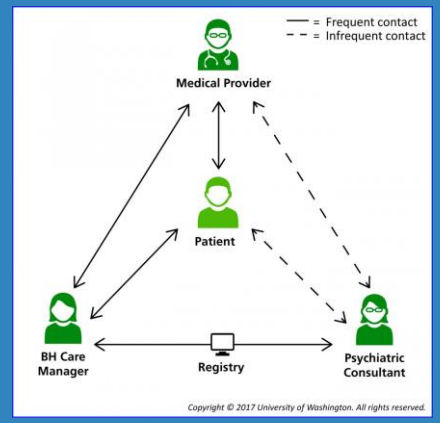
Presenter's Bio

Lucinda Leung, MD, PhD, MPH

Dr. Leung earned her undergraduate degree in Psychological & Brain Sciences and Chinese Language & Literature at Dartmouth College, her medical degree at Brown Alpert Medical School, her Master of Public Health degree in Family & Community Health at Harvard School of Public Health, and her Doctor of Philosophy in Health Policy & Management at UCLA Fielding School of Public Health.

Following Internal Medicine residency at UCLA Ronald Reagan Medical Center, she completed health services research fellowships through the Robert Wood Johnson Foundation Clinical Scholars Program, the Veteran Affairs Quality Scholars Program, and UCLA's Specialty Training and Advanced Research Program, where she was selected as a Chief Fellow.

Dr. Leung's expertise is in health services research to optimize care for primary care patients with mental health needs, through team-based care models and virtual care.



Depression Management in Primary Care

Lucinda B. Leung, MD, PhD, MPH
Assistant Professor of Medicine and Psychiatry
L.A. Care Behavioral Health Conference / October 1, 2022

lleung@mednet.ucla.edu
@lucindaleungmd

David Geffen School of Medicine

CSHIIP
Center for the Study of Healthcare Innovation, Implementation & Policy

Disclosures

- The following CME planners and faculty do not have relevant financial relationships with ineligible companies:
- Leilanie Mercurio, L.A. Care PCE Program Manager, CME Planner
- Alex Li, MD, L.A. Care Deputy Chief Medical Officer, CME Planner
- Michael Brodsky, MD, L.A. Care Senior Medical Director, Behavioral Health Department, CME Planner
- Lucinda Leung, MD, PhD, Assistant Professor of Medicine and Psychiatry UCLA David Geffen School of Medicine and Staff Physician, Division of General Internal Medicine West Los Angeles VA Medical Center, CME Planner and Faculty

An ineligible company is any entity whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.

Commercial support was not received for this CME activity.

Learning Objectives

Screen

- Identify depressive disorders using evidence-based screening tools in primary care.

Meds

- Choose among different first-line medications to treat depression.

Talk therapy

- Formulate a pharmacological and/or non-pharmacological treatment plan for depression.

Collaborative Care

- Summarize innovations in collaborative care management of depression between primary care and mental health specialties.

What do these patients have in common?

Case 1. *85-year-old nursing home patient with prior history of depression and dementia has been withdrawn and eating poorly.*

Case 2. *39-year-old postpartum woman with hypothyroidism (stable on levothyroxine) reports poor sleep, poor concentration, low energy, and conflict with her partner.*

Case 3. *65-year-old patient had a recent myocardial infarction and underwent coronary artery bypass grafting apathetic-appearing and making poor progress at cardiac rehabilitation*.

Spoelhof et al., *Am Fam Physician,* 2011; Park et al, *NEJM*, 2019

Depression has many faces

Case 1. *85-year-old nursing home patient with prior history of depression and dementia has been withdrawn and eating poorly.*

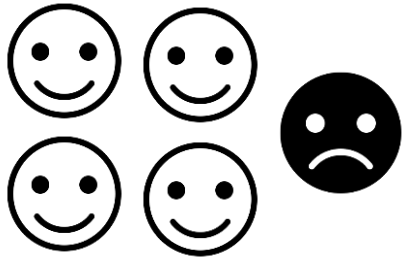
Case 2. *39-year-old postpartum woman with hypothyroidism (stable on levothyroxine) reports poor sleep, poor concentration, low energy, and conflict with her partner.*

Case 3. *65-year-old patient had a recent myocardial infarction and underwent coronary artery bypass grafting is apathetic-appearing and making poor progress at cardiac rehabilitation*.

Spoelhof et al., *Am Fam Physician,* 2011; Park et al, *NEJM*, 2019

Depression = #1 cause of disability worldwide

Common & Disabling



High Utilization & Costs

Poor Patient Outcomes

988 SUICIDE & CRISIS LIFELINE

Veterans Crisis Line

Military Crisis Line

1-800-273-8255 PRESS 1

Mitchell et al, *Lancet*, 2009; IsHak et al, *J Hosp Med*, 2017; Lustman et al, *Diabetes Care*, 2000; Meng et al, *J Hypertens*, 2012; Unutzer et al, *J Am Geriatr Soc*, 2009; Zulman et al, *BMJ Open*, 2015; Bostwick et al, *Am J Psychiatry*, 2014; Ahmedani et al, *J Gen Intern Med*, 2014; Cuijpers et al, *Am J Psychiatry*, 2014;

World Health Organization | Health Topics | Countries | Newsroom | Emergencies

COVID-19 pandemic triggers 25% increase in prevalence of anxiety and depression worldwide

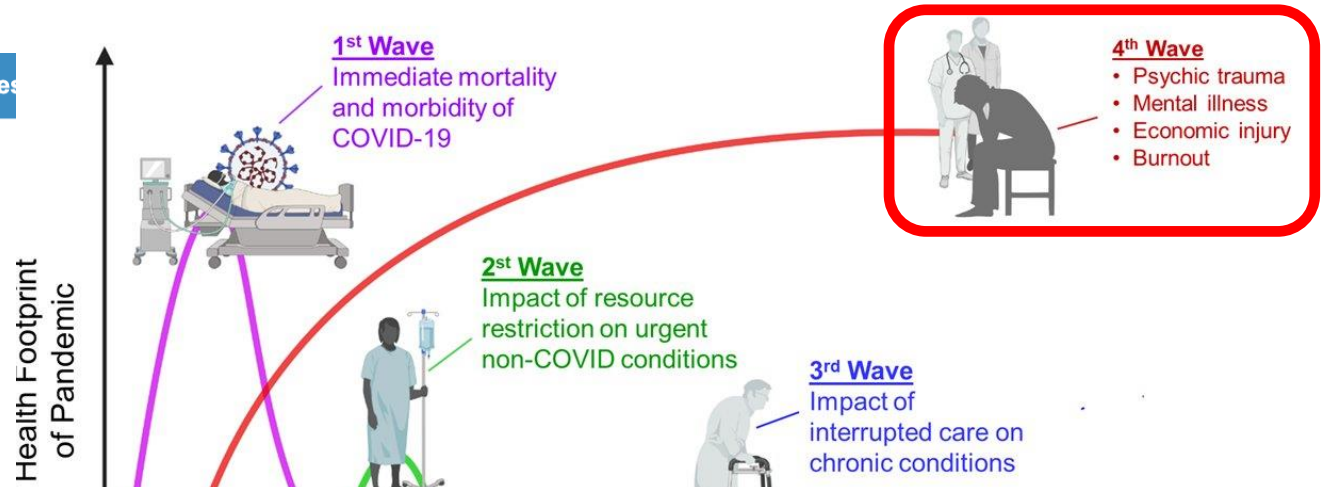
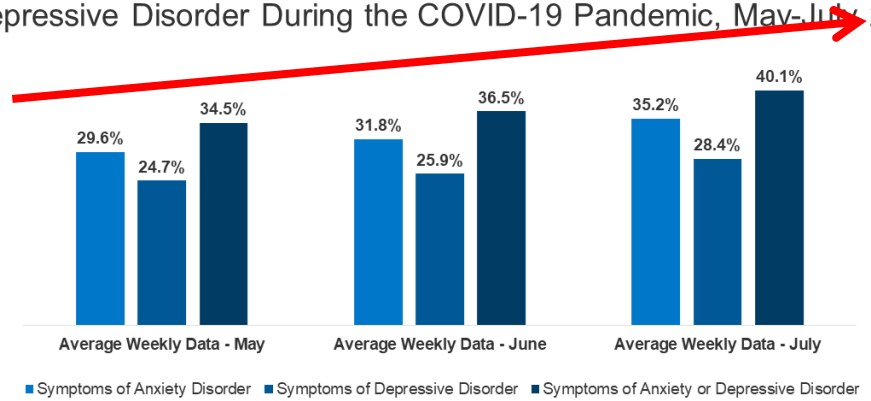


Figure 1

Average Share of Adults Reporting Symptoms of Anxiety or Depressive Disorder During the COVID-19 Pandemic, May-July 2020



S: These adults, ages 18+, have symptoms of anxiety or depressive disorder that generally occur more than half the days or nearly every day. Data ted for "symptoms of anxiety or depressive disorder" also includes adults with symptoms of both anxiety and depressive disorder. Data presented y is the average of the following weeks of data: May 7-12, May 14-19, May 21-26, May 28- June 2; for June, data is the average of June 4-9, June June 18-23, and June 25-30; for July, data is the average of July 2-7, July 9-14, and July 16-21 (last week of published data).
CE: U.S. Census Bureau, Household Pulse Survey, 2020.

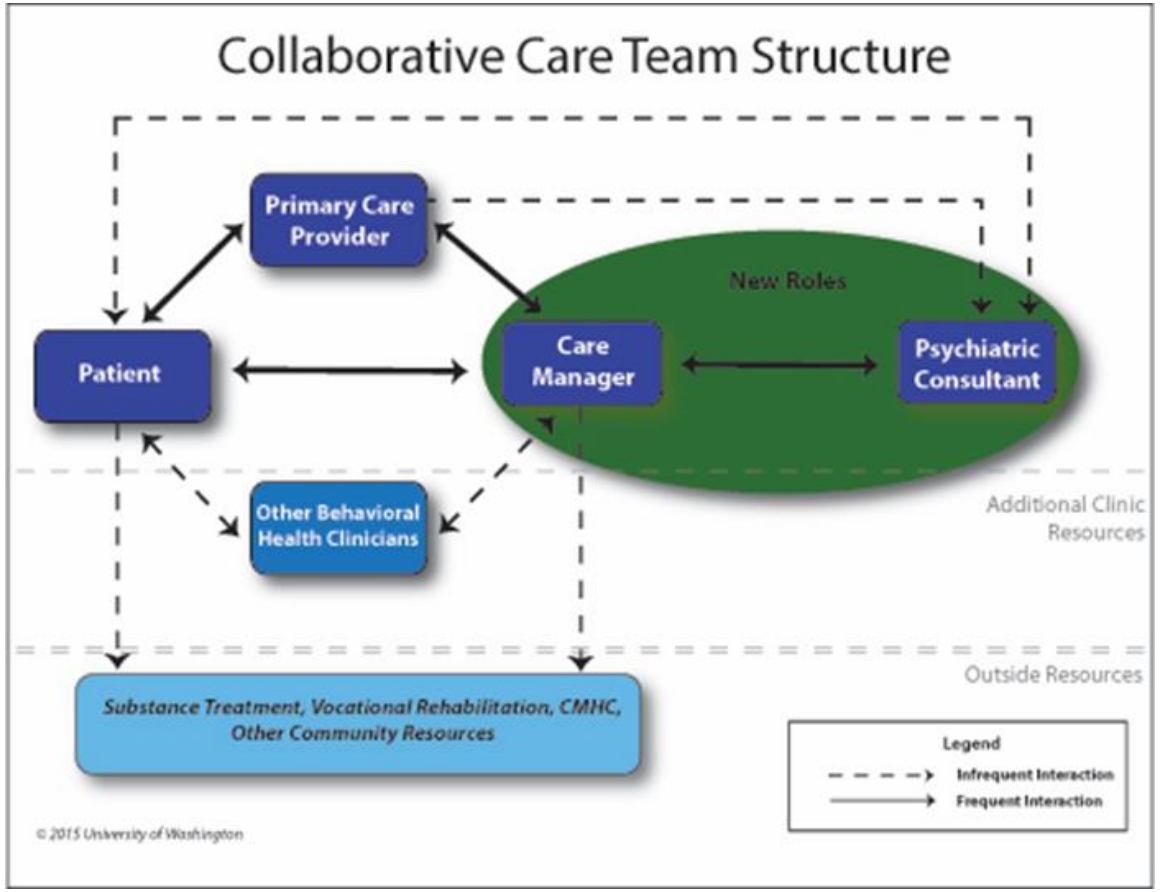
KFF HENRY J KAISER FAMILY FOUNDATION

Ettman et al, *JAMA Netw Open,* 2020

Integrating care improves depression

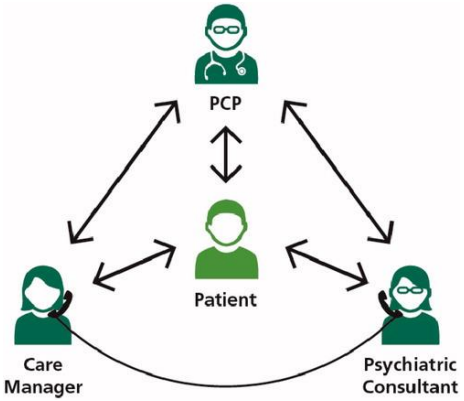
- Telephone-based depression care management
  - 79 RCTs for depression and anxiety worldwide (n=24,308)

THE COCHRANE COLLABORATION®



Archer et al, *Cochrane Database Syst Rev*, 2012

Integration is effective but hard to implement



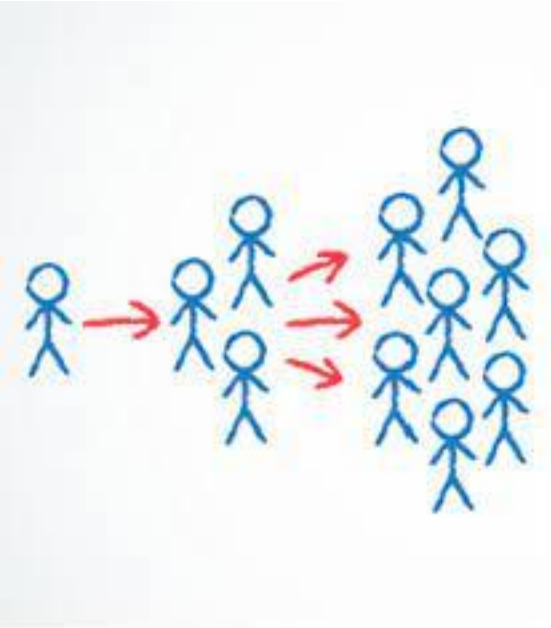
Efficacy/ Effectiveness → Dissemination/ Implementation

THE COCHRANE COLLABORATION®

>79 RCTs

>25 yrs since 1st RCT

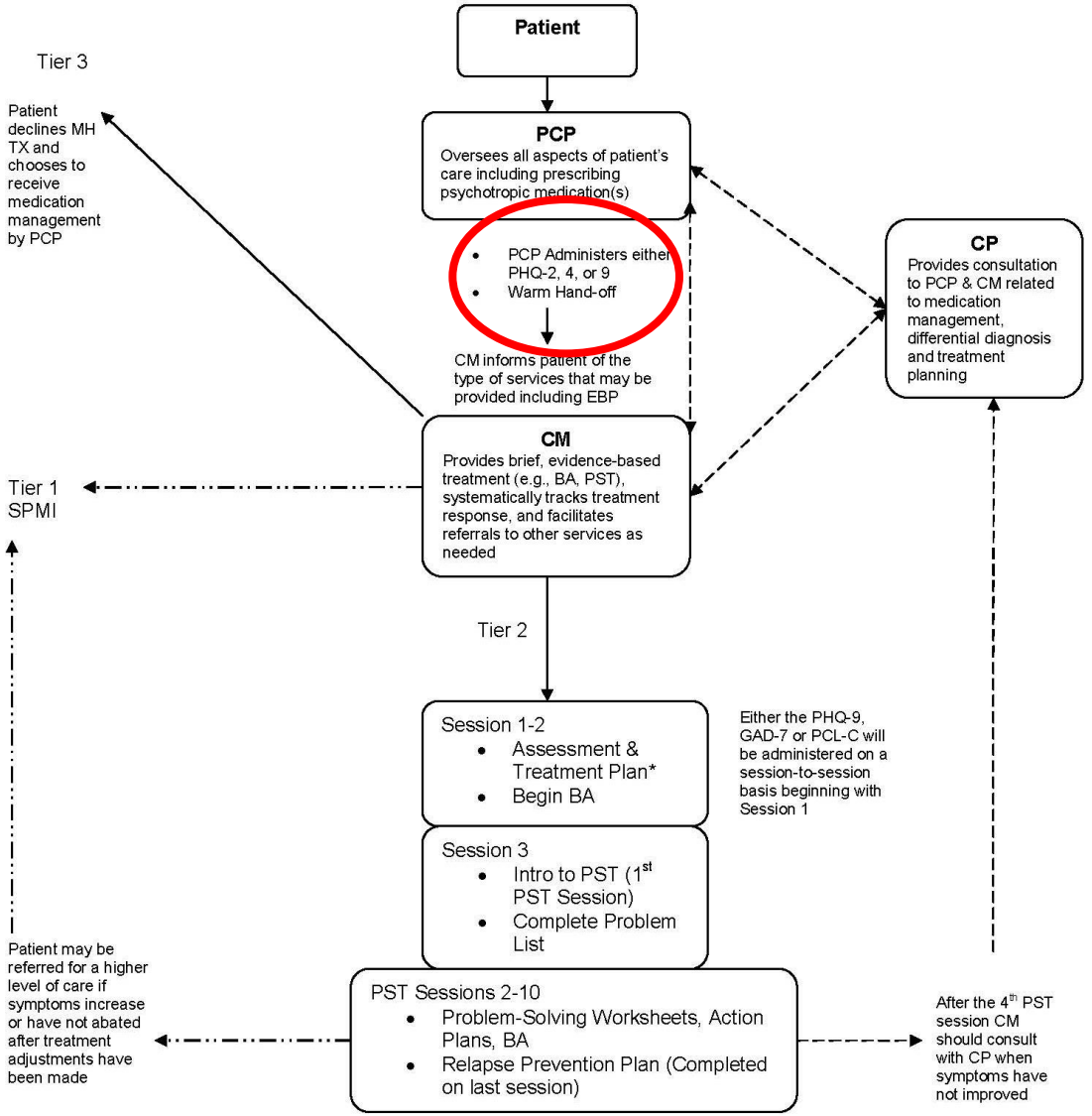
COUNTY OF LOS ANGELES CALIFORNIA



Archer et al, *Cochrane Database Syst Rev*, 2012; Katzelnick et al, *Psychiatr Serv*, 2015

Integration Workflow

1. Universal MH Screening
2. Medication Management
3. Specialty Care/Psychotherapy



Screening

Population	Recommendation	Grade (What's This?)
General adult population, including pregnant and postpartum women	The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.	B

The Patient Health Questionnaire-2 (PHQ-2)

Patient Name _____ Date of Visit _____

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

PHQ-2 score ≥3 (Sensitivity=83%, Specificity=92% for MDD)

USPSTF, *JAMA,* 2016; Kroenke et al, *Med Care*, 2003

Symptom Severity

- Mild (5-9)
- Moderate (10-19)
- Severe (20+)

PHQ-9 score ≥10 (Sensitivity=88%, Specificity=88% for MDD)

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	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 or 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 are 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 figety 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	0	1	2	3

Kroenke et al, *J Gen Intern Med*, 2001

Suicidality

PHQ-9 (Question 9)

9. Thoughts that you would be better off dead, or of hurting yourself

0	1	2	3

If +, then ask more ?s

988 SUICIDE & CRISIS LIFELINE

Population	Recommendation	Grade (What's This?)
Adolescents, Adults, and Older Adults	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for suicide risk in adolescents, adults, and older adults in primary care.	I

USPSTF, *Ann Intern Med*, 2014; Kroenke et al, *J Gen Intern Med*, 2001

What is the biggest predictor of completed suicide?

It is **previous suicide attempt(s)** in patients with major depression.

Brody et al, Gen Hosp Psychiatry. 1995

Suicidality

1. Wish to die
2. Active SI
3. SI + method
4. SI + intent
5. SI + intent + plan
6. Suicidal behavior
7. Suicidal attempt

Ask questions that are in bold and underlined. **Past month**

Ask Questions 1 and 2	YES	NO
1) Have you wished you were dead or wished you could go to sleep and not wake up?	☐	☐
2) Have you had any actual thoughts of killing yourself?	☐	☐
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Have you been thinking about how you might do this? e.g. "I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it."	☐	☐
4) Have you had these thoughts and had some intention of acting on them? as opposed to "I have the thoughts but I definitely will not do anything about them."	☐	☐
5) Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?	☐	☐
6) Have you ever done anything, started to do anything, or prepared to do anything to end your life? Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask: Was this within the past 3 months?**	**Lifetime** ☐ **Past 3 Months** ☐	☐

Posner et al., Am J Psychiatry, 2011

Firearm Safety

Annals of Internal Medicine®
LATEST ISSUES CHANNELS CME/MOC IN THE CLINIC JOURNAL CLUB WEB EXCLUSIVES AUTHOR INFO
‹ PREV ARTICLE | THIS ISSUE | NEXT ARTICLE ›
POSITION PAPERS | 20 NOVEMBER 2018

Reducing Firearm Injuries and Deaths in the United States: A Position Paper From the American College of Physicians FREE

Physicians should counsel patients on the risk of having firearms in the home when…

Condition
Acute risk for violence to self or others (based on information or behavior)
Individual-level risk factors for violence to self or others or unintentional firearm injury
Member of demographic group at increased risk for violence to self or others or unintentional firearm injury

+SI/HI ➡

+ETOH/drugs, SMI ➡

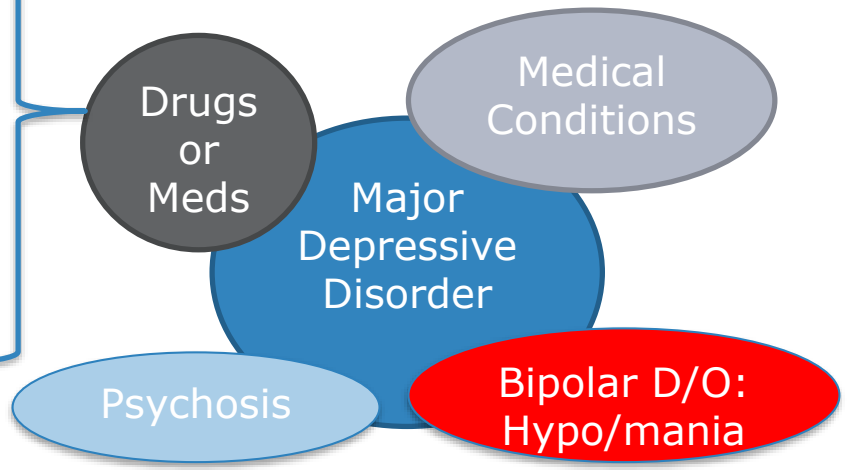
Middle-aged/older White or young Black men ➡

Butkus et al, *Ann Intern Med*, 2018; Wintemute et al, *Ann Intern Med*, 2016

Differential Diagnosis

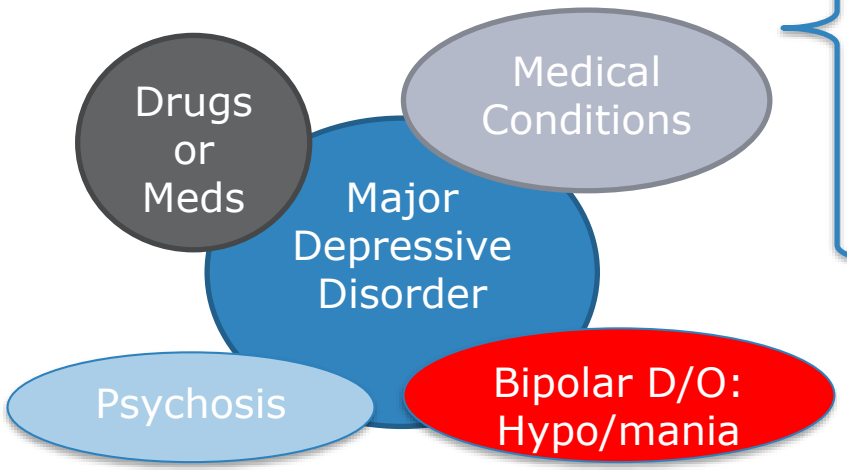
Take a history

- Drugs: marijuana, sedatives, hypnotics, opiates, cocaine, or stimulants)
- Rx: beta-blockers, barbiturates, anabolic steroids and glucocorticoids, statins, hormones, levodopa and methyldopa, opioids, some abx



Park et al, *NEJM*, 2019

Differential Diagnosis

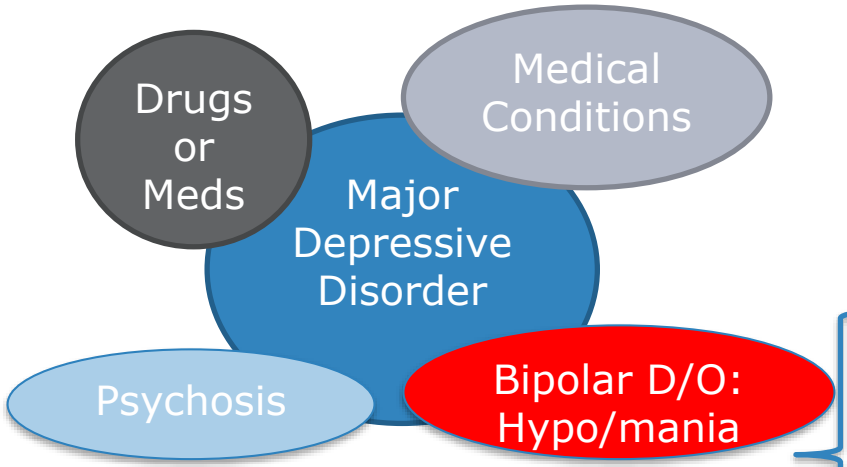


Consider labs

- Everyone: CBC, CMP, TFTs
- Optional: Utox, Vit B12, folate, RPR, HIV, Lyme, testosterone

Park et al, *NEJM*, 2019

Differential Diagnosis

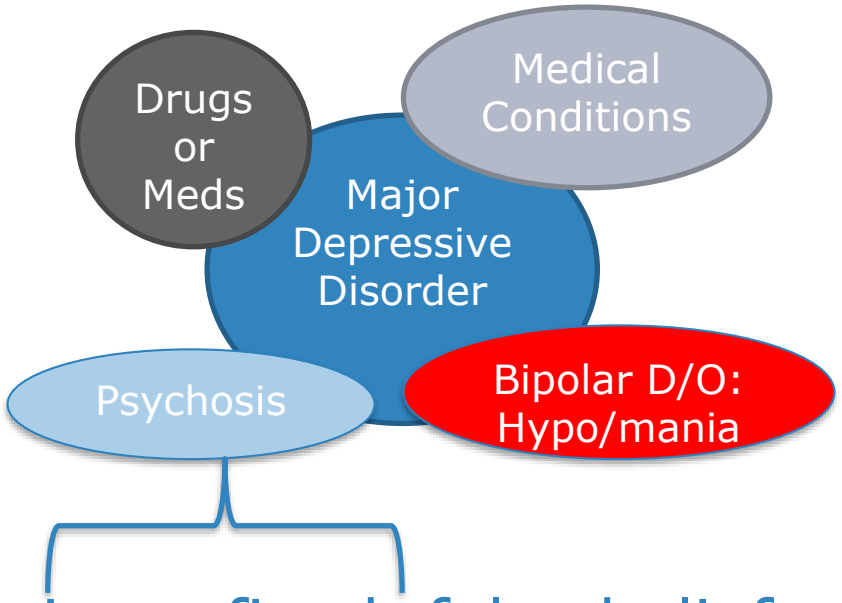


[Elevated or Irritable] &
[3 DIGFAST] for >4-7d

Distractibility
Indiscretion
Grandiosity
Flight of ideas
Activity increase
Sleep deficit
Talkativeness

Park et al, *NEJM*, 2019

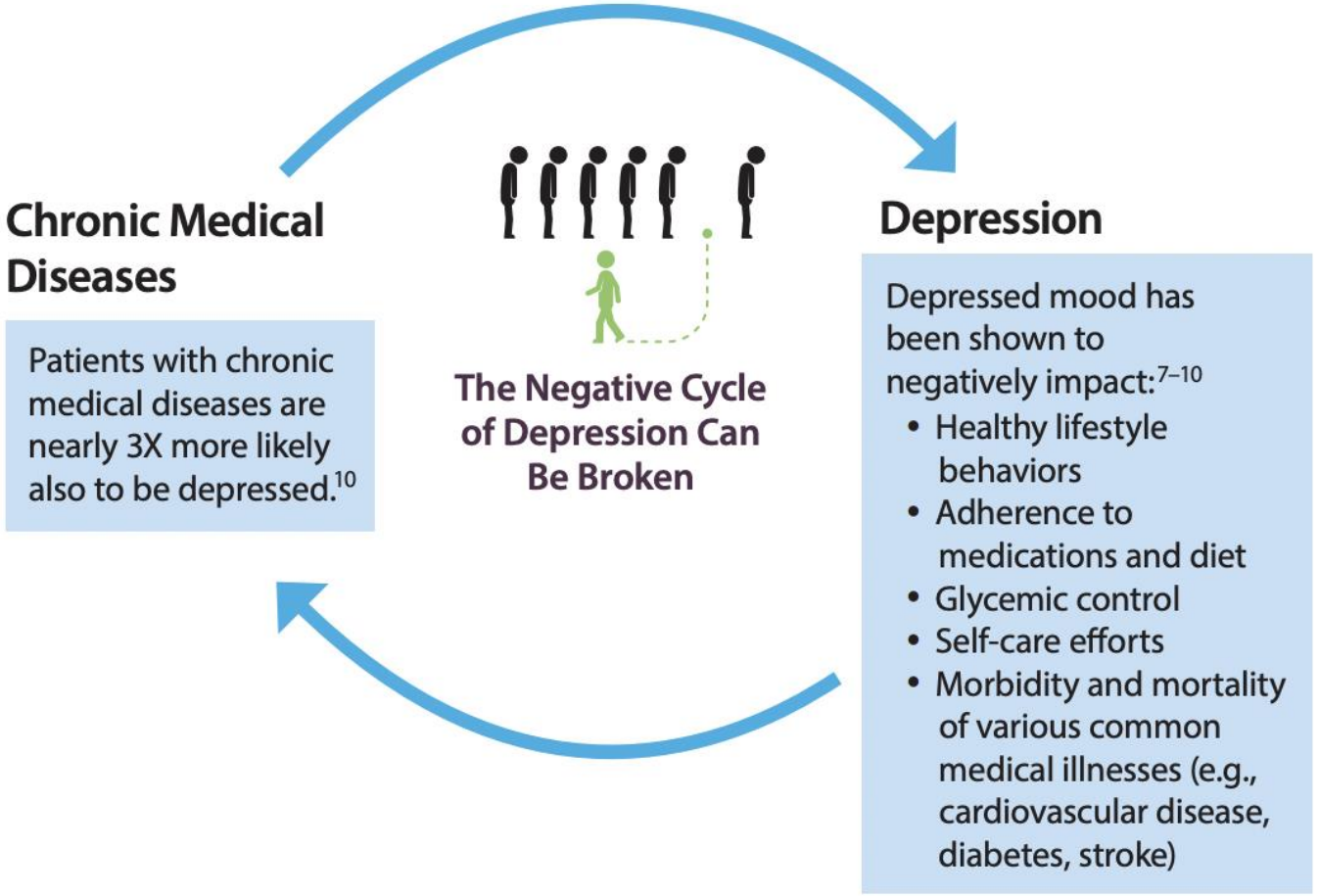
Differential Diagnosis



- Delusions: fixed, false beliefs
- Hallucinations: seeing or hearing things that others do not see or hear

Park et al, *NEJM*, 2019

Mental & Physical Health



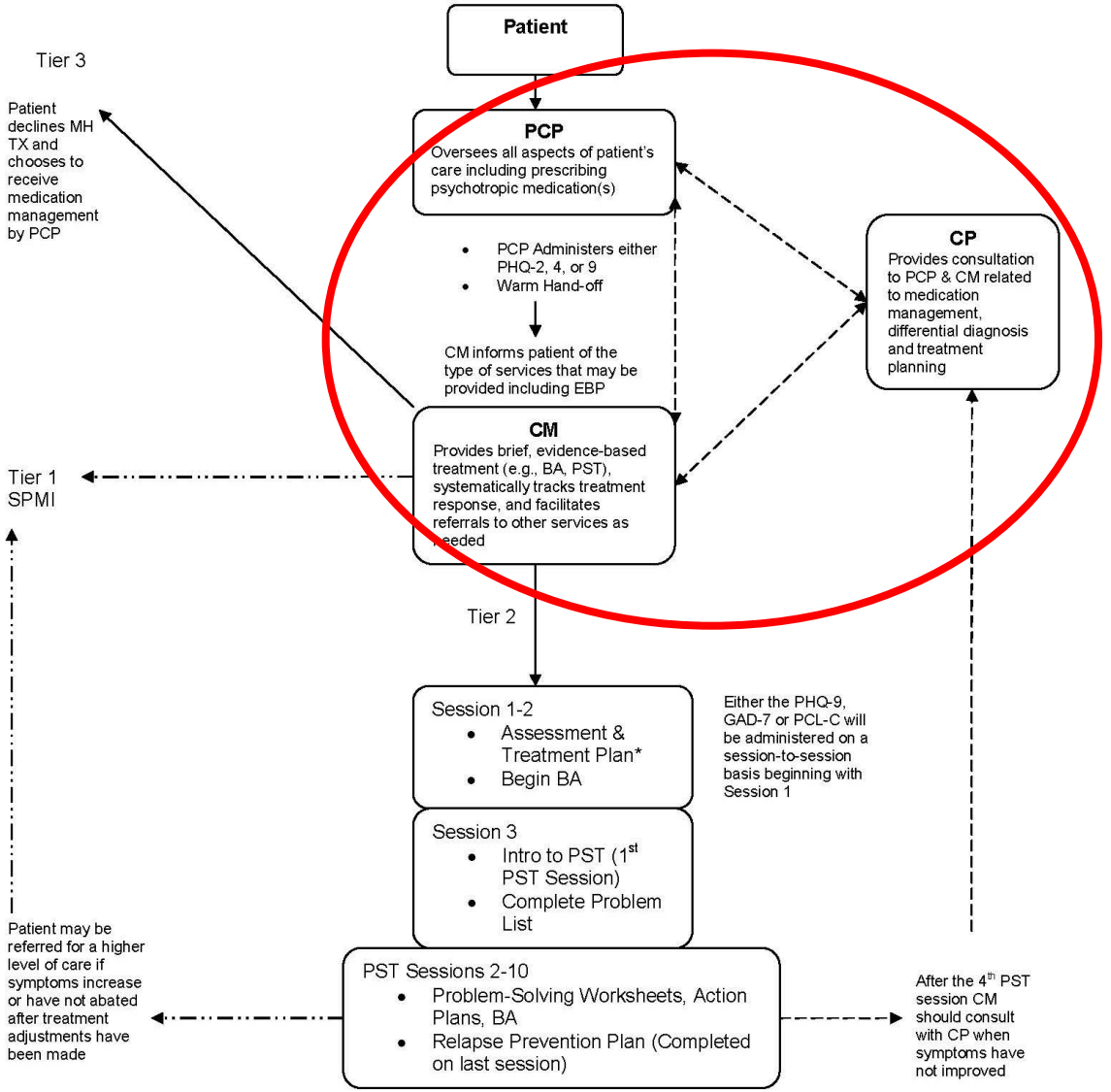
https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/508/IB10-1406DEP-Provider-DepressioninPrimaryCare_508Ready.pdf

Key points

- Prepare to screen for depression and SI in primary care
- Distinguish depression from bipolar disorder, drugs, etc.

Integration Workflow

1. Universal MH Screening
2. Medication Management
3. Specialty Care/Psychotherapy



Medication Treatment

- PCPs prescribe the *majority* (79%) of antidepressants.
- Consider side effect profile, co-existing conditions, specific symptoms, & history of response.

Fewest drug interactions→

Good for poor adherence→

Pregnant, breastfeeding→

Drug	Starting dose (mg)	Therapeutic dose (mg)	Safety*					
			Anti-Ach	Sedation	GI	Withdrawal	Drug interactions	OD risk
Selective Serotonin Reuptake Inhibitors (SSRI)								
Citalopram+	20	20–40	+	+	N ++	++	++	++
Escitalopram	5–10	10–20	+	+	N ++	++	+	++
Fluoxetine	20	20–80	+	+	N ++	+	+++	+
Paroxetine	20	20–50	++	++	N,D ++	+++	+++	+
Sertraline	25–50	50–200	+	+	N,D ++	++	++	+

Park et al, NEJM, 2019; https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/508/IB10-1406DEP-Provider-DepressioninPrimaryCare_508Ready.pdf

Medication Treatment

Treats pain→

Less sex side effects→

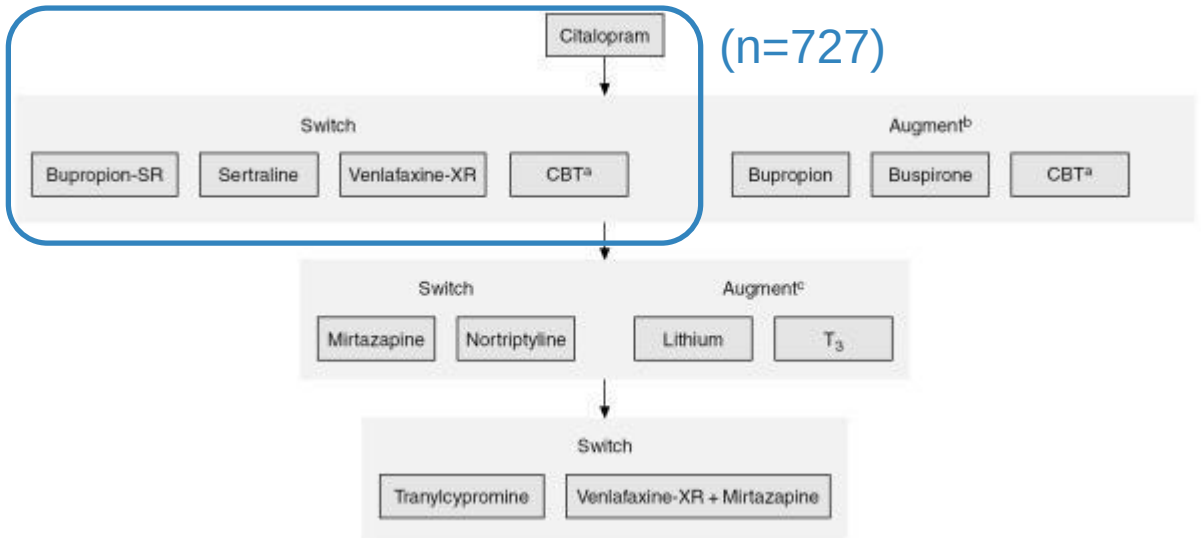
Sedating, weight gain→

Drug	Starting dose (mg)	Therapeutic dose (mg)	Safety*					
			Anti-Ach	Sedation	GI	Withdrawal	Drug interactions	OD risk
Serotonin Norepinephrine Reuptake Inhibitors (SNRI)								
Duloxetine	20–30	60	+	+	N ++	+++	++	++
Venlafaxine ER	75	75–225	+	+	N ++	+++	++	++
Tricyclic Antidepressants (TCA)								
Amitriptyline	25	100–300	+++	+++	C ++	++	++	+++
Nortriptyline**	25–50	75–150	++	++	C ++	++	++	+++
Norepinephrine and Dopamine Reuptake Inhibitor								
Bupropion XR	150	300–450	+	+	+	+	++	++
Noradrenergic Antagonist								
Mirtazapine	15	30–45	++	+++	+	++	++	+

https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/508/IB10-1406DEP-Provider-DepressioninPrimaryCare_508Ready.pdf

Rx evidence from STAR*D Trial (2001-2004)

- Equipoise-stratified, randomized study (n=4041)
  - Pragmatically designed to be generalizable to real-world settings
- Patients were publicly or privately insured, in primary or specialty care, & could have co-morbid medical illness.
  - If SSRI fails → then switch to…
    - SSRI
    - SNRI
    - Other



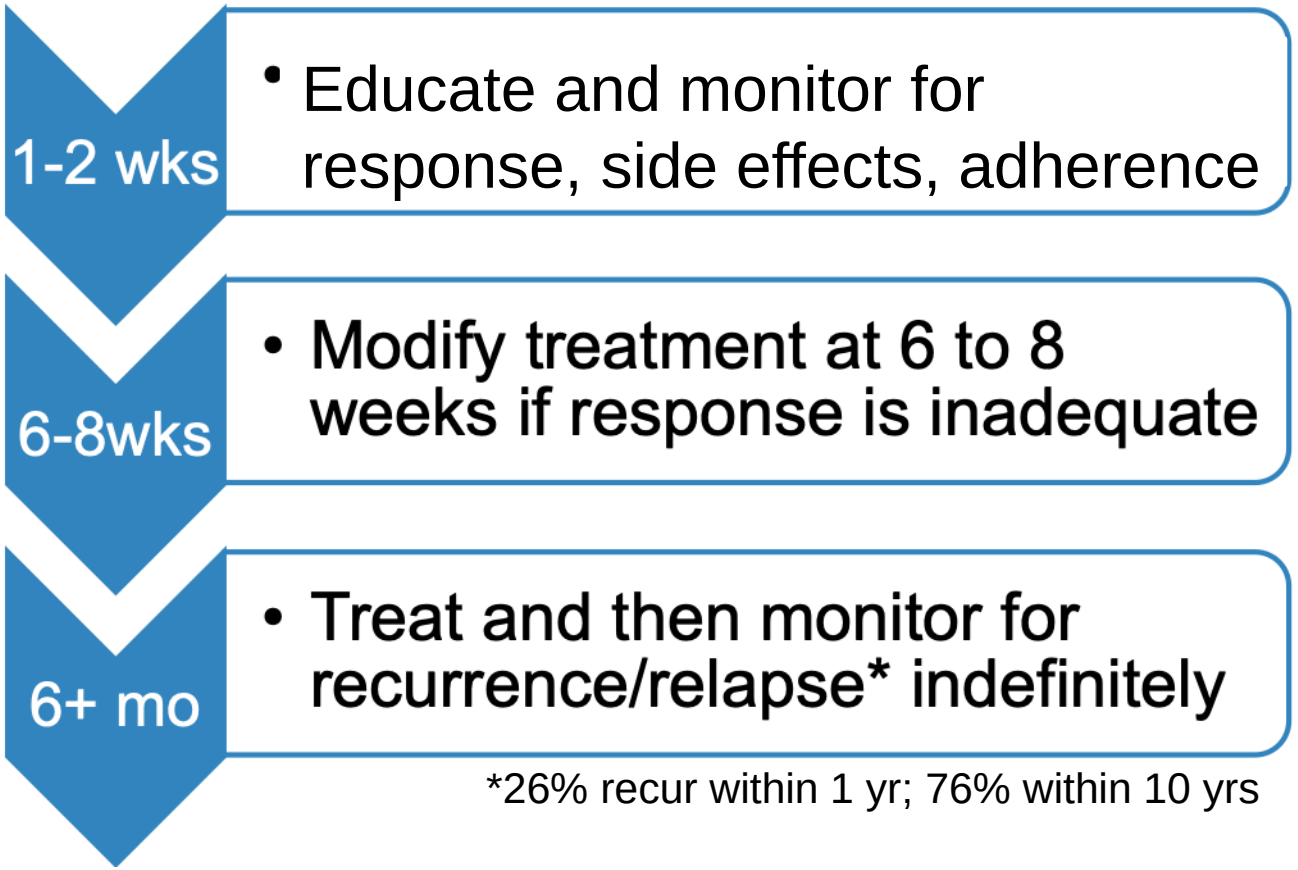
Rush et al, N Engl J Med 2006

Which treatment switch was most effective?

After unsuccessful treatment with an SSRI, approximately one in four patients had a remission of symptoms after switching to any other option.

Rush et al, N Engl J Med 2006

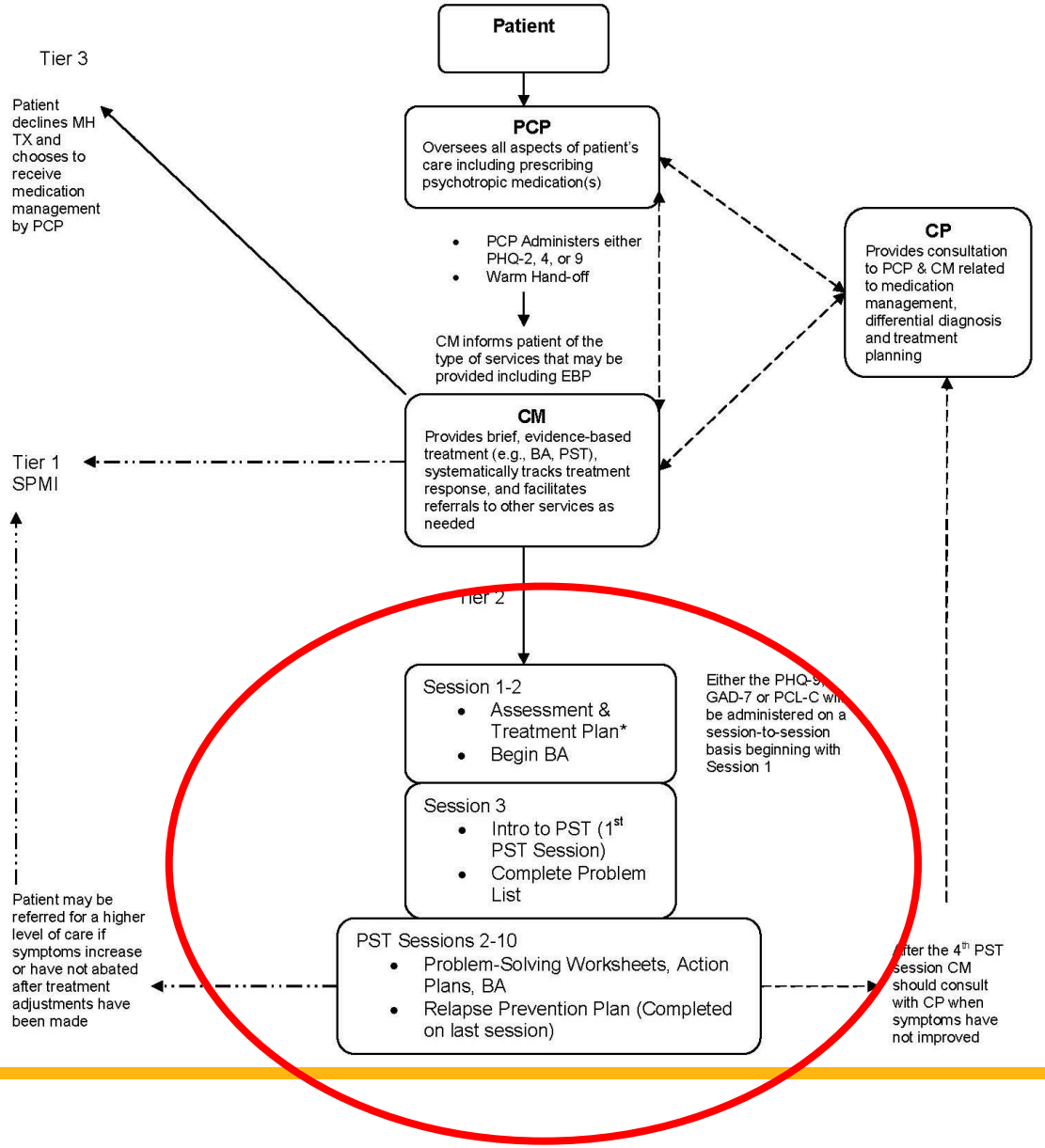
Treatment follow-up



McCarron et al, *Ann Intern Med*, 2021

Integration Workflow

1. Universal MH Screening
2. Medication Management
3. Specialty Care/Psychotherapy

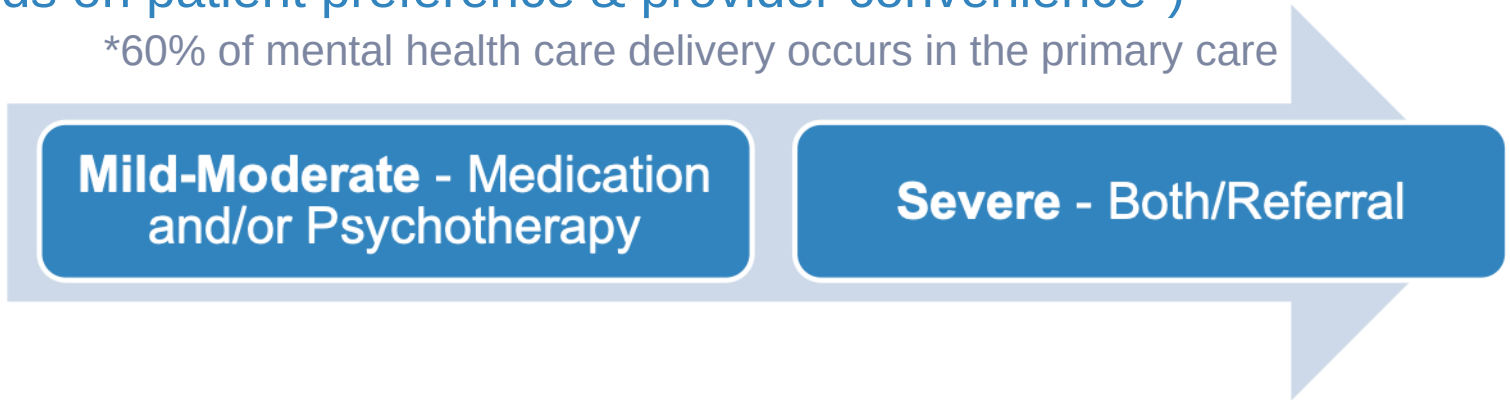


Measurement-Based Care

Ideal

Reality (depends on patient preference & provider convenience*)

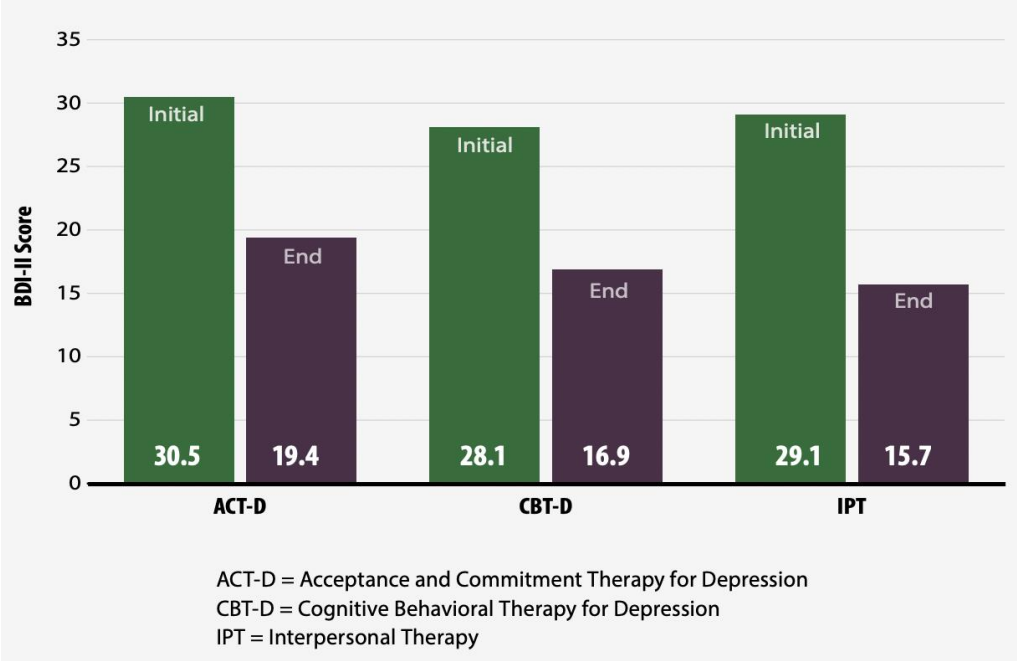
*60% of mental health care delivery occurs in the primary care

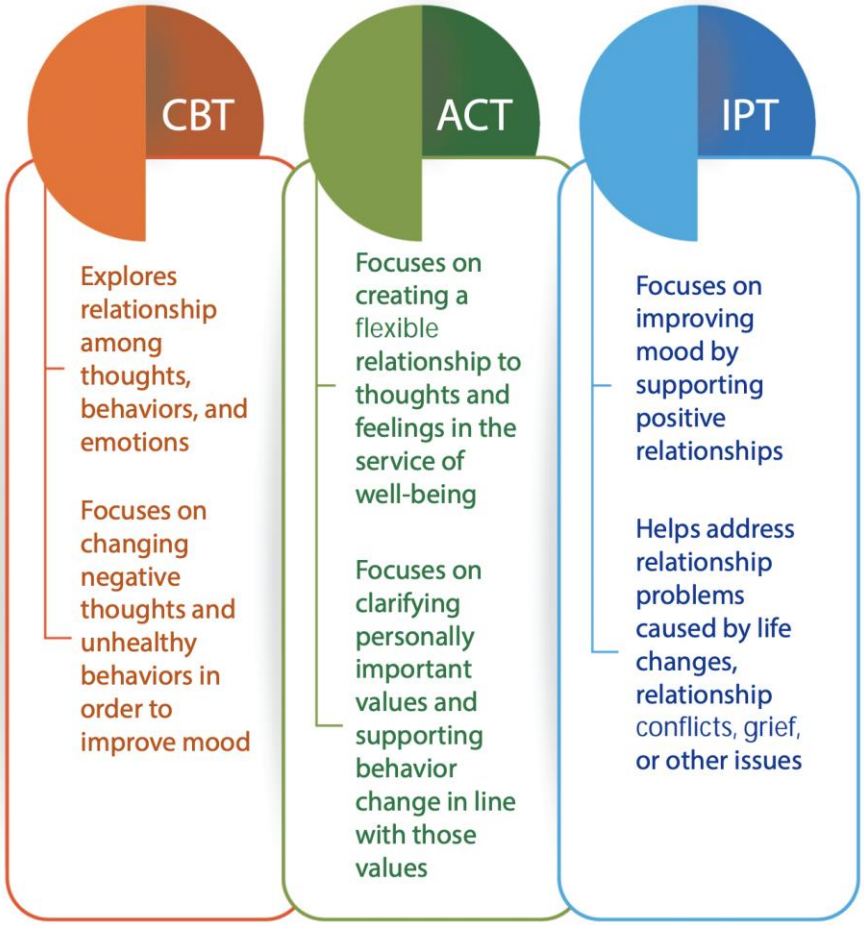


APA, *Practice Guideline for MDD*, 2010

Evidence-based psychotherapies

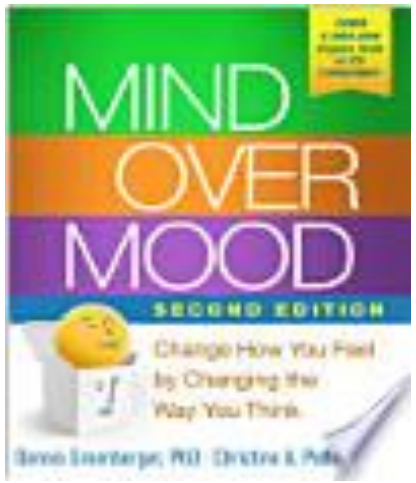
- Cognitive behavioral therapy, interpersonal therapy, problem-solving therapy, behavioral activation, etc. all work moderately well.

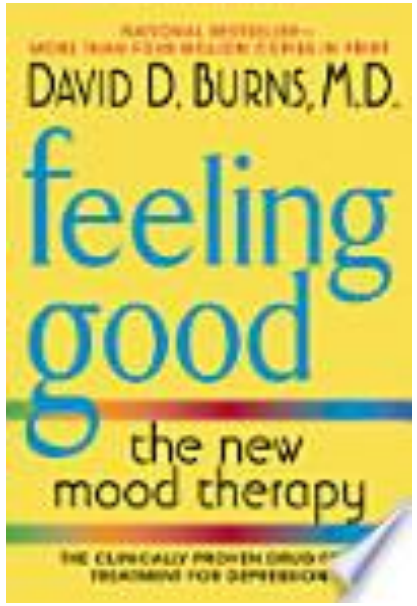




APA, *Practice Guideline for MDD*, 2010; https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/508/IB10-1213_Guidetodepressionandtheroleofevidencebasedpsychotherapies_508Ready.pdf

Self help





Exercise

- Excellent self-management and preventive strategy for MILD depression that can be used adjunctively with a first-line evidence-based treatment for moderate to severe depression.
- Recommend at least three moderate-intensity sessions weekly for at least 30–40 minutes.
- Energy expenditure correlates with mood improvement, not type of exercise.
- Cochrane review found moderate (-0.62, 95% CI -0.81 to -0.42) to small (-0.33 95% CI -0.63 to -.0.3) clinical effect based on study strength inclusion criteria.

Sleep Hygiene

- Sleep problems are common (e.g., insomnia, hypersomnia, disturbances in sleep maintenance).
- Information on sleep hygiene should be included for patients exhibiting any sleep disturbances.
- Studies indicate cognitive behavioral therapy for insomnia (CBT-I) significantly reduces depressive symptoms and increases remission rates.

Tobacco, Caffeine, and Alcohol Use

- Tobacco use has been demonstrated to negatively impact the recovery of depression; offer treatment to assist with quitting and refer to the VA Tobacco Quitline 1-855-QUIT-VET (1-855-784-8838).
- Excessive caffeine use may exacerbate some symptoms of depression (e.g., sleep, anxiety).
- Even low levels of alcohol use have been demonstrated to negatively impact recovery from depression; advise to abstain until symptoms remit.

Pleasurable Activities

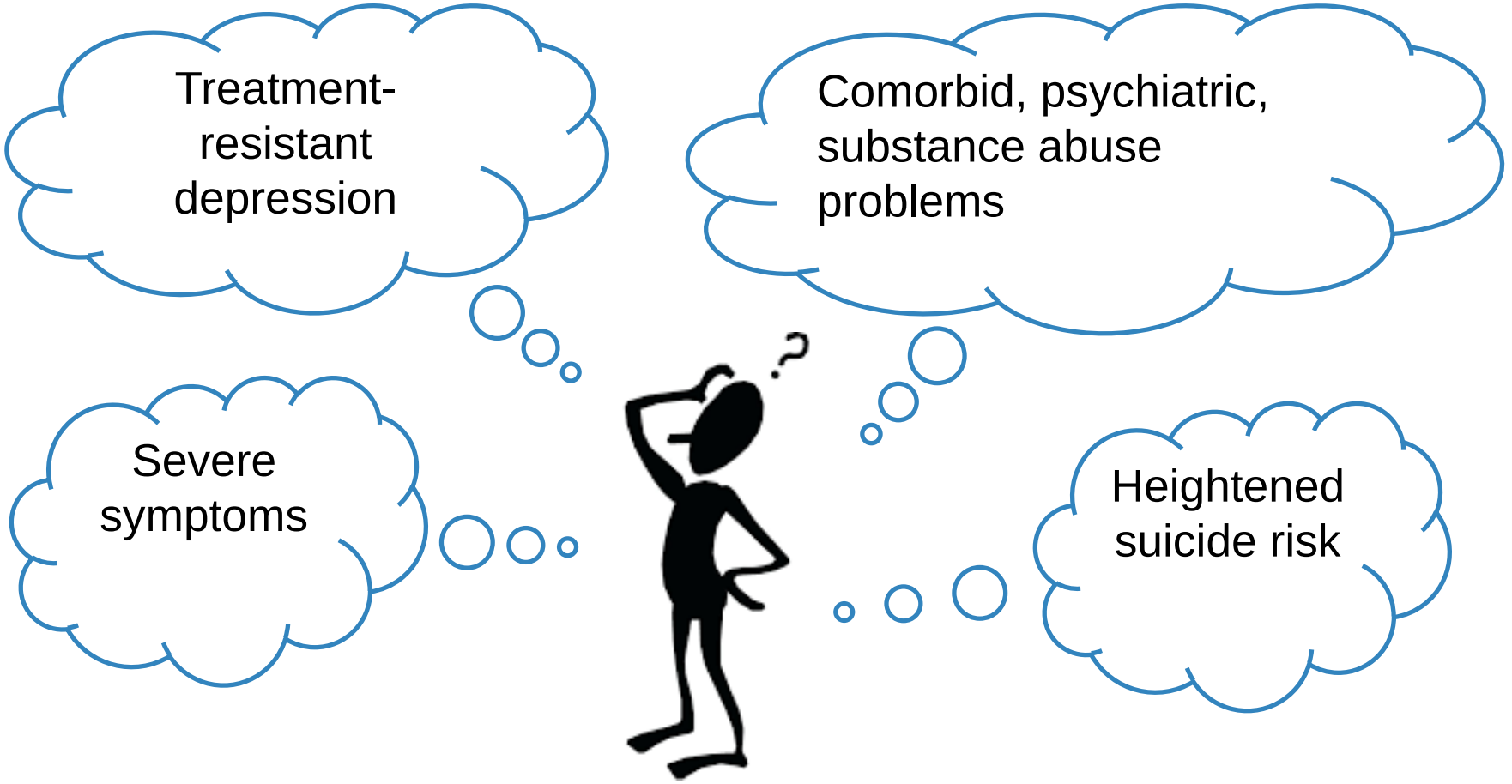
- Systematic scheduling and monitoring of pleasurable or reinforcing activities has been shown to have significant antidepressant effects.

Nutrition

- Often patients with MDD do not have a balanced diet. Expert opinion suggests that diet should be included in the treatment plan.
- Advise a diet high in fruits and vegetables, whole grains, seeds and nuts, and some lean proteins (e.g., Mediterranean diet).

https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/508/IB10-1406DEP-Provider-DepressioninPrimaryCare_508Ready.pdf

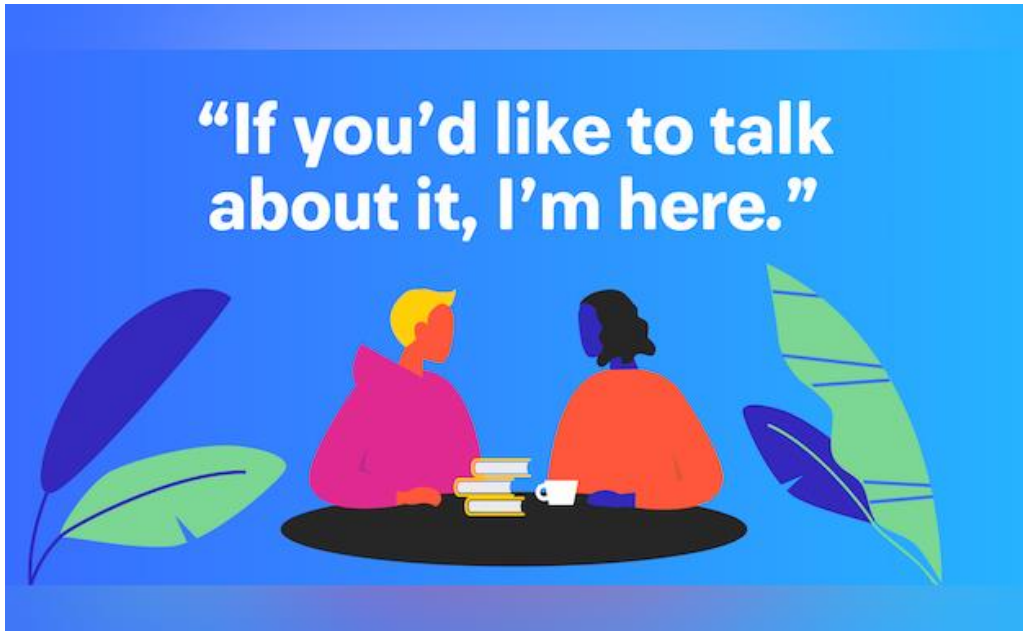
Referral to mental health specialist



McCarron et al, *Ann Intern Med*, 2021

Key Points

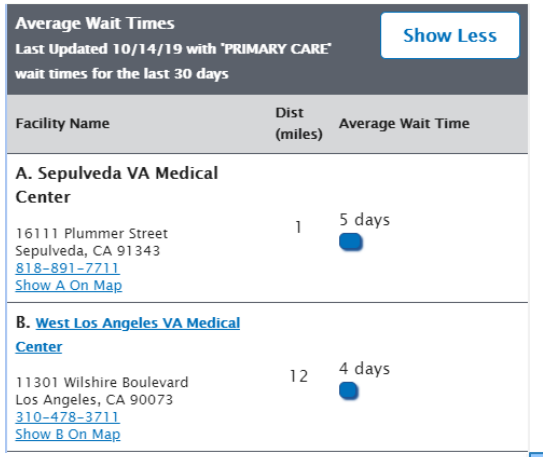
- Offer psychotherapy if available & patient willing
- Be familiar will a few antidepressant (2 SSRIs, an SNRI, & bupropion) to treat most cases of depression



Low treatment rates & long wait times!

Only 1/3 of primary care patients with newly diagnosed depression start treatment!

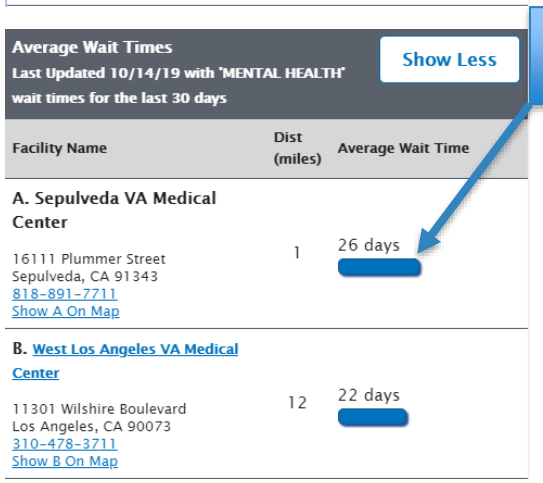
(…and even less complete a full course.)



Average Wait Times
Last Updated 10/14/19 with "PRIMARY CARE" wait times for the last 30 days
Show Less

Facility Name	Dist (miles)	Average Wait Time
A. Sepulveda VA Medical Center 16111 Plummer Street Sepulveda, CA 91343 818-891-7711 Show A On Map	1	5 days
B. West Los Angeles VA Medical Center 11301 Wilshire Boulevard Los Angeles, CA 90073 310-478-3711 Show B On Map	12	4 days

Return Visit to **Primary Care**



Average Wait Times
Last Updated 10/14/19 with "MENTAL HEALTH" wait times for the last 30 days
Show Less

Facility Name	Dist (miles)	Average Wait Time
A. Sepulveda VA Medical Center 16111 Plummer Street Sepulveda, CA 91343 818-891-7711 Show A On Map	1	26 days
B. West Los Angeles VA Medical Center 11301 Wilshire Boulevard Los Angeles, CA 90073 310-478-3711 Show B On Map	12	22 days

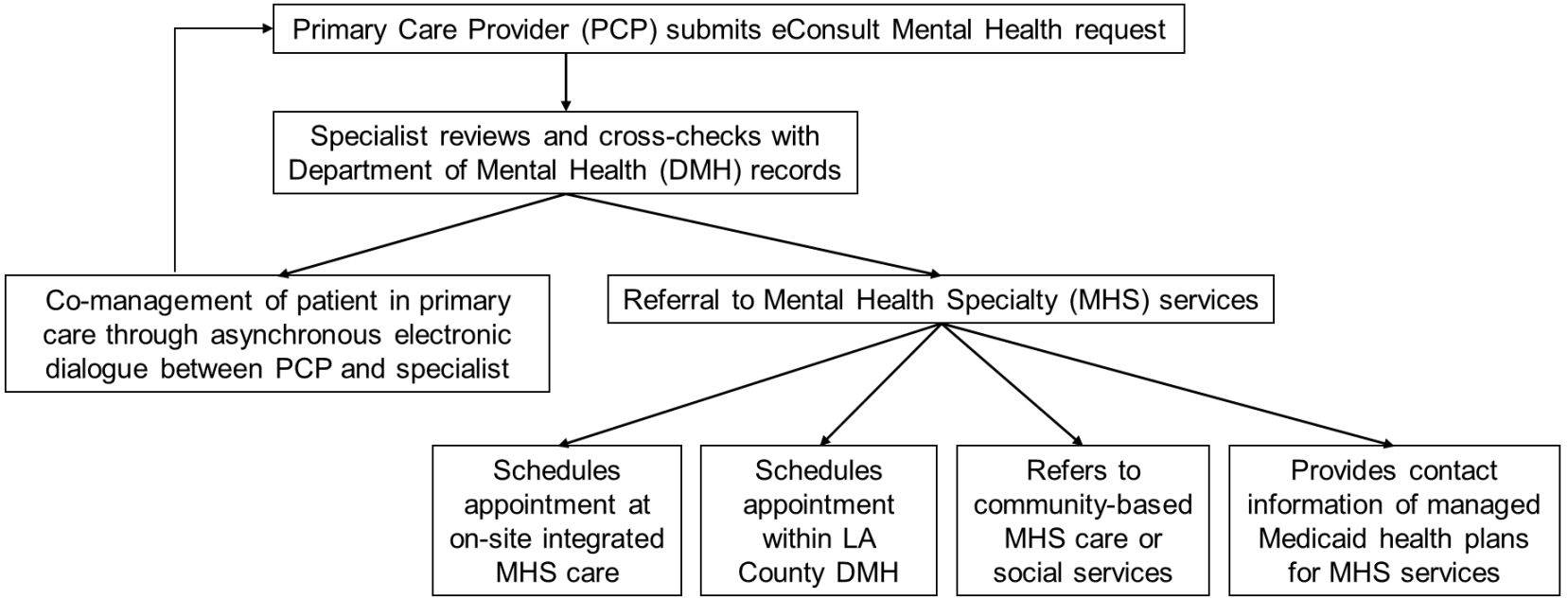
1 month wait!

New Visit to **Mental Health**

Leung et al, *JAMA Network Open*, 2022; Waitzfelder et al, *J Gen Intern Med*, 2018

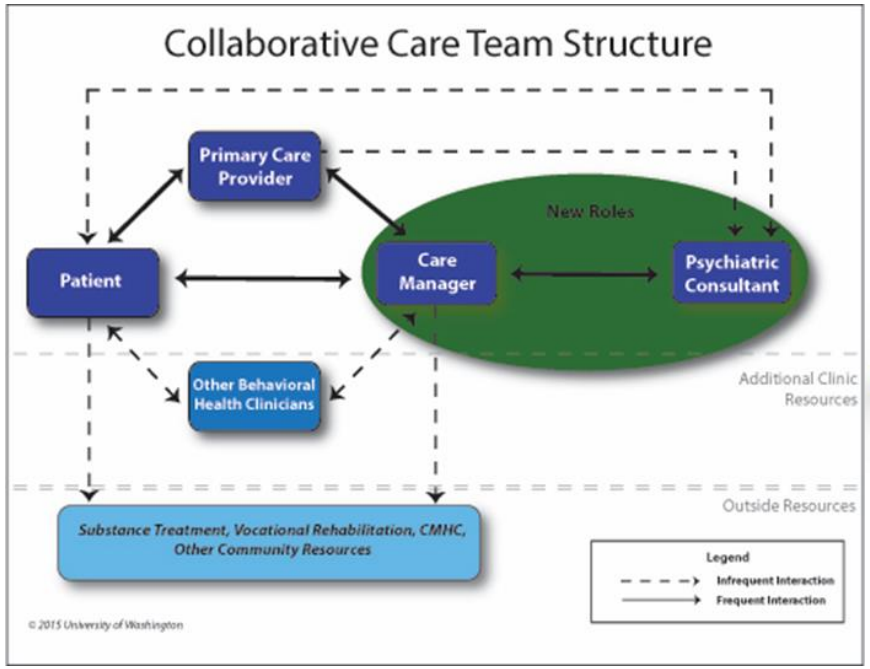
eConsult Mental Health

- Median response time = 1.8 days
- 13% resolved without a face-to-face visit
- 2/3 of visits sent to integrated mental health care



Leung, Benitez, & Yee, *J Ambul Care Manage*, 2019

Medication >>> Therapy



Rx

Therapy

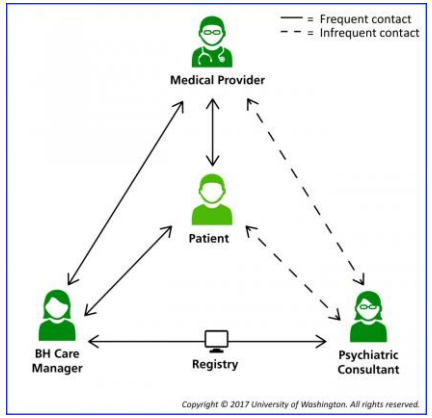
"Sometimes I feel like all I do is hang in there!"

- But *most* patients, especially minorities, prefer therapy over Rx

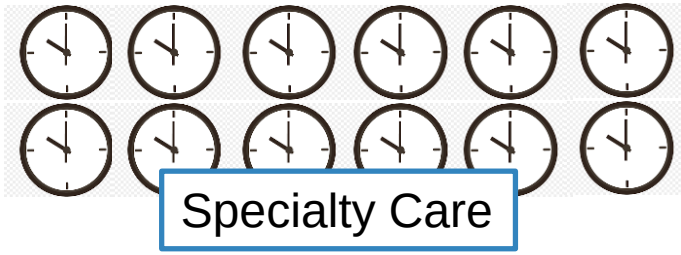
APA, *Practice Guideline for MDD*, 2010; Dwight-Johnson et al, *J Gen Intern Med*, 2000

Depression care models

Past → Present → Future



Keeping therapy short in primary care



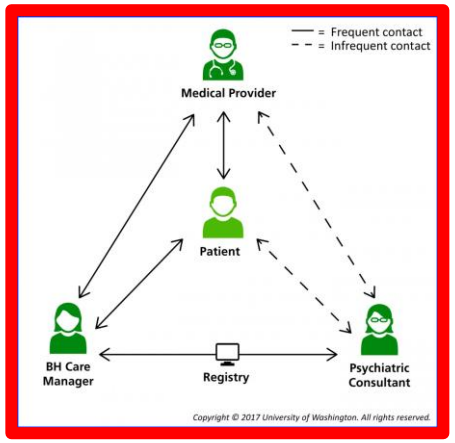
- **6-session PST** for primary care patients in UK
  - PST (MD/RN), PST + Med, Med improved depression (n=151)

→ **Behavioral Health Integration Program in Primary Care**

Mynors et al, *BMJ*, 2000

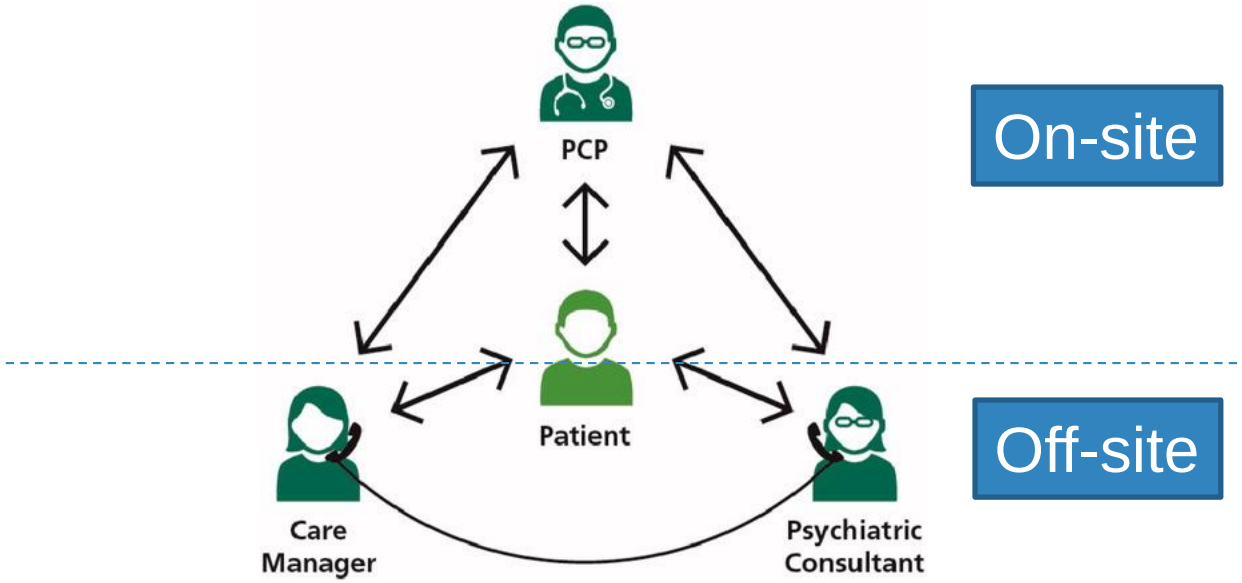
Depression care models

Past → Present → Future



Delivering collaborative care virtually

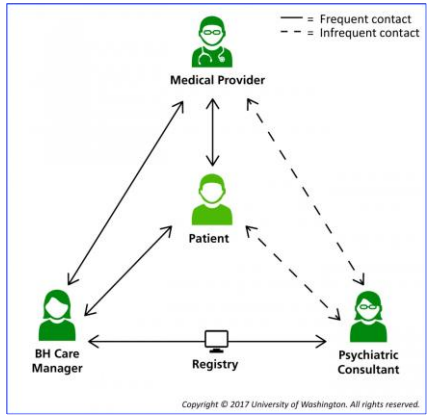
- **Telemedicine-based** collaborative care for patients with depression
  - Practice- (on-site) vs Tele-medicine-based (n=395, n=364)
  - Better treatment response, remission, and symptom reduction



Fortney et al, *J Gen Intern Med,* 2007; Fortney et al, *Am J Psychiatry,* 2013

Depression care models

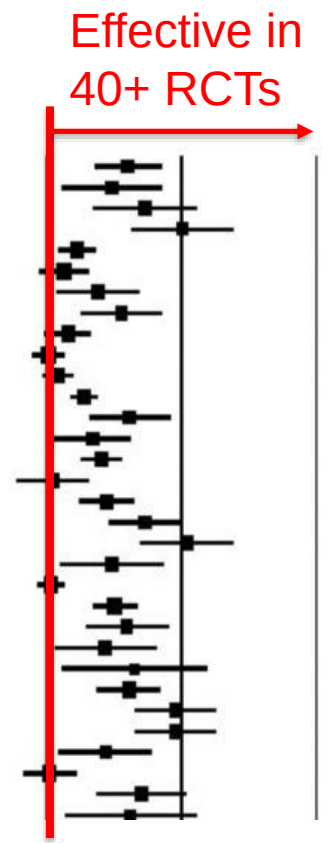
Past → Present → Future



Moving depression therapy online

- Computerized CBT (cCBT) is online 24/7 via desktop or mobile app
- **Non-inferior to face-to-face CBT** with modest asynchronous support
  - cCBT vs CBT (n=154)

		Hedges' g	Lower Limit	Upper Limit	p-Value
MDD	Anderson, 2005	0.90	0.52	1.28	0.00
	Berger, 2011a	0.72	0.16	1.28	0.01
	Berger, 2011b	1.09	0.51	1.67	0.00
	Choi, 2012	1.51	0.93	2.08	0.00
	Christensen, 2004	0.34	0.13	0.55	0.00
	De Graaf, 2009	0.19	-0.08	0.47	0.17
	Farrer, 2011a	0.57	0.11	1.03	0.02
	Farrer, 2011b	0.83	0.38	1.29	0.00
	Geraedts, 2014	0.24	-0.02	0.49	0.07
	Gilbody, 2015a	0.02	-0.16	0.21	0.81
	Gilbody, 2015b	0.12	-0.06	0.30	0.18
	Hallgren, 2015	0.42	0.26	0.57	0.00
	Johansson, 2012a	0.92	0.47	1.37	0.00
	Johansson, 2012b	0.51	0.07	0.94	0.02
	Kessler, 2009	0.61	0.38	0.85	0.02
	Kivi, 2004	0.06	-0.34	0.48	0.75
	Lintvedt, 2013	0.67	0.35	0.98	0.00
	Newby, 2016	1.08	0.68	1.49	0.00
	O'Moore, 2016	1.56	1.04	2.08	0.00
	Perini, 2009	0.73	0.14	1.31	0.01
	Phillips, 2014	0.05	-0.10	0.21	0.51
	Richards, 2015	0.75	0.50	1.00	0.00
	Rosso, 2016	0.89	0.43	1.35	0.00
	Ruwaard, 2009	0.65	0.08	1.22	0.03
	Selmi, 1990	0.97	0.15	1.80	0.02
	Smith, 2016	0.91	0.55	1.28	0.00
	Titov, 2010a	1.43	0.98	1.88	0.00
	Titov, 2010b	1.43	0.97	1.88	0.00
	Vernmark, 2010	0.65	0.13	1.17	0.01
	Warmerdan, 2008	0.04	-0.26	0.33	0.81
	Williams, 2013	1.05	0.55	1.55	0.00
	Wright, 2005	0.93	0.19	1.66	0.01

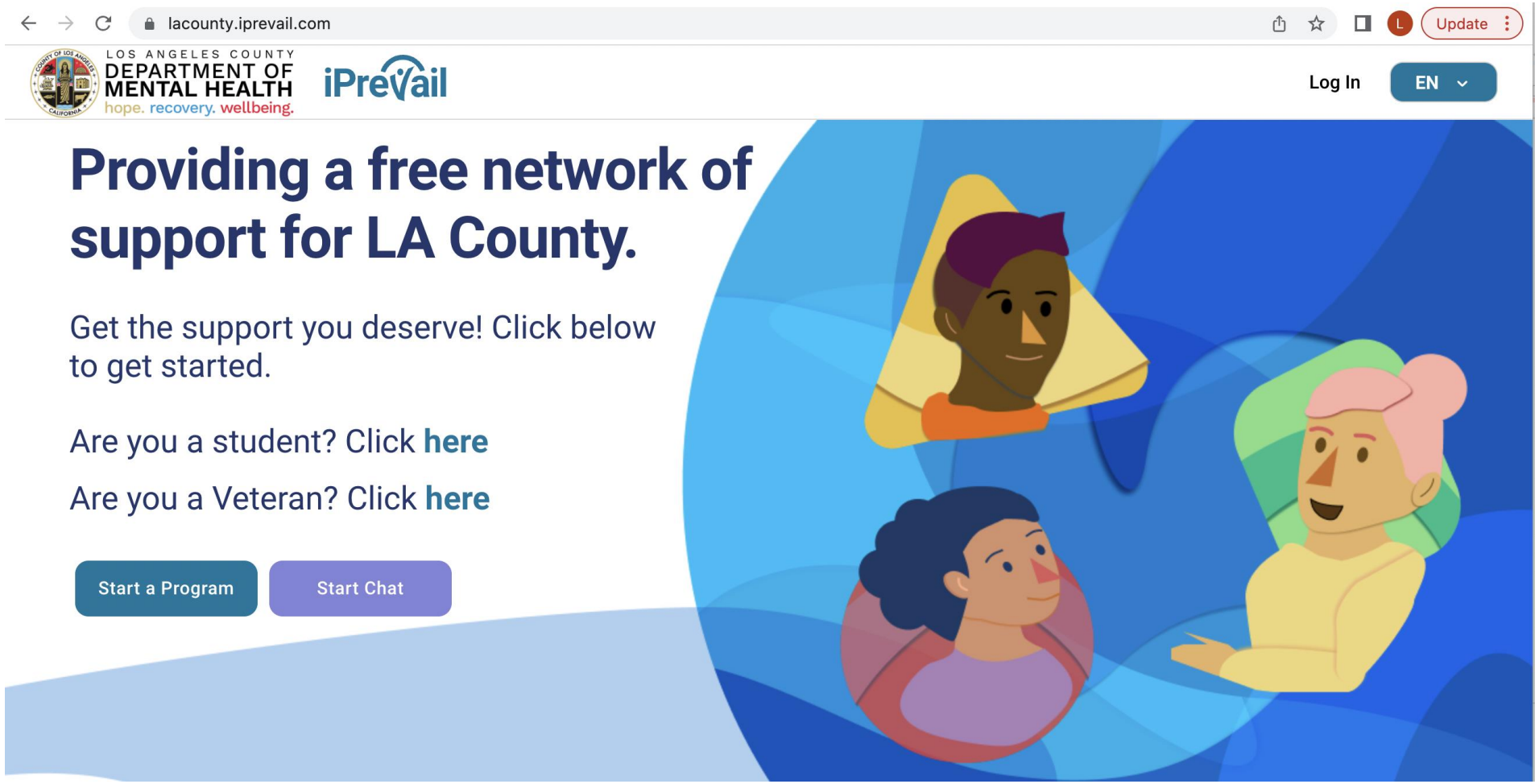


SilverCloud

beating the blues® cognitive behavioural therapy

Andrews et al, *J Anxiety Disord*, 2018; Thase et al, *Am J Psychiatry*, 2018; Karyotaki et al, *JAMA Psychiatry*, 2021

Therapy without a therapist?!



https://lacounty.iprevail.com/

Embedding digital mental health in primary care

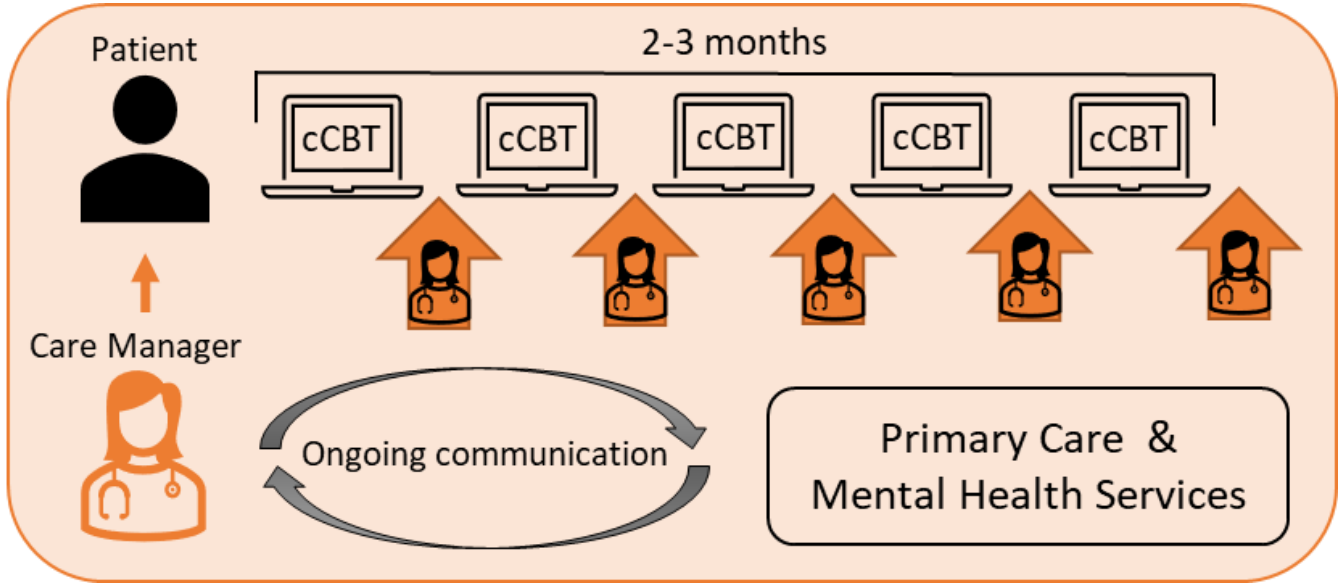
VetsPrevail
FOR VETS, BY VETS

Feedback from VA patients and clinicians used to design study

"I think it'd be good. I think it's a good idea, especially for a lot of like, the younger Vets, the online platform may be beneficial or like, the mobile platform. So, it's good to have that option." – Veteran

"I think you're going to capture a lot of people that really get benefit from treatment that either fall through the cracks because we just see them and say, 'It doesn't seem like meds would (work) great or groups,' or whatever. I think it's great. I think that it's a really good idea." - Psychiatrist

"I think you just need to make sure that there's really close follow up, making sure that that dashboard gets monitored and acted upon."- PCP



Leung VA HSR&D CDA (IK2 HX002867); Leung et al, *Trans Beh Med*, 2019

Working smarter (w/ tech), not necessarily harder

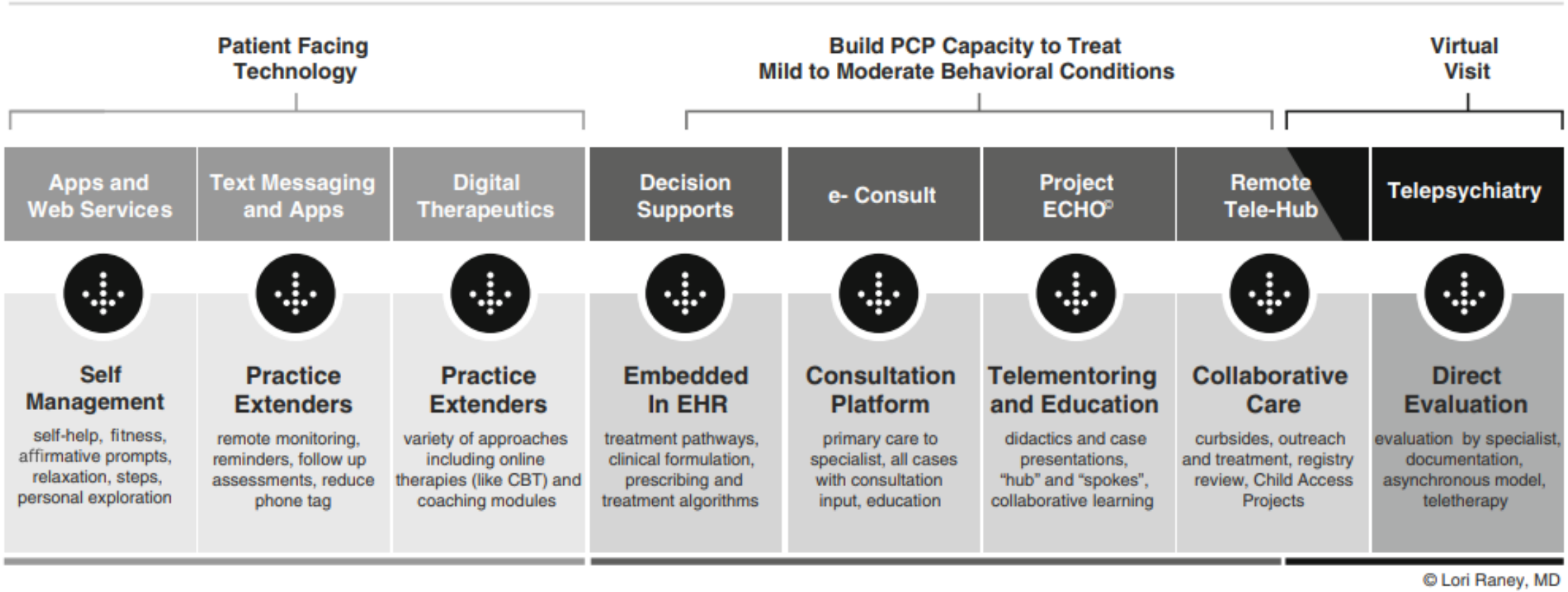
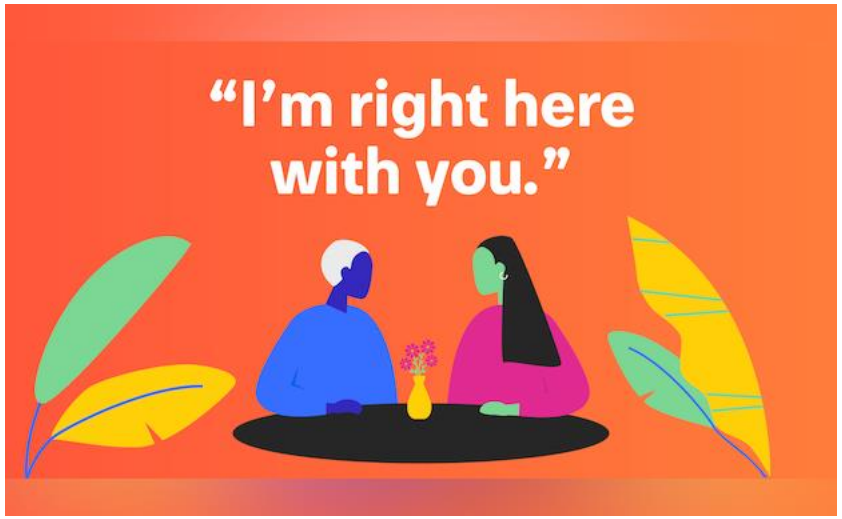


Fig. 1 Technology-enabled behavioral health services in primary care

Raney et al, *Curr Psychiatry Rep,* 2017

Key Points

- Begin depression treatment in primary care, as patients may never start treatment at all
- Know when and how to ask for MH specialist support



Closing thoughts

1. You will commonly encounter depression in primary care (SIGECAPS, medically unexplained symptoms).
2. You can effectively treat (and follow-up) mild-moderate depression with therapy and meds.
3. Be aware of new resources to help you collaboratively care for depression with mental health specialists.

Thank you!

Lucinda B. Leung, MD, PhD, MPH

Lleung@mednet.ucla.edu

@lucindaleungmd

David Geffen School of Medicine

CSHIIP
Center for the Study of Healthcare Innovation, Implementation & Policy

Collaborative Care Model

https://youtu.be/zXZTgq3GyPw

Billing for collaborative care services

CPT codes

- 99492 CoCM, is used to bill the first 70 minutes in the first initial month of collaborative care.
- 99493 CoCM, is used to bill the first 60 minutes in any subsequent months of collaborative care.
- 99494 CoCM is used to bill each additional 30 minutes in any month. It can be used in conjunction with 99492 or 99493.
- G2214 CoCM, is used to bill for the first 30 minutes in the first month of care or any subsequent month.

Must do 3 things

- Provide active treatment and care management for an identified patient population.
- Use a patient-tracking tool—for example the Patient Health Questionnaire-9—to promote regular, proactive outcome monitoring and treatment-to-target.
- Use a registry to hold regular—typically weekly—systematic psychiatric caseload reviews. This doesn't necessarily mean you need to be talking about every patient every week, but you need to be thinking about the whole caseload every week and identifying those patients needing to be discussed in that psychiatric case review.

https://www.ama-assn.org/practice-management/cpt/learn-about-4-new-cpt-codes-bill-collaborative-care

Frequently Asked Questions (FAQs)

1. How should PCPs assess patients with depression for risk of self-harm/suicide?

PCPs should ask depressed patients, especially those with addictive disorders and previous suicide attempts, directly about suicidal thoughts, intent, or plans. Asking about and reducing access to lethal means, especially firearms, can also reduce suicide risk.

2. What should PCPs first offer to treat major depressive disorder?

Initial treatment includes antidepressant medication, psychotherapy, or a combination of both, depending on patient preference, prior treatment experiences, and depression severity. Complementary, alternative, and exercise treatments have more limited evidence.

FAQs

3. When should PCPs modify medication treatment due to a suboptimal response?

The antidepressant dose can be increased by 50%–100% for a partial response (<50% symptomatic improvement) after 1 month of treatment, before considering switching medications or augmenting with a second agent.

4. When should PCPs consult mental health professionals regarding diagnosis of depression?

Psychiatric consultation is recommended for severe symptoms, heightened suicide risk, comorbid psychiatric or substance abuse problems, or lack of response to appropriate treatment.

Presenter's Contact Information

Lucinda Leung, MD, PhD, MPH

LLeung@mednet.ucla.edu