Improving Access and Outcomes: Collaborative Care Implementation in the Primary Care Setting

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Disclosures

- Agency for Healthcare Research and Quality (AHRQ)
- Centers for Disease Control and Prevention (CDC)
- UC Davis Practice Management Board
- Archstone Foundation
- California Health Care Foundation (CHCF)
- Center for Care Innovation (CCI)

Agenda

- Rationale for behavioral health integration within primary care
- Tiered Integrated Programs at UC Davis
  - Screening initiatives
  - Electronic Consultations
  - Ambulatory Case Management Team
  - Collaborative Care Model (CoCM)
  - Tele psychiatry Implementation
  - Embedded Psychiatric Consultants
- Training / Research / CQI Initiatives
The Problem

- Psychiatric disorders:
  - 25% of all disability worldwide
  - 10% of Years Lived with Disability (YLD) – depression alone
  - In U.S., one suicide every 14 minutes
  - Increase risk: diabetes, heart disease, cancer

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

C. Murray, Global Burden of Disease Study, Lancet 2012

Background: the youth mental health crisis

- 20% of youth have a MH condition
  - 50% of MH conditions onset <14 yo
  - 75% of MH conditions onset by age 24
- Only 20-30% of patients receive treatment
  - Average of 8-10 year delay to getting care
- Untreated youth MH conditions have long-lasting effects
  - Falling off trajectories: social, academic
  - Leading causes of death: accidental death and suicide

Background: the youth mental health crisis

- Gap between need for and availability of youth MH services
- AAP and AACAP have called for:
  - Partnership between CAPs and pediatricians / family medicine
  - Integration of MH services in pediatrics
  - Increased training for pediatricians to increase MH competency
  - Emphasis on training for pediatrics residents

https://www.aacap.org/aacap/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx
WHO GETS TREATMENT?

- 25-30% of primary care patients have a mental health diagnosis
- Only 50% of patients referred to specialty mental health actually followed through with making an appointment
  - Cunningham, Health Affairs
Background and Situation

- Stigma
- Lack of access to behavioral health for many primary care patients
  - Shortage of specialists and behavioral health providers
  - Increased social needs/barriers
- Patients with behavioral health conditions
  - High rates of medical complexity
  - Poor cardiovascular outcomes

Collaborative Care Model (CoCM)

- The CoCM is a specific model of integrated care
- Developed to treat common and persistent mental health conditions (e.g., depression / anxiety) in the primary care setting
- Provides MI / IBDU treatment in primary care settings through collaboration between a PCP, working collaboratively with a psychiatric consultant and a behavioral health clinician (LCSW, MFT, psychologist)
- An evidence-based model with over 90 validated studies to show efficacy
- Recognized by CMS with specific billing codes

Mental Health
Rarely Occurs in Isolation

- Chronic Physical Pain 25-50%
- Cancer 10-20%
- Neurologic Disorders 10-20%
- Heart Disease 10-30%
- Diabetes 10-30%
- Smoking, Obesity, Physical Inactivity 40-70%

Percentage with comorbid condition
Collaborative Care Model (CoCM)

- **Strong evidence base:**
  - Improves health outcomes
  - Improves access to care
  - Reduces healthcare costs

- 90+ randomized control trials (RCTs) demonstrating clinical efficacy in a variety of common conditions
  - Depression, anxiety and trauma disorders, chronic pain, ADHD, and substance use disorders including alcohol and AUD

### History of Collaborative Care

- **1980-1990s**
  - Recognition of need to address depression in primary care

- **2000-2010s**
  - Over 80 RCTs demonstrating effectiveness of collaborative care

- **2010-Present**
  - Focus on implementation, sustainability and reach

#### IMPACT Trial (JAMA, 2002)

- **RCT:** 1801 older adults with depression at 18 primary care clinics in 5 states
- **Usual care:** medications (70%) and/or behavioral health referral
- **Collaborative care:** tracked clinical outcomes, adjusted treatment.

  - **Results:**
    - Improved satisfaction
    - Doubled effectiveness with 50% reduction of symptoms at 12 months vs 19% with usual care
    - Better functioning (PCS-12)
    - Lower healthcare costs
    - Benefits persisted at 1 year follow-up
Improving Depression Care for Older Patients in Primary Care
(Medical Care, 2005)

- IMPACT trial data
- Compared depression severity, quality of life, and mental health service use at 0, 3, 6, and 12 months.
- Treatment effects were of similar magnitude in all sub-groups included in the trial.

<table>
<thead>
<tr>
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<th>N = 1801</th>
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<tr>
<td>Mean age (SD)</td>
<td>71.2 (7.5)</td>
</tr>
<tr>
<td>Male</td>
<td>35%</td>
</tr>
<tr>
<td>Female</td>
<td>65%</td>
</tr>
<tr>
<td>Non-Hispanic White</td>
<td>77%</td>
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<td>Black</td>
<td>12%</td>
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<tr>
<td>Latinx</td>
<td>8%</td>
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<tr>
<td>All Others</td>
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Effectiveness of Collaborative Care for Depression
(Psychiatric Services, 2017)

- **RCT**: 400 patients with depression in 3 LA primary care clinics serving predominantly Latinx individuals (included FM/IM resident clinics)
- **Enhanced usual care (N = 204)**: Regular care from PCP, depression pamphlet, a letter from PCP about positive depression screen, and a list of local mental health resources
- **Collaborative Care (N = 196)**: Social Workers and PCP's: CBT and/or antidepressant medication
- **Results**: By 16 weeks, Collaborative Care had two-fold increase in patients experiencing >50% reduction in depressive symptom severity
- **Outcome**: Significantly improved quality-of-care indicators, including the proportion of patients receiving either psychotherapy or antidepressant medication (77% versus 21%, p<.001)

UC Davis Health

- Sacramento, CA

Medical Center
- 690 Bed Hospital
- Level 1 Adult and Pediatric Trauma Center

Primary and Specialty Care
- 18 ambulatory sites across multiple counties
A Phased Approach to Integration

- Screening
- Psychiatry E-consults
- Case Management
- Collaborative Care Model (CoCM)
- Psychiatry Consultation

Improving Access to Care

- Psychiatric Evaluation and Management
- Community Referrals
- Mental Health Services
- Outpatient Psychiatry
- Case Management
- Direct Consultation
- Indirect Consultation and Therapy
- Asynchronous Consultation
Screening

UC Davis Primary Care Sites

Now screening 2500+ patients per week

Available in MyChart

Higher risk of being missed by appropriate screening based on race, ethnicity and insurance class.

Alcohol screening documented during less than 3% of primary care visits (2014-2016).

AUDIT and DAST

Annual Brief Screen

AUDIT

DAST
Psychiatry E-consults

- PCPs ask questions to specialists
- An effective and efficient way to connect psychiatrists to PCPs
- Straight forward questions that don’t need a psychiatry referral
- Cost effective and PCP satisfaction

E-consult structure

- Shared EMR inbox covered by a team
  5 adult psychiatrists, rotating coverage by day of the week
  2 child consultants, one women’s mental health consultant

- Recommendations are provided after brief chart review

- Common questions include:
  Medication recommendations, particularly anxiety and depression
  Safety of treatments in setting of comorbid medical issue or concerns for drug interactions

- Consider direct consultation if provider would like diagnostic clarification or more in-depth assessment is needed

Ambulatory Case Management

- Care Transitions
- Education
- Social Resources
- Transportation
- Linking patients to therapy
Health Management and Education

- Nurses
- Social Workers
- Pharmacists
- Health Educators
- Dieticians
- Health Psychologists
- Hospital Discharge Call Program

CoCM Achieves Quintuple Aim

- Population Health Outcomes
  - Increases access
  - Improves clinical outcomes
- Reduces Total Cost of Care
- Provider Satisfaction and Productivity
  - Compared to UC
- Patient Satisfaction
  - Increased 25%
- Reduces Health Disparities & Stigma
  - Equivalent or better outcomes

Unutzer 2002; Levine 2005; Arean 2005; Unutzer 2008; Bowen 2020; Hu 2020

Supervising Psychiatrist:
Kris Richards, M.D.:
- Consults with PCPs and BHC regarding diagnostic and medication questions.
- Meets with patients directly or via video visit if needed (one to three visits) to discuss specific medication options.

Behavioral Health Clinician:
Jorge Hernandez, LCSW:
Will provide short-term counseling services (usually eight visits) that include:
- Talk therapy
- CBT
- Mindfulness
- Problem-solving therapy
- Motivational interviewing
- Behavioral activation techniques
Will conduct periodic case review with psychiatry.
Consultative model
- Collaborative
- Recommendations to PCP

Weekly team systematic caseload reviews (SCR)
- EPIC Registry review
- Treat-to-target (time-limited)

UCD Collaborative Care Model: 2023 Data

- 39% of patients are in remission within 12 weeks
- 60% of the above patients have achieved a response to treatment within 12 weeks
  - Usual care is 19-25%

Access to Care: 2-3 weeks

Psychiatry Referrals
- UC Davis Psychiatry (Psychiatry Behavioral Health Referral)
- MIND Institute (children with ADHD or autism)
- UC Davis EDAPT (early psychosis program ages 12-40)
- Medicare (EMR list)/Medi-Cal (ACCESS referral)
- Therapy: Psychologytoday.com or back of insurance card
- Cognitive Disorders: Health Aging Clinic, TBI clinic, Neurology, or Neuropsychological testing
- Panic Disorder, OCD, Agoraphobia: The Anxiety Treatment Center
- Eating Disorders: Eating Recovery Center
Who should be referred?

Current patients who are:
- Age 50 and older.
- Suffering from depression or grief symptoms.
- Have a current (within 90 days) PHQ-9 score of 10 or above.

Patients who are acutely suicidal, have psychotic disorders, significant neurocognitive disorders, and/or substance use disorders do not qualify for the Collaborative Care Program at this time.

All payors qualify!

Referral Process

1. Select Network Behavioral Health referral.
2. Under Available Behavioral Health Resources, select Collaborative Care (for LCSW/short term therapy) or select Psych Consult 1.3 visits for psychiatry.

Tracking Performance Improvement

- Hemoglobin A1c
- Blood pressure
- BMI
- PHQ-9 (depression)
- GAD-7 (anxiety)
- Substance Use Screenings

Age 50 or over with depression/grief and recent PHQ-9 score of 10 or above
Short-Term Psychiatry Consults

- Short-term (1-3 visits total) coordinated with PCP regarding specific diagnostic questions or refractory symptoms.
- Not already established with a UCD/external psychiatrist.
- Open to medication management.
- Consider CMP, CBC, TSH/Free T4.

Teaching Builds Relationships

- Integrated Teaching
  - Every consultation is an opportunity to teach!
  - PCP / BHC

- Structured Teaching
  - "Lunch & Learns" on topics in Primary Care Psychiatry
  - CME

- Formal educational content
  - Journal articles / handouts / protocols
Building Relationships with PCPs

Maximize facetime with providers
Consider brief meetings for additional 1:1 psychopharm education
Lunch and Learns
Offer accessibility and drop-in discussion of cases
Communicate recommendations clearly
  • Route your notes
  • Clarify preferred pharmacy
  • Discuss risks and benefits of treatment recommendations
  • Include titration/tapering instructions, monitoring guidelines

Resident feedback

- ACLP 10-year follow up survey showed only 19.4% of responding programs had a required outpatient CL component (Beach et al, 2023)

- A 2020 systematic review in JACLP looked at interventions to train psychiatry residents in integrated care
  • Most surveyed residents found these experiences to be positive experience
  • Rotations were relevant in preparing them for their future careers
  • CoCM rotations enhanced learning on how to assess and manage complex medical-psychiatric patients

Zimbres et al., 2020
Resident feedback

A summary of 5 psychiatry training programs that provided integrated care training for residents found that the success of such programs depended on:

- Supervising psychiatrist with experience in integrated care
- Funding for faculty time
- Time to do the rotation within the residency program
- Office space accommodations within the clinical site
- PCP clinic "champion" who supports integrated care

Zimbres et al., 2020

Educating The Workforce

- Training PCPs
- Training Psychiatrists
  - C-L Fellows
  - PGY-5 Combined Residents
  - PGY-4 General Residents
- Medical Student rotations

Program Development
### Program Development (cont.)

- Clinical Quality Improvement
- Education
  - PCP education
  - Trainees
- Research
  - Telepsychiatry
  - Population health

### A program built from CQI projects

- **2011** – Depression Care Management – Pay for Performance Initiative
  - 2 clinics – improved depression outcomes
  - Highly rated by patients and PCPs
- **2012** – Depression Care Management – expanded
  - 3 clinics – replicated 2011 results
- **2013** – Care Coordination Program
  - New Ambulatory Care Management (ACM)

### Brief History -- Program Development

- **2015**: Asynchronous Telepsychiatry for Depression in Primary Care
- **2016**: PRIME – Public Hospital Redesign and Incentives in Medi-Cal
- **2016**: Universal screening
- **2017**: E-Consult launch
- **2018**: Collaborative Care Model implementation
- **2019**: Care Partners Grant for Late-Life Depression (Archstone Foundation)
- **2021**: Expansion to Academic Clinics
- **2022**: CHCF-CCI: Behavioral Health Equity in Primary Care
- **2023**: WITH Study; Expand Inclusion Criteria for CoCM
**Pediatric Integrated Care**

- Pediatric integrated care models can be based on adult models (with modifications) but there are unique challenges that face these pediatric programs.
- Successful programs take into consideration key differences like lower volume, longer visits, more complexity, importance of care coordination.
- Pediatric integrated care models are excellent training sites and can help expand the mental health workforce.
- It is possible to use a population health framework to shape a large system of care and improve access to mental health treatment.

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**Mental Health and COVID**

**CDC report**

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<tr>
<th>MMWR</th>
<th>Morbidity and Mortality Weekly Report</th>
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**Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020**

- Symptoms of depression and anxiety increased significantly during pandemic, compared with same period in 2019. - CDC August 2020
- 41% report at least one mental health condition, including substance use disorder.
- 11% reported seriously considering suicide in 30 days prior to survey.
COVID-Era Disparities

- COVID impact: Mental health conditions disproportionately impact specific populations
  - Young Adults
  - Black, Latinx and Indigenous communities
  - Essential workers
  - Unpaid caregivers for adults
  - Patients with pre-existing mental health conditions

Structural Racism in medicine impacts outcomes

CHCF-CCI Learning Collaborative: Advancing Behavioral Health Equity in Primary Care

- Aligning behavioral health and social needs
- Reducing Barriers to Care
  - Racism, discrimination, trauma
- Social determinants of health
  - Screening, tracking, and referral
  - Housing insecurity, food insecurity, legal support
Making the “business case” for integrated care

- Improved patient outcomes
- Savings in total health care costs
- Improved patient / provider satisfaction
- Improved provider productivity
- In safety net populations
  - Reduced homelessness / arrest rates

Alternative Payment Models
- Pay-for-Performance / Outcomes
- PRIME
- Health Homes
- CalAIM

Billing codes for Collaborative Care

Improved Access – Value-based care

- Mental Health Parity and Addiction Equity Act
- ACA insurance expansion
- Accountable Care Organizations

Key Talking Points with Leadership
  - Better outcomes
  - Lower costs
  - Better experience of care for patients and providers
Integrated Care – Next Steps

- Further align with population health team
- Expansion into Pediatrics settings (Dr. Hopkins)
  - Psychology Faculty and Trainees
- Expand workforce
  - Psych NPs / FNP / Clinical Pharmacy
- Expand inclusion criteria
- Financial sustainability
  - CoCM billing codes
  - Alternative payment models

A team approach to care

Interprofessional and Patient-centered

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Thank you

Questions?