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?

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

Reference: https://aims.uw.edu/collaborative-care/principles-collaborative-care

The Collaborative Care Model

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

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

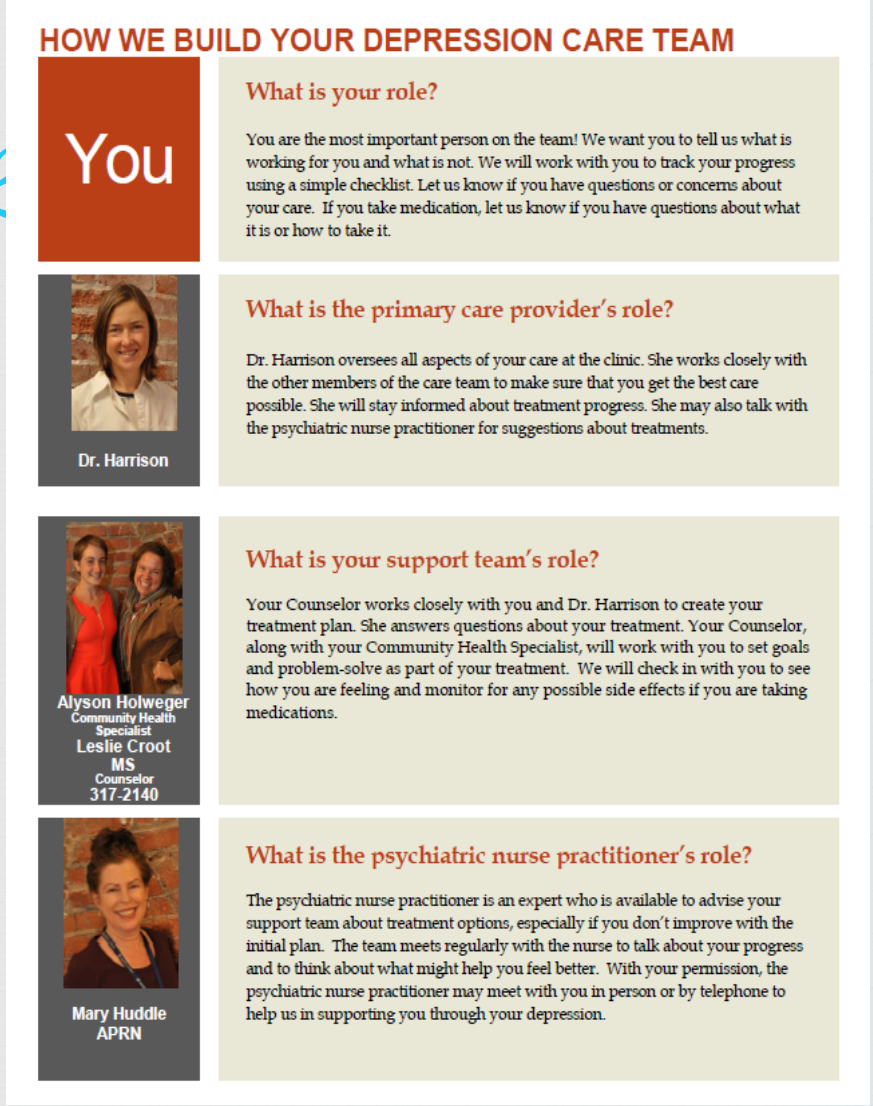
- Supports PCP and care manager in diagnosis, treatment plan, and treatment change recommendations

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



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	22	34	5	140 (99%)	0				

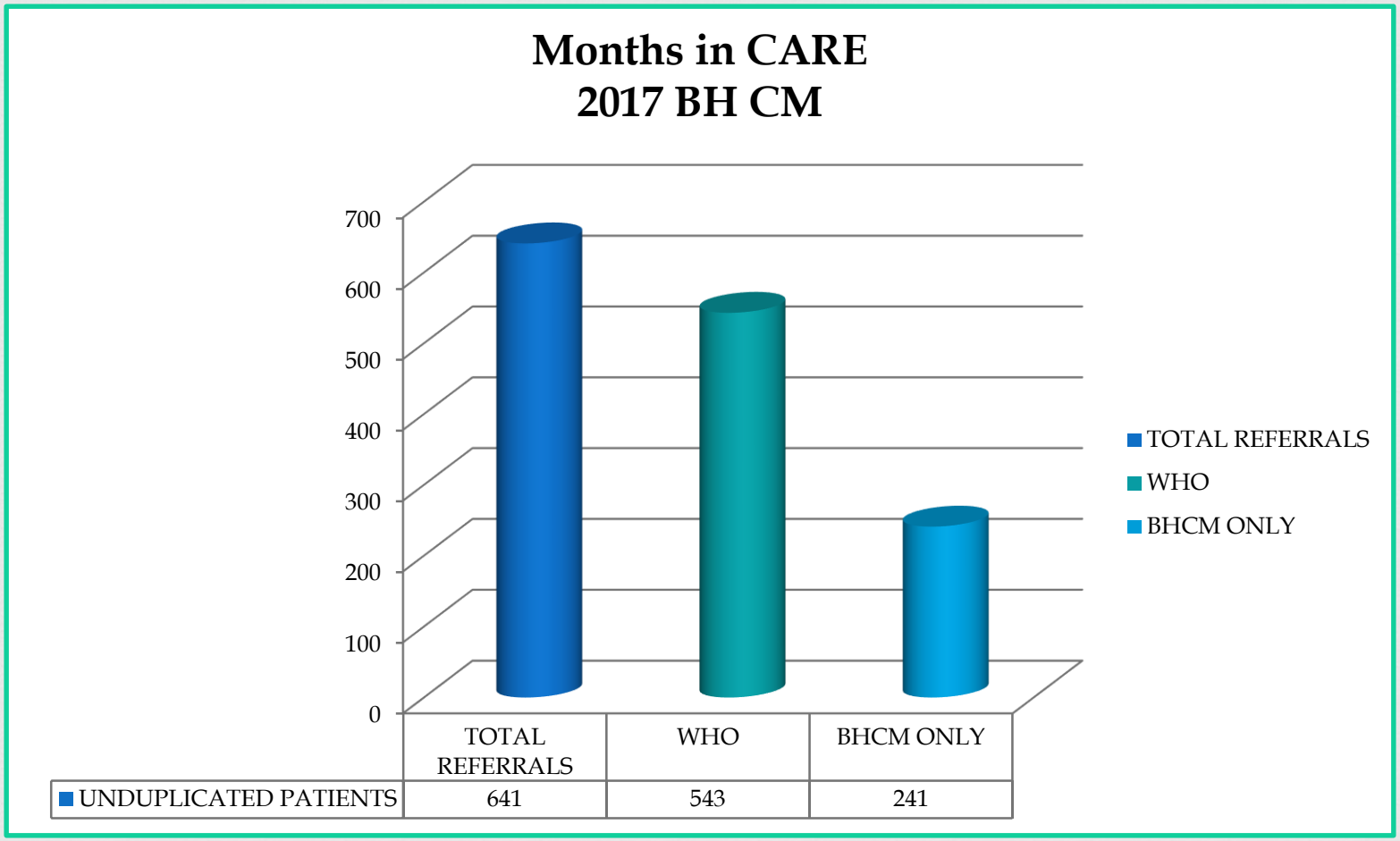
63% had improvement in PHQ-9 symptoms at 12 weeks.

PHC = Center line

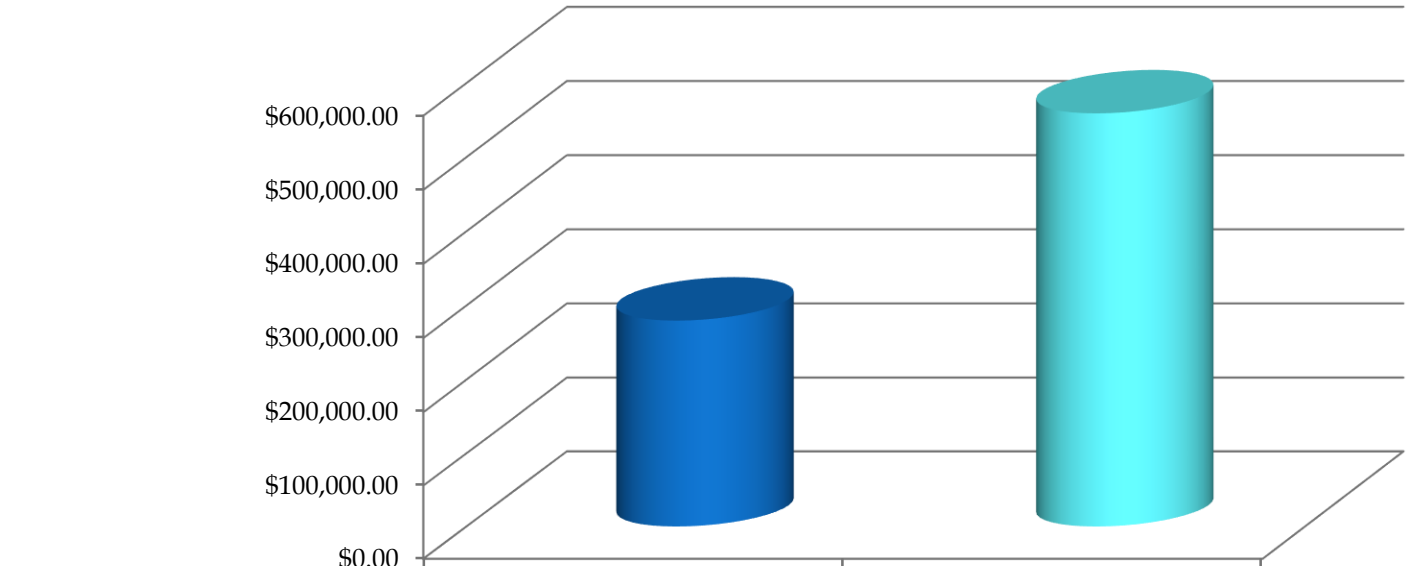
BHCM role after funded project

- 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.

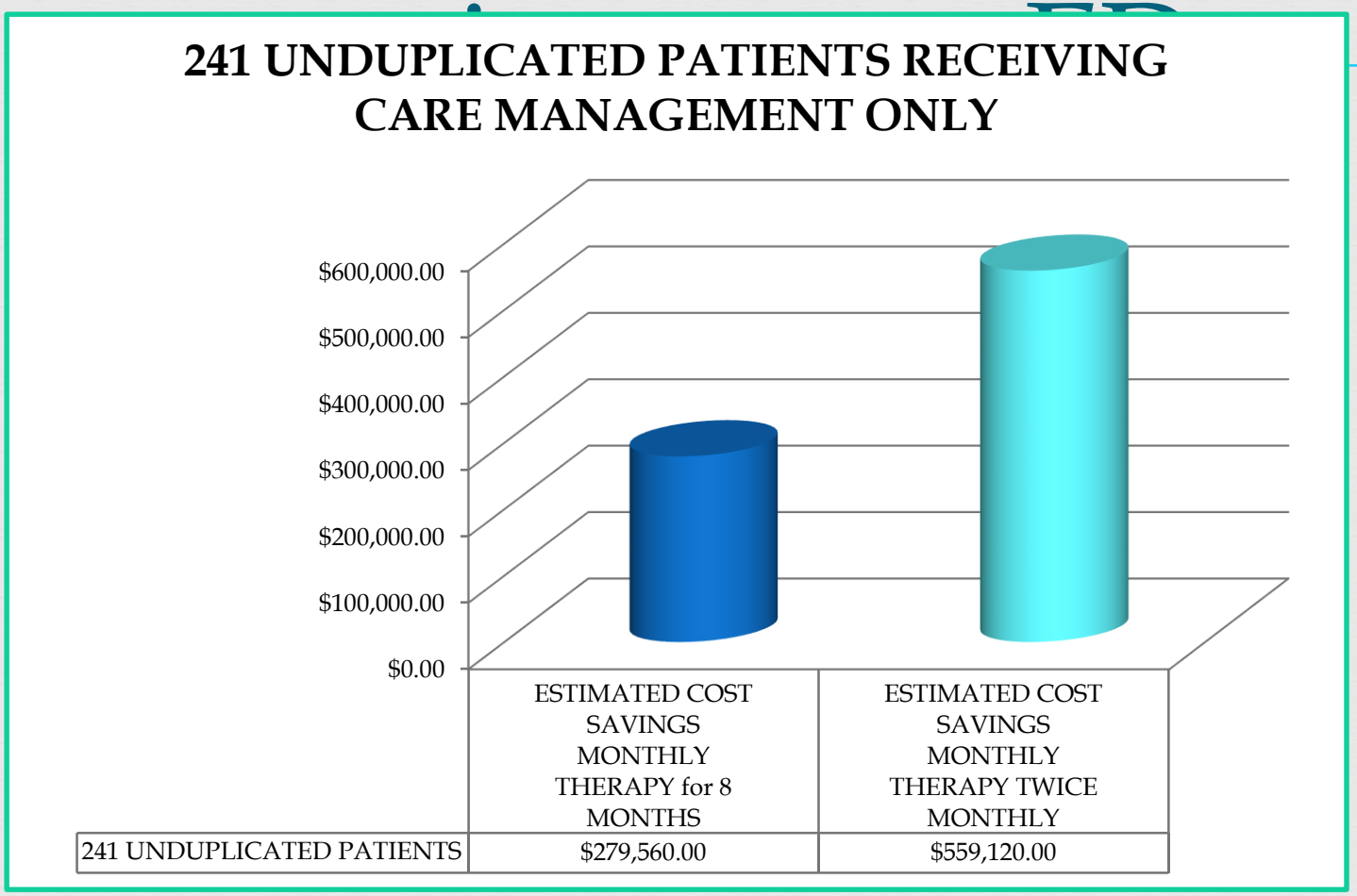
Year End Data 2017



Cost Savings if BHCM alone versus traditional therapy



Cost savings of WHO versus estimate of high



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. MCRR 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?

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