Depression and Anxiety Disorders: Impact, Screening and Treatment

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January 10, 2019
Depression and Anxiety Disorders – Outline

- Prevalence by age group
- Anxiety Disorders: screening and evaluation
- Depression: screening and evaluation
- Treatment
  - Lifestyle and environmental interventions
  - Psychotherapy
  - Medication
- Condition Care Management
Depression and Anxiety Disorders – Learning Objectives

• Recognize the prevalence of anxiety disorders and depression in different age groups
• Review screening and evaluation processes in primary care settings
• Understand current evidence based treatments
• Understand how the condition care model can enhance management of these common behavioral health disorders in primary care settings
Case Example

- 17 year old girl tells her school counselor she took an overdose the night before, feels hopeless and depressed and appears sleepy during school hours

- She reports that her parents won’t accept her homosexuality and refuse to let her have contact with her girlfriend. She has started raiding her mother’s supply of Xanax and also drinking surreptitiously from the family liquor cabinet
Case Example

- 39 year old man presents with chronic back pain following a work related injury the year before. His wife is threatening divorce due to his constant anger and irritability, and he is binge drinking on weekends. He denied feeling depressed or sad but said he feels like he is going to lose it over the slightest frustration. He also has severe insomnia and his wife reports that he has nightmares.

- He denies any history of trauma in childhood but said he immigrated with his parents from Central America when he was a young child and doesn’t remember much.
Case Example

- 64 year old woman brought in by her husband after an auto accident where she was at fault, he describes increased forgetfulness, decreased appetite and weight loss, loss of interest in her hobbies, and a decline in her hygiene

- She denies feeling sad or depressed and says everything is fine, but she is concerned about strange people coming into her house and rearranging her furniture and taking her belongings
Anxiety and Depression over the Lifespan

- Children
- Adolescents
- Young Adults
- Middle Aged Adults
- Older Adults
Children

- Think Anxiety Disorders

Bonus recording

Depression and Anxiety Disorders: Childhood
Adolescents

• Both anxiety/fearful symptoms and anxiety disorders in childhood are significant risk factors for mood disorders in adolescence and adulthood.

• Anxiety symptoms may lessen in adolescence and transitional ages, but functional impact may be worse – collide with expectations of more independence and autonomy.

• Maladaptive coping involving substance use, self-injury, social and educational withdrawal are more likely with unrecognized and untreated anxiety disorders.

• Sexual and racial minorities and immigrants have additional social stressors that can aggravate and precipitate depression.
Adolescents

• Least likely to be seen for routine health care or to interface with healthcare system so teachers, coaches, parents need to be liaisons

• Motivational approaches and patient centered care may be needed to engage

• Social media can help or harm; digital interventions may be more appealing
Adults

Depression Risk Factors:

- Adults with History of Childhood or Adolescent Disorders
- Time Demands from Work and Family
- Irregular Sleep Schedules
- Substance Use/Abuse
- Detachment from Parents and Other Social Supports
- Military Service
- Childbirth
- Medical Conditions
Depression

- The lifetime prevalence of major depression in adults is estimated to be 7 to 12 percent in men and 20 to 25 percent in women.

- The prevalence of depression in patients in primary care settings ranges from 5 to 10 percent.

- The rates are significantly higher in persons with certain medical conditions, including obesity, diabetes mellitus, cancer, and a history of myocardial infarction.
Recognizing Adult Anxiety Disorders

- Feelings of panic, fear and uneasiness
- Uncontrollable, obsessive thoughts
- Repeated thoughts or flashbacks of traumatic experiences
- Nightmares
- Ritualistic behaviors

- Problems sleeping
- Cold and sweaty hands and/or feet
- Shortness of breath
- Palpitations
- Dry Mouth
- Dizziness
- Nausea
- An inability to be still or calm
Screening for Depression and Anxiety Disorders
Guidelines for Depression Screening - USPSTF

• Children
  ▪ inconclusive about screening for depression for ages 11 and under

• Adolescents
  ▪ screen all adolescents age 12-18 for depression

• Adults
  ▪ screen all adults including pregnant and postpartum women for depression
Screening Tools for Depression

- PHQ-2 and PHQ-9 “Patient Health Questionnaire”
  - Multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression
  - Incorporates DSM-5 depression diagnostic criteria with other leading major depressive symptoms into a brief self-report tool
  - PHQ-9 rates the frequency of the symptoms which factors into the scoring severity index
  - Screens for the presence and duration of suicide ideation

PHQ-2 is a two question tool that can lead to administering the PHQ-9 which is a nine question tool that explores depression symptoms in more depth

www.phqscreeners.com
## Patient Health Questionnaire-9 (PHQ-9)

**Over the last 2 weeks, how often have you been bothered by any of the following problems?**

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**For office coding**

\[
0 + _____ + _____ + _____ = \text{Total Score: }_____
\]

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

<table>
<thead>
<tr>
<th>Difficulty Level</th>
<th>Not difficult at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Extremely difficult</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

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Specific Population Screening Tools

- Adolescents
  - PHQ-9-A (modified for adolescents)

- Postpartum
  - Edinburgh

- Geriatric
  - CES-D, Geriatric Depression Scale

- Dementia
  - Cornell Scale
Edinburgh Postnatal Depression Scale

Life with a new baby is not always what you expect.

Please underline the answer that most accurately describes your feelings in the last 7 days.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I have been able to laugh and see the funny side of things.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>As much as I always could&lt;br&gt;Not at all&lt;br&gt;Definitely not as much now</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I have looked forward with enjoyment to things.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>As much as I ever did&lt;br&gt;Farther into the future I used to&lt;br&gt;Definitely less than I used to&lt;br&gt;Hardly at all</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. I have blamed myself unnecessarily when things went wrong.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, most of the time&lt;br&gt;Yes, some of the time&lt;br&gt;Not very often&lt;br&gt;Never</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. I have been anxious or worried for no good reason.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No, not at all&lt;br&gt;Hardly ever&lt;br&gt;Sometimes&lt;br&gt;Very often</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. I have felt scared or panicky for no good reason.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, quite a lot&lt;br&gt;Yes, sometimes&lt;br&gt;No, not much&lt;br&gt;No, not at all</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Things have been getting on top of me.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, most of the time&lt;br&gt;Hardly at all&lt;br&gt;Sometimes&lt;br&gt;Never</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. I have been so unhappy that I have had difficulty sleeping.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, most of the time&lt;br&gt;Somewhat&lt;br&gt;Not very often&lt;br&gt;Not at all</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. I have felt sad or miserable.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, most of the time&lt;br&gt;Somewhat&lt;br&gt;Not very often&lt;br&gt;Not at all</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. I have been so unhappy that I have been crying.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, most of the time&lt;br&gt;Somewhat&lt;br&gt;Only occasionally&lt;br&gt;Never</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. The thought of harming myself has occurred to me.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, quite often&lt;br&gt;Somewhat&lt;br&gt;Hardly ever&lt;br&gt;Never</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Geriatric Depression Scale – Short Form

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you basically satisfied with your life?</td>
<td>Yes</td>
<td>NO</td>
</tr>
<tr>
<td>Have you dropped many of your activities and interests?</td>
<td>YES</td>
<td>No</td>
</tr>
<tr>
<td>Do you feel that your life is empty?</td>
<td>YES</td>
<td>No</td>
</tr>
<tr>
<td>Do you often get bored?</td>
<td>YES</td>
<td>No</td>
</tr>
<tr>
<td>Are you in good spirits most of the time?</td>
<td>yes</td>
<td>NO</td>
</tr>
<tr>
<td>Are you afraid that something bad is going to happen to you?</td>
<td>YES</td>
<td>no</td>
</tr>
<tr>
<td>Do you feel happy most of the time?</td>
<td>yes</td>
<td>NO</td>
</tr>
<tr>
<td>Do you often feel helpless?</td>
<td>YES</td>
<td>no</td>
</tr>
<tr>
<td>Do you prefer to stay at home, rather than going out and doing new things?</td>
<td>YES</td>
<td>no</td>
</tr>
<tr>
<td>Do you feel like you have more problems with memory than most?</td>
<td>YES</td>
<td>no</td>
</tr>
<tr>
<td>Do you think it is wonderful to be alive now?</td>
<td>yes</td>
<td>NO</td>
</tr>
<tr>
<td>Do you feel pretty worthless the way you are now?</td>
<td>YES</td>
<td>no</td>
</tr>
<tr>
<td>Do you feel full of energy?</td>
<td>yes</td>
<td>NO</td>
</tr>
<tr>
<td>Do you feel that your situation is hopeless?</td>
<td>YES</td>
<td>no</td>
</tr>
<tr>
<td>Do you think that most people are better off than you are?</td>
<td>YES</td>
<td>no</td>
</tr>
</tbody>
</table>
Cornell Scale for Depression in Dementia

Patient's name: __________________________________________
Date: __________________________________________________________________
Location: __________________________________________________________________

A. Mood-related signs
1. Anxiety (anxious expression, ruminations, worrying) a 0 1 2
2. Sadness (sad expression, sad voice, tearfulness) a 0 1 2
3. Lack of reactivity to pleasant events a 0 1 2
4. Irritability (easily annoyed, short-tempered) a 0 1 2

B. Behavioral disturbances
5. Agitation (restlessness, handwringing, hairpulling) a 0 1 2
6. Retardation (slow movements, slow speech, slow reactions) a 0 1 2
7. Multiple physical complaints (score 0 if gastrointestinal symptoms only) a 0 1 2
8. Loss of interest, less involved in usual activities (score only if change occurred acutely—in less than 1 month) a 0 1 2

C. Physical signs
9. Appetite loss (eating less than usual) a 0 1 2
10. Weight loss (score 2 if greater than 5 lb in one month) a 0 1 2
11. Lack of energy (fatigues easily, unable to sustain activities) (score only if change occurred acutely—in less than one month) a 0 1 2

D. Cyclic functions
12. Diurnal variation on mood (symptoms worse in the morning) a 0 1 2
13. Difficulty falling asleep (later than usual for this person) a 0 1 2
14. Multiple awakenings during sleep a 0 1 2
15. Early morning awakening (earlier than usual for this person) a 0 1 2

E. Ideational disturbances
16. Suicide (feels life is not worth living, has suicidal wishes, or makes suicidal attempt) a 0 1 2
17. Poor self-esteem (self-blame, self-depreciation, feelings of failure) a 0 1 2
18. Pessimism (anticipation of the worst) a 0 1 2
19. Mood-congruent delusions (delusions of poverty, illness, or loss) a 0 1 2

Total score: ____________________________

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Guidelines for Anxiety Disorder Screening

• No general population screening recommendations, but several brief screens available
  ▪ GAD-7 and GAD-2 for generalized anxiety disorder
  ▪ PC-PTSD-5 for posttraumatic stress disorder

• All MH and SA screens available online: www.hiv.uw.edu/page/mental-health-screening/gad-7
# GAD-7

## GAD-7

<table>
<thead>
<tr>
<th>Over the last 2 weeks, how often have you been bothered by the following problems?</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Feeling nervous, anxious or on edge</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Not being able to stop or control worrying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Worrying too much about different things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Trouble relaxing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Being so restless that it is hard to sit still</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Becoming easily annoyed or irritable</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Feeling afraid as if something awful might happen</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**Total Score** = Add Columns 

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all
- Somewhat difficult
- Very difficult
- Extremely difficult

- □
- □
- □
- □
Further Anxiety Disorder Screening

- Social Anxiety Disorder – SPIN (Social Phobia Inventory) – 17 item self
- Obsessive Compulsive Disorder – OCD Screening Test – 25 item self, OCI-R -18 item self
Treatment
Cognitive Behavior Therapy (CBT)

- Practice Guidelines: first line treatment for mild and moderate anxiety disorders, combined with SSRI antidepressants for severe anxiety disorders.

- CBT for adolescents and children is adapted from the method developed for adults.

- Most of the evidence base for children and adolescents is brief CBT: 10-16 weekly 50 minute individual sessions that involves the following elements:
  - Homework, between session practice
  - Psychoeducation for the child and parents
  - Exposure
  - Cognitive restructuring
  - Relaxation training
Adolescent Depression

- Both psychotherapy and medication recommended, but shared decision making and patient centered approach important to ensure adherence
<table>
<thead>
<tr>
<th>PHQ-9 Symptoms and Impairment</th>
<th>PHQ-9 Scores</th>
<th>Intensity</th>
<th>Treatment Recommendations</th>
</tr>
</thead>
</table>
| 1-4 symptoms minimal          | 5-9          | Subclinical| • Education to call if deteriorates  
| functional impairment        |              |           | • Physical activity, behavioral activation  
|                               |              |           | • Consider referral to behavioral health if no improvement in 1-2 months  |
| 2 symptoms,                   | 10-14        | Mild Major| • Pharmacotherapy, psychotherapy, or both  
| #1 or #2 > 0 score 2 +,       |              | Depression| • Education  
| functional impairment        |              |           | • Physical activity  
|                               |              |           | • Behavioral activation  
|                               |              |           | • Initially consider weekly contacts to ensure adequate engagement, then at least monthly  |
| ≥ 3 symptoms, #1 or #2 > 0  | 15-19        | Moderate Major| • Pharmacotherapy psychotherapy, or both  
| score 2 +,                    |              | Depression| • Education  
| functional impairment        |              |           | • Physical activity  
|                               |              |           | • Behavioral activation  
|                               |              |           | • Initially consider weekly contacts to ensure adequate engagement, then minimum every 2-4 weeks  |
| > 4 Symptoms question #1 or   | ≥ 20         | Severe Major| • Pharmacotherapy necessary & psychotherapy when patient is able to participate  
| #2 > 0 score 2 +,             |              | Depression| • Education  
| marked functional impairment,|              |           | • Physical activity  
| motor agitation               |              |           | • Behavioral activation  
|                               |              |           | • Weekly contacts until less severe  |

Source: Adult Depression in Primary Care Guideline 2013 Institute for Clinical Systems Improvement
Treating Depression – Beyond PHQ-9 Scores

• Patient centered care – addressing symptoms and functional goals most important to the patient

• Focus on interpersonal supports and liabilities, disability, cognitive functioning, sleep, self-care and adherence to medical treatment
Case Example

• 17 year old girl tells her school counselor she took an overdose the night before, feels hopeless and depressed and appears sleepy during school hours

• She reports that her parents won’t accept her homosexuality and refuse to let her have contact with her girlfriend. She has started raiding her mother’s supply of Xanax and also drinking surreptitiously from the family liquor cabinet

• Substance use disorder screening shows possible use disorder; parents and patient given education and brief counseling for substance use, referred for family therapy
Case Example

• 39 year old man presents with chronic back pain following a work related injury the year before. His wife is threatening divorce due to his constant anger and irritability, and he is binge drinking on weekends. He denied feeling depressed or sad but said he feels like he is going to lose it over the slightest frustration. He also has severe insomnia and his wife reports that he has nightmares.

• He denies any history of trauma in childhood but said he immigrated with his parents from Central America when he was a young child and doesn’t remember much.

• Screening for depression and PTSD both positive, both diagnosed with full assessment; treatment started with medication and psychotherapy. Also referred for pain management.
Case Example

• 64 year old woman brought in by her husband after an auto accident where she was at fault, he describes increased forgetfulness, decreased appetite and weight loss, loss of interest in her hobbies and a decline in her hygiene

• She denies feeling sad or depressed and says everything is fine, but she is concerned about strange people coming into her house and rearranging her furniture and taking her belongings

• Screened for cognitive disorder and for depression; mild major neurocognitive disorder found but also moderate to severe depression. Environmental interventions, antidepressant and cognition enhancing medication prescribed
Integrated Care

Figure. Diagram of TEAMcare collaborative care workflow

- Primary care physician
- Consulting psychiatrist
- Primary care consultant
- Care manager
- Patient

NOTE: Thick arrows denote more direct contact and communication within the team at regular intervals.
Case Example

- Mary, age 42, who has type II diabetes, high blood pressure and hyperlipidemia, appears tearful and relates to her PCP having poor energy, weight gain and poor sleep.

- The PCP tells her she may have clinical depression and refers her to a psychiatrist, who makes an appointment to see her in 45 days. She is also referred to a therapist who can see her the following week, but she doesn’t feel comfortable with him and stops treatment after one visit.
Case Example

- Mary, age 42, who has type II diabetes, high blood pressure and hyperlipidemia, appears tearful and relates to her PCP having poor energy, weight gain and poor sleep.

- Mary’s doctor also has results of a PHQ9 which she did in the waiting room and has her talk to a BH care manager (an RN) right after she finishes. She is evaluated and found to have moderate depression and she is given the option to return for brief problem solving therapy and/or start an antidepressant, both of which she opts for and starts that day. She returns the following week for another counseling session and medication management and does another PHQ9.
Why Integrate Care?

• Separate medical and behavioral health is a legacy from a past marked by a behavioral health specialty found mainly in state hospitals, community mental health centers or psychoanalytic office practices, a limited insurance benefit, federal and state financing, mind-body separation bias and stigma.

• The patients don’t make this distinction
  ▪ Those with a mental health disorder are likely to have a major medical condition (70%) and those with a medical disorder are more likely to have a major mental health disorder (30%).
  ▪ An estimated 80% of those first seeking BH care present to either primary care or emergency departments/urgent care.

• Integrated care is cost effective and also compatible with value based payment.
What is Integrated Care?

- The full range of health care services, which includes addressing health behaviors, behavioral health and substance use treatment, provided under one roof. Also, patient/family centered, team based, systematic and holistic

- Currently, when behavioral healthcare is considered in the context of primary care, there are three general models that reflect levels from least to most integrated: coordinated, co-located and fully integrated
  - This might also be viewed as a step process in the development of integrated BH-PC
Coordinated Model of Care

- Primary care and behavioral health in separate offices
- Primary care has some level of screening or assessment, then refers out to BH
- Information sharing is voluntary and varies depending on the provider
- This model operates with separate records, billing, etc.
- Least integrated, but also least disruptive
- Least efficient for access to BH care
Co-located Model of Care

• Primary care and BH providers in the same building or area, maybe the same office

• Primary care still assesses and refers, but may have better handoff, access due to co-location

• Maintain separate billing, records

• Regular face to face interactions, informal consultation possible, more awareness of each other’s practice, methods

• Variable level of cooperation that is highly dependent on providers’ flexibility, comfort with each other
Fully Integrated Model of Care

- Primary care and BH share office, staff, have same billing and medical record and work off the same treatment plan

- Function as a team, immediate BH services available, communicate during and after contact with patients. For the patient, seamless: no distinction between medical and BH care

- Population health focus; standard BH and SUD screening

- Quality focus; use of algorithms and practice guidelines
IMPACT

Collaborative Care Team Structure

- Patient
- Primary Care Provider
- Care Manager
- Psychiatric Consultant
- Other Behavioral Health Clinicians
- Substance Treatment, Vocational Rehabilitation, CMHC, Other Community Resources

Legend:
- Infrequent Interaction
- Frequent Interaction

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Collaborative Care Fundamentals – The Hyphens

- Patient-centered care teams
- Population-based care
- Measurement-based care
- Evidence-based care
- Systematic quality improvement and accountability for outcomes
Evidence Base for Collaborative Care

- Depression in adolescents
- Depression with other chronic physical conditions
- Cancer – improved psychosocial health and quality of life outcomes
- Alzheimer Disease
- Panic Disorder
- Chronic Pain
- Substance Use Disorders
- ADHD
- PTSD
Toward Integration – Interim Steps

• For Coordinated Care level systems: Building a BH ‘medical neighborhood’, Child Psychiatry Access Projects; BH and SUD Case Management, Project ECHO, tele-psychiatry (like Live Health Online psychology)

• For Co-located Care level systems: despite the administrative divisions the opportunity for forming a team by exposure and experience; cross-cultural enrichment between primary care and BH. This may be an important first step toward full integration
MCPAP Process
Project ECHO
(Extension for Community Healthcare Outcomes)

• Telehealth for community based primary care that allows access to specialists for education and consultation. Regularly scheduled video-conference with several primary care teams and tertiary care specialists where both didactic and de-identified patient consultation offered. “Virtual clinics”

• Developed first in New Mexico to allow primary care providers to get expert consultation on managing Hepatitis C – evidence showed that outcomes were as good as specialty care

• Addiction treatment developed next, especially MAT, and experience in NM showed a dramatic increase in the number of PCP’s providing care after ECHO
Summary: Promoting Integrated Care

• Leadership buy-in and support
• Team based primary care with a non-physician clinician designated for BH care
• Patient/family centered care
• Screening of all patients using standardized screens with algorithm based processes for positive screens
• Use of evidence based treatments following practice guidelines
• Tracking and measuring adherence and outcomes using patient tracking tools and standardized measures
• Connection with community resources and supports
Next Steps and Additional Resources

• Share today’s recording with colleagues (available within 24 hours of webinar)

• View “Depression and Anxiety Disorders: Children” bonus recording

• Utilize Screening Tools
  Anthem.com ⇒ Providers ⇒ Select a State ⇒ Pick Your State ⇒ Find Resources for "state" ⇒ Enhanced Personal Health Care Program ⇒ Provider Toolkit ⇒ Behavioral Health tab
  ▪ Implement screening for depression in adolescents and adults according to USPSTF guidelines
  ▪ Use optional screening tools for anxiety disorders in children, adolescents and adults who have signs of depression, problems sleeping or concentrating, or who have unusual or excessive somatic symptoms

• Explore the possibilities for adding care coordinator functions using existing staff in your practice or adding staff in order to be able to implement a collaborative care model process. Discuss integration options with your Care Consultant or local market representative
Next Steps and Additional Resources

continued

• Inquire about the availability of Child Psychiatry Access programs in your state or Project Echo Psychiatry programs

• View recordings of other webinars related to this topic presented under the Enhanced Personal Health Care Collaborative Learning Program:
  - Adult ADHD: Current Trends and Best Practice Treatment
  - Motivational Interviewing in Primary Care
  - The Integrative Approach to Pain Management: A non-opioid treatment model for addressing chronic pain recording
Questions?