Introduction to Collaborative Care

An Overview of Collaborative Care
Why Integrate Behavioral Health into Primary Care?

1. Access
   Serve patients where they are

2. Patient-centered
   Treat the whole patient

3. Effectiveness
   Better clinical outcomes
Primary Care is De Facto Mental Health System

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

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

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

Mental Health / Substance Abuse

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

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Services Poorly Coordinated, not Patient-Centered

“Don’t you guys talk to each other?”

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

“Of course you feel great. These things are loaded with antidepressants.”
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
• Peikes D et al: JAMA. 2009;301(6):603-618
What DOES work?

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

- Gilbody S. et al. *Archives of Internal Medicine*; Dec 2006

**Collaborative Care also more cost-effective**

- Gilbody et al. BJ Psychiatry 2006; 189:297-308.
- Glied S et al. MCRR 2010; 67:251-274.
Collaborative Care doubles effectiveness of depression care

50% or greater improvement in depression at 12 months

Co-Location is NOT Integration

50% or greater improvement in depression at 12 months

Participating Organizations

Usual Care

IMPACT

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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
# Principles of Effective Patient-Centered Integrated Behavioral Health Care

## Patient Centered Team Care / Collaborative Care
- Collaboration not co-location
- Team members have to learn new skills

## Population-Based Care
- 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
# IMPACT Team Care Model

## TWO PROCESSES

<table>
<thead>
<tr>
<th>1. Systematic diagnosis and outcomes tracking</th>
</tr>
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<tbody>
<tr>
<td>PHQ-9 to facilitate diagnosis and track depression outcomes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Stepped Care</th>
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</thead>
<tbody>
<tr>
<td>a) Change treatment according to evidence-based algorithm if patient is not improving</td>
</tr>
<tr>
<td>b) Relapse prevention once patient is improved</td>
</tr>
</tbody>
</table>

## TWO NEW ‘TEAM MEMBERS’

<table>
<thead>
<tr>
<th>Care Manager</th>
<th>Consulting Psychiatrist</th>
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<tbody>
<tr>
<td>- Patient education / self management support</td>
<td></td>
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<tr>
<td>- Close follow-up to make sure pts don’t ‘fall through the cracks’</td>
<td></td>
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<tr>
<td>- Support anti-depressant Rx by PCP</td>
<td></td>
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<tr>
<td>- Brief counseling (behavioral activation, PST-PC, CBT, IPT)</td>
<td></td>
</tr>
<tr>
<td>- Facilitate treatment change / referral to mental health</td>
<td></td>
</tr>
<tr>
<td>- Relapse prevention</td>
<td></td>
</tr>
<tr>
<td>- Caseload consultation for care manager and PCP (population-based)</td>
<td></td>
</tr>
<tr>
<td>- Diagnostic consultation on difficult cases</td>
<td></td>
</tr>
<tr>
<td>- Consultation focused on patients not improving as expected</td>
<td></td>
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<tr>
<td>- Recommendations for additional treatment / referral according to evidence-based guidelines</td>
<td></td>
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</tbody>
</table>

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“Care Manager” is a ROLE

Who are Care Managers?

• Common: MSW, LCSW, MA/MS Counselor, LMFT
• Others: RN, Clinical Psychologist

Characteristics of Effective Care Managers

• Able to engage patients and providers
• Flexible and open to new ways of practicing
• Adaptable to primary care culture and workflows
• Values working in a collaborative team
• Organized and able to track entire population of patients
• Strong advocate for changing treatments until patient improved
• Persistent
Care Manager Role

- Supports and collaborates closely with PCPs managing patients in primary care
- Facilitates patient engagement and education
- Performs initial and follow-up assessments
- Systematically tracks treatment response
- Supports medication management by PCPs
Care Manager Role (cont.)

- Provides brief, evidence-based therapeutic interventions (e.g. behavioral activation)
- Provides psychotherapy (e.g., PST) or refers patient for counseling services
- Reviews cases with psychiatric consultant weekly
- Facilitates referrals to other services as needed (e.g. substance abuse)
- Creates relapse prevention plan with patient
Primary Care Provider Role

- Oversees all aspects of patient’s care
- Diagnoses common mental disorders
  – Brief screeners: (e.g., PHQ-9, GAD-7, PCL-C)
- Starts & prescribes pharmacotherapy
- Introduces collaborative care team and care manager
- Collaborates with care manager and psychiatric consultant to make treatment adjustments as needed
Comparison of Contacts in Usual Care vs. Integrated 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. Integrated 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
Track Clinical Outcomes on all patients

Prevent people from ‘falling through the cracks’

Facilitate treatment planning and adjustment
  – Combat ‘clinical inertia’: patients staying on ineffective treatments for too long

Know when it is time to get consultation / get help and when it is time to change treatment
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
Behavioral Health Measures

Support screening
Support diagnosis
Establish baseline
Track effectiveness of treatments
Clarify change in status
Advantages

- **Objective assessment**
- **Creates common language**
- **Focuses on function**
- **Similar to other health outcomes** that are routinely tracked (e.g., BP)
- **Avoids potential stigma** of diagnostic terms
- **Helps identify patterns** of improvement or worsening
Depression: Patient Health Questionnaire (PHQ-9)

- Assists with identification and diagnosis
- Tracks 9 core symptoms over time
- Easy to use
- Can be done over the phone
- A good communication and teaching tool
- Available in many languages

(http://www.phqscreeners.com/)
<table>
<thead>
<tr>
<th>Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use &quot;✓&quot; to indicate your answer)</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

For office coding: 0 + 3 + 4 + 6 = Total Score: 13

Adapted from Kroenke K, Spitzer RL, Williams JB. The PHQ-9: Validity of a brief depression severity measure. Journal of General Internal Medicine, 16:606-13, 2001
Psychotherapeutic Treatments for Depression in Primary Care

No one therapy fits all clients

- Choose an evidence-based treatment
- Choose a therapy that fits the client, your skill set, the setting, and the program

Problem Solving Treatment

Behavioral Activation
Discussing Treatment Options

Review all treatment options available

– Behavioral interventions
  • Motivational Interviewing / Engagement
  • Behavioral Activation,
  • Problem-Solving Treatment,

– Medications

Explore pros and cons of each option with patient
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
Typical Duration of Care Management

6-10 Months (average) – followed by ‘Relapse Prevention Planning’ once patient is substantially improved (e.g., PHQ<10 and PHQ-9 reduced by at least 50%)

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
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
Questions

- Q&A now
Virna Little, PsyD, LCSW-r, SAP, CCM

Vice President, Psychosocial Services & Community Affairs, The Institute for Family Health

Virna Little’s responsibilities encompass administration and delivery of social work, mental health and community-based services across 35 full-time and multiple part-time centers and over 300 staff in New York City and into Dutchess and Ulster counties for the Institute for Family Health, the largest community health center network in New York.

Dr. Little is a nationally known speaker around integrating primary care and behavioral health services, collaborative care, and the development of viable behavioral health services in community health settings. Dr. Little is an advocate for integrated delivery systems and behavioral health workforce and development.

Before joining the Institute, Dr. Little provided social services at the Department of Corrections and was a domestic violence coordinator chosen by the Mayor’s office in New York City to promote family violence identification and prevention. She is a federally-certified Department of Transportation substance abuse professional and a certified New York State Mandated Reporter child abuse trainer. Ms. Little has a doctoral degree in psychology from California Coast University and a masters in social work from Fordham University. She currently has a faculty appointment at Columbia University and Mt Sinai and formerly served as an adjunct professor at Westchester Community College and the College of New Rochelle. In recognition of her work in behavioral health, some of the awards Dr. Little has received the Eleanor Clarke Award For Innovative Programs In Healthcare (2004) and the National Association of Social Workers Image Award (2006), the Society for Social Work Leaders in Healthcare Social Worker of the Year (2013), Community Health Center of New York Paul Ramos Award (2014)

Dr. Little is a member of the AIMS center consulting team Seattle Washington, currently serves as the Vice Chair for Association for Clinicians for the Underserved (ACU), a member of the Hudson Valley American Heart Association Board and chairs the Behavioral Health Sub-Committee for the Community Health Center Association of New York. Dr. Little is a member of the National Council for Community Behavioral Health Providers, American Association of Play Therapists, Social Work Managers, Society for Social Work Leaders in Healthcare, National Association of Social Workers and the American Psychological Association.
For more information about Collaborative Care, please visit the AIMS Center website: https://aims.uw.edu/
Thank-you!