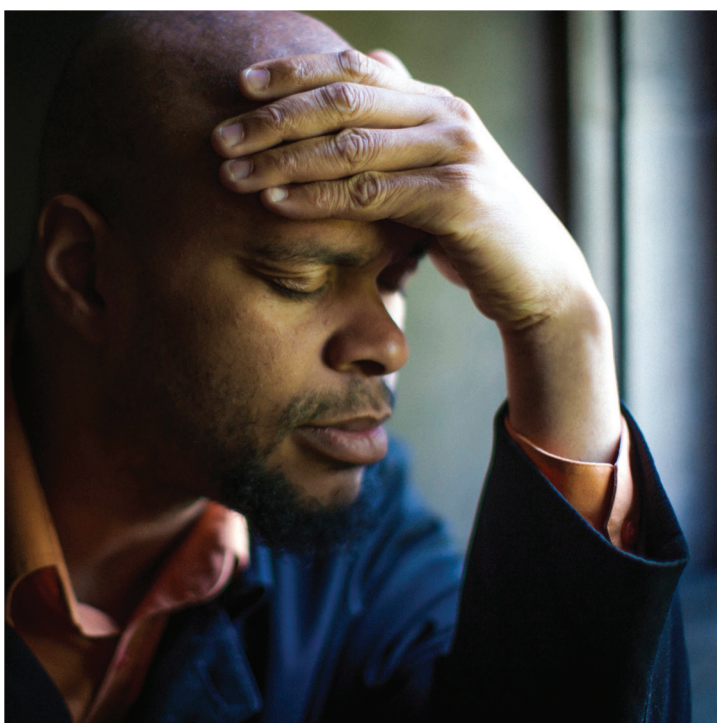




Value of Collaborative Care in Major Depressive Disorder



Importance of Collaborative Care for Patients With Major Depressive Disorder

An Overview for Mental Health Specialists

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Importance of Collaborative Care

for Patients With Major Depressive Disorder



It's important for the care team to recognize the interplay between MDD and medical and psychiatric conditions.¹

Patients with major depressive disorder (MDD) may require a broad array of possible therapeutic interventions.¹ It is important that members of the care team, including mental health specialists (psychiatrists, psychologists, psychiatric nurse practitioners, and social workers), primary care providers (PCPs), and pharmacists recognize the interplay between MDD and co-occurring medical and psychiatric conditions.¹

Recognizing the Connection With MDD and Comorbid Medical Conditions

Care coordination for patients with MDD and comorbid medical and/or psychiatric conditions relies on the implementation of a collaborative care model, integrating medical and psychiatric care teams to work together to effectively coordinate care.¹⁻³

Some common comorbid medical and/or psychiatric conditions that may occur in patients with MDD include^{1,4}:

Co-occurring medical conditions

- Cardiovascular disease (CVD) (heart disease, stroke, hypertension)
- Diabetes
- Cancer
- HIV/AIDS
- Hepatitis C
- Asthma
- Arthritis

Co-occurring psychiatric conditions

- Depressive and anxiety disorders
- Alcohol abuse and/or substance use
- Personality disorders
- Eating disorders

There may be a close relationship between MDD and psychosocial stressors with respect to the onset, exacerbation, or maintenance of MDD symptoms.¹ Depressive symptoms may be a common response to adverse life events, particularly bereavement. Other psychosocial stressors that may increase the risk of developing MDD include lower socioeconomic status, nonmarried status, unemployment, urbanization, and violent trauma.¹

It is recommended that patients with MDD receive a thorough psychosocial assessment to confirm a diagnosis of MDD and to assess for the presence of comorbid medical and/or psychiatric conditions.¹

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.⁵

Patients with mental illnesses, such as depression and anxiety disorders, often receive care in the primary care setting. As a result, integration of mental health into the primary care setting may help to create an improved, shared treatment plan, and meet a patient's overall health care needs.⁵

Collaborative care is designed to help⁶:

- Improve routine screening and diagnosis of depressive disorders
- Increase use of evidence-based protocols for proactive management of MDD
- Improve clinical and community support for active patient engagement in treatment goal-setting and self-management

Collaborative care helps to ensure the treatment plan and services provided to patients are appropriate and coordinated across providers with different expertise. This collaborative approach to care may help offer primary care and mental health providers the opportunity to improve access to treatment and improve quality.⁵

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.⁷



How Does Collaborative Care Work?

Collaborative care may be implemented in 1 of 2 ways⁵:

- Mental health care is introduced in primary care setting
- Primary health care is introduced in mental health setting

Collaborative care is an approach to care that includes the following⁵:

- 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 and outcomes
- Coordinating office visits to a PCP and/or mental health specialist

In the collaborative care team structure, the PCP, care manager, and psychiatric consultant each have separate roles to play in the treatment of patients.⁸

Collaborative Care Team Structure

Primary Care Provider

Prescribes medications, provides treatments for medical conditions, and refers patients to the psychiatric consultant when needed⁷

Care Manager

Supports PCP by coordinating treatment, provides treatment response follow-up, supports medication management, and facilitates communication with the psychiatric consultant⁹

Psychiatric Consultant

Supports PCP and care manager, suggests treatment modifications for PCP to consider, consults on patients who are clinically challenging or who need specialty mental health services¹⁰

New Roles

Collaborative Care May Be Effective in Managing Patients With Depression

The goal of an integrated collaborative care model is to foster cooperation and open communication between members of the treatment team when managing patients with MDD.⁶

Collaborative care programs are one approach to integration of members of the treatment team—PCPs, mental health specialists, and care managers—in order to work together to provide care.⁶



More than 70 randomized, controlled studies have shown collaborative care may be more effective and cost-effective than usual care in treating depression³:

- 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.^{3,11}
- In another analysis[†] of 5,463 Medicaid recipients with serious mental illness and a history of frequent emergency department (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.¹²

*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.³

[†]This study was based on a patient-centered medical home model using an integrated team and care plan to address medical, behavioral, and social needs.¹²



Evidence supports collaborative care for improving depression symptoms, adherence to treatment, response to treatment, and remission and recovery from depression.⁶

Collaborative Care May Help Improve Process of Care in Patients With Depression¹³

In a randomized, controlled study,* patients with major depression in a collaborative care intervention group had greater medication adherence for 90 days or more versus the usual care control group (75.5% vs 50.0%; $P<0.01$). Patients were more likely to rate the quality of their care as good to excellent (93.0% vs 75.0%; $P<0.03$), and patients were more likely to rate antidepressant medications as helping somewhat to helping a great deal (88.1% vs 63.3%; $P<0.01$).¹³

This primary care intervention provided increased patient education, longer and more frequent visits in the first 6 weeks of treatment, surveillance of adherence to medication regimens, and an integrated role for the psychiatrist in primary care, which significantly improved the process of care for depression.¹³

The study implemented processes to improve systematic communications between providers, which took the form of ongoing feedback and interaction between psychiatrists and PCPs. The role of the psychiatrist included common case management tasks, such as patient education on the biology of depression, how antidepressants work, and techniques for managing depression; liaison with other providers; monitoring and follow-up of patients; and physician education, including half-day didactic training sessions on antidepressant and behavioral treatment for PCPs.¹³

*This 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.¹³

Collaborative care may involve case managers who help support PCPs with functions such as patient education and tracking. PCPs screen and diagnose depressive disorders, prescribe antidepressants, and refer patients to mental health specialists as needed.⁶

Improving Care Coordination and Antidepressant Management

Kaiser Permanente's Complete Care for Depression Program's aim is to help maximize the quality of coordinated care by integrating behavioral health providers with other health care providers to maintain comprehensive treatment, including antidepressant medication management.¹⁴

Kaiser screens for depression and diagnosis for at-risk patients during primary care visits.¹⁵ Behavioral health specialists are on-call for PCP consultations.¹⁴ Patients can self-refer for behavioral health care at any time, and online resources allow less time to be spent scheduling, managing, or receiving care.¹⁵ In addition, members are monitored continuously for improvement and necessary follow-up care.¹⁴

As a result of these efforts, Kaiser Permanente's 2011 HEDIS® scores were in the top 10% for adherence to antidepressant treatments.¹⁵

Collaborative Care and Improving Patient Care in the Treatment of MDD

Implementation of a collaborative care model may help providers stay in regular contact with each other to allow treatments to be synchronized and provide relevant information to guide treatment decisions.^{1,6}



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