BH2I Behavioral Health Integration Initiative

Making the Business Case for a Collaborative Care Model for Managing Depressive Disorders

This paper is based upon the article: Economics of Collaborative Care for Management of Depressive Disorders[1]

Major depressive disorders are often underdiagnosed and undertreated. The introduction of the Collaborative Care model has been found to improve the quality of depression management in primary care clinic settings. For primary care clinics adopting a Collaborative Care model, the increase in quality has come with a price - higher costs of treatment for depression compared with the usual care of treatment for depression. However, Chattopadhyay, Sipe, et. al. argues that "collaborative care management for depressive disorders [still] provides good economic value."

Given that the cost of treatment for depression using a Collaborative Care model is higher, the authors were interested in exploring possible "cost offsets" from reduced overall health care utilization through collaborative care. It is well documented that people who have health condition(s) and depression use health care resources at a higher rate than patients with similar health conditions who do not have depression.

Key findings regarding "cost offsets" include:

1. In a study[2] a of health care costs between a primary care clinic where collaborative care was implemented as a pilot for depression treatment, and six (6) primary care clinics providing usual treatment for depression, in the study's post intervention period, the cost of claims per clients were lower in the primary care clinic where collaborative care was implemented - a difference of approximately $64 to $127 per patient.

2. In another study , five (5) clinics practicing collaborative care were compared with eight (8) demographically similar clinics practicing usual care for depression. Though total claims in the post intervention period increased for both clinic groups, the increase for the collaborative care clinics was lower compared with clinics practicing usual care; $722 per patient to $1,180 per patient. Additionally, patients from clinics practicing collaborative care were "54% less likely to use the emergency department and 49% less likely to use inpatient psychiatric care" compared with patients from clinics practicing usual care.

3. In the last study referenced in this paper, the impact of a collaborative care approach for patients with diabetes screening positive for depression in a clinic setting where collaborative care was practiced, and patients with diabetes screening positive for depression in clinics practicing usual care were compared. At the study's one-year follow-up, clinics utilizing a collaborative care approach incurred $889 per person more in outpatient depression care compared with the usual care clinics, and $254 less in outpatient non-depression care compared with usual care clinics. By two-years post study period, however, the cost for clinics with a collaborative care approached incurred only $127 per person more in outpatient depression care compared with the usual care clinics and $1,778 less in outpatient non-depression care compared with usual care clinics.

Though other studies have found that some models of collaborative care have minimal or no increased economic benefits, i.e., little or no "cost offsets", the authors argue that their metanalysis suggests that collaborative care has "good economic value."

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[1] Jacob V, Chattopadhyay SK, Sipe TA, Thota AB, Byard GJ, Chapman DP; Community Preventive Services Task Force. Economics of collaborative care for management of depressive disorders: a community guide systematic review. Am J Prev Med. 2012 May;42(5):539-49. doi: 10.1016/j.amepre.2012.01.011. PMID: 22516496.

[2] Reiss-Brennan B. Can mental health integration in a primary care setting improve quality and lower costs? A case study. J Manag Care Pharm 2006;12(2S):14 –20.

[3] Reiss-Brennan B, Briot PC, Savitz LA, Cannon W, Staheli R. Cost and quality impact of Intermountain's mental health integration program. J Health Manag 2009;55(2):97–113.

[4] Simon GE, Katon WJ, Lin EHB, et al. Cost-effectiveness of systematic depression treatment among people with diabetes mellitus. Arch Gen Psychiatry 2007;64(1):65–72.