FRAMEWORKS
in Health and Quality

Value of Collaborative Care in Major Depressive Disorder

# Importance of Collaborative Care for Patients With Major Depressive Disorder

## An Overview for Payers

This resource is provided for informational purposes only and is not intended as reimbursement or legal advice. You should seek independent, qualified professional advice to ensure that your organization is in compliance with the complex legal and regulatory requirements governing health care services, and that treatment decisions are made consistent with the applicable standards of care.

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# Importance of Collaborative Care
## for Patients With Major Depressive Disorder

It is estimated that **16.2%** **of Americans** will be affected with MDD during their lifetime.[12]

Patients with major depressive disorder (MDD) may require a broad range of possible therapeutic interventions, such as psychotherapy and pharmacotherapy.[1] In the treatment of MDD, collaborative care models may help foster cooperation and open communication between members of the care team, including primary care providers (PCPs), mental health specialists (psychiatrists, psychologists, psychiatric nurse practitioners, social workers), and community mental health centers (CMHCs) when necessary.[2]

## MDD Impact on Patient Outcomes, Costs, and Quality Measures

Patients with MDD have severe symptoms of depression that are present for at least 2 weeks, including depressed mood, loss of interest or pleasure, significant weight gain or loss, sleep disturbances, fatigue, feelings of worthlessness, difficulty concentrating, and/or suicidal thoughts.[3]

### MDD can have major implications within the health care system[4]:

- Patients with MDD are often undiagnosed, undertreated, or treatment resistant—representing a significant unmet need in treatment.[5-7]
- MDD diagnosis may be delayed in some patients as the projected median time between onset of MDD symptoms and first contact with a PCP or mental health specialist for MDD diagnosis is 8 years.[8]
- In the primary care setting, PCPs, who deliver the majority of care for patients with MDD, only identify about 50% of MDD cases.[9]

### Costly, comorbid medical conditions may impact outcomes for patients with MDD:

- Cardiovascular disease, diabetes, and cancer are common in patients with MDD. These conditions may negatively impact outcomes for patients with MDD and contribute to higher health care costs in this patient population.[4,10]
  - MDD is about 3 times more common among patients with diabetes and may lead to adverse health outcomes (eg, poorly controlled blood glucose) and an increased risk of complications.[11]

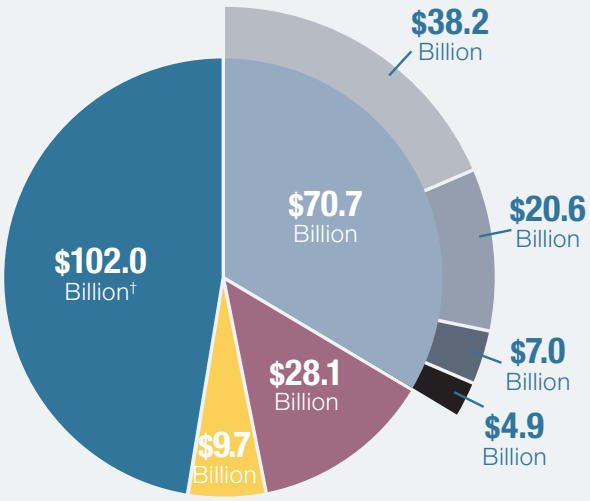
## Annual direct and indirect costs for patients with MDD are approximately $211 billion[13,*]

- Patients with MDD incur significant direct health care costs, with approximately $99 billion (2012 dollars) attributable annually to medical services and pharmaceutical costs. Indirect costs, including workplace costs, are also a significant economic burden on the health care system, totaling approximately $112 billion (2012 dollars) a year.[13]
  - In one study using National Comorbidity Survey-Replication data (2001–2002), US workforce respondents (n=4,465) who were diagnosed with severe depression were associated with a higher unemployment and disability rate compared to people with mild or moderate depression.[14]

## Nonadherence to medication in patients with MDD impacts quality measures:

- Treatment for MDD can have a significant impact on quality measures, such as the Healthcare Effectiveness Data and Information Set (HEDIS). The Antidepressant Medication Management (AMM) HEDIS quality measure utilizes adherence to antidepressant therapy as a key measure.[15]
  - Research demonstrates that 28% of patients discontinue their medications within 1 month, and 40% discontinue within 3 months, potentially impacting patient outcomes and quality performance measures.[16]
  - Research suggests that health care resources and costs may be lower in patients who maintain continuous therapy with antidepressants compared with those who discontinue early.[17]

## Economic Burden of MDD: Direct and Indirect Costs[13,*]




Annual direct and indirect health care costs for patients with MDD are approximately **$211 Billion.**[13]

DIRECT COSTS
- **Medical costs**
  - Outpatient
  - Inpatient
  - Other services
  - Emergency department visits
- **Pharmaceutical costs**

INDIRECT COSTS
- **Workplace costs**
- **Suicide-related costs**

*Incremental economic burden of patients with MDD; 2012 costs were estimated using 2010 national survey and administrative claims data.

†Total workplace costs include estimated costs of absenteeism ($23.3 billion) and presenteeism ($78.7 billion).

# Collaborative Care

## May Be Effective in Managing Patients With MDD

### What Is Collaborative Care?

Collaborative care, or integrated care, occurs when mental health and general medical care providers work together toward a common goal to address both the physical and mental health needs of patients.[18]

Patients with mental illnesses, such as depression, often receive care in the primary care setting. As a result, integration of mental health into the primary care setting may help create an improved, shared treatment plan and meet a patient's overall health care needs.[18]

**Collaborative care is an approach to care that may include the following[18]:**

- The role of a care manager in the primary care setting who works with the patient and the PCP to help develop a unified approach to care of the patient
- Patient education and support, including goals and a specific action plan
- Monitoring of treatment adherence
- Coordinating office visits to a PCP and/or mental health specialist

**The implementation of a collaborative care model is one way to help ensure that adequate systems are in place for efficient diagnosis, treatment, and follow-up for patients with depressive disorders.[19]**

More than 70 randomized, controlled studies have shown that collaborative care may be clinically and cost-effective in the treatment of common mental health disorders such as depression.[20]

- In one study, collaborative care for depression was associated with cost savings. The long-term cost analyses from the IMPACT study* found that after an initial investment in collaborative care of $522 per patient during the first year, there was a net cost savings of $3,363 over 4 years resulting in an average annual savings of $841.[20,21]
- In another analysis† of 5,463 Medicaid recipients with serious mental illness and a history of frequent ED and/or inpatient visits, readmission rates and ED admissions declined, resulting in an estimated $609,000 cost savings in mental health care, as well as $1.3 million on general medical care.[22]

*The IMPACT collaborative care management program included 1,801 adults age 60 and older with depression in 18 primary care clinics in 5 states. The trial included patients/sites with both fee-for-service and capitated Medicare and Medicaid coverage. In addition to depression, IMPACT patients also averaged 3.5 chronic medical disorders.[20]

†The study was based on a patient-centered medical home model using an integrated team and care plan to address medical, behavioral, and social needs.[22]

## Understanding the Importance of Referral to a Mental Health Specialist

Traditionally, PCPs have been on the frontline of diagnosing and treating patients with MDD, with PCPs prescribing approximately 70% to 80% of antidepressants.[23,24] The psychiatric consultant can support the PCP, suggest treatment modifications, and consult on patients who are clinically challenging or who need specialty mental health services.[25]

**Primary care practices with supportive services and appropriate consultation with a mental health specialist may help improve delivery of care.[26]**

Evidence supports the use of collaborative care for improving depression symptoms, adherence to treatment, response to treatment, and remission and recovery from depression.[2]

- In a meta-analysis of randomized studies of patients with depression receiving either collaborative care or usual primary care, collaborative care was shown to be more effective than standard care in improving standardized depression outcomes at 6 months.[27]
- In a randomized, controlled study,* patients with major depression in a collaborative care intervention group had greater adherence than the usual care controls to adequate dosage of antidepressant medication for 90 days or more (75.5% vs 50.0%; $P<0.01$), were more likely to rate the quality of the care they received for depression as good to excellent (93.0% vs 75.0%; $P<0.03$), and were more likely to rate antidepressant medications as helping somewhat to helping a great deal (88.1% vs 63.3%; $P<0.01$).[26]
- In a cluster, controlled study over a 3-month period of 387 patients with depression and diabetes and/or heart disease who were randomized to a collaborative care or usual care treatment group, the use of collaborative care was shown to reduce depression more than usual care, significantly lessen anxiety at follow-up, and improve self-management of chronic disease.[28]

*Study was conducted over a 12-month period and included 217 primary care patients who were recognized as having minor or major depression by their PCPs and were willing to take antidepressant medication.[26]

## Collaborative Care in the Treatment of Patients With MDD

The implementation of a collaborative care model is one way to help ensure that adequate systems are in place for efficient diagnosis, treatment, and follow-up for patients with depressive disorders.[19]

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