

REACH – NOLA
**Mental Health Infrastructure
and Training Program**

18-20 May 2009

**Collaborative Care:
the Intersection of
Communities, Primary care
and Mental Health Care**

History of Silos

Silos of Care



Depression Treatment in Primary Care

- Only about half with need are treated
- Only 20 – 40 % show substantial improvement over 12 months
- Increasing use of antidepressants but treatment is often not effective
 - Early treatment dropout
 - Staying on ineffective meds too long
- Access to evidence-based counseling
- Limited attention to related problems

Primary Care

Strengths:

- Normal to address multiple medical issues
- Structured diagnostic procedures & outcomes tracking
- THIS IS WHERE PEOPLE SEEK TREATMENT!

Challenges:

- Single practitioner with limited support
- Focus on acute care & health maintenance
- Physical and mental health care rarely integrated
- MENTAL HEALTH REQUIRES BEHAVIORAL CHANGE
 - REQUIRES CHRONIC DISEASE MODEL

Mental Health Specialty Care

Strengths:

- Understands chronic nature of mental health
- Able to spend more time with patient
- Finely tuned skills due to specialty focus

Limitations:

- Treat only mental health conditions
- Focus on *severe & persistent* mental disorders
- Subjective diagnosis & outcomes tracking

What would it take to do better?

30 years of research show that

- Screening for mental disorders in primary care
- PCPs trained & supported by guidelines to treat mental disorders
- Referrals to specialty mental health providers

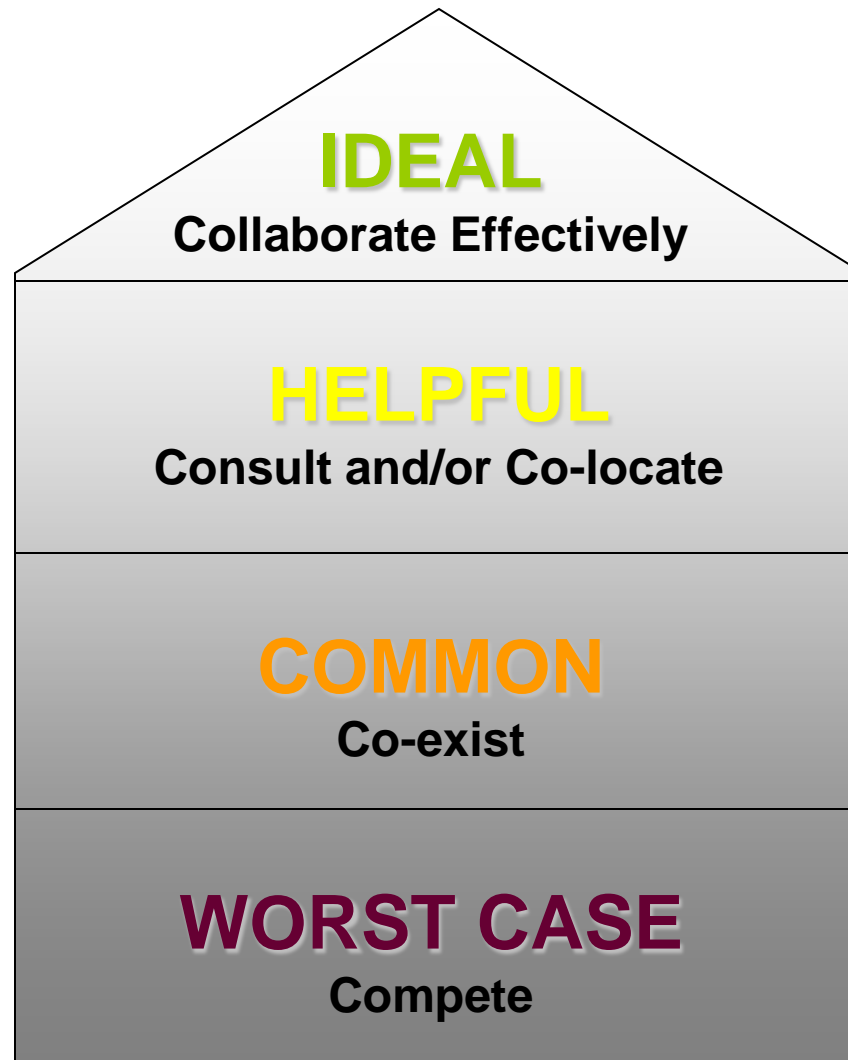
Necessary but not sufficient

- Strong evidence has emerged for collaborative / integrated care for common mental disorders

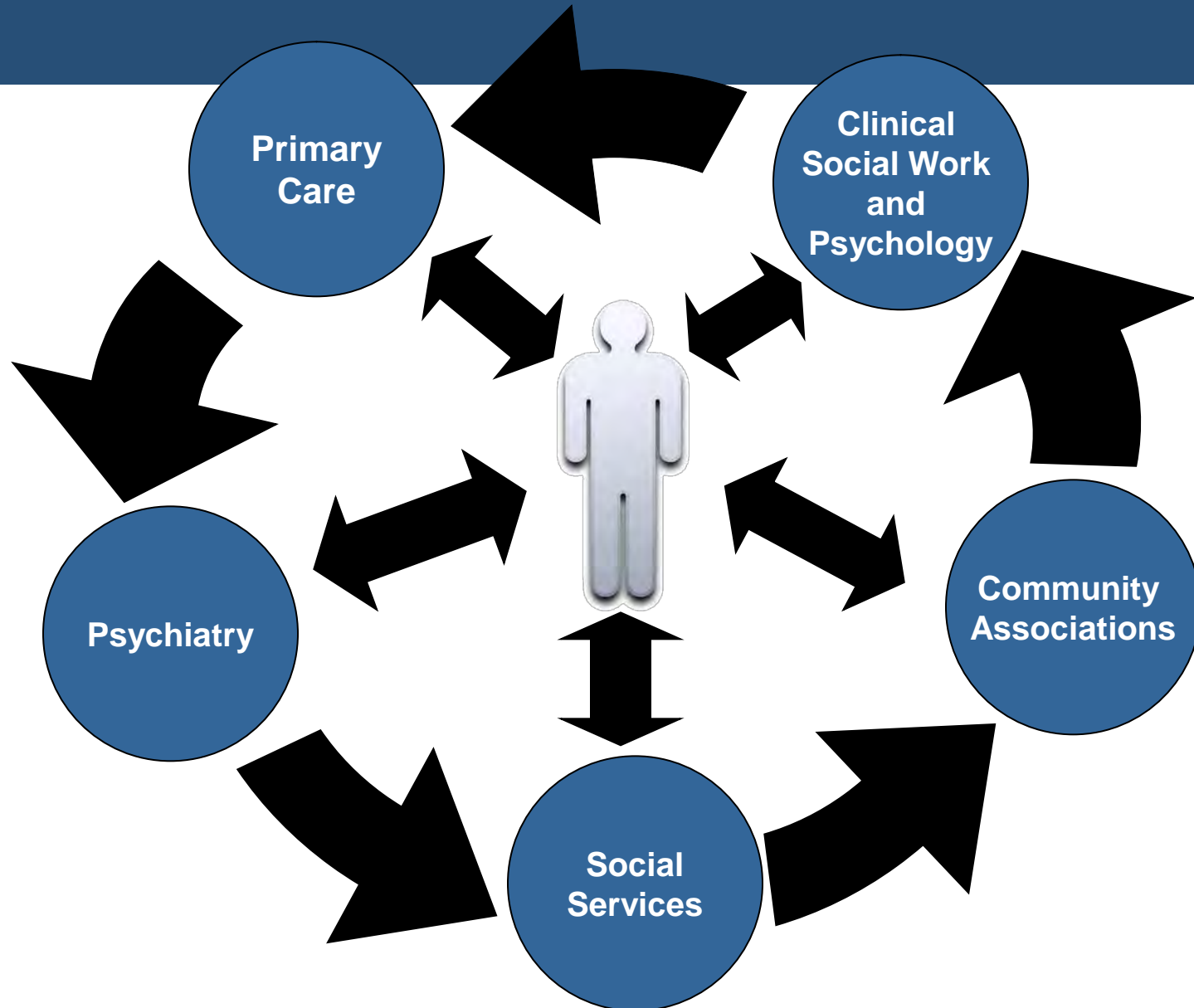
Integrating Care



Moving towards integrated care



Collaborative Care



Evidence for Collaborative Care for Depression

- ***37 trials*** of collaborative care for depression in primary care (US & Europe)
- **PIC and IMPACT** *two* of these 37 trials
- **Collaborative Care consistently more effective than usual care**

IMPACT Team Care Model



**Prepared, Pro-active
Practice Team**

**Effective
Collaboration**



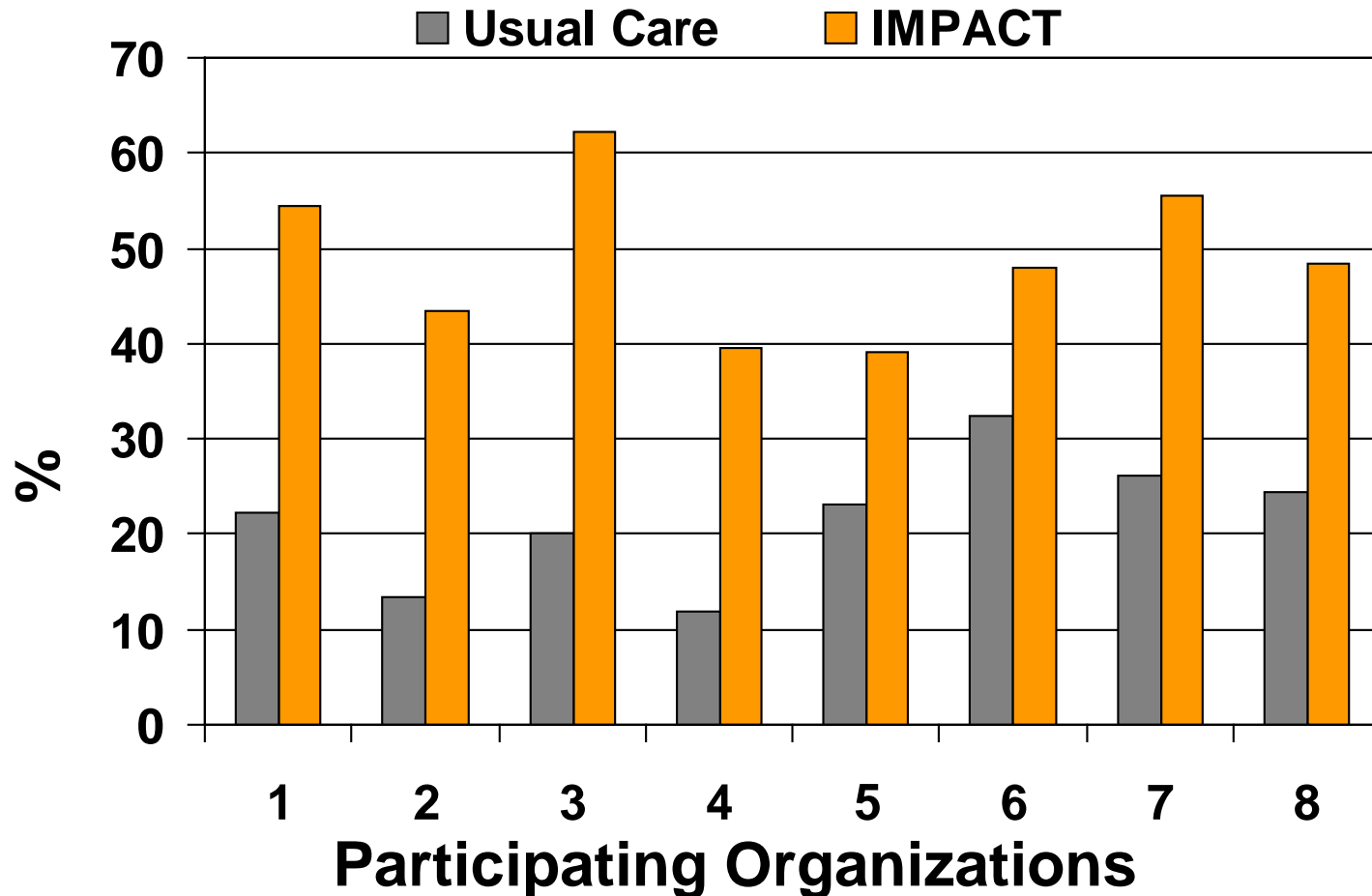
**Informed, Activated
Patient**

Practice Support



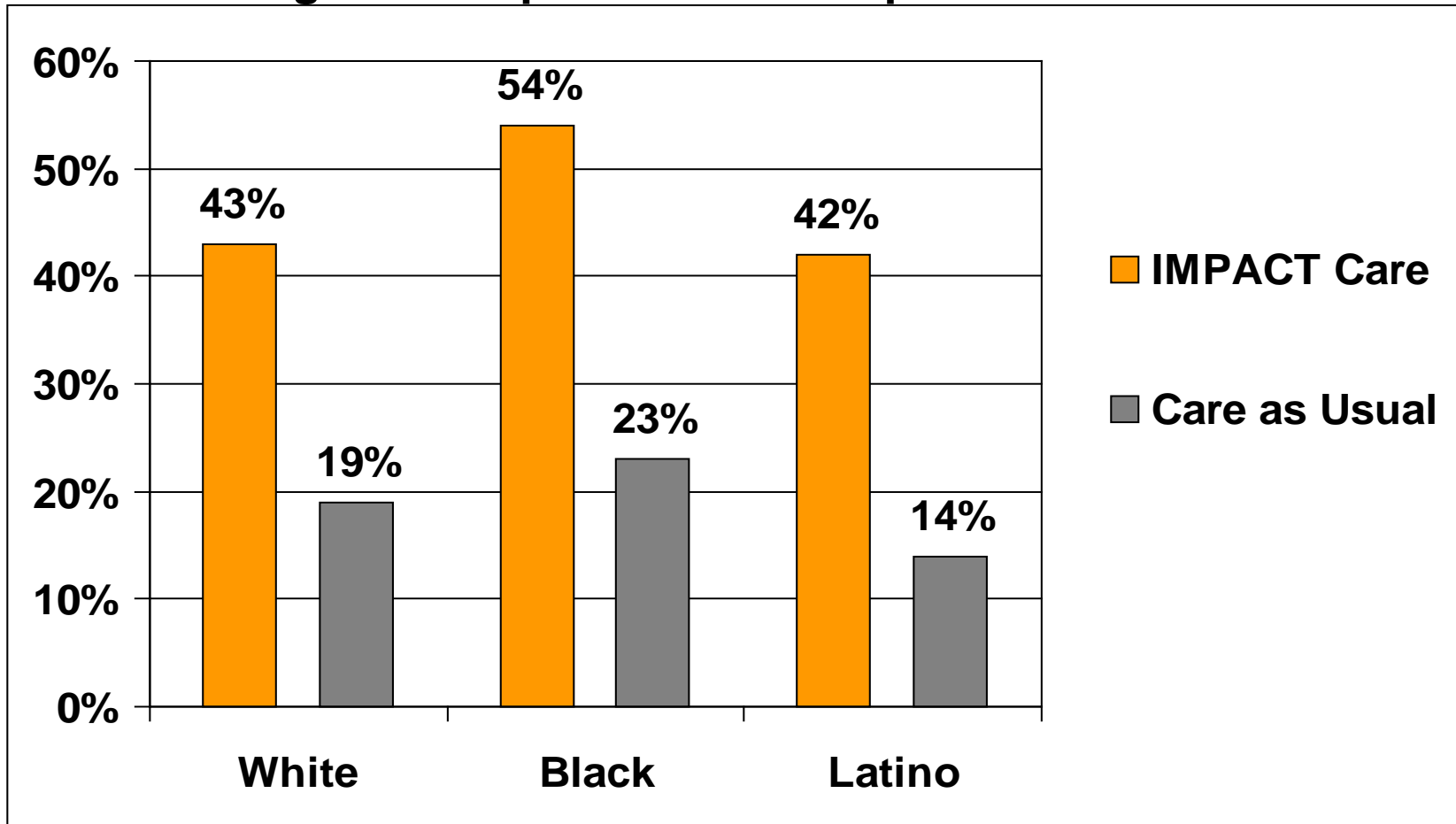
Double the Effectiveness of Usual Care

50 % or greater improvement in depression at 12 months



IMPACT Care Benefits Racial/ Ethnic Minority Populations

50 % or greater improvement in depression at 12 months



IMPACT Summary

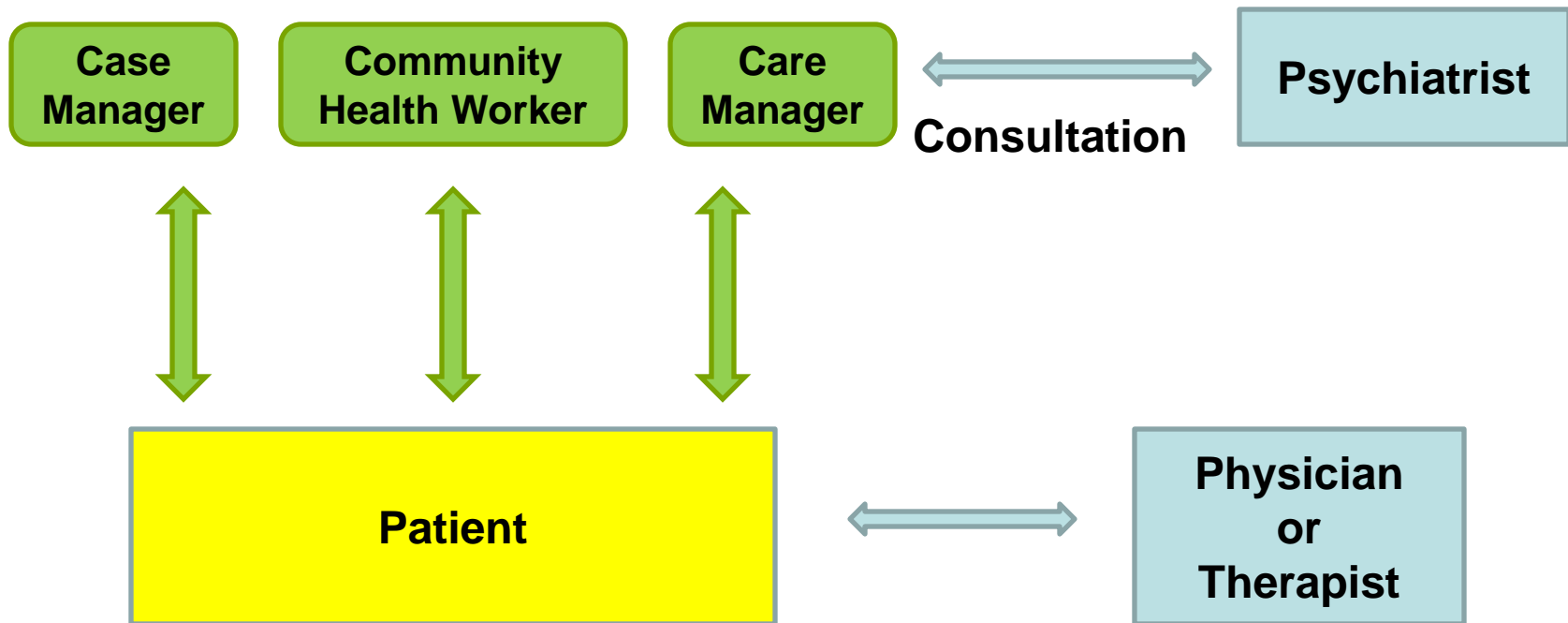
- **Less depression**
 - (IMPACT doubles effectiveness of usual care)
- **Less physical pain**
- **Better functioning**
- **Higher quality of life**
- **Greater patient and provider satisfaction**
- **More cost-effective**



“I got my life back”

Collaborative Care of Depression

Screening, Education, Collaborative Treatment Planning, Counseling, Track Outcomes, Follow-up, Communication, Engagement/Support



Care Management

- 1. Identify – Screen & Diagnose**
- 2. Treat – Provide Services**
- 3. Track Treatment Outcomes**
- 4. Facilitate Care**
- 5. Support Care Team**

Care Management

Tasks versus Job Description

Each organization will be different

- tasks performed by one person or several people
- some tasks performed within organization, other tasks performed by partner at other organizations
- based on level of training and current tasks

Identifying

Patient Self-Refers

Community Health Workers

Social Workers

PCPs

Other Pathways - ?

Screening

Depression:

- PHQ-2 and/or PHQ-9

Anxiety

- GAD-7

Post-traumatic Stress Disorder:

- PTSD-PC

Substance Abuse:

- AUDIT-CAGE

Depression: PHQ-2

PATIENT HEALTH QUESTIONNAIRE (PHQ-2)						
Name: <i>Jane Doe</i>			Date: <i>18 May 09</i>			
Over the <i>last 2 weeks</i> , have you been bothered by either of the following problems?	Not at all	Several days	More than half the days	Nearly every day		
	0	1	2	3		
Little interest or pleasure in doing things	0	✓	2	3		
Feeling down, depressed or hopeless	0	1	✓	3		
Add columns:		1	+	2	+	0
TOTAL:		Write TOTAL 3 Score Here				

Depression: PHQ-2

First 2 Questions of PHQ-9

If “yes” to either:

- complete PHQ-9 or refer to clinical provider who can assess**

Depression: PHQ-9

9 questions covering 9 DSM-IV core symptoms of major depression

- Patient self report**
- Score from 0-27**
- Established cut-points**
- Large supporting literature**
- English and Spanish (and more languages)**

Patient Health Questionnaire PHQ-9

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

Understanding the PHQ-9 Score

- **0-4** Minimal
- **5-9** Mild (probably no DSM-IV disorder)
- **10-14** Moderate (maybe DSM-IV for depression NOS)
- **15-19** Moderately Severe (likely MDD/Dysthymia)
- **20-27** Severe

Diagnosing

- **Screeners help but don't diagnose**
- **Clinical task requiring judgment**
- **Symptoms associated with impairment**

Linking To A Provider

- **Based on Diagnosis**
 - **Who**
 - **What**
 - **When**
 - **How**

Self Assessment

What concerns are there about identifying patients and getting them in for treatment?

What processes have been successful in getting screening done?

Where could this process breakdown?

Action Plan for Implementing Case Identification and Diagnosis

Treat/ Provide Services

Develop Treatment Plan

Provide Education about Symptoms & Treatment Options

Provide Education about Medications & Side Effects

Support Behavioral Activation

Provide Counseling

Prescribe Antidepressants/ other Psychotropic Medications

Treat Co-existing Medical Conditions

Provide Psychiatric Consultation

Community Outreach

Treatment Planning

Patient, Therapist, PCP & Care Managers all involved in making the treatment plan

Treatment plans are 'individualized' because patients differ in

- medical comorbidity**
- psychiatric comorbidity**
- prior history of depression and treatment**
- current treatments**
- treatment preferences**
- treatment response**

Patient Education

Depression affects the body, behavior, and thinking.

For many older patients, physical symptoms are the most apparent.

The ‘cycle of depression model’

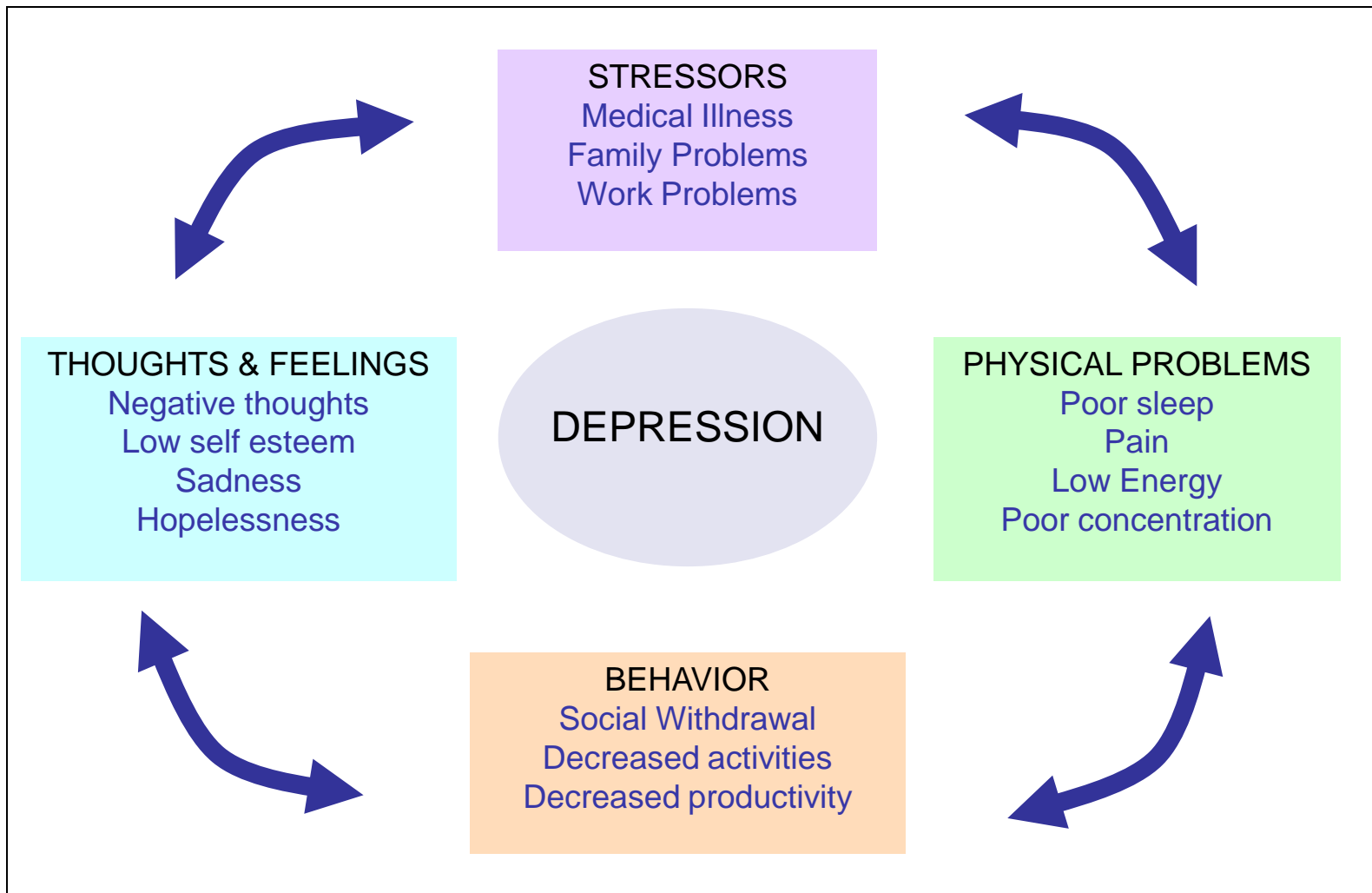
Depression can almost always be treated with antidepressant medications or psychotherapy.

Recovery from depression is the rule, not the exception

...but relapse is common if treatment is discontinued.

Minor tranquilizers, drugs, and alcohol can make depression worse, not better.

The 'Cycle of Depression'



Patient Education About Antidepressants

Key messages

How do these medications work?

By restoring a chemical imbalance in the brain

There are several options (over 20 available medications)

Anticipate

Patient concerns about medications

Side effects (these can be managed)

Problems with adherence

Reinforce

Need for continuation or maintenance treatment to prevent relapse even after the patient feels better

Supporting Antidepressant Management

**Become familiar with commonly used
antidepressant medications medication doses**

**Provide basic patient education about
antidepressants**

Support antidepressant medication adherence

Supporting Antidepressant Management

Help patients and providers identify

Potentially inadequate doses

Ineffective treatment (e.g., persistent depression after adequate duration of antidepressant trial)

Side effects

Facilitate patient-provider (e.g., PCP) communication about antidepressant medications

Consult with psychiatrist about medication questions

Behavioral Activation

Depression ⇔ inactivity and withdrawal

= downward cycle of doing less and feeling worse

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

Behavioral Activation

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

Goals:

Re-establish routines

Distract from problems or unpleasant events

Increase positively reinforcing experiences

Reduce avoidant patterns

Behavioral Activation

Some Strategies:

Review a list of pleasant activities for ideas
(list of 210 activities included on CD)

List activities and rate them for mastery and pleasure

Choose and schedule a daily pleasant activity

Mentally rehearse the selected activity

Identify potential barriers

Follow-up: celebrate successes and review 'failures'

Maybe we picked the wrong activity?

What might work better next time?

Counseling

Evidence Based Psychotherapy

Primary Treatment

Adjunct to medication

Stepped-Care tool

In-house or referral

Why track outcomes?

Facilitates treatment planning and adjustment

- Know when it's time to change
- Avoid patients staying on ineffective treatments for too long
- Know when to refer for consultation / get additional help

Example: Blood Pressure

Most patients need treatment adjustments

Only 30 – 50% of patients will have a complete response to initial treatment

Remaining 50 – 70% will require at least one change in treatment to get better

Track outcomes

- 1. Each contact ask yourself**
 1. Is this person getting better?
 2. Is there a change-in-plan needed?
- 2. Everyone's role**
 1. How can or do you incorporate this in what you do?

How does a registry help?

Keeps track of all clients

- Up to date contact information facilitates engagement and follow-up
- Identifies who has been referred and who is getting services

Tells you quickly who needs additional attention

- Who is improving or not improving
- Reminders for clinicians & managers
- Customized caseload reports

Facilitates mental health specialty consultation

Facilitates communication between treating providers

Follow-Up Contacts

Weekly or every other week during acute treatment phase

**In person or by telephone to evaluate
depression severity (PHQ-9)
treatment response**

Initial focus on

**adherence to medications and discuss side effects
follow-up on activation and PST plans**

Later focus on

**complete resolution of symptoms
complete restoration of functioning
long term treatment adherence**

Treatment Response

Full response: At least 50% reduction in PHQ-9 score (or less than 5)

Partial response: Reduction in PHQ-9 of less than 50%

No response: No reduction or increase in PHQ-9 score

Adjustments to Treatment Plan

Only 30 – 50 % will have a complete response with initial treatment

Treatment recommendations for ‘step B’:

- ‘Augment’ initial treatment choice with PST-PC or medication
- Switch to PST-PC or an(other) antidepressant (especially if NO response in step one)

Also consider:

- Combination therapy (if not tried earlier)
- Augmentation with more than one medication
- Referral to specialty mental health care for additional psychotherapy
- Electroconvulsive therapy (ECT)

Facilitate Care

- **Communication**

- Counselor

- PCP

- Psychiatrist

- Community Health Worker

- ??

- **Support Behavioral Activation**

- **Referrals to Specialty Mental Health,
Social Services, other Specialty Services**

- **Relapse prevention planning**

- **Relapse prevention support**

Working with Clinicians

- **Communicate changes in patient's clinical and functional status**
 - **Prioritize which changes need to be brought to the attention of the treating clinicians**
 - **Maintain enough contact so that they remember who you are but not so much that they see you as a pest**
 - **Determine who will be the person to talk with clinicians**

Key Elements to include when talking to Clinicians

Baseline symptom (PHQ-9) score

Current symptom (PHQ-9) score

Length of time patient on current treatment(s)

Problematic side effects

**Primary symptoms not substantially improved
(mood, sleep, energy, concentration...)**

Working with the Patient's PCP

Support antidepressant medication management prescribed by PCP

- Few PCPs have the support necessary to closely monitor side effects and treatment response

Working with PCPs

What are *YOUR* experiences working with PCPs?

Will you directly speak to the PCP or who will you communicate with to get this done?

Most patients will need adjustments to treatment plan

Only 30 – 50% of patients will have a complete response to initial treatment

Remaining 50 – 70% will require at least one change in treatment to get better

Seek consultation with psychiatrist when patient ...

Is severely depressed (PHQ-9 score ≥ 20)

Fails to respond to treatment

Appears to have bipolar, psychotic or trauma disorder

Has other complicating mental health diagnosis, such as, substance abuse or personality disorder

Has current substance dependence

Is suicidal or homicidal

Key Elements of Effective Consultation

Systematic review & presentation of

- entire caseload
- focus on patients who are not improving

Recommendations to patients and treating providers based on evidence-based guidelines

In person consultation or effective referral for complex patients

Caseload Consultation

Weekly consultation:

- About one hour
- In-person or by phone
- Group or individual
- Review new cases
- Focus on patients not improving
 - Review medications, treatment plans
 - Suggest additional assessments, treatment changes (to PCP), referrals

If Patients Don't Improve Consider

Wrong diagnosis?

Problems with treatment adherence?

Insufficient dose / duration of treatment?

Side effects?

Other complicating factors?

psychosocial stressors / barriers

medical problems / medications

'psychological' barriers

substance abuse

other psychiatric problems

Initial treatment not effective (e.g. wrong drug)?

Psychiatric consultation

Maintenance Treatment for Depression

After patient is 'in remission' from acute episode

Fewer than 2 depressive symptoms

Usually a PHQ-9 score less than 5

Make a relapse prevention plan in consultation with PCP

Follow the patient with monthly contacts

- by telephone calls
- individually OR
- in a maintenance group for PST patients

Bring patient back in if symptoms recur

Relapse prevention plan

Medication- dosage, amount of time to stay on meds

Warning signs of depression recurrence

Healthy behaviors that improve mood

Support Care Team

Support from all levels, including LEADERSHIP

Business Administration

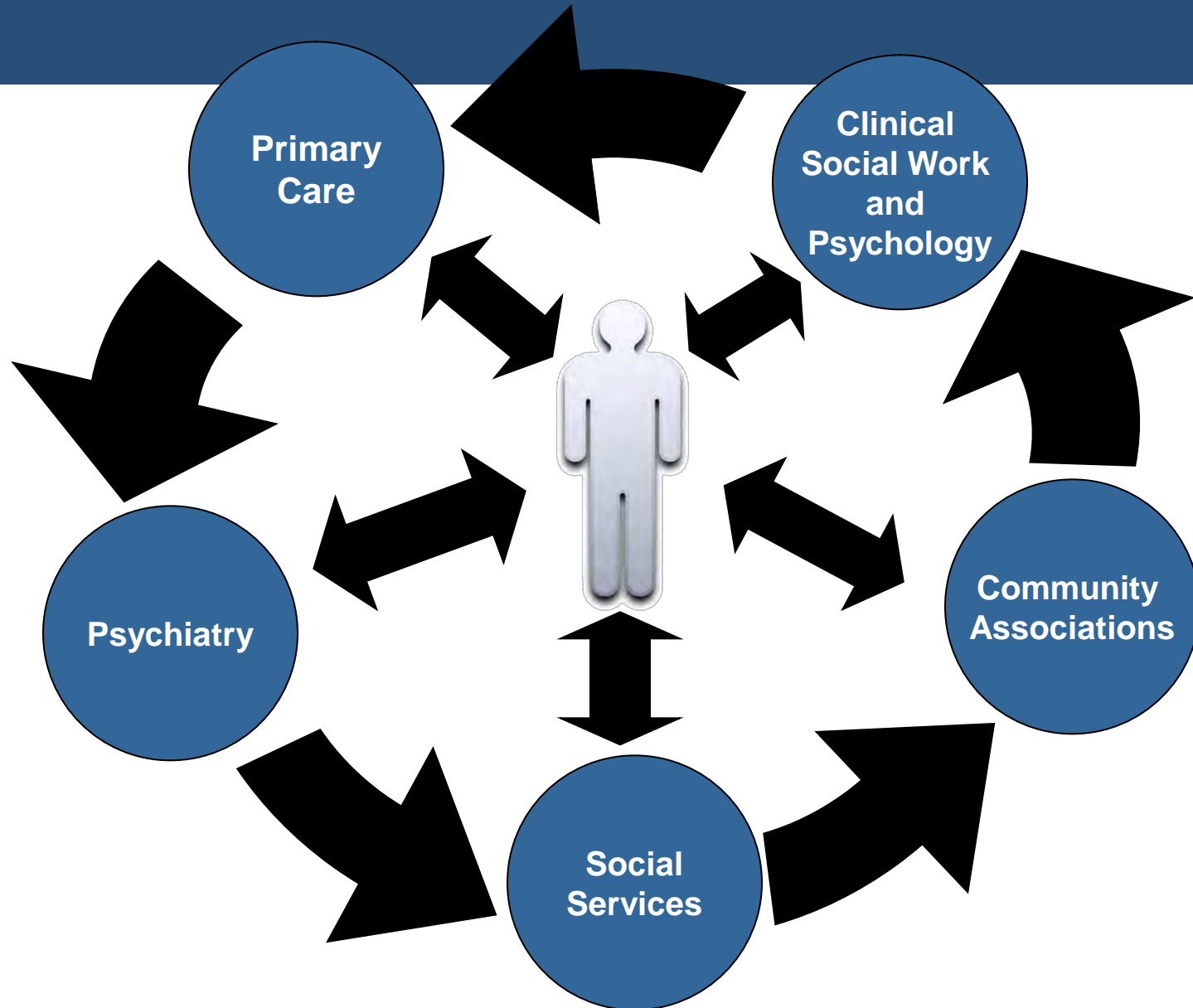
Clinical Directors

Staff

Multidisciplinary Team Meetings

On-going quality improvement

Collaborative Care



Introduce the Care Team

Your Care Team at XYZ Medical Clinic



What is the patient's role?

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



PCP Name
Telephone (xxx) xxx-xxxx
Email janed@email.org

What is the primary care physician's role?

The PCP oversees all aspects of your care at the clinic. He or she will work closely with the other members of the care team to make sure you get the best care possible. The PCP will rely on your care manager to keep informed about your treatment progress. The team psychiatrist and the PCP may work together if there are questions about the best available treatments for you. He or she will write and refill prescriptions for your medications.



CM Name
Telephone (xxx) xxx-xxxx
Email janed@email.org

What is the care manager's role?

The CM will meet with you regularly, in person and sometimes by telephone. The CM will work closely with you and the PCP to make sure you understand your treatment. The CM will answer any questions you have. He or she will be responsible for keeping track of your treatment progress. The CM will also help identify any treatment side effects. The PCP and the CM will also work together with you when a change in your treatment is needed. The CM may also provide counseling to you.



Team Psychiatrist Name

What is the team psychiatrist's role?

The team psychiatrist is a physician trained in mental health care. He or she is an expert consultant to the PCP and the CM. The team psychiatrist is available to advise your care team about treatment options, especially if you don't improve with your treatment. The CM meets regularly with the team psychiatrist to talk about your progress and to think about options. With your permission, the PCP may ask the team psychiatrist to meet with you in person.

