Facilitator Guide for readings on "Introduction to Integrated Care Consultation Models with focus on Collaborative Care Model "

Readings: The list of readings and the order of the readings are organized to give a stepwise learning experience to participants about integrated care and specifically the Collaborative Care Model (CoCM). The APA videos cover all the key points for population mental health: access problems, different integration consultation models to improve access, and details about CoCM. This is followed by article on the IMPACT trial by Dr. Unutzer, which to date is the largest trial showing the effectiveness of CoCM over usual care in primary care for treating depression. Dr. McGough's article, "Integrating Behavioral Health into Primary Care," describes an example of this model at the University of Washington. Once participants are familiar with this model, Dr. Bauer's article provides nice guidance on best practices for executing systematic case review, which is the key component of CoCM. The last article is a review article which explores the effectiveness of CoCM to improve health equity and reduce health disparities.

Online APA Training: 4 hr training
Goal: To understand in detail integrated care models, the reason for CoCM, evidence behind it, principles of CoCM, how it is different from other integrated care models.

Module	Summary *	Reflections *
Module 1: Introduction to Collaborative Care	Addresses some of the challenges around access to mental health care and outlines a framework for closing the gap between need and access through integrated care. The history and evolution of the Collaborative Care approach is provided, including its position as an evidence-based approach within the framework of other integrated care models. The 5 core principles of Collaborative Care are discussed, as well as outcomes and accountability.	- What is your understanding of current access to mental health care? How many people with a mental health problem get treated? - In your current rotation how do you think about the population with mental health in that setting (Inpt C-L, outpt clinic)? How is your current rotation impacting that population? - What are different consultation models and their impact on population mental health? - How is CoCM different? - How can you expand your impact if you used an integrated care approach?
Module 2: Collaborative Care 101	Expands upon the 5 core principles of Collaborative Care with a particular emphasis on their role in	- How do you know care being provided is consistent with CoCM? - Define each principle

	informing the clinical workflow of Collaborative Care teams. Core clinical team roles are described for the PCP, care manager, and psychiatric consultant. Perspectives from real world psychiatric consultants are also provided, addressing the different challenges they faced when starting to work in Collaborative Care.	- Which principles you can incorporate in your rotation? - What are challenges in incorporating these principles? - What are the barriers when working in CoCM?

Module 3: Assessment as Part of CoCM Team	Covers the process of identifying and assessing patients in Collaborative Care, with an emphasis on the psychiatric consultant's role in this phase of care. Common behavioral health measures are reviewed, including the PHQ-9 for depression. Central to the discussion in this module is how the role of the psychiatric consultant in patient assessment is different from more traditional specialty psychiatric settings. Perspectives from real world Collaborative Care psychiatric consultants are provided, addressing topics such as developing comfort with indirectly evaluating patients, the use of screeners as diagnostic aids, and some of their 'must have' pieces of information to make a provisional diagnosis.	- What is your understanding of Patient Centered Care?
		- How is the presentation of behavioral mental health patients different in primary care?
		- What does “Care shaped over time” mean in the Collaborative Care Model?
		- What experience do you have with assisting other health care providers to arrive at an effective working diagnosis?
		- Which resources might be used to improve the diagnoses made in a primary care setting?
		- What are your thoughts on using behavioral health measures?
		- How can you integrate the use of these measures in your practice?
		- What will be the “must have” information for you to feel confident to help make a diagnosis of
		  - Major Depressive Disorder?
		  - Bipolar disorder?
		- Practice Cases with trainees discussed in this module under “Interactivity Section”

Module 4: Treatment as Part of CoCM Team	Examines the process of treatment for patients engaged in Collaborative Care, with an emphasis on the psychiatric	- How is treatment different in CoCM compared to traditional consult? - Why is Evidence Based Care important in CoCM?

	consultant's role in this phase of care. A key part of the discussion in this module is how care is shaped over time for patients in Collaborative Care, with at least 1-2 treatment adjustments commonly needed before improvement is seen. Evidence-based treatment options and information around providing effective treatment recommendations is also reviewed. Real-world practicing Collaborative Care psychiatric consultants share their perspectives on the treatment phase, addressing topics such as initiating treatment and experiences with using measurement-based treatment to target and active caseload management.	- How do you make effective treatment recommendations? - What experience do you have with initiating treatment outside traditional psychiatry practice? - What does registry mean in CoCM? - What are the key components of a useful registry?

*Content from APA website: [Applying the Integrated Care Approach: Core (psychiatry.org)]

Unützer J, Katon W, Callahan CM, Williams JW, Jr., Hunkeler E, Harpole L, et al. Collaborative-care management of late-life depression in the primary care setting. JAMA. 2002;288(22):2836-45.
Goal: To understand the evidence of CoCM compared to usual care provided in primary care

Summary: The primary results of the IMPACT Collaborative Care clinical trial which included n=1801 older adults with depression and showed treatment with Collaborative Care more than doubled the effectiveness of depression treatment.
Reflections: - What is your understanding of the process to get mental health care in your primary care clinics? - How do you differentiate usual care from the IMPACT intervention in this study? - Which results from this study were most impressive for you?
Abstract:
Context: Few depressed older adults receive effective treatment in primary care settings. **Objective:** To determine the effectiveness of the Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) Collaborative Care management program for late-life

depression. **Design:** Randomized controlled trial with recruitment from July 1999 to August 2001. **Setting:** Eighteen primary care clinics from 8 health care organizations in 5 states. **Participants:** A total of 1801 patients aged 60 years or older with major depression (17%), dysthymic disorder (30%), or both (53%). **Intervention:** Patients were randomly assigned to the IMPACT intervention (n = 906) or to usual care (n = 895). Intervention patients had access for up to 12 months to a depression care manager who was supervised by a psychiatrist and a primary care expert and who offered education, care management, and support of antidepressant management by the patient's primary care physician or a brief psychotherapy for depression, Problem Solving Treatment in Primary Care. **Main outcome measures:** Assessments at baseline and at 3, 6, and 12 months for depression, depression treatments, satisfaction with care, functional impairment, and quality of life. **Results:** At 12 months, 45% of intervention patients had a 50% or greater reduction in depressive symptoms from baseline compared with 19% of usual care participants (odds ratio [OR], 3.45; 95% confidence interval [CI], 2.71-4.38; P<.001). Intervention patients also experienced greater rates of depression treatment (OR, 2.98; 95% CI, 2.34-3.79; P<.001), more satisfaction with depression care (OR, 3.38; 95% CI, 2.66-4.30; P<.001), lower depression severity (range, 0-4; between-group difference, -0.4; 95% CI, -0.46 to -0.33; P<.001), less functional impairment (range, 0-10; between-group difference, -0.91; 95% CI, -1.19 to -0.64; P<.001), and greater quality of life (range, 0-10; between-group difference, 0.56; 95% CI, 0.32-0.79; P<.001) than participants assigned to the usual care group. **Conclusion:** The IMPACT Collaborative Care model appears to be feasible and significantly more effective than usual care for depression in a wide range of primary care practices

McGough PM, Bauer AM, Collins L, Dugdale DC. Integrating Behavioral Health into Primary Care. Population Health Management. 2016 Apr;19(2):81-7.

Summary: This paper outlines the partnership with UW neighborhood clinics and the UW psychiatry department in implementing the Collaborative Care (CoCM) approach to integrating the management of anxiety and depression in the ambulatory primary care settings following the chronic disease model. In the beginning the authors make the case for the CoCM model by describing how common depression is and the challenges in the current system of limited access to appropriate treatment, insurance problems, etc. In the method section, the Behavioral Health Integration Program (BHIP) is described including the CoCM team with their roles (PCP, care manager and psychiatrist), settings (UW neighborhood clinics), target population (with depression and anxiety). The pilot program was initially created in one clinic with high mental health needs, and based on positive outcomes, the program was expanded in all UW neighborhood primary care clinics within a couple of years. The BHIP program uses a web-based registry, CMTS. The majority of the BHIP population in these clinics presents with depression (76%) and anxiety (42%); other diagnoses include PTSD (15%), bipolar disorder (16%), substance use (12%) and positive SI (40%). Greater than 60% of patients engaged in biweekly care (in person and phone contacts).

Reflections:

- What are the barriers in referring patients to community mental health clinics for depression and anxiety?
- What is your understanding about the chronic disease model?
- How did the Collaborative Care Model (BHIP) at UW impact access to mental health care and treatment engagement?

Abstract:

Depression is one of the more common diagnoses encountered in primary care, and primary care in turn provides most of the care for patients with depression. Many approaches have been tried in efforts to improve the outcomes of depression management. This article outlines the partnership between the University of Washington (UW) Neighborhood Clinics and the UW Department of Psychiatry in implementing a Collaborative Care approach to integrating the management of anxiety and depression in the ambulatory primary care setting. This program was built on the chronic care model, which utilizes a team approach to caring for the patient. In addition to the patient and the primary care provider (PCP), the team included a medical social worker (MSW) as care manager and a psychiatrist as team consultant. The MSW would manage a registry of patients with depression at a clinic with several PCPs, contacting the patients on a regular basis to assess their status, and consulting with the psychiatrist on a weekly basis to discuss patients who were not achieving the goals of care. Any recommendation (eg, a change in medication dose or class) made by the psychiatrist was communicated to the PCP, who in turn would work with the patient on the new recommendation. This Collaborative Care approach resulted in a significant improvement in the number of patients who achieved care plan goals. The authors believe this is an effective method for health systems to integrate mental health services into primary care. (Population Health Management 2016;19:81-87).

Bauer AM, Williams MD, Ratzliff A, Unutzer J. Best Practices for Systematic Case Review in Collaborative Care. Psychiatric Services. 2019 Nov 1;70 (11): 1064-1067.

Summary: This paper outlines best practices for the key component of the Collaborative Care Model (CoCM), “Systematic Case Reviews” (SCR). The consulting psychiatric provider and care manager (CM) are required for these meetings. Authors emphasize the importance of regular SCR meetings to avoid delays in treatment and improve support for the CM. Time allotted for SCR depends on factors like patient population, complexity, case load turnover, and the team’s experience. Doing regular SCR meeting helps to tailor treatment in a timely way and provides support to the CM. In the second part, authors describe best practices for SCR preparation, conduct and follow up. Prioritizing the patients to discuss in advance helps the SCR to be a systematic, succinct and organized data-driven case discussion. Setting an

agenda for the SCR and reviewing the registry to ensure no patient falls through the cracks reinforces the principle of accountable care. In the end authors list five common threats to CoCM and potential solutions: 1. Drifting to ad hoc review, 2. Neglect of population management, 3. Avoidance of patients who are not improving, 4. Diversion of SCR to other behavioral health matters, 5. Boundaries with patients.

Reflections:

- Have you done indirect psychiatric care or provided recommendations without seeing a patient?
- Is your indirect psychiatric care experience different from SCR described in this paper?
- What are the components of SCR you found useful after reading this paper?
- What were the best practices used in the SCR you observed in BHIP clinic?

Abstract:

Conducting systematic case reviews (SCRs) is a critical skill for psychiatrists leveraging their expertise to provide Collaborative Care in a primary care setting; however, there is little literature to guide best practices for executing an SCR. This column offers guidance to psychiatrists on best practices for conducting SCRs by drawing on experience from psychiatrists who teach Collaborative Care and who directly observe SCRs in established programs. Furthermore, it describes several common threats to successful SCR and presents potential solutions to assist programs in implementing indirect psychiatric care, an essential component of Collaborative Care.

Jackson-Triche ME, Unutzer J, Wells KB. Achieving Mental Health Equity: Collaborative Care. Psychiatric Clinical North America. 2020 Sep; 43(3):501-510.

Summary: This article reviews the impact of integrated care programs on improving health equity with emphasis on the Collaborative Care Model (CoCM). Authors review evidence supporting the effectiveness of CoCM: (1) to treat behavioral health conditions of at-risk populations, such as low-income populations, racial and ethnic minorities, and other populations with particular risk for poor access, such as geriatric and rural populations; (2) to reduce disparities in access, quality of care, and outcomes; and (3) to explore the promise of innovative approaches, including incorporating priorities of at-risk communities. Authors list a number of studies which show evidence of CoCM reducing disparities and that language/ cultural tailoring may improve implementation and engagement.

Reflections:

- Which health disparities have you observed in the health system?
- How do you think CoCM can address health disparities?
- What are your thoughts on culturally tailored treatment?

Abstract:

The literature supports the effectiveness of systems-based integrated care models, particularly Collaborative Care, to improve access, quality of care, and health outcomes for behavioral health conditions. There is growing evidence for the promise of Collaborative Care

to reduce behavioral health disparities for racial and ethnic, low-income, and other at-risk populations. Using rapid literature review, this article highlights what is known about how Collaborative Care may promote health equity for behavioral health conditions, by reducing disparities in access, quality, and outcomes of care. Further, it explores innovative intervention and engagement strategies to promote behavioral health equity for at-risk groups.

Optional/Additional Readings:

- Integrating Primary Care and Behavioral Health: The Role of the Psychiatrist in the Collaborative Care Model by Lori Raney
- Practical Approaches for Achieving Integrated Behavioral Health Care in Primary Care Settings by Ratzliff et al: The goal of this article is to introduce you to the concept of steps in implementation of a new program
- A Systematic Review of Interventions to Improve Initiation of Mental Health Care Among Racial-Ethnic Minority Groups by Su Yeon Lee-Tauler, Ph.D., John Eun, B.A., Dawn Corbett, M.P.H., Pamela Y. Collins, M.D., M.P.H.
- Evidence Base for Collaborative Care: Treating Racial and Ethnic Minority Groups (AIMS Center)

Resources:

- APA website Applying the Integrated Care Approach: Core (psychiatry.org)
- AIMS Center | Advancing Integrated Mental Health Solutions in Integrated Care (uw.edu)