Overview of Collaborative Care

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NYC HEALTH+ HOSPITALS | ONECITY HEALTH

Disclosures

Ms. **Eunice Kim, LMSW** has no actual or potential conflict of interest in relation to this presentation.

The members of the Collaborative Planning Committee have no actual or potential conflict of interest in relation to this presentation.

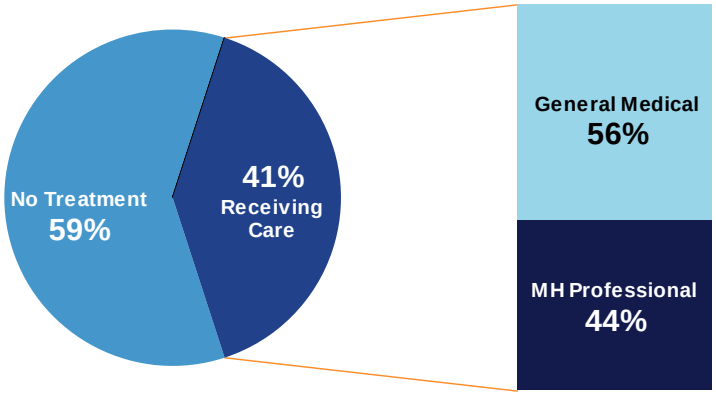
Presentation Objectives

Participants will:

- Demonstrate a greater understanding of the Collaborative Care model
- Be able to identify Collaborative Care team member roles
- To implement a Collaborative Care course of treatment

Primary Care is De Facto Mental Health System

National Comorbidity Survey Replication
Provision of Behavioral Health Care: Setting of Service



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

Only 2/10 of patients with diagnosable mental health problems see a mental health specialist

Mental Disorders are Rarely the Only Health Problem

Chronic
Physical Pain
25-50%

Cancer
10-20%

Smoking, Obesity,
Physical Inactivity
40-70%

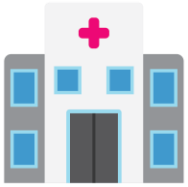
Mental Health / Substance Abuse

Neurologic
Disorders
10-20%

Heart Disease
10-30%

Diabetes
10-30%

Services Poorly Coordinated, Not Patient-Centered



Primary Care

Community Mental Health Centers

Alcohol & Substance Abuse Treatment

Social Services

Vocational Rehab

Other Community Based Social Services

Depression Care

- 1/10 see psychiatrist
- 4/10 receive treatment in primary care
- ~30 Million with an antidepressant Rx **but only 20% improve**
- 2/3 PCPs report poor access to mental health for their patients

Good ideas that DON'T WORK

Screening in primary care without adequate treatment / follow-up

- 20 years of negative studies

Provider education

- Knowledge is not enough
- Providers need systems and help to do the right thing

Telephone-based disease management

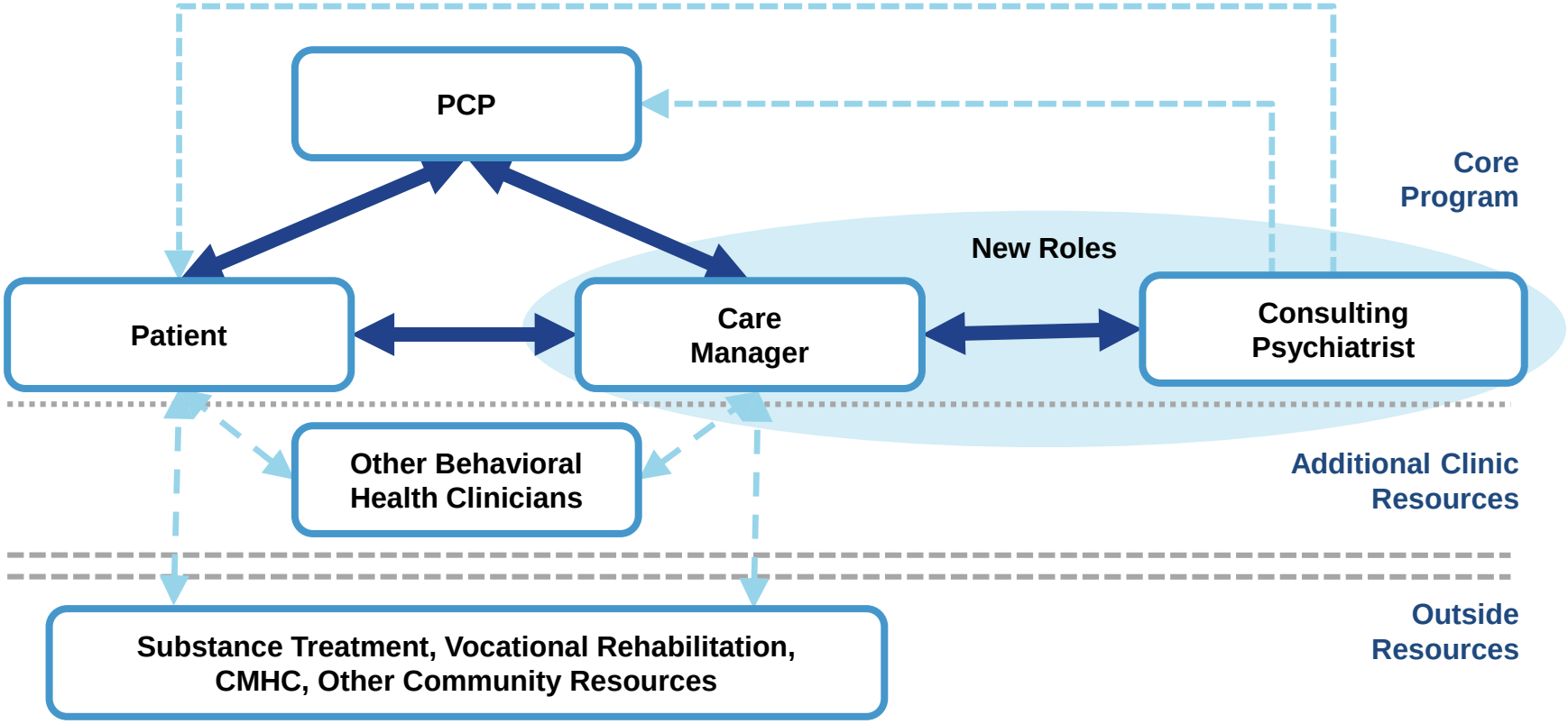
- 16 negative studies with ~300,000 Medicare recipients
  - McCall N, Cromwell J: N Engl J Med. 2011;365:1704-12.
  - Peikes D et al: JAMA. 2009;301(6):603-618.

What is Collaborative Care?

IMPACT

- Improving Mood Promoting Access to Collaborative Treatment
- Featured roles: PCP, Depression Care Manager and Consulting Psychiatrist
- PCP oversees patient's depression care

Collaborative Care Team Approach



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The results are in…

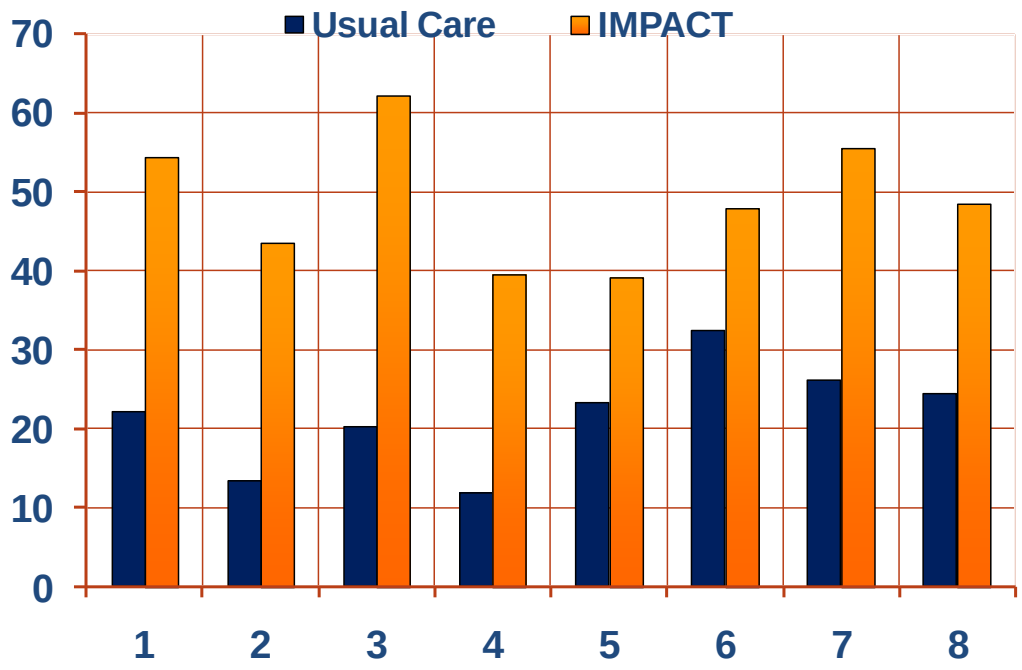
Collaborative Care is more effective than care as usual in primary care (over 80 randomized controlled trials)

- Gilbody S. et al. Archives of Internal Medicine; Dec 2006.
- Thota AB, et al. Community Preventive Services Task Force. Am J Prev Med. May 2012;42(5):521-524.
- Archer J, et al. Cochrane Collaborative. Oct 17, 2012.: 79 RCTs with a total of 24,308 patients

Collaborative Care also more cost-effective

- Gilbody et al. BJ Psychiatry. 2006; 189:297-308.
- Unutzer et al. Am J Managed Care. 2008; 14:95-100.
- Glied S et al. MCRR. 2010; 67:251-274.

Collaborative Care doubles effectiveness of depression care



Unützer et al., *JAMA 2002*; *Psych Clin NA* 2004.

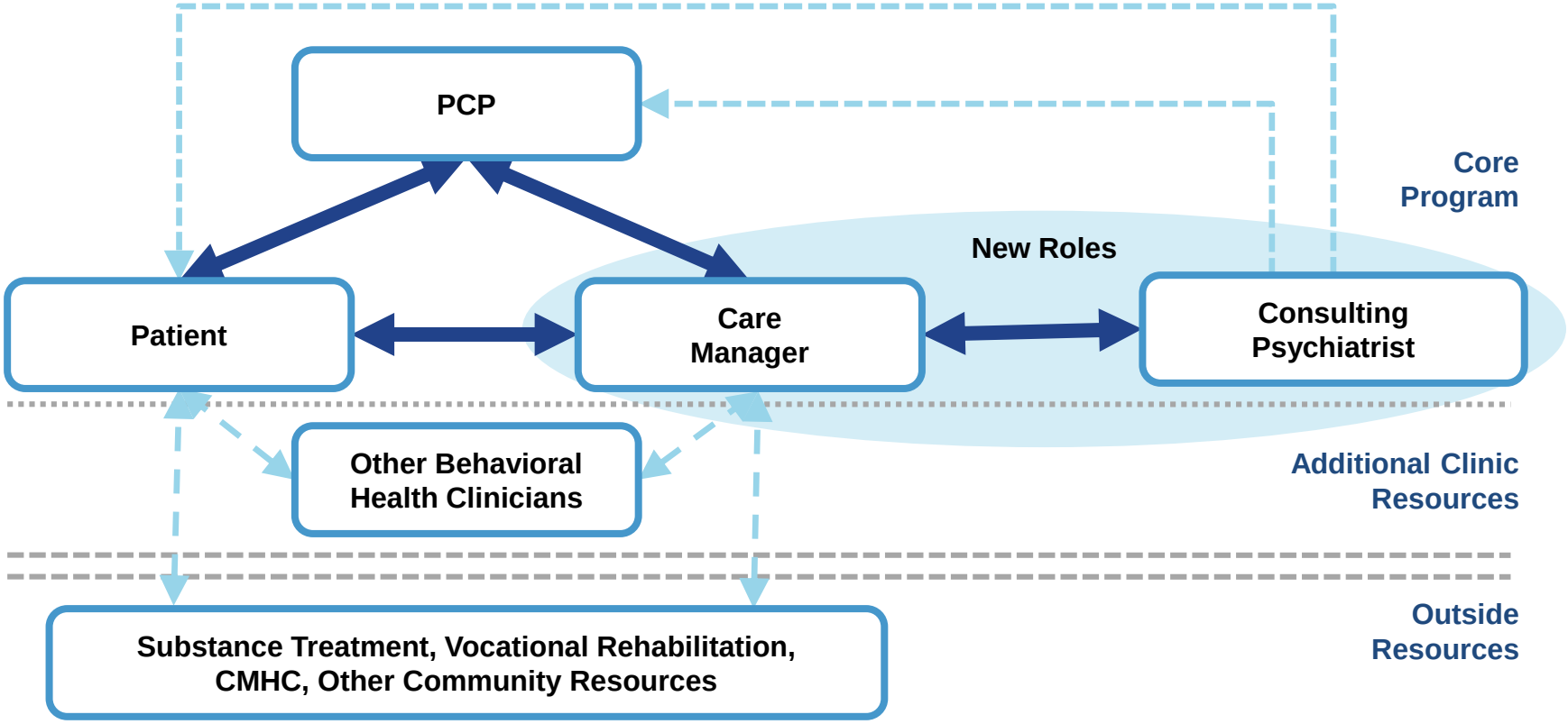
IMPACT: Summary

- 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

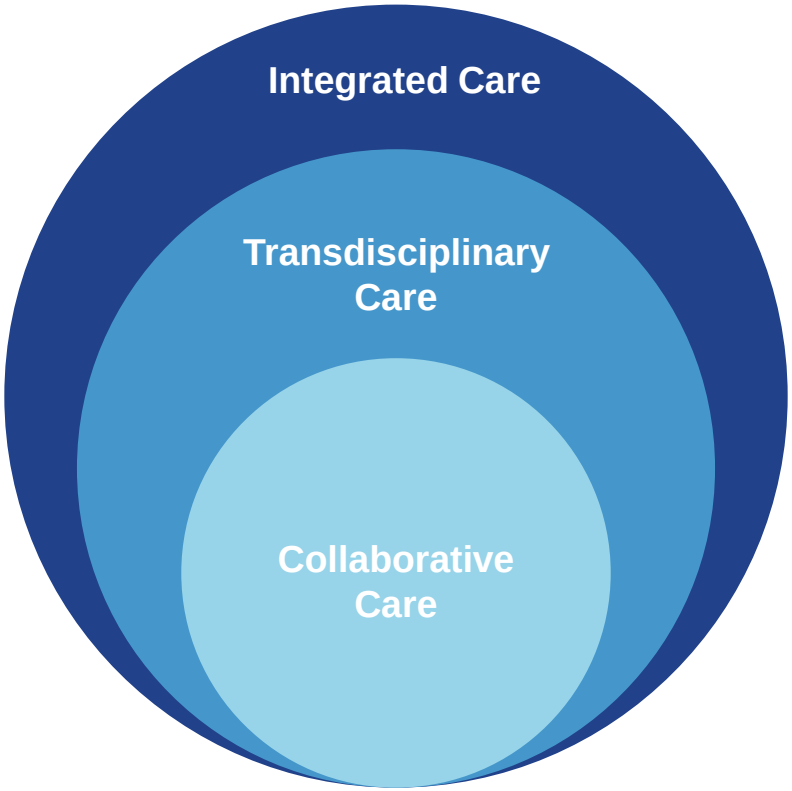
Collaborative Care Team Approach



Integration –All the BUZZ

- Integrated Care
- Interdisciplinary Care
- **Collaborative Care**
- Multidisciplinary Care
- **Transdisciplinary Care**
- Co-located Care

Integration



Core Principles of Collaborative Care

Patient-Centered Care

Primary care and mental health providers collaborate effectively using shared care plans.

Population-Based Care

A defined group of patients is tracked in a registry so that no one falls through the cracks.

Treatment to Target

Progress is measured regularly and treatments are actively changed until clinical goals are achieved.

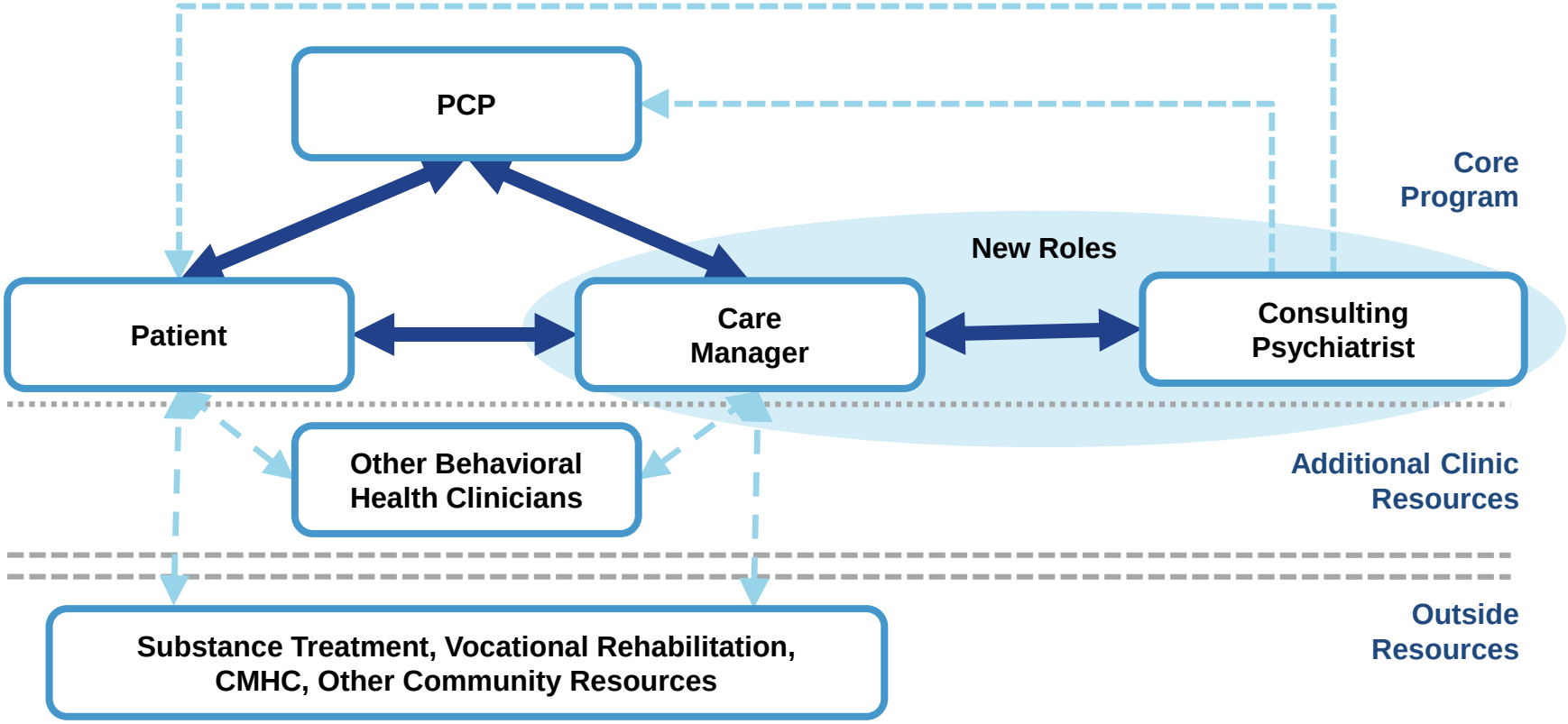
Evidence-Based Care

Providers use treatments that have research evidence for effectiveness.

Accountable Care

Providers are accountable and reimbursed for quality of care and clinical outcomes, not just volume of care.

Collaborative Care Team Approach



Collaborative Care Team Model

TWO PROCESSES	TWO NEW 'TEAM MEMBERS'	
	BH Care Manager	**Consulting Psychiatrist**
1. **Systematic diagnosis and outcomes tracking** PHQ-2/9 & GAD-2/7 to facilitate diagnosis and track outcomes	• Patient education / self management support • Close follow-up to make sure patients don't 'fall through the cracks'	• Weekly caseload consultation for care manager and PCP (population-based) • Diagnostic consultation on difficult cases
2. **Stepped Care** a. Change treatment according to evidence-based algorithm if patient is not improving b. Relapse prevention once patient is improved	• Support anti-depressant Rx by PCP • Brief talk treatment (behavioral activation, PST-PC, CBT, IPT) • Facilitate treatment change / referral to specialty behavioral health, as needed • Relapse prevention	• Consultation focused on patients not improving as expected • Recommendations for additional treatment / referral according to evidence-based guidelines

Consulting Psychiatrist Role

- Provides regular (weekly) consultation on patients followed in primary care, focusing on those not improving
- Provides ad hoc consultation to CM or PCP as needed for urgent cases
- In-person or telemedicine consultation or referral to specialty care for complex patients (typically < 10% of patients)
- Provides support and training for primary care-based providers

Seek Consultation with Psychiatrist when Patient…

- Is severely depressed (PHQ-9 score ≥20)
- Fails to respond to treatment
- Has complicating mental health diagnosis, such as personality disorder or substance abuse
- Is bipolar or psychotic
- Has current substance dependence
- Is suicidal or homicidal

Q: What clients are appropriate for referral to Collaborative Care?

A: Any client with a PHQ-9/GAD-7 greater than 9

1. Who is not already engaged in care with behavioral health i.e., not seeing a psychiatrist or a therapist
2. Does not present as high risk – e.g., recent psychiatric hospitalization, active suicidality with intent and/or plan, active homicidality
3. Does not have a previous bipolar disorder diagnosis or active psychosis

Primary Care Provider Role

- Oversees all aspects of patient's care
- Diagnoses common mental disorders
  - Reviews screeners: (e.g., PHQ-2/9, GAD-2/7)
- Starts & prescribes pharmacotherapy
- Introduces collaborative care team and care manager
- Collaborates with care manager and psychiatric consultant to make treatment adjustments as needed

Presenting Warm-Handoff[2]

When presenting to a patient, it is helpful to use terms like:

- Coworker
- Colleague
- Someone who specializes in…
- I work with *name* who is part of our team. I'd like to introduce you to them before you go."

To reduce fear/stigma, avoid terms like:

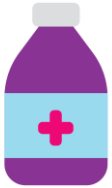
- Therapist
- Social Worker

[2]Warm Hand-Off Referrals By the Primary Care Provider To the Behavioralist. (n.d.). Retrieved 2016, from California Mental Health Services Authority: http://www.ibhp.org/?section=pages&cid=122

Collaborative Care Workflow

Discussing Treatment Options

Telephonic interventions



Medication Management

Talk Treatment

Follow-Up Contacts

Weekly or every other week during acute treatment phase

- In person or by telephone to evaluate symptom severity (PHQ-9, GAD-7) and treatment response

Initial focus on

- Adherence to medications
- Side effects
- Follow-up on activation and PST plans

Later focus on

- Complete resolution of symptoms and restoration of functioning
- Long-term treatment adherence

Outcome Targets & Definitions

Demonstrated improvement

- 50% reduction in PHQ-9 and/or GAD-7 scores from baseline OR
- Sub-clinical PHQ-9 and/or GAD-7 scores

“Remission”

- PHQ-9 score < 5 for 3 months

Treat to Target

REMEMBER: Most Patients Will Need Treatment Adjustments

- Over 30 – 50% of patients will have a complete response to initial treatment
- 50 – 70% will require at least one change in treatment to get better

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

50% - 70% treatment response/improvement

Collaborative CARE

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

Questions

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Thank You

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