



Health Reform, Research Pave Way for Collaborative Care for Mental Illness

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WAYNE KATON, MD, PROFESSOR of psychiatry at the University of Washington in Seattle, has worked to develop and test models for integrating mental health care into primary care practice for the past 30 years. For much of that time, dissemination of the model moved slowly, but this process has been rapidly accelerated by health reform and growing recognition of the benefits of integrated care.

Katon discussed the future of the model with *JAMA*.

JAMA: Why is collaborative care getting so much attention right now?

Dr Katon: There are 2 main reasons: there has been a tremendous amount of research on integrated care, and more than half of care for depression and anxiety occurs in primary care. Extensive evidence from clinical trials shows that the collaborative care model can almost double the rates of exposure to evidence-based depression/anxiety treatments as well as markedly improve clinical outcomes for patients with depression and anxiety.

More recent evidence also suggests that many people with depression have comorbid medical illnesses. In a 2010 trial (Katon WJ et al. *N Engl J Med.* 2010;363[27]:2611-2620), we aimed to improve care for depression and poorly controlled diabetes and/or heart disease with a multicondition collaborative care model. It improved not only the patients' depression-related outcomes, but also improved blood glucose, systolic blood pressure, and LDL cholesterol and reduced overall medical costs.

Health care reform changes are also incentivizing this type of care. Health reform initiatives will bring primary care, hospitals, and other centers into accountable care models in order to improve continuity and quality of care and reduce costs.

We don't want psychiatrists to be left behind in the changes that are rapidly going on. Many psychiatrists are involved in efforts to integrate mental health services into primary care and medical spe-

medication changes. The care manager communicates the psychiatrist's recommendation to the primary physician.

There are 3 key concepts in collaborative care: population-based care, measurement-based care, and integration of psychiatry expertise into primary care. At every step, the care manager is monitoring the patient's response.

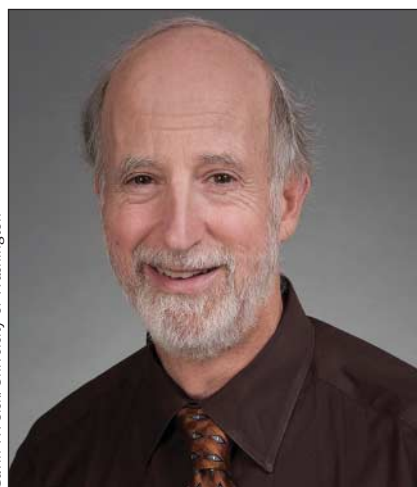
JAMA: Is this model widely used?

Dr Katon: We have contracts with multiple organizations to teach this model. Our clients are interested in changing because of the health payment incentives being set up as part of health care reform.

There are several examples of widespread dissemination of these models. In the state of Minnesota, all 6 insurers have agreed to pay for collaborative care. In our state, the collaborative care model has been disseminated to more than 140 primary care clinics. The Community Health Plan of Washington, which covers low-income individuals, has agreed to pay for a care manager and psychiatric supervision, and the University of Washington (UW) Advancing Integrated Mental Health Solutions (AIMS) Center has trained the collaborative care teams from these 140 clinics. The Veterans Health Administration has integrated this model of care. Kaiser has adopted this model. The Centers for Medicare & Medicaid Services is implementing the multicondition collaborative care model our team has developed [TEAMcare] in 8000 patients in 8 health care organizations [the COMPASS program]. Many other health care systems are also shifting to the collaborative care model.

JAMA: What kind of training do clinicians need to implement this model?

Dr Katon: It's a new role for psychiatrists because they are not directly seeing the patients. Most psychiatrists are



Psychiatrist Wayne Katon, MD, who has worked to develop and test models for integrating mental health care into primary care practice, said that health reform is helping to accelerate the dissemination of this approach.

cialty care as well as collaborative care and dissemination trials.

JAMA: What is collaborative care?

Dr Katon: It involves a care manager, who is a nurse or other collaborative care professional, who sees the patients and provides enhanced education and tracks their outcomes. The care manager uses a case registry to monitor all the patients being treated for mental illness in the practice. If a practice physician starts a patient on an antidepressant, the care manager monitors the patient's response. The care manager's job is to make sure patients don't fall through the cracks. The care manager receives weekly supervision from a psychiatrist, who, based on the patient's experience with the medication and initial clinical response, may recommend



used to working directly with the patient vs being responsible for a population of patients. It's a team approach. They must learn the concepts of measuring care outcomes and utilizing stepped-care approaches where increases in intensity of care are driven by outcomes. The American Psychiatric Association offered a course in collaborative care at its annual meeting. The Academy of Psychosomatic Medicine also has training in this model of care.

JAMA: What is the relationship between mental illness and physical illness?

Dr Katon: There is a bidirectional interaction between mental illness and physical illness. Depression often develops in a patient's 20s and leads to maladaptive behaviors such as smoking, poor diet, and obesity that contribute to poor health. Depression and other mental illnesses are associated with changes in the hypothalamic-pituitary-adrenal axis, which leads to higher cortisol and more centripetal [abdominal] obesity. Patients with anxiety or depression may have increased sympathetic nervous system responses, which may be a strain on the heart over time. Mental illness is also associated with greater inflammatory responses.

These health risk behaviors and psychophysiological changes may lead to the early development of health problems in individuals with mental illness. Having

depression, for example, increases risk of developing type 2 diabetes and heart disease at an earlier age. Psychiatric conditions are associated with poorer adherence to the lifestyle changes needed to manage many physical conditions.

Depression is also a risk factor for complications. If you have diabetes and depression, it raises your risk of death by 50% over the next 5 years. You can also imagine how health complications such as a heart attack or stroke may double back and worsen a patient's psychiatric condition.

JAMA: What are the advantages of integrating care for physical and mental conditions?

Dr Katon: We've shown that treating both types of conditions simultaneously leads not only to better control of depression, diabetes, and heart disease, but is also associated with health cost savings. Comorbid mental and physical illnesses are really expensive to the medical system. When you improve the quality of care, you can really save money for medical systems.

JAMA: What do primary care physicians think of the model?

Dr Katon: The incentives and disincentives of the health reform law are alerting people in primary care that they need to change: they need to improve the psychiatric care they provide. They have been frustrated by the current system in which they refer patients to psychia-

trists. Our study in Seattle found that only 50% of referred patients actually make a mental health visit and the mean number of visits is 2 (Grembowski D et al. *J Gen Intern Med.* 2002;17[4]:258-269). Most patients don't get evidence-based mental health care. Learning about the collaborative care model has been exciting for many of the primary care physicians I've worked with and improved their satisfaction with treating patients with depressive and anxiety disorders.

JAMA: Does substance abuse care fit into this model?

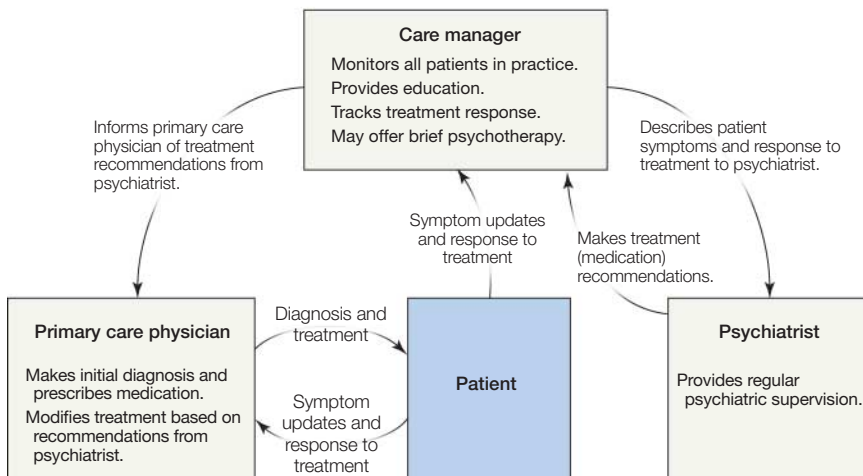
Dr Katon: After the University of Washington AIMS Center implemented collaborative care for depression in Washington in 140 primary care practices, the primary care physicians and care managers recognized a high rate of alcohol and substance abuse among their patients. They asked for more training in substance abuse treatment. There are interventions that have been developed to improve primary care for substance abuse, such as the Screening, Brief Intervention, and Referral to Treatment model. There are also medications physicians can learn to use. The UW AIMS center added training in these evidence-based treatments for substance abuse for the collaborative care teams. Many health care systems are training their physicians in the use of these approaches to substance abuse.

JAMA: How will health care reform affect collaborative care?

Dr Katon: Health reform has provided a tremendous stimulus for positive change in terms of integrating of mental health care into primary care. We've seen more interest in the last 5 years than the last 20. There are a number of dissemination centers around the country that are helping to train clinicians in this model.

There is also an overrepresentation of people with mental illness among the currently uninsured individuals who may gain access to insurance through health reform. That's another incentive to adopt collaborative care models to help provide mental health care more efficiently. Otherwise, this influx of patients will really stress the system. □

Collaborative care model for treatment of a population with mental illness



In the collaborative care model for mental illness, a care manager works with the primary care physician and a psychiatrist to optimize patient outcomes.