AMERICAN PSYCHIATRIC ASSOCIATION

Introduction to the Collaborative Care Approach

- Exercise: Practice Registry Management
- Exercise: Putting Principles into Practice
- Sample Case Review
- Evidence-Base Established and Emerging Evidence for Collaborative Care
- Resources

Exercise: Putting Principles into Practice

Step 1: Consider each statement in the checklist below. Put a check mark in the left column next to any tasks that you do now in your current practice. Put a check mark in the right column next to any tasks that you consider areas that you could work on in your practice. **Do not worry about the shaded area until Step 2.**

Step 2: Now focus on the shaded areas. Consider your responses from Step 1. Review the whole document and move any unmarked tasks to potential areas to improve. At the end of this exercise, you should have 3-5 small goals to improve your practice!

- Which principles have the most check marks? Great work! Keep doing what you are doing for this principle or consider taking your practice one step forward by more fully implementing Collaborative Care principles.
- Which principles have the fewest check marks? Great opportunity! Any tasks that are not yet checked could be potential next steps. Consider picking one or two tasks and setting them as practice goals.

	I do this now!	My Current Practice	Possible Areas to Improve	My Practice Goal
	**Population-Based Care**		**Population-Based Care**	
		I maintain a list of all my currently active patients.		
		I use a registry to track all my patients and to help identify patients who may be 'falling through the cracks'.		
		I actively reach out to patients on my caseload who are not following up or not improving.		
		I consider the entire population of potential patients when I think about delivering care.		

	**Treatment to Target**		**Treatment to Target**	
		I regularly use validated patient rated screeners or outcome measures to identify patients who need help.		
		I regularly track my patients' clinical progress with valid patient rated outcome measures such as the PHQ-9 for depression.		
		I set treatment goals that are measured by defined improvement on valid outcome measures (such as the PHQ-9).		
		I regularly use results from behavioral health measures (such as the PHQ-9) to inform my adjustment of clinical care to achieve goals / targets.		
	**Patient-Centered Collaboration**		**Patient-Centered Collaboration**	
		I ask about other providers that are involved in my patient's care.		
		I send notes to other providers caring for my patients.		
		I regularly communicate with other providers caring for my patients.		
		I share a medical record with other providers caring for my patients		
		I contribute to a shared / integrated care plan for my patients.		

	**Evidence-Based Care**		**Evidence-Based Treatment**	
		I have some familiarity with evidence-based medication approaches and behavioral interventions such as those summarized in APA treatment guidelines for the mental health disorders I commonly treat.		
		I consistently apply evidence-based medication approaches and behavioral interventions for the mental health disorders I commonly treat.		
		I can make recommendations for evidence-based medication approaches and behavioral interventions to support other team members.		
	**Accountable Care**		**Accountable Care**	
		I set outcome goals for the care I provide and evaluate if I am meeting those goals for individual patients.		
		I treat or get consultation for patients who are not achieving their outcome goals.		
		I regularly review if my panel / population of patients are achieving their outcome goals and adjust my practice if I am not achieving these goals.		
		I am able to report individual patient-level and patient panel aggregate outcomes such as the remission rate of patients treated for depression as measured by the PHQ-9.		

Practice Caseload Activity

Report run on 9/7/18

Flags	Patient ID	PHQ-9		Contacts					
		First Score	Last Score	Date of Initial Visit	Date of Last Follow-up	Psychiatric Case Review	Relapse Prevention Plan	# Sessions	# Weeks in Treatment
👉	1	23	10*	4/1/2018	7/12/2018	7/20/2018		14	25
	2	17	4	10/14/2017	8/30/2018	3/9/2018		18	46
	3	16	7	4/13/2018	9/6/2018	8/30/2018	9/6/2018	14	24
	4	25	25	7/28/2018	9/7/2018	8/3/2018		4	5
	5	20	12	10/12/2017	8/28/2018	5/11/2018	7/28/2018	16	46
	6	19	9	4/27/2018	8/9/2018	5/25/2018		7	18
	7	11	12	7/19/2018	9/6/2018	7/20/2018		3	6
	8	21	5	7/7/2018	8/13/2018	8/10/2018		8	10
	9	9	8*	7/16/2018	8/27/2018	8/27/2018		2	7
	10	17	13	2/9/2018	8/13/2018	7/20/2018		15	36
	11	19	13*	7/8/2018	9/2/2018	8/28/2018		3	8
	12	18	6	4/30/2018	8/11/2018	8/12/2018		14	20
	13	11	0	3/10/2018	8/30/2018	7/20/2018	5/27/2018	8	25
	14	17	9	10/28/2017	8/18/2018	2/17/2018		13	45
	15	13	20	6/30/2018	8/29/2018	8/11/2018		7	10

Key

👉 Indicates patient has been flagged for discussion during next psychiatric consultation

* Score in the Last column will have an asterisk (*) if it is older than the specifications for that clinical measure (e.g., if the PHQ-9 is older than 30 days)

Which patients should be reviewed with the psychiatric consultant? What information would you use to prioritize the cases for review?

- Which patients need consultation? How do you know?
- Which patients are not improving? How do you know?
- Which patients need engagement? How do you know?
- Which patients are ready for relapse prevention? How do you know?

Considerations Before Caseload Review

Review registry for:

☐ All patients who have 8-10 weeks of treatment without significant improvement.
☐ Patients who aren't engaged or who have other difficulties in their care.
☐ New patients who are more complex or ones who need a medication decision to support the PCP.
☐ Patients where there is a diagnostic question or concern that they may need referral to specialty mental health.
☐ Any patient you have **flagged for consult** or who is on a consult list you keep. For example:
  - Patients on a dose of medications for longer than 4 weeks without significant improvement
  - Patients with current acute safety risks
  - Patients with scores over 10 on PHQ-9 or GAD-7 with no psych note
  - Patients who have improvement and would normally be ready for relapse prevention but you want to clarify whether there is a reason to continue care
  - Patients who have been in treatment for a significant amount of time and remain on the caseload

SAMPLE CASE REVIEW NOTE

SUMMARY: Pt is a 28yo male presenting with depression and anxiety. Pt having trouble falling asleep (plays with laptop or phone in bed), sleeping 4-7 hrs/night.

Depressive symptoms: Moderate depression; PHQ-9: 18 Bipolar Screen: Positive screen; Appears more consistent with substance use Anxiety symptoms: Moderate to severe; GAD-7: 18 Past Treatment: Currently taking Bupropion and Citalopram (since 1/31) feels more in control, able to think before reacting, less irritable; Took sertraline, fluoxetine, bupropion at different times during teenage yrs: Doesn't recall effect Suicidality: Denies Psychotic symptoms: Denies Substance use: History of substance use/alcohol; Engaged in treatment currently Psychosocial factors: Completed court appointed time in clean and sober housing; Now living back with parents in Carnation; Attending community college; Continues to stay connected to clean and sober housing Other: ADHD: ASRS-v1.1 screening – positive; Not diagnosed as a child; Now getting B's at community college

Medical Problems: hx of frequent migraines

Current medications: Bupropion HCl (Daily Dose: 450mg); Citalopram Hydrobromide (Daily Dose: 40mg)

Goals: Improve school functioning; Long term goal employment

ASSESSMENT: MDD (but cannot r/o bipolar disorder); Anxiety NOS; Alcohol use disorder, in early remission; r/o ADHD

RECOMMENDATIONS:

1) Continue to target sleep hygiene

2) Options for antidepressant augmentation. Engage patient in decision making about which ONE option to pursue:

a. Option 1: Continue citalopram 20mg as reported sedation on higher dose; Make sure he is taking dose at night and allow for longer period of observation to evaluate efficacy

b. Option 2: Cross taper to fluoxetine; Week 1: Baseline weight. Consider BMP for baseline sodium in older adults. Start fluoxetine 10 mg qday. Continue citalopram; 20mg Week 2: Increase dose of fluoxetine to 20 mg qday, if tolerated, and stop citalopram; Week 4 and beyond: Consider further titration of fluoxetine in 10-20 mg qday increments. Typically need higher doses for anxiety; Typical target dosage: 20 mg qday.

3) Continue close contact with care coordinator, supporting substance use treatment and behavioral activation.

4) Can consider atomoxetine in the future if poor concentration persists; Would stay on 40 mg qday as combination with bupropion can increase drug level.

Resources for Collaborative Care

APA
APA Practice Management Helpline:
1-800-343-4671 or practicemanagement@psych.org
Stay up-to-date on APA's SAN offerings, addition information on collaborative care at:
www.psychiatry.org/SAN
Other questions? email Lori Klinedinst, SAN Grant Manager:
lklinedinst@psych.org

Other
AIMS Center: http://aims.uw.edu/collaborative-care/implementation-guide
Qualis Behavioral Health Integration http://www.safetynetmedicalhome.org/change-concepts/organized-evidence-based-care
AHRQ Playbook: https://integrationacademy.ahrq.gov/playbook/about-playbook
AMA Steps Forward - https://www.stepsforward.org/modules/integrated-behavioral-health

Evidence-Base for Collaborative Care

Evidence Base	Key Articles
Depression	Unützer J, Katon W, Callahan CM, Williams JW Jr, Hunkeler E, Harpole L, Hoffing M, Della Penna RD, Noël PH, Lin EH, Areán PA, Hegel MT, Tang L, Belin TR, Oishi S, Langston C. Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. JAMA 2002;288(22):2836-2845. http://www.ncbi.nlm.nih.gov/pubmed/12472325. Archer J, Bower P, Gilbody S, Lovell K, Richards D, Gask L, Dickens C, Coventry P. Collaborative care for depression and anxiety problems. Cochrane Database Syst Rev 2012;10:CD006525. http://www.ncbi.nlm.nih.gov/pubmed/23076925.
Adolescent Depression	Asarnow JR, Jaycox LH, Duan N, LaBorde AP, Rea MM, Murray P, Anderson M, Landon C, Tang L, Wells KB. Effectiveness of a quality improvement intervention for adolescent depression in primary care clinics: a randomized controlled trial. JAMA 2005;293(3):311-319. http://www.ncbi.nlm.nih.gov/pubmed/15657324. Richardson LP, Ludman E, McCauley E, Lindenbaum J, Larison C, Zhou C, Clarke G, Brent D, Katon W. Collaborative care for adolescents with depression in primary care: a randomized clinical trial. JAMA. 2014 Aug 27;312(8):809-16. doi: 10.1001/jama.2014.9259.
Depression, Diabetes and	Katon WJ, Lin EH, Von Korff M, Ciechanowski P, Ludman EJ, Young B, Peterson D, Rutter CM, McGregor M, McCulloch D. Collaborative care for patients with depression and chronic illnesses. N Engl J Med 2010;363(27):2611-

Heart Disease	2620. http://www.ncbi.nlm.nih.gov/pubmed/21190455.
Depression and Cancer	Strong V, Waters R, Hibberd C, Murray G, Wall L, Walker J, McHugh G, Walker A, Sharpe M. Management of depression for people with cancer (SMaRT oncology 1): a randomised trial. Lancet 2008;372(9632):4048. http://www.ncbi.nlm.nih.gov/pubmed/18603157. Ell K, Xie B, Quon B, Quinn DI, Dwight-Johnson M, Lee PJ. Randomized controlled trial of collaborative care management of depression among low-income patients with cancer. J Clin Oncol 2008;26(27):4488-4496. http://www.ncbi.nlm.nih.gov/pubmed/18802161 Fann, J. R. Fan, M. Y.Unützer, J. Improving primary care for older adults with cancer and depression. J Gen Intern Med 2009: 24 Suppl 2: S417-24.
Depression in Women's Health Care	Melville JL1, Reed SD, Russo J, Croicu CA, Ludman E, LaRocco-Cockburn A, Katon W. Improving care for depression in obstetrics and gynecology: a randomized controlled trial. Obstet Gynecol. 2014 Jun;123(6):1237-46. doi: 10.1097/AOG.0000000000000231.
Anxiety	Roy-Byrne P, Craske MG, Sullivan G, Rose RD, Edlund MJ, Lang AJ, Bystritsky A, Welch SS, Chavira DA, Golinelli D, Campbell-Sills L,Sherbourne CD, Stein MB. Delivery of evidence-based treatment for multiple anxiety disorders in primary care: a randomized controlled trial. JAMA 2010;303(19):1921-1928. http://www.ncbi.nlm.nih.gov/pubmed/20483968. Archer J, Bower P, Gilbody S, Lovell K, Richards D, Gask L, Dickens C, Coventry P. Collaborative care for depression and anxiety problems. Cochrane Database Syst Rev 2012;10:CD006525. http://www.ncbi.nlm.nih.gov/pubmed/23076925.
PTSD	Engel CC, Bray RM, Jaycox LH3, Freed MC, Zatzick D, Lane ME, Brambilla D, Rae Olmsted K, Vandermaas-Peeler R, Litz B, Tanielian T, Belsher BE, Evatt DP, Novak LA, Unützer J, Katon WJ. Implementing collaborative primary care for depression and posttraumatic stress disorder: design and sample for a randomized trial in the U.S. military health system. Contemp Clin Trials. 2014 Nov;39(2):310-9. doi: 10.1016/j.cct.2014.10.002. Epub 2014 Oct 12. Fortney JC1, Pyne JM1, Kimbrell TA1, Hudson TJ1, Robinson DE2, Schneider R3, Moore WM4, Custer PJ5, Grubbs KM1, Schnurr PP6. Telemedicine-based collaborative care for posttraumatic stress disorder: a randomized clinical trial. JAMA Psychiatry. 2015 Jan;72(1):58-67. doi: 10.1001/jamapsychiatry.2014.1575.
Chronic Pain	Dobscha SK, Corson K, Perrin NA, Hanson GC, Leibowitz RQ, Doak MN, Dickinson KC, Sullivan MD, Gerrity MS. Collaborative care for chronic pain in primary care: a cluster randomized trial. JAMA 2009;301(12):1242-1252. http://www.ncbi.nlm.nih.gov/pubmed/19318652. Kroenke K, Bair MJ, Damush TM, Wu J, Hoke S, Sutherland J, Tu W. Optimized

	antidepressant therapy and pain self-management in primary care patients with depression and musculoskeletal pain: a randomized controlled trial. JAMA 2009;301(20):2099-2110. http://www.ncbi.nlm.nih.gov/pubmed/19470987.
Dementia	Callahan CM, Boustani MA, Unverzagt FW, Austrom MG, Damush TM, Perkins AJ, Fultz BA, Hui SL, Counsell SR, Hendrie HC. Effectiveness of collaborative care for older adults with Alzheimer disease in primary care: a randomized controlled trial. JAMA. 2006 May 10;295(18):2148-57.
Substance Use Disorders	Watkins KE, Ober AJ,, Lamp K, Lind M, Setodji C, Osilla KC, Hunter SB, McCullough CM, Becker K, Iyiewuare PO, Diamant A, Heinzerling K, Pincus HA. (2017) Collaborative Care for Opioid and Alcohol Use Disorders in Primary Care: The SUMMIT Randomized Clinical Trial. JAMA Intern Med. 2017 Oct 1;177(10):1480-1488. **Brief Intervention for Alcohol (Positive)** Jonas, D. E., J. C. Garbutt, et al. (2012). Behavioral counseling after screening for alcohol misuse in primary care: a systematic review and meta-analysis for the U.S. Preventive Services Task Force. Ann Intern Med 157(9): 645-654. Willenbring, M. L. and D. H. Olson (1999). A randomized trial of integrated outpatient treatment for medically ill alcoholic men.Arch Intern Med 159(16): 1946-1952. **Brief Intervention for Drug Use (Negative to Date)** Roy-Byrne P, Bumgardner K, Krupski A, Dunn C, Ries R, Donovan D, West II, Maynard C, Atkins DC, Graves MC, Joesch JM, Zarkin GA.Bri ef intervention for problem drug use in safety-net primary care settings: a randomized clinical trial. JAMA. 2014 Aug 6;312(5):492-501. doi: 10.1001/jama.2014.7860. Saitz R, Palfai TP, Cheng DM, Alford DP, Bernstein JA, Lloyd-Travaglini CA, Meli SM, Chaisson CE, Samet JH. Screening and brief intervention for drug use in primary care: the ASPIRE randomized clinical trial. JAMA. 2014 Aug 6;312(5):502-13. doi: 10.1001/jama.2014.7862.
Emerging Evidence Key Articles	
ADHD	Myers K, Stoep AV, Thompson K, Zhou C, Unützer J. Collaborative care for the treatment of Hispanic children diagnosed with attention-deficit hyperactivity disorder. Gen Hosp Psychiatry 2010;32(6):612-614. http://www.ncbi.nlm.nih.gov/pubmed/21112453.
Bipolar Disorder	Simon GE, Ludman EJ, Bauer MS, Unützer J, Operskalski B. Long-term effectiveness and cost of a systematic care program for bipolar disorder. Arch Gen Psychiatry 2006;63(5):500-508. http://www.ncbi.nlm.nih.gov/pubmed/16651507.