Integrated Care for Depression, Anxiety & PTSD

An Evidence-based Approach for Behavioral Health Professionals (LCSWs, MFTs, and RNs)

Alameda Health Consortium
November 15-16, 2012

Introduction: Overview of Clinical Roles and Ideas

Alameda Health Consortium
Integrated Care Training
November 2012

Primary Care Provider Role

Oversees all aspects of patient’s care
Diagnoses common mental disorders
Brief screeners: (e.g., PHQ-9)
Starts & adjusts pharmacotherapy
Introduces collaborative care approach and team
In collaboration with BHC and consulting psychiatrist, makes treatment adjustments as needed

PCP Introduction

Patient NOT being “referred” or “handed off”
– PCP, patient, BHC and consulting psychiatrist all work together as a TEAM

This is how we treat depression because more patients get better

Commitment and Persistence
– Most important component of this approach is that we won’t give up until you feel better
**Behavioral Health Clinician Role**

- Supports and collaborates closely with PCPs on treatment planning and adjustment
- Facilitates patient engagement and education
- Performs initial and follow-up assessments
- Systematically tracks treatment response
- Supports medication management by PCPs

**Consulting Psychiatrist Role**

- Supports BHCs and PCPs
  - Provides regular (weekly) and as needed consultation on a caseload of patients followed in primary care, focusing on patients who are not improving
  - In person or telemedicine consultation or referral for complex patients
  - Provides education and training for primary care-based providers

**Consulting Psychiatrist cont.**

- **NOT traditional case consultation**
  - Weekly calls (not ad hoc)
  - Shared accountability for entire caseload of patients being treated
  - Focus on patients not improving, new patients
  - When possible, include option of in-person consultation when needed (less than 10% of IMPACT study patients ever met in-person with consulting psychiatrist)

**Other Team Members**

- **Medical Assistants / Nurses**
  - May screen patients
  - May re-check PHQ-9 at follow-up visits
  - May coordinate with BHC regarding co-occurring medical conditions
  - May help identify patients in acute distress

- **Front Desk Staff / HSRs**
  - Greet patients
  - May distribute questionnaires (if self-administered)
  - May answer questions about purpose of questionnaires
  - May help with scheduling
  - May help identify patients in acute distress
Integrated Care for Depression, Anxiety & PTSD: An Evidence-based Approach

**Other Team Members**

**Billing / Finance staff**
- Work with clinical staff to insure that integrated care services are documented appropriately
- Work with clinic leadership and others to insure a sustainable, long-term funding model
  - This can be challenging because funding models often lag significantly behind healthcare innovations and quality improvements
- AIMS Center has experts who can help

**Clinic Manager / Behavioral Health Manager**
- Facilitates Team Building process
- Implements plan generated by Team Building process
- Coordinates workflows and clinic systems to support integrated care
- Identifies and addresses challenges to success
- Regularly reviews program-level and provider-level outcomes with clinic leadership and adjusts, as necessary, to meet goals

**Other Team Members**

**Medical Director / CEO / COO / CFO / etc.**
- Champions of integrated care for quality improvement
- Communicate importance and support for integrated care to clinic staff
- Insure adequate resources / attention given to insure success
- Regularly review program-level and provider-level outcomes with clinic leadership and adjusts, as necessary, to meet goals

**Comparison of Contacts in Usual Care vs. Integrated Care**

**Typical Course of Care Management: Duration**

**Team Support of This Model**

**Usual Care**
- 3.5 contacts with PCP per year
- ~20% treatment response / improvement

**Integrated Care**
- 3.5 contacts with PCP
- 10 contacts with BHC (average)
- 2 consultations from psychiatrist to BHC / PCP (average)
- 30-60% treatment response / improvement

**6-10 Months (average)**
Best if determined by clinical outcomes, not preset
- 50%-70% of patients will need at least one change in treatment to improve
- Each change of Tx moves an additional ~20% of patients into response or remission

If pre-determined, minimum 6 months with option to extend to 12 months if additional prescription change is wanted

Know about PHQ-9
Know the treatment options
Offer support about antidepressant medications
Notice when patient sees Behavioral Health Clinician
Using supportive words / tones
Support behavioral activation
Patient Engagement

Warm handoff
Flyers
Not “program”
Don’t stress “mental health staff”
More work than patient

Screening and Symptom Tracking for Depression, Anxiety, PTSD

Warm handoff
Call immediately

Patient Engagement

Patient

Shared Stigma

IMPACT Study
– Provider referral at some sites
  • Lowest participation of men at these sites
  • Patient least likely to be identified if provider also an older White man
  • Qualitative interviews with providers
    – Typical provider comment:
      “I know he is depressed but he’s already got so many things going on I don’t want to make it worse for him by adding the burden of that.”

Minimizing Patients

Some patients minimize symptoms / don’t endorse depression if asked
– Could also have low PHQ-9 score but obviously depressed

Older adults (in general) more likely to minimize or focus on somatic symptom

Some cultures more stoic and more likely to minimize symptoms

PHQ-9 is a tool to help identify patients but does not replace clinical judgment

Depression: Patient Health Questionnaire (PHQ-9)

Assists with depression diagnosis
Tracks 9 core symptoms of depression over time
Easy to use
Patients become familiar with it
Can be done over the phone
A good teaching tool

PHQ-9: How to Administer

In-Person
– Especially initially
  – Facilitates assessment AND teaching about depression

Self-administered
Understanding the PHQ-9 Score

<table>
<thead>
<tr>
<th>Score</th>
<th>Severity</th>
</tr>
</thead>
<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>

Using PHQ 9 for Treatment Monitoring

Do PHQ9 each contact with patient

Compare scores

Discuss results with patient and their perception of improvement /or lack of improvement

Group Exercise

Screening for Anxiety Disorders: “Have you had…”

- Sudden unexpected anxiety or physical symptoms when no one around (PD)
- Worry, tense, anxious more days than not for 6 months (GAD)
- Anxiety and avoidance in social situations (SAD)
- Recurrent intrusive recollections of trauma or avoidance of trauma reminders (PTSD)
The Generalized Anxiety Disorder (GAD)-7 Scale

<table>
<thead>
<tr>
<th>Feeling nervous, anxious, or on edge</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>Not being able to stop or control worrying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Worrying too much about different things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Having trouble relaxing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Being so restless that it is hard to sit still</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Becoming easily annoyed or irritable</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling as if something awful might happen</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Score: 0-5 Mild Anxiety  
6-10 Moderate Anxiety  
11-15 Moderately Severe Anxiety  
16-21 Severe Anxiety

Scoring the GAD-7

Score Severity
0-5 Mild Anxiety  
6-10 Moderate Anxiety  
11-15 Moderately Severe Anxiety  
16-21 Severe Anxiety

PTSD Screening

If 4 item screener positive, complete 17 item PCL

Video Clip: BHC Medication Support
Collaborative Team Approach

- PCP
- Patient
- Behavioral Health Clinician
- Consulting Psychiatrist
- PEER PARTNER

Supporting Antidepressant Medications

Patients may tell you their concerns
Listen, answer what you can, refer to MD
Let MD know if you are hearing a patient or family member with concerns
Supportive comments

Supporting Medication Therapy

Become familiar with names of commonly used antidepressant and other psychotropic medications and medication doses
Provide basic patient education about medications commonly prescribed in primary care
Support medication adherence
Know when treatment is not working and alert the rest of the team to facilitate a change

Supporting “Elizabeth”

John A. Hartford Foundation
Slow Down and Listen: The 2011 Annual Report Video Series
**Video Clip: Behavioral Activation**

Reduce depression by getting patient to be active in simple day to day activities.

Gradually increasing engagement in pleasant and enjoyable activities that are patient/client identified.

Help patients re-engage in pleasant activities and learn new ways of dealing with distress.

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**Behavioral Activation**

Start with an assessment of what the patient currently does:

- What does their typical day look like?
- Are they getting dressed, doing dishes, laundry, papers piling up?
- Do they do any pleasant activities?
- What did they do before they were depressed?
- What life changes have affected their activity?

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**Physical Activity**

**Social Interaction**

**Pleasant Events**

**Household Activities / Projects**

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**Reasons for Change in Activity**

Some additional reasons:

- Inactivity due to loss of function, i.e. vision problems, mobility problems
- Loss of partner
- Pain
- Lack of interest
- Move to new facility or location
- YOUR ideas?

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**Behavioral Activation**

Depression → inactivity and withdrawal = Downward cycle of doing less and feeling worse

- Awareness of this pattern can help some patients understand the purpose and benefit of behavioral activation.
**Activity Scheduling**

Feel Bad  
Do Less  

Social / physical activities tend to be most potent mood boosters  
Treatment will also focus on increasing daily pleasant events  

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**Behavioral Activation**

**Goals:**
- Re-establish routines  
- Distract from problems or unpleasant events  
- Increase positively reinforcing experiences  
- Reduce avoidant patterns  
- Increase critical thinking  
- Decrease negative emotional response

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**Behavioral Activation**

**Some strategies:**
- Review pleasant activities for ideas  
  - Things that used to be ‘pleasant’ in the past  
  - Consider new activities  
- List activities and rate them for mastery and pleasure  
- Choose and schedule a daily pleasant activity  
- Mentally rehearse the selected activity  
- Identify potential barriers (feasibility, realistic activities)

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**Make a Specific Plan with Patient**

The more detailed the plan, the more likely it will be followed.

**In the plan consider:**
- Date or days of the week  
- What time of day  
- How long  
- With whom  
- Other aspects that need to be planned

**Ask patient:**
- How likely are you to do this?

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**Follow-up**

Normalize that this is a self experiment – learn from any results

Review all tasks  

Praise success – ask about how the activity affects their mood

Discuss things that didn’t work
- What obstacles got in the way?  
- Maybe we picked the wrong activity?  
- What might work better?

Set new goals and continue successful ones
Role play

LUNCH

Thank you!
http://uwaims.org/alamedacounty/index.html