**SIGN OF THE TIMES**

A Sampling of Successful Comprehensive Programs to Address Depression in the Primary Care Setting
Shahla Baharlou, MD; Lauren Peccoralo, MD, MPH; and Amy Weil, MD

Dr. Baharlou is assistant professor in the Brookdale Department of Geriatrics and Palliative Medicine at Icahn School of Medicine at Mount Sinai, Dr. Peccoralo is assistant professor in the Department of Medicine at Icahn School of Medicine at Mount Sinai, and Dr. Weil is associate professor of medicine and social medicine in the Division of General Internal Medicine and Epidemiology at the University of North Carolina in Chapel Hill, NC.

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 IMPACT1 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 continued on page 9
Internal Medicine Residents’ Inadequate Preparation in Mental Health

Patrick Hemming, MD, and Danielle Loeb, MD

Dr. Hemming is a second-year general internal medicine fellow at Johns Hopkins University, and Dr. Loeb is a faculty member in the Division of General Internal Medicine at the University of Colorado.

Generalist physicians who recognize mental illness among their patients are on the front lines of the mental health crisis in the United States. However, current modes of education are inadequate to train non-psychiatry residents to address mental health. The reasons for this inadequacy include health system barriers, lack of interdisciplinary education, and highly variable training requirements within the various primary care specialties. For example, although family medicine requires the longitudinal supervision of mental and behavioral health training for its residents, internal medicine does not. This variability in generalists’ training serves to perpetuate the mental health crisis highlighted in this special edition of SGIM Forum. We argue that organizations such as SGIM that focus on primary care training in the United States should challenge this by using tools developed in family medicine and pediatrics to create our own innovations to further the training of our residents in mental and behavioral health.

Generalists develop an interest in mental health at various stages of their careers—and often by chance interactions. One of our internist colleagues recalls a medical school family medicine clerkship director pointing out that “nearly half of patient issues relate to mental health, and if you close your eyes and listen, so are most of the rest.” Another physician speaks of working with a primary care physician as a medical student. The precepting family physician diagnosed his patient as having depression, walked the patient down the hall to his psychology colleague, and introduced the two. For the internist, this interaction represents an ideal that should be replicated in practice.

Others gain interest in residency. One physician stated that she benefited from the presence of a psychiatrist who happened to be practicing in the vicinity of her residency clinic. The availability of this psychiatrist was coincidental but gave her a great deal of added knowledge and curiosity about the topic. Still others gain interest from life experience later in their careers. A senior faculty member tells of watching his father-in-law struggle with a medical student. The precepting family physician diagnosed his patient as having depression, walked the patient down the hall to his psychology colleague, and introduced the two. For the internist, this interaction represents an ideal that should be replicated in practice.

Other Specialties’ Examples

Residencies in family medicine and pediatrics are required to involve behavioral and/or mental health continued on page 10
I was a primary care physician. I pulled than willing to take care of my patients application of my dilemma for my rolemitted, I began to reflect on the im-

Regarding provision of continuous long-term person-focused care, I have seen many of my patients for more than 20 years, including the patient who prompted this column. I try to understand how their medical problems affect their lives and those around them. I admit that time pressure in the clinic keeps me from spending as much time as I would like on asking about other aspects of their lives. I give myself a rating of “very good” for providing continuous care. The continuity of care would be diminished if I was not involved when patients were hospitalized.

As a general internist, I take very seriously my responsibility for providing comprehensive care. Most of my patients, especially the older ones, have numerous health problems. I generally give attention to every active problem at each visit in addition to routinely addressing health maintenance and preventive care issues. My commitment to providing comprehensive care is one of the factors motivating me to be the attending of record whenever a patient

Should I Admit My Patient to the Hospitalist Service?
Eric B. Bass, MD, MPH

From SGIM’s work with specialty organizations on the High Value Care initiative of the American College of Physicians, I have become more attuned to ways that I could improve communication with the specialists to whom I refer patients.

In the middle of an extremely busy week, I received a call from the Emergency Department about a 72-year-old patient of mine who needed to be admitted for an exacerbation of severe chronic obstructive pulmonary disease. Should I admit her to the hospital under my name, or should I admit her to the hospitalist service? For 24 years, I routinely accepted responsibility for being the attending of record whenever one of my patients was admitted to the hospital. My clinical practice was small enough that it did not impose an unreasonable burden on my time. Of course, it helped a lot that I was able to admit patients to a service covered by superb housestaff. Over the years, I came to realize how much my patients appreciated my presence when they were sick enough to require hospitalization.

Being there for my patients when they were sickest became part of my professional identity. In my mind, it was linked closely to why I chose a career in medicine—and general internal medicine in particular. What should I do now that we have a well-established hospitalist service that is more than willing to take care of my patients when they need to be hospitalized? What should I tell my family about how I am managing the work-life balance issue if I admit the patient and agree to be the attending physician?

As I pondered these questions in the context of feeling very overcommitted, I began to reflect on the implications of my dilemma for my role as a primary care physician. I pulled out one of Barbara Starfield’s classic articles on the contribution of primary care to health systems and health. I reviewed the four basic functions of an excellent primary care provider: first contact access for each new health problem, continuous long-term person-focused care, comprehensive care for most health needs, and coordination of care when health care services must be sought elsewhere.

So how do I grade myself as a primary care physician?

In terms of providing first contact access, I carry my pager 24 hours a day, seven days a week, except when I am out of town. I am willing to reply when patients contact me by e-mail, although I remind them to call if they have an urgent problem because I might not be able to answer e-mail until the end of the day. My patients know they can reach me anytime, and I do my best to answer calls promptly. My limitation in providing first-contact access is that I only see patients in the outpatient center one morning a week. That means that I sometimes refer patients to an urgent care center instead of asking them to come in to see me. On a 5-point scale (excellent, very good, good, fair, poor), I give myself a rating of “good” for first-contact access (Table 1). Maybe if I did not see patients when they were admitted I would have more time to make special arrangements when they need an urgent outpatient visit.

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My first message to you is: Please care about me; I am a person. I come to you vulnerably and often with fear. I trust you to help me with my current health issue. I want you to listen to me and value me—to find me worth caring for and caring about. When you look at my list of medications and see that I have psychotropic drugs listed there, do not make assumptions about my ability to report my health needs, my intelligence, or my symptoms.

Once I needed stitches for a cut on my finger, and the nurse who was prepping me for the doctor was chatting with me. She asked me what I did for a living. I replied that I worked in mental health. She stated, “Oh bless you! Give me the blood and guts anytime; when I see one of those nut cases coming, I want to run the other way.” Imagine my surprise. I wanted to ask her if she was willing to stay with me because I was a “nut case.” However, I did not do this for two reasons. First, I did not want to embarrass her, and second, I thought she might actually leave me while I was bleeding badly. I feared a physical exit, but more importantly, I feared her emotional exit. What if she checked my medication list before beginning her work on me? Would I have gotten the tender care I received from her? Certainly, with my attentive vigilance as a trauma survivor, her discomfort with me would have been clear. As she treated me, I might have interpreted her indifference as dislike, anger, overwork, or something else. Her behavior would have concerned me and lowered my comfort level and trust. She might have disrupted the most important part of our work together—the relationship.

As you, the Internist, and I, the patient with a serious mental illness, engage in our work together, we must develop a trusting relationship. I must believe that you will always do your best to identify what health challenges stand before me. I must believe that you see me as a whole person and that you understand I have a life that means something to me. You must believe I am an individual who is entirely capable of recovery from health challenges and mental health challenges. You must take a risk and care about me.

According to statistics, I have now exceeded my life expectancy. I began life fit, healthy, and was a swelter 105 pounds until I had my first child and was a healthy 120 pounds for the next 10 years. I had mental health challenges first diagnosed at age eighteen. I endured physical abuse from my father until I was seven and emotional and sexual abuse from my stepfather until I was 17. During that important time, I had one year of safety when my mother moved us in with my grandparents after she left my father. At age 18, I began to have intense feelings that I did not deserve to live. I did not want to die, and the feelings were very intense and frightening. These feelings were a trauma response. This response was a “normal” response to terrible events. I coped and received psychiatric care for the next 20 years.

My physical and mental health changed at age 38; I was carrying out the duties of my work as a social service provider in a very dangerous neighborhood. I loved the people in the community and cared very much about them. I had one more responsibility to carry out on Friday before I could go home. However, I was attacked by a stranger while carrying out my duties. Although I was not badly injured, my soul was wounded. I drove home, treated my slight cut, and enjoyed a weekend with my family. On Monday, I got up and got dressed for work and ended up at my friend’s house crying uncontrollably. Then, I lost about three months of time. This was also a trauma response.

However, in the continuum of my health care, that turning point was significant. During that time, I was put on anti-psychotics. My husband made sure I took the medication every day. I began to gain weight. I have always eaten a healthy diet, but within about a year, I had doubled my weight.

My primary care physicians told me to lose weight every time I went to them. I felt ashamed. My eating habits had not changed and remained healthy. I did sleep more because the medication made me groggy in the morning, but I still walked a lot with my baby in the stroller, and my husband often took us hiking in the mountains. I often walked with my older daughter who is blind to help her learn routes to buses or to her friends’ houses. However, the pounds kept coming.

I complained to my psychiatrist about my weight and was told, “At least you are not addicted to drugs or alcohol.” I did not understand what she meant. Years later, giving a speech in San Diego, I suddenly understood that the doctor thought I was addicted to food. I wasn’t and have never had a challenge with addictions, but I was not asked for input on that idea. It was so far removed from my lifestyle that it took me about 15 years to understand what she meant.

My primary care during this time focused on how fat I was. My blood pressure rose, and my cholesterol got high. I have had several primary care doctors. One told me I was attention seeking when I returned several times within two weeks with continued on page 13
Mental health care for older adults in the United States faces many of the same challenges as for younger ones. Although generalists can certainly prescribe an antidepressant when appropriate (and an estimated 35% of older adults in primary care settings have depression), they neither have the time nor the training to provide counseling. Furthermore, they are not trained to treat other mental health disorders (e.g. substance abuse, schizophrenia) that will only become more common in practice as the population ages.

In the United States, barriers to mental health treatment include stigma, poor coordination between primary care and mental health providers, poor insurance coverage, and reduced access to professional treatment. Often, mental illness goes unrecognized—nearly 60% of the approximately 8,600 people over age 60 who committed suicide in 2010 saw a physician in the month prior to death. In fact, the suicide rates rise as the elderly age; among white men age 85 and older, the rate is 31 per 100,000—twice the rate of middle-aged white men and almost three times the national average of 11.8 per 100,000. Additionally, between 25,000 and 50,000 elderly carry a diagnosis of schizophrenia, and about 44,000 are homeless. These numbers are projected to double in the next decade.

Dementia, which has an incidence of 3% per year among older adults but a prevalence of 50% among those 85 and older, takes a severe toll on all involved. Resources for these individuals are few—Medicare will reimburse a hospital for a $300,000 ICU stay for a 70-year-old man in cardiogenic shock but does not reimburse for the care needed for a moderately demented 70-year-old man who needs 24-hour supervision in order to stay safe in his home (or, for that matter, in any kind of home).

There is also a grave shortage of professionals trained to treat mental illness in the elderly. The American Association of Geriatric Psychiatry (AAGP) reports that 2,500 psychiatrists have received subspecialty training in geriatric psychiatry since 1990, yielding approximately 1,700 current board-certified physicians or one per every 27,000 older Americans.

The federal government has made some progress in overcoming this disparity in mental health care. The Mental Health Parity and Addiction Equity Act of 2008 requires mental health and substance use disorder benefits to be equal to medical and surgical benefits. It also prohibits annual lifetime coverage limits, expands covered diagnoses, and provides improved coverage of psychiatric medications under Medicare Part D.

Provisions within the Affordable Care Act (ACA) could also improve mental health care in the United States. Because the ACA emphasizes reducing overall costs, health care providers may be motivated to look at the costs of not providing appropriate care by referring patients to home and community services, using non-institutional treatment, and focusing on preventive services. Financial models within the ACA allow providers to experiment with innovative (i.e. non-fee-for-service) treatment options, which may show significant savings for, and satisfaction among, older Americans. The ACA also is designed to reward preventive services as cost-saving measures. Finally, the ACA is committed to more integrated delivery of medical care, which may enhance communication among health care professionals and improve patient outcomes.

Of course, the shortage of mental health care providers remains an issue, particularly those trained in geriatric behavioral health. As provisions in the ACA unfold over the next half decade, we need to be vigilant—both locally and nationally—to ensure that this portion of health care no longer struggles for recognition, funding, and trained providers.

Recommended Reading
www.aagponline.org
www.asaging.org
www.cdc.gov/nchs/fastats/suicide.htm
http://www.samhsa.gov/co-occurring/topics/data/ElderlyQuickFacts.pdf

Because the ACA emphasizes reducing overall costs, health care providers may be motivated to look at the costs of not providing appropriate care by referring patients to home and community services, using non-institutional treatment, and focusing on preventive services.
A 70-year-old man presents with new onset depression to an academic medical center primary care clinic. He is not suicidal. He has Medicare and a limited fixed income from Social Security. He is not disabled or on Medicaid. The academic psychiatry consultation clinic offers one-time consultation visits. The local community psychiatrists often do not accept new Medicare patients, and he does not think he can afford a private practice psychologist for therapy. What are his options?

Behavioral health problems are routinely treated by primary care providers. Many providers would treat this patient with an antidepressant medication and arrange short-term follow-up for medication adherence, clinical reassessment, and dose titration. Clinicians who have received additional training may provide short-term counseling using techniques such as cognitive behavioral therapy (CBT). In the teaching clinic, we may discuss with residents the pharmacology and practical aspects of using medications such as selective serotonin reuptake inhibitors (SSRIs) in primary care.

Scenario 1:
The patient is seen by a resident and an attending physician and started on fluoxetine. He is seen in close follow-up, and his dose is uptitrated. He wishes he could engage in other treatments in addition to pharmacotherapy. He is given a list of community psychologists and therapists but does not establish with any, citing geography and lack of coverage. Nevertheless, his depression improves slowly over the next six months.

In our academic internal medicine primary care clinic, the above scenario has been commonplace. The patient gets better, and the treatment—entirely encompassed within physician-patient encounters—is considered a success. Our trainees often find their practice most gratifying when they can address the clinical problem “on their own” without referral to a specialist.

But what does the evidence show regarding optimal outcomes for patients with common mental health disorders in primary care? Multiple studies have shown both short- and long-term benefit to a collaborative care model within primary care.1 Care models include a team comprising a primary care provider, case manager, and mental health specialist and have been shown to be effective at modest cost among older adults in primary care settings.2,3

Would referral of patients with mental health disorders to a separate specialty clinic be as effective? Possibly. At least one study has shown that enhanced referral was comparable to integrated care for six-month outcomes in depressed patients. However, most practices do not have enhanced referral services, which would include facilitation of the referral and availability of mental health providers. Additionally, Medicare participants have traditionally paid higher out-of-pocket outpatient costs for mental health care. While Medicare reforms are reducing these costs from approximately 50% to 20% to match other Medicare part B services, access to psychiatrists may be limited because providers often do not accept new Medicare patients.

Scenario 2:
The patient is referred to the Behavioral Health Integration Program and meets with a care coordinator located in the primary care clinic. He participates in therapy sessions, and his case is reviewed by a psychiatrist within the primary care clinic. The psychiatrist and primary care provider coordinate care, with the primary care provider adjusting medication therapy and tracking his PHQ-9 scores. The patient improves and is grateful for not having to go somewhere else for his care. He feels that he has developed long-term skills for managing his depression.

Because of the efforts of our psychiatry department, our clinic has been fortunate to have moved from the first scenario to the second in the past year. What has been our experience?

1. **Most patients prefer coming to the same clinic for their care, especially patients who already suffer from multiple chronic medical conditions.** Finding a mental health provider without a referral and encumbered by insurance restrictions is prohibitively difficult. For some patients, there is less stigma associated with making a dedicated trip to see a mental health provider in a familiar setting.

2. **Coordination with the behavioral health team is seamless compared to working with external providers.** When patients are seen by an external psychologist or other mental health provider, documentation may not be transmitted to primary care. The electronic medical record, coupled with standardized assessment/recommendation templates and...
O ne of the greatest challenges facing trained providers in medicine and psychiatry is finding a balanced practice of the two fields. About 10 years ago I began to contemplate my choices following graduation. The way I saw it, I faced two options: to follow the relatively straightforward path of a hospitalist or to embark on the more circuitous path of a physician-investigator. While I had a sense where each path could lead, my experience as a resident afforded me confidence in becoming a hospitalist. However, as my residency program had also prepared me to sit for two boards, that experience had also left me with the challenge of locating a practice that balanced the two fields. Ultimately, for me, acknowledging these practice realities came at a substantial cost.

Around nine years ago, I was employed as a locum tenens psychiatrist charged with the duties of performing brief, initial psychiatric assessments of recently admitted inmates as they were being processed into the correctional institution. On a particularly busy night I was asked to evaluate an individual on lithium who also happened to be an extremely anxious individual on lithium who also happened to be an extremely anxious individual. My activities in the classroom. During this period I discovered several interests that were previously unknown to me—I enjoyed data analysis, manuscript preparation, and grant writing. My day-to-day activities now balance clinical, teaching, and research duties. For my clinical work, I help manage a complex med-psych outpatient population at the local veterans’ hospital with a multifaceted treatment team (i.e. RN case manager, tele-health RN, pharmacists, clerical associates). My research activities largely consist of manuscript writing and editing, data analysis, grant writing, and building collaborative relationships with leaders in the field of post-traumatic stress disorder (PTSD). My teaching outlets are largely fulfilled on the ward when I serve as a preceptor for residents and medical students and enriched with the occasional lecture and small-group instruction. This approach has provided the balance I sought between the two fields.

Every day I experience new challenges in the pursuit of providing quality care to our veterans, staying abreast of new developments in each field and by the ever-tightening budgets of grant funding.

To me the most valuable benefit of my practice involves the exploration of observational data available through the Veterans Health Administration. I have found the process of first identifying a hypothesis and then testing it with large datasets to be one of my greatest sources of career satisfaction. It is through this process that I have been able to take simple clinical observations of med-psych disease interactions and confirm or refute them at a population level. I have discovered that my cross-discipline training has been most fruitful in identifying where these intersections lie and how to formulate the hypothesis, which ultimately will add to our understanding of PTSD outcomes in health services research.
The primary care behaviorist fits the PCMH model precisely by providing comprehensive integrated care. This allows for better coordination among the wide array of specialties utilized in patient care.
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 medications) 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.
specialists in the training of residents to develop skills in behavioral medicine. In family medicine, this training is overseen by a behavioral scientist who may be a faculty psychologist, psychiatrist, or family physician. In pediatrics, subspecialists in the field of behavioral and developmental pediatrics are required to be part of residents’ learning. Many of these interdisciplinary arrangements involve post-doctoral fellowships in primary care psychology. These fellowships, several of which exist around the country, offer the promise of training future leaders in primary care—physicians and psychologists—together. Internal medicine residencies at institutions with psychology fellowships would do well to create such partnerships. Other articles in this issue describe the innovations that various residency practices are making in behavioral health training. Most of these practices use the assistance of a mental health specialist in teaching and patient care.

Another model of change is the adoption by family medicine of the biopsychosocial model. This model, developed and proposed by George L. Engel, a prominent psychiatrist from the mid-20th century, argues that all medical illness should be considered within the full context of a patient’s life and surroundings and not simply as pathophysiology. This focus contributed to the recommendation by the American Academy of Family Physicians (AAFP) in 1977 that behavioral science be a core component of all three years of residency training. By adopting this model, family practice residencies have created space in their residency curriculum to teach behavioral health as a component of the evaluation and management of many medical conditions. The focus on behavioral science has proved to be sustainable for more than 35 years, and evidence suggests that family physicians are more likely than internists to feel comfortable treating mental health conditions.1 Specific requirements for residency programs give program directors guidance in implementing change. The Accreditation Committee for Graduate Medical Education (ACGME) requires behavioral science training in family medicine to be outpatient and longitudinal across three years of residency. In addition to didactics, programs are directed to supervise residents’ learning either through review of videos of residents’ performance or direct observation of them in patient care.2

Like internal medicine, pediatrics until recently had limited requirements for its residency programs with regard to mental and behavioral health. The American Academy of Pediatrics (AAP) addressed this in 2009 by convening a task force around mental health. This group created a list of 60 core competencies across the ACGME’s six domains. The report makes the following conclusion: “Just as mental health practice in primary care settings is collaborative, the process of training primary care clinicians for primary care practice will necessarily be collaborative.”3 These recommendations give the ACGME and residency directors in bringing mental health into their curricula. ACGME requirements in internal medicine currently give no direction to programs regarding mental health. Developing core competencies for internal medicine in this manner would be highly useful.

Existing Barriers
Several reasons may help explain why internal medicine has relatively less focus on mental and behavioral health than other generalist specialties. For one, internal medicine has increasingly become a subspecialized field. The career tracks of internal medicine residents are extremely varied. Unlike pediatrics, where there is a field of behavioral and developmental pediatrics, there is no subspecialty that focuses on this realm. Residents going into subspecialties other than primary care may not feel that gaining skills in behavioral and mental health is as crucial as other skills. The potential benefits of involving psychologists in residency training may be tempered by perceived lack of interest or lack of funding. Additionally, the current state of the US health care system creates many barriers to integrating mental health into general medical practice.

Although the barriers to establishing requirements for mental health are important, the reasons for changing current training patterns are compelling. In internal medicine, a common refrain among practicing internists is that their mental health training in residency has been inadequate. In one qualitative study, primary care general internists expressed high levels of distress about providing mental health care they did not feel competent to provide.4 Many subspecialists also struggle to provide adequate care for the subset of their patients with mental health difficulties. Examples include the high burden of depression among patients following myocardial infarction and common subspecialty conditions like irritable bowel syndrome and fibromyalgia that have strong associations with patients’ mental health. These examples highlight the importance of training in mental health care for internal medicine residents regardless of future subspecialty choice.

SGIM Task Force
The current issue of SGIM Forum highlights some steps that clinician-educators are taking to improve teaching and clinical care for mental health within our patient populations. As leaders in general internal medicine, SGIM members are in an ideal position to take on leadership roles in the process of transforming education in mental and behavioral health in our specialty. We propose SGIM convene a task force in mental health education. A task force would allow us to draw on the sig...
ing 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.

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**IN TRAINING**

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Significant expertise of SGIM members to outline the primary education needs of internal medicine residents. This would enable the Society to engage colleagues in psychiatry and psychology in the process of developing new competencies and curricular requirements and open future interdisciplinary partnerships with psychology and psychiatry. The task force would also be able to engage subspecialty colleagues to ensure that competencies are relevant for the future career paths of internal medicine residents. With a strong message from SGIM and related internal medicine societies, we hope to influence future ACGME requirements for internal medicine on the way to improving our teaching and clinical care.

**References**


tient is admitted to the hospital. I give myself a rating of “excellent” for providing comprehensive care but only if I continue to be involved when my patients are hospitalized. Coordination of care accounts for much of the time I spend on patient care that is not fully documented or reimbursed. Fortunately, our electronic medical record system makes it easier to coordinate care than was the case years ago. Even so, coordination of care continues to be a challenge in a health care system that does not give primary care providers enough support for this vital function. From SGIM’s work with specialty organizations on the High Value Care initiative of the American College of Physicians, I have become more attuned to ways that I could improve communication with the specialists to whom I refer patients. My commitment to coordination of care is the other major factor that motivates me to be the attending of record when a patient is hospitalized. On a few occasions when my patients were admitted to the hospitalist service, I noticed how difficult it was for the hospitalist to determine the full history of each complicated patient and to anticipate the challenges that will be faced after discharge. I give myself a rating of “very good” for coordination of care but again only if I continue to be involved when my patients are in the hospital.

When I reflect on my role as a primary care physician in this way, I find myself wanting to remain involved in the care of my patients whenever they are hospitalized. The competing concern is whether I can keep my inpatient knowledge and skills sharp enough to justify being the attending of record when highly skilled colleagues who specialize in hospital care are available. I also recognize that the question about how well I am doing as a primary care provider is different from the question of what will lead to the best quality of care. Perhaps the expertise and dedicated attention of a hospitalist will enhance the quality of inpatient care enough to compensate for sacrificing part of my role as a primary care provider. In this particular case, I decided to accept the responsibility of being the attending physician when the patient was admitted. While she was in the hospital, I had a long discussion with her and her family about her grave prognosis and how to manage her care in the limited time that she had left. During that discussion, I felt reassured that I made the right decision. It was best for me to be the one directing her care in the hospital.

What are the implications of my reflections for SGIM? First, I believe we should give explicit attention to supporting those general internists who want to continue providing comprehensive inpatient and outpatient care to their patients. This group includes faculty who have the option of admitting patients to a service covered by housestaff and who thus have unique opportunities to teach about coordination of care. Second, we need to acknowledge that the hospitalist movement and the organization of care within our health systems will continue to push more general internists into concentrating their efforts in the ambulatory care setting. For general internists who do not have the option of admitting patients to a service covered by housestaff, this may be the only realistic option for managing a busy practice. Third, we need to recognize the important role that our hospitalist members have in developing better ways to deliver comprehensive coordinated care in our evolving health systems. Recently, the American Board of Internal Medicine (ABIM) informed us of their plan to give internists a choice of exams for recertification: the traditional one that combines inpatient and outpatient medicine, a new one that concentrates on ambulatory care, and one that focuses on hospital medicine. Although SGIM and the American College of Physicians opposed this approach when it was suggested years ago, my own feeling is that this approach makes a lot of sense given how the practice of general internal medicine has evolved. I would welcome feedback on whether the SGIM Council should officially support the ABIM’s plan.

In addition to supporting the interests and needs of each of these groups, my hope is that SGIM will be a place to work together on improving the training of the next generation of general internists who will practice in ways that differ from how most of us were trained. Our patients should expect to receive high-quality acute care without sacrificing the vital functions of having an excellent primary care provider.

Table 1. Self-Rating of My Performance as a Primary Care Physician*

<table>
<thead>
<tr>
<th>Primary care function</th>
<th>Self-rating if I admit my patients to my service</th>
<th>Self-rating if I admit my patients to the hospitalist service</th>
</tr>
</thead>
<tbody>
<tr>
<td>First contact access</td>
<td>Good</td>
<td>Very Good</td>
</tr>
<tr>
<td>Long-term person-focused care</td>
<td>Very Good</td>
<td>Good</td>
</tr>
<tr>
<td>Comprehensive care</td>
<td>Excellent</td>
<td>Good</td>
</tr>
<tr>
<td>Coordination of care</td>
<td>Very Good</td>
<td>Fair</td>
</tr>
</tbody>
</table>

*Not intended to be a rating of the overall quality of care

References
terrible nausea, upper back pain, and vomiting. Finally, her physician’s assistant sent me for an ultrasound of my abdomen because he thought it might be my gallbladder. He told me he was taking a risk going against her, but he seemed to believe me when I said I felt terrible. I was in emergency surgery within three hours having a badly infected gall bladder removed that had enflamed all of the organs around it. Had I not reported my medications accurately, would I have had my problem recognized earlier and been treated like a person worth believing?

I had another set of experiences that demonstrate stigma against people with mental illness very clearly. I had recurrent chest pain and difficulty breathing over a period of three years. The pain increased in frequency and intensity during that time. I was hospitalized once and often had a low-grade fever and high levels of inflammation. My chest pain would wake me, and I would be terribly uncomfortable lying flat. Once I went to the urgent care and was sent by ambulance to the hospital (with all but one quarter of my right lung full of fluid). The doctor took a look at my medication list, asked me if I had taken my medications that day, which I had not because it was morning and I take them at night, and without examining me, or even listening to my chest, he told me I was having a panic attack. I told him I did not have panic attacks. He still sent me home.

The next day I saw my PCP and told him it was extremely painful to breathe. He told me to take some deep breaths. I reminded him that it hurt and that I could not breathe without pain. Reluctantly, he sent me for a CT. After I received the CT scan, I was sent directly to the ED, and within hours, I had heart surgery. Later an infectious disease specialist read my x-rays and told me that I had been sick for the last three years with pneumonia and coccidiodomycosis (i.e. Valley Fever), which had spread to my heart.

While these are my stories, I have heard countless stories from others that are like mine. In my work at Recovery Innovations, I have known many wonderful people who have died far too young. People with mental illness deserve to have a full life. Our medications are hard to take; they make us uncomfortable and have tremendous side effects. Still, most people I know take their medications. We want to be well, both physically and mentally. You and I as doctor and patient must engage in a relationship built on trust that the other is doing his/her best to make our work together valid. We must listen and work together as a team. I can plan my meeting with you, and you will accept my reporting as accurate. Then, we can learn to work together to create the best outcomes.

RESEARCHERS’ CORNER
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While I spend much of my time pursuing my research interests, I have also been able to carve out a flexible clinic schedule that allows me to explore, in detail, the medical and psychiatric complexities of my patients. This allows me to devote the necessary time to disentangle the medical complaints from the psychiatric underpinnings, which ideally will protect against repeating my prior practice failings.

Ultimately, the road in medicine is rich with opportunity and richer still for dual-trained graduates. While finding and maintaining the right mix in practice continues to be a challenge for med-psych physicians, I have discovered that an academic-based practice with a focus on health services research can provide a meaningful and rewarding career path.
tracking with the PHQ-9 and GAD-7, facilitates coordination.

3. Patient selection remains important. Resources remain limited, and over time, we realized that the elderly patient who is accustomed to coming to the primary care clinic but who would have difficulty finding and paying for external mental health care is the ideal candidate for our services. For other patients, the behavioral health team can still assist with coordination with other resources such as facilitating progression to long-term psychiatric care and accessing the community mental health system when appropriate.

4. Personal knowledge is very effective in starting the treatment program. When we refer patients, we can state with confidence, “I am referring you to ___ and Dr. ___ in our Behavioral Health Program. I know them both, and we’ve been working together for over a year now with great results for most of my patients.” In the era of ever-increasing size of health care organizations, patients may value this personal knowledge.

5. There is a positive spillover effect. There was use of instruments such as the PHQ-9 and GAD-7 questionnaires prior to the program, but their use has now become more routine. Many of us have become more adept at screening for bipolar disorder and choosing different medications through consultation with the psychiatrist on the team.

These positive impressions do not mean that the program has worked for every patient. However, it serves as an anchor for both patient and provider in the unsteady waters of our current mental health system by using a chronic disease management model housed within primary care. As the country moves toward Accountable Care Organizations and as more primary care clinics transform to patient-centered medical home, attention to behavioral health will be essential to maintaining the good health of our patient populations. Funding for integrated, coordinated behavioral health will continue to be a challenge in many locations, as will finding appropriate mental health providers, especially in underserved locations.

References
Multiple programs for training in primary care behavioral health are already in existence. The University of Michigan provides a Web-based certification, stating:

The Certificate in Integrated Behavioral Health and Primary Care (IBHPC) is designed for direct clinical practitioners—social workers, nurses, care managers, psychologists, and physicians—who deliver or plan to deliver integrated health services, and who serve populations often presenting with complex needs in physical health, mental health, and substance use.

University of Massachusetts Medical School provides certification described as “targeted to prepare behavioral health professionals for the Patient-centered Medical Home model.”

The role of the PCMH is to provide comprehensive, coordinated patient care with an eye to quality improvement. Simply focusing on behavioral health in primary care with the implementation of co-located services is feasible and will result in more timely care. However, further coordination can be achieved through the use of integrated behavioral health services in primary care, as with the primary care behaviorist. While this is an appealing option, there are some questions that remain unanswered. Further investigation is needed to assess the effectiveness of integrating behavioral health clinicians into primary care, particularly with regard to patient behavioral health outcomes. However, by working to improve integration of behavioral health in primary care under the PCMH model, needed attention will be given to the diagnosis and treatment of these disorders. Patients will receive comprehensive and coordinated care of both their medical and behavioral health problems, thereby improving the quality of care.

References
9. A video demonstrating the model was provided on the UMass Website and can be accessed at http://www.youtube.com/watch?v=UuJ298jk2Wc
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