The incidence of depression is high, and access to care is limited due to a variety of factors, including the shortage of psychiatrists and the stigma that prevents patients from seeking consultation. Legislative and insurance reform offer the hope of greater numbers seeking care, and trials such as IMPACT have suggested that a collaborative care approach can be successfully integrated into primary care practices and improve outcomes of depression.

Below we share our successful experiences implementing models of comprehensive integrated care for the treatment of depression and other mental illnesses in our respective primary care academic clinics. We believe that centering care in primary care clinics improves patients’ access to care in addition to providing real-time training experiences for our residents, an issue addressed by Hemming and Loeb’s “Internal Medicine Residents’ Inadequate Preparation in Mental Health” (page 2). We recognize that implementation of comparable initiatives in small and non-academic practices with limited resources is much more challenging.

The Mount Sinai geriatrics practice is comprised of more than 29 attendings and geriatrics fellows, two NPs, three nurses, and two social workers; it serves elderly patients age 85 on average with multiple morbidities. With grant support from The Fan Fox and Leslie R. Samuels Foundation, we implemented a practice redesign based on the IMPACT program for management of depression. Our program has three key members: a depression care manager (DCM) (LCSW), a geriatrician leader, and a psychiatric consultant (0.1 FTE).

All members of the team have received training in the IMPACT program and problem solving treatment (PST). This initiative allows annual practice-wide proactive screening for depression by nursing assistants who then alert providers to assess patients for possible depression and referral to IMPACT. Our DCM evaluates the patient and in collaboration with his/her primary care physician initiates a stepped care treatment plan (pharmacotherapy and/or PST) and closely monitors response to treatment. Our psychiatric consultant reviews the complicated cases with the team and evaluates them if appropriate. We have recently added a 0.3 FTE psychologist for supervision of the DCM.

Thus far, more than 2,500 patients have been screened for depression using the PHQ-2. More than 50% of patients enrolled reached remission (defined by a 50% decrease in their PHQ-9 from admission). This program has complemented our previously established co-located geriatric psychiatric clinic and allowed us to channel more complex patients to that setting. Additionally, it has improved the wait time for new patients with other mental health issues in the geriatric psychiatry clinic. Our geriatric fellows and primary care residents are exposed and directly involved in coordinated care for chronic disease management.

Mount Sinai’s Internal Medicine Associates Clinic is a large practice of more than 20 physicians, 140 internal medicine residents, six NPs, and five RNs providing care for 15,000 to 25,000 unique patients annually. We have developed a number of innovative programs to improve access and care for our patients with depression and other mental illnesses. In 2006, we implemented a Mental Health Evaluation Clinic (MHEC) in which patients with depression and anxiety are evaluated by internal medicine residents supervised by an internist with an interest in primary care mental health, a fourth-year psychiatric resident, and a psychiatric attending who is available by page. The visits are dedicated to mental health issues, allowing for more comprehensive evaluation as well as dedicated teaching time. Prior to each session, various topics, including psychiatric history and exam, screening, diagnosis, epidemiology of depression and anxiety, medication management, counseling treatments, and patient education, are discussed in a case-based format. Residents then utilize these skills during the visit.

In 2013, two additional services were added to our clinic. The first was collaborative care and universal annual depression screening. With the help of a grant from New York State to become a patient-centered medical home, we hired a DCM (LCSW) skilled in behavioral health assessments, short-term behavioral therapies (behavioral activation (BA) and PST), and care management. She works with patients to develop individualized care plans, provides PST and BA, and sets up appropriate referrals when necessary. She receives referrals either directly from a primary care provider or from the MHEC. Patients are often co-managed via MHEC (for medica-
tions) and the DCM. In the last four months, we have enrolled approximately 60 patients, including 40 with follow-up visits, of which 60% have experienced a clinical improvement (i.e. a decrease of at least five points in their PHQ-9 score). Of those in the program for at least 10 weeks, 67% achieved a 50% improvement or PHQ-9 less than 10. Our supervising psychiatrist and psychologist collaborate closely with the DCM and help the primary care physicians manage medications. With the implementation of this program, we have trained our clinical staff and physicians on collaborative care and depression diagnosis and management and are planning more seminars on related topics.

Finally, we have recently partnered with the psychiatry department to provide a 0.4 FTE co-located psychiatrist who sees patients with more severe mental illnesses and provides backup consultation to the primary care doctors and the MHEC. We are working closely with the psychiatry department to expand these services as we recognize that despite our current programs, there are many patients with mental illness in our clinic still lacking care.

The University of North Carolina (UNC) Chapel Hill Ambulatory Care Clinic is a large internal medicine clinic staffed by 70 residents and 25 attendings, two PAs, two NPs, and several PharmDs and with more than 10,000 outpatient visits annually. We first piloted screening for depression among our diabetes patients given that significant medical conditions commonly coexist with depression. Originally, care assistants administered the PHQ-9 and then worked with the resident or attending provider to come up with a care plan. This pilot identified many patients who were then followed using screening reminders and action items that appear in a visit planner that feeds into computer algorithms offering personalized reminders for various types of patient care (i.e. diabetic foot and eye care, colon cancer screening, etc).

The project was broadened in 2010 to include those with coronary artery disease and prior depression. Our nursing assistants administer the PHQ-2 for new assessments and the PHQ-9 for patients previously identified with moderate or severe depression. An LCSW was hired as a DCM to provide counseling and develop the program. Our DCM offers PST as well as Mind Body Skills (MBS). An internist serves as her clinical supervisor, collaborating with her and other team members on the algorithms for diagnosis, medication, and follow-up as well as with residents on quality improvement projects evaluating and improving the program. With the residents’ help, we have streamlined our algorithm and clinic flow processes. We developed a companion suicide screener administered when the suicidality item in the PHQ-9 is positive that includes detailed information on how to involuntarily commit a patient at our institution as well as guidance on assigning low, moderate, and high risk to patients. We have two yearly pre-clinic case-based conferences on depression and suicide, which refer to our visit planner and offer topic and institution-specific answers to three common depression scenarios.

In the last year, we screened more than 5,000 patients, with 53% of those diagnosed with depression showing improvement (i.e. at least a five-point drop in the PHQ-9). We have added a 0.1 FTE consultant psychiatrist who helps with management of patients who respond poorly to medication trials as well as patients with other mental health diagnoses (e.g. bipolar, psychosis, substance use, anxiety, and personality disorders). Our psychiatrist offers direct patient consultation and reviews cases of diagnosis/treatment challenges provided by our counselor and other providers. We are adapting some best practices for care outside our comfort zone based on her consultations. We have now expanded depression screening to most of our patients and follow them with our algorithms. We hope to develop a parallel anxiety program in the near future.

Whether in a generalist specialty clinic, a busy urban resident clinic, or a clinic in the South with a large geographic catchment area, collaborative care IMPACT-style clinics now exist that embrace universal screening and demonstrate significant improvement rates of depression at minimal expense with few additional personnel. These successful programs offer a hopeful way to identify and treat large numbers of depressed individuals nationwide, especially as we see more Americans accessing primary care due to the implementation of the Affordable Care Act. We also suggest several strategies to prepare physicians, staff, and trainees to work within these systems on team-based learning, case-based didactics, and quality improvement. We hope our programs can be adapted to other practices across the nation and that the model can be expanded to treat other mental health conditions, such as anxiety.

References