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**

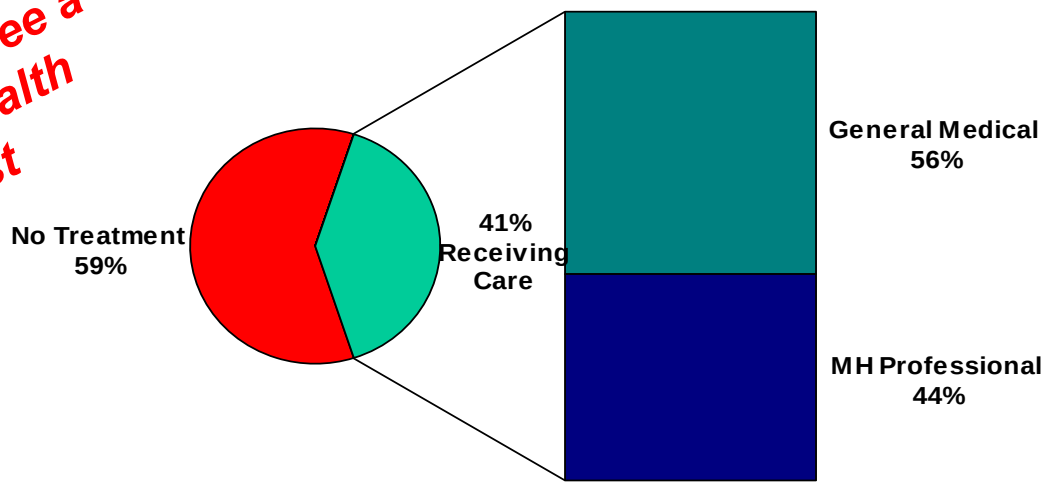
   Better clinical outcomes

Primary Care is De Facto Mental Health System

National Comorbidity Survey Replication

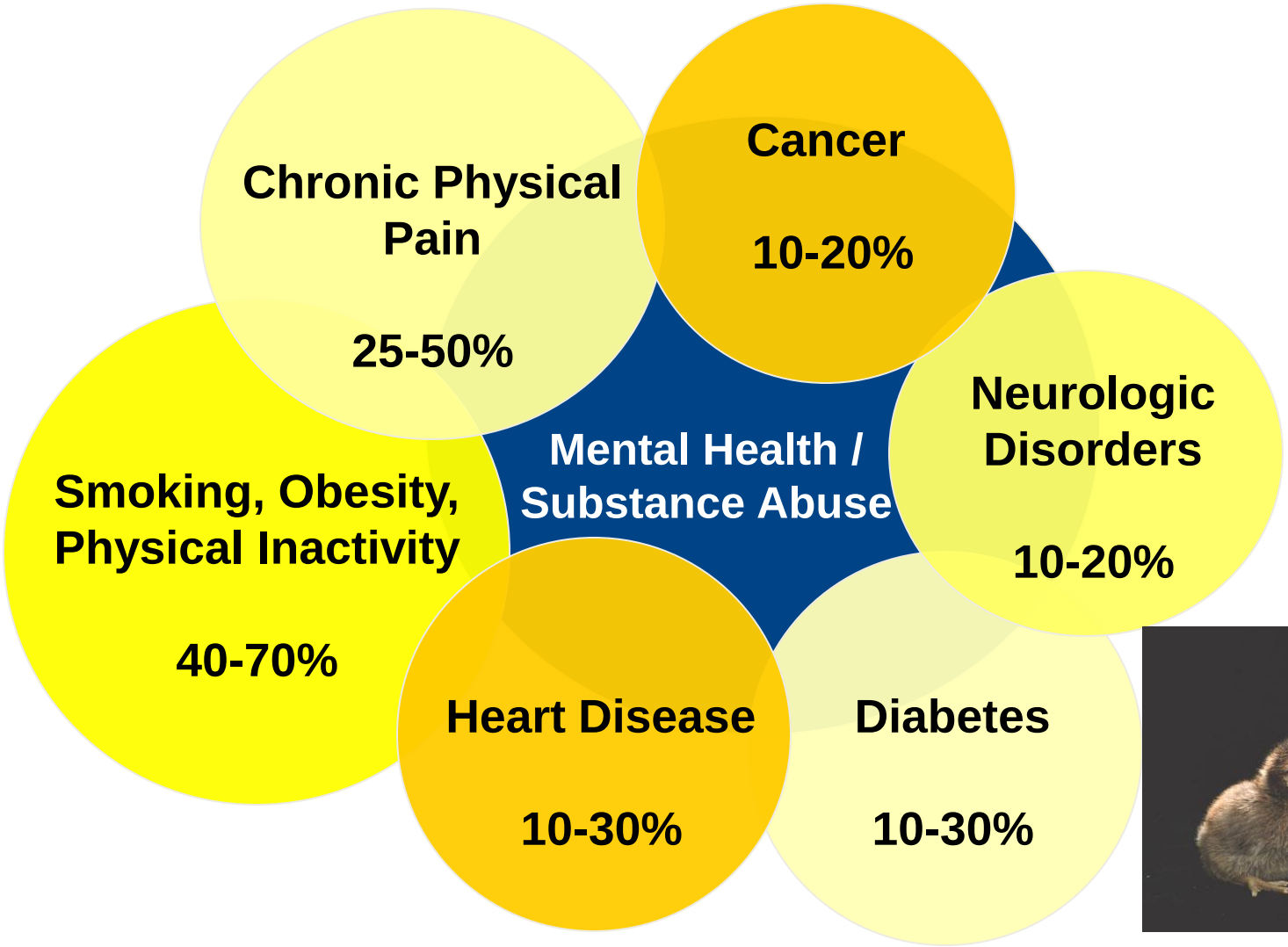
Provision of Behavioral Health Care: Setting of Service

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



Services Poorly Coordinated, not Patient-Centered

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

- McCall N, Cromwell J: N Engl J Med 2011;365:1704-12.
- 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
- 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.

Integrated Care Model

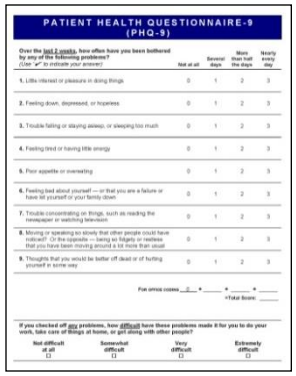
Prepared, Pro-active Practice Team

Effective Collaboration

Informed, Activated Patient

Practice Support

Measures


PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "✓" to indicate your answer)

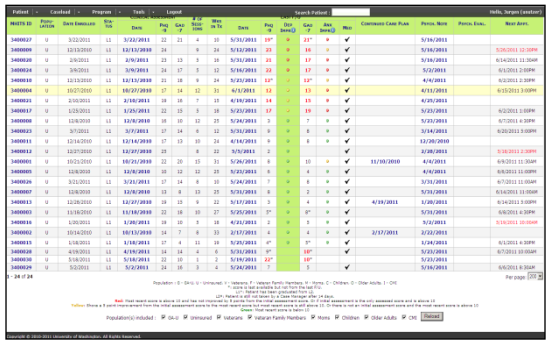
	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so figgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

For office coding: 0 + ____ + ____ + ____ =Total Score: ____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Registry

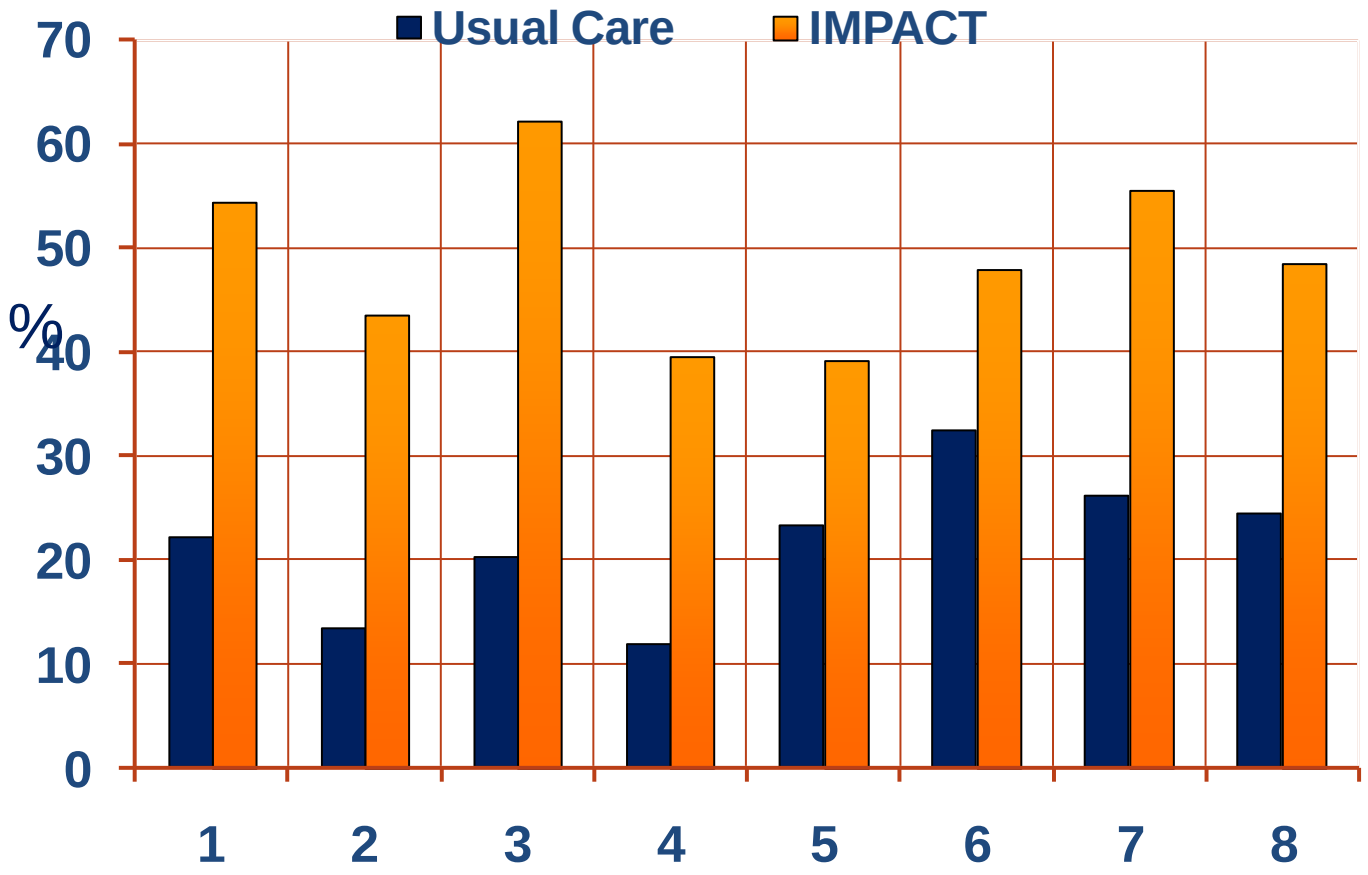


Tools & Training

Consultation

Collaborative Care doubles effectiveness of depression care

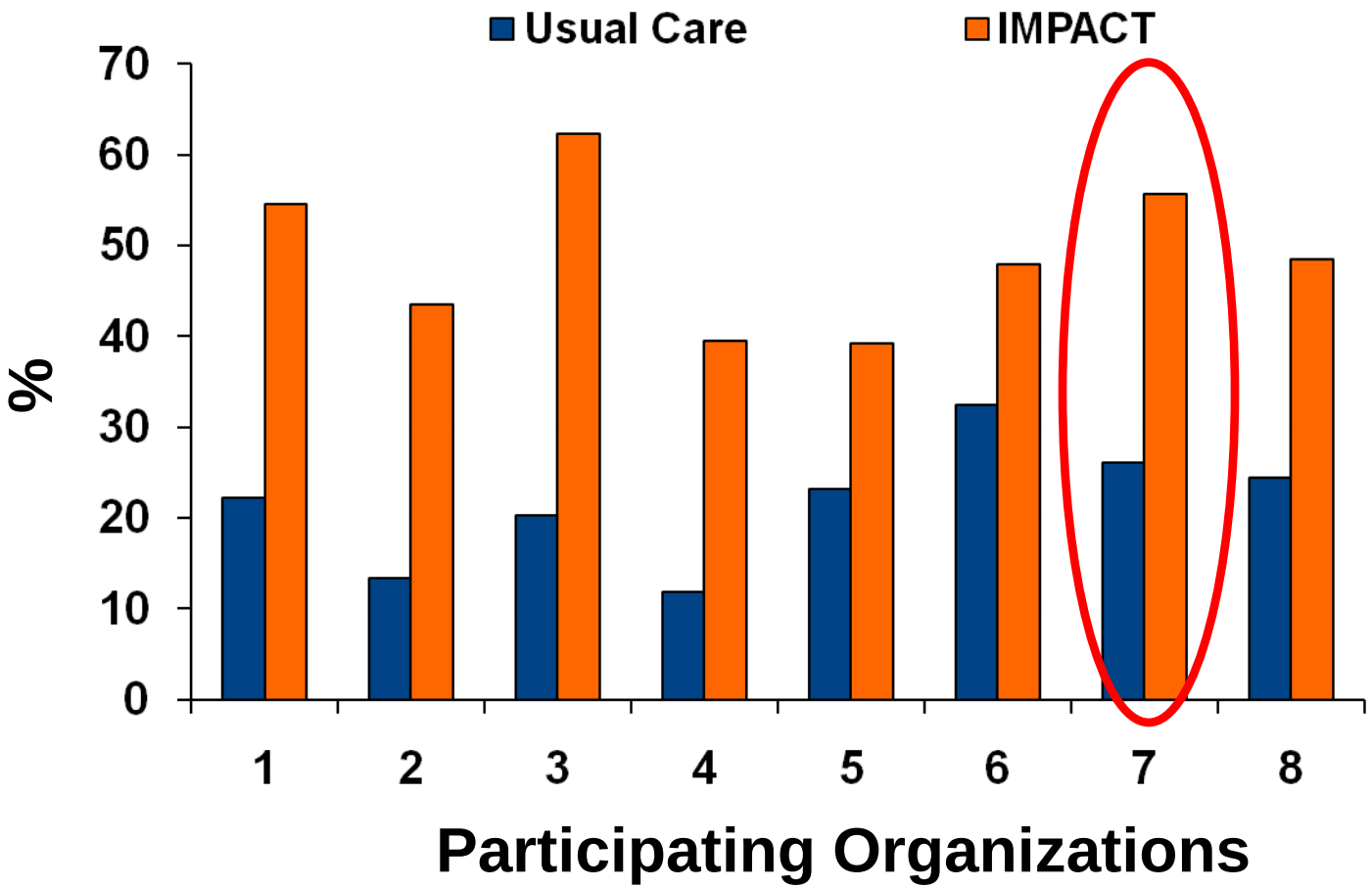
50% or greater improvement in depression at 12 months



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

Co-Location is NOT Integration

50% or greater improvement in depression at 12 months



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	TWO NEW 'TEAM MEMBERS'	
	Care Manager	Consulting Psychiatrist
1. Systematic diagnosis and outcomes tracking PHQ-9 to facilitate diagnosis and track depression outcomes	- Patient education / self management support - Close follow-up to make sure pts don't 'fall through the cracks'	- 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 counseling (behavioral activation, PST-PC, CBT, IPT) - Facilitate treatment change / referral to mental health - Relapse prevention	- Consultation focused on patients not improving as expected - Recommendations for additional treatment / referral according to evidence-based guidelines

“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/)

PHQ-9:

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	**1**	2	3
2. Feeling down, depressed, or hopeless	0	**1**	2	3
3. Trouble falling or staying asleep, or sleeping too much	**0**	1	2	3
4. Feeling tired or having little energy	0	1	2	**3**
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7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	**2**	3
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	0	1	**2**	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	**0**	1	2	3

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!