Introduction to Collaborative Care

Why Integrated Behavioral Health?
What is Collaborative Care?
How it differs from other integrated care
Evidence base for Collaborative Care
Key Principles of Effective Collaborative Care

Why Integrate Behavioral Health into Primary Care?
Mental Disorders are Rarely the Only Health Problem

- Chronic Physical Pain: 25-50%
- Cancer: 10-20%
- Mental Health / Substance Abuse: 20-30%
- Neurologic Disorders: 10-20%
- Heart Disease: 10-30%
- Diabetes: 10-30%
- Smoking, Obesity, Physical Inactivity: 40-70%
- Diabetes: 10-30%

How many of these people with mental health concerns will see a health provider?

- No Treatment
- Primary Care Provider
- Mental Health Provider

Wang P, et al., Twelve-Month Use of Mental Health Services in the United States, Arch Gen Psychiatry, 62, June 2005
Patient-Centered Care?

“Don’t you guys talk to each other?”
Collaboration is NOT a natural state

Bridging the Divide Between Mental Health & Medical Care

- Mental health is part of overall health
- Treat mental health disorders where the patient is / feels most comfortable receiving care
  - Established doctor-patient relationship is an important foundation of trust
  - Less stigma
  - Better coordination with medical care

What is IMPACT?

The IMPACT study tested the Collaborative Care Model on depressed, older adults
IMPACT Trial

- 1998 – 2003
- 1,801 depressed adults
- 18 primary care clinics –
  - 8 health care organizations in 5 states
    - Diverse health care systems
      - Urban & semi-rural settings
      - Capitated (HMO & VA) & fee-for-service
    - 450 primary care providers

IMPACT Treatment Protocol

1. Assessment, Engagement, Patient Education
2. Behavioral Activation / Pleasant Events Scheduling
   PLUS
3. a) Antidepressant Medication
   Usually an SSRI or other newer antidepressant
   AND / OR
   b) Problem-Solving Treatment in Primary Care (PST-PC)
   6-8 individual sessions
4. Maintenance and Relapse Prevention Plan once better

The IMPACT Study

- Effective Collaboration
- Practice Support
- Measures
- Informed, Active Patient
- Tools & Training
- Consultation
**IMPACT doubles effectiveness of treatment**

- 50% or greater improvement in depression at 12 months

![Graph showing the effectiveness of treatment](image)

**Improves physical function...**

![Graph showing improvements in physical function](image)

**... and Reduces Health Care Costs**

ROI: $6.5 saved / $1 invested

<table>
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<tr>
<th>Cost Category</th>
<th>4-year costs in $</th>
<th>Intervention group cost in $</th>
<th>Usual care group cost in $</th>
<th>Difference in $</th>
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<td>Outpatient mental health costs</td>
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<td>61</td>
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<td>Total health care cost</td>
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<td>29,422</td>
<td>32,785</td>
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</tbody>
</table>

![Savings graph](image)

IMPACT: Summary

- Less depression
- IMPACT more than doubles effectiveness of usual care
- Less physical pain
- Better functioning
- Higher quality of life
- Greater patient and provider satisfaction
- More cost-effective

“I got my life back”
THE TRIPLE AIM

The Collaborative Care Approach

Principles of Effective Collaborative Care

- Patient Centered Team Care / Collaborative Care
  - Co-location is not collaboration: team members learn to work differently.

- Population-Based Care
  - All patients tracked in a registry: no one “falls through the cracks”.

- Measurement-Based Treatment to Target
  - Treatments are actively changed until the clinical goals are achieved.

- Evidence-Based Care
  - Treatments used are “evidence-based”.

- Accountable Care
  - Providers are accountable and reimbursed for quality of care and clinical outcomes, not just the volume of care provided.
Primary Care Provider

- **Oversees all aspects of patient’s care**
- Diagnoses common mental disorders
- Starts & prescribes pharmacotherapy
- Introduces collaborative care team
- Makes treatment adjustment in consultation with care manager, team psychiatrists, and other behavioral health providers
Collaborative Team Approach

- **PCP**
- **Care Manager**
- **Consulting Psychiatrist**
- **Other Behavioral Health Clinicians**
- **Core Program**
- **Additional Clinic Resources**
- **Outside Resources**
- **Substance Treatment, Vocational Rehabilitation, Other Community Resources**

**Care Manager - I**
- Facilitates patient engagement and education
- Works closely with PCP and helps manage a caseload of patients in primary care
- Performs systematic initial and follow-up assessments
- Systematically tracks treatment response
- Supports medication management by PCPs

**Care Manager – II**
- Provides brief, evidence-based counseling or refers to other providers for counseling services
- Reviews challenging patients with the consulting psychiatrist weekly
- Facilitates referrals to other services (e.g., substance abuse treatment, specialty care and community resources) as needed
- Prepares client for relapse prevention
Psychiatric Consultant

- Supports care managers and PCPs
  - Provides regular (weekly) and as needed consultation on a caseload of patients followed in primary care
    - Focus on patients who are not improving clinically
  - In person or telemedicine consultation or referral for complex patients
  - Provides education and training for primary care-based providers
**Incorporate Other Behavioral Health Clinicians**

- Can provide valuable services such as
  - Comprehensive assessment
  - Evidence-based counseling / psychotherapy
    - Individual or Group
  - Behavioral health interventions focused on health behaviors
  - Chemical dependency counseling
  - Social work services

**Key Principles of Effective Collaborative Care**

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  - Collaboration not co-location
  - Team members have to learn new skills

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**Comparison of Contacts in Usual Care vs. Collaborative Care**

**USUAL CARE**

- 3.5 PCP Contacts per year

- 20% - 40% treatment response/improvement

Based on HRSA report of average PCP visit rates for FQHCs
Comparison of Contacts in Usual Care vs. Collaborative Care

INTEGRATED CARE
- 3.5 PCP Contacts per year
- 10 contacts with CM (on average)
- 2 case consultations from psychiatrist to CM/PCP (on average)

50% - 70% treatment response/improvement

Typical Course of Care Management: Duration
- 6-10 Months (average)
- Best if determined by clinical outcomes, not preset
  - 50%-70% of patients will need at least one change in treatment to improve
  - Each change of Tx moves an additional ~20% of patients into response or remission
- If pre-determined, minimum 6 months with option to extend to 12 months if additional prescription change is wanted

Typical Course of Care Management: Contact Frequency
- Active Treatment:
  - Initial 3-6 months until patient improved / stable
  - Minimum 2 contacts per month
    - Typical during first 3-6 months of treatment
    - Mix of phone and in-person works
- Monitoring:
  - 1 contact per month
    - After 50% decrease in PHQ / GAD (or similar) achieved
    - Monitor for ~3 months to ensure patient stable
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Proactive Treatment Adjustment

Current Patients

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In this module . . .

- rationale for integrated behavioral health in primary care
- collaborative care as special type of integrated care
- the evidence base for the collaborative care approach
- the 5 key principles of effective collaborative care