

Collaborative Care Outcomes Data

Considerations and Data Reporting – May 2022

Collaborative Care

Collaborative Care is an evidence-based model to identify and treat patients with depression and anxiety in health care settings. Since the introduction of Behavioral Health Integration billing codes in 2016, Collaborative Care has been rapidly adopted by health care settings nationally and on Medicaid fee schedules in almost half the states and nearly every commercial insurer in the country. As Collaborative Care adoption has expanded, the reporting of outcomes and the methods to obtain them have been as varied as the organizations reporting them.

As health care organizations adopt Collaborative Care, it has become critical to begin to standardize how both adoption and outcomes are reported. Concert Health, a leading behavioral health medical group, has been spearheading the development of rigor around Collaborative Care outcomes.

Measurement Based Care

A core component of Collaborative Care is “treat to target” and a desired reduction in symptoms for patients experiencing depression and/or anxiety. The Patient Health Questionnaire 9 (PHQ9) and the Generalized Anxiety Disorder 7 (GAD7) are the primary tools used to establish care, with a score of ten or greater suggesting the need for care and ultimate success defined by a sub-clinical score of less than five. A standard originated with some of the first Collaborative Care work, shortly after the IMPACT trial (Unutzer, Katon, Callahan, et al., 2002), establishing a benchmark of a 50% or 10 point reduction in scores in 90 days. Places like New York in the New York Collaborative Care Medicaid Program (CCMP) established a benchmark of 70 days, of which 47% have consistently met that over time. A recent publication by the AIMS center reported that a reduction in score of 5 points (Kroenke, Spitzer, Williams, et al., 2010) is significant. HRSA has implemented a measure for Federally Qualified and Rural Health Centers seeking a subclinical score at the end of twelve months (HRSA, 2021). Many organizations providing Collaborative Care have established independent reports which vary nationally. There is a need for a consistent set of standards both in outcomes and the process in which outcomes are calculated and reported.

Arriving at Outcomes

There are multiple ways in which outcome data is collected and reported:

- A reduced score at any point in treatment prior to 90 days, which may or may not be maintained, essentially any score lower than baseline collected at any point during treatment
- Achieving a 50% or 10 point reduction from a baseline score at any point during treatment, which may or may not be maintained and for which a time of treatment is not specified
- Achieving a 50% or 10 point reduction from baseline score using the last score prior to the end of treatment and for which a treatment time may or may not be specified; or
- Achieving sub-clinical scores at the end of treatment: a timeframe that may be consistent with UDS guidelines or may not be specified

In a review of varied reporting outcome measures and benchmarks, it appears there is a need to review outcomes at intervals during treatment as well as at the end of treatment, in addition to reporting scores at specified benchmarks.

Rigor in Outcome Reporting

A premise of Collaborative Care is that most patients will require changes in treatment over time, impacting scores positively or negatively throughout the course of treatment. As a result, it is helpful to consistently review progress during treatment to monitor outcomes and report progress. Given the generally 6-8 month duration of Collaborative Care reporting, outcomes at 90 days often limit some ability to report on patients who may require multiple treatment changes and/or be more complex with social determinants or comorbid medical conditions. Concert Health has adopted the reporting of patients at three intervals: 90 days, 120 days, and treatment end, with the continued optimal outcome of subclinical at treatment end.

Depression and anxiety have a natural “ebb and flow” reflected in scores across the span of care, so scores will naturally fluctuate during a treatment episode. Capturing and reporting a single decrease in a score or the lowest score during care is not significantly reflective of a treatment outcome as it may not have been maintained and in fact may have increased prior to a reporting interval. The reporting of scores at baseline and prior to benchmarks is a more rigorous and accurate way to report outcomes. Additionally, reporting at two intervals during treatment, 90 and 120 days, is more reflective of the work and outcomes occurring during the course of treatment and episode.

Concert Health Outcome Data

Data includes comparison of treatment outcomes of 12,877 patient episodes from 1/1/2021 through 3/28/2022, of which 6,554 had a primary diagnosis of anxiety and 5,563 had a primary diagnosis of depression. A review of patient outcomes indicates differences based on outcome measure:

Outcome Measure	% of Patients Meeting Outcome Measure
<u>Review of score at 90 days;</u> 50% or 10 point reduction at any point during treatment	52%
<u>Review of score prior to 90 days;</u> 50% or 10 point reduction	47%
<u>Review of score at 90 days;</u> 50% or 5 point reduction	48%
<u>Review of patients who achieved sub clinical by treatment end</u>	50%
<u>Review of patients 120 days at baseline, and the last score before 120 days</u>	49%
<u>Review of patients baseline and best score within 120 days</u>	52%

Including the last score prior to the benchmark (e.g. 90 days) clearly reduces the number of patients who met this measure, but is a more rigorous process and a more accurate outcome reporting.

The most rigorous review of outcomes would therefore include a review of measured outcomes at both the 90 and 120 day marks for a 50% or 10 point improvement during treatment using a baseline score and the score prior to the 90 and 120 days, respectively. The numerous outcome collection points take into consideration the “ebb and flow” of depression and anxiety. Ultimately, the optimal treatment outcome would be to achieve the end goal of sub-clinical, a score lower than 5.

While it is helpful to look at outcome measures through a variety of “lenses,” the ability to have consistency in reporting Collaborative Care outcomes will help to identify best practices. The ability to contribute best practices will expand overall learning and the adoption of Collaborative Care nationally. Consistency and rigor in outcomes will also “raise the bar” for Collaborative Care providers to provide outcomes that are consistent with the field and be compared with the Collaborative Care population as a whole.