NewYork-Presbyterian

Columbia University Irving Medical Center

Collaborative Care FAQs

1. **Q:** ***What is Collaborative Care?***
   A: Collaborative Care is an evidence-based model for treating mild to moderate depression in the medical setting.

2. **Q:** ***What are the roles of the PCP, depression care manager (DCM), and psychiatrist in Collaborative Care?***
   A: The PCP identifies a patient in need of Collaborative Care, prescribes the anti-depressant medication and maintains contact with the DCM. The PCP refers to the DCM and **NOT** to the psychiatrist for Collaborative Care.
   A: The DCM provides the patient with short-term evidence-based cognitive-behavioral therapy, monitors patients' PHQ9 scores using a registry, and serves as a link between the PCP and psychiatrist consultant.
   A: The psychiatrist plays a consultant role, discussing complex cases with the DCM and anti-depressant medication recommendations to the PCP through the DCM or directly. The psychiatrist does not typically treat Collaborative Care patients directly.

3. **Q*: Can we enroll patients who have not completed or refuse to complete a PHQ9 screen or patients that have been assessed with another form of depression tool?***
   A: No. Collaborative Care requires that patients are screened with a PHQ9 screen to be enrolled in the program.

4. **Q*: Are patients with anxiety disorders appropriate for referral to Collaborative Care?***
   A: A patient with co-morbid anxiety and depression is appropriate to be seen in Collaborative Care, but a patient with only anxiety cannot be seen at this time. A PHQ9 will still need to be done with the same depression eligibility cut-off $\geq$ 10. While Collaborative Care is effective for patients with anxiety disorders, billing and capacity issues prevent our DCMs from seeing patients who do not have depression diagnoses and eligible PHQ9 scores.

5. **Q*: Can patients with serious mental illness (i.e., Schizophrenia, Bipolar) be managed in Collaborative Care?***
   A: Patients with serious mental illness require a higher level of care than Collaborative Care provides. Patients with known Psychotic Disorders and Bipolar Disorder who need ongoing outpatient care should instead be referred to the clinic social worker for triage and linkage with appropriate care.

6. **Q:** ***Can DCMs work with patients who are substance-abusing or substance dependent?***
   A: Collaborative Care requires patients to engage in evidence-based talk therapy. These therapies are not proven effective with individuals abusing or dependent upon alcohol or other substances. This population requires referral to the clinic social worker for triage and linkage with appropriate care.

7. **Q:** ***What should I do if I have questions related to patients enrolled in Collaborative Care?***
   A: Providers are encouraged to engage the onsite Depression Care Manager and/or consulting psychiatrist with any questions you have regarding shared patients enrolled in Collaborative Care.

8. **Q:** ***When should I refer to the onsite psychiatrist in the clinic?***
   A: Providers could refer to the onsite psychiatrist through the Onsite Mental Health Service Order when they are:
   a. Treating a patient for behavioral health and want a psychopharmacology or diagnostic consultation and receive the patient back into their care
   b. Having questions about the Psychiatric Diagnosis of the patient to better determine the appropriate treatment plan and recommendations

(NOTE THAT THE TWO REFERRALS IN QUESTION 8 ARE NOT FOR COLLABORATIVE CARE; REFERRALS TO COLLABORATIVE CARE ARE MADE DIRECTLY TO THE DCM)