LAMMHA - Collaborative Care Flyer

- **The Collaborative Care Model (CoCM) is more effective than usual care[1,2], including in the perinatal population[3,4].**
    - Collaborative gets *twice* as many patients better than usual care, including co-located specialty behavioral health care[1]
        - About 50% for CoCM and 25% for usual care
    - Collaborative gets patients better *faster* than usual care
        - **Time to depression remission with Collaborative Care is *86 days versus 614 days* with usual care[5]**
    - Over "90 randomized controlled trials have shown the Collaborative Care model (CoCM) to be more effective than usual care for patients with depression, anxiety, and other behavioral health conditions. CoCM is also shown to be highly effective in treating co-morbid mental health and physical conditions such as cancer, diabetes, and HIV"[2,6]
    - Collaborative care is effective across multiple patient populations, including racial and ethnic minority groups, perinatal populations, populations in under-resourced communities, and even perinatal populations in under-resourced communities[6]

- **How is CoCM different than usual care, including co-located specialty BH care?**
    - Short answer: it involves a team (PCP, Behavioral Health Care Manager, and Psychiatric Consultant), as well as several activities that are not included in traditional community mental health
    - More detailed answer: Key Components of Collaborative Care
        - *Patient-centered team care*: Physical and behavioral health are co-located, but unlike usual care, CoCM is provided by a team of providers communicating with each other and using a shared care plan, instead of working in silos. This way, patients don't have duplicate assessments and see multiple prescribers for medication changes. This increases patient engagement, which can lead to better outcomes and a better patient experience[7]
        - *Population-based care*: "Care team shares a defined group of patients tracked in a registry to ensure no one falls through the cracks. Practices track and reach out to patients who are not improving, and mental health specialists provide caseload-focused consultation, not just ad-hoc advice"[7]
        - *Measurement-based treatment to target*: "Each patient's care plan clearly articulates personal goals and clinical outcomes that are routinely measured by evidence-based tools like the PHQ-9 Depression Scale. Treatments are actively changed if patients are not improving as expected until the clinical goals are achieved"[7]
        - *Evidence-based care*: "Patients are offered treatments with credible research evidence to support their efficacy in treating the target condition"[4]. These include a variety of evidence-based brief interventions and medications
            - *NOTE: Collaborative care without psychotherapy or medications is a form of evidence-based care all by itself. Activities such as care team collaboration, systematic caseload review, proactive outreach and follow-up, and regular symptom monitoring using validated scales can improve patient outcomes*[7]

- **Reimbursement**

- Collaborative Care is on the fee schedule in Medi-Cal, Medicare, and is covered by most commercial health plans. FQHCs can receive their PPS if they can demonstrate that they have Collaborative Care elements in place. One of the goals of LAMMHA is to support your team with the economics of implementing Collaborative Care. [8]

- **Patient and provider satisfaction**
  - Patients prefer to receive their behavioral health care in primary care and perinatal settings, rather than specialty care settings[9]
  - Patients receiving CoCM report more satisfaction than with usual care[1,10]
  - Providers prefer CoCM to usual care[11,12]

- **Why not refer to specialty behavioral health care?**
  - Less than 10% of Medicaid/Medicare patients follow through on referrals to specialty behavioral health care. [13]

- **The University of Washington Dept of Psychiatry and AIMS Center have extensive experience working with FQHCs to implement CoCM.**

References

1. Unützer J, Katon W, Callahan CM, et al. Collaborative Care Management of Late-Life Depression in the Primary Care Setting: A Randomized Controlled Trial. *JAMA.* 2002;288(22):2836–2845. doi:10.1001/jama.288.22.2836
2. Archer J, Bower P, Gilbody S, et al. Collaborative care for depression and anxiety problems. Cochrane Database of Systematic Reviews 2012, Issue 10. Art. No.: CD006525. DOI: 10.1002/14651858.CD006525.pub2
3. Melville JL, Reed SD, Russo J, et al. Improving care for depression in obstetrics and gynecology: a randomized controlled trial. Obstet Gynecol 2014; 123:1237-1246
4. Grote NK, Katon WJ, Russo JE, et al. Collaborative care for perinatal depression in socio-economically disadvantaged women: a randomized trial. Depress Anxiety 2015; 32:821-834
5. Blackmore, M. A., Carleton, K. E., Ricketts, S. M., Patel, U. B., Stein, D., Mallow, A. … Chung, H. (2018). Comparison of collaborative care and colocation treatment for patients with clinically significant depression symptoms in primary care. *Psychiatric Services, 69*(11), 1184-1187.
6. https://aims.uw.edu/collaborative-care/evidence-base-cocm
7. https://aims.uw.edu/collaborative-care/principles-collaborative-care
8. https://www.chcf.org/wp-content/uploads/2021/05/PsychiatricCoCMBenefitMediCal.pdf
9. Bhat A, Reed S, Mao J, Vredevoogd M, Russo J, Unger J, Rowles R, Unützer J. Delivering perinatal depression care in a rural obstetric setting: a mixed methods study of feasibility, acceptability and effectiveness. J Psychosom Obstet Gynaecol. 2018 Dec;39(4):273-280. doi: 10.1080/0167482X.2017.1367381.
10. Areán, Patricia A. PhD*; Ayalon, Liat PhD*; Hunkeler, Enid MA†; Lin, Elizabeth H.B. MD, MPH‡; Tang, Lingqi PhD§; Harpole, Linda MD¶; Hendrie, Hugh MD‖; Williams, John W. Jr MD, MHSc**¶; Unützer, Jürgen MD, MPH§. Improving Depression Care for Older, Minority Patients in Primary Care. Medical Care: April 2005 - Volume 43 - Issue 4 - p 381-390. doi: 10.1097/01.mlr.0000156852.09920.b1
11. Levine S, Unützer J, Yip JY, Hoffing M, Leung M, Fan MY, Lin EH, Grypma L, Katon W, Harpole LH, Langston CA. Physicians' satisfaction with a collaborative disease management program for late-life depression in primary care. Gen Hosp Psychiatry. 2005 Nov-Dec;27(6):383-91. doi: 10.1016/j.genhosppsych.2005.06.001.
12. Bentham WD, Ratzliff A, Harrison D, Chan YF, Vannoy S, Unützer J. The experience of primary care providers with an integrated mental health care program in safety-net clinics. Fam Community Health. 2015 Apr-Jun;38(2):158-68. doi: 10.1097/FCH.0000000000000067. PMID: 25739063.
13. Mojtabai, R. (2005). Compliance with mental health and other specialty care referrals among Medicare/medicaid dual enrollees. *Community Mental Health Journal*, *41*(3), 339–344.