Collaborative Care:
A Model of Integrated Behavioral Health in Primary Care

ALENA PETTY, DO
APRIL 1, 2020

Disclosures

I do not have any actual or potential conflicts of interest in relation to this program or presentation.
Learning Objectives

Describe the Collaborative Care model of behavioral health integration; contrast with co-located care

List the members of a Collaborative Care team

Discuss how Collaborative Care achieves the Triple (Quadruple) Aim of healthcare reform

Outline

Case
Current practices, barriers to effective mental health care, and relevance
Overview of Collaborative Care
  • AIMS model
  • Roles
  • Core principles

Barriers and benefits of implementing Collaborative Care
Case, revisited
Current Practices

Case to consider:

John, 62yo m, PMH poorly controlled HTN & DM2, presents for scheduled f/u with PCP
c/o insomnia, fatigue
Reports frequent nonadherence to treatment
• forgets to refill meds
• doesn’t check glucose or BP consistently
Upon further questioning, endorses depression & anhedonia x 2 months
Denies any prior psych hx

PCP prescribes escitalopram 5mg daily
Case, continued...

John returns after 2 weeks, with no improvement in depression

What would you do next?

Discussion

What is the current most common practice for managing depression within primary care?

What would you do as the PCP in this case?
Barriers to Effective Care

WHO GETS TREATMENT?

No Treatment

Primary Care Provider

Mental Health Provider
TRUE or FALSE?

25% of patients do not follow through on a referral to a mental health provider

FALSE.
- At least 50% do not follow through
- Of those who do, most are seen only once
Time & Geography as Barriers

If all patients with mental illness were referred to psychiatrists, they might not follow through, but if they did, there would not be enough time!

Geography matters: people might drive 4-5 hrs to see cardiologist, but only 30 min to see psychiatrist.

Relevance
Depression Is Common

16.1 million adults in the US had at least one major depressive episode in 2016
16.1% lifetime prevalence of depression, ~25% prevalence of any mental illness

The WHO recognizes depression as a leading cause of worldwide disability
  ◦ Mental illness causes 3x more disability than diabetes, 10x more than heart disease, 40x more than cancer

http://www.nimh.nih.gov/health/statistics/prevalence/major-depression-among-adults.shtml 03.27.17

Depression in Older Adults

Clinically significant depressive symptoms may be present in 8%-16% of older adults
  ◦ 25% combined prevalence of depression, subsyndromal depression, and persistent depressive disorder (formerly dysthymia) in adults aged > 60 years

Major depressive disorder
  ◦ ≥ 5% of community dwelling older adults
  ◦ 5%-10% of elderly patients in primary care
  ◦ up to 37% of elderly patients after critical care hospitalization
  ◦ 30%-50% of elderly patients in institutional and long-term care facilities
Disparities

Older men have the highest suicide rate of any age group.
- Men aged 85 years or older have a suicide rate of 45.23 per 100,000 compared to an overall rate of 11.01 per 100,000 for all ages

Older adults with depression:
- Visit the doctor and ED more often
- Use more medication
- Have higher outpatient costs
- Stay longer in the hospital

Depressive disorders are under-recognized and often untreated or undertreated among older adults

Adults age 65 or older were more likely than adults age 50–64 to report that they “rarely” or “never” received the social and emotional support they needed (12.2% compared to 8.1%, respectively).
- Approximately one-fifth of Hispanic and other, non-Hispanic adults age 65 years or older reported that they were not receiving the support they need, compared to about one-tenth of older white adults.

Integrating Care
TRUE or FALSE?

70-80% of antidepressants in the US are prescribed by psychiatrists (or other mental health providers)

FALSE.

70-80% of antidepressants in the US are prescribed by PCPs
Integrated care

SAMHSA’s definition: “systematic coordination of general & behavioral healthcare”

Shift from focus on acute flares of chronic illness to comprehensive, whole person care
  • Think biopsychosocial model in primary care

Improves patient adherence, patient satisfaction, provider satisfaction, and patient outcomes

Decreases fragmentation in care, provides wide array of services in familiar setting

Many different models, including:
  • Patient Centered Medical Home
  • Co-located care
  • Collaborative care
Collaborative Care

Treatment of common mental illnesses within primary care clinics
- Familiar setting, reduces stigma, improves adherence and satisfaction
- Indicated when “care as usual” is not effective

Specific model of integrated care
- Mental health clinician (“care manager”) embedded in primary care clinic
- Warm hand-offs (direct introduction)
- Brief, problem-focused interventions by the care manager
- Psychiatric consultation for “behind-the-scenes” care
Evidence Base for Collaborative Care

1995: 1st published RCT on collaborative care
2002: IMPACT trial, landmark study
2012: Cochrane review (79 RCTs)
  - Significantly greater improvement in depression for up to 2 years
  - Significantly greater improvement in anxiety for up to 2 years (fewer trials to date)

>80 RCTs have demonstrated benefits of collaborative care compared to care as usual for treatment of common mental health conditions

IMPACT trial

RCT including 1801 depressed, older adults
Followed for 2 years
18 primary care clinics within 8 organizations in the US
Intervention: collaborative care vs care as usual

Unutzer, J., Katon, W et al. Collaborative Care Management of Late Life Depression In The Primary Care Setting: A Randomized Control Trial. JAMA. 2002 Dec;288(22):2836-45
IMPACT trial

12 months:
- At least 50% reduction in symptoms in 45% intervention group vs. 19% control
- Higher treatment retention, satisfaction with care, and quality of life
- Lower depression severity, functional impairment

24 months:
- Average 107 more depression-free days

Unutzer, J., Katon, W et al. Collaborative Care Management of Late Life Depression In The Primary Care Setting: A Randomized Control Trial. JAMA.2002 Dec;288(22):2836-45
Roles

Patient
◦ chooses treatment and identifies goals

PCP
◦ primary provider of all care

Psychiatric Consultant
◦ indirect care provided via consultation with Care Manager

Care Manager
◦ coordinates behavioral healthcare, performs initial assessments and systematic follow-up, provides patient education, creates and updates treatment plan, performs brief psychotherapy, completes majority of documentation

Care Manager

New position

Needs formal education or specialized training in behavioral health
◦ Social work
◦ Nursing
◦ Psychology

Pros & cons of each background; choose based on expectations for your practice
◦ Example: RN may have more experience to discuss medications, adverse effects, etc. but licensed SW could also bill for counseling
A New Approach to Care

Culture change for both PCPs and Psychiatrists

PCP provides direct management based on input and recommendations from mental health clinicians, not just a referral to psychiatry, but requires involvement with another member of the team

Psychiatrist treats patients they haven’t seen and with little available data

Discussion: any concerns about this approach?

Core Principles of Collaborative Care

Patient centered team care
Population based care
Measurement based treatment to target
Evidence based care
Accountable care

University of Washington Psychiatry and Behavioral Sciences Division of Population Health
Patient Centered Team Care

Incorporates *patient goals and choice* of treatment into the plan

Direct collaboration between primary care and behavioral health providers

*Shared care plans: BeH and medical*

---

Population Based Care

Defined group of patients

Tracked over time (electronic patient registries)

Focus on those not improving as expected or at risk to fall out of care
Measurement Based Treatment to Target

Use of standardized assessments & rating scales
- PHQ-9, GAD-7 initial & follow-up
- CIDI-3, PRIME, SDoH initial & PRN

Registries are imperative

Case-load focused consultation by the Psychiatrist

Prompt adjustments in treatment plan
50-70% of patients need at least one change in the treatment plan in order to achieve remission of depression.
TRUE or FALSE?

50-70% of patients need at least one change in the treatment plan in order to achieve remission of depression

TRUE. Only 30-50% of patients have adequate response to initial treatment plan

Evidence Based Care

Treatments utilized are backed by credible research
- Pharmacotherapy
- Psychotherapy

Education to PCPs regarding evidence based treatment
- Included in the consultation note
Accountable Care

Pay for performance cuts median time to depression response in half
5-10% reduction in healthcare expenditures
- $6 saved for every $1 spent in one study
- $3000 saved per patient over 4 years, even when intervention ended after 2 years in another

Time to remission
...

2008-2013 retrospective study of >7,000 patients

Usual primary care: 614 days
Collaborative Care: 86 days
More Rationale for Collaborative Care

USPSTF 2016 guidelines recommend screening all adults for depression

Management of comorbidities
- Depression presents with somatic complaints (insomnia, pain, etc)
- Depression and anxiety associated with more CAD, DM, CVA, COPD, etc.

Implements access to care
- 70-80% antidepressants Rx’ed by PCPs already
- 50% don’t follow through on referral

Achieves Triple* Aim of healthcare reform
- Improved outcome
- Increased patient satisfaction
- Reduced healthcare cost


Barriers

New model of care

Up-front costs
- CM benefits, registry, psychiatric consultant

PCP discomfort with mental health issues

Shortage of mental health clinicians
- to be care managers and consultants

Technology (EHR, registry, etc.)

Insurance/billing, new codes
Benefits

Numerous, including:
- Financial
- Patient outcomes
- Patient satisfaction
- Provider satisfaction

Payment

CMS reimbursement began January 2017
- Medicare, Medicaid, and limited private/commercial plans

Paid to PCP

Based on time per calendar month

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>99492</td>
<td>Initial psych care mgmt., 70 min</td>
<td>$142.84</td>
</tr>
<tr>
<td>99493</td>
<td>Subsequent psych care mgmt., 60 min</td>
<td>$126.33</td>
</tr>
<tr>
<td>99494</td>
<td>Initial/subsequent psych care mgmt., add’nal 30 min</td>
<td>$66.04</td>
</tr>
<tr>
<td>99484*</td>
<td>Care mgmt. minimum 20 min, other models*</td>
<td>$47.73</td>
</tr>
</tbody>
</table>
Case, revisited

John, 62yo m, PMH poorly controlled HTN & DM2, presents for scheduled f/u with PCP c/o insomnia, fatigue
Reports frequent nonadherence to treatment
- forgets to refill meds
- doesn’t check glucose or BP consistently
Upon further questioning, endorses depression & anhedonia x 2 months
Denies any prior psych hx

PHQ-9 = 17. PCP prescribes escitalopram 5mg daily -> no improvement after 2 weeks
-> Now what?

Case, with Collaborative Care

PCP does warm hand-off to Care Manager (CM) for further evaluation using standardized screening tools and discussion of John’s preferred treatment methods
CM & PCP discuss results (likely Major Depressive Disorder)
Continue escitalopram 5mg daily
CM follows up with John in 2 weeks, and PHQ-9 still unchanged
Case, continued

John notes he is tolerating escitalopram well but frustrated he has not seen benefits.

Escitalopram increased to 10mg daily, and behavioral activation started, with pt’s consent.

CM follows-up with John twice more over the next 4 weeks, and PHQ-9 =13, but then remains unchanged after an additional 2 weeks of follow-up.

Case, continued

CM meets with psychiatrist for weekly consultation, and reviews John’s case based on the registry.

Psychiatric consultant recommends increasing escitalopram to 20mg daily and continuing behavioral activation.

John sees CM twice more over the next 4 weeks; PHQ-9 = 6.

John is taking his medications as prescribed and is more active & engaged with his family.
Questions & Discussion
alena.petty@bannerhealth.com

Resources

University of Washington AIMS Center https://aims.uw.edu/collaborative-care

APA https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care


Healthy People 2020 https://www.healthypeople.gov/