



AIMS CENTER

**W** UNIVERSITY of WASHINGTON

Psychiatry & Behavioral Sciences

# Resident Rotation: Collaborative Care Consultation Psychiatry

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# **Module 4:**

## **Assessment as Part of Collaborative Care Consultation**



# Learning Objectives: Module 4

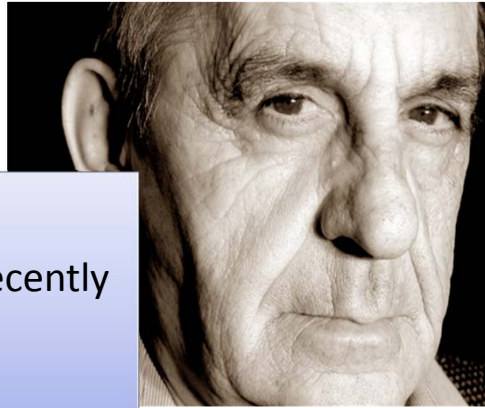
**By the end of this module, the participant will be able to:**

- **Recognize psychiatric presentations in primary care**
- **Learn about different types of consultation and how psychiatric consultation in Collaborative Care is different from the traditional model.**
- **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.**





# What Does a Behavioral Health Patient Look Like in a Primary Care Setting?



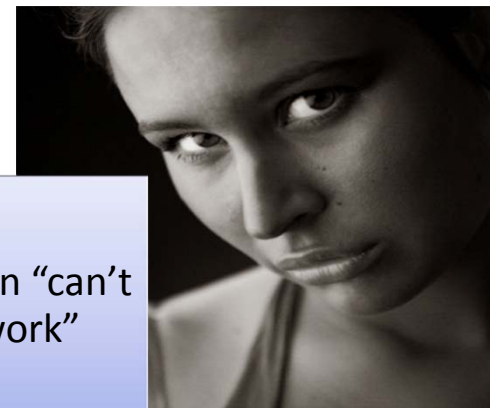
67yo man recently widowed



43yo woman drinks "a couple of glasses" of wine daily



19yo man "horrible stomach pain" when starts college

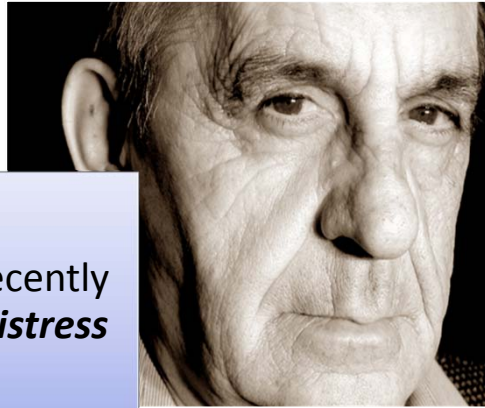


32yo woman "can't get up for work"





# What Does a Behavioral Health Patient Look Like in a Primary Care Setting?



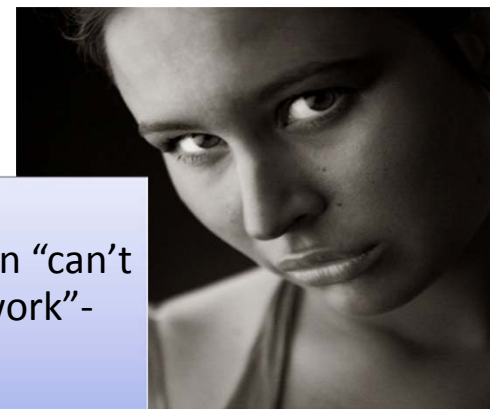
67yo man recently widowed- ***Distress***



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



19yo man "horrible stomach pain" when starts college: ***Social Anxiety Disorder***



32yo woman "can't get up for work"- ***MDD***







# Presenting Symptoms in Primary Care

## Number of Physical Symptoms and Association with Psychiatric Disorders

No. of Symptoms	No. of Patients	No. (%) With Psychiatric Disorder		
		Anxiety	Mood	Any
<b>Physical (n=1000)</b>				
0-1	215	2 (1)	5 (2)	16 (7)
2-3	225	17 (7)	27 (12)	50 (22)
4-5	191	25 (13)	44 (23)	67 (35)
6-8	230	68 (30)	100 (44)	140 (61)
≥ 9	139	66 (48)	84 (60)	113 (81)
<b>Somatoform (n=933)</b>				
0	654	68 (10)	107 (16)	162 (25)
1-2	143	42 (29)	60 (42)	74 (52)
3-5	87	35 (40)	40 (46)	77 (89)
≥ 6	49	27 (55)	34 (69)	46 (94)

Kroenke K, Spitzer RI, Williams JBW, et al. Physical symptoms in primary care. Predictors of psychiatric disorders and functional impairment. *Arch Fam Med.* 1994;3:774-779.



# Common Behavioral Health Presentations

## Common psychiatric presentations:

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

## Common primary care presentations:

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





# Common Consultation Questions

**Clarification of diagnosis**

**Address treatment resistant disorders**

**Recommendations for managing difficult patients**







# Types of Consultations in Collaborative Care

## 1. Indirect

a. Curbside by PCP, no documentation usually

b. Case reviews with BHPs/PCP

- Most frequent
- Information gathered by PCP and BHP

## 2. Direct

## 3. Teaching and educating other team members





# Indirect Case Reviews



## Functioning as a “back seat driver”

- Develop an understanding of the relative strengths and limitations of the providers on your team
- Relying on other providers (PCP and BHP/Care Manager) to gather history

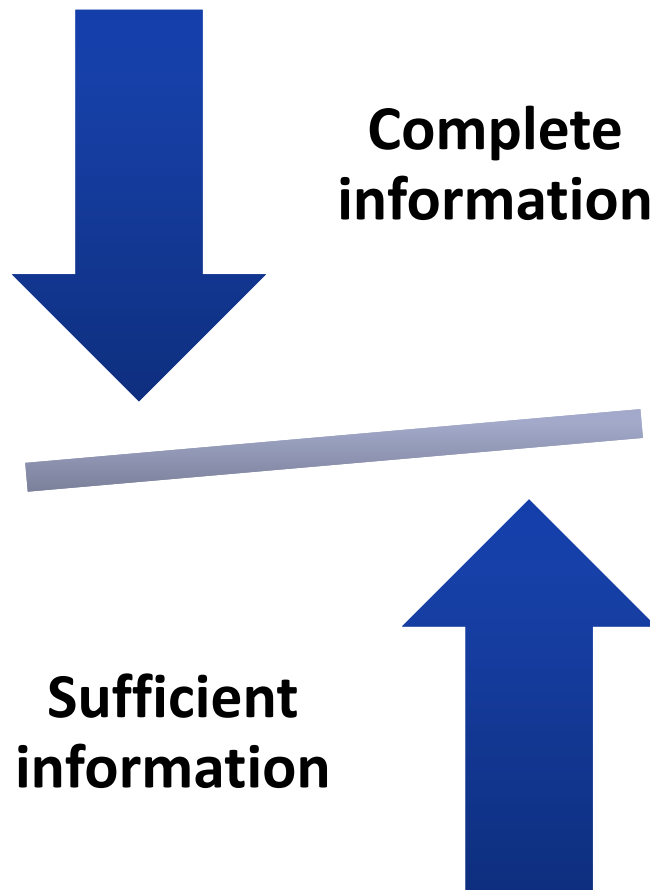


## How do you “steer”?

- Structure your information gathering
- Include assessment of functional impairment
- Pay attention to mental status exam



# Uncertainty: Requests for More Information



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





# Direct Consultation

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

## Patients pre-screened from care manager population

- Already familiar with patient history and symptoms
- Typically more focused assessment
- In person in BHIP and tele-video in MHIP

## Common indications for direct assessment

- Diagnostic dilemmas
- Treatment resistance
- Education about diagnosis or medications
- Complex patients, such as pregnant or medical complicated





# Screening Tools as “Vital Signs”

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





# Commonly Used Screeners

## Mood Disorders

PHQ-9: Depression

MDQ: Bipolar disorder

CIDI: Bipolar disorder

## Anxiety Disorders

GAD- 7: Anxiety, GAD

PCL-C: PTSD

OCD: Young-Brown

Social Phobia: Mini social phobia

## Substance Use Disorders

CAGE-AID

AUDIT

## Cognitive Disorders

Mini-Cog

Montreal Cognitive Assessment





# Who Should Get Screened?

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

Adapted from:

<http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/depression-in-adults-screening1?ds=1&s=Depression>

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# PHQ-2

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

- **Ultra brief screening**
- **Commonly used in primary care**
- **Scoring**
  - **0-2: Negative**
  - **3 or Higher: Positive and patient need further assessment**





# PHQ-9

Over the last 2 weeks, how many days have you been bothered by any of the following problems?	Not at All	Several Days	More than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3
<b>If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?</b>				
	Not difficult at all	Somewhat difficult	Very Difficult	Extremely difficult



# Understanding the PHQ-9 Score

Score	Severity
0 – 4	No Depression
5 – 9	Mild Depression
10 – 14	Moderate Depression
15-19	Moderately Severe Depression
20-27	Severe Depression

## Are there safety concerns?

- If Question 9 is a score  $< 0$ , needs to be assessed for safety

## Is it depression?

- MDD: needs to have either Question 1 or Question 2 with a score of  $>2$





# Example: Structured Assessment

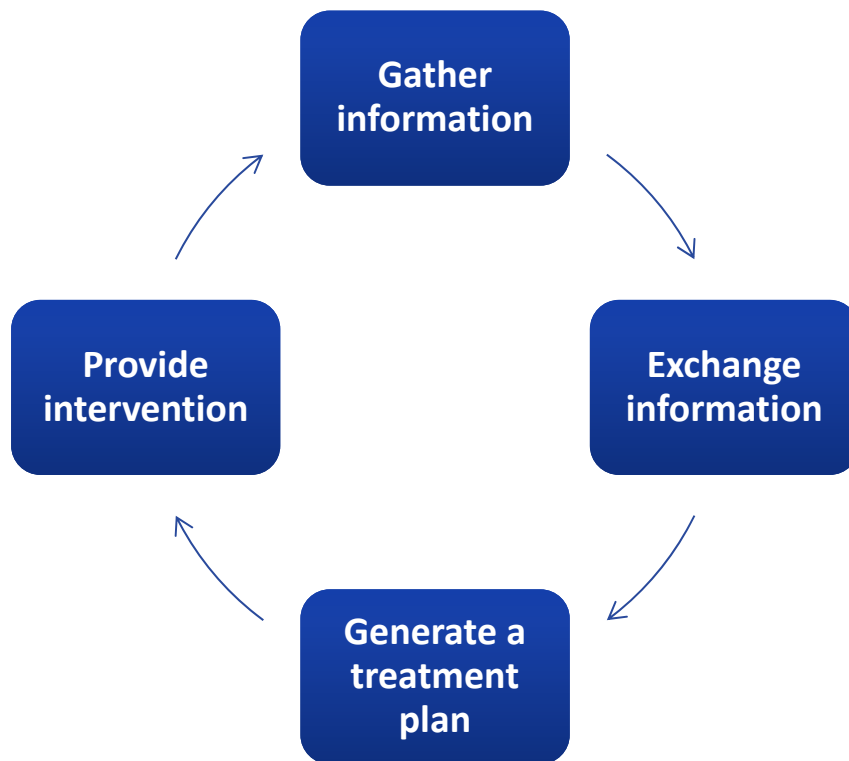
**BHP/Care Manager is asked to briefly report on:**

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





# Assessment and Diagnosis in the Primary Care Clinic



**-Diagnosis can require multiple iterations of assessment and intervention**

**-Advantage of population based care is longitudinal observation and objective data**

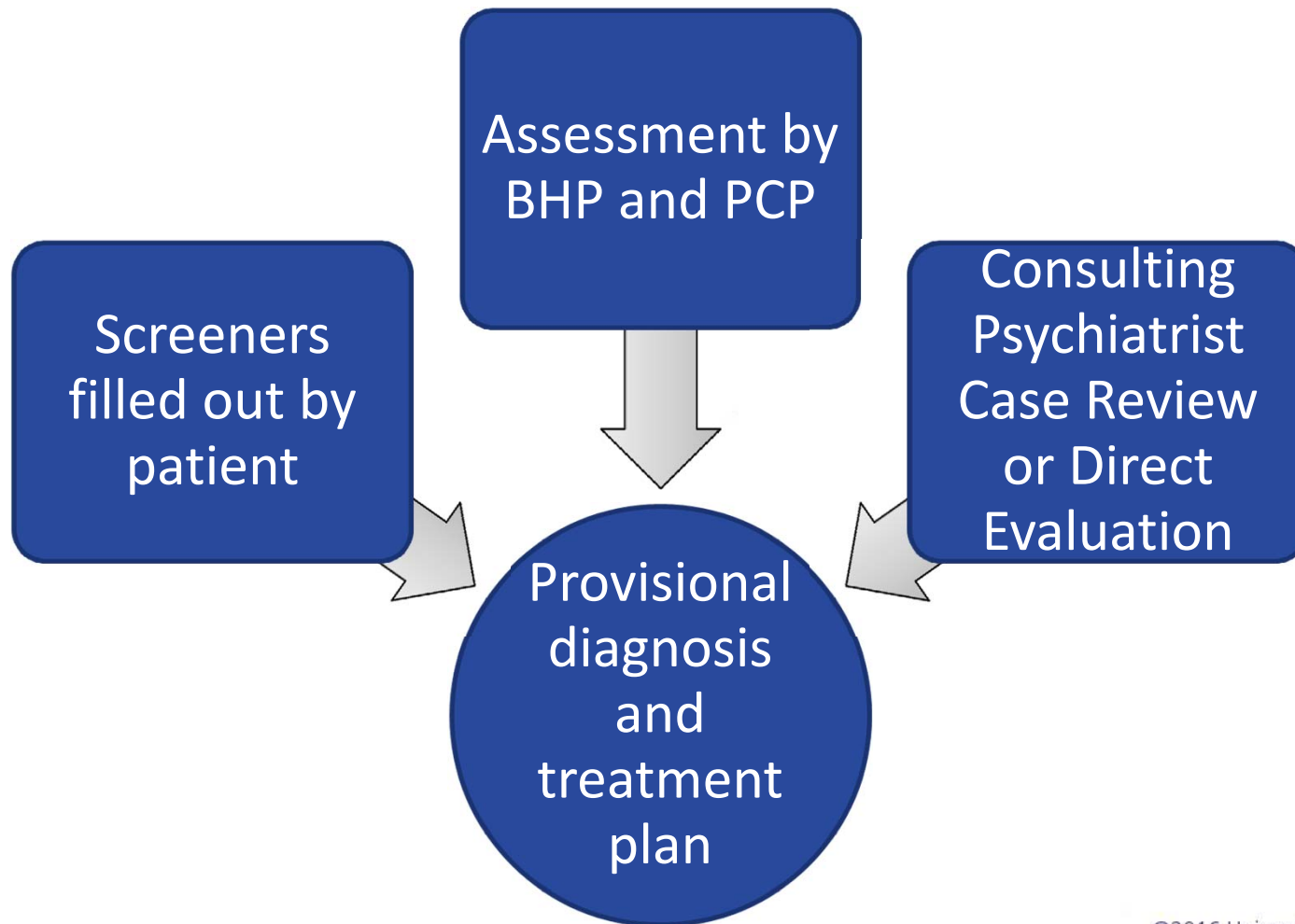
**-Start with diagnosis that is your 'best understanding'**







# Provisional Diagnosis





# A Different Kind of Assessment: Care Shaped Over Time

## Traditional Consult

One Session = One  
Assessment

## Collaborative Care Case Review

Review 1 in Jan →  
Acute Distress?

Pt still has high PHQ &  
impairment

Review 2 in Mar →  
MDD and initiate  
treatment



# Reflection Questions

- 1) 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?**
- 2) 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?**
- 3) 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?**

