CHEAT SHEET

for Health Plans and Payers

Collaborative Care Model

Embedding a behavioral health provider in a PCP office

Published - March 2021 • 15-min read

Key takeaways

- Backed by a great deal of research, the collaborative care model (CoCM) is one of the best programs for integrating medical and mental healthcare.
- The CoCM embeds behavioral health providers in a PCP office to increase access.
- The model's focus on depression and anxiety helps quickly identify and treat the two most common mental health illnesses.
- The CoCM is designed to cut through the access and stigma barriers that prevent patients from accessing behavioral health care.

Table of contents

What is it?

Integrated behavioral health care combines physical and mental health care to collaboratively address issues identified during primary care visits. Primary care providers (PCPs) and behavioral health (BH) specialists work together to address mental health and behaviors that affect physical health.

The collaborative care model (CoCM) is a specific type of integrated care in which PCPs and embedded BH providers—in one office—treat common mental health conditions. The CoCM's guiding principles are:

- A focus on depression and anxiety, the most common BH conditions
- Universal screening for all patients
- An embedded BH care manager, ready for a warm handoff from the PCP
- Behavioral health care delivered inside the PCP office
- Consulting psychiatrist on standby to assist with referrals or treatment

The CoCM, which was first conceived 20 years ago, has evolved over time. Three variations on the CoCM that have become popular in practice are:

Telephone-based: Several programs use a BH professional to deliver care over the phone, rather than in person.

Illness-specific: Designed to target anxiety specifically, the Coordinated Anxiety Learning and Management (CALM) intervention builds on the CoCM by spending more time educating patients on the nature of their condition before diving into Cognitive Behavioral Therapy.

Screening-focused: Intermountain Healthcare's variant of the CoCM puts more emphasis on screening, using a questionnaire significantly more detailed than the GAD-7[1] or PHQ-9[2] to begin their integration workflow.

1. General Anxiety Disorder #7, a patient health questionnaire.
2. Patient Health Questionnaire #9, a patient health measure of depression.

Why does it matter?

Higher-quality care

Mental illnesses are some of the most common and destructive illnesses worldwide. While evidence-based practices for behavioral health care exist, most people in need don't receive effective care due to stigma, lack of access to mental health specialists, and patients prematurely halting treatment. The CoCM helps people get the coordinated care they need in a familiar setting.

Under the CoCM, a patient can walk into their PCP office for a sore throat, wellness check, or a therapy session with the BH care manager without any other patients knowing the purpose of the visit. Some patients may decline treatment when forced to visit a BH provider office for the first time due to the stigma of mental illness. While many patients may not have access to a behavioral health clinic or specialist, most people have access to a primary care provider, which, in a collaborative care setting, could expand access to mental health care. This integrated approach to mental health treatment makes it more accessible than traditional care protocols.

Currently, the behavioral health terrain is deeply fragmented. Without behavioral health integration, patients, PCPs, and BH providers are siloed, preventing them from coordinating care on key patient indicators such as treatment progress and medication adherence. With the CoCM, patients receive higher-quality care because it is coordinated between all the different treatment plans they may already be receiving.

WHY DOES IT MATTER? (CONT.)

Reduced costs

Costs spike when BH conditions are left untreated. There are estimates that unaddressed behavioral health issues cost almost $68 billion per year in the United States.

As the CoCM is a PCP-centric model, it allows for easier treatment of comorbidities. Sixty percent of patients with a behavioral health illness carry a comorbid chronic physical condition. The collaborative care model can treat multiple diagnoses at once.

86

Days to remission of depression under the collaborative care model compared to **614 days** under typical care

79

Studies associate the CoCM with significant improvements in depression and anxiety when compared to typical care

Source: Garrison GM, *et al.* "Time to Remission for Depression with Collaborative Care Management (CCM) in Primary Care" *Journal of American Board Family Medicine.* January 2016. Archer J, *et al.* Collaborative care for depression and anxiety problems." Cochrane Database of Systematic Reviews 2012, Issue 10, https://www.cochrane.org/CD006525/DEPRESSN_collaborative-care-for-people-with-depression-and-anxiety.

How does it work?

Secure initial investment to set up the model

The CoCM can take time and be costly to launch, given that it requires new staff members and office procedures. Often, providers rely on grants to fund the embedded BH care manager and maintenance costs. One survey found that 78% of integrated care clinics reported covering costs with grant funding. The Institute for Clinician and Economic Reform found that organizations would need to invest anywhere from $3 to $22 per member per month to implement and sustain the collaborative care model.

Health plans, however, will also need to ensure that this doesn't mean members have to pay this additional fee out of their own pockets. First-time patients in the CoCM could end up stuck with a copay from both their PCP and their BH provider. Health plans utilizing the CoCM should ensure that their claims process doesn't charge members for both copays. Plans often justify the additional up-front costs of implementing the CoCM by pointing to the litany of quantitative metrics the CoCM performs against, such as the PHQ-9.

Embed BH provider in PCP office

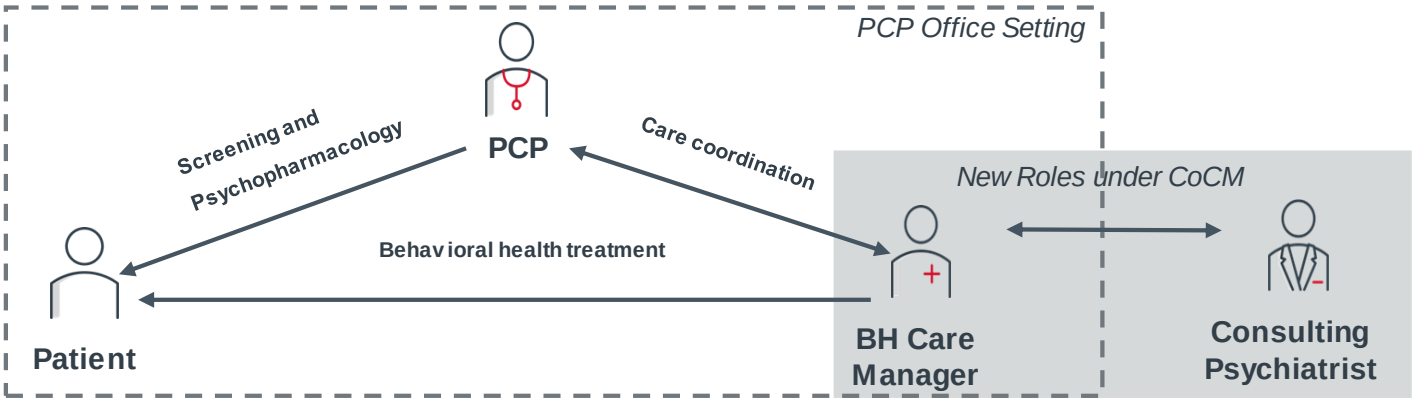
The BH care manager embedded in each PCP office could be a social worker, psychologist, master's level clinician, or other licensed behavioral health professional. If the behavioral health condition requires treatment, the mental health professional can deliver therapy in the PCP office for as long as necessary. Should the condition require medication, the patient's PCP can collaborate with the BH care manager and prescribe appropriately. This collaborative approach doesn't require a set number of staff in each office—only the introduction of a BH care manager, allowing the program to scale depending on the size of the office. The collaborative care model stands apart from other integration models for behavioral health care because of its potential to serve any community, regardless of size.

Source: "Enhancing patient outcomes and health system value through integration of behavioral health into primary care," ICER, June 2015, https://icer.org/wp-content/uploads/2020/10/BHI_Policy_Brief_060215.pdf; "The Colorado blueprint for promoting integrated care sustainability," Denver, CO: The Colorado Health Foundation, 2012.

HOW DOES IT WORK? (CONT.)

Some PCPs may support the implementation of a collaborative care model. But their staff may disapprove, disliking cooperation with "outsiders" who aren't fully fledged members of the practice. Health plans instituting the CoCM with provider partners need to keep company culture top-of-mind when hiring BH care managers, to ensure seamless integration.

The collaborative care model structure



Set up triage protocols for severe mental illness

The CoCM does not focus on treating high-acuity behavioral health conditions. The program can't use its signature in-office treatment protocols for complex issues like substance use disorders, OCD, PTSD, ADHD, and other similar conditions due to their treatment complexity. While the model isn't designed for high-acuity conditions, there are protocols in place to ensure even the most complex, chronic patients can receive care.

In the event of a seriously mentally ill patient, the behavioral health care manager can turn to a consulting psychiatrist who serves several BH care managers as shown in the graphic above. The psychiatrist can make a referral, take on the patient themselves, and/or prescribe medicine.

Source: "Enhancing patient outcomes and health system value through integration of behavioral health into primary care," ICER, June 2015, https://icer.org/wp-content/uploads/2020/10/BHI_Policy_Brief_060215.pdf

Conversations you should be having

01 Determine what models your provider partners currently have in place for behavioral health care integration.

02 Find out how well the current integration models are performing against your desired behavioral health metrics.

03 Decide if you should work with select provider partners to implement the collaborative care model.

04 Determine what supports your provider partners need from you to integrate behavioral health care.

These conversations might uncover the need to audit your current behavioral health integration efforts to ensure a comprehensive and scalable approach.

Related content

Advisory Board resources

TOOLKIT

Integrated Behavioral Health Implementation Toolkit

Read now

CASE STUDY

How Inland Empire Health Plan Trained PCPs in Behavioral Health

Read now

OUR TAKE

How Covid-19 Will Impact Behavioral Health Services

Read now

BLOG POST

How Montefiore, Intermountain, and Atrium Health use technology to increase behavioral health access

Read now

RESEARCH

Behavioral Health Access Playbook

Read now

CASE STUDY

How BCBS North Dakota Brought Behavioral Health to Rural Schools

Read now

Project director

Natalie Trebes

trebesn@advisory.com

Research team

Deep Deb

Daphney Gaston

Max Hakanson

Adam Jacobs

Sally Kim

Program leadership

Jared Landis

655 New York Avenue NW, Washington DC 20001
202-266-5600 | **advisory.com**