

Collaborative Care

*A Model for Embedding
Counseling in Oncology and
Palliative Care*





In 2018, officials at Rochester Regional Health Lipson Cancer Institute became increasingly aware that its growing program did not have enough social work resources to meet patient needs. There were only 3 social workers across the 6 clinic locations. Although medical providers were able to meet patients' physical needs, the cancer care team recognized an existing gap in addressing care for the whole person. Given the impact a cancer diagnosis has on many aspects of an individual's life, addressing these concerns became a priority. As a result, Lipson Cancer Institute began to investigate opportunities to expand social work support at the cancer program. Among the options our team explored was the existing outpatient social work program at the larger Rochester Regional Health system and, more specifically, the collaborative care program embedded in the primary care and obstetrics and gynecology (OB-GYN) clinics. Our leadership team identified that this program had the potential to be a financially sustainable solution. Building a collaborative care program in oncology would provide the financial infrastructure to allow the cancer program to expand its services and address many of the behavioral health needs of our patients.

The Need for Integrated Behavioral Health

Following a cancer diagnosis, patients are more vulnerable to mood disorders including depression, anxiety, and posttraumatic stress disorder. Additionally, patients struggle with grief on the impact that the disease has on their lives. Further, the uncertainty that accompanies a new cancer diagnosis could exacerbate underlying mental health conditions or potentially create new concerns. Research tells us that depression is one of the leading causes of disability and, in conjunction with cancer or other chronic diseases, is associated with reduced quality of life for patients as well as an increase in health care costs.¹ Among patients with cancer, clinical depression impacts around 10% of individuals and the prevalence of anxiety at a clinically significant level is around 13%.² In addition, patients diagnosed with a rare cancer experience higher levels of anxiety when compared to patients with more common cancer diagnoses.³ Furthermore, anxiety is associated with poor adherence to cancer treatments, a decrease in the ability to complete activities of daily living, and an increase in pain and fatigue.⁴ These data demonstrate a clear need for behavioral health care for individuals with cancer.

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A simple solution may seem to be to refer patients to an outpatient mental health provider, therapist, or support group. Unfortunately, this option is often not viable. We know that 30% to 50% of patients referred to outpatient mental health treatment never reach an intake appointment with a behavioral health provider.⁵ Barriers to engaging with behavioral health may include patient difficulties accessing the support, insurance coverage, stigma, and mental health provider shortages. Understanding this, Lipson Cancer Institute decided to establish a collaborative care program (based on the outpatient social work model discussed above) where support would be incorporated within the cancer program.

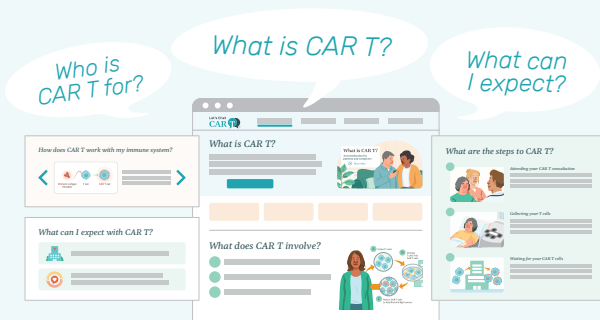
Why Collaborative Care?

Collaborative Care is a model for providing behavioral health care that was developed at the Advancing Integrated Mental Health Solutions (AIMS) Center at the University of Washington to address common mental health conditions in a medical setting. The name, Collaborative Care, is more than just a term for working together in an interdisciplinary model. This model of care embeds mental health treatment within the primary care physician's clinic and focuses on behavioral health conditions such as depression, anxiety, and post-traumatic stress disorder; collaborative care combines the knowledge and experience of several different disciplines to help individual patients move forward with their lives. It creates a team for the patient and their provider by pairing them with a therapist or social worker, oncologist, and psychiatric consultant. As Rochester Regional Health

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was already successfully using Collaborative care in the primary care and OB-GYN setting, Lipson Cancer Institute was able to easily adapt this model. The model creates a bridge that addresses gaps in care for patients without the need to refer outside the cancer program.

The Model

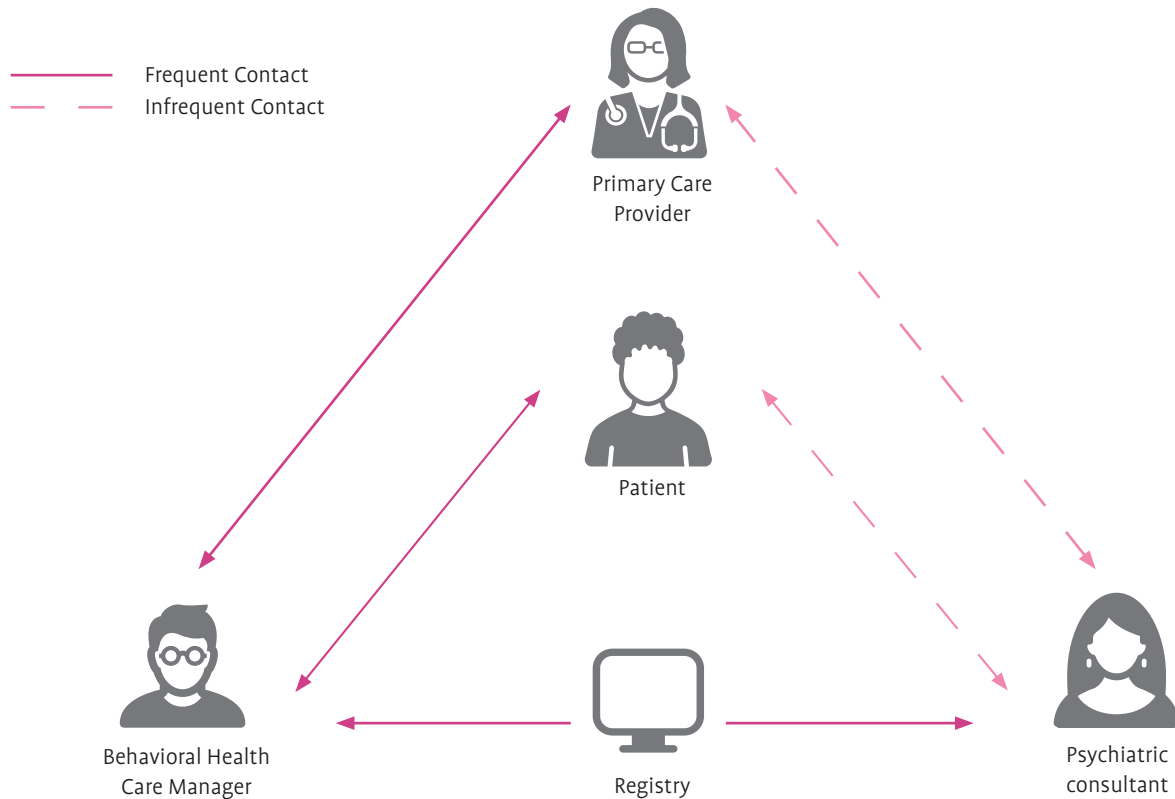
Collaborative Care includes 5 components: a patient-centered care team, population-based care, measurement-based treatment to target, evidence-based care, and accountable care. At enrollment, the care team works in partnership with the patient to develop a plan of care. Secondly, the care team tracks patients to ensure no individual falls through a gap and that treatment needs are uniquely tailored. Patient treatment and clinical outcomes are measured through validated tools such as the [Patient Health Questionnaire \(PHQ-9\)](#) and the [General Anxiety Disorder-7 \(GAD-7\)](#). Each patient is provided care through a model of treatment that is backed with researched evidence of success for their mental health diagnosis. These may include problem-solving treatment, behavioral activation, motivational interviewing, cognitive behavioral therapy, and/or medication management. Providers are accountable for their care and reimbursed on clinical outcomes not just volume of care.

The efficacy of the Collaborative Care model for behavioral health care has been established in over 90 randomized controlled trials.⁵⁻⁷ Results of a clinical trial of patients with comorbid depression and cancer showed that treatment with Collaborative Care was associated with statistically significant better depression outcomes.⁴ This study found that over 60% of people showed improvement when enrolled in the Collaborative Care model, compared with 17% of people enrolled in traditional behavioral health models.

Collaborative Care at Lipson Cancer Institute

For Lipson Cancer Institute providers, an embedded mental health program gives a clear, linear referral path. Providers know that once a referral is made, a social worker will reach out to the patient and talk about treatment options. Most patients are contacted within a few days of referral if not the same day. Our referral data shows that 8 in 10 patients who are referred to Collaborative Care are scheduling an intake appointment, and around half are choosing to enroll in the program once that intake is completed. Additionally, patients typically can schedule an intake within 1–2 weeks from their initial referral. Individuals who do not enroll may not qualify either due to a low clinical indication for behavioral health support or a need for a higher level of care than this model supports. In either

Figure 1. The Relationship Between the Patient and Their Care Team Under the Collaborative Care Model



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case, the social work team works to connect patients to services they need. Patients who may need a higher level of care include individuals who are actively suicidal or have diagnoses such as schizophrenia or bipolar disorder. In these cases, therapists provide bridge counseling to ensure patients are connected with the appropriate level of support and often meet with patients until they have completed an intake appointment with the requisite service. This support can be particularly helpful when community mental health clinics have long wait lists for intake appointments. Therapists also provide information on community resources, such as support groups, to individuals who may need additional support but do not meet clinical criteria for enrollment.

Treatment is individualized to each patient, allowing for flexibility based on each patient's situation. Once referred to the Collaborative Care program, patients can choose to enroll for talk therapy, brief check-ins, or medication management. These options are addressed over the first few intake appointments while treatment plans are being developed. Patients also have the option to receive support through a variety of modalities including in-person or virtually through telehealth and video visits. Lipson Cancer Institute patients report deep appreciation for this flexibility. At enrollment, this convenience removes the barrier of finding services and waiting for referrals while providing faster access to care. Further, the model provides continuity of care to patients while undergoing treatments. For example, patients may choose to switch an appointment from in-person to telehealth while they are recovering from surgery, chemotherapy, or other procedures. Once established in care, patients work with their therapist to create a schedule that best fits their needs.

After enrollment, all patients are reviewed by the program's psychiatric consultant. The consultant is available to anyone on the patient's care team, including oncologists, to provide recommendations regarding psychotropic medications as needed. The treatment team works to clarify goals and verify that enrolled patients are moving in the right direction. As patients reach their behavioral health goals, the therapist continues to strategize with patients to prevent a relapse in symptoms and plan for discharge from the program. Figure 1 illustrates the relationship between the patient and their care team under the Collaborative Care model.

Collaborative Care Is Fiscally Sustainable

As Lipson Cancer Institute began investigating solutions for closing the identified gap in care, our team was also looking for a financially sustainable solution. Our implementation team worked with the Rochester Regional Hospital's Outpatient Social Work Department to learn more about the Collaborative Care program that had been successfully implemented in the primary care and OB-GYN clinics. Since Collaborative Care is a billable model of service, we were able to develop a business plan that included additional staff to provide therapy services, expert training for the staff, and management support for program development. Lipson Cancer Institute administration worked closely to train a new supervisor in the Collaborative Care program, build the technical infrastructure that was needed for documentation and billing, and educate providers about this new service for patients that would be submitted to insurance under their

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credentials. The revenue stream provided by implementing this model makes the program sustainable after the initial ramp up period required to reach consistent patient volumes. Rochester Regional Hospital's Collaborative Care program has an average reimbursement rate of approximately \$111 per member per month. In addition to the direct revenue generated by the program, studies around Collaborative Care have shown positive economic outcomes regarding averted health care and productivity loss as well as reduced health care utilization.¹⁰ One study found that individuals participating in Collaborative Care had 114 additional depression free days compared to traditional treatment, as well as a savings of \$594 in outpatient health care costs.¹¹

The national recommendation from the AIMS Center is to carry a caseload of between 60 to 100 patients in a standard Collaborative Care program. Lipson Cancer Institute chose to create a program with a more therapeutic emphasis due to the nature of our population and the availability of alternative mental health supports in our community and, as such, set a caseload expectation at 70 patients. This caseload gives therapists the availability to provide specialized care to our patients with cancer while participating in weekly supervision, weekly consultation meetings, and frequent specialized training to stay abreast of both mental health training and oncology-related training.

Lessons Learned

The creation of the Collaborative Care program at Lipson Cancer Institute has addressed some of the identified needs of our program and we have learned lessons along the way. These include the following:

- It is vital to have physician supporters to champion the Collaborative Care program when starting up.
- Ongoing education for the whole treatment team is necessary when launching—both for educational purposes and for program visibility.
- Standing education about Collaborative Care for new team members plays a role in the program's ongoing success.
- Collaborative Care meets many of the needs of our patients, however, we need additional treatment options for patients who do not qualify for Collaborative Care or who have reached the maximum that insurance will allow.

Implementing a Collaborative Care program at Lipson Cancer Institute has bridged a gap in care that our team identified in 2018. We are hopeful that we will continue to innovate to address our patients' needs in the future. 

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References

1. Moussavi S, Chatterji S, Verdes E, Tandon A, Patel V, Ustun B. Depression, chronic diseases, and decrements in health: results from the World Health Surveys. *Lancet*. 2007;370(9590):851-858. doi:10.1016/S0140-6736(07)61415-9
2. Sakamoto R, Koyama A. Effective therapy against severe anxiety caused by cancer: a case report and review of the literature. *Cureus*. 2020;12(6):e8414. doi:10.7759/cureus.8414
3. Bergerot CD, Bergerot PG, Philip EJ, et al. Assessment of distress and quality of life in rare cancers. *Psychooncology*. 2018;27(12):2740-2746. doi:10.1002/pon.4873
4. Sharpe M, Walker J, Holm Hansen C, et al. Integrated collaborative care for comorbid major depression in patients with cancer (SMaRT Oncology-2): a multicentre randomised controlled effectiveness trial. *Lancet*. 2014;384(9948):1099-1108. doi:10.1016/S0140-6736(14)61231-9
5. Fisher L, Ransom DC. Developing a strategy for managing behavioral health care within the context of primary care. *Arch Fam Med*. 1997;6(4):324-333. doi:10.1001/archfami.6.4.324
6. Archer J, Bower P, Gilbody S, et al. Collaborative care for depression and anxiety problems. *Cochrane Database Syst Rev*. 2012;10:CD006525. doi:10.1002/14651858.CD006525.pub2 https://www.cochrane.org/CD006525/DEPRESSN_collaborative-care-for-people-with-depression-and-anxiety
7. Gilbody S, Bower P, Fletcher J, Richards D, Sutton AJ. Collaborative care for depression: a cumulative meta-analysis and review of longer-term outcomes. *Arch Intern Med*. 2006;166(21):2314-2321. doi:10.1001/archinte.166.21.2314
8. Panagioti M, Bower P, Kontopantelis E, et al. Association between chronic physical conditions and the effectiveness of collaborative care for depression: an individual participant data meta-analysis. *JAMA Psychiatry*. 2016;73(9):978-989. doi:10.1001/jamapsychiatry.2016.1794
9. Carlo AD, Drake L, Ratzliff ADH, et al. Sustaining the collaborative care model (CoCM): billing newly available CoCM CPT codes in an academic primary care system. *Psychiatr Serv*. 2020;71(9):972-974. doi:10.1176/appi.ps.201900581
10. Jacob V, Chattopadhyay SK, Sipe TA, et al. Economics of collaborative care for management of depressive disorders: a community guide systematic review. *Am J Prev Med*. 2012;42(5):539-549. doi:10.1016/j.amepre.2012.01.011
11. Katon W, Russo J, Lin EHB, et al. Cost-effectiveness of a multicondition collaborative care intervention: a randomized controlled trial. *Arch Gen Psychiatry*. 2012;69(5):506-514. doi: 0.1001/archgenpsychiatry.2011.1548