Mental Health Care in Primary Care Settings
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Supported by funding from the Center for Integrated Health Solutions
The SAMHSA/HRSA Center for Integrated Health Solutions

Providing information, experts, and resources dedicated to behavioral health and primary care integration

Online: www.CenterforIntegratedHealthSolutions.org
Phone: 202-684-7457
Email: Integration@thenationalcouncil.org
Goals and Objectives

Mental Health in Primary Care Settings

• Make the case for integrated behavioral health services in primary care, including the evidence for collaborative care.
• Discuss principles of integrated behavioral health care.
• Describe the roles for a primary care consulting psychiatrist in an integrated care team.
• Apply a primary care oriented approach to psychiatric consultation for common behavioral health presentations.
Why behavioral health care in primary care?

1. Access to care and reach: Serve patients where they are
2. Patient-centered care: Treat the ‘whole patient’
Primary Care is the ‘De Facto’ Mental Health System

National Comorbidity Survey Replication
Provision of Behavioral Health Care: Setting of Service

- No Treatment: 59%
- Receiving Care: 41%
- General Medical: 56%
- MH Professional: 44%

Wang P, et al., Twelve-Month Use of Mental Health Services in the United States, Arch Gen Psychiatry, 62, June 2005
- 2/3 of PCPs report poor access to mental health care for their patients.

“We couldn’t get a psychiatrist, but perhaps you’d like to talk about your skin. Dr. Perry here is a dermatologist.”

Cunningham PJ, *Health Affairs* 2009;28(3)490-501
Mental Disorders are Rarely the Only Health Problem

- Chronic Physical Pain: 25-50%
- Smoking, Obesity, Physical Inactivity: 40-70%
- Heart Disease: 10-30%
- Cancer: 10-20%
- Neurologic Disorders: 10-20%
- Diabetes: 10-30%

Patient-centered care?
Services are poorly coordinated.

“Don’t you guys talk to each other?”

- Primary Care
- Community Mental Health Centers
- Alcohol & Substance Abuse Treatment
- Social Services
- Vocational Rehab
- Other Community Based Social Services
Only a minority of patients receive effective treatment.

<table>
<thead>
<tr>
<th>Percentage Range</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>~ 25% - 50%</td>
<td>Not recognized or effectively engaged in care</td>
</tr>
<tr>
<td>~ 20 - 30%</td>
<td>Drop out of treatment too early</td>
</tr>
<tr>
<td>~ 25 - 50%</td>
<td>Stay on ineffective treatments for too long</td>
</tr>
</tbody>
</table>
Life of a Busy PCP

Challenges:
- Large patient panels (1,500 – 2,500)
- Fast paced: 20-30 encounters / day
- Huge range of problems / responsibilities
- Full range of medical, behavioral, social problems
- Acute care, chronic care, prevention

Ways to cope:
- Focus:
  - What is the most serious?
  - What is practical to accomplish today?
- Diagnose and treat ‘over time’
- Get help ➔ TEAMWORK

"Everything comes at me and I bat at the problem before me" ➔ hard to keep track of what happens once treatments started

Need practical solutions & effective communication ➔ COLLABORATIVE CARE
Health Care Reform: Moving towards coordinated / integrated care.

Un-managed
- Fee For Service
  - Inpatient focus
  - O/P clinic care
  - Low Reimbursement
  - Poor Access and Quality
  - Little oversight
- No organized networks
- Focus on paying claims
- Little Medical Management

Coordinated Care
- Organized care delivery
  - Aligned incentives
  - Linked by HIT
- Integrated Provider Networks
- Focus on cost avoidance and quality performance
  - PC Medical Home
  - Care management
  - Transparent Performance Management

Patient Centered
- Patient Care Centered
  - Personalized Health Care
  - Productive and informed interactions between Patient and Provider
  - Cost and Quality Transparency
  - Accessible Health Care Choices
  - Aligned Incentives for wellness
- Multiple integrated network and community resources
- Aligned reimbursement/care management outcomes
- Rapid deployment of best practices
- Patient and provider interaction
  - Information focus
  - Aligned self care management
  - E-health capable

Paul McGann, MD. Acting CMO; CMS. 2/25/2011
Principles of Effective Integrated Behavioral Health Care

Patient Centered Care

• Team-based care: effective collaboration between PCPs and Behavioral Health Providers.

Population-Based Care

• Behavioral health patients tracked in a registry: no one ‘falls through the cracks’.

Measurement-Based Treatment to Target

• Measurable treatment goals and outcomes defined and tracked for each patient.
• Treatments are actively changed until the clinical goals are achieved.

Evidence-Based Care

• Treatments used are ‘evidence-based’.

Accountable Care

• Providers are accountable and reimbursed for quality of care, clinical outcomes, and patient satisfaction, not just the volume of care provided.
The Research Evidence for Collaborative Care

- Over 69 Randomized Controlled Trials (RCTs)
- Meta-analysis by Gilbody S., *Archives of Internal Medicine*; Dec 2006
  - 37 trials of collaborative care (CC) for depression in primary care (US and Europe): CC is consistently more effective than usual care.
- Since 2006, several additional RCTs in new populations and for other common mental disorders
  - Including anxiety disorders, PTSD
- The IMPACT study is the largest research trial of integrated care to date.
  - 1,801 participants from 18 primary care clinics in 5 states randomly assigned to collaborative care or care as usual.
Collaborative Care

PCP supported by Behavioral Health Care Manager

Practice Support

Effective Collaboration

Informed, Active Patient

Measurement-based Stepped Care

Caseload-focused psychiatric consultation

Training
Doubles Effectiveness of Care for Depression

50% or greater improvement in depression at 12 months

<table>
<thead>
<tr>
<th>Participating Organizations</th>
<th>Usual Care</th>
<th>IMPACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
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<tr>
<td>3</td>
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<td>5</td>
<td></td>
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<td>6</td>
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<td>7</td>
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<tr>
<td>8</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Unützer et al., JAMA 2002; Psych Clin North America 2004
## Long-Term Cost Savings

<table>
<thead>
<tr>
<th>Cost Category</th>
<th>4-year costs in $</th>
<th>Intervention group cost in $</th>
<th>Usual care group cost in $</th>
<th>Difference in $</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMPACT program cost</td>
<td>522</td>
<td>0</td>
<td>522</td>
<td></td>
</tr>
<tr>
<td>Outpatient mental health costs</td>
<td>661</td>
<td>558</td>
<td>767</td>
<td>-210</td>
</tr>
<tr>
<td>Pharmacy costs</td>
<td>7,284</td>
<td>6,942</td>
<td>7,636</td>
<td>-694</td>
</tr>
<tr>
<td>Other outpatient costs</td>
<td>14,306</td>
<td>14,160</td>
<td>14,456</td>
<td>-296</td>
</tr>
<tr>
<td>Inpatient medical costs</td>
<td>8,452</td>
<td>7,179</td>
<td>9,757</td>
<td>-2578</td>
</tr>
<tr>
<td>Inpatient mental health / substance abuse costs</td>
<td>114</td>
<td>61</td>
<td>169</td>
<td>-108</td>
</tr>
<tr>
<td>Total health care cost</td>
<td>31,082</td>
<td>29,422</td>
<td>32,785</td>
<td>-$3363</td>
</tr>
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</table>

## IMPACT Replication Studies

<table>
<thead>
<tr>
<th>Patient Population (Study Name)</th>
<th>Target Clinical Conditions</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult primary care patients (Pathways)</td>
<td>Diabetes and depression</td>
<td>Katon et al., 2004</td>
</tr>
<tr>
<td>Adult patients in safety net clinics (Project Dulce; Latinos)</td>
<td>Diabetes and depression</td>
<td>Gilmer et al., 2008</td>
</tr>
<tr>
<td>Adult patients in safety net clinics (Latino patients)</td>
<td>Diabetes and depression</td>
<td>Ell et al., 2010</td>
</tr>
<tr>
<td>Public sector oncology clinic (Latino patients)</td>
<td>Cancer and depression</td>
<td>Dwight-Johnson et al., 2005  Ell et al., 2008</td>
</tr>
<tr>
<td>HMO patients</td>
<td>Depression in primary care</td>
<td>Grypma et al., 2006</td>
</tr>
<tr>
<td>Adolescents in primary care</td>
<td>Adolescent depression</td>
<td>Richardson et al., 2009</td>
</tr>
<tr>
<td>Older adults</td>
<td>Arthritis and depression</td>
<td>Unützer et al., 2008</td>
</tr>
<tr>
<td>Acute coronary syndrome patients (COPES)</td>
<td>Coronary events and depression</td>
<td>Davidson et al., 2010</td>
</tr>
</tbody>
</table>
Collaborative Team Approach

- **PCP**
- **Patient**
- **BHP/Care Manager**
- **Consulting Psychiatrist**
- **Other Behavioral Health Clinicians**
- **Substance Treatment, Vocational Rehabilitation, CMHC, Other Community Resources**

Core Program

Additional Clinic Resources

Outside Resources
A ‘real world’ example of a ‘mature’ integrated care program: MHIP

- Funded by State of Washington and Public Health Seattle & King County (PHSKC)
- Administered by Community Health Plan of Washington and PHSKC in partnership with the UW AIMS Center
- Initiated in 2008 in King & Pierce Counties & expanded to over 100 CHCs and 30 CMHCs state-wide in 2009.
- Over 20,000 clients served.
What is MHIP?

Integration & Collaboration

The Mental Health Integration Program is a state-wide, patient-centered, integrated program serving clients with medical, mental health, and substance abuse needs. The program provides:

- High quality mental health screening and treatment
- An evidence- and outcome-based model of collaborative stepped care to treat common mental disorders

Results-oriented
MHIP Integrated Care Team

- **PCP**
- **Client**
- **Consulting Psychiatrist**
- **Other clinic-based mental health providers**
- **Primary Care (Community Health Center)**

**Mental Health Centers**

**Social Services**

**Vocational Rehab**

**CD/SA Treatment**

* Psychologists, Social Workers, Therapists, Psychiatrists
MHIP: > 25,000 clients served across Washington State
## MHIP Client Demographics

<table>
<thead>
<tr>
<th></th>
<th>Mean or %</th>
<th>Range across clinics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Men</strong></td>
<td>52 %</td>
<td></td>
</tr>
<tr>
<td><strong>Women</strong></td>
<td>48 %</td>
<td></td>
</tr>
<tr>
<td><strong>Mean Age</strong></td>
<td>40</td>
<td>1-100</td>
</tr>
<tr>
<td><strong>Challenge with Housing</strong></td>
<td>29 %</td>
<td>3% - 52 %</td>
</tr>
<tr>
<td><strong>Challenge with Transportation</strong></td>
<td>21 %</td>
<td>10 % - 50 %</td>
</tr>
</tbody>
</table>
MHIP Co-Occurring Diagnoses

DISEASE CONDITIONS
Chronic Physical 71%
Mental Illness 66%
Substance Abuse 38%

72 percent had substance abuse or mental illness identified
15 percent had a chronic physical condition only

Co-occurring diagnosis among DL-U clients

Mental Illness
Physical + MI 27%
MI Only 8%
AOD + MI 5%
AOD only 3%
Chronic Physical + AOD 3%
ALL THREE 26%

SOURCES: MMIS claims, TARGET service encounters, and WSP arrest records, FY 2006-07. Chronic physical and mental illness diagnosis groups derived from CDPS grouper. Mental illness also indicated by receipt of mental health medications.
<table>
<thead>
<tr>
<th>Diagnoses</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>71%</td>
</tr>
<tr>
<td>Anxiety (GAD, Panic)</td>
<td>48%</td>
</tr>
<tr>
<td>Posttraumatic Stress Disorder (PTSD)</td>
<td>17%</td>
</tr>
<tr>
<td>Alcohol / Substance Abuse</td>
<td>17%*</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>15%</td>
</tr>
<tr>
<td>Thoughts of Suicide</td>
<td>45%</td>
</tr>
</tbody>
</table>

... plus acute and chronic medical problems, chronic pain, substance use, prescription narcotic misuse, homelessness, unemployment, poverty, ....
# MHIP Community Health Centers

(6 clinics; over 2,000 clients served)

<table>
<thead>
<tr>
<th>Population</th>
<th>Mean baseline PHQ-9 depression score</th>
<th>Follow-up (%)</th>
<th>Mean number of care coordinator contacts</th>
<th>% with psychiatric case-review consultation</th>
<th>% with significant clinical improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability Lifeline</td>
<td>16 / 27</td>
<td>92 %</td>
<td>8</td>
<td>69%</td>
<td>43 %</td>
</tr>
<tr>
<td>Uninsured</td>
<td>15 / 27</td>
<td>83 %</td>
<td>8</td>
<td>59%</td>
<td>50 %</td>
</tr>
<tr>
<td>Older Adults</td>
<td>15 / 27</td>
<td>92 %</td>
<td>8</td>
<td>55%</td>
<td>43 %</td>
</tr>
<tr>
<td>Vets &amp; Family</td>
<td>15 / 27</td>
<td>92%</td>
<td>7</td>
<td>54%</td>
<td>53%</td>
</tr>
<tr>
<td>Mothers</td>
<td>15 / 27</td>
<td>81%</td>
<td>7</td>
<td>50 %</td>
<td>60%</td>
</tr>
</tbody>
</table>

Data from Mental Health Integrated Tracking System (MHITS)
MHIP: Evidence-Based Treatments

- Training for participating primary care and behavioral health providers in evidence-based treatments
- Psychiatric recommendations for evidence-based use of psychotropic medications
- Brief evidence-based psychosocial interventions such as motivational interviewing and behavioral activation in primary care
- Referral for other evidence-based behavioral health or substance abuse treatments as needed.
- See http://integratedcare-nw.org
MHIP: Pay-for-performance-based quality improvement cuts median time to depression treatment response in half.

Traditional Consultation

Limited access
- There will never be enough psychiatrists to refer all patients for consultation.

Limited feedback
- PCPs experience psychiatry consultation as a ‘black box’.

Expensive
- All MH referrals require full intakes, often leaving little time and energy for follow-up or ‘curbside consultation’.

‘One Pass’
- Works best for one-time or acute issues that don’t need follow-up.
Co-Location

Psychiatrist comes to primary care.
• Opportunity for interaction / curbside consultations
• Better communication (often same chart) and coordination / ‘transfers’ back to primary care.

BUT:
• Not available in many settings (e.g., rural).
• Access still problematic: new slots fill up quickly; no shows; little capacity for follow-up.
• Limited ability to make sure recommendations are carried out.
Collaborative Care

Caseload-focused psychiatric consultation supported by a care manager

Better access
• PCPs get input on their patients’ behavioral health problems within a days /a week versus months
• Focuses in-person visits on the most challenging patients.

Regular Communication
• Psychiatrist has regular (weekly) meetings with a care manager
• Reviews all patients who are not improving and makes treatment recommendations

More patients covered by one psychiatrist
• Psychiatrist provides input on 10 – 20 patients in a half day as opposed to 3-4 patients.

‘Shaping over time’
• Multiple brief consultations
• More opportunity to ‘correct the course’ if patients are not improving
Collaborative Team Approach

- PCP
- Patient
- BHP/Care Manager
- Consulting Psychiatrist
- Other Behavioral Health Clinicians
- Additional Clinic Resources
- Substance Treatment, Vocational Rehabilitation, CMHC, Other Community Resources

New Roles

Core Program

Outside Resources

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BHP/Care Manager

- Patient
  - PCP
  - Other Behavioral Health Clinicians
- BHP/Care Manager
- Consulting Psychiatrist

Core Program

Additional Clinic Resources

Outside Resources

Substance Treatment, Vocational Rehabilitation, CMHC, Other Community Resources
Working with BHPs/Care Managers

Who are the BHPs/CMs?
• Typically MSW, LCSW, MA, RN, PhD, PsyD
• Variable clinical experience

What makes a good BHP/CM?
• Organization
• Persistence
• Creativity and flexibility
• Enthusiasm for learning
• Strong patient advocate
• Willingness to be interrupted
• Ability to work in a team
Clinical Skills

- Basic assessment skills
- Use of common screening tools
- Concise, organized presentations

Behavioral Medicine & Brief Psychotherapy

- Motivational interviewing
- Distress tolerance skills
- Behavioral activation
- Problem solving therapy

Other Skills

- Referrals to other behavioral health providers and community Resources
- Excellent communication skills
Tips for Working with BHPs/Care Managers

Ask about training
- Helpful to know training background and experience of BHP/CM
- What is in their tool kit?

Assess for Strengths
- Ability to give concise, organized patient presentations
- Utilize strong skills to aid in patient care (e.g., if BHP/CM trained in specific therapy modality suggest appropriate application of this skill)

Understand Limitations
- Can you trust their assessments?
- Lack of training in a certain area will be an opportunity to provide education

Monitor for ‘Burnout’
- Weekly/frequent consultation allows for early identification of caregiver fatigue
Communication with BHPs/Care Managers

Method of Consultation
- Electronic communication (e-mail, instant messaging, cell phone text)
- In person
- Tele-video
- Telephone

Consultation Schedule
- Regularly scheduled
- Frequency

Integrating Education
- Integrate education into consultations whenever possible.
- Scheduled trainings (CME, Brown Bag lunch, etc).
- Journal articles, handouts, protocols, etc (either in person or electronically).
- Encourage BHPs to attend educational meetings with me
<table>
<thead>
<tr>
<th>Caseload Consultation</th>
<th>Caseload Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Discuss overall caseload</td>
<td>- Discuss reactions to patients</td>
</tr>
<tr>
<td>- Specific case reviews</td>
<td>- May involve specific therapy planning</td>
</tr>
<tr>
<td>- Diagnostic clarification</td>
<td></td>
</tr>
<tr>
<td>- Treatment planning</td>
<td></td>
</tr>
<tr>
<td>- Medication recommendation</td>
<td></td>
</tr>
</tbody>
</table>
Your Offer

“I’m here for you.”
“I’ve got your back.”
**Availability and Accessibility**

- **Easy access** for PCP
  - Same day for curbside questions
  - Typically by pager, e-mail, cell phone
- **Not utilized as much as would expect!**

**Selling integrated care**

- Expect questions and possible skepticism / resistance
- Promote yourself as a resource
- Resist ‘regression to co-location’
- Teach the model
  - BHP/Care manager will assess patient first
  - New role to support the BHP/Care manager and support team treatment
Communication with PCPs

Recommendations
- Brief and focused
- Next steps for assessment and diagnostic clarification
- Treatment: Both medication recommendations and behavioral interventions

Provide Education
- Through patient-focused recommendations
- Webinar or in person at provider meetings
Other Behavioral Health Clinicians

- PCP
- Patient
- BHP/Care Manager
- Consulting Psychiatrist
- Other Behavioral Health Clinicians
- Substance Treatment, Vocational Rehabilitation, CMHC, Other Community Resources

Core Program: Additional Clinic Resources
Outside Resources
‘Silent’ Partners

PCP

Patient

BHP/Care Manager

Consulting Psychiatrist

Other staff and managers

Other Behavioral Health Clinicians

Substance Treatment, Vocational Rehabilitation, CMHC, Other Community Resources

Core Program

Additional Clinic Resources

Outside Resources
Consulting Psychiatrist

- PCP
- Patient
- BHP/Care Manager
- Consulting Psychiatrist
- Other Behavioral Health Clinicians
- Substance Treatment, Vocational Rehabilitation, CMHC, Other Community Resources

Core Program
Additional Clinic Resources
Outside Resources
# Roles of the Primary Care Consulting Psychiatrist

## Clinical Leader
- Shape behavioral healthcare for a defined population of patients in primary care

## Caseload Consultant
- Consult indirectly through care team on a defined caseload of patients in primary care

## Direct Consultant
- Consult directly by seeing selected patients in person or via telemedicine

## Clinical Educator
- Train BHCs and PCPs
- Both directly and indirectly
Leading the Development of an Integrated Care Program

- Understand the environment
  - The world of primary care
  - Find and nurture a primary care "champion"
- Identify current resources
  - Team building tools
- Create and support your team
- Develop a clinical workflow
Consulting Psychiatrist Leadership

**Administrative Leadership**

- Negotiate the scope of integrated care practice, contract and payment
- Identify and cultivate the primary care champions and partners
- Help build the collaborative care team
- Support the collaborative care team

**Clinical Leadership**

- Facilitate the development of clinical protocols
  - e.g., suicidal ideation, psychiatric emergencies, use of controlled substances (benzos, opiates), management of chronic pain
- Facilitate team approach to challenging patients
Team Building Process

1. Define Scope and Tasks
2. Assess current resources and workflow
3. Define team member responsibilities and integrated workflows
4. Assess hiring and training needs
Integrated Care: Core Components and Tasks

- Patient Identification and Diagnosis
- Engagement in Integrated Care Program
- Evidence Based Treatment
- Systematic Follow-up, Treatment Adjustment, Relapse Prevention
- Communication, Care coordination and Referrals
- Systematic Case Review and Psychiatric Consultation
- Program Oversight and Quality Improvement
“Your Care Team Template”

- Combine with other patient educational materials
- Customize template:
  - Insert staff photos and contact information
  - Put assessment tool (e.g. PHQ-9) on back
  - Make into tri-fold brochure and include other general information for patients
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"
<table>
<thead>
<tr>
<th>Medical Specialty</th>
<th>Problem Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthopedics</td>
<td>Low back pain</td>
</tr>
<tr>
<td>Ob/Gyn</td>
<td>Pelvic pain, PMS</td>
</tr>
<tr>
<td>ENT</td>
<td>Tinnitus</td>
</tr>
<tr>
<td>Neurology</td>
<td>Dizziness, headache</td>
</tr>
<tr>
<td>Cardiology</td>
<td>Atypical chest pain</td>
</tr>
<tr>
<td>Pulmonary</td>
<td>Hyperventilation, dyspnea</td>
</tr>
<tr>
<td>Dentistry</td>
<td>TMJ syndrome</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>Fibromyalgia</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>Chronic Fatigue Syndrome</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>Irritable bowel syndrome</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>Closed head injury</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>Hypoglycemia</td>
</tr>
<tr>
<td>Occupational Medicine</td>
<td>Multiple chemical sensitivity</td>
</tr>
</tbody>
</table>
Scope of Practice

What is the environment in which you are consulting and are you comfortable providing support for all these populations?

• Adults
• Children
• Pregnant patients
• Older Adults
• Chronic pain
• Substance use treatment
Screening Tools as “Vital Signs”

Behavioral health screeners 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
Commonly Used Screeners

Mood Disorders
- PHQ-9: Depression
- MDQ: Bipolar disorder
- CIDI: Bipolar disorder

Anxiety Disorders
- GAD-7: Anxiety, GAD
- PCL-C: PTSD
- OCD: Young-Brown
- Social Phobia: Mini social phobia

Psychotic Disorders
- Brief Psychiatric Rating Scale
- Positive and Negative Syndrome Scale

Substance Use Disorders
- CAGE-AID
- AUDIT

Cognitive Disorders
- Mini-Cog
- Montreal Cognitive Assessment
**Patient Health Questionnaire (PHQ-9)**

**Name:** John Q. Sample  
**Date:**

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></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></td>
<td>1</td>
<td>✓</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td></td>
<td>✓</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td></td>
<td>1</td>
<td>✓</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td></td>
<td>1</td>
<td>2</td>
<td>✓</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td></td>
<td>✓</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></td>
<td>1</td>
<td>✓</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td></td>
<td>1</td>
<td>✓</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></td>
<td>1</td>
<td>✓</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>✓</td>
<td>1</td>
<td>2</td>
<td>✓</td>
</tr>
</tbody>
</table>

Add columns: 2 + 10 + 3 = 15

(Highcare professional: If interpretation of TOTAL, please refer to accompanying scoring card.)

<table>
<thead>
<tr>
<th></th>
<th>Not difficult at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Extremely difficult</th>
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<tbody>
<tr>
<td>10. 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?</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Track Treatment Outcome Over Time

PCP SUMMARY

Care Coordinator

Working Diagnoses:
- L1: Depression (PHQ-9: 0/27; Minimal); Anxiety (GAD-7: 0/21); PTSD (PCL: 55/85)

Formulation: Pt feels significantly better. No depressive sx and only “normal” anxiety. States previously her sister had a fight w her mother, pt became estranged from her mother and sister for a time. Pt continues to have a good relationship w her mother and her sister if mending her relationship w the mother. Pt discussed how she would wok w her sister. Reports good relationship w her husband whose mood has significant w his new anti-depressant. She feels that her life in general has improved and has no particular concerns.

Treatment Progress:

Safety Concerns:
- Past Suicide Attempts: None reported.

Current Psychiatric Medications: Sertraline (Zoloft) / 50mg, 1 tablet once a day

Activity Goals: Pleasant Events Scheduling: Make it a point to do some things this week that you have identified that you enjoy. Likes to decorate and was interested in baking, creating her own recipes. Enjoys reading. Increased rewarding activity w her husband. Talking w her son. Dancing w children.

Referrals: None recorded

Psychiatrist Note

Last updated by: Consulting Psychiatrist (Marc Avery)

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# Caseload Summary:
## Prioritizing Cases to Review

<table>
<thead>
<tr>
<th>Patient ID</th>
<th>Status</th>
<th>Date Enrolled</th>
<th>Date</th>
<th>GAD</th>
<th>Mood</th>
<th>Anxiety</th>
<th>Psych. Note</th>
<th>Psych. Eval.</th>
<th>Next Addt.</th>
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<tr>
<td>3400016</td>
<td>L1</td>
<td>1/20/2011</td>
<td>1/20/2011</td>
<td>19</td>
<td>10</td>
<td>5</td>
<td>4/21/2011</td>
<td>2</td>
<td>5</td>
</tr>
</tbody>
</table>

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Example: Psychiatric Recommendations

Safety Concerns:
Past Suicide Attempts: None reported.

Current Psychiatric Medications: Sertraline (Zoloft) 50mg, 1 tablet once a day

Activity Goals:
- Pleasant Events Scheduling: Make it a point to do some things this week that you have identified that you enjoy.
- Likes to decorate and was interested in baking, creating her own recipes.
- Enjoys reading.
- Increased rewarding activity in her husband.
- Talking with her son.
- Dancing with children.
- Going soccer games and practices.
- Talk to my friends and brother.
- Eating at least one meal together w husband and children. Plans: pt will use exercise equipment to increase her energy and run. She will borrow her sister’s machine.

Referrals: None recorded

Psychiatrist Note

Note: this note was not uploaded into HMITS until 11/17/09 by

35 year old woman with most recent PHQ9 = 11, PCL 56/69, MDD is negative and GAD7 = 19.
Who presents with the pt. 6% of progressively worsening depression x 2 months. History of being molested as a child - with recent re-experiencing of flashbacks (and didn't start at all until 5 years ago).
Current medications: Sertraline 50mg, recently begun (10/19/09).
Prior medication trials include [none known]
Medical Problems: Allergic rhinitis. On medication. Left radial cut; Abrasion left.
Substance Use: SFC 1x per week. Social drink. Every Friday 1 - 3 glasses. Does not like to drink.

Safety Concerns: None

Assessment: Depression with remote trauma that may be surfacing in an PTSD-like condition.

Treatment recommendations: At next visit, please check in with another PHQ - if the depression is not substantially improved consider increasing Zoloft to 100mg per day.

The above treatment considerations and suggestions are based on consultation with the patient’s care coordinator and a review of information available in the Mental Health Integrated Tracking System (MHTS). 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.
Collaborative Team Approach
Assessment and Diagnosis 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
- Relying 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
BHP/Care Manager is asked to briefly report on each of the following areas:

- 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
A Different Kind of Assessment: Shaping Over Time

Traditional Consult

Integrated Care Consult

Visit 1: January
Pt still has high PHQ
Visit 2: March
Side effects
Visit 3 - Pt improved!
Uncertainty: Requests for More Information

- Tension between complete and sufficient information to make a recommendation
- Often use risk benefit analysis of the intervention you are proposing
Provisional Diagnosis

- Assessment by BHP and PCP
- Consulting Psychiatrist Case Review or Direct Evaluation
- Screeners filled out by patient
- Provisional diagnosis and treatment plan
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’.
Common Consultation Questions

Clarification of diagnosis
- Consider re-screening patient
- Patient may need additional assessment

Address treatment resistant disorders
- Make sure patient has adequate dose for adequate duration
- Provide multiple additional treatment options

Recommendations for managing difficult patients
- Help differentiate crisis from distress
- Support development of treatment plans/team approach for patients with behavioral dyscontrol
- Support protocols to meet demands for opioids, benzodiazepines etc…
- Support the providers managing THEIR distress
Caseload Consultation

If patients do not improve, consider

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

- Focus on evidence-based treatments and treatment algorithms
- Details about titrating and monitoring
- Brief medication instructions
Example: Medication Recommendation for Lithium

LITHIUM (LITHIUM CARBONATE), LITHIUM-CONTROLLED RELEASE (LITHIUM ER, LITHOBID)

**DOSING INFORMATION:** Initiation: Check baseline labs (urine pregnancy, basic metabolic panel (baseline BUN and Cr), CBC (for baseline WBC) TSH, EKG (for patients over 40 y/o). Week 1: Start Lithium 300 mg BID or 600 mg QHS (may start with 300 mg/qhs, if the patient is less acute or sensitive to side effects, to increase tolerability). Week 2 and Beyond: Check lithium level weekly and as indicated increase dose in 300 mg/day increments to target plasma level of 0.8-1.0meq/L. Typical Target: Plasma level 0.8-1.0meq/L and less than 1.2meq/L which usually equates with daily dose of 1200mg to 1800mg. Dosing: Schedule should be determined by tolerability and compliance; Typically BID or QHS. Formulation: There are both immediate release and sustained release formulations. Nausea is more common with IR formulations and diarrhea with ER formulations.

**ONGOING MONITORING:** Lithium: 5-7 days after dose change (ideally 12 hours after last dose) and Q6 months when stable. Other labs: Baseline labs as above, Repeat at Q3 months X 2 and Q6 months

**GENERAL INFORMATION:** Mechanism of action: Natural salt with mood stabilizer efficacy. FDA Indications: Bipolar disorder, mania; bipolar disorder, maintenance. Off-Label Indications: Bipolar disorder, depression; depression augmentation; anti-suicide effect. Pharmacokinetics: T ½ = ~24hrs. Side effects: Common: Nausea, tremor, polyuria (related to nephrogenic diabetes insipidus) and thirst, weight gain, loose stools, cognitive impairment (sedation, including changes in memory, concentration, apathy, and decreased creativity). Warnings and Precautions: The two most important long-term adverse effects of lithium involve the kidneys and thyroid gland. Cardiac rhythm disturbances have been described (these almost always occur in patients with preexisting cardiac disease). Contraindications: Known hypersensitivity reaction to the product. Significant renal impairment, significant cardiovascular disease, psoriasis, sodium depletion, dehydration, debilitation. Black Box Warning: (1) Toxicity can occur at levels close to therapeutic dosing: Mild symptoms occur at 1.5-2.5 meq/L (increase tremor, slurred speech, and increased lethargy), Moderate 2.5-3.5 meq/L (clonus, coarse tremors, worsening lethargy), and Severe above 3.5 meq/L which can be lethal. Pregnancy: Pregnancy: Category D; associated w/ increased risk of teratogenesis (need to inform women of childbearing age of this risk). Cardiac malformations, including Epstein’s anomaly (background rate of this defect is 1/20,000 births compared to the 1/1000 rate among infants exposed to lithium in utero), are the primary risk of using lithium during the first trimester. Breastfeeding: American Academy of Pediatrics Committee on Drugs has classified lithium as "incompatible" with breastfeeding, due to documented accumulations in both maternal breast milk and infant serum. Significant drug-drug interactions: Check all drug-drug interactions before prescribing. Examples include thiazide diuretics, NSAIDS (except aspirin), ACE-inhibitors, tetracyclines, metronidazole, potassium-sparing diuretics, theophylline, loop diuretics, and calcium channel blockers. Generic Available: Yes, and inexpensive.

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Recommendations: Other Interventions

Support managing difficult patients
- Working with demanding patients
- Protocols for managing suicidal ideation
- Working with patients with chronic pain

“Beyond Medications”
- Behavioral Medicine and Brief Psychotherapy
- Referrals and Community Resources
- Disability
Working Together to Sell a Treatment Plan

ONE treatment plan!

- Regular communication
- All members of the team give consistent recommendations
- Consider “team huddles”
- Share appointments

Your Care Team

What is the patient’s role?

You are the most important person on the team! You will get the best care if you participate actively with your primary care physician (PCP) and your care manager (CM). Tell them what is working for you and what is not working for you. Work with your team to track your progress using a simple checklist. Let them know if you have questions or concerns about your care. If you take medication, know what it is and take it as prescribed.

What is the primary care provider’s role?

The PCP oversees all aspects of your care at the clinic. He or she will work closely with the other members of the care team to make sure you get the best care possible. The PCP will make and/or confirm your diagnosis and may write or refill prescriptions for medications. The PCP works closely with your care manager to stay informed about your treatment progress. The PCP may also consult with the team psychiatrist if there are questions about the best treatments for you.

What is the care manager’s role?

The care manager works closely with you and the PCP to implement a treatment plan. The CM answers questions about your treatment. He or she will check in with you to keep track of your treatment progress and can help identify side effects if you are taking medications. The PCP and the CM work together with you if a change in your treatment is needed. The CM may also provide counseling or refer you for counseling if that is part of your treatment plan.

What is the team psychiatrist’s role?

The psychiatrist is an expert consultant to the PCP and the CM. The team psychiatrist is available to advise your care team about diagnostic questions or treatment options, especially if you don’t improve with your initial treatment. The CM meets and consults regularly with the team psychiatrist to talk about the progress of patients in the program and to think about treatment options. With your permission, the team psychiatrist may meet with you in person or via telemedicine to help inform your care.
Sample Program: Initial Model of Care – March 2008

- “Emergency Intake” style of initial evaluation.
- Premium on immediate availability to primary care provider.
- Frequent psychiatrist phone consultation.
- No routine patient contact with psychiatrist.
- Use of toolkit, brief documentation [paper], rating scales.
You can access mental health services in any part of the clinic system.

Welcome to NorthShore - a few screening documents...

Primary care doc identifies mental health need.

Hand off to BHC for immediate consult.

For a routine depression - we would prescribe by this protocol.

Hmm... maybe bipolar, I'll call the psychiatrist for a consult.

He concurs - gives treatment suggestions.

She uses toolkit of screenings, patient info, behavioral interventions.

Eliciting support from family & others...

Sounds like a plan!

Why didn't we think of this a long time ago?

We often recommend behavioral activation.

...and starting treatment with no other referral needed.

Reporting findings to primary care doc.

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Sample Program: Evolution of Model of Care

• More return visits – IMPACT model.
• Medication focused, though this not intended.
• Primary care providers’ communication with psychiatrist nearly always through BHC.
• Focus on family practice, fewer referrals from OB/GYN and pediatrics.
• Development of protocols for depression, then bipolar and ADHD.
• Role of depression registry.
Sample Program: Staffing

How many providers can be supported by 5-hr psychiatric consultant?

- Peds - 3 FTE
- OB/Gyn - 3.6 FTE
- Midwives - 2.5 FTE
- Family Practice – 6.7 FTE

→ Total: 15.8

But almost all the business is from the FP’s!
Sample Program: Psychiatrist Consultation

- 4 hours per week scheduled.
- Almost all by phone or text.
- “Rounds” one afternoon per week.
- Initially documented on palm pilot.
- Some personal contact essential → creates credibility with docs.
Sample Program: “Curbside” by Phone

- 70 per month or about 3.5 per day
  - 5.1 minutes per consult: about 15 mins per day.
- Subject – almost all diagnosis, disposition or psychopharmacology
- About 20% of cases lead to phone consult.
Sample Program: Consultation Subjects

Curbside subjects 2010

- Mood Disorder: 258
- Depression: 205
- ADHD: 83
- Anxiety: 69
- Substance Abuse: 35
- PTSD: 31
- Personality Disorder: 29
- Psychosis: 16
- Disposition: 14
- Medical: 10
- Emergency: 10
Sample Program: Curbside Consultation Duration

Duration of curbsides 2010 N=553
[Mean 5 mins 17 sec]
14 by email or text
Sample Program: Supporting Behavioral Interventions

- I have to continually redirect BHC’s to use non-med interventions, even they are experienced with using them – there is continual pressure from patients for “the magic pill”

- I also encourage them to keep track of this in the curbside database we keep, but they don’t always do that, either.
The ‘Business Case’

Payment

• Psychiatrist
  • Charges for time for consultation with care manager / PCPs (contracted time)
  • Bills for in-person consultations with patients → Lower no show rates because of increased access, shorter wait times, and support from care coordinator

• Care manager (e.g., LICSW) bills for in-person contacts using behavioral health or psychotherapy codes and / or charges ‘case rate’ payment to insurer

Additional Benefits

• Improve access for and satisfaction of patients
• Improve job satisfaction and productivity of PCPs → Shorter, more productive primary care visits
• Position organization for future
  • Long-term cost savings attractive to programs that aim to achieve the triple aim: improve access, quality and outcomes while containing costs.
  • Integrated Behavioral Health will be part of Patient Centered Medical Homes and ACOs
What About Liability for Collaborative Care?

**PCPs**
- The PCP oversees overall care of the patient and retains overall liability for care provided.
- PCP prescribes all medications
- Four elements of collaborative care should reduce risk:
  - Care manager supports the PCP
  - Use of evidence-based tools
  - Systematic, measurement-based follow-up
  - Psychiatric consultant

**Other clinic-based team members**
- Care managers and other clinic-based behavioral health team members are responsible for the care they provide within their scope of practice / license.
What About Liability for Collaborative Care?

Psychiatric consultant

- ‘Curbside consultation’ that does not involve the direct patient assessment → limited liability (see Olick et al, Fam Med 2003).
- Direct consultation (either in-person or via telemedicine) → liable for the content of the assessment and treatment recommendations.
- Should negotiate liability coverage as part of practice arrangement / contract.
Be clear about scope of involvement

“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, Consulting Psychiatrist
Phone #.
Pager #.
E-mail
### ‘Day in the life’ of a primary care consulting psychiatrist

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 AM - 10 AM</td>
<td>• Systematic caseload-based review of patients who challenging or not improving with care manager and recommendations to PCPs</td>
</tr>
<tr>
<td>10 AM – 12 PM</td>
<td>• Direct patient consultation / care (in person or via telemedicine)</td>
</tr>
<tr>
<td>12 PM - 1 PM</td>
<td>• Lunch: 30 min discussion of clinical topic with PCPs during provider meeting.</td>
</tr>
<tr>
<td>1 PM - 2 PM</td>
<td>• Return calls and questions from care managers and / or PCPs; curbside consultation with PCPs.</td>
</tr>
<tr>
<td>2 PM - 4 PM</td>
<td>• Direct patient consultation / care (in person or via telemedicine)</td>
</tr>
<tr>
<td>4 PM - 5 PM</td>
<td>• Monthly integrated care team meeting for caseload review, QI, and strategic planning</td>
</tr>
</tbody>
</table>
Consulting in primary care has been wonderful ‘time off the hamster wheel’.

... an opportunity for doing something other than 15-20 minute med evaluations

... to be involved in shaping the provision of mental health care for a large population of patients in primary care

... to teach


Selected References


Brief Behavioral Interventions

References - I

Motivational Interviewing:

Distress Tolerance:
• Linehan, M *Skills Training Manual for Treating Borderline Personality Disorder* Guilford Press, 1993

Behavioral Activation:
Problem Solving Therapy:


Disability:

Special Populations References

Medical Co-morbidity:

Pregnancy and Lactation:
• MGH Center for Women’s Mental Health http://www.womensmentalhealth.org/

Older Adults: