

# COST SAVINGS IN COLLABORATIVE CARE

Partnership Health Center, Missoula



# Depression Care



- ❧ 1/10 see psychiatrist
- ❧ 4/10 receive treatment in primary care
- ❧ 30 Million people receive antidepressant Rx
  - ❧ But only 20% improve
- ❧ 2/3 of Primary Care Providers report poor access to mental health for their patients
- ❧ Primary Care is the **de facto treatment setting** for most patients with common mental health conditions like depression and anxiety
- ❧ 70% of all antidepressant prescriptions in the United States are written by a primary care provider

# What is Collaborative Care?

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An evidence-based model for the treatment of depression ideal for primary care settings and includes these 5 core principles:

- ❧ Patient-Centered Team Care
- ❧ Population-Based Care
- ❧ Measureable Outcomes
- ❧ Research Supported Treatment
- ❧ Accountable Care – providers reimbursed for outcomes

# The Collaborative Care Model

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## What is it?

- ⌘ An integrated care model that uses a care team of primary and behavioral health care providers to treat mental health conditions such as depression, anxiety, and substance abuse in primary care settings.

## Why is it important?

- ⌘ Despite the prevalence of mental health conditions such as depression, anxiety, and substance abuse, many people – especially low-income individuals - do not receive effective care.

# Patient-Centered Team

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## Care Manager

- Behavioral health professional
- Coordinates overall team effort and communication
- Psychotherapy when needed

## Primary Care Provider

- Makes initial assessment
- Facilitates Warm hand-off
- Starts Treatment

## Psychiatric Consultant

- Supports PCP and care manager in diagnosis, treatment plan, and treatment change recommendations

## Patient

- The patient is an integral part of the care team and active participant in treatment

# Collaborative Care at PHC

## Team Approach

PCP

Behavioral Health CM

Consulting Psychiatrist

Therapist

- 4 year funded project, ended in

## HOW WE BUILD YOUR DEPRESSION CARE TEAM

You

### What is your role?

You are the most important person on the team! We want you to tell us what is working for you and what is not. We will work with you to track your progress using a simple checklist. Let us know if you have questions or concerns about your care. If you take medication, let us know if you have questions about what it is or how to take it.



Dr. Harrison

### What is the primary care provider's role?

Dr. Harrison oversees all aspects of your care at the clinic. She works closely with the other members of the care team to make sure that you get the best care possible. She will stay informed about treatment progress. She may also talk with the psychiatric nurse practitioner for suggestions about treatments.



Alyson Holweger  
Community Health  
Specialist  
Leslie Croot  
MS  
Counselor  
317-2140

### What is your support team's role?

Your Counselor works closely with you and Dr. Harrison to create your treatment plan. She answers questions about your treatment. Your Counselor, along with your Community Health Specialist, will work with you to set goals and problem-solve as part of your treatment. We will check in with you to see how you are feeling and monitor for any possible side effects if you are taking medications.



Mary Huddle  
APRN

### What is the psychiatric nurse practitioner's role?

The psychiatric nurse practitioner is an expert who is available to advise your support team about treatment options, especially if you don't improve with the initial plan. The team meets regularly with the nurse to talk about your progress and to think about what might help you feel better. With your permission, the psychiatric nurse practitioner may meet with you in person or by telephone to help us in supporting you through your depression.

# Data from Final Quarter Report

## CASELOAD STATISTICS

Time to f/u in days by BHCM was a critical difference in improvement.

CLINIC	# OF PT. 	INITIAL VISIT			FOLLOW UP			
		# 	MEAN PHQ 	MEAN GAD 	# OF PT. 	MEAN # 	MEAN # CLINIC 	MEAN # PHONE 
Partnership Clinic	141	140 (99%)	17.2	14.8	129 (92%)	8.2	5.1 (62%)	3.1 (38%)
All	141	140 (99%)	17.2	14.8	129 (92%)	8.2	5.1 (62%)	3.1 (38%)

More data from Final Report

PHQ-9 down 5 points in 55% of all and GAD-7 down in 40%.

Value of f/u on medication

# ON MEDS	# W/ MISSING MEDS	# IN R/P	PSYCHIATRIC CONSULTATION			DECREASED 5+ POINTS		50% IMPROVED OR < 10 AFTER > 10 WKS	
			# REQ'D	# W/ P/N	NOT IMPRV W/O P/N	PHQ	GAD	PHQ	GAD
93 (72%)	22 (16%)	34 (24%)	5 (4%)	140 (99%)	0	74 (55%) (n=135)	26 (40%) (n=65)	45 (63%) (n=71)	18 (25%) (n=71)
93 (72%)	22 (16%)	34 (24%)	5 (4%)	140 (99%)	0	74	26	45	18

63% had improvement in PHQ-9 symptoms at 12 weeks.

PHC = Center line

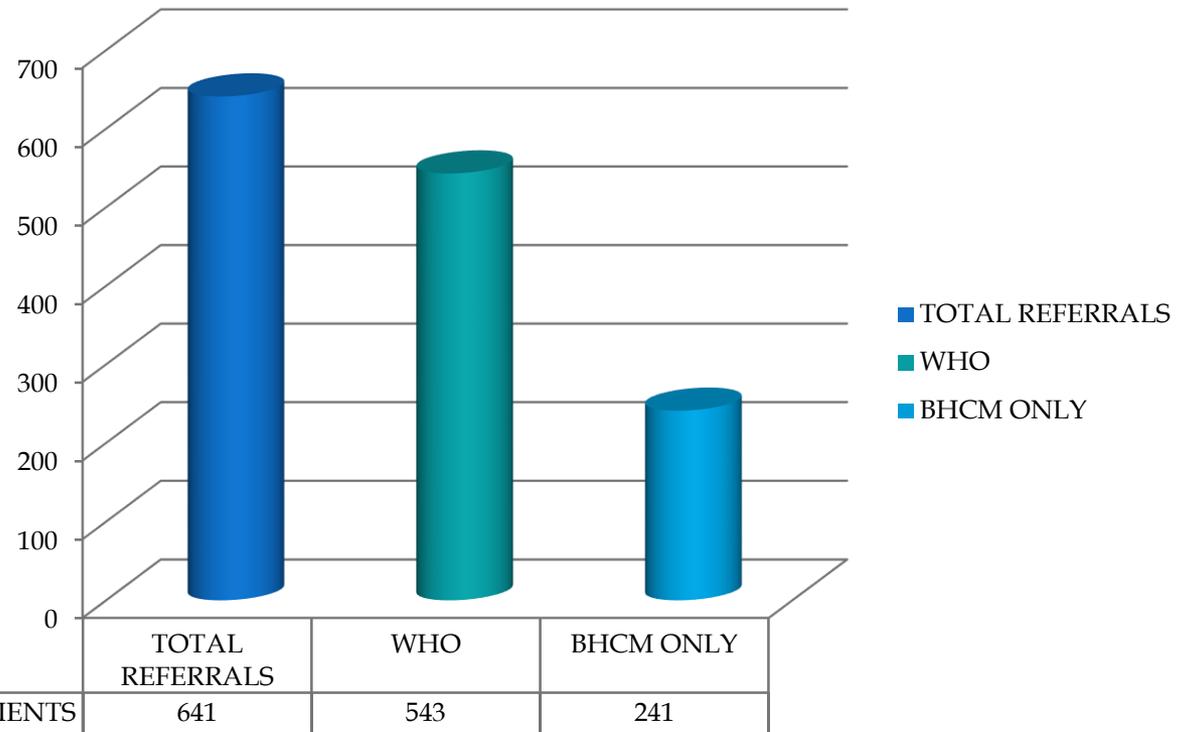
# BHCM role after funded project

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- ∞ Critical team member in linking patients to care for behavioral health, substance use disorder treatment, and social determinants of health. Provider calls for WHO, brief assessment of need and patient wishes.
- ∞ In 2017, BHCM served 543 patients, 241 were supported without a therapist visit.

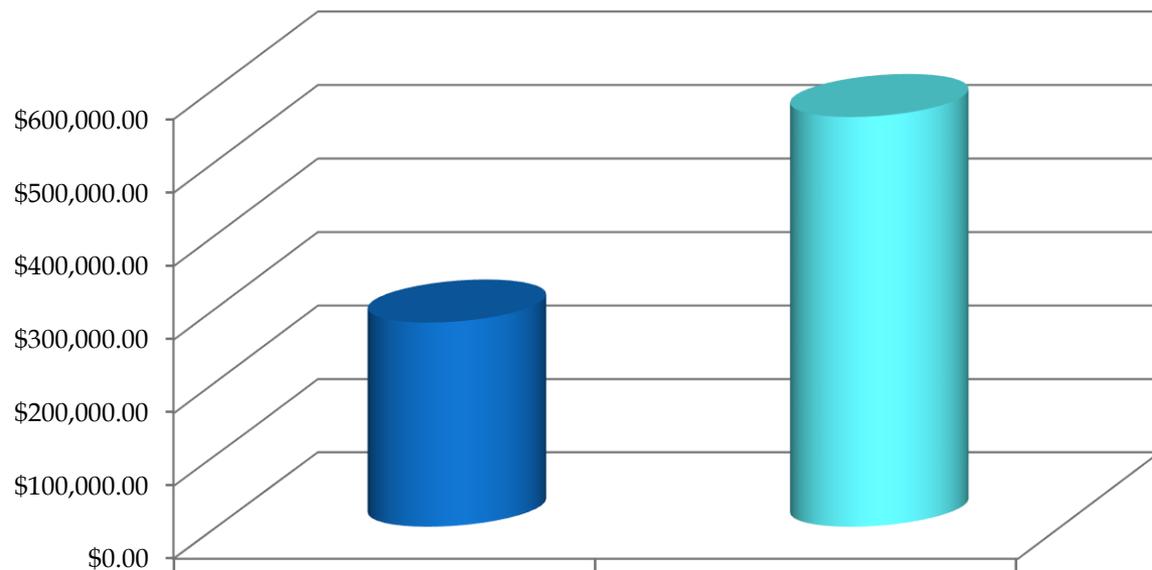
# Year End Data 2017

**Months in CARE  
2017 BH CM**



# Cost Savings if BHCM alone versus traditional therapy

## 241 UNDUPLICATED PATIENTS RECEIVING CARE MANAGEMENT ONLY



241 UNDUPLICATED PATIENTS

ESTIMATED COST SAVINGS MONTHLY THERAPY for 8 MONTHS

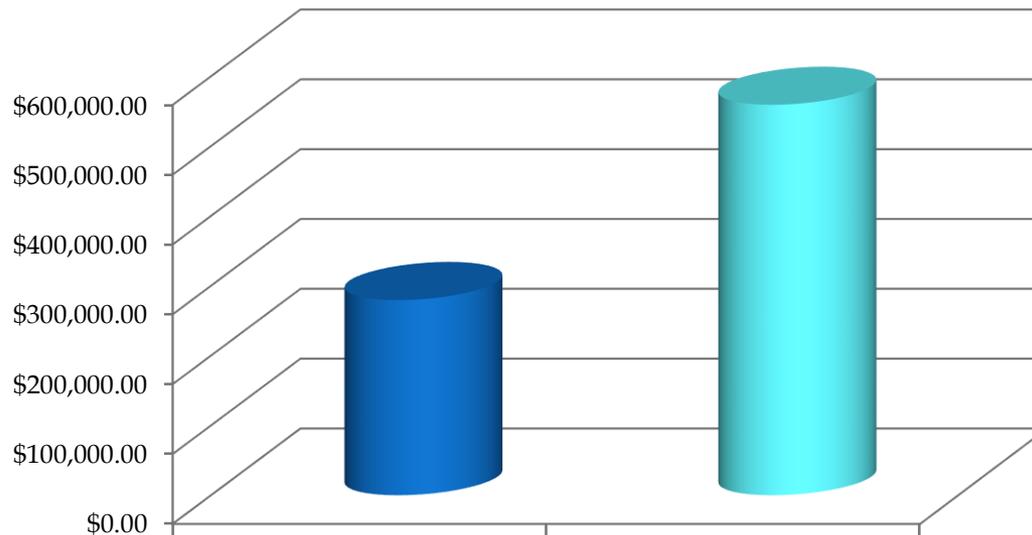
\$279,560.00

ESTIMATED COST SAVINGS MONTHLY THERAPY TWICE MONTHLY

\$559,120.00

# Cost savings of WHO versus estimate of high

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# Where we deploy BHCM at PHC

Warm Hand Off in  
Clinic

Super-utilizer  
Program

Kindness, Elegance  
and Love Project  
(KELP)

Integrated  
Medication Assisted  
Treatment

To track utilization at  
our new primary care  
site at the Western  
Montana Mental Health  
Center

# What DOES work?



**Collaborative Care is more effective than care as usual (over 80 randomized controlled trials)**

- ☞ Gilbody S. et al. *Archives of Internal Medicine*; Dec 2006
- ☞ Thota AB, et al. Community Preventive Services Task Force. *Am J Prev Med*. May 2012;42(5):521-524.
- ☞ Archer J, et al. Cochrane Collaborative. Oct 17, 2012.: 79 RCTs with a total of 24,308 patients

**Collaborative Care also more cost-effective**

- ☞ Gilbody et al. *BJ Psychiatry* 2006; 189:297-308.
- ☞ Unutzer et al. *Am J Managed Care* 2008; 14:95-100.
- ☞ Glied S et al. *MCCR* 2010; 67:251-274.

# Challenge with Sustainability



- ❧ No payment reform as expected when IMPACT model was funded.
- ❧ Paraprofessionals cannot bill, even under the care management reimbursement at this time.
- ❧ Cost of program could even be lower with a trained community health worker program, in development now in partnership with MSU Bozeman at PHC.
- ❧ Reimbursable telephonic intervention with a licensed provider allows for the support of their position as well as the paraprofessional partner.

# Opportunities with Funding



- Track other relevant data such as utilization and health claims, not a part of the original program.

# Questions?



# CONTACT



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