliness, greater trauma symptoms in the context of COVID-19, and lower quality of life.[4] The National Academies of Sciences Engineering and Medicine (NAM) report "Social Isolation and Loneliness in Older Adults, Opportunities for the Health Care System" identifies major goals to mitigate the negative health impacts of social isolation and loneliness, and offers recommendations for achieving them. NAM authors call on the research community to develop more evidence relating to assessment, prevention and intervention strategies for social isolation and loneliness, as well as a predictive association between loneliness and mortality.[6] The work of Urmanche et al. underscores the premise of the NAM report: there is evidence that many older adults are socially isolated and lonely in ways that puts their health at risk and this must be further studied and addressed.

While stating the tool could be a blueprint for case management agencies and senior centers nationwide, Urmanche et al. recognize more work must be done in several areas: improving referral acceptance rate; identifying and addressing barriers to receiving mental health services, including health-related stigma in geriatric patient populations; and simplifying mental health screenings/incorporating more narrative- or qualitative-based data.

The study, in our perspective, has emphasized the importance of health information technology (HIT) infrastructure in health care collaboration. Interoperability and real-time health information exchange are critical to provider collaboration and timely care coordination.[7] HIT infrastructure and policies that enable real-time data-sharing should increase efficiency, and even support referral rate acceptance, as well as reduce the administrative burden of programs seeking to extend care into community settings. The effects and success of HIT investment should be further studied at both the programmatic and macro levels. At a macro level, some researchers are looking at hospital involvement in partnerships; data-sharing capabilities; and involvement in health information exchanges in relation to patient outcomes like reduction of preventable emergency department visits, readmissions, and other measures. This line of research is one we are especially interested in and think must continue in order to understand relationships between HIT investments and benefits to patients and communities.

Another opportunity for technology optimization to improve outcomes relates to the unique audio, visual, and motor needs of older adults. Urmanche et al. wrote that design of digital tools should include client/patient as a partner, and we couldn't agree more. Older adults may need louder volume, slower speech, larger font, and different design features than digital tools aimed at a different population. Further, minority populations may require interpretation services or the availability of digital tools in languages other than English; and while trends show older adult broadband and technology access are steadily increasing, it's important to maintain parallel in-person screening and support services to avoid leaving those without access, or with low digital literacy, behind.

As important as HIT infrastructure is to the success of health care partnerships and the use of digital health tools, payment model may hold the greatest influence over whether partnership programs can succeed—or even get off the ground. The predominant fee-for-service payment model does not incentivize health care providers to collaborate. Yet, other models, such as accountable care organizations, which target population health through coordination and health information exchange, are designed to promote partnership and reduce inefficiencies. Mental health care, because of digital readiness, increasing need, and provider shortages, may be a prime area for building and studying payment models, partnerships, and technologies designed to encourage prevention and screening, treatment, and care management. The work of Urmanche et al. illustrates how partnerships and technology can support mental health patients and expand mental health care provider teams. Such work pulls health care toward better integration, high-value technologies, and innovative payment models.

DISCLOSURES

The authors have no disclosures to report.

DATA STATEMENT

The data has not been previously presented orally or by poster at scientific meetings.

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