COLLABORATIVE CARE

An Evidence Based Model for Primary Care

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Presented by:
The Institute for Family Health
Zachary Bodenweber, LMSW
Implementation Specialist & Collaborative Care Clinician
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 & Mental Health

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
Depression Care

• 1/10 see psychiatrist
• 4/10 receive treatment in primary care
• 30 Million people receive antidepressant Rx
  • But only 20% improve
• 2/3 of Primary Care Providers report poor access to mental health for their patients
• Primary Care is the de facto treatment setting for most patients with common mental health conditions like depression and anxiety
• 70% of all antidepressant prescriptions in the United States are written by a primary care provider
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

The Collaborative Care Model

What is it?

• An integrated care model that uses a care team of primary and behavioral health care providers to treat mental health conditions such as depression, anxiety, and substance abuse in primary care settings.

Why is it important?

• Despite the prevalence of mental health conditions such as depression, anxiety, and substance abuse, many people – especially low-income individuals - do not receive effective care.
Project IMPACT

• **Improving Mood - Providing Access to Collaborative Treatment**
  • Primary and behavioral health care services are integrated into the primary care setting to treat depression in patients.

• IMPACT study
  • 1998-2003
  • 1,801 older adults from 18 primary care clinics across U.S.
  • \( \frac{1}{2} \) randomly assigned IMPACT model/Collaborative Care
  • Found that Collaborative Care more than DOUBLED the effectiveness of depression treatment in primary care settings.
  • Highly cost-effective

http://aims.uw.edu/impact-improving-mood-promoting-access-collaborative-treatment/
Project IMPACT - Study Outcomes

TREATMENT RESPONSE
50% or greater improvement in depression at 12 months

Participating Organizations

Unutzer, et al. JAGS2003; 51:505-514

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
5 Core Components of Collaborative Care

1. Patient-Centered Team
2. Population Based Care
3. Measurement-based “Treatment to Target”
4. Evidence-based care
5. Accountable Care

http://aims.uw.edu/sites/default/files CollaborativeCarePrinciplesAndComponents_2014-12-23.pdf
Patient-Centered Team

- Treating (Billing) Practitioner
- Beneficiary
- Validated Rating Scales
- BH Care Manager
- Psychiatric Consultant
- Registry

--- = Frequent communication
--- = Infrequent communication

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## Patient-Centered Team

### Care Manager
- Behavioral health professional
- Coordinates overall team effort and communication
- Psychotherapy when needed

### Primary Care Provider
- Makes initial assessment
- Facilitates Warm hand-off
- Starts Treatment

### Psychiatric Consultant
- Supports PCP and care manager in diagnosis, treatment plan, and treatment change recommendations

### Patient
- The patient is an integral part of the care team and active participant in treatment
IMPACT Model

Depression Care Manager

- Supports and collaborates closely with PCPs managing patients in primary care
- Facilitates patient engagement and education
- Systematically tracks treatment response
- Supports medication management by PCPs
- Provide brief, evidence-based therapeutic interventions
- Reviews cases with psychiatric consultant
- Facilitates referrals as needed
- Creates relapse prevention plan
IMPACT Model

Who are Care Managers?

- Common: MSW, LCSW, MA/MS Counselor, LMFT
- Others: RN, Clinical Psychologist, Paraprofessionals if not providing psychotherapy

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 treatment until patient improved
- Persistent and consistent
IMPACT Model

• Psychiatric Consultant
  • Provides weekly consultation
  • Reviews cases for patients who are not improving as expected
  • Provides treatment recommendations and proposes changes to treatment plan
  • Provides consultation for diagnostic concerns
IMPACT Model

- Primary Care Provider
  - Oversees all aspects of patient’s care
  - Diagnoses depression
  - Starts and prescribes pharmacotherapy
  - Introduces Collaborative Care team and Care Manager
  - Collaborates with Care Manager and Psychiatric Consultant to make treatment adjustments as needed
Population-Based Care

• A defined group of patients is tracked in a registry

• Registry Functions
  • Track and manage caseloads
  • Facilitate the delivery of evidence-based care for specific conditions, in this case depression

• Care team uses registry to track patients & identify those who are not showing improvement

• Ensures that patients do not “fall through the cracks”
Measurement-based Treatment to Target

**Treatment Plan**
- Developed by the Care Team
  - Reflects the patient’s goals and clinical outcomes
- Clinical outcomes routinely measured
- Flexible treatment options to increase access

**Treatment to target**
- Treatments are actively changed until the clinical goals identified in the treatment plan are achieved
- Clinical outcomes measured by evidence-based tools such as the PHQ-9 and the GAD-7.
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
- Serves as a communication and teaching tool
- Available in many languages
  - www.phqscreeners.com
<table>
<thead>
<tr>
<th></th>
<th></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>
<td></td>
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<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
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<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>
<td></td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></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>
<td></td>
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<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>
<td></td>
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<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>
<td></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>
<td></td>
</tr>
</tbody>
</table>

For office coding: __ + _____ + _____ + _____

=Total Score: _____
IMPACT Model: Outcome Measurement

- Patients are screened for depression before and throughout treatment by the care team.

- Depression symptoms are actively monitored by the Depression Care Manager.
  - Treatment Target:
    - 50% reduction in symptoms within 10-12 weeks.
IMPACT Model: Stepped Care

Systemic Outcomes Tracking
(Using the PHQ-9)

Evidence based treatment informed by clinical outcomes/patient goals

If outcomes are not being achieved, adjust treatment in consultation with psychiatrist
Stepped Care

- Most patients will need treatment adjustments
  - Only 30-50% of patients will have a complete response to initial treatment
  - 50-70% will require at least one change in treatment to improve
  - Combat “clinical inertia”
Evidence-Based Care

Common Evidence-based treatments used in collaborative care include:

- Problem-Solving Treatment
- Behavioral Activation
- Cognitive Behavioral Therapy
- Interpersonal Therapy
- Medications
- Collaborative Care itself is an evidence-based model
Accountable Care

- Reimbursement is determined by the clinical outcomes outlined in the treatment plan
- This holds providers accountable for offering high-quality, effective, patient-centered care
- Team-based approach increases accountability
Technology

• Shared access by all members of care team

• Tracking can be done through the Electronic Medical Record, as long as it performs core registry functions

• Care Management Tracking System (CMTS)
  • Developed by AIMS Center
  • Alerts clinicians when a patient is not improving/ has not been seen
  • Facilitates measurement-based treatment to target
  • Assists with Accountable Care
  • Supplies reports for clinical leadership to monitor progress toward goals
Sustainability
NYS Collaborative Care Medicaid Program (CCMP)

- Supplemental Monthly Case Rate Medicaid Payment

- Eligibility Criteria
  - Trained Behavioral Health Care Manager(s)
  - Designated Psychiatric Consultant
    - Weekly caseload-focused consultation
    - Can be remote, but must have access to patient registry
  - Use of state-approved patient care registry
    - Tracks services delivered, patient responses through PHQ-9, and performance improvement
  - Trained Primary Care Providers
    - Screening and provided evidence-based, stepped care for depression
NYS Collaborative Care Medicaid Program (CCMP)

Quarterly Data Reporting Metrics

- Improvement Rate
  - 50% reduction from baseline PHQ-9
  - Drop from baseline PHQ-9 to less than 10
- Consultation Rate
- Change in Treatment Rate
- Screening Yield
- Total Enrollment
- Median PHQ-9
- Active Patients
- Staffing
- Clinical Contacts by phone
Psychiatric Collaborative Care Model (CoCM)

- Integrating behavioral health care with primary care ("behavioral health integration" or "BHI") is widely considered an effective strategy for improving outcomes for millions of Americans with mental or behavioral health conditions.

- As of 2017, Medicare makes separate payments to physicians and non-physician practitioners for BHI services they furnish to beneficiaries over a calendar month service period.

- There are 4 new Medicare billing codes to bill for monthly services furnished using the Collaborative Care Model.
## BHI Coding Summary

<table>
<thead>
<tr>
<th>BHI Code</th>
<th>Behavioral Health Care Manager or Clinical Staff Threshold Time</th>
<th>Assumed Billing Practitioner Time</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CoCM First Month (G0502)</strong></td>
<td>70 minutes per calendar month</td>
<td>30 minutes</td>
</tr>
<tr>
<td><strong>CoCM Subsequent Months (G0503)</strong></td>
<td>60 minutes per calendar month</td>
<td>26 minutes</td>
</tr>
<tr>
<td><strong>Add-on CoCM (Any month) (G0504)</strong></td>
<td>Each additional 30 minutes per calendar month</td>
<td>13 minutes</td>
</tr>
<tr>
<td><strong>General BHI (G0507)</strong></td>
<td>At least 20 minutes per calendar month</td>
<td>15 minutes</td>
</tr>
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