Depression in Primary Care: Lessons Learned in Collaborative Care

L. Lee Tynes, MD, PhD, FACP
Tulane Professor of Psychiatry
Agenda:

I. The Nature of Depression in Primary Care

II. Quick Diagnosis and Treatment Decisions

III. Lessons Learned as Collaborative Care Caseload Consultant

IV. Billing Codes/ Model Legislation (Time Permitting)
Primary Care is the ‘De Facto’ Mental Health System

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

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

Wang P, et al., Twelve-Month Use of Mental Health Services in the United States, Arch Gen Psychiatry, 62, June 2005
QuickStats: Percentage of Mental Health-Related* Primary Care† Office Visits, by Age Group — National Ambulatory Medical Care Survey, United States, 2010

* A mental health visit was defined by at least one of the following: ordering or provision of depression screening, psychotherapy, or other mental health counseling; a mental health diagnosis or reason for visit; or a psychotropic medication that was ordered, supplied, administered, or continued at the visit. Mental health diagnosis, reason for visit, and psychotropic medications were based on certain categories. Source: Olsson M, Kroenke K, Wang S, Blanco C. Trends in office-based mental health care provided by psychiatrists and primary care physicians. J Clin Psychiatry 2014; 75:247-53.
Physical Symptoms
Risk Of Psychiatric Disorder

Psychiatric Disorders in High Medical Utilizers

N = 119

Monthly Expenditures for Chronic Conditions
With and Without Comorbid Mental Illnesses

Mental Disorders and Medical Comorbidity by Druss BG and Reisinger Walker E: [http://www.nwf.org/pr/product.jsp?id=71883](http://www.nwf.org/pr/product.jsp?id=71883)
Original data from Adapted from Melek and Norris (2005 Marketscan data)
Survey of Primary Care Provider Comfort in Treating Psychiatric Patients in 2 Community Clinics: A Pilot Study

Figure 1. Comfort of All Providers (N = 54) With Psychiatric Disorders

- Anxiety disorders
- Unipolar depression
- ADHD
- Sleep disorders
- PTSD
- Bipolar I, II disorder
- Adult ADD
- Addictive disorders
- OCD
- Dementias/neurocognitive disorders
- Autistic spectrum disorders
- Schizophrenia spectrum disorders
- Eating disorder
- Conversion disorders

Least Comfortable | Neutral | Very Comfortable
--- | --- | ---
1 | 2 | 3 | 4 | 5

*Data show the mean response for all surveyed primary care providers for each variable, with survey items arranged from highest to lowest mean comfort.

Abbreviations: ADD = attention-deficit disorder, ADHD = attention-deficit/hyperactivity disorder, OCD = obsessive-compulsive disorder, PTSD = posttraumatic stress disorder.

Stilwell, et al. Prim Care Companion CNS Disord 2022;24(1):21m03020
Initial Screen: The PHQ-2

During the past 2 weeks, have you had any of the following:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Little interest in doing things?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Felt down, depressed, or hopeless?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
At least 4 of the following neurovegetative symptoms (SIG-ECAPS)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sleep</strong></td>
<td>Insomnia or sleeping too much</td>
</tr>
<tr>
<td><strong>Interest</strong></td>
<td>Diminished interest or pleasure in most activities</td>
</tr>
<tr>
<td><strong>Guilt</strong></td>
<td>Feelings of guilt or worthlessness</td>
</tr>
<tr>
<td><strong>Energy</strong></td>
<td>Loss of energy or fatigue</td>
</tr>
<tr>
<td><strong>Concentration</strong></td>
<td>Diminished ability to think or concentrate, indecisiveness</td>
</tr>
<tr>
<td><strong>Appetite</strong></td>
<td>Increase or decrease in appetite</td>
</tr>
<tr>
<td><strong>Psychomotor</strong></td>
<td>Psychomotor agitation or retardation</td>
</tr>
<tr>
<td><strong>Suicide</strong></td>
<td>Thoughts of death or suicidal ideation</td>
</tr>
</tbody>
</table>
Affective Disorders

- Major Depression
- Dysthymic Disorder
- Adjustment D/O with Depressed Mood
- Bipolar Disorder
- Mood D/O Due to General Medical Condition
- Substance-Induced Mood Disorder
Checking For Mania…

Screen for current or past hypomanic/manic episodes

“Have you ever felt the complete opposite of depressed, where friends and family were worried because you were abnormally happy, active, or energetic?”
AND
“Have you ever had a high level of energy running through your body—so much energy that, because of that energy, you did not need to sleep for at least a few days straight?”

If no, a bipolar spectrum disorder is less likely.

If yes to either question, ask the patient, “When did that happen last and can you tell me exactly what was going on in your life at the time?”

“Have you had a problem with depression or sadness like this in the past?”

If no, the depression is a single episode and will need a minimum of 12 months of treatment

If yes, the depression is recurrent and may need indefinite therapy
Behavioral and Mental Health Integration into Primary Care Practice

The COVID-19 pandemic, the opioid epidemic, extreme weather events, increased gun violence, and other local, national, and global political unrest have taken a devastating toll on mental health. One study has estimated that anxiety and depression have increased 26-28% since pre-pandemic levels, respectively.

- **BHI Collaborative**

- **Helpful BHI Resources**
  - **Waco Guide** - This psychopharmacology tool was created by Waco Family Medicine in consult with the Massachusetts General Hospital Psychiatry Academy. Also available in an smartphone app, the Waco Guide is intended to guide decisions regarding psychopharmaceutical treatment of common psychiatric conditions seen in adult and pediatric primary care (e.g., depression, anxiety, ADHD, substance use disorders, PTSD, eating disorders, etc.).
  - **AIMS Center** - This website from the University of Washington in Seattle offers a wealth of information to help...
ADULT DIAGNOSES

- Acute Stress Disorder
- Adult ADHD
  - Adult ADHD - Cardiac Impairment
  - Adult ADHD - Hepatic Impairment
  - Adult ADHD - Renal Impairment
  - Adult ADHD - Obesity
  - Adult ADHD - Geriatric
- Alcohol Use Disorder
- Anorexia Nervosa
- Atypical Antipsychotic Side Effect Management
  - Adult ADHD
  - Adult ADHD - Cardiac Impairment
  - Adult ADHD - Hepatic Impairment
  - Adult ADHD - Renal Impairment
  - Adult ADHD - Obesity
  - Adult ADHD - Geriatric
• Bulimia Nervosa

• Depressive Disorder
  ○ Depressive Disorder- Cardiac Impairment
  ○ Depressive Disorder- Hepatic Impairment
  ○ Depressive Disorder- Renal Impairment
  ○ Depressive Disorder- Obesity
  ○ Depressive Disorder- Geriatric

• Fibromyalgia
  ○ Fibromyalgia- Cardiac
Stepped Depression Treatment

SSRI, SNRI, Bupropion

Switch Medication, Switch Class, Augment with Bupropion, Mirtazapine

Antipsychotic, TCA

Other
STAR*D: Citalopram Treatment Failures: No Difference Between Switch to Bupropion, Sertraline, or Venlafaxine
Effects of antidepressant treatment

Therapeutic effects

Side effects

Time in weeks
Most Patients Need Treatment Adjustments

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

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

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STAR-D Remission Rates Based on Number of TREATMENT STEPS

First Step: 36.8%
Second Step: 30.6%
Third Step: 13.7%
Fourth Step: 13.0%

Bottom line: 1/3 respond with initial treatment but almost all patients respond eventually

Caveat: those requiring more Rx steps had higher relapse rates during naturalistic follow-up
Maintenance Therapy on Basis of Episodes

**Principles of the collaborative care model**

**Patient-centered Care**  
Primary care and behavioral health providers collaborate effectively using shared care plans.

**Population-based Care**  
Care team shares a defined group of patients tracked in a registry. Practices track and reach out to patients who are not improving and mental health specialists provide caseload-focused consultation, not just ad-hoc advice.

**Measurement-based Treatment to Target**  
Each patient’s treatment plan clearly articulates personal goals and clinical outcomes that are routinely measured. Treatments are adjusted if patients are not improving as expected.

**Evidence-based Care**  
Patients are offered treatments for which there is credible research evidence to support their efficacy in treating the target condition.

**Accountable Care**  
Providers are accountable and reimbursed for quality care and outcomes.

http://uwaims.org/overview-principles.html
Doubles Effectiveness of Care for Depression

50% or greater improvement in depression at 12 months

Participating Organizations

% of Improvement

Usual Care
IMPACT

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

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

Unützer et al., *Am J Managed Care 2008.*
Impact of a national collaborative care initiative for patients with depression and diabetes or cardiovascular disease

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c Kaiser Permanente Colorado Institute for Health Research, P.O. Box 378066, Denver, CO, 80237-8066
d Kaiser Permanente Southern California, Department of Research and Evaluation, 100 S. Los Rables Ave., 2nd Floor, Pasadena, CA, 91101-2453
e Mayo Clinic, Psychiatry and Psychology Division of Integrated Behavioral Health, 200 First St. SW, Rochester, MN, 55905
f University of St. Thomas, School of Social Work, 2115 Summit Ave, St. Paul, MN, 55105
g Community Health Plan of Washington, 720 Olive Way, Suite 300, Seattle, WA, 98101-1830
h Mount Auburn Cambridge Independent Practice Association, 1380 Soldiers Field Rd., Floor 2, Brighton, MA, 02135-1023
i Pittsburgh Regional Health Initiative, 650 Smithfield St., Centre City Tower, Suite 2400, Pittsburgh, PA, 15222-3900
j Michigan Center for Clinical Systems Improvement, 233 E. Fulton St., Suite 20, Grand Rapids, MI, 49503-3261
k University of Washington, 1959 NE Pacific Street, Box 356560, Seattle, WA, 98195-6560

Objective: The spread of evidence-based care is an important challenge in healthcare. We evaluated spread of an evidence-based large-scale multisite collaborative care model for patients with depression and diabetes and/or cardiovascular disease (COMPASS).

Methods: Primary care patients with depression and comorbid diabetes or cardiovascular disease were recruited. Collaborative care teams used care management tracking systems and systematic case reviews to track and intensify treatment for patients not improving. Targeted outcomes were depression remission and response (assessed with the Patient Health Questionnaire-9) and control of diabetes (assessed by HbA1c) and blood
Collaborative Care for Depression: Lessons Learned

Historical Factors

OSA
Glaucoma
Seizure d/o
CA
Serotonin load
Suicidality
Collaborative Care for Depression: Lessons Learned

“Must-Have Labs”

RECENT:

Renal FunctionQTc/Conduction Disturbance
Liver Function

TSH (target<3.5 for hypothyroid depressed)
Collaborative Care for Depression: Lessons Learned

Antidepressant Dose

1. Consider using Measurement Based Care: PHQ9
2. Educate patients not to stop meds w/o calling
3. See/contact patients in 2-4 weeks
4. ALWAYS ESCALATE DOSE UNLESS:
   1. Pt is asymptomatic
   2. Dose-limiting AEs emerge
   3. Pt refuses
   4. Top dose has been achieved
Collaborative Care for Depression: Lessons Learned
For Anxiety

SSRI/SNRIs are 1st line for anxiety
Buspar is not a PRN drug!
Bupropion does not help anxiety!
Alternatives for co-morbid anxiety:
  - Hydroxyzine (consider QTc)
  - Gabapentin/Pregabalin
  - A Second AD (trazodone, Remeron, TCA)
  - Quetiapine
If Bzd a must, long half life drugs are best (eg clonazepam)
Collaborative Care for Depression: Lessons Learned

For Insomnia

Hydroxyzine frequently effective

Trazodone
- remember orthostasis/priapism
- DO escalate dose like an AD! Top is 400mg!

Remeron
- remember weight gain (but also antiemetic)
- DON’T escalate dose if you need the hypnotic

ALL THE ABOVE HELPFUL WITH ANXIETY AND/OR DEPRESSION!!!

CBT-I might sometimes be the best alternative
## CoCM Specific Billing Codes

### Table 1. BHI Coding Summary

<table>
<thead>
<tr>
<th>BHI Codes</th>
<th>Behavioral Health Care Manager or Clinical Staff Threshold Time</th>
<th>Assumed Billing Practitioner Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add-On CoCM (Any month) (CPT code 99494)</td>
<td>Each additional 30 minutes per calendar month</td>
<td>13 minutes</td>
</tr>
<tr>
<td>BHI Initiating Visit (AWV, IPPE, TCM or other qualifying E/M)†</td>
<td>N/A</td>
<td>Usual work for the visit code</td>
</tr>
<tr>
<td>CoCM First Month (CPT code 99492)</td>
<td>70 minutes per calendar month</td>
<td>30 minutes</td>
</tr>
<tr>
<td>CoCM Subsequent Months** (CPT code 99493)</td>
<td>60 minutes per calendar month</td>
<td>26 minutes</td>
</tr>
<tr>
<td>General BHI (CPT code 99484)</td>
<td>At least 20 minutes per calendar month</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Initial or subsequent psychiatric collaborative care management (HCPCS code G2214)</td>
<td>30 minutes of behavioral health care manager time per calendar month</td>
<td>Usual work for the visit code</td>
</tr>
</tbody>
</table>

**CoCM is delivered monthly for an episode of care that ends when targeted treatment goals are met or there is failure to attain targeted treatment goals culminating in referral for direct psychiatric care, or there is a break in episode (no CoCM for 6 consecutive months).

†Annual Wellness Visit (AWV), Initial Preventive Physical Examination (IPPE), Transitional Care Management services (TCM).

**Full Code Descriptors**

[Link](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf)
QUESTIONS?

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