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Collaborative Care (IMPACT)- An Overview

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Mental Health in the US

- Depression is the leading cause of disability worldwide
- ~7% of US adults experienced major depression at least once during the previous year
    - 18% Anxiety
- **Only 41%** of adults with mental illness received treatment
- Impacts hospitalizations, ED utilization, and management of chronic disease

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www.nami.org

Current state of Depression Care

- Diagnose, refer out and then…
- 1/10 patients see psychiatrist
  - ~50% of those referred out never follow up
- 4/10 patients 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

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Table 1. Six Levels of Collaboration/Integration (Core Descriptions)

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Behavioral health, primary care and other healthcare providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:

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What is Collaborative Care

Collaborative Care (sometimes called IMPACT) is the most empirically supported model of behavioral health integration that seeks to treat commonly occurring mental health conditions such as depression and anxiety in the primary care setting.

- Over 80 randomized controlled studies have shown Collaborative Care to be more effective than “usual” care
- Shown a greater than 50% improvement in depression in 12 months
- Improves not only mental health, but has shown improvements in chronic disease

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Links for Delivery Reforms

- DSRIP 3.a.i – Model 3
- Advanced Primary Care
- PCMH 2014 Elements
- Triple Aim: Quality, Cost, Experience

    - *Over 40 practices in New York State already doing Collaborative Care*

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5 Pillars of the Collaborative Care Model

Patient Centered Team Care / Collaborative Care

- **Collaboration is 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

Accountable Care

- Providers are accountable and reimbursed for quality of care and clinical outcomes, not just the volume of care provided

Evidenced-Based Care

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The Collaborative Care Team

Collaborative Care requires a team of professionals with complementary skills who work together to care for a population of patients. It involves a shift in how medicine is practiced, *the creation of entirely new workflows*, expansion of skill sets and scope of practice and, frequently, the addition of new team members

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TWO PROCESSES	TWO NEW 'TEAM MEMBERS' Supporting the Primary Care Provider (PCP)	
	Care Manager	Consulting Psychiatrist
1. Systematic diagnosis and outcomes tracking e.g., 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

http://impact-uw.org/files/IMPACTwebslides.pdf

Depression Care Manager (DCM)

- Lynch pin for the CC model
- Commonly MSW, LCSW, MA/MS Counselor, LMFT
- Wears many hats including Navigator, Care Manager, Therapist, and liaison to PCP and Psychiatrist
- Typical interventions provided by the DCM: Problem Solving Therapy, Behavioral Activation for Depression, Motivational Interviewing
- Builds in house capacity to combat loss of patients referred to specialty care (~50% do not follow through on referral)
- Some Collaborative Care sites choose to divide the DCM role among two staff: a licensed professional who can provide treatment and a paraprofessional to help with care coordination and engagement.

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Primary Care Provider (PCP)

- Leads the Collaborative Care team
- Is ultimately responsible for the treatment delivered to patients, including prescribing psychiatric medications where appropriate.
- PCP “sells” the patient on the team approach for management of complex chronic physical conditions, like diabetes, so to here for depression care. Staunch support of PCPs is essential for Collaborative Care implementation.

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Consulting Psychiatrist

- Has online access to the patient care registry and reviews the DCM's patient caseload,
- Provides1-2 hours of remote (phone or video-link) supervision to the DCM each week, making treatment recommendations on those patients that are not improving.
- In most instances, the psychiatrist does not see the patient face to face, but instead supports treatment delivered by the DCM and PCP.

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Collaborative Care Process

- Patient screened for Depression with standardized tool (PHQ-2 or 9)
- Screened positive, reviewed by PCP to verify diagnosis; PCP gets patients buy-in for collaborative care
- Hand off to DCM; DCM conducts assessment and establishes treatment plan
- Patient entered into registry and officially ‘enrolled’

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Collaborative Care process cntd.

The DCM oversees the patient's progress, provides brief interventions, maintains an up to date record in the registry, and coordinates with the Psychiatrist for case review when necessary, and the PCP to manage medications when appropriate.

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What Makes Collaborative Care Different

- Builds in house capacity
- More efficient treatment, change in treatment when needed
- Allows for regular contacts, telephonic and otherwise
- Treatment to target

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NYS Collaborative Care Medicaid Program

- 2013-2014, NYS DOH Medical Home Grant Program estd. CC programs in academic medical centers
- To sustain the progress, OMH launched the Medicaid program in 2015
  - 32 sites currently participating; DOH grant sites and FQHCs
  - Pay for performance accountability

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Questions?

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