AIMS CENTER
UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

Resident Rotation:
Collaborative Care Consultation Psychiatry

Anna Ratzliff, MD, PhD
Ramanpreet Toor, MD
James Basinski, MD

With contributions from:
Jürgen Unützer, MD, MPH, MA
Jennifer Sexton, MD, Catherine Howe, MD, PhD
Deborah Cowley, MD

AIMS CENTER
UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

Module 1:
Introduction to Collaborative Care

Learning Objectives: Module 1

By the end of this module, the participant will be able to:

- **Understand the case for Collaborative Care and be familiar with the growing evidence base for Collaborative Care.**
- **Recognize the basic elements and principles of Collaborative Care and be ready to further explore both in later modules.**
- **Examine their own experiences and opinions of existing outpatient mental health systems while considering Collaborative Care psychiatry's potential for delivering more integrated and population based care.**

Why Make Any Change in the Existing Psychiatric Care?

The Challenge

Behavioral Health

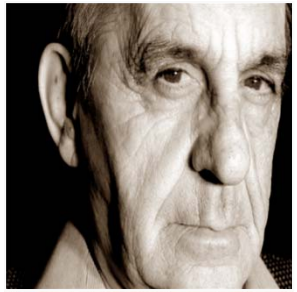
- Psychiatric disorders cause
- 25% of all disability worldwide*
- 10% of Years Lived with Disability (YLD) from depression alone
- 3x diabetes, 10x heart disease, 40x cancer
- In the US, one suicide every 14 minutes
  - Ex: WA State has 2-3 suicides per day

Health Behaviors

- Behavior determines ≈ 50 % of all mortality and morbidity
- Unhealthy behaviors are major drivers of health care costs
- 40 – 50% struggle with treatment adherence
- Employers struggle with absenteeism and presenteeism

**C. Murray, GBD Study, Lancet 2012*

Who Gets Treatment?





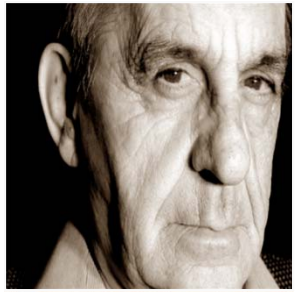





Wang et al., 2005

Who Gets Treatment?

No Treatment






Primary Care Provider




Mental Health Provider

Wang et al., 2005

Traditional Consultation

Limited access	Limited feedback	Expensive	'One Pass'
• There will never be enough psychiatrists to refer all patients for consultation.	• PCPs experience psychiatry consultation as a 'black box'.	• All MH referrals require full intakes, often leaving little time and energy for follow-up or 'curbside consultation'.	• Works best for one-time or acute issues that don't need follow-up.

Services are Poorly Coordinated.

Why Behavioral Health Care in Primary Care?

Why Behavioral Health Care in Primary Care?

1. **Access to care and reach:**
   - Serve patients where they are
2. **Patient-centered care:**
   - Treat the 'whole patient'
3. **Effectiveness of care:**
   - Make sure patients get better

What is Collaborative Care?

AIMS Center Definition of Collaborative Care

- **Collaborative Care is a specific type of integrated care that operationalizes the principles of the chronic care model to improve access to evidence based mental health treatments for primary care patients.**

Collaborative Care

Caseload-focused psychiatric consultation supported by a care manager

Better access

- PCPs get input on their patients' behavioral health problems within a days /a week versus months
- Focuses in-person visits on the most challenging patients.

Regular Communication

- Psychiatrist has regular (weekly) meetings with a care manager
- Reviews all patients who are not improving and makes treatment recommendations

More patients covered by one psychiatrist

- Psychiatrist provides input on 10 – 20 patients in a half day as opposed to 3-4 patients.

Shaping over time

- Multiple brief consultations
- More opportunity to 'correct the course' if patients are not improving

Principles of Effective Integrated Behavioral Health Care

Patient Centered Care

- Team-based care: effective collaboration between PCPs and Behavioral Health Providers.

Population-Based Care

- Behavioral health patients tracked in a registry: no one ‘falls through the cracks’.

Measurement-Based Treatment to Target

- Measurable treatment goals and outcomes defined and tracked for each patient.
- Treatments are actively changed until the clinical goals are achieved.

Evidence-Based Care

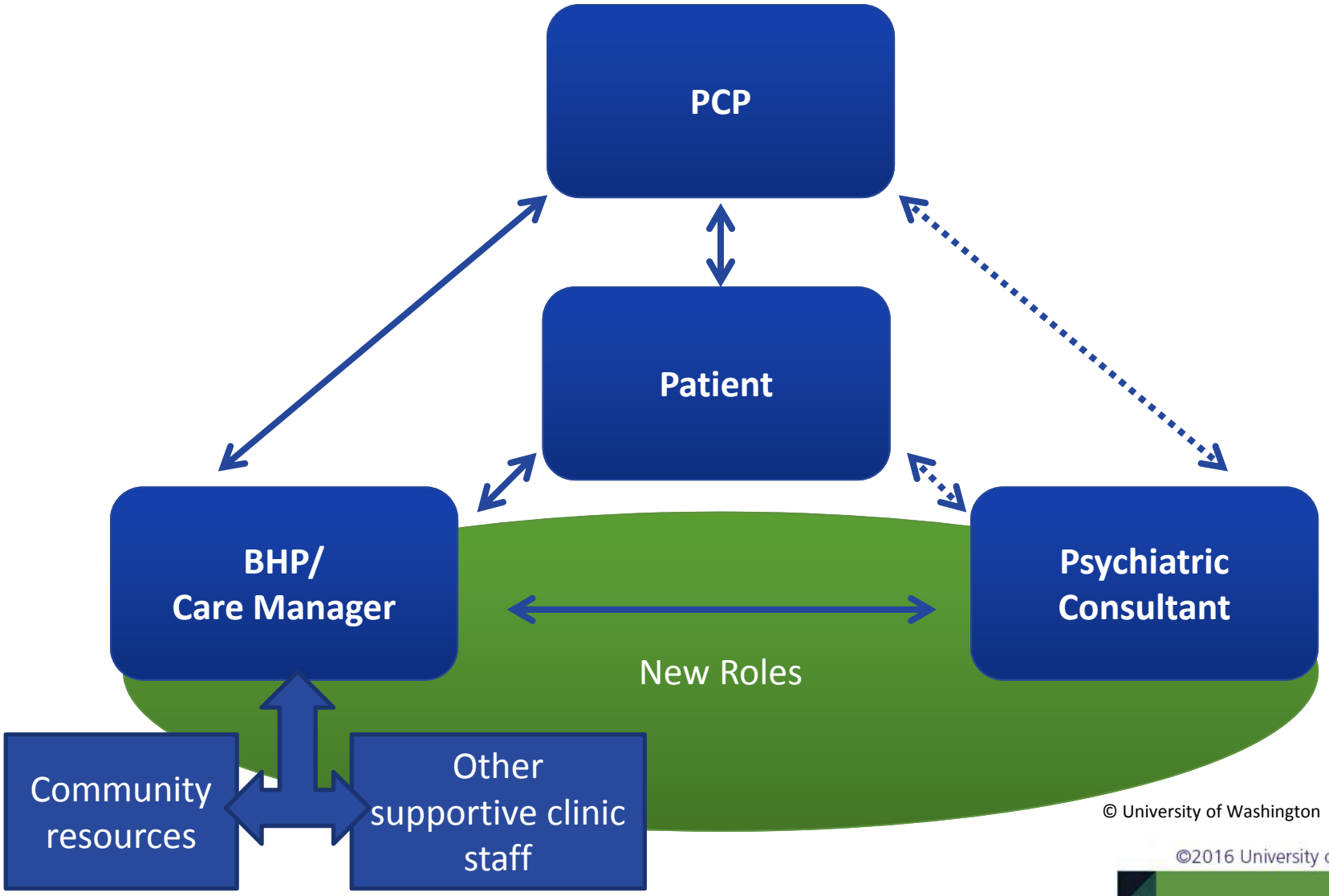
- Treatments used are ‘evidence-based’.

Accountable Care

- The delivery system is accountable and reimbursed for quality of care, clinical outcomes, and patient satisfaction, not just the volume of care provided.

Who is Involved?

Collaborative Care Team



Does Collaborative Care Work?

Collaborative Care

The Research Evidence

- **Now over 80 Randomized Controlled Trials (RCTs)**
  - **Meta analysis of Collaborative Care (CC) for depression in primary care (US and Europe)**

→ Consistently more effective than usual care

- **Since 2006, several additional RCTs in new populations and for other common mental disorders**
  - **Including anxiety disorders, PTSD**

Archer, J. et al., 2012

IMPACT Trial

- 1998 – 2003
- 1,801 depressed adults
- 18 primary care clinics
  - 8 health care organizations in 5 states
    - Diverse health care systems
      - Urban & semi-rural settings
      - Capitated (HMO & VA) & fee-for-service
    - 450 primary care providers
- Two groups compared:
  - Usual Care
  - Collaborative Care

IMPACT: Summary

1) Improved Outcomes:
   - Less depression
   - Less physical pain
   - Better functioning
   - Higher quality of life

2) Greater patient and provider satisfaction

3) More cost-effective

→ THE TRIPLE AIM

"I got my life back"

How Well Does It Work With Other Disorders?

Evidence Base Established	Emerging Evidence

• Depression
  - Adolescent Depression
  - Depression, Diabetes and Heart Disease
  - Depression and Cancer
  - Depression in Women's Health Care
• Anxiety
• Post Traumatic Stress Disorder
• Chronic Pain
• Dementia
	• Substance Use Disorders
	• ADHD
	• Bipolar Disorder

Reflection Questions

1) In your previous medical training, what have you observed around primary care delivery of mental health care services?
2) What have been your experiences in finding effective dispositions for patients from acute mental health settings?
3) Are there unmet needs in my community or clinic that could be addressed with a more effectively integrated behavioral health program?