UVM Project ECHO
Mental Health Advanced Series:
Depression in Primary Care

Course Directors: Sara Pawlowski, MD & Mark Pasanen, MD
ECHO Director: Patti Smith Urie

Series Faculty:

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Liz May, MD
Evan Eyler, MD
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Julia Terman, MA
Sravan Kakani, MD
Rick Dooley, PA-C
Sara Roberts, MD
Adam Greenlee, MD

Didactic presentation is recorded. Registered participants will receive the link.

The University of Vermont
LARNER COLLEGE OF MEDICINE
OFFICE OF PRIMARY CARE & AHEC PROGRAM

Project ECHO
University of Vermont

Session Agenda

- Welcome
- Objectives
- Didactic Presentation (20-30 min)
  - Q&A
- Case presentation(s)
  - Clarifying questions
  - Discussion
- Closing Announcements
  - Topic and cases for next session
  - Feedback and evaluation

ECHO Model: All Teach, All Learn

Cohort-based learning on ZOOM

- Have your camera on as much as possible, especially when joining the meeting and during discussions
- Questions and comments are welcome – use the “raise hand” feature or put them in the chat
- This is not a webinar! Participation is key

Case-based learning

- 1-2 participant cases each session using provided template
- Contact Mark Pasanen to present a case

Series Objectives

Learning objectives for this ECHO series include the ability to:

1. Develop enhanced diagnostic and treatment skills in the care of patients with depressive disorders
2. Implement brief intervention and “rapid” cognitive behavioral therapy into practice
3. Incorporate suicide risk assessment and prevention into practice
4. Design optimal pharmacologic treatment regimens for patients with depression

CMIE Disclosures

The Robert Larner College of Medicine at The University of Vermont is accredited by the American Nurses Credentialing Center (ANCC), the Accreditation Council for Pharmacy Education (ACPE), and the Accreditation Council for Continuing Medical Education (ACCME), to provide continuing medical education for the healthcare team.

The University of Vermont has approved your application and designates each session a maximum of **1.5 *AMA PRA Category 1 credit(s)***™.

This program has been reviewed and is acceptable for up to **1.5 Nursing Contact Hours**.

The Robert Larner College of Medicine University of Vermont has been authorized by the American Academy of PAs (AAPA) to award AAPA Category 1 CME credit for activities planned in accordance with AAPA CME Criteria. This activity is designated for **1.5 AAPA Category 1 CME credits**.

As a Jointly Accredited Organization, The Robert Larner College of Medicine at the University of Vermont is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. The University of Vermont maintains responsibility for this course. Social workers completing this course receive 1.5 continuing education credits.

Successful completion of this CME activity, which includes participation in the evaluation component, enables the participant to earn up to **1.5 MOC points** in the American Board of Internal Medicine's (ABIM) Maintenance of Certification (MOC) program; It is the CME activity provider's responsibility to submit participant completion information to ACCME for the purpose of granting ABIM or ABP MOC credit.

This activity was planned by and for the healthcare team, and learners will receive 1.5 Interprofessional Continuing Education (IPCE) credit for learning and change.

Participants should claim only the credit commensurate with the extent of their participation in the activity.

CMIE Disclosures

Interest Disclosures: As an organization accredited by the ACCME to sponsor continuing medical education activities, UVMCMIE is required to disclose any real or apparent conflicts of interest (COI) that any speakers may have related to the content of their presentations.

Meeting Disclaimer: Regarding materials and information received during this educational event, the views, statements, and recommendations expressed during this activity represent those of the authors and speakers and do not necessarily represent the views of the University of Vermont.

Session Objectives

Learning objectives for this ECHO session include the ability to:

1. Understand history of the Collaborative Care Model
2. Identify core principles of Collaborative Care
3. Consider the benefits of Collaborative Care for treating depression in a primary care setting

Collaborative Care Model Approach: Depressive Disorders

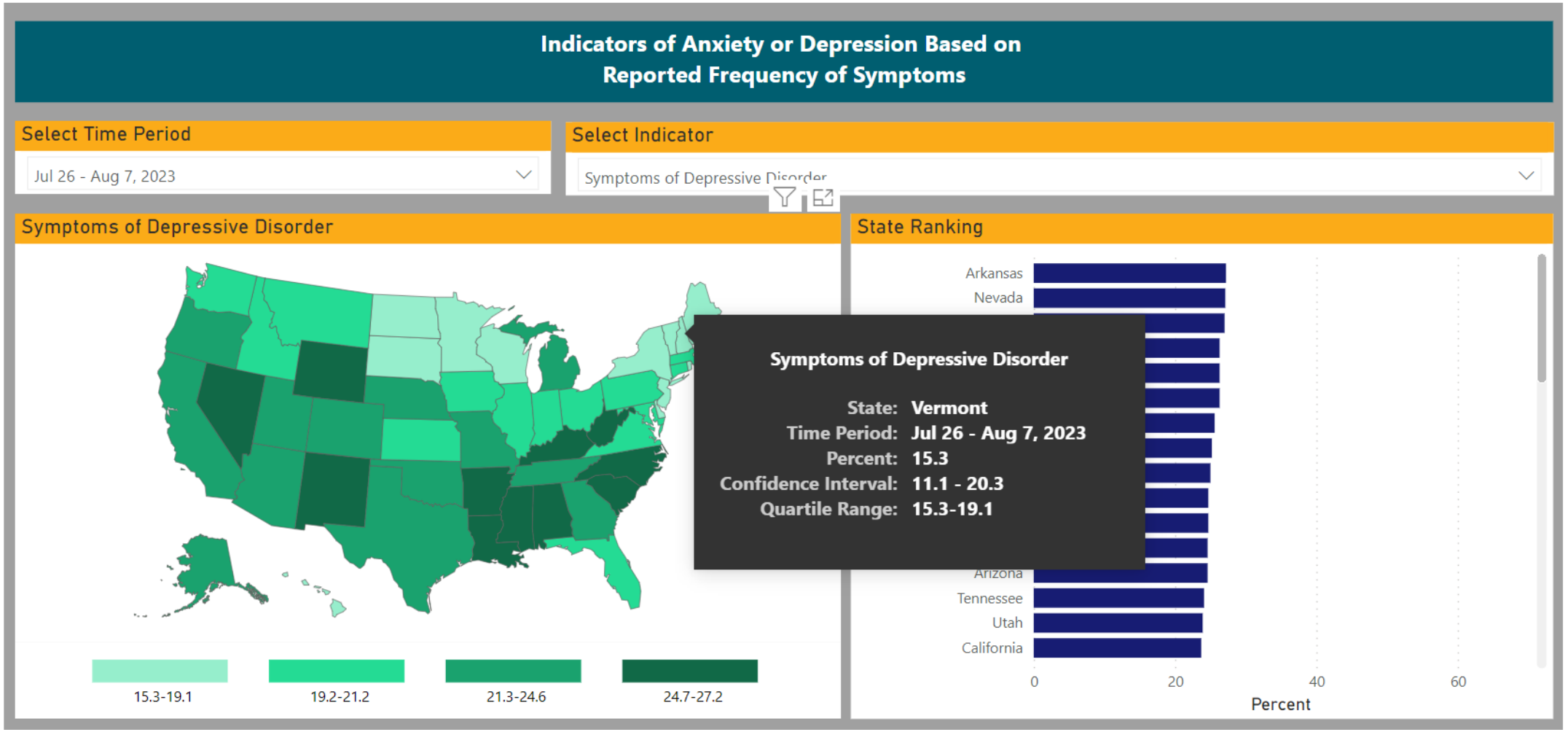
Clara Keegan, MD
Kerry Stanley, LICSW
University of Vermont Health Network

September 20, 2023

Quick Poll:

- How many of you have some familiarity with the “Collaborative Care model” for treating mental health conditions?

A look At The Problem…



Quick Facts

- Only 50% of patients who receive a referral for specialty mental health care ever follow through with the referral. Among those who do, many do not have more than one visit.
- 70% of all antidepressant prescriptions in the United States are written by a primary care provider.
- As few as 20 percent of patients started on antidepressant medications in usual primary care show substantial clinical improvements.
- Only 30-50% of patients have a full response to the first treatment plan. That means 50-70% of patients need at least one change in treatment.

History of Collaborative Care

- In 1995, Katon et al published data showing improvement in outcomes of patients receiving management by a consulting psychiatrist in collaboration with their family physician.
  - More consistent use of prescribed antidepressant medication
  - Greater satisfaction with care
  - Better outcomes in patients with major depression (effect not seen in patients with minor depression)
- In 2002, Unutzer at al published data about addition of a care manager to the team for older patients.
  - Significant improvement in reduction in symptoms of depression

Katon et al JAMA 1995

Unützer et al JAMA 2002ü

History of Collaborative Care

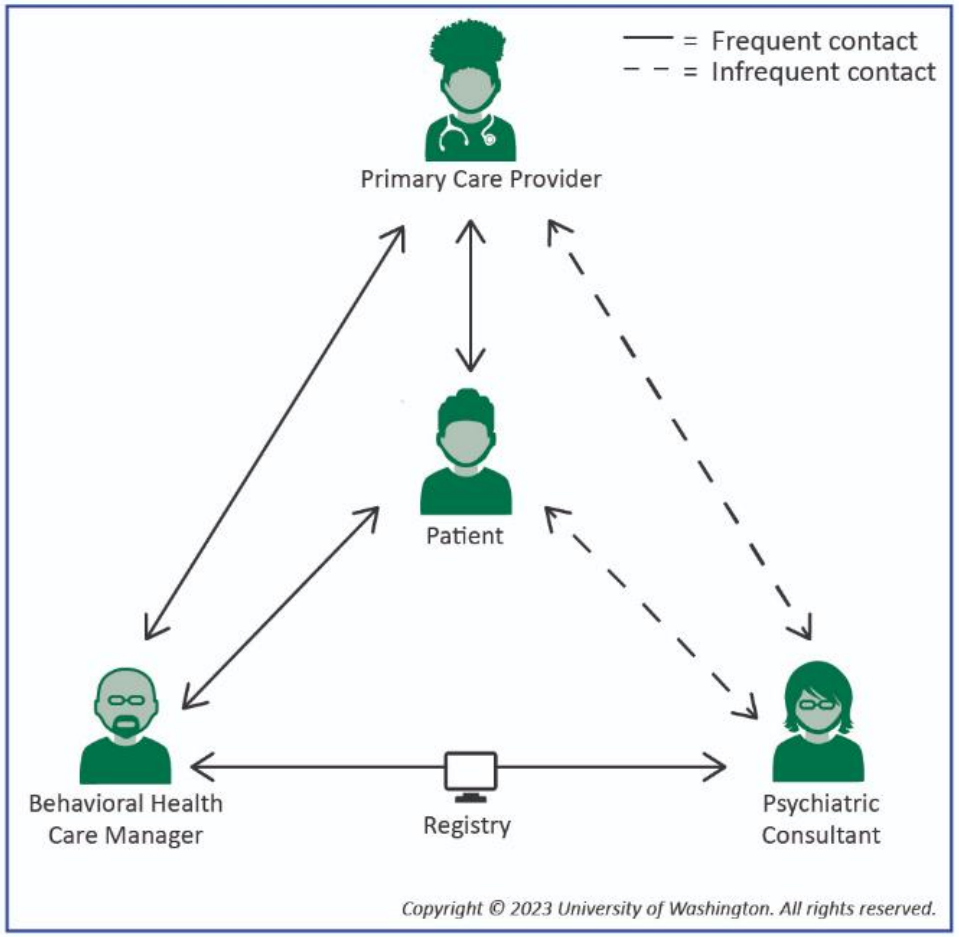
- These original findings have since been replicated in patients of many ages, ethnicities, and payment sources; and in both urban and rural settings.
- Dr. Unützer founded the AIMS Center at the University of Washington "to improve the health of populations by advancing effective, integrated behavioral healthcare."
- The AIMS Center supports institutions with implementation and maintenance of Collaborative Care programs

Raney Am J Psychiatry 2015

5 Core Principles: What Distinguishes Collaborative Care From other Integrated Models

- Patient-Centered Care Team
- Population-Based Care
- Measurement-Based Treat to Target
- Evidence-Based Care
- Accountable Care

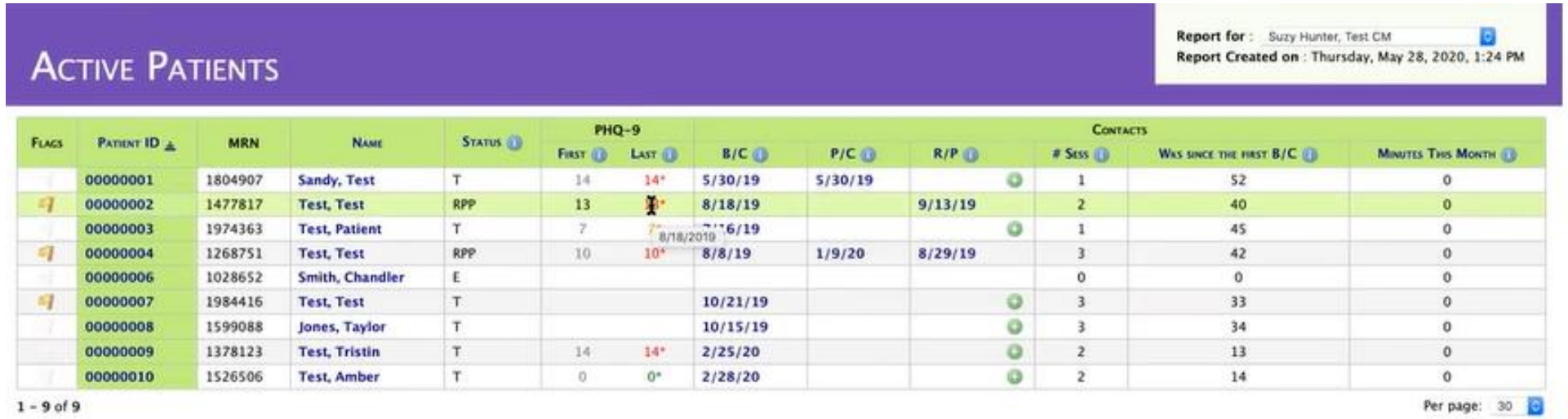
Principle 1: Patient Centered Care



Principle 1: Patient-Centered Care

- Collaborative Care Mental Health Clinician
  - Short term CBT
  - Medication adherence
  - Treat to target using registry
  - Leads ongoing case reviews with Psychiatric Consultant
  - Facilitates communication between patient, PCP, and Psychiatric Consultant
  - Facilitates outside referrals as needed
  - Relapse prevention planning
- Psychiatric Consultant
  - Focus on chart review and high-level recommendations more than face to face encounters
- Primary Care Provider
  - Remains the primary prescriber and first point of contact for the patient

Principle 2: Population-Based Care



Active Patients

Report for : Suzy Hunter, Test CM
Report Created on : Thursday, May 28, 2020, 1:24 PM

Flags	Patient ID	MRN	Name	Status	PHQ-9 First	PHQ-9 Last	Contacts B/C	Contacts P/C	Contacts R/P	Contacts # Sess	Contacts Wks since the first B/C	Contacts Minutes This Month
	00000001	1804907	Sandy, Test	T	14	14*	5/30/19	5/30/19		1	52	0
	00000002	1477817	Test, Test	RPP	13	[redacted]*	8/18/19		9/13/19	2	40	0
	00000003	1974363	Test, Patient	T	7	[redacted]	[redacted]6/19			1	45	0
	00000004	1268751	Test, Test	RPP	10	10*	8/8/19	1/9/20	8/29/19	3	42	0
	00000006	1028652	Smith, Chandler	E						0	0	0
	00000007	1984416	Test, Test	T			10/21/19			3	33	0
	00000008	1599088	Jones, Taylor	T			10/15/19			3	34	0
	00000009	1378123	Test, Tristin	T	14	14*	2/25/20			2	13	0
	00000010	1526506	Test, Amber	T	0	0*	2/28/20			2	14	0

8/18/2019

1 - 9 of 9

Per page: 30

Principle 3: Measurement-Based Treat to Target

- Collaborative Care requires a change in the treatment plan every 10-12 weeks if the patient has not had at least a 50% improvement in symptoms using a validated measure.

The Patient Health Questionnaire (PHQ-9)

Over the past 2 weeks, how often 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're 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

Principle 4: Evidence-Based Care

AIMS CENTER

UNIVERSITY of WASHINGTON

Psychiatry & Behavioral Sciences

Evidence Base for Collaborative Care

Foundational Evidence Base and Reviews

Table of Contents

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Project ECHO

University of Vermont

Principle 5: Accountable Care

- Compensation is based on quality of care and population health outcomes rather than "fee-for-service"
  - CMS codes specific for Collaborative Care Management
  - Psychotherapy time can be directly billed
- "$1 spent on Collaborative Care saves $6.50 in health care costs."
  - Even if CoCM is not directly reimbursed, patients with better management of depression have better health care outcomes in general
- Facilitates access to more patients
- Evidence-based tools identify outcomes

Tips For Implementation

- Engagement of key stakeholders
- Consider necessary systems changes
  - Scheduling mental health clinicians within primary care
  - Registry creation
  - Staff roles in administering and responding to screening tools
  - Consider how to implement a change to traditional billing models
- Process to obtain consent from patients prior to enrollment

What Can I Do Today?

- Identify and engage with natural mental health champions in primary care
- Increase screening and monitoring of depression symptoms using evidence-based tools; track symptoms over time
- Use a shared tool for charting
- Invite interdisciplinary clinicians to care team meetings
- Focus on brief CBT interventions in existing embedded models of care

References

- Katon W, Von Korff M, Lin E, et al. Collaborative management to achieve treatment guidelines: Impact on depression in primary care. JAMA 1995; 273(13):1026-1031.
- Raney, L. Integrating primary care and behavioral health: The role of the psychiatrist in the collaborative care model. Am J Psychiatry 2015; 172(8):721-728.
- Unützer J, Katon W, Callahan C, et al. Collaborative care management of late-life depression in the primary care setting: A randomized controlled trial. JAMA 2002; 288(22):2836-2845.
- Electronic PHQ form: PHQ-9 depression scale.pdf (nih.gov)
- Vermont Depression Data: Mental Health - Household Pulse Survey - COVID-19 (cdc.gov)
- Patient-Centered Care Graphic: Collaborative Care | University of Washington AIMS Center (uw.edu)
- Evidence-base For Collaborative Care: 1 Evidence Base_Foundational.pdf (uw.edu)
- Comparing Collaborative Care to Usual Care: Why CoCM (uw.edu)

Case Presentation

Bringing Knowledge to Action through interactive, case-based discussions

Participant presents the case and poses the question(s) for the group

↓

Clarifying questions about the case from group to case presenter

↓

Ideas, suggestions, recommendations from participants

↓

Ideas, suggestions, recommendations from ECHO faculty team

↓

Full group discussion

↓

Summary and wrap-up by facilitator

Case Presentation

DO <u>NOT</u> INCLUDE:

Names, Address, DOB, Phone/Fax #, Email address, Social Security #, Medical Record #

Consider the level of detail necessary. Go with less when possible.

The discussion and materials included in this conference are confidential and privileged pursuant to 26VSA Section 1441-1443. This material is intended for use in improving patient care. It is privileged and strictly confidential and is to be used only for the evaluation and improvement of patient care.

Case

Questions

1.
2.
3.
4.

DATES	DIDACTIC TOPIC
Sept 6	**Assessment of Depression in Primary Care** Sara Pawlowski, MD
Sept 20	**Collaborative Care Model Approach: Depressive Disorders** Kerry Stanley, LICSW and Clara Keegan, MD
Oct 4	**Brief Intervention Highlights and "Ultra-Rapid CBT"** Emily Greenberger, MD and Julia Terman, PhD
Oct 18	**Advanced Psychopharmacology** Suzanne Kennedy, MD
Nov 1	**Expectations in Treatment: STAR D Trial overview and update** Krista Buckley, MD
Nov 15	**Suicide Risk Assessment and Prevention** Panel with Sravan Kakani, MD, Rick Dooley, PA-C and Sara Roberts, MD
Nov 29	**Deprescribing in Depression Polypharmacy** Liz May, MD
Dec 13	**Wrap-Up and Review/Participant identified topics** Mark Pasenen, MD

Closing Announcements

- Slides are posted at www.vtahec.org
- Recording of didactic portion will be sent by email to the full cohort
  - **All recordings are for the use of registered participants only**
- Please complete the evaluation survey
- CMIE information and session QR code auto-send after evaluation
- Please contact us with any questions, concerns, or suggestions:
  - Mark.Pasanen@uvm.org
  - Patti.Smith-Urie@uvm.edu