Care Partners Training
Day 1
September 17th, 2015
**Care Partners Training**  
**Thursday, September 17, 2015**

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic/Activity</th>
<th>Presenter(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00</td>
<td><strong>REGISTRATION</strong></td>
<td></td>
</tr>
<tr>
<td>8:30</td>
<td><strong>Welcome</strong></td>
<td>Joseph Prevratil, Jürgen Unützer</td>
</tr>
<tr>
<td></td>
<td>- Archstone Foundation</td>
<td>Ladson Hinton, Stuart Henderson</td>
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<tr>
<td></td>
<td>- AIMS Center</td>
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<td></td>
<td>- Evaluation team</td>
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<tr>
<td>9:00</td>
<td><strong>Vision and Innovation Sharing</strong></td>
<td>Each team</td>
</tr>
<tr>
<td>10:15</td>
<td><strong>BREAK</strong></td>
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<tr>
<td>10:30</td>
<td><strong>Treating Depression in older adults: Why Collaborative Care?</strong></td>
<td>Jürgen Unützer</td>
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<tr>
<td>11:30</td>
<td><strong>Partnering with Family in Collaborative Care</strong></td>
<td>Ladson Hinton</td>
</tr>
<tr>
<td>12:00</td>
<td><strong>Primary Care Physicians break for lunch and focus group</strong></td>
<td>Ladson Hinton, Theresa Hoeft</td>
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<td></td>
<td>(Shanghai Room)</td>
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<td></td>
<td><strong>Reflection for remaining team members</strong></td>
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<tr>
<td>12:15</td>
<td><strong>LUNCH</strong></td>
<td>Anna Ratzliff, Rita Haverkamp</td>
</tr>
<tr>
<td>1:15</td>
<td><strong>Collaborative Care Team Skills Practice</strong></td>
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<tr>
<td>3:00</td>
<td><strong>BREAK</strong></td>
<td>Anna Ratzliff, Rita Haverkamp</td>
</tr>
<tr>
<td>3:15</td>
<td><strong>Facilitated Reflection in Teams</strong></td>
<td>Anna Ratzliff, Rita Haverkamp,</td>
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<td></td>
<td></td>
<td>Jürgen Unützer, Theresa Hoeft</td>
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<td></td>
<td></td>
<td>Ashley Heald, Ladson Hinton,</td>
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<tr>
<td></td>
<td></td>
<td>Stuart Henderson</td>
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<tr>
<td>4:00</td>
<td><strong>Big Idea/Goals Sharing (all together)</strong></td>
<td>Anna Ratzliff</td>
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<tr>
<td>4:45</td>
<td><strong>Day 1 Training Feedback</strong></td>
<td>Ashley Heald</td>
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<tr>
<td>5:00</td>
<td><strong>ADJOURN</strong></td>
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<tr>
<td>6:00 -</td>
<td><strong>Reception at the Archstone Foundation</strong></td>
<td><strong>Archstone Foundation</strong></td>
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<tr>
<td>7:00</td>
<td>- Doors open 5:45</td>
<td>401 E. Ocean Blvd.</td>
</tr>
<tr>
<td></td>
<td>- Located one block from Westin</td>
<td>Suite 1000</td>
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<tr>
<td></td>
<td></td>
<td>Long Beach, CA 90802</td>
</tr>
</tbody>
</table>
Presenters

Archstone Foundation

Joseph Prevratil, JD
President and CEO

Laura Rath, MSG
Senior Program Officer

University of Washington

Jürgen Unützer, MD, MPH, MA
Professor and Chair, Department of Psychiatry and Behavioral Sciences
Director, AIMS Center
Care Partners Role: Principal Investigator

Anna Ratzliff, MD, PhD
Associate Professor
Director, UW Integrated Care Training Program
Associate Director for Education, AIMS Center

Rita Haverkamp, MSN, PMHCNS-BC, CNS
Master Care Manager
Trainer, AIMS Center
Care Partners Role: Trainer

Theresa Hoeft, PhD
Acting Assistant Professor, Department of Psychiatry and Behavioral Sciences
Care Partners Role: Investigator

Ashley Heald, MA
Senior Project Coordinator, AIMS Center
Care Partners Role: Project Manager

University of California, Davis

Ladson Hinton, MD
Professor and Director of Geriatric Psychiatry
Care Partners Role: UCD Principal Investigator, Psychiatric Consultant (McClellan)

Stuart Henderson, PhD
Associate Director of Evaluation, Clinical and Translational Science Center
Care Partners Role: Evaluator
Treating Depression in Older Adults
September 17th, 2015
Collaborative Care

Jürgen Unützer MD, MA, MPH
Professor and Chair
Psychiatry & Behavioral Sciences, University of Washington
Seattle, Washington

Depression

- More than having a bad day, week, or month
- Pervasive depressed mood/sadness
- Loss of interest/pleasure
  - Lack of energy, fatigue, poor sleep and appetite, physical slowing or agitation, poor concentration, physical symptoms (aches and pains), irritability, thoughts of guilt, and thoughts of suicide
- A miserable state that can last for months or even years

What Do Patients Say?

“I am depressed.”
“My wife thinks I am depressed.”

Or...
“I just don’t feel right ... I hurt all over ...”
“I just don’t have any energy ... it’s all getting me down.”
“I just can’t sleep.”
“I don’t know what hit me ...I can’t do anything”
“I am not crazy”
“Isn’t depression just a part of normal aging?”
“Wouldn’t you feel this way if you had lost your spouse?”
Depression is Deadly

- One suicide every 14 minutes.
- Older men have the highest rate of suicide.

Depression is Usually Not the Only Health Problem

- Chronic Pain 40-60%
- Geriatric Syndromes 20-40%
- Neurologic Disorders 10-20%
- Heart Disease 20-40%
- Diabetes 10-20%
- Cancer 10-20%

Depression and Diabetes

- Breathing
- Secretory lifestyle
- Obesity
- Lack of adherence to medical regimens
- Psychosocial:
  - Insulin sensitivities
  - Autonomic nervous system
  - Inflammatory markers
  - Cortisol
- Diabetes and CHD at earlier age
- Poor symptom control
- Functional impairment
- Complications ofインドisual illness
- Mortality

Karon et al. Biol Psychiatry 2013
Effective Treatments for Late-Life Depression

- Antidepressant Medications
  - Over 25 FDA approved
  - All are effective in 40 - 50% of patients if taken correctly
  - It often takes several trials to find effective treatment
  - Patients need support during this time
- Psychotherapy
  - CBT, IPT, BA, PST, etc.
- Other somatic treatments
  - Electroconvulsive Treatment (ECT)
- Physical activity/exercise

BUT: Few Older Adults Get Effective Depression Treatment

- One in 10 older adults see a psychiatrist
  - Limited access and concerns related to stigma
- Increasing use of antidepressants in primary care
  - PCPs prescribe 70 – 90 % of antidepressants
  - 10 - 30 % of older adults are on antidepressants (> 4 million)
  - But treatment is often not effective
  - 30 % drop out of treatment within 4 weeks
  - Only 25 % receive adequate follow-up care
  - Only about 20 % improve substantially over 12 months
- Limited access to evidence-based psychosocial treatments (psychotherapy)

Bridging the Divide Between Mental Health & Primary Care

- Mental health is part of overall health
- Treat mental health disorders where the patient is/feels most comfortable receiving care
  - Established doctor-patient relationship is an important foundation of trust & helps reach more people in need
  - Less stigma
  - Better coordination with medical care
IMPACT Study
• 1998 – 2003
• 1,801 depressed adults
• 18 primary care clinics
  – 8 health care organizations in 5 states
    • Diverse health care systems
      – Urban & semi-rural settings
      – Capitated (HMO & VA) & fee-for-service
    • 450 primary care providers
• Two groups compared:
  – Usual Care
  – Collaborative Care

IMPACT Program

Doubles Effectiveness of Care for Depression

50 % or greater improvement in depression at 12 months

Unützer et al., JAMA 2002; Psych Clinics North America 2004
IMPACT Care Benefits
Disadvantaged Populations
50% or greater improvement in depression at 12 months

Areán et al. Medical Care, 2005

IMPACT: Summary
1) Improved Outcomes:
   — Less depression
   — Less physical pain
   — Better functioning
   — Higher quality of life
2) Greater patient and provider satisfaction
3) More cost-effective

"I got my life back"

THE TRIPLE AIM

Principles of Collaborative Care
- Patient-Centered Team
- Population-Based
- Treatment to Target
- Evidence-Based
- Accountable
Elizabeth's Story

https://aims.uw.edu/elizabeths-story

Collaborative Care
Delivering Care as a Team

Collaborative Care Workflow

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

System Level Supports
Collaborative Care Team Approach

PCP

Patient

Care Manager

Psychiatric Consultant

New Roles

Collaborative Care Workflow

Identify & Engage

Establish a Diagnosis

Initiate Treatment

Follow-up Care & Treat to Target

Complete Treatment & Relapse Prevention

System Level Supports

Identify and Engage

• Identify people who may need help
• Help patient understand how depression affects them and instill hope
  – “You don’t have to feel this way.”
• Identify safety and other concerns
• Introduce Collaborative Care, engage patient in program, and introduce team
PHQ-2 and PHQ-9 as “Vital Signs”

Like screening and monitoring blood pressure!
- Identify that there is a problem
- Need further assessment to understand the cause of the “abnormality”
- Track to measure response to treatment

Collaborative Care Workflow

Provisional Diagnosis

Screen filled out by patient

Assessment by PCP & CM

Psychiatric Consultant Case Review

Provisional diagnosis and treatment plan
Common Medical Causes of Depression

- Neurological Disorders
  - CVA
  - Parkinson's disease
  - Huntington's disease
  - Multiple sclerosis
- Cardiovascular disease
- Obstructive sleep apnea
- Cancers
  - Pancreatic cancer

Collaborative Care Workflow

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

System Level Supports

Patient Education

- What is depression?
- Instill hope about treatment:
  - "You don’t have to feel this way."
  - "We have several good treatment options"
- Discuss concerns and anticipate problems
- Involve significant others
- Systematically assess and follow
  - Treatment adherence (how are you using the meds?)
  - Depressive symptoms (use a scale such as the PHQ-9)
The ‘Cycle of Depression’

STRESSORS
Medical illness
Family problems
Work problems

THOUGHTS & FEELINGS
Negative thoughts
Low self esteem
Suicidal
Hopelessness

DEPRESSION

PHYSICAL PROBLEMS
Poor sleep
Pain
Low energy
Poor concentration

BEHAVIOR
Social withdrawal
Decreased activities
Decreased productivity

Treatment Options

• The treatment that WORKS is the best one
  – “One size fits few”
    • Medication therapy is not right for everyone; often several trials of medications are needed
    • Psychotherapy is not right for everyone; different approaches

• Supporting during treatment is important
  – Everyone knows the treatment plan, supports patients, and can help identify when treatment is not working and changes should be made.

FDA Approved Antidepressants

• Serotonin Reuptake Inhibitors (SSRIs)
  – fluoxetine (Prozac), paroxetine (Paxil), citalopram (Celexa), escitalopram (Lexapro), sertraline (Zoloft), fluvoxamine (Luvox)

• Newer Antidepressants (atypical)
  – bupropion (Wellbutrin), mirtazapine (Remeron), venlafaxine XR (Effexor), desvenlafaxine (Pristiq), duloxetine (Cymbalta)

• Tricyclics (TCAs)
  – secondary amines: nortriptyline, desipramine
  – tertiary amines: imipramine, doxepin, amitriptyline
  – Not recommended as 1st line for older adults due to side effects.
Choosing Antidepressants

• All FDA approved antidepressants are equally effective (~ 50% have a substantial response)

• Considerations in selecting an antidepressant:
  – Prior treatment history in patient / family members
  – Patient preferences
  – Expertise of prescribing provider
  – Side effect profile (sedating or activating)
  – Safety in overdose
  – Availability and costs
  – Drug-drug interactions

SSRIs: 1st Choice Agents

<table>
<thead>
<tr>
<th>Antidepressant</th>
<th>Starting Dose/day</th>
<th>Therapeutic Range/day*</th>
<th>Generic</th>
<th>CYP 450 effects</th>
<th>Side-effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fluoxetine</td>
<td>5-10mg Qam</td>
<td>10-20mg</td>
<td>Y</td>
<td>+++</td>
<td>+/-</td>
</tr>
<tr>
<td>Sertraline</td>
<td>12.5-25 Qam</td>
<td>50-150</td>
<td>Y</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>Paroxetine</td>
<td>10 Qhs</td>
<td>20-30</td>
<td>Y</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>Citalopram</td>
<td>10 Qhs</td>
<td>20-40</td>
<td>Y</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Escitalopram</td>
<td>5-10 Qam</td>
<td>10-20</td>
<td>N</td>
<td>±</td>
<td>±</td>
</tr>
</tbody>
</table>

Espinoza R. Unützer J. 2013; Mittman 1999; Solari 2001; Sommer 2003; Williams 2000

Assure Adequate Medication Trials

• Follow-up closely to assess progress:
  – Treatment adherence
    • “Are you taking medications?” “How are you taking them?”
    • Are you having side effects or concerns?
  – Treatment response
    • Use a scale such as the PHQ-9 to track symptoms

• Make sure the dose is high enough
  – Start low but make sure you achieve therapeutic dose.
Is The Patient at Maximum* Daily Therapeutic Dose?

- Fluoxetine (Prozac) 40 mg
- Paroxetine (Paxil) 50 mg
- Citalopram (Celexa) 20 mg
- Escitalopram (Lexapro) 20 mg
- Sertraline (Zoloft) 200 mg
- Venlafaxine (Effexor) 300 mg
- Desvenlafaxine (Pristiq) 100 mg
- Duloxetine (Cymbalta) 60 mg
- Bupropion (Wellbutrin) 450 mg
- Mirtazapine (Remeron) 45 mg
- Nortriptyline 125 mg (check serum level)
- Desipramine 200 mg (check serum level)

* Start all meds low but go to effective or maximum dose as tolerated over 4-12 wks.

Adverse Effect Profiles
SSRIs: serotonergic; variably anticholinergic, antihistaminergic or antidopaminergic

<table>
<thead>
<tr>
<th>Common</th>
<th>Less common</th>
</tr>
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<tbody>
<tr>
<td>nausea</td>
<td>weight loss / gain</td>
</tr>
<tr>
<td>loose stools</td>
<td>hyponatremia (SIADH)</td>
</tr>
<tr>
<td>restlessness</td>
<td>sinus bradycardia</td>
</tr>
<tr>
<td>akathisia</td>
<td>cardiac arrhythmia</td>
</tr>
<tr>
<td>insomnia</td>
<td>bleeding (anti-platelet effect)</td>
</tr>
<tr>
<td>headache</td>
<td>Parkinsonism</td>
</tr>
<tr>
<td>sexual dysfunction</td>
<td>Serotonin Syndrome</td>
</tr>
</tbody>
</table>

What If Patients Don’t Improve?

Is the diagnosis correct?

- Bipolar depression (manic symptoms: no sleep, excess energy / irritability): use mood stabilizers – not antidepressants: lithium, valproate, lamotrigine, quetiapine
- Psychotic depression: add antipsychotic (e.g., risperidone, olanzapine, quetiapine); consider ECT
- Medical conditions: hypothyroidism, sleep apnea, pain, neurological, neurodegenerative disease, vascular disease, chronic conditions / inflammation, geriatric syndromes
- Medications: steroids, interferon, hormones
- Withdrawal: stimulants, anxiolytics, alcohol, opioids
‘Plan B’

• No response: switch to antidepressant from a different class
  – SSRI, SNRI, Bupropion, Mirtazapine, TCA
• Partial response: augment antidepressant
  – Other antidepressants (e.g., Bupropion, Nortriptyline)
  – Lithium, Thyroid, Stimulants
• Psychotherapy
• Physical Activity / Exercise
• Social Activity
• Electroconvulsive therapy
  – Especially if severe, psychotic

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### "Dual Action" and Atypical Antidepressants

<table>
<thead>
<tr>
<th>Drug</th>
<th>Starting Dosage (mg)</th>
<th>Range (mg)</th>
<th>Treatment Resistance</th>
<th>Drug Interactions</th>
<th>Potential SE</th>
</tr>
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<tbody>
<tr>
<td>Venlafaxine (Effexor®)</td>
<td>37.5-75</td>
<td>75-225</td>
<td>Yes</td>
<td>Minimal</td>
<td>↑ DBP, ↑BP, ↓Na, Nausea</td>
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<tr>
<td>Desvenlafaxine</td>
<td>50-100</td>
<td>Unknown</td>
<td>Minimal</td>
<td></td>
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<tr>
<td>Mirtazapine (Remeron®)</td>
<td>7.5-15</td>
<td>30-60</td>
<td>Yes</td>
<td>Minimal</td>
<td>Sedation, ↑TK, Dry mouth</td>
</tr>
<tr>
<td>Duloxetine (Symbrlin®)</td>
<td>20-40</td>
<td>Unknown</td>
<td>Minimal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neefazodone (Serzone®)</td>
<td>10-50</td>
<td>50-200</td>
<td>Unknown</td>
<td>Probable (CYP inhibition)</td>
<td>Citrus ingestion, Sedation</td>
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<tr>
<td>Trazodone (Desyrel®)</td>
<td>10-50</td>
<td>100-400</td>
<td>Unknown</td>
<td>Minimal</td>
<td>↓ BP, ↑SED, ↑Gastritis, ↑PTN</td>
</tr>
<tr>
<td>Bupropion (Wellbutrin®)</td>
<td>150-300</td>
<td>50-75</td>
<td>Possible</td>
<td>Minimal</td>
<td>↓ GFR, ↑PTN</td>
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<tr>
<td>Viloxazine (Uplizna®)</td>
<td>10-30</td>
<td>10-60</td>
<td>Unknown</td>
<td>Minimal</td>
<td>↓ GFR, ↑PTN</td>
</tr>
<tr>
<td>Venlafaxine dextro (Effexor®)</td>
<td>20-40</td>
<td>60-120</td>
<td>Unknown</td>
<td>Unlikely</td>
<td>↓ GFR, ↑PTN, ↑HRT, ↑Constipation</td>
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<tr>
<td>Vortioxetine (Brintellix®)</td>
<td>10-20</td>
<td>5-20</td>
<td>Unknown</td>
<td>Possible</td>
<td>↑ SBP, ↑PTN, ↑Constipation</td>
</tr>
</tbody>
</table>

*Dosage for Major Depression; *Brand not available

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### Psychotherapy

**Orientation**
- Cognitive-behavioral
- Interpersonal
- Problem-solving
- Dialectical-behavioral
- Bereavement/Grief Therapy
- Psychodynamic Therapy
- Supportive Therapy
- Reminiscence and life review
- Bibliotherapy

**Modality**
- Individual
- Couple
- Family
- Group

**Practitioners**
- Psychiatrists
- Psychologists
- Social Workers
- Nurse therapists
- MFTs
**Communication: Care Manager and Primary Care Provider**

GOAL: Efficiently communicate about patient care.
- Specific Question or Request
- Brief history of problem
- Current treatment options, effectiveness, side effects
- Psychiatric recommendations

**Communication: Care Manager and Psychiatric Consultant**

GOAL: Provide psychiatric expertise to team
- Consultation
  - Scheduled
  - As Needed
- Education
  - Integrated
  - Presentation

**Psychiatric Consultation Model Consultation Hour**

- Brief check-in
  - Changes in the clinic
  - Systems questions
- Identify patients and conduct reviews
  - Requested by CM
  - Not improved
  - Severity of presentation
  - Disengaged from care
- Wrap-up
  - Confirm next consultation hour
  - Send any educational resources discussed
Provider to Provider Communication
How and When?

• Consider modality
  – In person
  – Staff (MA or nurse)
  – Phone
  – Fax
  – Email (careful with confidential info)
  – EMR

• Frequency
  – Scheduled
  – As needed

Collaborative Care Workflow

System Level Supports

Comparison of Contacts in
Usual Care vs. IMPACT

Usual Care
3.5 PCP Contacts per year*

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

20% - 40% treatment response/improvement
Comparison of Contacts in Usual Care vs. IMPACT

Collaborative Care

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

50% - 70% treatment response/improvement

Collaborative Care Workflow

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

System Level Supports

Typical Course of Care Management: Duration

Primary Care Panel
Collaborative Care Caseload
Referral to Specialty Mental Health
Relapse Prevention
Overview

• Defining “family”
• Why involve family?
• Challenges of involving family
• Overview of how family can strengthen depression collaborative care
• Questions/discussion

Who is “Family”? 

• Persons in the older adult’s social network who are
  – Present in patient’s home or community
  – Acceptable/preferred by patient
  – Motivated to be part of care team
• Wide range of kin and non-kin
  – Spouses, significant others, children, extended family, friends, neighbors, etc…
  – Paid in-home caregivers
Why Involve Family?

- Family members are often already involved!
- And patients want them involved
- But they are not well-supported by healthcare systems
- With recognition, support, and skills, family can be valuable depression care partners
- Together we have nice opportunity to advance the field

Common Challenges

- Time
- Confidentiality / privacy issues
- Family impedes treatment
- Elder abuse situations
- Provider comfort in working with family
- Multiple family members involved
- Cultural aspects of family caregiving
- Family unavailable (time, interest, etc.)

Role of Family in Collaborative Care

- Participation in assessment and treatment planning process
- Psychoeducation
- Supporting evidence-based care
  - Behavioral activation/problem-solving
  - Medication management
- Participation in primary care visits
- Facilitating connection to CBO
- Relapse and prevention planning
Partnering with a CBO and Family

Resources

- All of us!
  - Discussion of family involvement on calls
  - VA workflow document
- Consultation with UC Davis team
  - Ongoing NIMH funded study on depression and family engagement
- References
Collaborative Care Team Skills
September 17th, 2015
Delivering Care as a Team

Collaborative Care Workflow

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

Behavioral Health Measures as “Vital Signs”

- Behavioral health measures are like monitoring blood pressure!
  - Identify that there is a problem
  - Need further assessment to understand the cause of the “abnormality”
  - Help with ongoing monitoring to measure response to treatment
Common Measures

- Depression: PHQ-9

Advantages of Using Behavioral Health Measures

- **Objective** assessment
- Creates **common language**
- Focuses on **function**
- Avoids potential stigma of diagnostic terms
- Helps identify **patterns** of improvement or worsening
- **Flexibility** of administration

PHQ-9: How to Administer

- **In-Person**
  - Facilitates assessment AND teaching about depression symptoms
  - Can be administered orally for low literacy patients
- **By phone**
  - Send a copy home for patient to follow along
- **Self-administered**
  - In clinic or at home
### Understanding 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>

### Practice: PHQ-9

- Each person takes an activity sheet from the envelope.
  - One person plays the Care Manager
  - One person plays patient
  - One person observes (using checklist) and provides feedback to the Care Manager

- We will switch roles so that each person can practice!
Review

- What went well?
- What was challenging?

Collaborative Care Workflow

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

Introducing Care Partners

PCP
Patient (Family)
Care Manager Role
Psychiatric Consultant

INNOVATION
### Practice

- **Step 1: Personalize your Introduction**
  - Use model introduction to get started
  - Keep it short and simple
  - Key points
    - How shared care works and works well!
    - Your role and the team
    - The patient role
    - Next steps to engage in care

- **Step 2: Practice your based on real role on the team**
  - Each person practices introducing Care Partner Program
  - Each person plays the “patient”
  - “Patient” partner provides feedback
  - If time, practice twice

### Review

- What went well?
- What was challenging?

### Collaborative Care Workflow

- Identify & Engage
- Establish a Diagnosis
- Initiate Treatment
- Follow-up Care & Treat to Target
- Complete Treatment & Relapse Prevention
- System Level Supports
Provider to Provider Communication: How and When?

Frequency
- Scheduled
- As needed

Consider modality
- In person
- Staff (MA or nurse)
- Phone
- Fax
- Email (careful with confidential info)
- EMR

Planning Activity!

- Plan YOUR team communication!
- In your clinic group use Team Communication Planning Worksheet
  - Consider provider to provider communication
  - Consider modality
  - Consider frequency
- May need to capture which handoffs need further discussion!

Review

- Which handoffs are ready?
- Which handoffs need some further discussion?
Using the PHQ-9 Measure | Role Play Activity

OVERVIEW
The purpose of this role play activity is for you to have the chance to practice introducing the Patient Health Questionnaire 9 (PHQ-9) to a variety of patients.

MATERIALS
- Instructions
- color-coded role cards (provided by facilitator)
- PHQ-9 cards (provided by facilitator)

INSTRUCTIONS
- For this activity, you will have the opportunity to practice introducing the PHQ-9 measure to a patient.
- There will be several rounds of the role play, which means that you should have at least one turn (if not more) practicing in the Care Provider role.
- Allow 5 minutes for each round.
- For each round, you will receive a color-coded role card from your group facilitator.
- Have the Care Provider role start the round by introducing the PHQ-9 to the Patient role.
- The Patient has a specific challenge to present, indicated on the blue role card. If you are playing the Patient, please do not share the specific challenge with the others in your group until done.
- All other group members will be Observers and will use the checklist on the green role card to assess the Care Provider/Patient exchange and share constructive feedback with the Care Provider.
- Repeat the role play, switching roles after each round.


**PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)**

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use ✔ to indicate your answer)*

<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 or 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>

For office coding: 0 + _____ + _____ + _____ = Total Score: _____

If you checked off any problems, 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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.
PHQ-9 QUICK DEPRESSION ASSESSMENT

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment on accompanying tear-off pad.
2. If there are at least 4 √s in the blue highlighted section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

3. Consider Major Depressive Disorder
   —if there are at least 5 √s in the blue highlighted section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder
   —if there are 2 to 4 √s in the blue highlighted section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician and a definitive diagnosis made on clinical grounds, taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient. Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up √s by column. For every √: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying PHQ-9 Scoring Card to interpret the TOTAL score.
5. Results may be included in patients’ files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

PHQ-9 SCORING CARD FOR SEVERITY DETERMINATION

for healthcare professional use only

Scoring—add up all checked boxes on PHQ-9

For every √: Not at all = 0; Several days = 1; More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

<table>
<thead>
<tr>
<th>Total Score</th>
<th>Depression Severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-4</td>
<td>Minimal 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>15-19</td>
<td>Moderately severe depression</td>
</tr>
<tr>
<td>20-27</td>
<td>Severe depression</td>
</tr>
</tbody>
</table>
Helping Staff Talk with Patients about the PHQ-9

PURPOSE

Clinics often ask front desk reception, medical assistants, community health workers and other staff who have not have behavioral health training to interact with patients regarding screening and treatment monitoring for depression and other behavioral health conditions being treated in the clinic.

These staff sometimes feel unprepared to discuss these kinds of sensitive issues with patients and it’s important to make sure that they have the support and training they need to feel comfortable with patients. Whether or not clinic staff feel comfortable talking about behavioral health symptoms sends an important message to the patient. It’s important to send the message that the clinic, including all of the clinic staff, feel comfortable addressing these conditions and the clinic treats them the same they do any other condition being treated at the clinic.

This tool is designed to help clinic support staff with answers to common questions they may hear from patients to help increase their comfort talking with patients about the PHQ-9. It’s best for support staff to have the opportunity to role play these with other clinic staff to give them the opportunity to practice before using them with patients. It can also be helpful for support staff to keep this someplace where they can refer to it, as needed, when they get questions from patients.
# Presenting the PHQ-9 to Patient

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
</table>
| **Why do I need to fill this out?**                                      | **SCREENING**<br>Your provider is interested in how you are feeling. It’s like taking your blood pressure or temperature but it’s focused on how you’ve been feeling over the past 2 weeks. We ask these questions for all of our patients because we care about how you’re doing in all areas.  
**FOLLOW-UP (already in treatment)**  
Your provider wants to know how you are feeling so that we know if the treatment is working. It’s important to measure regularly so that we can change the treatment if it’s not working. |
| **I don’t have these problems. Why do you want me to fill this out?**   | It’s like taking your blood pressure or temperature. We check everyone so that we can keep track of how you’re feeling over time. If you’re concerned about these questions you can talk with your provider about it. |
| **Do I have to fill this out even if I’m not comfortable answering these questions?** | You never have to fill out a form or answer questions that you’re not comfortable with. If you’re concerned about these questions you can talk with your provider about it. |
| **I would rather just talk to my provider about these questions instead of filling this out. Is that OK?** | Yes, of course. |
| **I don’t understand some of these questions. Can you help me?**       | If you have questions about the specific items on the form and how they apply to you it would be best to talk about that with your provider. |
Script Example:

We have a new way we are providing mental health care - a partnership between a clinical team and community partner/family member for patients, like you.

In this program, you will have appointments with a PCP to work on your overall health, a care manager at the clinic and work with a care partner in the community/or family member.

The care managers, work with you to help you improve your day to day function, while you work on your medications if you choose to take them.

Your care manager will also see if there are other things that are contributing to your symptoms including your emotions and any stressful things going on in your life that may be contributing. The clinic care manager can also provide therapy if that makes sense as part of your treatment plan.

The care manager will also work closely with a psychiatrist to look at the situation and see if there are other things that can help you function better.

The team will be in communication about your care and function. The care managers will work closely with you between medical appointments to check in on how you’re doing and if what we are doing is working to improve your function; so it is really important that you work closely with the team so we get the clearest picture of what’s going on with you.

I want to set up appointments for you to meet with your team members, so we can start working on your health and your goals.

If you have any concerns our doubts about this program, you can call me to discuss them, and I’ll do my best to answer any questions, and I will also do my best to help you make the most of this opportunity to take a full look at how your symptoms have been getting in the way of your functioning the way you want to function, and what we can do to help you function better.
Fidelity Measure for Introducing Care Partners to Your Patient

As you listen to the provider explain the Care Partner Program, consider whether the following key points are reviewed.

- We provide mental health care as a team through a partnership between a clinical team and a community organization/family member
- You will be cared for by a team:
  - PCP will still be your medical provider
  - A care manager at the clinic to help improve your day-to-day function
  - A care partner or family to support your care
  - A psychiatric consultant works “behind the scenes” to make sure we offer you the best treatment options possible
- Other team members
- We communicate about your care.
- When you are working with one team member you are working with whole team.
- I want to set up a follow-up appointment for you to meet your team.
- If you have any concerns or doubts about the program, call me to discuss them.

![Partnering with a CBO and Family Diagram]
Provider-to-Provider Communication Exercise: Consider All Handoffs!

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient and team</td>
<td>PCP? Psychiatric Consultation? Psychotherapist? Other team members?</td>
</tr>
<tr>
<td>CBO CM/Family and team</td>
<td>PCP? Psychiatric Consultation? Psychotherapist? Other team members?</td>
</tr>
<tr>
<td>CM and PCP</td>
<td>Urgent? Routine?</td>
</tr>
<tr>
<td>CM and PC</td>
<td>How scheduled? Information to registry and/or EHR? Notes to PCPs?</td>
</tr>
<tr>
<td>PC and PCP</td>
<td>Urgent? Education?</td>
</tr>
</tbody>
</table>

Plans/things to work on: