APPLYING THE INTEGRATED CARE APPROACH:

PRACTICAL SKILLS FOR THE PSYCHIATRIC CONSULTANT

WORKSHOP: ASSESSMENT AND TREATMENT IN COLLABORATIVE CARE
FUNDING ACKNOWLEDGEMENT

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ASSESSMENT AS PART OF A COLLABORATIVE CARE TEAM
WHAT DOES A BEHAVIORAL HEALTH PATIENT LOOK LIKE IN A PRIMARY CARE SETTING?

- 67yo man recently widowed
- 43yo woman drinks “a couple of glasses” of wine daily
- 19yo man “horrible stomach pain” when starts college
- 32yo woman “can’t get up for work”
BEHAVIORAL HEALTH PATIENTS IN A PRIMARY CARE SETTING

**Distress**
- 67yo man recently widowed

**Substance Use Disorder**
- 43yo woman drinks “a couple of glasses” of wine daily

**Social Anxiety Disorder**
- 19yo man “horrible stomach pain” when starts college

**Major Depressive Disorder**
- 32yo woman “can’t get up for work”
COMMON BEHAVIORAL HEALTH PRESENTATIONS

Common outpatient psychiatry presentations

- Mood disorders
- Anxiety disorders
- Substance use disorders
- Psychotic disorders
- Cognitive disorders

Common primary care presentations

- Depression
- Anxiety
- Unexplained physical symptoms
- Somatic presentations & somatoform disorders
- Acute and chronic distress
- Adjustment disorders
- Pain
CASELOAD CONSULTANT

- Review cases with the care manager using the registry
  - Scheduled (ideally weekly)
  - Prioritize patients that are not improving
- Consult urgently (as needed)
COMMON CONSULTATION QUESTIONS

- Clarifying diagnosis
- Addressing treatment resistant disorders
- Making recommendations for managing difficult patients
A DIFFERENT KIND OF ASSESSMENT:
CARE SHAPED OVER TIME

Traditional Consult

One Session = One Assessment

Collaborative Care Case Review

Review 1 in Jan: Acute Distress?

Pt still has high PHQ & impairment

Review 2 in Mar: MDD and initiate treatment
IDENTIFY & ENGAGE

Identify & Engage

Establish a Diagnosis

Initiate Treatment

Follow-up Care & Treat to Target

Complete Treatment & Relapse Prevention

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A DIFFERENT KIND OF ASSESSMENT: USING BEHAVIORAL HEALTH MEASURES

**Mood Disorders**
- PHQ-2, PHQ-9: Depression
- MDQ: Bipolar disorder
- CIDI 3.0: Bipolar disorder

**Anxiety and Trauma Disorders**
- GAD-7: Anxiety
- PCL-C: PTSD

**Substance Use Disorders**
- CAGE-AID
- AUDIT

**Cognitive Disorders**
- Mini-Cog
- Montreal Cognitive Assessment
Behavioral health measures are like monitoring blood pressure!

— Identifies that there is a problem
— Needs further assessment to understand the cause of the “abnormality”
— Helps with ongoing monitoring to measure response to treatment
**PHQ-2**

<table>
<thead>
<tr>
<th>Over the last 2 weeks, how many days have you been bothered by any of the following problems?</th>
<th>Not at All</th>
<th>Several Days</th>
<th>More than Half the Days</th>
<th>Nearly Every Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

- Ultra brief screening
- Commonly used in primary care
- Scoring:
  - 0-2: Negative
  - 3 or Higher: Positive and patient needs further assessment
### PHQ-9

**Over the last 2 weeks, how many days have you been bothered by any of the following problems?**

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at All</th>
<th>Several Days</th>
<th>More than Half the Days</th>
<th>Nearly Every Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling asleep, staying asleep or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

<table>
<thead>
<tr>
<th>Difficulty Level</th>
<th>Not difficult at all</th>
<th>Somewhat difficult</th>
<th>Very Difficult</th>
<th>Extremely difficult</th>
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</table>
### UNDERSTANDING THE PHQ-9 SCORE

<table>
<thead>
<tr>
<th>Score</th>
<th>Severity</th>
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<tbody>
<tr>
<td>0 – 4</td>
<td>No Depression</td>
</tr>
<tr>
<td>5 – 9</td>
<td>Mild Depression</td>
</tr>
<tr>
<td>10 – 14</td>
<td>Moderate Depression</td>
</tr>
<tr>
<td>≥ 15</td>
<td>Severe Depression</td>
</tr>
</tbody>
</table>

**Are there safety concerns?**
If Question 9 is a score > 0, needs to be assessed for safety

**Is it depression?**
MDD: needs to have either Question 1 or Question 2 with a score of >2
WHO SHOULD GET SCREENED?

<table>
<thead>
<tr>
<th>Population</th>
<th>Recommendation</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>General adult population, including pregnant and postpartum women</td>
<td>The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.</td>
<td>The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.</td>
</tr>
</tbody>
</table>

ESTABLISH A DIAGNOSIS

- Identify & Engage
- Establish a Diagnosis
- Initiate Treatment
- Follow-up Care & Treat to Target
- Complete Treatment & Relapse Prevention

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INDIRECT ASSESSMENT AND DIAGNOSIS

Functioning as a “back seat driver”
• Develop an understanding of the relative strengths and limitations of the providers on your team
• Rely on other providers (PCP and BHP/care manager) to gather history

How do you “steer”?
• Structure your information gathering
• Include assessment of functional impairment
• Pay attention to mental status exam
• Help team improve differential diagnosis skills
BHP/care manager is asked to briefly report on:

- Depressive symptoms
- Bipolar Screen
- Anxiety symptoms
- Psychotic symptoms
- Substance use
- Other (Cognitive, Eating Disorder, Personality traits)
- Past Treatment
- Safety/Suicidality
- Psychosocial factors
- Medical Problems
- Current medications
- Functional Impairments
- Goals
BASIC DIFFERENTIAL DIAGNOSIS

Mood
• Depression
• Mania/Hypomania

Anxiety and Trauma Disorders
• Generalized anxiety
• Panic attacks
• PTSD
• OCD

Psychosis
• Primary
• Secondary

Substance Use
• Alcohol
• Illicit
• Prescription

Organic
• Cognitive function
• Relevant medical history
PROVISIONAL DIAGNOSIS

Screeners filled out by patient

Assessment by BHP/care manager and PCP

Psychiatric consultant case review (or direct evaluation)

Provisional diagnosis
ASSESSMENT AND DIAGNOSIS IN THE PRIMARY CARE CLINIC

- Diagnosis can require multiple iterations of assessment and intervention
- Advantage of population-based care is longitudinal observation and objective data
- Start with diagnosis that is your ‘best understanding’ and can adjust over time

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TOLERATING UNCERTAINTY

- Tension between complete and sufficient information to make a recommendation
- Often use risk benefit analysis of the intervention you are proposing
PSYCHIATRIC CONSULTANT ROLE: DIRECT CONSULTANT

- Different than seeing patients in traditional consultation
- Approximately 5 – 7% of patients may need direct consultation

Patients pre-screened from care manager population

- Already familiar with patient history and symptoms
- Typically more focused assessment, tele-video OK

Common indications for direct assessment

- Diagnostic dilemmas
- Treatment resistance
- Education about diagnosis or medications
- Complex patients, such as pregnant or medically complicated
The first part of the CIDI-3 consists of asking two stem questions. If either Question 1 or Question 2 is positive, continue with the criterion B Screening Question. If both are negative, than the measure is negative and the patient does not likely meet the criteria for bipolar disorder:

**Euphoria Stem Question:**
1. Some people have periods lasting several days when they feel much more excited and full of energy than usual. Their minds go too fast. They talk a lot. They are very restless or unable to sit still and they sometimes do things that are unusual for them, such as driving too fast or spending too much money. Have you ever had a period like this lasting several days or longer?

   *If this question is endorsed, the next question (Irritability Stem Question) is skipped and the respondent goes directly to the Criterion B screening question.*

**Irritability Stem Question:**
2. Have you ever had a period lasting several days or longer when most of the time you were so irritable and grouchy you either started arguments, shouted at people or hit people?

**Criterion B Screening Question**
3. People who have episodes like this often have changes in their thinking and behavioral at the same time, like being more talkative, needing very little sleep, being very restless, going on spending sprees, and behaving in many ways they would normally think inappropriate ways they would normally think inappropriate. Did you ever have any of these changes during your episodes of being excited and full of energy or very irritable or grouchy?
Think of an episode when you had the largest number of changes like these at the same time. During that episode, which of the following changes did you experience?

1. Were so irritable that you either started arguments, shouted at people or hit people?
2. Did you become so restless or fidgety that you paced up and down or couldn’t stand still?
3. Did you do anything else that wasn’t usual for you – like talking about things you would normally keep private, or acting in ways that you would usually find embarrassing?
4. Did you try to do things that were impossible to do, like taking on large amounts of work?
5. Did you constantly keep changing your plans or activities?
6. Did you find it hard to keep your mind on what you were doing?
7. Did your thoughts seem to jump from one thing to another or race through your head so fast you couldn’t keep track of them?
8. Did you sleep far less than usual and still not get tired or sleepy?
9. Did you spend so much more money than usual that it caused you to have financial trouble?
EXERCISE 2: PRACTICE COLLABORATIVE CARE CASE REVIEWS

- Find a partner
- Take turns playing the psychiatric consultant for one case
- Use NicelyDONE

Workbook pages 6-9
TREATMENT AS PART OF A COLLABORATIVE CARE TEAM
A DIFFERENT KIND OF TREATMENT: CARE SHAPED OVER TIME

Traditional Consult

One Session = One Time Recommendation

Collaborative Care

Jan: Review 1 → MDD and initiate treatment
Engaged with team but still symptomatic
Feb: Review 2 → Adjust treatment
Engaged with team but persistent symptoms
Mar: Review 3 → intensify treatment
INITIATE TREATMENT

System of Care

1. Identify & Engage
2. Establish a Diagnosis
3. Initiate Treatment
4. Follow-up Care & Treat to Target
5. Complete Treatment & Relapse Prevention

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PRINCIPLES OF COLLABORATIVE CARE

Population-Based Care

Measurement-Based Treatment to Target

Patient-Centered Collaboration

Evidence-Based Care

Accountable Care

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TREATMENT OPTIONS

- Make BOTH medication and non-medication recommendations
- Supporting whole person treatment is important
- The treatment that WORKS is the best one
- Review all evidence-based treatment options available
- Discuss pros and cons of each option

Bio
- Evidence-based Medications

Psycho
- Evidence-based Psychotherapeutic Interventions

Social
- Social support
MODEL OF DEPRESSION

Feel Bad → Do Less → Brief behavioral interventions → Medications → Feel Bad

1. Feel Bad
2. Do Less
3. Brief behavioral interventions
4. Medications

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<table>
<thead>
<tr>
<th>Disorder</th>
<th>Evidence-Based Behavioral Approaches</th>
</tr>
</thead>
</table>
| **Major Depression**  | Problem-Solving Treatment  
                          Behavioral Activation  
                          Cognitive Behavioral Therapy  
                          Interpersonal Therapy       |
| **Anxiety Disorders** | Modular Anxiety Treatment (CALM)  
                          Cognitive Behavioral Therapy |
| **PTSD**              | Cognitive Processing Therapy  
                          Prolonged Exposure           |
| **Substance Use Disorders** | Harm Reduction  
                          Motivational Interviewing  
                          Brief Interventions for Alcohol |
| **Chronic Pain**      | Cognitive Behavioral Therapy  
                          • Negative thoughts about chronic pain  
                          • Pain interference in life  
                          • Acceptance of chronic pain  
                          • Pain self-management strategies |
RECOMMENDATIONS: MEDICATION TREATMENT

- Focus on evidence-based treatments and treatment algorithms
- Details about titrating and monitoring
- Brief medication instructions
Includes information such as:

- Basic education
- Names and doses of medication
- Common side effects
- Precautions

EXAMPLE: PRESCRIBING CHEAT SHEET

https://aims.uw.edu/sites/default/files/PsychotropicMedications_0.pdf
Sample Case Review Note

SUMMARY: Pt is a 28yo male presenting with depression and anxiety. Pt having trouble falling asleep (plays with laptop or phone in bed), sleeping 4-7 hrs/night.

Depressive symptoms: Moderate depression; PHQ-9: 18 Bipolar Screen: Positive screen; Appears more consistent with substance use Anxiety symptoms: Moderate to severe; GAD-7: 18 Past Treatment: Currently taking Bupropion and Citalopram (since 1/31) feels more in control, able to think before reacting, less irritable; Took sertraline, fluoxetine, bupropion at different times during teenage yrs: Doesn't recall effect Suicidality: Denies Psychotic symptoms: Denies Substance use: History of substance use/alcohol; Engaged in treatment currently Psychosocial factors: Completed court appointed time in clean and sober housing; Now living back with parents in Carnation; Attending community college; Continues to stay connected to clean and sober housing Other: ADHD: ASRS-v1.1 screening – positive; Not diagnosed as a child; Now getting B’s at community college

Medical Problems: hx of frequent migraines

Current medications: Bupropion HCl (Daily Dose: 450mg); Citalopram Hydrobromide (Daily Dose: 40mg)

Goals: Improve school functioning; Long term goal employment
MAKING EFFECTIVE RECOMMENDATIONS

ASSESSMENT: MDD (but cannot r/o bipolar disorder); Anxiety NOS; Alcohol use disorder, in early remission; r/o ADHD

RECOMMENDATIONS:

1) Continue to target sleep hygiene

2) Options for antidepressant augmentation. Engage patient in decision making about which ONE option to pursue:
   a. Option 1: Continue citalopram 20mg as reported sedation on higher dose; Make sure he is taking dose at night and allow for longer period of observation to evaluate efficacy
   b. Option 2: Cross taper to fluoxetine; **Week 1:** Baseline weight. Consider BMP for baseline sodium in older adults. Start fluoxetine 10 mg qday. Continue citalopram; 20mg **Week 2:** Increase dose of fluoxetine to 20 mg qday, if tolerated, and stop citalopram; **Week 4 and beyond:** Consider further titration of fluoxetine in 10-20 mg qday increments. Typically need higher doses for anxiety; Typical target dosage: 20 mg qday.

3) Continue close contact with care coordinator, supporting substance use treatment and behavioral activation.

4) Can consider atomoxetine in the future if poor concentration persists; Would stay on 40 mg qday as combination with bupropion can increase drug level.
“The above treatment considerations and suggestions are based on consultations with the patient's care manager and a review of information available in the Mental Health Integrated Tracking System (MHITS). I have not personally examined the patient. All recommendations should be implemented with consideration of the patient’s relevant prior history and current clinical status. Please feel free to call me with any questions about the care of this patient.”

• Dr. X, Psychiatric Consultant
• Phone #
• Pager #
• E-mail
FOLLOW-UP CARE & TREAT TO TARGET

- Identify & Engage
- Establish a Diagnosis
- Initiate Treatment
- Follow-up Care & Treat to Target
- Complete Treatment & Relapse Prevention

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## Caseload Overview

<table>
<thead>
<tr>
<th>View Record</th>
<th>Treatment Status</th>
<th>Name</th>
<th>Date of Initial Assessment</th>
<th>Date of Most Recent Contact</th>
<th>Number of Follow-up Contacts</th>
<th>Weeks in Treatment</th>
<th>Initial PHQ-9 Score</th>
<th>Last Available PHQ-9 Score</th>
<th>% Change in PHQ-9 Score</th>
<th>Date of Last PHQ-9 Score</th>
<th>Initial GAD-7 Score</th>
<th>Last Available GAD-7 Score</th>
<th>% Change in GAD-7 Score</th>
<th>Date of Last GAD-7 Score</th>
<th>Flag</th>
<th>Most Recent Psychiatric Consultant Note</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Active</td>
<td>Susan Test</td>
<td>9/5/2015</td>
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<td>10</td>
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<td>17</td>
<td>-6%</td>
<td>23/2</td>
<td>1/27/2016</td>
<td>Flag for Discussion &amp; Safety Risk</td>
</tr>
<tr>
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<td>12/2/2015</td>
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<td>29</td>
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<td>3</td>
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<td>10</td>
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<td>2/26/2016</td>
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<td>4</td>
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<td>-17%</td>
<td>3/1</td>
<td>2/18/2016</td>
<td>Flag as Safety Risk</td>
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</tbody>
</table>

FREE UW AIMS Excel® Registry ([https://aims.uw.edu/resource-library/patient-tracking-spreadsheet-example-data](https://aims.uw.edu/resource-library/patient-tracking-spreadsheet-example-data))
**PRINCIPLE: MEASUREMENT-BASED TREATMENT TO TARGET**

<table>
<thead>
<tr>
<th>DATE OF CONTACT</th>
<th>CONTACT TYPE</th>
<th>WEEKS IN Tx</th>
<th>VISIT TYPE</th>
<th>PHQ-9</th>
<th>GAD-7</th>
<th>BIPOLAR SCREEN</th>
<th>PTSD SCREEN</th>
<th>CURRENT MEDICATIONS</th>
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<tr>
<td>1/19/2016</td>
<td>Clinical Assessment</td>
<td>0</td>
<td>Clinic</td>
<td>15</td>
<td>13</td>
<td>✓</td>
<td>✓</td>
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<td>1/29/2016</td>
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<td></td>
</tr>
<tr>
<td>2/2/2016</td>
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<td>Clinic</td>
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<td>11</td>
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<td>2/5/2016</td>
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<td>Clinic</td>
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<td>Fluoxetine HCI (Prozac) 20mg</td>
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<td>4/26/2016</td>
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<td>Clinic</td>
<td>4</td>
<td>6</td>
<td></td>
<td></td>
<td>· Fluoxetine HCI (Prozac) 20mg</td>
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**Collateral Contacts**

<table>
<thead>
<tr>
<th>DATE OF CONTACT</th>
<th>NAME</th>
<th>ROLE</th>
<th>AGENCY</th>
<th>CONTACT INFORMATION</th>
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<tr>
<td></td>
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<td></td>
<td></td>
<td>No Records Found</td>
</tr>
</tbody>
</table>

**Patient Progress**

[Graph showing patient progress over weeks in treatment]
STAR-D SUMMARY

Level 1: Citalopram
~30% in remission

Level 2: Switch or Augmentation
~50% in remission

Level 3: Switch or Augmentation
~60% in remission

Level 4: Stop meds and start new treatment
~70% in remission

Rush, 2007
Active Treatment
- Until patient has $\geq 50\%$ decrease in symptoms and/or PHQ-9 score under 10
- Minimum 2 contacts per month
  - Typical during first 3-6 months of treatment
  - Both phone and in-person contacts are appropriate

Monitoring
- 1 contact per month
  - After 50% decrease in PHQ/GAD (or similar) achieved
  - Monitor for ~3 months to ensure patient’s mood symptoms are stable
Usual Care

3.5 PCP Contacts per year*

= PCP contact

20% - 40% treatment response/improvement

*Based on HRSA report of average PCP visit rates for FQHCs
Collaborative Care

- = PCP contact (avg. 3.5 contacts per year)
- = Contacts with BHP/CM (avg. 10 contacts)
- = Case reviews from psychiatric consultant to BHP/CM, PCP (avg. 2 case reviews)

50% - 70% treatment response/improvement
TREATMENT IN THE PRIMARY CARE CLINIC

Functioning as a “back seat driver”
• Develop an understanding of the relative strengths and limitations of the providers on your team
• Rely on other providers (PCP and BHP/care manager) to gather history

How do you “steer”?
• Structure your information gathering
• Include assessment of functional impairment
• Pay attention to mental status exam
WEEKLY CASELOAD CONSULTATION

BHP/Care Manager

Psychiatric Consultant

Photo credit: Courtesy of the John A. Hartford Foundation

Photo: © University of Washington
MODEL CONSULTATION HOUR

- Brief check-in
  - Changes in the clinic
  - Systems questions

- BOTH looking at registry during consultation hour

- Identify patients and conduct reviews
  - Requested by BHP/CM
  - Not improved w/o note
  - Severity of presentation
  - Disengaged from care
  - Ready for relapse prevention or referral

- Wrap up
  - Confirm next consultation hour
  - Send any educational resources discussed
IF PATIENTS DO NOT IMPROVE, CONSIDER:

- Wrong diagnosis?
- Problems with treatment adherence?
- Insufficient dose/duration of treatment?
- Side effects?
- Initial treatment not effective?
- Other complicating factors?
  - psychosocial stressors/barriers
  - medical problems/medications
  - ‘psychological’ barriers
  - substance abuse
  - other psychiatric problems
RECOMMENDATIONS: OTHER INTERVENTIONS

**Beyond medications**
- Behavioral, brief psychotherapy
- Referrals and community resources

**Support managing difficult patients**
- Working with demanding patients
- Protocols for managing suicidal ideation
- Working with patients with chronic pain
<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
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<tr>
<td>Build mutual trust and respect</td>
<td></td>
</tr>
<tr>
<td>Diagnosis – provisional or confirm</td>
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<tr>
<td>Offer concise feedback and suggestions</td>
<td></td>
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<tr>
<td>Next steps, “if-then” scenarios</td>
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<td>Educational component</td>
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Used with permission from Lori Raney, MD
COMPLETE TREATMENT & RELAPSE PREVENTION

Identify & Engage
Establish a Diagnosis
Initiate Treatment
Follow-up Care & Treat to Target
Complete Treatment & Relapse Prevention

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TYPICAL COURSE OF CARE MANAGEMENT: DURATION
EXERCISE 3: USING A REGISTRY

Processes of care:
- Clinical Assessment → Goal: Completed
- Follow-up Contacts → Goal: Contact 2X per month
  % of active patients with psychiatric consultation note → Goal: patients without improvement every 2 months

Clinical outcomes:
- Look for improved patients with PHQ-9 and GAD-7 scores less than 10 or 5+ point decrease

<table>
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<th>Patient ID</th>
<th>Clinical Assessment</th>
<th># of Sessions</th>
<th>Weeks in Tx</th>
<th>Last Follow-Up Contact</th>
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Current Patient Overview

- Which patients need consultation?
- How do you know?
  - Patients not improving?
  - Patients not engaging?
  - Patients ready for relapse prevention?

Workbook page 10
QUESTIONS?
NEXT STEPS
APA SAN OBJECTIVE:
TRAIN, READY, CONNECT

The APA SAN will train 3500 psychiatrists in collaborative care through online and live trainings; offer certificates to those who complete learning collaboratives, and connect trained psychiatrists with PTNs across the country.
NEXT STEPS

Participate in a virtual Learning Collaborative

Technical Assistance

Network

Apply knowledge in practice settings

MOC Credit

How to Participate:
1. Indicate that you are interested on your YELLOW form
2. You will receive more information about participating in Learning Collaboratives in late October/early November
GET CONNECTED

Stay up-to-date on APA’s SAN and training offerings at:

www.psychiatry.org/SAN

For more information or questions, email: SAN@psych.org