COLLABORATIVE CARE CONSULTATION PSYCHIATRY: A CLINICAL ROTATION CURRICULUM FOR PSYCHIATRY RESIDENTS

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Overview

Integrated behavioral health is a rapidly growing field in mental health and to date there are limited training resources on this topic. There is now a strong evidence base of over 60 randomized controlled studies demonstrating the efficacy of a collaborative care approach for delivering mental healthcare to patients in primary care settings. The following clinical rotation curriculum introduces a senior resident to the role of the consulting psychiatrist in a collaborative care team. The curriculum describes both the structure of the clinical rotation and provides the educational content in the form of 'mini-modules.' In our model of collaborative care, the team consists of a care manager embedded in a primary care setting (usually MSW or other behavioral health provider), the primary care provider (both the source of referrals and the prescriber of any medications), and a consulting psychiatrist (provides weekly case load supervision and individual case reviews of four to six patients weekly). During this clinical rotation, the resident works directly with a consulting psychiatrist to participate in a one to two hour consultation with a care manager, also receives a one to two hour supervision with the attending, and may participate in interdisciplinary care team meetings. The supervision time includes reviewing assigned readings, discussion of a 20-30 minute didactic module, and the opportunity to discuss consultation observations and experiences. We believe close supervision is important in this rotation as for many residents this may be their first experience with indirect evaluation of patients. Working closely with a practicing consultant psychiatrist allows the resident the opportunity to gradually assume the role of the primary consultant to a care team over the course of the rotation. To support this clinic work, we have designed a set of six mini-modules to cover the fundamentals necessary to assume the role of a consulting psychiatrist on a collaborative care team. After these foundational modules have been reviewed, the didactic portion of the supervision hour is devoted to individualized topics relevant to reviewed patient cases. This curriculum trains a psychiatrist to function in any role at the interface of primary care and mental health.

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1) Introduction and Overview of Curriculum Design:

Integrated behavioral health is a rapidly growing field in mental health and to date there are limited training resources on this topic. There is now a strong evidence base of over 60 randomized controlled studies demonstrating the efficacy of a collaborative care approach for delivering mental healthcare to patients in primary care settings (Gilbody S, et al 2006; Thota AB et al 2012). This clinical rotation curriculum introduces a senior resident to the role of the consulting psychiatrist in a collaborative care team. The curriculum provides both the structure of the clinical rotation and the educational content in the form of 'mini-modules.' The educational content is designed to provide residents with an introduction and foundation to begin working in the unique role of a collaborative care consulting psychiatrist.

Structure of the rotation: This rotation is typically offered as a half day per week outpatient rotation for 6-12 months.
In our model of collaborative care, the team consists of a care manager embedded in a primary care setting (usually MSW or other behavioral health provider), the primary care provider (both the source of referrals and the prescriber of any medications), and a consulting psychiatrist (provides weekly case load supervision and individual case reviews of 4-6 patients weekly). The case reviews are indirect psychiatric evaluations consisting of care manager evaluation and records including common behavioral health screeners. The individual patients are not routinely evaluated in-person by the psychiatric consultant. After each case review, a note including recommendations for both the care manager and the primary care provider is generated. This work is facilitated by the use of a web-based registry. Residents consulting with onsite clinics have the opportunity for participation in interdisciplinary care team meetings, direct observation of care manager work, and more frequent direct evaluation of patients as well as informal interactions with interdisciplinary team members.

The resident works directly with a consulting psychiatrist to participate in a one to two hour consultation with a care manager and one to two hour supervision period. The supervision time includes reviewing assigned readings, discussion of a 20-30 minute didactic module, and the opportunity to discuss consultation observations and experiences. We believe the close supervision is important in this rotation as for many residents this may be their first experience with indirect evaluation of patients. This structure of working closely with a practicing consultant psychiatrist allows the resident the opportunity to gradually assume the role of the primary consultant to a care team over the course of the rotation with close attending support.

Didactic Materials: We have designed a set of six mini-modules to cover the fundamentals necessary to assume the role of a consulting psychiatrist on a collaborative care team. During the first weeks of the rotation, these six mini-modules are covered as part of the supervision time. Each week residents receive assigned readings and the resident guide for that module (please see pages 16-26). This guide include the objectives of the module, assigned readings, a synopsis of the reading, and any additional resources related to that topic which may be of interest to the resident. During supervision the faculty member reviews a slide set for each of the six modules (please see appendix page 35). These slides sets are short and designed to be reviewed in approximately 20 minutes. Our experience is this amount of defined didactic material allows for enough unstructured time to also discuss the many initial observation and questions generated in the initial consultation hours with care manager. Faculty guides for the slides sets are included to make sure key collaborative care concepts are reviewed (see page 7 -1 5). Lastly, each module suggests several reflection and discussion questions to prompt the resident's exploration of the didactic material on a more personal level. Discussions of these questions draw upon the residents' own individual thoughts and experiences. We encourage residents to journal or make process notes to enhance these discussions.

After these foundational modules have been reviewed, the didactic portion of the supervision hour is devoted to individualized topics relevant to reviewed patient cases. Typical primary care psychiatry topics include: treatment resistant depression, treating anxiety disorders in primary care setting, diagnosing bipolar disorder in a primary care setting, substance use disorder treatment in primary care settings, somatoform disorders and other unexplained physical symptoms, managing multi-morbidity, supporting teams around difficult patients, the use of screeners, assessment of special populations (pediatric, geriatric, pregnant women) and the leadership role assumed by the primary care psychiatrist.

Mini-Modules:

- Module 1: Introduction to Collaborative Care
- Module 2: Introduction to Specific Program (Example provided for Mental Health Integration Program - MHIP)
- Module 3: Collaborative Care Teams
- Module 4: Collaborative Care Consultation I - Case Finding, Differential Diagnosis and Case Formulation
- Module 5: Collaborative Care Consultation II - Making Recommendations and Treating to Target
- Module 6: Collaborative Care Consultation III - Team Building, Work Flow and Quality Improvement

Course Goals and Objectives

Learning Objectives for the Collaborative Care Consultation Psychiatry Rotation:

At the conclusion of this rotation, the resident will be able to:

- Define the key components of an integrated mental health program.
- Discuss the evidence-based literature about integrated mental health programs.
- Describe the different roles and providers in an integrated mental health program and the ways they support clients.
- Develop a collaborative care workflow (including triaging patients to appropriate level of care) and systems.
- Demonstrate that they actively participated in and provided psychiatric consultation in an integrated care team.
- Recognize benefits and limitations in using screening questionnaires to aid in diagnosis and treatment of common mental health disorders
- Evaluate the evidence-based literature about providing mental health care in a primary care setting.
- Formulate patient presentations and develop treatment plans (including stepped-care) to be delivered by an integrated care team.
- Work effectively with a care manager, including identifying the care manager's individual skill set, knowledge, and attitudes and tailoring the consultation hour to their education and needs
- Effectively communicate with primary care providers.

Goals for individual Modules:

Module 1: Introduction to Collaborative Care	
Objectives - At the conclusion of this module, the resident will be able to:	
Knowledge	Understand the case for collaborative care and be familiar with the growing evidence base for collaborative care.
Skills	Recognize the basic elements and principles of collaborative care and be ready to further explore both in later modules.
Attitudes	Examine their own experiences and opinions of existing outpatient mental health systems while considering collaborative care psychiatry's potential for delivering more integrated and population based care.
Module 2: Introduction to Specific Program (Example provided of the Mental Health Integration Program - MHIP)	
Objectives - At the conclusion of this module, the resident will be able to:	
Knowledge	Describe the populations served by and typical team configuration in the MHIP program.
Skills	Conceptually understand and be ready to use a tracking tool such as MHITS.
Attitudes	Consider quality aims a part of routine practice for working in MHIP.
Module 3: Collaborative Care Teams	
Objectives - At the conclusion of this module, the resident will be able to:	
Knowledge	Understand in more depth the typical role responsibilities for PCP's, care managers, and psychiatrists in collaborative care. Relate collaborative care processes and roles to a typical primary care work flow and practice environment.
Skills	Use telephone/telepsychiatry to perform psychiatric consultation. Demonstrate increased comfort in communications with both care managers and primary care providers.
Attitudes	Consider personally implanting strategies for improving communication with care managers and PCP's .
Module 4: Collaborative Care Consultation I - Case Finding, Differential Diagnosis and Case Formulation	
Objectives - At the conclusion of this module, the resident will be able to:	
Knowledge	Recognize common diagnostic dilemmas in primary care settings.
Skills	Use screeners effectively to aid in diagnostic evaluation.
Attitudes	Be flexible about making a diagnosis in the absence of a direct assessment. Integrate the patient's own and other providers' perspectives into a common understanding of the patient problems and presentation.
Module 5: Collaborative Care Consultation II - Making Recommendations and Treating to Target	
Objectives - At the conclusion of this module, the resident will be able to:	
Knowledge	Make recommendations for common primary care presentations.
Skills	Assess a patient that has not responded to initial treatment plan.
Attitudes	Apply a stepped-care approach to determine appropriate level of care.
Module 6: Collaborative Care Consultation III - Team Building, Work Flow and Quality Improvement	
Objectives - At the conclusion of this module, the resident will be able to:	
Knowledge	Identify administrative and clinical leadership roles for psychiatrists in collaborative care practices Understand the team building process tool including assessing staff and training needs
Skills	Address common collaborative care process challenges and problem solve simple

	work flow issues in a specific clinic
Attitudes	Appreciate the necessity of other clinic staff including program managers and 'primary care champions' in building and maintaining collaborative care teams Consider themselves a leader with regard to quality assessment and improvement efforts. Appreciate the need for flexibility and dynamism in creating and continuously improving collaborative care teams and their workflows

2) Faculty Curriculum Guides

Module 1: Introduction to Collaborative Care	
Brief Introduction	This module will introduce a resident to the rationale and evidence base for collaborative care, as well as the elements of effective collaborative care and the multi-dimensional role for the consulting psychiatrist in this type of care.
Module 1: Introduction to Collaborative Care Faculty Notes	
	Slide 3: Learning Objectives - The following module aims to provide a basic introduction to the rationale and structure of collaborative care with a brief overview of its empiric basis and increasing implementation. As seen in the provided reflection questions, we also aim for this module to also allow for more individualized discussion of participants experiences with outpatient mental health care systems and local healthcare systems as well as preexisting opinions about collaborative care processes. **Slide 4/5/6:** There is a great need for mental health care in primary care locations, but often limited access to mental health clinicians and/or limitations in patients' adherence or providers active adjustment of treatments. **Slide 7:** Health Care in Separate Silos: All of us can also think of examples of patients who have had a lot of assessments but never any well-coordinated treatment around a multidimensional mental health problem. **Slide 8:** There are several models of integrating mental health care and primary care, from more traditional consultation models to collaborative care models. Each system has advantages and challenges. For example, approach of using psychiatrists sited in primary care clinics, though often effective, is a strategy limited by the limited number. Of psychiatrists. Collaborative care was developed to address mental health needs on a population scale. **Slide 9/10:** In paragraph and table form, these slides list the core principles of integrated care and will be further illustrated and defined in the other modules. **Slide 11:** This slide introduces a flow chart of the integrated team. Of particular note, is the centrality of the BHP Care Manager as a coordinator and provider of care. Their role and working relationship with the consulting psychiatrist will be described in detail in upcoming modules. **Slide 12:** Over 60 RCTs that show a consistent effectiveness of collaborative care interventions for depression especially in the US. There is emerging evidence that collaborative care is effective for other mental health disorders. Some major individual trials for potential review include the references listed above. **Slide 13:** This list of recent integrated behavioral health care initiative is only a sampling, but does begin to illustrate the current widespread implementation of collaborative care **Slide 14/15:** The psychiatrist role in collaborative care draws upon core skills in diagnosis, formulation, and treatment planning, but also presents new opportunities and challenges around providing indirect consultation of patients, providing education to BHC's (behavioral health clinicians) and PCP's alike. A role in providing population based approach to mental health care which includes triaging

Discussion Points	patients to the appropriate level of care based on their presentation. **Slide 16:** Reflection Questions Clinicians' initial response to hearing about collaborative care processes can include concerns about potential pitfalls, including: providing indirect care with patients, working with care manager with varying skill and knowledge levels, and heterogeneity in patient population and primary care clinic settings. We aim to address these concerns in further modules that illustrate that collaborative care: -is an iterative process with many care points to allow clinicians a more complete picture mental health picture, which can be supplemented with an in-person evaluation as needed as part of a 'stepped care' approach. -has parallels to a community mental health center with the most points of care provided by non-psychiatrist clinicians -uses population registries that keep patients from falling through the cracks. -includes sufficient clinical and administrative supervision and training to build upon and expand care manager strengths and capabilities -has a robust and growing evidence base around treating depression and anxiety disorders

Module 2: Introduction to Specific Program (Example provided of the Mental Health Integration Program - MHIP)	
Brief Introduction	This module will review the populations served by Washington State's Mental Health Integration Program (MHIP). The basic program structure, quality aims and the tracking tool (MHITS) will also be introduced.
Module 2: Introduction to Specific Program Faculty Notes	
	Slide 3: Learning objectives: This module introduces the specific program for collaborative care, including details of teams and program goals. **Slide 4:** Principles of Effective Integrated Behavioral Health Care: Think about these five principles as we discuss the basics of MHIP **Slide 5:** A 'real world' example of a 'mature' integrated care program: MHIP: This program is funded through a collaboration of CHPW and PHSKC. Our services are paid for in a contract to provide a certain amount of consultation. We do not bill for individual case reviews. Two major populations served: Short term state disability (state-wide) and special populations (king county only)- MOMs, Older adults, Vets **Slide 6:** MHIP Webpage: Resources for the whole team! There is a public portion with an overview of the program and lots of resources for the PCPs. Also a password protected portion with tons training materials for the care coordinators. **Slide 7:** MHIP Team Structure: Patient is in the center. Pt seen in primary care clinic by PCP and care coordinator. The consulting psychiatrist mostly talks to the care coordinator who has limited direct communication with both the patient and PCP. We will talk more about these roles in Module 3. Some clinics have additional resources. Sometimes we refer to community resources such as chemical dependency or DVR. A small number of patients are referred to Level 2 which is 6 month benefit at a community mental health center. **Slide 8:** There are sites in every county in the state of Washington. There are urban clinics and rural clinics, each of which requires slightly modified approaches. **Slide 9:** Here are some of the demographics of the patients in our program: both men and women, in King County children to older adults and many patient with

	social challenges typical of safety net populations. **Slide 10:** Just as we discussed in Module 1, there are co-morbid medical, mental health and substance use diagnoses in this population. **Slide 11:** Most of the patients have anxiety and depression as you would expect in a primary care population. However, there are many patients struggling with PTSD, bipolar disorder and a few with psychosis. The number listed for substance use probably is an under-representation of the number of patients with substance co-morbidity. **Slide 12:** A fundamental principle of collaborative care is to recommend cutting edge evidence based treatment to the primary care providers. A fundamental part of this is training the team. Our medication recommendations should evidence based, ideally commenting on when treatments are FDA indicated verses evidence based. The care coordinators have some training in brief psychological interventions such as behavioral activation, distress tolerance and motivational interviewing. We can be helpful in identifying specific interventions to try with clients. **Slide 13:** The next few slides introduce our tracking tool. This page is the caseload summary. This page allows you to look at a care coordinator's whole patient caseload. Having a snapshot view of an entire caseload is very important to be able to practice population psychiatry. You can quickly identify the patients that are the most symptomatic and when they have last been seen by the case coordinator and when the last case review was written. This type of review is helpful to prioritize your time with the care coordinator. **Slide 14:** This is a patient summary. This is an example of how these notes are different than a typical EMR, as it is a shared note with sections authored by both the care coordinator and the psychiatrist. There should be one shared treatment plan. **Slide 15:** This is another page we commonly use when trying to make recommendations. We can see all the visits as well as all the medications that the patient has tried since enrolling in the program. This page also makes it easy to access the notes by clicking on any of the blue dates to see the notes. **Slide 16:** Here are some sample results from patients served in this program. You can see most patient start off with moderate to severe depression symptoms (Average PHQ-9 is 15). This program can be very effective in engaging clients as indicated by the high percentage of follow up. In these clinics, ~50% of patients were getting better. **Slide 17:** Pay for performance: With implementation of specific quality aims, the amount of time it took for clients to have a significant decrease in depression symptoms was cut in half (from 68 weeks to 24 weeks). This idea is covered in more detail in the reading. **Slide 18:** Current program details: This slide is to remind the lecturer to review current quality aims, discuss eligibility requirements, current disability programs and current treatment planning programs in the MHIP program. **Slide 19:** Within the UW primary care system of hospitals and neighborhood 'satellite' clinics, we have also implemented a blended model of collaborative care processes led by psychiatrists sited directly in the clinics. Their time in clinic is approximately divided in a 1:1 to 2:1 ratio between directly seeing patient s for time limited consultation or ongoing care provision and providing collaborative care support as described in this module. With the addition of auxillary staff like social workers, chemical dependency counselors, and occupational therapist, this model adds to the capacity of primary care to manage patients with more severe of chronic mental illness whom are unable or unwilling to access mental health center services. In this model the PCP maintains all the prescribing responsibility for

	patients followed by care manager, but the psychiatrist can provide ongoing medication management/prescriptions for some patients after discussion with and in coordination with the patient's PCP. **Slide 20:** Reflection Questions

Module 3: Collaborative Care Teams	
Brief Introduction	This module will describe in further depth the roles and practice environment of collaborative care teams in primary care clinics and further illustrate the process of caseload consultation.
Module 3: Collaborative Care Teams Faculty Notes	
	Slide 3: Learning Objectives: This module introduces the typical members of the collaborative care team and discusses how the team works together to provide behavioral health care. **Slide 4:** This module will provide an in-depth description of the role responsibilities for collaborative team members in the setting of a typical primary care work environment. It will further describe how team members coordinate with each other and give tips for optimizing communications. **Slide 6-8:** The primary care physician remains the long-term central provider of patient. The PCP identifies potential patients, can optimize positive expectations of the patient for participation, is the initial and ongoing prescriber of medications, and ultimately remains the long-term provider of patient care. Of course, the PCP often sees many patients each day for short encounters in which mental health and psychosocial concerns may be accompanied by multiple medical ones. PCP's understanding of their patients' mental health may be influenced by both how long they have been working with their patients (sometimes up to years of working with multigenerations of a family) as well as their comfort with biomedical models of mental health (diagnosis and evidence based treatment) vs more idiosyncratic understandings of a patient's condition . **Slide 9-11:** As pictured in the team role flow chart, the behavioral health professional/care manager assumes a central mental health care role for patient in collaborative care. They will be the 'face' of mental health care to patient in performing initial intakes, tracking treatment response via rating scales and more individualized treatment goals, support medication management, developing a therapeutic relationship with delivery of brief, evidence based counseling, triaging most appropriate patients for psychiatric review, and facilitating referrals to others services as needed. **Slide 12-13:** The psychiatrist's core work in collaborative care programs is a regular (most often weekly) consultation with care manager around about patients. A description of the content and process of this call will follow. Treatment plans follow a stepped care approach in which additional medications, psychotherapy, and psychosocial resources (including in-person psychiatric assessment) are implemented as needed for patients not improving according to symptom tracking scales and individualized goals. Finally, consulting psychiatrists can schedule regular visits to clinics (e.g. quarterly) for 'meet-and-greets' with clinic staff and provide education ranging from formal powerpoint presentation to informal question and answer sessions about patients. **Slide 14-15:** Collaborative care teams ideally integrate all available psychosocial resources into treatment teams. The resources available will vary by clinic. For example, a homeless individual with alcohol dependence and depression may benefit most from referral to a detoxification program and housing resources before more focused work on depression.

	Slide 16-17: Whether it's getting symptom rating scales completed in the waiting room, finding sufficient office space for the behavioral health clinician, or forming their own individualized supportive relationships, we have found that auxiliary staff are true 'silent partners' that are crucial glue for constructing well functioning collaborative care teams. **Slide 19:** Behavioral health care managers can be recruited from a number of professions with different strengths and limitations in core knowledge and skills. Such areas include familiarity and comfort working in a busy primary care setting (Medical Assistants) , doing mental health evaluations and planning treatment (Psychologists), and comfort with the longer term outreach to clients and connection to appropriate services (Social Worker). As collaborative team roles are an inevitable professional stretch for care team members (including us psychiatrists!), flexibility and enthusiasm about learning is essential. **Slide 20-21:** Existing strengths and aptitude for these skills should be considered as part of the hiring process for care managers, but can also be clarified and strengthened through orientation and continual education, which may include peer support groups, webinars, and centralized collections of papers and presentations. Care managers have should on-site supervisors whom monitor the overall quality of their work and attend to local support and educational needs. The psychiatrist is a caseload consultant rather than the caseload supervisor for the care manager. Unlike a caseload supervisor, the psychiatrist is not directly responsible for the quality of the care manager work, nor is the psychiatrist training the care manager to eventually assume the role and responsibilities of a psychiatrist (That would take 8 years of graduate medical education!). Instead the psychiatrist and case manager ideally form more of an egalitarian relationship of two professionals. Even so, the psychiatrist will inevitably provide education about mental health diagnosis and treatment in the consultation hour. Electronic or in-person distribution of journal articles, handouts, treatment guidelines may nicely complement the consultation hour. Frequent requests for in-person psychiatric evaluations may be symptomatic of either the psychiatrist or care manager promoting a more supervisory relationship. **Slide 22:** The consultation hour is structured around the psychiatrist providing case reviews to generate working diagnoses and treatment planning. Without specific attention for reviewing not improving patients, the consultation hour can inevitably involve a disproportionate number of new cases. Only in deliberately reviewing older and not improving cases may iterative, stepped care approaches to patients be implemented. **Slide 23:** Every psychiatrist and case manager combination will form individualized approaches to the structure and process of consultation hours. The duration and frequency of consultation can be varied according to care manager and psychiatrist schedule. Some psychiatrists prefer to read over cases before talking with care managers while others do no such 'pre-rounding.' With the availability of internet video connections like Skype, it is possible for consulting psychiatrists and care managers to see each other no matter the geographical location. We have found some clinicians nevertheless prefer to talk by telephone and maintain attention on the computer screen (especially when the patient's medical records may be also available for review) even when they are in the same location. To varying degrees, psychiatrist will request specific structures to presentation, with some requesting a specific template to be followed. Some sample templates are attached for illustration. As available, scheduling limited number of co-visits with psychiatrist and care manager alike may provide an excellent educational opportunity while also allowing for calibration between psychiatrist and care manager around mental status and other symptom reporting, e.g. both clinicians can compare their impressions of

	a patient's quality of speech, affect, or description of psychotic symptoms. **Slide 24-25:** We urge consulting psychiatrist to leave contact information (pager, e-mail) for direct communication with PCP's. Our experience is that PCP's sparingly rely on talking with the consulting psychiatrist directly, but these communications are inevitably helpful for patient care and mutual education of the involved clinicians. Having a few talking points and or chart, e.g. Table 1 from the 2007 Thielke, et al article from Module 1 at hand can be useful for explaining the set-up and evidence base of collaborative care to skeptical or clinicians primary care physicians. While PCP's may not be satisfied with public health appeals about the underavailability of psychiatrists to see every patient, they frequently will be reassured in hearing about ongoing monitoring of a panel of patients with stepped care approaches to meeting treatment needs with psychiatrist availability to persistently not improving patients. **Slide 26:** Assessments and recommendations of psychiatrist are ideally brief and focused to practically increase the likelihood of their implementation. Working familiarity with the PCP (through in person conversation, access to medical records, and information from the care manager) to whom the recommendations are addressed is ideal, however, for tailoring recommendations in breadth and/or depth to the PCP's interests. Recommendation often include tasks and roles for further diagnosis, e.g. administration of treatment scale or gathering of collateral information from care manager, and treatment, e.g. specific medication dosages and algorithms for PCP to recommend. **Slide 27:** Reflection Questions

Module 4: Collaborative Care Consultation I - Case Finding, Differential Diagnosis and Case Formulation	
Brief Introduction	This module will introduce the fundamentals of diagnosis in a collaborative care program. We will focus on how collaborative care assessment differs from an individual psychiatric consultation, as well as the use of screeners to aid in diagnosis and case formulation. We will also review common diagnostic quandaries, working with care coordinators to clarify diagnoses and identifying relevant biopsychosocial factors, and when to consider direct assessment of a patient.
Module 4: Collaborative Care Consultation I - Case Finding, Differential Diagnosis and Case Formulation Faculty Notes	
	Slide 3: Learning objectives: This module will focus on enhancing assessment skills , especially indirect evaluation, to facilitate collaborative care. **Slide 4:** Patients in primary care may present with a variety of concerns. The collaborative care process can be helpful to the primary care team to identify patients who meet criteria for a DSM diagnosis and engage them in care. **Slide 5:** The types of diagnoses identified in primary care will be different than a typical outpatient practice. Depression and anxiety are common, but so are adjustment disorders and physical symptoms related to mental health diagnoses. **Slide 6:** Remember you need to have a team approach to diagnosis, so typically the identification and preliminary diagnosis of patients will be done by the PCP and BHP. You will also need a way to assess if treatment is effective that can be shared by the whole team. **Slide 7:** Screeners are very helpful for both assessment and tracking treatment response. These are similar to the measurement of vital signs. When these are abnormal, it means that you need to do more assessment, just like a high blood pressure does not tell you what is causing it! An abnormal screener is NOT equivalent to a diagnosis. **Slide 8:** Here are some commonly used screeners. Some are used just for diagnosis like the MDQ and CIDI and some are used for screening and follow up like the PHQ-9, PCL-C and GAD7. **Slide 9:** Here is a sample PHQ-9. We typically use a cut off of 10 to screen for depression. However, it is also important to note which symptoms are marked, for example a diagnosis of MDD would require that either question 1 or question 2 be marked at a score of 2 or higher to meet diagnostic criteria. This is especially true in patients with other medical conditions and pregnancy. **Slide 10:** Assessment and diagnosis is different in this module and especially when you start if can feel like being a “back seat driver”. It is very important to develop a structured approach to your assessment to feel that you are making thorough assessments. The relationship with your care coordinator is also very important. This is usually the most difficult part of the job when people first start working in this program. We will talk about some helpful strategies. **Slide 11:** This is a checklist that is covered whenever a new patient is assessed. It is important to screen in all the major diagnostic domains as well as assess functional impairments (work), psychosocial stressors and medical disorders. Making sure to touch on each of these topics will give you a good sense about most patients in combination with the screening tools. **Slide 12:** It is helpful to provide a structured approach to considering possible diagnoses. Thinking about five “cards” or domains that need to be explored can be helpful to you, but also to model to the care manager. **Slide 13:** The screeners and other symptoms observed by the care manager can help you refine your differential. Sometimes this leads to a provisional diagnosis and other times you identify key pieces of history which must be obtained before a provisional diagnosis can be made.

	Slide 14: The assessment may take place over several short indirect assessments. Each of these sessions allows for more information and additional observation of the patient which may help clarify diagnosis. **Slide 15:** This role requires each psychiatrist to tolerate a fair amount of uncertainty. This is typically not very comfortable! We have found weighing the benefit of action vs the cost of inaction to be helpful in deciding if we have enough information to make treatment recommendations. Sometimes initiating treatment and following the patient can be part of the assessment (for example, you can consider a trial of using an SSRI for depression in a patient with only a slight probability of bipolar disorder). Also, thinking about what information we ideally like to have and how practical it is to obtain it may influence this decision. The amount of information you require to make a decision will vary amongst providers, so it can be helpful to observe several different consulting psychiatrists and how they make their decisions. **Slide 16:** These are the key factors that go into making a provisional diagnosis. In some ways this may be a more full assessment than could be obtained in a more traditional 1 hour consultation as you are often able to make your assessment based off of several providers' observations. **Slide 17:** Another advantage of a collaborative care model is that there are systems in place to make sure we closely follow the patients, so if your assessment needs to be adjusted, the patient will be identified by either the care coordinator or PCP. And this cycle allows the refinement of the diagnosis over time. At times, patients will need to be assessed in person either in the clinic or at higher level of care (Community Mental Health Center). **Slide 18:** Case formulation is important because it the basis for the treatment plan developed by the team. These do not need to be lengthy, but should include the provisional diagnosis, evidence based medication and behavioral treatments and any information that would be important for the treating team. Mine are typically a few sentences. I encourage the care managers to derive the treatment goals from a formulation. **Slide 19.** Over extended periods of working with each other, psychiatrists and care managers inevitably learn about each other's areas of interest and expertise in specific biopsychosocial aspects of care**. T**his slide illustrates some specific ways psychotherapeutic theories can be formulated into treatment approaches and goal setting. Ideally, the psychiatrist and care manager integrate across theories with flexible adaptation to individual patients and their longitudinal presentation and treatment response **Slide 20:** Reflection Questions

Module 5: Collaborative Care Consultation II - Making Recommendations and Treating to Target	
Brief Introduction	This module will review principles of goal setting and the development of care plans for common primary care presentations. Developing a treatment plan includes making medication recommendations to primary care providers, supporting the care coordinator use of appropriate brief behavioral and psychotherapeutic interventions (Behavioral Activation Distress Tolerance, Problem Solving Therapy, Motivational Interviewing; Health Behavior Change: Exercise, Tobacco, Diet), working with difficult patients and assessing patient for appropriate level of care. Other topics include enhancing medication compliance, supporting clinic development of safety protocols (to address suicidal thinking and violence) and utilizing community resources.
Module 5: Collaborative Care Consultation II - Making Recommendations & Treating to Target Faculty Notes	
	Slide 3: Learning Objectives: This module focuses on making recommendations in a collaborative care model, especially how this is different from a more traditional consultation. **Slide 4:** These are the common types of consultation questions and common strategies to approach them. It is important to reconsider these questions each time a patient is discussed. **Slides 5:** Since the focus of consultation is patients that are not improving, it is important to have a systematic approach to try to identify the barrier to improvement. **Slide 6:** Often your "note" may be generated through a series of short re-consultations with adjustments in treatment until remission is achieved. **Slide 7:** One of the principles of integrated behavioral health is to make evidence based recommendations. As a psychiatrist, we can keep track of advances in mental health treatment, and thoughtfully educate the PCP around the most practical and useful ones. Going to the literature will be an important part of any consulting psychiatrist role. **Slide 8:** Medication recommendations should consolidate the evidence into a specific plan that the PCP can implement. To be most helpful, the consulting psychiatrist has to do more than write "titrate SSRI" or risk the PCP not having enough detail to know how to do this. PCPs appreciate very specific instructions. **Slide 9-11:** Example of a brief medication instruction. Note the detailed titration instructions and the focus of monitoring. It is also helpful to include information on FDA vs non FDA indications for medications. **Slide 12:** Psychiatrists may also help develop protocols to manage difficult patients. As a consulting psychiatrist, you should be familiar with common brief behavioral and psychotherapeutic interventions, and may even coach the care manager to help deliver these interventions. **Slide 13:** This page shows examples of information that could be shared with the care team. **Slide 14:** Psychiatrists can also draw upon our expertise and experience in supportive psychotherapies in consultations with care manager and/or PCP's about difficult patients. Common areas of attention include balancing empathy/validation toward patients with encouragement of more adaptive behaviors, understanding possible dysfunctional reactions of patients to care providers or vice versa, as well as observing clinicians' job stressors like exposure to painful patient stories and emotions . Though such interventions may often not often make It into a written recommendations or a care plan, they can be critical for maintaining a functional care plan.

	Slide 15: It is important that the whole team shares one treatment plan. One successful PCP used to tell his patients that if he was treating them for depression than they had to see the care manager because that was one part of their treatment. **Slide 16:** This slide reminds the resident that each patient needs to be monitored form improvement. If there is not improvement, we need to re-consult on that case. **Slide 17:** It is a shared responsibility to look for patients that have not improved. This view allows us to sort by last psychiatric note. Currently, the quality aim is to consult on patients that have not improved after 8 weeks. Each consulting session presents opportunities to reexamine older case that have not been discussed recently and generate a new note. **Slide 18:** The next few slides discuss the scope of practice and liability. It is important to think about what limits you would put in place around the population of patients you consult on. Often working in this model forces us to "stretch" ourselves and have to learn more about special populations, such as pregnant women or substance use treatment. **Slide 19-20:** These two slides describe the liability of each provider. Typically, the PCP does all the prescribing and the consulting psychiatrist functions in the capacity of curbside consultation. The care manger must work within their scope of practice including NOT making medical recommendations (unless they are a nurse). **Slide 21:** On each note it is important to make the level of your scope and involvement clear. This is a sample disclaimer that is placed on each note. **Slide 22:** Reflection Questions

Module 6: Collaborative Care Consultation III - Team Building, Work Flow and Quality Improvement	
Brief Introduction	This module will illustrate more of the initial and ongoing team building and workflow task development process in collaborative care.
Module 6: Collaborative Care Consultation III - Team Building, Work Flow and Quality Improvement Faculty Notes	
	Slide 3: Learning Objectives: This model focuses on the leadership and team building roles a consulting psychiatrist may play on a collaborative care team. **Slide 4:** We have discussed the many roles of the consulting psychiatrist. This module will focus on the leadership role for a consulting psychiatrist in shaping behavioral healthcare for a population of patients. **Slide 5:** Psychiatrist leadership can occur in both administrative and clinical domains. The consulting psychiatrist will always act as clinical leaders by supporting a team approach to patients through their close contact with the care manger. Administrative leadership roles occur in more specific situations, especially when psychiatrists are helping create a collaborative care program Sl**ide 6:** As a team leader you can support the team by focusing on the principles of effective collaborative care. These objective goals help the team to focus on the goal and stay in problem solving mode to address any system issues that come up in working together as a team. **Slide 7:** Now that you have been working with a team for a few weeks, you get a sense of how your team works together to address the tasks in this list. Take a few minutes to talk through how this has been working for your team. **Slide 8:** Have there been any challenges for your team in working together? One of the important roles of the consulting psychiatrist is to help troubleshoot if patients are not getting better. Sometimes this is an individual patient challenge and sometimes this is a systems challenge. Going back through these fundamental task lists is a

	good way to identify systems problems and address them early. **Slide 9/10:** Up until now you have been able to see a functioning "mature" program in action, but what if you were asked to help start a new program? These slides describes some critical factors in developing a functional program. There are no easy solutions to these challenges but this list would be a good place to start when thinking about starting a new program. **Slide 11:** The AIMS center has developed a set of worksheets to facilitate teambuilding. The next few slides will be an introduction to this process. **Slide 12-14:** The first step is to define scope and tasks. The teambuilding tools have a generic list that can be customized to the scope of practice for the team. For example, if children will be seen, you may need to add someone who provides coordination with schools and CPS. It is import to be very specific. **Slide 15-18:** The next step is to assess current workflow by having ALL staff at a site (don't forget the "silent" partners) fill out the staff self assessment form to see what people are currently doing and which tasks might need to be assigned. You get this overview when you collate the responses on the worksheets. Lastly, using the information from this assessment you develop a work flow and training/hiring plan. **Slide 19-20:** It is important to define each member's roles and how important handoffs will be made. Team communication cannot be emphasized enough! **Slide 21-22:** Some staff may need to be hired. Although you may not have the final say in staff decisions you may be asked to help provide job descriptions and evaluate candidates. You also may be in the position to make sure that anyone who will be "re-deployed" from another role has adequate protected time to do this job. **Slide 23:** Different types of programs will have different caseloads and number of staff needed. This slide shows a few examples of different populations and their staffing ratios. **Slide 24:** If you are involved in hiring, you will quickly realize it can be challenging to find a good staff person for the BHP role. **Slide 25:** Program oversight and quality improvement are fundamental to effective care. When setting up a program, time to regularly assess and make adjustments to workflows is critical to getting good outcomes. Regularly reviewing quality aims is a good way to monitor for challenges. **Slide 26:** Reflection questions

3) Curricula Content

Resident Guides

Module 1: Introduction to Collaborative Care	
Brief Introduction	This module will introduce a resident to the rationale and evidence base for collaborative care, as well as the elements of effective collaborative care and the multi-dimensional role for the consulting psychiatrist in this type of care.
Objectives - At the conclusion of this module, the resident will be able to:	
Knowledge	Understand the case for collaborative care and be familiar with the growing evidence base for collaborative care.
Skills	Recognize the basic elements and principles of collaborative care and be ready to further explore both in later modules.
Attitudes	Examine their own experiences and opinions of existing outpatient mental health systems while considering collaborative care psychiatry's potential for delivering

	more integrated and population based care.
Reading	1. Thielke, S., S. Vannoy, et al. (2007). **Integrating mental health and primary care**. *Prim Care* 34(3): 571-592, vii. http://www.ncbi.nlm.nih.gov/pubmed/17868760 2. Gilbody, S., P. Bower, et al. (2006). **Collaborative care for depression: a cumulative meta-analysis and review of longer-term outcomes**. *Arch Intern Med* 166(21): 2314 - 2321. http://archinte.jamanetwork.com/article.aspx?articleid=411326 3. Thota AB, Sipe TA, Byard GJ, et al. of the Community Preventive Services Task Force. **Collaborative care to improve the management of depressive disorders. A Community Guide systematic review and meta-analysis**. *Am J Prev Med* 2012; 42(5):525-38. http://www.sciencedirect.com/science/article/pii/S0749379712000761
Synopsis of Reading	*Integrating mental health and primary care* : This article provides a thematic overview of historical efforts to effectively treat mental health disorders in primary care settings. The authors first describe challenges of treating mental health disorders including: diagnostic heterogeneity and comorbidity, stigmatization from providers and patients alike, perceived lack of time and training for providers, and systemic level difficulties with effectively tracking symptoms and funding. Intuitively appealing individual approaches to improving mental health in primary care are described as having limited efficacy (systematic screening, education and training of providers, dissemination of treatment guidelines) and limited feasibility (co-location of mental health providers are reviewed) in research to date. Table 1 in the article provides a concise overview of core processes and provider roles in collaborative care around effectively using systematic diagnosis and tracking of outcomes to ensure patients are treated to improvement using evidence based algorithms. The article concludes with a call for further research around identifying the most effective aspects of collaborative care processes alongside ongoing changes in health care delivery systems, information technology, and patient involvement in health care. *Collaborative care for depression: a cumulative meta-analysis and review of longer-term outcomes:* The authors report the results of a Meta-analysis of 37 randomized studies comparing collaborative care with usual primary care in patient with depression. Results indicated improved depression outcomes at 6 months (standardized mean difference, 0.25; 95% confidence interval, 0.18-0.32) and evidence of longer-term benefit up to 5 years (mean difference, 0.15; 95% confidence interval, 0.001-0.31). They also reported that studies with traditional elements of collaborative care (a case manager, a primary care physician, and access to specialist input) tended to be more effective. Further determinants of effectiveness included medication adherence, professional background and method supervision of case managers but not the addition of brief psychotherapy. They support the conclusion that collaborative care has a sufficient enough evidence base to support its active dissemination and implementation. *Collaborative care to improve the management of depressive disorders. A Community Guide systematic review and meta-analysis* This article follows-up Gilbody et al's 2006 Meta-analysis with an additional review of 32 studies of collaborative care conducted between 2004 and 2009. The authors describe their use of Community Guide methods for conceptualizing and carrying out a systematic review of collaborative care treatment of depression. They found a meaningful effect in all identified pertinent outcomes,

	including improvement of depressive symptoms (standardized mean difference, 0.34; 95% confidence interval, 0.25-0.43), adherence to pharmacological or psychotherapeutic treatment (Odds Ratio= 2.22), satisfaction with care (standardized mean difference= 0.39), with a smaller effect for quality of life (standardized mean difference= 0.12). They provide further subgroup analyses around potential modifiers of treatment effect including type of organization and case manager. They also offer discussion around barriers to treatment and need for further research around: optimal training and background of care managers, optimal type and frequency of case management sessions, and consideration of how to address patients with treatment resistance.
Discussion and Reflection Questions	1. In your previous medical training, what have you observed around primary care delivery of mental health care services? 2. What have been your experiences in finding effective dispositions for patients from acute mental health settings? 3. Are there unmet needs in my community or clinic that could be addressed with a more effectively integrated behavioral health program
Slide Set	Module 1_Introduction to Collaborative Care
Additional Resources	AIMS Center: http://uwaims.org/ IMPACT Website: http://impact-uw.org/

Module 2: Introduction to Specific Program (Example provided of the Mental Health Integration Program - MHIP)	
Brief Introduction	This module will review the populations served by Washington State's Mental Health Integration Program (MHIP). The basic program structure, quality aims and the tracking tool (MHITS) will also be introduced.
Objectives - At the conclusion of this module, the resident will be able to:	
Knowledge	Describe the populations served by and typical team configuration in the MHIP program.
Skills	Conceptually understand and be ready to use a tracking tool such as MHITS.
Attitudes	Consider quality aims a part of routine practice for working in MHIP.
Reading	1. Unutzer, J., Y. F. Chan, et al. (2012). **Quality improvement with pay-for-performance incentives in integrated behavioral health care**. *Am J Public Health* 102(6): e41-45 http://www.ncbi.nlm.nih.gov/pubmed/22515849
Synopsis of Reading	*Pay-for-Performance Incentives* This paper reviews the effect of monetarily incentivizing the implementation of quality aims in the MHIP collaborative care program. A portion of clinical payment to clinics was only given to clinics meeting quality aims including: twice monthly visits with clients, recording of clients' medications, the presence of a complete clinical assessment in the chart, and psychiatric case reviews completed for a 50% of the total caseload. Analyses showed that the median time elapsed for reaching improvement (rate of achieving a 50% or greater reduction or a score of less than 10 on thePHQ-9) was reduced from approximately 64 weeks pre-pay for performance implementation to 25 weeks post-implementation. These analyses strongly suggest that when key quality indicators are tracked and a substantial portion of payment is tied to such quality indicators, the effectiveness of care for safety-net populations can be substantially improved.

Discussion and Reflection Questions	1. What are your past experiences working with clients who are on disability? What have been the challenges in working with this population? What are some of the rewards? 2. Have you had any exposure to quality aims in your clinical work before? What do you see as the advantages and challenges of using quality aims to guide clinical interactions?
Slide Set	Module 2_ Introduction to MHIP
Additional Resources	MHIP Website: http://integratedcare-nw.org/index.html

Module 3: Collaborative Care Teams	
Brief Introduction	This module will describe in further depth the roles and practice environment of collaborative care teams in primary care clinics and further illustrate the process of caseload consultation.
Objectives - At the conclusion of this module, the resident will be able to:	
Knowledge	Understand in more depth the typical role responsibilities for PCP's, care managers, and psychiatrists in collaborative care. Relate collaborative care processes and roles to a typical primary care work flow and practice environment.
Skills	Use telephone/telepsychiatry to perform psychiatric consultation. Demonstrate increased comfort in communications with both care managers and primary care providers.
Attitudes	Consider personally implanting strategies for improving communication with care managers and PCP's .
Reading	1. Levine, S., J. Unützer, et al. (2005). **Physicians' satisfaction with a collaborative disease management program for late-life depression in primary care**. *Gen Hosp Psychiatry* 27(6): 383-391. http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=16271652
Synopsis of Reading	*Physicians satisfaction with a collaborative disease management program for late-life depression in primary care:* This study reports on a satisfaction survey of 450 primary care physicians at 18 participating clinics in the IMPACT collaborative care trial. Before intervention, about half (54%) of the physicians were satisfied with existing resources to treat depression. Afterwards, 90% reported the collaborative care intervention as helpful for treating patients with depression, and 82% felt that the intervention improved patients' clinical outcomes. Physicians identified close patient follow-up and patient education as the most helpful components of the IMPACT model. Significantly more resident than nonresident physicians indicated that an on-site consultation model would influence whether they would be more likely to diagnose and treat depressed patients. This further supports arguments for exposing general physicians to collaborative care processes during their training.
Discussion and Reflection Questions	1. What have been your experiences working as a psychiatrist in multidisciplinary care teams? Has sharing patient care, communication, teaching been enjoyable and frustrating? 2. To date, have you had any experience (e.g. telepsychiatry, 'curbside consultations' with medical colleagues or non-medical acquaintances) with providing indirect consulting in psychiatry? 3. How do you feel about a psychiatry consulting process that stresses iterative and longitudinal approaches to patient diagnosis and treatment?
Slide Set	Module 3 _Collaborative Care Teams
Additional Resources	MHIP Website: http://integratedcare-nw.org/index.html TEAMcare Website: http://www.teamcarehealth.org/

Module 4: Collaborative Care Consultation I - Case Finding, Differential Diagnosis and Case Formulation	
Brief Introduction	This module will introduce the fundamentals of diagnosis in a collaborative care program. We will focus on how collaborative care assessment differs from an individual psychiatric consultation , as well as the use of screeners to aid in diagnosis and case formulation. We will also review common diagnostic quandaries, working with care coordinators to clarify diagnoses and identifying relevant biopsychosocial factors, and when to consider direct assessment of a patient.
Objectives - At the conclusion of this module, the resident will be able to:	
Knowledge	Recognize common diagnostic dilemmas in primary care settings.
Skills	Use screeners effectively to aid in diagnostic evaluation.
Attitudes	Be flexible about making a diagnosis in the absence of a direct assessment. Integrate the patient's own and other providers' perspectives into a common understanding of the patient problems and presentation.
Reading	4. Kroenke, K., R. L. Spitzer, et al. (2010). **The Patient Health Questionnaire Somatic, Anxiety, and Depressive Symptom Scales: a systematic review**. *Gen Hosp Psychiatry* 32(4): 345-359. http://www.ncbi.nlm.nih.gov/pubmed/20633738 5. Manning, J. S. (2010). **Tools to improve differential diagnosis of bipolar disorder in primary care**. Prim Care Companion *J Clin Psychiatry* 12(Suppl 1): 17-22 http://www.ncbi.nlm.nih.gov/pubmed/20628502 6. Phelps, J. R. and S. N. Ghaemi (2006). **Improving the diagnosis of bipolar disorder: predictive value of screening tests**. *J Affect Disord* 92(2-3): 141-148. http://www.ncbi.nlm.nih.gov/pubmed/16529822
Synopsis of Reading	8. The PHQ-9 has good sensitivity and specificity* for detecting depressive disorders. Likewise, the GAD-7 can aid in detecting generalized anxiety, panic, social anxiety and post-traumatic stress disorder. The optimal cutpoint is > or = 10 on the parent scales (PHQ-9 and GAD-7). Cutpoints of 5, 10 and 15 represent mild, moderate and severe symptom levels on all three scales. Sensitivity to change is well-established for the PHQ-9 and emerging albeit not yet definitive for the GAD-7 and PHQ-15. The PHQ-9, GAD-7 and PHQ-15 are brief well-validated measures for detecting and monitoring depression, anxiety and somatization. 9. This paper describes an approach to bipolar diagnosis in primary care. The author estimates that up to 20% to 30% of patients presenting primary care setting for depressive and/or anxiety symptoms may have bipolar disorder and that patients with this disorder are often underrecognized. An awareness of the prevalence, characteristics, and predictors of bipolar disorder can help the primary care physician to properly differentiate between bipolar depression and unipolar depression. The authors review the use of two screening tools (Mood Disorder Questionnaire and the World Health Organization Composite International Diagnostic Interview 3.0). 10. This article examines the practical use of the screeners in evaluating bipolar disorder by looking at statistics. They describe how clinicians' clinical impression enhances the interpretation of a MDQ result. If a clinician believes that it is unlikely that a patient has bipolar disorder, they endorse the MDQ as a good tool to "rule out" bipolar disorder. The MDQ may help identify a true positive in patients with histories consistent with a possible diagnosis and an intermediate probability of bipolar disorder. If a clinician believes the patient has bipolar disorder, there is likely not much additional benefit in using the MDQ. In these cases, better history taking is probably the most useful tool. 11. *Remember: Sensitivity measures the proportion of actual positives which are

	correctly identified as such (e.g. the percentage of sick people who are correctly identified as having the condition). Specificity measures the proportion of negatives which are correctly identified (e.g. the percentage of healthy people who are correctly identified as not having the condition).
Discussion and Reflection Questions	12. What experience do you have using screeners as diagnostic aids and to measure treatment response? What are the advantages and challenges using screeners? How can you integrate the use of screeners into your practice? 13. After observing a care coordinator and consulting psychiatrist working together to make a diagnosis, what do you think will be challenging for you about indirect assessment? 14. What will be the "must haves" pieces of information for you to have to feel confident in a bipolar diagnosis? How can we help support more accurate diagnosis of bipolar disorder?
Slide Set	Module 4_ Collaborative Care Consultation I - Case Finding, Differential Diagnosis and Case Formulation
Additional Resources	15. APA Guidelines: http://psychiatryonline.org/guidelines.aspx 16. Stable Toolkit (Bipolar Disorder): http://www.cqaimh.org/stable_toolkit.html 17. Helping Patients Who Drink Too Much: A Clinician's Guide: http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm
Additional References	18. Bradley, K. A., A. F. DeBenedetti, et al. (2007). **AUDIT-C as a brief screen for alcohol misuse in primary care.** *Alcohol Clin Exp* Res 31(7): 1208-1217. http://www.ncbi.nlm.nih.gov/pubmed/17451397 19. Spitzer, R. L., K. Kroenke, et al. (2006**). A brief measure for assessing generalized anxiety disorder: the GAD-7**. *Arch Intern Med* 166(10): 1092-1097. http://www.ncbi.nlm.nih.gov/pubmed/16717171 20. Viron, M., T. Baggett, et al. (2012). **Schizophrenia for primary care providers:how to contribute to the care of a vulnerable patient population**. *Am J Med* 125(3): 223-230. http://www.ncbi.nlm.nih.gov/pubmed/22340915 21. Wittchen, H. U. (1994). **Reliability and validity studies of the WHO-Composite International Diagnostic Interview (CIDI): a critical review.** *J Psychiatr Res* 28(1): 57-84. http://www.ncbi.nlm.nih.gov/pubmed/8064641

Module 5: Collaborative Care Consultation II - Making Recommendations and Treating to Target	
Brief Introduction	This module will review principles of goal setting and the development of care plans for common primary care presentations. Developing a treatment plan includes making medication recommendations to primary care providers, supporting the care coordinator use of appropriate brief behavioral and psychotherapeutic interventions (Behavioral Activation Distress Tolerance, Problem Solving Therapy, Motivational Interviewing; Health Behavior Change: Exercise, Tobacco, Diet), working with difficult patients and assessing patient for appropriate level of care. Other topics include enhancing medication compliance, supporting clinic development of safety protocols (to address suicidal thinking and violence) and utilizing community resources.
Objectives - At the conclusion of this module, the resident will be able to:	
Knowledge	Make recommendations for common primary care presentations.
Skills	Assess a patient that has not responded to initial treatment plan.
Attitudes	Apply a stepped-care approach to determine appropriate level of care.
Reading	22. Roy-Byrne, P., M. G. Craske, et al. (2010). **Delivery of Evidence-Based Treatment for Multiple Anxiety Disorders in Primary Care: A Randomized Controlled Trial.** *JAMA* 303(19): 1921-1928. http://www.ncbi.nlm.nih.gov/pubmed/20483968 23. Rush, A. J. (2007). **STAR*D: what have we learned?** *Am J Psychiatry* 164(2): 201-204. http://www.ncbi.nlm.nih.gov/pubmed/17267779
Synopsis of Reading	24. STAR*D: what have we learned? This article is a practical review of the STAR*D trial that highlights some key treatment recommendations for depression in outpatient settings. All patients were initially offered treatment with citalopram. Highlights include observations of remission or response times occurring up to 6-10 weeks (at adequate doses) which suggest that as long as it remains tolerable, a medication should be continued for this trial period before switching or augmentation. If additional treatment is needed, patients with no response should likely switch medications while those having good tolerance and partial response to a medication are generally better candidates for augmentation. Second step options include within-class switch (another SSRI), out-of -class switch (to bupropion-SR or venlafaxine-XR) or augmentation (bupropion-SR or buspirone). There was no difference between cognitive therapy as a switch or as augmentation strategy versus medication as a switch or augmentation strategy, however this option was not picked by many patients (perhaps due to cost and other barriers). Third and fourth medication steps with markedly diminishing remission rates are also reviewed. Finally, this article validates the importance of remission as a goal for treatment. Delivery of evidence-based treatment for multiple anxiety disorders in primary care: a randomized controlled trial. This article describes a collaborative care intervention that has been developed to deliver evidence based treatment for anxiety (panic disorder, social anxiety disorder, generalized anxiety disorder and posttraumatic disorder) in primary care settings. Patients were randomized to treatment as usual or collaborative care. Collaborative care treatment included a team based approach (care manager, primary care provider and consulting psychiatrist) and allowed choice of cognitive behavioral therapy (CBT), medication, or both. Interventions included a pharmacotherapy algorithm (start with SSRI or SNRI and optimize dose with additional steps for non-responders) and modified CBT protocol. The CBT protocol utilized a

	computerized system for supporting CBT (CALM Tools for Living) to help guide non-expert care managers in delivering evidence based CBT. For patients with anxiety disorders treated in primary care clinics, CALM compared with usual care resulted in greater improvement in anxiety symptoms, depression symptoms, functional disability, and quality of care during 18 months of follow-up.
Discussion and Reflection Questions	1. What experiences have you had making recommendations on consultation services? How is this similar and different to treating patients directly? 2. How do you keep current about evidence based treatments? How do you plan to do this in your career? 3. What are your experiences with brief behavioral and psychotherapeutic interventions? What do you think will be challenging and rewarding in coaching care mangers about these types of treatments?
Slide Set	Module 5_Collaborative Care Consultation II - Making Recommendations and Treating to Target
Additional Resources	25. APA Guidelines: http://psychiatryonline.org/guidelines.aspx 26. Stable Toolkit (Bipolar Disorder): http://www.cqaimh.org/stable_toolkit.html 27. Helping Patients Who Drink Too Much: A Clinician's Guide: http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm
Additional References	1. Arroll, B., C. R. Elley, et al. (2009). **Antidepressants versus placebo for depression in primary care.** Cochrane Database *Syst Rev*(3): CD007954. http://www.ncbi.nlm.nih.gov/pubmed/19588448 2. Viron, M., T. Baggett, et al. (2012). **Schizophrenia for primary care providers: how to contribute to the care of a vulnerable patient population.** *Am J Med* **125**(3): 223-230. http://www.ncbi.nlm.nih.gov/pubmed/22340915

Module 6: Collaborative Care Consultation III - Team Building, Work Flow and Quality Improvement	
Brief Introduction	This module will illustrate more of the initial and ongoing team building and workflow task development process in collaborative care.
Objectives - At the conclusion of this module, the resident will be able to:	
Knowledge	Identify administrative and clinical leadership roles for psychiatrists in collaborative care practices Understand the team building process tool including assessing staff and training needs
Skills	Address common collaborative care process challenges and problem solve simple work flow issues in a specific clinic
Attitudes	Appreciate the necessity of other clinic staff including program managers and 'primary care champions' in building and maintaining collaborative care teams Consider themselves a leader with regard to quality assessment and improvement efforts. Appreciate the need for flexibility and dynamism in creating and continuously improving collaborative care teams and their workflows
Reading	1. Grypma, L., R. Haverkamp, et al. (2006). T**aking an evidence-based model of depression care from research to practice: making lemonade out of depression.** *Gen Hosp Psychiatry* 28(2): 101-107. http://www.ncbi.nlm.nih.gov/pubmed/16516059 2. Johnson, J. K., D. M. Woods, et al. (2010). **Joy and challenges in improving chronic illness care: capturing daily experiences of academic primary care teams.** *J Gen Intern Med* **25 Suppl 4**: S581-585. http://www.ncbi.nlm.nih.gov/pubmed/20737233
Synopsis of Reading	*Taking an evidence-based model of depression care from research to practie: making lemonade out of depression.* The authors examine how an adapted version of the IMPACT collaborative care trial was working in the "real-world" setting of an HMO 3 years after concluding the trial. They report on how core components of the collaborative care intervention, with the enthusiasm of on-site primary care physicians, were continued with modifications including a group education class about depression, the addition of a medical assistant to help expand the depression care manager's caseload and inclusion of all age groups. The post-study participants had significantly less mean contacts (19.8 to 13.6, t=7.6, P<.001), but used similar amounts of antidepressants (85% and 90%) and overall had similarly substantial improvement in depression over 6 months. Further subanalyses of results indicated larger drops in PHQ-9 scores for longer term patients (>6 months) than those remaining in care for shorter term (<10 weeks). They found men less likely to consistently return for follow-up in-person encounters. *Joy and challenges in improving chronic illness care: Capturing daily experiences of academic primary care teams.* This study report on efforts to better understand the daily experiences of participants from teaching hospitals working in a chronic care collaborative toward the goal of implementing the chronic are model (CCM) in resident continuity practices. They developed a qualitative survey delivered through daily e-mails that prompted participants to describe their individual and team feelings and experiences around providing care to patients with chronic health problems. The six most frequent themes from 1,145 narrative entries were: mindfulness of patient care, changes in work attributed to the collaborative experience, greater focus on patient education, multi-disciplinary team function, mindfulness of

	learner interactions, and reflection of action. The authors provide examples of each theme. They also compared high and lower performing sites and found the former reported more professional work satisfaction (i.e. a sense of "joy in work") and the latter had lack of professional satisfaction and reporting of "system failures."
Discussion and Reflection Questions	What challenges have you observed with workflow in your first few weeks of consultation? How has the consulting psychiatrist taken a leadership role around these issues? What collaborative care tasks or roles may be easier or harder to create in primary care clinics where you have worked? What would be my strengths and challenges as a clinical or administrative leader in a primary care?
Slide Set	Module 6: Team Building, Work Flow and Quality Improvement in a Primary Care Setting
Additional Resources	MHIP Website: http://integratedcare-nw.org/index.html

Sample Rotation Description:

Mental Health Integration Program Rotation

Attendings:

Anna Ratzliff, MD, PHD
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Jim Basinski, MD
e-mail: basinski@uw.edu

Rotation Description:

The Mental Health Integration Program (MHIP) provides collaborative stepped care to treat common mental disorders in primary care settings. Residents will work closely with a MHIP consulting psychiatrist and participate in weekly phone consultation with a care coordinator. Residents are responsible for developing formulations and treatment plans for patients, to be implemented in a primary care setting. Residents consulting with offsite clinics will have the opportunity to participate in clinic visits to remote primary care sites to provide in-person consultation and primary care provider education. Residents consulting with onsite clinics will have the opportunity for participation in interdisciplinary care team meetings, direct observation of MHIP care manager work, and more frequent visits to clinic for in-person consultation and informal interactions with interdisciplinary team members

Learning Objectives for the Mental Health Integration Program Rotation:

At the conclusion of this rotation, the resident will be able to:

- Define the key components of an integrated mental health program.
- Discuss the evidence-based literature about integrated mental health programs.
- Describe the different roles and providers in an integrated mental health program and the ways they support clients.
- Develop a collaborative care workflow (including triaging patients to appropriate level of care) and systems.
- Demonstrate that they actively participated in and provided psychiatric consultation in an integrated care team.
- Recognize benefits and limitations in using screening questionnaires to aid in diagnosis and treatment of common mental health disorders
- Evaluate the evidence-based literature about providing mental health care in a primary care setting.
- Formulate patient presentations and develop treatment plans (including stepped-care) to be delivered by an integrated care team.
- Work effectively with a care manager, including identifying the care manager's individual skill set, knowledge, and attitudes and tailoring the consultation hour to their education and needs
- Effectively communicate with primary care providers.

Requirements:

- Participate in weekly consultation with care coordinator
- Notes from consultation completed within 1 day and sent to attending
- Weekly supervision with attending about consultation cases
- Schedule in person evaluations at least once over the rotation
- At least one presentation of educational materials to care team

Optional:

- Attend a once monthly consulting psychiatrist meeting on the first Friday of the month at 1pm in bb1615
- Observe consultation with at least one other MHIP consulting psychiatrist

1) References

Module 1: Introduction to Collaborative Care

- Gilbody, S., P. Bower, et al. (2006). **Collaborative care for depression: a cumulative meta-analysis and review of longer-term outcomes**. *Arch Intern Med* 166(21): 2314 - 2321. http://archinte.jamanetwork.com/article.aspx?articleid=411326
- Katon, W., & Unutzer, J. (2011). **Consultation psychiatry in the medical home and accountable care organizations: achieving the triple aim**. *Gen Hosp Psychiatry* 33 (4), 305-310. http://www.ncbi.nlm.nih.gov/pubmed/21762825
- Thielke, S., S. Vannoy, et al. (2007). **Integrating mental health and primary care**. *Prim Care* 34(3): 571-592, vii. http://www.ncbi.nlm.nih.gov/pubmed/17868760
- Thota AB, Sipe TA, Byard GJ, et al. of the Community Preventive Services Task Force. **Collaborative care to improve the management of depressive disorders. A Community Guide systematic review and meta-analysis.** *Am J Prev Med* 2012; 42(5):525-38. http://www.sciencedirect.com/science/article/pii/S0749379712000761

Module 2: Introduction to Specific Program (Example provided of the Mental Health Integration Program - MHIP)

- Unutzer, J., Y. F. Chan, et al. (2012). **Quality improvement with pay-for-performance incentives in integrated behavioral health care**. *Am J Public Health* 102(6): e41-45 http://www.ncbi.nlm.nih.gov/pubmed/22515849

Module 3: Collaborative Care Teams

- Levine, S., J. Unützer, et al. (2005). **Physicians' satisfaction with a collaborative disease management program for late-life depression in primary care**. *Gen Hosp Psychiatry* 27(6): 383-391. http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=16271652

Module 4: Collaborative Care Consultation I - Case Finding, Differential Diagnosis and Case Formulation

- Bradley, K. A., A. F. DeBenedetti, et al. (2007). **AUDIT-C as a brief screen for alcohol misuse in primary care**. *Alcohol Clin Exp Res* 31(7): 1208-1217. http://www.ncbi.nlm.nih.gov/pubmed/17451397
- Kroenke, K., R. L. Spitzer, et al. (2010). **The Patient Health Questionnaire Somatic, Anxiety, and Depressive Symptom Scales: a systematic review**. *Gen Hosp Psychiatry* 32(4): 345-359. http://www.ncbi.nlm.nih.gov/pubmed/20633738
- Manning, J. S. (2010). **Tools to improve differential diagnosis of bipolar disorder in primary care.** *J Clin Psychiatry* 12(Suppl 1): 17-22 http://www.ncbi.nlm.nih.gov/pubmed/20628502
- Phelps, J. R. and S. N. Ghaemi (2006). **Improving the diagnosis of bipolar disorder: predictive value of screening tests.** *J Affect Disord* 92(2-3): 141-148. http://www.ncbi.nlm.nih.gov/pubmed/16529822
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- **generalized anxiety disorder: the GAD-7**. *Arch Intern Med* 166(10): 1092-1097. http://www.ncbi.nlm.nih.gov/pubmed/16717171
- Viron, M., T. Baggett, et al. (2012). **Schizophrenia for primary care providers:how to contribute to the care of a vulnerable patient population.** *Am J Med* 125(3): 223-230. http://www.ncbi.nlm.nih.gov/pubmed/22340915
- Wittchen, H. U. (1994). **Reliability and validity studies of the WHO-Composite International Diagnostic Interview (CIDI): a critical review**. *J Psychiatr Res* 28(1): 57-84. http://www.ncbi.nlm.nih.gov/pubmed/8064641

Module 5: Collaborative Care Consultation II - Making Recommendations and Treating to Target

- Arroll, B., C. R. Elley, et al. (2009). **Antidepressants versus placebo for depression in primary care.** Cochrane Database *Syst Rev*(3): CD007954. http://www.ncbi.nlm.nih.gov/pubmed/19588448
- Huynh, N., N. McIntyre, R., S. (2008) **What are the implications of the STAR*D trial for primary care. A Review and Synthesis.** *J Clin Psychiatry* 10:91–96. http://www.ncbi.nlm.nih.gov/pubmed/18458732
- Roy-Byrne, P., M. G. Craske, et al. (2010). **Delivery of Evidence-Based Treatment for Multiple Anxiety Disorders in Primary Care: A Randomized Controlled Trial.** *JAMA* 303(19): 1921-1928. http://www.ncbi.nlm.nih.gov/pubmed/20483968
- Rush, A. J. (2007). **STAR*D: what have we learned?** *Am J Psychiatry* 164(2): 201-204. http://www.ncbi.nlm.nih.gov/pubmed/17267779
- Viron, M., T. Baggett, et al. (2012). **Schizophrenia for primary care providers: how to contribute to the care of a vulnerable patient population.** *Am J Med* 125(3): 223-230. http://www.ncbi.nlm.nih.gov/pubmed/22340915

Module 6: Collaborative Care Consultation III - Team Building, Work Flow and Quality Improvement

- Grypma, L., R. Haverkamp, et al. (2006). **Taking an evidence-based model of depression care from research to practice: making lemonade out of depression**. *Gen Hosp Psychiatry* 28(2): 101-107. http://www.ncbi.nlm.nih.gov/pubmed/16516059
- Johnson, J. K., D. M. Woods, et al. (2010). **Joy and challenges in improving chronic illness care: capturing daily experiences of academic primary care teams**. *J Gen Intern Med* 25 Suppl 4: S581-585. http://www.ncbi.nlm.nih.gov/pubmed/20737233
- AIMS Center: http://uwaims.org/

5) Rotation Evaluation and Tools

Residents complete a pretest when beginning the rotation. Open ended questions assess their reasons and specific goals for taking the rotation as well as comfort level with providing indirect or 'curbside consultations.' Residents also complete an end-anchored six-point Likert scale to self-assess their level of interest and knowledge around specific rotation and curriculum goals including: understanding the key components, roles, and workflow of integrated care program, familiarity with evidence based literature for providing mental health care in primary settings, as well as working and communicating effectively within primary care teams.

The attending psychiatrist each week provides direct observation and immediate feedback around the residents' work with the care manager. The attending psychiatrist further evaluates all of the resident's case review and treatment recommendation notes with editing and verbal feedback as needed. Finally, the attending psychiatrist follows-up with the resident psychiatrist around their experiences providing agreed upon additional communication or educational steps with the PCP or another team member.

Residents are prompted for regular feedback for continuous changes of the rotation to meet their specific needs, e.g. observing additional psychiatrist-care manager dyads or additional opportunities for providing education to team members. We encourage residents to complete regular reflection journals to enhance their overall participation in the rotation as well as the quality of their feedback.

Care managers and any other relevant team members also provide '360 degree evaluations focusing on the resident's communication skills, professionalism, and team participation.

Upon completion of the rotation, residents complete a post-test with open-ended questions querying their overall impression of the rotation's strengths and areas for improvement as well as the degree to which they have accomplished their original goals. In more depth than the pretest, we ask them to self-assess their proficiency around rotation and curriculum objectives, including skills in: effectively formulating patient presentation, developing treatment plans, and communicating to the primary care team as part of an in-direct treatment approach. Residents complete the same end-anchored six-point Likert scale as the pretest to self-assess these competencies. We finally ask residents to evaluate the effectiveness of individual attending supervisors by using standardized residency evaluation forms containing both open and closed ended queries including specific strength and areas for improvement.

Evaluation Forms

Form 1: Collaborative Care Rotation and Curriculum Pre-test (Filled out by resident)

Collaborative Care Pretest	Name:
1. Why are you interested in taking this elective in collaborative care psychiatry	
2. Do you have any specific goals for this elective?	
3. How comfortable are you in providing 'curbside' or other indirect consultations on patients that you have not examined yourself?	High 5—4—3—2—1 Low
4. How would you self-assess your level of knowledge about the roles and workflow of collaborative care process	High 5—4—3—2—1 Low
5. What is level interest in learning more about this area?	High 5—4—3—2—1 Low
6. How would you self-assess your familiarity with the evidence base for providing mental health care in primary care settings?	High 5—4—3—2—1 Low
7. What is your level of interest in learning more about this area?	High 5—4—3—2—1 Low
8. How would you describe your skill in effectively working and communicating within primary care teams?	High 5—4—3—2—1 Low
9. What is your level of interest in addressing your skill-set in this area?	High 5—4—3—2—1 Low

Form 2: Collaborative Care Rotation and Curriculum Post-test (Filled out by Resident)

Collaborative Care Post test	Name:
1. Please comment on strengths of this rotation:	
2. Please provide constructive feedback about areas for improvement in this rotation:	
3. Has your experience with this rotation or curriculum changed any of your career plans?	
4. What was experience around completing any of your initial goals for this rotation?	
5. Level of knowledge about the roles and workflow of collaborative care process.	High 5—4—3—2—1 Low
6. Familiarity with the evidence base for providing mental health care in primary care settings.	High 5—4—3—2—1 Low
7. Comfort level using screening questionnaires to aid in diagnosis and treatment of common mental health disorders	High 5—4—3—2—1 Low
8. Skillfulness in working with individual care coordinator including tailoring the consultation hours to their specific needs	High 5—4—3—2—1 Low
9. Skillfulness in effectively formulating patient in consultation and developing effective treatment plans	High 5—4—3—2—1 Low
10. Skillfulness in communicating and coordinating care with primary care physicians and other clinicians.	High 5—4—3—2—1 Low

Form 3: Standard Evaluation of Resident in Collaborative Care Rotation (Filled out by collaborative care attending psychiatrist)

Standard Evaluation of Resident in Collaborative Care Rotation	**Name:**
Residents are rated on the following scale: O: Outstanding - A: Above Average - P: Proficient/meets Expectations – E: Emerging – N:Needs Attention	
Knowledge:	**O – A – P – E – N**
Displays appropriate knowledge of the evidence base for providing mental health care in primary care settings-	**O – A – P – E – N**
Effectively uses information technology in the service of patient care -	**O – A – P – E – N**
Practice-Based learning and Improvement:	**O – A – P – E – N**
Interpersonal and Communication Skills:	**O – A – P – E – N**
Effectively communicates and works with individual care managers including tailoring the consultation hour to their specific needs.	**O – A – P – E – N**
Works effectively as part of a multidisciplinary outpatient team, with all relevant mental health, chemical dependency, and primary care providers involved in the patient's care	**O – A – P – E – N**
Professionalism:	**O – A – P – E – N**
Demonstrates respect for others, compassion -	**O – A – P – E – N**
Demonstrates reliable attendance and appropriate professional attire -	**O – A – P – E – N**
Displays integrity, accountability, and an ethical approach to outpatient treatment -	**O – A – P – E – N**
Demonstrates understanding of patients and their illness in a sociocultural context, including displaying sensitivity to patients' culture, ethnicity, age, gender, socioeconomic status, sexual minority status, and/or disability -	**O – A – P – E – N**
Demonstrates concise, accurate, and timely record keeping -	**O – A – P – E – N**
Demonstrates appropriate autonomy for his/her level of training –	**O – A – P – E – N**
Systems-Based Practice:	**O – A – P – E – N**
Provides clinically appropriate and cost effective care –	**O – A – P – E – N**

Appropriately advocates for quality patient care and help patients with system complexities –	**O – A – P – E – N**
Leadership:	**O – A – P – E – N**
Displays effective team leadership skills, including the ability triage, prioritize tasks, and delegate work as appropriate –	**O – A – P – E – N**
Educational Attitudes -	**O – A – P – E – N**
Displays openness to supervision; accepts constructive criticism -	**O – A – P – E – N**
Seeks direction when appropriate; demonstrates eagerness to learn –	**O – A – P – E – N**
Observations concerning particular strengths of the residents:	
Suggestions concerning additional strengths which should be developed by the resident:	

Overall appraisal of the resident's performance: [ ] Met or exceeded expectations for his/her level of training [ ] Suggestions for improvement are being followed [ ] An informal review by the Site Coordination Committee could be useful [ ] Unsatisfactory performance. I recommend
Provide recommendation here, if you selected "unsatisfactory performance. I recommend" in the box above:

Form 4: 360-Degree Evaluation (to be filled out by care manager and/or PCP)

	Name:				
Service:	**Evaluator Name and Job Title:**				
Please indicate to what extent you agree or disagree with the following statements about this resident:					
Interpersonal and Communication Skills:					
1. Creates and sustains therapeutic and ethically sound relationships with team	**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**	**Can't Assess**
2. Uses effective listening skills	**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**	**Can't Assess**
3. Uses effective verbal, nonverbal, and written communication skills	**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**	**Can't Assess**
4. Works effectively with others as a member or leader of a team	**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**	**Can't Assess**
Professionalism	**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**	**Can't Assess**
1. Demonstrates respect, compassion, and Integrity	**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**	**Can't Assess**
2. Demonstrates accountability, conscientiousness	**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**	**Can't Assess**
3. Shows a commitment to ethical principles pertaining to provision/withholding of care, confidentiality of patient information, informed consent, business practices	**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**	**Can't Assess**
4. Displays appropriate dress, attendance, and professional conduct	**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**	**Can't Assess**
Systems-Based Practice	**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**	**Can't Assess**
1. Advocates for quality patient care and helps team deal with system complexities	**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**	**Can't Assess**
Please provide any written comments about this resident :					

Form 5: Standard Evaluation of Rotation and Attending (To be filled out by resident)

Evaluation of Collaborative Care Attending	Date:
Evaluation of:	Evaluator:
Please rate your attending:	
1. Told me when he or she should be contacted regarding patients:	**High 5—4—3—2—1 Low**
2. Was available when I needed him/her:	**High 5—4—3—2—1 Low**
3. Provided an appropriate balance of supervision and autonomy:	**High 5—4—3—2—1 Low**
4. Was skilled and knowledgeable:	**High 5—4—3—2—1 Low**
5. Modeled consultation with care manger/clinical skills for me:	**High 5—4—3—2—1 Low**
6. Observed me consulting with care manger	**High 5—4—3—2—1 Low**
7. Modeled effective interactions with the multidisciplinary treatment team:	**High 5—4—3—2—1 Low**
8. Reviewed my case reviews:	**High 5—4—3—2—1 Low**
9. Modeled effective interactions with other physicians (e.g. consultants, outpatient providers), and with insurance and managed care companies:	**High 5—4—3—2—1 Low**
10. Provided an adequate amount of supervision (one hour of individual supervision per week):	**High 5—4—3—2—1 Low**
11. Provided me with relevant readings and encouraged me to consult the literature to improve patient care:	**High 5—4—3—2—1 Low**
12. Gave me clear feedback and specific, constructive suggestions for improvement on at least two occasions (halfway through and at the end of the rotation):	**High 5—4—3—2—1 Low**
13. Treated me with courtesy and respect:	**High 5—4—3—2—1 Low**
14. Modeled interpersonal qualities of integrity, ethical and professional behavior, empathy, and compassion:	**High 5—4—3—2—1 Low**
15. Was enthusiastic and stimulated the learning process:	**High 5—4—3—2—1 Low**
16. Was helpful and responsive:	**High 5—4—3—2—1 Low**
17. Please rate the overall quality of your attending/supervisor's teaching:	**High 5—4—3—2—1 Low**
18. Please comment on the particular strengths of your attending/supervisor:	
19. Please provide constructive feedback to your attending/supervisor about areas for improvement:	
20. Please comment on strengths of this rotation:	