FRAMEWORKS
in Health and Quality

Value of Collaborative Care in Major Depressive Disorder

Case Study Considerations in Collaborative Care:

A Resource for Mental Health Specialists

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.

June 2016 MRC2.UNB.X.00069

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. [1]

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 to create an improved, shared treatment plan and meet a patient's overall health care needs.[1]

Collaborative care is designed to help[2]:

- Improve routine screening and diagnosis of depressive disorders
- Increase use of evidence-based protocols for proactive management of major depressive disorder (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.[1]

Collaborative care is an approach to care that may include the following[1]:

- The role of a care manager in the primary care setting who works with the patient and the primary care physician (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 a 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.[3]

Case Study Considerations: IMPACT and AIMS

The IMPACT (Improving Mood: Providing Access to Collaborative Treatment) study focused on collaborative care in depressed, older adults. It was a collaborative care management program with 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 averaged 3.5 chronic medical disorders.[4]

Patients assigned to the IMPACT intervention gained access to a depression care manager who was supervised by a psychiatrist and a primary care expert for up to 12 months. The psychiatrist and primary care expert provided education, care management, and support of antidepressant management by the patient's primary care physician or brief psychotherapy for depression.[5]

At 12 months, **45% of patients** assigned to the IMPACT intervention had a **50% or greater reduction in depressive symptoms** from baseline versus **19% of patients assigned to usual care**. Additionally, as compared to usual care, patients in the IMPACT arm experienced[5]:

- **Greater rates of depression treatment**
- **More satisfaction with depression care**
- **Lower depression severity**
- **Less functional impairment**

After the success of the IMPACT study, the AIMS (Advancing Integrated Mental Health Solutions) Center (formerly known as the IMPACT Implementation Center) was created to help organizations develop collaborative care in the management of patients with depression and comorbid medical conditions.[6]

Potential Elements for Depression Care

AIMS identified the following 5 important elements for effective, evidence-based depression care[7]:

1 Collaborative care is the cornerstone of the IMPACT model

PCPs work with depression care managers to help develop and implement a treatment plan that may include antidepressant medications and/or brief, evidence-based psychotherapy. Additionally, depression care managers and PCPs can consult with psychiatrists in order to alter treatment if patients do not show improvement.

2 The role of the depression care manager

A depression care manager is a nurse, social worker, or psychologist who may be supported by a medical assistant or other paraprofessional and who helps:

- Educate patients about depression
- Support antidepressant therapy prescribed by the patient's PCP if appropriate
- Coach patients in behavioral activation and pleasant events scheduling
- Offer a brief course of targeted counseling
- Monitor depression symptoms for treatment response

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3 The role of the designated psychiatrist

The designated psychiatrist acts as a consultant to the depression care manager and PCP on the care of patients not responding to treatments as expected.

4 Outcome measurement

The measurement of depressive symptoms using measurement tools (eg, PHQ-9 or other effective tools) should be performed by the depression care managers at the beginning of a patient's treatment and throughout treatment.

5 Stepped care

Treatment adjustments may be made based on clinical outcomes and according to an evidence-based algorithm. If patients have not significantly improved, consideration is given to changing the treatment plan.

A treatment plan change may be an increase in medication dosage, a change to a different medication, addition of psychotherapy, a combination of medication and psychotherapy, or other treatments suggested by the team psychiatrist.

Collaborative Care Implementation Guide

The AIMS Center has also developed a Collaborative Care Implementation Guide to help understand the process of implementing evidence-based collaborative care programs like IMPACT. Below are the recommended steps[8]:

Lay the foundation for change

- Understand a collaborative care approach
- Advocate for collaborative care with organizational leadership and the clinical team
- Create a vision for collaborative care that complements organizational missions and quality improvement efforts
- Compare the differences between any current care model with a collaborative care model

Plan for clinical practice change

- Identify and train all collaborative care team members
- Develop a clinical flowchart and detailed action plan for the care team
- Identify a population-based tracking system
- Plan for funding, space, human resources, and other administrative needs
- Plan to merge collaborative care monitoring and reporting outcomes into an existing quality improvement plan

Build clinical skills

- Describe collaborative care's key tasks, including patient engagement and identification, treatment initiation, outcome tracking, treatment adjustment, and relapse reduction
- Develop a qualified and prepared care team, equipped with the functional knowledge necessary for a successful collaborative care implementation
- Develop skills in psychotherapy treatment that are evidence-based and appropriate for primary care (eg, problem solving treatment, behavioral activation, etc)

Launch your care

- Engage patients
- Enroll and track patients in a registry
- Develop a care team monitoring plan to help collaborations
- Develop skills to help patients across their treatment

Nuture your care

- Implement the care team monitoring plan to help collaborations
- Update the program vision and workflow
- Offer advanced training and support when necessary

Collaborative care programs are one approach to integration of all members of the treatment team—PCPs, mental health specialists, and care managers—in order to work together to provide care.[2]

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June 2016 MRC2.UNB.X.00069