AMERICAN PSYCHIATRIC ASSOCIATION

The Collaborative Care Model for Mental Health: Rigorous Research Meets Real World Success

Over 80 randomized controlled trials (RCTs) have shown the Collaborative Care Model (CoCM) to be more effective than care as usual. Meta-analyses, including a 2012 Cochrane Review, further substantiate these findings.[1,2] As a result, the CoCM is recognized as an evidence-based best practice by a range of authorities, including the Centers for Medicare and Medicaid Services, the Substance Abuse and Mental Health Services Administration, the Surgeon General, the National Business Group on Health, and the Agency for Healthcare Research and Quality.

Economic studies demonstrate that Collaborative Care is more cost-effective than care as usual,[3,4] and several evaluations found cost-savings associated with its use. The largest RCT to date of the CoCM - the IMPACT study involving adults 60+ across 5 states and 18 primary care clinics - found that patients in Collaborative Care had substantially lower overall health care costs than those receiving usual care.[5] "An initial investment in Collaborative Care of $522 during Year 1 resulted in net cost savings of $3,363 over Years 1-4."[6]

CoCM programs have been successfully implemented in many locations. These include:

What Is Collaborative Care?

In the CoCM, primary care providers (PCPs) treating patients behavioral health problems are supported by a behavioral health care manager and a psychiatric consultant.

- The PCP is a primary care physician, physician assistant (PA), nurse practitioner (NP) or clinical nurse specialist (CNS).
- The care manager is a social worker or psychologist who works with the PCP. S/he is trained to deliver evidence-based care coordination and brief behavioral interventions, and support the treatments initiated by the PCP. In some implemented versions of the CoCM the care manager also conducts structured psychotherapy.
- The psychiatric consultant is a psychiatrist or PA, NP, or CNS with psychiatric training, whose primary responsibilities are making treatment recommendations to the PCP, including developing treatment strategies (e.g., medication, evidence based therapies) and medical management of any complications associated with treatment.

This model is flexible and can be implemented across varied geographic locations, practice sizes, and patient populations.

Mental Health Integration Program (MHIP) – Washington State

Created in 2008 by the Community Health Plan of Washington and Seattle & King County Public Health, the MHIP is a network of Federally Qualified Health Centers (FQHCs) and Community Behavioral Health Centers (CBHC). Collaborative care is delivered to low-income patients with medical and behavioral health needs, such as depression, PTSD, serious mental illness, and substance use disorders. Patients receive on-site primary and mental health (MH) care services for mild/moderate conditions. Patients with more severe MH needs are referred to CBHCs. The MHIP uses a patient registry (CMTS) to track patient goals and outcomes.

- **Success:** By 2012, the median time-to-improvement in depression was cut in half.
- **Population**: Statewide more than 45,000 patients, both children and adults, treated in over 100 FQHCs. Most patients were Medicaid Managed Care enrollees.
- **Payment**: Care coordinator stipend payments for providers, in addition to fee-for-service payment for PCP services. Psychiatric consultants are contracted with for blocks of time for systematic case reviews and consultation to PCPs. 25% of clinic payments are linked to meeting selected process and clinical outcome measures, such as demonstration of improved patient outcomes, timely follow-up with patients, or consultation and treatment adjustment for patients who are not improving.

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COMPASS (Care of Mental, Physical and Substance Use Syndromes) – CA, CO, MA, MI, MN, PA

The COMPASS Collaborative Care model treats adult patients in primary care suffering from depression and diabetes and/or cardiovascular disease.

- **Success:** Preliminary results through December 31, 2014 show that for patients enrolled more than four months, COMPASS exceeded its original goals of a 40% improvement in depression control and a 20% improvement in diabetes and hypertension control.
- **Population:** Supported by the Institute for Clinical Systems Improvement (ICSI), 18 regional medical groups in seven states reached nearly 4,000 patients, one of the largest Collaborative Care implementations to date. 71% of patients were in Medicare or Medicaid, 27% in commercial insurance and 2% self-pay.
- **Payment:** Collaborative Care costs covered by a Center for Medicare & Medicaid Innovation Award.

Improving the Patient's Experience

"When Jeff Schott went to the doctor in 2005, he needed major back surgery. He was also experiencing significant stress from a failed business. Plus, a loved one attempted suicide, and then he had a stent placed in his heart in 2010. Jeff was also diagnosed with diabetes. He got relief through the COMPASS program at the Mayo Clinic Health System. Through every other week contact from Sharon Learned, COMPASS care manager, Jeff's depression improved and he got his diabetes under control. He is more motivated to take care of himself and has a better outlook on life. Jeff says, 'There's definitely a need for a program like COMPASS. Sharon has been especially great to work with. Having her as the go-between for me and the doctors has been very helpful.'"

RESPECT-Mil: Re-Engineering Systems of Primary Care Treatment in the Military

The RESPECT-Mil treatment model utilizes PCPs, psychiatric consultants and RESPECT-Mil Care Facilitators (RCFs) trained to screen their patients for depression and PTSD. RESPECT-Mil uses the web-based care management tool FIRST-STEPS to track treatment effects in real time.

- **Success:** This model has led to earlier identification and treatment, delivering effective, easy-to-access care in the primary care setting with reduced stigma and promoting collaboration between primary care and behavioral health in military treatment facilities. A five-year randomized, effectiveness trial of a second-generation approach, with additional care elements is currently under way.
- **Population:** US soldiers are seen in over 97 primary care clinics worldwide.
- **Payment**: Funded by the Department of the Army, the program employs salaried clinicians.

Additional Resources:

- **Integrated Care, American Psychiatric Association** - www.psychiatry.org/integratedcare
- **AIMS Center, Advancing Integrated Mental Health Solutions,** University of Washington - https://aims.uw.edu/
- **Integrating and Coordinating Specialty Behavioral Health Care with the Medical System**, The Kennedy Forum - www.thekennedyforum.org/news/integrating-issue-brief
- **COMPASS Initiative**, ICSI - www.icsi.org/dissemination__implementation/compass/

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[1] AIMS Center (Advancing Integrated Mental Health Solutions). "Collaborative Care Evidence Base."

[2] Archer J et al. "Collaborative care for people with depression and anxiety". Cochrane Review. October 2012.

[3] Gilbody S et al. "Costs and Consequences of Enhanced Primary Care for Depression: Systematic Review of Randomised Economic Evaluations." The British Journal of Psychiatry. October 2006;189:297-308.

[4] Glied S et al "Review: The Net Benefits of Depression Management in Primary Care." Medical Care Research and Review. June 2010;67(3):251-274.

[5] Unützer J et al. "Long-term Cost Effects of Collaborative Care for Late-life Depression." American Journal of Managed Care. Feb 2008;14(2):95-100.

[6] Unützer J et al. "The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes." Health Home Information Resource Center Brief. Centers for Medicare and Medicaid Services. May 2013