Depression in Primary Care:
Lessons Learned in Collaborative Care

Our Lady of the Lake Regional Medical Center
Franciscan Missionaries of Our Lady Health System

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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)

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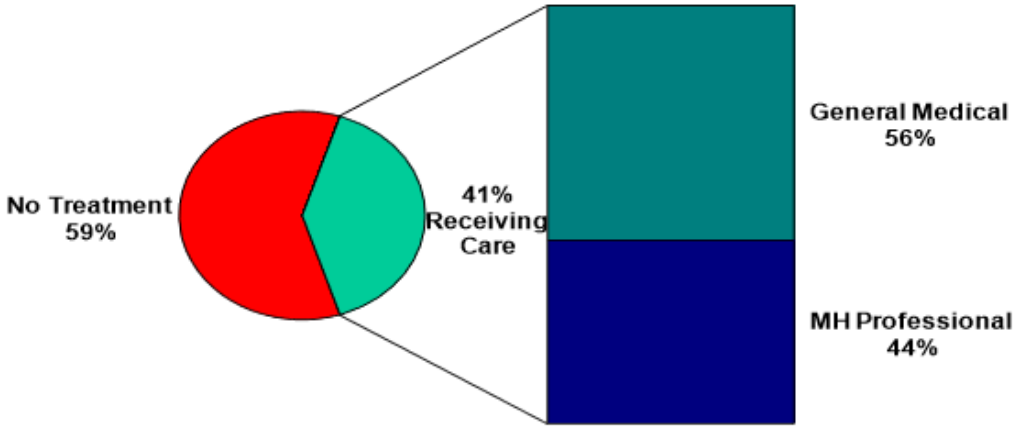
ESTABLISHED IN 1927 BY THE AMERICAN COLLEGE OF PHYSI

ACP Annals.org

Primary Care is the 'De Facto' Mental Health System

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



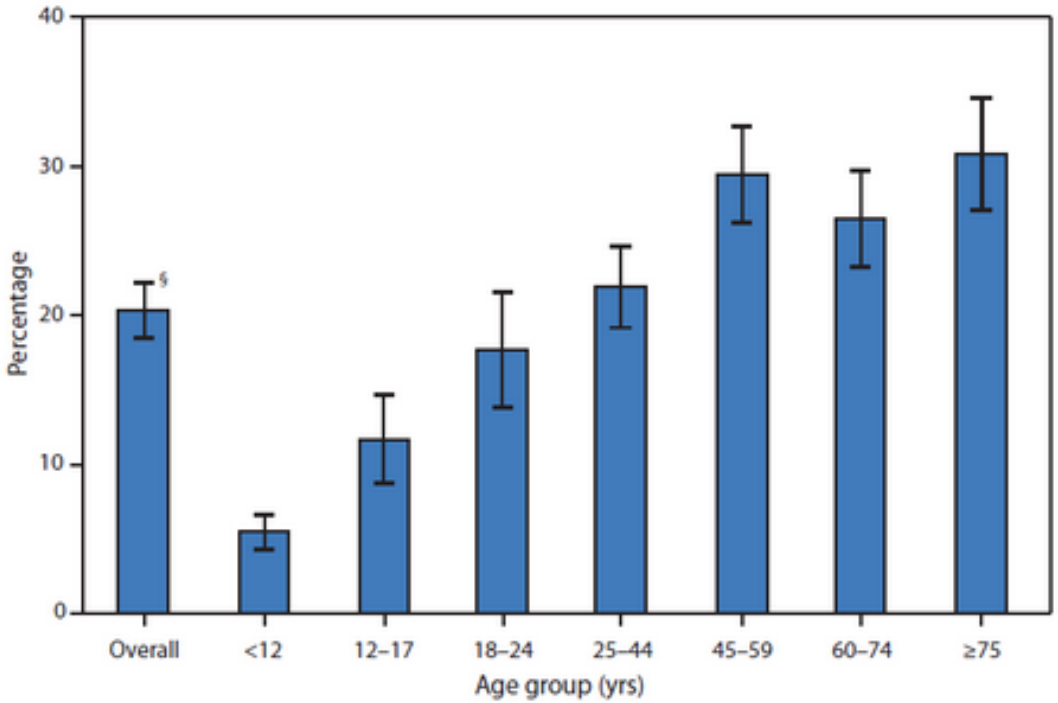
Wang P, et al., Twelve-Month Use of Mental Health Services in the United States, Arch Gen Psychiatry, 62, June 2005

Morbidity and Mortality Weekly Report (*MMWR*)

MMWR

QuickStats: Percentage of Mental Health-Related* Primary Care† Office Visits, by Age Group — National Ambulatory Medical Care Survey, United States, 2010

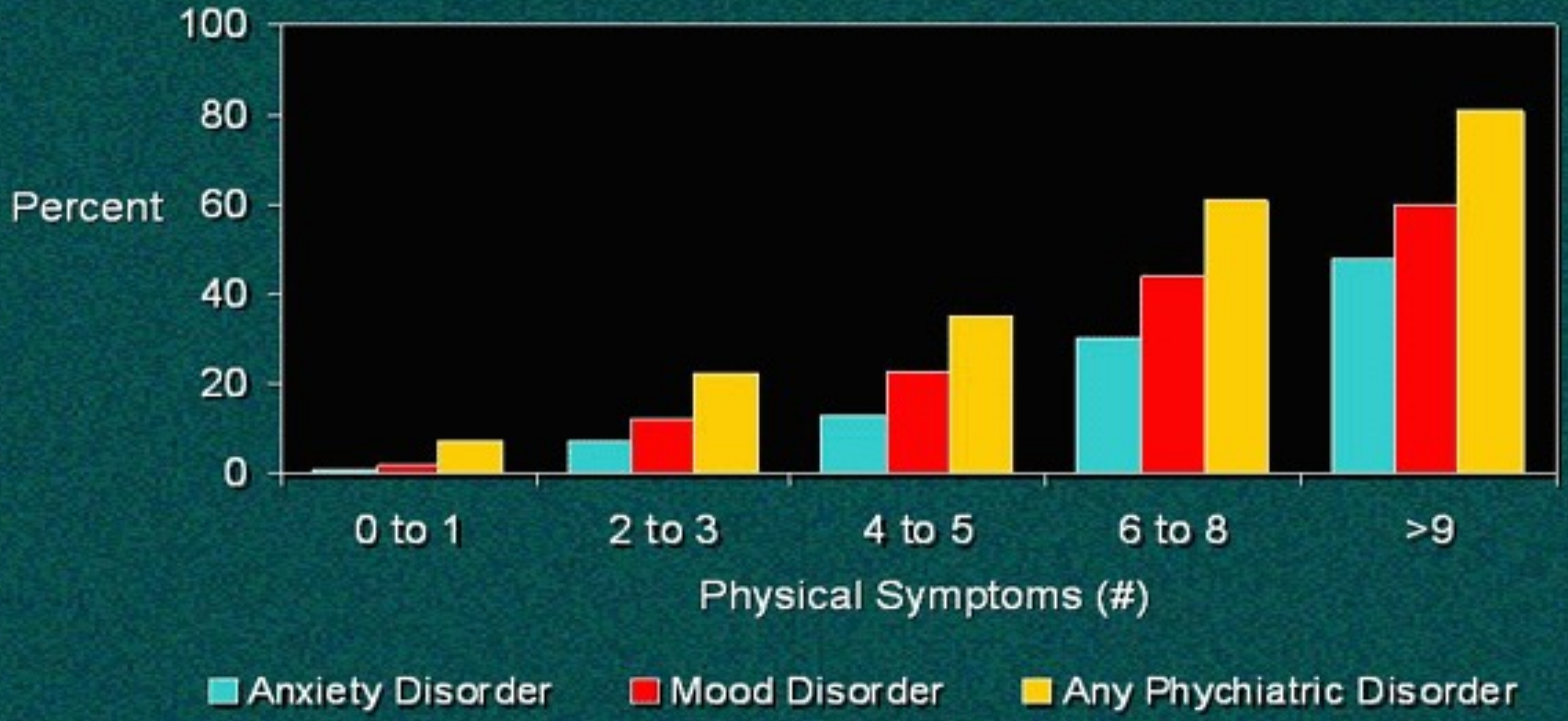
Weekly
November 28, 2014 / 63(47);1118



* 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: Olfson 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.

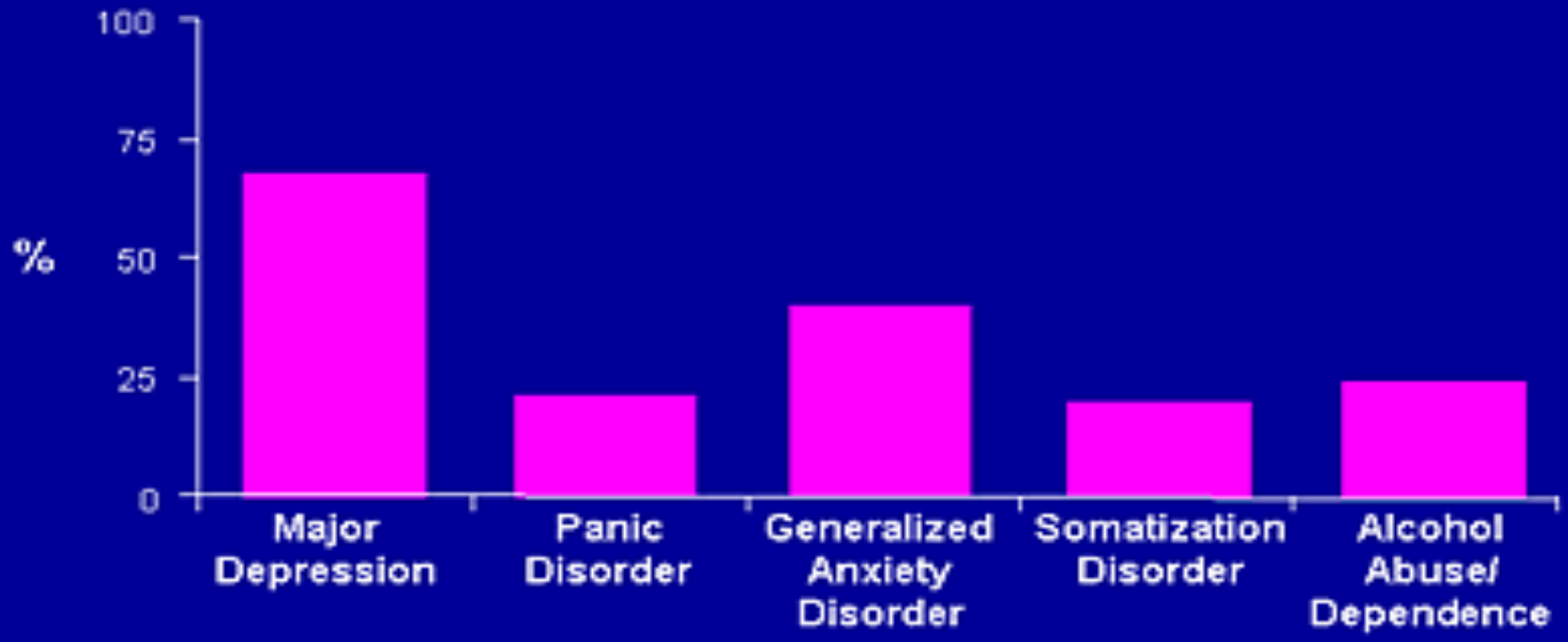
Physical Symptoms

Risk Of Psychiatric Disorder



Kroenke et al. *Arch Fam Med*. 1994;3:774.

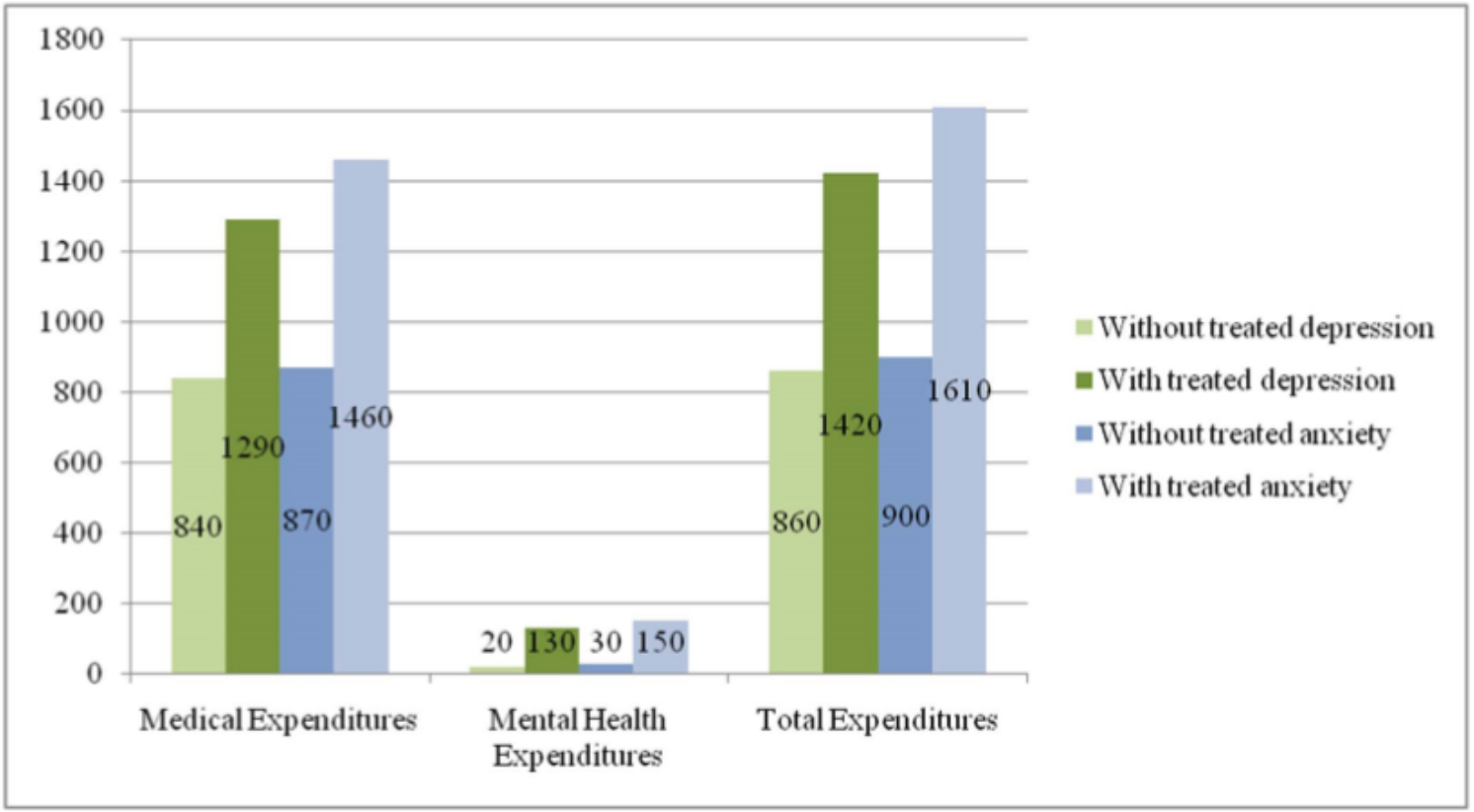
Psychiatric Disorders in High Medical Utilizers



N = 119

Katon W, et al. *Gen Hosp Psychiatry*. 1990;12:355–362.

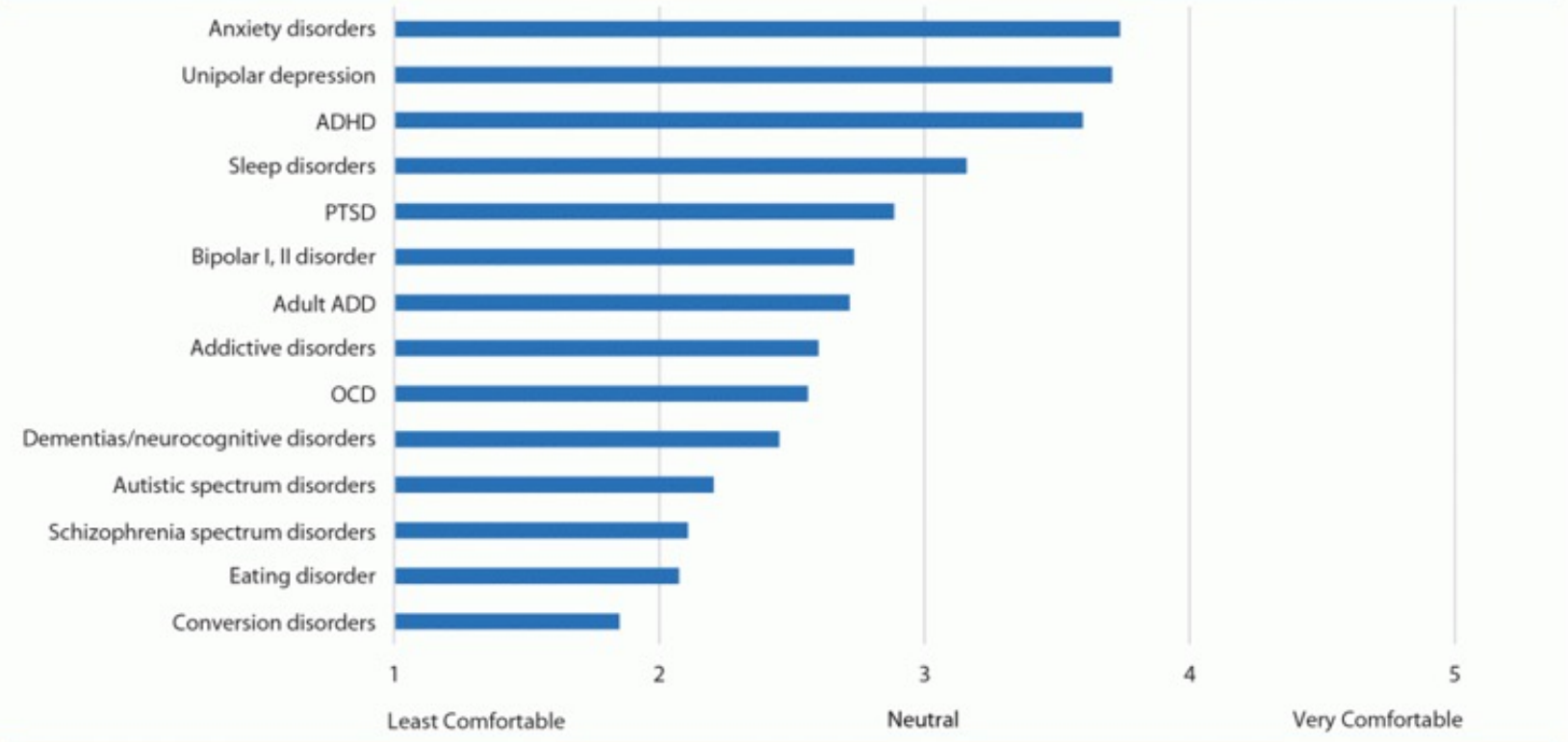
Monthly Expenditures for Chronic Conditions With and Without Comorbid Mental Illnesses



Mental Disorders and Medical Comorbidity by Druss BG and Reisinger Walker E:(http://www.rwjf.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[a]



[a]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:

	Yes	No
Little interest in doing things?	☐	☐
Felt down, depressed, or hopeless?	☐	☐

At least 4 of the following neurovegetative symptoms (SIG-ECAPS)

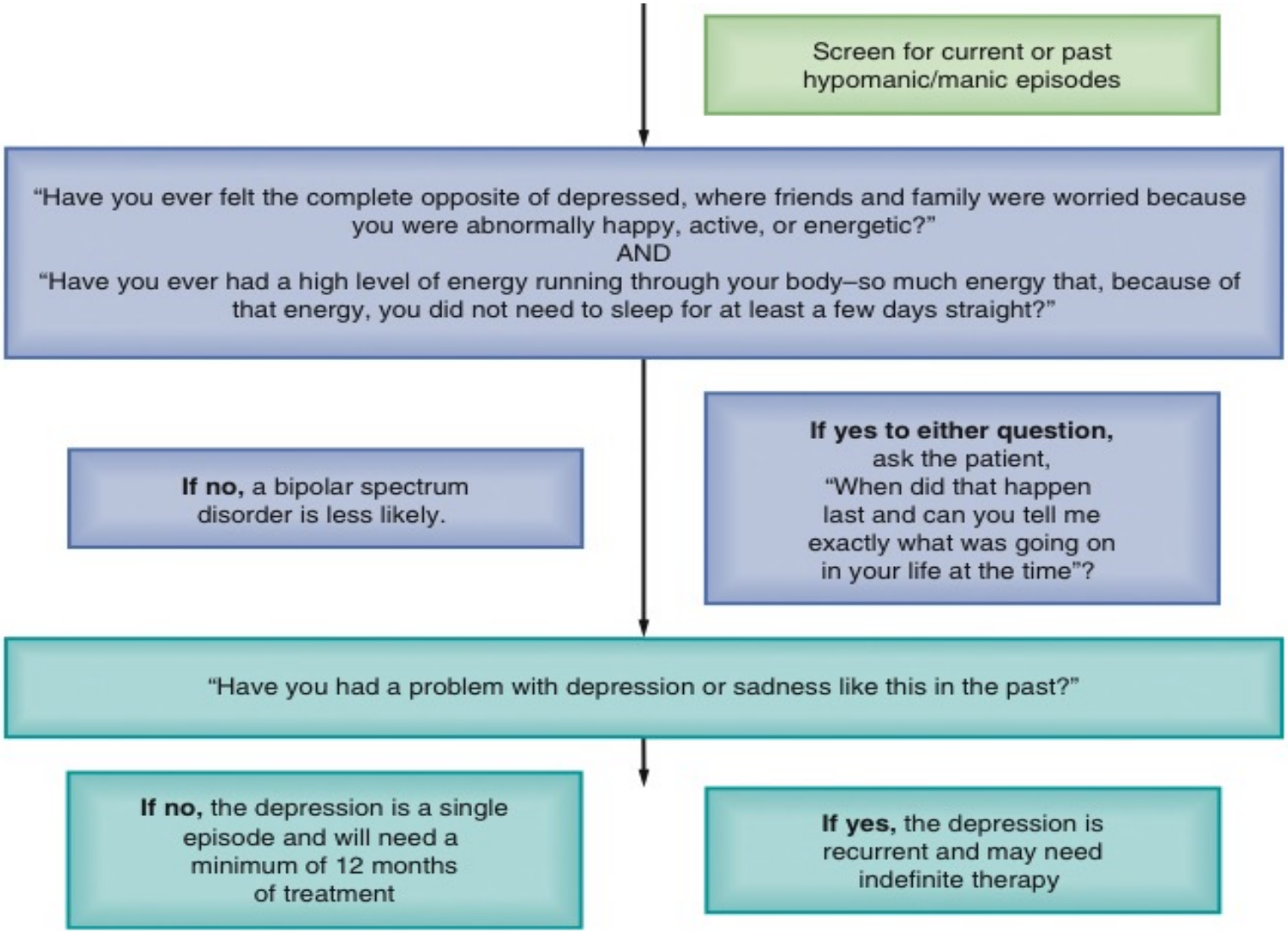
Sleep	Insomnia or sleeping too much
Interest	Diminished interest or pleasure in most activities
Guilt	Feelings of guilt or worthlessness
Energy	Loss of energy or fatigue
Concentration	Diminished ability to think or concentrate, indecisiveness
Appetite	Increase or decrease in appetite
Psychomotor	Psychomotor agitation or retardation
Suicide	Thoughts of death or suicidal ideation

GW Smetana, Depression: Pearls for Mgt in Primary Care

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…



Patient Care & Office Forms

Financial Management

Human Resources

Insurance

Practice Ownership Tools

Behavioral and Mental Health Integration into Primary Care Practice

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

THE WACO GUIDE

TO PSYCHOPHARMACOLOGY IN PRIMARY CARE

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-

uestions/ psychotherapy options
erapy
otherapy
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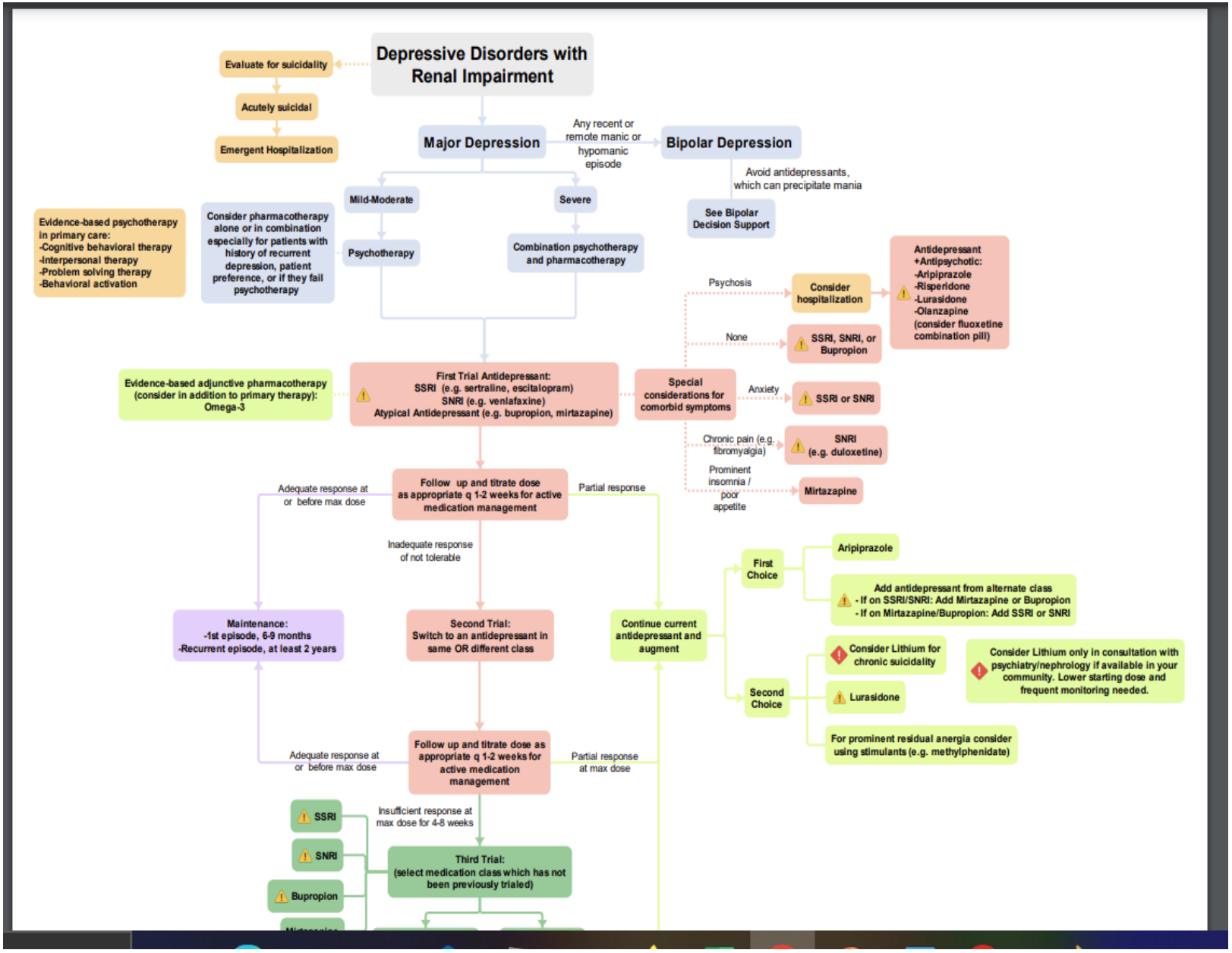
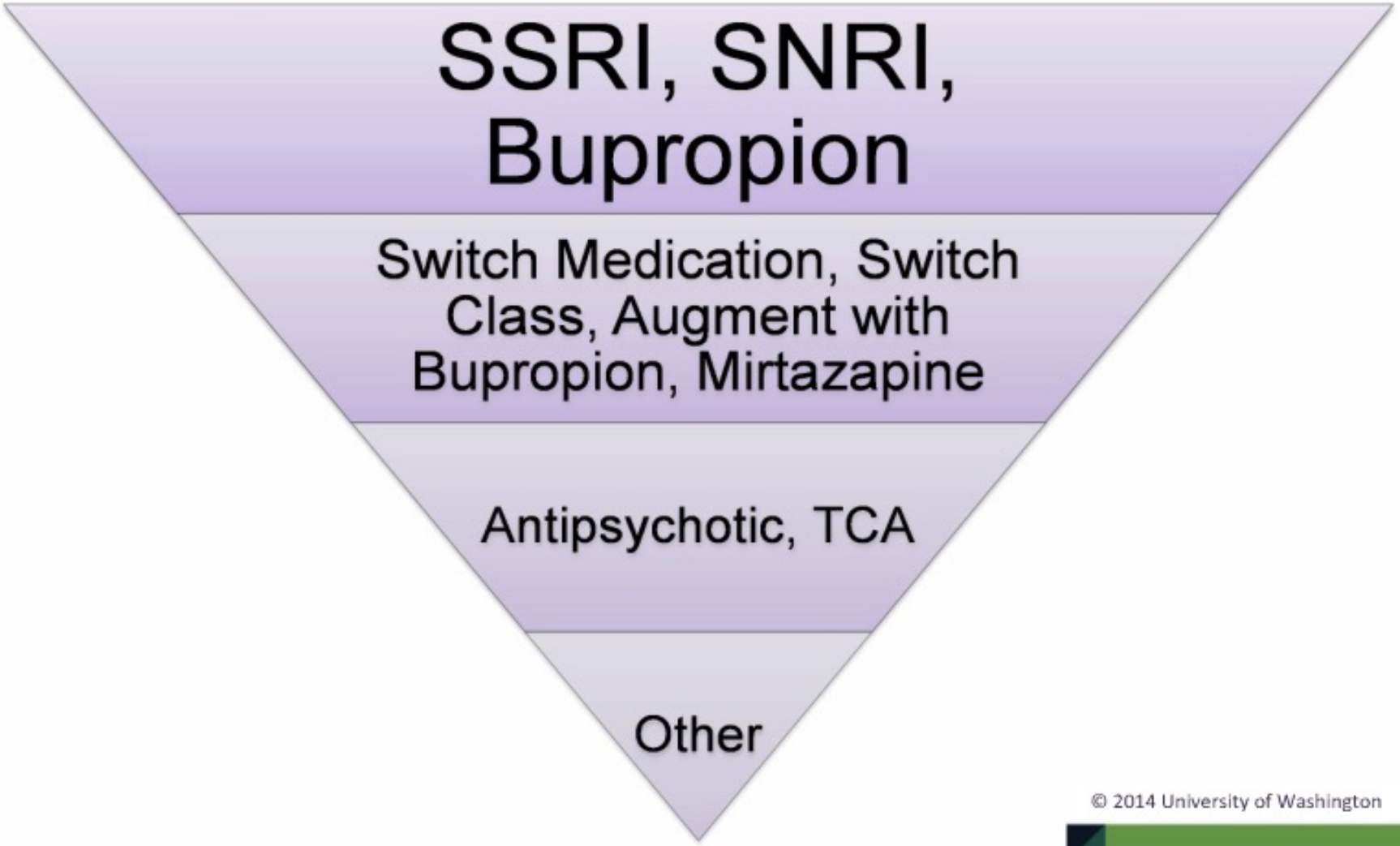
intenance therapy
Step / acute or severe management
rmacotherapy/ special populations

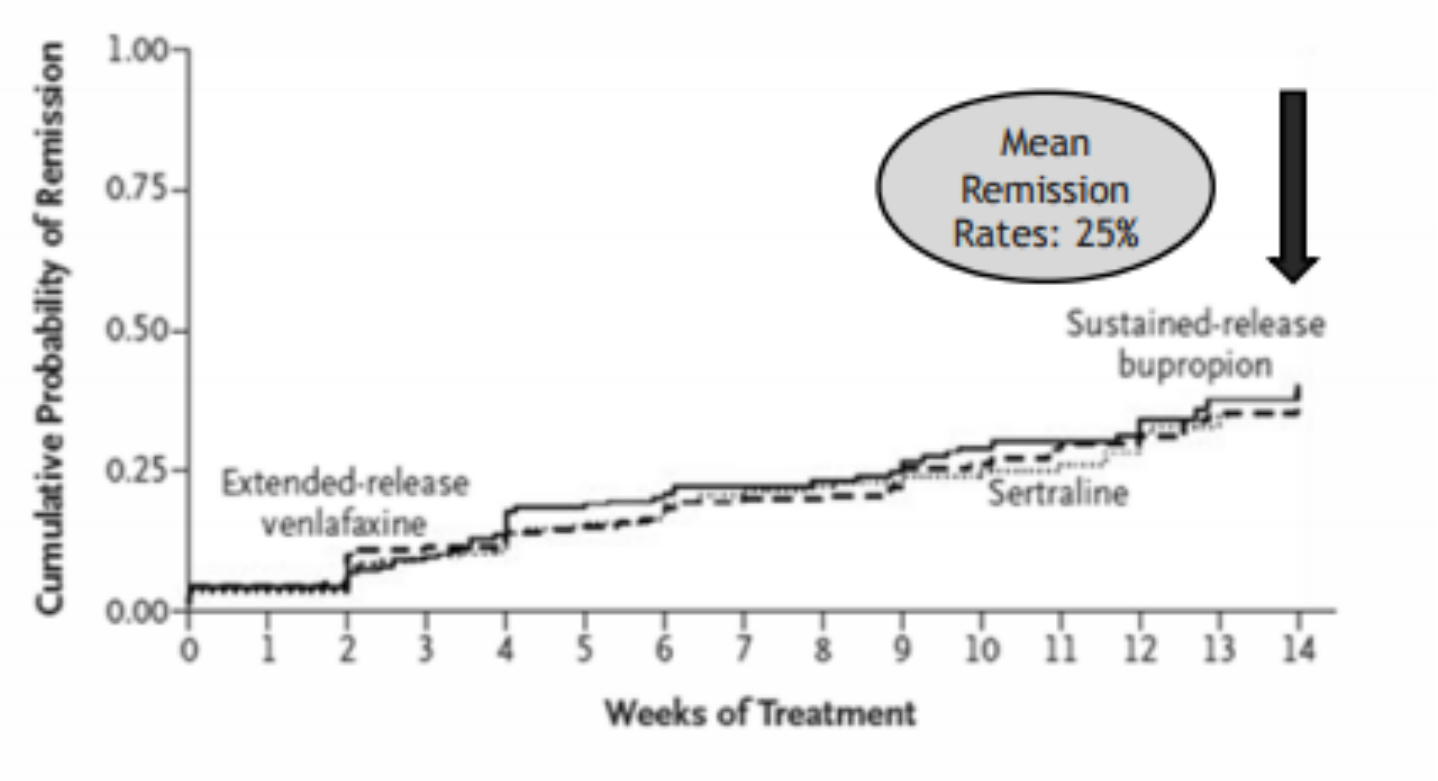
- Bulimia Nervosa
- Depressive Disorder
    - Depressive Disorder- Cardiac Impairment
    - Depressive Disorder- Hepatic Impairment
    - Depressive Disorder- Renal Impairment
    - Depressive Disorder- Obesity
    - Depressive Disorder- Geriatric
- Fibromyalgia
    - Fibromyalgia- Cardiac


Depressive Disorders with Renal Impairment
Evaluate for suicidality
Acutely suicidal
Emergent Hospitalization
Major Depression
Any recent or remote manic or hypomanic episode
Bipolar Depression
Avoid antidepressants, which can precipitate mania
See Bipolar Decision Support
Mild-Moderate
Severe
Evidence-based psychotherapy in primary care:
-Cognitive behavioral therapy
-Interpersonal therapy
-Problem solving therapy
-Behavioral activation
Consider pharmacotherapy alone or in combination especially for patients with history of recurrent depression, patient preference, or if they fail psychotherapy
Psychotherapy
Combination psychotherapy and pharmacotherapy
Psychosis
Consider hospitalization
Antidepressant +Antipsychotic:
-Aripiprazole
-Risperidone
-Lurasidone
-Olanzapine
(consider fluoxetine combination pill)
None
SSRI, SNRI, or Bupropion
Evidence-based adjunctive pharmacotherapy (consider in addition to primary therapy):
Omega-3
First Trial Antidepressant:
SSRI (e.g. sertraline, escitalopram)
SNRI (e.g. venlafaxine)
Atypical Antidepressant (e.g. bupropion, mirtazapine)
Special considerations for comorbid symptoms
Anxiety
SSRI or SNRI
Chronic pain (e.g. fibromyalgia)
SNRI (e.g. duloxetine)
Prominent insomnia / poor appetite
Mirtazapine
Adequate response at or before max dose
Follow up and titrate dose as appropriate q 1-2 weeks for active medication management
Partial response
Inadequate response of not tolerable
Maintenance:
-1st episode, 6-9 months
-Recurrent episode, at least 2 years
Second Trial:
Switch to an antidepressant in same OR different class
Continue current antidepressant and augment
First Choice
Aripiprazole
Add antidepressant from alternate class
- If on SSRI/SNRI: Add Mirtazapine or Bupropion
- If on Mirtazapine/Bupropion: Add SSRI or SNRI
Second Choice
Consider Lithium for chronic suicidality
Consider Lithium only in consultation with psychiatry/nephrology if available in your community. Lower starting dose and frequent monitoring needed.
Lurasidone
For prominent residual anergia consider using stimulants (e.g. methylphenidate)
Adequate response at or before max dose
Follow up and titrate dose as appropriate q 1-2 weeks for active medication management
Partial response at max dose
Insufficient response at max dose for 4-8 weeks
SSRI
SNRI
Bupropion
Third Trial:
(select medication class which has not been previously trialed)

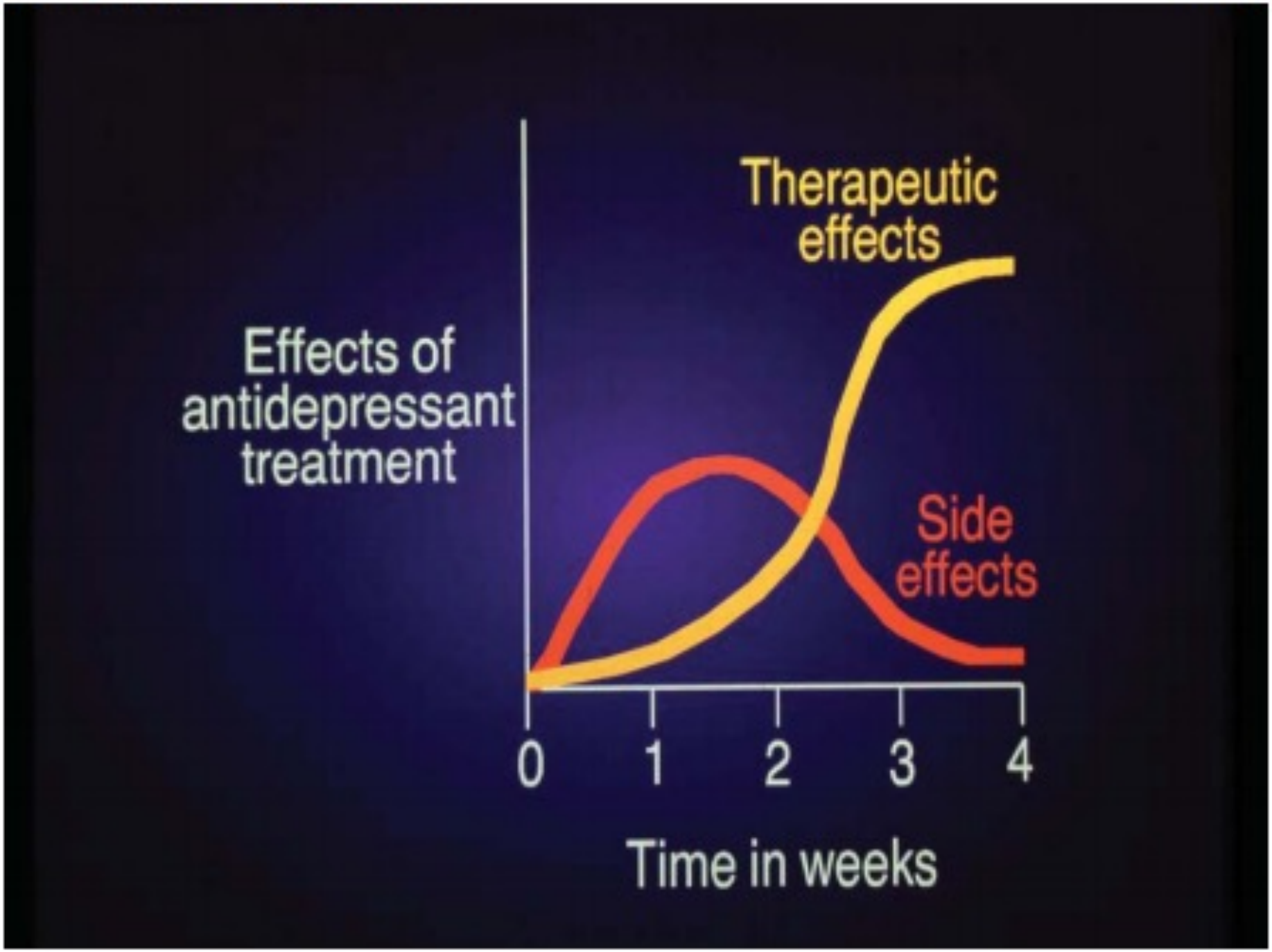
Stepped Depression Treatment



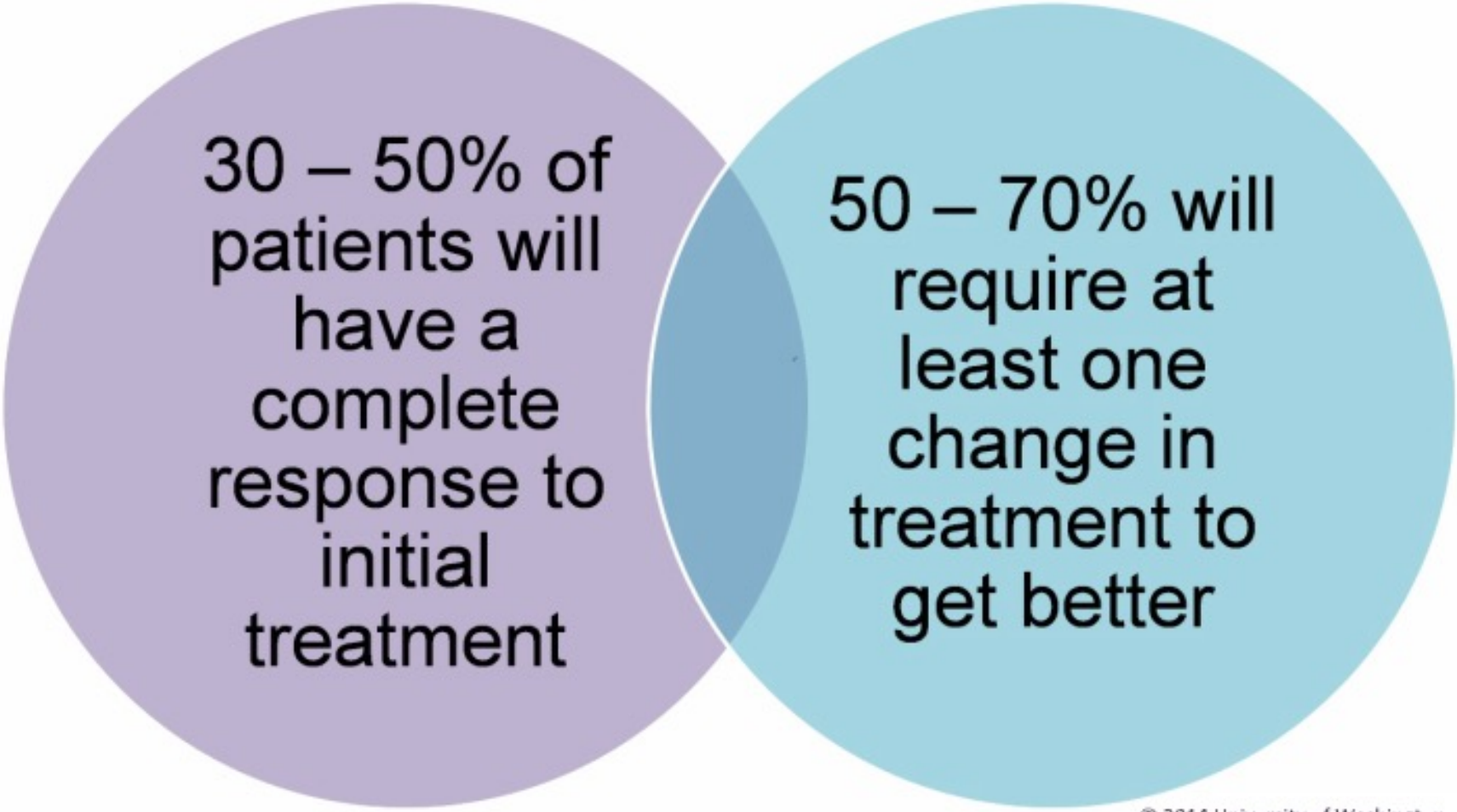
STAR*D: Citalopram Treatment Failures: No Difference Between Switch to Bupropion, Sertraline, or Venlafaxine



N Engl J Med 2006;354:1231


Therapeutic effects
Effects of antidepressant treatment
Side effects
0
1
2
3
4
Time in weeks

Most Patients Need Treatment Adjustments



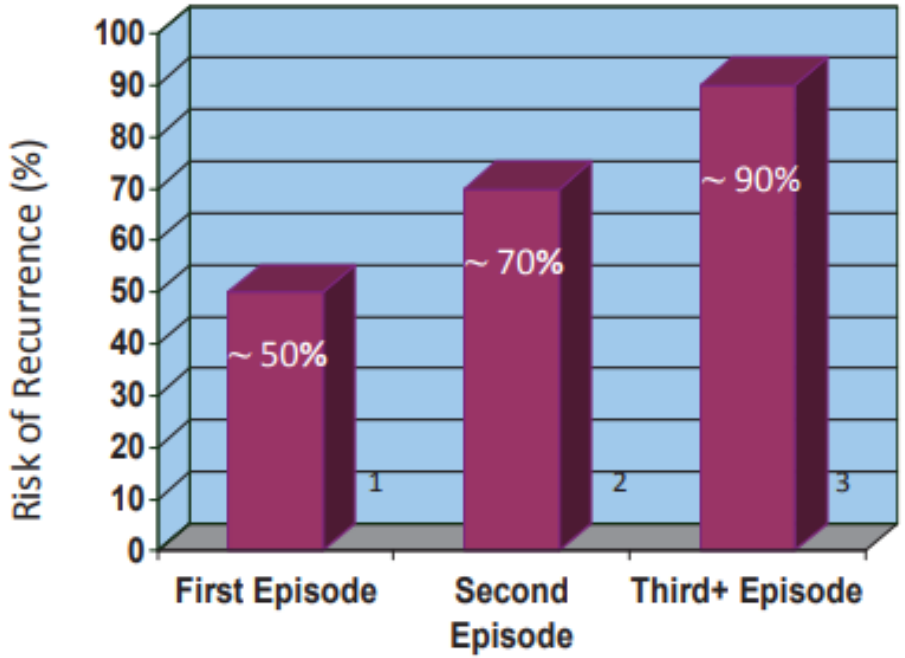
STAR-D Remission Rates Based on Number of TREATMENT STEPS

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



[1] Judd LL et al., *Am J Psychiatry*, 2000
[2] Mueller TI et al., *Am J Psychiatry*, 1999
[3] DSM-IV-TR. Washington, DC: American Psychiatric Association, 2000

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

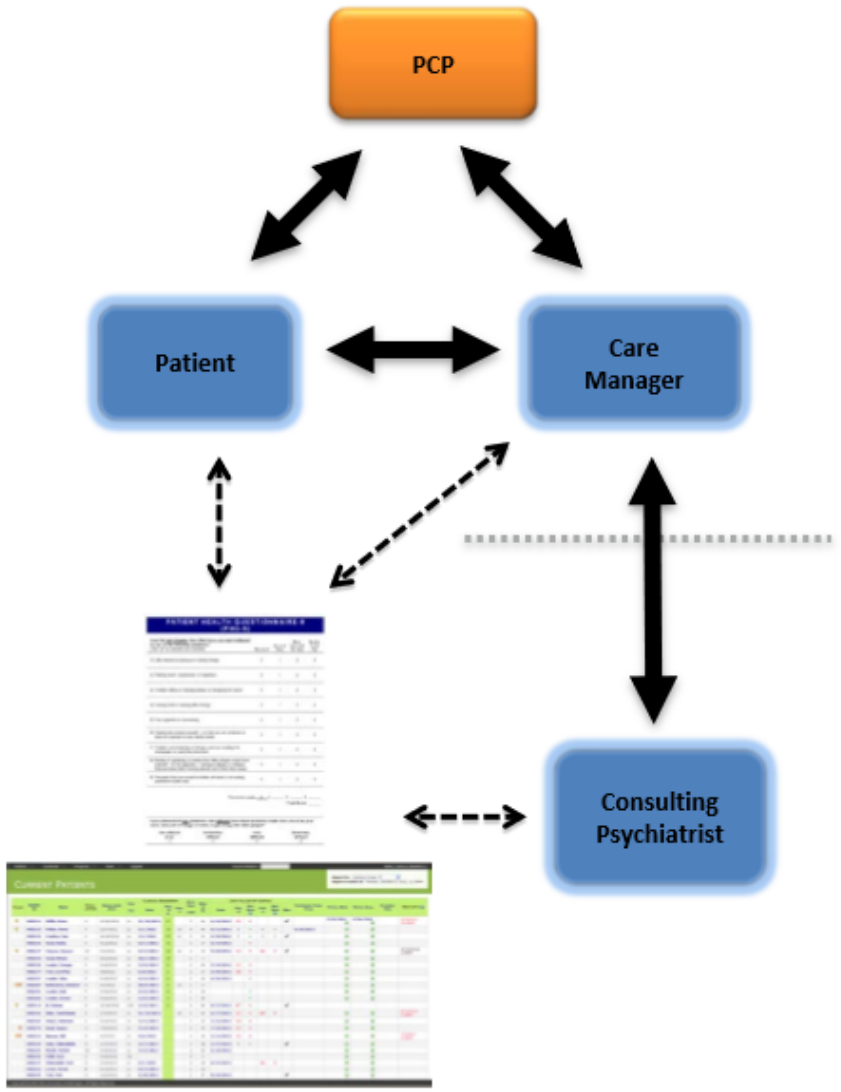
Each patient's treatment plan clearly articulates personal goals and clinical outcomes that are routinely measured. Treatments are adjusted if patients are not improving as expected.

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.

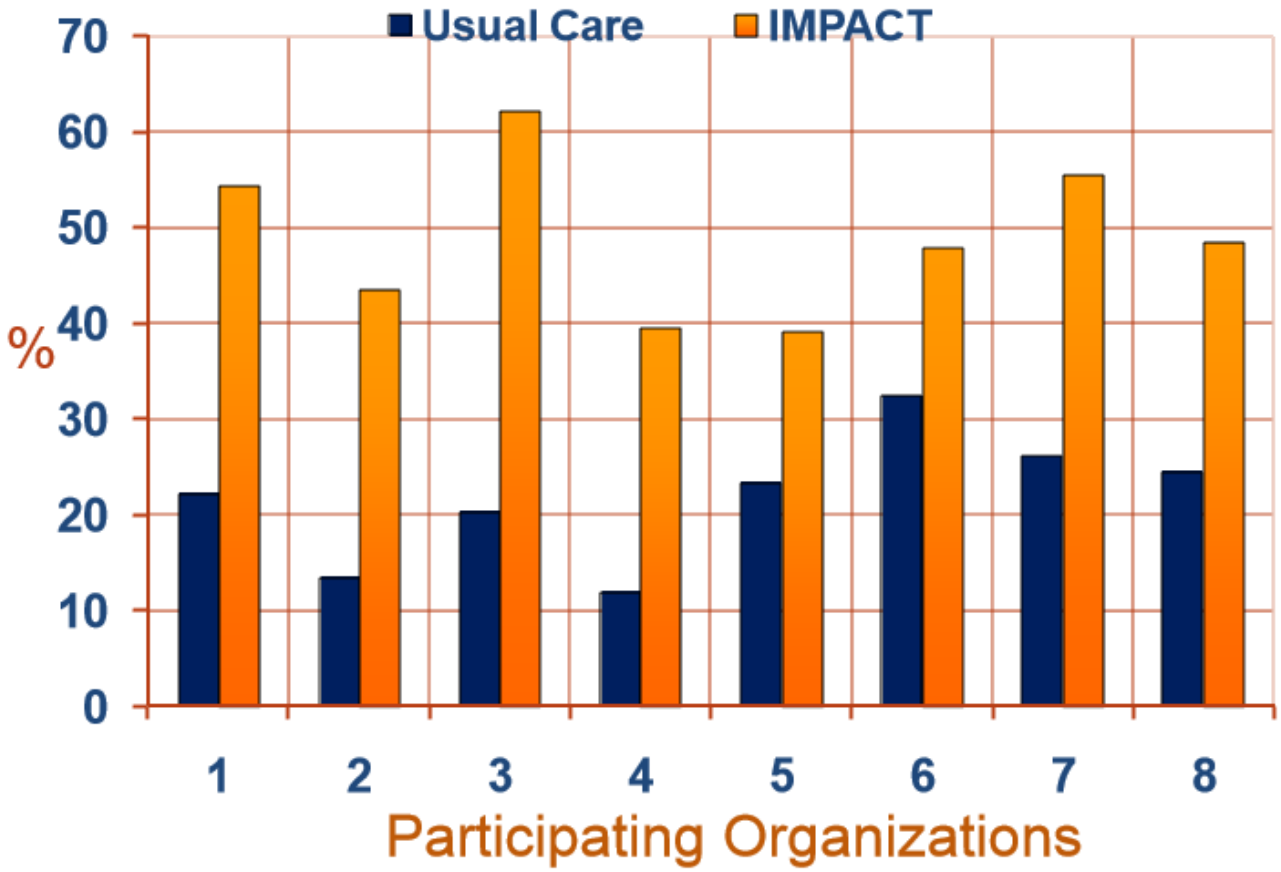


http://uwaims.org/overview-principles.html

UNIVERSITY of WASHINGTON

Doubles Effectiveness of Care for Depression

50 % or greater improvement in depression at 12 months



Unützer et al., JAMA 2002; Psych Clin North America 2004

Long-Term Cost Savings

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

Savings

Unützer et al., *Am J Managed Care 2008.*

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Impact of a national collaborative care initiative for patients with depression and diabetes or cardiovascular disease☆

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ABSTRACT

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 Function

QTc/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

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

**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

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

QUESTIONS?

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